Tissue Viability Policy, Practice Guidance Note

Wound Assessment – V03

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Author/Designation | Kevin Chapman – Tissue Viability – Modern Matron
Responsible Officer / Designation | Anne Moore – Group Nurse Director - Safer Care / Director of Infection Prevention and Control [DIPC]

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1 INTRODUCTION

1.1 Cumbria Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/CNTW) recognises that the treatment of wounds has a major impact on patients and carers and they are recognized as a major cost to the National Health Service. The Trust recognises the need to have a clinical policy and evidence based guidance to inform and guide staff in the selection of wound dressing products and wound management, and the importance of consistent individualised care in different care settings.

1.2 The main aims of providing the Trust practitioners with wound care guidelines are as follows:
- To safeguard the interests of patients
- To ensure that there is a variety of wound care products available to manage a range of wound types
- To ensure that practitioners have adequate information to support their wound care practice.
- To promote rationale prescribing
- To promote cost effective use of wound care products
- To provide a framework for staff who practice in wound care
- To ensure wound care practice is regularly reviewed

1.3 This policy acknowledges the physical, psychological and social impact of living with a wound. For the individual a wound can cause pain, systemic illness, an increased length of hospital stay, extended absence from work and normal activities, loss of earnings, low self esteem and altered body image.

1.4 The policy aims to provide a standardised approach to wound care within a framework of holistic care, where clinicians encountering a wide range of wounds including acute surgical wounds, factitious and long-term chronic wounds.

1.5 Where palliative care is being provided, healing may not the primary aim. The goal is to ensure comfort, freedom from pain and negative issues associated with the wound (e.g Malodour / haemorrhage etc.)

2 SCOPE

2.1 This policy applies to those members of staff that are directly employed by the Trust and for whom the Trust has legal responsibility. For those staff covered by a letter of authority/honorary contract or work experience this policy is also applicable whilst undertaking duties on behalf of Trust. As part of good employment practice, agency workers are also required to abide by the Trust policies and procedures, as appropriate, to ensure their health, safety and welfare whilst undertaking work for the Trust.
3 ROLES AND RESPONSIBILITIES

3.1 Chief Executive

- The Chief Executive is responsible for there being a structured approach to procedural document development and management in place. Although responsibility for procedural document development may be delegated to other officers, accountability remains with the Chief Executive.

3.2 Associate Directors and Senior Managers

- Will make arrangements for the effective implementation and monitoring of the policy.

3.3 Tissue Viability Nurse Specialists

3.3.1 Their role is:

- To provide expert professional advice and education on wound assessment, management and treatment to other professionals, multi-disciplinary groups, patients and carers.

- To lead in the investigation of identified breaches of Tissue Viability / wound management.

- To advise on treatments and interventions, delegating responsibility to Trust staff as appropriate.

- To give advice on complex issues relating to Tissue Viability and report findings to the relevant ‘Group’ Leads.

- To report any breaches in policy compliance via the web-based reporting system (electronic incident report form) as per the Trusts CNTW(O)05 – Incident Policy and practice guidance notes and to relevant governance groups - [http://nww1.CNTW.nhs.uk/spider/services/files/1508487576CNTW(O)05%20-%20Incident%20Policy-V04.1-Sep-17.pdf](http://nww1.CNTW.nhs.uk/spider/services/files/1508487576CNTW(O)05%20-%20Incident%20Policy-V04.1-Sep-17.pdf)

3.4 Ward Managers and Clinical Team Leaders

- Ward Managers and Clinical Team Leaders will ensure that all staff are aware of the policy and adhere to it.

- Will identify training needs and ensure staff are appropriately trained in wound management and will record all training.

- Will incorporate wound management into staff performance review and the knowledge and skills framework.

- Will ensure compliance with the Audit requirements of the policy.
3.5 Registered Healthcare Professionals

- Registered Healthcare Professionals will be competent in and responsible for the management of wounds relevant to their practice area and scope of professional practice. The qualified clinician has a duty to ensure that any care delegated to the Healthcare Assistant is in line with the training the Health care assistant has received and the competencies the Health care assistant has achieved and demonstrated.

- The Registered Healthcare Professionals will remain accountable for the care delivered and will continue to reassess the wound as clinically indicated and as a minimum weekly – seeking specialist advice and support as required.

3.6 Healthcare Assistants

- Healthcare Assistants may contribute to wound management under the supervision of a Registered Healthcare Professionals. On no account should they take responsibility for wound management unsupervised.

- Healthcare assistants must be aware of their individual levels of confidence, competence, accountability and skills in respect of wound care. Escalating queries and concerns in a timely manner to ensure effective clinical review.

3.7 All Staff Members

- Will adhere to the Trust Policy.

- Will use the information provided at clinical level to ensure correct choice of wound dressing and use this in a safe manner in accordance with manufactures guidance.

- Will identify their training needs and make their managers aware of training deficit (Bespoke training can be offered by the TVN’s).

- Will maintain personal records of training.

- Will report all clinical incidents around wound management in line with Trust policy.

- Will seek specialist advise from the Tissue Viability team for situations outside of their skills base.

4 WOUND HEALING PROCESS

4.1 The wound healing process is complex and is affected by numerous general and local factors. It is essential to treat the whole person and not just the wound in isolation.
In order to be able to select appropriate dressing, it is therefore essential that all wounds are thoroughly assessed and management needs established prior to this. Selection is therefore based around which product will most cost effectively meet those needs and achieve the desired outcome.

