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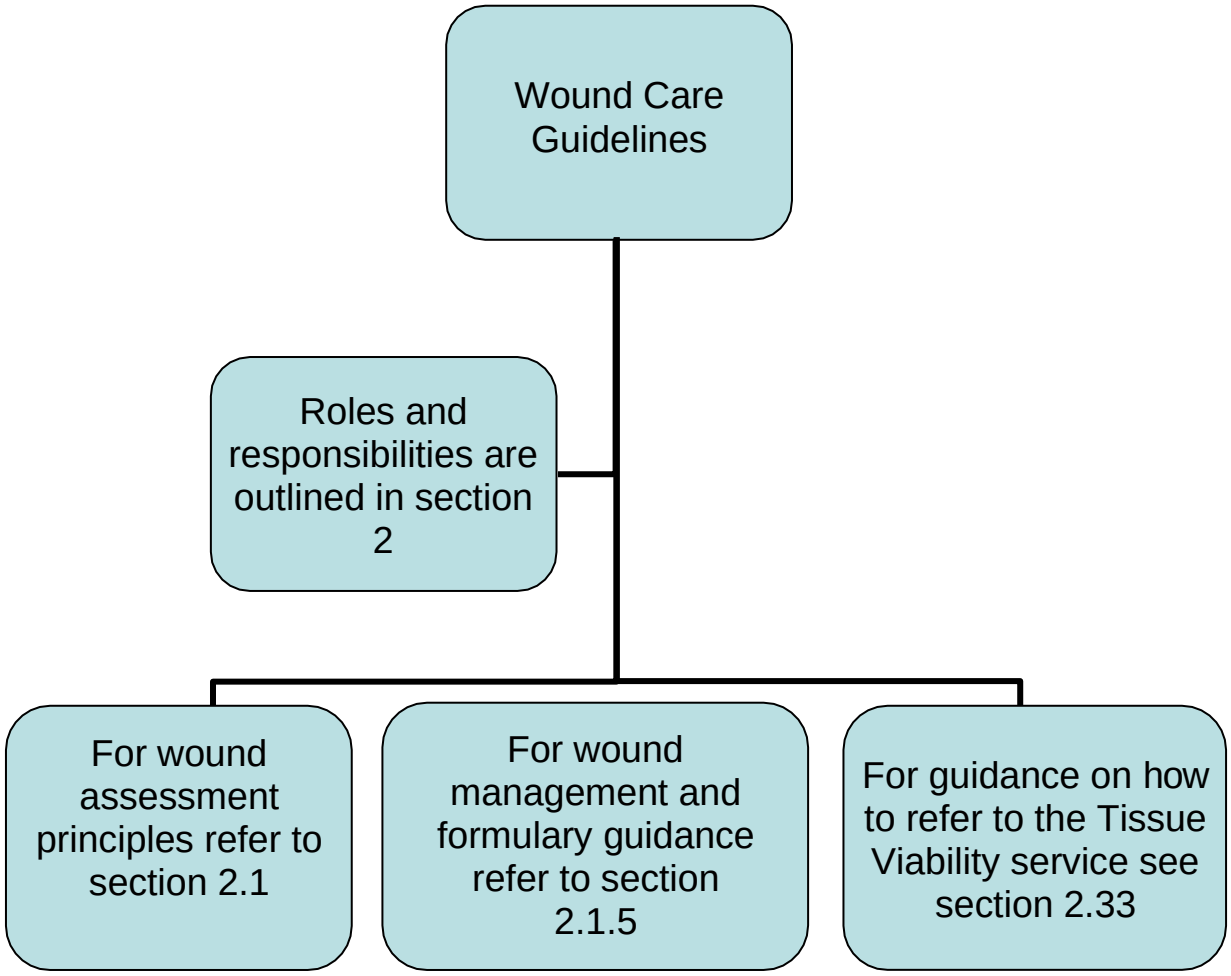
Royal Cornwall Hospitals NHS Trust

Wound Care Clinical Guideline

V2.0

February 2023

Summary


Wound Care Guidelines
Roles and responsibilities are outlined in section 2
For wound assessment principles refer to section 2.1
For wound management and formulary guidance refer to section 2.1.5
For guidance on how to refer to the Tissue Viability service see section 2.33

1. Aim/Purpose of this Guideline

1.1. The provision of effective wound care is dependent on a systematic and holistic individualised patient approach together with sound knowledge of anatomy and physiology, wound healing principles and appropriate wound management dressings.

1.2. Financial costs of managing acute and chronic wounds continue to rise and are estimated to be £4.5-£5.1 billion per year. Guest et al (2015).

1.3. Human costs of living with a wound cannot be measured however they include social isolation, impaired quality of life, pain and debilitation and potential loss of income.

1.4. Wound healing is a natural restorative response to tissue injury which involves the interaction of a complex systematic cascade of cellular phases; haemostasis, inflammation, proliferation and maturation to restore injured skin. Simon et al (2016)

1.5. This guideline aims to provide an evidence-based framework for the assessment and management of acute and chronic wounds in accordance with local and national guidelines. It is intended to be used by all staff employed within the Royal Cornwall Hospitals NHS Trust. (RCHT).

1.6. This guideline supports the use of the Cornwall Health Community joint wound dressing's formulary which has been developed in collaboration with RCHT, CFT and the CIOS ICB.

