Wound Assessment and Management Guideline
# Wound Assessment and Management Guideline

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<tr>
<th>Document Type</th>
<th>Clinical Guideline</th>
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<tr>
<td>Unique Identifier</td>
<td>CL-078</td>
</tr>
<tr>
<td>Document Purpose</td>
<td>To ensure safe practice and maintain core standards of evidence based practice in Wound management</td>
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</tbody>
</table>
| Document Author     | Jackie Stephen-Haynes, Professor and Consultant Nurse in Tissue Viability  
|                     | Rosie Callaghan, Tissue Viability Specialist Nurse      |
| Target Audience     | Worcestershire Health and Care Trust (WHCT) Staff who are involved in any way in wound assessment and management |
| Responsible Group(s)| Any healthcare professional with responsibility for wound assessment and management. |
| Date Ratified       | 8th January 2015                                       |
| Expiry Date         | 8th January 2018                                       |

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Version History

<table>
<thead>
<tr>
<th>Version</th>
<th>Circulation Date</th>
<th>Job Title of Person/Name of Group circulated to</th>
<th>Brief Summary of Change</th>
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<tbody>
<tr>
<td>01</td>
<td>25/11/2014</td>
<td>WHCT Tissue Viability County Team members, WHCT Tissue Viability Link Nurses, Associate Director of Nursing, Director of Quality, Consultant Nurse Infection Prevention and Control, Paediatric Lead, Clinical Services Locality Manager, Practice development and Service Lead- Mental Health, Community Hospital Matron, Clinical Services Operational Lead, Head of Quality Governance</td>
<td>Correction of grammatical errors.</td>
</tr>
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<td>02</td>
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Accessibility

Interpreting and Translation services are provided for Worcestershire Health and Care NHS Trust including:

- Face to face interpreting;
- Instant telephone interpreting;
- Document translation; and
- British Sign Language interpreting.

Please refer to the intranet page: [http://nww.hacw.nhs.uk/a-z/services/translation-services/](http://nww.hacw.nhs.uk/a-z/services/translation-services/) for full details of the service, how to book and associated costs.

Training and Development

Worcestershire Health and Care NHS Trust recognises the importance of ensuring that its workforce has every opportunity to access relevant training. The Trust is committed to the provision of training and development opportunities that are in support of service needs and meet responsibilities for the provision of mandatory and statutory training.

All staff employed by the Trust are required to attend the mandatory and statutory training that is relevant to their role and to ensure they meet their own continuous professional development.
1. **Introduction**
   
a. The effective care and management of individuals with wounds is dependent upon a systematic and holistic approach. It should be based upon the knowledge of anatomy and physiology, wound healing, holistic assessment, specific wound management and appropriate selection of wound management products. For the individual, having a wound may cause them pain, sleeplessness, immobility, depression and isolation. For the health care professional it is essential that they understand the fundamentals necessary to manage the variety of wounds to individuals they care for. Wound care can be the cause of frustration, whilst also a resource burden for the Health Service in terms of time and costs incurred (Palmer 1999, Posnett and Franks 2008). There are reported to be 200,000 individuals in the UK at any one time who are suffering with a chronic wound. The cost to the NHS of caring for these individuals is a conservative estimate of £2.3bn to £3.1bn per year, which is around 3% of total NHS spend. (Posnett and Franks 2008, Posnett et al 2009).
   
   
c. This guideline should be used to guide and direct staff on the evidence based best practice in the management of primary, secondary and tertiary wounds across a primary care setting.
   
d. Where individuals are failing to respond to treatment or their needs are beyond the scope of the clinician, it is advised that a referral is made to the Tissue Viability Service.
   
e. The principles upon which this guideline is based include:
      
i. An individualised holistic patient assessment undertaken and evidence-based treatment plans commenced. These should take into account the wound aetiology, the individuals circumstances and wishes, the overall aims of therapy, the practitioner’s clinical experience, available resources and evidenced research findings.
      
      ii. Those who undertake assessment, planning, implementation and evaluations of care should be trained, educated and competent in wound management.
      
      iii. The individual or their carers, if appropriate, should be informed and involved in the decision making process and consent to treatment.
      
      iv. To ensure continuity, the care should be clearly documented in the individuals records and made accessible to the individual and, where appropriate all those involved in their care.
v A collaborative, multi-disciplinary, inter agency approach should be adopted to address all the needs of the individual where appropriate.

vi, Individuals, staff and carers should have access to the equipment and resources necessary to deliver quality care.

iv Monitoring and development of quality initiatives should be undertaken regularly through a clinical audit process.

2. Competencies required

a. Health professionals must have a sufficient level of knowledge in wound management. They must have achieved the required level of competency to be able to assess and treat patients with a wound, develop their skills to enable the application of new technologies and therapies. Competency based training is available from Worcestershire Health and care Trust. Educational programmes, incorporating internal courses and accredited degree level study. This is available to all staff groups, for further information please contact Tissue Viability.

3. Patients covered

a. This guideline outlines the best practice recommendations to prevent, assess and manage wounds and applies to all individual groups including adults and children. The guideline is to be used by all staff employed across Worcestershire Health and Care Trusts, engaged in the prevention assessment and management of wounds. Whilst not mandatory it is recommended for use by Care Homes and general practice staff across Worcestershire Health Economy.

b. N.B When assessing a child clinicians as well as appropriate consent clinicians must consider, in the first instance consulting with the community children’s nursing team and/or the responsible medical practitioner i.e. GP/hospital consultant.

