Ashford and St. Peter's Hospitals
NHS Foundation Trust

WOUND CARE POLICY

Author(s): Sue Harris, Lead Nurse Tissue Viability
Bibiana Baumgart, Senior Specialist Nurse Tissue Viability

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Patients first • Personal responsibility • Passion for excellence • Pride in our team

History

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For more information on the status of this document, please contact:	
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1. POLICY STATEMENT

Ashford & St Peter's Hospitals NHS Foundation Trust are committed to providing consistent, evidence based quality care in the management and treatment of wounds for all patients. This will incorporate a holistic assessment and demonstrate patient/carer involvement in the care provided.

This policy forms part of Ashford & St Peter's Hospitals NHS Foundation Trust's commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

2. SCOPE

This policy applies to all employed clinical staff, qualified and unqualified, bank and agency staff required to work in clinical areas. This includes but is not limited to medical staff, nurses, allied healthcare professional (AHP) and health care assistants (HCA).

3. AIM

The aim is to provide consistent individualised high quality care in wound management for all patients/clients of Ashford & St Peter's Hospitals NHS Foundation Trust by providing:

- a standardised and holistic approach to wound care, whilst taking into account individuals preferences and beliefs
- effective wound management which is delivered by staff with the appropriate knowledge and skills
- symptom control and management when wound healing is not the primary objective i.e. for palliative patients
- clinically effective wound management dressings which are available and utilised for optimum wound healing, patient comfort and cost effectiveness

4. OBJECTIVES

- To establish continuity of care in the management of wounds across the health care boundaries.

- To promote cross boundary and multi professional working in the best interests of the patient.

- To ensure that a multidisciplinary approach is taken to address all of the needs of the patient where appropriate.

- To inform practitioners of the best practice in wound care management.

- To ensure a comprehensive wound assessment is undertaken and evidence based treatment plans commenced.

- To ensure continuity of wound management care when different nurses are providing the care

- To ensure an equitable and standardised approach to wound management takes place

- To ensure that appropriate wound management dressings are utilised to meet the patients individual needs

- To ensure that those who undertake assessment, planning, implementation and evaluation of wound care have had the appropriate education and training in wound management.

- To ensure there is a link nurse to lead on wound management within each ward/department .

5. RESPONSIBILITIES

5.1 All staff responsibilities

- To recognise and acknowledge their personal accountability to maintain and improve their knowledge and assist others both qualified and unqualified within the care team to develop professional competence by:

  - Adhering to the policy
  - Identifying and seeking training to address any personal competency, knowledge and skills issues.
  - To record all wound care activity according to the Quality Standards for Health Record-Keeping Policy.

- To acknowledge personal accountability to use the Trusts' Wound Care Formulary and in exceptional cases provide sound rationale for any deviation.

5.2 Healthcare practitioners

- Identifying patients with a wound undertaking and documenting holistic assessments
- Liaising with the patient and the multidisciplinary team to formulate strategies and interventions to manage/treat wounds.
- Ensuring that multidisciplinary patient focussed care plans are in place and interventions are recorded, dated and signed in line with the Quality Standards for Health Record-Keeping Policy.
- Liaising with the patient, their relatives or carers and health and social care professionals regarding treatment/management strategies.
- Ensuring that they maintain their knowledge and competence in caring for patients with wounds.
- Seeking the advice of the Tissue Viability Team where appropriate whilst maintaining the ongoing responsibility for the patient's episode of care.

5.3 Divisional Chief Nurses/Clinical Nurse Leaders and Ward Managers

- Ensuring that all clinical staff are aware of the policy.
- Ensuring that this policy is implemented in their clinical areas
- Ensuring that patients are assessed and multidisciplinary care plans are agreed and implemented
- Ensuring that staff understand their accountability and responsibility and comply with this policy
- Ensuring that all staff have access to copies of appropriate guidelines and resources referred to within this policy
- Ensuring that staff have the knowledge, skills and competence commensurate with their role and responsibilities to care for patients with wounds
- Ensure staff have access to training commensurate with their role and responsibilities.

