Queensland Health

Queensland Community Pharmacy Scope of Practice Pilot

Acute Minor Wound Management - Clinical Practice Guideline

Guideline Overview

Pilot and professional obligations

- Initial patient eligibility and suitability for management within the scope of the pilot
- Patient informed consent
  - Pilot participation
  - Financial
  - Pharmacist communication with other health practitioners
- Professional standards
- Privacy
- Documentation and record keeping
- Interprofessional communication

Gather information and assess patient's needs

- Patient history
- Wound history
- Wound assessment and examination
  - Anatomical location
  - Size and degree of tissue loss
  - Appearance
  - Signs of infection
  - Pain
- Requirements for pathology testing for gram staining and culture

Management and treatment plan

- Administration of local anaesthetic (if required)
- Wound cleansing
- Wound closure
- Wound dressing
- Pharmacotherapy:
  - Prophylactic/ presumptive antibiotic therapy for bite wound and clenched-fist injuries
  - Empirical antibiotic therapy for localised post-traumatic wound infections (excluding penetrating injuries through footwear, bite and clenched-fist wound infections and water-immersed wounds)
  - Tetanus post-exposure prophylaxis with tetanus toxoid vaccine

Confirm management is appropriate

- Contraindications and precautions
- Drug interactions
- Pregnancy and lactation

Communicate agreed treatment plan

- Wound management plan:
  - Schedule for dressing changes and suture removal
  - Instructions for individual product/dressing and medicine use and medicine dosing
  - How to recognise the signs of local and systemic infection
  - How to manage adverse effects of pharmacotherapy
- Adverse effects
- General advice
- Communication with other health practitioners

Refer when

Refer to a medical practitioner if:

- The patient has 'red flag' warning signs
- The patient is aged under 5 years
- The patient is immunocompromised or otherwise at high risk of infection or compromised wound healing
- The patient presents with infection of a surgical or chronic wound
- The patient presents with a penetrating wound through footwear, a marine envenomation or other penetrating injury (a complex wound at high risk of infection)
- The wound history is unclear (how, where and when the wound was acquired)
- The wound is showing abnormal signs of healing or not progressing through the normal stages of healing e.g., chronic ulcers or wounds, necrotic or hyper-granulation tissue, wounds older than 4 days that have not begun epithelialisation
- The patient presents with a skin tear
- The wound is suspected to be full thickness (involving epidermis, dermis and subcutaneous tissue), involve a fracture or vascular, joint, tendon, bone, muscle or nerve including crush injuries or partial amputation of digit
- The wound is to the head (scalp, face, ears) or neck, or where sustained closure is difficult to achieve
- The patient presents with a burn that is classified beyond minor or otherwise meets the anzba referral criteria
- Anaesthesia cannot be achieved for adequate cleansing or closure (if indicated)

Treat (if clinically appropriate) and concurrently refer

Initial management (cleansing, irrigation/debridement, temporary dressing and presumptive antibiotic therapy, where indicated) may be commenced concurrently to medical practitioner referral for:

- Acute wounds that are significantly contaminated (but not infected), complex or cannot be adequately cleansed with irrigation or simple mechanical debridement (at high risk of infection)
- A foreign body in the wound that cannot be removed
- Self-inflicted injuries

Antibiotic therapy may be provided (if indicated) concurrently to medical practitioner referral:

- Presumptive antibiotic therapy for bite wounds (including marine animal bites) and clenched-fist injuries
- Prophylactic antibiotic therapy for significantly contaminated water immersed traumatic wounds
- Empirical antibiotic therapy for localised post-traumatic wound infections (excluding infections from penetrating injuries through footwear, bite and clenched-fist wound infections and water-immersed wounds)

Clinical review

- If required:
  - Dressing changes
  - Suture removal
  - Concerns regarding healing
  - Adverse effects
  - Communication with other health practitioners

‘Red flag’ warning signs at patient presentation that necessitate referral to a medical practitioner (or emergency service)*:

- Burns classified beyond minor burns that require referral to a specialist centre as per the Australian and New Zealand Burn Association (ANZBA) Criteria
    - Burns greater than 10% total body surface area (TBSA)
    - Burns greater than 5% TBSA in children
    - Full thickness burns
    - Burns of special areas – face, hands, feet, genitalia, perineum, major joints and circumferential limb or chest burns
    - Burns with inhalation injury
    - Electrical burns
    - Chemical burns
    - Burns with pre-existing illness
    - Burns associated with major trauma
    - Burns at the extremes of age – young children and the elderly.
    - Burn injury in pregnant women
    - Non-accidental burns [1]
- Injury with suspected vascular, tendon or nerve involvement
- Fractures, crush injuries, partial amputations of a digit or potentially penetrating wounds of the torso
- Recent orofacial trauma (not yet seen by a dental practitioner) or concussive head injury
- The patient has pain that cannot be managed with over-the-counter analgesics and standard pharmacist care
- The patient is at a high risk of infection or with compromised wound healing due to underlying medical condition(s) and/or medicines (e.g., immunocompromised)
- The patient has signs/symptoms of systemic infection or generally unwell
- The patient presents with localised infections resulting from non-traumatic wounds (e.g., surgical or chronic), water-immersed wounds, bites or clenched-fist injuries or penetrating wounds through footwear
- The patient has a tetanus prone wound and requires tetanus immunoglobulin (patient has had less than 3 doses of the tetanus toxoid vaccine, or vaccination history is unknown)
- The patient is at a significant risk of suicide (e.g., if they have a current intent, a specific plan, access and means or have had previous suicide attempts)
- The patient has sustained an injury in the workplace or as a result of a work-related incident.

*First aid and presumptive antibiotic treatment may be initiated where appropriate

Key points

- Comprehensive assessment that includes wound, patient and environmental factors is required to determine appropriate management, including whether referral to a medical practitioner is required.
- Wound healing is optimised when the wound is cleansed to remove debris and devitalised tissue, kept moist, infection is prevented, and the wound has adequate blood supply [2].
- Topical antibiotics are not recommended for the treatment of wounds within this guideline and are not included for use within the Pilot for the treatment of wounds. Topical antibiotics do not improve healing potential and may contribute to antimicrobial resistance [3, 4].
- Antibiotic prophylaxis for acute minor wounds is not routinely recommended; thorough cleansing and dressing are the mainstay of treatment [5].

When applying the information contained within this clinical practice guideline, pharmacists are advised to exercise professional discretion and judgement. The clinical practice guideline does not override the responsibility of the pharmacist to make decisions appropriate to the circumstances of the individual, in consultation with the patient and/or their carer.

Refer when

Pharmacists may provide first aid and standard pharmacist care (if appropriate) but must refer the patient to an appropriate medical or nurse practitioner (including emergency services if required) when:

- The patient has 'red flag' warning signs
- The patient is aged under 5 years
- The patient is immunocompromised or otherwise at high risk of infection or compromised wound healing
- The patient presents with infection of a surgical or chronic wound
- The patient presents with a penetrating wound through footwear, a marine envenomation or other penetrating injury (a complex wound at high risk of infection)
- The wound history is unclear (how, where and when the wound was acquired)
- The wound is showing abnormal signs of healing or not progressing through the normal stages of healing e.g., chronic ulcers or wounds, necrotic or hyper-granulation tissue, wounds older than 4 days that have not begun epithelialisation
- The patient presents with a skin tear
- The wound is suspected to be full thickness (involving epidermis, dermis and subcutaneous tissue), involve a fracture or vascular, joint, tendon, bone, muscle or nerve including crush injuries or partial amputation of digit
- The wound is to the head (scalp, face, ears) or neck, or where sustained closure is difficult to achieve
- The patient presents with a burn that is classified beyond minor or otherwise meets the ANZBA referral criteria
- Anaesthesia cannot be achieved for adequate cleansing or closure (if indicated)

Initial management (cleansing, irrigation/debridement, temporary dressing, and/or presumptive antibiotic therapy, where indicated) may be commenced concurrently to medical practitioner referral:

- Acute wounds that are significantly contaminated (but not infected), complex or cannot be adequately cleansed with irrigation or simple mechanical debridement (at high risk of infection)
- A foreign body in the wound that cannot be removed
- Self-inflicted injuries (concurrent referral to an acute mental health service is required).

