



**THIS
APPENDIX
SECTION IS
IDEAL TO
CHECK YOUR
ANSWERS.**



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by the Royal College of Nursing,
Australia, according to approved
criteria.

APPENDIX 1- MODULE ONE ANSWERS



1. What is the function of Keratin?

- a. Keratin helps waterproof and protect the skin and underlying tissues from heat, light, microbes and many chemicals.

2. The epidermis is composed of stratified keratinized squamous epithelium and four principle cells.

Keratinocytes
Langherhan cells
Melanocytes
Merkel cells

3. What is thought to be the function of Langerhan cells?

- a. Langerhan cells interact with helper T cells in immune responses.

4. What is the process of Keratinisation?

- b. The process by which cells are continuously shed and replaced by cells which originate in the basal layer.

5. What is the dermis composed of to make it tough and elastic?

- a. Connective tissue containing collagen and elastic fibres.

6. What are the two types of sweat glands?

Eccrine sweat glands
Apocrine sweat glands

7. The skin performs five main functions?

Regulation of body temperature
Protection
Sensation

8. What stimulates sweat glands to produce perspiration?

- a. The increased temperature of the blood stimulates sweat glands to produce perspiration.

9. The skin is a physical barrier that protects underlying tissue from:

Bacterial and Viral invasion
Dehydration
Protection from mechanical assault

10. What is the role of Melanin?

- b. Melanin plays a role in protecting the skin from ultra-violet radiation.

11. Discuss the case of a patient in your care and identify the factors affecting his/her skin.

Your answers should include:

Age
Nutrition
Circulation
Infection
Medical history
Mobility

12. Tick the correct statement in regards to ageing skin.

- a. Blood supply weakens, the elastic fibres and the amount of collagen is reduced resulting in wrinkling.

13. What are the nerve receptors located in the skin sensitive to?

- b. Pain, touch, temperature, pressure.

14. Discuss the case of a patient in your care and identify the factors affecting his/her skin.

Answers to include:-

Age,
Nutrition,
Circulation,
Infection,
Medical history,
Mobility,
Moisture



APPENDIX 2 - MODULE TWO ANSWERS

1. What is the order of the four phases of wound healing.
 - b. Haemostasis, Inflammation, Proliferation, Maturation.
2. Haemostasis is achieved by what combination?
 - c. Vasconstriction to conserve blood loss, release clotting factors, clot acting as a bacterial barrier and framework for migrating cells.
3. Will a chronic wound go through the Haemostasis phase.
 - b. No.
4. What are the classic signs of inflammation which should not be confused with infection.
 - a. Local presence of heat, swelling, erythema, discomfort and functional disturbance.
5. Slough is a collection of dead cellular debris on the wound surface, it often occurs in which phases.
 - b. Inflammation
6. What day does the proliferation phase commence in the normal healing process.
 - b. 3-14
7. Healthy granulation tissue should appear as
 - a. A bright red or pinky red which does not bleed easily.
8. What is the tensile strength of scar tissue compared to normal skin?
 - c. 80%
9. What would be the effect of a dry environment on wound healing?
 - b. A dry healing environment will result in slower migration of epithelial cells and slower wound healing.
10. How does the inflammatory phase prepare the wound for healing.
 - a. During the inflammatory phase the disposal of microbes, foreign material and dying tissue occurs, which is necessary for the wound healing to begin.
11. What Phase of wound healing does this wound go through?
Surgical wound.

Answers need to include:-
The type of intention
Primary or secondary
Phases in wound healing



12. What phase of wound healing does this wound go through?

Open wound

Answers need to include:-

The tissue involved

Why is there exudate

Phases in wound healing

Tissue involved

13. Describe the physiological events that are taking place in these wounds.

Answers to include:-

The tissue involved

Why is there exudate

Phases of wound healing

Tissues involved.

14. Identify a chronic wound in your care and what are the factors of wounds becoming chronic. What environment should be provided for healing.

