Wound management rules

The treating health professional should consider the following:

- Establish the underlying cause of the wound.
- Treat both the wound and the cause, including infections, and consider specific local and extrinsic factors.
- If necessary, choose and apply an appropriate dressing.
- Plan appropriate follow-up.

Wound bed preparation

A new concept in wound healing is wound bed preparation. It was first presented by Professor Vince Falanga, who said that a wound must be in balance with respect to the healing cascade, bacterial balance, viable tissue and moisture management. A group of world leaders in the field developed the acronym TIME, which summarises the basic principles of wound bed preparation:

- **T—Tissue removal** of any non-viable slough or necrotic tissue is essential for healing.
- **I—Infection or Inflammation** in the tissue. If infected, treatment with the appropriate antibiotic is required; if inflamed anti-inflammatory medication (e.g. steroids) should be prescribed.
- **M—Moisture balance** involves maintaining the moist environment but removing excess exudate and protecting the peri-skin from damage caused by the high level of enzymes in the exudate.
- **E—Edge** of the wound must be healthy to allow for wound contraction.

Wound bed preparation is now accepted as the model by which wounds should be managed.

Classification of wound tissue

Assessment of a wound will depend on the colour, depth and the level of exudate present in the wound.

Colour

The colour of a wound will provide a guide to the status and stage of healing—see the following table.

Table D.21 Colour and status or stage of healing of wounds

Colour	Status or stage of healing
Pink	Epithelialising
Red, unbroken	Granulating
Black	Necrotic
Yellow	Sloughy
Green exudate	Infected

Depth

The wound may be superficial, moderate, deep or a cavity.

Exudate level

The wound may be dry or have slight, moderate or copious exudate.

Acute wound management

- Clean and decontaminate the wound of any dirt or foreign material, useing a surfactant solution diluted with water or 0.9% sodium chloride. Then apply a topical antiseptic, leave in place for three to four minutes, then wash off. Topical antiseptics will kill surface bacteria in approximately 90 seconds; washing off prevents any potential tissue damage.
- Stop bleeding by pressure and/or the application of a haemostat (e.g. alginate dressing).
- Close a laceration or deep cut with strips.
- Dress with a simple permeable dressing, either waterproof or not.
- If necessary, support with a retention bandage (e.g. lightweight cohesive).

Burns

Cool with cold running tap water for a minimum of 20 to 30 minutes. If the patient needs to be transferred to a doctor or hospital apply an amorphous hydrogel and cover with a non-adherent inert dressing. Burns are classified as superficial, partial thickness or full thickness.

Superficial

A superficial burn involves only the epidermis and the upper part of the dermal papillae. The burn may appear bright pink or red in colour. Blisters may or may not be present. The texture is normal or firm and the area is very painful and hypersensitive to touch. On application of pressure the burn area will blanch and capillary return will be rapid.

Partial thickness

A partial thickness burn results in the entire epidermal layer being destroyed, along with varying thickness of the dermis. It is characterised by a creamy coloured base that is mottled in appearance.

Full thickness

In a full thickness burn, injury occurs to the entire thickness of the epidermis, epithelial elements and dermal appendages. A full thickness burn is characterised by a whitish leathery appearance. It can