- **Appendix 1 – Wound Assessment tool**

**4.3 How to use the Guideline**

*4.3.1* This guideline is written to support practice. It starts by providing guidance on wound care to promote the standard of care we should all try to achieve.

*4.3.2* Information is also given regarding wound healing and wound assessment so that practitioners can compare this information with what the patient presents with, to allow good comprehensive information to be obtained. Good assessment leads to good care and early resolution of wound care challenges.

*4.3.3* Pain is the single most important factor for anyone with a wound. Patients do not like being in pain and the practitioner has a duty to ensure the patients pain is controlled wherever possible. Guidance on pain management is included within this guideline but for more in depth information please contact your clinical pharmacist.

*4.3.4* Once the issues stated above have been addressed it should be possible to match the patients wound with the wound care products available within the Trusts wound care formulary (Specialist products are only available following specialist assessment by the Tissue Viability Nurse (TVN) – i.e. Silver products)


*4.3.6* Practitioners are expected to refer to the products outlined in the Trust formulary and those locally negotiated for their clinical area. If it is necessary to use unlisted products a clear rationale should be given and discussed as soon as practical with the TVN’s.

**4.4 Holistic wound assessment** should be:

- Patient centred
- Accurate and precise
- Detect the presence of complications
- Detect general patient factors which may delay healing e.g. nutritional status, diabetes, chronic infection and concomitant medication e.g. steroids
- Able to provide a framework to monitor the stages of wound healing
• Evaluate the effectiveness of any treatment

4.5 **Local wound assessment** should take into account:-

• Type of wound

• Location of wound

• Stage of healing – using recognised scale e.g. pressure ulcer category 1–4?

• Wound dimensions – length, width, depth, position/extent of sinuses, undermining of surrounding skin, using one of the following methods. Measurement should be carried out regularly dependant on type/location and chronology of the wound.

• Cover the wound with a sterile transparent film and measure using a disposable tape the maximum length and width. Do not probe wound depth or extent of any undermining unless you are clinically competent to do so

• Where available use a tracing chart to draw and record the entire wound area

• Photography is a useful way of measuring when incorporating a rule or tape into the photograph so scale can be provided. Refer to Trust policy – CNTW(O)45 – Visual Imaging and Audio Policy

• Guidance for obtaining consent is available in the Trust’s CNTW(C)05, Consent to Treatment and Examination Policy

• Wounds should be assessed for any local barriers to healing, and the results documented at each dressing change using the attached assessment tool - Appendix 1

4.6 **Wound Care Provision**

4.6.1 The following should always be carried out when providing wound care:

• Check the wound care plan or documentation. All the information required for carrying out the wound care must be included in the care plan or record, i.e. all equipment and dressing materials required to successfully carry out the procedure, and specific techniques used to perform the procedure, including sedation or analgesic use

• Use the care plan/map or where available the pictorial care plan at the bedside if required

• Staff carrying out the procedure must follow the practice guidance note within CNTW(C)18 – Tissue Viability Policy, practice guidance note – TV-PGN-03 - Aseptic None Touch Technique’ (ANTT)

**NB** - *Hand washing should be done regularly during the procedure. It is up to the practitioner to decide on the frequency and appropriate time to undertake hand washing. All wounds should be treated as sterile unless otherwise stated*
4.6.2 The **T.I.M.E** acronym is a summary of the principles of wound bed preparation. It can be used as an aide-memoir to guide practice, heal wounds quickly and help your patients have a more comfortable path to healing.

<table>
<thead>
<tr>
<th>Wound Factors</th>
<th>Clinical Action</th>
<th>Wound Healing Outcome</th>
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<tr>
<td><strong>T</strong> Tissue Non-Viable</td>
<td>Remove defective tissue – Debride (only where competent to do so)</td>
<td>Viable – Vascularised wound bed</td>
</tr>
<tr>
<td>Necrotic tissue or slough present</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I</strong> Inflammation and / or Infection</td>
<td>Remove or reduce bacterial load Antimicrobial dressings, debridement of devitalised tissue or topical cleansers.</td>
<td>Reduce Bacterial burden and inflammation</td>
</tr>
<tr>
<td>Increased exudates, surface discolouration, purulent discharge, malodour, pain etc</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>M</strong> Moisture imbalance</td>
<td>Restore moisture balance Absorb exudates or add moisture to dry wounds</td>
<td>Optimal moisture balance</td>
</tr>
<tr>
<td>Heavy exudates – risk of maceration. Dry wound bed – risk of desiccation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E</strong> Edge of wound non-advancing or undermining.</td>
<td>Reassess <strong>T.I.M.E</strong> if no longer an issue consider alternative therapies to 'kick start' healing. If wound remains static or stalls for 2-4 weeks refer to TVN.</td>
<td>Restoration of appropriate cell migration (epithelialisation)</td>
</tr>
<tr>
<td>E.g. chronic wound with prolonged inflammation</td>
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- **T** = Tissue, non-viable or deficient:
  - Devitalised tissue (slough and necrosis) forms a physical barrier to healing. It does not necessarily indicate presence of infection, but can create an ideal site for bacterial growth. Its presence can prolong the inflammatory phase of healing and prevent progression into the proliferative phase. Healing wounds should progress through from black necrosis, to yellow slough to red granulation, to pink epithelialisation.
  - Record the tissue type(s) present. Where possible, estimate the percentage of each tissue type - this should add up to a total of 100% e.g. "50% slough, 10% necrosis, and 40% granulation"

- **I** = Inflammation / Infection:
  - Note: Inflammation within a wound within the first 1-7 days is part of the body's normal physiological response, unless there are clinical signs of infection wounds presenting with inflammation should be monitored before considering swabbing or topical, dressing or systemic treatment (Advise from TVN's can support the MDT decision making process)
Infection or heavy colonisation can interfere with all stages of healing and prolong the inflammatory phase, as can the presence of foreign bodies in the wound (e.g. grit or dressing particles). Be extra vigilant for signs of infection in patients with underlying medical conditions (such as diabetes or ischaemia) that may mask the usual signs of infection (e.g. redness or swelling).

