



CLINICAL PRACTICE GUIDELINE

Wound care

This document should be read in conjunction with this [Disclaimer](#)

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See SCGH Nursing Practice Guideline [No 16 Wound Management](#) for dressings, skin tear management, suture and staple removal, and negative pressure wound therapy.

Please note that this guideline is for clinical information only. Information contained in it regarding contacts and paperwork (e.g. MR numbers) are not applicable for KEMH.

KEMH Specific:

- KEMH uses Wound Assessment and Care Plan (MR263) and do not use Wound Management plan MR 637
- KEMH use MR 260.01 Risk assessment for pressure ulcers in combination with MR 260.03 Comprehensive skin assessment and do not use MR 856 pressure injury risk and skin integrity management
- Dressings as per medical instructions.
- For postoperative measures for surgical wounds, see also KEMH Infection Prevention and Management policy: [Prevention of Surgical Site Infections: Postoperative Measures](#)
- Detergent / disinfection wipes are used for cleaning of dressing trolley

Simple dressing

Refer to SCGH Nursing Practice Guideline [No 16 Wound Management](#)

Removal of sutures

Note: Specific instructions from the medical officer must be received before removing sutures.

In addition to the procedure in SCGH guideline [No 16 Wound Management](#):

Post procedure

- Document removal of sutures in the patient's medical record. MR 249.61 Caesarean Birth Clinical Pathway or MR 286 Gynaecology Nursing Observation Chart and MR 250 Integrated Progress Notes.
- Document wound healing/status in the patient's medical record.

Removal of staples

Note: Specific instructions from the medical officer must be received before removing staples.

In addition to the procedure in SCGH guideline [No 16 Wound Management](#):

Procedure

Prior to the procedure

- Check post op instructions for the time of staple removal MR 310 caesarean section or MR 315 operation record

Post procedure

- Document removal of staples in the patient's medical record. MR 249.61 Caesarean Birth Clinical Pathway or MR 286 Gynaecology Nursing Observation Chart and
- Document wound healing/status in the patient's medical record. MR250 Integrated Progress Notes

Care in the home (Visiting Midwifery Service)

- Check the VMS summary (referral) for post-operative instructions for the time of staple removal or contact the ward of discharge.
- Ensure patient and staff safety in terms of correct manual handling and posture within the home environment.
- Follow the procedure as documented.
- Document the care given and wound healing / status in the patients Caesarean Birth clinical pathway (MR249.61) or VMS progress notes (MR255).
- If concerned regarding the wound:
 - Discuss with the VMS Coordinator or a core staff member
 - Discuss with Obstetric or Gynaecology registrar (via KEMH switchboard)
 - Arrange review in the Emergency Centre at KEMH (if applicable)
 - Complete the VMS to EC referral form (MR026) and notify the department
 - Alternatively, the patient may choose to see her local general practitioner or present at an Emergency Centre closer to her home.

Drains

See SCGH Nursing Practice Guideline [No 65 Wound Drain Management](#) for drain dressings, shortening, emptying, suction (e.g. Varivac) and removal of drains.

Please note that this guideline is for clinical information only. Information contained in it regarding contacts and paperwork (e.g. MR numbers) are not applicable for KEMH.

KEMH uses

- Wound assessment and care plan MR 263
- Fluid Balance Chart MR 729
- Detergent / disinfection wipes for cleaning of dressing trolley

Wound drainage systems

1. Provide education to the patient regarding mobilising with a drain in-situ. Patient safety- See Clinical Guideline: O&G: [Falls Risk Assessment and Management](#).

