



**Berkshire Healthcare**  
NHS Foundation Trust

**CCR130**

# **WOUND CARE GUIDELINES**

**(contains graphic digital images)**

**Berkshire Healthcare NHS Foundation Trust**



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## **POLICY DEVELOPMENT**

### **CCR130 – WOUNDCARE GUIDELINES**

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## 1. INTRODUCTION

These guidelines are intended to be used in conjunction with CCR131 Pressure Ulcer Policy, CCR132 Leg Ulcer Guidelines and CCR0035 Consent to Examination and/or Treatment.

## 2. STATEMENT OF INTENT/PURPOSE

These guidelines are designed for the health care professional practicing in all care settings within Berkshire Healthcare Foundation Trust. The aim of this document is to provide the appropriate management strategy for optimum wound healing, patient comfort and cost effectiveness in line with best practice/evidence.

## 3. EDUCATION AND TRAINING

The flow charts and format within the document are intended to establish a standardised approach for the management of patients with wounds across Berkshire Healthcare NHS Foundation Trust. Health care professionals are accountable for their clinical practice.

For further information regarding courses available see the training prospectus (SLATE) on the intranet.

## 4. CAPACITY & CONSENT

It is important to gain the patients consent to any procedure undertaken. Guidance on this can be found in the Berkshire Healthcare - Consent to Treatment and Examination Policy CCR035.

Where a patient has capacity to consent there should be documentation around the discussion and the patient's views and consent status.

Where it appears that a patient may lack capacity to consent, the principles of the Mental Capacity Act 2005 (MCA) should be followed to establish whether there is a lack of capacity. If it established that there is a lack of capacity then a decision to proceed should be made using the best interest principles of the MCA. Documentation of the capacity assessment and best interest decision must be made within the clinical records of the patient.

If the patient is non-concordant with care please use the non-concordance paperwork with the patient.

## 5. WOUND DEFINITION

A wound by true definition is a breakdown in the protective function of the skin; the loss of continuity of epithelium, with or without loss of underlying connective tissue (i.e. muscle, bone, nerves (Leaper DJ and Harding KG1998.) Following injury to the skin or underlying tissues/ organs caused by surgery, a blow, a cut, chemicals, heat/ cold, friction/ shear force, pressure or as a result of disease, such as leg ulcers or carcinomas. (Hutchinson J 1992).

## 6. WOUND CLASSIFICATION

**6.1 Acute Wounds** Abrasions (grazes) are superficial wounds, generally caused by friction as a result of brief or indirect contact between the skin and a harder or rougher surface. Abrasions are generally confined to the outer layers of the skin.

**6.2 Chronic Wounds** Chronic wounds are the hard to heal wounds which are often linked to patients with multiple co-morbidities.

**6.3 Pressure ulcers** are usually caused by the sustained application of pressure over a bony prominence, which inhibits capillary blood flow to the skin and underlying tissue. If the pressure is not relieved it will result in cell death followed by tissue necrosis and breakdown. (Refer to N.I.C.E. Prevention Guidelines and Berkshire Healthcare Foundation Trust Pressure Ulcer Policy and European Pressure Ulcer Advisory Panel, 2014)

**6.4 Leg ulcers** which maybe venous, ischaemic, mixed aetiology or traumatic in origin. (Refer to Berkshire Healthcare Foundation Trust Leg Ulcer Policy, RCN Guidelines on Venous Leg Ulcer Management, 2017. SIGN Guidance on the Management of Venous Leg Ulcers 2010).

**6.5 Malignant wounds** a lesion may presents with a mixed appearance of both proliferating and ulcerating areas. Lesions that have a predominantly proliferative growth pattern may develop into a nodular 'fungus' or 'cauliflower' shaped lesion whereas a lesion that is ulcerating will produce a wound with a crater-like appearance. In treating patients with malignant wounds, the goal of care is to maintain or improve quality of life through symptom control. The four most common symptoms associated with malignant wounds are exudate, malodour, bleeding and pain.

**6.6 Penetrating wounds** maybe caused by knives, bullets or may result from accidental injuries caused by any sharp or pointed object. Internal damage can be considerable depending upon size and depth of penetration, and/or the velocity of the bullet or missile.

**6.7 Bites** caused by animals, insects or humans may become infected by a range of pathogenic organisms including Spirochetes, Staphylococci, Streptococci and various gram positive bacilli.

**6.8 Burns and Chemical Injuries**

Specific Advice to Emergency Departments, General Practitioners and other non-specialised providers:

The suggested minimum threshold for referral into specialised burn care services can be summarised as:

All burns  $\geq 2\%$  TBSA in children or  $\geq 3\%$  in adults

All full thickness burns

All circumferential burns

Any burn not healed in 2 weeks

Any burn with suspicion of non-accidental injury should be referred to a Burn Unit/Centre for expert assessment within 24 hours

In addition, the following factors should prompt a discussion with a Consultant in a specialised burn care service and consideration given to referral:

All burns to hands, feet, face, perineum or genitalia

Any chemical, electrical or friction burn

Any cold injury

Any unwell/febrile child with a burn

Any concerns regarding burn injuries and co-morbidities that may affect treatment or healing of the burn

If the above criteria/threshold is not met then continue with local care and dressings as required.

For advice and dressing choices please go to The London and South England Burns Network they publishes burn care guidance and guidelines for health care professionals. The documents have been developed by senior clinical members of the burns multi-disciplinary team, and approved by the ODN Board. <http://www.lsebn.nhs.uk/>

**6.9 Dermatological** conditions (refer to Dermatology).

**6.10 Diabetic foot ulcers** and **foot pressure ulcer** (require urgent referral to Podiatry).

**6.11 Skin Tears** - See appendix C for skin tear classification and treatment.

## **7. WOUND ASSESSMENT**

Berkshire Healthcare staff should use TIMES to accurately assess wounds see appendix D.