Inflammation is not always a result of infection. Underlying disorders such as untreated venous congestion or vasculitis can prompt an inflammatory response. Record any signs of infection or heavy colonisation, using the criteria set out in the European Wound Management Association Position Document 'Identifying criteria for wound infection (2005)


**M = Moisture Imbalance:**

- Excess moisture / exudates, particularly chronic wound exudates that is chemically imbalanced, is harmful to the wound bed and surrounding skin. It can destroy growth factors and newly formed granulation tissue, as well as causing maceration, excoriation and breakdown of surrounding skin. Its nature may provide clues as to the presence of infection. Record the level of wound exudates (e.g. high, moderate, low, dry), its nature (e.g. serous, haemoserous, purulent), and its colour (e.g. yellow, green, red). Record its effect on the surrounding skin (e.g. maceration or excoriation).

**E = Edge of wound, non advancing or undermined or is the epidermis failing to migrate across the granulation tissue:**

- Wound dimensions - length, width, depth, sinus formation and undermining of surrounding skin

- Wound bed preparation is not an isolated process. A holistic approach should be used to diagnose and treat the underlying disorders / disease processes contributing to the wound, and any wider factors delaying healing.

### 4.6.3 Tissue Management (Debridement)

- Debridement involves the removal of devitalised tissue and bacteria that impede wound healing it is a specialist procedure and staff should not undertake this without referral / consultation with the TVN lead

- Referral to Podiatry for expert clinical debridement is essential if the patient has or is suspected to have diabetes and issues relating to foot care / wounds

- There are a range of debriding options, the method chosen will depend on comfort, odour control, patient acceptability, wound type and location, other patient factors, resources available and skill of the practitioner. These are summarised below:
4.6.4 Autolytic Debridement

- This is the body's own method of debridement. During the inflammatory stage of healing white blood cells and proteolytic enzymes flood the wound to destroy and remove debris.

- If the underlying cause of the wound is well managed, autolysis is likely to progress easily and rapidly. Failure to treat the underlying cause is likely to simply result in more slough being produced. e.g. uncomplicated venous ulcers are likely to be sloughy due to the venous congestion.

- Autolysis relies on a moist environment. If the wound is too wet or too dry, use an appropriate dressing to create a moist environment e.g. hydrogels and occlusive dressings to re-hydrate dry slough and necrosis; hydrofibres and semi-permeable dressings to absorb excess exudates in wetter wounds.

- The choice of secondary dressing may also effect the moist environment e.g. film as the secondary dressing over hydrogel will achieve the maximum rehydration of the wound bed. For more complex wounds, autolysis may prove too slow and an alternative method should be considered – specialist advice can be sought from TVN.

**WARNING:** Do not attempt to re-hydrate dry necrosis in a diabetic or ischaemic wound or where the underlying aetiology is unknown, as this may encourage a wet spreading gangrene. Keep the wound dry and refer urgently to a diabetic consultant / vascular specialist.

4.6.5 Sharp/Surgical Debridement

- Involves the cutting away of dead tissue using a sterile technique, usually under local or general anaesthetic. It can help stimulate healing by converting a chronic wound back into an acute wound. It can cause trauma and pain. **It must be carried out by a professional qualified in sharp debridement.**

**WARNING:** Do not attempt sharp or surgical debridement unless you have successfully completed the necessary course(s) and are qualified and competent in this skill.

4.6.6 Maggot Debridement (Biosurgery)

- Involves the use of sterile larvae to remove slough and is available only via specialist referral to the TVN.

4.6.7 Mechanical Debridement

- This involves the use of non-discriminatory physical force to remove necrotic tissue, and is not recommended. Traditionally wet-to-dry dressings were used, but this method can cause severe pain and trauma and should no longer be practiced.

- Please refer to the other available Trust’s policies for

**Please refer to the other available Trust’s policies for**
Wounds should not be routinely swabbed. A swab should be taken only where there is suspected infection present. Swab results do not identify infection (we rely on clinical assessment to do this), but the results will help to identify the organisms present and guide on most appropriate antibiotic therapy.

5 USE OF TOPICAL ANTI-MICROBIAL SOLUTIONS AND DRESSINGS

5.1 Anti-microbial solutions and dressings should generally be reserved for situations where the wound presents with an acute infection or is heavily colonised (when the practitioner suspects bacteria are contributing to delayed healing or wound breakdown) and/or the patient is particularly susceptible to infection, e.g. due to diabetes, ischaemia, or immunosuppression. Evidence to support the use of these products is limited.

