

WOUND MANAGEMENT POLICY

This procedural document supersedes PAT/T 7 v.2 – Wound Management Policy

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Amendment Form

Version	Date	Brief Summary of Changes	Author
Version 3	April 2012	Updated: <ul style="list-style-type: none"> • documentation section • referral section • evaluation section • reporting section 	Sue Johnson
Version 2	September 2008	<ul style="list-style-type: none"> • PAT/T 15 – Protocol for Accessing Wound Care Products has been withdrawn and incorporated into this policy • Wound Assessment section updated • Additional sections: <ul style="list-style-type: none"> - New Products - Samples of wound management products - Referral criteria - Wound swabbing - Access to specialist wound care products - Management of infected wounds - Use of antimicrobial dressings • Addition of Appendix 1, 2 and 3 	Sue Johnson

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1.0 Policy Statement

This policy has been developed to enable nursing staff to manage wounds and select appropriate dressings according to best recognised practice. Wounds are an expensive and growing problem: today over 2,000 wound management products are available on the market. In addition, all members of the healthcare team can be involved in wound care in a variety of settings, with patients often moving between professionals and environments. This policy will help ensure best practice and minimise the potential for inconsistency of care locally.

2.0 Introduction

- 2.1 This document should be used in conjunction with the most recent edition of the Royal Marsden NHS Trust Manual of Clinical Procedure and Wound Management Guideline - PAT/T6
- 2.2 It is intended for nurses working within Doncaster and Bassetlaw Hospitals NHS Foundation Trust, and recognises that nurses fulfil an essential role in wound management.
- 2.3 All nurses within Doncaster and Bassetlaw Hospitals NHS Foundation Trust recognise the importance of consistent individualised care and the need to include the latest evidence based techniques and wound management products that are clinically effective (NMC 2008).

3.0 Purpose

- 3.1 To provide a standardised approach to wound care within the framework of holistic care.
- 3.2 To ensure appropriate management of acute, surgical and chronic wounds.
- 3.3 To ensure the most appropriate product is utilised for optimum wound healing, patient comfort and cost effectiveness.
- 3.4 To ensure no act or omission on the nurses part leads to inappropriate management of a wound (NMC 2008).
- 3.5 To promote and co-ordinate a systematic approach to wound management, addressing symptom control and maintaining the individuals quality of life recognising that complete healing is not always achievable.
- 3.6 Ensure the Trust complies with the requirements of the Health Act (2006a): A Code of Professional Practice for the Reduction of Healthcare Associated Infections.

4.0 Key principles

- 4.1 To ensure a comprehensive assessment of health needs, in relation to wound care, is undertaken.

- 4.2 To ensure that continuity of care takes place where different nurses may be called upon to meet the needs of the patient.
- 4.3 To ensure that a standardised approach to wound care takes place.
- 4.4 To ensure the appropriate wound management product is utilised for optimum wound management, cost-effectiveness and patient comfort.
- 4.5 Where palliative care is being provided healing is not the primary aim. The goal is to ensure comfort, freedom from pain, itch, malodour and haemorrhage.
- 4.6 To ensure that wound management products are used cost-effectively thereby minimising waste and inappropriate usage.
- 4.7 To ensure no products are left in the wound at dressing change

5.0 Definitions

- 5.1 A wound is defined as a break in the epidermis or dermis that can be related to trauma or to pathological changes within the skin or body. (Collins, Hampton and White 2002)
- 5.2 The following statement reflects a holistic perspective and is therefore an appropriate framework for nursing care:

‘wound healing is only one aspect of the body’s response to injury and the whole person not just the injury must be treated’.

(Dealey 2005)

6.0 Roles, Duties and Responsibilities

6.1 Wound Assessment

- 6.1.1 The healing process is complex and is affected by numerous general and local factors. It is essential to treat the whole person and not just wound in isolation (Dealey 2005).
- 6.1.2 All wounds will be assessed using evidence based methods to optimise wound healing. The details from the full assessment will be recorded in the appropriate IPOC (Integrated Pathway of Care) i.e. Wound Care, Pressure Ulcer, Leg Ulcer (NMC 2008).
- 6.1.3 Wound assessments will be completed at every dressing change.
- 6.1.4 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 (Todorovic 2004), Diabetes (Silhi1998), Chronic infection (Meggers 1998) Concomitant medication (McCulloch et al 1995) e.g. steroids
- Provide a framework to monitor the stages of wound healing
- Evaluate the effectiveness of any treatment.
- Smoking history
- Patient concordance

6.1.5 Local wound assessment should take into account:

- Type of wound (Dealey 2005)
- Location of wound (Dealey 2005)
- Stage of healing - using recognised scales (Dealey 2005)

6.1.6 Wound assessment will be guided by utilising the TIME framework. The key components of TIME are recognised as follows (Watret 2005)

- **T – Tissue**

Nature of the wound bed - healthy/unhealthy granulation tissue, epithelialisation tissue, sloughy or necrotic tissue or eschar. This should be recorded as a percentage of the wound bed.