Answers need to include:-

Moist wound healing

Definition of chronic wounds

Phases of wound healing

Tissue involved



APPENDIX 3 - MODULE THREE ANSWERS



1. How does cigarette smoke reduce perfusion and oxygenation of tissues?
Choose two statements from the list.

- b. Nicotine reduces tissue perfusion by causing vasoconstriction and also the tendency of the blood to clot.
- c. Carbon Monoxide binds to haemoglobin in red blood cells reducing its capacity to carry oxygen to tissues.

2. Why are diabetic patients prone to developing ulcers?

- c. Diabetes Mellulits can increase sympathetic stimulation which results in vasoconstriction and lead to the development of ulcers.

3. Why is it necessary to have adequate dietary intake of protein for adequate wound healing to occur?

- a. Protein is required for collagen synthesis.

4. Why may it be useful to know the position of the wound?

- c. Position of a wound can help determine the most appropriate treatment choice.

5. What does the term necrotic eschar relate to?

- d. A necrotic eschar is devitalised which can mask the true size of a wound and can provide an ideal breeding ground for bacteria.

6. What would the presence of macerated skin indicate?

- a. Macerated skin is an indicator that exudate control is inadequate.

7. How does infection delay wound healing?

- c. Infection results in increased inflammation, delayed collagen synthesis, prevention of epithelialisation and increases the production of pro inflammatory cytokines resulting in delayed wound healing.

CASE STUDY A

Answers to include:-

age
weight
medical history
vascular disease
nutrition
dehydration
pressure ulcers
risk - extrinsic/intrinsic factors involved
baseline observations

CASE STUDY B

- a. What type of tissue involved - answers to include:
Include assessment of size
Depth
Position
Cause
Pain

b. Identify type of wound involved

Identify type of tissue involved

Potential cause of wound

Is there exudate, if so what colour

Discuss documentation

Aspects of assessments to document size, depth, cause, position, pain

What tools you could use in the assessment, ie photography

Measurement

c. All assessment factors

Size

Depth,

Position

Cause

Highlight risk assessment

Identify risks

Documentation

Issues surrounding photography, wound measurement.

Consent



APPENDIX 4 - MODULE FOUR ANSWERS

SECTION 1: MINOR INJURYS

1. An abrasion can be defined as?

- c. A scraped are of the skin or mucous membrane

2. A laceration can be defined as?

- a. A torn, jagged wound

3. A contusion can be defined as?

- c. An injury in which the skin is not broken.

4. How are abrasions usually managed?

- a. An abrasion should be left to scab over.

5. What do bites and puncture wounds have in common?

- b. Bite and puncture wounds are at increased risk of infection and will require thorough cleansing.

6. What is the definition of a skin tear?

- d. As a traumatic wound resulting from separation of the epidermis from the dermis.

7. Skin tears occur due to which of the following?

- c. Shear and Friction.

8. Payne and Martin (1993) classify skin tears. What is the definition of a skin tear for a Category II skin tear?

- b. Has partial loss of the overlying tissue. The sub types are scant loss (<25%) of the epidermal flap and moderate to large tissue loss (>25%) of the epidermal skin flap.

9. What is the definition of a skin tear for a Category III skin tear?

- c. Has complete loss of overlying tissue, with no epidermal flap remaining.

10. What is the definition of a skin tear Category I skin tear?

- a. Is a incision like lesion with separation between the epidermis and dermis, the flap type has an epidermal flap skin tear almost covers the dermis.



SECTION 2: SURGICAL WOUNDS AND BURNS

1. The aim of wound closure in surgical wounds is to oppose the wound edges and heal by?

- a. Primary Intention

2. What is dehiscence?

- b. Separation of the opposed edges of a surgical wound

3. Burns are traumatic that may be caused by exposure to?

Thermal heat
Caustic chemicals
Electricity
Radiation

4. Thermal burns are caused by?

- b. Caused by flame, hot water or steam, other hot liquids and hot surfaces.

5. Radiation burns are caused by?

- a. Over exposure to the sun.

