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Wound Management induction

Wound Management

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The Complex wound Care Team.

CWC Team:

- Complex wounds which fail to heal / deteriorate despite appropriate management for 4 weeks
- Clinically infected wounds not responding to appropriate treatment
- Complex leg ulcers
- Healed leg ulcer advice
- Wounds which require conservative sharp debridement
- Wounds which require Topical Negative Pressure therapy
- Specialist treatment options
- Cat 3 and above pressure ulcers
- Pressure ulcer prevention advice
- Current/ recurrent cellulitis of the lower limb

Exclusion criteria:

- Patients who do not fall under the care of Adult services
- Patients that do not have a wound or skin condition

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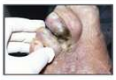
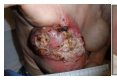
Wound Types

- Pressure ulcers
- Leg ulcers Venous/Arterial
- Chronic wounds
- Acute wounds
- Fungating
- Skin tears
- DFU pods
- Surgical wounds





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Putting the patient at the centre of wound care…

- Holistic approach
- Identifying reasons for non concordance
- Quality of life/ wellbeing
- Joint care planning
- Timely referral
- Social model
- Audit

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WOUND HISTORY

- Cause
- Duration
- Site
- Pain
- Characteristics of the wound for example
- Wound bed –tissue type
- Wound margins
- Surrounding skin
- Exudate
- Infection
- Odour

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FACTORS WHICH AFFECT HEALING

- Co-morbities
- Pressure Ulcer Risk
- Nutritional assessment
- Mobility status
- Continence status
- Advancing age
- Cognitive impairment
- Patient concordance Environment
- Carer input/involvement
- MDT involvement

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TIMES Assessment

T: Tissue, Viable or non Viable

I: Infection, inflammation or Biofilm

M: Moisture Imbalance

E: Edge of the wound: Non-advancing, undermining

S: Surrounding skin

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Assessment

- Use the assessment form in RiO
- Say what you see
- Measure the wound width/length and depth
- Take a photo on a trust phone or Ipad and upload to RiO with a clear name and date. Ensuring that the patient dignity is maintained at all times.
- Document TIMES And finding in RiO note
- Refer on if needed
- Update the risk assessment scores
- Update the care plan.

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Types of Tissues ??

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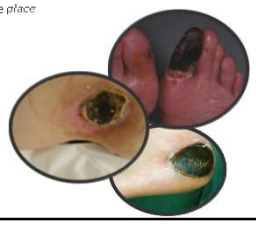
NECROTIC

- A layer of dry hard black eschar which can be of varying depth.
- Can be intact or demarking at the edges of the wound.
- Must be removed before wound healing can take place



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SLOUGHY

- Varies in colour from dark brown to yellow
- Can anything from thick and dry to moist and thin.

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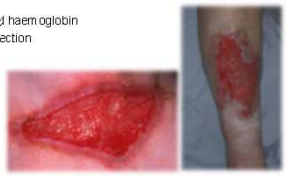
GRANULATION

- Granulating
- Healthy bright red
- Can also be pale red due to lack of O2 and haemoglobin
- Can be dark dull red in the presence of infection



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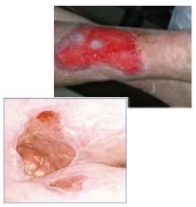
EPITHELIALISING

- Epithelising
- Generally pink smooth tissue
- Can be found around the wound margins
- Also as islands within the wound bed



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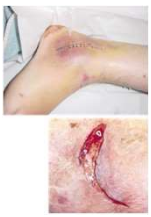
Acute wounds

- Acute wounds
- Defined as 'any wound that heals within the anticipated time frame or up to 6 weeks



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Chronic wounds

- **Chronic wounds:** A wound that does not heal as expected because complexities that lead to stalled healing or even fails to occur, leading to long-term duration

To Hard-to-heal wounds:

- A wound that has failed to respond to an evidence-based standard of care – typically one that exhibits exudate, slough, and an increase in size by the third day of its occurrence. These conditions allow biofilm to develop and thrive, which in turn causes the wound to regress and prevents healing.

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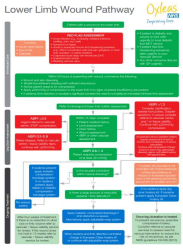
Leg ulcer pathway

Lower Limb Wound Pathway



- Online Leg ulcer course
- 2 day Face to face bandaging session
- Competency sign off

- Next face to face sessions:
- 29.5.25 & 30.5.25
- 20.11.25-21.5.25

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ANTT CLINICAL GUIDELINES

- ANTT clinical guidelines have been formulated by the Association of Safe Aseptic Practice
- (ASAP) to standardise common invasive clinical procedures. These guidelines aim to reduce
- practice variability and to ensure hand decontamination occurs at the appropriate times
- during the ANTT procedure. They also aim to ensure susceptible key-sites and key-parts are
- protected at all times by using a non-touch technique.
- The set of clinical guidelines for hospital/clinic and community-based procedures are
- available as appendices to this policy and are also available to download from the Infection
- Prevention and Control page on the trust intranet. The guidelines include:
- • Community peripheral and central IV therapy
- • Community peripheral venepuncture
- • Community wound care
- • Peripheral cannulation
- • Peripheral and central intravenous therapy
- • Indwelling urinary catheterisation
- • Peripheral venepuncture/phlebotomy
- • Wound care (uncomplicated)

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ANTT Wound care

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ANTT

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Wound Cleansing

- NICE GUIDANCE:

- Prontosan shows promise but there is not enough evidence of its clinical benefit
- 4.1 The committee noted that much of the evidence comparing Prontosan and saline in treating chronic wounds had some concerns or was at high risk of bias. The committee noted that there was very limited evidence for acute wounds. The committee agreed that the technology showed promise based on clinical expert advice, but that this was not supported by the evidence. The committee concluded that there was not enough good quality evidence to make a clear judgement about the benefits of Prontosan compared with saline or water

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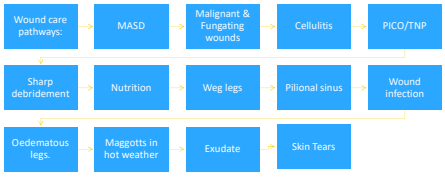
Pathways TBC



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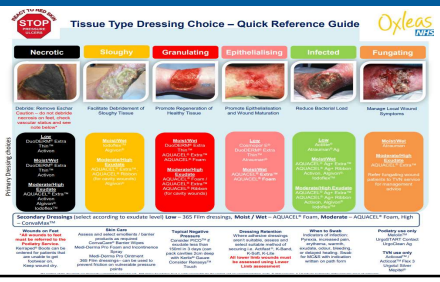
Quick reference guide Greenwich



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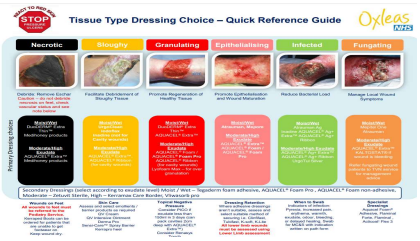
Quick reference guide BEXLEY



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TWPT & PICO

Smith and Nephew Masterclass:

10.6.25

17.9.25

4.12.25

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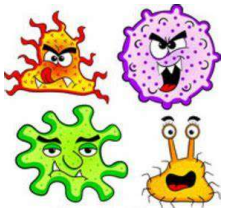
What is Wound Infection?

- Wound infection is a host inflammatory response to interfering microorganisms that either directly or indirectly damage viable host tissue, hence preventing wound healing
- Wound infection in "hard to heal" or chronic wounds manifests as an unclear & prolonged (covert) condition, in which biofilm is the root of the problem



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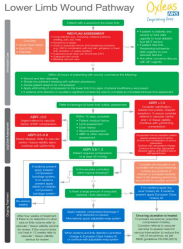
Leg ulcer pathway

Lower Limb Wound Pathway



- Online Leg ulcer course
- Face to face bandaging session
- Competency sign off

- Next face to face sessions:
- 14.3.24
- 9.5.24
- 12.9.24
- 14.11.24

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Prevention of pressure ulcers

The key recommendations within NICE clinical guideline 179- Pressure ulcers: prevention and management of pressure ulcers (NICE April 2014) are in relation to:

- Risk assessment
- Skin assessment
- Care planning
- Repositioning
- Devices for prevention of pressure ulcers
- Healthcare professionals' education and training
- Management of heel pressure ulcers

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Background:

- Despite national and international clinical guidelines, there is currently no up-to-date standardised pathway for implementing these guidelines in England. Consequently, individual health and care organisations develop their own pathways and protocols, which may vary substantially, leading to increased and unnecessary workload and variation in clinical practice.
- The recommendations in the NICE Clinical Guideline: Pressure ulcers: prevention and management and the NICE Quality Standard: Pressure ulcers updated using the EPUAP, NPIAP, PPPIA Pressure Ulcer Guidelines.
- This new guidance replaces the 2018 guidance.

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What's changed?

At present 8 reportable categories of pressure ulcer:

Category 1
Category 2
Category 3
Category 4
DTI
DRPD
MASD
Unstageable

Category 1
Category 2
Category 3
Category 4
Including deteriorations

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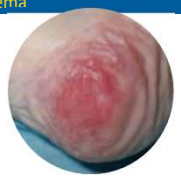
Category 1: Non blanchable Erythema

- Intact skin - In lighter skin tones, this presents as non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching, but its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate "at risk" individuals (a heralding sign of risk)



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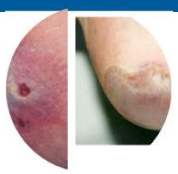
Category 2: Partial Thickness Skin Loss

- Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister or as a shiny or dry shallow ulcer without slough or bruising*. This Category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation



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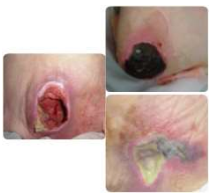
Category 3: Full Thickness Skin Loss

- Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough or necrosis may be present. May include undermining and tunnelling.
- The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. **Bone/tendon is not visible** or directly palpable.



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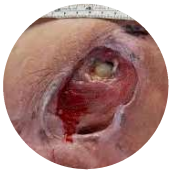
Category 4: Full Thickness Tissue Loss

- Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling.
- The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.



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DTI's/Unstageable

Pressure ulcers where the skin is broken but the wound bed is not visible due to slough or necrosis (formally referred to as '**unstageable**') should initially be recorded as Category 3 pressure ulcers but immediately re-categorised and re-recorded in the patient's records if debridement reveals category 4 pressure ulceration.

Deep tissue injuries (DTIs) should **not be reported** as pressure ulcers unless they result in broken skin or they fail to resolve and it is evident on palpation that there is deep tissue damage present, at which point, they should immediately be categorised and reported.

However, the skin change must be recorded within the clinical record and appropriate preventative care delivered as soon as the damage is noted

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Reverse staging

- This tool cannot be used to 'reverse stage' a pressure ulcer. This means that the scores cannot be counted in reverse to describe a healing pressure ulcer. For example:
- A category 4 pressure ulcer does not become a category 3 as it heals. Instead use descriptions such as: Healing category 4 ulcer

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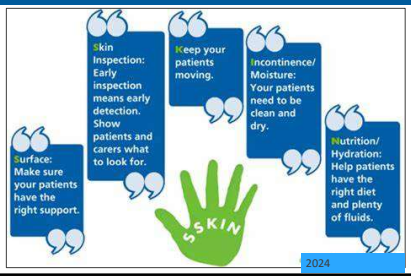

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Datix

Whenever a patient develops a pressure ulcer, this must be reported on **Datix.** The classification is:

Type -Clinical Care
Category -Pressure ulcer *or*
Deterioration of a pressure ulcer

- Category 1
- Category 2
- Category 3
- Category 4
- Sub category-Deterioration of a pressure ulcer

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Duty Of Candour

Duty of candour - volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.

When any pressure ulcer of this category is reported and has developed whilst in Oxleas care (whether newly reported or a deterioration from a lesser category), then the Datix report must show this as a 'moderate harm'. The Team Lead will follow the principles of Trust's 'Being Open and Duty of Candour Policy' and contact the patient, their family and/or carer, to explain that an investigation relating to the development of the pressure ulcer will be undertaken. This process includes a written letter that will include a *"written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the patient safety event, should also be given."* A template letter is available for use and must be sent within ten working days of confirmation of the category of pressure ulcer.

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What to do next for DOC

When completing the Datix for the pressure ulcer you must complete the **whole section** for DOC, otherwise this will breach the trust compliance for DOC.

Send and upload the letter, to Datix and RiO with 10 days of the incident

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DOC letter

Adult Community Health Services

Name
Address

Team address
Tel:
Team email

NHS

Dear

Thank you for speaking with me on the telephone today, as discussed You will be aware that following our visit to you on DATE that we noted you have developed a pressure ulcer (enter the site of the pressure ulcer). We are sorry that this has developed.

During the assessment we discussed ..... (enter in the facts about the SSKIN assessment such as the category/site of pressure ulcer/contributing factors such as equipment, nutrition, continence issues,mobility issues

We also discussed if you would like this information to be shared with your next of kin or family member, you advised.....?

You said that you did/did not understand how the pressure ulcer developed and advised that (developing the pressure ulcer has made you Feel..... Patient experience.....) (How does the patient think the pressure ulcer developed?)

We offered you ..... (enter discussion around equipment advised, was a PUP Useflet given to the patient/relative, you agreed to the care plan discuses/declined to accept equipment/education/advice on repositioning and off loading pressure.

Plan..... (enter the discussion and plan that you have agreed with the patient/relative/carers

As a Trust we are committed to being open with patients and carers when unexpected incidents occur so that we can gain a shared understanding of what happened and if there is anything we can do to prevent such an incident occurring in the future.

As part of the process, we would like to offer you, your carer/family members/friend the opportunity to ask any questions. Please let me know within the next two weeks if you would like to take up this offer and we can arrange a mutually convenient time and place to meet, if it is easier, you can send your questions to me by post or email.

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Mental Capacity Act 2005

The Mental Capacity Act 2005 (the Act) provides the legal framework for individuals over 16 years of age in England and Wales to make legally binding personal decisions as long as they have the mental capacity to do so. The Act also provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.

The five statutory principles are:

Assumption of capacity. Every adult has the right to make their own decisions if they have the capacity to do so. Family carers and healthcare or social care staff must assume that a person has the capacity to make decisions, unless it can be established that the person does not have capacity.

Provide support for decision making. People should receive support to help them make their own decisions. Before concluding that individuals lack capacity to make a particular decision, it is important to take all possible steps to try to help them reach a decision themselves.

Ability to make an unwise decision. People have the right to make decisions that others might think are unwise. A person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision.

Individual's best interests. Any act done for, or any decision made on behalf of, someone who lacks capacity must be in their best interests.

Regard to less restrictive options. Any act done for, or any decision made on behalf of, someone who lacks capacity should be an option that is less restrictive of their basic rights and freedoms – as long as it is still in their best interests.

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Mental Capacity Act 2005

Assessing capacity

The assessment of capacity must be a continuous and ongoing process informed by the principle (see above) that a person is to be assumed to have capacity until it is established otherwise. All professionals involved in the provision of care and treatment must assure themselves either that the person continues to have capacity or that, where they do not, the care and treatment given is necessary and in the person's best interests.

When assessing capacity to consent consideration must be given to people with communication difficulties, for example those whose first language is not English, People with Learning Disabilities, sensory or physical impairments. The Trust may need to provide information in a range of formats, for example, Braille, easy read, large print, interpreters, or translation into a language other than English. Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to decide based solely on their inability to communicate.

A person lacks capacity for a specific decision, at the time it needs to be made, if:

- They are unable to make a specific decision at the time it needs to be made (sometimes called the functional test); and
- This is because of because of an impairment of, or disturbance in the functioning of, the mind or brain (sometimes called the diagnostic test)
- The functional test means that the person is unable to make a decision if they cannot carry out any one of the following
- Understand information about the decision to be made (relevant information);
- Retain the information in their mind long enough to be able to make the decision;
- Use or weigh that information as part of the decision making process;
- Communicate their decision – this could be talking, using sign language or even simple muscle movements such as blinking an eye.
- **A person should not be deemed to be without capacity because they make what seem to be 'unwise' or 'risky' decisions.**

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Useful guides

- Time is pressure booklet
- TIMES quick guide
- PUPS booklet
- QRG
- Leg Ulcer pathway

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Thank you

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