

Wound Healing Pathway

For all wounds which fail to heal or improve within 2 weeks

Complete a full holistic wound assessment, assess risk and take appropriate action.

Include: TIMES, establish wound aetiology and ensure all appropriate standards of care are implemented.

Considerations

For a new or deteriorating wound. Consider if the wound is:

- A diabetic foot ulcer - refer to the High-Risk Foot Team within 24hours.
- A malignant or suspected malignant wound - refer to Dermatology and/or Palliative Care.
- A leg ulcer - commence primary dressing as per guidance below, then refer to Lower Limb/Leg Ulcer Pathway for ABPI and compression selection.

Complete Wound Hygiene



Caution with patients on anticoagulant therapy or wound-related pain.

Do not use on malignant wounds.

cleanse the wound with Octenilin irrigation solution and a wound debridement pad. **(See Wound Hygiene Steps on Page 2).**

Consider if sharp wound debridement is appropriate and ensure this is performed only by a skilled and competent Clinician.

Is the wound showing signs and symptoms of local infection or suspected Biofilm?
(Refer to the infection continuum on page 2 for signs and symptoms)

No

Commence UrgoStart Plus Treatment Range

UrgoStart Plus Pad/Border

Can be used on all levels of slough (0-100%) From day 1 to complete healing.

- Change the dressing as a minimum once weekly or more frequently depending on exudate levels.
- Reassess and document weekly as per local policy and continue with the treatment for a minimum of 12 weeks, monitoring for signs of improvement.

(Improvement is evident when levels of slough reduce and when there is a reduction in wound surface area)

Yes

Commence UrgoClean Ag for 2 weeks

UrgoClean AG

- Change the dressing twice per week or more frequently depending on exudate levels.
- Monitor weekly and document accordingly.
- Apply a secondary absorbent dressing as required.

Have the clinical signs of infection resolved?

Yes

No

Continue with UrgoClean Ag for a further 2 weeks.

If the wound deteriorates or signs of spreading infection present, clean the wound with saline, obtain a wound swab and consider a referral to the Tissue Viability Service for advice.

If the patients general condition is deteriorating or systemic infection is suspected complete NEWS score and if necessary escalate for emergency care.

Contraindications

UrgoStart Plus Treatment Range must not be used on:

- Infected wounds
- Hard eschar/ Necrosis
- known or suspected malignant wounds

Does the wound require an adhesive bordered dressing?

Yes

No

UrgoStart plus
Border

UrgoStart plus
Pad

Once the wound has healed

Provide appropriate discharge information regarding skin care, standards of care and when and where to escalate any concerns.

This guidance does not replace clinical judgement of the assessing clinician.

i.e. Sinus/Deep Cavity wounds. Consider an alternative treatment (refer to local wound care formulary) or seek further advice for dressing selection from Tissue Viability Service.

* Biofilm

A biofilm can be described as bacteria embedded in a thick, slimy barrier of sugars and proteins. The biofilm barrier protects the microorganisms from external threats (Phillips PL, Wolcott RD, Fletcher J, Schultz GS, 2010)

- Biofilms on a wound cannot be observed by the naked eye
- If a wound is hard-to-heal and is not responding to standard protocols of care (e.g. antimicrobial intervention), it should be assumed that biofilms with microorganisms, tolerant to treatment, are present
- Biofilms rapidly recover from mechanical disruption and reform mature biofilm within 24 hours. Therefore using a dressing that continuously cleans (UrigoClean Ag) the wound is beneficial.

Wound with signs of infection*



Local infection

Covert Signs (Subtle)

- Hypergranulation (excessive 'vascular' tissue)
- Bleeding, friable granulation
- Epithelial bridging and pocketing in granulation tissue
- Delayed wound healing beyond expectations

Overt Signs (Classic)

- Erythema (redness may not be evident on dark skin tones)
- Local warmth
- Swelling
- Purulent discharge
- Wound breakdown and enlargement
- New or increasing pain
- Increasing malodour

Action:

Topical antimicrobial, monitor for signs of spreading / systemic infection complete infection score/NEWS 2

Spreading infection

- Lymphangitis (infection of lymph vessel)
- Spreading erythema (redness may not be evident on dark skin tones)
- Crepitus (crackling sensation when skin palpated)
- Wound breakdown
- Malaise / lethargy / general deterioration

Action: Topical and systemic antimicrobials, monitor for signs of systemic infection complete infection score/ NEWS 2. Escalate to GP for assessment obtain a wound swab

Systemic infection - medical emergency

- Severe Sepsis
- Septic shock
- Organ failure
- Death

Action: Escalate for emergency care Complete wound infection score/NEWS 2

Action: Escalate to GP for assessment

Wound Hygiene

Step 1 Cleanse the wound and peri wound skin with Octenilin irrigation solution and debridement pad (Alprep or Debrisoft lolly).

Mechanically debride the wound bed and peri wound skin to remove debris, slough, skin scales and biofilm. This may cause pinpoint bleeding. Consider if appropriate, an onward referral for sharp debridement by a skilled clinician to support with the removal of devitalised tissue and callus.

Cleanse 10-20cm from the wound edge or area where a device or dressing has been applied. Consider Octenisan wash mitts. This process of wound cleansing should take 2-5 minutes depending on the wound size.

Step 2 the wound edges. Remove necrotic, crusty and/or overhanging wound edges that may be harbouring biofilm. Ensure the skin edges align with the wound bed to facilitate epithelial advancement and wound contraction. Select method based on skill of clinician.

Step 3 the wound. Address residual biofilm while preventing or delaying regrowth of biofilm by using dressings containing antibiofilm and/or antimicrobial agent. See page 1. Do not debride Diabetic Foot ulceration or Ischaemic Leg / Foot ulcers without MDT advice.

Ordering Codes




UrigoClean Ag

Dressing Size	Pack Size	Product code	NHS Code*	PIP Code
6 x 6cm	10	551123	ELY609	401-9774
10 x 10cm	10	552155	ELY610	401-9782
15 x 20cm	5	551125	ELY611	401-9790




UrigoStart plus Pad

Dressing Size	Pack Size	Product code	NHS Code*	PIP Code
6 x 6cm	10	552301	ELZ884	406-4432
10 x 10cm	10	552302	ELZ885	406-4440
15 x 20cm	10	552305	ELZ886	406-4457




UrigoStart plus Border

Dressing Size	Pack Size	Product code	NHS Code*	PIP Code
8 x 8cm	10	552291	ELZ879	406-4390
10 x 10cm	10	552292	ELZ880	406-4408
13 x 13cm	10	552293	ELZ881	406-4416
15 x 20cm	10	552296	ELZ882	406-4424