OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Wound care

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH and home visiting

This document should be read in conjunction with this Disclaimer

Contents

Introduction

See Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG) Nursing Practice Guideline No 16 Wound Management for dressings, skin tear management, suture and staple removal, and negative pressure wound therapy.

Please note the SCGOPHCG 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 general points:

- KEMH uses Wound Assessment and Care Plan (MR263)
- KEMH uses Pressure Injury Prevention and Management Plan (MR260.05) or pressure injury screening section within relevant obstetric clinical pathway where applicable, in combination with Comprehensive Skin Assessment (MR 260.03) and do not use ‘Pressure Injury Risk and Skin Integrity Management Plan’
- Dressings as per medical instructions
- For postoperative measures for surgical wounds, see also WNHS Infection Prevention and Management policy: Prevention of Surgical Site Infections: Postoperative Measures

Simple dressing

Refer to SCGOPHCG Nursing Practice Guideline No 16 Wound Management

Removal of sutures and staples

Note: Specific instructions from the Medical Officer must be received before removing sutures or staples.

Check post op instructions for the time of suture or staple removal in the Caesarean Section (MR 310) or Operation Record (MR 315) (for postnatal care in the home, this information may be found in the Stork home visiting summary).

Note: If combined with topical negative pressure wound therapy, see post-operative chapter for routine removal of sutures / staples on day 7

In addition to the procedure in SCGOPHCG guideline No 16 Wound Management:

- Post procedure: Document the removal of sutures and wound healing/status in the medical record. Use Postnatal Clinical Pathway or Gynaecology Nursing Observation Chart, and Progress Notes.

Care in the home

Visiting Midwifery Services (VMS), Midwifery Group Practice (MGP), Community Midwifery Practice (CMP)

- Check the Stork home visiting summary (referral) or Postnatal Clinical Pathway for post-operative instructions for the date/day of staple removal. Contact the ward of discharge if missing.
- Ensure patient and staff safety in terms of correct manual handling and posture within the home environment.
- Document the care given and wound healing / status in the patient's Postnatal Clinical Pathway or VMS progress notes.
- If concerned regarding the wound:
  - Discuss with the Coordinator or Clinical Midwifery Consultant / Specialist (CMC/S)
  - Discuss with Obstetric or Gynaecology Registrar (via switchboard)
  - Arrange review
    - **KEMH patient:** In the Emergency Centre (EC) at KEMH (if applicable). Complete the VMS to EC Referral form (MR026) and notify the EC
    - **OPH patient:** In OPH Maternity Assessment Unit (AU). Complete VMS Emergency Assessment Referral form (MR(OPH)26.2) and notify the AU.
  - Alternatively, the patient may choose to see their local general practitioner (GP) or present at an Emergency Department closer to their home.
  - Document discussions and plan in the clinical pathway.

Drains

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

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

KEMH specifics:

KEMH uses:

- Wound Assessment and Care Plan (MR263)
- Fluid Balance Chart (MR729)

Wound drainage systems- general principles

- Provide education to the patient regarding mobilising with a drain in-situ. Patient safety- See WNHS Clinical Guideline: Obstetrics and Gynaecology: Falls Risk Assessment and Management.

Assessment and documentation

1. **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).

2. **Document fluid drainage:**
    - Fluid drainage should be measured and recorded on the fluid intake/ output medical record (where applicable) and progress notes.
    - Monitor the amount and type of drainage with post-operative observations or as clinically indicated. As a minimum, mark the drain fluid level with a line, date and time at 2400hrs each day or as specified by medical team[1] (e.g. 0700hrs). The frequency of monitoring is adjusted according to clinical situation.[1]
    - Drainage amount and type should be recorded on the Fluid Balance Chart
        - At 2400 hours. Mark the fluid level. Note time and date.
        - When / if the drainage system is changed. Note the time and date.
        - On removal

3. **Consider contacting medical team**: Excessive drainage must be reported to the medical team. 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 Gynaecology Nursing Observation chart or Postnatal 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.

Removal

- **The removal of drains is at the direction of the medical team and must be documented** in the post-operative instructions of the relevant Operation Record or patient notes.[1]
- Explain the procedure and obtain verbal consent from the patient.
- 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.

After removal

- **Document** the procedure in the patients notes and removal of drain on the MR 325 Handover to Recovery/Ward. Documentation in notes should include:
    - presence of ongoing drainage exudate
    - volume of drainage (as applicable)
    - signs of infection at the wound site
- **Monitor** ongoing discharge. Encourage the patient to:
    - Report excessive drainage to the medical team
    - Vaginal drain: replace sanitary pads as required

Signs of infection

- 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.
- 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. See also section: Collection of a Wound Swab. If sample from the drainage canister is requested- see SCGOPHCG guideline No 65 Wound Drain Management (drain pathology sampling section).

