Northern Devon Healthcare NHS Trust

Document Control

Title			
Care of Open Wounds			
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Directorate Corporate Nursing			**Department** Tissue Viability
Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
0.1	July 2017	Draft	Initial version for consultation
0.2	October 2017	Draft	Amended following review and placed on correct Trust template.
1.0	Feb 2019	Final	Approved Patient Safety6 Operational Group.
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Superseded Documents Care of Open Wounds Policy			
Issue Date November 2018	**Review Date** November 2021		**Review Cycle** Three years
Consulted with the following stakeholders: (list all) • Divisional Nurses • Senior Nurses • Senior Nurse Community Nursing • Patient Safety Operational Group			
Approval and Review Process • Patient Safety Operational Group			
Local Archive Reference G:\\Tissue Viability **Local Path** Policies/Care of Open Wound Policy **Filename** Care of Open Wounds draft v0.3 Sept 18			
Policy categories for Trust's internal website (Bob) Nursing, Allied Health Professionals			**Tags for Trust's internal website (Bob)** Wound care, tissue viability,

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CONTENTS

1. Purpose

1.1. The purpose of this document is to;

Identify the procedure for treating open wounds in a safe and appropriate manner and in line with relevant national guidance.

Minimise the risk of wound infection

Ensure patients receive individualized care plans to meet their needs for treatment or palliation dependent on the primary wound care objective

Ensure staff are aware of referral pathways to specialist services such as Tissue Viability, Podiatry and Vascular team.

Ensure patients receive appropriate wound dressing products from a standard local formulary.

1.2. The policy applies to The policy applies to;

- Registered Nurses
- Registered Nursing Associates
- Support workers
- Midwives
- Operating Department Practitioners
- Medical Staff
- Radiologists
- Physiotherapists
- Occupational Therapists
- Podiatrists.

1.3. Implementation of this policy will ensure that:

- 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

Closed wounds (primary intention)

2.1. These are wounds with edges approximated by stitches, staples, glue or other tissue adhesive such as wound closure strips.

Open wounds (Secondary Intention)

2.2. Those wounds left to heal by the process of granulation tissue formation and epithelialisation, sometimes referred to as healing by secondary intention. 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.

Fungating Wounds

2.3. Are malignancies which cause exuberant skin infiltration. It is possible to palliate the symptoms of these wounds but in most circumstances not to heal them.

Moist Wound Healing

2.4. 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

2.5. Is a concept which combines a number of wound management processes. It is devised as an algorithm which is applicable to all wound types to enable a systematic approach to wound healing. It incorporates the principles of moist wound healing. Refer to Appendix A.

T.I.M.E: Tissue, Infection, Moisture, Edge

2.6. This is a development of the wound bed preparation concept and is designed to enable systematic assessment of open wounds. This is detailed in Appendix

3. Responsibilities

Role of Chief Nurse

3.1. The Chief Nurse is responsible for:

- Tissue Viability as Lead Executive

Role of the Tissue Viability Service

3.2. The Tissue Viability Service is responsible for:

- Ensuring this policy is kept updated and changes disseminated.
- Providing direction for research activities.
- Working with procurement, pharmacy and other colleagues at local and regional level to ensure that wound management products are available which ensure clinical and cost efficacy.
- Establishing and publicising referral pathways and criteria for NDHT, Primary care and private providers in line with commissioned requirements
- Provision of comprehensive training and education programmes/ opportunities.
- Reviewing the care of patients with complex wounds with the frontline nursing team when patients are referred for advice/support.
- Providing clinics for patients with complex wounds and those not responding to standard therapies given by the frontline nursing team.
- Confidential storage of patient records and photographs in line with Trust policies.

Role of Registered Nurses and Midwives

3.3. Registered Nurses and Midwives and Nursing Associates are responsible for:

- Assessment of the skin integrity of the patients under their care, including any relevant risk assessments.
- Assessment of existing wounds of patients under their care utilising appropriate documentation where applicable.
- Devising an effective care plan for promoting moist wound healing/maintenance as appropriate and prevention of infection, and evaluating the effectiveness of this care plan.
- Delivery of care as specified in the patients' care plans
- Documenting any variance from care plans and any deterioration in condition in the patient's case notes and escalating as appropriate
- Supervising unregistered staff working under their charge
- Asking for guidance within their immediate team from more experienced colleagues when unsure how to manage non-complex wounds.
- Attending a planned consultation with other members of the healthcare team such as Doctor, Tissue Viability specialist or Podiatrist for a patient in their care in order to take advantage of the learning opportunity.
- Facilitating wound care education/opportunities of student nurses.
- Maintaining the necessary knowledge and skills to retain competence to practice wound care.
- Ensuring competence in the use of different wound therapies such as negative pressure and Larval therapy.

