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Assessment, Treatment and Management of Wounds for Adult Patients in the Community - Guidance

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1. INTRODUCTION 5
2. PURPOSE 5
3. SCOPE 5
3.1 Types of wounds 5
4. FAIRNESS, RESPECT, EQUALITY, DIVERSITY, INCLUSION & ENGAGEMENT 6
5. ABBREVIATIONS & DEFINITIONS 7
6. ROLES & RESPONSIBILITIES 9
7. ASSESSMENT AND REVIEW 10
7.1 Assessment 10
7.1.1 Patient Assessment 10
7.1.2 Lower Limb Wounds 11
7.1.3 Wound Assessment 11
7.2 Wound Photography 12
7.3 Wound Review 13
7.4 Patient Engagement with Treatment Plan 14
7.5 Primary Care Pathways 14
7.6 Escalation Pathways 14
7.6.1 Pressure Ulcerations 14
7.6.2 Negative Pressure Wound Therapy: 14
7.6.3 Deteriorating Wound 14
7.6.4 Wounds at 4 weeks: 15
7.7 Tissue Viability Service 15
8. WOUND TREATMENT AND MANAGEMENT 16
8.1 Wound Bed Preparation 17
8.2 Cleansing Protocol 19
8.3 Opportunistic Maggots in wounds 21

8.4 Debridement....23
8.5 Surrounding Skin....23
9. MANAGEMENT OF WOUND INFECTION....24
9.1 Wound Infection Framework....25
9.2 Antibiotic Therapy....28
9.3 Wound Swabbing....29
10. BIOFILMS....30
11. MANAGEMENT OF WOUND EXUDATE....31
12. DRESSING CHOICE....34
13. DISCHARGE FOLLOWING WOUND HEALING....34
14. HYPERGRANULATION....35
15. LOWER LIMB WOUNDS AND ULCERATION....37
15.1 Red Flag assessment....37
15.2 Lower Limb – Immediate and Necessary Care....38
15.3 Lower Limb – 1st Assessment....39
15.4 Lower Limb – Ongoing Care and Review....40
15.4.1 Compression Therapy....40
15.5 Lower Limb – Healed Wound....40
16. SKIN DISEASE ASSOCIATED WITH ULCERATION....42
17. CHRONIC OEDEMA....47
18. MANAGEMENT OF PRESSURE ULCERS....47
18.1 Assessment and Prevention....47
18.2 Pressure Ulceration Categorisation....53
18.3 Pressure Relieving Device....58
18.4 Use of Offloading Interventions for Foot Wounds....59
18.5 Specific Conditions....63
18.6 Clinical Incident Reporting Pathway for Pressure Ulceration Category 2 and Above64

18.7	Community Nursing: Pressure Ulcer Reporting	66
18.8	Bedded Units: Pressure Ulcer Reporting	68
18.9	Communications Between Healthcare Settings	71
19.	MOISTURE ASSOCIATED SKIN DAMAGE (MASD)	71
20.	SURGICAL WOUNDS	73
20.1	Immediate Actions for Surgical Wound Dehiscence	73
20.2	Tissue Viability Care of SWD	74
21.	CAVITY WOUNDS	74
22.	MANAGEMENT OF MALIGNANT / FUNGATING WOUNDS	76
23.	INCS – NEGATIVE PRESSURE WOUND THERAPY	79
24.	INCS – NEGATIVE PRESSURE WOUND THERAPY PATHWAY	86
25.	SKIN TEAR PATHWAY	87
26.	INCS – SKIN TEARS IN CARE HOMES	89
26.1	Responsibility of the Care Home Staff	90
26.2	Responsibility of the INCS Clinicians	91
27.	MEDICAL ADHESIVE RELATED SKIN INJURY (MARSI)	91
28.	TRAINING REQUIREMENTS	93
29.	APPROVAL	93
30.	MONITORING & COMPLIANCE	93
31.	REVIEW	94
32.	REFERENCES & ASSOCIATED DOCUMENTATION	94
33.	Related Items	96

1. INTRODUCTION

The increasing prevalence and complexity of wound care presents a significant challenge to healthcare services across the UK. Evidence from national studies highlighted a substantial rise in wound incidence, associated resource use and overall cost to the NHS, with wound management now representing a major component of community-based care. (Guest et al. 2020)

By standardising processes and reinforcing best practice principles, this SOP supports quality improvement, reduces unwarranted variation in care and aligns with national strategies to enhance patient outcomes and service efficiency, such as:

- Enhanced rates of wound healing
- Mitigation of the physical, emotional, and socioeconomic effects that wounds have on patients
- Lowering the overall burden of wounds, which could lead to reduced workloads and costs related to wound care
- Boosting morale among both practitioners and patients by achieving better patient outcomes

2. PURPOSE

The purpose of this document is to describe the standard procedures for the assessment, treatment and management of wounds in the community including:

- Assessment and review
- Wound treatment and management
- Lower limb ulceration and chronic oedema management
- Pressure ulceration prevention and management in adults
- Other general wound management and adjunct wound therapies

3. SCOPE

This document applies to all staff employed within CHCP and its subsidiaries for whom assessing / treating or managing wounds is part of their role - including both registered and unregistered professionals.

3.1 Types of wounds

- Leg Ulcerations:

  Venous Leg Ulcer (VLU)

  Arterial Leg Ulcer (ALU)

Mixed Aetiology Leg Ulcer

Leg Ulcer - other e.g. Pyoderma Gangrenosum

- Foot Ulcer type:
  Ischaemic foot ulcers
  Neuroischaemic foot ulcer
  Neuropathic foot ulcer
  Diabetic foot ulcer
  Foot ulcer – other – e.g. gout

- Pressure Ulcer:
  Vulnerable skin
  Category 1 / 2 / 3 / 4
  Medical device related pressure ulcer
  INC: Moisture Associated Skin Damage (MASD)
  Medical Adhesive Related Skin Injury (MARSI)

- Wound type – other:
  Surgical wounds
  Traumatic wounds e.g. skin tears, lacerations and incisions
  Malignant and fungating wounds
  Haematomas – open or closed
  Burns and scalds
  Wounds – other e.g. fistulas and sinus wounds

4. FAIRNESS, RESPECT, EQUALITY, DIVERSITY, INCLUSION & ENGAGEMENT

CHCP promotes the principles of FREDIE (Fairness, Respect, Equality, Diversity, Inclusion and Engagement) throughout the organisation and beyond. Whilst supporting and sustaining an inclusive and diverse workforce that is representative of the community it serves, equally we are committed to the provision of services that not only respect our increasingly diverse population but also which promotes equity of access and care.

5. ABBREVIATIONS & DEFINITIONS

Abbreviations:

ABPI – ankle brachial pressure index

ALU – Arterial Leg Ulcer

BMI – Body Mass Index

CCH – Care Coordination Hub

CHCP – City Health Care Partnership

DTI – Deep Tissue Injury

ESR – Electronic Staff Record

FTU – Fingertip Unit

GP – General Practitioner

HCP - Health Care Professional

INCS – Integrated Nursing and Conditions Service

ISTAP – International Skin Tear Advisory Panel

IV - Intravenous

MARSI – Medical Adhesive Related Skin Injury

MASD – Moisture Associated Skin Damage

MCA – Mental Capacity Act

MUST – Malnutrition Universal Screening Tool

NICE - National Institute of Health and Care Excellence

NHS- National Health Service

NPWT – Negative Pressure Wound Treatment

NWCSP – National Wound Care Strategy Programme

PEG – Percutaneous Endoscopic Gastrostomy

PSII – Patient Safety Incident Investigation

PSIRF – Patient Safety Incident Response Framework

SBAR – Situation, Background, Assessment, Recommendation

SOP – Standard Operating Procedure

SSI – Surgical Site Infection

SWD – Surgical Wound Dehiscence

TBPI- Toe Brachial Pressure Index

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

TVaLL - Tissue Viability/Lymphoedema and Lower Limb Service

TVN – Tissue Viability Nurse

VLU – Venous Leg Ulcer

WBP – Wound Bed Preparation

cm - Centimetres

mm - Millimetres

> - More than

Definitions:

SystmOne (S1): is a widely used electronic patient record that enables healthcare staff to securely record, access, and share patient information across various care settings

MyCompliance: CHCP's electronic document management system

Wound: damage or disruption to the normal anatomical structure and function of the skin

Acute wound: An acute wound is an injury to the skin that occurs suddenly rather than over time. It heals at the predictable and expected rate of the normal wound healing process. Acute wounds can occur anywhere on the body and vary from superficial scratches to deep wounds damaging blood vessels, nerves and muscles.

Non-healing wound: When a wound fails to follow the normal wound healing trajectory it may get 'stuck' in one of the stages of wound healing. This can be due to various factors such as poor circulation, infection, weakened immune system, or underlying medical conditions. These wounds are often multifaceted and can pose significant challenges for clinicians

Primary intention: occurs when wound edges are clean, closely approximated, and secured together (using sutures, staples, or glue) to promote rapid closure with minimal tissue loss and scarring. It is typically used for surgical incisions or clean lacerations with low infection risk. The process is fast, with epidermal continuity often restored within 24–48 hours.

Secondary intention: is a natural wound closure process where open wounds, with edges that cannot be opposed (approximated), heal from the base upward through granulation, contraction, and epithelialisation.

Tertiary wound healing or delayed primary closure: for management of heavily contaminated wound by leaving the wound open for 4 – 5 days before primary closure

Pressure Ulcer: is localised injury to the skin and/or underlying tissue usually over a bony prominence or related to a medical or other device, resulting from sustained

pressure, including pressure associated with shear. The damage can be present as intact skin or an open ulcer

Leg Ulcer: a leg ulcer is a break in the skin below the knee which has not healed within 2 weeks.

Venous Leg Ulcer: a venous leg ulcer occurs in the presence of venous disease and is the most common type of leg ulcer, accounting for 60–80% of cases. It typically occurs in the gaiter area of the leg (from the ankle to mid-calf)

Diabetic foot ulcer: is defined an open wound or sore on the skin that's slow to heal. These are common in people with diabetic polyneuropathy

Non-diabetic foot ulcer: Non-diabetic foot ulcers, though less common than those stemming from diabetes. These ulcers are often related to poor circulation, nerve damage, or trauma. Risk factors include peripheral artery disease, neuropathy, infections, and pressure injuries

Lower Limb Compression therapy: A management option that applies pressure on the patient's lower limb to promote blood flow and improve venous return to the heart. The beneficial effects of compression can reduce oedema, inflammation, pain and cellulitis while promoting the healing of wounds/ulcers caused by venous insufficiency

Off Loading: Refers to an intervention to minimise or remove the mechanical stress from a specific region of the foot to aid the wound healing process

6. ROLES & RESPONSIBILITIES

All healthcare professions who undertake wound care have the responsibility for the implementation of this guidance. All clinical staff, whether registered or non-registered, who are involved in wound care procedures are responsible for implementing this guidance, completing the appropriate Wound Care training/clinical skills book and ensuring they are deemed competent in the relevant assessment, treatment, management, and procedures relating to wound care.

Operational Managers / Team Leaders / Practice Teachers have the overall responsibility to ensure all healthcare professionals who undertake wound care adhere to this guidance.

Professional Lead has the responsibility to ensure this guidance is in date and is written in line with best practice and national guidelines.

7. ASSESSMENT AND REVIEW

All patients should be assessed and reviewed by a clinician with the necessary knowledge, clinical skills, and competences, ensuring that outcomes for patients are optimised in both their effectiveness and cost-efficiency.

The clinician will conduct the initial assessment during the first face-to-face meeting, as well as at any further appointments/visits if required, drawing on their expertise, abilities, and clinical judgement tailored to the individual patient's needs.

Every assessment and review must be completed and documented in the patient's electronic care record, in accordance with the relevant service record keeping policy and standard operating procedure.

7.1 Assessment

All clinicians when assessing a patient with a wound must ensure a comprehensive assessment is undertaken:

A comprehensive assessment should identify all factors requiring intervention and will guide the clinician appropriately on the patients' needs for the safe and effective delivery of wound treatment and management.

History taking is a key component of the assessment and patients should have the opportunity to discuss concerns about their wound and their expectations during the assessment. Involving patients from the first intervention can encourage and empower them to take a more active role in their treatment and improve outcomes.

7.1.1 Patient Assessment

At the initial episode of care an individual holistic patient assessment should be undertaken and must include the following:

- Assessment of the patient's mental capacity. If the patient is deemed to lack capacity, then the best interest's pathway should be followed in accordance with **Ref 459**: Mental Capacity Act and Deprivation of Liberty Safeguards Policy.
- Consideration of both intrinsic and extrinsic factors that may influence wound healing. To include consideration of the patient's environment, social circumstances, and general health, including any co-morbidities.

- Identification and addressing of any predisposing factors that could impact wound healing.
- Recording all allergies.
- Completion of all applicable service risk assessment tools relevant to wound management, such as:
  - Manual Handling Risk Assessment
  - Fullers Assessment
  - Malnutrition Universal Screening Tool (MUST)
  - Purpose T Pressure Ulcer Risk Assessment Tool
  - aSSKINg
- Thorough assessment of pain and prompt escalation any concerns to the patient's GP or refer to the pain management team, as appropriate.
- Documentation of all medications and consideration of their impact on wound healing.

7.1.2 Lower Limb Wounds

See **Section 15 LOWER LIMB WOUNDS AND ULCERATION** for additional information relating to assessment and care of patients with a lower limb wound or ulceration.

See **Suspected Foot Pressure Damage Incidence Reporting Pathway** section **18.6** for more information relating to the care and management of patients with suspected pressure damage to their feet when the skin is intact or blistered.

7.1.3 Wound Assessment

Use of the **T.I.M.E** framework to support wound assessment will help to inform the correct diagnosis / aetiology of the wound and the treatment required

	Clinical Need	Clinical Action
T	**T**issue management	Wound bed preparation to remove non-viable tissue and foreign material
I	Control of **I**nfection and **I**nflammation	Identify signs of infection or excessive inflammation and treat them appropriately, managing bacterial load

M	**M**oisture balance	Removal of excess wound exudate or dryness and provision of a controlled moist environment for optimal healing
E	Advancement of the **E**pithelial **E**dge of the wound	Evaluate the wound edges for undermining, tunnelling, or epithelialisation, provision of an optimal environment for cell migration across the wound

Contemporaneous, concise documentation is also essential to facilitate ongoing review of the wound and monitor wound progress.

Documentation must include the following and is supported by use of the SystmOne 'Integrated wound assessment and review template 2022' where available:

- History
- Duration of wound
- Previous wound management treatment – if any
- Location of wound
- Measurement of the wound width / length / depth
- Description of the wound bed – applying the T.I.M.E framework.
- Evidence of infection using the CHCP Wound Infection Framework.
- Exudate management
- Assessment of peri-wound skin
- Odour
- Pain assessment and management – wound related
- Skin care

7.2 Wound Photography

For every assessment or review, wound photographs should be taken with the patient's consent. These images must clearly show the wound's location and anatomical position, include a measuring tape for reference, and always uphold the patient's dignity.

For wounds on the lower limb additional images should be taken of signs of venous disease and these should be added to any onward referrals.

A wound image should also be taken at the point of wound healing and prior to discharge of the patient, or at any other time when clinically appropriate or to support information sharing.

Clinicians should follow CHCP REF 137 **Photography Video and Audio Recording Policy** for all image taking.

For more information relating specifically to digital images of wounds see: **NWCSP Practical Recommendations for the use of Digital Images in Wound Care (2021)** Futures - Futures

7.3 Wound Review

It is accepted that within the normal parameters of wound healing, re-epithelialisation should be reached within 4 weeks, or a wound should reduce in size by 40% following 4 weeks of optimal therapy.

To ensure that wounds maintain a healing trajectory all wounds must be reviewed and reassessed:

- at least every 4 weeks
- sooner when there is a change in the patient or wound presentation
- two weekly if antimicrobial is being used following the '**TWO WEEK CHALLENGE'** for Antimicrobial Stewardship

For more information regarding the **'TWO WEEK CHALLENGE'** see **CHCP Wound Infection Framework** in section **9.1** below.

It is essential that the review is documented as per the assessment criteria.

Additionally, any change to the dressing choice and/ or management plan must be supported by providing a rationale within the record and any changes must be reflected in the relevant care / management plan and actions.

7.4 Patient Engagement with Treatment Plan

At every visit or appointment, it is essential to assess the extent to which the patient is participating in their treatment plan. In the context of wound care, a lack in engagement can have significant consequences, such as delayed wound healing and a variety of other clinical complications.

INCS clinicians - in all circumstances, when a patient lacks engagement with any aspect of treatment plans the following guidance should be followed – CHCP Ref 1217 **Optimising Care Through Patient Engagement – Integrated Nursing and Conditions Service**

7.5 Primary Care Pathways

The CHCP Wound Care Primary Care Pathways document has been developed to support GP Practices to deliver the Wound Care Local Enhanced Service (LES) across the Hull and East Riding localities.

See Related item 1 – CHCP Wound Care Pathways (LES)

7.6 Escalation Pathways

To ensure that all wounds are treated appropriately and maintain a healing trajectory, the following escalation pathways should be followed:

7.6.1 Pressure Ulcerations

All category 3 or 4 pressure ulcerations should be referred to the Tissue Viability Service immediately.

7.6.2 Negative Pressure Wound Therapy:

Patients within the INCS service should be referred to the Tissue Viability Service at point of assessment or on commencement of treatment

7.6.3 Deteriorating Wound

If there are any concerns or deterioration noted **at any point** a referral to the Tissue Viability Service must be made

INCS clinicians follow CHCP **Ref 980:** Clinician to Clinician Referral and Communication within the same SystmOne Unit SOP to make a Tissue viability referral.

7.6.4 Wounds at 4 weeks:

If a wound fails to progress toward the normal parameters of wound healing **after 4 weeks of treatment** a referral to the Tissue Viability Service must be made.

7.7 Tissue Viability Service

Tissue Viability comprises of Tissue Viability Nurses (TVN) who have additional skills to be able to deliver comprehensive wound care. The service works as part of the INCS Treatment Room/Community Nursing service across the Hull and East Riding areas.

Prior to referral to the Tissue Viability Service the following assessments and information **must** be complete and up to date within the patients SystmOne record:

- Completion of a holistic patient assessment
- Completion of a wound assessment within the last 2 weeks
- Upload of recent photograph record within the last 2 weeks where possible
- Information relating to any other specialist service the patient is known to e.g. podiatry, vascular services.

If the referring service is not a SystmOne user, the above information must be included within the Tissue Viability Referral form via SystmConnect on the CHCP website City Health Care Partnership, referral forms are also available on ARDENS

The TVN will triage all referrals and if any of the above information is missing, incomplete or out of date the TVN may decline the referral. Patients should be encouraged to attend a TVN clinic appointment where possible.

The TVN will contact the referrer to provide telephone advice, virtual review or, if appropriate, arrange a joint home / clinic visit.

All referrals accepted by the team will be triaged within 10 working days.

It should be noted that not all referrals to the TVN will result in a face-to-face contact, but could include:

- **Telephone discussion:** the TVN will contact the referrer via the information provided at the point of referral.

- **Advice:** provided via a suitable means e.g. SystmOne Task / email etc
- **Virtual Assessment**: the TVN will contact the referrer via the information provided at the point of referral and may arrange a virtual meeting to discuss and review the patient.

Follow up, if required, by the TVN to assess outcomes of treatment / progress may include a further one-off visit / appointment, planned visit(s) or appointment(s), telephone call or virtual clinic appointments.