1.7. The guideline should be used as an adjunct to clinical judgement and individualised holistic patient assessment.

1.8. This version supersedes any previous versions of this document.

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2. The Guidance

2.1. Wound Assessment principles

2.1.1. A comprehensive, patient and wound assessment must be completed and documented by a Registered Nurse or Assistant Practitioner using the RCHT wound assessment tool (CHA 3903) when the wound is first identified.

2.1.2. This should include assessment of the wound, the surrounding skin, presence of infection or biofilm, the individual's ability to heal considering nutritional status, continence, general physical and psychological health, past and current systemic and local treatments, medications, comorbidities, environment of care, other factors influencing ability of the wound to heal. The wound size must also be recorded.

2.1.3. Reassessment of the wound and the impact of the dressing plan should be undertaken according to the wound characteristics and effectiveness of the dressing.

2.1.4. Wound photographs can be a useful method of recording wound characteristics. The RCHT policy re the management of information and records should be followed with specific reference to consent. The general consent to recording form CHA 2891 must be used and filed in the patient record prior to taking photographs.

Management of Information Records and Data Quality Policy

Medical photography can also be contacted VIA switch to assist with gaining wound images.

2.1.5. The RCHT wound assessment tool is based on the **TIME** framework (Falanga 2004) which was developed by an International Advisory Board. The wound surface and the skin are also included to ensure a thorough assessment of the wound in relation to specific criteria.

- **T = Tissue non-viable**

  It is important to identify any non-viable tissue at an early stage as this has the potential to lead to infection and delay in wound healing. The wound bed will show signs of tissue necrosis or slough which is most circumstances will require debridement. (See section 2.24).

- **I = Infection or Inflammation**

  Wound infection is defined according to an infection continuum (see section 6.1) and early recognition of subtle signs of infection is key to preventing spreading and

systemic infection and sepsis. Inflammation especially if chronic will significantly delay wound healing and must be recognised and treated for a wound to heal.

- **M = Moisture imbalance**

  Creating an ideal environment for wound healing is essential. If a wound is too dry epithelial tissue will not progress over the wound surface. If the wound is too wet the wound will become saturated and the surrounding skin macerated and excoriated.

- **E = Edge of wound non-advancing or undermined.**

  When the edge of the wound fails to progress, there may be a specific cause such as malignancy or inflammation which must be identified and treated. **Refer to the Tissue Viability team who will assess the need for biopsy to confirm diagnosis.**

- **S = Skin.**

  Identifying the patient's skin type especially around the wound site can detect if there are any other factors influencing wound healing such as infection, dry, cracked skin which increases infection risk and / or maceration from wound exudate.

2.1.6. Protecting the surface of the wound to prevent trauma and pain is of paramount importance. Wounds will fail to heal if the surface is unprotected whilst risk of infection increases.

2.2. Wound characteristics

A wound can present with a variety of tissue types, namely necrosis, slough, granulation, and epithelializing tissue. They can be a combination of any of these and it is important to identify the type of tissue present when assessing a wound to be able to determine the correct management actions.

- **Necrosis:**

  Necrosis indicates dead tissue and can present as black or brown in appearance. It can present as dry necrosis or wet necrosis.

  Necrotic tissue interferes with cell migration, wound contraction, and epithelialisation and in most circumstances, should be removed. It increases the risk of clinical infection and whilst present on or in the wound it may be difficult to determine the true depth of tissue damage. Wet necrosis produces higher levels of exudate and can also have an odour as the necrosis breaks down.

- **Slough:**

  Slough is the accumulation of dead cellular debris and can have a yellow, white or grey colour. Some wounds have areas of fibrous tissue which can combined with slough can be challenging to remove. The presence of slough can delay healing and can act as a source of infection.

- **Granulation:**

  Granulation tissue when healthy is red and moist and often has an uneven texture. It forms at the base of wounds and comprises of new capillary vessels and cells which produce collagen to form an extra cellular matrix. Granulation tissue can be fragile. Unhealthy granulation tissue appears dull or pale and can bleed easily indicating infection or ischaemia. Occasionally the tissue can become over granulated above the level of the wound and prevents epithelisation. Infection can be a cause of some wound dressings can cause an exuberance of new tissue.

  Over granulation is described as an excess of granulation tissue beyond the level of the wound bed. It can delay healing as it prevents epithelialisation. It can be caused by infection, biofilm or by dressings which encourage growth of granulation tissue such as Hydrocolloids.

- **Epithelialising:**

  Epithelialising tissue is the final stage of healing where the cells migrate across the wound bed from the wound margins. The cells can appear translucent or pink / white in colour.

2.3. Factors affecting wound healing.

The ability of the wound to heal in a timely way is influenced by several factors which should be taken into consideration as well as the specific wound and skin assessment process. (DH 2010)

- A person's general physical and psychological health and the type of illnesses and the level that they affect the patient. Level of cognitive impairment as well as behavioural and lifestyle choices.
- Current systemic and local treatments.
- Nutrition and hydration status
- Blood supply to the wound and peri wound area.
- Wound temperature
- Levels of oedema
- Disruption to normal sleep pattern and where the patient sleeps

- History of smoking and alcohol consumption
- Medications such as steroids, immune suppressants and chemotherapy
- Allergy status
- Level of mobility
- Blood glucose levels and any other outcomes of investigations relevant to underlying comorbidities such as blood pressure.
- Outcomes of interventions such as duplex scans, x rays.

