



**THE VERY BASICS IN WOUND CARE**

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WOCC(C)-ET

## DISCLOSURE OF FINANCIAL SUPPORT

I Michelle Fleur de Lys  
have no actual or potential conflict of interest  
in relation to this program/presentation.

## OBJECTIVES

1. To understand IHA wound care resources, and how to access the online notes, photos and product information.
2. To understand different types of necrotic tissue and determine when the wound is progressing.
3. To understand red flags for diabetic, arterial, venous and pressure wounds.
4. To understand basic dressing selections.



**UNDERSTANDING IHA ONLINE WOUND  
CARE RESOURCES**



**IHA DOCUMENTATION**  
HCN AND NSWOC-ET

## HOME HEALTH CHARTING IN MEDITECH

# Pixelere Patient File

## Wound Management Plan

**Patient Name**

**Pix ID**

**PHN**

**Wound Location** Right Ankle/Foot

**Wound Alpha** B

**Wound Start Date** 18/Feb/2012

### Products to Apply

0 Drsg tray, 0 No sting barrier spray 28ml, 0 Normal Saline 100ml Dual Top, 0 Scissors, 0 Seasorb Ag rope 3 x 44 cm, 1 Gloves - unsterile 1pair, 1 Kling Bandage 5cm x5M, 1 Mesorb 10x13 cm,

### Dressing Change

Q2 days



1604h 21/May/2012 - RN:ID#

### Nursing Care Plan

**Goal:** Debride necrotic slough and prevent infection

**Plan:** Cleanse with NS, protect periwound with skin prep. Silver nitrate to wound edges (activate with H<sub>2</sub>O). Seasorb ag to wound bed, mesorb and wrap in kling. Client wears blue booties at night.

## ETN (NSWOCC) DOCUMENTATION IN ACUTE

### ETN Progress Notes – Meditech

Located in the patient's chart under clinical notes. Photos are attached to the notes, sometimes you have to click on the attachment icon.

The screenshot displays a patient chart interface. At the top, patient information is shown: ADM ACIN, KELKGHC6W, KGHC0610-A, 154.94cm, 62.142kg, BSA:1.64m², BMI:25.9., Allergy/Adv: grapefruit, penicillin G. Below this, there are tabs for Assessment, Intervention, Regulatory, and Scanned Form. A table lists three ETN progress notes:

Date	Name	Note	Documented By	Provider Type	Cosign	Esig
31/08/18 12:30 PDT	ETN Progress Note		Michelle Fleur Delys	Registered Nurse		
28/08/18 15:24 PDT	OT 3 Occupational Therapy Progress Note			Occupational Therapist		
28/08/18 14:46 PDT	PT 3 Physiotherapy Progress Note			Physiotherapist		

The interface also includes a sidebar with various menu options like Status Board, Select Visits, Summary, Review Visit, New Results, Clinical Panels, Vital Signs, I & O, Medications, Laboratory, Microbiology, Blood Bank, Reports, Patient Care, Notes, Refresh EMR, Orders, Clinical Data, Worklist, and Write Note. At the bottom, there are buttons for Scanned Report, Earlier, Later, Load All Data, View Snapshot, View History, and Print.



# AVAILABLE RESOURCES

**insideNet** Welcome Sommerey, Lauren ▾ My Links ▾ Search the InsideNet...  Advanced

About Interior Health | Employee Resources | Quality & Patient Safety | Clinical Care Resources | Education & Development | Employee Health & Safety


Technology & Computers | Manager Resources | Projects & Initiatives | Finance & Purchasing | Graphics & Printing | Buildings & Security | Informational Resources

Home > Clinical Care Resources > Skin and Wound Care

## Clinical Care Resources

- ▶ Aboriginal Health
- ▶ Access & Care Transitions
- ▶ Cardiac Care
- ▶ Communicable Disease
- ▶ Critical Care
- ▶ Dementia Care
- ▶ Diabetes
- ▶ Diagnostic Imaging
- ▶ Dietitian Services
- ▶ Early Childhood Development
- ▶ Emergency & Trauma Care
- ▶ General Interprofessional Practices
- ▶ Home Health
- ▶ Infection Prevention & Control
- ▶ Laboratory
- ▶ Medical Device Reprocessing
- ▶ Medication Management
- ▶ Mental Health & Substance Use
- ▶ Palliative Care
- ▶ Parenteral Practices
- ▶ Perinatal and Pediatric Practices
- ▶ Pharmacy
- ▶ Promotion & Prevention
- ▶ Rehabilitation
- ▶ Renal Care
- ▶ Residential Care
- ▶ Respiratory Care
- ▶ Skin and Wound Care
  - Practice Manual
- ▶ Social Work
- ▶ Stroke Care
- ▶ Surgical Care
- ▶ Transfusion Practices
- ▶ Transportation (Patient)