8. WOUND TREATMENT AND MANAGEMENT

The development of an appropriate treatment or management plan must include the treatment, or management of, any factors identified during the assessment or review process which may impede wound healing and should consider the impact of the patient's overall health and wellbeing on the healing process.
Establishing an individualised treatment plan should always be done in partnership with the patient / carer.

The objectives of the treatment plan should be:

- optimise healing potential
- preparation of the wound bed
- minimise the risk of wound infection
- manage exudate
- pain management
- control odour
- skin care
- peri wound skin care

The treatment plan should also consider:

- appropriate and realistic outcomes including what is the patient's goals and are they achievable
- patient and carers involvement in the management of their wounds, when safe to do so
- agreement to share-care with patients and carers where appropriate.
- education and aftercare required to promote and maintain wound healing
- education on prevention of wounds and maintaining skin integrity

All elements of wound care must be undertaken using an Aseptic Non-Touch Technique (ANTT) – see CHCP Ref 1303 Infection Prevention and Control Practice Policy

INCS and Podiatry clinicians - for more information relating to shared care see: CHCP Ref 1011 **Shared Care of Wounds – Integrated Nursing and Conditions Service and Podiatry Service Hull and East Riding**

8.1 Wound Bed Preparation

Wound bed preparation (WBP) assists clinicians to identify and address the barriers of wound healing to create an optimal healing environment. WBP is a multifaceted approach that includes cleansing and debridement to enhance the effectiveness of therapeutic measures and prepare the wound for healing.

To promote wound healing and remove the barriers to wound healing the following should be followed to prepare the wound bed:

<u>See the **TIMES TABLE**: removing the barriers to wound healing and wound bed preparation below:</u>

Tissue, non-viable or deficient



The overall appearance of the wound bed indicates the 'health' of the tissue within the wound bed.

Devitalised tissue provides an ideal environment for microbial growth and , in most cases, should be removed to expedite healing.

Key Action:
Follow CHCP Cleansing Protocol

Infection, inflammation or biofilm



Wounds contain bacteria, which may proliferate and cause infection – delaying healing and increasing pain, exudate and malodour.

Even where infection is not apparent, healing may also be impeded by the presence of biofilm.

Key Action:
Follow CHCP Infection Management Framework

Moisture imbalance



Exudate is a normal part of wound healing, and drying out can impede the healing process.

High levels of moisture (often containing harmful proteases) can break down new wound tissue and macerate periwound skin.

Key Action:
Follow CHCP Exudate Managment Pathway

Edge of wound: non-advancing, undermining



Lack of new, healthy tissue at the wound edges, or the presence of rolled edges, indicate wound healing is not progressing normally.

Key Action:
Follow CHCP Cleansing Protocol

Surrounding skin



The wound management strategy may effect the surrounding skin — the condition of which can, in turn, affect the wound healing process.

Key Action:
Follow CHCP Cleansing Protocol

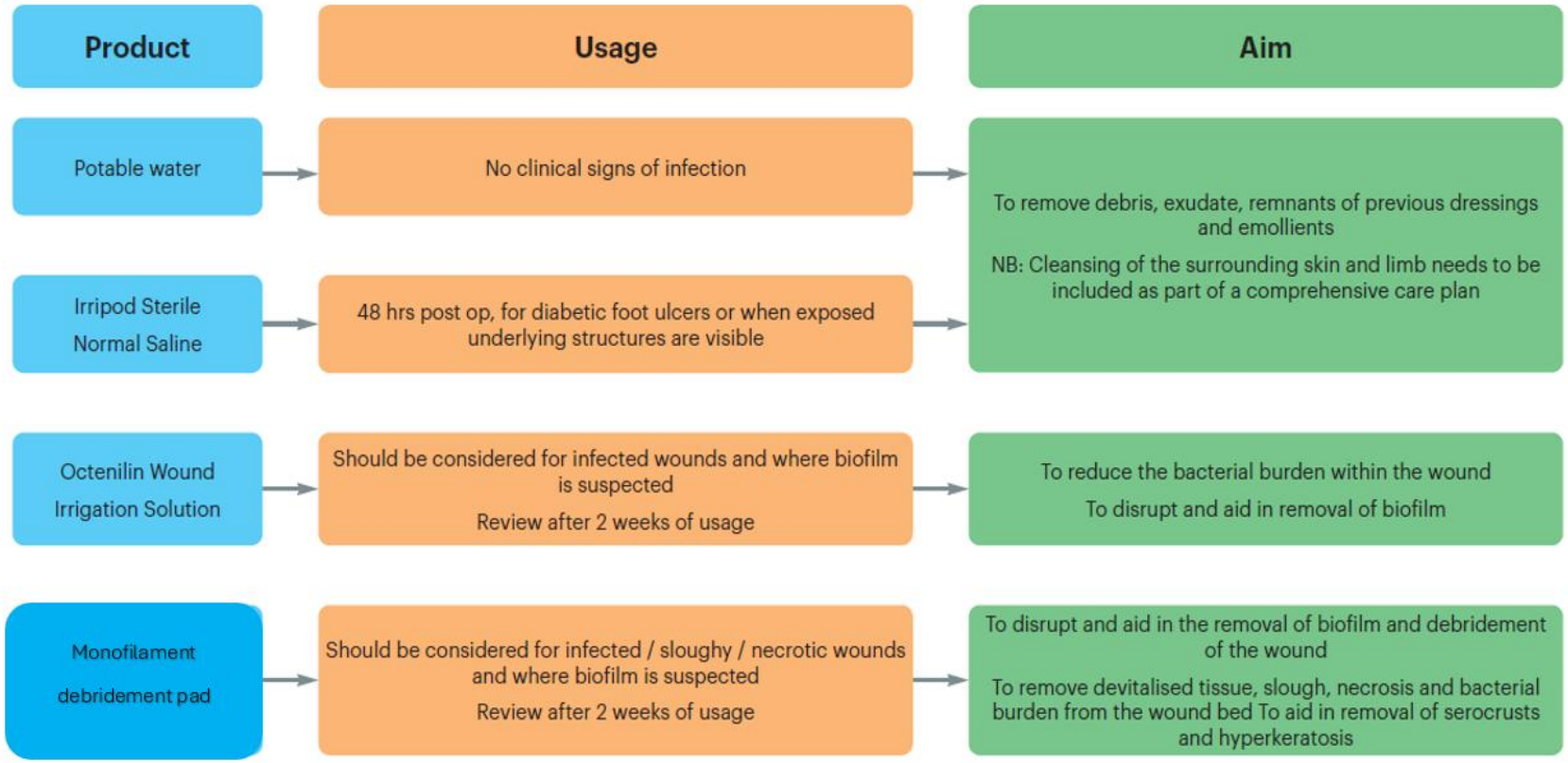
8.2 Cleansing Protocol

The purpose of wound cleansing is to remove debris / of previous dressings / management of biofilm/ removal of devitalised tissue and to mitigate the risk of wound infection.

A skin management regime must be included in the care plan for peri wound skin / surrounding skin / limb.

It is important that gangrenous wounds are kept dry!

Cleansing Protocol: for all Wounds



8.3 Opportunistic Maggots in wounds



Opportunistic Maggots in wounds

Every year during the hot weather we experience an increase in patients with opportunistic maggots in the community.

Maggots require a moist environment to survive and thrive, there only needs to be the tiniest gap in a dressing for a female fly to lay her eggs in the wound bed.

- **Female flies** lay between 50-300 eggs at a time which hatch **8-12 hours later**
- In all cases the infestation **is self-limiting** (maggots reach their full potential within 50 – 60 hours will stop feeding and migrate from the wound, in an attempt to find soil to pupate)

Patients may be upset and concerned when maggots have been found in their dressing. This is an act of nature – not a reflection of nurses dressing technique, the environment of clinics/treatment rooms. Flies are attracted to clean environments as well as dirty, the presence of maggots does not reflect the state of a patient's living conditions.

Insects in this group typically feed only on necrotic tissues and slough, rarely affecting viable tissue. However, it is crucial to avoid leaving the maggots on the wound unattended, as they are not sterile.

When managing wounds, it's important to consider factors that may have contributed to the presence of flies or maggot, reflect on the condition of the dressing when it was removed. For patients who may have been lacking in engagement with treatment i.e. compression therapy, this situation might serve as a reminder of its role in improving wound healing by controlling oedema and exudate. Engage the patient in conversations about their care to optimise wound management and prevent reoccurrence.

Red flags

- **If patient is unwell and showing signs of infection or Sepsis,** arrange for hospital admission
- **Recent foreign travel** in the past seven days, especially to South America or west coast of Africa. Flies from both these continents are known to eat healthy tissue and should be **removed immediately and aggressively** (if risk contact infection control for further advice).

Action

Reassure the patient & advise patients to be vigilant of flies.

Remove the maggots, using tap water or a shower, try to avoid using forceps to pick them out as this is likely to cause the maggots to tear apart.
Try to catch them in a bag that can be disposed of.
(suffocation of the maggots can be achieved by using cling film to wrap the wound or limb).

Complete wound review. The wound bed may be cleaner with less devitalised tissue, reassess and dress the wound accordingly using products best suited for the wound conditions (refer to CHCP Wound Product Formulary).

Consider daily dressing changes in the short term to manage risk of further infestation.

Document that maggots have been found and communicate with colleagues to be observant of their presence or absence at subsequent dressing changes.

Infection

The risk of infection from maggots is low, maggots are an unlikely source of infection.

Maggots do not increase infection risk; instead, they reduce bacterial load in wound beds.

Maggots originating from the UK will feed only on devitalised tissue.

Maggots' clean wounds, including infections such as MRSA bacteria.

Their presence stimulates the growth of granulating tissue in wounds.

Antibiotics are ineffective for eliminating maggots, assess for clinical signs of infection and follow CHCP Infection Management Framework

- The presence of maggots alone **does not** require a safeguarding alert
- The presence of maggots alone **does not** require admission to hospital
- The presence of maggots **does not** require a completion of a Inphase report.

Adapted from Hertfordshire Community NHS Trust guidance on "Maggots in wounds during hot weather." Author: Heidi Sandoz (2018)

8.4 Debridement

The decision to debride a wound, or not, is a key part of any wound assessment or review. The patient's tolerance and any comorbidities should be considered prior to commencing any form of debridement.

It is essential an arterial assessment is completed for all foot and leg wounds prior to commencing debridement. If there is any indication of arterial insufficiency debridement should NOT be commenced and escalation is required!

Debridement can involve:

- Mechanical – monofilament pad
- Hydro surgical.
- Biological – Larvae.
- Ultrasound
- Enzymatic – prescribed topical agents.
- Autolytic - uses the body's own enzymes and moisture
- Surgical sharp / conservative sharp and curette debridement - should only be performed by a skilled practitioner who has been assessed as competent

8.5 Surrounding Skin

Assessment of surrounding skin is a key part of any holistic wound assessment.
The skin surrounding of any wound should be cleansed to remove any residual debris and/or hyperkeratosis. For patients with lower limb wounds leg washing is a therapeutic, non-invasive, holistic intervention designed to promote healing, reduce the risk of infection and improve patient quality of life. Leg washing also affords time to observe the whole limb in detail, and to soften dry scaly skin to optimise wound healing.

A skin cleanser/soap substitute along with a barrier product may be considered to protect the surrounding skin, for example to prevent maceration if the wound has high exudate levels.

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9. MANAGEMENT OF WOUND INFECTION

Of all possible complications that may interfere with the healing process, infection is the most significant, having the greatest potential for negative impact on the wound. The detrimental effects of an elevated bacterial burden within the wound include the following:

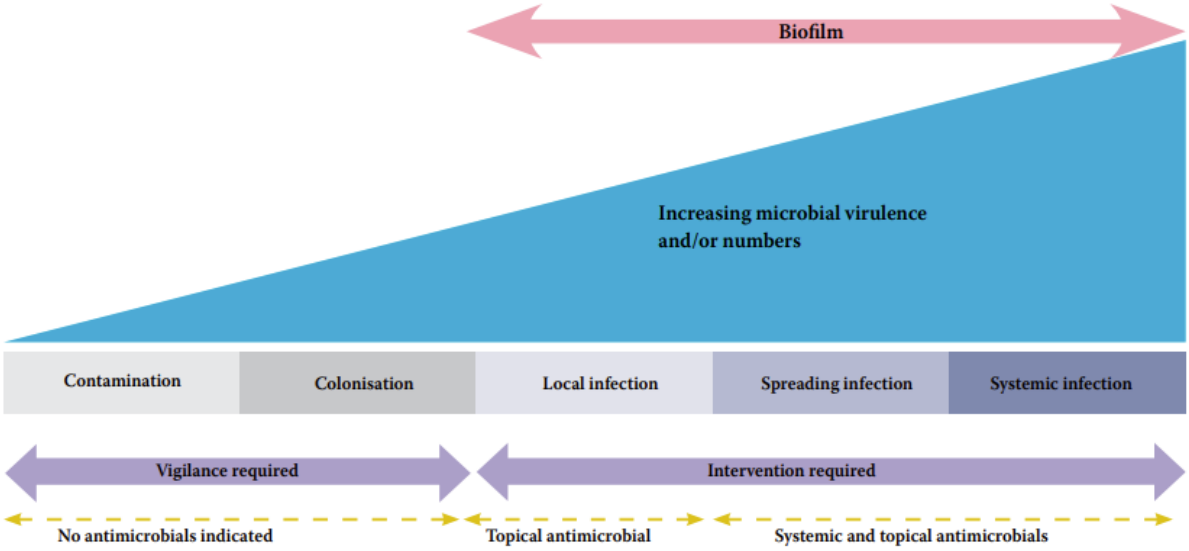
- Delayed wound healing/deterioration
- Increased pain
- Reduced quality of life for the patient
- Deterioration in the patient's general condition and health
- Increased financial demands due to elevated costs of care.

Consequently, every effort must be undertaken to prevent infection and the application of suitable infection control measures which includes adherence to CHCP Ref 1303 Infection Prevention and Control Practice Policy.

On diagnoses of a wound infection the appropriate interventions must be initiated swiftly, and the effectiveness of these measures monitored closely to ensure they achieve the desired clinical outcome for the patient and raise the standard of patient care.

The primary aim for all clinicians is to identify the level of microbial bioburden within wound, reduce the risk of cross infection and, following assessment, apply the appropriate wound care product, thus reducing the use of antibiotics on wounds where no signs of spreading or systemic infection are present.

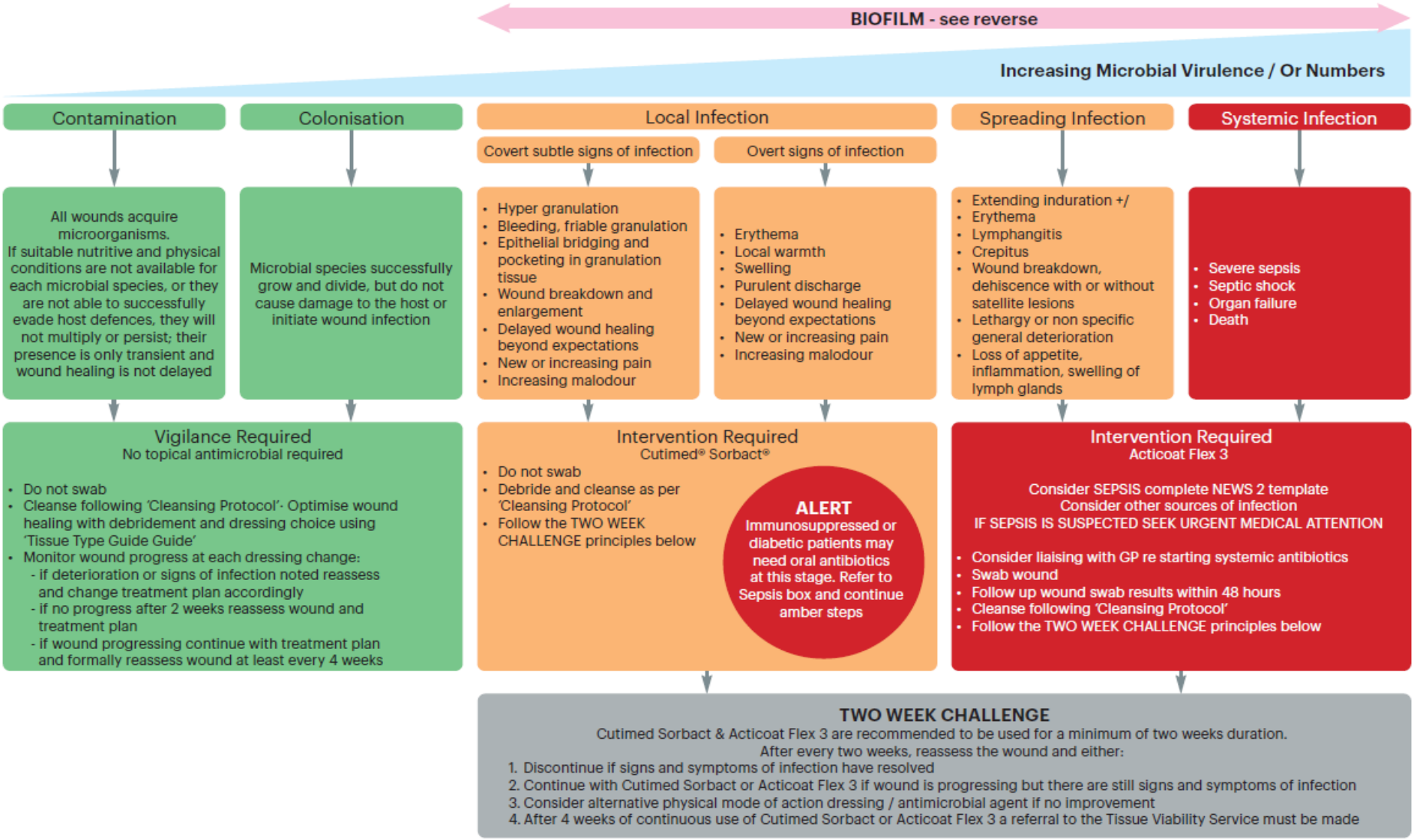
The Infection Continuum:

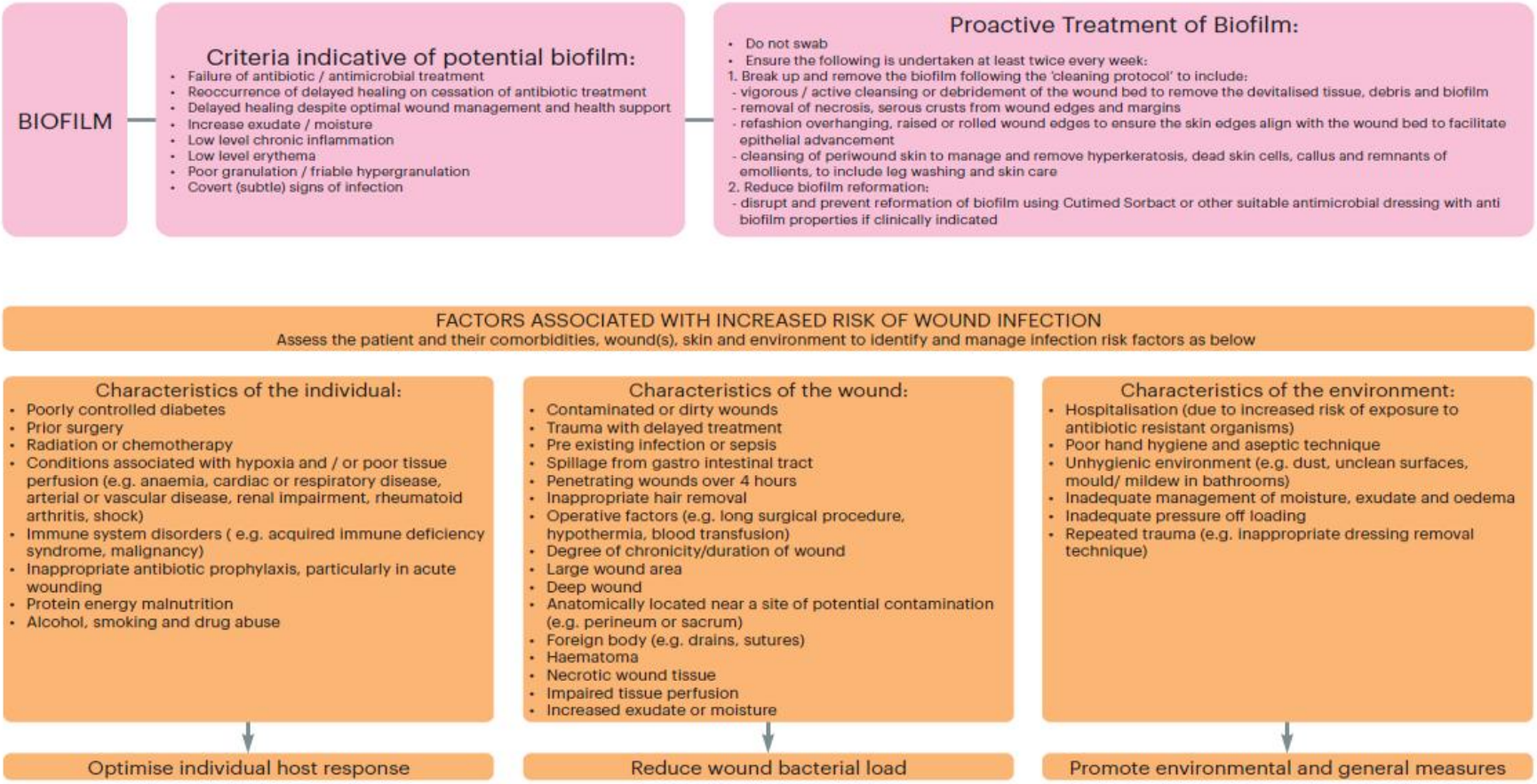


9.1 Wound Infection Framework

The Wound Infection Framework is designed to support all clinicians with achieving the principles of antimicrobial stewardship, including the use of the **TWO-WEEK CHALLENGE** to help address issues with antimicrobial resistance:

Wound Infection Framework





References:
European wound infection continuum 2022
Wound infection in clinical practice. An international consensus

When wound infection has been identified then topical antimicrobials should be used following the Wound Infection Framework as below:

- A review date of **2 weeks** should be set at the initiation of topical antimicrobial treatment.
- At re-evaluation after 2 weeks if the antimicrobial agent has been effective in reducing bacterial burden and the wound has improved antimicrobial use may be continued until evidence of critical colonisation / local infection resolves or for a **maximum of 4 weeks.**
- On the initiation of a topical antimicrobial and at all reviews the clinician must document the rationale for the product and complete the wound assessment/review template
- Any changes in the treatment plan must be supported by a TIME assessment of the wound and a review of the care plan to align review dates
- If an antimicrobial product is required for more than 4 weeks a Tissue Viability referral should be made.

9.2 Antibiotic Therapy

In situations where the bacterial load becomes too great or the immune response is compromised (spreading and systemic infection), then medical management should be sought at the earliest opportunity.

Antibiotic therapy is likely to be the treatment of choice to resolve the underlying infection with the application of an antimicrobial wound dressing / treatment to reduce the level of bacteria at the wound surface and prevent re-infection. For identified spreading infection a swab is obtained from the wound, prior to antibiotic therapy, to identify the organism(s) present.

Antimicrobial Stewardship:

The overuse and misuse of antibiotics and antimicrobials is a global concern, across many clinical specialities, in the development of resistance seen today in managing infection. Strategies to tackle this crisis of antimicrobial resistance include implementing antimicrobial stewardship across the healthcare sectors by developing policies to advise practitioners on how to prescribe antibiotics more effectively.

Antibiotic therapy should not be routinely used for the healing of wounds. When antimicrobials are prescribed these should be in line with the Humber and North Yorkshire Area Prescribing Committee formulary and guidelines.

9.3 Wound Swabbing

Indications for initiating microbiological analysis of a wound specimen:

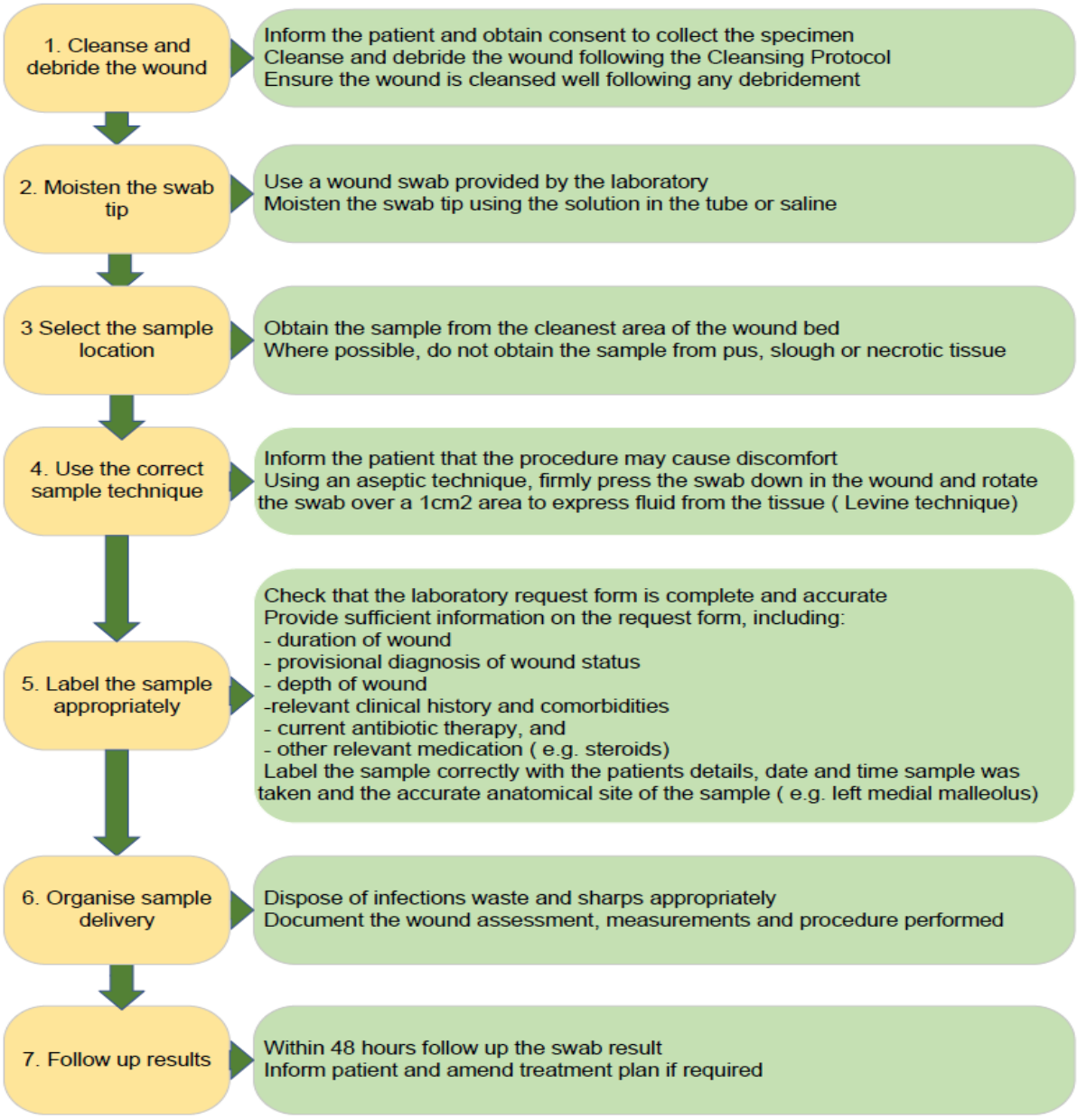
- Acute or nonhealing wounds with signs of spreading or systemic infection
- Infected wounds that have failed to respond to antimicrobial intervention, or are deteriorating despite appropriate antimicrobial treatment
- In compliance with local protocols of the surveillance of drug-resistant microbial species
- Wounds where the presence of certain species would negate a surgical procedure (e.g. beta haemolytic streptococci in wounds prior to skin grafting)
- In immunocompromised patients (e.g. those taking immunosuppressants or corticosteroids, or with diabetes mellitus or peripherals arterial disease) also consider sampling chronic wounds with signs of local infection and / or delayed healing

Note: the clinician who initiates the taking of a swab holds the responsibility of following up on the results.

In individuals showing sign of sepsis, or with signs of spreading infection, complete the **NEWS** template embedded within the patients SystmOne record.

IF SEPSIS IS SUSPECTED SEEK URGENT MEDICAL ATTENTION!

Taking a wound swab for culture:



For more information relating to wound infection and swabbing see **International Wound Infection Institute: Wound Infection in Clinical Practice**
IWII-CD-2022-web-1.pdf (woundinfection-institute.com)

10. BIOFILMS

Biofilm communities can compromise wound healing as the microbial to host balance is weighted in favour of the micro-organisms, and the term critically colonized has

been used to describe this state. At this stage, the micro-organisms, while interfering with the wound healing process, may not necessarily induce any clinical signs of infection, although there may be subtle signs that indicate bacterial imbalance.

Criteria indicative of potential biofilms are:

- Failure of appropriate antibiotic treatment.
- Resistance to appropriate antimicrobial treatment.
- Recurrence of delayed healing on cessation of antibiotic therapy.
- Delayed healing despite optimal wound management and health support.
- Increased exudate/moisture.
- Low-level erythema
- Poor granulation/friable hyper granulation.
- Covert signs of infection.

If biofilms are managed effectively the wound will progress on towards healing.

If biofilms are suspected ensure the **CHCP Cleansing Protocol** and **CHCP Wound Infection Frameworks** are adhered to.

11. MANAGEMENT OF WOUND EXUDATE

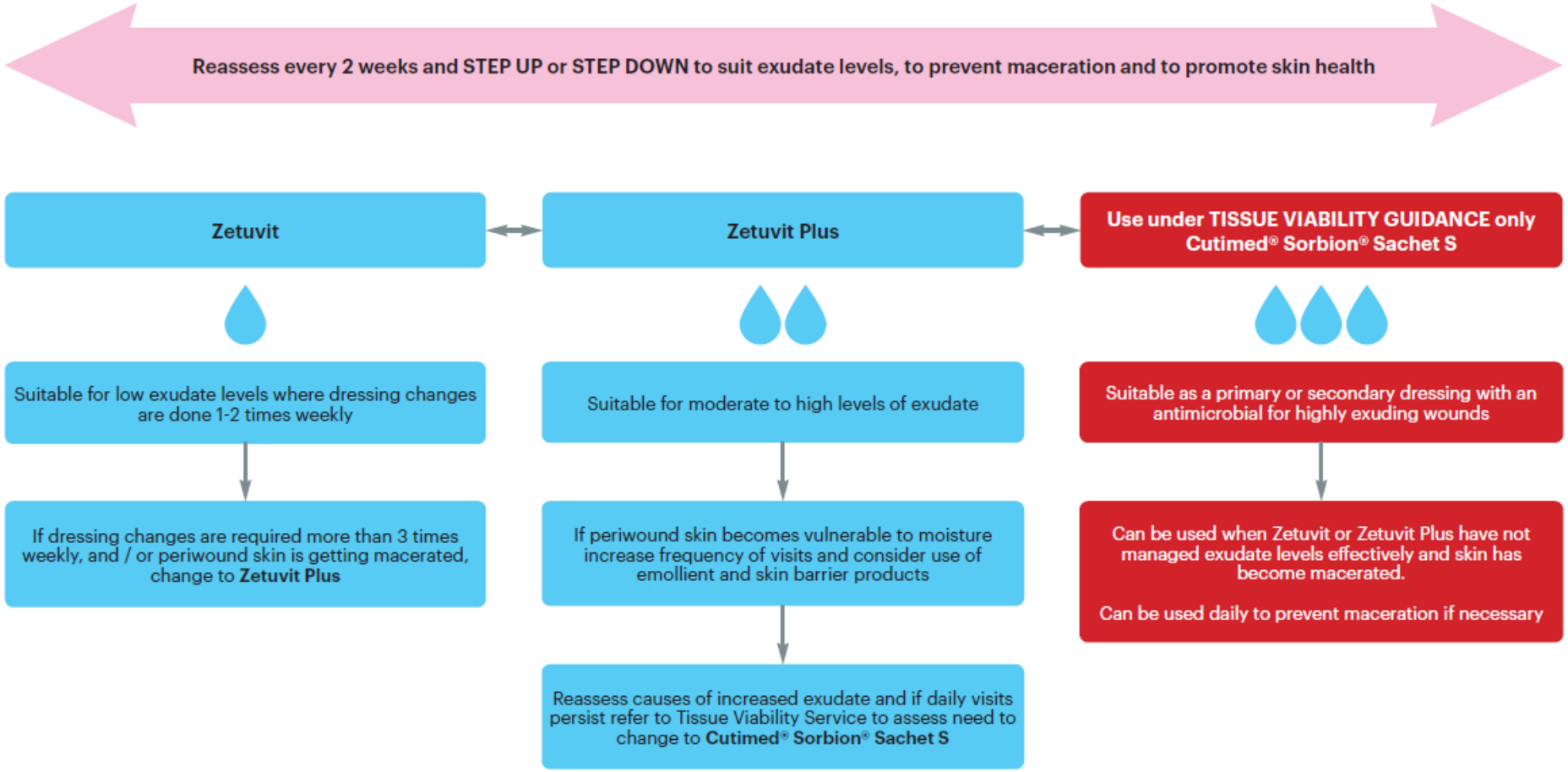
The purpose of the Exudate Management Pathway is to support clinicians in adopting a **STEP UP** and **STEP-DOWN** approach to the choice of absorbent used to manage wound exudate. Appropriate management of exudate assists in the prevention of the breakdown to the tissue and surrounding skin due to excoriation and / or maceration and reduces the risk of infection.

Wound exudate needs to be monitored at every dressing change.

For more information relating to Wound Exudate see: **Consensus Document – Wound Exudate effective assessment and management**

WUWHS Consensus Document – Wound Exudate, effective assessment and management – Wounds International

Exudate Management Pathway



Exudate Management Pathway - Supporting Information

CAUSES OF EXUDATE

Increased bioburden - High levels of exudate can be associated with increased levels of bacteria. When a wound becomes infected, exudate will increase abruptly as a result of vasodilation and extravasation.

Devitalised tissue - Slough and necrosis. Removing the tissue by debridement can result in an increase of exudate.

Underlying disease - Co morbidities such as venous disease, lymphoedema, cardiac failure or prolonged immobility can lead to oedema, particularly in the lower leg. Patients with conditions that cause oedema may also have increased wound exudate levels due to fluid overload. These conditions need treatment in order to effectively manage exudate volume.

Chronic oedema - If the patient has lymphatic failure, referral to a lymphoedema specialist to establish the cause may be appropriate. Patients with lymphoedema will benefit from compression therapy.

Heart disease - Grossly oedematous legs that leak fluid can be a symptom of chronic heart failure; diuretic therapy may be required to treat the heart failure, in conjunction with compression bandaging and leg elevation. Care must be taken to ensure that the cardiac system is not overloaded by a large quantity of fluid being suddenly pushed from the interstitial spaces of the skin into the circulation referral to a heart failure / cardiac specialist may be required.

TYPES OF EXUDATE

Serous - Clear, amber, thin and watery
Often considered normal, but may cause further tissue destruction or wound healing failure if excessive

Serosanguineous - Clear, pink, thin and watery
Due to the presence of red blood cells; this indicates capillary damage e.g. Traumatic dressing removal

Sanguineous - Thick creamy and bright red
Due to deeper wounds involving thicker layers of tissue should resolve after first few days of wounding

Purulent - Purulent Opaque, milky; sometimes green, Thick may be indicative of bacterial infection

12. DRESSING CHOICE

It is essential to recognise that dressings alone do not heal a wound!

A dressing will facilitate healing by assisting to prepare or manage factors which may delay or prevent healing.

Clinicians should refer to **REF: 936 Wound Management Formulary (Adults) and Guidance Document** to guide their dressing choice:

When selecting an appropriate dressing from the formulary it is essential to inform the patient and, if appropriate, their family or carers, what type of dressing will be used, considering the following:

- Pain and tolerance
- Allergies and odour
- Position of the wound
- Amount of exudate
- Expected outcome

It is also critical to consider the frequency of dressing changes and choosing dressings which will afford the longest possible wear time when appropriate.

Dressing will be supplied to the patient if using a shared-care model providing the correct supply for the frequency of dressing changes.

13. DISCHARGE FOLLOWING WOUND HEALING

It is important that when a wound has healed the patient is discharged from the service with the appropriate advice and guidance to maintain wound healing and prevent the risk of a reoccurrence.

The discharging clinician will provide appropriate education and advice to the patient, which should include the need to refer back to the service should they have any concerns or deterioration in their healed wound.

The discharging clinical should ensure that the patient knows how to access the service following discharge should they need to, including relevant telephone numbers.

The patient's GP or care co-ordinator should be notified of the discharge from Community Nursing Services when there is any handover of ongoing care needs required – see Ref 359 Discharge from Community Services Policy.

INCS and Podiatry Service - it is important that all discharge information, including image, is documented on the Wound Healed / Discharge tab of the correct Wound Site template within the patients SystmOne Record:



Discharge of a patient with a foot ulcer:

The discharging clinician should inform the Podiatry Service that the patient has been discharged to ensure that additional aftercare is arranged as required

Discharge of a patient with a leg ulcer:

See **LOWER LIMB – MAINTENANCE AND PREVENTION** section 15

14. HYPERGRANULATION

Definition:

Hypergranulation is also known as over granulation and usually presents in wounds healing by secondary intention. Unhealthy hypergranulation tissue presents as either a dark red or a pale bluish / purple uneven mass rising above the level of the surrounding skin. The presence of hypergranulation tissue increases the patient's risk of infection and prevents epithelial migration across the wound and delays healing.

Causes of hypergranulation:

- Moderate or high levels of exudate
- Unmanaged exudate
- Increased bacterial burden / wound infection
- Presence of foreign material
- Prolonged physical irritation/friction/movement at the wound interface.



NOTE: Malignant tissue can sometimes resemble hypergranulation tissue. It can be present for many months and may have a cauliflower appearance. Carefully assess and examine any suspected cases and liaise with the GP to undertake an onward referral to the Dermatology Team or other relevant specialist.

