

**Clinical standard for managing patients with wounds**

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**Clinical standard for managing wounds**

**Introduction**

This document has been written to standardise wound care within Oxford Health NHS Foundation Trust with the aim of improving quality and patient related outcomes.

Owing to the diversity of wound aetiologies and their associated co-morbidities, a range of health care professionals may be involved in delivering wound care. It is essential that these clinicians have the appropriate knowledge, skills and competence to undertake this role.

A wound is defined as a break in the continuity of the skin (Schultz et al. 2003). It may arise from an underlying altered physiological state or be primary in origin. As the largest organ in the body, damage to the skin and alteration in its functions can have catastrophic consequences for the individual. Most wounds will heal uneventfully, however, whether it is due to the nature of the injury, or the health of the individual, some wounds will have a delayed course of healing (Falanga 2001).

Wounds can be broadly classified as acute or chronic. Acute wounds usually heal in an ordered, timely fashion, and are typically seen as post-operative wounds, minor lacerations, abrasions, minor burns and scalds and some trauma wounds (Falanga 2002, Schultz et al. 2003). Conversely, chronic wounds do not follow this ordered sequence of events and are commonly characterised by delayed healing and recurrent infections (Schultz et al. 2003).

Wounds impose a substantial health economic burden on the UK’s NHS, comparable to that of managing obesity (£5.0 billion). There are approximately 2.2 million patients with a wound, equivalent to 4.5% of the adult population (Guest et al, 2015). Most of these patients will be managed in the community by District nurses, practice nurses and GPs.

**This document sets out the clinical standard expected by any clinician delivering wound care within Oxford Health NHS Foundation Trust. These relate to the following:**

1. Wound assessment
2. Treatment and management objectives
3. Wound cleansing
4. Wound dressing procedure/ infection prevention and control
5. Wound debridement
6. Wound dressings
7. Management of acute traumatic minor wounds
8. Care plans
9. Evaluation/ re-assessment
10. Documentation
11. Patient and carer education
12. Clinician training and competence to practice.

**Policies this standard links to:**

Pressure damage prevention and management policy CP66

Infection prevention and control policy IF1

Nutrition and hydration policy CP94

Integrated information governance procedures and guidance CORP 19

Waste management guidelines 2015

All Tissue Viability resources referred to in the document can be accessed from [www.oxfordhealth.nhs.uk/tissue-viability](http://www.oxfordhealth.nhs.uk/tissue-viability)

**Senior management team responsibilities**

Clinical practice in wound management should comply with, and respect; legislation, codes of practice, scope of practice, clinical practice guidelines, and organisational policies.

All clinical leads and managers will be expected to support the implementation of this standard; monitoring will be completed via clinical audit.

**Individual clinician responsibilities**

The clinician will ensure optimal wound healing is facilitated by an ongoing process of clinical decision making to determine the risk of wounding, the wound aetiology, and wound healing responses.

The clinician will acknowledge the need for interdisciplinary working/ referral in all aspects of the wound management process.

Documentation in the patient’s notes must facilitate communication and continuity of care between interdisciplinary team members. The clinician must ensure that all relevant documentation is maintained.

The clinician is accountable for his/her clinical practice.

The clinician will implement wound management practices based on local standards and guidelines.

**Wound Management standards**

**Standard 1. Assessment**

**1.1.** All patients will be informed of the need for a comprehensive holistic wound assessment and the rationale for doing this.

**1.2.** All patients will receive a **comprehensive** **holistic** assessment that reflects the intrinsic and extrinsic factors which have the potential to impact on wound healing. This should be undertaken within 4 weeks of presentation to caseload.

*(If a patient has a leg ulcer, a full leg ulcer assessment should be undertaken within 2 weeks of presentation to case load using the Oxford Health Leg ulcer assessment form)*

**1.3.** All wound assessments should be documented using the Oxford Health Wound Assessment form. This can be found on the Tissue Viability website.