5.2 When selecting an antimicrobial staff should take into consideration the following:

- The provision of an optimal healing environment
- Selection of appropriate antimicrobials to minimise the emergence of resistant bacterial strains
- Appropriate antimicrobial to manage symptoms e.g. exudates, pain
- Avoidance of topical sensitisation and/or allergic reaction
- Topical antimicrobials include iodine based products, silver products and medical honey. (Some products are restricted and can only be prescribed following referral to TVN)

6 USE OF SYSTEMIC ANTIBIOTICS

6.1 Where infection is suspected, and the patient is not particularly susceptible to infection, take a wound swab and await the result before prescribing the antibiotics. If the patient is particularly susceptible to infection (e.g. due to diabetes, ischaemia or immunosuppression) or there is obvious spreading cellulitis, take a swab and begin antibiotics immediately.

When the results of the wound swab are available, adjust the antibiotics accordingly. The length of the course should reflect Trust guidance on Antibiotic stewardship. (Refer to medicines policy or seek specialist advice from medical microbiologist).

The Health Care Professional taking the wound swab is responsible for obtaining and recording the result in the patient’s notes, and for liaising with the medical team regarding antibiotic therapy.
7 WOUND CLEANSING

7.1 The aim of wound cleansing is to remove gross contamination with minimal pain to the patient and minimal trauma to the tissue. Wounds should be cleaned to:-

- Remove excess exudates
- Remove slough and/or necrotic tissue
- Remove remnants of previous dressings
- To facilitate accurate assessment of the wound/wound bed
- To promote patient comfort
- To reduce bio-load within the wound bed

7.2 For healthy wounds irrigation with either a sterile solution of 0.9% sodium chloride or tap water is appropriate. For some wounds, showering is appropriate for others precautions should be taken to keep the wound dry and free from possible contaminants dislodged during showering/bathing. A transparent limb-shaped plastic cover can be used to keep areas dry during bathing or showering cover. e.g. Limbo™

7.3 Irrigation fluids should be close to body temperature. Care should be taken to avoid trauma to the wound when applying or splash back of fluids to the clinician

7.4 Repeated cleansing may do more harm than good by traumatising newly produced delicate tissue, by reducing the surface temperature of the wound and removing exudates which may have bactericidal properties

7.5 If wiping of the peri-wound area is necessary, a non-filamented swab should be used. The wound bed itself should not be dried. Wiping the wound bed may leave fibres that could be a focal point for infection or may damage newly formed tissue

7.6 The general use of antiseptics/disinfectants is not recommended, as these solutions have been shown to kill fibroblasts and therefore hamper the healing matrix

8 WOUND INFECTION

8.1 Wound infection is one of the commonest hospital acquired infections. Nursing staff should recognise the distinction between contamination, colonisation and infection or when a client may be developing sepsis.

8.2 Contamination is when small numbers of bacteria may be detected in a wound but their presence is transient and they are not multiplying

8.3 In the colonised wound the levels of organisms not only increase but they have become established. An intermediate stage between colonisation and infection is also sometimes referred to as critical colonisation. This is because at the point at which an impact on wound healing may occur, there being evidence that heavy bacterial load may delay healing
True clinical infection however is defined as the process by which organisms bind to, multiply and then invade viable tissue. These responses are visible as clinical signs and include; Localised heat, pain, swelling and erythema. There may be purulent discharge, uncharacterised odour and increased pain. The patient may also feel unwell and have a raised or even lowered body temperature.

Further criteria include:

- Abscess
- Discharge which may be vicarious in nature
- Discoloured and purulent,
- Delayed healing not previously anticipated
- Discolouration of tissues both within and at the wound margins
- Friable
- Bleeding granulation tissue, despite gentle handling of and the non-adhesive nature of wound management materials used
- Unexpected pain / and or tenderness either during the dressing change or reported by the patient as associated specifically with the wound even when the wound dressing is in place
- Abnormal smell
- Wound breakdown, associated with wound pocketing/bridging at the base of the wound, i.e. when a wound that was assessed as healing starts to develop strips of granulation tissue in the base as opposed to a uniform spread of granulation tissue across the whole of the wound bed

All clinical staff should recognise when the normal inflammatory process becomes abnormal and when it is due to infection.

Staff should be familiar with the parameters of Systemic infection and refer to the Trust’s CNTW(C)29 – Trust standard for the assessment and management of physical health policy, practice guidance note, AMPH-PGN-05 - Sepsis Assessment Tool.

Key areas to monitor and respond to are:

- **Identified/Potential source of infection:**
  - Invasive devices (e.g. In-dwelling catheter, PEG, Tracheostomy etc.)
  - Respiratory Tract Infection (Chest infection)
  - Urinary Infection
  - Post-surgical intervention
  - Skin infection / Wound Infection
  - Any other Infection / Suspected Infection (e.g. Recent clostridium difficile infection)
  - Immunocompromised (Including medications that may increase susceptibility of infection)
Marked Change from physical base-line observations/or:
- Temperature >38 or <36 Degrees Celsius
- Heart Rate >90 BPM
- Respiratory Rate >20/Min
- SP02 (Sats) <95 (lower threshold for CO2 retention COPD)
- Blood pressure Systolic <111
- Change to normal BM range

Changes in response (AVPU)
- Onset of confusion, disorientation, lethargy, joint aches/limb/muscle pain, chills, shivers, Skin changes (pale/mottled), rash and <urine output

NOTE: Use high index of suspicion with suspected sepsis even if treatment for any underlying infection has commenced. In all cases doctor must be informed of any significant change in condition/physical observations. Use in conjunction with National Early Warning (NEWS)

Selection of Wound Dressing Product

Dressings that promotes a moist environment at the wound/dressing interface should be selected

The wound dressing product should be appropriate to meet the needs of the wound and/or promote the next stage of the wound-healing matrix, taking into account wound bed preparation tool T.I.M.E.

In wound care, accurate assessment of pain is essential with regard to choice of the most appropriate dressing. Assessment of pain before, during and after the dressing change may provide the nurse with vital information for future wound management

Exception: Patients with peripheral neuropathy, other neurological conditions or are minimally conscious and therefore not able to feel pain e.g. diabetic patients, patients with Multiple Sclerosis may be unable to feel pain in the foot

In general, pain experienced by patient although extremely subjective and variable from patient to patient falls into the following categories:-

- A deep dull constant pain
- A superficial burning type pain
- A neuralgic type pain
- An ischaemic type pain
- The pain resulting from cellulites

Whatever the cause of the pain, the patient’s perception should be acknowledged and appropriate action taken. European Wound Management Association (2002),
Address and treat underlying cause where possible, e.g. infection, ischaemia, venous hypertension deep dull constant pain

Address local factors which may be contributing to pain experience, e.g. oedema, desiccation, excess exudates / maceration

Appropriate use of analgesia

Reduce anxiety during dressing procedure by preparation of environment, giving simple explanations and reassurance, use distraction techniques

Minimise trauma by careful wound handling, avoid prolonged wound exposure and choose atraumatic dressings

There are a range of tools available to assist the professional to assess patient’s levels and perception of pain.

- **Verbal Rating Scales** (VRS) Descriptors from no pain to unbearable pain – patient should define these
- **Numerical scales** ~ 0-10 (O= No pain, 10 = Worst ever)
- **Visual Analogue Scales** (VAS) Patient indicates level or intensity of pain by placing a mark or indicating on a line.

The wound dressing should be appropriate to the type, location and size of the wound.

The wound dressing product should be acceptable to the patient, comfortable, trauma free on removal and take into consider such factors as odour and taking into account their culture and beliefs.

The wound dressing product should be used in accordance with the manufacturer’s instructions.

If there is leakage or strikethrough causing a break in the barrier that the dressing provides to external contamination, the dressing should be changed.

If it not possible to change the dressing in a timely manner, then an appropriate physical barriers needs to be established, with application of dressing pad over area of strikethrough. If leakage or strikethrough occurs frequently it may be appropriate to re-evaluate the dressing product choice.

The effectiveness of the selected dressing product should be evaluated after one week, unless there is an adverse reaction to the dressing product. Any suspected adverse reaction from the wound dressing product should be reported via the Trust clinical incidence reporting system and the TVN alerted.

Position Document : Pain at wound dressing changes'
9.19 The effectiveness of the dressing product and wound assessments/evaluations should be recorded in the patients’ electronic records or other appropriate Trust documentation.

9.20 Methods for wound management should be re-assessed at each dressing change.

10 ASSESSMENT AND TREATMENT OF WOUNDS

10.1 As it is not possible to list every possible type and location of a wound, staff should ensure that where the wound appears outside of their clinical competency they ensure timely assessment by a qualified professional. In the first instance this may be a competent colleague, medical staff member or referral to the Trust TVN. However, if the wound is ‘acute’ in nature timely transfer and assessment by Accident and Emergency should be considered.

10.2 Access to and use of Telemedicine

Tele-medicine or remote review of wounds is a facility that allows staff to remotely connect with a member of the Tissue Viability team to support timely and specialist review of wounds. It is not intended as a replacement to urgent / emergency care where specialist hospital based review may be indicated.

Clinical judgement is required to ensure that patient care is not adversely impacted by any potential delays.

- Tele-medicine review is an ‘opt in’ facility available to the staff during the normal working day (0900-1700 – Mon-Fri). By ‘opt-in’ this means that consent by the service user is required for it to be undertaken. Staff are responsible for obtaining consent from the service user. This consent can be sought via witnessed verbal consent or by written (time allowing – using PGN CNTW (O) 45). Where verbal consent is taken this must be recorded in RiO.

- Staff will then contact the TVN’s using the specified remote solution (i.e. iPod, Android device etc.). A procedural guide and unit based instruction should have been provided to the clinical area when the devices were introduced. **Staff who are not trained should not use the solution without assistance and support from someone familiar and competent to use the equipment.** Staff who have not received training can view the Tissue Viability Assessment eLearning via the RiO User Guides site on the Intranet. Ward Link Nurses can provide and cascade training via ‘train the trainer’. If more in depth or face to face training is required, staff can request this via the Informatics Training Team (IMTTrainingDL@CNTW.nhs.uk).

- A meeting request will be made via the solution to the TVN team who will arrange a remote review time slot at their earliest convenience.

- The TVN will then initiate the call back and support the review of the wound.

- Where a photograph is required to be taken for clinical reference by either MDT staff or at the request of the TVN, this may be done. Photographs can only be taken on Trust encrypted devices. MDT staff should then send this photograph to the TVN via e-mail (secure e-mail arrangement) for upload to the health record. Once this has been sent to TVN/uploaded to the health record, the
image must be deleted from the device. Any photographs stored on CNTW encrypted devices should only be retained for as long as is needed and no longer than 30 days.

- Where extended use of personal identifiable information is required i.e. sharing for training or publishing purposes, specific permissions need to be sought from the service user in line with Trust PGN CNTW(O)45 – Visual Imaging and Audio Policy.

There is an assumption of capacity to share information for adults and children over the age of 13 years. Where capacity to share information is questioned or queried, a capacity assessment should be undertaken by the clinical team and any appropriate decision makers, and where appropriate a ‘Best interest decision’ should be considered. Appropriate recording of the assessment and any best interests’ decision must be documented via the health record.

11 GENERAL GUIDE TO WOUND MANAGEMENT

11.1 Acute wounds normally heal within an expected time frame and they may heal by primary, secondary or tertiary intention.

11.2 Acute wounds should be assessed and managed using the following principles:-

- Ward staff should liaise with relevant ‘acute trust provider’ to ensure the aims and methods of treatment are handed over to our team and where necessary TVN is involved. e.g. time span for suture removal, recommended dressing type etc

- Consider the wound history and presence of foreign bodies e.g. trauma

- Wounds maybe contaminated and may require tetanus injection

- Consider the position of the wound e.g. wounds over a joint may be susceptible to stretching, wounds near in/near axilla, groin and anus may be more susceptible to infection due to warm, moist environment: the position of the wound may influence dressing choice

- Surgical wounds healing by first / primary intention, aim to promote primary wound closure, wound maybe left exposed. If patient requests cover for aesthetic reasons or to stop irritation from clothing, vapour-permeable film or island dressing.

- Traumatic wounds/human/animal bites following basic first aid and follow-up referral for Accident and Emergency, GP or Minor Injuries Unit requires dressing selection taking into account TIME wound assessment. Incidents classed as inoculation injuries should also be actioned in-line with the Trust’s CNTW(C)46 – Inoculation Policy

- Always consider tetanus status and possible antibiotic cover with contaminated or high risk wounds
- Skin tear/Pre-tibial injuries – attempt to re-oppose any skin flap after thorough wound. Refer to Appendix 6 - ‘Aide Memoire’ – Skin Tear

- Pilonidal sinus care will be dictated by presentation of the wound (depth/size) and any surgical intervention (Pre or post abscess management). For patients left to heal by secondary intention and presenting with cavity they will require a specific and tailored dressing plan, this should be completed with the TVN. The dressing chosen to pleat and fold into the cavity will depend on the results of the TIME wound assessment

- Burns and scalds require initial treatment to cool. For deep/extensive burns or where staff are unsure of extent of injury, prompt referral and assessment via Accident and Emergency or specialist burns teams is essential. (Burns team are happy to provide phone triage / support for queries) Any post assessment management should involve the TVN so they can assist the team in management and sourcing of required dressings

- Chronic wounds which fail to heal or where delayed, halted or failed closure of wounds occur refer to TVN

113 General principles:-

- Treatment will be based largely on managing or resolving the under laying causes
- Assess and address local barriers to wound healing using the TIME wound assessment tool
- Assess and address wider factors delaying healing

12 Leg Ulcers

12.1 Leg ulcer management requires specialist assessment and advice and staff should refer to Trust TVN

122 General principles:-

- A leg ulcer may be due to a number of underlying pathologies, including venous disease, arterial disease and rheumatoid arthritis, either alone or in combination
- Accurate diagnosis of the underlying cause is an essential part of management. The specific knowledge and competencies required by registered nurse who encounter patients with leg ulcers should include:-
  - General assessment of the patient using a dedicated tool (TVN has this)
  - Differential diagnosis with the use of Doppler ultra sound / Vascular assessment
  - T.I.M.E wound assessment
Treatment priorities:-

- Identifying and address the cause of leg ulceration with differential diagnosis to assist with identification and address the underlying cause. Bandage regime as appropriate, the theory, application and management. Provide health promotion advice aiming to prevent recurrence

- Wound cleansing: This may require specialist products, seek advice from TVN

- Debridement: This may require specialist products, seek advice from TVN. The presence of devitalized tissue can prevent or delay healing. When considering debridement options consideration to the underlying circulation and blood supply is essential to whether healing is a realistic goal

- Dressing choice should be made by a registered healthcare professional and should be based on the principles of TIME assessment and consistent with patient goals (pain relief, odour)

- Whilst wound care and wound bed preparation plays an important role in the management of leg ulcers it is important to remember that wound dressing selection is supported with an appropriate bandaging regime.

Pressure Ulcer

13.1 Please refer to the Trust’s CNTW(C)18 – Tissue Viability Policy, practice guidance note - TV-PGN-02 - Pressure ulcer care.
Each wound requires a separate care plan

<table>
<thead>
<tr>
<th>Surname:</th>
<th>Patient Rio:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forename:</td>
<td>D.O.B:</td>
</tr>
<tr>
<td>Address:</td>
<td>NHS №:</td>
</tr>
<tr>
<td>Sex:</td>
<td>M / F</td>
</tr>
</tbody>
</table>

Is the patient known to District Nursing team, TVN’s, Practice Nurse or Nursing home team for management of this wound? Yes ☐ No ☐ NA ☐

If yes, what is the dressing regime used in the community prior to admission?

Mark wound site on body map

Wound size (in cm) | Width: | Length: | Depth: | Photograph taken: Yes / No
|------------------|--------|--------|--------|-----------------------------|

Exudates: None / Scant / Moderate / Copious
Exudates colour: Serous (clear) / Haemoserous (clear/blood) / Purulent(Yellow/green)
Odour: Malodorous / Offensive. Present / Slight / None
Pain at dressing change: Yes / No
Wound infection: Yes / No
Wound swabs taken: Yes / No
Pictorial Care plan completed: Yes / No / N/A

Initial Plan | Wound to be dressed with: | Date: | Signature / Initials
|-------------|-----------------------------|-------|------------------|

Frequency | Daily / Alternate Days / Twice Weekly / Weekly | Time: |
<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Wound Assessment (Please Tick)</th>
<th>Dressing Regime Action Taken if Wound is Deteriorating / Static or Improving</th>
<th>Dressed by?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
<td></td>
<td>Dressed by</td>
</tr>
<tr>
<td>Time:</td>
<td></td>
<td></td>
<td>(Signature / Initials)</td>
</tr>
<tr>
<td>Date:</td>
<td></td>
<td></td>
<td>Dressed by</td>
</tr>
<tr>
<td>Time:</td>
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<td></td>
<td></td>
<td>(Signature / Initials)</td>
</tr>
</tbody>
</table>

Key for Wound Reassessment

- = Wound Improving
- = Wound the same
- = Wound deteriorating
Heel Damage Aide Memoire

1. Pressure damage identified on patients heel

2. Classification

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non blanchable redness</td>
<td>Partial thickness loss of Dermis. May appear as an open shallow ulcer, blister or de-roofed blister.</td>
<td>Full thickness tissue loss, bone tendon &amp; muscle NOT visible or palpable.</td>
<td>Full thickness tissue loss, with exposed structures (Bone, tendon etc.)</td>
</tr>
<tr>
<td>In patients with darkly pigmented skin, skin may appear as discoloration. May present as soft, hard, warm or cool.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Documentation

Ensure Braden Scale, MUST, Wound Assessment, Positional change chart are completed. Where risk of infection may be present staff should also ensure baseline observations and NEWS charts are completed and monitored.

4. Management

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3/4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offload heel, document all interventions. Assess patients ability to re-position independently and advise accordingly. DO NOT apply dressings. Monitor Daily Complete electronic reporting</td>
<td>Offload heel &amp; provide positional changes, if patient unable to do so independently. If presents as blisters and remains intact, do not apply dressing or burst blister. If skin broken apply simple dressing in accordance with wound care formulary and contact TVN &amp; complete electronic reporting</td>
<td>Apply appropriate dressing in accordance with wound care formulary. Offload heel. Ensure positional changes. Assess nutritional status &amp; mobility. Dry necrotic tissue not to be debrided or re-hydrated. Seek specialist advice from TVN and complete electronic reporting</td>
</tr>
</tbody>
</table>

5. Reporting and Recording

- All diabetic patients with pressure damage to the feet MUST be referred to podiatry
- Complete electronic reporting and notify TVN as soon as possible for review.
- If Category 3/4 noted and believed to be avoidable then complete electronic reporting and consider Local authority safeguarding alert. (Discuss with TVN or safeguard team if unsure)
- Ensure that Rio and or pictorial care plans are in place. Note all interventions in RIO.

6. Reassess - It is essential that patients are reviewed on an ongoing basis, particularly if the condition remains static or deteriorates.

Adapted from original by Jeanette Milne - South Tyneside NHS Foundation Trust 2014
Adapted from Jeanette Milne—South Tyneside NHS Foundation Trust 2013
Over-granulation pathway

1. Assessment (Ensure Malignancy has been excluded)

Granulation tissue proud of the skin
Increased levels of exudates
Bleeds Easily
Peri-wound excoriation

Pathway 1

Increase in size suspected infection / Critical colonisation
(Tissue bleeds readily, malodour, pain, tissue colour changes - pink to dark purple)

Arrange Medical and TVN review

Reassess in 1 Week

Pathway 2

No foreign body present

Apply moderately potent topical steroid daily for one week, then alternate days for another week - review

Please note - If patient immune compromised, use moderately potent topical steroid with an antimicrobial.

Pathway 3

Evidence of Foreign body e.g Sutures / Clips, PEG, Suprapubic Catheter etc.
If clinically competent to do so remove sutures when appropriate.

Manage the symptoms - apply topical antimicrobials for two weeks, review daily.

2. Reassess - Reassess as clinically indicated by patients condition

If symptoms resolve, revert to standard wound care. If symptoms persist follow Pathway 2 but follow advice for immune compromised patient.

If symptoms resolve, revert to standard wound care
If static refer patient to Tissue Viability Nurse

If symptoms resolve, revert to standard wound care. If symptoms persist contact the relevant team for advice and review.

If symptoms persist or reoccur or patient has more than two episodes in 3 months, apply topical antimicrobial to manage symptoms and refer to Tissue viability nurse.

3. Documentation

- Complete Wound assessment & relevant risk assessment documentation
- Record clearly the assessment process and evaluation in RiO
- Refer to Tissue Viability Nurse for advice and or assessment.

Adapted from original by Jeanette Milne - South Tyneside NHS Foundation Trust 2014
## 1. Reduced Skin Integrity

## 2. Classification

<table>
<thead>
<tr>
<th>Healthy</th>
<th>Excoriation</th>
<th>Moisture Lesion</th>
<th>Combined lesion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not dry, scaly or moist</td>
<td>Erythema / Redness</td>
<td>Moisture is present</td>
<td>One or more elements of skin damage caused by pressure, moisture or both</td>
</tr>
<tr>
<td>Diffuse irregular shape</td>
<td>Diffuse superficial spots</td>
<td>‘Butterfly or Kissing’ lesion</td>
<td>Bony prominence periwound area</td>
</tr>
<tr>
<td>Skin intact</td>
<td>Irregular wound edges</td>
<td>Partial thickness skin loss</td>
<td>Necrosis may be present</td>
</tr>
<tr>
<td>Wet / moist</td>
<td>Necrosis may be present</td>
<td>Necrosis may be present</td>
<td>Distinct edges, over bony prominence, irregular margins to satellite lesions.</td>
</tr>
<tr>
<td>Consider pain relief</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Erythema / Excoriation</th>
<th>Moisture lesions</th>
<th>Combined Lesion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shower / Wash</td>
<td>Shower</td>
<td>Shower / Clean</td>
<td>Shower / Clean</td>
</tr>
<tr>
<td>Observation</td>
<td>Wash with warm water and hydromol as soap substitute</td>
<td>Wash with warm water and hydromol as soap substitute</td>
<td>Apply appropriate wound care and Tailor skin care to suit the wound, its location and presenting symptoms e.g. Exudates management, excoriation.</td>
</tr>
<tr>
<td>Repositioning / Assess for Hydration and Nutrition—Encourage healthy balanced diet.</td>
<td>Use a barrier cream or film every 3rd wash or every 24hrs.</td>
<td>Use a barrier cream or film every 3rd wash or every 24hrs.</td>
<td>Use a barrier cream or film every 3rd wash or every 24hrs.</td>
</tr>
<tr>
<td></td>
<td>Reposition / Assess for Hydration and nutritional needs.</td>
<td>Reposition / Assess for Hydration and nutritional needs.</td>
<td>Reposition / Assess for Hydration &amp; nutritional needs.</td>
</tr>
</tbody>
</table>

## 3. Documentation

Complete Braden Scale, repositioning chart, MUST and Electronic incident reporting as well as RIO. Where concerns are noted refer to TVN.

## 4. Management

<table>
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<td>Reposition / Assess for Hydration &amp; nutritional needs.</td>
</tr>
</tbody>
</table>

## 5. Reporting and Recording

Complete electronic reporting, record when the incident occurred and how? Refer to Tissue Viability Nurse for specialist advise and support if required.

## 6. Reassess on each personal care intervention or as clinically indicated

Adapted from original by Karen York - Northumbria Healthcare NHS Foundation Trust 2014
1. Skin Tear identified

2. Classification

<table>
<thead>
<tr>
<th>Type 1</th>
<th>Type 2</th>
<th>Type 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="Image" alt="Type 1" /></td>
<td><img src="Image" alt="Type 2" /></td>
<td><img src="Image" alt="Type 3" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin Tears without tissue loss</th>
<th>Skin Tears with partial Tissue loss</th>
<th>Skin Tears with complete tissue loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linear and flap type skin tears. Skin flap can be approximated so that no more than one millimetre of dermis is lost.</td>
<td>2a – 25% or less of the epidermal flap is lost and at least 75% or more of the dermis is covered by the flap. 2b – Moderate to large tissue loss, in which more than 25% of the epidermal flap is lost and more than 25% of the dermis is exposed.</td>
<td>Epidermal flap is absent</td>
</tr>
</tbody>
</table>

3. Documentation

Complete wound assessment and risk assessment documentation, complete IR1 and refer to Tissue Viability Nurse

4. Management

<table>
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<td><img src="Image" alt="Type 3" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clean wound with normal saline and pat dry the area</th>
<th>Control the bleeding, apply pressure and elevate limb if required</th>
<th>Control the bleeding, apply pressure and elevate limb if required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apply a silicone dressing that is at least 1-2cm bigger than the skin tear</td>
<td>Clean wound with sodium chloride 0.9% and pat dry the area</td>
<td>Clean wound with sodium chloride 0.9% and pat dry the area</td>
</tr>
<tr>
<td>Indicate by drawing an arrow on the dressing, the direction the dressing needs to be removed. Also put date of application on dressing - see picture below.</td>
<td>Approximate the skin flap; use a gloved finger</td>
<td>Approximate the skin flap; use a gloved finger</td>
</tr>
<tr>
<td>Leave dressing in situ for as long as possible to avoid disturbing the flap.</td>
<td>Avoid adhesive strips</td>
<td>Avoid adhesive strips</td>
</tr>
<tr>
<td>Take care when removing the dressing so as not to damage the flap</td>
<td>Apply a silicone dressing that is at least 1-2cm bigger than the skin tear</td>
<td>Apply a silicone dressing that is at least 1-2cm bigger than the skin tear</td>
</tr>
<tr>
<td>Determine date of wound review and dressing change: document in Rio</td>
<td>Indicate by drawing an arrow on the dressing, the direction the dressing needs to be removed. Also put date of application on dressing - see picture below. Leave dressing in situ for as long as possible to avoid disturbing the flap.</td>
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</tr>
<tr>
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<td><img src="Image" alt="Type 2" /></td>
<td><img src="Image" alt="Type 3" /></td>
</tr>
</tbody>
</table>

5. Reporting, Recording, Action and Learning

Complete electronic reporting, record when the incident occurred and how? Refer to Tissue Viability Nurse for specialist advise and support if required

6. Reassess - Reassess on each dressing change and as clinically indicated

Adapted from original by Jeanette Milne - South Tyneside NHS Foundation Trust 2014