## Skin and Wound Care



### Practice manual

The [Skin and Wound Care Practice Manual](#) is designed to be a resource for all health care workers in the Interior Health Authority who are treating acute and chronic wounds.

Clients with wounds, ostomies and challenges with skin integrity often require an interprofessional approach to provide comprehensive, evidence informed assessment and treatment. The current version of the Skin and Wound Care Practices manual only addresses the scope of practice of nurses. A future phase will include scope of practice for Allied Health Professionals in wound care. Although the decision support tools included are intended for use by nurses, other health professionals may find the content useful in their practice.

### Education

- Resource Type : Competency Validation & Practice Review Requirements (5)
- Resource Type : Instructor Led Classes (5)
- Resource Type : PixaLere (1)
- Resource Type : Self Learning (6)
- Resource Type : WebEx Recordings (18)

### I need to find...

- **\*\* Report a Product Concern \*\***
- PixaLere Home Page
- Pressure Ulcer Prevention (6 min.presentation)
- Product Information
- Skin and Wound Care Scope of Practice

### Practices Newsletters

- Year : 2016 (5)
- Year : 2015 (12)
- Year : 2014 (4)

### Web resources

- Canadian Association of Wound Care
- Provincial Skin and Wound Community of Practice
- Registered Nurses Association of Ontario
- WoundPedia

