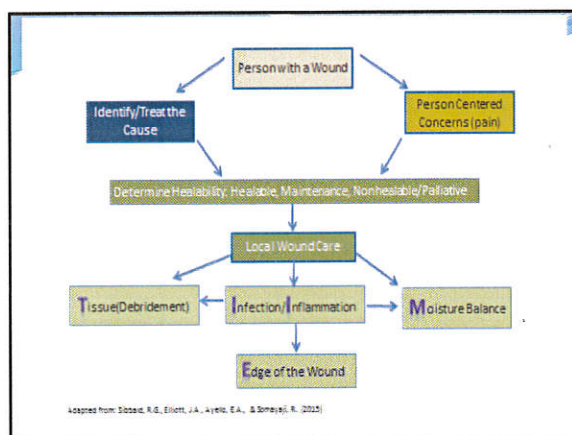


## Wound Management and Infection Control and Prevention

by  
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### Objectives

- Understand the Wound Care Paradigm
- Identify common complex wounds prone to infection
- Differentiate Surgical vs. Medical Asepsis
- Identify infection prevention and control IPAC strategies and the impact on wound management
- Understand the interdependent roles of IPAC clinician and wound care clinician/nurse



### Wound Classification

#### Acute

- Traumatic injuries
  - burns, scalds, lacerations, abrasions (grazes) cuts and bites.
- Surgical wounds (intentional acute wounds.)

#### Chronic

- When acute wounds fail to heal within the expected time (4 weeks)
- Associated with underlying pathologies which delay the healing process such as leg ulcers, pressure sores and malignant tumors

### Common complex wounds

Prone to infection:  
Host-comorbidities  
Staff-latrogenesis  
Environment: housekeeping/waste management

### WRHA Evidence Informed PRACRICETOOLS Wound Care & Skin Tears

<http://www.wrha.mb.ca/extranet/eipt/EIPT-013.php>

**WRHA wound bed preparation**  
<http://www.wrha.mb.ca/extranet/eipt/files/EIPT-013-015.pdf>

**MEASURE**

<b>M</b>	Measure: Length, width, and depth, in centimeters. Measure the longest length in a head to toe method, measure the widest width at right angles to the length. Measure depth using a sterile probe at the deepest area.
<b>E</b>	Exudate amount: Remove dressing to assess the quantity (none, scant, moderate, heavy) and characteristics (serous, sanguinous, purulent or combinations) and odour
<b>A</b>	Appearance of the wound bed: Evaluate the tissue: Necrotic (black), fibrin (firm yellow), slough (soft yellow), granulation (pink and healthy vs. red and friable = unhealthy), hyperkeratosis, epithelial
<b>S</b>	Suffering: Assess for pain, other symptoms or an impact to activities of daily living or quality of life
<b>U</b>	Undermining: Measure in centimeters and use hands of clock to document location. Measure tunneling to help determine appropriate dressing selection, and determine process of healing/non-healing
<b>R</b>	Re-evaluate: Assess the wound to determine the effectiveness of the wound treatment every week.
<b>E</b>	Edge: Assess the edge of the wound and the area 2-4 cm from the edge of the wound which is the peri-wound skin

Note: Adapted from "MEASURE: A Proposed Assessment Framework for Developing Best Practice Recommendations for Wound Assessment," by D.H. Keast, et al., 2004. *Wound Repair and Regeneration*, 12 (3), S1-S17.


NERDS (Superficial Infection)	STONEES (Deep Infection)
N- Non healing	S- Size is bigger
E- Exudate Increasing	T- Temperature is increased (of wound and surrounding tissue)
R- Red and Bleeding surface tissue	O- Os-probes to bone or bone visible
D- Debris (slough or eschar)	N- New areas of breakdown
S- Smell or odour from wound	E- Exudate increasing
	E- Erythema/Edema
	S- Smell
If any 2 or more criteria present treat the wound topically	If any 2 or more criteria present, suggest systemic antibiotic treatment

**What is the function of dressing?**

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**Role of Infection Prevention and Control in Wound Care**

- Specialized service which enables others to prevent and control infection
- Reliable aseptic and clean techniques.
- Prevent wound contamination from extrinsic sources such as hands and non-sterile/dirty utensils contaminating vulnerable wound sites



Hand Hygiene

- **Wound Assessment**

## Wound Care Technique

Aseptic technique
Clean technique

## Wound infections

- MRSA
  
- Community Associated MRSA (CA-MRSA)
  
- Others:

## Patient Participation

- Patient and caregiver education
  - wound hygiene
  - dressing application.
  - diagnosis of infection

## WRHA Infection Prevention and Control (IP & C) Wound Management Principles

<http://www.wrha.mb.ca/extranet/eipt/files/EIPT-013-010.pdf>

- Hand Hygiene
- Personal Protective Equipment (PPE)
- Waste Disposal
- Aseptic Technique
- Clean Technique
- no-touch technique, sterile materials and supplies and maintaining a clean field
- Wound Cleansing Agents/Equipment
- Dressing, Pastes and Gels
- Antibiotic Resistant Organisms (ARO)

(especially if individual known to be colonized or infected with an ARO, e.g. Methicillin resistant Staphylococcus aureus (MRSA), Vancomycin resistant Enterococcus (VRE))

- **Some of these HAIs can be directly linked to poor infection control practices during wound care.**

## IP&C practices related directly to wound care

- Routine Practices should be used for wound care for any type of wound in any health care setting:
  - Point of Care Risk Assessment
  
  - Hand hygiene
  
  - Personal Protective Equipment (PPE)
  
  - Clean and aseptic technique
  
  - Cleaning equipment and the environment
  
  - Waste management

### Point of care risk assessment (PCRA)

- Assessment of the task at hand
- Minimize the risk of exposure to potentially harmful organisms
- Minimize the risk of exposure for the health care worker, the patient, other patients, visitors and other staff

### Point of care risk assessment (PCRA)

- Consider:
  - What are you going to be doing.
    - Is there a risk of being exposed to blood or body fluids?



Courtesy slide from Chantelle Riddle-Yarycky

### What is the patient doing?

For example:

- E.g.: are they bleeding?
- Coughing and/or sneezing and not covering their mouth/nose?
- Have an Antibiotic Resistant Organism (ARO)?
- Are they cooperative?
- Do they understand what is going on?



Courtesy slide from Chantelle Riddle-Yarycky

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### Special considerations:

- Non respiratory TB suspected or confirmed and there is potential for aerosolization from the site (e.g., open abscess or wound irrigation)
- Draining Wounds:
  - Routine practices
  - CONTACT (Major uncontrolled drainage)
  - CONTACT plus DROPLET for first 24 hours of antimicrobial therapy if invasive group A streptococcal infection suspected.
- Shingles
  - Localized (Routine)
  - Localized in immuno-compromized host or Disseminated (airborne and contact)

### 4 moments of Hand Hygiene



