

Wound Management Clinical Practice Guidelines

Tissue Viability Service

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1.0 Policy Summary

This document is been written by the Tissue Viability Service (TVS) and contains practical guidance for clinical staff on the assessment and management of patients with **chronic** wounds. It replaces previous local guidance published in 2019 and considers national and international recommendations, including the National Wound Care Strategy Recommendations (1,2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14,15,16,17,18,19, 20, 21, 22,23, 24, 25). The following document should be read in conjunction with national guidance and the other Clinical Practice Guidelines in the TVS Portfolio on pressure ulcer prevention and management and leg ulcer prevention and management.

2.0 Overriding Duty of Care Statement

Should the content or operation of this policy be challenged on any grounds whatsoever then the impact on the past, present or future duty of care to patients will be taken to be a primary factor in deciding the outcome of that challenge.

3.0 To whom this Guideline applies

This document is aimed at practitioners working in East London NHS Foundation Trust who are responsible for the assessment and management of patients with wounds. Nursing Home and General Practice staff may also use the document where appropriate.

4.0 Background

This document contains practical guidance on the **general principles** of chronic wound management, including wound assessment, dressings and device selection, measuring and evaluating wounds, identifying and treating infection and referral pathways and wound photography.

5.0 Aims & Objectives

1. To provide practical guidance for clinical staff on the principles of wound management.
2. To promote an evidence based, standardised approach to the care of patients with chronic wounds
3. To promote rational prescribing, by encouraging safe, effective, appropriate and economic use of dressings and other products and services.
4. To provide a framework to ensure that the quality of wound care can be monitored and improved in line with the national agenda for improving quality and patient experience.

6.0 Quality Assurance & Audit

This document should be used to support wound management decisions. It does not replace professional responsibility, clinical judgment or more recent national guidance.

The principles upon which this document is based are:

- An individualised holistic patient assessment should be undertaken, and evidence-based treatment plans commenced. These should consider the wound aetiology, patient's

circumstances & wishes, the overall goals of therapy, the practitioner's clinical experience, available resources and knowledge of more recent research findings.

- Those who undertake assessment, planning, implementation, and evaluations of care should be trained/educated/competent in wound management.
- The patient / carers should be informed and share in the decision-making process and consent to treatment.
- To ensure continuity, the care should be clearly documented in the patient's records and made accessible to the patient and all those involved in their care.
- A collaborative, multi-disciplinary, inter agency approach should be taken to address all the needs of the patient where appropriate.
- Patients, staff and carers should have access to the equipment and resources necessary to deliver quality care.
- Monitoring and development of quality initiatives should be undertaken regularly through a clinical audit process.

7.0 Dissemination

This document is available electronically to all staff on the trust Intranet site. Copies can be printed for use if required.

Courses related to wound management will be held as part of the in-house annual education and training programme to introduce the standards of care within these guidelines.

This document will be subject to review in November 2025 or before if significant additional national guidance or relevant research is published.

8.0 Definition of a Wound

A wound is a break in the skin, which may result from physical, mechanical or thermal damage, or develop as a result of the presence of an underlying medical or physiological disorder. For example:

Physical damage: pressure ulcers

Mechanical damage: abrasions, grazes, lacerations, knife wounds (surgery), or bullet wounds and bites etc.

Thermal damage: burns caused by flames, chemicals, radiation, friction or electricity and frostbite.

Medical or physiological disorder: arterial or venous ulcers, autoimmune, endocrine, dermatology and haematological disorders, wounds associated with certain systemic infections, malignant diseases, or neuropathy.

9.0 Wound Healing & Classification

Wound healing is a collective term for the physiological processes that repair and restore damaged skin tissue. Healing involves a complex series of molecular, cellular, and chemical changes that result in inflammation, proliferation, granulation, re-modeling, and re-epithelialisation. Wounding and healing involve a whole-body response and the individual should be assessed and treated as a whole not just the visible injury.

Acute wounds proceed through the healing process in a timely manner as they generally have no underlying aetiology to disrupt a normal inflammatory response. Acute wounds that do not heal within four-six weeks or develop complications that delay healing may then be described as chronic.

Chronic wounds are generally characterised by the presence of underlying pathology and are generally associated with a persistent state of inflammation, which prolongs or interrupts the healing process. These wounds heal by a process called **secondary intention** where granulation tissue is produced. For example: pressure ulcers, leg ulcers, dehisced surgical wounds.

Non-Healing wounds: For some patients healing is not achievable, for example, with some leg/foot ulcers or malignant fungating wounds. The primary goals of care should be to maximise patient comfort and control symptoms such as exudate, odour and pain (6). The decision that a wound is 'non-healing' should be made by the multi-disciplinary team that includes the tissue viability service.

10.0 Factors Affecting Wound Healing

An individual's ability to heal and the time required can vary greatly, and is influenced by the following factors, which should be taken into consideration during assessment:

- General physical and psychological health and type and level of concurrent illnesses
- treatment: systemically and locally
- Nutritional and hydration status
- Type of wound, location, depth and extent of damage and type of tissue in wound
- Wound temperature, moisture level and pH balance
- Levels of bacterial colonisation and infection
- Blood supply to the wound and surrounding area & oedema of surrounding tissues
- Disruption to normal sleep pattern
- History of smoking and alcohol consumption
- Medications such as steroids, immune-suppressants and chemotherapy.
- environment

11.0 Patient Assessment

Successful wound management depends on holistic patient assessment and should include **physiological, psychological, environment and social aspects**. Establishing wound aetiology depends on an understanding of the anatomy and physiology of the skin, pathology of the wound, intrinsic and extrinsic causative factors, the normal stages of wound healing and factors that may delay the healing process. When planning care, the clinician must take into account the patient's circumstances & wishes and the overall goals of treatment. Opportunities to involve the patient in their own care or supported self-care should be encouraged and explored.

The following information should be documented at the initial assessment:

11.1 Medical History

- Past & current medical condition and general health
- Drug history including current prescribed medications, alternative therapies and recreational drugs
- Smoking and alcohol history
- Allergies: including reactions to dressings, topical applications and natural rubber latex
- Nutrition and hydration level. Weight, height and Body Mass Index (BMI)
- Mobility
- Temperature, Pulse and Blood Pressure, blood sugar level, blood results, urinalysis
- Previous/planned investigations/procedures. For example: venous/arterial duplex, X-rays, surgery etc.

11.2 Nutritional Assessment

- All patients should have a nutritional screen, which proceeds to full assessment if deficit is suspected.
- Patients considered as 'malnourished', or 'at risk' of malnutrition should be managed according to local and national guidance.
- Nutritionally compromised patients who have wounds may have an increased dietary need and a referral to a Dietician should be considered for further assessment, advice, and supplementation.
- Patient's weight, height, and body mass index (BMI) should be recorded at initial assessment and then weekly for inpatients and monthly for patients in the community where facilities for weighing the patient are available.

11.3 Psychological & Social Assessment

The following aspects should be considered during the patient' assessment:

- Stress level, depression, ability to sleep and where the patient sleeps e.g. bed or chair.
- Ability to understand cause of wound and ability to participate in care
- Factors that may affect concordance with treatment. For example: dementia, lack of mental capacity, cognitive impairment, learning difficulties, and behavior and lifestyle choices.
- Drug / Alcohol dependency
- Occupation, family structure, carers and their ability to assist with care.
- Detail attitudes and any avoidance of social activities due to general condition and wound
- Consider referral to Community Psychological services if required

11.4 Learning Disability Assessment

- If the patient has a learning disability and help is required with assessment and management, consider a referral to the learning disability service and tissue viability team if required.

12.0 Wound Assessment

- The Triangle of Wound Assessment is a tool that can be used to assess patients and their wounds. It divides assessment of the wound into three areas: the wound bed, the wound edge and the periwound skin. It should be used in the context of a holistic assessment that involves the patient, caregivers and family (Dowsett et al 2015) –(See Appendix 1)

12.1 Documentation

Use the template for Wound Assessment on EMIS, Systemone or if on Rio use the wound assessment chart (Appendix 2) to document findings. The following information should be documented.

- Date and time of assessment
- Type of wound and underlying aetiology
- Factors that could delay healing
- Location of the wound on the body
- Duration of the wound
- Wound measurements
- Depth of damage
- Type and color of tissue in wound bed

- Presence of infection
- Exudate levels and type
- Presence of odour.
- Pain
- Wound margins
- Periwound skin
- Dressing selection and regime

The wound should be re-assessed at each dressing change and measured/photographed at 4 weekly intervals or before if there are signs of deterioration.

12.2 Wound Type & Aetiology

Wound type and cause should be identified e.g., venous leg ulcer caused by venous hypertension or pressure ulcer caused by pressure or pressure in combination with shear.

12.2.1 Leg Ulcers

- Please refer to the Leg Ulcer Assessment & Management – Clinical Practice Guideline for specific assessment and management :
http://elftintranet/Sites/Common/private/ajax_objectincontext.aspx?objectkind=2&objectid=28656&linktype=1&webboxid=undefined&ParentID=0

12.2.2 Pressure Ulcers

- Please refer to the Pressure Ulcer Prevention and Management – Clinical Practice Guideline for specific assessment and management :
http://elftintranet/sites/common/private/search_quick20.aspx?q=pressure%20ulcer

12.2.3 Burns and Scalds

A burn is an injury caused by exposure to thermal (heat), chemical, electrical or radiation energy.

A Scald is a burn caused by contact with a hot liquid or steam

Most Burns/ scalds first present in Primary care or Accident & Emergency (A&E) departments however, there may be occasions when a burn is referred to community services or presents in ELFT inpatient ward settings. **See appendix 3** for guidance on management and referral.

12.3 Wound Measurements

Accurate measurement is an important part of wound assessment and can assist with:

- Detailing progress or deterioration by comparing dimensions over time
- Communication between health professionals
- Encourage the patient that healing is progressing
- Evidence of skin condition when admitted to, or discharged from, caseload

12.3.1 Wound Depth Assessment

Describe wound depth in terms of the anatomy of the skin and related structures. Use millimetres (mm) or centimeters (cms) to measure undermined tissue with a sterile measure. The following terms may be useful:

Blister: filled with serum or blood

Abscess: filled with pus

Superficial or partial thickness skin loss: skin loss involving epidermis and/or dermis, with or without undermining of adjacent tissue.