5.4 Medical Directors' and Consultants

- Ensuring that all relevant medical staff are aware of this policy
- Ensuring compliance with this policy within their areas of responsibility
- Ensure that relevant staff are appropriately trained and updated

5.5 Procurement Department

- Maintenance of stock and distribution of the wound care formulary products
- Ordering of non-formulary wound care products following agreement/discussion with Tissue Viability Team
- Involvement in the decision process regarding the stocking of wound care products.
- Participation in regular updating of the formulary in line with current research and best practice guidelines

5.6 Tissue Viability Team

- Support the Divisional Chief Nurses/Clinical Nurse Leaders and Ward Managers in implementing this policy.
- Support implementation of this policy via clinical audit and review
- Provision of education and training for nursing and other members of the multidisciplinary team in wound care management
- Provision of specialist advice within the Trust
- Provision of specialist advice to managers with regard to case reviews and clinical incidents.

N.B. In situations where the Tissue Viability Team is involved in an individual patients care, the ongoing responsibility for the review and monitoring of the patient remains with the nursing and medical team in charge of their care.

Wound management should be seen as a multidisciplinary activity.

6.0 DEFINITION

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

- Physical damage: pressure ulcers
- Mechanical damage: abrasions, grazes, lacerations, knife wounds (surgery), bullet wounds or bites.
- Thermal damage: burns caused by flames, chemicals, radiation, friction or electricity and frostbite.
- Medical or physiological disorders: arterial or venous ulcers, autoimmune, endocrine, dermatological or haematological disorders, wounds associated with certain systemic infections, malignant diseases or neuropathy.

6.1 Wound Types and classification

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

- Acute Wounds: including surgical and traumatic wounds. Clean surgical wounds will heal by primary intention where the skin edges are brought together using sutures, clips, adhesive strips or glue*.* Acute wounds proceed through the healing process in a timely manner as they generally have no underlying aetiology to disrupt a normal inflammatory response. Acute wounds that do not heal within four to six weeks or develop complications that delay healing may then be described as chronic.

- Chronic Wounds: including pressure ulcers, leg ulcers, fungating lesions, diabetic foot ulcers. They will heal by secondary intention, when skin edges are not brought together as demonstrated in cavity wounds, leg ulcers, sinuses, dehisced surgical wounds. Chronic wounds are generally characterised by the presence of underlying pathology and are generally associated with a persistent state of inflammation which prolongs or interrupts the healing process.

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

6.2 Categories of Tissue Loss

- Partial thickness: Involves damage/loss of epidermal and dermal layers of skin

- Full thickness: Involves damage and loss of epidermal, dermal and subcutaneous layers of skin. Tendon, muscle and bone may be exposed.

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

6.3 Factors contributing to delayed wound healing

All individual's ability to heal and the time required to heal can vary greatly and are influenced by the following factors which should be taken into consideration during assessment.

- General physical and psychological health. Type and level of concurrent illnesses; systemic and local
- Levels of bacterial colonisation and infection
- Nutrition – consideration should be made regarding referral to the Dietetics Department for all patients with complex wounds (See Nutritional Care Bundle)
- Infection – specific reference should be made to the Infection, Prevention and Control Policy where appropriate
- Malignant disease
- Diabetes – diabetic ulceration should be assessed and managed by the vascular team in conjunction with the Tissue Viability Nurse Specialist
- Poor blood supply/peripheral vascular disease/cardio-vascular disease
- Presence of foreign bodies
- Excess debris
- Anaemia
- Rheumatoid Arthritis
- History of smoking and/or alcohol consumption
- Medications – steroids, anti-inflammatory, immunosuppressant's, anti-coagulants
- Patient concordance

- Environment

7.0 PRINCIPLES

7.1 Assessment and evaluation

The purpose of assessment is to record baseline information regarding the wound and the patient and to allow the registered practitioner to make clinical judgements and treatment decisions based upon this. The assessment also acts as means of identifying and recording changes in the wound. The purpose of wound assessment is to obtain baseline information with which to produce a treatment plan.

- Assessment and evaluation should be carried out at regular stated intervals and the process clearly documented.

- All patients and carers (with the patients consent) who wish to, will be fully involved in the assessment and care of the patients wound(s).

- All patients admitted with a wound will have their wound(s) assessed by a Registered Nurse or a Student Nurse under the direct supervision of a Registered Nurse and the wound assessment chart completed within that shift.

- All patients who develop an open wound whilst in the Trust will have their wound(s) assessed by a Registered Nurse or a Student Nurse under the direct supervision of a Registered Nurse and a Trust Wound Assessment Chart completed within that shift.