Pathway for Hypergranulation:

Identify cause of Hypergranulation

Immediate Actions:

- Moderate or high levels of exudate - Follow CHCP wound exudate management pathway - use barrier product to protect the surrounding skin.
- Presence of foreign material i.e., dressing fibres - Remove any foreign material ensure CHCP wound cleansing protocol is in use and review wound using Integrated wound template-change dressing if appropriate.
- Allery/hypersensitivity - remove allergen if dressing causing issue review using Integrated wound template-change dressing if appropriate dressing.
- Inflammation/increased bacterial burden - consider swabbing the area for culture and sensitivity, follow CHCP wound infection framework.
- Wound infection- Follow CHCP wound infection framework.
- Occlusive dressing - review using Integrated wound template-change dressing if appropriate dressing.
- Physical irritation/friction/movement – Use fixation device, follow CHCP wound cleansing protocol, follow CHCP exudate management pathway. If stoma, ensure bags are correctly sized and if required appropriate seals are in use.

First Line: Day 1–14

- Apply barrier product to surrounding skin.
- Apply foam dressing with firm pressure to flatten area of over granulation, a double layer of foam can be applied to a provide non traumatic layer to push back the hyper granulated tissue.
- If infection is suspected follow CHCP wound infection framework, CHCP wound cleansing protocol and the above if required.

Second Line: Day 15–21

- Apply barrier product to the surrounding skin, which is clean, dry and shorn of hair.
- Liaise with GP and consider use of Fludroxycortide tape 4mcg per cm2, change daily.

OR

- Apply barrier product to the surrounding skin, which is clean, dry and shorn of hair.
- Liaise with GP and consider use of low potency steroid cream, hydrocortisone 0.1%. Foam dressing can be applied to flatten area of hyper granulation.

NB Fludroxycortide tape is a steroid and should be limited to a maximum usage of 7 days.

Low potency steroid should only be used for 7 days.

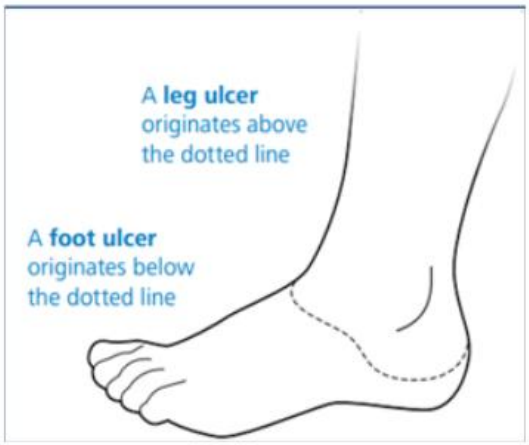
Onward referral: Day 22

If no improvement refer to TVN

Malignancy may have a similar appearance to over granulation, so referral should be made urgently to Dermatology or Plastic Surgery if suspected.

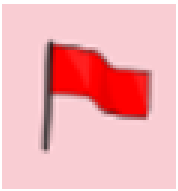
15. LOWER LIMB WOUNDS AND ULCERATION

A lower limb wound occurs below the knee and can be a **leg ulcer** or a **foot ulcer**:



As soon as a wound, ulcer or break to the skin below the knee is identified, irrespective of cause, origin or duration the clinician must undertake a 'red flag' assessment and provide appropriate Immediate and Necessary care when unable to undertake a full lower limb assessment.

15.1 Red Flag assessment



Red Flag assessment: **Immediately escalate to the relevant clinical specialist, those with the following 'red flag' symptom / conditions:**	
• Acute infection (mild, moderate or severe).	• Acute infection

• Deep or tracking foot ulcers where abscess or osteomyelitis is suspected. • Symptoms of sepsis • Acute or suspected chronic limb-threatening ischaemia • Suspected acute deep vein thrombosis (DVT) • Suspected skin cancer • Unexplained inflamed foot (possible acute Charcot foot).	• Symptoms of sepsis • Acute or suspected chronic limb threatening ischaemia • Suspected acute deep vein thrombosis (DVT). • Suspected skin cancer • Bleeding varicose veins

15.2 Lower Limb – Immediate and Necessary Care

Immediate and necessary care for foot ulcers:
• Arrange referral to CHCP Podiatry service: **Diabetic foot ulcer** – refer with 1 working day **Non-diabetes related foot ulcer** – refer within 1 working day See **CHCP Ref 1280**: **Hull and East Riding Lower Limb Pathway - Integrated Nursing and Conditions Service and Podiatry Service Standard Operating Procedure** for more referral details • Treat any wound infection • Clean wound and surrounding skin and apply emollient • Record digital image(s). • Apply a simple, low adherent dressing with sufficient absorbency • Implement offloading or pressure redistributing strategies • Provide relevant, high-quality information

Immediate and necessary care for leg ulcers:

- **Refer or arrange for a comprehensive Lower Limb - 1st assessment to be undertaken within 14 days:**

- Treat any wound infection
- Clean wound and surrounding skin and apply emollient
- Record digital image(s).
- Apply a simple, low adherent dressing with sufficient absorbency
- For those without red flag symptoms, offer mild graduated compression as follows:
  - Regular Limb Shape – apply JOBST UlcerCare liner (15 – 20 mmHg) or K-TWO reduced bandage system
  - Abnormal limb shape, chronic oedema or lymphoedema present – apply K-Soft to reshape limb and Actico short stretch bandage
- Provide relevant, high-quality information

15.3 Lower Limb – 1st Assessment

Lower Limb 1st Assessments should be undertaken by clinicians with the relevant wound care capabilities/competencies working within a multi-disciplinary team system for assessment, diagnosis, and treatment.

Patients with a lower limb wound / ulceration require a comprehensive lower limb assessment which includes a detailed examination of the following:

- Limb size and shape
- Vascular assessment
- Neuropathic assessment

for further guidance on Lower Limb Assessments See **CHCP Ref 1280**: **Hull and East Riding Lower Limb Pathway - Integrated Nursing and Conditions Service and Podiatry Service Standard Operating Procedure**

15.4 Lower Limb – Ongoing Care and Review

Following a 1st Assessment, the assessing clinician will have initiated a treatment plan and ongoing care, and review will commence.

15.4.1 Compression Therapy

Patients with unhealed venous leg ulcers and no symptoms of arterial insufficiency should be reviewed for replacement of compression garments every 6 months, if required, and to ensure ongoing compression therapy remains appropriate. This review should include a DOPPLER assessment to determine the ABPI/TBPI.

Changes in lower limb symptoms or skin problems relating to hosiery should trigger an earlier comprehensive re-assessment that include a vascular assessment for arterial supply.

For patients under the care of the INCS service, these assessments should be undertaken by the registered clinical with the knowledge and skill within the Community Nursing Team.

15.5 Lower Limb – Healed Wound

Foot Ulcer:

When a foot ulcer heals, and the patient is ready to be discharged, a SystmOne task should be forwarded to the Podiatry Team to inform them of wound healing and discharge so any appropriate follow up care can be arranged.

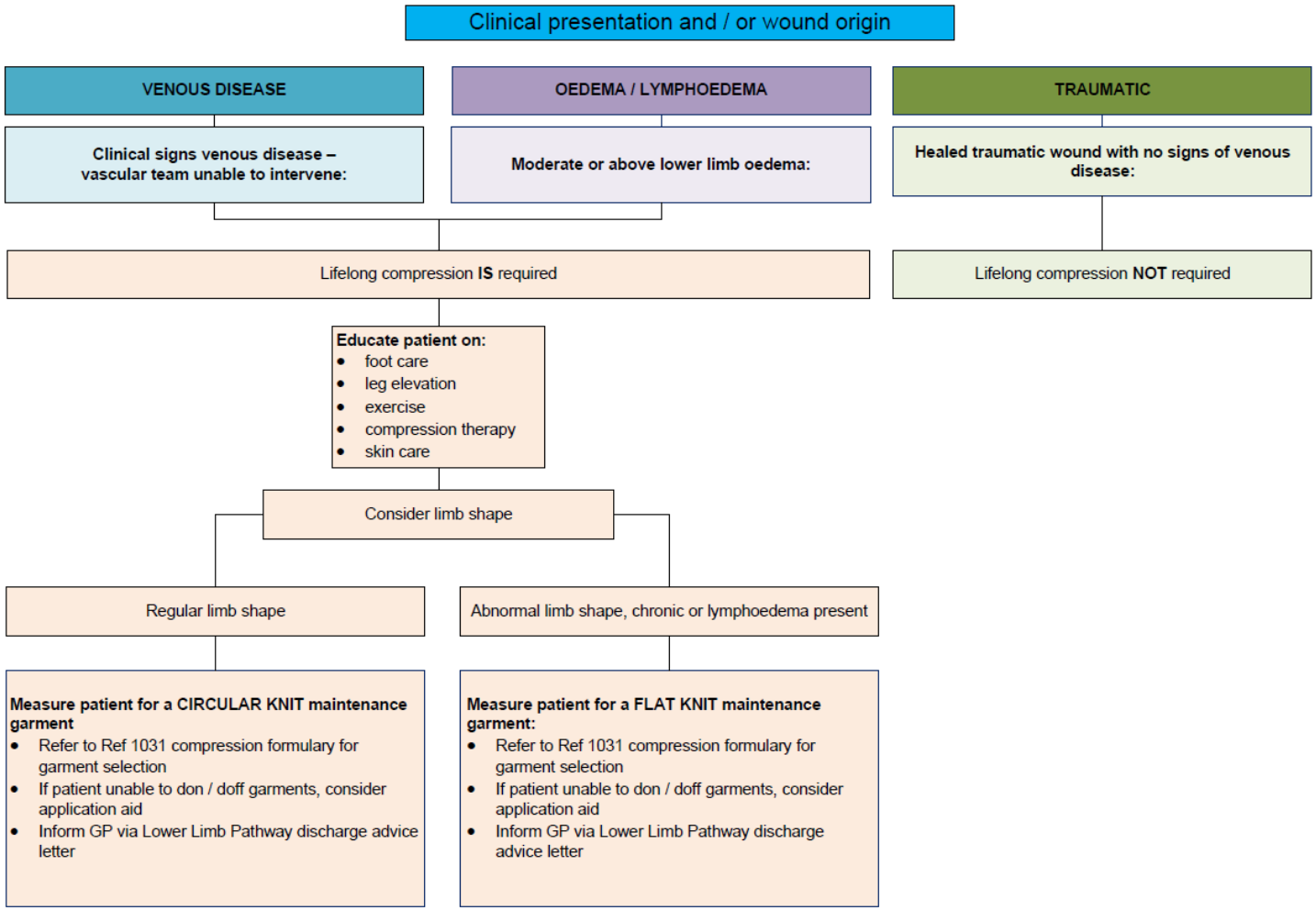
It is important that any healed foot ulcers are not mistaken for ‘capped wounds’ and therefore essential that an image is attached to the patient record at the time of discharge.

Leg Ulcer:

Patients who have been treated with any type of compression therapy may require additional arrangements to be made in preparation for their discharge.

The patient should be assessed in advance of anticipated wound healing to establish if lifelong compression hosiery is required using the compression therapy decision pathway for prevention and healing following wound healing flow chart to guide decision making:

Compression therapy decision pathway following wound healing:



If lifelong compression hosiery is required, the following steps should be taken:

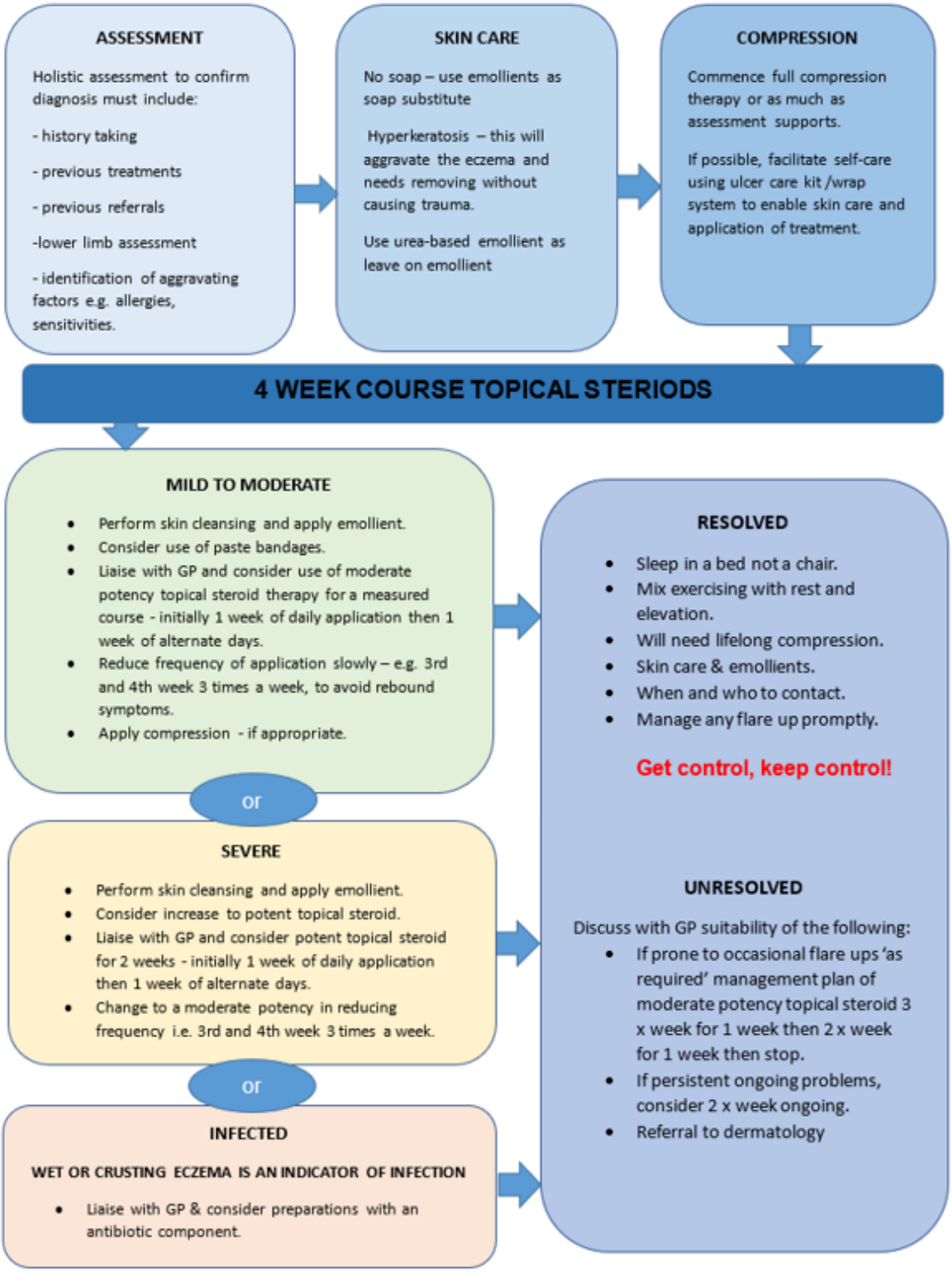
- Assess patient to establish if they can maintain / change their own compression hosiery
- Discuss aids required to support self-care including 'donning and doffing' aids
- Make onward referrals as required – this may include 3rd sector support or Social Services
- Measure for appropriate compression hosiery using **Ref 1031 CHCP Compression Formulary** to guide choice
- Order the compression hosiery via the '**JOBST online'** ordering platform (INCS ONLY)
- Advice may be sought from the Tissue Viability Service regarding garment choice if necessary
- Maintain compression therapy until hosiery is available
- Advise patient that garments should be brought to next appointment to allow fit to be checked
- At the point of discharge generate the **Compression Hosiery Discharge Advice Letter** and provide patient with a copy
- A Compression hosiery discharge letter must be sent to the GP and ensure the patient is aware of the arrangements for repeat prescribing of garments
- Ensure that the patient understands their responsibility to monitor and care for their legs
- Discharge from caseload by ending appropriate SystmOne referral(s)

16. SKIN DISEASE ASSOCIATED WITH ULCERATION

Venous eczema, sometimes called stasis eczema or gravitational varicose eczema is associated with secondary venous hypertension. Venous eczema is classed as an inflammatory dermatosis that will respond to skin care, emollients and when appropriate topical steroids. When infected venous eczema is present the patient may need intensified treatment application to bring the eczema under control, if the legs are weeping and dressings are required, the patient may be unable to apply the topical steroids, and it may be necessary to increase visits.

Skin diseases such as venous eczema can be potential primary causes of lower limb cellulitis. It is important for the clinician to be able to diagnosis lower limb cellulitis so that a multidisciplinary approach for treatment can be applied.

Varicose Eczema Pathway – for use in discussion with GP:



CONTACT DERMATITIS

Localised 'reaction' to a suspected allergen, e.g., exudate, dressings, jewellery, bandage, hosiery.

- Remove suspected allergen and treat with appropriate topical steroid if necessary.
- Refer to Dermatology for patch testing.

EMOLLIENTS:

Emollients help to restore the barrier function of the skin, reduce itching, and increase the level of hydration, some assist in maintaining the normal PH of the skin.

They work either by occlusion 'trapping' moisture into the skin, which slows the evaporation of water, or in an active way by drawing moisture into the stratum corneum from the dermis.

Emollients should be used as part of the patients' everyday care routine.

Emollients should be applied with a downward stroke to avoid irritation of the hair follicles.

Refer to Humber APC Formulary for suitable products.

IMPORTANT: SKIN PRODUCTS CONTAINING PARAFFIN BASED PRODUCTS, FOR EXAMPLE WHITE SOFT PARAFFIN, WHITE SOFT PARAFFIN PLUS 50% LIQUID PARAFFIN OR EMULSIFYING OINTMENT, ARE HIGLY FLAMMABLE. WHEN IN CONTACT WITH DRESSINGS AND CLOTHING ARE EASILY IGNITED WITH A NAKED FLAME OR A CIGARETTE.

TOPICAL STEROIDS:

The use of a stronger topical steroid (potent strength) for a short period of time and decreasing the strength (moderate strength) as the condition improves will bring most flare-ups of eczema under control.

Refer to Humber APC Formulary for potency and prescribing details.

There are no standard rules regarding whether to apply a steroid preparation before or after an emollient.

Following bathing or washing pat the skin dry and apply topical steroid, wait 10 minutes, and apply emollients over the skin. If the skin is very dry use the emollient first to treat the dry skin, followed by the topical steroids.

It is important to leave a gap between the two treatments to avoid diluting the topical steroid and spreading it to areas where it is not required.

All steroids will be marked with a use-by-date and should not be used after the time stated.

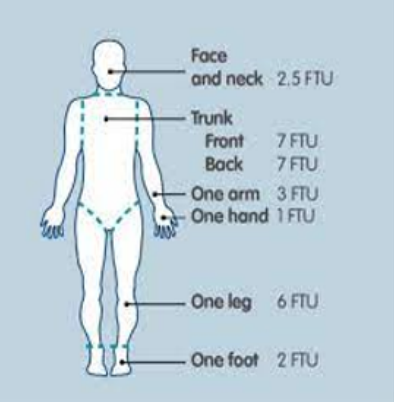
Any steroid remaining unused at the end of the treatment should be disposed of as per CHCP policy.

Quantities of corticosteroid preparation for specific area of the body:

A fingertip unit (FTU) is the amount of medication needed to squeeze a line from the tip of an adult finger to the first crease of the finger. It should be enough to treat an area of skin double the size of the flat of your hand with your fingers together.

Topical steroids can be applied directly to the area affected, if dry, or mixed into a carrier dressing e.g. Atraumen.

Recommended dosage – Fingertip unit (FTU):



17. CHRONIC OEDEMA

Chronic oedema is a progressive and debilitating long-term condition and is used to describe swelling that has been present for longer than three months. Chronic oedema has an ongoing effect on the structure and viability of the skin, leading to complications such as infection, cellulitis, hospital admissions, and ulceration.