All wounds should have a completed wound care plan and assessment form documented on RIO

The normal stages of wound healing are:

- Haemostasis
- Inflammatory phase
- Proliferative phase
- Maturation

WOUNDS MAY BE IN SEVERAL STAGES OF HEALING AT ANY ONE TIME

### **7.1 Necrotic tissue**

Wound containing dead tissue:

- It may appear hard, dry and black.
- Dead connective tissue may appear grey.
- Necrotic tissue in Ischaemic leg ulcers should be left dry – moist wound healing is not promoted with this wound aetiology.

**7.2 Slough** is devitalised tissue; it is formed by an accumulation of fibrin, white blood cells and debris that collects in the wound. It can be light yellow to dark green and can be mobile, stringy or rigid. It must not be confused with infected tissue or pus. Slough interferes with the action of leucocytes and can help in the formation of biofilms. Slough can make it impossible to visualise the wound bed and therefore the extent of the wound.

### **7.3 Granulation tissue**

Healthy red tissue, (strawberry jam colour) which occurs during the proliferative phase of wound healing. Fibroblasts migrate to the wound to produce collagen fibres. The tissue is well vascularised and bleeds easily.

### **7.4 Epithelial tissue**

The process by which the wound surface is covered by new epithelium, this begins when the wound has filled with granulation tissue. The tissue is pink, almost white, and occurs on top of healthy granulation tissue.

### **7.5 Biofilms**

These are dynamic communities of bacteria and fungi, which live within a self-secreted matrix of proteins and sugars. Biofilms will develop within 2-4 days of initial colonisation,



of the wound bed and can become tightly attached to the extracellular matrix components or the wound bed. This can make them difficult to remove by surface irrigation or superficial debridement, as the biofilm barrier protects the microorganisms.

If needed Octenilin can be used to help reduce infection and biofilms and should always be used after initial washing of the wound. Please order via the specialist dressing form.

For further guidance on Wound bed characteristics and suitable treatments see Appendix B - Wound Treatment Matrix.

## **8. PAIN**

All health care professionals should regularly monitor whether patients experience pain associated with leg ulcers and formulate an individual management plan. Please see the pain assessment section of the Leg Ulcer Assessment form

## **9. WOUND MEASUREMENT**

Wound measurement is vital to monitor the healing process of a wound. The wound should be measured at its greatest length head to toe (or 12.00 – 6.00 if using a clock face) and then the greatest width perpendicular to the length. Use the sterile measuring ruler in the dressing packs. The depth of the wound is measured using a sterile gloved finger.

## **10. WOUND CLEANSING**

NICE Guidelines 2014 recommend the use of Debrisoft to remove slough and biofilms present.

Sterile water should be used for surgical wounds

Tap water should be used for all other wounds.

## **11. WOUND MANAGEMENT DRESSINGS/PRODUCTS**

Always read and adhere to manufacturers guidelines which are in the packaging of every dressing.

Dressings do not heal wounds, they aid wound healing. There are many hundreds of wound products available, all having slightly different properties. The ideal wound management choice is dependent on the type, depth and exudate of the wound taken in conjunction with the stage of healing and what the main objectives of treatment e.g. debridement or protection.

Dressing selection needs to be decided in conjunction with the patient and based upon the clinical findings of the wound following a comprehensive assessment. Where possible, Berkshire Healthcare dressings' formulary should be used unless there is a clinical reason to deviate.

If following assessment, the needs of a particular wound cannot be fully or partly met by products on the formulary, then the Tissue Viability Nurse can be asked to advise on a more appropriate product. Products required 'off' formulary can be requested via Tissue Viability using the Specialist Dressing Request Form, available on TeamNet.

<http://teamnet.berkshire.nhs.uk/clinical/tissue/docs/Pages/home.aspx>

Company Representatives must only discuss products that are on Berkshire Healthcare Main Formulary.

The Wound Treatment Matrix Appendix B gives further guidance on wound bed appearance and suitable dressing choices.

Always provide a rationale on the care plan / wound assessment form on RiO with regards to dressing choice and any treatment changes.

## 12. WOUND DEBRIDEMENT - See appendix A

Debridement is the removal of dead, non-viable/devitalised tissue, infected or foreign material from the wound bed and surrounding skin. (Wounds UK 2013). This occurs naturally by the body through autolytic debridement. Autolytic debridement can be slow and is not always the most beneficial treatment for progressing a wound towards healing (Young 2011)

## 13. LARVAE THERAPY Refer to Larvae Therapy SOP.

[http://teamnet.berkshire.nhs.uk/clinical/tissue/docs/Pages/home.aspx?Paged=TRUE&p\\_SortBehavior=0&p\\_FileLeafRef=SKIN%20bundle%20chart%2c%20essential%20rounding%2epdf&p\\_ID=17&PageFirstRow=31&&View={2E0B0DCB-FFFF-4601-AC01-08DA3FA9FB97}](http://teamnet.berkshire.nhs.uk/clinical/tissue/docs/Pages/home.aspx?Paged=TRUE&p_SortBehavior=0&p_FileLeafRef=SKIN%20bundle%20chart%2c%20essential%20rounding%2epdf&p_ID=17&PageFirstRow=31&&View={2E0B0DCB-FFFF-4601-AC01-08DA3FA9FB97})

Any registered practitioner who has undergone specific training in the theoretical knowledge and application of larval therapy may undertake it. Advice can be sought through TVN. For further information about how to use larvae therapy visit [www.biomonde.com](http://www.biomonde.com)

### 13.1 Larvae therapy contraindications

- i. Hard necrotic eschar. A hydrogel should first be used to re-hydrate this tissue, but this should be thoroughly washed out before Larvae application, as propylene glycol has adverse effects on Larvae viability and growth.
- ii. Fistula or wounds that might connect to vital organs
- iii. Caution is needed near exposed blood vessels- monitor for blood loss
- iv. Caution is needed with ischaemic leg ulcers.
- v. Patient's within their own home environment, receiving anti-coagulation therapy (this does not include a daily dose of Aspirin or similar).