**1.4.** Patient assessment should include:

* Past and current medical history (including a review of blood tests)
* Current and past drug therapies that may impact on healing.
* Identification of factors which have the potential to delay healing; This may include malnutrition, certain co-morbidities such as diabetes, immobility, frailty, smoking, pressure, lifestyle factors, concordance with treatment, pain and anatomical location of wound.
* Quality of life/ impact of wound on patient’s life and wellbeing.

**1.5.** Wound assessment should include:

* Type of wound and aetiology of wounding
* Wound duration
* Location of wound
* Size of wound – To include surface area in cm² (using opsite flexigrid mapping) and depth in mm. Undermining should be measured with a probe and documented using the clock face method.
* Assessment of surrounding skin (Dry, moist, fragile, eczematous, oedematous)
* Wound photograph (Gaining verbal consent which should be documented. Signed consent should be gained if photographs are to be used for media/ educational purposes)

**1.6.** Wound bed assessment based on TIMES acronym – to include:

|  |  |
| --- | --- |
| **T**issue – percentages of: | * Necrosis
* Slough
* Granulation
* Epithelialisation
* Hypergranulation
 |
| **I**nfection | * Local (Wound bed only – treat the wound topically)
* Systemic (Swab to be taken if patient presenting with a systemic infection or a deteriorating condition. In these cases, oral antibiotics may be advised).
* Odour
 |
| **M**oisture (exudate) | * Volume (Low, Moderate, High)
* Type/ consistency (serous, haemoserous, purulent)
 |
| **E**dge | * Rolled, fragile, hypergranulated
 |
| **S**urrounding skin | * Excoriated, macerated, oedematous.
 |

**1.7.** Pain assessment using a validated pain assessment tool.

**1.8**. Wound swabbing should not be routine but when there are signs of systemic infection (Cellulitis, pyrexia, patient feels unwell). A deteriorating wound may require more than an standard M, C & S investigation. Refer to the guidelines on wound swabbing on the Tissue Viability website.

**1.9.** Following assessment, there should be a documented wound aetiology (cause) or wound status within the assessment form.

**1.10.** The patient and their carer, if they permit, will be informed of the outcomes of the assessment and will be supported in the decision making for potential management options.

**Standard 2. Treatment and Management objectives**

**2.1.** The patient and if applicable their carers should be actively involved and supported in setting treatment goals.

**2.2.** Treatment and management regimes should be based on wound bed status and the issues identified in the assessment.

**2.2.** In addition to wound dressings, the underlying causes of wound related factors such as high exudate or pain should be addressed. High compression should always be considered for lower limb wounds where clinically indicated.

**2.3.** Healing may not be the primary objective in each case. This should be based on the wound assessment and in discussion with the patient and their carers.

**2.4.** Wounds that are unlikely to heal should be identified and a palliative wound plan agreed with the patient.

**2.5.** Routine use of antibiotics is unnecessary unless there are signs of systemic infection. However, In cases of frailty or general ill health, the patient should be monitored closely for signs of sepsis and advise sought urgently if their condition deteriorates.

**2.6.** All wounds are potentially painful. A holistic approach to pain management should address the cause, type and intensity of the pain.

**Standard 3. Wound Cleansing**

The primary objective of wound cleansing is to remove wound debris and reduce the bioburden (bacterial load) in order to treat or prevent wound infection.

**3.1.** Clean wound cleansing

In most cases a clean wound management technique i.e. Irrigation with tap water or showering of wounds should be implemented.

For patients with chronic wounds such as venous leg ulcers, immersion of the limb in a bucket (lined with disposable plastic bag if using this within a treatment room or a preference of the patient with their own home) and filled with tap water or showering is acceptable. The bowl/ bucket should be thoroughly cleaned afterwards using green Clinell wipes and allowed to dry afterwards.

Wounds should not be cleansed with products that potentially leave fibres in the wound e.g. cotton wool or cotton wool containing products. The gauze listed within Oxford Health/ OCCG wound formulary and the e- procurement catalogue is suitable for wound cleansing.

