



 SKILL TRACK

Wound Fundamentals Study Guide

VERSION 1.0

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Welcome to the Wound Fundamentals Study Guide!

The purpose of this guide is to help you revise subjects covered in the Skill Track that will be tested in the Capstone Assessment, such as wound assessment and classification principles, management strategies for acute and chronic wounds, and specialised approaches to wound management in diverse settings. Reviewing the Study Guide is optional but strongly recommended.

This guide has been authored by the Ausmed team in collaboration with the subject matter experts.

We hope you find this guide useful, and good luck with your Capstone Assessment!

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This study guide is for educational purposes only. The contents of this document and availability of resources is subject to change. Consult the Ausmed online platform for the most up-to-date version.

Available from: <https://www.ausmed.com.au/learn/skill-tracks/wound-fundamentals>



Section 1: Holistic Wound Management

Learning Outcome 1

Apply a holistic approach to wound management that demonstrates clear recognition of how key factors relating to the person, their wound and the environment directly influence healing trajectory and outcomes.

Key Concepts

- Holistic wound management: The person, their wound, and the environment.
- Patient-centred factors influencing the healing process, including:
 - Comorbidities (e.g. diabetes, kidney disease, hypertension), lifestyle (e.g. nutrition, activity) and psychosocial factors (e.g. stress, depression, social support).
- Environmental influences: The impact of factors including access to care, living conditions and support systems.
- Healing objectives: Distinguishing between healing, maintenance, and palliative care goals.

Key Video Units

[Wound Assessment](#)

- Unit 2: Wound Assessment Fundamentals
- Unit 3: Assessment Components
- Unit 4: Types of Wounds

Study Tips

- Learn the key elements of holistic assessment and how they relate to healing trajectories.
- Reflect on patients with wounds you have cared for and identify their physical and psychosocial barriers to healing.
- Understand chronic wound definitions and the differences between healable, maintenance and non-healable wounds.

Practice Question 1.1



Sentence completion:

Using the options below, complete the following statement about best practices for wound identification during the initial assessment:

'Whilst all the options are important, determining the Answer is fundamental for developing an effective treatment plan to address the **specific cause** of the wound.'

Healing potential
Wound dimensions
Patient's comorbidities
Patient's willingness and ability to participate in their care
Aetiology/Diagnosis

Your answer:

Answer	[Select answer from drop-down box]
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Practice Question 1.2 

Multiple choice:

When assessing a patient with a skin tear, which of the following specialised assessment tools would be most appropriate to utilise?

Your answer:

A)	Rule of nines
B)	1-4 staging system
C)	ISTAP
D)	SINBAD
E)	University of Texas wound classification system (UTWCS)

See [page 21](#) for the correct answers and rationale.



Section 2: Assessment of Wound Characteristics

Learning Outcome 2

Demonstrate the ability to accurately assess and describe wound characteristics such as size, depth, tissue types, exudate and surrounding skin according to best practice.

Key Concepts

Assessment parameters:

- Size/dimensions: Measuring length, width and depth.
- Tissue types: Identifying the tissues in the wound bed.
- Exudate: Identifying the type, consistency, amount and colour of fluid produced by the wound.
- Odour: Determining if the wound is producing any smell.
- Edge: Determining the appearance where the intact skin meets the wound.
- Surrounding skin: Assessing the condition of periwound area.
- Pain: Assessing the patient's pain associated with their wound.

Assessment tools:

- The HEIDIE framework: for holistic assessment.
- The TIME framework: for assessment of the wound
- Classification systems for specific wound aetiologies (e.g. SINBAD for foot ulcers, 1-4 staging system for pressure injuries).

Key Video Units

[Wound Assessment](#)

- Unit 4: Types of Wounds
- Unit 5: Assessment of Wound Characteristics
- Unit 6: Key Practice Points for Assessment

Study Tips

- Practice identifying wound characteristics through visual examples or case studies.



- Understand when and how often to document wound assessments in different care settings (e.g., community, hospital) and for different wound types (acute, chronic).
- Master the TIME framework and apply it to clinical practice scenarios.

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Practice Question 2.1 

Drag and drop:

When assessing wound characteristics, which of the following would you assess before and after wound cleansing/debridement?

Edge	Exudate	Odour	Pain
Periwound + Surrounding Skin	Size/dimensions	Tissue type/s	

Your answer:

Assess prior to cleansing/debridement	<i>[Drag and drop answer here]</i>
Assess following cleansing/debridement	<i>[Drag and drop answer here]</i>

.....

Practice Question 2.2 

Multiple choice:

Identify if the following wound edges are healthy or unhealthy.



Your answer:

A)	Healthy
B)	Unhealthy

See [page 21](#) for the correct answers and rationale.

Section 3: Accurate Wound Identification and Documentation

Learning Outcome 3

Communicate findings from wound assessments and routine wound management practices clearly, comprehensively and accurately.

Key Concepts

Documentation:

- Accurate recording of wound characteristics.
- Using standardised terminology for wound characteristics.

Collaborative communication:

- Involving care teams, patients and families in wound management decisions.



- Ethical considerations in documentation, including consent for clinical photography.