Full thickness skin loss: Damage involving subcutaneous layers, which may expose fat, bone, tendon or joint capsule, with or without undermining of adjacent tissue.

Sinus: A blind ended tract

Wound Fistulae: An abnormal passage from an internal organ to the body surface

12.3.2 Wound Length & Width may be taken with a disposable measuring tape and recorded in cms (available from your usual ordering route). Measure the length of the wound along the vertical axis of the body (from head to foot), and the width along the horizontal axis of the body.

12.4 Wound Photographs are a useful visual record for wounds that are difficult to trace, large, deep or irregularly shaped. Patient consent should always be obtained prior to wound photography. Images should be stored according to recommended guidelines.

12.4.1 Criteria for Wound Photography - see Appendix 4 for guide

- Verbal consent for wound photography can be obtained for the purpose of wound evaluation, triage or to obtain virtual specialist advice from the tissue viability team
- Obtain written consent (see Appendix 4) from the patient if the photograph is for the purpose of teaching, product evaluations or publication.
- Where the patient lacks capacity to consent. Written consent must be obtained from the next of kin or those with Lasting Power of attorney
- Photograph the wound on initial assessment and repeat every four weeks or more frequently if the wound condition changes rapidly.
- Photographs for wound evaluation should be labeled with the patient's Initials, date of photograph and wound position.
- Include a ruled measure to give an indication of scale.
- Secure/upload in the patient's electronic records in chronological order.
- All photographs should be clear and in focus.
- Privacy and dignity should be protected and maintained at all times.
- If photographs are used for training purposes or publication confidentiality must be maintained and the wound measure should be labelled as patient 1, 2 etc and the date of the photograph.
- Wound images should be taken using a digital device Members of the tissue viability team will have access to a digital camera.
- Wound photographs should only be taken on Trust equipment e.g. iPads or Trust mobile phones. **Personal devices should not be used to take wound images.**
- The camera/mobile device should be cleaned after use with disinfectant wipes to prevent cross infection
- Images should be deleted from the mobile device as soon as possible once the images have been uploaded onto the patient electronic record

12.5. Type of Wound Tissue

Wound assessments should include a description of the type and amount of tissue present using the T.I.M.E framework for example: epithelialising, granulating, sloughy, necrotic, or non-healing. (See Appendix 6). Different stages of healing can exist at the same time and should be recorded as an estimated percentage of the whole wound e.g. granulation tissue 80% and sloughy tissue 20%. This allows comparison over time. Percentages are used as a guide only.

12.5.1 Necrotic tissue may appear **black**, hard, dry and leathery or grey in colour and usually indicates devitalised tissue. Assess the patient's circulation to the affected area before deciding on method of debridement. If digits or heels are necrotic do a Doppler assessment to determine Ankle Brachial, Pressure Index (ABPI) or refer for specialist

vascular assessment and keep these types of wounds **dry** until circulation is established.

12.5.2 Sloughy tissue is also devitalised but may appear **yellow** or waxy white in colour and may be wet or dry and is usually attached to the wound base. Sloughy tissue requires debridement.

12.5.3 Infected tissue or cellulitis may appear an angry red colour, which extends past the margins of the wound. If this is associated with clinical signs of infection then systemic antibiotics are indicated with local wound management to control odour, pain and exudates. See Appendix 7. Chronic wounds are often colonised with bacteria therefore diagnosis of infection is a clinical decision and should **not** be made solely on the basis of a microbiology swab result. Care should be taken with patients who have conditions such as diabetes or who are immune-suppressed as they may not show the signs of infection.

12.5.5 Granulating tissue appears **red** with small mounds caused by growth of capillary loops and requires protection.

12.5.6 Epithelialising tissue appears **white, pink or mauve** in colour. This tissue should be kept warm (body temperature) and moist to facilitate epithelial growth. Wound colour is related to tissue type and can enhance description of wound status.

13.0 Wound Management

Effective wound management is based on identifying and treating the underlying cause, addressing patient concerns and Wound Bed Preparation (WBP). The principles of WBP are wound debridement, infection prevention and control and effective exudate management.

13.1 Debridement

Debridement is the removal of necrotic, devitalised, sloughy or infected tissue, or foreign bodies from a wound. The body can debride itself by a natural process called autolysis; however, this may take time if large amounts of slough are present. Slough can provide an environment for bacteria to thrive, increasing the risk of infection. Debridement is recommended as a principle of wound management (6)

There are different methods of debridement.

- **Autolytic debridement:** where the body gradually sheds itself of devitalised tissue. This process can be augmented using dressings such as hydrogels, hydrocolloids or capillary action dressings, alginates, foams, antiseptic dressings.
- **Monofilament Debridement:** Debrisoft monofilament debridement pad is a single use pad used to remove devitalised tissue, debris, and hyperkeratotic skin around acute or chronic wounds. (21)
- **Bio-surgery:** sterile larvae (maggots)
- **Sharp debridement:** using a sterile blade, scalpel, or scissors. **This should only be undertaken by a healthcare professional with specific training and competence.**
- **Surgical debridement:** used when there is an urgent clinical need to remove or drain devitalised tissue and when fast debridement would speed patient recovery. If this is required, the patient should be referred to a surgeon.

When deciding whether to debride a wound or which method to choose, the clinician should consider the following: the condition of the patient and wound, condition of

surrounding skin, the quality and strength of the underlying blood supply, risk of adverse incidents, patient preference, pain level, equipment and dressings availability and characteristics and the overall goals of treatment.

14.0 Peri-wound Skin (i.e.the skin within 4cm of the wound edge as well as any skin under the dressing)

Problems with the Periwound skin are common and may delay healing, cause pain and discomfort, enlarge the wound and adversely affect a patient's quality of life. The amount of exudate present is a key factor for increasing the risk of Periwound skin damage. Greater moisture exposure reduces skin barrier function and increases the risk of skin breakdown and maceration. This may make patients more susceptible to developing contact dermatitis. Erythema and swelling may also indicate infection. In addition to the Periwound skin, patients with wounds should also be assessed for any problems that may be affecting their skin more widely.

The Periwound skin should be assessed for the following signs and recorded on the wound assessment chart.

- Maceration
- Excoriation
- Dry Skin
- Hyperkeratosis
- Callus
- Eczema

15.0 Wound Exudate

Exudate is a fluid produced from most wounds. It can vary in volume, consistency and biochemical composition and may be either beneficial or harmful to underlying tissues and surrounding skin. Some studies indicate that exudate is beneficial to healing acute or superficial wounds while others have found that chronic wound exudate contains enzymes that disrupt healing by degrading the extra-cellular matrix and excoriate surrounding skin. Quantifying the volume of wound exudate can be difficult. The following terms can be used to describe and evaluate the dressing: exudate interaction

Status	Indicator
Dry	Wound bed is dry; there is no visible moisture and the primary dressing is unmarked; dressing may be adherent to wound. NB This may be the environment of choice for ischaemic wounds
Moist/Low exudate	Small amounts of fluid are visible when the dressing is removed; the primary dressing may be lightly marked; dressing change frequency is appropriate for dressing type. NB In many cases, this is the aim of exudate management
Wet/Medium	Small amounts of fluid are visible when the dressing is removed; the primary dressing is extensively marked, but strikethrough is not occurring; dressing change frequency is appropriate for dressing type
Saturated/High	Primary dressing is wet and strikethrough is occurring; dressing change is required more frequently than usual for the dressing type; surrounding skin may be macerated
Leaking	Dressings are saturated and exudate is escaping from primary and secondary dressings onto clothes or beyond; dressing change is required much more frequently than usual for dressing type

Chronic wound management techniques and dressings are based on the principle of moisture balance. In general, this means that:

- Drier wounds, (except those with poor circulation), should be moistened with dressings that hydrate tissue, e.g., hydrogels, hydrocolloid sheets and pastes.
- Wounds with excess exudate require dressings that absorb or control fluid, e.g. alginates, hydrofibres, capillary action, foams, Negative Pressure Wound Therapy (NPWT) and compression bandages, wraps and hosiery.
- Surrounding intact skin should be protected from exudate with barrier films, creams and absorbent dressings as it can cause excoriation.

Type of exudate can be described as serous (thin/watery), or haemoserous (pink/red). If exudate is thick, cloudy, or purulent (yellow/brown/green) it can indicate infection.

16.0 Therapeutic Wound Cleansing

The rationale to cleanse wounds should include - Removal of debris, (e.g. foreign bodies, dressing residue and devitalised tissue), exudate from the surrounding skin and to refresh the patient. Routine cleansing of clean granulating wounds with the aim of bacterial removal has been proven ineffective. A guide to wound cleansing can be found in Appendix 8.

When cleansing and dressing wounds the practitioner should:

- Be familiar with the contents of the local Infection Control Policy
- Assess the risk of infection and cross infection and plan care accordingly
- Maintain hand hygiene and use Universal precautions
- Use non-woven sterile swabs as they shed fewer fibers than cotton wool
- Use an aseptic non touch technique (ANTT) (gloved fingers should not touch the wound surface)
- Use dated sterile equipment appropriately. For example: forceps, scissors, dressings and do not reuse single use items
- All equipment should be stored and used according to manufacturer's instructions.
- All products used to dress the wound such as forceps, scissors, dressings and gauze etc. should be from sterile packs.
- Left over dressings should not be kept for use at the next dressing change or used for other patients.

16.1 Normal Saline (0.9% sodium chloride)

- Avoid using pressurised canisters as splash back may occur.
- Sterile normal saline should be used if the local tap water is not fit for drinking.

16.2 Tap Water

- Chronic wounds may be cleansed with tap water, or water which is suitable for drinking, showering, or bathing is appropriate.
- Use minimal mechanical force when cleansing or irrigating the wound.
- Irrigation can be useful for cleaning a cavity ulcer
- Appliances used (e.g., bath, shower, etc.) should be cleaned before and after use with a multi-purpose detergent and dried, then wiped with an antiseptic.

16.3 Universal Cleansing System (UCS)

The use of buckets for cleansing of leg ulcers is now discouraged and has been replaced with a UCS Pad, which is available on FP10 prescription or via your usual ordering route. If for any reason a bucket is used it should be lined with a new clinical waste bag.

