

The Role of the Australian Community Pharmacist in Acute Wound Care

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Introduction

This Made Easy provides a practical and actionable overview of the 2025 Best Practice Statement, "The Role of the Australian Community Pharmacist in Acute Wound Care". It aims to educate healthcare professionals and equip pharmacy teams to manage acute wounds with confidence, supporting improved clinical outcomes for people across Australia.



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Community pharmacies in Australia have become an essential and highly trusted component of the healthcare system, often serving as the first point of contact for individuals seeking medical advice and support²⁻³. With an expanded scope of practice, pharmacists are increasingly assessing and managing minor acute wounds, while referring more complex cases to other healthcare professionals where appropriate.

THE ROLE OF THE PHARMACIST IN WOUND CARE

In wound care practice, pharmacists may be expected to:

-  Assess, document, treat and triage wounds
-  Select appropriate dressings based on wound characteristics and the patient
-  Cleanse wounds, and apply or supervise and remove dressings
-  Provide patient education on treatment, dressing changes, healing progress and red flags
-  Review medications and comorbidities that may impair wound healing
-  Recognise when referral to another healthcare professional is needed⁴⁻⁶.

WOUND CLASSIFICATION

Understanding wound type guides the pharmacist's management approach and helps identify when referral is needed.

Wounds can generally be classified as either acute or chronic (otherwise known as hard-to-heal).

Defining acute versus chronic wounds

Acute wound

An acute wound occurs suddenly (either intentionally or unintentionally) and heals in a timely manner within the expected healing trajectory.

Examples may include:

- Abrasions
- Cuts
- Burns (including sunburn)
- Bites
- Blisters
- Skin tears
- Surgical wounds
- Self-inflicted injuries.

Acute wounds may also involve bleeding, pain, infection, exudate or complications associated with comorbidities that affect healing.

See [Table 1](#) for image examples and special considerations.

Chronic or hard-to-heal wound

Chronic or hard-to-heal wounds stagnate or remain prolonged in the inflammatory phase, with healing delayed by intrinsic or extrinsic factors.

Examples may include:

- Diabetic foot ulcers
- Venous leg ulcers
- Pressure injuries.

Chronic wounds typically require referral to a wound care specialist and generally fall outside the scope of community pharmacy practice without additional qualifications and/or credentialing.

For pharmacists, this distinction is important, as acute wounds are more likely to fall within the scope of community pharmacy practice.

THE IMPORTANCE OF WOUND ASSESSMENT

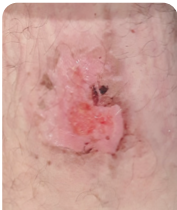
Thorough assessment is the first step in successful wound management.

A structured approach to assessment supports clinical decision-making and appropriate referral. A practical framework for assessing acute wounds includes three key components: history taking, visual and physical examination and functional assessment [\[Figure 1\]](#).