Assessment & documentation

2. Assess and document the type and number of drains, suction, drainage, volume, colour, and description of drainage:
 - Sanguineous- bright red;
 - Serosanguineous / Haemoserous- pink- usually appears a few hours post-op and decreases over time;
 - Serous fluid- clear/straw coloured;
 - Purulent- thick yellow or grey/green, malodorous;
 - Chyle- cloudy/milky white lymph drainage).
3. Monitor the amount and type of drainage with post-operative observations or as clinically indicated. Monitor the drainage bottles 4 hourly in the first 24 hours after insertion.¹ The frequency of monitoring is adjusted according to the clinical situation.
 - Closed vacuum systems should be assessed regularly, with a minimum of 4 hourly assessments in hospital (PRN & daily in community) for the presence of continued intended vacuum and volume/ consistency of fluid drained. Vacuum systems may need to be changed or suction used to re-establish a vacuum.¹
 - Open drain dressings must be assessed regularly and changed if wet. It may be necessary to weigh the dressings before and after changing to accurately assess the amount of drainage. Make note of any signs of wound infection or maceration, particularly if there is excessive

drainage fluid making prolonged contact with the surrounding skin.

Document as for Closed Vacuum Drainage.

4. Fluid drainage should be measured and recorded on the 24 hour fluid intake/output medical record (where applicable) and integrated progress notes. As a minimum, mark the drain fluid level with a line, date and time at 2400hrs each day² or as specified by medical team (e.g. 0700hrs).
5. Excessive drainage must be reported to the medical team.³ Drainage may be blood stained immediately following surgery, but then becomes serous. Any blood stained drainage or blood clots may indicate haemorrhage. Document the amount and colour of any drainage on the MR 286- Gynaecology Nursing Observation chart or MR 249.61 Caesarean Birth Clinical Pathway. Consider contacting the medical team.
 - If the amount is >100mL in 1 hour: Perform vital sign observations, inform the shift co-ordinator and request medical staff review.
 - If there is no drainage or the presence of swelling and increased pain: Perform vital sign observations, assess the wound and drain patency, and notify the medical staff.

Signs of infection

6. Monitor the wound and drain insertion site for signs of infection (e.g. inflammation, pain, redness, swelling, heat, discharge) and notify the medical staff if signs are present.
7. A specimen/swab for culture and sensitivity should be collected from the drain site if there is presence of purulent discharge or an inflamed site.³ See also section: [Collection of a Wound Swab](#).
8. All drains should be assessed to ensure they are complete after removal. Any suspected incomplete drains or missing fragments must be reported to the medical staff immediately for review.¹
9. The removal of drains must be signed off in the operative notes MR 310 Caesarean Section or MR 315 Operation Record.

Pre-vacuumed closed system: Management

Change of unit

The pre-vacuumed units should be changed in these situations:

- When the indicator system shows minimum or no vacuum
- The bottle is full
- The bottle is nearly full at or near 2400 hours.

Removal of pre-vacuumed closed system drain

- The pre-vacuumed closed system drain is removed at the doctor's discretion or according to post-operative orders.

Recording drainage volume closed systems

Drainage amount and type should be recorded on the Fluid balance chart: MR 729

- At 2400 hours. Mark the fluid level with a horizontal line using a felt tipped pen. Note time and date.
- When the drainage system is changed. Note the time and date.
- On removal.

Removal of a drainage tube

Procedure

1 Prior to the procedure

Confirm written instructions by the medical officer regarding removal of the drainage tube in the patient medical records.

2 Procedure

If the drain is not easily removed leave it in situ. Notify the nursing Co-ordinator and medical staff for review.³

2.1 Assess the drain to ensure it is complete.

Report to the medical staff if the drain appears incomplete or has jagged edges

If the tip of the drain is required for microbiological investigation, it should be cut off with sterile scissors and placed in a sterile container to maintain asepsis

3 Document the procedure in the patient's medical record and on MR325 (Handover to Recovery/Ward)

Documentation should include:

- presence of ongoing drainage exudate
- volume of drainage (as applicable)
- signs of infection at the wound site

3.1 Monitor dressing regularly.

Replace dressings as required.

Report excessive drainage to the medical team.³

Removal of a vaginal drain

Aim

- To guide the removal of a vaginal drain.

Equipment

- Sterile dressing pack
- Optional additional equipment – stitch cutter, sterile scissors, and gauze swabs
- Contenance sheet
- Combine / sanitary pad
- PPE- gloves, face mask and protective eyewear
- Rubbish receptacle

Ensure dressing trolley is cleaned with hospital grade detergent before and after the procedure.

Procedure

PROCEDURE

- 1 Prior to the procedure**
 - 1.1 Confirm written instructions by the medical officer regarding removal of the vaginal drain in the patient medical record.
 - 1.2 Explain the procedure and obtain verbal consent from the patient.
 - 1.3 Assess patient comfort and analgesia requirements.
Place incontinent sheet under the patient's buttocks.
 - 1.4 Open and prepare equipment as required.
 - 1.5 Perform hand hygiene.
 - 1.6 Don clean gloves and personal protective equipment.
 - 1.7 Remove dressing and discard.
 - 1.8 Release suction on the drain, if appropriate.
 - 1.9 Perform hand hygiene. Don sterile gloves as required.
- 2 Procedure**
 - 2.1 Cleanse wound site with normal saline as required. Dry.
 - 2.2 Remove the suture if the drain is held in situ with it.
 - 2.3 Maintain gentle traction and ease the drain gently out from the wound.

PROCEDURE

2.4 Apply a dressing pad / sanitary pad on the perineum.

2.5 Remove gloves and perform hand hygiene.

3 Post procedure

3.1 Ensure the patient is comfortable.

3.2 Document the procedure on the MR 325 Handover to Recovery/Ward

Documentation should include:

- presence of ongoing drainage exudate
- volume of drainage (as applicable)

3.3 Monitor vaginal discharge.

- Encourage the woman to replace sanitary pads as required.
- Report excessive drainage to the medical team.³

Removal of a vaginal T-Tube

Aim

- To guide staff with the removal of a vaginal T-Tube.

Equipment

- Sterile dressing pack
- Stitch cutter
- Optional equipment – sponge holding forceps
- Gloves
- Sanitary pad / combine
- Contenance sheet (bluey)
- Rubbish receptacle

Ensure dressing trolley is cleaned with hospital grade detergent before and after the procedure.

Procedure

PROCEDURE	
1	Prior to the procedure
1.1	Confirm written instructions by the medical team regarding removal of the vaginal t-tube in the patient medical record.
1.2	Explain the procedure and obtain verbal consent from the patient.
1.3	Assess patient comfort and analgesia requirements. Place incontinence sheet under the patient's buttocks.
1.4	Open and prepare equipment as required.
1.5	Perform hand hygiene.
1.6	Don clean gloves and personal protective equipment.
1.7	Remove dressing/pad and discard.
1.8	Release suction on the drain, if appropriate.
1.9	Perform hand hygiene. Don sterile gloves.
2	Procedure
2.1	Remove the suture if the drain is anchored in situ.
2.2	Grasp the drain as close to the visible insertion site as possible and pull firmly, applying gentle constant force.
2.3	Place a perineal pad or sanitary napkin over the perineum.
2.4	Remove gloves and perform hand hygiene.
3	Post procedure
3.1	Ensure the patient is comfortable.
3.2	Document the procedure in the patient's medical record. Documentation should include: <ul style="list-style-type: none"> • presence and type of discharge • volume of drainage (as applicable) • signs of infection
3.3	Monitor ongoing vaginal discharge. <ul style="list-style-type: none"> • Encourage the patient to change perineal pad as required. • Encourage the patient to report excessive drainage to nursing/medical personal.

Collection of a wound swab

Purpose

- To provide the appropriate interventions for the needs of the individual patient while reassessing the clinical status of the patient in response to all interventions and disease processes.
- To collect wound exudate for microscopy and culture without contamination
- To enable identification of organism(s) causing infections
- To enable identification of an antibiotic sensitivity pattern to guide appropriate treatment.

Key points

1. Wound swabs should be collected when any of the following are present
 - Local heat; Redness / erythema;
 - Increased pain or tenderness;
 - Oedema
 - Inflammation;
 - Abscess / pus; Purulent discharge; Malodour
 - Delayed healing
 - Discolouration of wound bed
 - Friable granulation tissue that bleeds easily.
 - Pocketing / bridging at the base of the wound
 - Wound breakdown
2. This procedure requires [aseptic technique](#).
3. Local anaesthetic should not be used prior to swab collection.
4. Wound swabs should be collected prior to the patient commencing systemic antibiotic therapy.
5. The swab must be collected from an area of viable tissue where the clinical signs of infection are present.
6. The swab should not contain dead tissue or yellow, fibrous slough, pooled exudate or be taken from the wound dressing.
7. The wound swab should be taken before antiseptic solutions have been used on the wound.
8. Swabs must be transferred to the laboratory as quickly as possible. Do not place in a refrigerator prior to transfer, they must remain at room temperature.
9. If the wound swab is from a caesarean section or gynaecology wound, contact Infection Prevention and Management and complete a surgical site notification slip.

Procedure

Equipment

- 70% Alcohol or Detergent wipe (for decontaminating trolley)
- Dressing pack; Dressing trolley
- Sterile swabbing solution (sodium chloride 0.9% is normally used to clean wounds)
- Bag to dispose of used items
- Sterile swab stick
- Transwab (dual tube with swab stick plus charcoal transport medium)
- PPE: Gloves; Plastic apron; Eye protection – risk assess if deemed necessary

Collecting a wound swab

1. Positively identify the patient.
2. Perform hand hygiene.
3. Don gloves. If a dressing is present, perform hand hygiene, remove the old dressing and repeat hand hygiene.
4. Before collecting a swab remove all excessive debris and dressing product residue without unduly disturbing the wound surface. This can be achieved by using a gently stream of sterile 0.9% sodium chloride. Normal saline cleanses the contaminants without destroying the pathogen.
5. Remove excess saline with a sterile gauze. This exposes the wound to ensure a good culture is collected
6. Wait for 1 -2 minutes to allow the organisms to rise to the surface of the wound.
7. Exudating wounds – do not pre moisten the swab.
8. Non-exudating wounds – pre moisten the swab with normal saline.
9. If fresh pus or wound fluid is present ensure this collected on the swab.
10. The Levine technique is the preferred method when taking a wound swab. A swab is rotated over a 1cm² area of the wound with sufficient pressure to express fluid from within the wound tissue.
11. Once collected the swab should be placed in the charcoal medium.
12. Correctly label the specimen(s).
13. Ensure the following information is on the request form
 - Area the swab was collected from.
 - Patient condition or diagnosis
 - If the patient is receiving antibiotics.
14. Send the specimen(s) immediately to the lab on the sealed pocket of a Biohazard bag
15. Complete a Wound Assessment and Care Plan form (MR 263).

Topical negative pressure wound therapy (TNPWT) –single use

- Note KEMH uses wound assessment and care plan MR 263 and does not use NWPT Chart MR 871
- For all clinical photography contact page number 3465 between 0800 and 1600hrs Monday to Friday.
- NPWT equipment available from CNC ward 6 or via CNS in theatre. KEMH does not obtain equipment from SCGH Hospital Equipment Service

Aim

- To promote wound healing in high risk patients and reduce rates of infection and wound dehiscence.

Overview description

The application of Topical Negative Pressure Wound Therapy can assist with the prevention of wound complications in surgical incision sites. Complications include surgical site infection (SSI), dehiscence and haematoma. Patients regarded as being in the 'high risk bundle'^{4, 5} (see risk factors below) are deemed suitable candidates for this therapy.

Background

NPWT involves applying a vacuum across a wound to improve the wound healing process and is indicated for use on clean, closed surgical wounds.⁵⁻⁷ It has been found to reduce the incidence of SSIs in high risk patients through improving blood flow to the area, reducing haematoma and oedema formation, enhancing the development of granulation tissue, splinting the wound edges and sealing the wound from exposure to bacteria.⁶ Each patient should have a holistic assessment to identify the suitability for NPWT prior to its application.

NB: Using these dressings on low risk patients has not been shown to improve outcomes.⁵

Key points ⁷

1. Dressing lengths of 30cm and 40cm are available. Ensure the wound is entirely covered by the absorbent island.
2. The system is designed to provide 7 days of therapy⁷. There are two dressings in the pack.
3. Each system comes with a patient information booklet. Place a hospital sticker onto the booklet and ensure it remains with the patient.
4. As the wound is visualised less frequently while the system is in place, ensure to monitor for signs of infection. These include pyrexia, heat, pain and erythema.
5. If at any time the fixation strips and/or dressing are lifted or removed, the

dressings must be replaced.

6. Excessive bleeding is a serious risk associated with suction to wounds. Careful patient selection is essential.

Indications for TNPWT

This therapy is indicated for clean, closed surgical wounds⁵⁻⁷ on patients who are deemed high risk. Higher rates of SSI are associated with but not limited to the following risk factors:

- High BMI >35^{4, 6, 8, 9}
- Diabetes (Type 1, Type 2 & Gestational)^{4, 5, 8}
- History of wound infection or dehiscence⁴
- Prolonged labour
- Rupture of membranes > 6 hours¹⁰
- Multiple Caesarean Births ≥3⁴
- Poor skin integrity⁴
- Smoker and/or IV Drug User⁵
- Pre-operative pyrexia (>38 degrees)⁵
- Immunocompromised (current infection, neutropenic)^{4, 5}
- Comorbidities i.e. Hypertension, Vascular disease, Cancer^{4, 5, 8}
- Length of procedure exceeding 2 hours⁸ (>48 minutes for caesarean section)¹⁰

It is the responsibility of the surgical team to determine which patients are suitable for this therapy. Patients are recommended to have this therapy if they have a BMI >45 or a **minimum of three of the above risk factors** (KEMH directive) to be deemed suitable for this dressing post-operatively.

Wounds NOT suitable for the use of NPWT⁷

- Non enteric, non-explored fistulae to other organs or body cavities.
- Necrotic eschar
- Confirmed and untreated osteomyelitis
- Malignancy in the wound (once any malignancy has been removed its use may be indicated following discussion with medical staff).
- Direct placement of NPWT over exposed blood vessels.
- Anastomotic sites.
- Pleural, mediastinal or chest tube drainage

Wounds where caution is required using NPWT⁷

- Enteric fistulae
- Active bleeding

- Patients on anticoagulants
- Difficult wound haemostasis
- Proximity to blood vessels
- Haemoglobinopathy (Sickle Cell)
- Abnormal clotting
- Underlying structures in the wound e.g. organs and bowel
- May be used with surgical drains provided the dressing is not placed over the tubing where it exits the skin. Any surgical drain should be routed under the skin away from the edge of the dressing and function independently.

Risks with use ⁷

- Patients must be closely monitored for bleeding. If sudden or increased bleeding is observed, immediately turn off the negative pressure. Leave the dressing in place, take appropriate measures to stop bleeding and seek immediate medical assistance.
- The use of anticoagulants does not deem a patient inappropriate for negative pressure therapy; however haemostasis must be achieved before applying the dressing. Patients suffering from difficult haemostasis or who are receiving anticoagulant therapy have an increased risk of bleeding. During therapy, avoid using haemostatic products that, if disrupted, may increase the risk of bleeding. Frequent assessment must be maintained and considered throughout the therapy.
- At all times care should be taken to ensure that the pump and tubing does not:
 - Lie in a position where it could cause pressure damage to the patient.
 - Trail across the floor where it could present a trip hazard or become contaminated.
 - Present a risk of strangulation or a tourniquet to patients.
 - Rest on or pass over a source of heat.
 - Become twisted or trapped under clothing or bandages so that the negative pressure is blocked.
- In the event that defibrillation is required, disconnect the pump from the dressing prior to defibrillation.
- MRI is unsafe. Do not take the vacuum unit into the MRI suite.
- This therapy is not intended for use on board an aircraft, the batteries should be removed during air travel.
- Although the dressing can be used under clothing and bedding it is important that occlusive materials (e.g. film dressings) are not applied over the pad area of the dressing as this will impair the device's performance.