6. A superficial dermal burn can be said to be?

- c. Extend beyond the epidermis into the layer of the dermis.

7. A Deep dermal can be said to be?

- b. Extend into deeper layers of the dermis and may involve the hair follicle or sweat glands.

8. A full thickness burn can be said to be?

- a. Full destruction of the epidermis and dermis, which may extend into the subcuticular layer and may involve muscle and bone.

9. Escharotomy can be defined as?

- d. A incision through deep circumferential burns of the limbs or trunk in order to relieve the tourniquet effect.

10. What is the management of deep dermal and full thickness burns?

- d. Excision of necrotic tissue and skin grafting for speedy healing.



SECTION 3: TISSUE TYPES

1. Necrotic tissue is?

- b. Devitalised, dead tissue that often appears black.

2. What is the primary treatment aim for sloughy wound?

- a. To remove devitalised tissue.

3. Choose a treatment option for moderately exuding granulating wounds?

- c. It may be appropriate to use a hydrocolloid dressing although it may be necessary to use a foam dressing.

4. What is the primary treatment aim for an epithelising wound?

- b. To protect this delicate tissue.

5. Granulation tissue is?

- c. Red, granular tissue that fills a wound as it is healing.

6. Choose a treatment option for a necrotic wound?

- a. It may be necessary to use a Hydrogel dressing, covering with an appropriate secondary dressing.

7. Sharp debridement is defined as?

- a. The removal of dead tissue with a scalpel or scissors above the level of viable tissue.

8. Slough tissue is?

- a. Fibrous and yellow wound tissue that adheres to the wound bed.

9. What is the aim of wound management, please tick the appropriate answers.

- a. Optimise moist wound healing.
- b. Remove and manage exudate.
- c. Protect from infection.
- d. Encourage growth of new tissue.
- e. Prevent infection.

10. In epithelialising wounds what dressing should be used? Please tick appropriate answers.

- b. Hydrocolloids.
- c. Films
- d. Silicone dressings.
- e. Wound contact layers.



SECTION 4: INFECTION

1. Necrotic tissue in a wound?

- b. Provides a perfect medium for bacteria to grow

2. Body flora are?

- b. Normal bacteria found on the surface of the skin

3. Most likely cause of increased exudate in a wound would be?

- c. Systemic infection
- d. Wound infection

4. Are wounds sterile?

No

5. An infected wound will heal if?

- b. Bacterial load of the wound is reduced
- d. Treated with antibiotics and dressings to deal with the symptoms

6. Antibiotics are required in?

- c. Spreading infection or systemic infection.

7. Manuka honey is effective in treating MRSA?

True

8. MRSA is?

- d. Methicillin Resistant Staphylococcus Aureus

9. Wounds colonised by *Pseudomonas* are likely to have which colour of exudate?

- c. Green

10. Signs of clinical infection in a wound are?

- a. Pyrexia
- b. Raised white cell count
- c. Erythema
- d. Malodour
- e. Increased exudate
- f. Inflammation

CASE STUDY:

Answers should include details on the following:

Symptom Control
Maceration
Reducing bacterial burden



SECTION 5: PRESSURE ULCERS

1. What are the intrinsic factors in the development of a pressure ulcer?

b. Malnutrition, Immobility, Age, Medical condition, Dehydration.

2. What are the extrinsic factors in the development of a pressure ulcer?

c. Pressure, Shear, Friction, Moisture.

3. Pressure ulcers can occur anywhere on the body but where do they most commonly occur?

c. Over a bony prominence which is covered by a thin layer of tissue.

4. According to the Waterlow Pressure Ulcer prevention/treatment policy what pressure relieving mattress should be used for a patient with Waterlow score of 24?

b. A low air loss, alternating pressure mattress or fluidised bed.

5. The European Pressure Ulcer Advisory Panel (EPUAP) classification system describes a Stage/Category 3 pressure ulcer as?

c. Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed.