- **I – Infection/ Inflammation**

Colonisation/Infection - suspected, confirmed (specify organisms)

Odour - offensive, some/none.

Pain - specify site, frequency, continuously/intermittent, only at dressing change and severity.

- **M – Moisture**

Exudates - colour, type, approximate amount/extent of strikethrough onto primary and/or secondary dressings or bandages.

- **E – Edge**

Wound dimensions - length, width, depth, sinus formation and undermining of surrounding skin. Tracing of the wound may assist with wound measurement. Incorporating a rule or tape into the photograph will provide a scale.

NB written patient consent must be obtained prior to photography being taken.

Wound margins - oedema, colour, erythema (measure extent), and maceration.

General condition of surrounding skin - dry, eczema, fragile, macerated, inflamed.

6.2 Wound Cleansing

6.2.1 The aim of wound cleansing is to remove gross contamination with minimal pain to the patient and minimal trauma to the tissues.

- 6.2.2 For a healthy acute wound, irrigation with either a sterile solution of 0.9% sodium chloride or sterile water is appropriate - showering is appropriate in the case of chronic wounds (Flanagan 1997).
- 6.2.3 The irrigation fluid used should be close to body temperature. Care should be taken to avoid trauma to tissues or splash back.
- 6.2.4 If wiping is necessary, a non-filamented swab should be used. The wound bed itself should not be dried, only the surrounding skin. Wiping the wound bed may leave fibres that could be a focal point for infection or may damage newly formed tissues (Thomlinson 1987).
- 6.2.5 The general use of antiseptics/disinfectants and dyes is not recommended as these are cytotoxic to fibroblasts (Sibbald et al 2007).

6.3 Wound Infection

- 6.3.1 Wound infection is one of the commonest hospital acquired infections (Bruce et al 2001, NICE 2003).
- 6.3.2 Specific reference to Infection Control Policies (PAT/IC) should be made where appropriate e.g. the procedure for taking a wound swab.(Appendix 1)
- 6.3.3 Nurses should recognise the distinction between contamination, colonisation and infection (Kingsley 2001).
- 6.3.4 Nurses should recognise when the normal inflammatory process becomes abnormal and when it is due to infection.
- 6.3.5 There may be different signs and symptoms when infection occurs in different wounds (Cutting and Harding 1994, Cutting et al 2005).
- 6.3.6 If the clinician is unsure of appropriate management of an infected wound advice should be sought from the Tissue Viability/ Wound Care Nurse Specialists.

6.4 Selection of Wound Dressing Product

- 6.4.1 Nurses should adhere to the wound care guidelines (PAT/T 6) when choosing appropriate wound management products.
- 6.4.2 Dressings used should promote a moist environment at the wound/dressing interface. (Winter 1963).

- 6.4.3 The wound-dressing product should be appropriate to meet the needs of wound and/or promote the next stage of the wound-healing matrix. It should be comfortable and take into consideration factors such as odour control, patient acceptability, type and location of the wound. (NICE 2001).
- 6.4.4 It is essential that the patient is provided with clear information about their treatment plan and that the wound dressing product should be acceptable to the patient, taking into account their culture and beliefs.
- 6.4.5 The wound-dressing product should be used in accordance with the manufacturers' instructions and Specialist Dressing Guidelines (PAT/T18).
- 6.4.6 If there is a leakage or strikethrough causing a break in the barrier that the dressing provides to external contamination, the dressing should be changed. If this occurs frequently, it may be appropriate to re-evaluate the dressing product choice.
- 6.4.7 The effectiveness of the selected dressing product should be evaluated after one week, unless there is an adverse reaction to the dressing product (NICE 2001).
- 6.4.8 The effectiveness of the dressing product and wound assessments/evaluations should be recorded in the Wound Management/ Pressure Ulcer Integrated Pathway of Care (IPOC) in the patients' records.
- 6.4.9 Any suspected adverse reactions from the wound product in use should be reported to a member of the Tissue Viability / Wound Care Team.
- 6.4.10 The number of dressings used should be documented and this should correlate with the number of dressings removed at the next dressing change

6.5 New Products

- 6.5.1 Healthcare staff wishing to use a new wound management product should make their request in writing to the Trust Wound Management Group. All relevant evidence to support the use of the product should be provided.
- 6.5.2 The Trust Wound Management Group will review the request looking specifically at the clinical advantages and disadvantages to using the new product compared to similar products currently on the formulary. All available evidence will be reviewed.