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 (or nearly full at or near 2400 hours)

Removal of a drainage tube

See 'Removal of Drain' within SCGOPHCG Nursing Practice Guideline No 65 Wound Drain Management. In addition:

- Follow general principles section above for checking medical order prior to commencing and patient consent.
- If the drain is not easily removed leave it in situ. Notify the nursing Co-ordinator and medical staff for review.
- 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.
- Monitor dressing regularly. Replace dressings as required. Report excessive drainage to the medical team.

Removal of a vaginal drain or vaginal T-tube

Equipment

- Sterile dressing pack
- Continence sheet (e.g. bluey); Sanitary pad / combine
- **PPE**- gloves (sterile and non-sterile), face mask and protective eyewear, plastic apron– risk assess if deemed necessary
- Rubbish receptacle
- Optional equipment – stitch cutter, gauze swabs, sponge holding forceps (vaginal T-tube)

Procedure

Prior to the procedure

1. Follow general principles section above for checking medical order and patient consent. Assess patient comfort and analgesia requirements. Place continence sheet under the patient's buttocks.
2. Follow principles of 'Sequence for Standard Aseptic Technique Practice' within the WNHS IPM Aseptic Technique guideline. **In addition:** Once equipment, staff member (appropriate hand hygiene, PPE) and patient prepared (removed dressing/pad),release suction on the drain, if appropriate. Remove gloves and perform hand hygiene. Don sterile gloves as required.

Procedure

1. Vaginal drain: Cleanse wound site with normal saline as required. Dry.
2. Remove the suture if the drain is held in situ with it.
3. Grasp the drain as close to the visible insertion site as possible and pull firmly, applying gentle constant force to remove the drain / T-tube.
4. Apply a sanitary pad / combine on the perineum. Remove continence sheet.
5. Remove gloves and perform hand hygiene. Clean trolley/ work surface, perform hand hygiene.

Collection of a wound swab

Aims

- To collect wound exudate for microscopy and culture without contamination
- To enable identification of organism(s) causing infections and 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; inflammation; oedema
    - Increased pain or tenderness
    - 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 is 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.

Procedure

Equipment

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

Collecting a wound swab

1. Perform hand hygiene.
2. Don gloves. If a dressing is present, perform hand hygiene, remove the old dressing and repeat hand hygiene.
3. 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.
4. Remove excess saline with a sterile gauze. This exposes the wound to ensure a good culture is collected.
5. Exudating wounds – do not pre moisten the swab.
6. Non-exudating wounds – pre moisten the swab with normal saline.
7. If fresh pus or wound fluid is present ensure this is collected on the swab.
8. The Levine technique is the preferred method when taking a wound swab. A swab is rotated over a $1cm^2$ area of the wound with sufficient pressure to express fluid from within the wound tissue.
9. Once collected the swab should be placed in the charcoal medium.
10. Identify the patient and correctly label the specimen(s).
11. Ensure the following information is added to the request form:
    - Site the swab was collected from
    - Patient condition or diagnosis
    - Optional: If the patient is receiving antibiotics
12. Send the specimen(s) immediately to the lab in the sealed pocket of a Biohazard bag.
13. Complete a Wound Assessment and Care Plan form (MR 263).

Negative pressure wound therapy (NPWT)

NPWT- Negative pressure wound therapy uses continuous or intermittent negative pressure (vacuum) to assist in wound healing.

TNPWT-Topical NPWT - is a type of NPWT that is generally used for incision management for closed surgical incision, or small dehiscence.

Each patient should have a holistic assessment to identify the suitability for NPWT prior to its application.

Non-topical NPWT

- For management of NPWT for an **open wound** (e.g. dehisced, surgically debridement), see section within: SCGOPHCG Nursing Practice Guideline No 16: Wound Management
- On discharge with a non-topical NPWT, the patient is referred for ongoing wound management with Home Link at SCGH- see chapter in this document.

Topical NPWT (single use)

See information within SCGOPHCG Nursing Practice Guideline No 16: Wound Management

KEMH specific:

- Note: WNHS uses Wound Assessment and Care Plan (MR263) and does not use Negative Pressure Therapy Dressing Treatment Chart.
- For all clinical photography contact page number 3465 between 0830 and 1630hrs Monday to Friday. See also WNHS policy Clinical Photography and Videography within WNHS.
- Equipment available from CNC (Gynaecology Ward 6) or via CNS (Perioperative Services). 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 TNPWT 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'[2, 3] (see risk factors below) are deemed suitable candidates for this therapy.