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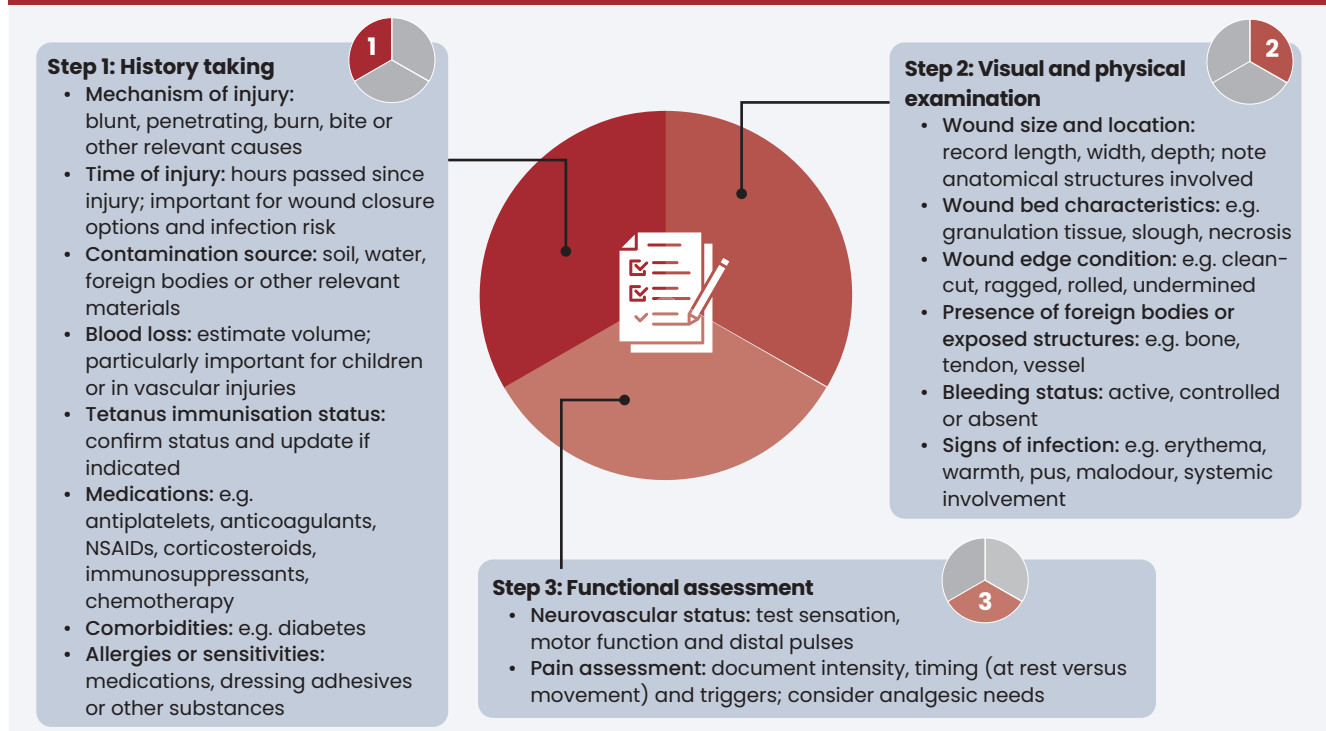
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Table 1. Common acute wounds seen in community pharmacies in Australia.

Type	Special considerations	Example	Type	Special considerations	Example
Abrasions, grazes, scrapes	- Provide first aid if required - Cleanse and remove debris/exudate at assessment and at each dressing change - Apply an appropriate dressing based on size, depth, exudate level and location		Bites (insect or animal)	- Assess for infection (e.g. cellulitis) and allergic reaction - Cleanse immediately with antiseptic; flush exposed mucous membranes with copious amounts of water - Refer if open wound is present or patient is at high risk of infection	
Bleeding wounds	- Apply direct pressure and elevate - Apply an alginate dressing to control bleeding and promote haemostasis - Refer if bleeding persists >15 minutes or wound is deep or exposes fat, tendon, joint or bone		Blisters	- Cleanse gently - Use a silicone foam dressing for deflated blisters - Prevent MARSIs: use low-adhesion dressings and remove gently in the direction of hair growth - Monitor for infection	
Burns and scalds (including sunburn)	Superficial burns: - Cool under running water for 20–30 minutes (do not use ice) - Apply an appropriate dressing based on severity - Refer if >10% TBSA (adults) or >5% TBSA (children), if it involves face/hands/genitalia, is circumferential or not healed within 1 week		Cuts (minor lacerations)	- Cleanse and control bleeding - Consider closure strips or tissue glue only for non-flexor areas - Apply film or island film dressing for small, superficial cuts - Refer if deep, gaping, on face/hands, heavily bleeding, signs of infection or uncertain closure	
	Deep burns: - Damage extends to dermis/subcutaneous tissue - Assess cause and extent of damage - Refer to burn or emergency specialist - May require infection prevention, debridement and grafting⁷		Skin tears	- Common in older people with fragile skin - Gently reposition skin flap without stretching the skin - Prevent MARSIs: avoid adhesive strips and use minimal-adhesion dressings (e.g. silicone-coated)	
Surgical wounds (e.g. sutures)	- Monitor for infection and dehiscence (wound reopening) - Cleanse with sterile saline or a non-cytotoxic antiseptic cleanser, and cover with an island film dressing or a silicone foam dressing, as appropriate - Refer for ongoing wound care or specialist review as needed		Self-inflicted injuries/self-harm	- Provide first aid if necessary - Assess for mental health needs - Refer to appropriate psychological and support services	
			Post radiotherapy burns	- Avoid high-tack adhesives and excessive drying - Use sheet or amorphous hydrogels to minimise skin desquamation and damage - Monitor for infection or delayed healing - Refer if breakdown is severe or persistent	

MARSIs – Medical adhesive-related skin injury; TBSA – Total body surface area

Figure 1. The three key components of a structured wound assessment.



THE TIME(S) FRAMEWORK

Although developed for chronic wounds, the TIME(s) framework⁸ [Table 2] remains a practical guide for observing and describing acute wounds and identifying potential complications or delayed healing.

IDENTIFYING INFECTION

Although infection and inflammation share clinical features, assessment of signs, symptoms, timing, wound appearance, microbiological findings, response to treatment and clinical judgement can help differentiate between them and guide management. See Box 1 for clinical signs and symptoms of infection.

Tetanus reminder

- Any acute wound, including small cuts, punctures and animal bites, may be tetanus-prone
- Always triage for tetanus risk and review vaccination status to guide management.

ANTIMICROBIAL STEWARDSHIP (AMS)

Most wounds do not require antibiotics; antiseptics and appropriate dressings are usually sufficient. Antibiotics

should only be used as per local guidelines when there is clear evidence of infection. Inflamed but non-infected wounds may respond to cleansing, debridement and topical anti-inflammatory therapies⁹.

Given the global concern regarding antibiotic resistance, topical antibiotics should only be used in infected wounds under specific circumstances and by experienced clinicians^{10–12}. Topical antimicrobials or antimicrobial dressings are not required without clinical signs of infection, unless used prophylactically in at-risk wounds or individuals¹³.

MEDICATIONS THAT MAY IMPAIR WOUND HEALING

As a pharmacist, reviewing medication history is one of the most valuable contributions to wound care. Pharmacists should always obtain a comprehensive history, including prescribed, over-the-counter and complementary medicines. See Table 3 for examples of medication classes commonly associated with impaired wound healing¹⁴.

WOUND CLEANSING

According to the International Wound Infection Institute, a wound dressing involves cleansing, debridement, wound assessment and application of a new dressing

Table 2. Principles of TIME(S)[®], their effects and possible clinical actions to improve the wound bed and promote healing.

	Component	What to observe	Pharmacist action	Refer if...
T	Tissue	Viable, non-viable or unhealthy tissue (e.g. slough, necrotic tissue)	- Identify non-viable tissue - Recommend appropriate non-adherent or absorptive dressings to protect the wound and minimise trauma	Devitalised tissue is present (debridement may be required and should be performed by a qualified healthcare professional)
I	Inflammation/ Infection	Signs of infection (e.g. pain, erythema, heat, swelling, excessive exudate)	- Assess for local infection - Recommend suitable antimicrobial dressings (e.g. iodine, silver, honey-based) - Educate on signs of deterioration	Infection worsens, spreads or does not improve
M	Moisture balance	Excessive or insufficient exudate levels; rolled, thickened or macerated wound edges	- Select dressings to manage moisture (e.g. absorbent dressings for moderate-to-high exudate; hydrogels for dry wounds) - Ensure appropriate dressing change frequency	Exudate is heavy, persistent, malodorous or associated with skin breakdown
E	Edge of wound	Rolled, thickened, undermined, macerated or non-advancing edges	- Observe for stalled healing - Reinforce wound hygiene and exudate control - Select appropriate dressing size and check for adherence	Wound edges are deteriorating or healing is not progressing
S	Surrounding skin	Condition of periwound area (4cm) and surrounding skin (20 cm) ¹⁵	- Recommend barrier creams, protective films or emollients to maintain periwound skin integrity - Advise on dressing selection to reduce excess moisture	Surrounding skin becomes inflamed, broken or vulnerable to further damage

Box 1. Clinical signs and symptoms of wound infection (adapted from¹²).

Overt (classic) signs	Covert (subtle) signs	Systemic signs
- Erythema (which may present differently depending on individual skin tone) - Local warmth - Swelling or induration - Purulent discharge - Malodour - New or increasing pain - Wound breakdown and enlargement	- Hypergranulation - Bleeding or friable granulation tissue - Epithelial bridging or pocketing - Increasing exudate - Delayed wound healing beyond expected timeframe	- Fever (pyrexia) - Malaise - Rigors - Chills - Severe sepsis - Loss of appetite - Septic shock - Hypotension - Multiple organ failure

Table 3. Common medications that may impair wound healing (adapted from¹⁴).

Medication/substance class	Examples
Corticosteroids	Prednisolone, Dexamethasone
Non-steroidal anti-inflammatory drugs (NSAIDs)	Ibuprofen, Ketorolac, Diclofenac, Naproxen
Drugs for gout	Colchicine
Cytotoxic/antineoplastic agents (antimetabolites, chemotherapy)	Cyclophosphamide, 5-fluorouracil derivatives, Hydroxyurea
Nicotine (tobacco, patches, gum, vaping)	Nicotine

Note: Medications with long half-lives may continue to affect wound healing even after discontinuation. It is important to identify both current and recent medications to mitigate potential complications.

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to protect the wound, promote healing and manage or prevent infection. Wound cleansing solutions have different purposes and properties¹⁵:

- Clean wounds typically do not require antiseptics. Cleansing with water and a suitable surfactant is usually sufficient
- Antiseptics (e.g. hypochlorous acid, octenidine dihydrochloride [OCT], polyhexamethylene biguanide [PHMB]) are effective in preventing and managing wound infections and biofilms, particularly when used in combination with debridement and antimicrobial dressings.

THE IMPORTANCE OF UNDISTURBED WOUND HEALING

An important goal in acute wound management is to minimise unnecessary disturbance to the wound site. Known as 'undisturbed wound healing', this involves leaving a dressing in place for as long as clinically appropriate. Dressing wear time may be extended to 5–7 days, depending on the wound, individual and dressing type¹⁶. This approach is not appropriate if exudate causes strikethrough or leakage, frequent wound inspection is required (e.g. post-operative wounds with signs of infection), the dressing becomes detached or maceration develops.

Dressing management and patient education

Pharmacists play a key role in educating individuals on the safe use of dressings between clinical visits. As most acute wounds are eventually managed by individuals or carers, understanding when a dressing needs changing [Box 2], as well as correct dressing application and removal [Box 3], is essential.

For a summary of dressing properties, indications and precautions⁷, see Table 4.

KNOWING WHEN TO REFER

Referral should be guided by scope of practice, clinical judgement and local protocols.

Factors prompting referral may include:

- Size, depth or location of the wound (e.g. face, joints, hands)
- Cause (e.g. chemical or electrical burns, animal bites)
- Severity
- Age of the individual
- Presence/signs of infection.

Suitable referrals may be to general practitioners, wound care clinicians, podiatrists, dermatologists, surgeons or emergency services. Specific referral triggers for each wound type are also noted in Table 1.

Box 2. Signs that a dressing change or review is needed.

- Dressing is saturated or there is visible strikethrough
- Wound fluid is leaking from the dressing
- Excessive or new bleeding is present
- Surrounding skin shows signs of maceration (whitening, softening or breakdown)
- Signs of local infection are present (e.g. increasing pain, redness, swelling, malodour or purulent exudate)
- Wound shows signs of deterioration (e.g. increasing size, tissue breakdown or worsening appearance)
- Dressing has lost adhesion (e.g. lifting, peeling or becoming detached)
- Wound pain has increased
- Local skin irritation, itching (pruritus) or rash develops

Box 3. Correct dressing application and removal techniques.

▼ Correct dressing application

- Ensure the wound and periwound area are fully dry before applying the dressing
- Position the dressing so that it does not restrict patient movement
- Do not apply tension or stretch the dressing
- If using an adhesive dressing, apply firm but gentle pressure to smooth the dressing, ensuring there are no gaps or wrinkles that could compromise adhesion, promote dehydration or allow contamination to enter
- Always follow manufacturer's instructions

▲ Correct dressing removal

- Loosen the edges of the dressing first
- Peel the dressing slowly in the direction of hair growth while supporting the surrounding skin with the free hand (the 'low and slow' approach¹⁷)
- Consider using medical adhesive removers to reduce pain and skin stripping by softening and dissolving adhesive bonds
- Change every 5–7 days or when clinically appropriate

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Table 4. Wound dressings: properties, indications and precautions (adapted from?).

Product classification	Properties	Indications	Precautions
Contact layer dressings (silicone contact layers)	- Soft silicone mesh - Gentle on fragile skin	- Superficial wounds - Postoperative incisions - Fragile or elderly skin	Check for silicone sensitivity or allergy
Non-adherent dressings	- Low adherence - Minimal absorption - Requires secondary fixation	- Superficial, low-exuding wounds - Minor cuts and abrasions	Not suitable for moderate-to-high-exuding wounds
Film dressings (transparent or island)	- Polyurethane film with adhesive backing - Moisture control - Waterproof and bacterial barrier - Allows wound observation (except island dressings with an absorbent centre)	- Superficial, low-exuding wounds (film island dressings) - Clean, granulating or epithelialising wounds (film island dressings) - Post-operative wounds and minor injuries - To retain a primary dressing	- Not suitable for fragile or compromised surrounding skin - Not suitable for deep, infected or moderate- to highly exuding wounds - Risk of maceration if fluid accumulates
Hydrocolloid dressings	- Absorbs exudate and forms a gel - Promotes autolytic debridement	- Clean, low- to moderate-exuding wounds - Superficial wounds	- Not suitable for dry or highly exuding wounds - Risk of maceration - May produce an odour on removal, which is normal
Soft silicone-coated polyurethane foam dressings	- Non-adherent - Gentle removal - Available in low- to non-adherent forms for delicate skin - Available in 'lite' versions (2-3 layer foams) for low-exuding wounds	- Fragile skin - Moderate- to high-exuding wounds - Pressure redistribution (minor degree)	Consider silicone sensitivity or allergy
Amorphous gel/hydrogel dressings	- Rehydrates wound bed - Promotes autolytic debridement - Cooling and pain relief	- Dry or low-exuding wounds - Superficial burns	Not suitable for highly exuding wounds (risk of periwound maceration). Avoid use if anaerobic infection is suspected
Povidone iodine antimicrobial dressings	- Rapid-release iodine with broad-spectrum antimicrobial activity - Minimal or no debriding effect	- Superficial, infected wounds - Presurgical or acute wound antisepsis (short-term)	- Not recommended for deep wounds or prolonged use - Overuse may delay healing - Caution in thyroid disorders or renal impairment
Silver-based dressings (elemental, nanocrystalline)	- Broad-spectrum antimicrobial activity against bacteria, fungi and viruses - Available in foams, alginates, carboxymethyl cellulose formats for exudate absorption	- Critically colonised or infected wounds - Low- to high-exuding wounds	- May cause skin discolouration - Check for silver sensitivity - Reassess if no improvement after 2 weeks - Avoid saline with nanocrystalline silver dressings

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