- 6.5.3 If the Trust Wound Management Group decide there are potential clinical advantages to using the new product the cost benefit will be assessed (taking into consideration any impact on wound healing time, nursing time and additional resource costs).
- 6.5.4 If The Trust Wound Management Group decide the new product has clinical advantages, with increased or no change to cost benefit or has equal clinical efficacy and significant cost benefit, a practical evaluation will be conducted.
- 6.5.5 The Trust Wound Management Group will agree the scope of the evaluation and agree patient types and numbers, wound types and position, and the nurses who will conduct the evaluation.
- 6.5.6 Nurses conducting the evaluation will complete the standard Product Evaluation Form (WPR28190) for each consenting patient and submit the forms to the Wound Management Group.
- 6.5.7 A summary of the evaluation will be produced by the nurses conducting the evaluation with assistance from the Tissue Viability/Wound Care Nurse Specialists. The summary will then be submitted to the Trust Wound Management Group by the Tissue Viability / Wound Care Nurse Specialist involved in the evaluation for a decision.
- 6.5.8 Results of the evaluations will be disseminated to all interested parties, including nurses, doctors, pharmacists and therapeutic sub groups.
- 6.5.9 Samples provided by Wound Management companies may only be used by the designated staff that have been identified as part of the product evaluation process

6.6 Samples of Wound Management Products

- 6.6.1 Samples should not be accepted by any staff as this may drive the use of products whose effectiveness and cost-effectiveness have not been properly evaluated in line with the Trust's product evaluation process.
- 6.6.2 Nurses should only use products on the Wound Care Guideline (PAT/T6 v2) for the treatment of patients.

6.7 Referral Criteria

- 6.7.1 Health care professionals requiring advice with regard to wound management should contact the site-specific Nurse Specialist as outlined in the Tissue Viability/Wound Care referral guidelines. (Appendix 2)

6.7.2 Referral should be made to the Tissue Viability / Wound Care Nurse Specialist using the appropriate referral document (WPR 17010a).

6.7.3 It is the responsibility of the nurse discharging the patient to complete the TV/WC discharge form (WPR), faxing it to Community Liaison/ SPA and giving the white copy to the patient. The discharge nurse is also responsible for supplying the patient with the correct number of dressings i.e. enough to cover 48 hrs/ longer at weekends and bank holidays.

6.8 Specialist Dressings

6.8.1 Specialist dressings i.e. dressings not on the Wound Management Guidelines PAT/T6 , can only be obtained following a full wound assessment performed by a Tissue Viability/ Wound Care team member.

6.8.2 The Tissue Viability/ Wound Care team member will inform supplies who will organise a supply of appropriate dressings (Appendix 3).

6.8.3 A further assessment should be undertaken within two weeks to determine if use of the specialist dressing is to be continued. This assessment should be performed by a Tissue Viability/ Wound Care team member.

6.9 Management of Infected Wounds

6.9.1 All chronic wounds are colonised with bacteria but their presence in high numbers does not necessarily mean the wound is infected.

6.9.2 Staff need to observe wounds closely for any changes within the wound bed.

6.9.3 Localised wound infections should be treated with topical antimicrobials and not systemic antibiotics

6.9.4 Clinically infected wounds should be treated with systemic antibiotics in association with topical antimicrobials.

6.9.5 All patients with clinically infected wounds should be referred to a member of the Tissue Viability/ Wound Care teams.

6.10 Use of Antimicrobials in Wound Management

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

- The provision of an optimal healing environment
- Selection of appropriate antimicrobials to minimize the emergence of resistant bacterial strains
- Restriction of the use of systemic antimicrobials to minimize the emergence of resistant bacterial strains
- Avoidance of topical sensitization and/or allergic reactions.
- Appropriate antimicrobial to manage symptoms e.g. exudates, pain.

6.10.2 Topical antimicrobials include:

- Iodine based products
- Silver products
- PHMB
- Mesalt

6.10.3 When using antimicrobial products refer to the Specialist Wound Management product guidelines PAT/T18

7.0 Education and Training

- 7.1 It is the responsibility of every nurse to maintain an up to date knowledge regarding wound management (NMC 2008).
- 7.2 All educational sessions delivered through the Trust's Education and Training Manual promote evidence based practice and the principles of clinical effectiveness and clinical governance.
- 7.3 All staff will have access to study days/workshops relating to wound management. A multidisciplinary approach will be taken and the education programme updated on a regular basis based on best practice.
- 7.4 All training will be evaluated and continually adapted to improve effectiveness.