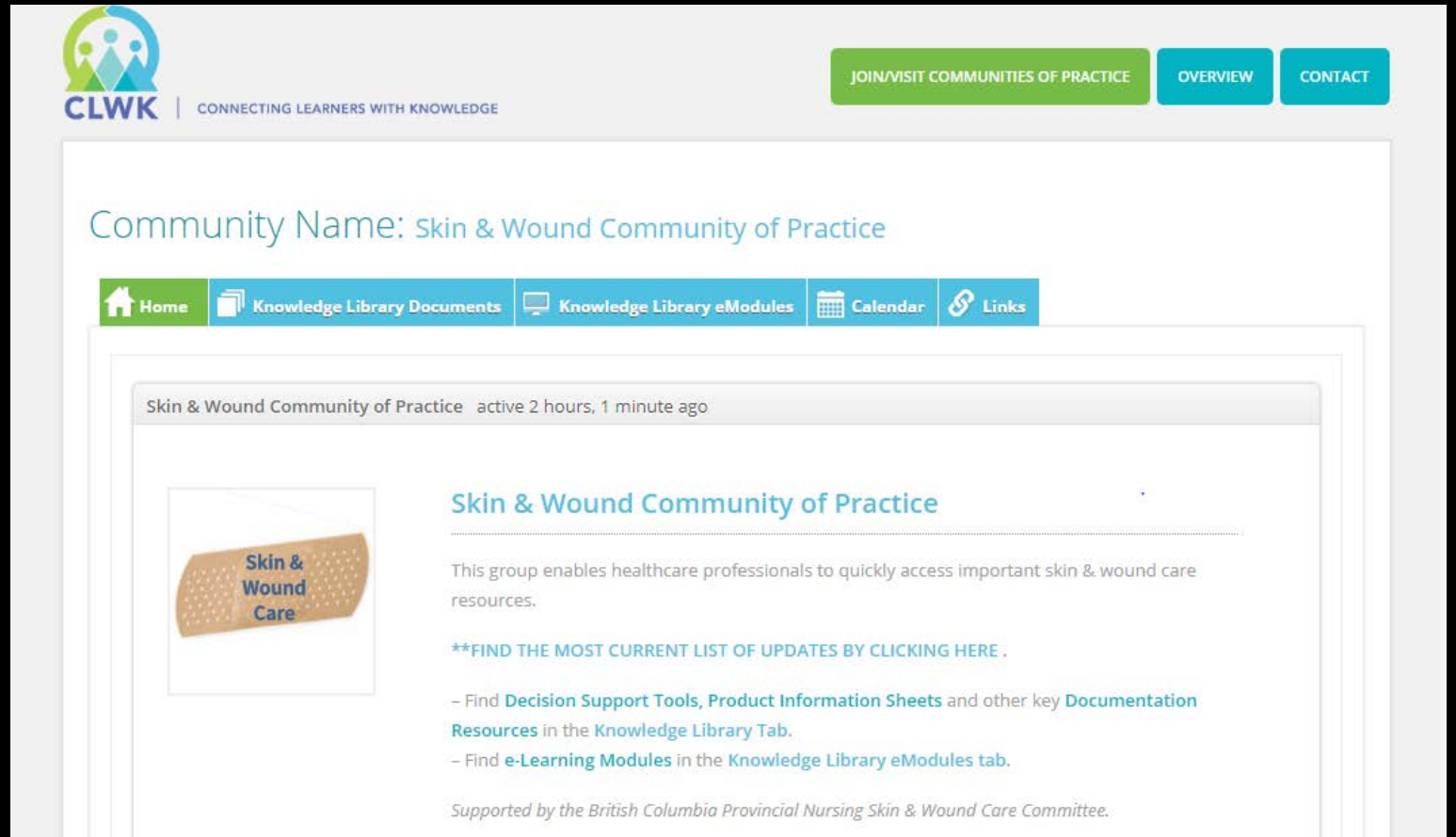


# PROVINCIAL INFORMATION

Skin & Wound Community  
of Practice

CLWK: Connecting Learners  
With Knowledge

<https://www.clwk.ca/communities-of-practice/skin-wound-community-of-practice>



The screenshot displays the CLWK website interface. At the top left is the CLWK logo with the tagline "CONNECTING LEARNERS WITH KNOWLEDGE". To the right are three buttons: "JOIN/VISIT COMMUNITIES OF PRACTICE" (green), "OVERVIEW" (teal), and "CONTACT" (teal). Below the navigation is a search bar with the text "Community Name: skin & Wound Community of Practice". A secondary navigation bar contains icons and labels for "Home", "Knowledge Library Documents", "Knowledge Library eModules", "Calendar", and "Links". The main content area shows a community card for "Skin & Wound Community of Practice" with a status of "active 2 hours, 1 minute ago". The card features a graphic of a bandage labeled "Skin & Wound Care". The text on the card describes the group's purpose and provides links to resources and updates. At the bottom of the card, it states: "Supported by the British Columbia Provincial Nursing Skin & Wound Care Committee."

CLWK | CONNECTING LEARNERS WITH KNOWLEDGE

JOIN/VISIT COMMUNITIES OF PRACTICE OVERVIEW CONTACT

Community Name: skin & Wound Community of Practice

Home Knowledge Library Documents Knowledge Library eModules Calendar Links

Skin & Wound Community of Practice active 2 hours, 1 minute ago

**Skin & Wound Community of Practice**

This group enables healthcare professionals to quickly access important skin & wound care resources.

**\*\*FIND THE MOST CURRENT LIST OF UPDATES BY CLICKING HERE .**

- Find **Decision Support Tools, Product Information Sheets** and other key **Documentation Resources** in the **Knowledge Library Tab**.
- Find **e-Learning Modules** in the **Knowledge Library eModules tab**.

*Supported by the British Columbia Provincial Nursing Skin & Wound Care Committee.*



**UNDERSTANDING NECROTIC TISSUE AND  
WOUND HEALING**

## NECROTIC TISSUE

- Impedes healing
- Physical barrier to granulation tissue
- Prevents wound contraction
- Prevents re-epithelialization
- Fosters inflammation
- May lead to infection
- Promotes odour



## NECROTIC TISSUE WHAT WE DO NOT WANT TO SEE

Avascular tissue that lacks blood supply and referred to as:

**NECROTIC, DEAD, DEVITALIZED, NON-VIABLE**

- Prevalent types of necrotic tissue include:

- Slough
- Fibrin
- Eschar
- Gangrene
- Hyperkeratosis



## SLOUGH

Soft, moist necrotic tissue that may presenting as tan, yellow or green in colour.