2.4. General Medical History

Assessment should consider the current and past medical history as well as medication history, allergy status, mobility, previous and planned procedures and fundamental patient observations including TPR, blood glucose and standard blood testing.

2.5. Nutritional assessment

All patients will have had a Malnutrition Universal Screening tool (MUST) nutritional assessment completed on admission to hospital. Interventions will depend upon level of risk however nutritionally compromised patients with wounds may have an increased dietary need and a referral to a dietitian for advice should be considered.

2.6. Psychological assessment

An assessment of the patient's ability to understand the cause and the management of the wound should be made to plan appropriate and realistic care. Understanding the needs of the patient is important and involving them in their care where possible can help with concordance and participation in care.

2.7. Pain assessment

2.7.1. An individual's experience of pain is unique, complex and influenced by many factors. Minimising pain at dressing change is an essential part of the wound management process.

2.7.2. The level of pain experienced by the patient should be assessed and recorded on the wound assessment chart. The level of pain experienced should be kept to a minimum and analgesia should be provided as required. Referral to the Pain team should be considered if pain is not well controlled.

2.8. Wound type

Wounds can be classified as Surgical, Acute or Chronic.

2.9. Surgical wounds.

2.9.1. These are intentional acute wounds created through surgery. They predominantly heal through primary intention where the skin edges are held together by sutures, clips, tapes or glues. Closure techniques include:

- Primary where the wound is closed at the time of surgery.
- Delayed primary where the wound is closed within 4-6 days.
- Secondary closure within 10 – 14 days.

2.9.2. Occasionally wounds are unable to be closed and these are therefore left to heal by secondary intention.

2.10. Acute wounds.

These are usually traumatic wounds such as cuts, abrasions, skin tears, pre-tibial lacerations, burns or other traumatic wounds.

- Skin tears result from separation of the top 2 layers of the skin. The wound is generally superficial and is common on the arms and hands in the elderly, dehydrated patient.
- Pre-tibial injury also affects the elderly where there is poor blood flow and underlying comorbidities. It can present as a small laceration or a deep degloving injury. They can be slow to heal because of underlying pathology and location over the bone.
- Surgical wound dehiscence can occur as a result of wound infection as well as factors such as obesity, malnutrition, post operative oedema, medications such as steroids and other immune suppressants.

2.11. Chronic wounds.

2.11.1. Chronic wounds are classified as those wounds which have failed to progress through the normal healing process in a timely manner. (Frykberg and Banks 2015)

2.11.2. They include pressure ulcers, leg ulcers diabetic foot ulcers and fungating wounds. Longstanding sinuses or fistulas are also included.

2.11.3. Reasons for the delay in healing may be multi factorial and include underlying disease such as peripheral vascular disease, comorbidities such as diabetes, ongoing pressure / shear and malnutrition.

2.12. Pressure ulcers

- Pressure ulcers are areas of localised damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. (NPUAP 2016) The damage can present as intact skin or an open ulcer. Classification is based on the NPUAP (2016) where the pressure damage is classified as category 1-4 with Unstageable and Deep tissue injury.

- All pressure ulcers should be reported on Datix to ensure monitoring of incidents which is facilitated by the Tissue Viability Service.

- A more detailed understanding of pressure ulcer assessment and management can be found in the RCHT Pressure Ulcer prevention guidelines.

http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/CorporateClinical/PreventionOfPressureUlcersPolicy.pdf

2.13. Leg ulcers

- Leg ulcers are defined as open lesions between the knee and the ankle and can be venous, arterial, mixed disease or because of an underlying condition such as sickle cell disease. Venous ulceration is as a result of underlying venous hypertension whilst arterial ulceration results from reduced blood flow to the lower leg as a result of stenotic or occlusive arterial disease. Patients with mixed disease ulceration usually present with a combination of venous and arterial disease- the degree of which can vary

- Leg ulcers should be assessed using the RCHT wound assessment tool (CHA 3903 V1) and dressed appropriately, community practitioners should be contacted where possible to ensure continuation of care. Where compression therapy is indicated this should be replaced with standard bandaging regime and elevation. If there are concerns regarding deterioration of leg ulcers with suspicions of either infection or increasing disease a referral to Tissue Viability or Vascular surgery can be made.

2.14. Diabetic foot ulcers (DFU)

- Diabetic foot ulcers (DFU) are complex, chronic wounds that develop as a result of neuropathy and / or vascular disease. The development of a DFU is often seen as a pivotal event in the life of a person with diabetes and a marker of serous disease and comorbidities. (Wounds International 2013)

- Diabetic foot ulcers are managed by the specialist podiatry service and referral to this service at RCHT is via the Maxims referral system. Accurate assessment information is required on the referral to facilitate a timely review. A hot foot service involving the podiatry, vascular, orthopaedic and endocrinology MDT is also available.

2.15. Fungating wounds

- Fungating wounds are wounds which arise from a tumour. Once ulcerated, they can be malodourous with high levels of exudate. They are prone to bleeding and wound tissue can be very fragile.

2.16. Fistula and Sinus wounds

- A Fistula is defined as an abnormal tract between 2 epithelial surfaces connecting one viscera to another or to the body surface. Examination of the exudate will often indicate the source of the fistula.

- A Sinus is a discharging blind end tract that extends from the surface of the body to an underlying area of abscess cavity.