8.0 Audit

- 8.1 Prospective audits of the Wound Care/ Pressure Ulcer IPOC's will monitor the effectiveness of the Wound Management Policy.
- 8.2 Regular audits will be undertaken to review the prescribing trends in wound management, to include wound dressing product combinations, appropriate dressing selection and wound healing rates.

9.0 Associated Documentation

9.1 This policy should be used in conjunction with:

- PAT/T 6 - Wound Management Guidelines
- PAT/T 32 - Aseptic Technique
- PAT/T11 - Policy for the use of sterile maggots in Wound Management
- PAT/T18 - Guidelines for Specialist Wound Care Products
- PAT/IC 5 - Hand Hygiene Policy
- PAT/IC19 - Standard Precautions Policy
- PAT/IC 24 - Disinfection Policy
- PAT/PA 19 - Mental Capacity Act 2005 Policy and Guidance

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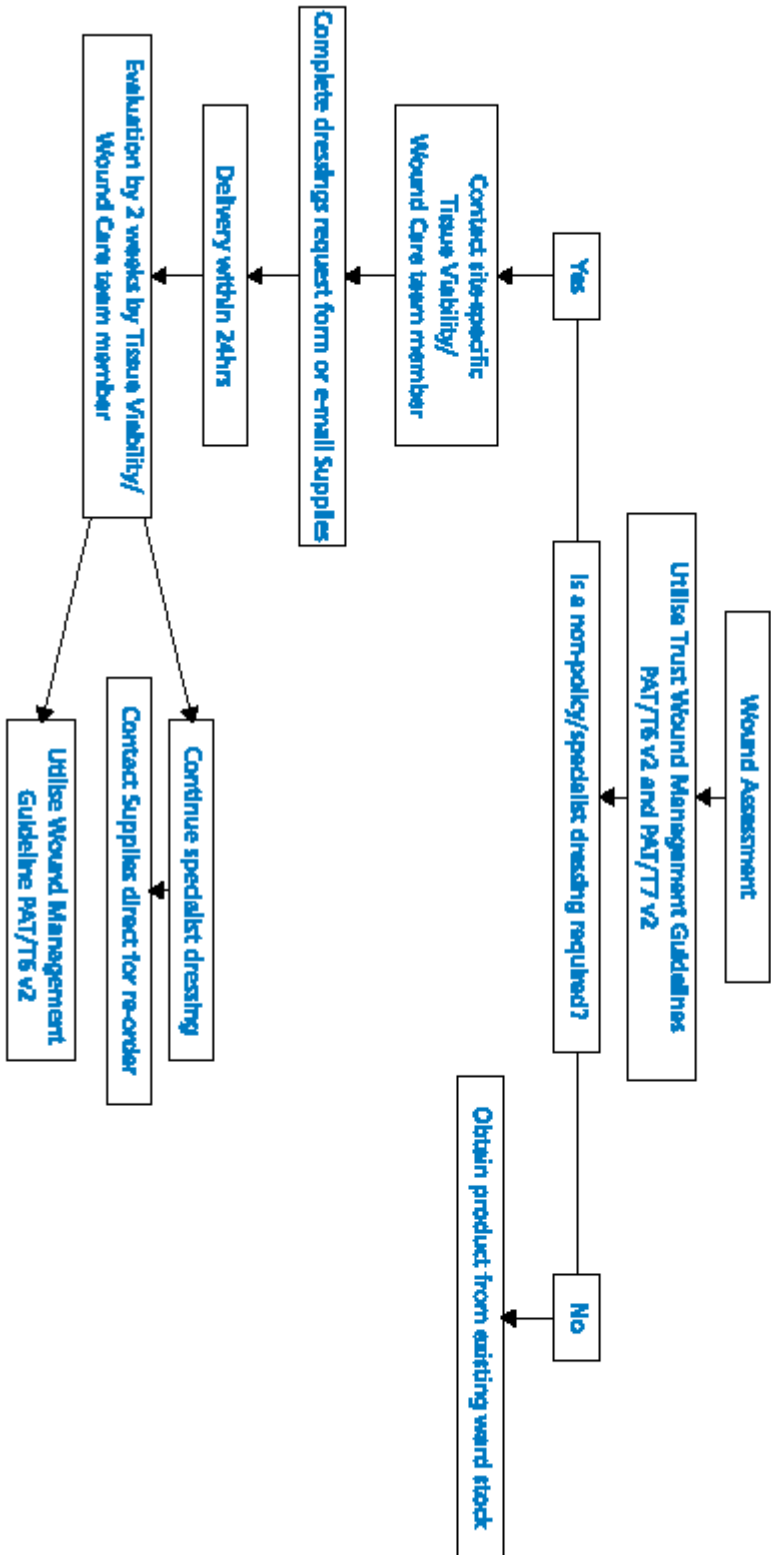
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Appendix 1