Key Video Units

[Wound Assessment](#)

- Unit 7: Wound Documentation

[Wound Dressing](#)

- Unit 4: Dressing Regimens and Documentation

Study Tips

- Learn how standardised templates can improve documenting wound assessments.
- Role-play scenarios where you explain wound conditions and management plans to patients and families.
- Understand legal and professional responsibilities related to clinical documentation.



Practice Question 3.1

Multiple choice:

Select the correct description of the type of exudate present in the following image:





Your answer:

A)	Serous
B)	Purulent
C)	Sanguineous
D)	Haemopurulent
E)	Haemorrhagic
F)	Haemoserous/serosanguinous



Practice Question 3.2 

Multiple choice (multiple answers):

Which of the following factors can have a detrimental impact on the healing ability of a patient with a chronic wound? (Select all that apply.)

Your answer:

A)	Age < 60
B)	Allergies/sensitivities
C)	Poorly controlled diabetes
D)	Peripheral arterial disease
E)	Chronic kidney failure
F)	Sex
G)	Non-smoking status

See [page 21](#) for the correct answers and rationale.



Section 4: Principles of Aseptic Technique

Learning Outcome 4

Understand and apply the principles of aseptic technique when cleansing and debriding wounds.

Key Concepts

Principles of asepsis:

- Understanding why aseptic technique is important during wound dressing procedure.
- When to use standard or surgical aseptic technique.
- Maintaining asepsis during wound cleansing and dressing changes.

Common errors:

- Avoiding contamination of aseptic fields, especially when handling gloves and instruments.

Key Video Units

[Wound Assessment](#)

- Unit 6: Key Practice Points for Assessment

[Wound Cleansing and Debridement](#)

- Unit 3: Key Practice Principles
- Unit 4: Cleansing
- Unit 5: Debridement
- Unit 6: Practical Demonstrations

Study Tips

- Watch videos or simulations demonstrating correct aseptic techniques.
- Reflect on your clinical practice when performing a wound dressing procedure.
- Practice identifying errors in aseptic technique from case scenarios.

Practice Question 4.1



True or false:

When there is a need to directly handle sterilised wound dressings (e.g. when performing a traditional negative pressure therapy dressing change or when packing a large cavity), surgical aseptic technique is required.

Your answer:

A)	True
B)	False

See [page 21](#) for the correct answers and rationale.

Section 5: Wound Cleansing Techniques

Learning Outcome 5

Understand and select various wound cleansing agents and techniques according to the specific needs of the person, their wound and the environment.

Key Concepts

Cleansing agents:

- Characteristics of saline, antiseptics, surfactants and their indications.

Cleansing techniques:

- Cleansing and debridement techniques available.
- Wound hygiene protocol.

Clinical considerations:

- Factors influencing cleansing agent/technique selection (e.g. wound type, infection risk, patient tolerance).
- Cleansing and debridement techniques suitable for use in general clinical practice.

Key Video Units

[Wound Cleansing and Debridement](#)

- Unit 4: Cleansing



- Unit 6: Practical Demonstrations

Study Tips

- Create a comparison chart for different cleansing agents, listing their indications, advantages and limitations.
- Familiarise yourself with wound hygiene protocols using the T.I.M.E. framework.
- Reflect on your clinical practice and how you manage wounds with non-viable tissue or likely to have biofilm.



Practice Question 5.1

Multiple choice (multiple answers):

Which of the following cleansing techniques are generally **avoided** in contemporary practice? (Select all that apply.)

Your answer:

A)	Soaking in buckets/bowls of potable water
B)	Cleansing with gauze and sterile solution
C)	Washing wounds in the shower
D)	Cleansing with potable water (i.e. clean technique)
E)	Cleansing with solutions (e.g. surfactants and/or antiseptics)

See [page 21](#) for the correct answers and rationale.

Section 6: Selection of Debridement Methods

Learning Outcome 6



Recognise the importance and relevance of simple wound debridement within a nursing scope of practice in order to confidently select and perform appropriate debridement techniques accordingly.

Key Concepts

Types of debridement:

- Autolytic, mechanical, enzymatic, biological, conservative sharp, surgical.

Indications and contraindications:

- Matching debridement techniques to patient needs, preferences, and wound characteristics.

Role of nurses:

- Scope of practice for debridement and decision-making.

Key Video Units

[Wound Cleansing and Debridement](#)

- Unit 5: Debridement
- Unit 6: Practical Demonstrations

Study Tips:

- Understand the pros and cons of each debridement method and when to refer to specialists.
- Reflect on patients you have cared for and how debridement might have improved their clinical outcomes.
- Learn how to communicate with patients about the purpose and process of debridement.



Practice Question 6.1

Drag and drop/sentence completion:

Drag and drop two options below to correctly complete the following sentence:

'All healthcare professionals can perform debridement techniques such as simple Answer 1 using force, such as gauze, debridement pads or blunt curettage to



remove loose non-viable tissue or Answer 2 which involves the use of dressings to facilitate the body to break down non-viable tissue.'