2.17. Wound exudate

2.17.1. Exudate is fluid that is naturally produced because of injury or wounding. It is a normal part of wound healing and promotes a moist environment which allows cells to migrate across a wound bed. (Dowsett 2011) It can vary in volume, consistency, and biochemical composition and as such can be either beneficial or harmful to underlying tissues and surrounding skin as in chronic wounds.

2.17.2. Exudate can be defined by colour as follows:

2.17.2.1. Clear – represents serous exudate which is considered as normal. Can be confused with urine or lymphatic leakage so assessment is vital.

2.17.2.2. Cloudy, creamy or milky – may indicate presence of inflammation or infection.

2.17.2.3. Pink or red – indicates presence of red blood cells / capillary damage.

2.17.2.4. Green / yellow fluorescence – can indicate infection caused by Pseudomonas.

2.17.2.5. Yellow or Brown – Indicates presence of slough or could be indicative of fistula.

2.17.2.6. Grey or blue – may be as a result of the use of silver dressings.

2.17.2.7. Documenting the amount of exudate can be difficult and it is recommended that the terms none, low, moderate or high are used. The viscosity of the exudate should also be recorded. High viscosity, where the exudate is thick and sticky, indicates infection, inflammation, necrotic material, enteric fistula or dressing residue. Low viscosity where the exudate is thin and runny indicates higher levels of venous or cardiac congestion or malnutrition.

2.17.2.8. Assessing exudate is an important part of wound assessment and wound management dressing selection is often based on the principles of moisture balance.

2.18. Assessment of the surrounding skin.

When assessing a wound, it is also important to assess the surrounding skin as this may also influence dressing selection. Consideration must be given to the quality of the surrounding peri wound skin and whether it is dry and dehydrated or moist and macerated. It may be fragile, bruised, erythematous or discoloured and vulnerable to further breakdown. The skin condition must be recorded on the wound assessment chart and a body map is skin is extensively discoloured / bruised.

2.19. Assessing for wound infection

All wounds should be assessed for the presence of infection. Wound infection is the invasion of a wound by proliferating microorganisms to a level that evokes a local and / or systemic response in the host. (Wound International 2016) The wound infection continuum describes the gradual increase in the number and virulence of microorganisms together with the host response.

- **Contamination:** The presence of non-proliferating microbes within a wound at a level that does not evoke a host response.

- **Colonisation:** The presence of microbial organisms within a wound that undergo limited proliferation without evoking a host response. Microbial growth occurs at a non-critical level.

- **Local Infection:** Bacteria and other microbes move deeper into wound tissue and proliferate at a rate that invokes a response in the host. Local infection is contained in one location, system or structure. Local wound infection often presents as classic (overt) signs such as erythema, local warmth, swelling, purulent discharge, increasing pain and odour. Subtle (covert) signs such as bleeding and friable tissue, wound breakdown or enlargement, delayed wound healing, new or increasing pain, increase in odour, hyper granulation may also be present.

- **Spreading Infection:** This is defined as the invasion of the surrounding tissue by infective organisms that have spread from a wound. Signs and symptoms extend beyond the wound border. Spreading infection may involve deep tissue, muscle, fascia, organs or body cavities.

- **Systemic infection:** Affects the whole body with microorganisms spreading throughout the body.

2.20. Over-granulating wounds

2.20.1. In some cases, it is possible for a wound to continue to form granulation tissue even when it has reached surface level. This is known as over- granulation, hyper-granulation or proud flesh. It is healthy or unhealthy. Healthy over-granulation presents as an overgrowth of pink, red bleeding cauliflower like moist tissue. It can be related to the use of Hydrocolloid dressings (Vandeputte and Hoekstra (2006) or a prolonged inflammatory phase of healing.

2.20.2. Unhealthy over-granulation tissue presents as either a dark red or pale purple uneven mass rising above the skin level. It may have a dull surface and bleed easily. It can delay healing and increase risk of infection. It can also be a sign of infection if associated with odour and increased exudate.

2.21. Wound Cleansing

2.21.1. Routine cleansing of clean granulating wounds with the aim of reducing bacterial loads has been found to be ineffective. (EWMA 2008).

2.21.2. Wound cleansing should be undertaken to remove debris which includes dressing residue and devitalised tissue and excess exudate.

2.21.3. Recommended cleansing solutions include normal saline 0.9% solution as single use sachets or pods in hospital. Tap water suitable for drinking can be used in a patient's own home. Solutions should be warmed prior to use to avoid reducing the temperature of the wound bed.

2.21.4. Routine use of topical antiseptics for wound cleaning is not recommended however they may be useful for those wounds presenting with obvious signs of critical colonisation including the presence of biofilm, necrotic tissue or debris. (Wounds UK 2013).

2.22. Wound swabbing

2.22.1. Wound swabs should be taken when clinical infection is suspected. Spreading redness, increased pain and odour and increased exudate are the classic signs. In some cases, failure of the wound to progress, friable, bleeding tissue and

unhealthy- looking granulating tissue may also indicate infection. Where slough is present this does not necessarily indicate the presence of infection unless there are other clinical signs.

2.22.2. Clinicians should consider the value of taking the swab and whether suspected bacteria on the wound are causing an infection that requires treatment.

2.22.3. When taking a wound swab, the surface of the wound should be cleansed first to remove surface bacteria. The tip of the swab should then be rolled in a zigzag manner across the wound bed.

