East Cheshire NHS Trust

Wound Management Policy
Policy: Wound Management Policy

Executive Summary: This policy for the Management of Wounds is for East Cheshire Trust. The aim is that all wounds will be managed appropriately.

This policy covers details on wound assessment, factors that influence healing, use of the dressing formulary, use of Larvae therapy and TNP for the management of wounds (via standard operating procedures). Leg ulcer management and the management of the diabetic foot ulcer are covered in separate policies.

Supersedes: Wound management guidelines Date of issue 2015

Description of Amendment(s): Rewritten

This policy will impact on: All Trust Staff

Financial Implications: Table

<table>
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<th>Policy Area:</th>
<th>Clinical</th>
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<tr>
<td>Issued By:</td>
<td>Sally Walsh</td>
</tr>
<tr>
<td>Author:</td>
<td>Tissue Viability Nurse Lead</td>
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</table>

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APPROVAL RECORD

<table>
<thead>
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Wound Management Policy v1 Sally Walsh Tissue Viability May 2018
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1. Introduction

A wound can be defined as an injury to the body that involves a break in the continuity of tissue or of body structures. This document contains practical guidance on the general principles of chronic and acute wound management, including wound assessment, dressings and device selection, measuring and evaluating wounds, identifying and treating infection and referral pathways.

This policy is for the management and treatment of wounds within East Cheshire Trust. Where the policy is specific to either “community” or “hospital” this will be stated. The aim is that all wounds will be managed appropriately following national guidance where available.

This policy has been produced for use by any member of the healthcare team. They are not intended as a substitute for professional judgement but are in support of the practitioner making an informed decision relating to the management of the patient, in accordance with individual professional competence.

This document should be used in conjunction with the most recent edition of the Royal Marsden NHS Trust Manual of Clinical Procedure.

2. Objectives of Policy

The purpose of this policy is to ensure best practice following national guidance and minimise the potential for inconsistency of care through standardising approaches to wound assessment and care by:

- Promoting a systematic approach to wound management, addressing symptom control and maintaining the individuals quality of life recognising that complete healing is not always achievable
- Providing a standardised approach to wound care within the framework of holistic care.
- To ensure appropriate management of acute, surgical and chronic wounds.
- Standardising the assessment of wounds using agreed documentation.
- Implementing individualised treatment plans to effectively manage wounds
- Ensuring the most appropriate product is utilised for optimum wound healing, patient comfort and cost effectiveness (following the agreed standardised formulary list for dressings).
- Ensuring that use of Larvae therapy and Topical negative pressure for the management of wounds is used safely and appropriately
- Ensuring that an appropriate management plan is in place that meets the set aims of treatment.
- Supporting families, carers and healthcare professionals with a framework for the management of wounds.
- Ensuring referral onto Tissue Viability services are appropriate and timely

3. Roles and Responsibilities

3.1 The Director of Nursing, Performance and Quality:
- On behalf of the Chief Executive, will ensure that comprehensive policy for wound management within the Trusts are developed, agreed and reviewed
- Will ensure that resources are made available for the provision of appropriate dressings/equipment
• Will ensure that there is a rolling programme for training for staff to ensure that care is provided by a competent workforce
• Will ensure that there is a robust monitoring system in place for the measurement of readmission of patients through wound breakdown or surgical site infections.

3.2 Lead Nurses/Professional Leads/Business Service Managers:
• Will ensure that this policy is implemented within their area of responsibility

3.3 Hospital Matrons:
• Will ensure that all staff in their areas are aware of, understand the policy and will ensure compliance with the policy
• Will ensure monitoring processes are in place to give confidence that this policy is being followed
• Will ensure that any actions related to clinical areas in relation to wound breakdown are put in place
• To ensure staff have access to appropriate dressings dependant on their area needs

3.4 Head of Safety Risk and Resilience:
Is responsible for;
• Ensuring Datix incident reporting system is in place
• Providing trend analysis and assurance reports in relation to improvement action and learning in line with trust as a result of incidents reported

3.5 Ward/Department/ Managers/ District Nurse Leads/ Community Matrons
• Will ensure that all staff are aware of the policy and adhere to it
• Will identify training needs and ensure staff are appropriately trained in wound management and will record all training
• Will incorporate wound assessment and management into staff performance review and the Knowledge and Skills framework, (this will include Larvae and Topical negative pressure)
• Will ensure that the Matron/Professional leads responsible for the clinical area are aware of all incidents/ failures to comply with the policy

3.6 All Staff
• Will adhere to the policy
• Will report “non-accidental” injuries via datix incident reporting system and consider if safeguarding processes need to be instigated
• Will report wound breakdowns and surgical site infections via datix incident reporting system
• Will identify their training needs and make their managers aware of any training deficit. It is an individual’s responsibility to maintain personal records of all training
• Will refer all patients to Tissue Viability with wounds who do not respond to appropriate management – following referral guidance
• Have the ability to recognise non-healing wounds and when to refer on to the Tissue Viability Nurse

3.7 Tissue Viability Service
The Tissue Viability Nurse will be responsible for;

- Monitoring and liaising with other members of the Trust to ensure clinical practice is developed in line with evidence and best practice.
- Identifying to the line manager when the practice is not compliant with best practice/guidance
- Review wounds referred (that meet criteria) within allocated timescales
- To deliver training on the assessment and management of wounds as identified through personal development plans
- Reviewing the wound management policy within review timescales set
- Review patients who are having TNP therapy where required (following standard operating procedure)
- Reviewing trends in relation to wound management incidents to ensure appropriate audits and training is in place as required.
- Reviewing the wound formulary guidance and updating every 2 years.

4. Wound Definition

A wound can be defined as “an abnormal break in the normally intact skin covering of the body” (Collier 2002). These wounds can then be categorized into Acute or Chronic. There are principally two types of acute wound; traumatic wounds and surgical wounds. The majority of these wounds heal uneventfully and within 4 weeks. If an acute wound fails to heal within 4 weeks then it becomes chronic as defined by (“Leading Change Adding Value” (NHS England 2017)

Recent work has demonstrated that over 30% of chronic wounds (wounds that have failed to heal for 4 weeks or more) do not receive a full assessment which is based on research evidence and best practice guidelines (Guest 2015)

5. Assessment

5.1 Holistic assessment

The clinical and cost effective management of wounds requires an accurate assessment of the patient and of any intrinsic/extrinsic factors that may impede wound healing or influence dressing choice. The healing process is complex and is affected by numerous general and local factors. It is essential to treat the whole person and not just the wound in isolation (Dealey 2005). Failure to complete a full assessment can contribute to ineffective treatment which therefore delays the rate of wound healing for the patients. NHS England’s improving Wound Care Project (2017/18) has identified a national minimum data set for generic wound assessment which all wounds that have failed to heal after 4 weeks should be assessed against. Wound assessment should be undertaken on first contact unless there is a valid reason why this is not appropriate. Wound assessment will include the impact that the wound is having on the patient’s quality of life.

Holistic assessment to include:

- Full medical history to identify and factors which would influence wound healing or management;
  - Diabetes
  - Anaemia
  - Vascular disease
  - Immune disorders
Inflammatory disease
Rheumatoid disease
Cancer
Renal disease
Neuropathy

- Medications and drug therapy that impact on wound healing
- Number of wounds present
- Effects of pressure /Shear and friction
- Nutritional status
- Social environment and lifestyle changes eg smoking and impaired mobility
- Psychological factors
- Factors affecting Quality of Life
- Pain

Additional Considerations for Neonates
Due to the reduced development of the skin this will impact on wound healing and dressings that can be used. Ensure the dressings used have a product licence for use on Neonates.

In order for a wound to heal there must be
- fuel (adequate nutrition)
- an adequate blood supply to carry energy and oxygen to the regenerating cells (Cartwright, 2002).

It must be considered that any condition that reduces the oxygen intake (e.g. chronic obstructive pulmonary disease), reduced oxygen within the blood cells (e.g. low Hemoglobin) or circulation of the oxygen (e.g. smoking, arterial disease, medications) will be detrimental to wound healing.

5.2 Wound type and healing.
Acute wounds proceed through the healing process in a timely manner as they generally have no underlying aetiology to disrupt a normal inflammatory response.
Acute wounds that do not heal within four weeks or develop complications that delay healing may then be described as chronic.
Chronic wounds are generally characterised by the presence of underlying pathology and are generally associated with a persistent state of inflammation, which prolongs or interrupts the healing process. These wounds heal by a process called secondary intention where granulation tissue is produced. For example: pressure ulcers, leg ulcers, dehisced surgical wounds.
Non-Healing wounds: For some patients healing is not achievable, for example, with some leg/foot ulcers or malignant fungating wounds. The primary goals of care should be to maximise patient comfort and control symptoms such as exudate, odour and pain. The decision that a wound is ‘non-healing’ should be made by the multi-disciplinary team that includes the tissue viability service.

5.2.1 Healing by Primary Closure
Most clean surgical wounds are managed by primary closure. The edges are approximated together, using sutures, clips or steristrips or glue following aseptic non-touch technique. Surgical wounds normally heal uneventfully when covered by an appropriate interactive
dressing that provides a barrier to infection (NICE CG 74 2008). Any of these wounds that break down are then classed as healing by secondary intention.

5.2.2 Healing by Secondary Intention
This is when the edges of the wound are not artificially drawn together and the wound is allowed to heal through contraction and development of connective tissue. This should follow the normal healing process of Haemostasis, Inflammation, Proliferation, and Maturation. Pathway for assessment and management of these wounds to follow the wound pathway Appendix 1

Tertiary healing is when the wound is left open until the risk of infection or foreign body has gone, only then can the wound be closed.

5.3 Clinical Assessment
This is to be performed by a registered healthcare professional that is trained and competent to undertake a wound assessment.

All wounds to receive an initial wound assessment on occurrence or admission to hospital/caseload (or on first visit), by a registered clinician using agreed standardized wound assessment tool.

The wound assessment must be formatted in the agreed Trust Style and will include;

- Date and time of assessment
- Type of wound and underlying aetiology including acute or chronic
- Location of the wound on the body
- Duration of the wound
- Wound measurements - The length, width and if depth of the wound is deep or superficial
- Depth of damage – identify stage if a pressure ulcer
- Type and colour of tissue in wound bed - necrosis, slough or infected tissue or is there healthy granulation and evidence of epithelisation? (Indicating a wound is healing well).
- Presence of infection
- Exudate levels and type
- Presence of odour.
- Pain
- Wound margins
- Factors that could delay healing
- Any known sensitivities to wound management products
- Impact of wound on quality of life and level of involvement the patient wants in their care
- Aims of treatment

5.3.1 Wound Type & Aetiology
Wound type and cause should be identified e.g. burn, laceration, skin tear, or venous leg ulcer caused by venous hypertension or pressure ulcer caused by pressure/shear/friction.

5.3.2 Wound Measurements
Accurate measurement is an important part of wound assessment and can assist with:
- Detailing progress or deterioration by comparing dimensions over time
• Communication between health professionals
• Encouraging the patient that healing is progressing
• Evidence of skin condition when admitted to, or discharged from, caseload

Photographs can be used as an adjunct to wound assessment but do not replace measurements or wound assessment. Consent needs to be obtained from the patient and stored following trust policy (SOP Photography and Video Recordings of Patients: Confidentiality, Consent and Storage 2014)

**Wound Depth Assessment**
Describe wound depth in terms of the anatomy of the skin and related structures. Use millimetres (mm) or centimetres (cm) to measure undermined tissue with a sterile measure. The following terms may be useful:

**Undermining**: this is when the wound is spread out underneath the skin that surrounds the visible part of the opening.

**Blister**: filled with serum or blood

**Abscess**: filled with pus

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

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

**Sinus**: A blind ended tract

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

**Wound Length & Width**
To be taken with a disposable measuring tape in the dressing pack and recorded in cms or mms. 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.

5.3.3 **Wound Photographs**
Photographs are a useful visual record for wounds that are difficult to trace, large, deep or irregularly shaped. Patient consent should be obtained in writing prior to wound photography following Digital imaging policy 2017.

Photographs of pressure ulcers should be recorded as indicated in the pressure ulcer treatment and prevention policy (on initial occurrence and on any change)
All Images should be stored according to recommended guidelines “Digital imaging policy”.

**Criteria for Wound Photography**
• Obtain written consent from the patient
• Photograph the wound on initial assessment and repeat if the wound condition changes
• Photographs should be labelled with the patient’s NHS number, date of photo, wound position/location – this is to be written on the paper ruled measure (to give an indication of scale) included in the dressing pack.
• Secure/upload in the patient’s EMIS records in chronological order (for community use)/ through Tissue Viability imaging database for storing on PACs (hospital).
• All photographs should be clear and in focus.
• Privacy and dignity should be protected and maintained at all times.
• If photographs are used for training purposes confidentiality must be maintained.
• Images cannot be used for publication, without separate & specific consent.
- Photos should not be taken using a mobile phone and images should be deleted from the digital camera / IPAD once transferred to a secure site e.g. Digital imaging database/EMIS.
- The camera should be cleaned after use to prevent cross infection

5.3.4 Type of Wound Tissue and Exudate
Wound assessments should include a description of the type and amount of tissue present for example: epithelialising, granulating, sloughy, necrotic, or non-healing.

Different stages of healing can exist 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 can also be estimated from wound photographs.

Table 1 – Terminology Used in wound descriptions

<table>
<thead>
<tr>
<th>Superficial</th>
<th>Not deep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Granulation</td>
<td>Wound bed looks pink/red and looks bumpy on the surface – a healing wound – requires protection.</td>
</tr>
<tr>
<td>Epithelisation</td>
<td>New areas of skin either showing at the edges first or as islands, looks white, pink or mauve in colour and healthy – a wound that is almost healed. This tissue should be kept warm (body temperature) and moist to facilitate epithelial growth.</td>
</tr>
<tr>
<td>Slough</td>
<td>Devitalised tissue that can appear as a Thick, yellow, waxy substance which may be wet or dry but cannot easily be removed. Do not mistake for bone. Needs debridement.</td>
</tr>
<tr>
<td>Necrotic Tissue</td>
<td>Black dry, dead tissue, which can be hard and leathery or grey and soft. Indicates devitalised tissue. <strong>Before</strong> debridement; Assess the patient’s circulation to the affected area before deciding on method of debridement. If digits or heels are necrotic do an ABPI or refer for specialist vascular assessment and keep these types of wounds <strong>dry</strong> until circulation is established.</td>
</tr>
<tr>
<td>Debridement</td>
<td>The removal of tissue via surgery or special dressings or larvae</td>
</tr>
</tbody>
</table>
### Exudate

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serous exudate</td>
<td>Discharge from wound. Strawberry coloured</td>
</tr>
<tr>
<td>Haemoserous exudate</td>
<td>Reddish in colour. May be stained with blood giving it a pink/brown colour.</td>
</tr>
<tr>
<td>Pus</td>
<td>Creamy yellow/green, thick and viscous</td>
</tr>
<tr>
<td>Blood/sanguineous</td>
<td>Frank blood</td>
</tr>
<tr>
<td>Macerated</td>
<td>White soggy skin due to increase of exudate</td>
</tr>
<tr>
<td>Excoriated</td>
<td>Red itchy looking skin, which can be wet in areas.</td>
</tr>
<tr>
<td>Cavity</td>
<td>Deep wound</td>
</tr>
</tbody>
</table>

### 5.4 Infection

#### 5.4.1 Signs and Symptoms of Infection

All chronic wounds contain bacteria, but not all are infected or should be swabbed for Culture & Sensitivity. Infection is the result of a complex interaction between the host, organism, wound environment and therapeutic interventions, which is complicated by bacterial virulence. Identifying wound infection should be viewed as a clinical skill which can be supported by laboratory findings when necessary.

A thorough assessment of the patient and wound is required prior to diagnosis.

**Signs and symptoms of infection:**

- Abscess formation, cellulitis, an increase in white blood cell count
- Increased wound exudate; serous, thick, pus
- Patient feels unwell and has a pyrexia
- Increased heat production, redness and swelling around the wound
- Delayed healing or wound breakdown, discolouration of wound and surrounding skin
- Granulation tissue that bleeds easily (frangible tissue)
- Increasing or unexpected pain
- Increase in malodour

**NB:** 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, quality of vascular supply or the use of medications such as steroids, anti-inflammatory, immune-suppressants and Chemotherapy etc. Patients with wounds that show spreading cellulitis and/or systemic infection require a swab for Culture & Sensitivity and blood cultures taken to identify the offending organism and to assess for differential diagnosis. Deep swab or tissue sampling will give a more accurate result but is not always practical.

Please see Appendix 2 – “algorithm of wound infection”
5.4.2 Management of the infected wound
If two or more clinical signs of infection are present, a wound swab is to be taken. Prevention and management of surgical site infection needs to follow NICE guidance (Nice guidance surgical site infection CG74 www.nice.org.uk)

Management of wound infection includes treatment with broad spectrum antibiotics which in some cases may be given intravenously. When using antibiotics for wound infection follow the recommended antibiotic and dosage guidance (Management of Infection Guidelines for Primary Care: Edition 14) and East Cheshire Antibiotic policy for Inpatients. If further advice is required Microbiology should be contacted.

Neglect in treating an infected wound could result in Septicaemia (infection of the blood stream)

Topical antiseptic/antimicrobial dressings should also be used to help reduce the wound bioburden.
Consider dressings containing silver/antimicrobials if the wound is colonised with bacteria. These dressings should not be normally used for more than 10-14 days at a time, in line with section 6.0.

5.4.3 How to Take a Wound Swab
• Cleanse the surface of the wound to remove surface bacteria
• Rub the tip of the swab across the wound in a ‘zig zag’ motion and at the same time
• Rotate the swab handle between fingers as it is moved across the wound
• Return the swab to the container
• Fill in form with sufficient information for lab staff and Microbiologist to know from where and why the swab was taken (include any other relevant information e.g. previous antibiotic use).

5.5 Factors to consider that can affect wound healing
An individual’s ability to heal and the time required can vary greatly, and are influenced by the following factors, which should be taken into consideration during assessment:
• General physical and psychological health and type and level of concurrent illnesses
• Stress level, depression, ability/ location of sleep.
• Ability to understand cause of wound and ability to participate in care
• Factors that may affect concordance with treatment. For example: dementia, lack of mental capacity, cognitive impairment, learning difficulties, and behaviour and lifestyle choices.
• Occupation, family structure, carers and their ability to assist with care.
• Treatment: systemically and locally
• Nutritional and hydration status
• Type of wound, location, depth and extent of damage and type of tissue in wound
• Wound temperature, moisture level and pH balance
• Levels of bacterial colonisation and infection
• Blood supply to the wound and surrounding area & oedema of surrounding tissues
• Disruption to normal sleep pattern
• History of smoking and alcohol consumption
• Medications such as steroids, immune-suppressants and chemotherapy.
• Environment
6. Wound Care/Management Dressing

Effective wound management is based on identifying and treating the underlying cause, addressing patient concerns and Wound Bed Preparation (WBP). The principles of WBP are wound debridement, infection prevention and control, measures to facilitate moist wound healing (wounds UK 2017) and effective exudate management.

Assess the patient’s circulation to the affected area before deciding on method of debridement. If digits or heels are necrotic do an Ankle Brachial Pressure Index or refer for specialist vascular assessment and keep these types of wounds dry until circulation is established.

6.1 Wound Cleansing

Prior to wound assessment wound cleansing may need to occur to remove debris, (e.g. foreign bodies, dressing residue and devitalised tissue) and exudate from the surrounding skin. NB: Routine cleansing of clean granulating wounds with water and saline, with the aim of bacterial
removal has been proven to be ineffective at promoting healing of chronic wounds where biofilms are present.

**When cleansing and dressing wounds the practitioner should:**
- Be familiar with the contents of the local Infection Control Policy
- Assess the risk of infection and cross infection and plan care accordingly
- Maintain hand hygiene and use Universal Precautions
- Use non-woven sterile swabs as they shed fewer fibres than cotton wool
- Use a no-touch technique (gloved fingers should not touch the wound surface)
- Be aware of timescales following any surgery to wound

6.1.1 **Sterile Normal Saline (0.9% sodium chloride)**
- Avoid using pressurised canisters as splash back may occur.
- Sterile normal saline should be used if the local tap water is not fit for drinking.
- To be used up to 48 hours after surgery (NICE CG 74)

6.1.2 **Tap Water**
- Chronic wounds may be cleansed with tap water, or water which is suitable for drinking, showering or bathing.
- Use minimal mechanical force when cleansing or irrigating the wound.
- Irrigation can be useful for cleaning a cavity ulcer
- Can be used 48 hours following surgery (NICE CG 74)

6.1.3 **Topical Antimicrobial / Antiseptic Cleansing Agents**
Antiseptic solutions (e.g. hypochlorites, EUSOL, chlorhexidine and betadine iodine) are not be used for routine wound cleansing as they cause pain and reduce the proliferation of macrophages and lymphocytes, which are essential to the wound healing process. Topical antimicrobial agents are not to be used for those wounds that are healing by primary intention (NICE CG 74).

6.1.4 **Potassium Permanganate**
This is a tablet preparation for external use only and **MUST NOT** be ingested orally. Potassium permanganate is licensed for the treatment of weeping or varicose eczema not wound management. 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 for a maximum of two weeks. The solution stains skin and nails dark brown and can cause skin irritation and has a potential risk of toxicity if used on large areas over a long period of time. Ensure all patients are informed that the tablet should not be swallowed – Patient safety alert December 2014 (Stage One; Warning NHS/PSA/W/2014/18)

6.2 **Debridement of wounds**
Debridement is defined as “the process of removing necrotic or devitalised tissue, bacteria and cells that impede the wound healing process to reduce wound contamination and tissue destruction” (Halem et al 2012). Chronic wounds, through this process, are converted into acute wounds.

There are many different methods used for debridement – the most common ones used within ECT are:
- Surgical
- Sharp debridement
- Autolytic – with dressings
- Larvae - Maggots
- Mechanical – UCS wipes and Debrisoft

Larvae is used as a method of debridement and is covered in the Larvae Application SOP (2018)

Larval therapy can be prescribed on FP10, but is not on the Nurses Formulary. A prescription will need to be obtained from the GP in the community or prescribed on the patients medication chart in hospital.

Further evidence is required to suggest which form of mechanical debridement is most effective.

6.3 Managing the wound/ selecting the best dressing/technique.

Following a wound assessment a management plan is to be devised, based on the holistic assessment of the patient.

This is to include:
- Optimizing condition of patients skin
- Reducing adverse effects of pressure, shear and friction (if appropriate)
- Addressing external factors that will make the patient more susceptible to wound breakdown/ non-healing such as; inadequate nutrition and fluids, reduction in haemoglobin levels.
- Patients’ involvement in self-care.
- Physiological, psychological and social aspects

Ensure Standardized documentation for wound care plans are used.

The care plan should clearly outlines the aims and objectives for management of the wound with clear milestones for treatment and re-assessment identified on the care plan.

Discussion with the patient/carer should be held to ensure optimal concordance with the treatment plan.

Choosing the right dressing is a fundamental part in effective wound management. A range of dressing types may be required to meet the needs of the wound and the patient at different stages of healing.

A dressing consists of two parts: the wound contact layer (primary dressing) and the secondary dressing. The primary dressing provides the wound with the right environment for healing, the secondary dressing is used to hold the first layer in place and or absorb exudate. In some dressings both layers are in the same dressing e.g. adhesive foam dressing.

Therefore, selection should be made on an individual basis after thorough assessment and discussion with the patient. Please use the Trust Wound Management Formulary when selecting dressings.
All wound dressings should be performed using principles of ANTT (Aseptic Non-Touch Technique).

### 6.3.1 Management of skin tears

Skin tears occur in individuals with fragile skin, common in neonates and older people, commonly occur on the extremities including lower limbs, hands and arms. A skin tears are caused by shear, friction and/or blunt force resulting in the separation of skin layers. They are documented in a class system.

**Classification Skin Tears**

- **Type 1 - No Skin Loss** - Skin tear is a liner tear where the flap can be reposition to cover the wound bed.
- **Type 2 - Partial Flap Loss** - Skin tear involves partial flap loss means that the skin flap cannot be repositioned to cover the whole of the wound bed.
- **Type 3 - Total Flap Loss** - Skin tear involves total flap loss that exposes the entire wound bed. 
  
  NB Total thickness wounds may require specialist intervention

**Treatment of Skin Tears**

The aim is to preserve the skin flap (if possible) and maintain the surrounding tissue, reline the skin edges (without stretching the skin) reduce infection and promote healing.

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute injury: cover with non-adhesive dressing and apply pressure, if possible elevate limb.</td>
<td>Control bleeding.</td>
</tr>
<tr>
<td>Irrigate the skin tear with warm normal saline</td>
<td>To remove residual debris for area.</td>
</tr>
<tr>
<td>Complete wound assessment</td>
<td>Document type of skin tear.</td>
</tr>
<tr>
<td>If skin flap viable, ease the flap back in to place with a gloved finger and moist non-woven fabric swab.</td>
<td>Use skin flap ‘as a dressing’</td>
</tr>
<tr>
<td>For skin flaps that are difficult to realign, apply a moist non-woven fabric swab for 5-10 mins.</td>
<td>To rehydrate skin flap and allow for realignment if possible.</td>
</tr>
<tr>
<td>Wound closure strips should only be used for large skin flaps.</td>
<td>To be applied with care to keep flap edges together – do not apply with tension – as will cause more skin damage.</td>
</tr>
</tbody>
</table>
An appropriate dressing for the skin tear conditions should be selected, an atraumatic all-in-one-dressing e.g. silicone foam dressing Kliniderm. Ensure a 2 cm overlap around the wound when dressing applied. For limb skin tears apply wound contact layer (e.g. atrauman silicone or urgotul if not being disturbed for 5 days), non-adhesive dressing pad and retain dressings with clinifast. Consider k-soft and k-lite toe to knee over the above for lower limb oedema and added absorption.

To address exudate, protect and allow for healing. Minimise trauma on removal. 

Mild support will assist reducing oedema in conjunction with elevation to aid healing.

Back of dressing should be marked with an arrow. To indicate which direction dressing should be moved to minimise trauma to healing skin flap.

NB Complex skin tears with full thickness skin loss, significant bleeding or formation of large haematoma may require surgical review.

### 6.3.2 Topical Negative Pressure (TNP)

Some wounds may be complex and benefit from Topical Negative pressure. A guide to when this might be indicated is covered in “TNP standard operating procedure 2018” (available on East Cheshire Infonet; Policies; Topical Negative Pressure SOP 2018)

### 7. Reassessment and Review

All wounds need to be reassessed at each dressing change or at least weekly using a standard wound assessment proforma. If a wound is not responding as expected reassess holistically addressing any factors that may delay wound healing.

### 8. Potential Complications following wound healing

#### 8.1 Keloid scaring

A Keloid is a growth of extra scar tissue where the skin has healed after injury (Juckett G, Hartman Adams 2009).

There are several treatments available, one which may include further surgery. The surgeon will be mindful that if Keloid scaring has occurred previously, it may occur again.

Topical managements normally consist of silicone type dressings or gels used for many months. These may reduce the redness and raised areas of the Keloid scar. The recommended, cost effective, topical dressings are detailed in the Wound care formulary.

#### 8.2 Overgranulation

##### 8.2.1 Signs and symptoms of Overgranulation

These relate to 3 areas: inflammation, occlusion or cellular imbalance:
• Prolonged inflammation caused by infection or dressing fibre irritant (Harris & Rolstad 1994; Nelsen 1999). Clinical infection will halt the healing process and will increase fluid loss and may contribute to overgranulation.
  o Presence of a foreign body would also cause prolonged inflammation; an example of this could be in-growing nail or bone.

• Continued minor trauma or external friction. Reported in Gastrostomy tubes and supra pubic catheter sites (Lyon & Smith 2001; Hanlon & Heximer 1994).

• Over use of occlusive dressings is thought to have an influence on overgranulation as it creates a hypoxic environment that causes the body to produce more but immature blood vessels to compensate (Dealey 2007).

A malignancy may be mistaken for overgranulation and, if there is any suspicion that this is not normal tissue, the patient should be referred by the GP for a biopsy. This may appear as:

• Overgranulation that has been present for many months
• Having a cauliflower appearance or is hard to touch
• Growing outward beyond the wound margins
• Not responding to any of the appropriate treatments

Overgranulation normally occurs at the edges of wounds and can occur for a number of reasons. These need to be considered as part of the assessment.

### 8.2.2 Treatment of over granulation

<table>
<thead>
<tr>
<th>Cause</th>
<th>Treatment options</th>
<th>Dressing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection</td>
<td>Manage infection</td>
<td>Antimicrobial, 10-14 days</td>
</tr>
<tr>
<td>Continued Trauma</td>
<td>Prevent friction and trauma – address cause e.g Anchor Tube</td>
<td>Must exclude infection before use of; steroid cream, haelan tape/cream</td>
</tr>
<tr>
<td>Occlusive dressings</td>
<td>Alter dressing</td>
<td>Change to non-occlusive dressing e.g. foam</td>
</tr>
<tr>
<td>Foreign body</td>
<td>Either removal of foreign body or if caused by nail may need to use silver nitrate on skin around</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If all the above fail, consider silver nitrate pencil (stick should be moistened first and surrounding skin protected with petroleum jelly) – not recommended for prolonged or excessive use.</td>
<td></td>
</tr>
</tbody>
</table>

### 9. Documentation

• Patients who are admitted or transferred from another hospital, nursing home or their own home with a wound should have a holistic /wound assessment documented on admission/transfer.
• All pressure ulcers stage 2 and above to be reported using the Datix incident reporting system. This includes unstageable pressure ulcers, deep tissue Injury and moisture lesions.
- To ensure all wound care is documented regularly and clearly to aide continuity of care, a wound assessment tool must be completed.
- Each wound must have a separate plan of care completed (this may be in paper format on an in template on EMIS).
- It is likely a number of staff will be involved in the care of a patients’ wound, so to ensure continuity of care is maintained, it is important to keep a detailed account of the progress of the wound. It is also a legal requirement.
- All assessment details should be noted and if possible, supported by photos, body maps (for acute) and measurements of the wound.
- A plan of treatment needs be clear and understandable for other members of staff to follow and implement. Dressings used should be indicated on the wound management care plan.
- A clear and concise evaluation of the progress of the wound and how it is being managed after each dressing change must be documented and made accessible to all staff involved.
- A formal review of the wound should be done at least weekly unless otherwise indicated and documented.

10. Referral to Tissue Viability

Referral to be made to Tissue Viability if:
- Wound is not responding following 2 weeks of appropriate management
- There is rapid deterioration of wound for no apparent reason

Prior to referral:
- All wounds to have a wound assessment completed and a documented evidence of plan of care

10.1 Timescales for referral

<table>
<thead>
<tr>
<th>Very High Risk</th>
<th>To be seen within 2 working days by Tissue Viability or Specialist Podiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>- New Diabetic Ulcer</td>
<td></td>
</tr>
<tr>
<td>- Deteriorating Diabetic Ulcer</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At Risk</th>
<th>To be seen within 3 working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Any wound showing rapid deterioration for no apparent reason</td>
<td></td>
</tr>
<tr>
<td>- Stage 3 &amp; 4 pressure ulcers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>To be seen within 7 working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any wound with no improvement after 2 weeks of appropriate management (following “Wound assessment pathway and the use of Silver dressings” Appendix 1. - Advice or assessment relating to alternative treatments - Leg Ulcers over 6 weeks that do not respond to appropriate treatment</td>
<td></td>
</tr>
</tbody>
</table>

10.2 How to refer to Tissue Viability
- Referrals will be accepted by post, fax or EMIS
- Complete standard referral form Appendix 3 for post or fax referrals.
11. Referral to other Specialist

In conjunction to Tissue Viability, consider referral to other specialist disciplines as required. Prevention and management of complex wounds requires a holistic approach and further specialist intervention may be advised.

This may include:
- Vascular Nurse /Consultant
- Dermatology
- Plastics
- Diabetologist / Diabetic Specialist Nurse
- Dietitian
- Specialist Podiatry – this should be made by faxing a referral form to the hub (fax 01625 661482). Tel 01625 661875.

12. Education and Training

Those who undertake assessment, planning, implementation and evaluations of care should be trained/educated/competent in wound management

It is important that all clinicians involved in the care of patients with wounds maintain their clinical knowledge which can be achieved through reading relevant literature, attending study days, courses and conferences.

Training dates can be accessed through the Learning and Development Department.

13. Compliance and Monitoring/Audit of Formulary Use

Audit of Formulary use

The local formulary is updated on an ongoing basis through evaluation of new products and review of evidence relating to these products

Use of dressings should follow the “guidance for the management of wound care products”

http://www.centralandeasterncheshiremmt.nhs.uk/mmt-documents/fcategories/139-clinical-guidelines

NEW 201820 Wound Care Guide.pdf

The medicines management department will provide data for Community prescribing against the formulary. This will be reported back to the team leaders for investigation of any non-compliance.
Dressing ordering within MDGH will be monitored through procurement and non-formulary items may be masked. No non-formulary items will be ordered through pharmacy.

**Surgical Site Infections**
The number of surgical site infections reported will be monitored and any trends/concerns will be investigated.

**Referrals to Tissue Viability service**
Number of inappropriate/delayed referrals will be monitored and investigated as appropriate.

**Completion of Wound assessment documentation**
Completion of full wound assessments will be undertaken for the community through CQUIN monitoring.
Wound assessment and management documentation will be monitored and audited whilst undertaking stage 3 and 4 RCA reviews to ensure they are in-line with this policy.

14. **Usage of First Dressing**

The first dressing supply for community nursing will be through a reduced selection of dressings devised from the wound formulary. These are to be used when assessing a patient for the first visit or if the wound changes significantly.

**Supply of Dressings from Hospital**
All patients discharged from hospital with a wound will be discharged with a supply of dressings sufficient for 5 days care or at least 3 dressing changes. This is to include all equipment required for the dressing change including any suture removal. If this does not occur please complete as an incident on Datix.
REFERENCES


Cartwright. A. (2002).Nutritional assessment as part of wound management Nursing Times. 98 (44) 62


Collier, M 2002, Nursing Times 99 (25) 63-4


European Wound Management Association (EWMA); ewma.org (2006)


Guidance for the use of wound care products. May 2018– April 2020


Hanlon, M., Heximer, B (1994) Excess granulation tissue around a gastrotomy tube exit site with peritubular skin irritation. Journal Wound Ostomy Continence Nursing 21 (2) p76-77


Merryfield C. (2010). Nutrition and Wound Care. CN Focus; Vol 2, No. 3
National Institute for Clinical Excellence (2008), Clinical Guidelines; Surgical Site Infection CG74 www.nice.org.uk

Standard operating procedure for Photography and Video Recordings of Patients: Confidentiality, Consent and Storage July 2017


Todorovic, V. (2002) 'Food and wounds: nutritional factors in wound formation and healing' British Journal of Community Nursing. 7 (9) pp.53-54.


Appendix 1  Wound Assessment Pathway

Is the wound clinically infected?

Yes

Swab and treat with antibiotics and antimicrobial dressings e.g. Silver or honey (following formulary)

No

Measure on initial assessment and at least weekly. Photographs can be taken as an adjunct to assessment

Identify different tissues in wound bed and %?

% Epithelialised % Granulation % Slough % Necrotic

Identify levels of exudate?

Min Moderate Large

Identify what is your short-term aim? For the dressing and the wound!

Dressing – to absorb, donate fluid Wound – Deslough Debride Protect

Document all of above on wound assessment form

Follow wound care formulary to determine dressing to meet aims.

Avoid any know sensitivities

Is the dressing meeting the aims?

Yes

Continue with present dressing

No

Reassess (at least weekly or if wound changes)

If not responding after 2 weeks Or wound deteriorates rapidly Refer to Tissue Viability

Holistic assessment still needs to be undertaken to determine any general factors that may delay healing. Once healed protect fragile skin. Tracing and measuring may not be appropriate for all wounds e.g. malignancy, but rationale for this should be indicated in the nursing documentation.

All stage 3&4 pressure ulcers to be referred to Tissue Viability straight away and new Diabetic foot ulcers to Specialist Podiatry
Appendix 2 Algorithm of infection

- **Signs of infection**
  - **No signs other than healing progress altered**
    - Are other risk factors present, e.g., immunosuppression or malignancy?
  - **Stages 1 & 2 Signs limited to wound only**
    - Select topical antimicrobial (box, bottom left)
  - **Stage 3 Spreading local sepsis**
    - Consider combination therapy. Drain any local collections
  - **Stage 4 Systemic signs**
    - Start broad-spectrum systemic antibiotics while awaiting culture results
    - If systemic signs only, look outside wound for source of infection

---

**Factors to consider when selecting antimicrobials**

**Agent:**
- specificity
- efficacy
- cytotoxicity
- allergenicity

**Dressing:**
- absorbency
- conformity
- odour management
- pain management

- Select alternative antimicrobial agent
- Consider adding antibiotic

- Stop antimicrobial therapy. Monitor wound progress. Continue managing wound according to local protocol. Reconsider antimicrobial treatment if wound or patient status changes adversely

- Complete course of antibiotics. Reassess wound and patient
- Adjust antibiotic selection according to causative agent, sensitivity and patient preference

**Good clinical response**

**Poor clinical response**
**Referral to Tissue Viability Specialist Nursing Service**

This must be completed, both sides

<table>
<thead>
<tr>
<th>Name of Client / Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr / Mrs / Miss / Ms</td>
</tr>
<tr>
<td>NHS number</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>Religion</td>
</tr>
<tr>
<td>(or sticker)</td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Postcode</td>
</tr>
<tr>
<td>Tel No</td>
</tr>
<tr>
<td>GP Name</td>
</tr>
<tr>
<td>Address</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source of Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Designation</td>
</tr>
<tr>
<td>Tel:</td>
</tr>
<tr>
<td>District Nurse Mobile Tel No</td>
</tr>
<tr>
<td>Community / Nursing Home / MCHFT / MDGH Ward</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for Referral</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Type of Wound</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Current Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Pressure Ulcer - Stage</td>
</tr>
<tr>
<td>1 ☐ 2 ☐ 3 ☐ 4 ☐</td>
</tr>
</tbody>
</table>

* If this is a pressure ulcer, has a Datix form been completed  
  YES ☐ NO ☐  
  (All stage 2 and above need an Datix completing)

<table>
<thead>
<tr>
<th>Location of Wound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of present wound</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Result of Last Hb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>
| Is this a leg ulcer over 6 weeks old  
  YES ☐ NO ☐ |

<table>
<thead>
<tr>
<th>If YES has a leg ulcer assessment been completed (If Yes attach LU assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES ☐ NO ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is Client / Patient Diabetic</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES ☐ NO ☐ If Yes last HbA1c or glucose Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are there any risks that should be considered prior to the nurses visiting the patient?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g VRSA, MRSA, dogs, environmental risk, any known aggressive behavior or Health &amp; Safety Issues)</td>
</tr>
<tr>
<td>No ☐ YES ☐ Please list:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the patient live alone?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES ☐ NO ☐</td>
</tr>
</tbody>
</table>

| Patient Medical History (Please attach summary/medication) |

<table>
<thead>
<tr>
<th>Please indicate intervention required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound static, no signs of healing despite appropriate management</td>
</tr>
<tr>
<td>Wound deteriorate, despite appropriate management</td>
</tr>
<tr>
<td>Telephone advice</td>
</tr>
<tr>
<td>Mattress required</td>
</tr>
<tr>
<td>Joint visit</td>
</tr>
</tbody>
</table>

---

26
**Wound Assessment Chart**

<table>
<thead>
<tr>
<th>Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stage of pressure ulcer:</td>
<td></td>
</tr>
<tr>
<td>2. Wound Dimension (a) Maximum length - cm</td>
<td></td>
</tr>
<tr>
<td>(b) Maximum breadth - cm</td>
<td></td>
</tr>
<tr>
<td>3. Nature of Wound bed: (a) Epithelialisation</td>
<td></td>
</tr>
<tr>
<td>(please indicate %) (b) Healthy Granulation</td>
<td></td>
</tr>
<tr>
<td>(c) Sloughy</td>
<td></td>
</tr>
<tr>
<td>(d) Black Necrotic Tissue</td>
<td></td>
</tr>
<tr>
<td>4. Exudate: (a) Colour</td>
<td></td>
</tr>
<tr>
<td>(b) Amount (heavy / mod / min / none)</td>
<td></td>
</tr>
<tr>
<td>5. Odour: (None = N; Some = S; Offensive = O)</td>
<td></td>
</tr>
<tr>
<td>6. Pain (Site)</td>
<td></td>
</tr>
<tr>
<td>7. Pain (frequency): (a) None</td>
<td></td>
</tr>
<tr>
<td>(b) Dressing changes only</td>
<td></td>
</tr>
<tr>
<td>(c) Intermittent</td>
<td></td>
</tr>
<tr>
<td>(d) Continuous</td>
<td></td>
</tr>
<tr>
<td>(e) Day or Night</td>
<td></td>
</tr>
<tr>
<td>7. Pain (severity): Score as a number</td>
<td></td>
</tr>
<tr>
<td>0 = no pain to 10 = uncontrollable</td>
<td></td>
</tr>
<tr>
<td>8. Condition of wound edge:</td>
<td></td>
</tr>
<tr>
<td>9. Condition of surrounding skin:</td>
<td></td>
</tr>
<tr>
<td>10. Infection: (a) Suspected</td>
<td></td>
</tr>
<tr>
<td>(b) Swab sent (time)</td>
<td></td>
</tr>
<tr>
<td>(c) Confirmed</td>
<td></td>
</tr>
</tbody>
</table>

Wound assessed by:

Any other relevant information:

*When completed, please return to:*

Tissue Viability Service
East Cheshire NHS Trust
Silk House, MDGH
Macclesfield, SK10 3BL

Tel: 01625 663375 | Fax 01625 661226
Equality Analysis (Impact assessment)

1. What is being assessed?

Wound Management Policy

Details of person responsible for completing the assessment:

- **Name:** Sally Walsh
- **Position:** Lead Nurse
- **Team/service:** Tissue Viability

State main purpose or aim of the policy, procedure, proposal, strategy or service:

(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

The aim is that all wounds will be managed appropriately. The guidance covers details on wound assessment, factors that influence healing use of the dressing formulary, use of larvae therapy and topical negative pressure for the management of wounds. The following documents have been used: National Institute for Clinical Excellence, Nursing and Midwifery Council, Department of Health, European Pressure Ulcer advisory panel.

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it.

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

The population of Cheshire as at the 2005 mid year figures (Cohesia Report 2008) is 684,400.

**Age:**

17.8% (30,500) of the population in Cheshire East is over 65 compared with 15.9% nationally. This results in a high “old age” dependency ratio, i.e. low numbers of working-age people supporting a high non-working dependant older population. The percentage of “older” or “frail” old is also considerably higher, with 2.3% (8,200) persons 85 and over compared to 2.1% nationally.

Cheshire East has the fastest growing older population in the North West. By 2016, the population aged 65+ will increase by 29.0% (8,845) and the population aged 85+ by 41.5% (3,403).

This will have an impact on the number of patients being managed by ECT and the complexity of the health and social care issues that the older person is experiencing. In addition the staffing profile of ECT will change to include an increasing number of staff over 65 in the workforce.

**Race:**

The 2005 mid year estimate (Cohesia Report 2008) show that the majority of the population in Cheshire (94.6%) is White British, with 5.4% non White British. The Cheshire 2007-10 Local Area Agreement identified that minority ethnic communities account for around 3% of the population.
Issues for BME communities include lack of knowledge of services, access to services, access to translation/interpretation, cultural differences, family values. Many people from BME communities experience poverty, poor housing and unemployment which make it difficult for them to lead healthier lives. 4180 migrant workers registered in Cheshire in 2006/07 and comparison to the mid-year population estimates for Cheshire in 2005 strongly suggests that Cheshire’s migrant worker population is larger than every individual BME group other than the White-Other White group.

_Gypsies and travellers_ – at the last count (July 2006) the highest number was recorded in the Borough of Congleton (125). 42% of gypsies and travellers report limiting long term illness compared to 18% of the settled population, with an average life expectancy 10-12 years less than settled population. 18% of gypsy and traveller mothers have experienced the death of a child compared to 1% in the settled population.

**Disability:**
There are over 10 million disabled people in Britain, of whom 5 million are over state pension age. Nearly 1 in 5 people of working age (7 million, or 18.6%) in Great Britain have a disability. 

*Hearing loss:* 1 in 4 has a hearing problem.

*Sight problems:* There are 2 million people with sight problems in the UK.

*Learning disabilities:* There is quite a high proportion of people with learning disabilities in the local area due to there being a number of residential homes/institutions in the area. Problems encountered can be lack of staff awareness, communication issues, information requirements.

**Dementia**
Approximately six in 100 people aged over 65 develop dementia and this rises to around 20 in 100 people aged 85 or over. Dementia affects 750,000 people in the UK.

**Carers**
Around 6 million people (11 per cent of the population aged 5+) provided unpaid care in the UK in April 2001. While 45% of carers were aged between 45 and 64, a number of the very young and very old also provided care. By 2037, it is anticipated that the number of carers will increase to 9 million.

**Gender**
On average in Cheshire, 49% of the population are male and 51% are female.

*Transgender:* No local data available, national trends show:

1/12,000 males, transgender from male to female

1/33,000 females, transgender from female to male

Specific issues around access to services, specific services for men or women, and ‘single sex’ facilities. In terms of the transgender population, GIRES (Gender Identity Research and Education Society) gives an estimate of 600 per 100,000. If these figures were applied to the Cheshire East community based on the 2005 mid year estimates, there may be around 2,100 trans people in the area.

**Religion/Belief**
In the Cheshire East area:

<table>
<thead>
<tr>
<th>Religion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>- 80%</td>
</tr>
<tr>
<td>Buddhist</td>
<td>- 0.16%</td>
</tr>
<tr>
<td>Hindu</td>
<td>- 0.15%</td>
</tr>
<tr>
<td>Jewish</td>
<td>- 0.12%</td>
</tr>
<tr>
<td>Sikh</td>
<td>- 0.05%</td>
</tr>
<tr>
<td>Other religion</td>
<td>- 0.15%</td>
</tr>
<tr>
<td>No religion</td>
<td>- 11.84%</td>
</tr>
<tr>
<td>Not stated</td>
<td>- 6.67%</td>
</tr>
</tbody>
</table>
Muslim - 0.36%

The Muslim population has the highest levels of ill health amongst faith groups – this includes higher smoking rates amongst men and higher rates of coronary heart disease and diabetes.

**Sexual Orientation**
Lesbians, gay men and bi sexual people (LGB) make up to 5-7% of the UK population (Dept of Trade and Industry, 2003). 13% of Gay men and 31% Lesbian women are parents (Morgan and Bell, First Out: Report of the findings of Beyond the Barriers national survey of LGB people)

The experience and health needs of gay men and women will differ. However, both groups are likely to experience discrimination, higher levels of mental ill health and barriers to accessing health care National Health Inequalities data shows that lesbian, gay, bisexual and transgender (LGBT) people are 2001 census showed: significantly more likely to smoke, to have higher levels of alcohol use and to have used a range of recreational drugs than heterosexual people. They are also at greater risk of deliberate self-harm. Although most LGBT people do not experience poor mental health, research suggests that some are at higher risk of mental health disorder, suicidal behaviour and substance misuse

**2.2 Evidence of complaints on grounds of discrimination:** (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

| No |

**2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?**

| No |

3. **Assessment of Impact**
Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

**RACE:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently? Yes ☐ No √

**Explain your response:** If a person’s first language is not English, staff will follow the trust interpretation and translation policy to ensure good understanding.

---

**GENDER (INCLUDING TRANSGENDER):**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently? Yes ☐ No √

**Explain your response:** No impact identified.

---

30
DISABILITY
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently? Yes ☐ No √

Explain your response: If a person has sensory loss then communications aids can be used to ensure the patient understands their care and treatment. If they are profoundly Deaf, a BSL interpreter can be booked via the Trust interpretation policy. Information can be translated into other formats as required. If a patient has learning disabilities or autism, reasonable adjustments will be made and carers involved as appropriate.

AGE:
From the evidence available does the policy, procedure, proposal, strategy or service, affect, or have the potential to affect, age groups differently? Yes √ No
Explain your response: Some dressings are not suitable for Neonates as their underdevelopment deems them at risk from absorption from some ingredients within the dressing products. All products used for neonates need to deemed safe prior to application.

LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently? Yes ☐ No √
Explain your response: No Impacts identified. All patients will be treated with dignity and respect.

RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently? Yes ☐ No √
Explain your response: Some dressings have gelatin in so would not be suitable for some Muslim groups. Alternative products are available on the dressing formulary for use.

CARERS:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently? Yes ☐ No √
Explain your response: Carers may need to be involved to ensure compliance with treatment at home and to support patients with disabilities.

OTHER: EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? Yes ☐ No √
Explain your response: No impacts identified – wound care would be dependent on the wound and individual, and would not be affected specifically for pregnancy etc.
4. Safeguarding Assessment - CHILDREN

<table>
<thead>
<tr>
<th>a. Is there a direct or indirect impact upon children?</th>
<th>Yes ✓</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people: Some dressings are not suitable for Neonates as their underdevelopment deems them at risk from absorption from some ingredients within the dressing products. All products used for neonates need to deemed safe prior to application.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. If no please describe why there is considered to be no impact / significant impact on children</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

The guideline has been disseminated to
District nurses via Debbie Burgess and Denise Bailie
Lead Nursing’s – Lisa Minshall and – Jeanette Sarker
Podiatry – Estelle Crook
Sam Leonard – Hospital Matron
Anita Swaine– Infection Control
Mr Khan (Surgical Consultant) and Mr Barnes (Orthopaedic Consultant)

6. Date completed: 17.5.18 Review Date: 18.05.20

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact? No

8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead:
Date: 2.7.18