



Care Bundle – Wound Care Guidance

A wound may be defined as a break in the structure of an organ or tissue caused by an external agent; for example, a bruise, cut, or burn (Oxford Living Dictionaries, 2017).

The cost of non-healing wounds in the UK is estimated to be £5.3 billion per year (Guest et al, 2017). Most bacteria enter the wound bed through external contamination from the environment, dressings, the patient's body fluids, or the hands of the patient or health care provider. Healing in acute wounds involves a multitude of processes that occur in a carefully structured and methodical manner. In chronic wounds, healing is often delayed, interrupted or stalled, especially in the inflammatory stage. Matrix metalloproteinase (MMP) activity and pro-inflammatory cytokine levels increase. As a result, exudate levels increase, and slough and necrotic tissue develop in the wound bed (Percival and Suleman, 2015). Infection can be responsible for turning acute wounds into chronic wounds and, if unchecked, has serious consequences such as osteomyelitis, amputation, sepsis, multiple organ failure or death.

A chronic wound is categorised as an area which won't heal and requires management by health professionals. If the quality of wound care can be improved, it is likely that the healthcare spending and patient's quality of life will improve (Adderley, Evans & Coleman, 2017).

Overarching Objective

A reduction in incidence of chronic wounds in patients within CWP West – Physical Health services

This Care Bundle will form part of the trust wide policy for wound care once developed

Care Bundle - Wound Care

Outcome measure	Method	Rationale	Supporting Evidence	Measure	Source of information
<p>1. All patients with a wound referred to District Nurses will have a wound assessment completed.</p>	<p>District Nurses will complete the wound assessment and management plan including photographs and measurements.</p> <p>All new wounds (including traumatic injuries, pressure ulcers Stage 2 and below, Deep Tissue Injuries and moisture lesions) below 20mm in diameter will be assessed without completing a full wound assessment. Staff should record wound size, wound bed appearance, pain and dressing regime in the comment section. If the patient is new, the short version of the universal assessment should be completed. At this point, the patient should be scheduled for a full review and assessment of needs in case the wound has not healed within 5 visits or 2 weeks (whichever comes</p>	<p>The wound assessment provides baseline information to evaluate the effectiveness of care and promotes individualised care, thus ensuring all factors are considered that may affect the healing process. Close observation of wounds ensures any signs of infection are identified early.</p>	<p>The Tissue Viability Society provides expertise in wound management to all healthcare professionals, www.tvs.org.uk</p>	<p>The wound assessment and management plan, including the pain assessment tool, will be completed for each wound where a care plan is required.</p>	<p>Full universal holistic assessment to be completed within 1 week of initial patient contact if the wound dimension is above 20mm.</p> <p>Wound management chart and treatment plan as needed.</p> <p>Pain assessment tool</p> <p>Photograph of wound</p> <p>EMIS information system</p> <p>Braden tool (if high risk – monitor skin integrity).</p>

	<p>first). If they become static or deteriorate, they should be referred to the 'Link Nurse' initially and the Tissue Viability Service if appropriate.</p> <p>If the trauma injury is to the lower leg, they should undergo a full holistic leg ulcer assessment following a period of six weeks from the initial assessment.</p> <p>Following the six week period the frequency of the wound reassessment will be determined by the patient's clinical condition, treatment objectives and effectiveness using the practitioners clinical judgement. Consider taking relevant blood tests at this period to rule out any other factors which may delay wound healing.</p> <p>For all diabetic patients, HbA1C and CRP bloods should be taken to rule out infections. All non-</p>	<p>All diabetic wounds require close monitoring due to the increased complications associated with diabetes.</p>			
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	healing foot wounds should be referred to the diabetic foot clinic. All mobile patients should be referred for heel casting if they have a wound to their heel.				
2. All wound interventions will follow the wound formulary to ensure optimum healing unless otherwise advised by Tissue Viability or other specialist services.	<p>Evaluation of current dressing regime at each visit.</p> <p>If wound fails to heal within the normal healing continuum, the District Nurse should consider contacting the Link Nurse initially or Tissue Viability Team for advice if appropriate.</p>	<p>Appropriate treatment to ensure optimum wound healing.</p> <p>To ensure continuity of dressing across the Trust.</p>	Worldwide Wounds www.worldwidewounds.com	The treatment plan and an explanation of the procedure for wound care is discussed and agreed with the patient.	<p>Wound assessment and management plan</p> <p>Wound treatment plan</p> <p>EMIS information system</p> <p>Wound management formulary (April 2013).</p>
3. All patients' nutritional and hydration status will be assessed at the time of universal holistic assessment.	<p>All patients will be assessed for risk of malnutrition using the Malnutrition Universal Screening Tool (MUST).</p> <p>All patients who score 2 or above in the nutritional assessment of MUST score or who present with nutritional or hydration difficulties will have a nutritional treatment plan put in place.</p>	The "MUST" score is recognised nationally and so will dictate the management of dietary needs	Malnutrition Universal Screening Tool - Bapen and the Malnutrition Advisory agency (2008)	<p>The MUST score will dictate the management of dietary needs:</p> <p>Score 0 - Low risk - repeat screening annually for at risk groups</p> <p>Score 1 - Medium risk - Observe and offer Food First dietary advice and leaflets. If no improvement refer to GP for consideration</p>	<p>The MUST document and the treatment plan should reflect the outcome of assessment</p> <p>EMIS information system</p>

				<p>of oral nutritional supplements or referral to a dietician</p> <p>Score 2+ - High risk - Offer Food First dietary advice and refer to GP for consideration of oral nutritional supplements or referral to a dietician</p> <p>The nutritional assessment should be reviewed at least monthly or if there is any change in patient's condition.</p> <p>The MUST score should not override clinical judgement. See MUST pathways for further information</p>	
<p>4. Incidence of wound infection will be minimised</p>	<p>Follow the policy for Aseptic Non Touch Technique (ANTT) when redressing a wound. (IC8)</p> <p>A wound swab will be taken if clinically indicated.</p> <p>Consider the use of an antimicrobial dressing.</p>	<p>To reduce the risk of cross infection</p>	<p>Infection control Department 2010, Policy for Aseptic Non Touch Technique (ANTT)</p>	<p>The treatment plan and an explanation of the procedure for wound care is discussed and agreed with the patient.</p>	<p>Wound assessment and management plan</p> <p>EMIS information system</p> <p>Policy for Aseptic Non Touch Technique (ANTT).</p>
<p>5. All patients and carers who have capacity will be</p>	<p>Patient's care provision to be discussed with patient/carer as</p>	<p>National guidance to help people make informed decisions</p>	<p>Consent with understanding is given verbally.</p>	<p>The treatment plan and an explanation of the procedure for wound</p>	<p>Wound assessment and management plan</p>

provided with all appropriate information verbally regarding their condition and how they can be involved in treatment. For those patients who are receiving care in their 'best interests', information will be shared with their relatives/carers/GP.	appropriate.	about their health and wellbeing and the treatment options available to them. Ensure professional accountability.		care is discussed and agreed with the patient.	EMIS information system
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REFERENCES

Adderley, U., Evans, K. and Coleman, S. (2017). Reducing variation in chronic wound care. [online] Wounds UK. Available at: http://www.wounds-uk.com/pdf/content_12057.pdf [Accessed 21 Dec. 2017].

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Percival, S.L., & Suleman, L. (2015). Slough and biofilm: removal of barriers to wound healing by desloughing. *Journal of Wound Care* 24(11): 498-510.