Autolytic debridement
Mechanical debridement
Enzymatic debridement
Biological debridement
Conservative sharp debridement
Chemical debridement
Surgical debridement

Your answer:

Answer 1	<i>[Select answer from the drop-down box]</i>
Answer 2	<i>[Select answer from the drop-down box]</i>

See [page 21](#) for the correct answers and rationale.

Section 7: Wound Dressing and Product Selection

Learning Outcome 7

Select appropriate wound dressings and products based on wound aetiology and characteristics, product specifications, the person and their healing objective.

Key Concepts

Dressing types and classification:

- Understanding and selecting dressings based on their functionality.
- The differences between, and indications for conventional and specialised dressings.

Criteria for dressing selection:



- Based on wound characteristics (e.g. exudate levels, infection, goals of care).
- Considering product characteristics.

Adapting regimens:

- Modifying dressings based on wound progress.

Key Video Units

[Wound Dressing](#)

- Unit 2: Wound Dressing Fundamentals
- Unit 3: Types of Dressings
- Unit 4: Dressing Regimens and Documentation
- Unit 5: Troubleshooting and Complications

Study Tips

- Learn to identify signs that a dressing regimen is no longer effective.
- Reflect on why you do or don't change dressing regimens for patients with wounds in your workplace.
- Understand how to manage the wound dressing regimen for wounds with limited healing capacity.



Practice Question 7.1

Multiple choice:

A 58-year-old patient with diabetes presents with a chronic diabetic foot ulcer on the plantar surface of their foot. The wound has moderate levels of exudate, has noticeably reduced in size in the last four weeks and shows signs of granulation tissue development.

Which dressing type is most appropriate from the following options?

Your answer:

A)	Hydrocolloid dressing
B)	Foam dressing with silicone interface



C)	Island dressing
D)	Silver antimicrobial dressing
E)	Transparent film dressing

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Practice Question 7.2 

Multiple choice:

How often should the efficacy of a silver-containing dressing be reviewed?

A)	At every dressing change
B)	Weekly
C)	Every 2 weeks
D)	Every 4 weeks
E)	Review not required – if a silver dressing has been commenced, it should only be ceased when the wound heals

See [page 21](#) for the correct answers and rationale.

Section 8: Evaluating Dressing Regimens

Learning Outcome 8

Increase confidence in evaluating the effectiveness of a dressing regimen and making informed decisions about whether or not changes are necessary in order to achieve optimal outcomes.

Key Concepts

Indicators for reassessment:

- Justifiable rationales for continuing or changing a dressing regimen.



Holistic approach:

- Considering the person, wound and environment when evaluating dressing regimen effectiveness.

Frequency of evaluation:

- General guidelines for changing and reassessing dressings.

Key Video Units

[Wound Dressing](#)

- Unit 4: Dressing Regimens and Documentation
- Unit 5: Troubleshooting and Complications

Study Tips

- Learn to identify signs that a dressing regimen is no longer effective.
- Reflect on why you do or don't change dressing regimens for patients with wounds in your workplace.
- Understand how to manage the wound dressing regimen for wounds with limited healing capacity.



Practice Question 8.1

Multiple choice:

Generally, how often should a dressing regimen for a chronic wound in a community setting be formally reviewed?

Your answer:

A)	Once daily
B)	Every week
C)	At every dressing change
D)	Every 4 weeks
E)	Every 6 weeks



.....

Practice Question 8.2

Multiple choice (multiple answers):

What is the purpose of reviewing a patient's dressing regimen if the patient has been determined to have a healable wound? (Select all that apply.)

Your answer:

A)	To assess dressing-related objectives.
B)	To ensure the dressing regimen is regularly changed.
C)	To assess if the dressing regimen meets the goals of the patient and the wound.
D)	To ensure the wound is healing/improving.
E)	To ensure that the dressing regimen includes your preferred type of dressing.

See [page 21](#) for the correct answers and rationale.

Section 9: Evaluating Wound Healing Progress

Learning Outcome 9

Evaluate wound healing trajectory and progress against a patient's goals of care.

Key Concepts

- Understand the primary and secondary indicators of wound progress.
- Identify when there are delays in healing
- Identify when and how to seek further assistance.

Key Video Units

[Wound Assessment](#)

- Unit 3: Assessment Components



- Unit 4: Types of Wounds

[Wound Dressing](#)

- Unit 4: Dressing Regimens and Documentation

Study Tips

- Reflect on the processes and systems used in your workplace to monitor wound progress and if/how they specifically identify improvement, deterioration or an unchanged status.
- Understand how to document and communicate findings indicating wound improvement or deterioration.
- List resources that you can use when you require additional assistance for wound management.
- Learn strategies for managing wounds when healing is not the primary goal.



Practice Question 9.1

Multiple choice:

You are caring for a patient with a venous leg ulcer who has steadfastly declined best-practice management using compression therapy. During a routine wound assessment, you notice that the size of the patient's wound has noticeably increased in size during the last week when compared to the documentation from previous assessments and clinical photographs. The wound has been classified previously as having 'poor healing potential'.

What does this information indicate about the nature of the wound's healing trajectory?