Chronic oedema is the formation of excessive fluid in the interstitial area. Initially the lymphatic system will remove this excess fluid but in time the system will be unable to cope, causing overload and eventually swelling.

Managing patients with associated chronic oedema:

- For Hull GP and East Riding registered patients without a wound refer to the Hull Lymphoedema Service

18. MANAGEMENT OF PRESSURE ULCERS

The primary aim for all clinicians is to **assess and aid in preventing** the occurrence of pressure ulcers.

18.1 Assessment and Prevention

Pressure area assessment and care should form part of the holistic assessment of the individual's risks and health needs.

It is important to avoid unnecessary skin damage to patients who are at risk of pressure damage and therefore the assessment should include consideration of the following contributing factors associated with development of pressure damage and ulcers:

- Frail, elderly, seriously ill or palliative care patients
- Patients with poor nutritional or fluid intake
- Patients who are immobile, or have reduced mobility, or inability to reposition themselves
- Significant loss of sensation
- Previous history of pressure ulcer
- Significant cognitive impairment
- Incontinence

- Medical conditions affecting blood flow such as diabetes/vascular conditions

18.2 Purpose T Pressure Ulcer Risk Assessment Tool:

PURPOSE-T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) is a pressure ulcer risk assessment framework (PURAF) intended to identify adults at risk of pressure ulcer development and makes a distinction between primary prevention (applicable to those at risk of pressure ulcer development) and secondary prevention (applicable to those who already have a pressure ulcer). It has been developed for use in adult populations in hospital and community settings by Registered Nursing staff.

PURPOSE-T uses colour (rather than a numerical score) to describe risk in terms of a personal profile to help in the planning of appropriate interventions.

It incorporates 3 steps:

1. a screening stage to be used for all patients to target assessment towards those in need

2. a full assessment stage to be completed for those potentially at risk as determined by step

3. decision pathways to be undertaken for all patients who have undergone step 2.

These steps make a clear distinction between patients with an existing pressure ulcer(s) (or scarring from previous ulcers) who require secondary prevention and treatment and those at risk who require primary prevention.

The primary aim of this tool is to identify patients who are at risk, as well as determining the degree of risk of developing a pressure ulcer.

An assessment that identifies risk must lead to action which should include the ongoing preventative strategies and management of any pressure ulcers. Patient deemed to be at risk of pressure damage a prevention of pressure damage care plan must be initiated.

Timeframes for completion of Purpose T:

Inpatient areas:

- Within 6 hours of admission
- On change of clinical condition
- Minimum weekly
- On change of care setting

Community:

- First scheduled visit or appointment
- On change of care setting
- Re-admission to caseload e.g. following discharge from hospital
- At scheduled intervals, according to their risk assessment outcome
- On change of clinical condition

If the person undertaking the Purpose T assessment does not have the skills and knowledge to undertake steps 2 and 3 they should provide immediate and necessary, care as below and refer to a suitably trained professional who has been assessed as competent to continue and complete the assessment.

Immediate and Necessary Care:

• Reposition the patient off the affected area and record the position in which the patient was found

• If the skin is broken, clean and dress the wound using a sterile dressing as per local policy

• Ensure any existing equipment is functioning and in use

• Take a digital image of any broken skin

• Seek assistance / escalate care / refer to specialist as necessary

• Give patient, family and carers information about what they can do to help manage the skin damage, including what they should avoid doing

• Document any interventions, conversations or care plans and ensure these are handed over to other caregivers to ensure continuity

• Check if medical devices in use are still required. If it is still, necessary fit and position correctly

18.3 aSSKINg - a seven-step model for pressure ulcer prevention:

The **aSSKINg** model is used in preventative interventions for people who are at high risk of developing or have already developed a pressure ulcer and or scarring from previous ulceration to improve clinical care.

The aSSKINg model for pressure ulcer prevention:

The aSSKINg Framework

	Action	Best Practice
a	**Assess risk**	Consider risk factors associated with compromised skin integrity. Undertake screening and risk assessment using the PURPOSE T screening and risk assessment tool or similar evidence-based and validated tool which contains as a minimum, the same risk elements. Refer to appropriate members of the interprofessional team. Be aware of safeguarding policies and take appropriate action when necessary. Document risk status and timing of review in the clinical record.
S	**Skin assessment and skin care**	Carry out a comprehensive skin assessment including skin under devices where it is safe to do so. Consider colour, texture and temperature of the skin. Ask the individual to identify any areas that are painful, itchy, uncomfortable or numb. Consider risk factors associated with impaired skin integrity. Identify complex health conditions that affect skin integrity. Keep the skin clean, dry and well hydrated. Implement evidence-based skin interventions to promote skin integrity. Document the presence of vulnerable skin, including where there is a change in colour, temperature or texture or patient reported changes in sensation.
S	**Surface**	Consider risk factors associated with a range of support surfaces including but not limited to beds, mattresses, chairs, cushions, wheelchairs and in vehicle systems. Consider the impact of offloading devices such as boots or other orthoses. Consider the impact of medical devices and their contact with the skin. Consider the range of available equipment, including the mechanism of action, benefits and associated risks. Identify and undertake relevant seating and moving and handling risk assessments. Consider the role of support surfaces and equipment on the patient's level of independence while managing the risk of pressure ulcer development. Refer to appropriate members of the inter-professional team throughout the patient journey, including discharge planning.

K	**Keep moving**	Consider level of mobility and risk factors associated with reduced mobility. Consider the range of available moving and handling equipment, including the mechanism of action, benefits and associated risks. Use relevant formal tools to assess mobility - falls risk, moving and handling risk assessments to balance the risk from other harm. Consider the impact of reduced mobility on an individual's posture, engagement in activities of daily living (ADL) and psychosocial functioning (mood, isolation, social engagement). Safely use a range of appropriate equipment to promote self mobilisation and good posture - hoists and slings, standing hoists and frames, electronic bed frames, appropriate seating and mobility aids, sleep systems, wheelchairs etc - to promote individualised plan of mobility and assisted transfers. Refer to appropriate members of the interprofessional team throughout the planning journey, including discharge planning. Consider the individual's usual daily routine when planning repositioning or activity schedules. Identify and understand and, where possible, address the cause of any change in mobility level.
I	**Incontinence or increased moisture**	Identify the cause of moisture-related skin damage ie. incontinence, sweat, saliva, stoma effluent, wound leakage. Where possible, address the cause of the moisture. Consider whether incontinence-related skin damage is an issue. Differentiate between aetiologies associated with incontinence. Consider how increased moisture increases the risk of skin damage caused by skin and friction. Implement appropriate prevention and management strategies. Refer to continence services where necessary. Keep the skin clean, dry and well hydrated. Maintain hydration.

N	**Nutrition**	Consider the impact of key nutritional elements in wound healing. Understand the impact of disease on nutritional need and nutrient absorption. Utilise the relevant tools and documentation which should include food and fluid charts, for example, food diaries, MUST, BMI, MUAC, bloods, feeding risks and PEM assessment. Advise on food fortification, nutritional supplementation and moderation of dietary restrictions in event of pressure ulceration. Collaborate to deliver appropriate care with relevant members of the multidisciplinary teams (MDT) (dietician, speech and language therapist, occupational therapist). Consider the practical elements of maintaining nutrition and hydration including portion sizing, food texture, access and ease of use of implements and good dentitition.
g	**Give information**	Select and implement the most appropriate communication approach to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies. Consider the patient's level of capacity and perform the necessary checks. Communicate effective and safe use of interventions effectively for the patient, family and within the MDT. Recognise when clinical concerns need to be escalated. Promote effective pressure ulcer prevention approaches. Consider effective resource allocation and escalate concerns when resources are unavailable. Be aware of safeguarding policies and take appropriate action when necessary. Use the clinical record as the source of documentation to ensure information is available to all members of the MDT. Use appropriate language to ensure the clinical record can be appropriately used for coding/analytic purposes. When capturing/using digital images, ensure appropriate consent has been obtained.

18.2 Pressure Ulceration Categorisation

Each area of pressure damage or pressure ulcer should be classified. The following categories are taken directly from the International Pressure Ulcer Guidelines (EPUAP, NPIAP, PPPIA 2019 pp 203 – 205) and reflect the National Wound Care Strategy Programme Pressure Ulcer Recommendations and Clinical Pathway 2024. Minor amendments have been made to the language to reflect new understanding of assessing patients with dark skin tones.

Category 1 Pressure Ulcer / Non blanchable erythema

The ulcer appears as a defined area of persistent redness (erythema) in lightly pigmented skin tones, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues, without skin loss. The patient may report pain or discomfort over the area.

This is a category 1 pressure ulcer in brown skin. Note the erythema (redness) is still visible as the skin is much lighter on the margin of the foot:



The image below shows non-blanching erythema in white skin:

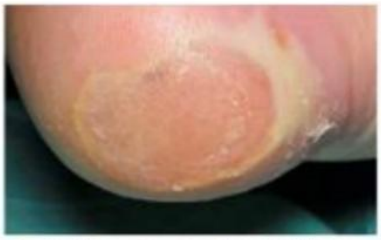


Category 2: Pressure Ulcer

Pressure ulcer with abrasion, blister, partial-thickness skin loss involving epidermis and or dermis



An intact serum-filled blister



A shallow open ulcer with a red pink wound bed without slough



A superficial ulcer with a collapsed blister

A category 2 pressure ulcer progresses into, but not through, the dermis, therefore the blister may be blood streaked if vessels within the dermis are damaged.

Category 3: Pressure Ulcer

Pressure ulcer with full-thickness skin loss involving damage or necrosis of subcutaneous tissue. Undermining and tunnelling may occur, fascia, muscle, tendon, ligament, cartilage and or bone are not exposed.

This image shows a Category 3 pressure ulcer, subcutaneous fat is visible but no underlying structures:



The image below shows a dry necrotic wound over the heel, the skin surrounding the wound should be carefully palpated and consideration given to the location to help determine the category. It is, as a minimum, a Category 3 pressure ulcer:



Additionally, intact or non-intact skin with localised area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister should also be defined as Category 3 pressure damage. Pain and temperature change often precede skin colour changes. Discoloration may appear differently in darkly pigmented skin. This injury results from

intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss.



Category 4: Pressure Ulcer

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage and/or bone in the ulcer. There is an increased risk of osteomyelitis.

In the first wound, the bone is clearly visible. There is an increased risk of osteomyelitis, and this should be addressed within the plan of care. Both wounds have visible underlying structures (they are both Category 4):



In this wound, the bone is clearly visible



This wound shows exposed muscle

Any area of skin discolouration with associated changes in skin texture and temperature or patient reports of pain and discomfort that do not fit the above categories should be clearly documented with a full description of the clinical signs. This should be recorded as vulnerable skin so that the pressure ulcer prevention pathway (Orange pathway in PURPOSE-T) is triggered. This more thorough assessment of the surrounding tissue may alert the clinician to potential tissue damage

beyond what is readily visible. Once again, these should be considered in relation to the anatomical location and the likelihood of further breakdown based on the temperature and texture of the area. If this area of discolouration breaks down, the standard categorisation listed above should be used and documented.

Recommend further reading of Pressure Injury:

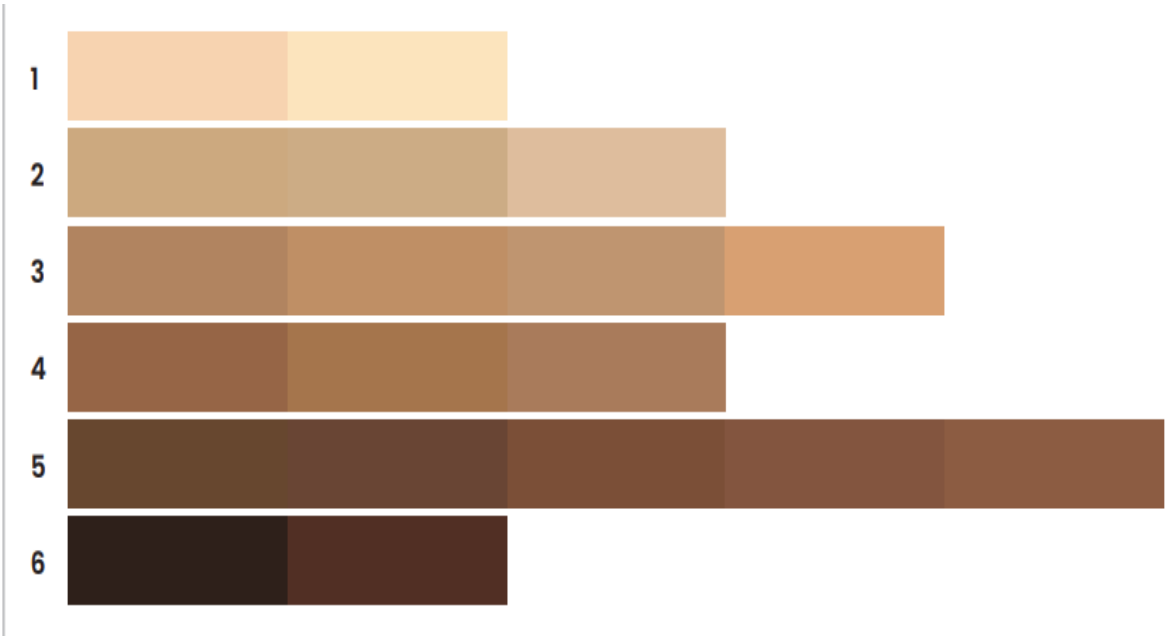
Overview | Pressure ulcers: prevention and management | Guidance | NICE

Pressure Ulcer Recommendations and Clinical Pathway May 2024

NWCSP Pressure Ulcer Clinical Recommendations and Clinical Pathway - Improving Wound Care: Building on The National Wound Care Programme - Futures

Skin tone assessment

Accurate and comprehensive assessment is essential for effective wound care and prevention, enabling prompt, personalised treatment. This involves a detailed examination of the skin, including establishing the patient's baseline skin tone to allow early detection of any changes. Failure to identify changes promptly can result in missed warning signs and subsequent skin or tissue damage. Assessment should be holistic, considering the patient's skin, overall health, medical history, and wound, to ensure care is tailored to individual needs. All patients, regardless of skin tone, deserve equitable assessment; awareness of skin tone should be standard practice, with the aim of recognising issues early and providing appropriate interventions for every patient.



Skin tone tool (Adapted from Ho and Robinson, 2015)

For guidance on accurate assessment and diagnosis across all skin tones, refer to practical resources to optimise patient care and improve outcomes.

See: **Best Practice Statement Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones**
Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones – Wounds UK

Skin Assessment: Assessing skin on patients with darker skin tones in relation to PU prevention - Society of Tissue Viability

18.3 Pressure Relieving Device

All vulnerable patients who are at risk of developing pressure ulcers, or have a history of pressure ulceration, should be considered as being at high risk of developing a pressure ulcer in primary and community care settings.

Decisions about appropriate pressure-relieving support surfaces, for patients with pressure ulcers should be made by clinicians. The decision must consider the following:

- Do not use standard-specification foam mattresses for adults with a pressure ulcer.
- Use high-risk foam mattresses for adults with a pressure ulcer. If this is not sufficient to redistribute pressure, consider the use of a dynamic support surface.
- Consider a hybrid mattress for complex / palliative patients to avoid complex mattress replacement requirements
- Consider the seating needs of adults who have a pressure ulcer, or are at risk, who are sitting for prolonged periods.
- Consider a high-risk foam or equivalent pressure-redistributing cushion for adults who use a wheelchair or sit for prolonged periods and who have a pressure ulcer, or who are at risk.

Clinicians need to complete the TCES (Medequip) online training programme and formal completion of the associated competency document prior to being issued with an authorisation PIN to enable future ordering of equipment. The type of equipment ordered will be dependent on individual assessment undertaken and patient need.

Formulary – Humber Area Prescribing Committee (northernlincolnshireapc.nhs.uk)

18.4 Use of Offloading Interventions for Foot Wounds

Offloading interventions or pressure redistribution techniques are commonly used within the Podiatry service to support the healing of foot ulcers. Offloading interventions reduce excessive mechanical stress either in the form of pressure, friction, or shear stresses.

Podiatry offloading devices include:

- soft cast devices such as total contact casts, slipper casts and heel casts
- footwear and insoles housed within footwear
- surgical appliances
- silicone splints
- other techniques such as felt padding.

Offloading interventions need to be applied under specialist direction as failure to apply in the correct manner can result in additional mechanical stress on the tissue leading to further tissue damage.

Offloading devices should only be applied to the foot when a Podiatry Service management plan is in place.

Types of devices used:

Footwear housed devices - total contact insole, chair side orthotic:

These devices should be in situ within patients most worn footwear.

No nursing interaction necessary.

Custom made casted devices - slipper casts, heel cast, removable below knee cast:

All casts need a fabric layer between the skin, to minimise sheer stress. This can be hosiery, bandage or stockinette.

Heel casts will be marked for orientation purpose, i.e. foot / heel / left / right and should be reapplied at each dressing change. Heel casts can often become stained with exudate leakage, however, staining does not decrease the effectiveness of the cast. Remanufacture only needs to be instigated if the integrity of the cast has been compromised e.g. visible peeling or delamination of the casting tape.

Example of a slipper cast:



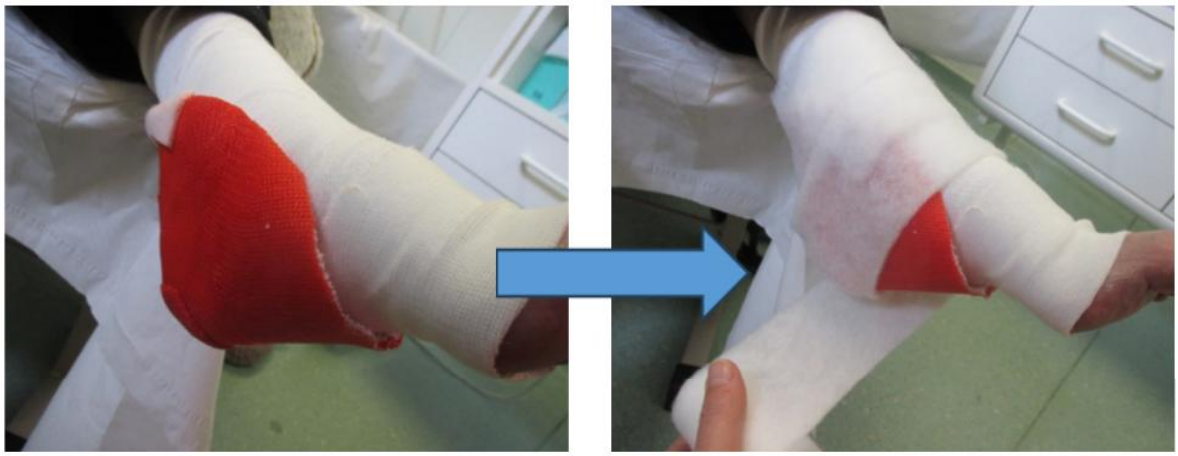
Example of a heel cast:



Example of how a heel cast will be marked to show orientation:



How to secure a heel cast:



Silicone splint:

A silicone split is a custom-made device to address deformities which are flexible within the foot. The silicone splints are washable, with soap and water, and are reusable.

Silicone splints can be marked for orientation and correct positioning, and they should not be applied directly to an open wound but are to be positioned and placed over a low-profile dressing if required.

Silicone splint can be different colours.