- Clumps
- Loose or firmly attached
- Adherence to wound base and/or wound edge

## FIBRIN

An insoluble protein formed from fibrinogen during the blood clotting cascade.



- White, yellow or tan
- Loose or firmly attached
- Adherence to wound base and/or wound edge

## ESCHAR

Dead tissue that indicates full-thickness tissue loss.



- Black or brown
- Hard and scab-like
- Firmly attached to wound base

**\* May be dry and stable or soft and boggy**

## GANGRENE

Death or decay of body tissue which may involve bacterial infection. It is usually due to loss of blood supply and may be wet or dry.





## HYPERKERATOSIS

Thickening of the horny layer of epidermis or mucus membrane.

- Soft, soggy or hard
- White/grey
- Firmly attached
- May surround wound edge



**DRY**



**WET**

## NECROTIC TISSUE

As depth of tissue damage increases, the colour of necrotic tissue changes.

**White/Gray**



**Tan/ Yellow**



**Brown/Black**



**Worsening Tissue Damage**

## GRANULATION TISSUE WHAT WE WANT TO SEE

New connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process.





**HOW DO YOU GET THERE**

## DEBRIDEMENT

- Autolytic
- Enzymatic
- Mechanical
- Biological
- Conservative Sharp Wound  
Debridement
- Surgical



## AUTOLYTIC DEBRIDEMENT

Liquidation of devitalized tissues by bodies naturally present enzymes.

Dressings can support but the process is slow.



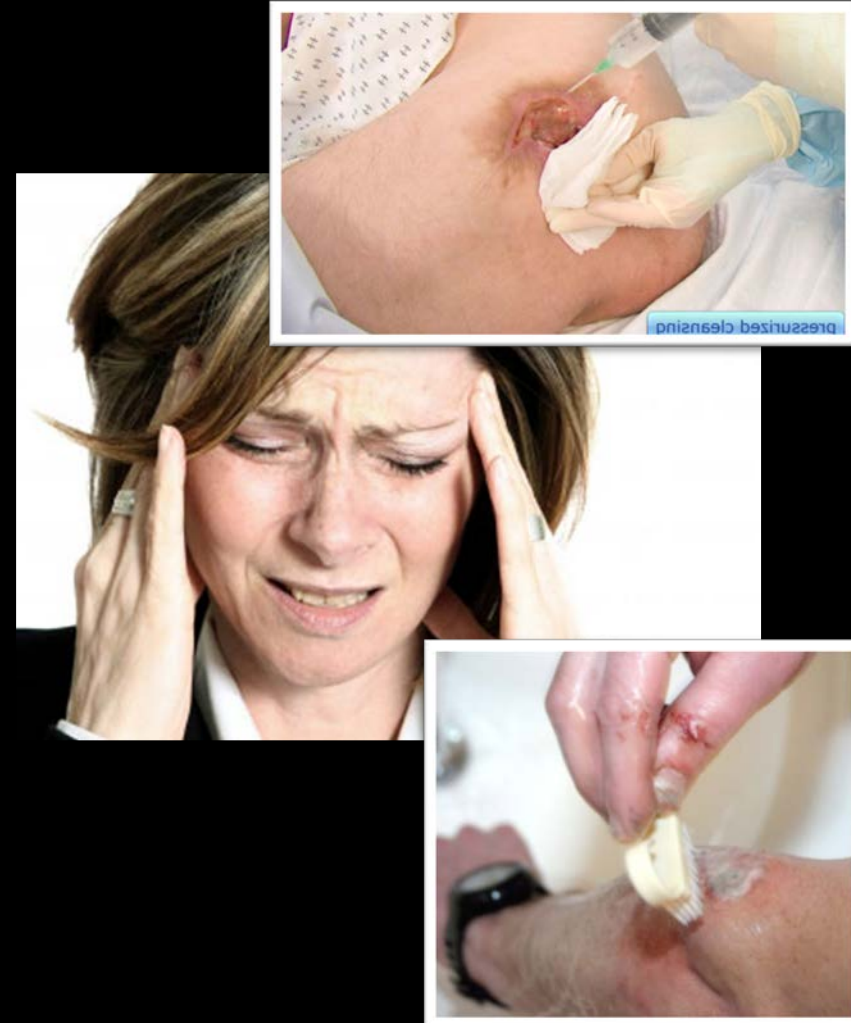
## ENZYMATIC DEBRIDEMENT

- Topical application of proteolytic enzymes to breakdown devitalized tissue
- Not harmful to healthy tissue
- Physician/NP order required for collagenase



