Trust Guideline	Worcestershire Acute Hospitals NHS Trust

Wound Assessment and Management Guideline

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Accountable Director:	Chief Nurse
Approved by:	Fundamentals of Care Committee
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First Revision Due **This is the most current document and should be used until a revised version is available:**	14th January 2028
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	
Target staff categories	Worcestershire Acute Hospital Trust (WAHT) Staff who are involved in wound assessment and management.

Policy Overview:
This guideline is to ensure safe practice and maintain core standards of evidence-based practice in Wound Management.

Key amendments to this document

Date	Amendment	Approved By:
27/04/2017	Wound assessment Chart added to guideline	
August 2017	Document extended for 6 months as per TMC paper	TMC
December 2017	Sentence added in at the request of the Coroner	
December 2017	Document extended for 3 months as per TLG recommendation	TLG
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as per TLG recommendation	TLG
April 2019	Document extended for 6 month whilst review process is completed	Lisa Hill
March 2020	Document extended for 3 months whilst review is completed.	Lisa Hill
June 2020	Document extended for 6 months during COVID period	
January 2021	Policy Reviewed	Lisa Hill
February 2021	Document extended as per Trust agreement 11.02.2021	
May 2021	Document approved for 3 years	CGG
January 25	Document extended for 3 months	Claire Hughes/Alison Robinson
January 25	Document approved with no changes	Fundamentals of Care Committee

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1. Introduction & Scope of this document

This policy has been developed to enable nursing staff to manage wounds and select appropriate dressings according to best recognised practice. Wound care is a critical aspect of healthcare that affects people of all ages. Chronic wounds are a substantial burden on healthcare systems worldwide, with their management accounting for a significant portion of healthcare budgets. Given the rising prevalence of wounds and the growing strain on healthcare resources, there is an urgent need for more efficient treatment options in wound care. Since the inception of the NWCSP, it has aimed to implement a high standard of wound care across England by reducing variation, improving safety and improving patient outcomes, while minimising the burden of wound care for patients, carers and healthcare providers across a range of wound types. Integral to promoting timely wound healing is an effective holistic patient assessment, supported by a structured wound bed assessment Wounds Uk,2021. This policy will help ensure best practice and minimise the potential for inconsistency of care locally.

The National Wound Care Strategy Programme seeks to improve care for people with wounds by addressing the unwarranted variation in wound care services, underuse of evidence-based practices and overuse of ineffective practices.

The goal is to reduce pain and suffering for patients, improve healing rates, prevent wounds from happening or coming back, and use healthcare resources more efficiently. The Professional Records Standards Body (PRSB) Wound Care Information Standard will help to support this goal by encouraging the consistent recording of information which can be shared with all those involved in the person's care. https://theprsb.org/standards/wound-care-standard(2023)

Purpose

The aim is to support The National Wound Care Strategy Programme (NWCSP) commissioned by NHS England, who has developed from several previous initiatives which addressed the issue of sub-optimal wound care. Evidence points to marked unwarranted variation in UK wound care services, underuse of evidence-based practices and overuse of ineffective practice.

This offers major opportunities to improve the quality of chronic wound care through innovative solutions that will improve wound healing, prevent harm, increase productivity of staff, and produce financial savings in line with the requirements of the recent NHS Long Term Plan.

The National Wound Care Strategy Programme – Wound Care Workforce Framework(2023) Wound assessment, investigations, and diagnosis (and subsequent treatment) requires a multi-professional approach rather than an overreliance on specialist wound care practitioners with other health care practitioners need to develop accurate wound assessment skills and understand the complexities of wound assessment to be able to effectively plan, implement and evaluate care for people with wounds. Without appropriate assessment and diagnosis, care will be sub-optimal leading to delayed healing, discomfort for the individual, increased risk of infection, inappropriate use of wound

dressings and a reduction in a person's quality of life. Developing the capabilities of all members of a multi-disciplinary team in relation to assessment, investigations and diagnosis is of great importance. Collaborative working across the multi-disciplinary team and the use of appropriate referrals also support delivery of optimal but cost-effective, consistent, and continuous care.
In September 2018, the NWCSP was launched to address this situation. The vision is to develop recommendations which support excellence in preventing, assessing, and treating people with wounds to optimise healing and minimise the burden of wounds for patients, carers and health and care providers. The NWCSP was noted in the NHS Long Term Plan and in the National Patient Safety Strategy and is underpinned by the following principles:

- Wound care should not be viewed as a separate clinical issue but be integrated into care of underlying co-morbidities that cause or contribute to wounding and delayed/ non-healing.
- The National Wound Care Strategy Programme is a long-term commitment to improving wound care.
- Success will depend on recognising and addressing the interdependencies between the different professional groups and services involved in wound care.
- The key priority is to improve patient care.

1.2. The policy applies to: 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, midwives, and allied healthcare professional (AHP) and health care assistants (HCA).

1.3. Implementation of this policy will support individualised high-quality delivery of care in wound management for all patients/clients of Worcestershire Acute Hospitals NHS Trust by:

• A standardised and holistic approach to wound care, whilst considering 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 Patients receive safe and effective wound care in line with relevant national guidance.
- Staff have access to support and resources to support them with managing patients' wounds.

2. Definitions

2.1Surgical Wounds

Surgical wounds healing by first intention have sutures or clips or staples drawing the edges of the wound together, aiming to promote primary wound closure. Liaise with the surgical team to ensure the aim and methods of treatment are co-ordinated e.g. time span for post-operative dressing removal and method for sutures, clip or staple removal.

If patient requests a dressing cover for aesthetic reasons or to stop irritation from clothing, a vapour-permeable film or island dressing can be used.

2.2Trauma Wounds
A trauma wound is a severe break or injury in the soft tissue of the skin. Trauma wounds may include skin tears, abrasions, lacerations, crush wounds, penetration and puncture wounds, large hematomas. Trauma wounds can be injuries resulting from accidents or acts of violence and can worsen and become infected quickly if not treated appropriately. For skin tears guidance (Appendix1)

Consider the wound history and presence of foreign bodies e.g. trauma wounds maybe contaminated and may require tetanus injection (appendix 2: WAHT Tetanus Prophylaxis guide) Consider the position of the wound e.g. wounds over a joint maybe susceptible to stretching, wounds near/in axilla, groin and anus may be susceptible to infection due to warm, moist environment.

2.3Thermal Wounds
Burns and scalds require initial treatment to cool; for deep/extensive burns follow the advice provided by the The Midlands Critical Care & Trauma Network. https://www.mcctn.org.uk/

2.4. Chronic Wounds
A chronic wound is a wound that does not heal in an orderly set of stages and in a predictable amount of time; wounds that do not heal within three months are often considered chronic.
Chronic wounds seem to be delayed in one or more of the phases of wound healing.