2.22.4. The swab request form must be completely in full detailing the rationale and clinical indications of infection such as erythema, increased pain and exudate.

2.22.5. Once swab results are obtained it is important to ensure that the appropriate antibiotic / antimicrobial therapy is prescribed. Consider if antibiotics are required or whether topical antimicrobials will reduce the level of bacteria if confined to the wound bed alone.

2.23. Infection control principles when undertaking wound management.

2.23.1. When undertaking wound management, the use of ANTT must always be maintained according to the RCHT Infection prevention ANTT policy.

2.23.2. Strict standard precautions must be followed for any episode of care where there is contact with non-intact skin or body fluids, including undertaking wound management.

2.23.3. Wound dressings should be single use and any unused dressings should not be kept for use on the same patient or another patient.

2.23.4. Any wound that is clinically infected with MRSA must be treated with an antimicrobial dressing according to the Cornwall Health Community formulary recommendations. This will be discussed in more detail in the wound dressing section 2.2.7.

2.24. Wound debridement

2.24.1. Debridement is the removal of necrotic, devitalised, sloughy, infected tissue or foreign bodies from a wound. (Ousey and Cook 2012) Wound debridement is recommended in most cases to facilitate wound healing.

2.24.2. There are several methods of debridement:

- Autolytic – the body naturally removes the devitalised tissue. This process can be enhanced using dressings such as hydrogels / hydrocolloids which facilitate debridement of the wound.

- Bio surgical – the use of sterile larvae (Maggots). These are ordered via the pharmacy.

- Sharp debridement – the use of a sterile blade, scalpel or scissors to remove dead or foreign material to just above the level of viable tissue. This should only be undertaken by a healthcare professional that is competent in the technique and has approval to undertake this extended role.

- Surgical debridement – this is usually undertaken in a theatre environment by a surgeon. This facilitates rapid removal of devitalised tissue. RCHT have an agreed protocol for referral to a surgeon if surgical debridement for pressure ulceration is required.

  Debridement of Necrotic or Infected Pressure Ulcers Policy

2.25. Individualised patient centred wound management

2.25.1. Where possible the patient should be involved in their care and be aware of the potential risks and / or complications. They should be involved in the planning of their wound care considering their individual needs and preferences.

2.25.2. When discharging a patient from hospital the type and reason for the wound and treatment regime must be communicated to the ongoing health care team

2.25.3. The Community nursing team should receive a referral (usually by SERF referral) stating when the next dressing change is due, and this should be supported in writing using the Community Nursing referral letter.

2.25.4. 7 days' worth of dressings should be supplied on discharge to enable continuity of care.

2.26. Wound dressing selection

2.26.1. Wound dressing selection must be made on an individual basis following assessment using the RCHT wound assessment tool. CHA 3903 V1

2.26.2. The following criteria should be considered when selecting wound dressings.

The ability to:

- Prevent penetration of capillary loops into the dressing material to avoid dressing adherence and wound trauma.
- Maintain high humidity and optimum Ph. at the wound / dressing interface.
- Remove excess exudate, and toxic components from the wound.
- Maintain a moist environment but not macerated. (Exception where wounds need to be kept dry i.e. those with poor arterial circulation).
- Prevent particles and fibres being deposited in the wound bed.
- Allow gaseous exchange at the wound interface.
- Provide thermal insulation to encourage mitotic cell division.
- Be impermeable to bacteria.
- Allow dressing removal without causing trauma.

2.27. Dressing selection formulary guide – updated 2022

NECROTIC	Dressing selection	Instructions
Hydrocolloid	**Comfeel Plus Transparent**	Comfeel Plus Transparent is for low exudate wounds. Can be left in place for a week if required. Warm before application.
	Comfeel Plus	Comfeel Plus can be used on wounds with moderate exudate Do not use on infected wounds
Hydrogel	**ActivHeal Hydrogel**	Use to hydrate dry wounds
Hydrogel	**ActiFormCool Sheet**	To remain in place for 2-3 days. Use for rehydration and debridement. Cut to size. Not for cavity wounds

INFECTED / COLONISED	Dressing selection	Instructions
Antimicrobial Primary Silver	**Urgotul Ag/Silver**	To be used on low exudating infected wounds and under NPWT (Obtain from RCHT equipment library)
	Aquacel Ag+ Extra	Broad-spectrum antimicrobial and anti-

INFECTED / COLONISED	Dressing selection	Instructions
		biofilm. Can be used on wet wounds. Can be left in place up to 7 days. Use 2-3 weeks then wound reviewed. (Obtain from RCHT equipment library)
Alginate/Manuka Honey	**Algivon Plus** **Activon Tube** **Activon Tulle**	Alginate dressing impregnated with Manuka Honey. Useful for wetter wounds (Obtain from RCHT Equipment Library) Ointment impregnated with Manuka honey. (Obtain from RCHT Equipment Library) Tulle dressing impregnated with Manuka honey. Suitable for shallow wounds and those with lower exudate
Antimicrobial cream/ gel	**Flamazine (Silver Sulfadiazine 1% cream) 50g**	Topical antimicrobial cream. Can increase level of exudate therefore daily application recommended. Max 7-day open storage time. Not to be used 1st line for burns.
Antimicrobial cream/ gel	**Flaminal Hydro (blue) POM** **Flaminal Forte (yellow) POM**	Contains alginate and antibacterial enzyme. Used for dry wounds Contains alginate and antibacterial enzyme. Used for wet wounds
Cadaxomer Iodine	**Iodoflex**	For use on wet wounds. Do not use on patients with Thyroid disorders or sensitivity to Iodine. (Obtain from pharmacy)
Iodine Tulle	**Inadine**	Use for arterial, diabetic and minor trauma wounds. Not for use on wet wounds or on patients with sensitivity to Iodine. Colour change indicates when to change dressing.