6. According to the Waterlow Pressure ulcer Prevention/Treatment policy what pressure relieving mattress should be used on a patient with a Waterlow score of 12?

a. An overlay or specialist foam mattress.

7. The European Pressure Ulcer Advisory Panel (EPUAP) classification describes a Stage/Category 2 pressure ulcer as?

a. A partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed without slough.

8. According to the Waterlow Pressure Ulcer Prevention/Treatment policy what pressure relieving mattress should be used for a patient with a Waterlow score 17?

c. An alternating pressure overlay, mattress and bed systems.

9. Complete the sentence – Pressure ulcers will not be able to heal if they are continued to....

b. Be subjected to the forces that caused them.

10. What is the optimal pH of the human skin?

c. pH 5.5

11. Patients with pressure ulcers may require a greater of what in their diet?

c. Protein

12. What are the causes of moisture lesions?

a. Moisture in the form of sweat, urine or faeces, wound exudate.



13. What happens to the skin when the pH rises?

- c. Becomes more permeable and eventually tiny invisible breaches will form on the skin surface.

14. What is the likely shape of a moisture lesion?

- c. Different, diffuse superficial spots.

15. What is the single most important aspect for the prevention and treatment of a moisture lesion?

- d. Skin Care.

16. Should the skin following an episode of loose stools be washed with soaps?

- b. No



SECTION 6: LEG ULCERS

1. What is the definition of a leg ulcer?

- a. A breakdown of epidermal and dermal tissue below the knee on the leg or foot due to any cause, which fails to heal.

2. Choose one cause of calf muscle pump failure?

- c. Fixed ankle flare.

3. What is venous hypertension?

- a. Venous hypertension is increased pressure in the veins.

4. What does the presence of oedema cause?

- b. A slow down of gaseous exchange, resulting in reduced tissue oxygenation and inadequate toxin removal.

5. Poor valve performance can be caused by which of the following (tick the appropriate answers).

- a. Damage from a previous deep vein thrombosis (DVT)
- b. Pregnancy
- e. Varicose veins
- f. Mechanical defect due to a higher obstruction to venous return.

6. There are some classical signs to look for when assessing a leg wound that will indicate that the patient may have a venous ulcer.

Choose three from the following list.

- a. The leg has a woody appearance and may have a champagne bottle appearance.
- d. The ulcer is shallow.
- e. The ulcer is located in the gaiter area of the leg, on or near the medial malleolus.

7. The treatment of a venous leg ulcer include which of the following;

- a. Compression
- c. Exercise.
- d. Elevation of the limb.

8. What is atherosclerosis?

- c. Is a focal thickening of the inner most layer of elastic and muscular arteries.

9. Choose three risk factors for the development of atherosclerosis.

- a. Cigarette smoking
- b. Hypertension
- d. Obesity.

10. If atherosclerosis is present in the arteries supplying the limbs it is called:

- c. Peripheral Vascular disease.



11. Intermittent claudication can be defined as one of the following.

- a. Reduced perfusion through an artery caused by atheroma, which causes hypoxia in the muscle distal to the site of atheroma and a cramping pain caused.

12. There are some classical signs to look for when assessing a leg wound that will indicate that the patient may have an arterial ulcer. Choose three from the following list.

- b. The ulcer appears punched out and is deep.
- c. The leg has a shiny, hairless appearance.
- f. The ulcer is on the foot, front of the skin or the lateral malleolus.

13. What are the treatments for an arterial ulcer? Choose three answers.

- b. Angioplasty.
- d. Drug Therapy.
- e. Bypass surgery.



SECTION 7: DIABETIC FOOT ULCERS

1. Diabetes occurs when there is:

- a. an inadequate uptake of glucose by the cells of the body resulting in raised blood glucose levels.

2. What are the risk factors for developing Diabetes Mellulitis (Type 2)? Choose three.

- a. Increasing age.
- c. Obesity
- e. Impaired glucose levels.

3. What is neuropathy?

- b. Is impairment of nerve function.