Your answer:

A)	The wound has improved and is healing.
B)	This is likely an acute, healable wound, and therefore, this kind of deterioration is cause for concern.
C)	This is likely a chronic, maintenance wound, and therefore, this kind of deterioration is to be expected.



D)	This is likely a chronic, palliative wound, and therefore, this kind of deterioration is to be expected.
E)	This is likely a chronic, maintenance wound, and therefore, this kind of deterioration is cause for concern.
F)	This is likely a chronic, palliative wound, and therefore, this kind of deterioration is cause for concern.



Practice Question 9.2

True or false:

You are caring for a bed-bound patient with a pressure injury on their sacrum. The patient refuses to be repositioned and insists that they are only comfortable when lying flat on their back.

True or false: In order to ensure that this patient's wound can heal and that they receive the best care possible, you should still ensure that they are regularly repositioned regardless of their wishes.

Your answer:

A)	True
B)	False

See [page 21](#) for the correct answers and rationale.





Practice Question Answers

Practice Question 1.1

Sentence completion:

Using the options below, complete the following statement about best practices for wound identification during the initial assessment:

'Whilst all the options are important, determining the **Answer** is fundamental for developing an effective treatment plan to address the **specific cause** of the wound.'

Healing potential
Wound dimensions
Patient's comorbidities
Patient's willingness and ability to participate in their care
Aetiology/Diagnosis

Your answer:

Answer	<i>[Select answer from drop-down box]</i>
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Practice Question 1.1

Correct answer: Aetiology

Rationale:

This question requires careful attention to the statement's intended purpose in developing an effective treatment plan. The phrase 'tailored to the **specific cause** of the wound' indicates that in order to develop an effective treatment plan, the underlying cause of the wound must be identified. This recognises that simply observing wound characteristics is not enough. Different wound aetiologies require different management plans that actively and effectively treat the root cause through an individualised treatment plan. Without determining and treating the aetiology, treatment risks being generalised and less effective.

.....

Practice Question 1.2



Multiple choice:

When assessing a patient with a skin tear, which of the following specialised assessment tools would be most appropriate to utilise?

Your answer:

A)	Rule of nines
B)	1-4 staging system
C)	ISTAP
D)	SINBAD
E)	University of Texas wound classification system (UTWCS)

Practice Question 1.2 

Correct Answer: C) ISTAP

Rationale:

The ISTAP (International Skin Tear Advisory Panel) classification system is specifically designed to assess and categorise skin tears. It provides a standardised framework for evaluating their severity and characteristics, enabling clinicians to select appropriate management strategies.

Why the other options are incorrect:

- A) Rule of nines: Designed for estimating the total body surface area (TBSA) affected by burns.
- B) 1-4 staging system: A specialised wound classification tool primarily used for classifying pressure injuries.
- D) SINBAD: A specialised wound classification tool for assessing diabetic foot ulcers.
- E) University of Texas wound classification system (UTWCS): A specialised wound classification tool for assessing diabetic foot ulcers.





Practice Question 2.1

Drag and drop:

When assessing wound characteristics, which of the following would you assess before and after wound cleansing/debridement?

Edge	Exudate	Odour	Pain
Periwound + Surrounding Skin	Size/dimensions	Tissue type/s	

Your answer:

Assess prior to cleansing/debridement	<i>[Drag and drop answer here]</i>
Assess following cleansing/debridement	<i>[Drag and drop answer here]</i>

Practice Question 2.1

Correct answer:

Assess prior to cleansing/debridement	Pain, Exudate
Assess following cleansing/debridement	Size/Dimensions, Odour, Periwound + Surrounding Skin, Tissue type/s.

Rationale:

The order of assessment prioritises patient comfort and clinical accuracy. Pain should be assessed first because it provides immediate insight into the patient's experience and tolerance for the wound dressing procedure. Evaluating pain early allows for adjustments in technique to minimise discomfort and establishes a baseline for managing patient-centred care.

Exudate is also assessed prior to cleansing/debridement as assessing the interaction between the exudate and the dressing before, during and following removal informs the clinician as to whether the dressing is meeting the wound needs and is appropriate. Exudate quantity, type, colour and consistency can only be assessed prior to cleansing, as once the wound is cleaned, the exudate is removed.



Size/Dimensions, tissue type/s, edge, periwound + surrounding skin and odour should be assessed following wound cleansing/debridement, as exudate, dressing remnants, and debris might be present on removal of the dressing, and if not removed, the assessment might not reflect the true nature of these characteristics.

This sequence aligns with best-practice in wound assessment, ensuring that patient comfort and safety are prioritised while still achieving an accurate evaluation of all wound components.



Practice Question 2.2

Multiple choice:

Identify if the following wound edges are healthy or unhealthy.



Your answer:

A)	Healthy
B)	Unhealthy

Practice Question 2.2

Correct answer: B) Healthy

Rationale:

The wound edge in the image is healthy due to the following observations:

- There is considerable new epithelialisation (new skin growth), as evidenced by the pale pink tissue growing across the wound, which has a matte finish.



- The wound has a gentle slope towards the centre.
- The border where the epithelialisation (new skin) meets the wound is irregular and indistinct in places.

These characteristics suggest that the wound is progressing towards healing.

