# HSE National Wound Management Guidelines 2018

Clinical Strategy and Programmes Division

Office of the
Nursing & Midwifery
Services Director

## Background

Evidence based knowledge and skills related to advancing wound care management are of crucial importance in meeting the needs of the patient/client safely, effectively and efficiently.

Every day hundreds of patients/clients require care of their wounds across the Health Service. Wounds have a major impact on the individual, their quality of life, social, and on our health service and our society as a whole. Including an economic impact.

It is estimated that 1.5% of the population worldwide develop a wound at any one time, the growing prevalence and incidence of non-healing wounds (acute and chronic) are a major source of morbidity to patients and a major cost to hospital and community healthcare providers globally.

Increased prevalence and incidence of multiple comorbidities are challenging health care providers to provide ever more complex interventions with fewer resources.

It is estimated that between 25% and 50% of acute hospital beds are occupied by patients with a wound. Of these wounds between 55%-60% are non-healing wounds, infected surgical wounds, pressure ulcers and leg/foot ulcers.

Chronic wounds of all aetiologies cost the Irish Health Service Executive an estimated at €285.5 million per annum.

It is estimated that more than 23% of all hospital in-patients have a pressure ulcer, many of which are acquired during hospitalisation for an acute episode of illness or injury and therefore are avoidable.

Wound management is dynamic and is dependent on the clinician's ability and skill in assessing, planning care and evaluating outcomes.

Wound therapeutics are continuously evolving requiring the clinician to keep abreast of the research evidence to inform and underpin their practice.

The complexity of wounds requires practitioners who are skilled in wound assessment, diagnosis, treatment and evaluation of outcomes.

## The Guideline Review Group

Membership of the Guideline Review Group included professional clinical experts from across disciplines representing a range of clinical settings and various wound care pathways and disciplines, including an expert group of dietitians and colleagues from Higher Education Institutes.

A comprehensive Systematic Review was undertaken following which the recommendations Developed for wound care management, adapted to reflect care in the Irish healthcare setting

**The Purpose**

The purpose of the HSE National Wound Guidelines 2018 is to ensure that the most up-to-date evidence is available to support the standardisation consistent approach for wound care in Ireland across all care settings and encourage best clinical practice, to contribute to improved patient outcomes.

The guideline will support safe, quality care for patients, who access healthcare. These guidelines constitute a general guide to be followed, subject to the medical practitioner's judgement in each individual case.

Replaces the 2009 Wound Management Guidelines.

## Collaborative Working

The underlying approach and promotion of Wound Management Care is through collaborative working to support the delivery of safe, evidenced based quality care to patients and service users.

The guideline is a resource for all clinicians and specialist teams involved in the care of patients, residents or clients, adults and children with an acute or chronic wound:

- doctors,
- nurses,
- midwives and
- health and social care professionals

These guidelines and the general principles of wound management largely apply to the care of all wounds, particular emphasis in this document is on wounds most commonly encountered in routine clinical practice and which provide many challenges to practitioners.

The recommendations in the Wound Management Guidelines 2018 are organised into specific sections to enable the clinicians to directly seek the advice relating to a particular clinical practice situation which they need to address.

- General wound care
- Diabetic foot ulcers
- Pressure ulcers
- Leg ulcers
- Palliative wound care
- Education

The needs of special populations with wounds are addressed in the relevant sections.

The format of the Guideline follows the HSE National PPPG Framework

Each section includes for example

Pressure Ulcers

- An introduction to the Specific area
- Clinical Questions
  - An Evidence Statement for each Clinical Question posed
  - Recommendations 1 -20
- “Good Practice Points” where relevant
- “Alert” where relevant

***Good Practice Point***

***Do not rely on the results of a risk assessment tool alone when assessing a patient's pressure ulcer risk***

***Alert!***

***When documenting skin redness, differentiate between blanching or non-blanching redness***

**Pressure Ulcers**
**Section Three**

**13 Sections** grouped in line with the elements of the SSKIN Bundle

33 **Clinical Questions**

**33 Evidence Statements-** Literature review of existing National & International guidelines appraised using AGREE II tool. Where there were gaps in evidence specific research questions were set using PICO framework (Irish Context).

**298 Recommendations**

The recommendations in the pressure ulcer section which unless otherwise stated, were graded using the NPUAP/EPUAP/PPPIA (2014) grading system and
HSE Recommendations Level A-D

# HSE 2018 PRESSURE ULCER CATEGORY / STAGING SYSTEM

**Definition:** ***"A pressure ulcer is a localised injury to the skin and / or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance has yet to be elucidated"***

**Category/ Stage I:** Intact skin with non – blanchable redness of a localised area usually over a bony prominence. Discolouration of the skin, warmth, odema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching. The area may be painful, firm, soft, warmer or cooler as compared to adjacent skin. (EPUAP 2009).

**Category / Stage II:** Partial thickness skin loss of dermis presenting as a shallow ulcer with a red pink wound bed, without slough. May present as an intact or open/ ruptured serum filled blister filled with serous or sero-sanguineous fluid. Presents as a shiny or dry shallow ulcer without slough or bruising. (EPUAP 2009).

**Category / Stage III:** Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. The stage may include undermining or tunnelling (EPUAP 2009).

**Category / Stage IV:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. This stage often includes undermining and tunnelling. Exposed bone / muscle is visible or directly palpable (EPUAP 2009).

**Suspected deep pressure and shear induced tissue damage, depth unknown**

In individuals with non-blanchable redness and purple/maroon discoloration of intact skin combined with a history of prolonged, unrelieved pressure/shear, this skin change may be an indication of emerging, more severe pressure ulceration i.e. an emerging **Category/Stage III or IV Pressure Ulcer**. Clear recording of the exact nature of the visible skin changes, including recording of the risk that these changes may be an indication of emerging more severe pressure ulceration, should be documented in the patients' health record. These observations should be recorded in tandem with information pertaining to the patient history of prolonged, unrelieved pressure/shear.

It is estimated that it could take **3-10 days** from the initial insult causing the damage, to become a **Category/Stage III or IV Pressure Ulcer** (Black et al, 2015).

Stable eschar (dry adherent, intact without erythema or fluctuance) on the heel serves as the body's biological cover and should not be removed. It should be documented as at least Category / Stage III until proven otherwise.

This guideline aims to support all clinicians in the clinical decision making process in their wound care practice. The availability of these national guidelines will also support the implementation of standardised wound care in healthcare organisations nationally and the quality and safety of patients/clients in our care.

But the most important factor is that these guidelines will positively impact on the individual patients quality of life and that of their carer's and they will also have a significant impact on our health service and our society as a whole.

# Thank You

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