Cleansing should be achieved by using a gentle sweeping motion over the wound bed. Rubbing the wound should be avoided.

**3.2.** Sterile wound cleansing

Sterile wound cleansing should be used when:

* The individual is immuno-compromised.
* The wound enters a sterile body cavity (i.e. nephrostomy or central venous line)

In these cases, Irrigation with single use sachets or pods of normal saline stored at room temperature is the method of choice.

**3.3.** There may be cases when wound cleansing is not indicated. For example, the management of a diabetic foot or an ischaemic/ gangrenous limb. In times of doubt, advice should be sought from Tissue Viability, podiatry or the specialist team leading on the patients care.

**Standard 4. Wound dressing procedure**

In chronic wound management a ‘clean’ dressing technique is generally recommended, particularly in relation to wound cleansing. However, maintaining sterility when handling and applying the dressings is essential, to reduce the risk of wound infection.

4.1 The following procedure should be followed:

* Wash and dry hands and apply non – sterile gloves
* Open dressing pack
* Apply plastic apron
* Remove bandages/ old dressings and place in plastic waste bag. Assess wound status.
* Dispose of soiled gloves, apply hand gel.
* Open the dressings/ bandages required onto the sterile field avoiding contact with the dressings. Non- sterile secondary dressings such as absorbent pads should be placed to one side.
* Open sterile scissors and probes (if applicable) on to sterile field
* Apply non - sterile gloves
* Cleanse wound (as per 3.1 or 3.2). If using the dressing pack tray, add tap water and place tray next to sterile field.
* Apply emollient to skin (If applicable) If using a tub (not a pump action) this should be decanted from the pot using a spatula or clean glove. Do not dip contaminated hands back in to the pot.
* Remove gloves, dispose of in waste bag and apply hand gel
* Apply sterile gloves from sterile field
* Pick up and apply dressings to the wound, using sterile scissors to cut to size if applicable.
* Apply secondary dressings and bandages if applicable.
* Remove gloves and apron and place in waste bag.
* Ensure bag is well sealed or double bagged before being disposed of in general waste bin.
* Wash hands.

**4.2** Equipment

Any equipment used for wound assessment/ management (e.g. Doppler machines) should be cleaned with green Clinell wipes.

Records must be kept that equipment is being cleaned. These can be found on the G drive G:\Oxfordshire\Public\Infection Control\Medical devices cleaning\Weekly Medical Records 2018 - 2019\Community Health

**4.3** Clinical waste

All waste associated with wound care should be disposed of as per local agreements/ protocols. All non – infectious clinical waste produced in a patient’s house should be sealed in a bag and placed in general waste bin. In-patient/ out-patient clinics/ minor injury clinics should dispose of wound related waste as per the Trusts waste management guidelines.

**Standard 5. Wound Debridement**

**5.1**. Sharp debridement (e.g. Using a scalpel) should not be attempted unless the clinician holds a certificate in this skill.

**5.2.** Debridement of necrotic heels should not be attempted until the patient’s arterial status to the foot has been established. This should be determined by undertaking a lower limb assessment and using a hand held Doppler device. (Guidance available on Tissue Viability website)

**5.3**. In all wounds, if debridement is indicated, first line use of dressings such as a hydrogel sheet, an alginate, a gelling fibre dressing or a hydrocolloid should be used to assist the process. An antimicrobial dressing should not be used unless wound has been assessed as infected. Consider using the AMBL tool for determining wound infection. (Accessed from Tissue Viability website)

**Standard 6. Wound Dressings**

**6.1.** The integrity of wound management products and devices must be ensured through proper storage and use. Many dressings degrade in extreme temperatures of hot and cold so avoid car boot stocks during these periods.

Sterile scissors are single use and should be disposed of after use in a sharps box.