Post-operative care^{7, 11}

- Patients may shower while the dressing is in place. Place the pump into a water-tight bag or disconnect the pump and ensure the port is pointing downwards so that water cannot enter the tube. Jets of water and soaking must be avoided.
- Monitor the dressing for loss of negative pressure and high amounts of exudate.
- NPWT can cause discomfort and pain. Analgesia may be required during therapy and dressing changes.
- More frequent dressing changes may be required depending on the level of exudate, condition of the dressing, wound type and size etc.
- The dressing should be inspected every 4 hours for the initial 24 hours post operatively and then at a minimum of each shift.
- The patient should be monitored carefully for any evidence of a sudden change in blood loss status.
- Sudden or abrupt changes in the volume or the colour of the exudate must be reported to the medical team.
- The system is designed to provide 7 days of therapy. There are two dressings in the pack. The first dressing will be changed at 48 hours (earlier if there is a high level of exudate) and the wound will be visualised and assessed.
- 7 days of therapy should be achieved where possible.
- If staples/removable sutures are in place, remove the second dressing on day 5 along with the staples/sutures.
- Appropriate patient education should be provided prior to discharge. A detailed booklet is supplied with the dressing; this must be given to the patient. If this booklet is missing, please contact Theatre or the company representative.
- When the therapy is complete, the dressing can be discarded in general waste. The batteries must be removed from the pump and disposed of according to local regulations.

Troubleshooting

- A troubleshooting guide can be found inside the dressing box
- The patient booklet provides information on post-operative case and what the coloured lights on the pump display mean.
- If education is required in your area or you are seeking brand-specific information about application, use and troubleshooting please contact the relevant company Representative.

Negative pressure wound therapy (NPWT) (non-topical)

Management of NPWT for an open wound (e.g. dehisced, surgically debridement) see Application and care of NPWT see [SCGH practice guideline No 16 : Wound management](#)

On discharge with a non-topical NPWT, the patient is referred for ongoing wound management with HITH at SCGH- see section below.

Complex wound management: Referral to HITH at SCGH

Aim

To provide appropriate and timely referral to the HITH programme at SCGH for women requiring complex wound management.

Key points

1. This service is only available to women who have a complex wound and meet the criteria for referral.
2. Women may only be referred as outpatients. If hospitalisation is required they shall remain at KEMH.
3. All issues identified by SCGH shall be communicated to KEMH medical staff at Registrar level or above.
4. All women shall have a wound review at KEMH monthly while receiving treatment through HITH at SCGH. SCGH will fax a referral to 6458 1031 for the outpatient's appointment.
5. Once care is complete SCGH will inform KEMH of the outcome by fax to 6458 1031.

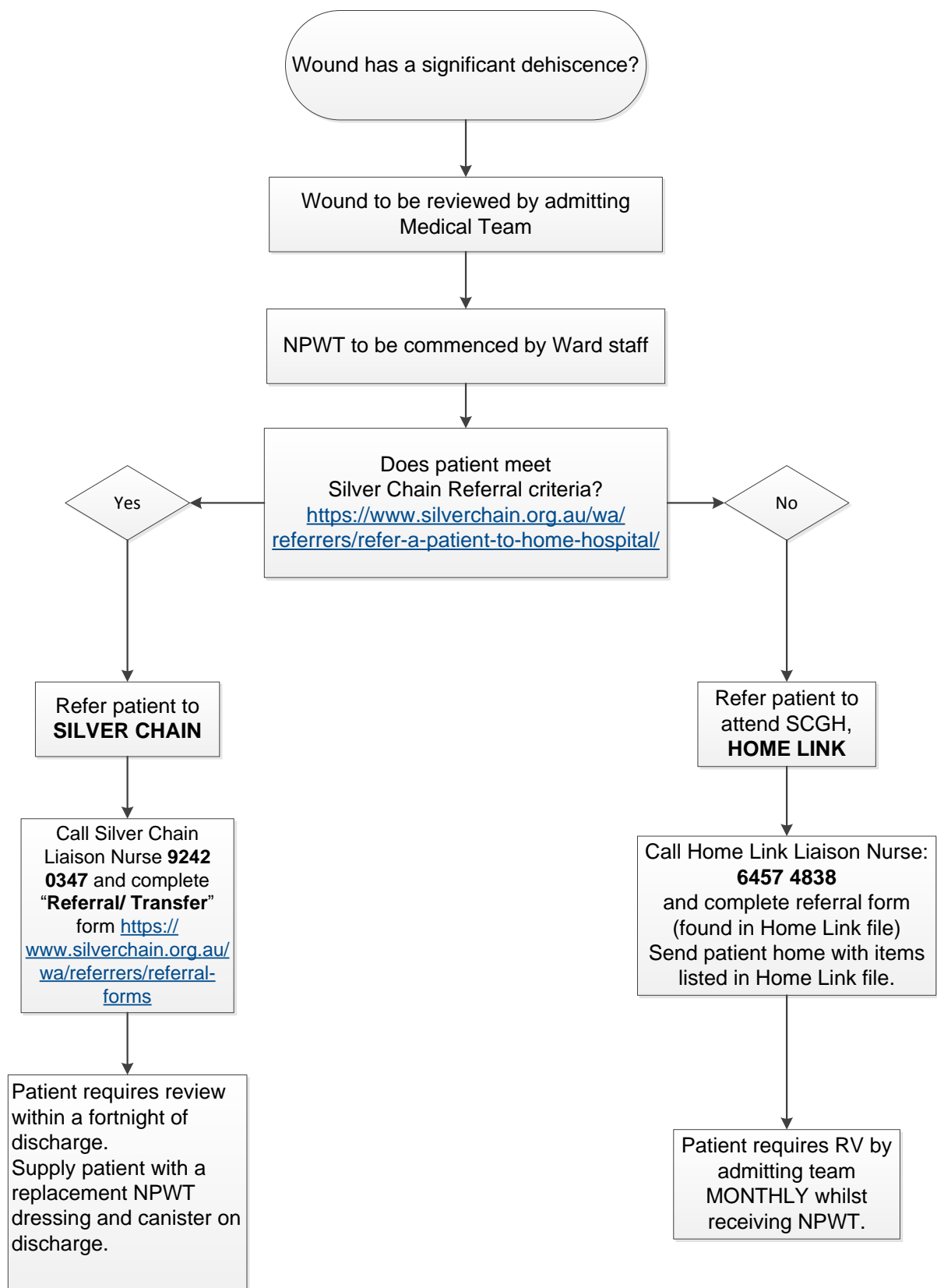
Criteria for referral

- Complex wound
- Unsuitable for [Silver Chain referral](#)
- Ambulant
- Have transportation to and from SCGH at least 2 times per week.
- Weight limits of
 - Maximum 180kg for a bed
 - Maximum 300kg for a chair

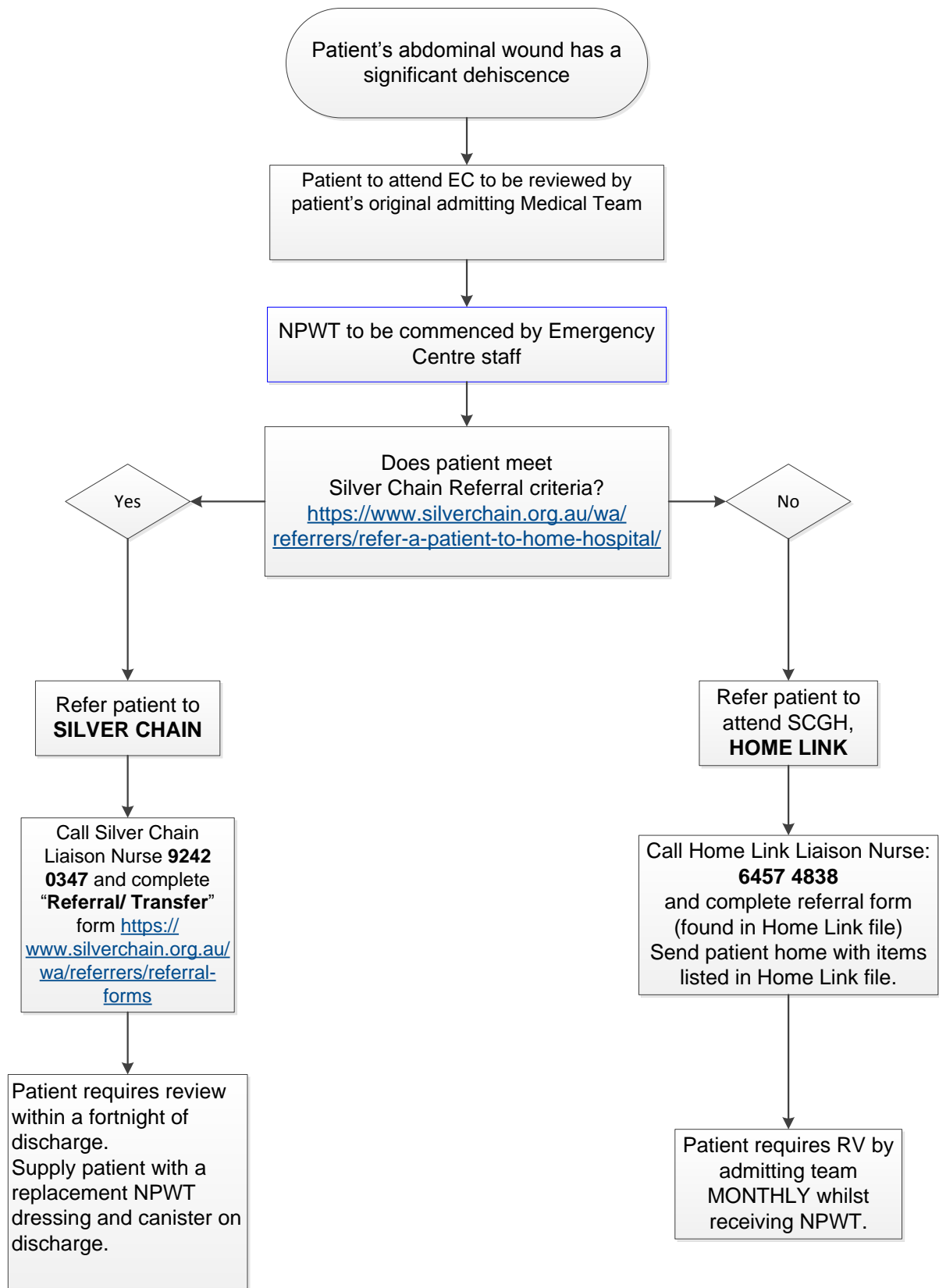
Process for referral

- The patient is identified as suitable for referral
- KEMH staff contacts the HITH LAN nurse on 6457 4838 to discuss the management.
- KEMH staff to commence a referral and wound care plan.
- Fax the referral and wound care plan to 6457 2880
- SCGH will contact the patient and inform her of the appointment details.

Inpatient referral process



VMS referral process



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Resources

SCGH Nursing Practice Guidelines:

- [No 16 Wound Management](#)
- [No 65 Wound Drain Management](#)

Silver Chain: [Referrals Criteria](#) & [Referral Forms](#)

World Health Organization (WHO): [Global Guidelines for the Prevention of Surgical Site Infection](#) (2016)








Related WNHS policies, procedures and guidelines

KEMH Clinical Guidelines:

- O&G: [Referral to Silver Chain](#)
- Infection Prevention and Management Manual: [Hand Hygiene](#) ; [Prevention of Surgical Site Infections](#); [Aseptic Technique](#)

Related forms used at KEMH for recording wound and drain care:

- Risk assessment for Pressure Ulcers (MR 260.01)
- Comprehensive Skin Assessment (MR 260.03)
- Wound Assessment and Care Plan (MR263)
- Caesarean Birth Clinical Pathway (MR 249.61)
- Gynaecology Nursing Observation Chart (MR 286)
- Caesarean Section (MR 310) or Operation Record (MR 315)
- Handover to Recovery/Ward (MR 325)
- Fluid Balance Chart (MR 729)
- Integrated Progress Notes (MR 250)
- VMS to EC referral form (MR026)
- VMS progress notes (MR255)

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Endorsed by:	GSMSC	Date:	05/07/2018
	MSMSC	Date:	24/07/2018
National Standards Applicable (V2):	<p>1  Governance, 3  Preventing and Controlling Infection, 5  Comprehensive Care (incl ) , 6  Communicating (incl ) , 8  Recognising & Responding to Acute Deterioration</p>		
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