Role of Medical Staff

3.4 It is the responsibility of the medical staff to:

- Ensure that they are aware of and have documented any skin integrity issues/open wounds sustained by their patients during their stay as well as those present on admission.
- Ordering appropriate laboratory investigations for suspected infected open wounds
- Working within antibiotic prescribing guidelines when managing infected open wounds.
- Working with nursing and Allied Health Professional colleagues to ensure appropriate care plans are in place for the management of open wounds

Role of Allied Health Professionals

3.5 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.
- Have an awareness of patients open wounds where they exist and the impact this may have on therapy goals.

Role of Unregistered Staff

3.6 It is the responsibility of unregistered staff to:

- Performing delegated tasks from registered nursing colleagues
- Delivery of care as specified in the patients' care plans
- Escalating any deterioration or other concerns to registered nurse in a timely manner.
- Documenting any variance from care plans and any deterioration in condition in the patient's case notes.

Role of Patient Safety Operational Group

3.7 The Patient Safety Operational Group is responsible for:

- Reviewing and approving the policy
- Monitoring compliance with the policy

4. Wound Assessment and Management

The following resources are available to support with the assessment and management of wounds:

Wound management guidelines can be found here: https://northeast.devonformularyguidance.nhs.uk/formulary/chapters/17.-wound-management

Refer to Appendix C for a guide to dressing selection.

Additional resource regarding the assessment and management of wounds can be found at: https://webview.rxguidelines.com/Viewing/Index/172#4JKOrMsRRx

Refer to the Skin Care Guidelines for Neonates including care of nappy rash for guidance regarding this patient group.

Wound Assessment

4.1. All patients admitted within a hospital setting with an open wound will have an assessment carried out by a registered healthcare professional, normally within the period of the admitting shift and no later than 6 hours from admission.

An appropriate care plan for the management of existing wounds and the prevention of further deterioration of these and the prevention of further skin damage will be devised within 24 hours of assessment. For patients in the community setting the assessment will be carried out by a registered healthcare professional either on the initial visit/referral or following escalation from an unregistered staff member within the team.

All patients who acquire an open wound whilst in hospital will have an assessment carried out within 6 hours of identification of the wound and a care plan devised by a registered healthcare professional within 24 hours of the assessment.

The wound will be assessed for change (improvement or deterioration or absence of change) at every re-dressing and documented.

Documentation

4.2. All wounds present on admission or occurring during a hospital stay or episode of care in the community must be recorded and the aetiology of the wound identified.

A full and comprehensive wound assessment will be completed and documented on the appropriate wound assessment and management form for the clinical area. A separate wound assessment form should be used for each individual wound.

Wound dimensions must be recorded at initial assessment and then at least weekly for subsequent re-assessments, or sooner if there has been a significant change in the wound size.

Wounds should be re-assessed at each dressing change and this should be documented on the appropriate wound assessment forms.

A care plan will be devised by a registered healthcare professional for each wound and this care plan will detail dressing choice, rationale for choice and the frequency of dressing change required.

The care plan must be evaluated in writing when changes to the wound occur. This will be documented on the wound assessment and management form.

A new care plan should be written each time the care is changed to reflect the changing status of the wound.

Wound dressings

4.3. Most commonly used dressings are supplied via Materials Management at NDDH and via web basket ordering systems at community hospitals.

Larval therapy is ordered through pharmacy with a valid prescription, a referral to Tissue viability is required to facilitate this.

For in-patients at North Devon District Hospital and Community Hospitals a selection of non-stock dressings are available via Web basket for named patients.

Refer to the Dressings Standardisation List Appendix E for a full list of products available from Web Basket.

First dressing stock may be ordered through Web basket for Community nurse bases.

Following use of a first dressing supplied through Community nurse stock, dressing supply for patients nursed in their own homes will be obtained via prescription. Prescription items legally belong to the patient for whom they were originally prescribed and any surplus should be left with the patient. Items should be prescribed in sufficient quantity to enable a reasonable period of treatment but should not be stockpiled to avoid un-necessary waste. The status of a wound can change and therefore the quantity of dressing products prescribed should reflect this.

Community nursing teams when selecting wound dressing products on prescription should adhere to the wound care formulary in Appendix D.

Antimicrobial products should be used for a period of 2 weeks and then continued used must be reviewed to ensure that they remain clinically indicated.

All dressing products must be used in accordance with the manufacturer's instructions for use. 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.

Any adverse events with dressings should be reported via the trusts incident reporting system (Datix) and the yellow card system

On occasions a patient may insist on using a particular product for their wound management. The Registered health professional will discuss the request with the patient in the first instance ensuring relevant information is given and understood particularly if the product is considered to be unsuitable. The product may be unlicensed for the particular application or it may not be considered to be of 'medical grade'. The registered health professional will then discuss the request with the patient's consultant or GP, Medicines Information Pharmacist and/or the Tissue Viability service to determine whether the care can be supported. If it can be supported then the product should be prescribed. Patients may use product that they have purchased themselves providing the reason for use and whether or not it is supported is clearly documented.

Wound cleansing and dressing application will follow the guidance listed in the Aseptic Techniques policy http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2012/11/Aseptic-Techniques-Policy-v3.2-28Jan16.pdf

5. Referrals to Tissue Viability

5.1. Referrals to the Tissue Viability Service are governed by the Tissue Viability Operational Policy

5.2. Referrals should be written and can be made electronically via BOB

5.3. You can e-mail the tissue viability team at ndht.tissueviability@nhs.net

5.4. Patients with diabetes who have new or deteriorating foot wounds must be managed and referred in accordance with the acute diabetes foot pathway http://www.northdevonhealth.nhs.uk//wp-content/uploads/2014/06/Diabetes-Footcare-pathway-Jan161.pdf

Referrals to the multidisciplinary foot care team can be facilitated via Tissue Viability or Podiatry services or by emailing ndht.diabeteshotfoot@nhs.net

Education and Training

5.5. Education and training is accessible via the Tissue Viability Service which will be tailored according to the local needs and TV service prioritisation at the time of request. Training is advertised and bookable via STAR

Specific skills with an increased potential to do harm will require specific education and training with competency development before that skill can be used unsupervised in practice. In particular this means sharp debridement, for which the normal practitioner is a surgeon or podiatrist. Staff with education, training and competence to practice will have this skill detailed in their job description.

6. Monitoring Compliance with and the Effectiveness of the Policy

Standards/ Key Performance Indicators

6.1. 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.

Process for Implementation and Monitoring Compliance and Effectiveness

6.2. The policy will be implemented via BOB.

6.3. It will be monitored informally by ward/team managers and the tissue viability service.

7. Equality Impact Assessment

7.1. 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. The Author must make comment on how the policy makes this impact.

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age			✓	
Disability			✓	
Gender			✓	
Gender Reassignment			✓	
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership			✓	
Pregnancy			✓	
Maternity and Breastfeeding			✓	
Race (ethnic origin)			✓	
Religion (or belief)			✓	
Sexual Orientation			✓	

8. References (Optional)

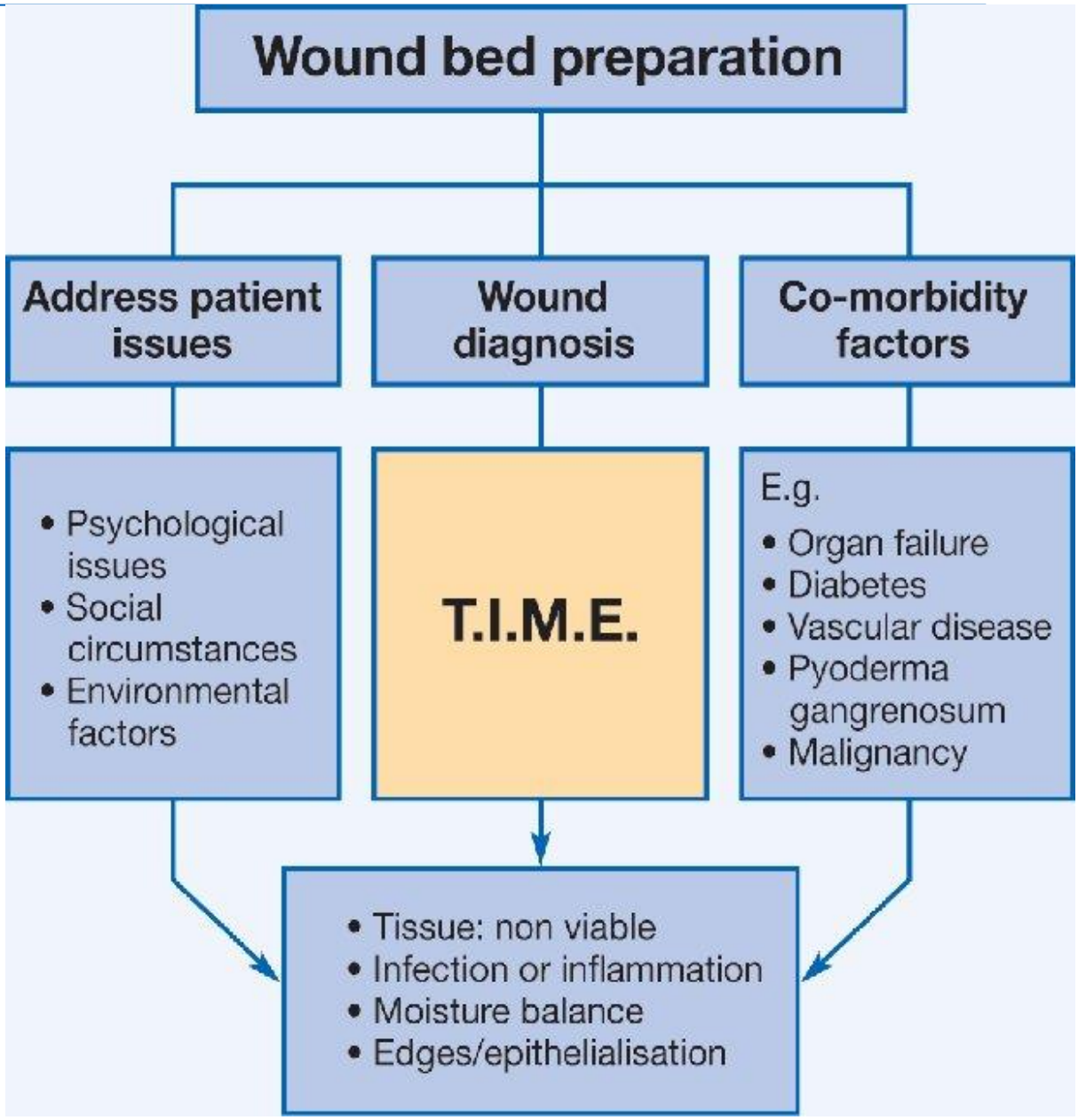
- Hadi, S.A., and Inwood, R. (2016) Current And Emerging Debridement Options In Wound Care. Podiatry Today 29: 12 pp 46-51

- Watret,L. (2005) Teaching wound management: a collaborative model for future education. **World Wide Wounds**. Available at: http://www.worldwidewounds.com/2005/november/Watret/Teaching-Wound-Mgt-Collaborative-Model.html [Accessed 24/10/2017]

9. Associated Documentation

- Pressure Ulcer Prevention and Management Policy
- Tissue Viability Operational Policy
- Documentation Policy
- Aseptic Technique Policy
- Skin Care Guidelines for Neonates including care of nappy rash

Appendix A. Wound Bed Preparation



Reference: Watret,L. (2005) Teaching wound management: a collaborative model for future education. **World Wide Wounds**. Available at: http://www.worldwidewounds.com/2005/november/Watret/Teaching-Wound-Mgt-Collaborative-Model.html

Appendix B. T.I.M.E

A Guide To The Principles Of Wound Bed Preparation

Clinical Observations	Proposed Pathophysiology	Wound Bed Preparation Clinical Actions	Effect of Wound Bed Preparation Actions	Clinical Outcome
Tissue	Defective matrix and cell debris impair healing	Debridement (episodic or continuous): • Enzymatic, surgical/sharp, autolytic, biologic, or mechanical	Restoration of wound base and functional extracellular matrix proteins	Viable wound base
Infection or inflammation	High bacterial counts or prolonged inflammation: ↑ Inflammatory cytokine ↑ Protease activity ↑ Growth factor activity	Remove infected foci with topical/systemic • Antimicrobials • Anti-inflammatories • Protease inhibition	Low bacterial counts or controlled inflammation: ↓ Inflammatory cytokine ↓ Protease activity ↑ Growth factor activity	Bacterial balance and reduced inflammation
Moisture balance	Desiccation slows epithelial cell migration Excessive fluid causes maceration of wound margin	Apply moisture-balancing dressings Compression, negative pressure or other methods of removing fluid	Restored epithelial cell migration, desiccation avoided, edema, excessive fluid controlled, maceration avoided	Moisture balance
Edge of wound	Non-migrating keratinocytes Non-responsive wound cells and abnormalities in extracellular matrix or abnormal protease activity	Reassess cause or consider corrective therapies: • Debridement • Skin grafts • Biological agents • Adjunctive therapies	Migrating keratinocytes and responsive wound cells Restoration of appropriate protease profile	Advancing edge of wound

Adapted from Dowsett C. Using the TIME framework in wound bed preparation. *Br J Community Nurs.* 2008;13(6):S15-16,S18,S20.

Hadi, S.A., and Inwood, R. (2016) Current And Emerging Debridement Options In Wound Care. *Podiatry Today* **29:** 12 pp 46-51

Appendix C. Guide to Dressing Selection

Guide to Primary
Dressing Selection V 1