Antibiotic therapy may be provided (if indicated) concurrently to medical practitioner referral:

- **Presumptive** antibiotic therapy for bite wounds (including marine animal bites) and clenched-fist injuries
- **Prophylactic** antibiotic therapy for significantly contaminated water immersed traumatic wounds
- **Empirical** antibiotic therapy for localised post-traumatic wound infections (excluding infections from penetrating injuries through footwear, bite and clenched-fist wound infections and water-immersed wounds).

Gather information and assess patient's needs

A comprehensive and holistic wound assessment must consider both patient and wound history [2, 6-8].

For the purposes of the Pilot, an acute minor wound is defined as a wound:

- caused by injury or trauma (as opposed to surgical wounds)
- involving the epidermis and upper dermis (superficial) or dermis (partial) [7]
- in the inflammation stage (approximately 0-4 days post injury) and expected to follow the normal physiological wound healing process.

Patient history

Sufficient information must be obtained from the patient to assess the safety and appropriateness of any recommendations and medicines.

The patient history should consider:

- age
- pregnancy and lactation status (if applicable)
- patient weight (if local anaesthesia is required)
- current medical conditions, particularly conditions that may increase risk of infection (immunocompromised) or impair wound healing (e.g., vascular disease, diabetes mellitus, autoimmune disorders, malignancy)
- factors that may impact on successful wound healing as per the Therapeutic Guidelines: Factors affecting ulcer and wound healing
- symptoms that may indicate systemic infection or other injury including fever, lymphadenopathy, nausea and vomiting
- current, recently commenced or recently ceased medicines (including prescribed medicines, vitamins, herbs, other supplements and over-the-counter medicines), including medicines that may delay wound healing
- previous healing and scarring experiences
- allergies/adverse drug reactions
- alcohol and drug history
- smoking status
- immunisation status including tetanus vaccination
- risk factors for infection with methicillin-resistant *Staphylococcus aureus* (MRSA)
- psychosocial history, emotional and mental state including level of distress, history of mental health conditions and potential for family violence
- ability to undertake appropriate self-care
- nutritional and hydration status.

Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies and current medical conditions.

Wound history

Consider:

- mechanism of injury:
  - other injuries that may require medical attention e.g., head injuries, bone fractures, animal bites, scratches or envenomation
  - potential for retained foreign bodies.
- date and time of injury
- environment where the wound was acquired e.g., fresh or salt water, muddy locations, contaminated soil
- treatments already provided and response e.g., dressings, antiseptics, antibiotics
- whether the injury was sustained in a workplace or related to employment
- injury/ies that may be associated with family violence or self-harm (see below).

Injuries associated with family violence or non-accidental injury in children

Indications of injuries associated with family violence may include injuries and/or bruising to the head, neck, face, areas usually hidden from view, bite marks, unusual burns, injuries that do not match the history/explanation given by the patient (or parent/caregiver) or no explanation can be provided [9].

If the pharmacist suspects the patient has been subjected to family violence, they should provide appropriate support and assistance to the patient (separate from other family members), including referral to support options. A list of services is provided on the Queensland Government webpage.

Pharmacists are strongly encouraged to voluntarily report suspected child abuse and neglect to Child Safety. Information on the reporting process and other supports for affected families can be found on the Queensland Government Child Safety Website.

Injuries associated with self-harm

The most common form of deliberate self-harm is self-poisoning, followed by self-cutting and other methods such as hanging, burns, bruising and picking at sores [10]. It is often done in secret and on places of the body that may not be seen by others (e.g., thighs). People may try to conceal wounds caused by self-harm by wearing long-sleeve clothing, or high neck shirts [10, 11].

Pharmacist assessment of a patient presenting with self-inflicted injuries, or a suspected self-inflicted injury, should consider:

- the patient's emotional and mental state and level of distress
- whether there is an immediate concern related to the patient's safety
- the need for referral to a mental health service [12].

Self-harm may be a repetitive behavior [10]. People presenting for treatment of self-inflicted injuries must be concurrently referred to a medial practitioner or mental health service. They may be provided treatment if clinically appropriate.