4. Wound assessment and documentation

a. Wound management practice can vary greatly, therefore, local guidance is required to aid clinical decision-making, standardise documentation and recommend best practice in wound care.

b. This guideline offers practical guidance on the general principles of wound management, to include; describing tissue type, dressing selection, measuring wound size, detecting infection and bacterial sampling.

c. A wound assessment must be completed and documented by a registered practitioner using the approved Worcestershire Health and care trust wound assessment tool (Appendix 1). This should take place during the first contact with the individual and within one week of referral to primary care/ Care home.
d. An individual's ability to heal and the time it takes can vary greatly, and can be influenced by a number of factors. These should be taken into consideration during the assessment (DH 2010a):

i. General physical and psychological health and type and level of concurrent illnesses

ii. Treatment: systemically and locally

iii. Nutritional status

iv. Type of wound, location, depth and extent of damage and type of tissue in wound

v. Wound temperature, moisture level and pH balance

vi. Levels of bacterial colonisation and infection

vii. Blood supply to the wound, peri wound area and oedema of surrounding tissues

viii. Disruption to normal sleep pattern

ix. History of smoking and alcohol consumption

x. Medications that may include; steroids, immune-suppressants, chemotherapy

xi. Environment

e. The Worcestershire Health and Care Trust Wound assessment tool is based upon the TIME framework developed by an International Advisory Board (Falanga 2004). The TIME framework is used to facilitate the assessment of wounds and incorporates assessment and management (Dowsett & Ayello 2004) in relation to the clinical observations and interventions to the cellular level.

\[
\begin{align*}
T &= \text{Tissue non viable or deficient} \\
I &= \text{Infection and/or inflammation, incorporating the infection continuum (Kingsley et al 2004).} \\
M &= \text{Moisture imbalance} \\
E &= \text{Edge of wound, non-advancing or undermined}
\end{align*}
\]

The following information should be documented at the initial assessment:

4.1 Medical history

a. Individuals past and current medical condition and general health

b. Drug history and current prescribed medications, over the counter medicines and alternative therapies
c. Smoking and alcohol history

d. Allergies: including any previous reactions to dressings, topical applications and natural rubber latex

e. Nutrition and hydration level. Weight, height and Body Mass Index (BMI)

f. Mobility

g. Temperature, Pulse and Blood Pressure, blood glucose level, blood results, urinalysis

h. Previous/planned investigations/procedures. For example: venous/arterial duplex, X-rays, surgery

5. Nutritional assessment and support

a. The prevention and treatment of malnutrition requires assessment and the Malnutrition Universal Screening Tool (MUST) should be utilised taking guidance from the MUST guidelines. (BAPEN 2013)

i. All individuals should have a nutritional screen, which proceeds to full assessment if deficit is suspected (NICE 2006, DH 2010e, Elia 2003, Elia and Russell 2009)

ii. Individuals considered as 'malnourished', or 'at risk' of malnutrition should be managed according to local and national guidance (NICE 2006, DH 2010e, Elia 2003, Elia and Russell 2009)

iii. Nutritionally compromised patients who have wounds may have an increased dietary need and a referral to a Dietician should be considered for further assessment, advice and supplementation (NICE 2006, DH 2010e, Elia 2003, Elia & Russell 2009)

iv. Individuals weight, height and body mass index (BMI) should be recorded at initial assessment and then weekly for community hospital inpatients and a minimum of monthly for individuals in the community

6. Psychological and Social Assessment

a. The following aspects should be considered during the individuals assessment (DH 2010a)

i. Stress level, depression, ability to sleep and where the patient sleeps e.g. bed or chair

ii. Ability to understand cause of wound and ability to participate in care

iii. Factors that may affect concordance with treatment. For example: dementia, cognitive impairment, learning difficulties, behavior, lifestyle choices etc.

iv. Drug/Alcohol dependency
v. Occupation, family structure, carers and their ability to assist with care

vi. Detail attitudes and any avoidance of social activities due to general condition and wound

7 Documentation

a. The following information should be documented on the wound assessment tool;
   
i. Biographical data, date and time of assessment
   ii. Type of wound and any underlying aetiology
   iii. Location of the wound on the body
   iv. Allergies
   v. Wound measurements including depth of damage
   vi. Type of tissue in wound bed
   vii. Colour of tissue in the wound bed
   viii. Method and type of debridement, if appropriate
   ix. Amount and colour of exudate
   x. Presence of any odour.
   xi. Condition of surrounding skin and edge of wound
   xii. Presence of oedema/lymphoedema.
   xiii Wound cleaning fluid (if used)
   xiv Presence/signs of infection
   xv Dressing selection and regime
   xvi Forms should be supported with photographs
   xvii Care plans should be individualised and address the factors identified in the holistic assessment

8. Wound Type and Aetiology

a. Wound type and cause should be identified e.g. venous leg ulcer caused by venous hypertension or pressure ulcer caused by pressure/shear/friction etc. Reference should always be made to the appropriate Worcestershire Health and Care Trust guideline. For assessment and management of the diabetic foot please refer to separate trust guidance.
b. Leg ulcers should be assessed using leg ulcer assessment and management guidelines

c. Pressure ulcers should be assessed and treated in accordance with the guidelines for the prevention and management of pressure ulcers