## MECHANICAL DEBRIDEMENT

- Use of mechanical forces to remove non-viable tissue
- Wet-to-dry dressings
- Wound irrigation
- Pulsatile lavage
- Can be painful





## BIOLOGICAL

First described in 1500's

Release of enzymes that liquefy necrotic tissue

Secrete substances that destroy bacteria



**MAGGOT**



**SELECTIVE**

**CONSERVATIVE SHARP WOUND  
DEBRIDEMENT**



# SURGICAL DEBRIDEMENT

Expensive

Quick

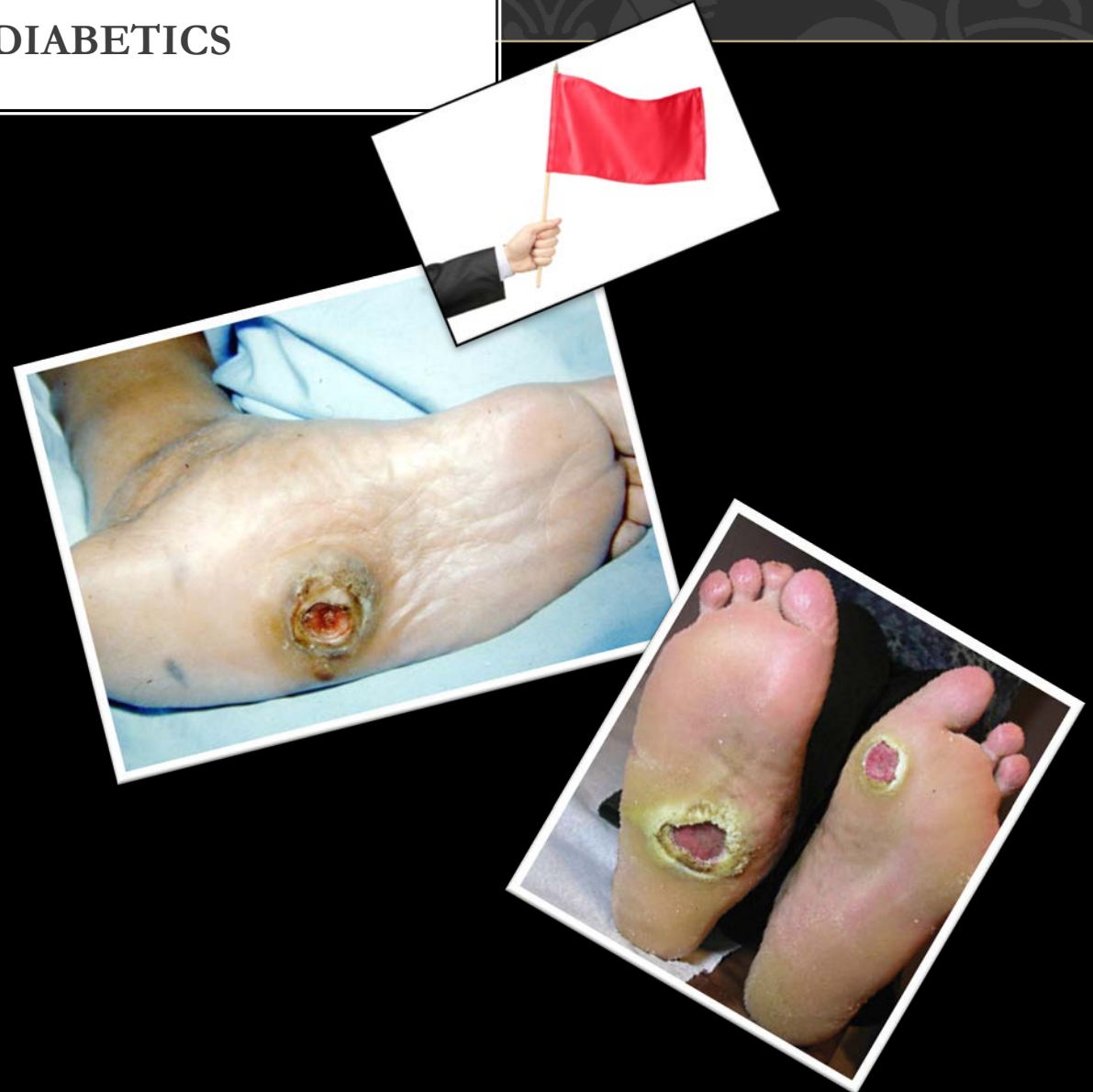




**RED FLAGS**

## RED FLAGS – DIABETICS

**PAIN  
IN THE  
NEUROPATHIC  
FOOT**



## DIABETICS

Compromises blood flow and sensation to limbs and causes decreased visible signs of infection

What you may see:

Uncontrolled blood sugars.

Difference in temperature between limbs.

Slight peri-wound redness and increase in wound size.

Wound that probes to bone.



**Areas of wet gangrene and spreading or systemic infection in diabetic foot ulcer, especially if the wound probes to bone, are potentially limb or life threatening and require immediate attention.**

**Antibiotics, debridement and offloading are needed.**

## DIABETIC

Foot care - Check both feet at each appointment, shoes should be professionally fitted if any abnormalities.



## RED FLAGS – ARTERIAL WOUNDS

**PERSISTENT NON HEALING  
ULCER**

**NEW OR INCREASING PAIN**

**AND OR A CHANGE FROM**

**DRY GANGRENE TO WET  
GANGRENE**





## ARTERIAL

Decreased blood flow and blunting of the inflammatory process decreases local infection symptoms. Leave eschar that is dry and stable intact until blood supply has been determined. Dry stable arterial wounds with eschar that become moist and boggy at the edges or peri-wound redness are signs of infection .



Areas of wet gangrene and spreading or systemic infection in extremity arterial wounds, especially if the wound probes to bone, are potentially **limb or life threatening** and require immediate attention.