Examples of two different silicone splints:



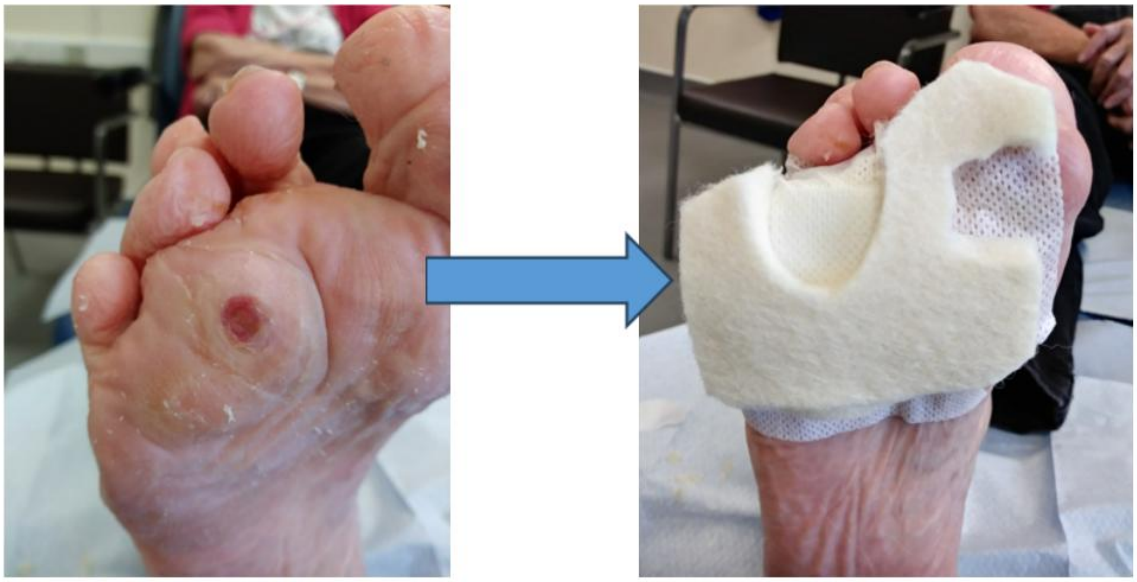


Semi -compressed felt padding:

Comes in various thicknesses i.e. 5, 7 and 10mm. It can be shaped and applied to the foot with adhesive backing. However, the felt is not sterile and therefore must not come in contact with an open wound.

Semi -compressed felt padding should be applied on top of dressings to reduce risk of contamination and skin damage. The padding will need to be removed at each dressing change and a new pad shaped and applied as per the Podiatry Service management plan. As part of the management plan a picture will be uploaded to the patients SystmOne record showing the correct orientation of the pad. A template will be supplied by Podiatry Service to aid future shaping.

Example of semi-compressed felt padding:



Note: In the event of skin damage occurring due to use of any offloading intervention or device, omit and escalate immediately to the Podiatry Service for review.

18.5 Specific Conditions

Bariatric Patients:

Patients are classed as being obese when they have a Body Mass Index (BMI) >40. The healthcare practitioner should be aware of the increased risk of pressure ulcers and MASD, and ensure management to prevent pressure ulcers in bariatric patients by addressing their individual special needs and must consider the following:

- Maintain skin integrity especially in the skin folds that the patient may have changes in the skin physiology due to a greater skin-weight ratio, reduced vascularity, and perfusion in adipose tissue, which can result in poor wound healing.
- Be aware that obesity has many associated long-term health problems.
- Mobility problems that can limit the range of movement and position changing that a patient can achieve.
- Discuss with the patient and seek consent to refer to a dietician and other relevant HCPs, also consider a referral for Social Prescribing.

- Any specialised lifting equipment must address the weight of the patient and the safety of all healthcare professionals that are involved in the patient care – Continuing Health Care funding may be required to fund such equipment.

Palliative Care Patients:

The principles for preventing pressure ulcers for the patient with palliative care needs are the same as outlined within this guidance.

However, whilst these supportive measures may be achievable for patients who are acutely or chronically ill, patients who are approaching the end of life will have physiological deterioration making successful management difficult and healing may not be achievable.

The focus should be on the patient's comfort, dignity and wishes, additionally carers support may take priority. Therefore, management goals may be redefined from prevention to management of the pressure ulceration including pain, infection, odour etc.

Pressure damage, occurring in palliative care patients should be reported, managed and treated in line with any other pressure ulcer.

18.6 Clinical Incident Reporting Pathway for Pressure Ulceration Category 2 and Above

It is a requirement to report pressure injuries of Category 2 or above.

Each pressure ulcer and area of MASD identified must be separately incident reported, within 48 hours of identification.

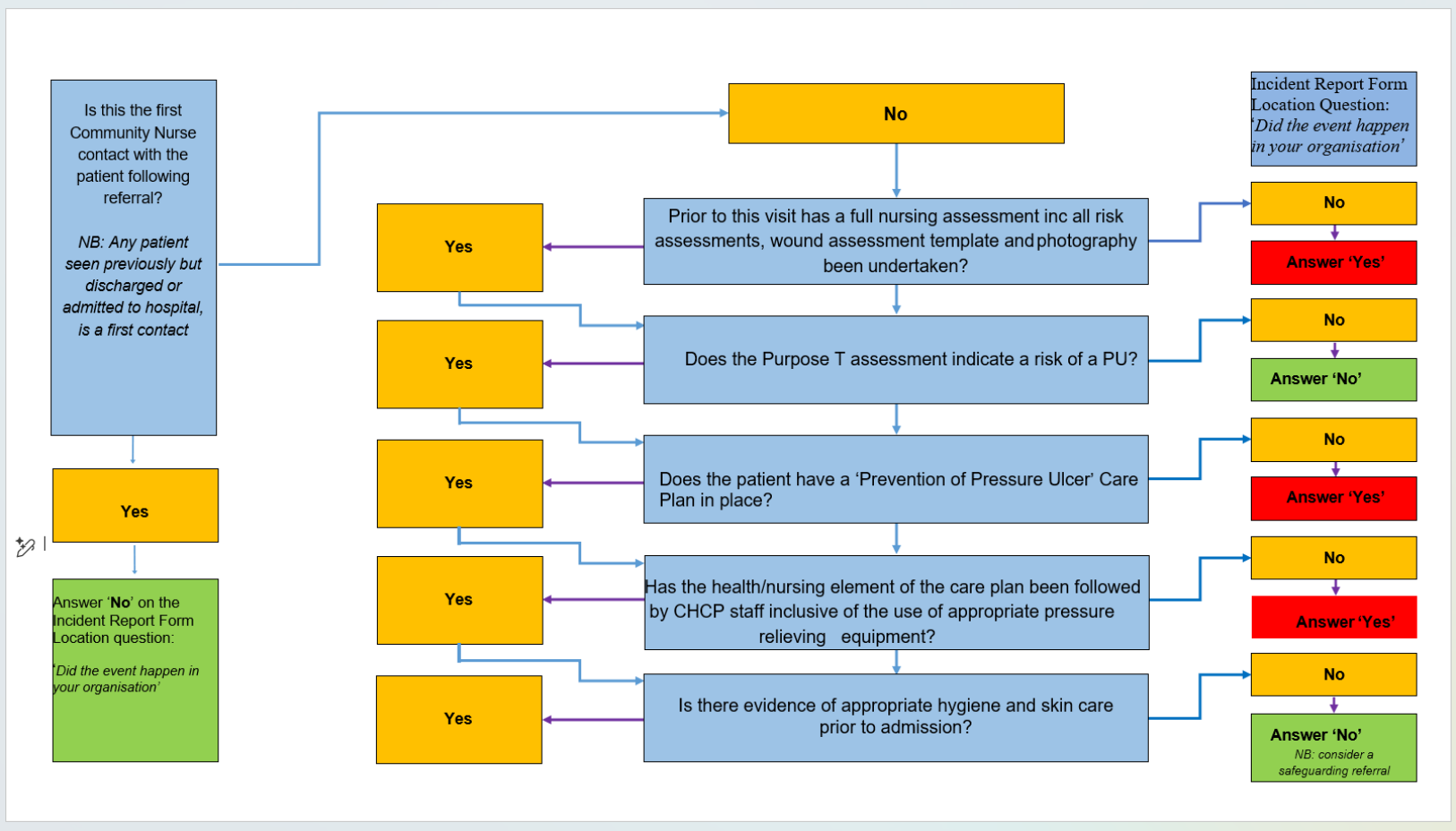
The clinician who identifies any of the following pressure related issues must report using CHCP and its subsidiaries Incident reporting system:

- New or deterioration of existing pressure ulceration categorised as:
  - Category 2
  - Category 3
  - Category 4
- Medical Device related pressure damage
- Moisture -Associated Skin Damage (MASD)

- MASD with pressure damage - in such cases the pressure ulcer is categorised
- Diabetic foot ulcers

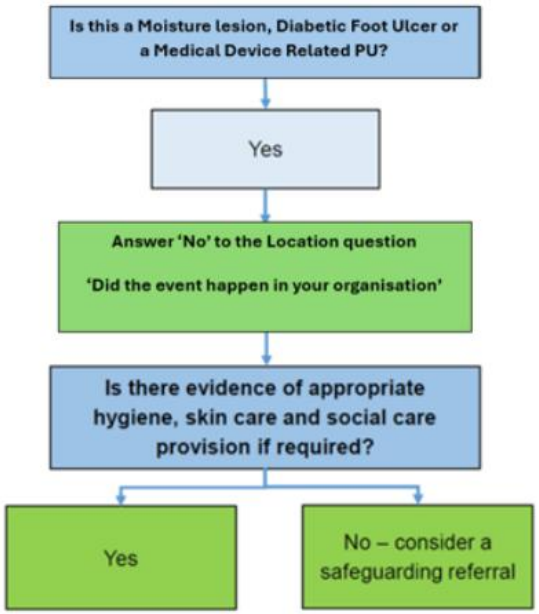
18.7 Community Nursing: Pressure Ulcer Reporting

Flow chart 1



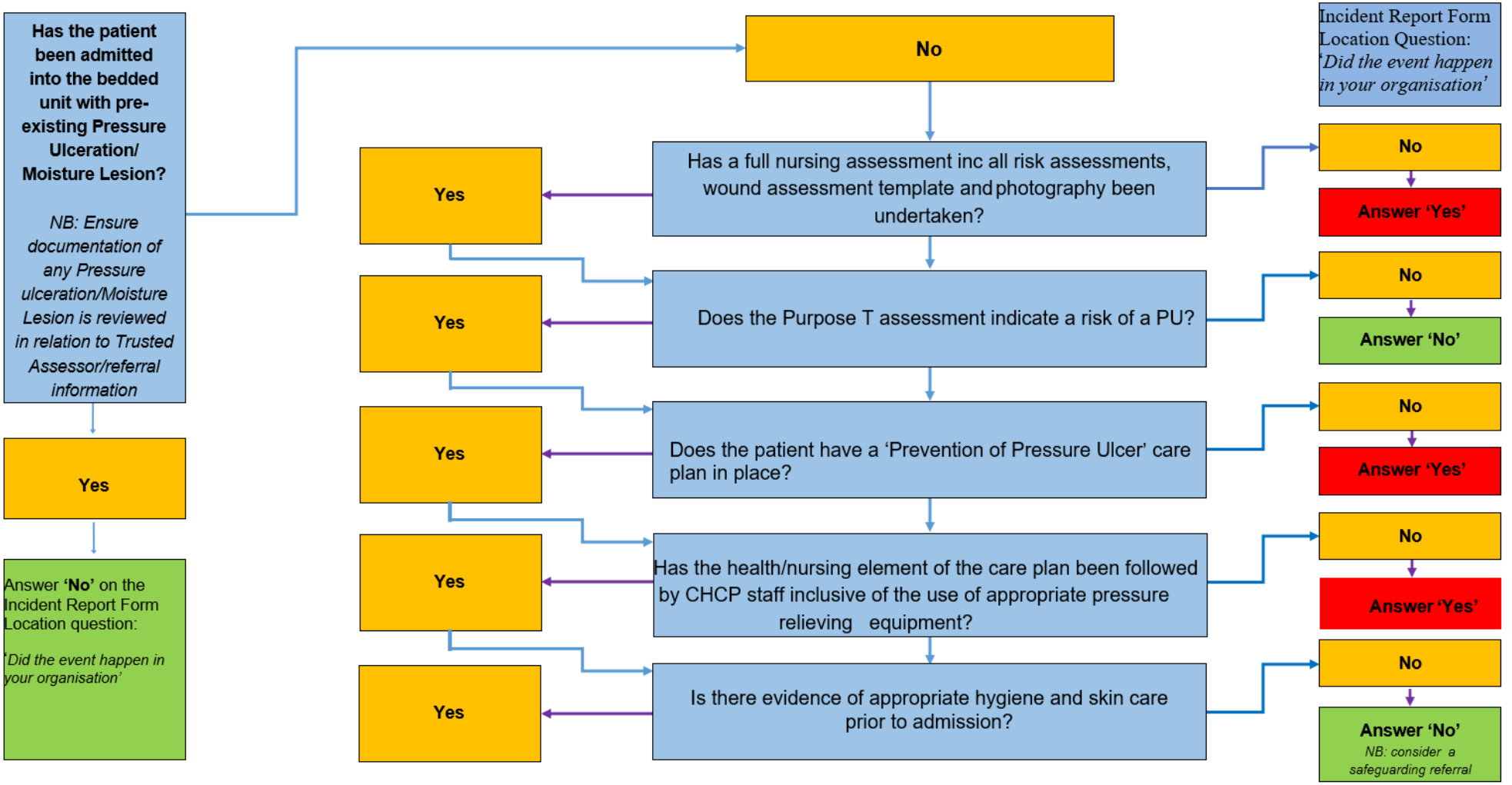
COMMUNITY NURSING: PRESSURE ULCER REPORTING

Flow Chart 2



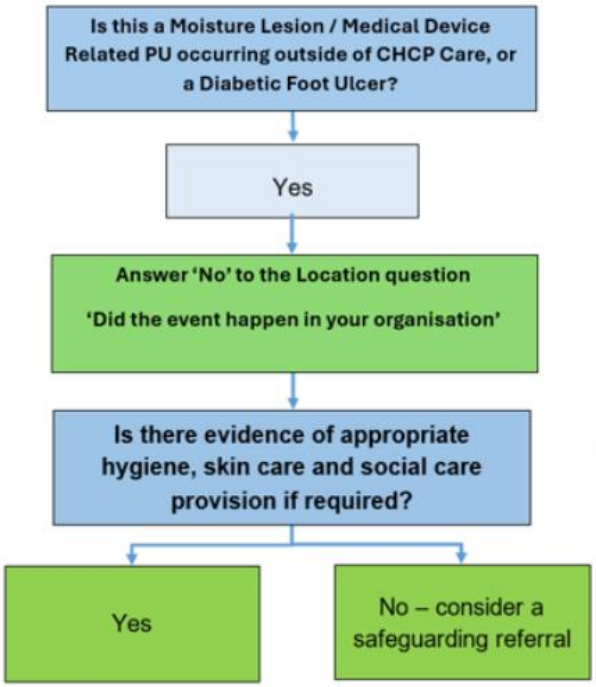
18.8 Bedded Units: Pressure Ulcer Reporting

Flow Chart 1



BEDDED UNITS: PRESSURE ULCER REPORTING

Flow Chart 2



Notes to support reporting:

- '*Category'* must be used as the correct terminology for documenting and reporting all pressure damage.
- The application of Duty of Candour applies for those patients who have sustained pressure damage deemed as '*moderate or above harm'* and inside care of CHCP.
- For pressure damage identified as moderate or above harm inside CHCP and its subsidiaries will require a learning response.
- Cat 3 or 4 pressure ulcers inside CHCP care are reviewed under the Patient safety Incident Response Framework and assessed if the incident requires a Full Patient Safety Incident Investigation (PSII)
- Where tissue damage has occurred due to any of the following the clinician must contact the CHCP Safeguarding Team to discuss concerns and assess whether an appropriate safeguarding referral is required: Ref 876 Safeguarding Adults Referral Pathway for CHCP (referrals forms can be located on the SystmOne patient electronic record):
    - self-neglect
    - neglect or an act of omission
    - inadequate delivery of care either in the patients' home or care setting
    - concerns of or allegations of abuse
    - the presence of multiple pressure ulcers

- Pressure damage categories **cannot** reverse when the pressure ulcer is healing.
- Any learning response must be shared with teams to ensure a high standard of practice is maintained.
- Special Note re Nursing Homes: CHCP clinicians who offer advice and support regarding the management of any of the above should also report using CHCP's incident reporting system ensuring that the incident is identified as a 'Nursing Home incident'. In addition, Nursing Homes should have their own incident reporting process in line with NICE Guidelines

18.9 Communications Between Healthcare Settings

For any patient who has sustained any pressure damage in any care setting, and is being transferred to another team or service, information pertinent to the patient must be communicated. This information should include the Pressure Ulcer category, a management plan and the Incident Report Number.

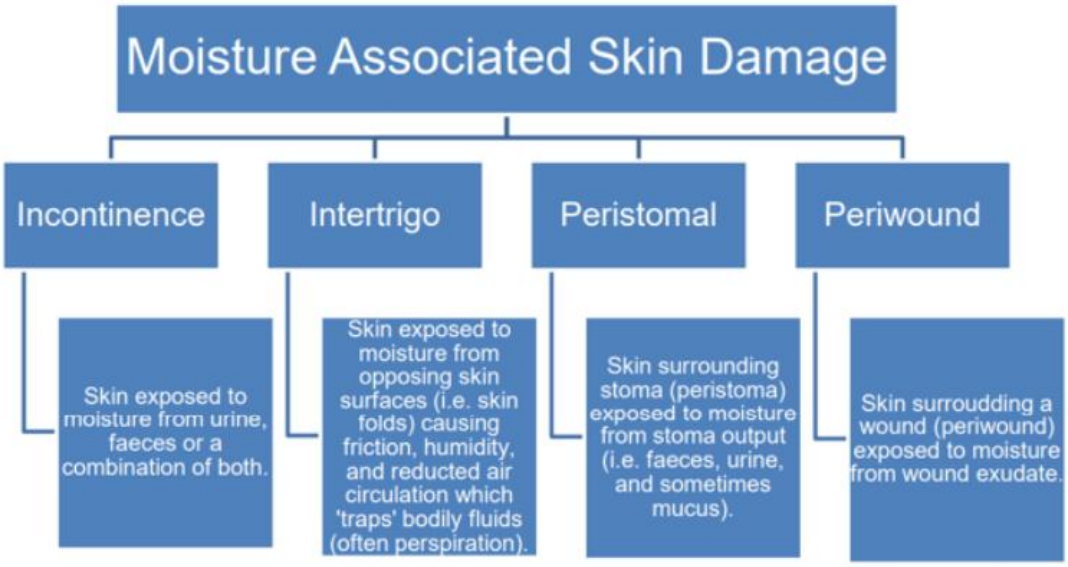
Patients under the care of the Community Nursing Service, or other relevant CHCP Health Care Professional, who are admitted to hospital: - it is the responsibility of the CHCP Community Nurse or clinician to inform the ward staff of the current care and management of the patient

For Hospital Acquired tissue damage: - the Community Nursing Service or other relevant CHCP Health Care Professional should be informed of any tissue damage that the patient may have on discharge from secondary care. Any tissue damage acquired in a hospital or other external care setting should be reported via the incident reporting system, as it is considered to have occurred outside of CHCP care.

19. MOISTURE ASSOCIATED SKIN DAMAGE (MASD)

Moisture lesions, also known as moisture, associated dermatitis, are referred to as Moisture Associated Skin Damage (MASD). The condition is characterised by irritation and inflammation to skin and folds of the skin and is caused by excessive moisture e.g. due to incontinence or wound exudate.

MASD can incorrectly be identified and classified as pressure damage if located on buttocks, particularly if risk factors are present for each type of wound (for example immobility and incontinence). Thus, it is important to identify the correct cause of skin damage as moisture lesions and their treatment / management differs to the treatment / management of pressure damage and ulceration. A pressure ulcer is likely to be located on the bony prominences of sacrum or ischial tuberosity (sitting bones) with a regular shape. MASD can present as a linear wound in the natal cleft between the buttocks and / or on the cheeks of the buttocks, with an irregular shape and sometimes with a wound often being present on both buttocks (commonly known as a ‘kissing lesion’).



Management approach for MASD:

- Routine skin assessment to include the folds of skins in the groin/scrotal area and under breasts.
- Skin Protection - aimed to isolate exposed skin from harmful or irritant substance.
- Treatment and management of incontinence.
- Education of patients and carers to offer patient-centred information about care and prevention of further skin damage.
- Assessment of the extent of tissue damage
- Report all MASD (see point **18.7** Community Nursing: Pressure Ulcer Reporting – Flow Chart 2 and **18.8** Bedded Units: Pressure Ulcer Reporting – Flow Chart 2 for more detailed guidance)
- Where skin damage is caused by a combination of moisture and pressure, it will be reported based on the category of pressure damage.

Dependant on the holistic patient assessment findings and degree of skin damage discharge of the patient should be considered, a clear management plan with clear instruction to contact the service again if there is no improvement or any deterioration should be provided to the patient. Prior to discharge a wound assessment and aSSKINg should be completed as a baseline should the patient return to the service.

If following assessment there is a need to initiate of a management plan for MASD to be reviewed by the INCS a care plan should be commenced and if the MASD does

not improve an appropriate referral to either the patients General Practitioner (GP), Bladder and Bowel Specialist nurse or the Tissue Viability Nurse must be considered.

20. SURGICAL WOUNDS

Only 79% of acute wounds heal within 12 months and for the 21% that fail to heal, there is considerable patient suffering and NHS cost.

Delayed healing is commonly caused by **surgical site infection (SSI**). The clinical definition of SSI is an 'infectious process present at the site of surgery. Clinical signs and symptoms of infection include heat, redness, swelling, elevated body temperature and purulent exudate from the wound or the drain' usually within one week of surgery.

SSI can result in dehiscence, but **surgical wound dehiscence (SWD)** may also be caused by non-microbial aetiologies such as haematoma, seroma or mechanical stress, obesity or pre-existing chronic disease states. The clinical definition of SWD is the separation of the margins of a closed surgical incision that has been made in skin, with or without exposure or protrusion of underlying tissue, organs or implants. Separation may occur at single or multiple regions, or involve the full length of the incision, and may affect some or all tissue layers. A dehisced incision may, or may not, display clinical signs and symptoms of infection.

Most SSI occur within 7 days of surgery and SWD within 9 days. Misdiagnosis of SWD as SSI may lead to potentially severe follow-on consequences for the patient and clinical practice.

20.1 Immediate Actions for Surgical Wound Dehiscence

Wound bed presentation

Epidermis only with no visible subcutaneous tissue

- Adhere to the wound management recommendations detailed in this document, and consider the use of negative pressure wound therapy

Subcutaneous layer is exposed with no visible fascia

- Adhere to the wound management recommendations detailed in this document, and consider the use of negative pressure wound therapy

Subcutaneous layers and fascia exposed

- Adhere to the wound management recommendations detailed in this document, and consider the use of negative pressure wound therapy
- Make a referral to Tissue viability team and consider escalation to the surgical team

Fascial dehiscence with organ space, viscera, implant, or bone exposed

- Apply dressing and treat as a medical emergency

If signs of infection are identified in any of the above clinical presentations, refer to section 9 for guidance on infection management

20.2 Tissue Viability Care of SWD

The Tissue Viability Service should promptly review and triage any referrals for SWD and consider the following:

- commencement of PICO/NPWT
- arrange a face-to-face review if appropriate
- escalate directly to surgical team as needed.

For more information relating to surgical wounds see **National Wound Care Strategy Programme: (2021) Recommendations for surgical Wounds.**

Futures - Futures

Surgical wound dehiscence: Improving prevention and outcomes - Wounds International

21. CAVITY WOUNDS

The management of cavity wounds frequently pose a number of clinical and practical challenges to healthcare professionals. They often need debridement, in addition to biofilm, infection and exudate management. The hidden nature of some cavities can present practical challenges in terms of visualising and managing the wound bed and documenting the wound's condition.

Definition of a cavity wound:

Cavity wounds have been defined as a wound that extends beneath the dermis, however there is a lack of a standard definition with some considering wounds less than 2cm deep as cavities, while others include those over 2cm deep or those extending beneath the dermis, including wounds exposing underlying structures such as fascia, tendons, muscle, and bone.

However, a cavity can exist in most wound aetiologies including chronic wounds (e.g. leg ulcers, pressure ulcers, malignant wounds and diabetic foot ulcers), traumatic and surgical wounds (e.g. wound dehiscence, sinus/fistula formation) and abscess drainage and excision. A poor nutritional state can also result in a poor quality of wound healing and the development of a cavity.

For more information relating to cavity wounds see: **Addressing the challenges of cavity wounds in clinical practice**

Wound Care Today - Article: Addressing the challenges of cavity wounds in clinical practice - Wound Care Today (woundcare-today.com)

Dressing a cavity wound

Health care professionals must use their clinical judgment when deciding to use a dressing to fill the space (cavity) and are accountable for their practice when undertaking this. The following guidance must be followed in all situations:

ASK THE QUESTION: WHY AM I PACKING THIS WOUND?

DO NOT completely fill the cavity with the dressing material, loosely insert the dressing. The dressing will expand when it absorbs wound exudate and if it is tightly packed this will be detrimental to the wound and cause pain.

DO leave a 2cm or longer overlay of the dressing out at the external wound opening so it can be easily removed

DO count and document all pieces of dressing inserted into a wound and removed

DO document the size and type of dressing material used within the care plan

DO use caution when inserting dressing material into the wound using forceps

DO establish the end of the wound prior to packing to avoid dressing material being lost within the wound

DO use dressings that are designed for one-piece removal and do not shed fibres within the wound – these are also beneficial in reducing infection risk in cavity wounds

DO consider a gel dressing to pack narrow cavities, inserting a gel instead of dressing material to narrow wounds avoids trauma, is easier to insert and some gel products do not need to be removed, they can be 'topped up'.

DO review wound healing progress and evaluate effectiveness of treatment plan

DO escalate any deterioration to the Tissue Viability Service

DO discontinue filler once the cavity is filled with granulation tissue and continue to review 4 weekly

22. MANAGEMENT OF MALIGNANT / FUNGATING WOUNDS

The cause of fungating malignant wounds is by tumour infiltration of the skin and its supporting blood and lymph vessels. Anaerobic and aerobic bacteria proliferate in these conditions and are a cause of malodour and exudate associated with these types of wounds.

It is essential that when caring for a patient with a fungating wound that all appropriate Specialist Palliative Care / End of Life referrals are in place where appropriate.

The aims of management of a fungating wound should include assessment of:

Pain:

- Choose dressings that minimize trauma and pain during application and removal
- Evaluate the patient's need for both pharmacological (e.g., analgesics) and non-pharmacological (e.g., relaxation techniques, repositioning) strategies to manage wound-related pain.
- Identify and Treat Infection using CHCP Infection Management Framework
- Administer analgesia continuously or before dressing changes, depending on pain levels.
- Consult a pain specialist nurse, GP, or palliative care team when necessary for comprehensive pain management.

Odour

Establish the Cause of Odour consider:

- Infection: Presence of bacteria, particularly anaerobes (e.g., Pseudomonas aeruginosa, Proteus spp., or Bacteroides). Look for signs such as increased exudate, redness, pain, or swelling.
- Devitalised Tissue: Necrotic or sloughy tissue provides an ideal environment for bacterial growth and odour production.
- Excessive Exudate: Can lead to bacterial proliferation and worsening smell.

Consider Autolytic Debridement

- Autolytic debridement uses the body's own enzymes and moisture to break down devitalised tissue.
- This can be facilitated by using wound dressings

Consider Odour-Control Dressing

- Activated charcoal dressings absorb odour molecules.
- Hydrofiber or alginate dressings help with exudate management.
- Antimicrobial dressings can reduce bacterial load, helping with odour control.

Skin

Consider maceration

- Protect the surrounding skin with a skin barrier product
- Use CHCP wound product formulary & CHCP Exudate management pathway to choose appropriate absorbent dressing

Consider excoriation

- Protect the surrounding skin using skin barrier product
- Be aware of skin sensitivities and allergies
- If skin stripping is evident consider using a silicone dressing
- If required use adhesive remover at dressing changes

Consider itching

- Manage the source of the itching i.e skin sensitivity, allergy, exudate
- Liaise with specialist to consider oral antihistamines or topical steroid treatment

Infection

- Follow CHCP Infection Management Pathway

Exudate

- Assess exudate levels using T.I.M.E
- Use CHCP Exudate pathway NB use non adherent contact layer to minimise the risk of bleeding/trauma

- Use skin barrier product to peri wound skin
- Discuss referral to dietetics if exudate is excessive due to the loss of protein in exudate to optimise the patient.

Bleeding

Bleeding can be caused by erosion or compression of the blood vessels, decreased platelet function, abnormal microcirculation caused by the tumour or dressings.

For light bleeding consider:

- Apply local pressure for 10 – 15mins with a moist absorbent dressing (consider this may cause pain)
- Apply alginate haemostatic dressing
- Apply non adherent/silicone dressing to support atraumatic removal and longer wear times

For heavy bleeding consider:

- Apply pressure and seek urgent medical advice via 999
- Be aware of the patient's wishes in relation to preferred place of care

If bleeding is anticipated, consider:

- Ensure patient/carer/family are aware who to contact in the event of a significant bleed
- Ensure there is a supply of dark coloured towels along with gloves, clinical waste bags etc.
- Liaise with other health care professional/specialist services to consider the following medications
    - Benzodiazepine (midazolam 10mg can be given into a large muscle such as deltoid, gluteal)
    - Adrenaline 1 in 1,000
    - Calcium alginate dressing (kaltostat)

This is an emergency situation and if the wound is not responding to treatment and continues to bleed heavily a 999 response is required – it is then the patient's choice to remain at home if this is their preferred place of care as documented in advanced care plan.

These wounds can lead to a range of emotional and psychosocial challenges, including depression, anxiety, low self-esteem, and loss of sexual intimacy. It is essential for patients to feel supported throughout their journey.

Healthcare providers should continuously assess the psychological and social needs of patients during each intervention. Engaging in open discussions about available support options can help patients and their families cope more effectively.

Consider referring patients to counselling services, Macmillan nurses, and other relevant support networks that can provide emotional and practical assistance for both the individual and their loved ones.

Wound care dressings and treatment used in the management of fungating wounds should be guided by the presentation and priorities of the wound, and appropriate use of the **CHCP Cleansing Protocol, Exudate Management Pathway** and **Infection Management Framework.**

23. INCS – NEGATIVE PRESSURE WOUND THERAPY

There are two types of Negative Pressure Wound Therapy (NPWT) available for use, the RENASYS TOUCH device and the PICO Single Use Negative Pressure Wound Therapy System.

- Hull and East Riding CHCP CIC hold a contract with Smith and Nephew (S & N) for the provision of the RENASYS TOUCH NPWT devices.
- Smith and Nephew PICO NPWT dressings are also available to CHCP clinicians for advance wound management.

NPWT may be initiated prior to discharge from hospital following surgery / plastic interventions or pressure injury. However, NPWT can be initiated in the community, when clinically appropriate, a referral to the TVaLL Service is required when initiating any form of NPWT, it is the responsibility of the CN case manager to ensure all patients being treated with NPWT also have a referral to the TVaLL Service.

In all cases it is essential that the principles of wound bed preparation (WBP) are followed prior to commencement of treatment and during use. In addition, it is the responsibility of the CHCP clinician to liaise with the patient's consultant and the TVaLL Service, during the ongoing care, working in partnership the CHCP clinician and TVaLL nurse will set appropriate reviews dates to support the ongoing evaluation of wounds being treated with NPWT. Evaluation/review must be undertaken at least every 2 weeks and ensure that the device / dressing is discontinued when the outcome of wound healing is achieved or if it is appropriate to continue wound management

with conventional dressings, for wounds where complete wound healing has not occurred.

Rationale for using NPWT:

NPWT therapy should only be used when clinically appropriate for:

- Management of exudate
- Prevention of infection
- Promoting angiogenesis
- Reducing oedema in a wound
- Promoting granulation of a wound and drawing the wound edges together

Contraindications:

There are contraindications when using NPWT and the clinician must be aware of these:

- Necrotic tissue with eschar
- Malignancy in wound - with exception of palliative care to enhance quality of life
- Non-enteric and unexplored fistulas
- Anastomotic sites
- Untreated osteomyelitis
- Exposed arteries, veins, organs or nerves

When should NPWT be discontinued:

- At the patient's informed request
- When granulation tissue is level with the surrounding skin
- When exudate level is less than 20 ml per day RENASYS TOUCH or no exudate when PICO is in use
- There is no improvement / reduction in wound size over 2-week period, or at two consecutive dressing changes
- Patient is experiencing problems on the surrounding skin
- Patient is experiencing pain
- There is a change in the patient's health, home environment or social circumstance that affects the safe and effective use of NPWT.
- If there are any signs of systemic infection or localised cellulitis
- Bleeding

Consumables:

The consumables required for the RENASYS TOUCH application include: the dressing port / gauze (rolls / packs) or foam packs and cannisters specific to the device.

In order to ensure timely initiation of NPWT the RENASYS TOUCH consumables and the PICO dressings can be ordered via Formeo for patients in the Hull and East Riding areas, for the ongoing management of wounds using NPWT any subsequent consumables/PICO dressings will be prescribed by a CHCP prescriber, this may be the TVaLL Nurse or CN clinician with the appropriate prescribing qualification using the FP10 prescribing route.

a. The RENASYS TOUCH

RENASYS TOUCH is an innovative negative pressure wound therapy choice. Designed for portability, flexibility, and simplicity. This system is indicated for use with patients who would benefit from a suction device (negative pressure wound therapy) as it may promote wound healing via removal of fluids, including irrigation and body fluids, wound exudates, and infectious materials. Examples of appropriate wound types include non-healing, acute, traumatic, subacute and dehisced wounds, ulcers (such as pressure or diabetic ulcers), partial thickness burn, flaps and grafts.

Training:

RENASYS TOUCH training will be provided by S&N clinical wound care specialist for Hull and East Riding.

Distribution of the RENASYS TOUCH NPWT:

CHCP will have access to 10 devices across Hull and East Riding.

Location of the units are:

- **East Riding (6 units)**:

Goole, Beverley, Driffield, Bridlington, Haltemprice, Holderness

- **Hull (3 units):**

East (Longhill), North (Bransholme), West (Priory Park)

- **Spare Device:**

One spare device will be held at Bransholme for use by Children's services or when a second device is required for use within a team.

S&N may be contacted in extreme circumstances for supply of additional devices if all 10 CHCP devices are in use at any one time.

Process - Discharge from hospital

Prior to the patient discharge the hospital must liaise with the Community Nursing service to ensure a seamless transition of care, this should occur at least 3 days prior to discharge.

A date of discharge must be agreed upon and everyone informed. Just prior to discharge the hospital staff should remove the RENASYS TOUCH device and dress the wound with conventional dressings.

The patient will then be discharged home with an appropriate number of consumable equipment / dressings, and the Community Nursing team will visit on agreed date and time to recommence NWPT using a CHCP device.

Commencing care – hospital discharge

Once the community team is aware of the patient's discharge it is the appropriate team member's responsibility:

- To ensure that the RENASYS TOUCH unit is taken on the first visit to the patient home.
- The Serial number of the device in use is recorded in the patient care plan
- Arrangements made to ensure an adequate supply of consumables is available to facilitate ongoing care and review to meet the patient's needs.

Exceptional cases:

In some situations, it may not be clinically appropriate to remove the NPWT prior to discharge home. In such cases the hospital must provide enough consumables for 2 dressing changes, and the appropriate number of canisters required for any changes needed to manage the exudate. If a pump is sent home with the patient the discharging clinician must provide the Community Team with adequate information relating to the return of the device once it has been replaced with a community device. The Community Team must contact HUTH Medical Equipment Library to arrange

collection: 01482 608976 / 01482 608957 / 07824635128 or the HUTH email address as labelled on the Pump

It is the responsibility of the CHCP clinician to ensure they complete the signing in/out sheets when initiating NPWT using a Renasys Touch device or when transferring a patient to a CHCP pump and back at base admin will undertake weekly checks within each CN base to monitor the location of each device this information will be kept by back at base admin within the U drive (U:\CHCP\Adult Services\Community Nursing\Private\RENASYS PUMPS)

Care and management of the RENASYS TOUCH device:

Inspect device for visible signs of damage before each use, including canister and tubing.

Do not use the device if it has been dropped or shows signs of damage.

Visually inspect the device inlet port O-ring for damage and if replacement is needed contact S&N.

There are no serviceable parts inside the device, hence never attempt to open the device.

Cleaning and Disinfection Guidelines:

Follow CHCP Ref 1303 Infection Prevention and Control Practice Policy

Bags and Straps:

Carry bag and straps are designed for single patient use only and should be discarded when patient therapy is complete.

Carry bag and straps may be cleaned during a single patient treatment as follows:

- Wipe clean using a soft damp cloth dampened with warm water and mild soap solution.
- A soft brush may be used if necessary.
- Wait one minute before wiping clean with a soft cloth dampened with water only.

Battery operation and charging:

To allow the patient greater mobility, the device contains a lithium-ion rechargeable battery that requires a full charge before initial use. A fully charged battery will last between 8 to 12 hours. Disconnect the device from AC power prior to mobile use.

Annual Maintenance:

When the device reached time for annual maintenance check is reached, an annual maintenance notification will display every time the device is powered on.

S&N should be contacted to arrange for the annual maintenance check to be undertaken by:

Email: uk.serviceoperations@smith-nephew.com and request an on-site service, providing details of time and place and pump serial number, Community Nursing Back at Base Admin Team will support with this process.

As part of the annual maintenance check S&N will verify the device is in proper working order and reset the alarm timer. The O-Ring and odour filter should also be replaced at least once per year as part of the annual maintenance check.

S&N are responsible for the servicing / annual maintenance check of the RENASYS units every one year, hence as well as the on the screen display warning it is important to regularly check devices not in use as they are issued with a sticker which holds the following information:

- Serial Number
- Base the device is allocated to
- Date the next annual maintenance check is due

b. Rationale for commencing PICO NPWT

The PICO dressing is advanced wound care technology from S&N which delivers the same level of effective negative pressure as traditional systems, but in a unique pocket-sized, canister-free device. The system's silicone-based, four-layer dressing design manages exudate through simultaneous absorption and evaporation, providing greater comfort, reducing the number of dressing changes, and enabling NPWT to be an option for a wider range of patients in all care settings.

The PICO system may not be appropriate for very large wounds with excessive exudate, in such cases the RENASYS TOUCH should be considered

Accurate and regular re-assessment must be undertaken on the effectiveness of the PICO NPWT use for each individual patient; this must occur at least every 2 weeks.