- All patients with a wound(s) will have them reassessed at a minimum of weekly or more often as determined by the Registered Nurse.

- All adult patients with a wound(s) will have their nutritional status assessed using the MUST tool within 6 hours of admission and as condition changes or at least weekly. If appropriate, the patient will be referred to a dietitian for nutritional advice with regards to wound healing.

- All paediatric patients with a wound(s) will have their nutritional status assessed using the STAMP tool within 6 hours of admission and as condition changes or at least weekly. If appropriate, the patient will be referred to a dietitian for nutritional advice with regards to wound healing.

- All patients with a wound(s) will have their pain assessed as part of the wound assessment and will receive analgesia as appropriate.

- All patients with non healing and/or complex wounds will be discussed with the Tissue Viability Team for specialist advice and clinical input.

- All Registered Nurses involved in wound management will have the opportunity to receive training in wound assessment on the Trust Wound Management Core study day

- All patients with a wound will have their wound dressing evaluated on a daily basis to determine if:
  - the wound dressing has become displaced
  - strike through of exudates to the surface of the dressing has occurred

- Wound assessment charts will be completed after each dressing change

- Each nurse/doctor is accountable for his/her own practice and for the initial and subsequent assessments that will be documented within the patient healthcare record (nursing and/or medical) and according to the Trust Policy for Health Record-Keeping

- Wound management decisions and procedures are defined and based on national guidance and recognised best practice.

- Training issues will be identified and addressed accordingly.

- Wound management must be agreed with the multi disciplinary team in partnership with patients and/or carers and demonstrate evidence of on going reassessment.

- For patients whose first language is not English, practitioners should involve link workers in communicating with the patient. Consideration should be given to providing the information in a format that meets the diverse needs of patients eg. Hard of hearing, partially sighted.

7.2 Wound photography

Wound photographs are a useful visual record for wounds that are difficult to trace, measure, that may be large, deep or irregular in shape. Patients consent must be gained prior to wound photography and documented on the ‘Consent to Medical

Photography' form. Patients should be referred to the Trust Medical. For photographs not taken by the medical photographer the Trust Policy for photography must be followed and this includes not taking photographs of patient wounds on staffs personal devices such as smartphones.
Patient may wish to take photographs of their own wounds on their digital device as a means of personal record keeping and staff can assist with this where necessary.

7.3 Wound Management

- All wound management must be acceptable to the patient and seek to provide the optimum environment for wound healing, management of exudate, odour and pain.

- Wounds and dressings must not be considered in isolation but as part of holistic patient centred care. This should include management of factors such as nutrition, underlying disease, skin protection, care of the surrounding skin, and the assessment of pain and infection for example.

- Wound dressings must be changed according to the amount of exudate, when it becomes soiled or loose and in line with the manufacturer's guidelines.

- Each of the patient's wounds must be documented on the wound assessment chart and wound care plan, monitoring and evaluation documentation that details the history and evaluation of the wound. This documentation must include details of the site, known allergies/reactions, and previous dressings used, stage of wound healing, exudate (colour, amount, odour), pain, wound swab results, wound measurement (mapping/photograph where appropriate) and include any underlying medical conditions and current medications.

- A multi disciplinary approach to the management of patients with wounds must be established. This includes utilising the skills of other health professionals.

- Aseptic technique- all wounds will be dressed using guidance enclosed in the Aseptic Non Touch Technique (ANTT) procedure found on the Trust intranet.

- The stages of wound healing should be taken into account using the Trust Wound Management Guidance and Decision Tree (available on the Tissue Viability Page of Clininet) for dressing selection taking into account patients choices, preferences and beliefs

- It must be remembered that there is a difference between treating and managing wounds and that the aim of care for wounds is not always healing, for instance ischaemic wounds/digits. Advice must be sought from the vascular team and tissue viability team regarding ischaemic digits and limbs.

- Debridement of necrotic tissue must not be undertaken unless expert advice has been sought.
- For information regarding the use of Topical Negative Pressure (TNP) please refer to the Guideline for the use of Topical Negative Pressure

7.4 Discharge or transfer

- Details of the patients wound care management, including a copy of the Trust wound assessment chart and wound care plan, must accompany the patient on discharge if further wound management is required
- Community Nurse referral must be made prior to patient discharge
- The patient must be discharged with sufficient dressings for 3 dressing changes

7.5 Education of staff

- All registered nurses who are routinely caring for patients with wounds will attend the Trust Wound Management Core Study Day
- Patient focused wound management training will be provided by the Tissue Viability Team on an on going basis

7.6 Characteristics of the ideal dressing

Different wounds will have different requirements and although there is no one 'ideal' dressing, there are key criteria which should be considered.

- Provide the optimum environment for wound healing – a warm and moist environment – at the wound/dressing interface.

- Allow gaseous exchange of oxygen, carbon dioxide and water vapour.

- Provide thermal insulation – wound healing is temperature dependent.

- Impermeable to micro-organisms (in both directions)

- Free from particulate contaminants.
- Non-adherent (many products are described as non-adherent but are low-adherent).
- Safe to use (non-toxic, non-sensitising, non-allergenic).
- High absorption characteristics (for exuding wound).
- Acceptable to the patient
- Cost effective.
- Carrier for medicaments, e.g. antimicrobials.
- Capable of standardisation and evaluation.
- Allow monitoring of the wound (transparent dressings***).***
- Provide mechanical protection.
- Non-flammable.
- Conformable and mouldable (especially over sacrum, heels and elbows).
- Available (hospital and community) in a suitable range of forms and sizes.

Consideration must be given to the potential fire hazard when choosing any dressing or skin product with a paraffin base as per the
National Patient Safety Agency's Rapid Response Guidance (Feb 2008).
For further information and tools, go to: www.npsa.nhs.uk.

7.7 Wound debridement

Debridement is the active removal of dead tissue, cell debris or foreign bodies from a wound (O'Brien 2002).

Care should be taken when debriding wounds as debridement could reveal underlying structures obscured by necrotic tissue. Debridement should not be performed on ischaemic areas, necrotic eschar or diabetic ulcers without first seeking advice from the vascular team or Tissue Viability Team

7.7.1 Methods of debridement

- Autolytic debridement - Autolysis uses the body's own enzymes and moisture to re-hydrate, soften and finally liquefy hard eschar and slough.

- Enzymatic debridement - the application of exogenous enzymes to the wound bed in order to degrade necrotic tissue without harming viable, granulation tissue. Not to be performed without advice from the Tissue Viability Nurse Specialist.

- Surgical debridement – excision of necrotic tissue to the point of bleeding. Performed in theatre setting by members of the surgical team.

- Conservative sharp debridement - the removal of loose avascular tissue that will not result in total debridement. Must only be performed by Tissue Viability Specialist Nurses who have successfully completed the validated Wound Debridement module.

- Bio-surgical therapy/maggot debridement therapy – the use of therapeutic larvae to remove dead and devitalised tissue. Patients selected for potential larvae application must be assessed by either the Tissue Viability Nurse Specialist or senior member of the vascular team prior to ordering. Therapy to be applied by either the Tissue Viability Nurse Specialist or staff assessed as competent.

7.8 Infection control in wound management

- Disposable sterile instruments should be used when cutting dressing products that are applied to the wound. These should be disposed of in accordance with Trust Waste Management Policy.

- In order to prevent cross-contamination to third parties, all wound care products should be handled and disposed of in accordance with Trust Infection Control Guidance and Waste Management Policy (available on Trustnet).

- In order to prevent cross-contamination within a wound, dressings should be changed at appropriate intervals, and in accordance with manufacturer's recommendations.

- Wounds should be redressed using an aseptic non touch technique as detailed in the ANTT Guidelines.

7.9 Safeguarding

Consideration must be made for referral to social services, Safeguarding Team for all patients presenting to the Trust with a wound relating to an untoward injury. This includes stage 3 or 4 pressure ulcers (see Pressure Area Management Policy).

8.0 IMPLEMENTATION

This policy will be introduced via the Nursing, Midwifery & Therapy Professional Board by the Lead Nurse Tissue Viability. It will then be cascaded onto the relevant areas by the Clinical Nurse Leaders and Ward Managers. It will also be available on the Trust intranet.

9.0 REVIEW

The Lead Nurse Tissue Viability will be responsible for the review of this policy at three yearly intervals.

10.0 ACCOMPANYING DOCUMENTS

- Quality Standards for Health Record-Keeping Policy.
- Infection, Prevention and Control Policy
- Nutritional Care Bundle
- Medical Photography and Patient Images Policy and Procedure
- Waste Management Policy.
- Pressure Area Management Policy

11.0 REFERENCES

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