## RED FLAGS – VENOUS WOUNDS



**NEWLY FORMED ULCERS**

**INCREASE IN SIZE**

**PERI-WOUND INFLAMMATION**



## VENOUS

Venous wounds may exhibit periwound inflammation and warmth caused by venous dermatitis, allergic contact dermatitis or irritant contact dermatitis.

Chronic inflammation may present as erythema, scaling, erosions, & excoriations.



## HEMOSIDERIN STAINING

EARLY CHANGES



LATE CHANGES



## VENOUS

Compression bandaging is for treatment, stockings are for prevention.

**COMPRESSION IS FOR LIFE!** The right compression is the one the patient will wear.



## RED FLAGS – PRESSURE INJURIES

**DERERIORATION  
AND OR NOT  
PROGRESSING AS EXPECTED  
NEW ABILITY TO PROBE TO  
BONE**

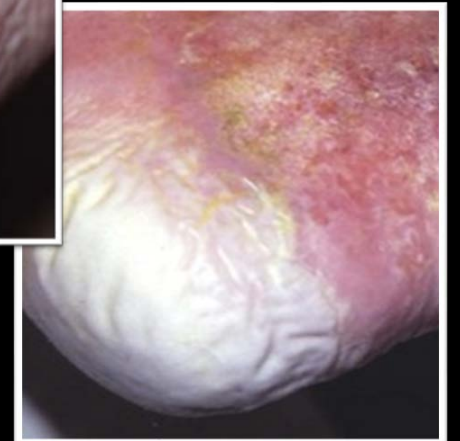


## PRESSURE

Consider osteomyelitis if the wound probes to bone.

Lower leg compromises of any kind be aware of pressure concerns to heels.

Heel ulcers are **LIMB THREATING** and take a long time to heal.





## **DRESSINGS**

Selecting appropriate ones



## DRESSING DECISIONS

Dressing selection is not just a rudimentary process, but rather a well–thought-out pathway that can help lead a wound to closure.

The clinician needs to understand the current state of the wound as well as the product components of the dressing and how they will meet the needs of the wound or ulcer.

## WHAT SHOULD THE DRESSING DO

- Promote rapid healing
- Debridement of necrotic tissue
- Prevent/treatment of infection
- Reduce dead space
- Absorption of exudate
- Maintenance of moist environment
- Protection and insulation
- Reduce pain
- Cost-effective

## THINGS TO ASK

What is it made of and what can it do for this clinical situation that I am dealing with?