SLOUGHY	Dressing selection	Instructions
Non-adherent poly absorbent fibre	**Urgoclean Pad** **Urgoclean Rope**	For low to moderate wounds. First line for cavity wounds. Record the number of ropes inserted into the wound cavity. Leave end of rope visible.
Biotherapy	**Larvae - Maggots**	RCHT order from pharmacy.

EPITHELIALISING	Dressing selection	Instructions
Polyurethane film	**Opsite Flexigrid**	Used to retain primary dressings or to protect newly epithelializing wounds. Used to reduce friction.
Adhesive Island	**Opsite Post Op** **Cosmopore**	Vapour permeable, waterproof / bacteria proof surgical wound dressing Not waterproof. Not first line for surgical wounds due to lack of bacteria and waterproofing capacity

ODOUR	Dressing selection	Instructions
Charcoal Dressing (Non Absorbent)	**CliniSorb**	Carbon dressing for malodorous wound.

GRANULATING	Dressing selection	Instructions
Foam Adhesive	**UrgoTul Absorb Border**	Low to moderately exuding wounds. First line skin tear dressing- not to be applied daily.
Foam Non-adhesive	**UrgoTul Absorb**	Low to moderately exuding wounds. Use under bandages or where adhesive dressings not suitable.
Non-adherent	**Atrauman**	Use where contact layer requires frequent changing. Petroleum free.
Silicone Non-adherent	**Adaptic Touch**	Use where dressing needs to stay in place for 7 – 14 days. Renew outer bandages / dressings as required

MISCELLANEOUS	Dressing selection	Instructions
Barrier	**Cavilon No Sting Barrier Film 1ml and 3ml**	Prevents maceration and for general skin protection. Ensure correct application. One application stick lasts 72 hours. DO NOT OVER APPLY.
Barrier	**Cavilon Film pump Spray 28ml**	Useful for larger areas of moisture associated skin damage (MASD)

MISCELLANEOUS	Dressing selection	Instructions
Barrier	**MediDerma-S Barrier cream 28g**	28g tube should be sufficient for 1 months' supply. Pea-sized amount applied daily or every 3rd to 4th episode of incontinence. Can be used on broken skin.
Absorbent Cellulose Dressing	**Zetuvit Plus** **Eclypse Range**	First line – superabsorbent secondary dressing for moderate to heavily exuding wounds Superabsorbent secondary dressing for heavily exuding wounds
Topical Negative Pressure Therapy	**PICO 7** **ActiVac** **VAC Ulta**	Single use portable negative pressure therapy device. Manages low volumes of exudate. Available via RCHT Equipment library Portable negative pressure therapy device. Requires consumables. Contact RCHT Equipment library to rent the device and obtain the dressings and canisters. Wound management system of Negative pressure therapy with an instillation option. Used for higher exuding wounds. Contact RCHT Equipment library to rent the device and obtain the dressings and canisters.
Bleeding wounds	**Kaltostat**	To aid the cessation of bleeding in wounds
Wound irrigation	**Normal saline 0.9% solution**	

BANDAGES	Dressing selection	Instructions
Type 1 retention bandage	**K-band**	Dressing retention bandage
Crepe Bandage	**Crepe bandage**	Conforming bandage used to hold dressings in place
Type 3a Compression	**K Plus**	Has a blue line through the bandage to aid application. Provides up to 20mmHG pressure at the ankle when applied in a Figure of 8. Latex free
Multilayer compression	**UrgoKTwo**	2-layer compression bandage system. Comes in standard and reduced compression

BANDAGES	Dressing selection	Instructions
Cohesive Short stretch	**Actico**	Inelastic short stretch bandage system. Apply after padding. Useful to manage Lymphoedema and chronic oedema.
Stockinette	**Comfifast blue-7.5cm** **Comfifast yellow-10.75cm**	Elasticated viscose stockinette. Used as a retention for dressings.
Paste bandage	**Zipzoc**	Zinc oxide impregnated medicated stocking. Can be used under compression as primary contact layer or for patients with dermatological conditions.
Padding	**K-Soft**	Absorbent, sub bandage wadding. Latex free. Used as under padding and to reshape limbs.
Compression Hosiery	**Altiform**	Ready to wear compression hosiery Class 1 – 3.

2.28. Treatment goals

In order to provide safe, effective wound care staff need to understand what their treatment goals are and what the wound dressing impact is expected to be.

2.28.1. Dry necrosis – treatment goals:

In most wounds there is a need to facilitate removal of necrosis through:

- Wound debridement if appropriate. **For those patients with circulatory impairment or Diabetes seek Vascular or Tissue Viability advice before debridement as it may be best to leave the wound dry.**
- Rehydration of the necrosis with hydrogel or hydrocolloid dressings.
- Consider antimicrobial dressings if wound is infected.
- Consider referral for debridement.

