KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

CHECKLIST: WOUND MANAGEMENT

Date:		**Unit:**	
Name:		**IP Number:**	

The purpose of this management checklist is to guide an appropriate and acceptable standard of management and care for neonatal wounds. It should be started for any baby with a wound of any kind.
It is aimed at nurses and junior/inexperienced medical practitioners. It does not replace individualized expert management.

Authorized By:		**Prof NH McKerrow - KZN Provincial Paediatrician**	
Date:	19 May 2022	**Review Date:**	1 July 2024

Perform Initial assessment	✓		✓
Determine cause		Identify factors which many delay healing	
Describe location		Document presence of sutures/drain	
Develop a treatment plan including cleansing method for skin & wound bed; dressing required and frequency of changes			

Sign:		**Print:**	
Date:		**Time:**	

Prevent wound infection and promote healing	✓		✓
If doing more than one dressing - prioritise wound hygiene. Dress cleanest wounds first and most contaminated last.			
Rub hands with ABHR till dry before setting dressing trolley		Perform sterile procedure hand wash	
Clean trolley with Hibiscrub & water and then alcohol spray		Use aseptic technique during dressing	
To clean and remove biofilm: Compress wound for 10 mins with warm saline mixture: Add 25 ml baby shampoo and 10 ml ascetic acid to 1L normal saline			
Remove necrotic tissue and slough using autolytic debridement (leave dressing on for about 3 days with good moisture balance) or sharp debridement (using scalpel or scissors)			
Keep wound warm & moist to promote healing			
Discard old dressing into red plastic bag (expel any air) and discard to hazardous waste box			

Sign:		**Print:**	
Date:		**Time:**	

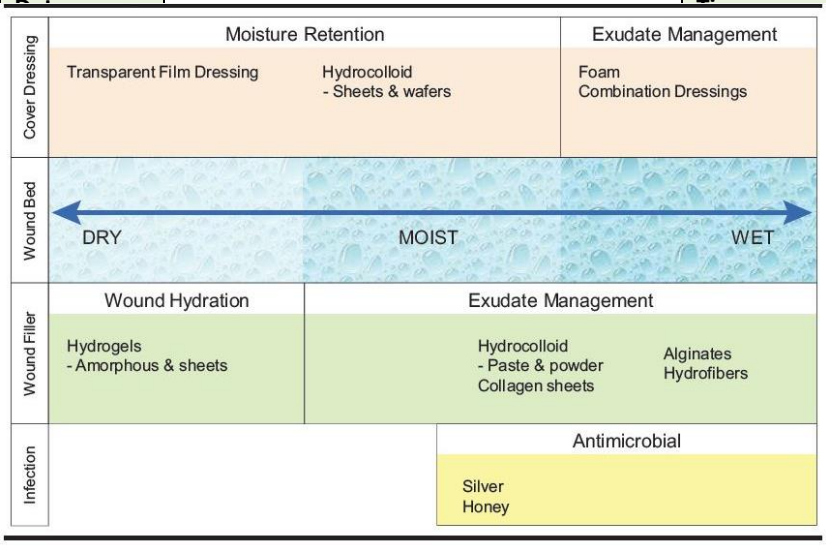
Assess for, prevent and manage pain	✓		✓
Use pain assessment tool before and after dressing		2 mins prior to dressing, administer: • Preterm: 0.3 ml/kg 24% sucrose per os; • Term: 1 - 2 ml 24% sucrose per os; **OR** • Analgesia as ordered	
Monitor for signs of pain during dressing			
Perform dressing change in KMC position if possible			
Use comfort techniques eg swaddling/non-nutritive sucking			
Ensure wound is covered and moist to reduce pain from exposed nerves			

Sign:		**Print:**	
Date:		**Time:**	

Assess wound (Using wound assessment chart)	✓		✓
Use a separate chart for each wound		Use a clean ruler. Assess longest length (straight line), width (90° to length) & depth (estimated from edge)	
Describe the type of wound			
Identify factors which may delay wound healing		Are the edges coming together and epithelializing?	
Develop a wound treatment plan		Assess the tissue type & colour of wound bed	
Assess wound perfusion - capillary refill time		Evaluate the volume and type of exudate	
Describe the wound shape - use a drawing if possible		Assess the condition of the surrounding skin	
Assess for signs of infection STONEES:			
Size increase		**E**xudate volume increasing	
Temperature - increase or decreased		**E**rythema or oedema	
Osteo - Probing to the bone		**S**mell - Offensive odour	
New breakdown or satellite wounds		**NB.** Take pus swab only if infection suspected	

Sign:		**Print:**	
Date:		**Time:**	

Select appropriate dressing				✓
In order to prevent maceration of healthy skin ensure dressing is intact with no leaking				
If wound is clean & healthy - change dressing 1 – 2 x per week			Exudate covers 75% of dressing-change immediately	
Maintain a physiological moist wound environment to facilitate healing.				
Select dressing based on the colour and depth of the wound bed, volume of exudate and presence of infection. See figures below to guide dressing choice				
Fragile /Preterm skin:	Use soft silicon gauze/ foam (eg Adaptic touch/ Askina Silknet) or hydrogel dressings plus non adhesive bandages or cling wrap to secure dressings			
Severe dermatitis:	Cavalon spray or egg whites			
Superficial, clean, non-exuding:	Extra thin hydrocolloid dressing			
Superficial contaminated/exuding:	Zinc paste (without lanolin/alcohol) with silicone gauze & transparent dressing			
Surgical (non-exuding):	Transparent dressing			
Local infection:	Topical antimicrobial & silicon gauze			
Deep infection:	Topical antimicrobial & possible antibiotics			
Contaminated/infected:	Bacteria binding dressing			
Cavity wounds:	Wound packing			
Avoid: Products that may result in skin stripping and peri-wound skin injury.				
Avoid: Betadine and gauze as these require frequent dressing changes & often stick leading to poor epithelialisation				
Avoid: Paraffin impregnated dressings (eg Jelonet): The paraffin evaporates under radiant warmers and dressing adheres				
Avoid allergens: Lanolin / latex / iodine / mercurochrome and merthiolate				
Sign:		**Print:**		



Reference: *Miriam Fox. Wound Care in the Neonatal Intensive Care Unit. Neonatal Network Vol. 30 No. 5. Oct 2011*

Category	Composition	Adhesion	Indications
Transparent film	Polyurethane membrane Semipermeable	Acrylic adhesive inactivated by moisture	Dry to minimal moisture Enables autolytic debridement Secure other dressings Intravenous access sites
Hydrocolloid	Carboxymethylcellulose most common Occlusive Forms a colloidal gel as exudate absorbed Wafers, sheets, powders, and pastes	Adhesive inactivated by moisture but strong so inappropriate for fragile periwound skin	Light to moderate exudating wounds Enables autolytic debridement
Foam	Polyurethane	May or may not have adhesive incorporated	Moderate to heavily exudating wounds Thin foams for minimal exudating wounds like skin tears Absorption around drains and catheters
Alginate	Fibers derived from brown seaweed Exchange Ca+ in dressing for Na+ in exudate Sheets, pads, or ropes	No adhesion Irrigate wounds to remove fibers	Moderate to heavily exudating wounds Hemostatic properties useful for bleeding wounds Tunneling or undermining
Hydrofiber	Sodium carboxymethylcellose Absorbs exudate and forms a gel structure Sheets or ropes	No adhesion	Moderate to heavily exudating wounds Tunneling or undermining
Composite	Multiple dressing categories layered as one dressing	Adhesive border with semiadherent or nonadherent properties	Depends on components in dressing
Hydrogels	Hydrophilic gel-forming polymer in an aqueous medium Amorphous or sheets	No adhesion Irrigate wounds to remove	Dry wound beds Autolytic debridement of necrotic material and slough Extravasation injuries Monitor for periwound maceration