9. Wound Measurements

a. Wound measurements should be recorded on the first assessment and thereafter every four weeks as a minimum. Accurate measurement is an important part of wound assessment and can assist with:

i. Detailing progress or deterioration by comparing dimensions over time

ii. Communication between health professionals

iii. Encourage the individual that healing is progressing

iv. Evidence of skin condition when admitted to, or discharged from the Community Nurse caseload

b. Describe wound depth in terms of the anatomy of the skin and related structures. Use millimeters (mm) or centimeters (cms) to measure undermined tissue with a sterile measure as found in a standard wound dressing pack. The following terms may be useful:

i. **Blisters**: filled with serum or blood or discoloured base

ii. **Abscess**: filled with pus

iii. **Superficial or partial thickness skin loss**: skin loss involving epidermis and/or dermis, with or without undermining of adjacent tissue

iv. **Full thickness skin loss**: damage involving subcutaneous layers, which may expose fat, bone, tendon or joint capsule, with or without undermining of adjacent tissue

v. **Sinus**: a blind ended tract

vi. **Wound Fistulae**: an abnormal passage from an internal organ to the body surface

c. A disposable measuring tape can be used to record length and width in cms. Measure the length of the wound along the vertical axis of the body (from head to foot), and the width along the horizontal axis of the body. A sterile probe should be used to measure the depth of the wound or any undermining or sinus. Use an imaginary clock face to increase accuracy of sinus/undermining position.
10. Wound Photographs
   a. Regular photography of the wound provides a useful visual record.
   b. Criteria for Wound Photography
      i. Obtain written consent (where possible or verbal) from the individual.
      ii. Photograph the wound on initial assessment and repeat every four weeks or more frequently if the wound condition changes rapidly.
      iii. Photographs should be labeled with the individual's NHS number, name, date of birth, date of photo, wound position and the name of the health care professional who has taken the image. Include a ruled measure to give an indication of scale. Secure/upload in the patient’s records in chronological order or print clearly labeled as above.
      iv. All photographs should be clear and in focus with an image of the wound and the wound in context.
      v. Privacy and dignity should be protected and maintained at all times.
      vi. If photographs are used for training purposes confidentiality must be maintained and appropriate level of consent gained.
      vii. Images can only be used for publication with specific consent (individual agreement for photography and release of data for third party use).
      viii. Photographs should not be taken using a non NHS mobile phone and images should be deleted from the digital camera once transferred to their secure documentation system.

11. Type of Wound Tissue
   a. The wound assessment must include a description of the type and amount of tissue present to the wound bed (Ousey & Cook 2012), using the terms epithelialising, granulating, sloughy, necrotic, or non-healing. Different tissue types can exist in the wound at the same time and should be recorded as an estimated percentage of the whole wound e.g. granulation tissue 80% and sloughy tissue 20%. This allows comparison over time. Percentages are used as a guide only and do not need to be precise.
   b. Necrotic tissue may appear black, hard, dry and leathery or grey in colour and usually indicates devitalised tissue. Assess the patient’s circulation to the affected area before deciding on method of debridement. If digits or heels are necrotic establish the patient’s vascular status using a Doppler or refer for specialist vascular assessment. These wounds should be kept dry until circulation is established.
c. Sloughy tissue is also devitalized and includes a build up of dead white cells and may appear yellow or a waxy white in colour. It may appear wet or dry and is usually attached to the wound base (Ousey & Cook 2012)

d. Infected tissue or any associated cellulitis may appear red in colour, which extends beyond the wound margins and periwound edge. If this is associated with any clinical signs and symptoms of infection then systemic antibiotics are indicated with local wound management to control odour, pain and exudate (EWMA 2004, EWMA 2008, DH 2010a). Chronic wounds are often colonised with bacteria therefore diagnosis of infection should not be made solely on the basis of a microbiology swab result. Care should be taken with individuals that have conditions such as diabetes or are immuno-suppressed as they may not exhibit any signs of infection

e. Granulating tissue appears red (strawberry jam in colour and appearance) with small mounds caused by growth of capillary loops and should be protected

f. Epithelialising tissue appears white, pink or blue/mauve in colour. This tissue should be kept warm (body temperature) and moist to facilitate epithelial growth and mitotic cell division (Winter 1962, Hinman and Maibach 1963)

g. Wound colour is related to tissue type and can enhance description of wound status

12. Debridement

a. Debridement is the removal of necrotic, devitalised, sloughy, infected tissue, or foreign bodies from a wound (EWMA 2008, Gray et al 2011, Ousey & Cook 2012). The body can debride itself by a natural process called autolysis; however, this may take time if large amounts of slough are present. Slough can provide an environment for bacteria to thrive, increasing the risk of infection. Debridement is recommended as a principle of wound management (EWMA 2008, Gray et al 2011)

b. There are a number of different methods to facilitate wound debridement.

i. Autolytic debridement: where the body naturally removes the devitalised tissue. This process can be enhanced and encouraged by the use of dressings such as hydrogels, hydrocolloids or capillary action dressings, alginates or foam wound dressings

ii. Bio-surgery: sterile larvae (maggots)

iii. Sharp debridement: using a sterile blade, scalpel or scissors. This should only be undertaken by a healthcare professional with specific training and who has achieved the appropriate level of competence.

iv. Surgical debridement: used when there is an urgent clinical need to remove or release devitalised tissue and when fast debridement would speed the individual's recovery. Referral should be made to an appropriate consultant surgeon via the GP
c. When deciding whether or not to debride a wound or which method to choose, the clinician should consider the following:

i. The environment

ii. The condition of the individual and their wound

iii. The condition of the surrounding skin

iv. The quality and strength of the underlying blood supply

v. Any risk of an adverse incident

vi. The preference of the individual with a wound

vii. Pain and tolerance level

viii. Equipment and the availability of wound management products

ix. The overall treatment goals (EWMA 2008)

13. Wound Exudate

a. Exudate is the fluid produced as a result of wounding. It will vary in volume, consistency and biochemical composition and may be either beneficial or harmful to underlying tissues and surrounding skin (WUWHS 2007). Some studies indicate that exudate is beneficial to healing acute or superficial wounds while others have found that chronic wound exudate contains enzymes that disrupt healing by degrading the extra-cellular matrix and excoriate surrounding skin. Quantifying the volume of wound exudate can be difficult. This should be recorded as none, low moderate, high. These terms are subjective but can be qualified by using the dressing to record exudates levels, strike through and/or wear time. The colour, viscosity or change in the wound exudate should be noted. The presence of any surrounding oedema/lymphedema should also be documented.

b. Exudate as defined by its colour:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Possible cause</th>
</tr>
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<tbody>
<tr>
<td>Clear, amber</td>
<td>Serous exudate, often considered ‘normal’ but may be associated with infection by fibrinolysin-producing bacteria such as <em>staphylococcus aureus</em> may also be due to fluid from a urinary or lymphatic fistula/leak.</td>
</tr>
<tr>
<td>Cloudy, milky or creamy</td>
<td>May indicate the presence of fibrin strands (fibrinous exudate – the response to inflammation) or infection (purulent exudate containing white cells and bacteria).</td>
</tr>
<tr>
<td>Pink or Red</td>
<td>Due to the presence of red blood cells and indicating capillary damage (sanguineous or hemorrhagic exudate).</td>
</tr>
<tr>
<td>Green</td>
<td>May be indicative of bacterial infection, e.g. <em>pseudomonas aeruginosa</em>.</td>
</tr>
<tr>
<td>Yellow or</td>
<td>May be due to the presence of wound slough or material from</td>
</tr>
</tbody>
</table>
brown an enteric or urinary fistula.
Grey or blue May be related to the use of silver dressings.
N.B Some medications are known to discolour urine and consideration could be
given to drugs as a cause of exudate discolouration when all other causes have
been excluded.

c. Exudate as defined by its consistency:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Possible cause</th>
</tr>
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<tbody>
<tr>
<td>High viscosity (thick, often sticky)</td>
<td>High protein content due to: Infection, inflammatory response, Necrotic material, Enteric fistula, Residue from some types of dressings or topical preparations.</td>
</tr>
<tr>
<td>Low viscosity (thin, ‘runny’)</td>
<td>Low protein content due to: venous or congestive cardiac disease, malnutrition.</td>
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</tbody>
</table>

(WUWHS 2007)

d. Chronic wound management techniques and dressings are based on the principle of moisture balance (EWMA 2008, WUWHS 2007, and Cowan 2014). In general this means that:

i. Drier wounds, (except those with poor circulation), should be moistened with dressings that hydrate tissue, e.g. hydrogels, hydrocolloid sheets and pastes

ii. Wounds with excess exudate require dressings that absorb or control fluid, e.g. alginates, gelling fibers, capillary action, foams; negative pressure wound therapy (NPWT), compression bandages and hosiery. Also consider the frequency of dressing changes to minimize any further skin damage.

iii. Surrounding intact skin should be protected from exudate with the use of barrier films and creams to prevent excoriation.

iv. Dressings should be selected from the Worcestershire Wound Management Formulary

14. Wound cleansing

a. Routine cleansing of clean granulating wounds with the aim of bacterial removal has been proven to be ineffective (EWMA 2008, WUWHS 2007, Lloyd-Jones 2012, Davies 1999, Lindsey 2007).

b. The rationale to cleanse wounds should include: Removal of debris, (e.g. foreign bodies, dressing residue and devitalised tissue), exudate from the surrounding skin and to refresh the individual. Chronic wounds may be cleansed with tap water, or water which is suitable for drinking (WUWHS 2008, Griffiths et al 2001, and Fernandez et al 2010). Showering/bathing with these wound types is acceptable.
c. Use minimal mechanical force when cleansing or irrigating the wound.

d. Irrigation can be useful for cleaning of a cavity ulcer

e. Appliances used (e.g. bath, shower, bucket or bowl etc.) should be cleaned before and after use in accordance with the infection prevention and control guidance. If a bucket is used it should be lined with a new clinical waste bag or bin liner and the bucket should be kept solely for that specific use and individual, appropriate polythene bags can be obtained from NHS Supply Chain

f. Tap water is not recommended for wounds that can be probed to bone, for those that are immuno-compromised and where the safety of the tap water cannot be assured.

g. Any cleansing solution should be warmed prior to use

15. Infection control principles in relation to wound care

a. When carrying out any wound care intervention the clinician should:
   i. Be familiar with Worcestershire Health and Care Trust Infection prevention and control policies and guidelines
   ii. Assess the risk of infection and cross infection and plan care accordingly
   iii. Maintain hand hygiene and use standard precautions
   iv. Use non-woven sterile swabs if cleansing the wound to reduce fiber shedding (cotton wool is not indicated for use)
   v. Use a non-touch technique, gloved fingers should not touch the wound surface (Dougherty and Lister 2011)
   vi Equipment used should be in accordance with trust and manufacturer guidance eg; forceps, scissors, dressings. Single item products should not be reused (MHRA 2013)
   vii Unused part dressings must not be kept for use at the next dressing change or used on other individuals with a wound

16. Topical Antimicrobial/Antiseptic Cleansing Agents

a. Antiseptic solutions (e.g. hypochlorite’s, EUSOL, chlorhexidine and betadine iodine) should not be used for routine wound cleansing as these can cause pain and reduce the proliferation of macrophages and lymphocytes essential to the wound healing process (Naylor et al 2001).
17. Potassium Permanganate

a. The product license for Potassium permanganate is for the treatment of weeping or varicose eczema (Leppard and Ashton 1998, BNF 2014) and is not a wound management product. It should be diluted in lukewarm water to a concentration of 1:10,000 and used as a soak for no more than 20 minutes daily and for a maximum of two weeks (EWMA 2006). The solution stains skin and nails dark brown and can cause skin irritation. It has the potential risk of toxicity if used on large areas over a long period of time (EWMA 2006). This product is not recommended for use across Worcestershire Health and Care Trust. Any individual prescribed for Potassium permanganate should have the treatment rationale confirmed by the prescriber prior to the commencement of treatment and should be regularly reviewed.

18. Wound Infection

a. All chronic wounds will contain bacteria, but not all are infected. Routine swabbing for Microscopy, culture and sensitivity is not required and an unnecessary expense (EWMA 2004). Infection is the result of a complex interaction between the host, organism, wound environment and therapeutic interventions. This is complicated by bacterial virulence (EWMA 2005, EWMA 2006). Identifying wound infection should be viewed as a clinical skill which can be supported by laboratory findings when necessary. A thorough assessment of the individual and their wound is required prior to diagnosis.

b. Observations should be made for:

i. Abscess, cellulitis, an increase in the white blood cell count

ii. Increased wound exudate; serous, seropurulent, haemopurulent, purulent wound fluid

iii. Individual with a wound feels unwell with possible pyrexia

iv. Increased heat production, redness and swelling (cellulitis) to the peri wound

v. Delayed healing or wound breakdown, discoloration of wound and surrounding skin

vi. Granulation tissue that is friable and bleeds easily

vii. Increased, unexpected or a change in the individuals pain experience

viii. Pocketing to the wound bed

ix. Bridging of tissue between cavities

x. Change in wound odour/Malodour
c. NB: The wound aetiology and bacteria will define both the signs and symptoms that are present to the wound and individual. Not all signs or symptoms will be present in all cases. This may be due to the type of bacteria, auto-immune impairment, diabetes mellitus, and quality of vascular supply or the use of medications such as steroids, anti-inflammatory, immune-suppressants and chemotherapy (EWMA 2004). Individuals with wounds that exhibit a spreading cellulitis and/or systemic infection should have a wound swab and blood cultures taken, this is to identify the offending organism and an assessment of the differential diagnosis. The individual should be treated with antibiotics which in some cases may be given intravenously dependent on the severity of the host response. Topical treatment should be considered in accordance with the Wound care formulary.

19 Taking a Wound Swab for microscopy

a. Cleanse the surface of the wound to remove surface bacteria

b. Rub the tip of the swab across the wound in a ‘zig zag’ manner and at the same time rotate the swab handle (Kelly 2003, Levine et al 1976)

c. Complete the microscopy form with sufficient information for laboratory staff and microbiologist to know from where and why the swab was taken and any additional supporting information such as current antimicrobial therapy

d. NB: Systemic treatment for wound infection should not be delayed while waiting for swab results. Topical antibiotics are not generally used in wound care due to the risks of resistance (DH 2010b). Follow microbiology/pharmaceutical guidance on the systemic treatment of wound infection

20 Wound Dressing Selection

a. Choice of dressing, method of debridement and the optimum wound healing environment should be created using modern dressings (NICE 2001). A different treatment or dressing type may be required to meet the needs of the individual with a wound at their different stages of healing. Wound management selection must be made on an individual basis after a thorough assessment and following discussion with the individual with the wound.

b. The following characteristics should be considered in dressing selection (Cowan 2014):

i. The ability to prevent penetration of capillary loops into the dressing material avoiding adherence

ii. Be hypoallergenic, sterile and have a long shelf life
iii. Be cost effective with a supporting evidence base
iv. Maintain high humidity and an optimum pH at the wound / dressing interface
v. Remove excess exudate, toxic components and not release toxic chemicals, particles or fibres into the wound bed
vi. Allow gaseous exchange at the wound interface
vii. Provide thermal insulation to encourage mitotic cell division
viii. Be impermeable to bacteria
ix. Be free from particulate and toxic contaminants
x. Allow removal without causing additional trauma and be comfortable to the individual to wear
xi. Ensure the wound remains moist with exudate but not macerated (except wounds with no underlying circulation, which must be kept dry)

21. Wound re-assessment

a. It is essential for all health care professionals to set a deadline. This should be undertaken according to individual need, and always undertaken if the patient’s condition changes. Maximum period before re-assessment is 1 month but may be as little as daily. Frequency should be based on vulnerability and condition of the patient.

b. Any alterations to the treatment regime will be discussed with the patient, Healthcare Professional and the rationale for this will be documented

   i. Rationale:-
   
   ii. Monitor appropriateness of current treatment

   iii. Respond to any changes as a result of the re assessment

22. Pain assessment

a. Consideration should be given to pain in relation to wound management and a pain assessment undertaken in patients identified during screening. When a patient has pain the pain assessment tool should be completed. (Appendix 2). The International Association for the Study of Pain (IASP 2014) defines pain as: “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage”.


b. An individual’s experience of pain is unique, it is complex and influenced by many factors. A systematic and rational approach to the assessment and management of pain is essential. This is a specific role of the clinician and should be documented as with other aspects of the assessment (NMC 2009). A number of publications have been published since 2000 including: Pain at wound dressing change, (EWMA 2002) and, Minimising pain at wound dressing-related procedures (WUWHS 2004) which suggests that we need to consider that all wounds are painful, that over time wounds may become painful, acknowledge that the surrounding skin can become sensitive and painful, the lightest touch can be intensely painful and that the healthcare professional should know when to refer for specialist assessment.

23. Surgical/plastics referral

a. Referral for surgical/plastics opinion should be made based on the needs of the individual, their health status, their risk (anaesthetic and surgical intervention), the assessment of psychosocial factors regarding the risk of recurrence, the failure of previous conservative treatment and the positive effect of surgical intervention (NICE 2008).

24. Individual Centred self care

a. Individuals and carers should be made aware of their wound and the potential risk and/or complications. Treatment and care should take into account the individual needs and preferences, carers and relatives should have the opportunity to be involved in discussions where appropriate.

i. Individuals should be encouraged to maintain their independence and attend appointments at clinics, GP surgeries and wound healing clinics

ii. Individuals and carers who are willing, competent and able to should be taught how to undertake dressing changes based on professional advice

25. Transfer of individuals with a wound between care settings

a. All individuals with wounds who are transferred to any other care setting must have their treatment regime communicated to the appropriate health care professional prior to discharge. Referral and transfer information (Appendix 4)
26. **Clinical audit monitoring tool**

<table>
<thead>
<tr>
<th>Standards</th>
<th>%</th>
<th>Clinical exceptions</th>
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<tbody>
<tr>
<td>Holistic wound assessment will be carried out within the specified time</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>scale</td>
<td></td>
<td></td>
</tr>
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<td>All individuals will have their wound size documented within the specified</td>
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<td></td>
</tr>
<tr>
<td>time scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management will be in accordance with wound assessment and the wound</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>care formulary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regime of care will be communicated on transfer of care setting</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

How will monitoring be carried out? Ongoing clinical audit, led by Tissue Viability Services within Worcestershire Health and Care Trust

27. **References**


Gray, D. Chadwick, P. Acton, C et al (2011) Consensus guidance for the use of debridement techniques in the UK. Wounds UK. (7) 1 p77-84


Lindsay, E. (2007) to wash or not to wash: what is the solution for chronic leg ulcers? Wound essentials; 2: 74-83

Lloyd-Jones, M. (2012) Wound cleansing: has it become a ritual or is it a necessity? Wound care S22-26, December


NMC (2009) Nursing and midwifery code of professional conduct. London


## Appendix 1 WOUND ASSESSMENT AND TREATMENT CHART

**TYPE OF WOUND** (Please circle)

- Pressure Ulcer
- Leg Ulcer (*)
- Diabetic Ulcer
- Surgical
- Fungating
- Traumatic
- Burn
- Skin Tear
- Other: ___________________

(*) NB Alternative Assessment Chart

---

**Position of Wound(s)** (plot on diagram on reverse):

**Length of time wound(s) present:** ________________________________

---

**General Assessment**

**Waterlow Score:**

**Urinalysis:**

**Hb:**

**Capillary Blood Glucose**

**Platelets:**

**FBC/Serum Protein:**

**Other:**

**Factors which may delay wound healing** (Please circle)

- Diabetes
- Anaemia
- Infection
- Poor Nutritional status
- Under/Over weight
- Immobility
- Smoking
- Jaundice
- Non-concordance
- Medication
- Other:

**Health Promotional literature provided:** YES/NO

**Known reaction to treatment products** YES/NO

Please state __________________________ Refer to: __________________________

**Allergies:** __________________________ Refer to: __________________________

**SIGNATURE:** __________________________ **Date:** __________________________ **Time** __________________________

---

Wound Assessment and Management Guidelines
### Wound Dimensions (cm)
1. Length
2. Width
3. Depth
4. Tracing / photo no

### Tissue - Wound Appearance (Colour copy in Wound Management Formulary). Specify %
1. Epithelialisation (Pink)
2. Granulating (Red)
3. Sloughy (Yellow)
4. Infected (Green)
5. Necrotic (Black)
6. Over granulation
7. Unhealthy granulation

### Infection
1. Colonised
2. Critically Colonised
3. Local Infection
4. Systemic Infection

Swab sent
Organism isolated
Anti-microbial therapy

### Managing Exudate
1. Colour
2. Amount (specify dressing wear time)
3. Type
4. Odour

### Edge of Wound: Cliff/flat/rolled
Surrounding Skin
1. Erythema (distance)
2. Blanching/non-blanching
3. Excoriated
4. Macerated
5. Dry / scaly
6. Oedema
7. Healthy
8. Skin stripping from adhesive dressing removal

### Pain Assessment
Yes – specific pain assessment chart
No

**Signature:**

**Date & time:**
### TREATMENT OBJECTIVE

1. Promote Epithelialisation
2. Promote Wound Granulation
3. Remove Slough/debridement
4. Manage/Remove Infection/Odour
5. Promote Wound Maturation
6. Manage exudate
7. Manage pain
8. Palliative Care
9. Prevent skin stripping

### EVALUATION

<table>
<thead>
<tr>
<th>Objective (insert number of evaluation above)</th>
<th></th>
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<tr>
<td>Wound cleansing method</td>
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<tr>
<td>Dressing Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type and size of dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instructions for application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emollients, Skin Cream</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments (i.e. allergies to dressings)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date, time &amp; Signature</td>
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<tr>
<td>Print Name</td>
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</table>
APPENDIX 2 - WOUND ASSESSMENT AND TREATMENT CHART

PODIATRY

Type of wound
Pressure Ulcer  Neuropathic Ulcer  Ischaemic ulcer  Surgical
Traumatic  Gout  Fissure
Other:

Position of Wound(s):

Length of time wound(s) present:

Consultant/GP:

General Assessment

Waterlow Risk  Texas  Pressure Ulcer Grade  FBC/Serum Protein  HbA1C
ESR/CRP  Doppler ultrasound  Monofilament  Other:

Factors which may delay wound healing
Diabetes  Anaemia  Infection  Alcohol Smoking  Poor Nutritional status  Under/Over weight
Immobility  Foot deformity  Footwear  Non-concordance  Medication  Rheumatology  Other:

Investigations
x ray  Other:

Refer to
Tissue Viability  Orthopaedics  Diabetologist  Vascular  Dermatology  GP  Orthotics  Other:

Allergies:

Health Promotional literature:
Care of foot ulcer  High risk foot  Nail surgery  Pressure ulcer  Skincare

Signature: ___________________________  print name: ___________________________  Date: ___________________________

Wound Assessment and Management Guidelines
Location of Wound

Photograph taken YES/NO

Consent obtained YES/NO

Wound No: _______  Diagram:  
Date: __________

Wound No: _______  Diagram:  
Date: __________

Wound No: _______  Diagram:  
Date: __________

Patient Name..............................................

Patient No..............................................
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<th>Evaluation</th>
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<th>Evaluation</th>
<th>Evaluation</th>
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<td><strong>Wound Dimensions (cm)</strong></td>
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<tr>
<td>4. Length</td>
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<tr>
<td>5. Width</td>
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<tr>
<td>6. Depth</td>
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<td>7. Probe to bone</td>
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<td><strong>Tissue - Wound Appearance Specify %</strong></td>
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<td>1. Epithelialisation (Pink)</td>
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<tr>
<td>2. Granulating (Red)</td>
<td></td>
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<td>3. Sloughy (Yellow)</td>
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<td>4. Infected (Green)</td>
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<td>5. Necrotic (Black)</td>
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<td>7. Unhealthy granulation</td>
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<td>8. Systemic Infection</td>
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<tr>
<td>Swab sent</td>
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<td>Organism isolated</td>
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<td><strong>Managing Exudate</strong></td>
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<td>1. Colour</td>
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<td>3. Type</td>
<td></td>
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<tr>
<td>4. Odour</td>
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<td>Surroading Skin</td>
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<td>9. Erythema (distance)</td>
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<td>10. Blanching/non-blanching</td>
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<td>13. Dry / scaly</td>
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<td>15. Healthy</td>
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<td>16. Undermining</td>
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<td>17. Callous</td>
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<tr>
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**Podiatrists Signature**

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**Patient Name**

**Patient No.**

Wound Assessment and Management Guidelines
## Treatment Objective

1. Promote Epithelialisation  
2. Promote Wound Granulation  
3. Remove Slough/debridement  
4. Manage/Remove Infection/Odour  
5. Promote Wound Maturation  
6. Manage exudate  
7. Manage pain  
8. Palliative Care  
9. Offload

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## Appendix 3 - Pain assessment

### Timing

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<th>Do You Have Pain?</th>
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<th>Comments</th>
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<td>At Night</td>
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<td>Rest</td>
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<td>Movement</td>
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### Quality

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<th>Is Your Pain:</th>
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<th>No</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Stabbing</td>
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<td></td>
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</tr>
<tr>
<td>Burning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comes &amp; Goes</td>
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</tr>
<tr>
<td>Continuous</td>
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<tr>
<td>Does it move</td>
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### Relieving Factors

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<th>Is There Anything That Gives You Relief:</th>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
<th>Comments</th>
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</thead>
</table>

### Duration

- < 2 Weeks
- 1 – 2 Months
- 2 – 4 Months
- > 4 Months

Signature: ______________ Date: ____________________ Time: ______________

### PAIN RATING SCORE

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<th>Description</th>
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<td>0</td>
<td>SLIGHT, BUT NOT DISTRESSING</td>
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<tr>
<td>1</td>
<td>MODERATE, ANALGESIA REQUIRED</td>
</tr>
<tr>
<td>2</td>
<td>BAD ENOUGH TO DISTURB SLEEP</td>
</tr>
<tr>
<td>3</td>
<td>SEVERE UNABLE TO COPE</td>
</tr>
</tbody>
</table>
Appendix 4

