CONSERVATIVE SHARP WOUND DEBRIDEMENT POLICY

POLICY

Reference	CPG-TW-TV-CSWD		
Approving Body	Surgery, Anaesthetics and Critical Care Divisional Clinical Governance Group		
Date Approved	26.1.24		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
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Version	1.0		
Summary of Changes from Previous Version	NA – new policy		
Supersedes	NA – new policy		
Document Category	• Clinical		
Consultation Undertaken	Senior Tissue Viability Nurses.Mr A. Bidwai (Consultant Orthopaedic Surgeon), Mr. H Salem- Saqer (Consultant Trauma and orthopaedics), Miss. E Gemmill (Consultant Surgeon)		
Date of Completion of Equality Impact Assessment	11.12.23.		
Date of Environmental Impact Assessment (if applicable)	11.12.23.		
Legal and/or Accreditation Implications	Not applicable		
Target Audience	Health Care Professionals educated and competent to perform conservative sharp wound debridement (CSWD)		
Review Date	January 2027		
Sponsor (Position)	Chief Nurse		
Author (Position & Name)	Nurse Consultant Tissue Viability, Stephanie Anstess		
Lead Division/ Directorate	Surgery, Anaesthetics and Critical Care		
Lead Specialty/ Service/ Department	Tissue Viability		
Position of Person able to provide Further Guidance/Information	Nurse Consultant Tissue Viability		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
1. Wound Management Care plan	July 2022

CONTENTS

1.0 INTRODUCTION

The presence of non-viable tissue in the form of slough and necrosis in a wound delays healing.

The increased bacterial load can also cause malodour and promote local and systemic infection. If the necrotic tissue is not removed from the wound, a dysfunctional and disorganised acute inflammatory response results which disrupts and delays the normal healing process. It can also mechanically reduce the wound from contracting and physically reduce epithelialisation by preventing the passage of epithelial cells from the wound edges. Non- viable tissue can also prevent the delivery of topical treatments, as it forms a barrier to the wound bed.

Conservative sharp wound debridement (CSWD) is defined as the removal of non- viable tissue, infected (including biofilm) or foreign material from the wound bed and surrounding skin, which accelerates the healing process. CSWD involves removing the non- viable tissue up to the level of viable tissue with forceps and scalpel, scissors, or curette. It is usually completed over several days. There is minimal bleeding during CSWD, and pain is assessed, managed, and monitored before and during the procedure. This policy will focus on the removal of devitalised tissue by CSWD.

The purpose of debridement is to:

- Determine the extent of the wound and identify any undermining.
- Remove non-viable tissue.
- Reduce the bacterial load and minimise risk of local and systemic infection.
- Allow wound drainage.
- Reduce odour.
- Remove foreign tissue.
- Promote healing.

Evidenced based practice dictates removal of non-viable tissue.

2.0 POLICY STATEMENT

The aim is for all skilled health care practitioners with appropriate wound management and CSWD education to provide safe effective sharp debridement of wounds and to promote wound healing and reduce wound infection.

This policy applies to all:

Staff group(s)
Clinical staff employed by or working on behalf of the Trust, who are required to undertake CSWD as part of their role and job description, e.g., Tissue Viability Nurses, Podiatrists

Clinical area(s)
This policy applies to all clinical areas the Trust, where care is being provided to patient(s) who require CSWD.

Patient group(s)
This policy applies to adult patient(s) who are either inpatient or outpatients.

3.0 DEFINITIONS/ ABBREVIATIONS

3.1 Definitions

Trust: Sherwood Forest Hospitals NHS Foundation Trust

Staff: All employees of the Trust including those managed by a third party on behalf of the Trust

Non-viable tissue: Dead tissue which will delay wound healing and increase the risk of infection and malodour.

Debridement: Any method to remove dead, nonviable/devitalised tissue, infected or foreign material from the wound bed and surrounding skin

3.2 Abbreviations

- **CSWD** Conservative sharp wound debridement

4.0 ROLES AND RESPONSIBILITIES OF THE REGISTERED HEALTH CARE PROFESSIONAL

- Sherwood Forest Hospitals employees will be expected to act at all times in such a manner as to safeguard and promote the interests of patients and clients.
- Must have knowledge and skills and effective practice; recognise and work within the limits of personal competence according to their Professional Code of Conduct
- Must have knowledge of the underlying structures of the areas to be debrided.
- Must have completed a recognised education programme in wound debridement which includes CSWD.
- Must have competency checked and signed off by an expert practitioner before completing CSWD alone.
- Must be conversant and adhere to the policy.

5.0 APPROVAL

Following consultation, version 1.0 was approved by the Surgery, Anaesthetics and Critical Care Divisional Clinical Governance Group.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

All procedures to be undertaken should be risk assessed to establish the risk of introducing micro-organisms/infection before the procedure is commenced.

Prior to undertaking CSWD, the Registered Health Care Professional must ensure that the appropriate consent has been gained. Where relevant the associated documentation must be completed, or the information recorded in the medical notes. For further information see the Trust's "Consent Policy".

6.1 Patient assessment

A full holistic assessment of the patient and their wound(s) will be completed following the wound management policy.

6.2 Identifying tissue that requires CSWD:

- Moist necrotic tissue – green, yellow, or grey appearance.
- Dry necrotic tissue – dry and leathery, it appears as hard black/brown eschar.
- Slough – stringy moist necrotic tissue grey or yellow that adheres to the wound bed.
- Haematoma- a collection of blood following trauma/ surgery.
- Hyperkeratosis of peri wound skin.
- Malodour is also an indication to provide CSWD.

Debridement should not be considered as a single event (Falanga 2002). In order to promote continuous healing and prevent wound deterioration, it may be necessary to consider alternative methods of debridement concurrently or once the initial removal of devitalised tissue has been achieved.

In some instances, sharp debridement is NOT an appropriate option.

6.3 Identifying the patient that requires CSW:

CSWD is a quick effective method of preparing a wound bed for healing with granulation tissue. However, it is not always appropriate for all patients. When there is evidence of underlying peripheral arterial disease associated with gangrene, it is not appropriate to remove necrotic tissue. Gangrenous digits should be kept dry and allowed to auto-amputate as creation of a moist environment may precipitate wet, infected gangrene, which is potentially limb and/or life threatening (Leaper 2002, Vowden and Vowden 2002). Limb revascularisation should be considered and treatment goals realistic, based on the assessed potential for wound healing.

Prior to debridement of pressure ulcers on the lower leg, practitioners should ensure there is an adequate blood supply to rule out arterial insufficiency (NPUAP-EPUAP 2014)

CSWD is not usually appropriate for patients towards the very end of life unless it is causing uncontrolled malodour.

Clinical judgement must be used in choosing the debridement method.

Furthermore, patients may require immediate extensive debridement by a surgeon in theatre.

6.3 Contra-indications of CSWD:

- Patients with blood clotting disorders.
- Wounds that are fungating or malignant wounds.
- Anatomical structures that cannot be identified.
- Below-knee, non-infected, ischaemic ulcer, covered with dry, stable eschar and the goal of care is maintenance rather than healing, e.g., arterial ulcer, diabetic ulcer with dry gangrene.
- Interface between viable and non-viable tissue cannot be clearly identified.
- Autoimmune ulcers.

6.4 Cautions for CSWD, always discuss with the responsible Consultant:

- Arterial structures, vascular grafts, prosthesis, dialysis fistula.
- Significant pain in the wound or pain associated with CSWD.
- Anticoagulation therapy.
- Arterial disease (ABPI less than 0.6 and greater than 1.3).
- Untreated infection.

6.5 CSWD Procedure

- Explain the process to the patient or complete it in their best interests.
- Ensure good lighting over the wound.
- Provide adequate analgesia and allow time to work prior to procedure.
- Prepare the environment, no cleaning, use of fans etc.
- Prepare the wound dressing trolley with sharp fine scissors or size 15 scalpel or curette, with metal forceps and a sharps bin. Also include a haemostatic dressing if bleeding occurs and does not stop with pressure.
- Assist the patient to get into a comfortable position, where the wound can be viewed and managed easily.
- The HCP must undertake the procedure, using the Trust's Moving and Handling guidance.
- One HCP can undertake the procedure, but where a patient might not be able to verbalise pain or wants to be 'stoic' another healthcare professional/ support worker will be required to monitor the patient for any signs of pain. The procedure will stop if the patient feels pain. If Nitrous oxide is required and 2nd HCP will be required.
- Photographs ideally to be taken before and after the procedure.
- Inform the nursing team/carers of the procedure, and the possibility of any pain or bleeding from the wound that will require monitoring.
- Where appropriate the HCP will follow up the patient.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Full policy	Nurse Consultant / Lead for TV	Appraisal. Competency sign off. Daily complex management handover.	Yearly Ongoing	Clinical Outcomes and Effectiveness Committee.

8.0 TRAINING AND IMPLEMENTATION

Required for new staff only

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix A.
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix B.

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

Ashworth, J. (2002) Conservative sharp debridement: the professional and legal issues. Nursing Times accessed 23/09/21 from https://www.nursingtimes.net/archive/conservative-sharp-debridement-theprofessional-and-legal-issues-01-06-2002/ 2.

Edwards J (2000). Sharp debridement of wounds. Journal of Community Nursing. 14 (1)

Falanga V. (2004) Wound Bed Preparation: ~Science Applied to Practice. European Wound Management Association Position Document. London: Medical Education Partnership.

Fairburn K et al (2002). A sharp debridement procedure devised by specialist nurses. Journal of Wound Care 11 (10) 371-375

Leaper D. (2003) Sharp technique for wound debridement. World Wide Wounds accessed 23.09.21 from http://www.worldwidewounds.com/2002/december/Leaper/Sharp-Debridement.html

Leaper D, SchultzG et al (2012) Extending the TIME Concept: What have we learned in the past 10 years International Wound Journal (suppl.2)1-19

Murphy C, Atkin L, Swanson T, Tachi M, Tan YK, Vega de Ceniga M, Weir D, Wolcott R. International consensus document. Defying hard-to-heal wounds with an early antibio€ lm intervention strategy: wound hygiene. J Wound Care 2020; 29(Suppl 3b):S1–28

National Wound Care Strategy Programme (NWCSP) and Skills for Health, 2023, 31

NMC (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates accessed 23.09.21 from https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

O'Brien M (2003) Debridement: ethical, legal and practical considerations. British Journal of Community Nursing, Wound Care Supplement. March 2003, 23-25

TVNA (2005) Conservative Sharp debridement – procedure, competencies and training. Available at: www.tvna.org

Vowden, KR and Vowden, P. (1999) Wound debridement, Part 2: sharp techniques. Journal of Wound Care, 8 (6) 291-294

WoundsUK (2013) Effective Debridement in a changing NHS: A UK Consensus. Wounds UK, London.

Related SFHFT Documents

- Aseptic Non-Touch Technique Policy

11.0 KEYWORDS

Necrosis, haematoma, non-viable tissue, CSWD,

12.0 APPENDICES

Appendix A – Equality Impact Assessment
Appendix B – Environmental Impact Assessment

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Conservative Sharp Wound Debridement Policy			
New or existing service/policy/procedure: New policy			
Date of Assessment: 13.11.23			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None		
Gender	None	None	None
Age	None	None	None
Religion	None	None	None
Disability	None	None	None
Sexuality	None	None	None
Pregnancy and Maternity	None	None	None
Gender Reassignment	None	None	None
Marriage and Civil Partnership	None	None	None

Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	None	None

What consultation with protected characteristic groups including patient groups have you carried out?

- None

What data or information did you use in support of this EqIA?

- Information from within this policy and the evidence base.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- None

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Stephanie Anstess

Signature:

Date: November 2023

APPENDIX 2– ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	