16.4 Prontosan

- This is a wound irrigation solution and gel that contains betaine and polyhexanide, antimicrobial agents that can reduce bioburden in the wound bed. Suitable for use in a wide variety of wounds such as leg ulcers, pressure ulcer etc. The solution is used to cleanse the wound and the dressing and gel can be used in low to moderately exuding wounds.

16.5 Topical Antimicrobial / Antiseptic Cleansing Agents

- Antiseptic solutions (e.g. hypochlorites, EUSOL, chlorhexidine and betadine iodine) **should not be used** for routine wound cleansing as they cause pain and reduce the proliferation of macrophages and lymphocytes, which are essential to the wound healing process.

17.0 Wound Infection

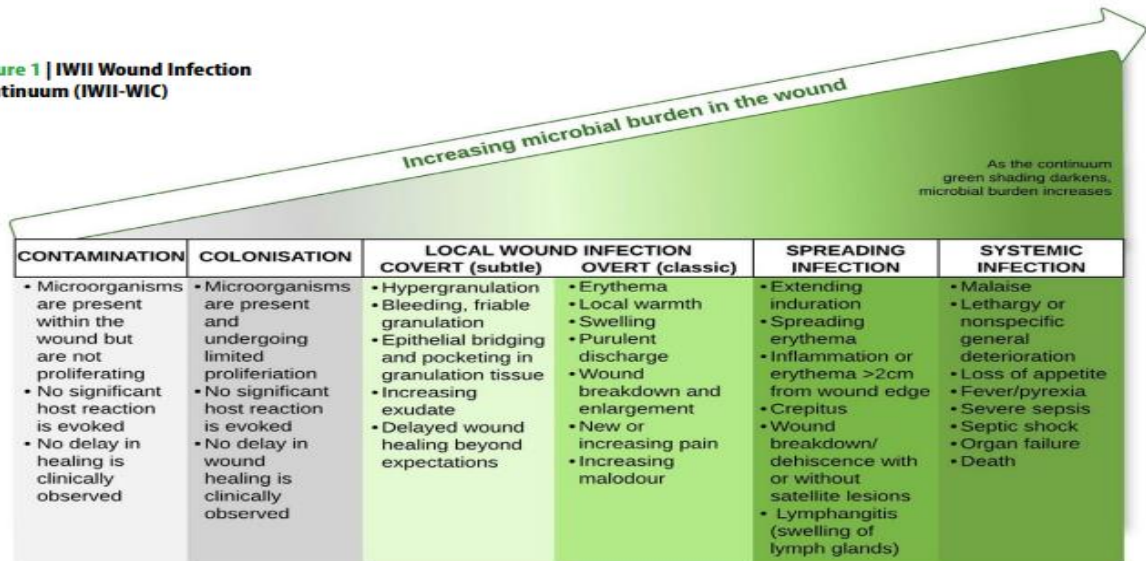
A holistic and collaborative approach is fundamental to the delivery of best practice in prevention, diagnosis, assessment, and management of wound infection. This is of particular importance in the context of increasing antibiotic resistance and the significance of ensuring antimicrobial stewardship. All chronic wounds contain bacteria, but not all are clinically infected or should be swabbed for MC&S. Infection is the result of a complex interaction between the host, organism, wound environment, and therapeutic interventions, which is complicated by bacterial virulence. Identifying wound infection should be viewed as a clinical skill which can be supported by laboratory findings when necessary.

It is now understood that microbial burden evolves on a continuum. The five conceptual stages:

- Contamination
- Colonisation
- Local infection (covert and overt stages)
- Spreading infection
- Systemic infection

Common signs and symptoms associated with each stage is outlined in the infection continuum Figure 1. from the International Wound Infection (2022)²⁴

Figure 1 | IWII Wound Infection Continuum (IWII-WIC)



Clinical diagnosis of wound infection should be based on signs and symptoms and can be confirmed with hematological, radiological, and microbiological investigations. The purpose of undertaking diagnostic investigations is to: identify systemic effects of infection, assess for the presence of osteomyelitis, or deeper collections, identify any potential complications, identify the causative organism(s), select antibiotic therapy, or ensure empirical antibiotic therapy is appropriate to the resistant microorganism(s) and to guide management approaches.

Patients with wounds that show spreading cellulitis and/or systemic infection should have a tissue sample taken to identify the offending organism and to assess for differential diagnosis. The patient should be treated with broad spectrum antibiotics which in some cases may need to be given intravenously. Check wound swab results to ensure the patient is on the antibiotics appropriate for treatment. Topical antiseptic/antimicrobial dressings should also be used to help reduce the wound bioburden (See section 18.1.10 for advice on the use of topical antimicrobial / antiseptic agents in wound management).

17.1 How to Take a Wound Swab/tissue sample

Before taking a wound swab, gently cleanse wound with water, either by irrigating or using sterile gauze. Do not use an antimicrobial cleansing solution as this may result in a false negative result. If wound surface is dry, slightly moisten the swab with sterile water. Use a zig-zag motion to draw the swab across the wound surface, while rotating the swab gently between fingers.

Fill in form with sufficient information for lab staff and Microbiologist to know from where and why the sample was taken.

17.2 Infection Management

A comprehensive wound infection prevention and management plan should arise from assessment outcomes and seek to achieve the person's goals of care. Holistic management addresses:

- Optimising the individual host response
- Reducing local microbial burden
- Promoting a positive environment for wound healing

The infection management pathway ²⁵ (Appendix 7) has been developed to support the assessment of patients with wound infection and selection of the correct treatment to promote wound healing.

18.0 Wound Dressing Selection

There are many dressings available on the market with different properties and modes of action. There is a paucity of evidence to support the choice of one particular dressing in preference to another for specific wound types, which makes evidence-based dressing selection difficult. A range of dressing types may be required to meet the needs of the wound and the patient at different stages of healing. Therefore, selection should be made on an individual basis after thorough assessment and discussion with the patient. Please use the Wound Management Formulary relevant to your area (Newham, Tower Hamlets, Bedfordshire) when selecting dressings. The Newham and Beds Formulary can be downloaded from the trust intranet and from CLICK in Tower hamlets

http://elftintranet/sites/common/private/search_quick20.aspx?q=wound%20dressing

The TIME framework and Triangle of wound Assessment should be used as an aid to wound dressing

The following characteristics should be considered when choosing a dressing:

- Have the ability to prevent penetration of capillary loops into the dressing material
- Be hypoallergenic, sterile and have a long shelf life
- Be cost effective and have an evidence base
- Maintain high humidity and optimum pH at the wound / dressing interface
- Remove excess exudate, toxic components & not release toxic chemicals, particles, or fibers
- Allow gaseous exchange
- Provide thermal insulation
- Be impermeable to bacteria
- Be free from particulate and toxic contaminants
- Allow removal without causing additional trauma & be comfortable to wear
- Ensure the wound remains moist with exudate but not macerated (except wounds with no underlying circulation, which should be kept dry).

18.1.1 Dressing Types & Classification

Most dressings have been classified according to their properties and mode of action. The following classification terms are generic, and some products are listed as examples. This is not a full list, and it is not an endorsement or recommendation of these products by the TVS. The practitioner should read the product literature when choosing and using any dressing as they may differ, even within the same category.

18.1.2 Hydrocolloids are occlusive dressings and contain a matrix of gelatin, pectin and carboxymethylcellulose (CMC) with elastomeric and adhesive substances attached to a polymer foam and film base. On contact with wound exudate the hydrocolloid matrix liquefies to form a moist gel, which softens devitalised and sloughy tissue, maintains moisture and promotes granulation. This dressing is not suitable for heavily exuding wounds. If over granulation occurs change to a semi-occlusive or foam dressing. Examples: DuoDERM® Extra Thin (ConvaTec). Comfeel®, (Coloplast)

NB: Aquacel Extra® (ConvaTec) is also a hydrocolloid but is classified as a Hydrofibre™ and a Matrix Modulating dressing, by the manufacturers because it is made differently to form a fibrous material that has an exudate handling capacity similar to Alginates.

18.1.3 Alginates are made from alginic acid, which is found in certain species of brown seaweed and are designed to absorb exudate, form a gel and maintain moisture at the wound surface. Alginates are not suitable for wounds with little or no exudate. Alginates should not be moistened prior to application as this reduces their ability to absorb exudate. Cavity wounds should only be packed lightly to prevent forming a plug and blocking drainage. Alginates are manufactured in the form of flat sheets, ropes and ribbons. Example Kaltostat® (Convatec).

18.1.4 Foams are made from polyurethane foam and are designed to absorb exudate. They are available in various thicknesses and shapes and are suitable for moderate to heavily exuding wounds. They are available with and without adhesive borders and can be used as primary or secondary dressings.

Examples: Allevyn® (Smith & Nephew) Biatain® (Coloplast)

18.1.5 Semi-permeable Adhesive Films are thin transparent sheets of polyurethane, coated with a film of acrylic adhesive. They are permeable to moisture vapour and allow some gaseous exchange but are impermeable to liquids and bacteria and as a result are termed 'semi-permeable'. They are useful for maintaining a moist warm environment on superficial wounds, such as cuts, burns or grazes or as retention aids around the margins of un-bordered hydrocolloids or non-adhesive foams. Practitioners should read each product information sheet for removal instructions as these can vary.

Examples: Tegaderm® (3m Healthcare)

18.1.6 Hydrogels are mostly made up of carboxymethylcellulose or starch polymer and are 80-90% water. They are available in the form of sheets or amorphous gels and are used to re-hydrating dry necrotic or sloughy tissue. Hydrogels should not be used on moderate to highly exuding wounds as this may contribute to maceration and excoriation of surrounding skin. Most hydrogels also contain humectants and preservatives such as propylene glycol, which may kill or reduce the effectiveness of maggots if not cleaned away prior their use. Some gels have been impregnated with iodine and are available in paste or ointment format.

Examples: Intrasite® (Smith & Nephew) Nu-gel® (Systagenix).

18.1.7 Low Adherent Dressings and Wound Contact Materials are used as non adherent dressings and require secondary dressings to keep them in place and absorb any exudate. Some types are impregnated with paraffin or silicone Examples: Atrauman® (Hartman),

18.1.8 Odour Absorbent and Deodorising Dressings are low adherent dressings that have been impregnated with activated charcoal or silver. These products may reduce the odour but they tend not to remove devitalised tissue, which can harbour bacteria causing the odour. Examples: Carboflex® (Convatec).