Referral and transfer form to be used for all referrals to Tissue Viability

Name
Address (Please include Key code if applicable)
Telephone number
DOB
GP (Name, Address and telephone number)
Next of Kin (Include telephone number)
Date of transfer (include where from and where to)
Referring Health Care Professional
Relevant medical history
Nutritional status
Location of wound
Aetiology of the wound
Wound classification
Wound swab taken and results
Size of wound
Peri - wound skin condition
General skin condition
Pain and pain management
Allergies
Previous dressings used
Current treatment
Frequency of dressing change
Date and time of completion
Equality Analysis

<table>
<thead>
<tr>
<th>Title of Policy/Function</th>
<th>New</th>
<th>Existing/Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline for Wound management</td>
<td></td>
<td>Revised</td>
</tr>
</tbody>
</table>

Short description of Policy/Function (aims and objectives, is the policy/function aimed at a particular group if so what is the intended benefit):

This document has been produced to support Registered Healthcare Professionals working within Worcestershire Health & Care NHS Trust; it should be referred to for the recommended best practice for managing a patient with a wound.

The guideline will reduce potential risk and harm to patients with a wound.

The role of the Registered Health Care Professional will be defined in this guideline, outlining their responsibility and accountability for the patients with a wound.

<table>
<thead>
<tr>
<th>Name of Lead/Author(s)</th>
<th>Job Title</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Jackie Stephen-Haynes</td>
<td>Professor &amp; Consultant Tissue Viability Nurse</td>
<td><a href="mailto:j.stephen-haynes@nhs.net">j.stephen-haynes@nhs.net</a> 07775 792775</td>
</tr>
<tr>
<td>Rosie Callaghan</td>
<td>Tissue Viability Specialist Nurse</td>
<td><a href="mailto:r.callaghan@nhs.net">r.callaghan@nhs.net</a> 07717 543046</td>
</tr>
<tr>
<td>Monique Maries</td>
<td>Tissue Viability Nurse</td>
<td><a href="mailto:Monique.maries@nhs.net">Monique.maries@nhs.net</a></td>
</tr>
<tr>
<td>Suzy Tandler</td>
<td>Tissue Viability Nurse</td>
<td><a href="mailto:Suzanne.tandler@nhs.net">Suzanne.tandler@nhs.net</a></td>
</tr>
</tbody>
</table>

When the policy/function involves patients/staff/partners/stakeholders etc. please where possible include them in the Equality Analysis to demonstrate openness, transparency and inclusion and particularly by those who this policy/function is most likely to have impact.

Does this Policy/Function have any potential or actual impact that is positive (+), neutral (N) or negative (-) impact on the following protected characteristics please indicate:

<table>
<thead>
<tr>
<th>+</th>
<th>N</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please provide a rational/justification for each of the following regardless of impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>N</td>
<td>This policy encompasses all ages.</td>
</tr>
<tr>
<td>Disability</td>
<td>N</td>
<td>Reasonable and appropriate adjustments will be made to ensure that any person who has a disability/learning disabilities will not be discriminated against as will no person with mental health issues. Equally, consideration for careers and family members who have either a disability/learning disability or mental health issue to avoid associative discrimination.</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>N</td>
<td>This policy is relevant to any persons who are undertaking or have undertaken gender reassignment in the same way as those who have not undertaken or who are undertaking gender reassignment.</td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity</td>
<td>N</td>
<td>This policy is relevant to any person who may be pregnant or receiving post natal care. It is not relevant to the unborn child.</td>
</tr>
</tbody>
</table>
### Race
This policy is relevant to any race.

### Religion & Belief
All patients will be treated equally; this is regardless of their religion or belief.

### Sex
This policy is relevant to any gender and applies to both sexes equally.

### Sexual orientation
This policy is relevant to any sexual orientation/preference.

### Marriage & Civil Partnership
This policy is relevant to marriage and civil partnership equally.

**Other Groups who could experience inequality**, e.g. carers, homeless, travelling communities, unemployed, people resident within deprived areas, different socio/economic groups e.g. low income families, asylum seekers/refugees, prisoners, people confined to closed institutions or community offenders, people with different work patterns e.g. part-time, full-time, job-share, short-term contractors or shift workers - *Access, location and choice of venue, timings of events and activities. Support with caring responsibilities*

---

**Analysis conducted by:** (minimum of 3 people)

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>J. Stephen-Haynes</td>
<td>Professor &amp; Consultant Tissue Viability Nurse</td>
<td><a href="mailto:j.stephen-haynes@nhs.net">j.stephen-haynes@nhs.net</a> 07775 792775</td>
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<tr>
<td>Rosie Callaghan</td>
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<td>Monique Maries</td>
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<td><a href="mailto:Suzanne.tandler@nhs.net">Suzanne.tandler@nhs.net</a></td>
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**Start date of policy/function**
December 2014

**Period valid for**: 24 months

**Review date of policy/function**
December 2016

**Service Delivery Unit:**

**Reference/Version:**

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<th>D</th>
<th>M</th>
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If you have identified a potential discriminatory impact on the policy/function please refer it to the author together with suggestions to avoid or reduce the impact.

A copy of the completed Equality Analysis must be attached to the policy/function and a copy sent to:

Patrick McCloskey  
Equality Inclusion Practitioner  
Isaac Maddox House, Shrub Hill Road, Worcester, WR4 9RW  
Tel: 01905 761324

Patrick.mccloskey@hacw.nhs.uk