.....

Practice Question 3.1 

Multiple choice:

Select the correct description of the type of exudate present for the wound depicted in the following image:



Your answer:

A)	Serous
B)	Purulent
C)	Sanguineous
E)	Haemopurulent
F)	Haemorrhagic
G)	Haemoserous/serosanguinous



Practice Question 3.1

Correct answer: B) Purulent

Rationale:

Purulent exudate is thick, opaque and yellowish in appearance (pus-like), which might be associated with infection.

Why the other options are incorrect:

- A) Serous: Serous exudate is thin (watery) in consistency and clear or yellowish. Whilst the pictured exudate is a slightly yellowish colour, it is too thick and opaque to be serous exudate.
- C) Sanguineous: This would imply the presence of fresh blood, which is not visible here.
- E) Haemopurulent: Whilst the exudate is purulent, there is no blood present in the exudate.
- F) Haemorrhagic: No heavy bleeding is evident.
- G) Haemoserous/serosanguinous: No blood is mixed with the exudate, and the exudate is too thick and opaque to be haemoserous/serosanguinous.



Practice Question 3.2

Multiple choice (multiple answers):

Which of the following factors can have a detrimental impact on the healing ability of a patient with a chronic wound? (Select all that apply.)

Your answer:

A)	Age < 60
B)	Allergies/sensitivities
C)	Poorly controlled diabetes
D)	Peripheral arterial disease
E)	Chronic kidney failure



F)	Sex
G)	Non-smoking status

Practice Question 3.2

Correct answer:

- B) Allergies/sensitivities
- C) Poorly controlled diabetes
- D) Peripheral arterial disease
- E) Chronic kidney failure

Rationale:

Several factors can negatively affect wound healing in patients with chronic wounds by impeding circulation, delaying the immune response, or altering the wound environment. Here's why each correct answer applies:

- B) Allergies/sensitivities: Allergic reactions or sensitivities to dressings, adhesives, or topical agents can cause inflammation and delay healing. It is important to identify and avoid agents that result in an adverse reaction.
- C) Poorly controlled diabetes: High blood glucose levels impair neutrophil function, reduce oxygen delivery to tissues, slow collagen synthesis, and increases infection risk, all of which compromise the wound healing process.
- D) Peripheral arterial disease (PAD): PAD reduces arterial blood flow to the wound and surrounding tissues, depriving tissues of oxygen and nutrients essential for healing. This is particularly relevant in chronic wounds below the knee.
- E) Chronic kidney failure: Uraemia, electrolyte imbalance, and anaemia associated with kidney failure impair wound healing by disrupting cellular and vascular functions.

Why the other options are incorrect:

- A) Age < 60: Age below 60 is not typically a detrimental factor. While advanced age can slow healing due to reduced regenerative capacity, based on age alone, younger individuals generally have adequate healing ability.
- F) Sex: Biological sex, in itself, generally does not have a significant impact on wound healing. Factors like comorbidities, nutrition and wound care are generally more critical.



- G) Non-smoking status: Smoking negatively impacts healing by reducing oxygen delivery and impairing vascular health, but non-smoking status supports healing and is not a detrimental factor.

These factors emphasise the importance of addressing underlying comorbidities and individual patient needs to optimise wound healing outcomes.

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Practice Question 4.1 

True or false:

When there is a need to directly handle sterilised wound dressings (e.g. when performing a traditional negative pressure therapy dressing change or when packing a large cavity), surgical aseptic technique is required.

Your answer:

A)	True
B)	False

Practice Question 4.1 

Correct answer: A) True

Rationale:

Standard aseptic technique promotes asepsis through wearing non-sterile gloves and using a non-touch technique. A non-touch technique means that the parts or surfaces of equipment or dressings that have been directly touched must not come into direct contact with the wound.

Using a surgical aseptic technique ensures asepsis and allows for direct contact of dressings and parts of equipment that will come into direct contact with the wound as the clinician is wearing sterile gloves.

In the examples given, the dressings must be directly handled – therefore, surgical aseptic technique is required.

.....

Practice Question 5.1 

Multiple choice (multiple answers):



Which of the following cleansing techniques are generally **avoided** in contemporary practice? (Select all that apply.)

Your answer:

A)	Soaking in buckets/bowls of potable water
B)	Cleansing with gauze and sterile solution
C)	Washing wounds in the shower
D)	Cleansing with potable water (i.e. clean technique)
E)	Cleansing with solutions (e.g. surfactants and/or antiseptics)

Practice Question 5.1

Correct answer:

- A) Soaking in buckets/bowls of potable water
- C) Washing wounds in the shower
- D) Cleansing with potable water

Rationale:

In contemporary wound care practice, wound dressing procedure is considered an invasive procedure. Invasive procedures require an aseptic technique, which involves the use of sterile equipment and solutions.