## 14. WOUND SWABBING

Bacteriological swabbing should only be considered if there are clinical signs of infection (see section 14). A wound swab using the Essen Rotary Technique needs to be taken as per Trust Policy ICC010 Safe Handling and Transportation of Laboratory Specimens ICC018 Aseptic Non Touch Technique

A wound swab will not differentiate between colonization and infection. Even an indication of the level of growth can be misleading, as some patients will continue to heal despite a heavy growth, whereas a light growth will overwhelm others. Wound swabs should therefore only be used to identify micro-organisms as an aid to informed treatment decisions, after the diagnosis of wound infection has been made by clinical signs and history. Where pus is present, it is preferable, if possible, to withdraw pus with a syringe and collect in a sterile container.

### 14.1 How to take wound swab: This is the Essen Rotary technique.

- Moisten wound swab with sterile normal saline or transport medium if the wound is dry; if the wound is moist then there is no need to pre moisten.
- Using a spiral motion, start at the outside of the wound applying slight pressure and work towards the centre, rotating swab between fingers.
- Sample surface area – whole wound.
- Place swab straight into transport medium.
- Complete laboratory request form and send to laboratory with swab as soon as possible, include recent antibiotic therapy and topical antimicrobials used.
- Document date, time and type of swab taken in nursing care plan.

## 15. WOUND INFECTION

Wound infection is the invasion of a wound by a proliferating microorganism to a level that invokes a local and /or systemic response in the host. The presence of microorganisms within the wound causes local tissue damage and impedes wound healing. (International consensus update 2016 wound infection in clinical practice)

<b>Signs and symptoms associated with stages of the wound infection continuum</b>					
<b>contamination</b>	<b>colonisation</b>	<b>Local infection</b>		<b>Spreading infection</b>	<b>Systemic infection</b>
All wounds may acquire micro – organisms. IF suitable nutritive and physical conditions are available for each microbial species or they are not able to successfully evade host defences, they will not multiply or persist; their presence is therefore only transient and wound healing is not delayed	Microbial species successfully grow and divide but do not cause damage to the host or initiate wound infection	Covert signs of local infection <ul style="list-style-type: none"> <li>▪Hypergranulation</li> <li>▪Bleeding, friable granulation</li> <li>▪Epithelial bridging and pocketing in granulation tissue</li> <li>▪Wound breakdown and enlargement</li> <li>▪Delayed wound healing beyond expectations</li> <li>▪New or increasing pain</li> <li>▪Increased malodour</li> </ul>	Overt signs of local infection <ul style="list-style-type: none"> <li>▪Erythema</li> <li>▪Local warmth</li> <li>▪Swelling</li> <li>▪Purulent discharge</li> <li>▪Delayed wound healing beyond Expectations</li> <li>▪New or increasing pain</li> <li>▪Increasing malodour</li> </ul>	Extending induration /erythema <ul style="list-style-type: none"> <li>▪Lymphangitis</li> <li>▪Crepitus</li> <li>▪Wound breakdown/dehiscence with or without satellite lesions</li> <li>▪Malaise/lethargy or non-specific general deterioration</li> <li>▪Loss of appetite Inflammation swelling of lymph glands</li> </ul>	Severe sepsis <ul style="list-style-type: none"> <li>▪Septic shock</li> <li>▪Organ failure</li> <li>▪Death</li> </ul>

(International consensus update 2016 wound infection in clinical practice)

For guidance of antimicrobial use see Berkshire Healthcare wound infection algorithm (Appendix E)

Refer to Trust Policies:

ICC001 Infection Prevention & Control

ICC002/CCR032 Hand Hygiene

ICC013 Standard precautions and the use of PPE

ICC010 Safe collection, handling and transportation of laboratory specimens

ICC013 MRSA screening

ICC018 Aseptic Non Touch Technique

ICC030 Multidrug organism

## 16. ANTIMICROBIALS

Please refer to the section on Skin and Skin Structure in the guidelines below.

<http://microguide.horizonsp.co.uk/viewer/BHFT/Adult>

Antimicrobial dressings have been developed which combine an active agent within a modern dressing format. This ensures that the wound's general needs can be met whilst the imperative to reduce the bacterial burden is addressed. Effectiveness is dependent on their remaining active throughout the life of the dressing; therefore slow-release presentations have also been developed.

Always read the product literature carefully for contra indications and cautions as certain products are toxic to persons with certain conditions or sensitivities and may in any event only be used for a limited period. Practitioners should also be aware that some products may stain the tissues significantly which can mar the accuracy of some aspects of the wound assessment. Many silver dressings require exudate to activate the silver; therefore do not use these on dry wounds. Water based creams containing silver are not appropriate for wounds with excessive exudate; the properties will be washed away. Remember silver sulfadiazine cream needs daily application. Do not use preparations with a slow release formula on wounds requiring frequent dressing changes

Antimicrobial dressings are only indicated when infection is present or strongly suspected and should not be used prophylactically or routinely. Ideally the bacterial load within the wound should have been addressed prior to using antimicrobial dressings so that in addition an appropriate oral antibiotic can be prescribed if required, i.e. if the patient is showing signs of becoming systemically unwell. Use for up to 2 weeks, if problem not resolved reassess using Wound Infection Algorithm Appendix E.

## 17. TOPICAL NEGATIVE PRESSURE WOUND THERAPY (TNPWT)

Refer to Topical Negative Pressure Standard Operating Procedures.