2.5 Lower Leg wound
Lower leg wounds presentations are due to several underlying pathologies, including venous disease, arterial disease, rheumatoid arthritis, and complication of diabetes etc.It is essential that patients presenting with these wounds receive timely and appropriate escalation to the relevant clinical specialist/specialty (e.g. vascular, dermatology, etc.) requiring referral to dedicated leg ulcer service(s) to complete a comprehensive assessment (National Wound Care Strategy Programme (2024) Leg Ulcer Best Practice Bundle.

Accurate diagnosis of the underlying cause is an essential part of management.

- Holistic assessment of the patient
- Differential diagnosis of Ankle Brachial Pressure Index (APBi) with Doppler ultrasound: performed by trained competent clinicians with the appropriate knowledge, skills, equipment medical staff, in the Acute setting please refer to by the vascular Clinical Nurse Specialist (CNS) Team for guidance.
- Diagnosis of diabetes or any other co-morbidities that are influential on the normal wound healing cascade.

2.6. Malignant/ Fungating Wounds

Wounds that occur as a result of cancer may be referred to as: cancer wounds, oncology wounds, ulcerative cancers, fungating cancers, or malignant wounds (Cancer Research UK, 2024) 'Fungating' malignant wounds occur when cancers grow and break through the skin surface, creating a wound; wounds can also develop directly from primary skin cancers such as squamous cell carcinomas and malignant melanomas, or as a result of treatments such as radiotherapy, which can have an adverse effect on the skin and increase the risk of skin damage. A malignant cutaneous wound may be one that grows either outwards (presenting as raised nodules) or inwards from the skin (presenting as crater-like ulcers), or both (Starace et al, 2022)

The malignancy can cause exuberant skin infiltration. It is possible to palliate the symptoms of these wounds but in most circumstances not to heal them the priorities of care are to ensure the patient has been reviewed by an oncology team, therefore options for any form of curative treatment have been exhausted and symptom control, based on the patient's needs have been addressed.

Consider "POSIE'S" assessment

P = Pain
O= Odour
S = Skin
I = Infection
E = Exudate and Bleeding
S = Self

Malignant Wounds: further information
https://cks.nice.org.uk/topics/palliative-care-malignant-skin-ulcer/
Malignant wounds: Management in practice – Wounds UK

3.0 Wound Healing:

There are three main types of wound healing, known as primary, secondary, and tertiary wound healing.

3.1 Primary wound healing, or primary intention wound healing: refers to when doctors close a wound using staples, stitches, glues, or other forms of wound-closing processes. Closing a wound in this way reduces the tissue lost and allows the body to focus on closing and healing a smaller area wound rather than the larger initial wound.

3.2 Open wounds (Secondary/tertiary Intention)

Secondary wound healing, or secondary intention wound healing, occurs when a wound that cannot be stitched causes a large amount of tissue loss. Doctors will leave the wound to heal naturally in these cases. This may be more common for wounds that have a rounder edge, cover uneven surfaces, or are on surfaces of the body where movement makes stitches or other closure methods impossible Secondary wound healing relies on the body's own healing mechanisms. This process takes longer, which may be due to increased wound size, the risk of infection and contamination, and other factors, such as the use of certain medications... Examples of these wounds include leg ulcers, pressure ulcers and traumatic injuries such as pre-tibial flaps. Some surgical wounds may also be left open to heal and some surgical wounds which breakdown (dehisce) post operatively are left to heal by secondary intention.

3.1 Tertiary wound healing

Healing by delayed primary closure, occurs when there is a need to delay the wound-closing process. This could be necessary if a doctor fears that they may trap infectious germs in a wound by closing it. In these cases, they may allow the wound to drain or wait for the effects of other therapies to take place before closing the wound

4.0 Why Moist Wound Healing?

4.1. Is an underpinning principle of evidence based wound management. In the majority of circumstances wounds that require active intervention to facilitate healing should be kept moist. Excessively wet or dry wounds delay wound healing.

Wound Bed Preparation

4.2. Is a concept which combines several wound management processes. Wound bed preparation (WBP) focuses on optimising conditions at the wound bed to encourage healing, identifying the cause of the problem in non-healing wounds, and implementing a care programme to achieve a stable wound (Dowsett, C., 2008) WBP is embedded into the framework commonly known by acronym TIMES (Tissue, Infection/inflammation, Moisture imbalance, Edge of wound, Surrounding Skin) Schultz G, Sibbald G, Falanga V, et al (2003)

5.0 Wound Assessment/ Management

5.1 Wound assessment is required at the initial patient contact with a documented holistic framework, including photographs and measurements. Care planning is necessary with the patient (and/or carers) developing goals and aims towards wound healing. Without appropriate assessment and diagnosis, care will be sub-optimal leading to delayed healing, discomfort for the individual, increased risk of infection, inappropriate use of wound dressings and a reduction in a person's quality of life. Developing the capabilities of all members of a multi-disciplinary team in relation to assessment, investigations and diagnosis is of great importance.

Safeguarding concerns: Where pressure ulcer wounds occur, the Department of Health & Social Care (2024) guidance offers a clear process for the clinical management of the removal and reduction of harm to the individual, while considering if an adult safeguarding response under section 42 of the Care Act 2014 is necessary. The guidance demonstrates that the focus on removing harm to the individual will usually be secured by speedy clinical intervention. Full Guidance accessible via: https://www.gov.uk/government/publications/pressure-ulcers-how-to-safeguard-adults/safeguarding-adults-protocol-pressure-ulcers-and-raising-a-safeguarding-concern

5.2 Wound management can be confusing, matching wound dressings to the requirements of the wound and the varied presentations of wounds make prioritising the treatment complicated (White, R 2014)

3. Responsibility and Duties

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 on (Electronic Patient Records (EPR) or paper wound assessment (WR2058), to acknowledge personal accountability to use the Trusts' Wound Care Formulary and in exceptional cases provide sound rationale for any deviation.

3.1. Role of Chief Nurse: The Chief Nurse is responsible for:

Overall responsibility for ensuring that the Trust has in place clear processes for managing risks associated with the wound management.
Ensure that appropriate arrangements are in place to enable safe and effective care and that employees are fully aware of their statutory, organisational, and professional responsibilities and that these are fulfilled.