Cleansing using potable water is generally avoided. While potable water may be used in low-resource settings, it is generally avoided in favour of sterile solutions whenever available for the following reasons:

- Risk of infection
 - This can lead to contamination of the wound by exposing it to non-sterile water, and what is on the surrounding skin, which may harbour bacteria or other pathogens.
- Maceration
 - Prolonged exposure to moisture (particularly during soaking in buckets/bowls) can cause maceration of the periwound skin, leading to skin breakdown and delayed healing.
- Limited efficacy
 - Does not effectively remove debris, biofilm, or contaminants compared to other methods, such as cleansing with gauze.
- Sterility



- Sterile solutions minimise contamination risks, particularly in wounds with high infection susceptibility.
- Consistency
 - Potable water quality varies and may contain microorganisms, making it less reliable than sterile solutions.

Why the other options are incorrect (i.e. not avoided):

- B) Cleansing with gauze and sterile solution: This is a common, effective practice for mechanical cleansing, and removing debris without excessive trauma.
- E) Cleansing with solutions (e.g. surfactants and/or antiseptics): These solutions are used selectively to reduce microbial load and possibly assist with biofilm disruption for wounds at high risk of infection or those with biofilm.

Modern wound care emphasises evidence-based techniques that minimise harm while optimising wound bed preparation, making use of potable water generally an outdated and less favourable option. Using potable water is less favourable in modern practice due to its risks, especially when safer and more effective alternatives are widely available.

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Practice Question 6.1

Drag and drop/sentence completion:

Drag and drop two options below to correctly complete the following sentence:

'All healthcare professionals can perform debridement techniques such as simple Answer 1 using force, such as gauze, debridement pads or blunt curettage to remove loose non-viable tissue or Answer 2 which involves the use of dressings to facilitate the body to break down non-viable tissue.'

Autolytic debridement
Mechanical debridement
Enzymatic debridement
Biological debridement
Conservative sharp debridement



Chemical debridement

Surgical debridement

Your answer:

Answer 1	<i>[Select answer from the drop-down box]</i>
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Answer 2	<i>[Select answer from the drop-down box]</i>
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Practice Question 6.1

Correct answer:

Answer 1	Mechanical debridement
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Answer 2	Autolytic debridement
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Rationale:

Simple mechanical debridement techniques such as using gauze with a vigorous scrubbing action, debridement pads and blunt curettage (using the serrated end of a plastic forcep from the dressing pack) can be very useful to remove loose debris, gelatinous slough and disrupt biofilm. Because these techniques do not involve sharp instruments or specialised equipment, they can be performed safely and effectively with minimal training and specific competency is not required.

Autolytic debridement can be achieved by matching the dressing to the wound characteristics. Conventional dressings such as hydrogels, polymers and gelling fibres achieve autolytic debridement by optimising the moisture balance in the wound and tissues. Specialised dressings such as hypertonic saline, polyacrylate fibre and wound honey have components that can actively contribute to the breakdown of non-viable tissue.

Why the other options are incorrect:

- Enzymatic debridement: Relies on specific, enzymatic topical agents to break down non-viable tissue.
- Biological debridement: Uses maggots to consume necrotic tissue.
- Chemical debridement: Utilises chemical agents to break down non-viable tissue.
- Conservative sharp debridement: Uses sterile sharp instruments (e.g. scissors, scalpels) to remove non-viable tissue to the margin of healthy tissue



without deliberately excising healthy tissue. It is typically performed in outpatient or bedside settings by trained healthcare professionals and is less invasive than surgical debridement.

- **Surgical debridement:** Involves the removal of non-viable tissue and often extends into healthy tissue to ensure the complete removal of infection, non-viable tissue and/or debris. Due to its invasive nature, surgical debridement is typically performed by a surgeon in an operating theatre under sterile conditions.



Practice Question 7.1

Multiple choice:

A 58-year-old patient with diabetes presents with a chronic diabetic foot ulcer on the plantar surface of their foot. The wound has moderate levels of exudate, has noticeably reduced in size in the last four weeks and shows signs of granulation tissue development.

Which dressing type is most appropriate from the following options?

Your answer:

A)	Hydrocolloid dressing
B)	Foam dressing with silicone interface
C)	Island dressing
D)	Silver antimicrobial dressing
E)	Transparent film dressing

Practice Question 7.1

Correct answer: B) Foam dressing with silicone interface.

Rationale:

Foam dressings with silicone interfaces are highly effective for diabetic foot ulcers with moderate exudate. They absorb exudate while protecting the wound bed and surrounding fragile skin. The silicone interface allows for atraumatic removal,



reduces shear, and reduces the risk of damage to granulation tissue during dressing changes.

Why the other options are incorrect:

- A) Hydrocolloid dressing: This dressing is not ideal due to limited exudate absorption and the risk of maceration in moderate exudate wounds, particularly on a weight-bearing area such as the plantar surface of the foot.
- C) Island dressing: This dressing is not absorbent enough for moderate exudate, so is likely to leak and cause maceration of the periwound skin.
- D) Silver antimicrobial dressing: Antimicrobial dressings are not required for healing wounds without clinical signs of infection. The current evidence-based guidelines for the management of diabetic foot ulcers state that antimicrobial dressings should not be used routinely.
- E) Transparent film dressing: Does not absorb any exudate and can lead to maceration in exudative wounds.



Practice Question 7.2

Multiple choice:

How often should the efficacy of a silver-containing dressing be reviewed?

A)	At every dressing change
B)	Weekly
C)	Every two weeks
D)	Every four weeks
E)	Review not required – if a silver dressing has been commenced, it should only be ceased when the wound heals

Practice Question 7.2

Correct answer: C) Every two weeks

Rationale:

Silver-containing dressings are generally indicated for reducing bacterial load when



there are clinical signs of infection. As these dressings have a specialised mode of action, are for the treatment of a wound complication, and are generally more costly than conventional dressings, it is important that their efficacy is assessed regularly. This ensures that the dressing is addressing the signs of clinical infection.

Just like a course of systemic antibiotics, topical antimicrobial dressings should generally be used for a limited time. If the signs of clinical infection are resolved in two weeks, the silver-containing dressing can be ceased. If the signs of clinical infection are not resolved in two weeks the patient might require further investigation, systemic treatment, or treatment with a dressing containing an alternative antimicrobial agent. This is consistent with best-practice recommendations.



Practice Question 8.1

Multiple choice:

Generally, how often should a dressing regimen for a chronic wound in a community setting be formally reviewed?

Your answer:

A)	Once daily
B)	Every week
C)	At every dressing change
D)	Every 4 weeks
E)	Every 6 weeks

Practice Question 8.1

Correct answer: D) Every 4 weeks

Rationale:

In general, a dressing regimen should be formally reviewed every four weeks unless there are specific clinical indications to review it sooner (e.g., the wound becomes infected). This timeframe allows sufficient time to evaluate wound healing progress and assess the appropriateness of the dressing regimen.



Key considerations for a 4-weekly formal review of the dressing regimen:

- Suitability of the dressing regimen
 - Dressings are often selected to support the patient's healing over a longer term, and a 4-week formal review ensures continuity, allowing the chosen dressing regimen to have an effect.

Why the other options are incorrect:

- A) Once daily: Daily formal reviews of the dressing regimen are generally unnecessary. If the dressing regimen is changed this frequently, it is not possible to determine if it is appropriate for the wound.
- B) Every week: Weekly regimen reviews are appropriate for some acute or complex wounds in a hospital setting, but they are generally unnecessarily frequent for stable chronic wounds in a community setting.
- C) At every dressing change: Whilst an informal assessment of the suitability of the dressing regimen should be performed every dressing change, this is too frequent for a formal, documented regimen review to be conducted for most wounds. However, if the wound status has changed or complications have occurred and the current dressing regimen is no longer suitable, it should be changed.
- E) Every 6 weeks: This is generally too infrequent for most wounds, as formal, documented review demonstrates that there has been regular evaluation, of the dressing regimen and its suitability. Lack of formal review could mean an inappropriate or ineffective dressing regimen is continued for a prolonged period, which could also carry professional and legal risks.

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Practice Question 8.2 

Multiple choice (multiple answers):

What is the purpose of reviewing a patient's dressing regimen if the patient has been determined to have a healable wound? (Select all that apply.)

Your answer:

A)	To assess dressing-related objectives.
B)	To ensure the dressing regimen is regularly changed.



C)	To assess if the dressing regimen meets the goals of the patient and the wound.
D)	To ensure the wound is healing/improving.
E)	To ensure that the dressing regimen includes your preferred type of dressing.

Practice Question 8.2

Correct answer:

- A) To assess dressing-related objectives.
- C) To assess if the dressing regimen meets the goals of the patient and the wound.
- D) To ensure the wound is healing/improving.

Rationale:

The purpose of reviewing a patient's dressing regimen is to evaluate its effectiveness and ensure it aligns with the wound care plan and the patient's overall healing objectives.

Here's why each correct option applies:

- A) To assess dressing-related objectives: Dressing-related objectives might include maintaining a moist wound environment, managing exudate, preventing infection, and protecting the periwound skin. Reviewing the regimen ensures that these objectives are being met effectively.
- C) To assess if the dressing regimen meets the goals of the patient and the wound: A suitable dressing regimen should align with the specific goals of care, such as promoting healing and maintaining comfort. It should also account for the patient's individual needs and preferences.
- D) To ensure the wound is healing/improving: Regular review ensures that the wound is progressing toward healing. If the wound is not improving, adjustments can be made to address any barriers, such as infection, moisture imbalance or development of non-viable tissue.

Why the other options are incorrect:

- B) To ensure the dressing regimen is regularly changed: The focus of reviewing a regimen is to evaluate its effectiveness, not simply change it



regularly. Over-frequent dressing regimen changes might not allow the dressing to be effective and could delay healing.

- E) To ensure that the dressing regimen includes your preferred type of dressing: Dressing selection should be based on the wound's specific needs, not personal preference. There is not one dressing type or frequency of dressing changes that is suitable for all wounds. Therefore, the chosen dressing regimen should address individually assessed wound and patient factors. Just as wounds and patients vary, so too will the dressings used.

The purpose of reviewing a dressing regimen is to evaluate its effectiveness, ensure it aligns with patient-specific and wound-specific goals, and monitor progress, rather than focusing on arbitrary changes or personal preferences.