Water, polymers, collagen, cellulose, hydropolymer, top secret patented ingredients, honey, iodine, oxygen ( and much more).

What is the mechanism of action?

Absorbs drainage, Hydration, hydrophobic, protects tissue, conforms to depth, conforms to margins, provides active pathogen control, provides odor control, stays in place, adhesive/ non-adhesive.

## DECISIONS BASED ON WOUND APPEARANCE

Divide your wounds into one of the 4 categories then look at what you are going to do.

1. Necrotic, do you need to debride
2. Infected, control bioburden
3. Draining, going to absorb
4. Granular, provide moisture

Most of the wounds will be in one of these four categories.

Often with 2 of these things happening.

## KEEP THE PROCESS SIMPLE

1. Protect the skin
2. Fill the wound
3. Cover the wound
4. Prevent or treat the cause



There are over 6000 products out there so we need to keep the decision process as simple as possible.

## RULE OF THUMB

If it is wet dry it out

If it is dry wet it down

If it is dirty clean it out

## THINGS TO PONDER

Dressings do not heal patients, patients heal patients.

- Always determine etiology of the wound it is the diagnosis that drives healing, treatment and plan of care.
- Know the dressings you have available.
- Know when to refer, it is a team effort.
- Know your patient's situation and listen to their story.

## THE TYPE OF PRODUCT DEPENDS ON

Wound Characteristics

Wound bed composition

Infection

Wound depth

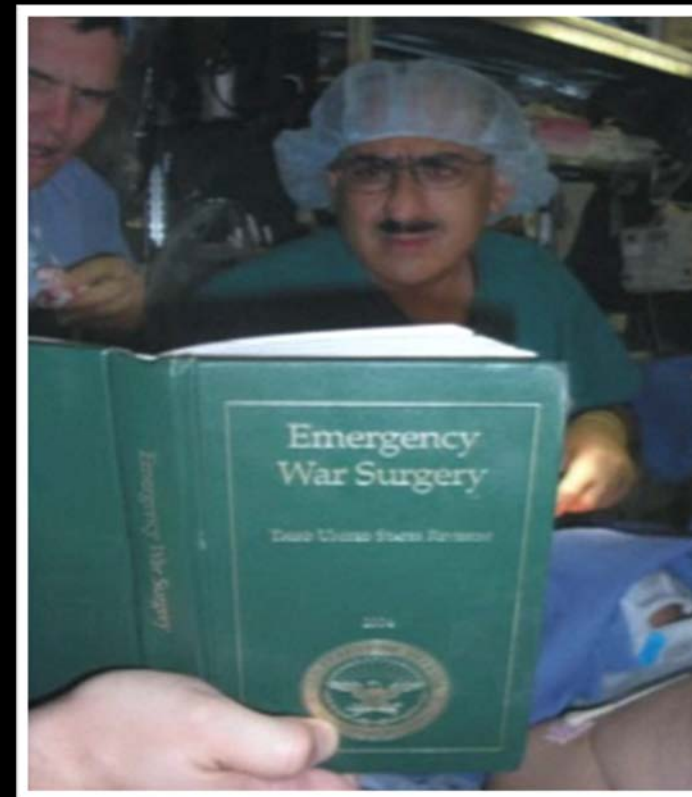