**6.2.** All products and devices must be used in accordance with manufacturers guidelines.

**6.3.** The choice of dressing should be influenced by:

* Wound type
* Wound size and depth
* Tissue type
* Amount of exudate
* Location of the wound
* Skin condition of the patient
* Presence/absence of infection
* Characteristics of dressings available (size, wear time, showerproof etc)
* Treatment goals
* Cost effectiveness
* Patients acceptance/tolerance of the dressing.

**6.4.** All dressings should be selected from the Oxford Health/ Oxfordshire CCG wound management formulary using either ONPOS or FP10 prescription. (This can be accessed from the Tissue Viability website). For in-patient settings, most dressings will be available from the e – procurement catalogue. A small number of products may need to be obtained through the hospital pharmacy.

**6.5.** To avoid potential waste, dressings requiring a prescription should not be put on ‘repeat’. Most prescription dressings will be a course of treatment and therefore will not require on-going repeat prescriptions.

**6.6.** Antimicrobial dressings should only be prescribed when local wound bed infection has been identified and should only be used for a period of 2 weeks. They should not be used prophylactically unless advised by Tissue Viability. If the wound remains locally infected after 2 weeks, advice should be sought from Tissue Viability.

**6.7**. Dressings in the restricted section of the formulary should be discussed with Tissue Viability before being prescribed.

**6.8.** When ordering/ prescribing and using dressings:

* Use the size closest to the dimensions of the wound.
* Only Issue or prescribe enough for the course of treatment or a maximum of a 2 weeks supply. This includes the stock taken out to the patient’s home that is supplied via ONPOS.
* Do not layer dressings as this will be counterproductive.
* Asepsis should be maintained when applying the dressings to the wound (Sterile scissors should be used to cut the dressings and sterile gloves worn when handling/ applying the dressing)
* Once opened, any remaining dressing must be disposed of and not retained and used on another day.
* Only renew the dressing in line with manufacturers guidance or when clinically indicated (e.g. – as per level of exudate/ strikethrough).
* Do not pack a wound if depth/ underlying structures is unknown.
* Old/ residual dressings should be removed or irrigated out before new dressings are applied.
* Avoid the use of adhesive dressings for managing moisture lesions. Follow the skin barrier pathway for guidance. (Accessed from Tissue Viability website)
* If the selected dressing does not appear to be effective, contact Tissue Viability for advice.

**6.9.** Retention of dressings:

* Where possible, avoid the use of tape for securing dressings, particularly on fragile skin.
* Where anatomically possible, consider a tubular bandage (i.e. blue line) for keeping dressings in place.
* Where possible, do not apply adhesive dressings to the lower legs. Dressings should be secured with K Soft wool and bandage. The type of bandage will be based on the clinical/ patient assessment and may include a retention bandage or a compression bandage).
* If using a dressing with an adhesive border, ensure manufacturer’s instructions are followed when removing the dressing to avoid skin stripping/ trauma.
* Refer to the skin barrier pathway for managing incontinence associated dermatitis/ moisture lesions and superficial pressure damage to buttocks/ sacral area. Dressings are not indicated for these conditions.

**Standard 7. Management of acute traumatic minor wounds**

**7.1.** A traumatic wound is considered minor when it doesn’t present with a complication which would require referral to a specialist team for closure (Purcell 2010).

**7.2.** Unless excessive bleeding or life threatening these wounds can be seen in the Community Minor Injury units where the specialist practitioners can fully assess and refer to specialities as required.