Practice Question 9.1

Multiple choice:

You are caring for a patient with a venous leg ulcer who has steadfastly declined best-practice management using compression therapy. During a routine wound assessment, you notice that the size of the patient's wound has noticeably increased in size during the last week when compared to the documentation from previous assessments and clinical photographs. The wound has been classified previously as having 'poor healing potential'.

What does this information indicate about the nature of the wound's healing trajectory?

Your answer:

A)	The wound has improved and is healing.
B)	This is likely an acute, healable wound, and therefore, this kind of deterioration is cause for concern.
C)	This is likely a chronic, maintenance wound, and therefore, this kind of deterioration is to be expected.
D)	This is likely a chronic, palliative wound, and therefore, this kind of deterioration is to be expected.
E)	This is likely a chronic, maintenance wound, and therefore, this kind of deterioration is cause for concern.



F)	This is likely a chronic, palliative wound, and therefore, this kind of deterioration is cause for concern.
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Practice Question 9.1

Correct answer: E) This is likely a chronic, maintenance wound, and therefore, this kind of deterioration is cause for concern.

Rationale:

A chronic, maintenance wound is one that is not expected to fully heal but is managed to prevent further deterioration and maintain its current state. The noticeable increase in wound size observed during the assessment is cause for concern because it indicates a deviation from the goal of stabilisation, suggesting that the current wound care regimen may not be effectively managing the wound. It is also concerning that a noticeable deterioration has occurred during a short time frame (one week).

Key indicators of concern in a chronic, maintenance wound include:

- Increase in size
 - This could indicate various problems, including (but not limited to): infection, worsening of the underlying aetiology, an ineffective dressing regimen or changes to lifestyle (in this case, increased leg dependency). Further evaluation of the other wound characteristics, evaluation of the wound dressing regimen and possibly investigations or a review by an expert practitioner might be required. The aim is to identify why the wound size has increased and implement a management plan to address the identified factor/s.
- Deviations from the expected trajectory
 - Even though healing may not be the primary goal, maintenance wounds should generally not worsen rapidly.

Why the other options are incorrect:

- A) The wound has improved and is healing: The wound size has increased, which indicates deterioration, not improvement.
- B) This is likely an acute, healable wound, and therefore, this kind of deterioration is cause for concern: The wound has been determined to be a venous leg ulcer which is a chronic wound and has been classified as having poor healing potential, ruling out the possibility of it being an acute, healable wound.



- C) This is likely a chronic, maintenance wound, and therefore, this kind of deterioration is to be expected: While these wounds are not expected to heal, rapid deterioration is not expected and indicates a need for reassessment.
- D) This is likely a chronic, palliative wound, and therefore, this kind of deterioration is to be expected: The wound is classified as "maintenance," meaning it should be relatively stable.
- F) This is likely a chronic, palliative wound, and therefore, this kind of deterioration is cause for concern: The wound is not classified as palliative. A 'palliative' wound is generally one with a known, progressive trajectory, where deterioration might be expected, such as a malignant wound or a leg ulcer in the presence of ischaemia.



Practice Question 9.2

True or false:

You are caring for a bed-bound patient with a pressure injury on their sacrum. The patient refuses to be repositioned and insists that they are only comfortable when lying flat on their back.

True or false: In order to ensure that this patient's wound can heal and that they receive the best care possible, you should still ensure that they are regularly repositioned regardless of their wishes.

Your answer:

A)	True
B)	False

Practice Question 9.2

Correct answer: B) False

Rationale:

While regular repositioning is a critical component of pressure injury prevention and management, patient autonomy and informed consent are fundamental principles in healthcare. If a patient refuses to be repositioned, their wishes must be respected if they have made an informed decision that is clearly documented.



Forcing repositioning against the patient's wishes violates their autonomy and could damage the therapeutic relationship. While repositioning is essential for wound healing, care must be tailored to the patient's preferences and choices, prioritising comfort and dignity alongside clinical goals. However, this does not mean that care stops.

Prior to agreeing not to reposition the patient, the clinician should:

- Discuss the importance of repositioning with the patient, explaining how it can alleviate pressure, improve circulation and promote healing. Provide education about the potential consequences of not repositioning, such as worsening of the pressure injury, increased risk of infection or increased pain.
- Explore alternatives - if the patient is unwilling to be repositioned completely, consider and discuss alternative strategies, such as:
 - Use of specialised support surfaces (e.g. pressure-relieving mattresses).
 - Small position adjustments that cause minimal discomfort but help redistribute pressure.
- Healthcare providers are ethically and legally bound to respect the patient's decisions, even if they conflict with the best clinical recommendations, as long as the patient has the capacity to make informed choices and the consequences of refusal to follow recommended care has been clearly explained in understandable terms, the patient is able to demonstrate understanding of the risks and accepts these.
- Ensure that the patient's refusal to reposition and all associated discussions and education provided are thoroughly documented in their healthcare record.
- Explore if your employer has a formal 'dignity of risk' procedure that supports patients having the right to choose, even if that choice involves some risk.

The best care for a bed-bound patient with a pressure injury involves balancing clinical best practices with respect for the patient's autonomy, ensuring that decisions are informed and made collaboratively.