Background

Topical NPWT involves applying a vacuum across a wound to improve the wound healing process and is indicated for use on clean, closed surgical wounds.[3, 4] 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.[4]

NB: Using these dressings on low risk patients has not been shown to improve outcomes.[3]

Key points

1. Dressing lengths of 30cm and 40cm are available. Ensure the wound is entirely covered by the absorbent island.[5]
2. The system is designed to provide 7 days of therapy.
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 dressing 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 wounds [3, 4] on patients who are deemed high risk. 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 below risk factors** (KEMH directive) to be deemed suitable for this dressing post-operatively.

Higher rates of SSI are associated with but not limited to the following risk factors:

- High BMI >35 [2, 4, 6, 7]
- Diabetes (Type 1, Type 2 and Gestational) [2, 3, 6]
- History of wound infection or dehiscence [2]
- Prolonged labour
- Rupture of membranes > 6 hours [8]
- Multiple Caesarean births ≥3 [2]
- Poor skin integrity [2]
- Smoker and/or IV drug user [3]
- Pre-operative pyrexia (>38 degrees) [3]
- Immunocompromised (current infection, neutropenic) [2, 3]

- Comorbidities i.e. Hypertension, vascular disease, cancer [2, 3, 6]
- Length of procedure exceeding 2 hours[6] (>48 minutes for Caesarean section[8])

Wounds NOT suitable or where caution required for NPWT

- See contraindications and precautions/considerations within SCGOPHCG Nursing Practice Guideline No 16: Wound Management (section 'Negative Pressure Wound Therapy')

Notes:

- Malignancy in the wound (once any malignancy has been removed its use may be indicated following discussion with medical staff)
- For patients at high risk of bleeding (consider proximity to blood vessels, haemoglobinopathy (Sickle Cell), abnormal clotting)
- 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

- 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 [9]

- 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. Document wound status e.g. on wound section of observation chart.
- 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 TNPWT dressing is to remain intact for 7 days.
- If staples/removable sutures are in place, remove on day 7.
- Appropriate patient education should be provided prior to discharge. A 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 therapy is complete, the dressing is discarded in general waste. The batteries are removed from the pump and disposed of according to local regulations.[5]

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.

Complex wound management: Referral to Home Link at SCGH

Aim

To provide appropriate and timely referral to the Home Link programme at SCGH for patients requiring complex wound management.

Key points

1. This service is only available to patients who have a complex wound and meet the criteria for referral.
2. Patients 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 Home Link 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.

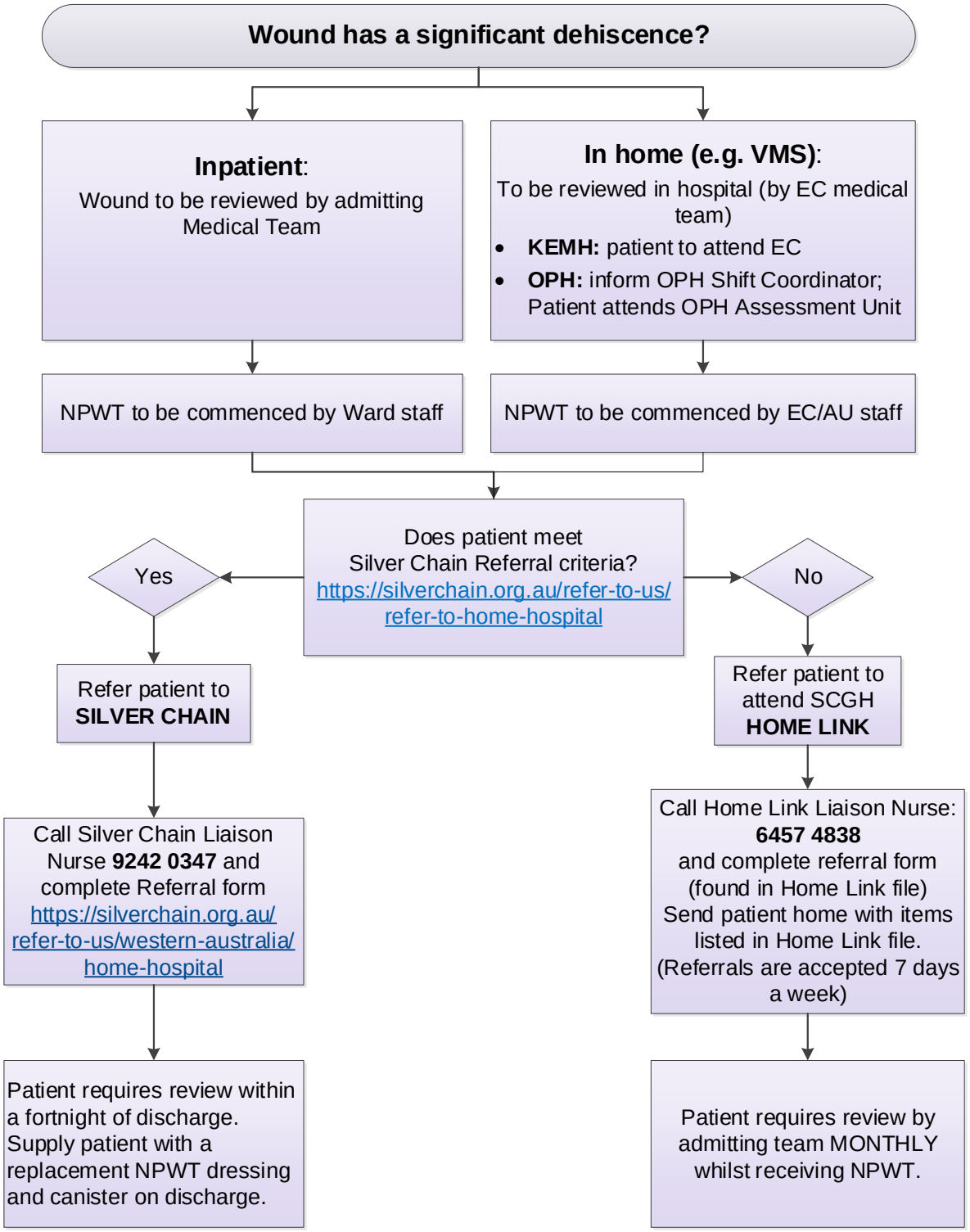
Criteria for referral

- Complex wound
- Unsuitable for Referral to Silver Chain
- 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 Home Link LAN nurse on 6457 4838 to discuss 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 them of the appointment details

Referral process



Pressure injuries and skin tears

Refer to :

- WNHS policy Pressure Injury Prevention and Management
- KEMH Perioperative guideline: Patient Positioning and Pressure Injury Prevention in Theatre
- SCGOPHCG Nursing Practice Guideline: Wound Management: 'Skin Tear Prevention and Management'
- **Form**: Pressure Injury Prevention and Management Plan (includes skin inspection and Waterlow risk assessment)

References

1. Sir Charles Gairdner Osborne Park Health Care Group [SCGOPHCG]. Wound drain management: Nursing Practice Guideline No. 65: SCGOPHCG. 2021. Available from: https://healthpoint.hdwa.health.wa.gov.au/policies/Policies/NMAHS/SCGH/SCGOPHCG.NPG.Wound_Drain_Management.pdf
2. Hickson E, Harris, J., & Brett, D. A journey to zero: Reduction of post-operative cesarean surgical site infections over a five-year period. **Surgical Infections**. 2015;16(2):174-7.
3. Stannard J, Atkins, B., O'Malley, D., Singh, H., Bernstein, B., & Fahey, M. et al. Use of Negative Pressure Therapy on Closed Surgical Incisions: A Case Series. **Ostomy Wound Management**. 2009;55(8):58-66.
4. Bullough L, Wilkinson, D., Burns, S., & Wan, L. Changing wound care protocols to reduce postoperative caesarean section infection and readmission. **Wounds UK**. 2014;10(1):84-9.
5. Smith & Nephew. User guide (PICO 7, PICO 14) 2020.
6. Cheng K LJ, Kong Q, Wang C, Ye N, Xia G. Risk factors for surgical site infection in a teaching hospital: a prospective study of 1,138 patients. **Patient preference and adherence**. 2015;9:1171-7.
7. Lindholm CS, R. Wound management for the 21st century: combining effectiveness and efficiency. **International Wound Journal**. 2016;13:5-15.
8. McCann R, Stirling M, Parker C, editors. Healthcare infection surveillance of Western Australia (HISWA). 7th ed. Perth, WA: Healthcare Associated Infection Unit, Communicable Disease Control Directorate, Department of Health WA; 2020.
9. Australian Wound Management Association Inc. Standards for wound management. 2016. 3rd ed. Available from: http://www.woundsaustralia.com.au/home/

Resources

- ACSQHC: Action 5.21- Preventing pressure injuries and wound management (external website)
- Department of Health WA: HISWA tools and resources
- Silver Chain: Referrals Criteria and Referral Forms (external websites)
- Smith & Nephew PICO 7 dressing application example video
- World Health Organization (WHO): Global Guidelines for the Prevention of Surgical Site Infection 2nd ed. (2018) (external website)

Related NMHS, WNHS, SCGH/OPH policies, procedures and guidelines

WNHS Policies:

- Clinical Photography and Videography within WNHS
- Pressure Injuries: Prevention and Management of

WNHS Clinical Guidelines:

- Obstetrics and Gynaecology: Referral to Silver Chain
- Infection Prevention and Management Manual: Aseptic Technique ; Hand Hygiene ; Prevention of Surgical Site Infections ;

SCGH/OPH Group- Nursing Practice Guidelines:

- No 16 Wound Manadgement
- No 65 Wound Drain Management

Forms:

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

- Progress Notes
- MR 026 VMS to EC referral form
- MR 249.60 Postnatal Clinical Pathway
- MR 255 VMS Progress Notes
- MR 260.03 Comprehensive Skin Assessment (Gynaecology inpatients only)
- MR 260.05 Pressure Injury Prevention and Management Plan
- MR 263 Wound Assessment and Care Plan
- MR 286 Gynaecology Nursing Observation Chart
- MR 315 Caesarean Section (MR 310) or Operation Record
- MR 325 Handover to Recovery/Ward
- MR 729 Fluid Balance Chart

File path:	WNHS.OG.WoundCare		
Keywords:	wounds, wound drain, wound healing, closed drain, open drain, drain, vacuum drain, free drainage, replacing, changing a drain, drainage tube, shortening drain, T-Tube, vaginal drain, wound care, Topical negative pressure therapy, complex referral, Silver Chain, HITH, home link, hospital in the home		
Document owner:	Obstetrics and Gynaecology Directorate		
Author / Reviewer:	Pod- CNC Gynaecology Ward 6 and CMC Obstetric Wards		
Date first issued:	July 2018 (v1)	Version:	2
Reviewed dates:	Jan 2019 (v1.1); Apr 2023 (v2)	Next review date:	Apr 2026
Endorsed by:	Obstetrics and Gynaecology Directorate Management Committee	Date:	05/04/2023

National Standards Applicable (V2):	☒ 1: Clinical Governance ☐ 2: Partnering with Consumers ☒ 3: Preventing and Controlling Healthcare Associated Infection ☐ 4: Medication Safety	☒ 5: Comprehensive Care ☒ 6: Communicating for Safety ☐ 7: Blood Management ☒ 8: Recognising and Responding to Acute Deterioration
Printed or personally saved electronic copies of this document are considered uncontrolled. Access the current version from WNHS HealthPoint.		

Version history

Version number	Date	Summary
1.0	July 2018	First version **History**: July 2018 Amalgamated 12 individual wound and drain care guidelines from O&G (11 from wound/drain care and 1 wound swab guideline, dated from April 2001) into one document
1.1	Jan 2019	Minor amendments- added link to IPM guideline for surgical site dressings, hyperlinks updated and brands for detergent wipes removed
2	Apr 2023	• Forms change- removed MR260.01. Document on Pressure Injury Prevention and Management Plan (MR260.05) or pressure injury screening section within relevant obstetric clinical pathway in combination with MR260.03 • Condensed content on similar procedures (staples and sutures; vaginal drain and T-tube; drain general principles), and updated alongside latest SCGOPHCG wound and drain guidelines • Suture/staples- Care by VMS - added if concern about OPH patient wound: Review in OPH Maternity AU. Complete VMS Emergency Assessment Referral form (MR(OPH)26.2) and notify AU • Wound drains- ➢ Added that the frequency of monitoring is adjusted according to clinical situation. ➢ The removal of drains is at the direction of the medical team and must be documented in the post-operative instructions • Collection of a wound swab- removed notification to IPM • NPWT: ➢ Added descriptions of NPWT and topical NPWT ➢ **Topical NPWT dressing is to remain intact for 7 days** ➢ Clinical photography updated hours of operation ➢ Contraindications / precautions - links to SCGOPHCG guideline • Complex wound management through SCGH services for home wound care is now called Home Link (prev. HITH). • Wound dehiscence flowcharts (inpatient and outpatient processes) merged; for patients in the home (e.g. VMS) needing review, OPH

		AU added for OPH patients; patients attending EC have review by EC medical team. Home Link referrals are accepted 7 days a week. • Pressure injuries and skin tears section added with links to relevant guidelines