Wound swabbing

Action	Rationale
Follow procedure for aseptic technique. Remove wound dressing and assess wound bed for clinical signs of infection	To determine if a wound swab required
Cleanse wound with sterile saline as per aseptic technique procedure	Wound cleansing reduces the risk of introducing extraneous micro-organisms into the specimen
If the wound bed is dry moisten the tip of the swab with sterile saline	To allow organisms to adhere to the swab increasing the amounts of available pathogens for examination Micro-organisms will die on a dry swab.
If the wound is producing copious amounts of exudate do not moisten the swab	In heavily exudating wounds, the swab absorbs excess overlying exudate, resulting in an inadequate swab.
Apply swab with light pressure to wound bed and rotate the swab whilst zig-zagging across the wound surface. When the tip is saturated, transfer to the specimen container (charcoal media) and send to the laboratory as soon as possible.	To ensure that organisms embedded throughout the wound are isolated. To identifying both anaerobic and aerobic pathogens
Wound swabs should NOT be kept in the fridge until transport is due.	Wound swabs should be kept at room temperature. To prevent organisms from being killed off
Wash hands with soap and water /or alcohol gel on removal of gloves.	To prevent cross infection
Continue aseptic technique Re dress, the wound with current prescribed dressing. Contact Wound Care / Tissue Viability Team for advice.	To maintain temperature of wound bed and enable wound healing re-dress the wound as soon as possible following wound swabbing.
On completion of the aseptic technique ensure all documentation is completed. Ensure the correct information is sent to the laboratory. Specimen forms must have information inclusive of antibiotic therapy, anti microbial dressing, length of time on treatment, where the swab was taken and any other relevant medical history.	To ensure the relevant information is obtained by the Microbiologist. To ensure appropriate interventions are undertaken.

Protocol for Accessing Wound Care Products



Formulated by Tracy Vernon, Lead Nurse - Tissue Viability; Sue Johnson, Lead Nurse - Wound Care. Review date September 2011.

HMR 2

Doncaster and Bassetlaw Hospitals **NHS**
 NHS Foundation Trust

AFX LABEL HERE IF AVAILABLE

Unit Number:

Surname:

Forename(s):

Address:

.....

D.o.B.:

Date:

Ward:

WOUND CARE REFERRAL FORM

Reason for referral:

Wound Care IPOC commenced? Yes No

Type of wound: Surgical Traumatic Leg Ulcer Burn Other:

Location of wound:

Duration of wound:

Wound size: Length: cms Width: cms Depth: cms

Tissue: Granulation: % Sloughy: % Necrotic: %

Infected: Yes / No Wound Swab sent Yes / No

Exudate levels: High/Moderate/Low

Pain Score: 0 / 1 / 2 / 3 Continuous / Dressing change only

Current management:

.....

Other relevant information:

.....

Office use only

Date referral received: **Date 1st contact:**

Advice given:

Outcome:

Print name: Signature: Designation:

Fax to: 01302 381481

WPR31590
 Jan 2010
 LEMON

HMR 3

Doncaster and Bassetlaw Hospitals **NHS**
NHS Foundation Trust

APRY LABEL HERE IF AVAILABLE

Unit Number:

Surname:

Forename(s):

Address:

D.o.B.:

TISSUE VIABILITY REFERRAL

Date:

Ward/Department:

Reason for referral:

Pressure Ulcer Demographics

Site: Category 1

Date developed: 2

Hospital acquired Yes / No 3

4

Tissue on wound bed (%)

Epithelialisation: Infection Suspected Yes / No

Granulation: Wound swab Yes / No

Slough:

Necrosis:

Moisture (exudate)

Heavy

Moderate

Minimal

None

Edges (cm)

Wound width:

Wound length:

Wound depth:

Pressure Ulcer Management

Waterlow score: Repositioning schedule Yes / No

Equipment

Softform/Transwave supreme

Alpha X Cell

Nimbus/Transair MR

Karomed chair

OFFICE USE ONLY

Date/Time of referral received:

Date/Time of 1st visit:

Outcome:

.....

.....

Signature of referrer:

Print Name:

Date:

Designation:

Send to Tissue Viability Office, DRI

WPR30951
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GOLD