Exudate amount

Cost effectiveness

Ease of use

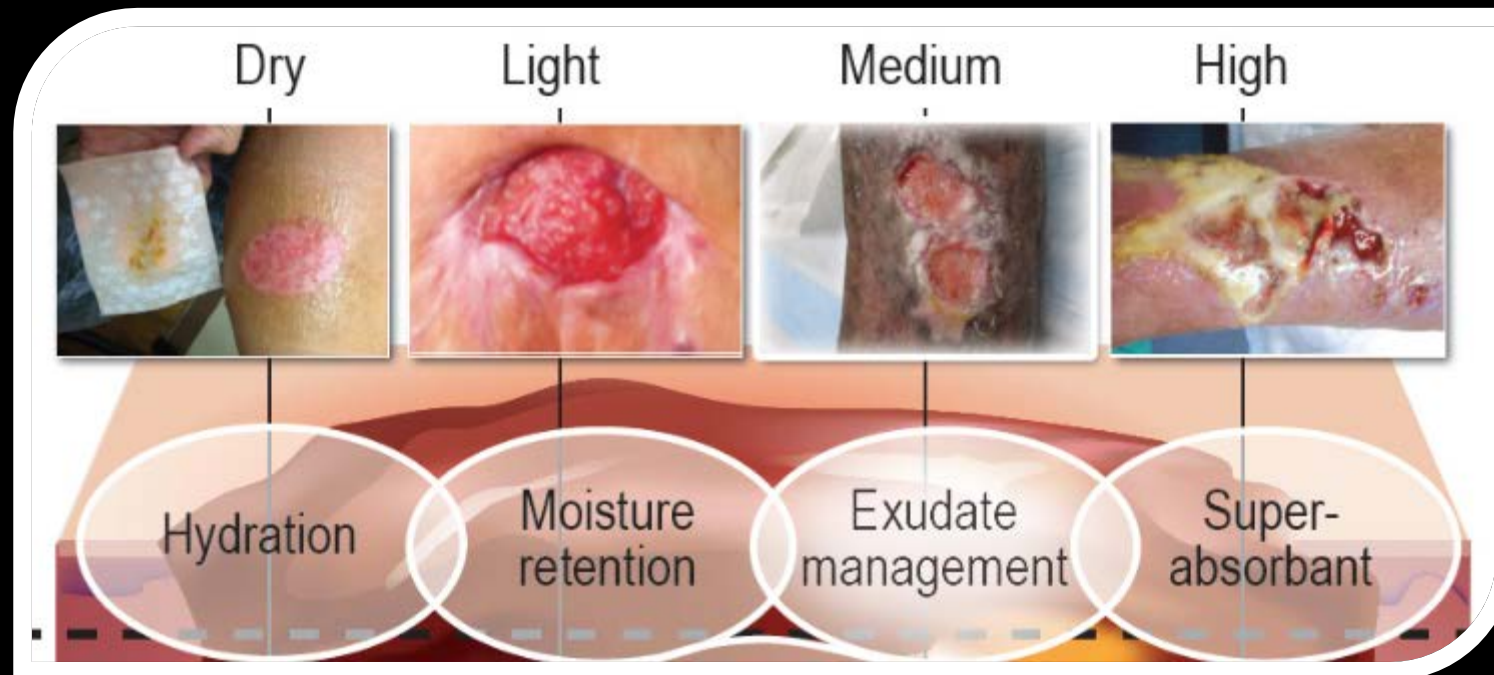
Consider the setting

Client concerns





## WHAT IS HAPPENING IN THE WOUND



## DO WE NEED TO DEBRIDE?

Hydrogel

Hypertonic Gauze

Cadexomer Iodine

Dakins Solution



IS THE WOUND INFECTED (LOCAL /  
SYSTEMIC)?

Antimicrobial or antiseptic dressings

Iodine based

Silver based

PHMB

Topical antibiotics

Dakin's solution



## DO WE NEED TO PACK?

Gauze

for daily change

Hydrofiber or alginate

Moderate to heavy exudate

Impregnated gauze

Mesalt

PHMB

Antimicrobial



**MOISTURE BALANCE  
ADD OR ABSORB MOISTURE?**

Water based gel

Cover Dressing: Composite:

Designed to maintain moisture balance they can remove and lock fluid away when too wet.

Mesorb

Mepilex foam

Alldress

Hydrocolloid  
can add

Calcium Alginate, Hydrofibers



## CONCERNED ABOUT STICKING?

For fragile wounds that you are concerned the dressing will stick and cause pain or damage with removal.

Adaptic

Mepitel

Restore

Restore Sliver





**PEARLS FOR SUCCESS**

## TAKE HOME

There are many dressing and treatment choices available.

Keep it simple - it really is about moisture balance.

If unsure the safest option is to keep things dry.

Once etiology is determined care plan can be changed.





AND WHEN YOU JUST DON'T KNOW...

*REMEMBER THE TEAM*

*WE ARE WILLING TO PUT IN ALL THE TIME  
AND EFFORT REQUIRED*

*SO WE CAN HELP YOU HELP YOUR PATIENT*

***IT TAKES A TEAM!***

*ANY QUESTIONS?*