[http://teamnet.berkshire.nhs.uk/clinical/tissue/docs/Pages/home.aspx?Paged=TRUE&p\\_SortBehavior=0&p\\_FileLeafRef=SKIN%20bundle%20chart%2c%20essential%20rounding%2epdf&p\\_ID=17&PageFirstRow=31&&View={2E0B0DCB-FFFF-4601-AC01-08DA3FA9FB97}](http://teamnet.berkshire.nhs.uk/clinical/tissue/docs/Pages/home.aspx?Paged=TRUE&p_SortBehavior=0&p_FileLeafRef=SKIN%20bundle%20chart%2c%20essential%20rounding%2epdf&p_ID=17&PageFirstRow=31&&View={2E0B0DCB-FFFF-4601-AC01-08DA3FA9FB97})

•Negative pressure wound therapy (NPWT) is the application of negative pressure across a wound to aid wound healing. The pressure is thought to aid the drainage of excess fluid, reduce infection rates and increase localised blood flow. There are many

different systems now available on the market See local standard operating procedures (SOPs) available on TeamNet.

•For principal indications and contraindications refer to the individual manufacturers guidelines.

## **18. NUTRITION AND WOUND HEALING**

Good nutrition facilitates the wound healing process while malnutrition will delay, inhibit and complicate it. Many nutrients have a role to play in wound healing, working either in isolation, or in combination with others.

### **Fluids**

Dehydrated skin is less elastic, more fragile and more susceptible to breakdown. Dehydration will also reduce efficiency of blood circulation, which will impair the supply of oxygen and nutrients to the wound. One of the main risk factors for dehydration is poor oral intake.

In long-term care, dehydration is one of the most common problems affecting good nutrition.

### **Proteins**

Protein deficiency results in impairment of the proliferative and remodelling stage of wound healing. It has also been reported that protein deficiency can cause impaired collagen synthesis, reduced wound strength and an increase in risk of infection due to a compromised immune system. Protein loss via wound exudates needs to be monitored.

### **Energy**

The main sources of energy for the human body – and for wound healing – are carbohydrates and fats. The main demand for energy from a wound is for collagen synthesis. Caloric needs for healing increase with increasing size and complexity of the wound.

Carbohydrate availability is essential to prevent proteins from being converted into energy. In people with diabetes, monitoring (e.g. blood glucose levels, glycated haemoglobin) will be required.

### **Fats**

These have a key role in the structure and function of cell membranes and are directly involved in cholesterol metabolism, the formation of inflammatory mediators, and clotting components. Adequate fats are also needed to prevent the body using protein for energy.

### **Vitamins**

Many vitamins are involved in wound healing, the main one being vitamin C. Deficiency of vitamin A and Vitamin B complex will also have adverse effects on wound healing. Vitamin C plays an important role in collagen synthesis and subsequent crosslinking, as well as the formation of new blood vessels. Adequate vitamin C levels help strengthen the healing wound. It also has important antioxidant properties that help the immune system, and it increases the absorption of iron.

Vitamin A increases the inflammatory response in wounds, stimulating collagen synthesis. Low vitamin A levels can result in delayed wound healing and susceptibility to infection. Supplementation with vitamin A requires caution, as there is a risk of toxicity. It

is possible that vitamin E can reduce injury to the wound by controlling excessive free radicals.

Contrary to popular opinion, there is limited evidence for the benefits of vitamin E in decreasing scar formation. There is also some evidence that suggests oral supplementation of vitamin E over 400mg/day has an increased health risk.

Vitamin B complex is essential for carbohydrate metabolism and therefore energy production.

### **Minerals**

Zinc, Copper and Iron are the main minerals in wound healing.

Zinc plays a key role in protein and collagen synthesis, and in tissue growth and healing.

Zinc deficiency has been associated with delayed wound healing, reduced skin cell production and reduced wound strength. Zinc supplementation in people who are not zinc deficient generally has no benefit.

Insufficient dietary intake of zinc can be further exacerbated by zinc loss from excess wound drainage.

Assessing zinc deficiency can be difficult as serum/plasma levels may not be a true indication of zinc levels at the wound itself.

Iron is part of the system that provides oxygen to the site of the wound; therefore iron (haemoglobin) deficiency can impair healing. Iron deficiency can also result in impaired collagen production and strength of the wound. Iron absorption from non-meat sources can be enhanced with vitamin C consumed at the same meal.

Zinc and iron compete for absorption; therefore if someone is receiving supplements of both, they should be given with meals but not at the same time.

Other supplements of vitamins and minerals, however, should be avoided as this can be detrimental to the patient, affecting absorption and metabolic interactions and, ultimately, impair nutritional status.

### **Diabetes**

People with diabetes need adequate energy for wound healing, but tight glycaemic control is also important. For this reason regular blood glucose monitoring is needed, whether diet alone/oral hypoglycaemic agents or insulin is the current therapy. These may need adjusting while the wound is healing.

### **Obesity**

It is not appropriate for people with wounds to follow diets that limit intake, such as diets to reduce cholesterol or weight and diets that avoid entire food groups such as carbohydrates. People with vegetarian or vegan diets, food allergies, or on dialysis need careful consideration and in these situations it is recommended that you seek the help of a dietician.

All patients must be nutritionally screened on admission to hospital or at 1st visit in the community.

Patients identified as at risk of malnutrition must have action plans incorporated into their management guidelines (Nice 2006). Screening should be reviewed regularly.

The Malnutrition Universal Screening Tool (MUST) or the Durham cachexia scale should be used see the Nutritional policy  
<http://teamnet.berkshire.nhs.uk/policies/DOCUMENTS%20POLICIES/CCR074.pdf>.

Referral to the Community Nutrition and Dietetic Team should be made where appropriate / necessary.

## 19. MONITORING COMPLIANCE

Regular audits will be undertaken to monitor the effectiveness of all wound management related guidelines.

## 20. USEFUL WEBSITES

Further information can be found on the following websites:

Name	Web address
Tissue Viability Team net Site	<a href="http://teamnet.berkshire.nhs.uk/clinical/tissue/Pages/home.aspx">http://teamnet.berkshire.nhs.uk/clinical/tissue/Pages/home.aspx</a>
European Wound Management Association	<a href="http://www.ewma.org">www.ewma.org</a>
Leg Ulcer forum	<a href="http://www.legulcerforum.org">www.legulcerforum.org</a>
The Wound Alliance UK	<a href="http://www.wcauk.org/">http://www.wcauk.org/</a>
The Tissue Viability Society	<a href="http://www.tvs.org.uk">www.tvs.org.uk</a>
European Tissue Repair Society	<a href="http://www.etr.org">www.etr.org</a>
Nursing Times	<a href="http://www.nursingtimes.net">www.nursingtimes.net</a>
European Pressure Ulcer Advisory Panel	<a href="http://www.epuap.org/">http://www.epuap.org/</a>
World Wide Wounds	<a href="http://www.worldwidewounds.com">www.worldwidewounds.com</a>
KCI VAC Therapy	<a href="http://www.kci1.com/KCI1/vactherapy">http://www.kci1.com/KCI1/vactherapy</a>
Renasys Go/PICO Smith & Nephew	<a href="http://www.smith-nephew.com/uk/products/wound_management/product-search/renasys/">http://www.smith-nephew.com/uk/products/wound_management/product-search/renasys/</a> <a href="http://www.smith-nephew.com/uk/products/wound_management/product-search/pico/">http://www.smith-nephew.com/uk/products/wound_management/product-search/pico/</a>
Venturi Talley	<a href="http://www.talleygroup.com/talley_medical/negative_pressure/venturi">http://www.talleygroup.com/talley_medical/negative_pressure/venturi</a>
Larvae Therapy Biomonde	<a href="http://www.biomonde.com">www.biomonde.com</a>

## 21. RELATED DOCUMENTS/REFERENCES

**Document Name**

Leg Ulcer Guidelines  
Pressure Ulcers Guidelines - Prevention and management  
Aseptic Technique Clinical Care Protocol  
Hand Hygiene Clinical Care Protocol

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**Appendix A**

**Debridement flow chart  
Trigger questions**

Do I need to accelerate debridement?  
What are the expected outcomes?

What are the risks?  
What are my options?

**Assess the wound**  
Underlying cause, site size signs of infection, condition of periwound skin/wound bed

**Assess the patient**  
Comorbidities, medication, cooperation with therapy, psychosocial issues, nutritional status

**Yes**  
Decide debridement goals/desired treatment outcomes.  
Am I certain what to do?

**Discuss with patient**

**Consult with MDT** if further advice needed:  
eg contraindications/unsure how to proceed  
OR  
**Refer to MDT** if specialist debridement method required

Implement debridement treatment plan and document in patient's record

**Debride**  
If competent in chosen method

**Do not debride**  
Eg ischaemic limbs or high risk patient

Keep wound dry eg mummified diabetic toe  
(nb some areas such as exposed tendons may need to be kept moist)

**Autolytic** (generalist) **Mechanical** (generalist) **Larval** (generalist)  
**Hydrosurgery** (competent practitioner) **Sharp** (competent practitioner)  
**Surgical** (surgeon)

Reassess at dressing change and review goals/treatment plan and change method if appropriate

Taken from Guidelines for practice, Effective debridement in a Changing NHS, A UK consensus



# Wound Dressing Decision Chart

This is a guide to support cost effective dressing choices but should not replace clinical judgement. The table below shows the preferred 1st line options.

Where appropriate, use the 1st line dressing choice unless the patient has a known allergy to the dressing or following a discussion with one of the Tissue Viability Clinical Nurse Specialists (TVCNS). Ensure the care plan is followed. Where the dressing indicated is not available on the formulary complete a specialist dressing request form.

**Remember:**

- Diabetic foot ulcers should be referred to podiatry. All ulcers/wounds below the ankle should be referred to podiatry.
- Keep the following wounds dry: intact necrotic areas on heels, diabetic foot ulcers and wounds caused by Peripheral Vascular Disease.

**When to swab:**

- Where there are clinical signs of infection e.g. pain, heat, exudate, odour.
- Where the wound is deteriorating e.g. sudden increase in pain and /or bleeding in the wound bed.

Wound Type	Epithelialising	Granulating	Slough	Infected/Critically Colonised	Necrotic	Malignant	Burns*
<b>Treatment Goals</b>	<ul style="list-style-type: none"> <li>• Optimise moist wound healing</li> <li>• Protect from infection</li> </ul>	<ul style="list-style-type: none"> <li>• Optimise moist wound healing</li> <li>• Manage exudate</li> <li>• Protect from infection</li> </ul>	<ul style="list-style-type: none"> <li>• Remove slough</li> <li>• Manage exudate</li> <li>• Protect from infection</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce bacterial load</li> <li>• Manage exudate</li> </ul> Antimicrobials should be used in line with the local wound infection flow chart and alongside the first line dressing choices for the type of wound	<ul style="list-style-type: none"> <li>• Debride</li> <li>• Manage exudate</li> </ul>	<ul style="list-style-type: none"> <li>• Contact TVCNS for advice</li> <li>• Manage wound symptoms whilst awaiting specialist advice</li> </ul>	<ul style="list-style-type: none"> <li>• Optimise moist wound healing</li> <li>• Protect from infection</li> </ul>
<b>DRESSINGS</b>							
<b>No Cavity</b>							
Low /No Exudate	Clearpore	Foam Lite™ ConvaTec	DuoDERM® Extra Thin™ OR Foam Lite™ ConvaTec	<ul style="list-style-type: none"> <li>• Iodine products are usually preferred for low exuding wounds</li> <li>• Cutimed® Sorbact® Ribbon is usually preferred for highly exuding wounds</li> </ul>	Foam Lite™ ConvaTec	Cuticol® Contact OR Eclypse OR AQUACEL® Foam dressing	Cuticol® Contact with an appropriate secondary dressing. Discuss with a TVCNS
High Exudate	AQUACEL® Foam dressing	AQUACEL® Foam dressing	AQUACEL® Extra™ dressing plus Eclypse OR AQUACEL® Extra™ dressing plus AQUACEL® Foam dressing	<ul style="list-style-type: none"> <li>• Honey products are usually preferred when there is evidence of thick slough or biofilm</li> </ul>	AQUACEL® Foam dressing	Cuticol® Contact OR Eclypse OR AQUACEL® Foam dressing OR CarboFlex® (if odorous)	
<b>Cavity</b>							
Low/No Exudate	Not Applicable	AQUACEL® Ribbon dressing plus Eclypse OR AQUACEL® Ribbon dressing plus Foam Lite™ ConvaTec	AQUACEL® Ribbon dressing plus Eclypse OR AQUACEL® Ribbon dressing plus AQUACEL® Foam dressing	<ul style="list-style-type: none"> <li>• Cutimed® Sorbact® Ribbon is usually preferred for highly exuding wounds</li> <li>• Honey products are usually preferred when there is evidence of thick slough</li> </ul>	AQUACEL® Extra™ dressing OR Honey OR Iodine OR Cutimed® Sorbact®	Cuticol® Contact OR Eclypse OR AQUACEL® Foam dressing	Refer to appropriate burns unit <a href="http://www.lebn.nhs.uk">www.lebn.nhs.uk</a>
High Exudate	Not Applicable	AQUACEL® Ribbon dressing plus Eclypse OR AQUACEL® Ribbon dressing plus AQUACEL® Foam dressing	AQUACEL® Ribbon dressing plus Eclypse OR AQUACEL® Ribbon dressing plus AQUACEL® Foam dressing		AQUACEL® Extra™ dressing OR Honey OR Iodine OR Cutimed® Sorbact®	Cuticol® Contact OR Eclypse OR AQUACEL® Foam dressing OR CarboFlex® (if odorous)	

Date of issue – October 2018

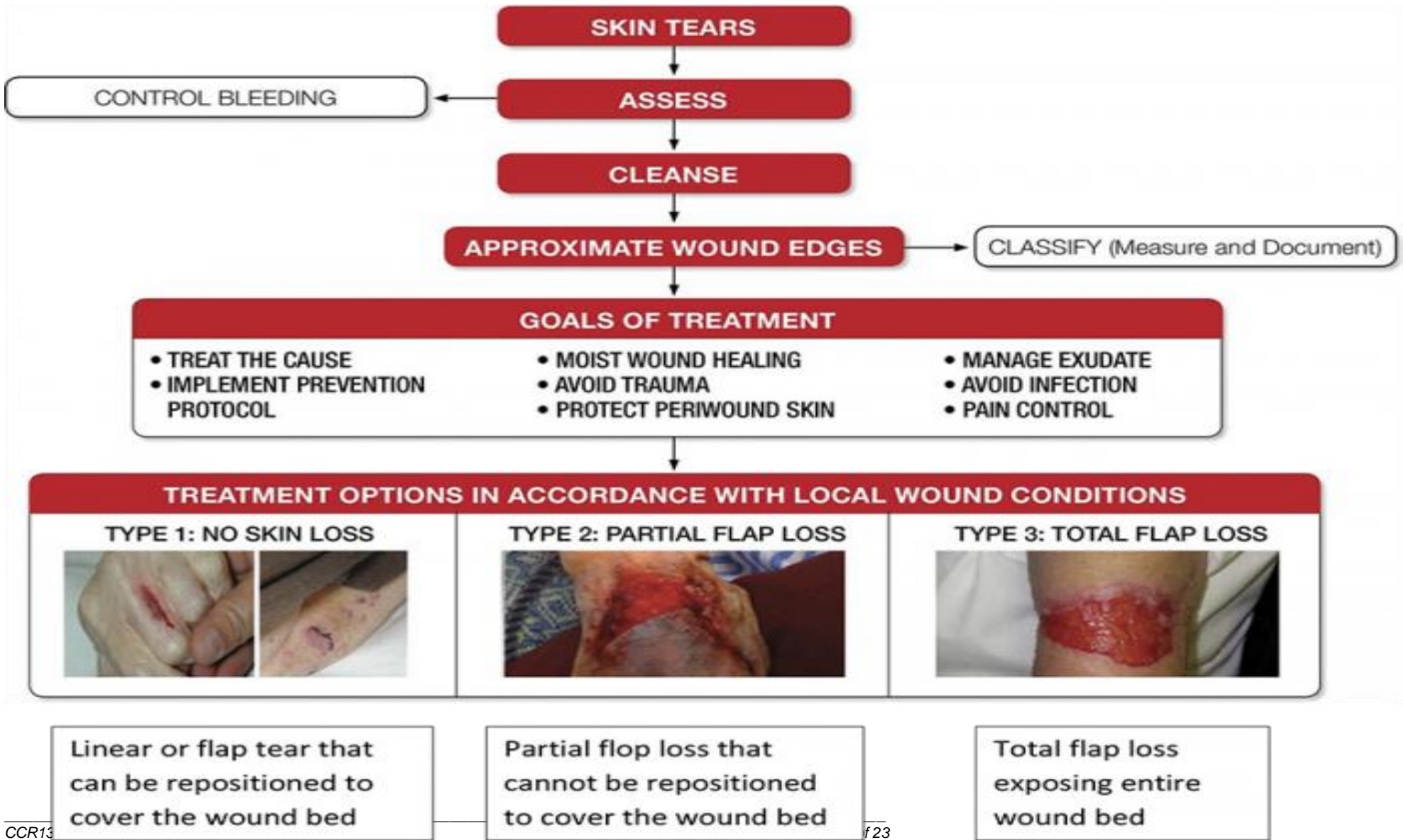
The printing of this document was financially supported by ConvaTec Limited, Berkshire Healthcare NHS Foundation Trust, Berkshire West CCG and East Berkshire CCG are solely responsible for the content of the document.

\*Photo - Kind permission given by Mr D Copson - CNS Tissue Viability, Nottingham City Hospital











Appendix C



Appendix D

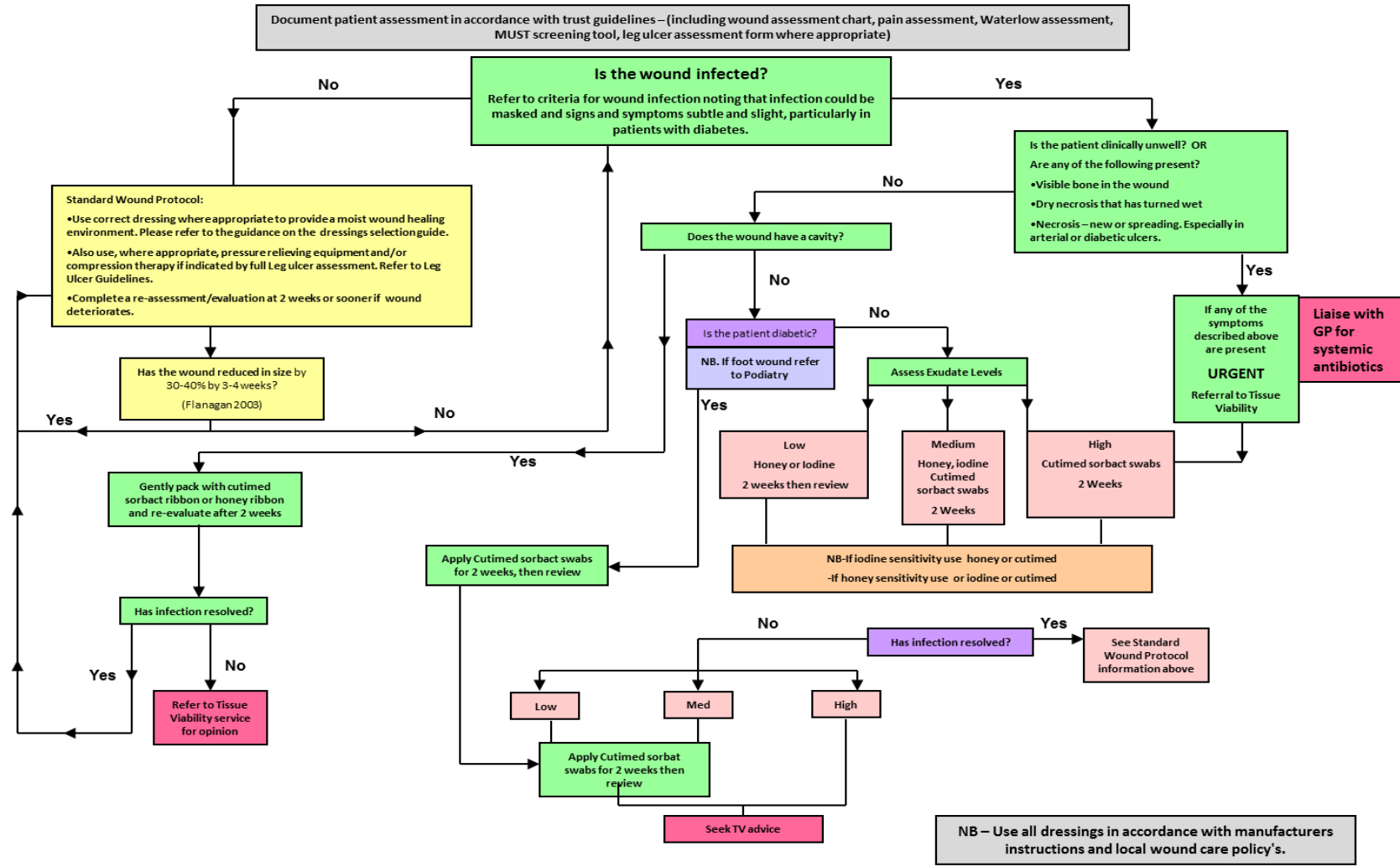
## TIMES - A Guide for Best Practice in Wound Assessment

	<b>T</b> Tissue, non-viable or deficient		<b>I</b> Infection, inflammation or biofilm	<b>M</b> Moisture imbalance	<b>E</b> Edge of wound, non-advancing or undermining	<b>S</b> Surrounding skin
	Necrotic	Sloughy	Infected	Granulating	Epithelialising	Scaly skin / hyperkeratosis
Priority						
Considerations	Necrotic tissue and hard eschar creates a barrier to healing and harbours bacteria, increasing the risk of infection  Unless ischaemic ulcers, necrotic tissue should be removed	Slough creates a barrier to healing and can be the ideal environment for microbial growth Slough should be removed to reduce risk and expedite healing Slough may appear yellow, cream, grey, green colour and can be loose or firmly adherent	<b>Infection</b> can delay the healing process and also causes an increase in exudate production Malodour, heat, redness and swelling are all signs that infection may be present Even where infection is not apparent, healing may be impeded by the presence of <b>biofilm</b> . Indications that a biofilm is present include slow-to-heal, a slimy shiny film, quick reformation of slough and an increase in exudate	Care should be taken to maintain a moist environment Allowing the wound bed to dry out may impede the healing process, whilst excess exudate can break down new tissue and macerate periwound skin Healthy granulation tissue is typically pink/red in colour and can be moist and granular in appearance	The wound management strategy should continue to protect the wound and delicate skin	The periwound skin may be dry and scaly which may affect the wound healing process  There may be skin conditions such as hyperkeratosis present in which case the skin scales will need to be removed as safely as possible
Action 1: Debride	Soften necrotic tissue using moisture-donating dressings such as hydrogels  <b>Debrisoft®/Debrisoft® Lolly</b> (mechanical debridement) to remove soft/loose necrosis	Removes moist/superficial slough using: <b>Debrisoft®</b> - for shallow wounds and accessible areas of skin <b>Debrisoft® Lolly</b> - for hard to reach areas such as cavities, between digits and skin folds	Follow local guidelines for managing wound infection Use <b>Debrisoft®/Debrisoft® Lolly</b> to remove slough and debris present Use <b>Debrisoft®/Debrisoft® Lolly</b> to frequently mechanically disrupt a biofilm and follow the Biofilm-based wound management pathway	<b>Debrisoft®/Debrisoft® Lolly</b> may be useful to remove any problematic loose skin If there is a high level of exudate, consider if a biofilm is present - if so, use <b>Debrisoft®/Debrisoft® Lolly</b> to frequently mechanically disrupt the biofilm and follow the Biofilm-based wound management pathway	If there is encrusted exudate or other local barriers to healing, consider removing with <b>Debrisoft®/Debrisoft® Lolly</b>	Use <b>Debrisoft®/Debrisoft® Lolly</b> to remove hyperkeratosis
Action 2: Dress	Reassess the wound following use of <b>Debrisoft®/Debrisoft® Lolly</b>  If there is remaining devitalised tissue, use moisture-donating dressings such as hydrogels - dress with: Sheet Hydrogel or Biocellulose Dressing  If no devitalised tissue remains, select a dressing from the following wound categories according to wound condition		Use a topical antimicrobial in conjunction with the <b>Debrisoft®/Debrisoft® Lolly</b> biofilm-based wound management pathway for 2 weeks and then review For low-moderate exudate: Topical Antimicrobial Biocellulose Dressing For moderate-high exudate: Topical Antimicrobial Alginate Dressing	Select a dressing aiming to achieve moisture balance For low levels of exudate use moisture donating dressings: Sheet Hydrogel or Biocellulose Dressing For high levels of exudate, select a dressing able to absorb and retain large amounts of fluid, for example a Superabsorbent Dressing or Alginate Dressing For superficial wounds: Superabsorbent Dressing	Protect delicate tissue whilst promoting a moist wound healing environment  For dry-low exudate: Gel Forming Contact Layer provides moisture to the wound  For low-moderate exudate: Non Adherent Absorbent Dressing provides light absorbency  To simply protect: Film Dressing	Use emollients as necessary Refer to: Management of Hyperkeratosis of the lower limb: Consensus recommendations. Wounds UK 2015



When treating a Venous Leg Ulcer, refer to the Activa L&R Venous Leg Ulcer treatment algorithm to ensure appropriate selection of compression therapy. This document is intended as a guide only. Clinical judgement should guide decisions on most appropriate treatment pathways following full holistic patient and wound assessment.

**Local Wound Infection**  
Decision making pathway for the use of antimicrobials





**Equality Analysis – Template**

**‘Helping you deliver person-centred care and fair employment’**

<p><b>1. Title of policy/ programme/ service being analysed</b> WOUNDCARE POLICY</p>	
<p><b>2. Please state the aims and objectives of this work and what steps have been taken ensure that the Trust has paid <u>due regard</u> to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics.</b></p> <p>These guidelines define and guide effective practice in the management of patients with wounds. This supports programmes of care which will optimise wound management for patients. The principle behind the wound management foundation is evidence-based practice, which is supported by research.</p>	
<p><b>3. Who is likely to be affected? e.g. staff, patients, service users</b> Clinical Staff and Patients.</p>	
<p><b>4. What evidence do you have of any potential adverse impact on groups with protected characteristics?</b> No adverse impact.</p> <p><b>Include any supporting evidence e.g. research, data or feedback from engagement activities</b></p>	
<p><b>4.1 Disability</b> <i>People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)</i></p>	<p><i>Consider building access, communication requirements, making reasonable adjustments for individuals etc</i></p> <p><i>No impact</i></p>
<p><b>4.2 Sex</b> <i>Men and Women</i></p>	<p><i>Consider gender preference in key worker, single sex accommodation etc</i></p> <p><i>No impact</i></p>
<p><b>4.3 Race</b> <i>People of different ethnic backgrounds, including Roma Gypsies and Travelers</i></p>	<p><i>Consider cultural traditions, food requirements, communication styles, language needs etc</i></p> <p><i>No impact</i></p>
<p><b>4.4 Age</b> <i>This applies to people over the age of 18 years. This can include safeguarding, consent and child welfare</i></p>	<p><i>Consider access to services or employment based on need/merit not age, effective communication strategies etc</i></p> <p><i>No impact</i></p>
<p><b>4.5 Trans</b> <i>People who have undergone gender reassignment (sex change) and those who identify as trans</i></p>	<p><i>Consider privacy of data, harassment, access to unisex toilets &amp; bathing areas etc</i></p> <p><i>No impact</i></p>
<p><b>4.6 Sexual orientation</b></p>	<p><i>Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc</i></p>

<i>This will include lesbian, gay and bi-sexual people as well as heterosexual people.</i>	<i>No impact</i>
<b>4.7 Religion or belief</b> <i>Includes religions, beliefs or no religion or belief</i>	<i>Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc</i> <i>No impact</i>
<b>4.8 Marriage and Civil Partnership</b> <i>Refers to legally recognised partnerships (employment policies only)</i>	<i>Consider whether civil partners are included in benefit and leave policies etc</i> <i>No impact</i>
<b>4.9 Pregnancy and maternity</b> <i>Refers to the pregnancy period and the first year after birth</i>	<i>Consider impact on working arrangements, part-time working, infant caring responsibilities etc</i> <i>No impact</i>
<b>4.10 Carers</b> <i>This relates to general caring responsibilities for someone of any age.</i>	<i>Consider impact on part-time working, shift-patterns, options for flexi working etc</i> <i>No impact</i>
<b>4.11 Other disadvantaged groups</b> <i>This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.</i>	<i>Consider ease of access, location of service, historic take-up of service etc</i> <i>No impact</i>
<p><b>5 Action planning for improvement</b></p> <p>5.1 Please outline what mitigating actions have been considered to eliminate any adverse impact? No adverse impact associated with this policy</p> <p>5.2 If no mitigating action can be taken, please give reasons.</p> <p>5.3 Please state if there are any opportunities to advance equality of opportunity?</p> <p>An Equality Action Plan template is appended to assist in meeting the requirements of the general duty</p>	

<b>Sign off</b>
Name of person who carried out this analysis: Kate Mellor
Date analysis completed: October 2018