Self-inflicted injuries are a warning sign that indicate a patient might be at a heightened risk of suicide [13]. Consider key questions and/or other risk factors for suicide risk in accordance with Therapeutic Guidelines: Assessing suicide risk [14].

Patients at significant risk of suicide (e.g., if they have a current intent, a specific plan, access and means or have had previous suicide attempts) require urgent referral to a medical practitioner and/or acute psychiatric/mental health service.

Helplines and support services for people at risk of suicide include:

- Beyond Blue (1300 224 636)
- for young people, e-headspace (1800 650 890)
- Kids Helpline (1800 551 800)
- Lifeline (13 11 14)
- Suicide Call Back Service (1300 659 467) [14].

Assessment and examination

Wound-related factors to be considered and documented during initial clinical assessment and at clinical review (if applicable) are detailed in

Table 1.

Table 1. Clinical acute wound assessment [2, 4, 6, 7, 15]
Anatomical location
• Consider possible damage to joint, tendon, nerve and vascular structures • Check distal sensation, motor function, range of motion (extensors and flexors) and vascularity.
Size and degree of tissue loss
• Length, circumference and width • Approximate depth – measured with a damp cotton tip, although generally not required for a minor acute wound • Tissue loss – superficial, partial or full thickness.
Wound appearance
• Presence of wound contamination – consider if the wound can be adequately cleaned, including with simple debridement, in the community pharmacy setting, or if referral is required • Stage/phase of healing – inflammation, reconstruction/proliferation, maturation • Wound bed clinical appearance (if visible) – granulation tissue, epithelial tissue, sloughy, necrotic, hyper-granulation tissue • Wound edges and surrounding skin (colour, contraction, change in sensation) – signs of normal or abnormal healing • Exudate – type, amount, colour and odour.
Signs of infection
• Local infection – redness, heat, pain and swelling above normal inflammatory responses, presence of exudate, odour, impaired wound healing, contact bleeding, tissue breakdown, unhealthy granulation tissue • Spreading infection – increasing wound size, lymphangitis, inflammation and swelling of lymph nodes, wound breakdown, patient malaise or deterioration in health • Systemic infection – fever, tachycardia, hypotension, other signs of sepsis
Pain
• Timing, triggers, severity and impact • Type of pain – background, breakthrough pain, precipitating factors, pain before during and/or after dressing, cleaning and exposure to air Response to any medication used to manage wound.

Conduct assessment of vital signs for any patients presenting with signs of infection in Table 1.

The TIME acronym (Tissue, Infection/Inflammation, Moisture balance, Edge and peri-wound area) as detailed in the Therapeutic Guidelines: Assessing patients with an ulcer or wound may also be used to guide wound examination and documentation of characteristics [3].

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Pathology testing for Gram stain, culture and sensitivity testing

Pathology testing for Gram stain, culture and sensitivity testing, with referral to a medical practitioner for ongoing management is required for:

- spreading infection

- infections resulting from penetrating wounds through footwear
- water-immersed wounds
- bites/clenched-fist injuries.

The patient must be referred to a medical practitioner to conduct specimen collection for pathology testing for Gram stain, culture and sensitivity testing and for ongoing management. The patient must be advised to commence antibiotic therapy only after specimen collection has been completed.

Management and treatment plan

Pharmacist management of acute minor wounds may involve:

- **administration of local anaesthetic:**
  - Use of 1% lidocaine (without adrenaline, maximum of 10ml) if required, in accordance with the:
    - Therapeutic Guidelines: Pain and analgesia (local anaesthetics for acute pain management) [17]
    - Australian Medicines Handbook: Drugs for local anaesthesia [18]
    - Queensland Health and Royal Flying Doctor Service (Queensland Section) Primary Clinical Care Manual [4].
- **wound cleansing**:
  - Irrigation, simple mechanical debridement (using sterile gauze) and use of antiseptics (if required) in accordance with the:
    - Therapeutic Guidelines: Ulcer and wound management [3]
    - Queensland Health and Royal Flying Doctor Service (Queensland Section) Primary Clinical Care Manual [4].
- **wound closure:**
  - Closure using topical skin/tissue adhesives and basic suturing techniques (if required and appropriate) in accordance with the:
    - Therapeutic Guidelines: Ulcer and wound management [3]
    - Queensland Health and Royal Flying Doctor Service (Queensland Section) Primary Clinical Care Manual [4].
- **wound dressing:**
  - Application and changing of dressings (if required and appropriate) in accordance with the:
    - Therapeutic Guidelines: Ulcer and wound management [3]
    - Queensland Health and Royal Flying Doctor Service (Queensland Section) Primary Clinical Care Manual [4].
- **pharmacotherapy:**
  - Presumptive antibiotic therapy[1] for bite wounds (including marine animal bites) and clenched-fist injuries (if indicated) in accordance with the:
    - Therapeutic Guidelines: Antibiotic (Traumatic wound infections – Bite wound infections, including clenched-fist injuries) [5]
  - Prophylactic antibiotic therapy[1] for significantly contaminated water immersed traumatic wounds (if indicated) in accordance with the:
    - therapeutic guidelines: antibiotics (traumatic wound infections – water immersed wound infections) [5].

- Empirical antibiotic therapy[1] for localised post-traumatic wound infections (excluding penetrating injuries through footwear, bite and clenched-fist wound infections and water-immersed wounds) in accordance with
  - therapeutic guidelines: antibiotic (traumatic wound infections – post-traumatic wound infections) [5].
- Tetanus post-exposure prophylaxis[2] with tetanus toxoid vaccine in accordance with the therapeutic guidelines: antibiotic (traumatic wound infections – post-traumatic wound infections) [5].

NB1: Patients' prescribed antibiotic therapy must be concurrently referred to a medical practitioner for pathology testing and ongoing management.

NB2: Tetanus-toxoid vaccines must be given in accordance with the Australian Immunisation Handbook: Tetanus and recorded on the Australian Immunisation Register [19].

Confirm management is appropriate

Pharmacists must consult the Therapeutic Guidelines, Australian Medicines Handbook and other relevant references to confirm the treatment recommendation is appropriate, including for:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information if required), should be provided to the patient regarding the wound management plan. Relevant information may include:

- schedule for dressing changes and suture removal
- instructions for individual product/dressing and medicine use
- how to recognise the signs of local and systemic infection
- when to commence antibiotic therapy and required follow up
- measures to prevent further injury
- how to manage adverse effects of pharmacotherapy.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources and information provided to patients (and parents/caregivers if applicable) and compliance with all copyright conditions.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

General advice

At the time of initial consultation, patients should be advised to return to the pharmacist (or see a medical practitioner) for clinical review if the wound becomes infected, or to see a medical practitioner as soon as possible if they become systemically unwell or the wound deteriorates.

Clinical review

Clinical review with the pharmacist (if required), including dressing changes and suture removal, should occur in line with recommendations in the Therapeutic Guidelines and other relevant guidelines.

Pharmacist resources

- Australian and New Zealand Burn Association - ANZBA Referral Criteria
- Therapeutic Guidelines:
  - Ulcer and wound management
  - Local anaesthetics for acute pain management
  - Antibiotics: Traumatic wound infections
- Australian Medicines Handbook:
  - Drugs for local anaesthesia
  - Antibacterials
- DermNet NZ:
  - Wounds
  - Synthetic wound dressings
  - Topical skin adhesives
  - Suturing techniques
  - Surgical wound closure
- Wound Australia – Standards for Wound Prevention and Management
- Queensland Health and Royal Flying Doctors Service (Queensland branch) - Primary Clinical Care Manual 11th edition 2022
- Australian Immunisation Handbook - Tetanus
- Royal Children's Hospital Melbourne: Wound assessment and management
- MSD Manual: Lacerations

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Version 1.0	01.02.2024	
Version 1.1	25.03.2024	Updated Pathology testing for Gram stain, culture and sensitivity testing section with requirement to refer patients for pathology testing for Gram stain, culture and sensitivity testing section to a medical practitioner.
Version 1.2	11.11.2024	Administrative update

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