3.2. The Tissue Viability Service is responsible for:

Be an expert resource and exemplary role model in relation to wound care.
- Provide expert clinical advice, education and support to clinical staff and the multidisciplinary team within the Acute setting.
- Monitor wound care standards and support Acute trust teams to achieve them.
- Maintain a supportive tissue viability champion network.
- Liaise with medical and surgical teams when interventions are required. Ensuring that this policy is reviewed regularly in line with Evidence base and current national guidelines. Maintaining confidential storage of patient documentation in line with WHAT NHS Trust Policies

3.3. Role of Registered Nurses and Midwives and pre-registration students

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.

3.4. Role of pre-registration students – nursing and AHP

- Can undertake as above once assessed as competent by a competent registered professional.

3.5. Role of Medical Staff

Review and assess patient's wounds as part of their holistic assessment.
• Ensure that their teams are aware of this policy and provide collaborative multidisciplinary working to ensure the policy is adhered to.
• Perform surgical procedures and expert medical intervention as required to promote appropriate wound management.
• Medical teams to liaise directly with the Tissue Viability Team (TVT) for urgent/complex wound management, along with understanding and acknowledgement of any contraindications associated with using specific wound treatments.

3.6. Role of Allied Health Professionals

It is the responsibility of Allied Health Professionals to:

- Work with nursing and medical colleagues to ensure appropriate care plans are in place for the management of patients with open wounds documenting and escalating concerns to registered nursing staff.

- Have an awareness of patients open wounds where they exist and the impact this may have on therapy goals.

3.7. Role of Unregistered Staff

It is the responsibility of unregistered staff to:

- If any variance from care plans and any deterioration in condition in the patient's is identified:
- Escalate any deterioration to registered nurse in a timely manner
- Performing delegated tasks, within their scope of practice, from registered nursing colleagues
- Deliver individualised care as specified in the patients' care plans and updating/modifying care plans when identified /escalated within their scope of practice.

All staff working on Trust premises, including agency and locum staff – are responsible for adhering to this policy and for reporting breaches of this policy to the person in charge and to their line manager

4. Policy

4.1 Holistic assessment

A multi-professional approach to wound care is required, rather than an overreliance on specialist wound care practitioners. Wound assessment, investigations, and diagnosis (and subsequent treatment) will often take place at times where there is no access to a specialist wound care practitioner. Therefore, other health care practitioners need to develop accurate wound assessment skills and understand the complexities of wound assessment to be able to effectively plan, implement and evaluate care for people with wounds.
Without appropriate assessment and diagnosis, care will be sub-optimal leading to delayed healing, discomfort for the individual, increased risk of infection, inappropriate use of wound dressings and a reduction in a person's quality of life. Developing the capabilities of all members of a multi-disciplinary team in relation to assessment, investigations and diagnosis is of great importance. Performing a thorough wound assessment is the first step in developing a comprehensive plan of care that includes correction of etiological factors, systemic support, and evidence-based topical therapy and management (Krapfl & Peirce, 2016). The initial assessment should include the patient's overall health status and medical history, skin status, wound aetiology, and the patient's ability to heal. The initial assessment should be completed when the wound is first observed (Krapfl&Peirce,2016)

Best practice is that the holistic assessment should occur on first presentation of the wound. In the in-patient area. In most circumstances within six hours of admission, when initial risk assessment and Body map is completed, however if the admission is directly related to issues with the wound, assessment should be performed sooner as part of the admission procedure and involve medical staff and if necessary, the wider multi-disciplinary team. The timing of a scheduled holistic wound reassessment will depend on the condition of the patient, the condition of the wound and care setting

Holistic wound reassessment should be carried out:

"Clinicians must respond rapidly if a patient with a wound demonstrates signs of potentially fatal infection, including a systemic inflammatory response, sepsis, extensive tissue necrosis, gas gangrene or necrotizing fasciitis".

- if the condition of the wound deteriorates/evolves
- at the time scheduled for holistic wound reassessment - as a minimum every 2 weeks

In inpatient settings – as a minimum every 2 weeks and prior to discharge. (If the wound is the primary cause for admission, more frequent reassessment may be necessary). STATEMENT: Best Practice IMPROVING HOLISTIC ASSESSMENT OF CHRONIC WOUNDS 2018

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The National Wound Care Strategy Programme (2023) states basic skills for accurate wound assessment include the following skills

•Undertake and accurately record a wound assessment in line with current recommended good practice and take appropriate action.

•Correctly swab a wound and send sample for culture and sensitivity **(**Appendix 4**)** Please refer to **WAHT-INF-049***(Methicillin Resistant Staphylococcus aureus (MRSA) Screening and Management Policy Appendix A High Risk Groups for MRSA colonisation and/or infection)***.** Please swab wound when first identified /if sepsis indicated for admission.

•The Tissue Viability Team will swab any wounds, if clinically indicated, during their first assessment.

•Undertake an accurate risk assessment Pressure Ulcer Risk Assessment Tool (PURAT)e.g. Waterlow

•Capture a digital wound image and save within the patient's clinical record.as recommended by NWCSP Digital Images, practical recommendations for the use of Digital Images in Wound care, Sept 2021. (Digital-images-in-wound-care-12Sept21.pdf)

Generic wound assessment minimal data set (Coleman et.al 2017): Domain Core data set items

By identifying factors that require intervention and indicating objectives for management holistic assessment will guide appropriate patient and wound management.

- General health information Risk factors for delaying healing (systematic and local blood supply to the wound, susceptibility to infection, medication affecting wound healing, skin integrity)
- Allergies
- Skin sensitivities
- Impact of the wound on the quality of life (physical, social and emotional)

Wound baseline information

- Number of wounds
- Wound location
- Wound type/classification
- Wound duration
- Treatment aim
- Planned reassessment date.

Wound assessment parameters

- Wound size (maximum length, width, depth)
- Undermining / tunnelling
- Category (pressure ulcers only)
- Wound bed tissue type
- Wound bed tissue amount (%)
- Description of wound margins/edges
- Colour and condition of the surrounding skin.
- Whether the wound as healed

Wound symptoms

- Presence of wound pain
- Wound pain frequency
- Wound pain severity
- Exudate amount
- Exudate consistency/type/colour
- Signs of systemic infection, whether a wound swab has been taken.

Specialist Intervention

- Investigation for lower limb wounds (Ankle Brachial Pressure Index APBI)
- Referrals Tissue Viability Team: Wounds /Pressure Ulcers,
- Podiatrist: Diabetic Foot Ulcer
- Vascular Team CNS: leg Ulcers (Venus/arterial)
- Dermatology and Plastic teams

Additional assessment parameters may be necessary according to wound type e.g. for signs and symptoms of peripheral neuropathy in a patient with a diabetic foot ulcer.

Aseptic Non-Touch Technique (ANTT) will be the expected standard of aseptic technique throughout the organisation using the ANTT® Clinical Practice Framework for all invasive procedures, including maintenance of indwelling medical devices, promoting safe practice and reducing the risk of healthcare associated infections This technique if performed correctly will aid in the prevention of wound infections. (See WHAT-INF-048 Policy for ANTT) The full ANTT® Clinical Practice Framework is provided on the intranet and is also freely available from www.antt.org

ANTT is divided into 2 different processes: Standard-ANTT and Surgical ANTT (Pratt et al 2007)

Health and Social Care Act (Doh 2008, updated 2022) stipulates that:

- ANTT should be carried out in a manner that maintains and promotes the principles of asepsis.
- The technique should be sustained across the organisation.

All staff undertaking procedures involving asepsis should be provided with education, training, and assessment

4.2. Wound assessment with TIMES

The **TIMES** concept promotes a holistic approach to patient well-being in wound care and contributes to identifying barriers to healing and guides the plan of care to remove them Wounds UK. (2018) allowing the clinician to interpret characteristics of a wound and to decide on the most appropriate intervention Optimal wound management can lead to a reduction in the frequency of dressing changes which further enhance the patient's quality of life Grey et al (2006). The **TIMES** assessment tool has become the gold standard model for wound assessment. This assists clinicians to identify and address the barriers of wound healing to create an optimal wound healing environment. Ousey et al (2021)

T.I.M.E.S: Tissue, Infection, Moisture, Edge, Surrounding Skin.

TIMES assessment is an easy-to-use tool that can be used visually at every wound contact; this will ensure all aspects of the wound healing are considered and measured against previous wound recordings. (Appendix 5)

The key components of wound assessment, namely.

- T - tissue non-viable or deficient
- I - infection or inflammation
- M - moisture imbalance
- E - edge (non-advancing or undermining)
- S - surrounding skin

T - Tissue

Description of tissue types found in the wound area should include details relating to

- the wound margins and edges
- the wound bed

Tissue type present in the wound bed is key to determining treatment aims and method. It is important to note that more than one tissue type may be present at the same time. Chronic wounds can accumulate necrotic tissue and slough within the wound bed and margins. The appearance and depth of necrotic tissue and slough can vary, as can the moisture. As

healing progresses, the quantity of necrotic and slough tissue will reduce, as granulation tissue increase. Healing can only occur when the wound bed is covered with healthy granulation tissue. Therefore, the aim of management should be to remove devitalised and dead tissue from the wound bed, while protecting and maintaining moisture balance to encourage granulation.

At each wound assessment the percentage of tissue type presenting within the wound should be recorded and compared with previous assessment findings to mark progress e.g. 80% slough 20% granulating tissue.

There are several factors that will influence the depth and appearance of the wound bed and these need consideration during the assessment process. For example, the structure and function of skin varies: the skin of legs and trunk is thinner and differs from that on the soles of the feet
where it is thicker and lacks hair follicles. Age, comorbidities and medication, such are steroids, can affect the skin, changing its appearance, thickness and susceptibility to damage and ability to heal.
The anatomical location and depth of a wound will also define what structures are likely to be encountered at the base of a wound. For example, tendons are close to the surface over the dorsum of the foot and bone is in close proximity to the skin surface on the elbows, knees, heels where there is little or no subcutaneous tissue. There should also be a note of surgical intervention where implanted materials or sutures may be present in the wound.

Necrotic tissue can act as a potential source of wound and systemic infection therefore there is an emphasis on removal of necrotic tissue and slough. As wounds progress, an increasing proportion of the wound bed should be covered in granulating tissue. Treatment aims at this stage are focused on maintaining moist wound environment and protecting developing granulation tissue and encouraging progressive epithelisation.

I - Infection or inflammation

Wound infection is a change within the wound that may delay healing, cause unpleasant symptoms for the patient and requires appropriate timely treatment and management. It is one of the most challenging and frequently reported complications of wound care. Wound infections occur when microorganisms start to increase in numbers and overwhelm the host's immune response. This response may be localised within the wound bed or systemic.

It is often misdiagnosed and treated inappropriately and consequently lead to delayed wound healing, increased treatment costs, and poor outcome for the patient due to uncontrolled symptoms, poor quality of life and in the worst-case scenario may lead to sepsis and death. Certain factors may increase the patient's risk of developing wound Infection.

Patient related factors.

- comorbidities: that may reduce oxygen perfusion (cardiovascular,
- respiratory, anaemia)
- metabolic disorders: that may impair immune response (diabetes)

- medication, which will reduce neutrophil activity and effect immune response (corticosteroids, cytotoxic therapy)
- chronic disease/comorbidities; obesity, cognitive impairment,
- respiratory/ liver/ kidney failure
- age: increasing age contributes to slower healing, while the very young
- have immature immune systems.
- psychological factors; poor lifestyle choices such as poor diet,
- smoking, alcoholism, substance misuse and poor hygiene
- unsuitable or poor living conditions
- Wound related factors.
- duration of the wound (>6 months)
- size of the wound (>10cm^2)
- anatomical site of the wound (wounds in highly contaminated areas
- such as anus)
- type of wound e.g. surgical wound that result from long or
- contaminated surgery
- wounds containing devitalised tissue.

Clinical indicators for wound infection can be present in all types of wounds.

Acute wounds:

- erythema,
- oedema,
- pain,
- increase temperature.
- Purulent exudate.

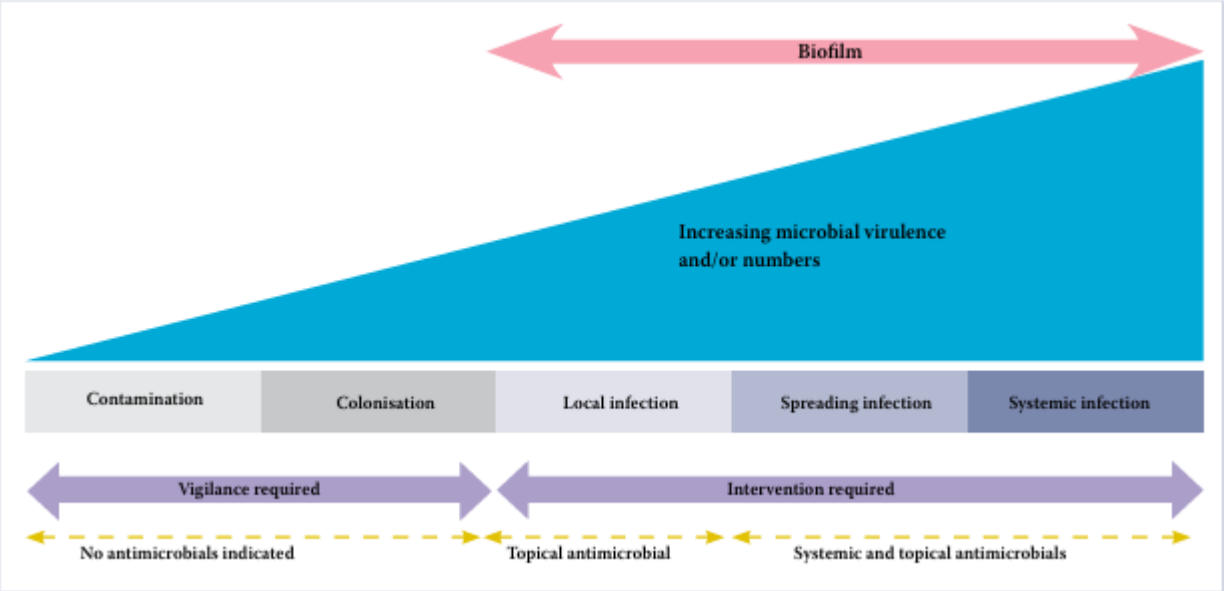
In chronic wounds the additional indicators.

- serous exudate with inflammation delayed healing
- friable granulation (bridging where strands of granulation tissue bleed
- easily)
- discoloured granulation
- pocketing at the wound bed (strips of granulation tissue that appear at the base of the wound, as opposed to uniform spread of granulation across the whole wound
- odour
- Wound breaking down/ delayed wound healing.

In the absence of overt wound infection, Wound biofilm is a complex structure formed by communities of bacteria and other microorganisms. Its presence in a wound is problematic as, unlike free-floating bacteria, biofilm-encased bacteria can be more resistant to the body's immune response and traditional antibiotic treatments. Biofilms are present in most chronic wounds and are likely to be located both on the surface and in deeper wound layers[1].

The presence of biofilm in hard-to-heal wounds and its significant contribution to delayed healing is well documented. Knowing how to recognize wound biofilm means understanding the characteristics and clinical signs that can suggest its presence through a combination of clinical assessment, patient history and laboratory testing. Biofilm-associated wounds may have a characteristic appearance, such as a slimy or discolored film on the wound bed. The wound may appear to have stalled in the inflammatory phase of healingShultz(2017) Biofilm should be considered as the possible cause of delayed healing in all wounds that are failing to progress adequately after more than 14 days of optimal management.

Wound continuum International Wound Infection Institute (IWII) (2016) Wound infection in clinical practice. Wounds International, London



7. Prevention and Management

The Department of Health “Saving Lives” High Impact Actions Chronic Wound Bundle (2011) provides instructions on how to reduce the risk and incidence of chronic wound infections and chronic wound-related blood stream infections. The risk of infection reduces when all the key elements of care within the clinical process are performed every time and for every patient. Nursing staff must be trained and competent to carry out these tasks.

Patient management and wound care phase
1. Aseptic technique • Wound management is undertaken utilising an approved aseptic technique as per local policy and protocols [4].
2. Wound assessment • Dressing type and frequency, wound assessment including referral for imaging and/or biopsy if deep seated infection; outcomes and next wound review date are documented [6-8, 12-15, 17, 18].
3. Wound swabs • Wound swabs are taken only when signs and symptoms of infection are present or when non healing persists, using an appropriate technique and documented. • Antibiotics are prescribed if indicated in accordance with local prescribing guidance [2, 16, 17].
4. Wound management • The wound is dressed creating an optimum wound healing environment according to the local wound management formulary documented • If applicable referral is made in the case of static or deteriorating wounds (referral may include tissue viability specialist, multi-disciplinary foot care team, surgeon and other specialists e.g. dietician as required) [7-9, 12-15, 18].
5. Documentation of patient education • Education and information is provided to the patient as appropriate with involvement in decision making where appropriate. • Clear communication of patients known to be infected or colonised with pathogenic organisms, including MRSA, is given to all relevant healthcare providers involved with the patient's care [3, 4, 7-15, 18]

Inflammation is not always a result of infection. Underlying disorders such as untreated venous congestion or vasculitis can prompt an inflammatory response.

M - Moisture imbalance

Achieving moisture balance is essential for the maintenance of skin integrity and wound healing. During wound assessment there is a need to note the volume, colour, consistency and odour of exudate to guide wound treatment decisions.
A certain amount of wound fluid is necessary as it is full of substances needed for healing, such as electrolytes, growth factors, nutrients, protein digesting enzymes, inflammatory mediators, and white blood cells. Exudate is a good indicator of the state of a wound. Changes in colour, amount, viscosity, or smell can be a trigger to reassess the wound.

E – Edge

Examination of the edge of the wound can assist in the identification of the wound's origin. For example, venous leg ulcers are shallow and generally irregular in shape, arterial ulcers are well defined.
The lack of new, healthy tissue at the wound edges, or presence of rolled edges, indicates wound healing is not progressing normally. Rolled and or raised edges should alert to the possibility of malignancy and referral to a specialist service for a biopsy of the affected tissue and analysis.
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In normal wound healing granulation tissue from the base of the wound and edges of deeper wounds and /or from islands of epithelial tissue that originates from intact skin appendages; hair follicles and sweat glands. Concurrent contraction of the wound edges minimises the size and depth of the defect, reducing wound volume and area.

S - Surrounding skin

The integrity of fragile skin around a wound can be impaired if the conditions of the wound are not managed appropriately; excess exudate can cause maceration, repeated dressing changes skin stripping.
In the presence of infection, the surrounding skin may appear red, hot to touch; local oedema and the patient may be experiencing an increase in pain.

4.3. Wound Management Guidelines with TIMES

T – Tissue
Devitalised tissue (slough & necrosis) forms a physical barrier to healing it does not necessarily indicate presence of infection but can create an ideal site for bacterial growth. Its presence can prolong the inflammatory phase of healing and prevent progression into the proliferative phase.
Healing wounds should progress through from black necrosis, to yellow slough to red granulation, to pink epithelialisation.

Autolytic debridement
This is the body's own method of debridement. During the inflammatory stage of healing white blood cells and proteolytic enzymes flood the wound to destroy and remove debris. If the underlying cause of the wound is well managed, autolysis is likely to progress easily and rapidly. Failure to treat the underlying cause is likely to simply result in more slough being produced. E.g. uncomplicated venous ulcers are likely to be sloughy due to the venous congestion.

Autolysis relies on a moist environment. If the wound is too wet or too dry, use an appropriate dressing to create a moist environment e.g. hydrogels and occlusive dressings to re-hydrate dry slough and necrosis; calcium alginates, hydro-fibres and semi-permeable dressings to absorb excess exudate in wetter wounds. The choice of secondary dressing may also affect the moist environment.
E.g. film as the secondary dressing over hydrogel will achieve the maximum rehydration of the wound bed.

For more complex wounds, autolysis may prove too slow, and an alternative method should be considered.

Sharp/surgical Debridement (Royal Marsden Manuel of clinical procedures)
Chapters - Royal Marsden Manual (rmmonline.co.uk)
Involves the cutting away of dead tissue using a sterile technique, usually under local or general anaesthetic. It can help stimulate healing by converting a chronic wound back into an acute wound. It can cause trauma and pain. It must be carried out by a professional qualified in sharp.

Debridement and is often undertaken by Podiatrists.

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

Larval debridement
Involves the use of sterile larvae to remove slough and is available on prescription. There is some evidence it stimulates healing and reduces bacterial burden. It is important to fully assess the wound to determine if it is safe to use larvae. The nature of this product may not be sensitive to patient's expectations, it is important to recognise that patients need to be well informed and are provided with appropriate information literature. (Appendix 6)

Mechanical debridement
This involves the use of non-discriminatory physical force to remove necrotic tissue and is not recommended. Traditionally wet-to-dry dressings were used, but this method can cause severe pain and trauma and should no longer be practiced. Other methods include ultrasonic therapy, pressure irrigation and whirlpool therapy. The use of debriding wound care products and monofilament debriding pad are widely available.

I - Inflammation and infection control
Inflammation and infection prevention and control involves measures to minimise the risk of infection, to reduce bacterial burden and to treat any infection or excess inflammation. NB: inflammatory conditions such as phlebitis, vasculitis, and pyoderma gangrenosum, etc., do not respond to antibiotic therapy, but usually require. anti-inflammatory therapy such as immunosuppressant's and systemic cortico steroids.

Wound Swabs:
All wounds MUST be swabbed on admission for MRSA, as per infection prevention and control policy (WHAT-INF-049: Action card 1)

A wound swab should be taken only where there is suspected infection present. Swab results in isolation do not identify infection but in conjunction with clinical assessment, but the results will help to identify the organisms present and guide on most appropriate antibiotic therapy.

- Wound swabs are taken only when signs and symptoms of infection are pre sent or when non-healing persists. They will determine the microbial content of a wound but not differentiate between colonisation and infection. This procedure only collects surface bacteria, therefore may fail to identify the causative
- Swabs are taken, if indicated as above, from the base or margin of the wound following removal of slough if present. (Appendix 4)

Use of topical anti-microbial solutions and dressings
Anti-microbial solutions and dressings should generally be reserved for situations where the wound presents with an acute infection or is heavily colonised, when intervention is required for the removal and reduction of biofilm.

M – Moisture Balance

Moist wound healing is generally thought to accelerate healing, particularly. Re-epithelialisation. However excess exudate is thought to be harmful to the wound bed and surrounding skin. The chemical imbalance of chronic wound fluid can cause destruction of growth factors, new granulation tissue and the surrounding skin.
Even acute wound fluid, which is chemically balanced to promote healing, may be harmful if left in contact with the wound bed over a long period of time – evidence suggests that chemicals become trapped within the tissue and set off a cascade of pathogenic abnormalities.
Wounds that are left to dry out completely may be slow to epithelialize and are more likely to scar.

Achieving a moist, but not wet, environment relies on.

- Matching the moisture level of the wound with the fluid handling properties of the dressing
- Identifying and treating the source of the wound exudate e.g. infection, or oedema.

*****WARNING: Do not attempt to re-hydrate or soften ischaemic or diabetic necrosis, as this may stimulate a wet gangrene. These wounds should be. kept dry and any decision regarding debridement should be led by a Specialist practitioner. *****

E – Edge Advancement

Failure to achieve successful wound closure and re-establishment of an intact epithelium may be due to several factors including.

- cellular dysfunction (possibly as a result damage from prolonged contact with wound fluid)
- infection
- repeated trauma due to adhesion of dressing materials / poor dressing technique
- ischaemia
- desiccation
- failure to correctly manage the underlying cause of the wound (e.g. pressure, venous congestion)

Where more conservative management has failed, use of advanced therapies should also be considered. These include

- Negative Pressure Wound therapy (NPWT), with canisters for wounds with heavy exudate.

- Single use Portable NPWT device: PICO™single use and canister free, application to be undertaken only by a competent practitioner. **(WAHT NPWT Policy: WAHT-NUR- 091)**
- Consider referral to specialist team's e.g. Vascular team, or Plastics team to consider such procedures as skin grafts.

The general condition of the patient can interfere with wound healing therefore a need to assess and manage wider factors delaying healing. Patients who are immunocompromised due to illness or medication will heal slower. Risk of infection and progression through the inflammatory phase can be particularly problematic, and management should include close vigilance for signs of infection as well as efforts to optimise the patient's general health, for example through nutrition.

S – Surrounding Skin
Failure to assess and manage conditions affecting the peri-wound skin which can, in turn, affect the wound healing process. There is a need to address the cause of skin issue.

- Hyperkeratosis – occurs as a result of over-proliferation of keratin producing cells over the surface of the skin, which results in increased thickening of the epidermis and dermis. The affected area needs to be exfoliated to remove the dead tissue – this can be achieved safely and easily with a monofilament debridement pad or cloth.
- Dermatitis – this is an itchy epidermal and dermal inflammatory reaction of the skin, and the cause needs to be identified to ensure appropriate treatment to resolve the issue.
- Cellulitis – is an acute, painful infection of the skin and subcutaneous tissue and requires immediate intervention with appropriate antibiotic therapy, pain relief and support to the tissues.
- Oedema – requires elevation and/or support of the tissue to assist in the reduction of the swelling cause by the fluid in the interstitial space.
- Maceration/excoriation – occurs when the dressing selected is unable to manage volume of exudate being produced and so overflowing onto the surrounding skin.

Wound cleansing What is recommended to cleanse the wound?
The aim of wound cleansing is to remove gross contamination with minimal pain to the patient and minimal trauma to the tissue. Wounds should be cleaned with 0.9% sodium chloride solution sterile normal saline (0.9%) this has been used due to its isotonic qualities, which mean it will not disrupt the normal healing process (Flanagan, 2013)why do wounds ned to be cleaned to: -

- remove excess exudates.
- remove slough and/or necrotic tissue.
- remove remnants of previous dressings
- to facilitate accurate assessment of the wound/wound bed
- to promote patient comfort

4.5. Wound Dressing Decision Guide -Products

The wound dressing product should be appropriate to meet the needs of the wound and /or promote the next stage of the wound-healing matrix, considering wound bed preparation principles of TIMES. (Appendix 7)

Infected Wounds:

Wound dressings to treat/manage infected wounds may include drainage of pus, debridement of necrotic tissue and consideration of the use of topical antimicrobials

- Choose an antimicrobial dressing based on patient and wound needs, i.e. exudate level, wound depth, need for conformability, odour control, ease of removal and safety (see types in appendix).
- The major roles for antimicrobial dressings in the management of infected wounds are to:
- reduce bioburden in acute or chronic wounds that are infected or are being prevented from healing by microorganisms
- act as an antimicrobial barrier for acute or chronic wounds at high risk of infection or re-infection
- not to promote wound healing directly

The wound dressing product should be used in accordance with the manufacturer's instructions. Consider the biochemical reactions of combining interactive dressing. This information is available within the data sheet accompanying the product. Particular attention should be paid to indications, cautions, contra-indications, and frequency of dressing change.

Antimicrobial Dressings

An antimicrobial is an agent that kills microorganisms or stops their growth Antimicrobial medicines can be grouped according to the microorganisms they act primarily against. For example, antibiotics are used against bacteria, and antifungals are used against fungi. They can also be classified according to their function.

For local wound infection, a topical antimicrobial dressing can be used to reduce the level of bacteria at the wound surface but will not eliminate a spreading infection. Some dressings are designed to release the antimicrobial into the wound, others act upon the bacteria after absorption from the wound. The amount of exudate present and the level of infection should be considered when selecting an antimicrobial dressing.

Dressings with topical antimicrobials are indicated for the treatment of infected wounds, critically colonized wounds or in specific cases for the prevention of infection. They should not be used routinely on wounds healing normally. These products must be prescribed / indicated for use by a specialist practitioner. Antimicrobial dressings aim to reduce the number of micro-organisms at the wound bed to allow normal healing to resume. Effectiveness is dependent on their remaining active throughout the life of the dressing therefore slow-release presentations have been developed.

Dressings containing non-sensitising antibacterial agents (as included on the Worcestershire Wound Management Formulary) Herefordshire & Worcestershire Formulary (hereworcsformulary.nhs.uk) will be considered for topical treatment. These must be discontinued once signs of infection resolve. see appendix 8
Ward /Dept. responsible to negotiating with their site materials management team to ensure sufficient stock levels and appropriate dressing selection for their area. Ensuring the "…Right Dressing, Right Wound, Right Time…"

4.6 Pain Assessment

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

Exception - patients with peripheral neuropathy who may have lost sensation and therefore not able to feel pain e.g. diabetic patients may be unable to feel pain in the foot.

In general, pain experienced by patient although extremely subjective and variable from patient to patient may be considered as:

- Deep dull constant pain
- Superficial burning type pain
- Neuralgic type pain
- Ischaemic type pain

The patient's perception should be acknowledged, and appropriate action taken to alleviate the pain. The wound dressing should be appropriate to the type, location, and size of the wound.

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

4.7. Surgical Wounds

Surgical wounds healing by first intention have sutures or clips /staples or glue drawing the edges of the wound together, aiming to promote primary wound closure. Liaise with the surgical team to ensure the aim and methods of treatment are co-ordinated e.g. time span for post- operative dressing removal and method for sutures, clip or staple removal.

If patient requests a dressing cover for aesthetic reasons or to stop irritation from clothing, a vapour-permeable film or island dressing can be used.

4.13 Essential nutrients for wound healing

Wound healing requires an adequate supply of macro and micronutrients as well as adequate hydration. Deficiencies can interfere with wound healing due to reduced tensile strength of new tissue, wound dehiscence, increased risk of infection and fragile scar tissue.

Protein, Vitamin C, B complex and A, Zinc, Iron and Copper are essential for wound healing. In addition to these nutrients, it is essential that adequate energy/calories are obtained from fats and carbohydrates to prevent tissue protein being used as a source of energy.
For patients presenting with poor nutritional status or with extensive/ multiple wounds referral to dietetic services.

Factors affecting delay wound healing.

Table 3. Factors that may impair wound healing or increase risk for wound development (adapted from Guo & DiPietro, 2010; Thomas Hess, 2011; Vowden, 2011; Khalil et al, 2015; Wounds UK, 2017b)

Factor category	Examples
Patient-related	• Age >65 years • Suboptimal compliance with local treatment and/or management of other conditions that affect wound healing • Psychological stress • Pain • Chronic disease/comorbidities – e.g.: - Diabetes mellitus - Circulatory disorders – e.g. peripheral arterial disease - Obesity - Chronic respiratory, kidney or liver disease; anaemia - Immunosuppression – e.g. due to disease or medication - Malnutrition/dehydration - Reduced mobility - Incontinence - Cognitive impairment - Autoimmune disease • Medication – e.g. corticosteroids, chemotherapy, immunosuppressants, anticoagulants, non-steroidal anti-inflammatory drugs (NSAIDs) • Radiotherapy • Acute illness • Smoking, alcoholism, substance misuse • Previous chronic wound • Unsuitable or poor living conditions
Wound-related	• Large initial wound size (>10cm^2) • Long duration of wound (>6 months) • Presence of devitalised tissue • Infection • Contamination/foreign body • Hypoxia/ischaemia – e.g. peripheral arterial disease • Oedema – e.g. due to venous insufficiency • Inflammatory conditions – e.g. vasculitis, pyoderma gangrenosum • Ongoing local mechanical stress, pressure or trauma

4.14. Wound photography

Patients with wounds will have an initial and on-going assessment of their wound using the Trust recognised wound assessment tool. This assessment should be supported by digital photography.
Photographs should not be taken using a non-NHS secure device and images should be deleted from the device as soon as they are transferred to their secure documentation system.
Taking a digital wound image allows for a clear record of the wound on first assessment against which progress, or deterioration can be measured. A clear image may also be useful in case of safeguarding concerns or litigation.
There should be local guidelines in place on how to take, transmit and store images and the relevant level of patient consent should be obtained.
It is the responsibility of the individual taking the digital image to ensure that informed consent is obtained for digital imaging that includes where and how the images will be used. The process of recording consent should follow the consent policy of the health or care professional's employing organisation. Verbal consent is acceptable if the image is part of the patient's treatment or care record but should be documented in the patient's clinical record. Consent must be obtained from the person themselves but if a person does not have the capacity to decide about their treatment and they have not appointed a lasting power of attorney (LPA), digital imaging can happen if the healthcare professionals believe it is in the person's best interests prefer to WAHT-KD-026 : policy for Assessing Mental Capacity and Complying with the Mental Capacity Act 2005)

Prior to undertaking any examination, treatment and care clinicians must ensure that the Appropriate consent has been gained. Where relevant the associated documentation must be completed, or the information recorded in the medical notes. Obtain written consent (where possible or verbal) from the individual. For further information see Trust: Policy for Consent to Exam or Treatment. (WAHT-CG-075)

Photographs will be taken on initial assessment or as soon as possible if the digital device is not available on the day. The wound should be re-photographed: Every 2 weeks or if there are any significant changes or concerns regarding the wound. Regular photography of the wound provides a useful visual record. These will be uploaded to the patients evolve patient record for full MDT access /review. (Appendix 8)

- Photographs should be labelled with the individuals NHS number, name, date of birth, date of photo, wound position and the name of the health care professional who has taken the image. Include a ruled measure to give an indication of scale. Secure/upload in the patient's records in chronological order or print clearly labelled (Appendix 9)
- Privacy and dignity should be protected and maintained at all times
- If photographs are used for training purposes confidentiality must be maintained and appropriate level of consent is gained.
- Images can only be used for publication with specific consent (Individual agreement for photography and release of data for third party use)

- Guidance on taking a digital wound image can be found at:

https://www.nationalwoundcarestrategy.net/wp-content/uploads/2021/09/Digital-Images-in-wound-care-17Sept21.pdf

4.15. Safe discharge for patients with complex wounds:

- Patients discharged with wounds will have details of their wound management plan within the Electronic Discharge Summary (EDS)
- Supply of dressings for 3 days.
- Referral to appropriate community services team

4.16. Referrals to Acute Trust Tissue Viability Team:

Acute Trust in- Patients referrals:

- Referral order placed via the Electronic Patient Record (EPR) (Appendix 11)
- Referrals triaged daily by the Tissue Viability Team against the Tissue Viability Patient case load criteria. (Appendix 10)
- Patients with diabetes who have new, or deteriorating foot wounds must be managed and referred in accordance with the Diabetic Footcare Team (Appendix 3).
- Patients with Lower leg wounds who present with potential or known venous disease or arterial disease will be referred to the Vascular specialist Team via EPR.

5.0. Implementation

5.1. Plan for implementation.

- This is a reviewed document, to ensure all clinical staff are aware of the updated document via the Trust intranet and cascading through the Divisions.

5.2. Dissemination

- Circulation via Divisional Governance Groups, IPC Team, Divisional Directors of Nursing, Matrons, Ward/Dept. Managers and Tissue Viability Champions.

5.3. Training and awareness

- Wound Assessment and Management Study Days
- Pressure Ulcer prevention as essential to Role training every 2 years (face to face monthly /eLearning)
- Categorisation Workshops.
- Student Nurse Forum
- Tissue Viability Champions Events
- Preceptor Courses
- International Nurses
- TV Intranet site :All national guidance ,resources and eLearning available
- Ward based Resource folders.
- Bespoke training following individual ward areas highlighted themes and trends.

6.0. Monitoring and compliance

- Monitoring compliance with this policy will be the responsibility of ward/team managers and the Tissue Viability team. This will be through either formal or informal monitoring of wound assessment documentation.
- Additional monitoring will be achieved via monitoring Tissue Viability referrals.

The table below should help to detail the 'Who, What, Where and How' for the monitoring of this Policy.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
Full document	Wounds are cared for well	Reported via Fundamental of Care (FOC 12) exception report: **Wounds are cared for**	Monthly	Tissue Viability Team	Ward managers, matrons, Divisional directors of Nursing,	Every month

7.0. Policy Review

The Policy will be reviewed every 3 years, by the Lead Nurse for Tissue Viability.

8.0. References

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9.0. Background

9.1. Equality requirements

The author must include the Equality Impact Assessment Table and identify whether the policy has a positive or negative impact on any of the groups listed. Supporting Document 1

9.2. Financial risk assessment: No Financial Impact implementing this policy Supporting Document 2

9.3. Consultation

Contribution List

This key document has been circulated to the following individuals for consultation.

Designation
Fundamental of Care Committee members
IPC: Liz Watkins DIPC

9.4. Approval Process

This section should describe the internal process for the approval and ratification of this Policy.

- This key document has been circulated to the chair(s) of the following committee's / groups for comments.

Committee
Fundamentals Of Care Committee Chair
Fundamentals Of Care Committee members

9.5. Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:
Feb 2025	Wound swabbing appendix Antimicrobial dressing appendix	

Appendices

Appendix 1: Top Tips Skin Tear & ISTAP Skin Tear Classification Tool /Flyer

7 Skin Tear Top Tips Version 2.pdf

ISTAP 2-Page Flyer 2024.pdf

Appendix 2: WAHT Tetanus Prophylaxis Guidance

Tetanus prophylaxis.pdf

Appendix 3: Diabetic Foot Care Pathway

18 Diabetic footcare pathway_2

Appendix 4: Wound Swabbing

Best Practice wound swabbing g

Appendix 5 TIMES assessment

TIMES Assessmnet PDF.pdf

Appendix 6. Larvae Patient Information Leaflet

PIL Biomonde.pdf

Appendix 7. Wound Dressing Decision Chart.

1 Wound Dressing Decision Chart (NEW

Appendix 8: Antimicrobial dressings

ANTIMICROBIAL DRESSINGS appendi

Appendix 9: Evolve/CLIP image upload Instructions

Uploading image to CLIP on EPR -.pdf

Appendix 10: Appendix 5. Photography Consent Forms

Clinical photography video consent form.d

Consent Form 4.docx

Appendix 11: TV Case Load Criteria.

Tissue Viability case Load Criteria NEW 2

Appendix 12: Tissue Viability referral process

TV REFERRAL PROCESS NEW Jan 2

Supporting Document 1 - Equality Impact Assessment Tool
To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	Claire Hughes

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Claire Hughes	**Lead |Nurse Tissue Viability**	**claire.hughes9@nhs.net**
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Wound Assessment And Management Guidelines.**			
What is the aim, purpose and/or intended outcomes of this Activity?				
Who will be affected by the development & implementation of this activity?	X X ❑	Service User Patient Carers	❑ ❑ ❑	Staff Communities Other _____

		Visitors	❑	
Is this:	X Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.				
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)				
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		X		
Disability		X		
Gender Reassignment		X		
Marriage & Civil Partnerships		X		
Pregnancy & Maternity		X		
Race including Traveling Communities		X		
Religion & Belief		X		
Sex		X		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sexual Orientation		X		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		X		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		X		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected

characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Claire Hughes
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	NO
2.	Does the implementation of this document require additional revenue	NO
3.	Does the implementation of this document require additional manpower	NO
4.	Does the implementation of this document release any manpower costs through a change in practice	NO
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	NO
	Other comments:	N/A

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval