

WOUND MANAGEMENT POLICY

		POLICY			
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Approving Body		Clinical Outcomes and Effectiveness Care Group (COEC)			
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		X			
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Position of Person able to provide Further Guidance/Information	The Tissue Viability Team
Associated Documents/ Information	Date Associated Documents/ Information was reviewed
1. <i>Wound Management Care plan</i> 2. <i>Larvae Therapy Care Plan</i> 3. <i>Negative Pressure Wound Therapy Care Plan</i> 4. <i>Cellulitis Care Plan</i> 5. <i>Wound Care Formulary</i> 6. <i>Wound care discharge letter</i> 7. <i>Conservative Sharp Wound Debridement Policy</i> 8. <i>ANTT Policy</i> 9. <i>Pressure Ulcer Prevention and Management Policy</i> 10. <i>Photography on Nervecentre Standard operating Procedure</i>	1. April 2019* 2. April 2019* 3. April 2019* 4. 2022, being updated 5. September 2022 6. July 2025 7. February 2024 8. July 2022 9. September 2025 10. July 2022
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*Care plans will be reviewed when updates are required or when the printed care plans are due for re-order

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1.0 INTRODUCTION

A wound can be described as a break in the skin; it can be superficial or complex, closed, or open and can happen to any individual of any age causing pain and discomfort. In addition, patients with a wound are at increased risk of infection and potential sepsis. The management of wounds is a complex subject requiring appropriate knowledge and skills. In the UK, 2.2 million people have a wound that has not healed within 4 weeks and the estimated annual cost to the NHS of managing patients with wounds is between £4.5-£5.1 billion. (National Wound Care Strategy 2024)

The aim of this policy is to provide the appropriate wound management strategy for patients, to optimise healing potential, and enhance patient comfort and dignity, whilst also considering cost effectiveness in line with best practice/evidence.

All patients with wounds must be assessed (and reassessed) by a competent registered healthcare professional who will undertake a comprehensive assessment of the wound, as part of the holistic assessment. This assessment must inform a plan of care for the on-going management with wound care products selected and wound management techniques chosen according to best recognised practice, with regular monitoring and evaluation of the care. This will help to ensure best practice in wound care is delivered whilst minimising the potential for inconsistent care.

2.0 POLICY STATEMENT

The aim of the document is to ensure clinical staff are aware of and adhere to the standards expected of them to provide safe and effective wound care. It is relevant to all Sherwood Forest Hospitals NHS Foundation Trust staff and staff employed through other agencies working on a temporary basis, who provide care for patients with wounds.

The Trust aims to provide excellence in wound care. Nursing and medical staff are responsible and accountable for delivery of safe and cost-effective wound care across the Trust. They must ensure the following:

- A comprehensive and timely holistic wound care assessment
- A continuous process of assessment planning, implementation and evaluation of care using evidence-based care
- Completion of wound assessments and care on the wound management care plan (WMCP) by Registered Nurses and Midwives with accurate measurements and descriptions to ensure objective assessment is obtained and care and progress can be evaluated.

3.0 DEFINITIONS/ ABBREVIATIONS

Trust:	Sherwood Forest Hospitals NHS Foundation Trust
Staff:	All employers of the Trust including those managed by a third party on behalf of the Trust
TVT	Tissue Viability Team
TVN	Tissue Viability Nurse
TV Champions	Tissue Viability Champions

AHP	Allied Health Professionals
WMCP	Wound Management Care Plan

4.0 ROLES AND RESPONSIBILITIES

All employees working in clinical areas have an individual responsibility to maintain knowledge of the basic principles of wound management and adhere to the wound management policy.

4.1 The Chief Nurse and Medical Director

- Overall responsibility for ensuring that the Trust has in place clear processes for managing risks associated with the wound management
- Ensure that appropriate arrangements are in place to enable safe and effective care and that employees are fully aware of their statutory, organisational and professional responsibilities and that these are fulfilled

4.2 Heads of Nursing, Clinical Directors and General Managers

- Responsible for ensuring that this policy is implemented throughout their areas of management.
- Provide the necessary management arrangements and ensure structures are in place so clinical teams have the required knowledge, skills and equipment to enable them consistently to provide safe, evidence based wound care and harm free care

4.3 Consultant Medical Staff

- Assess and review the patient's wounds as part of their holistic assessment
- Ensure that their teams are aware of this policy and provide collaborative multidisciplinary working to ensure the policy is adhered to
- Perform surgical procedures and expert medical intervention as required to promote appropriate wound management.
- Medical/Surgical teams to liaise directly with the TVT for urgent/complex wound management

4.4 The Deputy Chief Nurse

- Provide senior management support and day to day leadership for effective wound management.
- Ensure that senior management receive regular information and reports (via COEC: Clinical Outcomes and Effective Care group) to inform decision-making and to provide assurance that this policy is being implemented across the organisation.

4.5 Clinical Outcomes and Effective Care Group (COEC)

COEC will meet regularly in accordance with defined terms of reference and will be responsible for:

- Developing, reviewing, and monitoring the application of the wound care policy
- Monitoring and reviewing relevant audit results, analysing incident trends and identifying specific areas that require additional training or targeted improvement action
- Evaluating the effectiveness of wound prevention measures and effective wound management standards within the Trust

- Learning related to the prevention of wounds and wound care throughout the Trust

4.6 The Tissue Viability Nurse Consultant and Lead Tissue Viability Nurse

- Provide expert clinical, professional, and managerial advice for wound management across the Trust
- Develop, implement, and evaluate evidence-based strategies and policies for wound management, whilst ensuring economic value
- Agree levels of education and competency for staff managing wounds
- Plan and oversee the development and delivery of education and training of all staff groups and evaluate the effectiveness
- Plan and oversee audit of wound care management at least once a year or, as and when required. Work collaboratively with the Ward Leader to support any improvement plans
- Escalate concerns related to wound care to the COEC group and to the Nursing, Midwifery and Allied Health Professional Committee

4.7 Matrons

- Responsible for ensuring that this policy is implemented throughout their areas of management.
- Support the WLs to ensure staff have the correct levels of wound management education
- Required to ensure that staff understand the expectations of them and are both competent and confident to implement the policy requirements
- Ensure Ward Leaders are supported to enable the ward staff provide wound management in line with the policy

4.8 Sisters/ Charge Nurses

- Responsible for ensuring the staff in their services are aware of this policy and have the required knowledge and skills to deliver the wound care standards within it
- Ensure improvements are made to services where deficiencies are identified through audit, or monitoring processes, complaints, and investigations
- Support staff to attend teaching on wound management and complete e-learning on Sherwood Academy
- Support the TV Champion and provide the resources to fulfil their role

4.9 The Tissue Viability Team

- Be an expert resource and exemplary role model in relation to wound care
- Provide expert clinical advice, education and support to clinical staff and the multidisciplinary team
- Monitor wound care standards and support teams to achieve them
- Undertake wound care audit once a year
- Maintain the supportive tissue viability Champions network
- Liaise with medical and surgical teams when interventions are required

4.10 Tissue Viability Champions and AHPs

- Be responsible, accountable and role model the delivery of high-quality wound care
- Establish a system to effectively disseminate all relevant wound management information to staff within their work area

- Act as a liaison between the TVT and the clinical environment cascading best practice
- Undertake wound care audit once a year with the Tissue Viability Team
- With the support of the Sister / Charge Nurse and TVN, ensure that all staff in their work environment are aware of and adhere to this policy
- Escalate wound management concerns in their clinical area to ward Sister/Charge Nurse/Matron/TVN

4.11 Ward Nurses, Clinic Nurses, Ward Midwives and Clinic Midwives

- Have a responsibility to maintain the knowledge and skills needed for safe and effective wound care
- Will complete management and evaluation of wounds on a day-to-day basis, adhering to the wound care policy
- Will maintain own competencies within wound care
- Will seek advice/ escalate concerns to experienced clinical staff
- Will make appropriate and timely referrals to the Tissue Viability Team

4.12 Ward Nursing Associates and Clinic Nursing Associates

- Have a responsibility to maintain the knowledge and skills needed for safe and effective wound management.
- Will complete assessment and management of wounds on a day-to-day basis, adhering to the wound care policy
- Will maintain own competencies within wound care
- Will seek advice/ escalate concerns to experienced clinical staff
- Will make appropriate and timely referrals to the Tissue Viability Team

5.0 APPROVAL

- Following consultation, version 3.1 has been approved by the Clinical Outcomes and Effectiveness Care Group

6.0 DOCUMENT REQUIREMENTS (NARRATIVE)

Prior to undertaking any examination, treatment and care clinicians 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 to Examination, Treatment and Care Policy 2024.

6.1 Patient assessment

- All patients will have a comprehensive assessment of their health status in relation to their wound management
- Factors adversely affecting wound healing will be identified
- Nutrition status will be screened and analysed to ensure appropriate nutritional requirements are met. This may include urgent referrals to the Dietician where the patient has a complex wound compounded by unmet nutritional needs.

6.2 Wound Assessment (s) – each wound will be assessed separately

- See [Appendix A](#) – Removal of wound dressings
- Wounds will be assessed in emergency or admission areas as part of the A-E medical assessment, which will include patients with compression bandaging for leg ulceration. Where the patient has a diagnosis not related to sepsis and is not at risk of pressure ulcers, use clinical judgement to decide if the compression bandages can stay on. Record decision making in the notes. Please see also [Appendix B](#) Removal of Compression Bandaging for further advice
- It is imperative for patients with suspected sepsis, that their wounds are assessed for signs of infection and the possible source of sepsis, in order to ensure appropriate antimicrobial treatment and monitoring.
- The type of wound will be identified and recorded
- The age and history of the wound will be recorded including previous microbiology results e.g MRSA
- All wounds will be assessed and (reassessed) by a competent healthcare professional who will undertake an assessment, which will include:
 - Site
 - Size length, width, depth and details of any undermining
 - Wound bed description
 - Exudate volume and description
 - Odour and extent of odour
 - Peri - wound condition
 - Signs of infection
 - Pain
- All wounds will be photographed within 1-2 working days. The Nerve Centre handheld device should be used for immediate wound management decisions and or out of hours. Consent must be recorded on Nervecentre prior to patient photography and photographs taken on Nervecentre must be clearly labelled with the anatomical area. Further guidance for photography on Nervecentre can be found: [showcontent.aspx](#). For hospital acquired wounds or patients with safeguarding concerns, the photographs must also be taken by the Clinical Illustration team.
- On admission a wound swab will be taken for MRSA screening. **If a wound infection is suspected, a wound swab will be taken and sent for microscopy, culture and sensitivity and the presence of MRSA will automatically be checked (a separate swab is not required).** The procedure for taking a wound swab can be found: [Swab sampling: wound - Royal Marsden Manual](#)
- The microbiology results will be followed up and the wound care plan updated accordingly.
- Patients who have had their compression bandages left intact must have an MRSA screening swab at the time of the first dressing change.

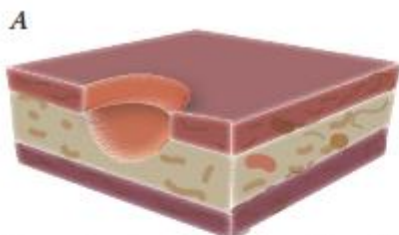
6.3 Wound Management Care Plan (WMCP)

- An individualised plan of care with appropriate goals will be completed in collaboration with the patient and the MDT and recorded in the WMCP

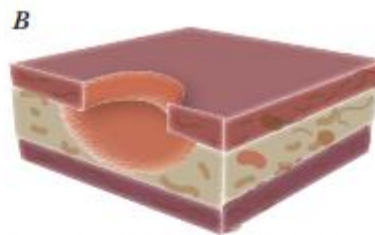
- The frequency of dressing changes will be determined by the patients' clinical condition, treatment goals and effectiveness - and recorded on the WMCP
- Standard ANTT must be used for all wound dressing procedures; Surgical wounds must be managed using surgical ANTT (see appendix A, C and D for guidance)
- A 'mock' wound care plan can be accessed on the Tissue Viability intranet site for staff to view [KM1816761084-20160225140855](https://www.sherwoodforesthospitals.nhs.uk/record/1816761084-20160225140855)

6.4 Cavity Wounds

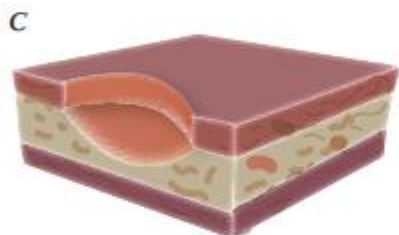
- A cavity wound is characterised as a wound extending to subdermal underlying layers and structures such as fascia, tendon, muscle or bone. Other terms associated with cavity wounds include undermining, fistula, sinus, tracking, tunnelling: see diagram below. (Wounds UK, 2025)



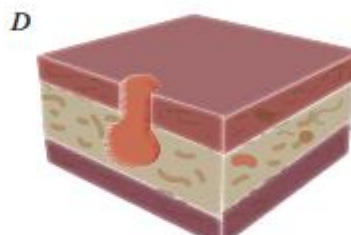
A regular-shaped cavity, with uniform shape and sloping sides



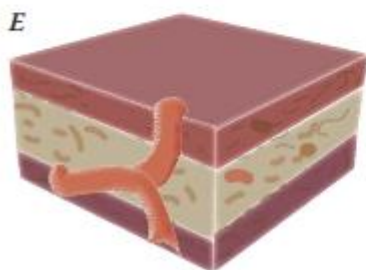
A cavity with undermining (tissue destruction underneath intact skin around the wound margins)



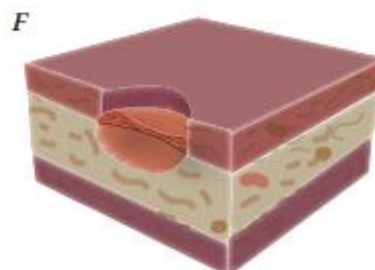
A cavity with a tunnel (a pathway extending from the cavity) or pocket (an area of dead space)



A sinus (a blind-ended tunnel leading to a cavity which commonly contains a collection of infected matter)



A fistula (an abnormal tunnel connecting two organs or an organ to the skin)



A cavity wound with bridging (tissue that bridges one side on the cavity to another)

- Thorough assessment is important in cavity wounds to determine the structures involved in the wound bed.
- Measuring cavity wounds can be challenging and is often subjective. Weekly digital photography must be obtained to support wound measurements and assessments. A clock

face can also be utilised to record undermining: this should be recorded in the wound assessment.

- It is important to note that complex wounds may become larger as part of the healing process, especially where non-viable tissue is debrided.
- Where a wound bed and exposed structures cannot be easily visualised and assessed, imaging should be considered to facilitate accurate diagnosis and enable an appropriate management plan e.g. MRI/CT
- Where the wound bed cannot be visualised, dressing products should be selected which are easy to retrieve from the wound; individual dressing pieces should be counted and recorded in the patient records on insertion and removal. This includes dressings used for Topical Negative Pressure.
- Cavity wounds should be loosely filled with appropriate dressing, ensuring sufficient material to maintain contact with the wound bed. Over packing the wound must be avoided as this may cause additional pain and pressure and prevent effective healing.
- Surgeons may specify advice for individual patients in relation to avoiding packing abscess cavities for some conditions, e.g. perianal abscess; where evidence of benefits of wound packing is limited, and repacking cavities may be painful.

6.5 Wound Bed Preparation

It is becoming widely accepted that hard-to-heal wounds contain biofilm: a complex community of microorganisms that adheres to the wound surface and forms a protective matrix, presenting a significant barrier to wound healing and requiring removal during debridement. Current figures put the presence of biofilm in 60%–100% of non-healing wounds. There is currently no diagnostic test available for wound biofilm. Biofilms can form within hours and reach maturity within 48-72 hours. To facilitate wound healing in chronic wounds, biofilm must be managed with a regular strategy of cleansing, debridement, refashioning (maintaining and cleansing wound margins to allow epithelisation) and appropriate dressings (Murphy et al, 2020)

- Clinicians must assess the wound bed and exudate levels and ensure that any excess exudate and wound debris are effectively removed during wound cleansing, including loose non-viable tissue.
- Dry exudate and skin scales must be removed from the wound edges to refashion the wound to facilitate granulation and epithelisation.
- Wounds should be cleaned with sterile saline or a prescribed anti-microbial cleansing solutions where a wound is clinically infected, or biofilm is suspected.
- Where non-viable tissue is present in the wound bed which cannot easily be removed, the patient should be referred to the TVT to consider conservative sharp debridement. See conservative sharp wound debridement policy [showcontent.aspx](#)

6.6 Wound Monitoring and Evaluation

- Wound evaluation will be completed at each dressing change with progress or deterioration recorded and care plan revised as necessary.
- The frequency of wound assessment will be determined by the patient's clinical condition, treatment goals and effectiveness – but must be completed at least weekly as a minimum requirement, **and twice weekly for acute complex wounds**
- Infected wounds (non surgical) must be assessed at least daily, until there is evidence of the infection responding to antibiotics. Where no or little improvement is seen the

medics/surgeons will discuss with the Microbiology Team, for an appropriate management plan

- Infected surgical wounds will be assessed and managed as per Surgeons/Tissue Viability advice.
- Complex wounds must be photographed regularly, determined by the patient's clinical condition, treatment goals and effectiveness - a minimum of weekly/fortnightly

6.7 Hospital acquired wounds and skin damage

- Hospital acquired wounds and skin damage must be reported on the Datix as a clinical incident relating to a patient. The incident should be reported as skin damage and an appropriate sub-category chosen according to the cause of damage.
- Skin tears are one of the most common types of skin damage in the Trust; further guidance on skin tear management is available on the Trust Skin Tear Pathway (2025) [showcontent.aspx](#)
- For hospital acquired pressure ulcers refer to the Pressure Ulcer Prevention and Management Policy (2025)

6.8 Surgical Wounds

- Surgical wound complications are defined as a disruption to normal incisional wound healing following surgery. Surgical site infection (SSI) is the most common surgical wound complication affecting either the incision or the deep tissues at the operation site and can lead to surgical wound dehiscence. 21% of surgical wounds fail to heal within 12 months leading to considerable patient suffering and cost to the NHS. (National Wound Care Strategy, 2024). Many surgical wound complications are preventable.
- Non-complicated surgical wounds should be monitored for signs of infection as per speciality post operative nursing and midwifery care plans, and recorded in nursing evaluations.

Superficial incisional infection	Deep/open incisional infection	Organ/space incisional infection
■ Increased pain and tenderness at the surgical site ■ Localised swelling and induration ■ Localised heat and redness ■ Purulent drainage ■ Cellulitis limited to the wound and adjacent soft tissues ■ Evident superficial wound abscess	■ Increased pain at the surgical site ■ Spreading induration and swelling ■ Erythema and heat at the surgical site ■ Purulent drainage from the incision ■ Spreading cellulitis at the surgical site ■ Evident deep wound abscess or fasciitis ■ Separation of the edges of incision, exposing the deeper tissues ■ Unexpected post-operative fever accompanied by increasing wound pain and/or wound dehiscence ■ Pathological blood test findings (elevated C-reactive protein, white blood counts, erythrocyte sedimentation rates, pro-calcitonin)	■ Purulent drainage from a drain placed through the skin into the organ or body space ■ Organ or body space abscess diagnosed by radiological or histopathological examination ■ Evidence of infection involving the organ or body space seen on direct examination during surgery ■ Post-operative fever ■ Positive result of blood cultures, deep tissue biopsies, surgical sampling or pathological blood test findings (as in deep SSI)

- Risk factors for SSI should be carefully considered

Table 3. Main risk factors for SSI, which may vary depending on surgery type (adapted from WUWHS, 2018)

Category	Modifiable patient-related	Pre-operative	Peri-operative	Post-operative
Major	■ BMI $\geq 35.0 \text{ kg/m}^2$ ■ Diabetes mellitus ■ Current or recent smoking	■ Emergency surgery ■ Age > 65 years	■ Extended duration of surgery ■ Inadequate surgical closure ■ Peri-operative hypothermia	■ Mechanical pull on incisional wounds ■ Patient/family touching the wound
Moderate	■ COPD ■ Malnutrition: hypoalbuminaemia (serum albumin $< 3.0 \text{ g/dl}$) ■ Anaemia ■ BMI $30.0\text{--}35.0 \text{ kg/m}^2$ ■ Alcohol abuse	■ Male gender ■ ASA Physical Status ≥ 2 ■ Previous wound healing problems ■ Immunosuppression ■ Long-term steroid use ■ Malignant disease ■ Chemotherapy ■ Radiotherapy ■ Uraemia ■ Peripheral vascular disease ■ Suboptimal timing or omission of prophylactic antibiotics	■ Blood transfusion ■ High wound tension closure ■ Tissue trauma/large area of dissection and/or undermining	■ Failure to wean from ventilator ■ One or more other surgical complications ■ Premature suture removal
Minor	■ BMI $25.0\text{--}29.9 \text{ kg/m}^2$ ■ Congestive cardiac failure ■ Cardiovascular disease	■ Extended pre-operative hospitalisation or residency in a nursing home	■ Failure to obliterate dead space	■ Trauma across incision

ASA=American Society of Anaesthesiologists; BMI=body mass index; COPD=chronic obstructive pulmonary disease

- To reduce the risk of SSI, post operative wounds within all specialities should remain covered for a minimum of 48 hours following surgery. (NWCS 2024; NICE 2020) Aseptic Non-Touch Technique (ANTT) should be used for all dressing changes. For guidance on Surgical ANTT see Appendix D
- If surgical site infection is suspected, relevant samples must be obtained for culture and sensitivity, the surgical team involved should review the patient and wound, antibiotic therapy should be considered, the wound should be monitored at least daily and patient monitored for signs of sepsis. SSI must be reported on Datix as a patient incident.

6.9 Tissue Viability Referral Criteria

Complex wounds will be referred to the TVT using the ICE system. For urgent referrals please contact directly via x4565 or mobile phones (See TV intranet).

These will include patients with:

- Complex wounds that require advanced therapy e.g. topical negative pressure, larvae therapy
- Wounds that require sharp conservative sharp debridement
- Infected wounds- not responding to treatment
- Diabetic foot ulcers (in line with the diabetic foot team and the diabetic foot guidelines)
- A wound that falls beyond the knowledge and skills of the practitioner and their senior ward colleagues including deteriorating wounds
- Hospital acquired traumatic wounds that cause moderate to severe harm e.g haematomas, large lacerations, infected cannula sites with devitalised tissue
- Category 2- 4, mucosal and medical device related PUs
- Patients admitted with Category 3 and 4 PUs
- Category 2 heel pressure ulcers that require a vascular assessment
- Wounds that fail to progress or symptoms that are not controlled e.g., pain, exudate, odour
- Adult safeguarding concerns/ investigations in place relating to wound/skin management and/or pressure relief
- Poor patient concordance to wound care advice and care following appropriate ward level intervention and escalation

7.0 Safe discharge for patients with wounds:

- Patients discharged with wounds will have details of the wound management plan within the discharge letter along with a supply of dressings (7 days' supply)
- The **Discharge Letter: Wound care** must be completed by the RN or clinician responsible for the patient's wound care and transferred with the patient or sent to the clinician who will take responsibility for wound care following discharge, e.g., Community nurse, practice nurse, care home RN.
<https://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=69332>
- Where the TVT have been involved with a patient's wound management, a TVN will record in the medical notes when the patient's wound can be managed in the community, the ward RN must complete the Wound Care Discharge letter.
- The TVT will advise in the medical notes if the patient requires a referral to the community TVT. The TV team will complete and send referrals to the community TV team.

8.0 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)
Wound care documentation	Tissue Viability Nurse Consultant/Lead Tissue Viability Nurse – to plan and oversee. Tissue viability team, ward leader and TV champion to take part in the audit process.	Audit	A maximum of 6 patients will be audited on each ward at least every 12 months	Written report will be presented to COEC: Action plan and escalation to the Nursing, Midwifery and AHP Board if standards not achieved.

9.0 TRAINING AND IMPLEMENTATION

All staff working with patients with wounds in clinical areas will read and understand the Wound Management Policy.

The Tissue Viability department organise and deliver both formal and informal education and training across the Trust to medics, nurses and allied health practitioners. The training includes:

- Wound management study days including associated e-learning
- Pressure area management study days including associated e-learning
- Lower leg/leg ulcer study days including associated e-learning
- E learning modules available on Sherwood Academy
- Induction programme for registered nurses and health care support workers
- Tissue Viability Champion study days
- Ad hoc training during the provision of specialist advice regarding individual patients during the provision of clinical care
- Further education can be arranged for specific clinical areas that is tailored to meet the individual team or departmental needs
- Tissue Viability intranet site

Attendance at formal training is monitored via Sherwood Academy

10.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at [Appendix E](#)
- This document is not subject to an Environmental Impact Assessment

11.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) and RELATED SFHFT DOCUMENTS Check

- Diabetic foot problems: prevention and management NICE guidelines (NG19) Update: October 2019
- Journal of Wound Care (2023) Best practice for wound debridement VOL 33, 6,SUP C
- National Wound Care Strategy Programme (2020) Lower Limb: Recommendations for Lower Limb Ulcers.
- Murphy et al (2020) International Consensus Document: Defying hard-to-heal wounds with an early antibiofilm intervention strategy: wound hygiene, Journal of Wound Care, 1 March, 2020-Volume 29,Issue Sup3b
- National Institute for Health and Care Excellence. Pressure ulcers: prevention and management of pressure ulcers (April 2014) NICE clinical guideline 179
- Prevention and Treatment of Pressure Ulcers: Quick Reference Guide European Pressure Ulcer Advisory Panel 2019
- Surgical site infections: prevention and treatment NICE guideline (NG125) Update August 2020
- Surgical Wound: Recommendations for Surgical Wounds. National Wound Care Strategy Programme February 2021
- The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. Nursing and Midwifery Council (2018)
- The International Guideline: Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline (3rd Edition) 2019

- Wounds UK. Best Practice Statement. Improving holistic Assessment of Chronic Wounds July 2018
- Wounds UK (2020). Best Practice Statement: Antimicrobial stewardship strategies for wound management. Wounds UK, London.
- Wounds UK (2020) Best Practice Statement: Post-operative wound care – reducing the risk of surgical site infection. Wounds UK
- World Union of Wound Healing Societies (WUWHS), (2016) Florence Congress, Position Document. Management of Biofilm. Wounds International

12.0 KEYWORDS

- Laceration; WMCP; wound

13.0 APPENDICES

[Appendix A](#) – Removal of wound dressings

[Appendix B](#) – Removal of compression bandages

Appendix C – ANTT for standard woundcare

Appendix D – ANTT for surgical wounds

[Appendix E](#) – Equality Impact Assessment Form (EQIA)

Appendix A

Introduction

Wound assessment should form part of a holistic patient assessment. All patients with a wound should have dressings removed to facilitate assessment on admission and as part of on-going reviews, individual to each patient. Wound dressing changes should be planned according to the patient's clinical condition, individual assessment of the wound and surrounding tissue and take into account patients' pain, infection, level and type of exudate and odour.

Wounds can be a source of sepsis and should be assessed / reassessed as soon as sepsis is suspected, i.e. on patient admission or in-patient deterioration where sepsis is suspected. Microbiological samples should be taken for culture and sensitivity during this assessment, e.g. wound swab / pus or tissue sample.

Principles of Aseptic Non Touch Technique (ANTT) should be applied to **ALL** wounds whether they are healing by primary or secondary intention. ANTT is essential to reduce the risk of contamination at the wound bed and surrounding tissue by pathogenic micro-organisms, which may be transferred from hands or equipment.

It is estimated that Surgical Site Infection (SSI) affects 1 in 3 patients globally (WHO 2016) Surgical dressings should be kept undisturbed for a minimum of 48hours post-operative, unless there are signs/symptoms that wound inspection is required at an earlier stage, for example excessive bleeding / spreading erythema.

Preparation of the area to reduce contamination with airborne bacteria

- Avoid removal of wound dressings when bed making or cleaning tasks are being performed nearby
- Windows should be closed
- Electrical fans should be turned off

Equipment required for wound dressing removal

- Personal protective equipment (gloves and plastic apron as minimum)
- Dressing trolley (pre cleaned with soap and water wipes)
- Sterile dressing pack
- Fluid for wound cleansing and /or irrigation to facilitate dressing removal, e.g. saline or Prontosan Solution if indicated
- Appropriate dressings
- Sterile scissors if required

Dressing removal procedure

- Appropriate analgesia should be given prior to the dressing procedure where indicated. Consider administering analgesia 20-30minutes prior to the dressing procedure to optimise the effects
- Explanations should be given to the patient and verbal consent obtained
- Prepare equipment by opening your sterile dressing pack onto the trolley. Using only the corners, the pack should be opened. The sterile bag within the pack can be used to rearrange the sterile field.

- Outer dressings, for example bandages can be removed first using non sterile gloves.
- Change into sterile gloves to remove dressings to the open wound.
- Carefully assess pain, exudate level and type, odour and peri-wound skin on dressing removal.

A YouTube video demonstrating how to open a dressing pack can be accessed using the link:
<https://youtu.be/NZsluMdbppI>

Covering the wound

The wound should be redressed with appropriate products according to Sherwood Forest Hospitals Wound Care Formulary. An individualised plan should be documented on the Wound Management Care Plan.

Occasionally it is necessary to wait for further assessments or wound treatments before the wound can be redressed eg Tissue Viability or Diabetic Foot Team assessments, Clinical Illustration, medical or surgical reviews. In this instance, consider soaking the wound with Saline or Prontosan solution applied on sterile gauze and apply the sterile sheet provided in the sterile dressing pack to cover the wound temporarily. It is not acceptable to use continence products / non sterile procedure pads / towels, or leave the wound uncovered. The wound should be redressed as soon as possible following assessments to prevent microbiological contamination and to maintain an optimum healing environment for the wound.

Appendix B – Removal of compression bandages

Introduction

Venous leg ulcers (VLU) are believed to be the most common chronic wound type in the UK. In the Burden of Wounds study, there were 278 000 patients with VLUs, equating to 1 in 170 adults having a VLU in the UK. Compression therapy is the recommended treatment for venous leg ulcers and should be used as the first-line treatment, however it is important that treatment is optimised by being used in conjunction with a holistic approach and that underlying challenges are addressed. (Wounds UK 2016,2019) The risk of harm from compression therapy must be based on individualised risk assessment of the patient. Patients admitted to secondary care settings present with acute health care needs and a thorough examination of the patient's skin and wounds is a vital aspect of a holistic assessment. Patients who become acutely unwell also have a higher risk of developing pressure damage and skin should be assessed accordingly in vulnerable patients.

Managing patients who use compression bandages

Compression bandages can and should be removed to facilitate limb assessment by any clinician. Compression bandages should only be reapplied by appropriately trained clinicians. In the absence of an appropriately trained clinician, patients requiring acute admission should be managed with soft padding bandages (ie Soffban/Formflex) and crepe applied toe to knee; limbs should be elevated and heels offloaded appropriately. People with leg and foot wounds with **red flag symptoms** should **not** be treated with compression therapy (National Wound Care Strategy Programme, 2020) The following indicate symptoms which could be considered a 'red flag'

People with leg and foot wounds should not be treated with compression if they have any of the following red flags:

- Acute infection of the leg or foot (eg increasing unilateral redness, swelling, pain, pus, heat)
- Acute or chronic limb threatening ischaemia
- Suspected acute deep vein thrombosis
- Suspected skin cancer

When should compression bandages be removed to facilitate assessment?

- **For patients with confirmed or suspected sepsis:** Bandages should be removed in the admitting area as soon as clinically possible (eg Emergency department) to facilitate assessment of any potential source of sepsis, as per the Trust Sepsis guideline
- **Where a pressure ulcer risk assessment indicates a risk of pressure damage:** ie: PURPOSE-T screen or full PURPOSE-T assessment which indicate a risk of pressure damage; bandages should be removed within 6 hours of admission
- **Patients without risk of pressure damage or sepsis:** Bandages should be removed within 24 hours of admission, or according to clinical judgement. Clinicians should escalate to senior staff for advice where indicated.
- **Existing in-patients with clinical deterioration or new suspected sepsis:** compression bandages should be removed as soon as clinically possible as part of a holistic clinical assessment.

Recognising types of compression bandages

The following photographs indicate typical types of compression bandages used within the Trust and local community Trusts



K-Two (has printed circles visible on both layers of the bandage system)



Actico (pale beige colour, firm/tightly applied, short stretch bandage)



K plus (used alone as reduced compression, or as part of a 4 layer bandage. Pale blue stripe is visible. Often applied in figure of 8. Soft wadding and crepe are applied below this layer)



Coban or K-four (beige elastic bandage, commonly used as the final layer of a 4 layer bandage system)

Referral for compression bandaging

Patients who require compression bandaging should be referred to the Tissue Viability team. Where possible and appropriate, the Tissue Viability nurses will facilitate reapplication of compression bandages in ward areas.

Appendix C

Standard ANTT Guidance Poster

Simple Wound Care
Using Standard-ANTT

for the ANTT Practice Framework see: www.antt.org

Preparation zone

1
Disinfect Hands
with alcohol hand rub
or soap & water

2
Disinfect Tray
according to local policy
creating a General
Aseptic Field

3
Gather Equipment
& place on bottom shelf
of trolley

Patient zone

4
Apply Apron
& disinfect hands with
alcohol hand rub or soap
& water

5
**Apply Non-Sterile
Gloves**
as local policy

6
Remove Dressing
protecting Key-Site
with non-touch
technique (NTT)

7
Dispose of Dressing

8
Dispose of Gloves
& immediately
decontaminate hands

9
Disinfect Hands
with alcohol hand rub or
soap & water

10
Open Equipment
protecting Key-Parts with
NTT & Micro Critical
Aseptic Fields

11
**Apply Non-Sterile
Gloves** as local policy
& assemble equipment
using NTT

12
Clean Wound
protecting Key-Site
using NTT

13
Dress Wound
using NTT

14
Dispose of Waste
gloves then apron &
immediately ...

15
Disinfect Hands
with alcohol hand rub or
soap & water

Decontamination Zone

16
Disinfect Tray
& trolley according
to local policy

17
Disinfect Hands
with alcohol hand rub
or soap & water

ANTT® v4.0. Please note that local policy or equipment changes may be applied. For advice, please see enquiries@antt.org

★

Appendix D Surgical ANTT Guidance Poster

Complex Wound Care
using Surgical-ANTT

for the ANTT Practice Framework see: www.antt.org

Preparation zone 1 Disinfect Hands with alcohol hand rub or soap & water 2 Disinfect Surface according to local policy creating a General Aseptic Field 3 Gather Wound Pack & equipment & place around the prepared working surface	Patient zone 4 Apply Disposable Apron & disinfect hands 5 Open Wound Pack creating a Critical Aseptic Field 6 Prepare Equipment protecting Key-Parts using non-touch technique (NTT)	
7 Apply Non-Sterile Gloves as per local policy 8 Place Drape under the wound 9 Remove Dressing protecting Key-Site using NTT & dispose of dressing in waste bag	10 Dispose of Gloves & Immediately ... 11 Disinfect Hands with alcohol hand rub or soap & water 12 Apply Sterile Gloves	13 Clean Wound protecting Key-Site using NTT
14 Dress Wound using NTT 15 Dispose of Waste remove gloves & apron & immediately ... 16 Disinfect Hands with alcohol hand rub or soap & water	Decontamination zone 17 Disinfect Surface according to local policy 18 Disinfect Hands with alcohol hand rub or soap & water	

ANTT® © v4.0. Please note that local policy or equipment changes may be applied. For advice, please see enquiries@antt.org



APPENDIX C – EIA form

Equality Impact assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: Heidi McMillan		Date of EIA completion: 12.11.2025
Department: Tissue Viability		Division: Surgery
Name of service/policy/procedure being reviewed or created: Wound Management Policy		
Name of person responsible for service/policy/procedure: Heidi McMillan		
Brief summary of policy, procedure or service being assessed: Trust wide policy for wound management, covers roles/responsibilities for staff providing wound care, documentation, assessment, ANTT and surgical wounds, cavity wound management, management of hospital acquired wounds and discharging patients with wounds		
Please state who this policy will affect: Patients and Service Users, Carers or families, nursing and medical staff		
Protected Characteristic	Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)	Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening. Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.
Race and Ethnicity	No	
Sex	No	
Age	No	
Religion and Belief	No	
Disability	No	
Sexuality	No	

Pregnancy and Maternity	No	
Gender Reassignment	No	

Marriage and Civil Partnership	No	
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	No	

If you have answered 'yes' to any of the above, please complete Stage 2 of the EIA on Page 3 and 4.

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

None

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?

No

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)

Positive				Negative			
High	Medium	Low	Nil	Low	Medium	High	

If you identified positive impact, please outline the details here:

Nil impact

EIA Form Stage Two:

Signature:

*I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form



Date: 01/12/2025