2.28.2. Wet necrosis – treatment goals:

To facilitate removal of necrosis and control exudate. Maintain healthy surrounding skin.

- fibrous wound dressing.
- consider antimicrobial if infected.

- larval therapy if not too wet.
- consider referral for debridement if dressings ineffective or risk of infection / sepsis is high.
- foam dressing.
- barrier cream or film.

2.28.3. Sloughy – treatment goals:

To facilitate the removal of slough and debris and manage moisture balance.

- If dry – hydrogel + / - foam dressing.
- If wet – fibrous dressing + / - foam dressing.
- cadexomer iodine.
- larval therapy.

2.28.4. Granulating – treatment goals:

To promote new granulation tissue by maintaining a moist wound environment.

- Hydrogel.
- ydrocolloid – (can cause hypergranulation).
- fibrous dressing.
- foam dressing.
- silicone dressing if shallow

2.28.5. Overgranulation – treatment goals:

To reduce the amount of granulation tissue to enable epithelialisation to occur:

- If using a hydrocolloid dressing change to a foam dressing. This is a non-traumatic option.
- Apply light pressure to wound bed using additional tape to secure secondary dressing in place.
- Apply steroid cream – (no evidence base to support this) or steroid tape such as Haelan tape.
- Silver nitrate – traditional practice which is reserved for more stubborn areas of over-granulation once other options have failed.

- Often a transient problem and will correct itself with no treatment.
- If not responsive to above treatments consider biopsy to exclude malignancy.

2.28.6. Epithelialisation – treatment goals:

To promote the final stage of wound healing and protect wound from trauma and drying out.

- thin hydrocolloid.
- silicone dressing
- non-adherent dressing.

2.28.7. Cavity wounds – treatment goals

Where cavity wounds are required to have dressings inserted the process detailed below must be followed:

- The number of dressings inserted into a cavity wound during surgery must be recorded on the operation sheet with clear post-operative instructions for removal and ongoing management of the wound.
- If wound dressings are to be continued the number of cavity fillers inserted must be recorded on the wound assessment and care plan sheet after each dressing change.
- It is recommended that a cavity filler is inserted that enables single piece removal to avoid leaving part of the dressing inside of the cavity.
- The end of the cavity filler / rope must be left visible at the entrance to the cavity.
- Discharge advice to the ongoing care team must include the number of cavity fillers inserted and the frequency of dressing change.
- No wound dressings should be left inside a cavity for longer than the manufacturers recommended guidance.

2.29. Management of the peri wound skin

Where wound exudate is high or expected to increase, the peri-wound skin must be protected with a barrier product which prevents moisture from damaging the protective function of the epidermis. Barrier films have been developed to provide a breathable, transparent, protective film which can last up to 72 hours. Products which have the potential to clog up the skin pores should be avoided.

2.30. Negative pressure wound therapy

Negative pressure wound therapy is a therapeutic technique using a vacuum assisted device and dressing to promote healing in acute or chronic wounds. The therapy involves using a sealed wound dressing system attached to a pump unit to create a negative pressure environment in the wound. The RCHT has specific clinical guidelines for the use of negative pressure wound therapy accessed via link below. http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/CorporateClinical/NegativePressureWoundTherapyProcedures.pdf

2.31. Skin tear guidance

2.31.1. A skin tear is a traumatic wound which occurs most often on extremities resulting in the separation of the epidermis from the dermis or both the epidermis and the dermis from the underlying structures.

"A skin tear is a wound caused by shear, friction, and/or blunt force resulting in separation of skin layers. A skin tear can be partial-thickness (separation of the epidermis from the dermis) or full-thickness (separation of both the epidermis and dermis from underlying structures.)" (LeBlanc and Baranoski 2011)

2.31.2. Specific wound assessment will be needed to determine the following:

- location
- dimensions (length, width depth)
- percentage of viable/non-viable tissue
- Degree of flap necrosis.
- presence of any haematoma
- type and amount of exudate
- integrity of surrounding skin

2.31.3. The STAR acronym may be used as a prompt to ensure the appropriate assessment and prompt treatment of skin tears (Stephen- Haynes and Carville 2011):

- **S**elect appropriate cleanser to clean the wound - saline or tap water.
- **T**issue alignment – if the skin flap is viable bring the edges together easing the flap into place using a gloved finger. If difficult to align a moistened glove of moist non-woven swab applied for 5-10 mins may help to rehydrate the area.

- **A**ssess and dress – select a soft silicone facing dressing and apply without tension over the flap with at least a 2cm overlap around the wound. Mark the dressing with an arrow to indicate the direction to which the dressing should be removed which will be in the direction of the approximated flap.

- **R**eview and re-assess - If possible, the dressing should remain in place for up to 5 days to avoid disturbance of the flap. Subsequent dressings should be every 3-5 days.

2.31.4. If there are concerns regarding the viability of the flap advice should be sought from surgeons or plastic surgeons regarding possible debridement and / or the need for skin grafting.

2.31.5. Many skin tears occur during routine patient care activities therefore it is important to try and create a safe environment. Identifying and removing factors that cause skin tears can help to reduce prevalence, particularly in the older person. Increasing awareness of risk by patients and carers should also be encouraged.

2.32. Tissue Viability referral

2.32.1. Referral to the Tissue Viability service should be undertaken using the MAXIMS referral system. The reason for referral should be clearly stated on the form.

2.32.2. The referral process can be found using the following link:

Tissue Viability Referral Pathway Policy

2.32.3. This process details the priority that referrals are considered by the team according to wound type and severity.

2.32.4. Urgent referrals will be accepted by phone and advice given or patient seen on the same day where possible.

2.32.5. The Tissue Viability service has the right to reject referrals based on the referral pathway if the criteria for referral is not met or where there is incomplete detail in the referral to enable a triage decision to be made.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	1. Completion of wound assessment charts 2. Formulary review
Lead	1. Tissue Viability Clinical Nurse Specialist 2. Tissue Viability Consultant Nurse
Tool	1. Simple audit tool with each element assessed 2. Meeting and consensus with CFT and CIOS ICB
Frequency	1. Annual Audit of compliance 2. Every 2-3 years
Reporting arrangements	Report will be shared at Governance and Senior Nurse Cabinet / Leaders meetings
Acting on recommendations and Lead(s)	Senior Nurse Cabinet / Senior Leaders
Change in practice and lessons to be shared	Annually or as required

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Wound Care Clinical Guideline V2.0
This document replaces (exact title of previous version):	Wound Care Clinical Guideline V1.1
Date Issued/Approved:	January 2023
Date Valid From:	February 2023
Date Valid To:	February 2026
Directorate / Department responsible (author/owner):	Heather Newton, Tissue Viability Consultant Nurse
Contact details:	01872 252673
Brief summary of contents:	Wound Assessment. Wound Management Formulary guidance
Suggested Keywords:	Wound care. Wound dressings. Wound dressing formulary
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Nursing Officer
Approval route for consultation and ratification:	RCHT Clinical Cabinet
General Manager confirming approval processes:	Louise Dickinson, Deputy Director of Nursing, Midwifery and Allied Health Professionals
Name of Governance Lead confirming approval by specialty and care group management meetings:	Louise Dickinson, Deputy Director of Nursing, Midwifery and Allied Health Professionals
Links to key external standards:	None required
Related Documents:	Cowan T (2014) Wound Care Handbook 7th edition. MA Healthcare.

Information Category	Detailed Information
	Dowsett C (2011) Moisture in wound healing: exudate management. British Journal of Community nursing 16 (supp 4) S6-12 European Wound Management Association (EWMA) (2008) Position document: Hard to heal wounds: A holistic approach. London. MEP Ltd. http://www.woundsinternational.com/pdf/content Falanga V. (2004) Wound bed preparation: science applied to practice. Introduction in Wound bed preparation. EWMA Position document. MEP Ltd. www.ewma.org Guest et al. Health economic burden that wounds impose on the National Health Service in the UK. 2015 BMJ. LeBlanc, K. Baranoski, S. (2011) Skin Tears: State of the Science: Consensus Statements for the Prevention, Prediction, Assessment, and Treatment of Skin Tears. Adv Skin Wound Care; 24(9):2-15 Ousey K, Cook L (2012) Wound assessment Made easy. Wounds UK Vol 8 No 2. www.wounds-uk.com/made-easy Simon et al. Skin Wound Healing. 2016. Medscape. Stephen-Haynes, J. and Carville. (2011) Skin Tears made Easy. Wounds International 2(4) November. http://www.woundsinternational.com/made-easys/skin-tears-made-easy/page-1 Vandeputte J, Hoekstra H (2006) Observed hyper granulation may be related to oedema of granulation tissue. www.medline.com/woundcare/products/dermagel/documentation.asp Wounds International. Wound Infection in Clinical Practice. International Wound Infection Institute. 2016. London Wounds UK (2013) Best Practice statement. The use of Topical Antimicrobial Agents in Wound Management. London.
Training Need Identified?	YES – Workshops provided on a regular basis throughout the year
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet

Information Category	Detailed Information
Document Library Folder/Sub Folder:	Clinical / Infection Prevention and Control

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
25.04.19	V1.0	Initial version	Heather Newton Tissue Viability Consultant Nurse
15.03.21	V1.1	Addition of section 2.23.7	Heather Newton Tissue Viability Consultant Nurse
30.12.22	V2.0	Updated information regarding reporting of pressure ulcers (as per Pressure ulcer policy already in place) and the use of compression therapy for venous leg ulcers Tissue Viability referral pathway policy updated Hyperlinks checked and updated where required Updated dressing formulary added	Heather Newton Tissue Viability Consultant Nurse

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Wound Care Clinical Guideline V2.0
Directorate and service area:	Infection Prevention and Control
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Heather Newton, Tissue Viability Consultant Nurse
Contact details:	01872 252673

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To promote best practice in wound assessment and management
2. Policy Objectives	To promote best practice in wound assessment and management
3. Policy Intended Outcomes	To ensure all patients receive appropriate and safe wound care
4. How will you measure each outcome?	Annual audit of assessment charts
5. Who is intended to benefit from the policy?	All staff involved in caring for patients with wounds

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Tissue Viability Link Practitioners Community Tissue Viability team (CFT) Consultant Surgeons
6c. What was the outcome of the consultation?	Document approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the parent/carer/patient's needs – i.e. available in different languages if required/access to an interpreter if required

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those parent/carer/patients with any identified additional needs will be referred for additional support as appropriate - i.e to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g. easy read, audio etc
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Heather Newton, Tissue Viability Consultant Nurse

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis