Wound Management - Summary Clinical Guideline

Reference No:CG-T/2023/069

- Staff should undertake and document a full wound assessment within **12 hours** of admission.
- If sepsis is suspected **ALL** dressings should be removed immediately on admission.
- The wound management care pathway (WPH 1697) should be used at RDH and FNCH and the wound assessment form on Meditech V6 activated QHB, SRP & SJCH.
- Aseptic Non-Touch Technique principles are to be maintained when dressing all wounds.
- Wounds should NOT be left exposed.
- Wounds should only be cleansed to remove foreign materials, debris, or bioburden.
- Signs and symptoms of infection should be examined at each dressing change including purulent discharge, erythema, swelling, malodour, and pain. Other covert signs include delayed healing, friable tissue, delay in healing or deterioration in the wound bed. If infection is suspected, follow the wound infection management guidance flowchart in full clinical guideline.
- Wounds should not be swabbed routinely unless there is a history of MRSA.
- Wounds should be swabbed if infection suspected or failing to heal.
- Best practice is that antimicrobial products should only be used if clinical signs and symptoms of infection or biofilm are present.
- Wounds that fail to make progress or deteriorate should initially be discussed with Tissue Viability champion.
- Referral to the Tissue Viability team should be made if wounds continue to deteriorate or fail to heal. Referral should also be made for complex, extensive wounds and those that require specialized therapy such as maggots or Negative Pressure Wound Therapy (NPWT)
- Discharge arrangements should be made for all wound types, with follow up by an appropriate community care provider.

The following actions should be taken according to wound type:

Wound Type	Actions
Pressure ulcer	• Complete datix. • Classify using EPUAP grading system. • Follow preventative measures in pressure ulcer prevention pathway. • Refer to Pressure Ulcer policy. • Tissue Viability team to follow pressure ulcer debridement pathway for all large, complex category 3 and 4 pressure ulcers.
Chronic leg ulcer	• Refer to Vascular Nurse Specialist. • Refer to the leg ulcer pathway within the wound management pathway. • If considered infected, commence the infected leg ulcer pathway.
Closed surgical incisions	• Complete and follow surgical wound care plan, available on Neti under Tissue Viability Care Plans.
Necrotising Fasciitis	• Initial management by surgical team. • Commence pathway for necrotizing fasciitis associated wound management and consider plastics team.
Large open wounds including dehiscence	• Refer to Tissue Viability, via Extramed or Meditech, to assess for Negative Pressure Wound Therapy (NPWT). • If NPWT not appropriate, commence appropriate wound packing regime.
Haematomas	• Refer large haematomas to the Tissue Viability team via Extramed or Meditech. • Follow the pathway for the management of open and closed hematomas.
Skin tears	• Follow the classification of skin tears/avulsion injuries and nursing management pathway.
Fungating/Bleeding wounds	• For fungating wounds follow the pathway for wound management of fungating wounds • For fungating wounds that bleed excessively follow the pathway for the use of Tranexamic acid in bleeding, fungating wounds. • The palliative care team can also be consulted.
Diabetic foot ulcers	• Refer to diabetic foot team on Derby sites, Podiatry on QHB site, and Tissue Viability for Sir Robert Peel hospital and Samuel Johnson hospital
Abscesses	• Please consult general surgical team
Rashes, Cellulitis, suspicious lesions, or erosions	• Please consult dermatology
All the above pathways are within the appendices of the full wound management guideline	