4. What problems can autonomic neuropathy cause in the diabetic patient?

- c. Patients with autonomic neuropathy will experience lack of sweating in the feet which can extend up to the knees. The lack of sweating causes dry skin with fissuring.

5. What does neuroischaemia results from :

- b. Artherosclerosis of the arteries in the leg.

6. What is the commonest site for a neuroischaemic diabetic ulcer?

- b. The commonest site for a neuroischaemic diabetic ulcer is in the margin of the foot.

7. What are the classic signs of an ischaemic foot? (Choose two from the following list.)

- a. The ischaemic foot may have thin shiny skin.
- d. The ischaemic foot may lack hair.

8. What problems can sensory neuropathy cause in the diabetic?

- b. The loss of sensation associated with sensory neuropathy puts the patient at risk from mechanical, chemical and thermal trauma.

9. What problems can motor neuropathy cause in the diabetic foot?

- a. Impairment of the nerves controlling muscles associated with motor neuropathy causes muscle atrophy in the toes and foot deformities.

10. What is the commonest site for a neuropathic diabetic ulcer?

- c. The commonest site for a neuropathic diabetic ulcer is the apex of the toe.

11. According to the Edmonds and Foster framework for managing diabetic feet, when does a diabetic foot reach stage 3?

- b. The diabetic foot enters stage 3 when it has broken down and ulceration is present.



12. According to the Edmond and Foster framework for managing diabetic feet, at what stage is a diabetic foot when it develops necrosis (gangrene)?

e. Stage 5

13. Which type of necrosis occurs in neuropathic ulcer?

a. Wet Necrosis

14. Which type of necrosis occurs in a neuroischaemic ulcer?

b. Wet necrosis and dry necrosis.

15. Explain the differences and management between wet and dry necrosis?

Answers to include:-

Why wet necrosis occurs.

Why dry necrosis occurs.

Discuss management of the patients, including wound control,

Vascular control,

Mechanical control,

Metabolic control and educational,

Microbiological control.



SECTION 8: EXUDATE

1. As a normal wound moves through the phases of healing exudate levels will?

c. Decrease

2. Normal exudate contains?

a. White blood cells

3. Normal exudate should be?

b. Thin, pale yellow, minimal odour

4. Exudate production is most prolific in which phase of wound healing?

c. Inflammation

5. Correct moisture level in a wound should be?

c. Moist

6. Maceration is caused by?

b. Too much exudate

7. The appearance of macerated skin is?

a. White

b. Pale pink

8. To reduce moisture in a wound the treatment option would be?

c. Use a dressing with greater fluid handling capabilities

9. A chronic wound has a prolonged?

c. Inflammatory phase

10. An assessment of wound exudate should include?

a. Colour

b. Consistency

c. Odour

d. Amount

CASE STUDY:

A patient is admitted to a Coronary Care Unit following a severe myocardial infarction. The patient develops swollen oedematous legs which leak copious amounts of exudate which are macerating the patients skin.

How should this patient be managed?

Answers should include details on the following:

Calf muscle pump/venous return

Leg elevation

Cardiogenic shock



APPENDIX 5 - MODULE FIVE ANSWERS

1. There are lots characteristics of an ideal dressing, choose the correct combination from the following list?

- b. Mouldable, provides thermal insulation & acceptable to the patient.

2. What should dressing selection be based on?

- b. On a comprehensive and holistic assessment of the patient and their wound.

3. Which of the following dressings are considered to be 'First Line Advanced Wound Care'?

- c. Foam dressings

4. What exudate level is an alginate suitable for?

- c. Moderate to highly exuding wounds.

5. Choose two of the statements below that best describe Alginates.

- a. Alginates that contain both mannuronic and guluronic acids form a soft gel that maintains it's wet strength when wet.
- c. Alginates that contain calcium have haemostatic properties.

6. What exudate level is a Hydrogel dressing suitable for?

- b. Dry to lightly exuding wounds.