**7.3.** On assessing a traumatic wound the following needs to be taking into consideration:

* **Depth of wound** – consider underlying structural damage – reduced function in hands can indicate possible tendon damage
* **Size of wound –** consider onward management of wound
* **Site of wound** – hand wounds can be complex/wounds over joints require robust closure, head wounds can bleed excessively from a small area and the patient will need to have a neurological assessment to exclude acute head injury signs.
* **Mechanism of wound** i.e.: penetrating, bite wound – animal or human, underlying fractures, foreign bodies (glass), contamination – will require a washout
* **Delayed presentation** - consider risk of infection/types of closure that can be used/clots can disguise the base of a wound

**7.4.** Describing traumatic wounds:

* **Penetrating/Puncture** – wound to the skin may be minor but underlying structures could be damaged
* **Abrasion** – graze to skin
* **Laceration** – a mechanical force causing a tear in the skin
* **Bite –** caused by human or animals – high risk of infection – possible teeth in wound will require an x-ray
* **Incisional** – a wound caused by a sharp instrument – if suspicion of glass – will require an x-ray
* **Burn** – chemical, flame (dry heat) , scald ( wet heat) , radiation from sun, electrical

**7.5.** Types of wound closure in minor injury wounds. These procedures should only be undertaken by staff trained and competent to do so.

* **Skin Glue** – superficial wounds – not hands/near eyes
* **Skin Staples** - useful for scalps
* **Interrupted Suturing** – local anaesthetic required prior to closure
* **Steristrips** – sticky, porous, reinforced paper tapes – variant width – cannot be used near hair

**Standard 8. Care plans**

**8.1.** Every patient should have a current wound care plan in place that clearly sets out the management objective/s.

**8.2.** These should be:

* **S**pecific
* **M**easurable
* **A**chievable
* **R**ealistic
* **T**imely

**8.3.** Following initial wound assessment,complete healing may not be the primary objective. Care plans should reflect the priorities for the patient and may include objectives such as pain management, odour reduction, exudate control etc.

**8.4.** The care plan should be written in partnership with the patient and their carer/ family (if applicable) and updated as changes occur.

**Standard 9. Evaluation/ re- assessment**

**9.1.** On-going evaluation of wound healing should be performed through continuous monitoring and formal re- assessment to ensure that the treatment objective/s are being met.

**9.2.** Evaluation and re-assessments should be documented in the patients notes.

**9.3.** Patients whose wounds failing to progress as expected (i.e. 40% reduction of wound surface area at 6 weeks) should be referred immediately to Tissue Viability using the Tissue Viability referral form.

**Standard 10. Documentation**

**10.1.** All patients with a wound will have a completed wound assessment form in their notes within 4 weeks of presentation to case load.

**10.2**. All patients with a wound will have a wound progression chart in their notes that will map the healing process. (Accessed from Tissue Viability website)

**10.3.** All patients will have a current wound care plan in their notes that reflects the treatment objectives agreed with them at the point of assessment/ re- assessment.

**10.4**. Photographs should be uploaded to care notes and then deleted from the device used, in line with information governance policy.

**10.5**. Documentation in the individuals’ notes must facilitate communication and continuity of care between interdisciplinary team members.

**10.6.** For those clinicians working in urgent and ambulatory care, all assessment and treatment documentation will be uploaded to Adastra and the clinical notes emailed directly to their General Practitioner on closure.

**Standard 11. Patient/ carer education**

**11.1.** Patients and/ or carers should be providedwith relevant information for the prevention of wounding and promotion of healing.

**11.2.** Clinician should maximise opportunities for teaching and learning for the patient and /or their carer in relation to preventing wounds (For example skin tears/ pressure ulcers).

**Standard 12. Clinician education/ competence to practice**

**12.1**. All clinicians (excluding those working in Minor Injury Units – refer to point 12.3) undertaking wound care within Oxford Health NHS Foundation Trust are required to attend Wound Assessment and Management (WAM) training every 3 years.

**12.2**. All clinicians are expected to self-assess against the wound assessment and management competency framework criteria on joining the organisation and review these annually as part of their PDR.

**12.3.** All registered and unregistered clinicians working in Minor Injury Units (MIU) are expected to complete Urgent and Ambulatory Care wound management competencies prior to being deemed confident in wound care management.

**References**

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**Appendices**

All resources that support this standard can be found on the Tissue Viability internet site at:

<http://www.oxfordhealth.nhs.uk/tissue-viability>