18.1.9 Capillary Action Dressings are; multi-layer dressings made from polyester and cotton and are designed to rapidly absorb exudate and interstitial fluids. They have a central wicking layer that quickly distributes absorbed fluid throughout the dressing and create a sustained movement of fluid away from the wound bed. Example: Advadraw® (Advancis Medical)

18.1.10 Topical Antimicrobial / Antiseptic Dressings

This term means substances capable of broad-spectrum bactericidal activity. This includes Gram-positive and Gram-negative, aerobic, and anaerobic bacteria that are commonly found in wounds and can cause infection in wounds healing by secondary intention. Examples include - Silver, Iodine, Honey and PHMB impregnated dressings.

Once thorough assessment of the wound has been carried out and the wound is considered to be either colonised, locally infected or has spreading infection, appropriate topical antiseptic/antimicrobial treatment may be started. These dressings should only be used for a maximum of 2 weeks, thereafter the patient and the wound should be reviewed and evaluated. If signs of infection persist or the wound is not progressing to healing then please refer to tissue viability using the recommended referral form for your area (Appendix 9). Please refer to the Wound Dressings Formulary for details of products agreed for use within the Trust.

18.1.11 Liquid barrier film/cream

Excoriation of the surrounding skin can be caused by frequent removal of adhesive dressings or contact with wound exudate, urine or faeces. This may be reduced by using a liquid film barrier or barrier cream. Choose a liquid film that does not contain alcohol to prevent staining on application. Example Cavilon® (3M Health Care) No sting barrier film or cream,

18.2 Negative Pressure Wound Therapy (NPWT)

Negative Pressure Wound Therapy (NPWT) is based on the principle that negative pressure, measured in mmHg, applied in a uniform manner to a wound surface will facilitate;

- increased local blood flow and stimulate growth of granulation tissue
- reduced interstitial oedema
- stimulated cell proliferation
- removal of cytokines and matrix metalloproteinase, which inhibit healing
- reduced bacterial load

NPWT therapy is available as a foam or gauze dressing attached via a port and tube to the Renasys Touch/Go machine (Newham & TH) or the VAC (Beds) or PICO a simple conformable innovative dressing with port attached to a small single use pump. These treatments may be used on patients under certain conditions. Please follow the recommended guidelines for ordering the Renasys Go in Newham community (Appendix 10) and the manufacturer's instructions for use. PICO and the Renasys dressings can be prescribed on FP10 prescription.

When using single use negative pressure wound therapy (NPWT) e.g. PICO and PICO 14 please follow the recommended pathway outlined in (Appendix 10). Monitor the impact of the treatment on the wound to determine if the wound is responding and if the wound is not reducing in size or improving treatment should be discontinued and the patient referred to specialist services.

18.2.1 Contraindications and Cautions to NPWT

Contraindications	Caution
Osteomyelitis: NPWT is contraindicated in untreated osteomyelitis	Weakened blood vessels: patients who have weakened blood vessels, friable vessels and infected vessels (direct negative pressure may cause trauma or bleeding)
Malignancy: NPWT is not recommended in malignant wounds because it may stimulate proliferation of malignant cells	Exposed delicate structures: patients with exposed blood vessels, delicate fascia, exposed tendons or ligaments (direct negative pressure may cause trauma and bleeding)
Non-enteric and unexplored fistulae: There may be communication with underlying vulnerable organs	Bleeding: wounds that are actively bleeding or where the patient is at high risk of bleeding or hemorrhage, receiving anticoagulant therapy and or platelet aggregation inhibitors (negative pressure could encourage bleeding as local perfusion will be increased and therefore blood loss will be greater)
Exposed vasculature, nerves, anastomotic sites or organs: if directly applied to exposed structures, NPWT can cause damage or rupture vessels due to the force of negative pressure	Fistulae: Wounds with enteric fistulae (these require special precautions to optimize therapy) Refer to Tissue Viability Specialist for these patients
Necrotic tissue with eschar present or thick slough in the wound bed: appropriate debridement should be performed before application of NPWT. This therapy is not designed to debride and quicker results will be obtained if the wound is debrided prior to the application of NPWT	Patients requiring certain treatments: special consideration and caution should be taken where patients require Magnetic resonance imaging (MRI), hyperbaric oxygen treatment, defibrillation, etc

18.3 Larvae (Maggots)

Sterile larval (Maggots) are one method of debriding sloughy or necrotic wounds. Maggots secrete a powerful mixture of proteolytic enzymes that breakdown slough and necrotic tissue into a semi-liquid form that can then be ingested. Through ingestion, maggots have also been shown to take up and destroy bacteria. As maggots are living creatures, they must be stored, handled and disposed of appropriately. The suppliers suggest that maggots be delivered directly to the pharmacy or health centre on the day of application. Larval therapy can be prescribed on FP10 but is not on the Nurses Formulary. A prescription will need to be obtained from the GP or Independent

prescriber. Although the cost of each separate shipment of larvae is relatively high, it may be a more cost-effective way of debriding some wounds because it is faster.

18.3.1 Indications for use

- when a wound contains sloughy or necrotic tissue that needs to be debrided quickly
- Other methods of debridement are considered not to be appropriate.
- Patients (and family) are fully informed and have consented.
- Staff trained and competent in wound assessment, use and disposal of larval therapy.

18.3.2 Contra-indications

- Wounds that tend to bleed easily
- Wounds or fistulae that communicate with the brain, body cavity or any internal organ.
- Wounds that are near large blood vessels

For further information, training and support please contact the Tissue Viability Service.

19.0 Multiagency Involvement

- Consider appropriate referrals to the wider Multiagency teams for those patients with wounds and who have complex physical or mental health needs.
- The tissue viability team will follow up referred patients at 4-6 weekly intervals or sooner if required.
- The tissue viability service will attend all relevant multiagency meetings as required

20.0 Education & Training

Health care professionals involved in the care of patients with chronic wounds should be knowledgeable and skilled in the following areas.

- Pathophysiology of chronic wounds including Pressure ulceration, leg ulceration etc.
- Wound assessment & differential diagnosis skills
- Use of Doppler ultrasound to measure ABPI
- Normal and abnormal wound healing
- Compression therapy – theory, management and application
- Dressing selection
- Skin care and management
- Health education
- Prevention of recurrence
- Criteria for referral for specialist assessment

It is important that all clinicians involved in the care of patients with chronic wounds maintain their clinical knowledge. This can be achieved through reading relevant literature, attending study days, courses, and conferences. Please contact the Tissue Viability team for details of training available. The Tissue Viability Service is happy to provide tailor made sessions for individual teams to meet their needs.

20.1 Patient information and education

A number of patient information leaflets can be found on the intranet on leg ulcer prevention and management and pressure ulcer prevention and management, which can be printed and given to patients and carers. The leaflets are available to download from: http://elftintranet/sites/common/private/search_quick21.aspx?q=wound%20information%20leaflet&orderby=0

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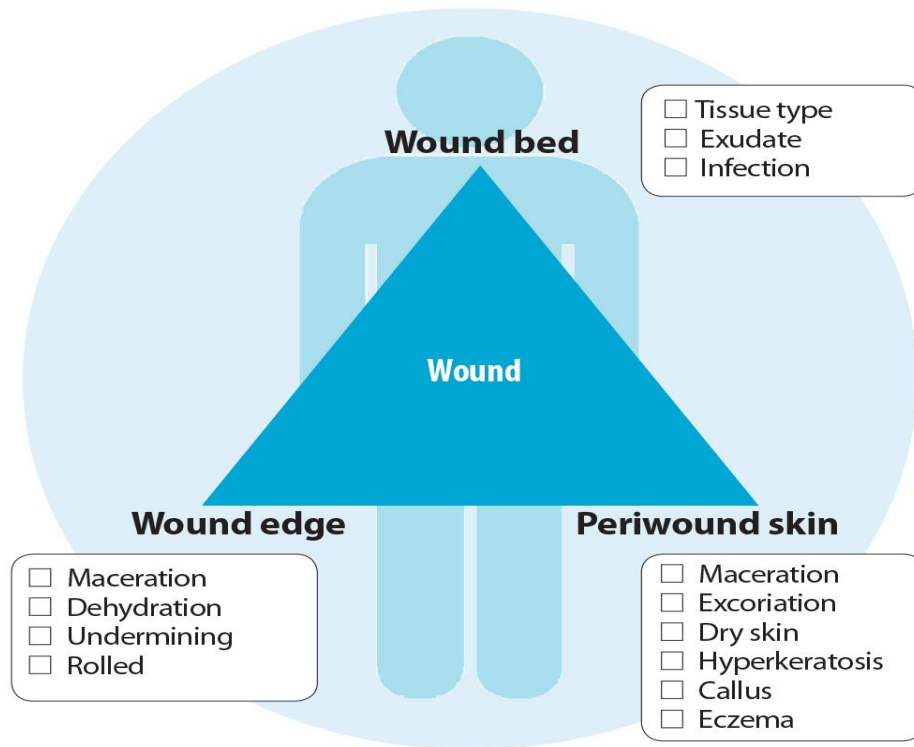
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APPENDIX 1

Triangle of Wound Assessment

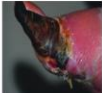

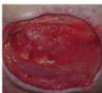



Dowsett, Protz, Drouard, France, Harding (2015) Triangle of wound assessment. Made Easy
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The Triangle of Wound assessment is supported by an Educational grant from Coloplast www.woundsinternational.com

The Triangle of Wound Assessment – Wound Bed

Wound bed: look for signs of granulation tissue, while seeking to remove dead or devitalised tissue, manage exudate level and reduce the bioburden in the wound.

Record wound size: length __ cm width __ cm depth __ cm
Record wound location

Tissue type	Exudate	Infection																
<p>Please tick</p> <p>Necrotic  <input type="checkbox"/> __%</p> <p>Sloughy  <input type="checkbox"/> __%</p> <p>Granulating  <input type="checkbox"/> __%</p> <p>Epithelialising  <input type="checkbox"/> __%</p>	<p>Please tick all <input type="checkbox"/> that apply</p> <table border="1"> <thead> <tr> <th>Level</th> <th>Type</th> </tr> </thead> <tbody> <tr> <td>Dry <input type="checkbox"/></td> <td>Thin/watery <input type="checkbox"/></td> </tr> <tr> <td>Low <input type="checkbox"/></td> <td>Thick <input type="checkbox"/></td> </tr> <tr> <td>Medium <input type="checkbox"/></td> <td>Cloudy <input type="checkbox"/></td> </tr> <tr> <td>High <input type="checkbox"/></td> <td>Purulent (yellow/brown/green) <input type="checkbox"/></td> </tr> <tr> <td></td> <td>Pink/red <input type="checkbox"/></td> </tr> </tbody> </table>	Level	Type	Dry <input type="checkbox"/>	Thin/watery <input type="checkbox"/>	Low <input type="checkbox"/>	Thick <input type="checkbox"/>	Medium <input type="checkbox"/>	Cloudy <input type="checkbox"/>	High <input type="checkbox"/>	Purulent (yellow/brown/green) <input type="checkbox"/>		Pink/red <input type="checkbox"/>	<p>Please tick all <input type="checkbox"/> that apply</p> <table border="1"> <thead> <tr> <th>Local</th> <th>Spreading/systemic</th> </tr> </thead> <tbody> <tr> <td> <input type="checkbox"/> ↑ Pain or new onset <input type="checkbox"/> Erythema <input type="checkbox"/> Oedema <input type="checkbox"/> Local warmth <input type="checkbox"/> ↑ Exudate <input type="checkbox"/> Delayed healing <input type="checkbox"/> Bleeding/friable granulation tissue <input type="checkbox"/> Malodour <input type="checkbox"/> Pocketing </td> <td> As for local, plus: <input type="checkbox"/> ↑ Erythema <input type="checkbox"/> Pyrexia <input type="checkbox"/> Abscess/pus <input type="checkbox"/> Wound breakdown <input type="checkbox"/> Cellulitis <input type="checkbox"/> General malaise <input type="checkbox"/> Raised WBC count <input type="checkbox"/> Lymphangitis </td> </tr> </tbody> </table>	Local	Spreading/systemic	<input type="checkbox"/> ↑ Pain or new onset <input type="checkbox"/> Erythema <input type="checkbox"/> Oedema <input type="checkbox"/> Local warmth <input type="checkbox"/> ↑ Exudate <input type="checkbox"/> Delayed healing <input type="checkbox"/> Bleeding/friable granulation tissue <input type="checkbox"/> Malodour <input type="checkbox"/> Pocketing	As for local, plus: <input type="checkbox"/> ↑ Erythema <input type="checkbox"/> Pyrexia <input type="checkbox"/> Abscess/pus <input type="checkbox"/> Wound breakdown <input type="checkbox"/> Cellulitis <input type="checkbox"/> General malaise <input type="checkbox"/> Raised WBC count <input type="checkbox"/> Lymphangitis
Level	Type																	
Dry <input type="checkbox"/>	Thin/watery <input type="checkbox"/>																	
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<p>Record tissue types and % of tissue visible in the wound bed</p>	<p>Record level and type (e.g. consistency and colour)</p>	<p>Record signs and symptoms. These may be aetiology-specific</p>																
<p>Aim to remove non-viable tissue (e.g. reduce infection risk) Protect and promote new tissue growth</p>	<p>Aim to treat cause (e.g. compression therapy) and manage moisture balance (exception: dry gangrene)</p>	<p>Aim to identify infection Manage bioburden to treat infection/control odour</p>																

The Triangle of Wound Assessment – Wound Edge

Wound Edge: Lower barriers to wound healing by reducing undermining for dead space, debriding thickened or rolled edges, and improving exudate management to minimise risk of maceration.

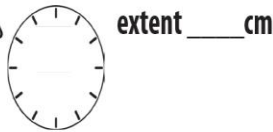
Maceration

Dehydration

Undermining

Rolled edges

Please tick all that apply



Assess edge of the wound for moisture level

Assess edge of the wound for moisture level

Use clock positions to record position
Record extent of undermining

Assess amount of rolling (may be associated with thickening)

Aim to establish cause and correct
Address patient concerns
Refer to specialist

Aim to establish cause and correct (e.g. rehydrate)
Refer to specialist

Aim to reduce the amount of undermining/allow the edge to reattach (e.g. stimulate granulation)

Aim to return the wound edge to a condition that will permit epithelial advancement

The Triangle of Wound Assessment

Periwound Skin

Periwound Skin: Rehydrate dry skin and avoid exposure to exudate/moisture to minimise the potential for damage

Maceration

Excoriation

Dry skin

Hyperkeratosis

Callus

Eczema

Please tick all that apply



__-__cm



__-__cm



__-__cm



__-__cm



__-__cm



__-__cm

Assess periwound skin and record extent of any problems, e.g. <1-4cm of the wound edge

Aim to protect periwound area and maintain intact healthy skin
Establish cause and correct, e.g. minimise contact with moisture or rehydrate periwound skin

Aim to remove hyperkeratotic skin plaques and rehydrate

Aim to remove callus and offload to prevent recurrence

Aim to relieve symptoms and avoid allergens

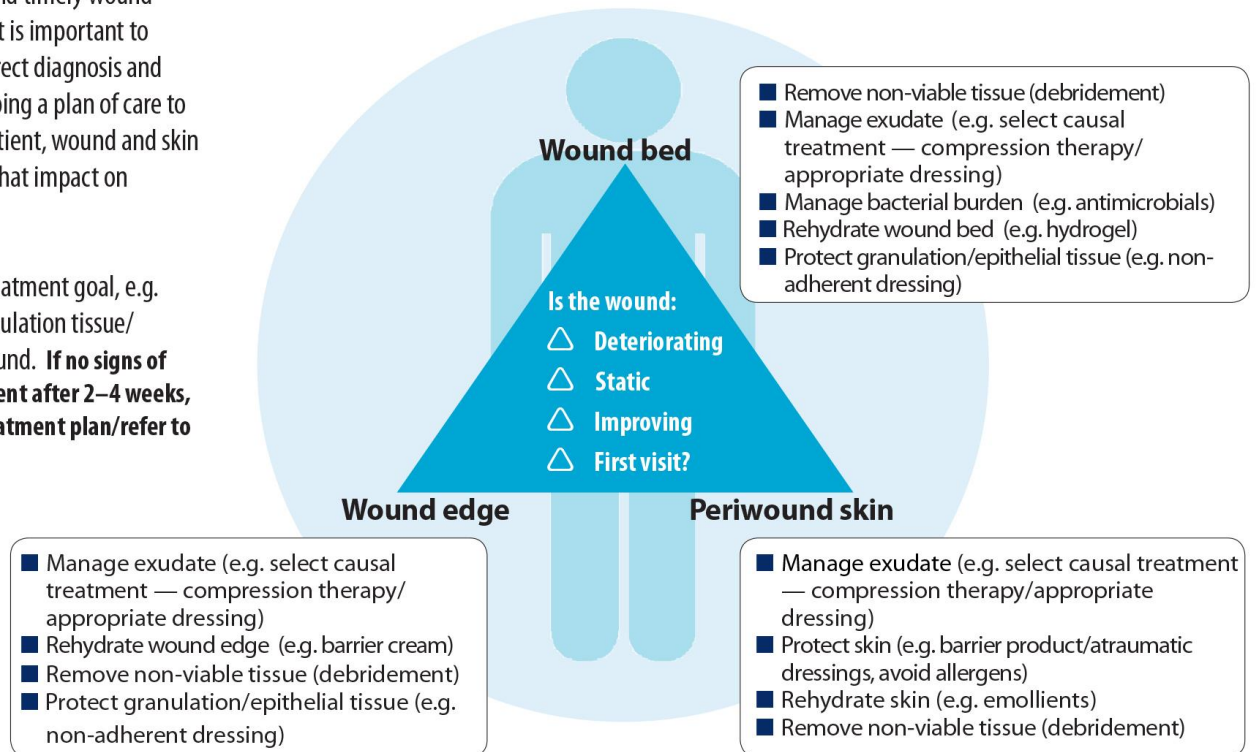
The Triangle of Wound Assessment

Devising A management plan

Treatment choices should aim to correct the underlying cause e.g. compression therapy to address underlying venous disease and offloading/pressure relief for the management of diabetic foot ulcers and pressure ulcers. In addition the aim should be to manage the local wound environment to promote wound healing by removing non-viable tissue, controlling exudate, preventing and managing infection

Accurate and timely wound assessment is important to ensure correct diagnosis and for developing a plan of care to address patient, wound and skin problems that impact on healing.

Identify treatment goal, e.g. 100% granulation tissue/ healed wound. **If no signs of improvement after 2–4 weeks, review treatment plan/refer to specialist**



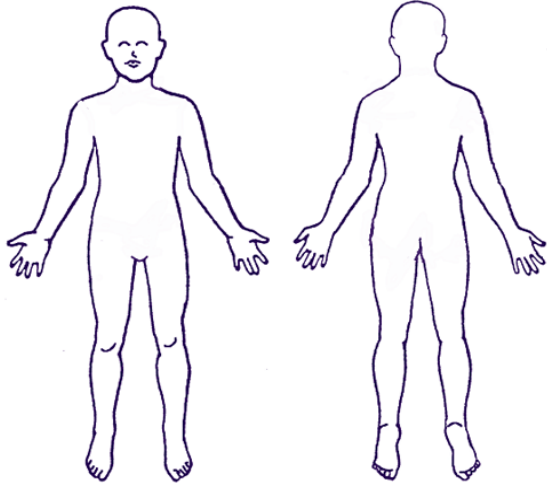
APPENDIX 2





Wound Assessment Chart

(If not on electronic patient record)

WOUND ASSESSMENT & EVALUATION FORM. To be completed on initial assessment
(One to be completed for each wound)

Patient Name:	Date of Birth:	NHS Number:
Assessment Date:	Waterlow Score:	
Current Medication:		
Medical History:		
Factors that can delay wound healing:		Allergies:

<p>Wound Location:</p> 	<p>Wound Type:</p> <p><input type="checkbox"/> Pressure Ulcer</p> <p><input type="checkbox"/> Grade.....</p> <p><input type="checkbox"/> Moisture Lesion</p> <p><input type="checkbox"/> Leg Ulcer</p> <p><input type="checkbox"/> Trauma</p> <p><input type="checkbox"/> Skin Tear</p> <p><input type="checkbox"/> Surgical Wound</p> <p><input type="checkbox"/> Dehisced Wound</p> <p><input type="checkbox"/> Burn/Scald</p> <p><input type="checkbox"/> Fungating Lesion</p> <p><input type="checkbox"/> Pilonidal Sinus</p> <p><input type="checkbox"/> Abscess</p> <p><input type="checkbox"/> Diabetic Ulcer</p> <p><input type="checkbox"/></p> <p>Other.....</p>
--	--

Wound size			Tissue Type
Length (cm)	Width(cm)	Depth(cm)	Necrotic  %
Exudate:	Type	Signs of Infection Yes/No	Sloughy  %
Level		Tick all that apply	Granulating  %
<input type="checkbox"/> Dry	<input type="checkbox"/> watery	<input type="checkbox"/> Cellulitis	Epithelialising  %
<input type="checkbox"/> Moist	<input type="checkbox"/> Thick	<input type="checkbox"/> Abscess/Pus	
<input type="checkbox"/> Wet	<input type="checkbox"/> Cloudy	<input type="checkbox"/> Increased Pain	
<input type="checkbox"/> Saturated	<input type="checkbox"/> Purulent	<input type="checkbox"/> Increased Exudate	
<input type="checkbox"/> Leaking	<input type="checkbox"/> Red	<input type="checkbox"/> Malodour	
		<input type="checkbox"/> Delayed healing/deterioration	
		<input type="checkbox"/> Friable Granulation tissue	
		<input type="checkbox"/> Pocketing at wound base	
Wound Pain (insert pain score 0 = no pain, 10 excruciating unbearable pain)		Pain Frequency	
0-----5-----		<input type="checkbox"/> Continuous	
10		<input type="checkbox"/> Intermittent	
		<input type="checkbox"/> Dressing change	
		<input type="checkbox"/> Post Dressing	

Periwound Skin

<input type="checkbox"/> Maceration	<input type="checkbox"/> Excoriation	<input type="checkbox"/> Healthy	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Hyperkeratosis	<input type="checkbox"/> Callus	<input type="checkbox"/> Eczema
-------------------------------------	--------------------------------------	----------------------------------	-----------------------------------	---	---------------------------------	---------------------------------

Wound Evaluation: Monitor Progress every 2 weeks or sooner if condition changes									
Week Date	1	2	3	4	5	6	7	8	9
Size									
Length (cm)									
Width (cm)									
Depth cm									
Tissue Type%									
Necrotic Black/Brown									
Sloughy Cream/Yellow									
Granulating Red									
Epithelialising Pink									
Signs of infection - Y/N (see page 1)									
Exudate Levels Type	D = Dry W= watery	M = Moist T = Thick	W = Wet C = Cloudy	S = Saturated P = Purulent	L = Leaking R = Red				
Surrounding Skin: M = Maceration, E = Excoriation, D = Dry, H = Hyperkeratosis C = Callous, E = Eczema									
I - Intact									
Pain level 0-10									
Pain frequency: C = Continuous, I = Intermittent, DC = Dressing Change, PD = Post Dressing									
Requires Analgesia pre dressing Y/N									
Treatment objective (Tick all that apply)									
Promote Granulation									
Protect Epithelialisation									
Debride									
Manage Infection									
Rehydrate wound									
Manage Exudate									
Protect Surrounding Skin									
Manage Pain									
Minimise Odour									
Peri wound skin: Tick product required									
Barrier Cream									
Emollient									
Topical Steroid									
Wound Condition									
Deteriorating									
Static									
Improving									
Healed									
Primary Dressing									
Secondary dressing									
Bandage Regime									
Frequency									
Nurse Signature									

APPENDIX 3

Guidance on referral and management of Burns and Scalds taken from the NICE Clinical Skill Summary (2020)

Where the Burn occurs in a ward environment

- The person should be given immediate first aid ensuring the staff member avoids personal injury by checking the area is safe (for example in chemical burns or electrical burns).
- The staff member should wear personal protective equipment.
- Assess the persons airway, breathing and circulation

Thermal burns:

- Stop the burning process (for example extinguish flames using 'drop and roll' or smother them with a blanket), and remove non-adherent clothing and potentially restricting jewelry.
 - Do not attempt to remove tar stuck to the skin.
- Within 20 minutes of the injury, irrigate the burn with cool or tepid running water for 20–30 minutes.
 - Note: do not use ice or very cold water, as this may cause vasoconstriction and may deepen the wound.
 - If water is not available, use wet towels or compresses.
 - Ensure the person is kept warm with coats, sheets, or blankets to avoid hypothermia, especially if cooling large areas of skin in children and the elderly.
- Immediately after cooling, cover the burn using cling film, layered onto the burn rather than wrapped circumferentially, to reduce the risk of vasoconstriction. Consider using a clean, clear plastic bag for burns to the hand.
 - If cling film is not available, use a clean, cotton sheet.
 - Note: do not use wet dressings or topical creams.

- Elevate the affected area if possible, to reduce the risk of oedema.
- Offer pain relief, such as paracetamol or ibuprofen for mild-to-moderate

Refer the patient to the ward Doctor/ A&E Department

Electrical burns:

- If the person has been injured by a low-voltage source (for example 220–240 volts, domestic electricity supply), safely switch off the power supply, or remove the person from the electrical source using a non-conductive material (such as a wooden stick or wooden chair).
- Note: do not approach a person connected to a high-voltage source (1000 volts or more).
- Arrange immediate admission to the nearest major A & E Department.

For chemical burns:

- Determine the causative chemical, where possible.
- Remove affected clothing, brush the chemical off the skin if it is in a dry form, and copiously irrigate the burn with water for an hour.
- Do not attempt to neutralize chemicals as additional heat will be generated, which may increase tissue damage.
- Arrange immediate transfer to A&E

Community Services

At the first visit, the nurse will complete a full holistic assessment, which will include a wound assessment and pain assessment as described in section 12 of this Guideline.

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

- All burns $\geq 2\%$ Total Body Surface Area (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

Where this threshold is met, refer the patient back to their GP requesting a referral

In addition, the following factors should prompt a discussion with a Consultant in a specialised burn care service. The clinician should refer the patient back to their GP for discussion and referral to be actioned:

- 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
- If the burn wound changes in appearance / signs of infection or there are concerns regarding healing then discuss with a specialised burn service
- If there is any suspicion of Toxic shock syndrome (TSS) then refer early

<https://cks.nice.org.uk/topics/burns-scalds/>

APPENDIX 4

Consent to Wound Photography

Consent Form for use of photography/film/interviews/artwork

The work we do is often featured in newspapers, leaflets, reports and on the TV and radio. These often include the words or pictures of our staff, our patients and clients, their carers and relatives and local residents. We would like your permission to obtain and then publish or broadcast the following:

A **What we want to use [tick the boxes as appropriate]**

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Photographs | <input type="checkbox"/> Film/audiotape footage |
| <input type="checkbox"/> Interviews | <input type="checkbox"/> artwork/drawings |

B **What we want to use it for:**

- | | |
|--|---|
| <input type="checkbox"/> Wound monitoring and evaluation | <input type="checkbox"/> Education and training |
| <input type="checkbox"/> Publications (e.g Leaflets, posters, newsletters, reports, displays, website etc) | |

Other – please specify

Declaration

I give consent for my words, pictures or images to be obtained and used as set out above. I confirm that I understand the nature of the use(s) that will be made of this information.

Signed..... (By parent/guardian if relating to a child under 16

Name..... Dated.....
(Please print full name clearly)

Name of staff member obtaining consent.....
(Please print full name clearly)

APPENDIX 5

TISSUE VIABILITY SERVICE WOUND PHOTOGRAPHY MADE EASY



Introduction

Wound assessment is an important process that allows clinicians, patients and carers to monitor the stages of healing detect the presence of complications and assess the effectiveness of treatment. These observations of the wound can then form the basis for clinical decisions including the selection of a suitable wound care regime.

Digital photographs are an important component of effective wound assessment and management. Digital photography in wound management adds objective visual confirmation to the written record and allows for continuous monitoring and evaluation. Wound photography may also be used for education and training and to support evaluations of products and devices, which may be published at a later date.

This made easy guide have been written to ensure best practice and standardisation of digital wound photography for the Tissue Viability Team.

Patient consent

The healthcare professional is responsible for ensuring the patient has given informed consent before any photography takes place. This consent will be documented in the patient's clinical record. If the Photograph is for wound evaluation, triage or for virtual advice from the tissue viability team then verbal consent can be obtained. A full explanation should be given to the patient for the reason the photograph is being taken. Photographs will not be used for any purpose other than for which consent has been obtained. If photographs are for the purpose of education and training or for a clinical evaluation and are likely to be published then written consent should be obtained for this purpose. Care should be taken to protect patient identity by ensuring that faces or any other obvious features are obscured. A copy of the patient consent form can be found on the Trust website.

Equipment

Wound images should be taken using a digital device Member of the tissue viability team will have access to a digital device which can take photographs e.g. Trust iPad. Wound photograph should only be taken on Trust equipment. **Personal devices should not be used to take wound images.**

Taking photographs

Ensure the digital device is pre-set to record the date and time picture is taken. Care will be taken to protect patient identity by ensuring that faces or any other obvious features are obscured. Patient dignity and modesty will be protected by ensuring minimum patient skin exposure. Genitalia will be covered to preserve dignity. If damage is around or on genitalia and safeguarding is a concern, clinical judgement should be used.

The wound and surrounding skin should be cleansed prior to the photograph being taken and a visual measurement scale used in each photograph with the date recorded on the scale. This will be placed next to the wound. Paper sterile ruler supplied in dressing pack should be used for this purpose. The patient's

identification/initials can be added to the sterile ruler. Please leave blank or use patient number if the photography is to be used for educational purposes or for dressing/device evaluations which may be published. Blue paper towel should be used as a background to the image to ensure no background images such as furniture in the frame. The picture should be taken from a distance of between 25cm – 35cm. Follow up photographs will be taken with the patient in a similar position and from the same angle and distance to previous photographs to allow for comparison.

The iPad device should not come into contact with the wound. Clinician will ensure gloves are removed and hand washing undertaken between dealing with the patient/wound and using the digital device. Universal infection control principles should be followed.






Storage of photographs

All Trust staff will be professionally accountable for the correct storage of all images that they have taken. Photographs should be stored in the patients' electronic record system unless they are being used for education and training or agreed dressings device evaluation in which case they will be stored on the tissue viability service shared drive in the relevant evaluation folder. These images should not contain the patient's initials. Photos should be deleted from the device as soon possible after the picture has been added to the clinical record or the shared tissue viability drive.

APPENDIX 6

T.I.M.E Framework for Wound bed Preparation

Wound Care: A T.I.M.E Approach

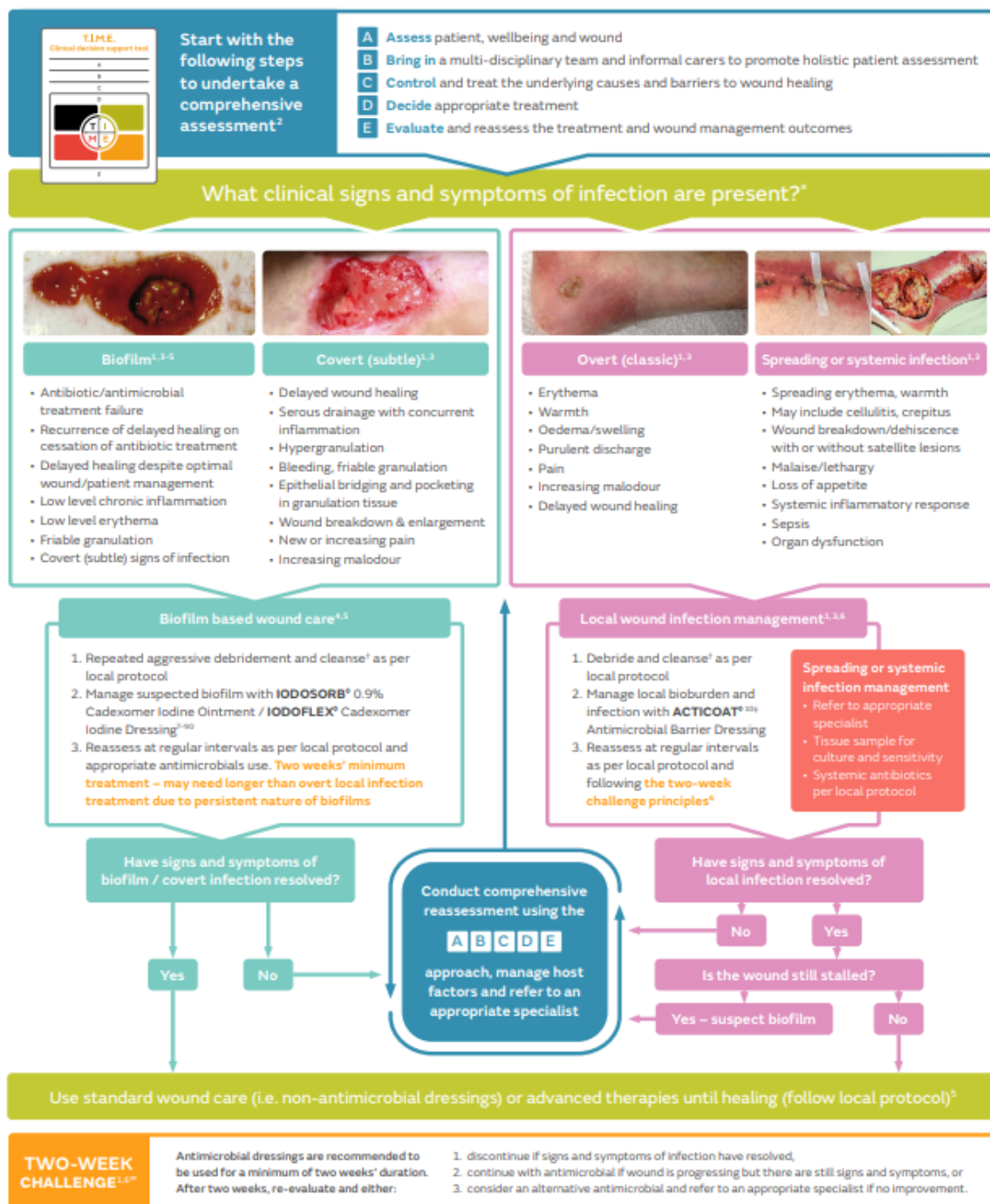
PROBLEM	AIM	METHOD/TREATMENT	WOUND CARE PRODUCT
<p>TISSUE</p> <p>Non-viable Necrotic/Sloughy</p> <p>Viable Tissue Granulation/Epithelialisation</p>	<p>To Debride Necrotic/Sloughy Tissue</p>  <p>To Promote Healing</p> 	<p>Autolytic</p> <p>(For sharp debridement/larvae therapy refer to tissue viability services)</p> <p>Moist interactive wound dressings</p>	<p>Hydrocolloid for dry necrosis: Comfeel Plus, Duoderm <u>Hydrogels to debride: Intrasite, Nu- Gel</u> <u>Foams Allevyn, Biatain</u> <u>Hydrofibre –Aquacel</u> <u>Alginate: Kaltostat for bleeding</u></p> <p>Allevyn, Biatain, Bioclusive, Tegaderm, Comfeel Plus,, Adaptic Touch, Atrauman</p>
<p>INFECTION</p>	<p>Prevention and Management of Infection</p> 	<p>Local infection</p> <p>Systemic infection</p>	<p>Antimicrobial therapy – Cadexomer Iodine. Honey: Silver , PHMB</p> <p>Systemic antibiotics with antimicrobial therapy as above</p>
<p>MOISTURE</p> <p>Imbalance</p>	<p>To Promote Moisture Balance</p> 	<p>Treat underlying cause and control exudate (For NPWT therapy refer to tissue viability service)</p> <p>To protect surrounding skin</p>	<p>Compression therapy for venous ulceration/: Profore: 4 layer, Actico short stretch, Coban 2 layer, Leg ulcer hosiery kit</p> <p>Alginate: Kaltostat for bleeding Foams: Biatain, Allevyn Barrier film Cavilon,</p>
<p>EDGE</p> <p>of Wound Non-Healing</p>	<p>To Reduce Wound Size</p> 	<p>Measure wound: length, width, depth Re-assess cause</p>	<p>by Tissue Viability</p> <p>Refer to tissue viability service for Larvae therapy, Negative pressure wound therapy and further specialist advice</p>

APPENDIX 7

INFECTION MANAGEMENT PATHWAY

A route to more effective infection management

Improve patient outcomes¹ with accurate decision making, a fast response and effective treatment choices



* No one sign or symptom can reliably confirm the presence of infection, and those with immunosuppression may not exhibit signs and symptoms of clinical infection.
 † Cleanse wound and periwound skin thoroughly. Should an antiseptic cleanser be selected, the product's Instructions for Use (IFU) and soak time should be followed.
 ‡ Consider the use of **DURAFIBER[®] Ag Silver Gelling Fibre Dressing** for deep infected wounds.
 † Unless iodine contraindicated.
 ¶ For very-high risk patients and wounds (e.g. osteomyelitis), it may be appropriate to use antimicrobial treatment for longer than the two-week challenge.
 For detailed product information, including indications for use, contraindications, precautions and warnings, please consult the product's Instructions for Use (IFU).

References 1. International Wound Infection Institute (IWII) Wound infection in clinical practice. Wounds International (2016). 2. Moore Z, et al. J Wound Care 28(3):154-161 (2019). 3. Weir D, Schultz G. Assessment and Management of Wound-Related Infections. In Doughty D & McNicol L (Eds.). Wound, Ostomy and Continence Nurses Society Core Curriculum: Wound Management (p. 156-180). 2016. Philadelphia: Wolters-Kluwer. 4. Wolcott RD, et al. J Wound Care 19(2): 45-53 (2010). 5. Schultz G, et al. Wound Repair Regen 25(5): 744-757 (2017). 6. Ayello EA, et al. Wounds Int 1-24 (2012). 7. Roche ED, et al. Int Wound J 1-10 (2019). 8. Malone M, et al. J Antimicrob Chemother 72, 2093-2101 (2017). 9. Schwarzer S, et al. J Infect 80(3):261-270 (2020). 10. Gago M, Garcia P, Gaztelu V, Verdu J, Lopez P, Nolasco A. A comparison of three silver-containing dressings in the treatment of infected, chronic wounds. Wounds. 2008;20(10):273-278.
 Photographs (from left to right) courtesy of Karlyn Carville, Kevin Woo, and Henri Post.
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Appendix 8

A Guide to Wound Cleansing

Wound Cleansing Technique Guide

The following Wound Cleansing Guide has been adapted from the Royal Marsden Hospital Manual of Clinical Nursing Procedures for use in the Community.

WOUND CLEANSING TECHNIQUE FOR GENERAL WOUND CARE		
No	Action	Rationale
1	Explain and discuss procedure with the patient. Ensure patient is comfortable and has had analgesia as prescribed and required	To ensure that the patient understands and consents to the procedure and is comfortable and pain is controlled.
2	Hospital/Clinic – Clean trolley or working surface with general purpose detergent and wipe over with chlorhexidine in 70% spirit and dry with a paper towel. Patients home – ensure that the work surface is clear from clutter, clean and dry.	To provide a clean working surface
3	Hospital/Clinic – place all equipment and products required for the procedure on the bottom shelf of the trolley Patient's home – ensure all the equipment is brought near to the work surface	To maintain the top shelf as a clean working surface To ensure all equipment is within easy reach while doing the procedure
4	Hospital/Clinic - Screen the bed/chair/ treatment couch. Patient's home – Maintain privacy as much as conditions allow Position the patient comfortably so that the area to be dealt with is easily accessible without exposing the patient unduly Prepare the patient and area before opening the dressing pack, dressing or products. Hospital/Clinic – Take the trolley to the treatment area disturbing the screens as little as possible	To maintain the patient's privacy To maintain the patient's dignity, and comfort To allow dust and airborne organisms to settle before the sterile field, products and wound is exposed. To minimize airborne contamination
5	Standard precautions should be used. Patient's home – If suitable washing facilities are not available alcohol gel or hand rub may be used before and after the use of gloves	To reduce the risk of cross infection or contamination of the wound
6	Loosen the dressing tape or bandage	To ease dressing removal
7	Check all sterile equipment is undamaged, intact and dry and has not exceeded the expiry date	To ensure that only valid sterile products are used
8	Open sterile field using the folded in corners of the paper Place opened products on the sterile field or open packaging but leave product within outer wrapping if sterile field/dressing pack is not used.	So that areas of potential contamination are kept to a minimum To reduce disruption to procedure while wound is exposed
9	Hospital/Clinic – Wash hands according to Infection Control Manual Patient's home – If suitable washing facilities are not available alcohol rub or hand gel may be used before and after the use of gloves	Hands may have become contaminated by handling outer packets etc.
10	Remove used dressing with gloved hand covered with the disposable bag, turn bag inside out with dirty dressing inside and stick to trolley or near working area	Performed at this stage to reduce length of time wound is exposed To contain dirty dressing
Carry out procedure		
12	Dispose of waste in yellow plastic clinical waste bags Hospital/Clinic - send clinical waste for incineration Patient's home – dispose of as clinical waste or in household rubbish according to local policy.	To prevent environmental contamination

APPENDIX 9

Referral Form to Tissue Viability Service

Tower Hamlets - referral to Accelerate CIC- online form
[Wound referral - AccelerateCIC](#) for lower legs

Pressure ulcers/ wounds refer to tissue viability via Tower Hamlets community nurse's referral form

Please complete and email to tissueviability.service@nhs.net

Patient Details		
Patients Name		Address:
Date of Birth		Telephone No:
GP' s Name & Address		NHS Number
Telephone No:		Nurse
Medical History: (or attach EMIS Summary)		Telephone No:
Allergies:		Medication:
Assessment		
WATERLOW Score: Skin assessment completed: Yes <input type="checkbox"/> No <input type="checkbox"/>		MUST nutritional score: Pain score – patient reported 1-10 <input type="checkbox"/>
Wound Assessment		
Wound Type: Leg ulcer <input type="checkbox"/> Pressure ulcer <input type="checkbox"/> Diabetic foot wound <input type="checkbox"/> Surgical wound <input type="checkbox"/> Laceration/abrasion <input type="checkbox"/> Other <input type="checkbox"/>		
Wound cause:	Wound location:	Wound duration:
Leg ulcers: Venous <input type="checkbox"/> Mixed <input type="checkbox"/> Arterial <input type="checkbox"/> Other <input type="checkbox"/> DOPPLER ASSESSMENT DATE: <input type="text"/> ABPI Right leg <input type="text"/> Left leg <input type="text"/>		Pressure Ulcers: Grade 1 <input type="checkbox"/> Grade 3 <input type="checkbox"/> Grade 2 <input type="checkbox"/> Grade 4 <input type="checkbox"/> Please provide Doppler result for heel pressure ulcers ABPI Right Leg <input type="text"/> Left leg <input type="text"/> Datix report completed <input type="checkbox"/> Safeguarding Alert Raised <input type="checkbox"/>
Wound Measurement: Maximum length & width & depth _____ Tissue type: % Epithelialising <input type="checkbox"/> Granulating <input type="checkbox"/> Sloughy <input type="checkbox"/> Necrotic <input type="checkbox"/>		Infection: Clinical signs of Infection: Yes/No List signs and symptoms: _____ Moisture levels: High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/>
Wound Dressings and Equipment		
Primary dressing:	Frequency of dressing change:	Compression therapy:
Secondary dressing:		Equipment issued:
Name of Referrer: Contact number:	Reason for referral:	Date:

Beds Community Wound Care & Tissue Viability Services

Beds Tissue Viability Services, Queensborough House, Friars Walk, Dunstable, LU6 3JA
Tel: 01582 709047

wound.care@nhs.net

Please complete in full.

Failure to do so will result in return of referral and possible delays in appropriate patient care.

NHS No:	Address of Patient:
Patient Name:	
Patient Date of Birth:	Nursing Home Contact Number:
Patient Ethnicity:	Name of Referrer:
Patient Religion:	Date of referral:
Patient Allergies:	Any recent hospital admissions/referrals:
	GP name and address:
Is the Patient mobile?:	

Type of Wound

(Please tick below)

Leg Ulcer <input type="checkbox"/>	Pressure Ulcer <input type="checkbox"/>	Moisture Lesion <input type="checkbox"/>	Diabetic Foot Ulcer <input type="checkbox"/>
Burn <input type="checkbox"/>	Trauma (eg: Skin Tear) <input type="checkbox"/>	Post-Op <input type="checkbox"/>	Other <input type="checkbox"/>

Location of Wound:	
Duration of Wound:	
Size of Wound:	
Relevant Medical History:	Current Medication:

Present Dressing Regime:	Swab Results (if recent):
---------------------------------	----------------------------------

T ISSUE TYPE		Epithelisation (pink)	<input type="checkbox"/>
		Granulating (red)	<input type="checkbox"/>
		Slough (yellow/tan/green/grey)	<input type="checkbox"/>
		Necrotic Tissue (black/brown)	<input type="checkbox"/>
		Does wound bleed easily?	Yes <input type="checkbox"/> No <input type="checkbox"/>
I NFECTION	Does the patient exhibit any of the following?	Increase in wound size or not healing	<input type="checkbox"/>
		Odour	<input type="checkbox"/>
		Increase in exudate levels	<input type="checkbox"/>
		Increase in slough	<input type="checkbox"/>
		Surrounding skin hot and red	<input type="checkbox"/>
		Change or increase in wound pain	<input type="checkbox"/>
		Is the patient unwell/feverish?	Yes <input type="checkbox"/> No <input type="checkbox"/>
M OISTURE		Dry wound	<input type="checkbox"/>
		Wet wound	<input type="checkbox"/>
		Maceration (white soggy skin surrounding wound)	<input type="checkbox"/>
		Excoriation (red and sore, possibly weeping)	<input type="checkbox"/>
E PITHELISATION	Edges Advancing	New pink skin forming	<input type="checkbox"/>

If the wound is a PRESSURE ULCER, please answer the following:

Waterlow Score:	
MUST Score:	
Recent Weight Loss:	

S urface	Please specify equipment in place (e.g. mattress, cushion or other aids):
S kin	Frequency of skin inspection:
K eeP moving	Repositioning regime:
I ncontinence/Moisture	Management regime:
N utrition	Type of diet (Normal/Fortified/Pureed):

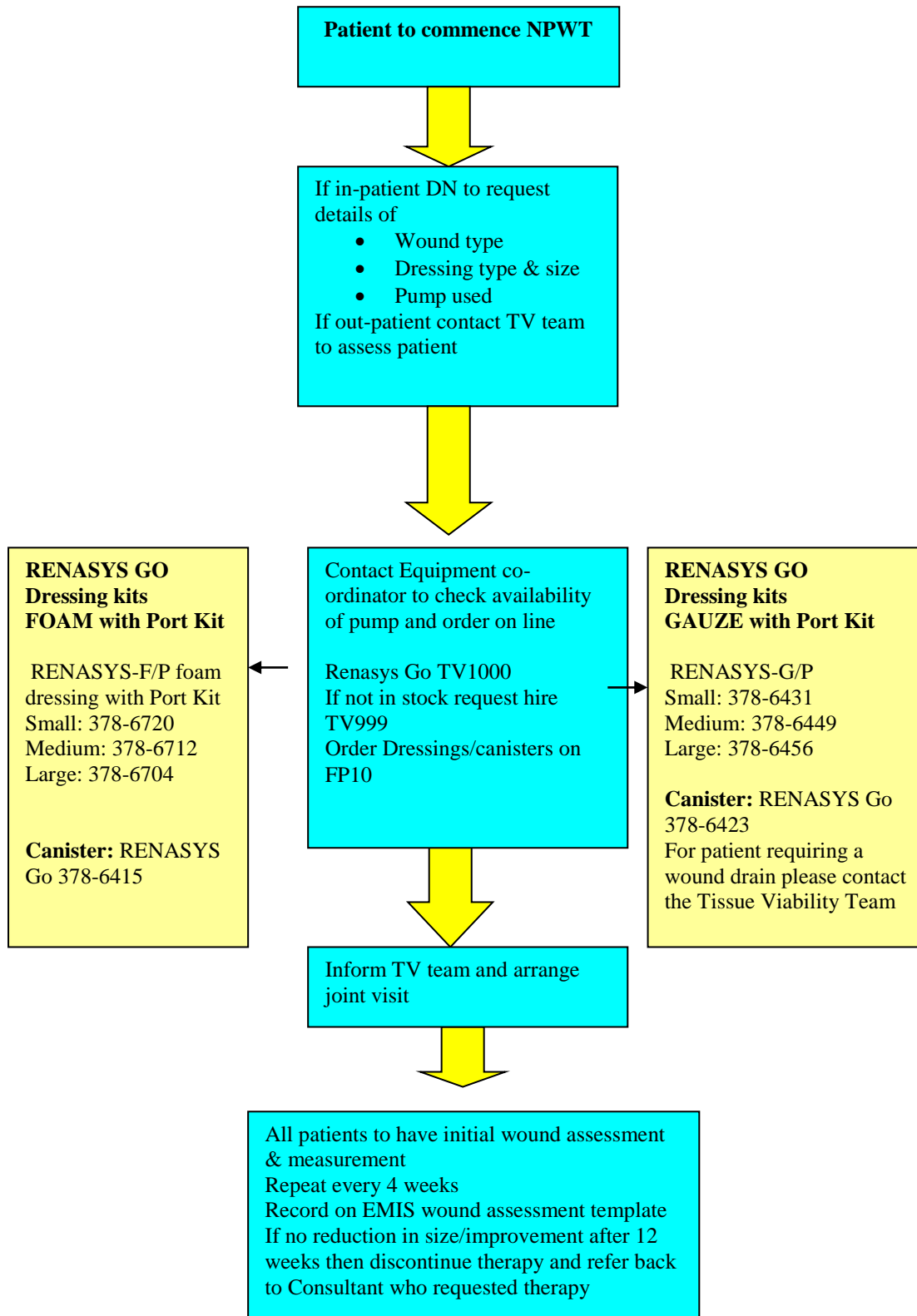
APPENDIX 10

Guidelines for ordering and using Negative
Pressure Wound Therapy in Newham
Community

For Tower Hamlets and Luton and Beds
contact TV team directly

Guidelines for Newham District Nurses Ordering and Commencing Negative Pressure Wound Therapy

RENASYS GO



APPENDIX 11

PICO PATHWAY

PICO PATHWAY