7. Hydrogels can contain what substances which can effect mortality of maggots?

- b. Propylene glycol

8. Hydrogels should not be used on heavily exuding wounds as it can cause?

- a. Maceration to the surrounding skin

9. Foam dressings should not be held in place with adhesive film as it will reduce(please complete the sentence by choosing one correct statement)?

- b. MVTR

10. What are foam dressings not indicated for?

- c. Dry wounds

11. Hydrocolloids are used to encourage?

- b. Autolytic debridement.

12. Hydrogels are indicated for (Choose one correct statement)?

- a. To debride wounds by rehydration and the promotion of autolysis.

13. Hydrocolloids are indicated for wounds that are (Choose one of the following)?

- c. Low to moderate exuding wounds.





14. What is the definition of moisture vapour transfer rate?

- c. The rate at which moisture passes through a dressing and evaporates into the atmosphere.

15. When would maggot therapy be indicated?

- c. Maggot therapy is used to debride necrotic and sloughy tissue from a wound.

16. What wound types should maggots not be used on?

- c. Fistulas
- e. Wounds that may connect vital organs.
- f. On exposed blood vessels.

17. Maggots secrete a mixture of proteolytic enzymes to (complete the statement)?

- a. Break down dead and devitalised tissue.

18. Honey is indicated for use in infected wounds. How does the honey inhibit bacterial action?

- b. There are low concentration of slow release hydrogen peroxide found naturally in honey which inhibits bacterial action.

19. The application of honey is known to facilitate (Complete the sentence)?

- a. Wound bed preparation through the promotion of autolytic debridement.

20. How is silver released into a wound from a silver containing dressing?

- b. Silver dressing release silver in the presence of wound exudate as it ionises to release Ag⁺.

21. What is the primary aim of silver dressings?

- b. To release continuously small amounts of antimicrobial silver into the wound to inhibit the growth of bacteria.

22. Silver dressings are expensive therefore silver should not be used?

- a. If wounds are not infected or not at risk of becoming infected.

23. There are many advantages of topical negative pressure therapy. Choose one from the following?

- c. Accelerates debridement.

24. Topical negative pressure is indicated for the following wounds. Choose one answer?

- b. Pressure ulcers, Diabetic ulcers, Chronic wounds, infected wounds.

CASE STUDY

Majorie has recovered from her medical event and has been transferred back to the medical ward from the high dependency unit. Following assessment and review by the medical staff the decision was made to take Majorie to theatre for surgical debridement of the wound. On return from theatre the below wound was left.

- a. What would your treatment of Majorie's be with this type of wound involve and discuss rationale for the dressing selection.
- b. Use an example from practice and analyse the current dressing choice in terms of effectiveness.
- c. In light of the knowledge gained from this module what are the alternate dressings that could be used.

Your answers should include.

Tissue involved

Phase of wound healing

Rationale for dressing choice ie manage exudate.

Why particular product liked/chosen/used.

Type of wound the product used on.

Treatment aims

Effectiveness of products in regards to treatment aim.

Exudate management

Maintenance of wound environment.

Aiding autolysis.

Exudate management

Primary dressings to pack the wound

Secondary dressings, (consider positioning of the wound.)





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**THIS
GLOSSARY
IS AN IDEAL
DESCRIPTION
OF WORDS
AND TERMS
USED IN THIS
BOOK.**

GLOSSARY

A

Acute wound - A recently inflicted wound that will usually heal without problems.

Aerobic Bacteria - Bacteria that thrive in an oxygen rich environment.

Alginate - Dressing derived from seaweed.

Anaerobic Bacteria - Bacteria that thrive in an oxygen free environment.

Autolysis - The body's natural capacity for breaking down necrotic tissue. In wound care autolysis is encouraged through the use of moist wound dressings.

B

C

Cellulitis - Inflammation and infection of the cells, associated with heat, redness, swelling and pain.

Chronic wound - Wound that has remained unhealed for more than six weeks.

Collagen - Most abundant protein in the body and is responsible for holding the body together. Collagen is laid down and modified during the proliferation and maturation phase of wound healing.

D

Debridement - Removal of devitalised tissue through surgery, larval therapy, autolysis or occlusive dressings.

Dehiscence - Separation of the opposed edges of a surgical wound.

Devitalised Tissue - Tissue that is no longer viable.

E

Epithelialisation - Wound bed level with the surface, epithelial cells will migrate over the wound bed to complete healing.

Eschar - Hard necrotic tissue.

Erythema - Redness as seen in inflammation surrounding wounds.

Excoriation - Skin has been traumatised, worn away or eroded as a result of incontinence or inappropriate dressing.

Exudate - Serous fluid that has passed through the walls of a damaged or overextended vein.

F

Fibroblast - In wound healing, fibroblasts stimulate cell migration, angiogenesis, embryonic development and healing.

Film Dressing - Transparent film that can be used as a primary or secondary dressing.



G

Gangrene - Devitalised, dead tissue caused by failure of the blood supply.

Granulation - Combination of newly formed vascular tissue and fibroblasts which lay down a matrix of cellular tissues during wound healing.

Guluronic acid - Present in alginates, maintains the structure making removal in one piece.

H

Haematoma - A bruise or collection of blood in the tissues.

Haemostasis - Control of bleeding.

Homeostasis - The body's natural mechanism for maintaining health constancy and ensuring survival. Includes blood pressure and thermoregulation.

Hydrogel - Water based product for rehydrating necrotic tissue.

Hydrophilic - Water loving - absorbent dressing.

Hydrophobic - Water Hating - Non absorbent dressing.

Hypergranulation- (Overgranulation) - Excessive production of granulation tissue.

I

Infection - Caused by micro organisms which evade the immunological defences, enter and establish themselves within the tissues.

Inflammation - Natural defence against bacterial invasion, stimulates wound healing.

Ischaemia - Localised deficiency of arterial blood.

J

K

Keratinised - The process whereby epidermal cells differentiate to form the stratum corneum.

L

Leg Ulcer - Wound of the lower limb that is frequently chronic in nature.

M

Maceration - Softening of tissue that has remained moist or wet for a long period. The skin becomes white and soggy and less resilient. Can pre dispose to tissue breakdown.

Malnutrition - Poor nutritional status from impaired absorption, poor diet.

Mannuronic acid - Present in alginates, form a soft flexible gel , breaks down in the prescence of sodium and rinses away.



Maturation - Final stage of wound healing which involves wound contraction, full epithelialisation and reorganisation.

Moisture Vapour transfer rate (MVTR) - The rate at which moisture (Mainly from wound exudate) passes through a dressing and evaporates into the atmosphere.

N

Necrosis - Death of tissue or organ in response to injury, disease or occlusion of blood flow.

O

Oedema - An unnatural accumulation of fluid in the interstitial spaces.

P

Pressure Ulcer - An area of localised damage to skin and underlying tissue caused by pressure, shear and friction.

Proliferation Phase - Third phase of wound healing, intense proliferation of fibroblasts and endothelial cells.

Pus - A production of inflammation usually caused by infection containing used cells, debris and tissue elements.

Q

R

S

Sharp debridement - Method of debridement using scalpel or scissors to remove necrotic tissue.

Sinus - An epithelial cell lined tube from the outside of the body to the inside.

Slough - A mixture of dead white cells, dead bacteria, rehydrated necrotic tissue and fibrous tissue.

T

Tissue Viability - The ability of tissue to perform it's function optimally.

U

V

Vapour permeable - Gases and water vapour pass through e.g. dressing surface.

Vasoconstriction - The arteries and arterioles constrict under the influence of drugs, hormones or cold.

Vascularity - Blood supply in an area of tissue.



Vascular Response - May be dilation or contraction in a response to a variety of stimuli e.g. temperature, inflammatory state and blood volume.

Vasodilation - The lumen of blood vessels opens and becomes wider. Blood flow slows and oxygen reaches the tissues.

W

Wound - A breakdown in the epidermis that can be related to trauma or pathological changes within the skin or body.

X

Y

Z