- **USEFUL CONTACT NUMBERS**

Additional advice from Smith & Nephew clinical support nurses / and or training contact:

Smith & Nephew customer service:

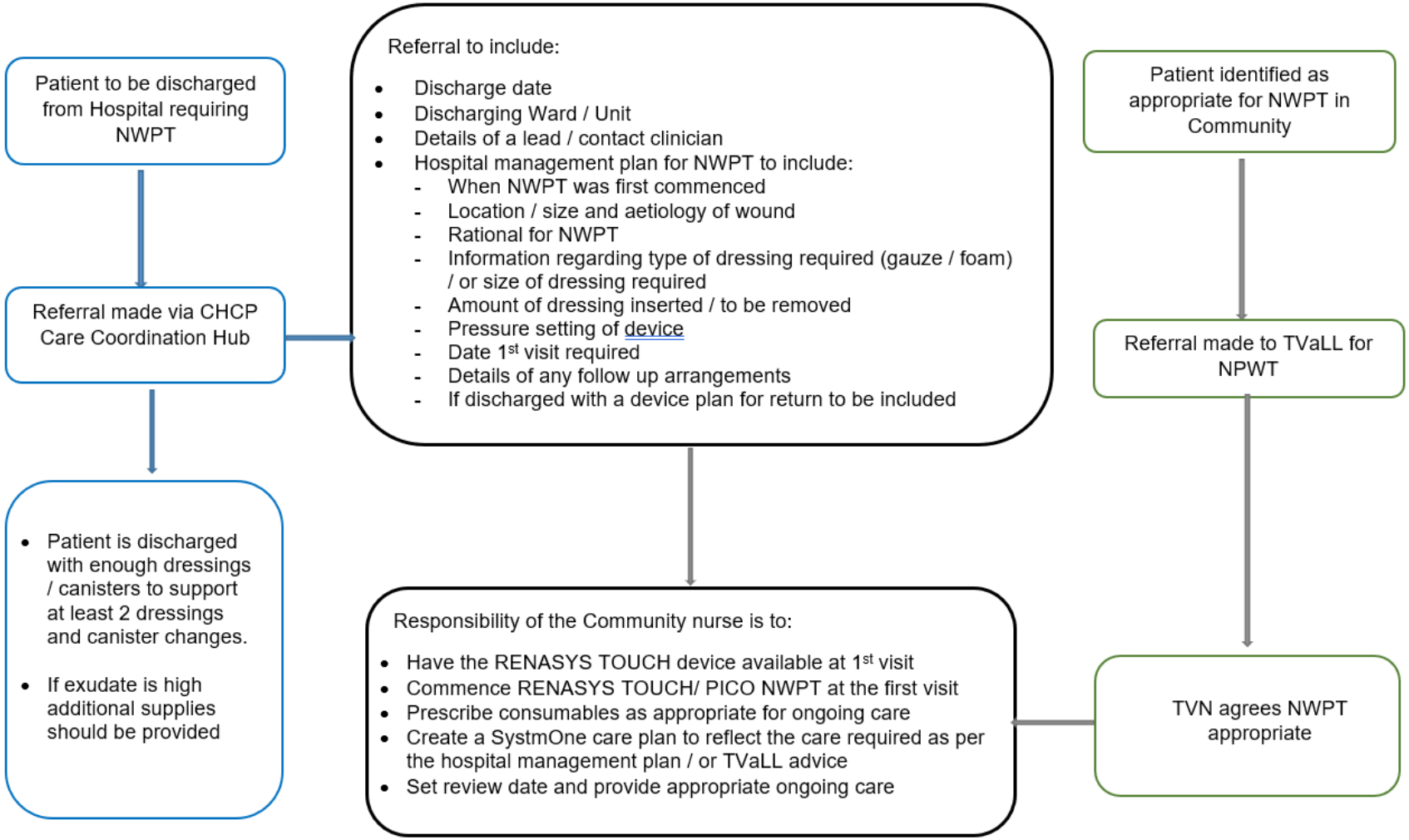
Monday to Thursday 8.00am – 5.30pm: Friday 8.00am – 5.00pm

Freephone number T: 08000 157 573 (Choose option 1)

For NPWT technical support contact the helpline for patients and clinicians: UK: 08009 155394

Hull University Teaching Hospitals (HUTH): 01482 608976 / 01482 608957 / 07824635128

24. INCS – NEGATIVE PRESSURE WOUND THERAPY PATHWAY



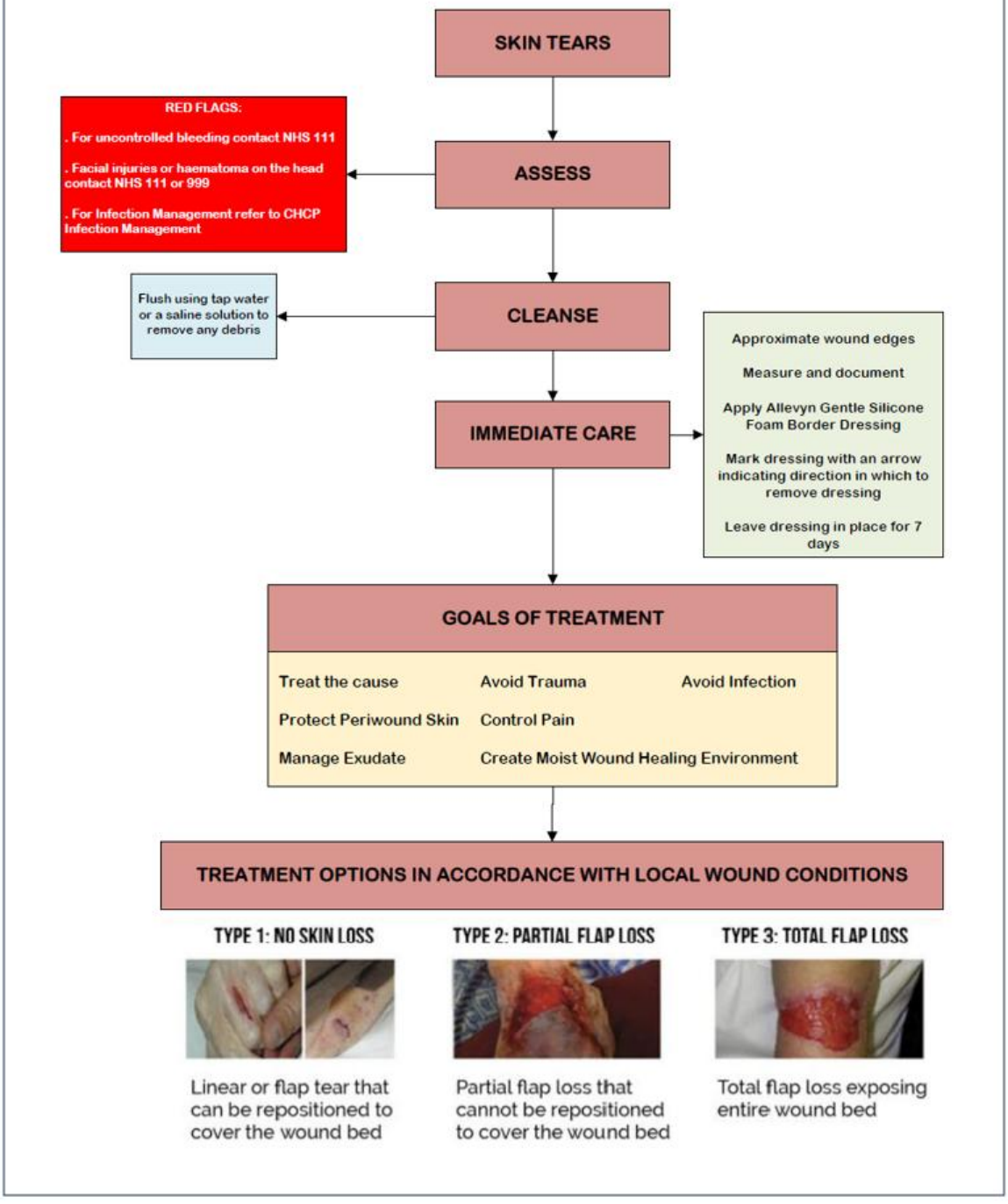
25. SKIN TEAR PATHWAY

Definition of a skin tear: The 2018 International Skin Tear Advisory Panel (ISTAP) definition of a skin tear is a traumatic wound caused by mechanical forces, including the removal of adhesive, and is distinct from a general laceration. **Medical adhesive related skin injury is avoidable harm, their occurrence should be considered as negligence.**

Key points:

- Skin tears are acute wounds that have a high risk of becoming complex chronic wounds
- Skin tears have been reported in the literature to have prevalence rates equal or greater than those of pressure ulcers
- Although commonly associated with the older adult population, skin tears are also common in the critically ill, paediatric and premature neonatal population
- A comprehensive risk assessment should include assessment of the individual's general health (chronic / critical disease, polypharmacy, cognitive, sensory, visual, auditory and nutritional status), mobility (history of falls, impaired mobility, dependent activities and mechanical trauma), and skin (extremes of age, fragile skin and previous skin tears)
- The ISTAP skin classification system should be utilised to ensure a common language for identifying and documenting skin tears

DECISION ALGORITHM



26. INCS – SKIN TEARS IN CARE HOMES

The INCS has worked with the Humber and North Yorkshire Integrated Care Board, and our industry partner Smith and Nephew, to improve first aid care and management of skin tears within residential care homes.

The **Care Home First Aid and Management Process** for skin tears should be followed when appropriate and a dressing applied by the Named First Aider on duty following the guidance provided.

Care Home staff should assess skin tears and escalate any concerns appropriately, this includes making appropriate onward referrals.

Dressings applied to skin tears should be checked daily and left in place for 7 days, if possible, as per the **Care Home First Aid and Management Process**.

Care home guidance for the initial management of Skin Tear wounds:



26.1 Responsibility of the Care Home Staff

Following the identification of a skin tear it is the Care Home staff's responsibility to identify the cause of the skin tear where possible and take appropriate action e.g. use of moving and handling equipment / faulty wheelchairs / unexplained falls etc.

It is the Care Home staff responsibility to make any onward referrals which are necessary e.g. a referral to the falls team may be required or contact with the GP when an unexplained fall has occurred

Documentation:

- When a dressing has been applied to a new skin tear it must be recorded on the resident's Medication Administration Record, (MAR chart),
- The MAR Chart must be signed by the person applying the dressing.
- Full details of the incident must be entered into the 'Accident book'
- A record of the following must be recorded in the Resident's Care Plan:
    - Location and date the new skin tear was detected, this should include update of resident's body map
    - Type of dressing applied
    - An opinion as to what was the probable cause of the new skin tear
    - What further action was taken, when and by whom?
    - The dressing should be observed daily and record made by signing MAR chart and adding observation to patient record
    - Any issues should be fully documented and escalated appropriately
    - If Community Nursing are contacted, record this request in the resident's Care Plan.

Stock Management:

- Skin Tear boxes should be available in each home and checked weekly
- Type of dressing to be applied / used -Allevyn Gentle Border.
- Dressings should be stored in a locked room in a manner as described by the manufacturer, e.g. at room temperature in a horizontal position.
- A record of the stock of dressings must be kept, their expiry date, when they were received and each time a dressing is used must be kept.

26.2 Responsibility of the INCS Clinicians

The INCS clinicians must arrange a visit in a timely manner when concerns are raised by the residential care home staff about a skin tear.

A visit **must** be undertaken within 72 hours after a referral is made by the care home on Day 7, or **sooner** if clinically indicated.

A Care Home Skin Tear Link Nurse must be identified for each home within the community locality to support the **Care Home First Aid and Management Process**.

The INCS are to supply dressings to the Care Home when requested, however the requests for additional dressings should be monitored, and questioned when appropriate, to ensure that care home staff are following the **Care Home First Aid and Management Process** correctly.

27. MEDICAL ADHESIVE RELATED SKIN INJURY (MARSI)

Medical adhesive-related skin injury (MARSI) is an overlooked and underestimated problem. MARSI refers to skin damage caused by the use of products containing a medical adhesive – e.g. tapes, dressings, electrodes, medication patches and wound closure strips. MARSI should be considered as a preventable injury.

Anyone who requires the use of medical adhesives can be affected by a MARSI.

- Extremes of age (neonates/premature infants and older people)
- Patients with stomas
- Patients with PICC lines, central lines, IV cannulas and PEG tubes
- Patients with dermatological conditions (e.g. eczema, dermatitis, chronic exudative ulcers and epidermolysis bullosa)

MARSI is known to have a significant effect on a patient's quality of life resulting in pain, trauma, skin injury and risk of wound infection, chronicity and/or scarring. Increased anxiety, leading to a negative impact on patient wellbeing, and may have a negative impact on patient engagement with treatment, all leading to increased costs to the healthcare provider.

Intrinsic and extrinsic risk factors:

Intrinsic	Extrinsic
• Malnutrition and dehydration • Oedema (swelling) • Increased frailty	• Inappropriate selection of product • Improper application and removal of product • Repeated application and removal of product

• Dry skin — due to harsh skin cleansers, excessive bathing, low humidity, etc	• Prolonged exposure to moisture • Certain medications (e.g. anti-inflammatory agents, anticoagulants, chemotherapeutic agents and long-term corticosteroid use)

Actions:

- Follow assessment guidance including wound imagery
- If necessary, clip or trim any excess hair
- Select appropriate adhesive Consider applying a skin barrier product under medical adhesive
- Check the patient is not allergic to any of the ingredients used in the products
- Consider using dressings that minimise trauma upon removal.
- Apply adhesive dressing/device correctly, do not apply tension or stretch the dressing
- Remove adhesive correctly, consider using a medical adhesive remover
- Loosen edges first and take the time to remove adhesive in the direction of hair growth, close to the surface of the skin and slowly ('low and slow')
- Review adhesive usage: review type and frequency of adhesive dressing or device used and whether continuous use is necessary
- Monitor and re-evaluate: continuously assess the skin's condition, response to adhesives and any signs of irritation or damage
- Provide education: educate patients, caregivers and healthcare professionals about MARSI prevention and proper application and removal techniques

Causes of MARSI Fumarola et al, 2020			
Causes	**Type**	**Action**	**Result**
1 Mechanical forces	1a Skin stripping	Single and/or repeated application/removal of medical adhesive Shear, friction and/or blunt force	superficial removal of one or more layers of epidermal cells Skin may appear shiny and lighter than surrounding areas
	1b Skin tears	Single and/or repeated application/removal of medical adhesive Shear, friction and/or blunt force	Separation of skin layers from epidermis to dermis Can be partial-thickness or full-thickness

	1c Tension blisters	Excessively stretched or tightened adhesive Swelling underneath a correctly applied product	Blistering
2 Dermatitis	2a Non-allergic irritant contact dermatitis	Presence of a chemical or physical irritant that may be exacerbated by occlusion or length of time in contact with skin	Localised inflammation Skin may appear 'red' and swollen Vesicles may form
	2b Allergic dermatitis	Presence of an allergen in the medical adhesive that comes into contact with skin	Local/systemic inflammatory response Skin may appear 'red', inflamed, blistered and itchy
3 Other	3a Folliculitis	Irritation of the hair follicle by adhesive pulling on hair	Local infection, rash, raised bump and pustules

28. TRAINING REQUIREMENTS

Prior to undertaking any care described within this document all clinicians with an identified role and / or responsibility must access this document via MyCompliance.

All clinicians who undertake and deliver any type of wound care must have completed the relevant wound care training and associated competencies relevant to their role.

Wound care training can be accessed via ESR, the training comprises of on-line and face to face sessions. The guidance will be discussed during the relevant face to face training courses.

29. APPROVAL

This guidance has been reviewed and approved by the stakeholders identified on the document checklist submitted to the Safety and Quality Group which reviewed the checklist and ratified this document.

30. MONITORING & COMPLIANCE

All relevant clinical staff to adhere to this guidance.

Any adverse incidents must be reported through the electronic incident reporting system and Comments, compliments, complaints and concerns to be reported through the 4Cs reporting system.

The clinicians nominated supervisor must monitor the staff member's compliance to this guidance and the application of the practices must be discussed and reviewed within clinical supervision.

31. REVIEW

This guidance will be reviewed every 3 years or sooner if prompted by changes in legislation or best practice requirements.

32. REFERENCES & ASSOCIATED DOCUMENTATION

References:

Beeckmann D. & Van Tiggelem H. (2018) International Skin Tear Advisory Panel (ISTAP) Classification System – Skin Integrity Research Group (SKINT) Ghent University

External Publications:

- Best Practice Statement Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones
  Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones - Wounds UK (wounds-uk.com)
- NWCSP Practical Recommendations for the use of Digital Images in Wound Care
  Digital-Images-in-wound-care-17Sept21.pdf (nationalwoundcarestrategy.net)
- International Wound Infection Institute: Wound Infection in Clinical Practice
  Resources - International Wound Infection Institute (woundinfection-institute.com)
- Consensus Document – Wound Exudate effective assessment and management
  WUWHS Consensus Document - Wound Exudate, effective assessment and management - Wounds International
- Hull and East Riding Prescribing Committee (2020)
  Hull and East Riding Prescribing Committee | Hull University Teaching Hospitals NHS Trust (hey.nhs.uk)

Internal documents:

- CHCP REF: 137 Photography Video and Audio Recording Policy

- CHCP REF: 1217 Optimising Care Through Patient Engagement – Integrated Nursing and Conditions Service
- CHCP REF: 980 Clinician to Clinician Referral and Communication within the same SystmOne Unit
- CHCP REF: 1011 Shared Care of Wounds – Integrated Nursing and Conditions Service and Podiatry Service Hull and East Riding
- CHCP REF: 1303 Infection Prevention and Control Practice Policy
- CHCP REF: 936 Wound Management Formulary (Adults) and Guidance Document
- CHCP REF: 1280 Hull and East Riding Lower Limb Pathway - Integrated Nursing and Conditions Service and Podiatry Service Standard Operating Procedure
- CHCP REF: 1031 CHCP Compression Formulary
- CHCP REF: 1181 Use and Management of Tasking within SystmOne Guidance
- CHCP REF: 359 Discharge from Community Services Policy
- CHCP REF: 876 Safeguarding Adults Referral Pathway for CHCP Standard Operating Procedure
- CHCP REF: 459 Mental Capacity Act and Deprivation of Liberty Safeguards Policy

Associated Documents:

Guest JF, Ayoub N, McIlwraith T et al (2017) Health economic burden that different wound types impose on the UK's National Health Service. Int Wound J 14(2): 322-30

Health economic burden that different wound types impose on the UK's National Health Service - PubMed (nih.gov)

- Wounds UK: Leg washing and peri wound care
  Explained: Leg washing and periwound care - Wounds UK (wounds-uk.com)

- National Wound Care Strategy Programme 2020 - National Wound Care Strategy Programme | NWCSP
- NICE (NICE, 2021) Leg ulcer - venous | Health topics A to Z | CKS | NICE

- The International Guideline - Prevention and Treatment of Pressure Ulcers/Injuries - International Guideline
- REF: 375 CHCP CIC Record Keeping (Clinical) Policy
- REF: 34 CHCP Consent to Treatment Policy
- REF: 176 CHCP CIC Supervision Policy
- REF: 494 Safeguarding Adults Policy
- REF: 1292 Patient Safety Incident Response Policy V1
- REF: 241 Patient Safety Incident Reporting V6

33. Related Items

- Related item 1 – CHCP Wound Care Pathways (LES)