

Newham Wound Care Provision

Carole Taylor
Lead Nurse Tissue Viability



Newham Simple Wound Care / Suture Removal Service

Specification - Aims

- To increase the availability of basic wound care, dressings and suture removals within Primary Care
- Providing patients with a more appropriate place of care rather than attending Urgent care, Complex Care clinics, and A&E.
- Providing this activity in primary care/community clinics will increase the capacity for all clinics that provide wound care services.
- To deliver an integrated model of care that spans across primary and community care
- Delivers care closer to home
- Puts patients at the centre of care by reducing variation
- Improving access, and standardising the quality of provision, regardless of where services are accessed



We care
We respect
We are inclusive

- To ensure that there is a **5-day wound care service available**
- Delivered by PCN's – Simple Wounds & Suture/Clip Removal
 - sufficient appointments to support your patient list
- EPCT Dressing Clinic Complex Wounds
- Venous Leg Ulcers Tissue Viability Clinic



- The service will deliver routine simple wound care to registered and temporarily registered patients.
- To include
 - Removal of sutures, clips, staples and steri-strips
 - Closed Post-op wound dressings
 - Open surgical wounds of a depth up to 2cm or less
 - Superficial wounds, such as lower leg wounds caused by trauma or insect bites
 - Superficial and superficial partial burns/scalds
 - bruises, skin tears and lacerations capable of simple closure.



• Complex Wound Care – EPCT Dressing Clinic

- Progressive leg ulcer management requiring compression bandage therapy – TV LU Clinic
- Wound cavities greater than a 2cm depth
- Fistula dressings
- Compression bandages
- Diabetic foot ulcer dressings
- Negative pressure wound therapy



- If a patient presents to Urgent and Emergency Care services between 8.00am and 6.30pm Monday to Friday with the following wound care requirements;
 - Post-surgical sutures and clips removal
 - Post-surgical dressing changes
 - Superficial wound care –
 - Superficial burns (not children 0 – 16)
 - Bruises,
 - Minor leg wounds
- The wound will be assessed and treated
- The patient will be advised to contact the SPA to book into their PCN/practice for follow up wound care treatment.
- If a patient requiring simple wound care arrives in the complex EPCT wound care clinic, they will be advised to contact their practice for an appointment.



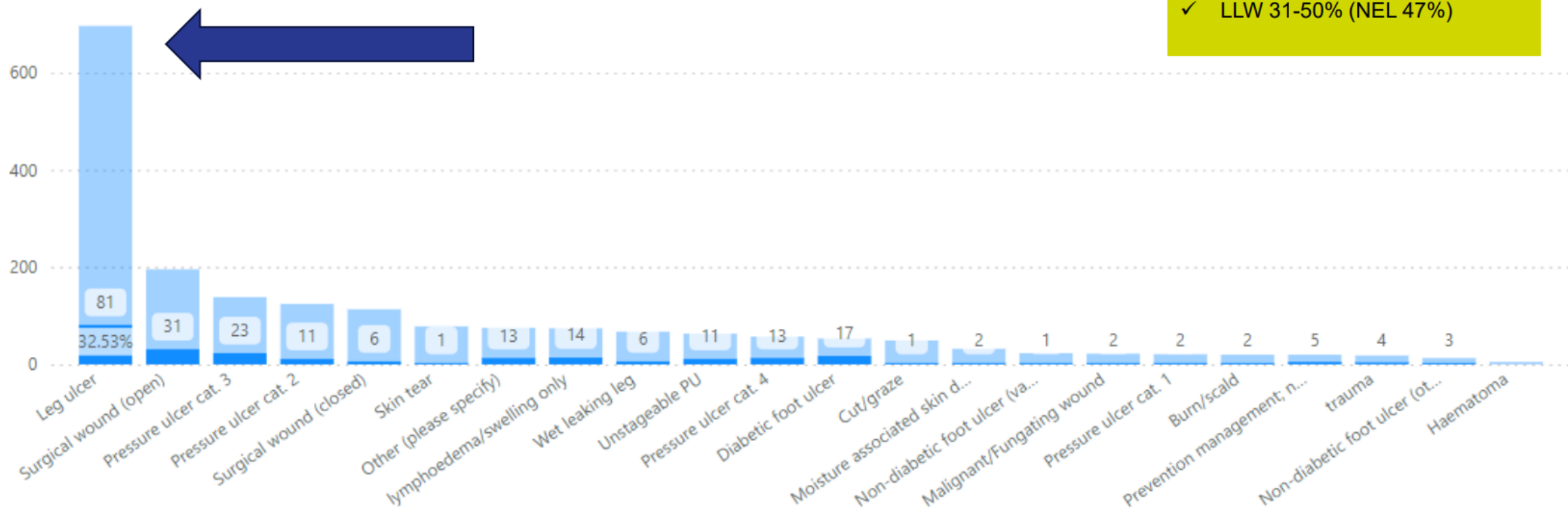
Wound costs

- The patient: reduced quality of life and wellbeing
- The Clinician: frequent dressing change. Supporting patients.
- The cost to the NHS: £2.5 - 3.1 million per annum accounting for between 2-4% of health-care budgets

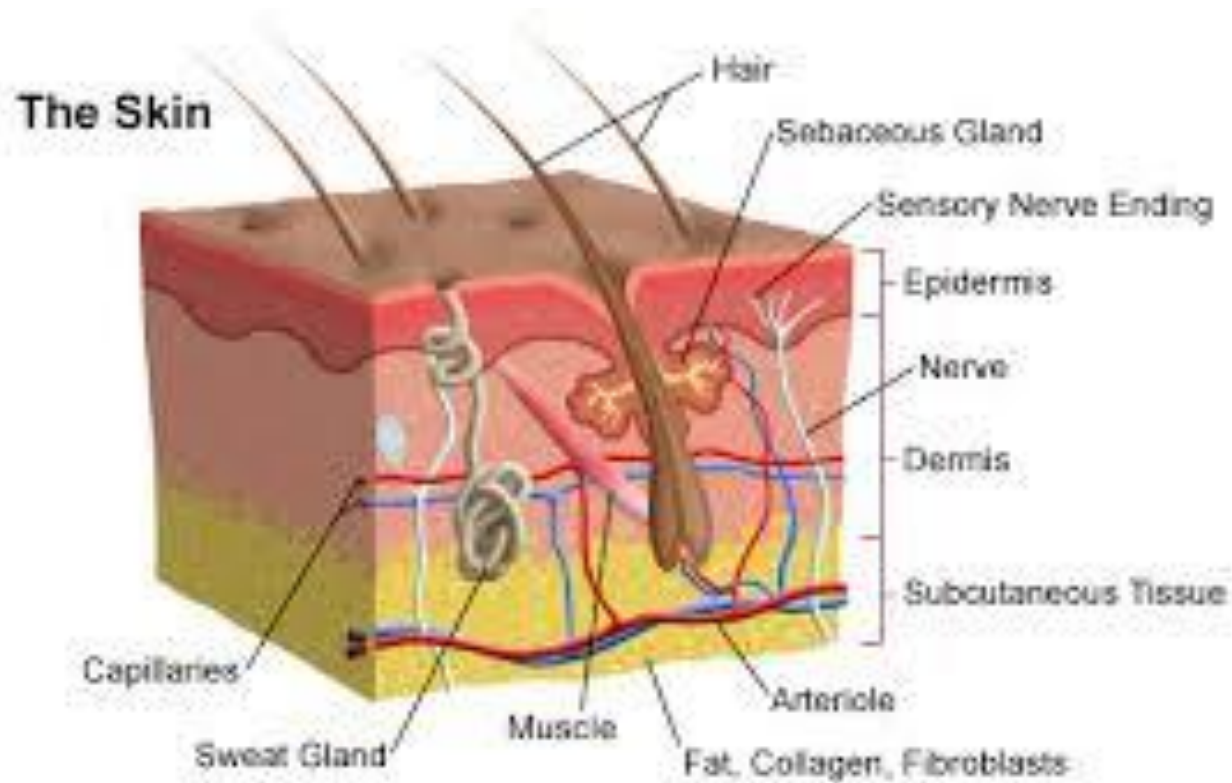
(Posnett et al 2009)

Newham: Worst wound as classified by the clinician

Worst Wound Type?



JWC
 ✓ LU 19-30% (NEL 36%)
 ✓ LLW 31-50% (NEL 47%)



- Largest organ in the body
- Made up of 3 layers
 - Epidermis
 - Dermis
 - Subcutaneous tissue
- Protective shield against heat, light, injury, and infection.

- Caused by an disruption to the skin resulting in it being cut or broken and will heal by primary, secondary or tertiary healing
- Surgery
- Trauma
- Burn
- Bites
- Cancer
- Dermatological conditions



4 phases of healing

- Haemostasis
- Inflammatory phase
- Proliferative phase
- Maturation



Haemostasis

- Injury occurs
- Blood vessels constrict
- Platelets stick together
- Coagulation occurs
- Platelet plug



Inflammatory Phase

- Neutrophils and macrophages engulf to clean up any debris
- Hyperaemia and heat
- Swelling and pain
- Loss of function
- Sets the stage for the next steps of healing
- This stage lasts for up to 72 hours and can be mistaken for infection



Proliferative Phase

- Rebuilding of new tissue
 - Collagen & extracellular matrix
- Wound contracts
- New network of blood vessels
- Granulation tissue
 - Pink, red with a bobble like texture
- Epithelial Islands



Maturation phase

- Wound closure
- Vascularity decreased
- Granulation/ Epithelialisation
- Tissue becomes pale (Scar)
- Strengthening/remodelling phase
- Can take from 3 weeks or longer
- Area will never be as strong
- 80% the tensile strength of healthy skin



- Acute wounds

- Intentional e.g surgical wounds
- Traumatic wounds e.g stab wounds, burns



- Primary Healing

- Chronic wounds

- Pressure ulcers
- Leg ulcers
- Infected surgical wounds
- Diabetic foot ulcers
- Malignant wounds
- Burns can become chronic



- Secondary Healing



- Usually heal by primary intention in which the wound edges are brought together and held by sutures or clips
- Expected to heal in a orderly and timely healing pathway
- Full healing usually within 6-10 days



Chronic Wounds

- Heal by secondary intention
- Failure to go through the orderly healing process
- Wound edges cannot be brought together
- Will leave some scarring usually an oval or circular shape
- Can take up to 8 weeks or more to heal
- Can become stuck/static
- 76% of patients with a chronic wound may have three or more co-morbidities
- 46% have diabetes making them more likely to be harder to heal



- Tertiary intention (delayed primary closure)
- wound is initially left open after debridement of all nonviable tissue.
- Wound edges may be surgically approximated following a period of open observation, when the wound appears clean and there is evidence of good tissue viability and tissue perfusion
- Example Pilonidal Sinus



Wound Assessment

Effective treatment of patients with wounds

- Determine the cause of the wound
- Identifying underlying conditions that may contribute to the wound and to delayed healing
- Assessment of the wound status: Wound bed and progress
- Development of a management plan

(World Union of Wound Healing Societies 2008)

Patient Assessment

- Assess the patient and not the 'hole in the patient'
- Wound cause
- Underlying pathology/ co-morbidities
- Mobility, nutrition, pain
- Impact on the patient/family



Assessment

Involve

- The patient
- Carers
- Families

To ensure

- Engagement
- Concordance with treatment
- Promote Self Care where possible



Best practice

- Accurate and timely patient and wound assessment
- Identify the cause
- Treatment of the underlying cause
- Appropriate wound management interventions
- Wound Management Guidelines
- Wound dressing Formulary
- Documentation

Factors affecting healing

- Nutrition
- Oxygenation
- Infection
- Age
- Chronic health conditions
- Medications
- Smoking
- Socioeconomic factors
- Psychological factors
- Patient concordance with treatment

Wound assessment -

- Type
- Location
- Duration
- Size
- Photography
(Consent)
- Wound Bed



Leg Wounds

- In England, there is considerable variation in leg ulcer practice and outcomes
- increases care costs and extends healing times
- estimated 739,000 leg ulcers in England
- estimated associated healthcare costs of £3.1 billion per year



Leg Ulcer
Recommendations
August 2023

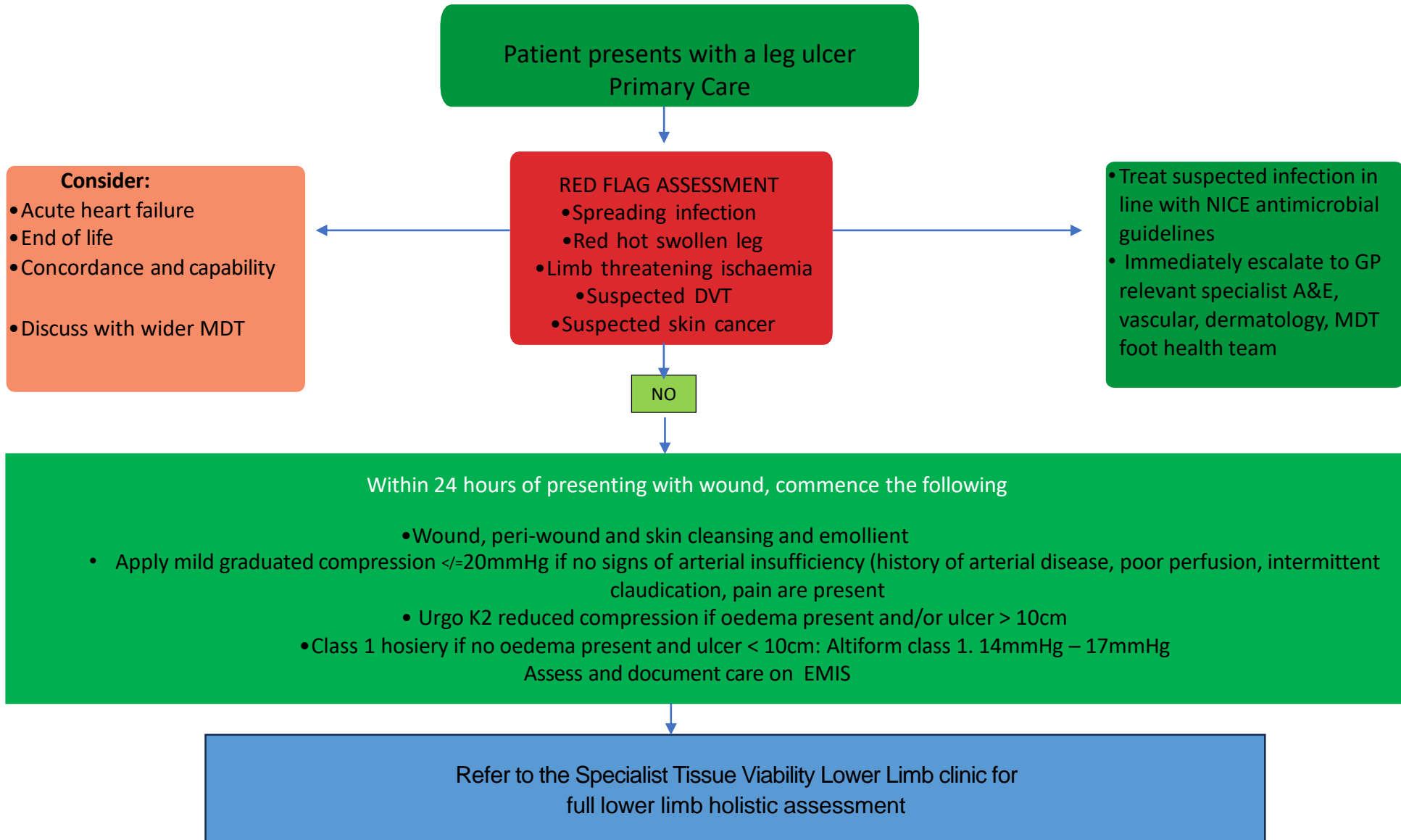


Working in partnership with

The **AHSN** Network

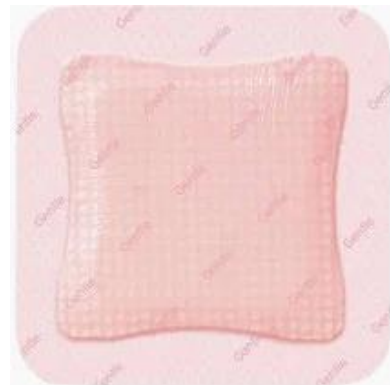


Lower Limb Wound Pathway: Immediate and Necessary Care



GP Practice Lower Limb Wound

- Patient present with lower limb wound <10cm
- Cleanse with saline
- Apply one layer dressing such as Biatain Silicone or Allevyn Gentle
- Class 1 hosiery if no oedema present : Altiform class 1. 14mmHg – 17 mmHg
- Assess and document care on EMIS
- Refer to TV service continue with care until patient has appointment



Measuring Guide

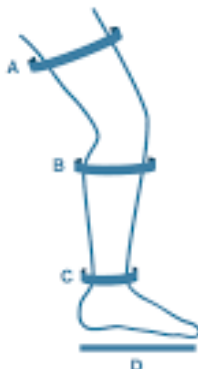
	A: Mid-thigh	B: Calf	C: Ankle	D: Foot
Small	41 - 54	32 - 38	19 - 25.5	20 - 25
Medium	44 - 58	34 - 40.5	21 - 27.5	22 - 28
Large	47 - 61	36 - 43.5	23 - 29.5	24 - 31
XLarge	50 - 64	38 - 47	25 - 32	26 - 33

Measurements in cm

Available Styles

	BELOW KNEE		THIGH	
	Open Toe	Closed Toe	Open Toe	Closed Toe
Class I	●	● ●	●	● ●
Class II	●	● ●	●	● ●
Class III	●	● ●	●	● ●

Soft Heel ● Back ●



Arterial Leg ulcers

- Pain on elevation
- Relieved if leg hangs out of bed
- No Compression
- Refer to Vascular Services
- Simple dressing secured with bandage
- Keep Dry
- Manage Pain



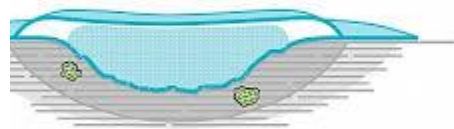
Surgical wounds

- One or two visits
- Removal sutures/clips
- Simple post op dressing



Dehisced Surgical Wound

- Unable to re-suture
- Heal by secondary intention
- If up to 2cm deep or less Biatain Silicone Dressing



Burns Scalds

- Dressing choice should be based on the findings of the holistic assessment
- Maintains a moist wound environment
- Contours easily
- Non-adherent to protect delicate skin
- Retains close contact with the wound bed
- Easy to apply and remove
- Painless on application and removal
- Protects against infection
- Cost-effective.



Referral Burns Scalds

- Burns should be managed using a multidisciplinary approach and refer to a specialist burns unit :
- All complex burns
- All full thickness burns
- Deep dermal burns affecting more than 5% the TBSA in adults
- All deep dermal burns in children
- Superficial epidermal burns for adults with TBSA 15-25% with blistering
- Superficial epidermal burns for children with TBSA >10%
- All Circumferential burns
- Any high pressure steam injury
- Any burn associated with suspected non accidental injury regardless of the complexity of the burn
- surface, such as the neck, axilla, elbow or knee
- People with significant co-morbidities that may affect wound healing or increase the risk of complications that may affect wound healing or increase the risk of complications, or those clinically judged to be at risk of complications
- People with other significant injuries in addition to the burn such as crush injuries, fractures, head injuries or penetrating injuries
- If there is any uncertainty as to whether referral is needed or appropriate
- Superficial epidermal burns e.g sunburn
- Where there are signs and symptoms of heat exhaustion or heat stroke
- All burn wounds that are not healing as expected or that have not healed within 2 weeks of initial injury should be referred to a specialist burns unit
- Burns associated with suspected inhalation injury e.g singed nasal hair, sore throat, black carbon in the sputum, hoarse voice, stridor, wheeze or signs of carbon in the oropharynx
- Burns with associated sepsis
- Burns affecting the face, hands, feet genitalia/perineum, or flexural

London & South East England Burn Network

Appendix 5 London & South East England Burn Network

The LSEBN serves a population of around 21 million people, living in London, the East of England, Kent Surrey and Sussex, Thames Valley and Wessex.

Burn Referral Guidelines: Criteria for Referral

Adults and children with the following injuries should be discussed with the local Burn Service

Cause	<ul style="list-style-type: none"> - Inhalation injury - Deep dermal and full thickness - Electrical - Chemical - Burns with trauma
Affected Area	<ul style="list-style-type: none"> - Face, hands, genitals, feet, joints, scalp, ears - Circumferential
Size	<ul style="list-style-type: none"> - >1% Total Body Surface Area [TBSA] in children - >3% TBSA in adults
Age	<ul style="list-style-type: none"> - Neonates (<28 days old)
Wound	<ul style="list-style-type: none"> - Not healed within 2 weeks - Infected
DISCUSS	<ul style="list-style-type: none"> - Suspected non accidental injury, mental health history or self-harm - Progressive non burn skin loss conditions (TENS, SSSS, Necrotising Fasciitis) - Significant co-morbidity (eg diabetes) or immunocompromised patients - Friction burns with full thickness skin loss - Cold burns with full thickness skin loss - Older people (60+) - Children "unwell" with a burn (see below) * - Any other case that causes concern

*** Toxic Shock Syndrome / Burns Sepsis Syndrome**
 Seek early advice from local Burn Service
 Consider treating with fluid resuscitation, IV antibiotics +/- FFP

MEDICAL EMERGENCY

Any patient
Any size burn
Any of these symptoms
=

Risk of Toxic Shock Syndrome

➔

- Temperature > 38°C
- Rash
- Diarrhoea and vomiting
- General malaise
- Not eating or drinking
- Tachycardia/tachypnoea
- Hypotension
- Reduced urine output

CONTACT DETAILS

www.trips.nhs.uk

St Andrews Burns Service
Broomfield Hospital (Chelmsford)
Adults/Children **01245 516037**

Chelsea & Westminster Hospital (London)
Adults **02033152500**
Children **02033153706**

Queen Victoria Hospital (East Grinstead)
Adults **01342 414440**
Children **01342 414469**

Stoke Mandeville Hospital (Aylesbury)
Adults and Children **01296 315040**

If in doubt, seek early advice from local Burn Service

Telephone support and advice on initial care of any patient with a burn injury is available at all times

Approved by LSEBN CGG on December 2015

Skin Tear

- A skin tear is a traumatic wound caused by mechanical forces including, removal of adhesives
- A skin tear is a partial or complete separation of the outer skin layers from the inner tissue
- 70-80% occur on the hands or arms
- Avoid using Steristrips
- Using Gentle Silicone dressing



ISTAP Skin Tear Classification System

The ISTAP Skin Tear Classification System should be utilized to ensure a common language for identifying and documenting skin tears. It can be accessed in several languages online at www.skintears.org/resources, including:

- Arabic
- Chinese
- Czech
- Danish
- Dutch
- English
- French
- German
- Hebrew
- Italian
- Japanese
- Portuguese
- Brazilian
- Portuguese
- Spanish
- Swedish
- Turkish

If you'd like the tool translated into another language, please contact info@skintears.org.

Type 1: No Skin Loss



Linear or Flap Tear which can be repositioned to cover the wound bed

Type 2: Partial Flap Loss



Partial Flap loss which cannot be repositioned to cover the wound bed

Type 3: Total flap loss



Total Flap loss exposing entire wound bed

Definition of a flap: "A flap in skin tears is defined as a portion of the skin (epidermis/dermis) that is unintentionally separated (partially or fully) from its original place due to shear, friction, and/or blunt force. This concept is not to be confused with tissue that is intentionally detached from its place of origin for therapeutic use e.g. surgical skin grafting." Van Tiggelein et al, 2020

LeBlanc et al 2013

International Official Partners

ISTAP currently has formal partnerships with over 20 organisations globally including global & national associations, research centres, and higher education institutions. For a full list of ISTAP's International Official Partners, please visit: www.skintears.org/partners. To inquire about becoming an International Official Partner, please contact info@skintears.org.



NURSES SPECIALIZED IN WOUND, OSTOMY AND CONTINENCE CANADA
INFIRMERES ESPECIALIZADAS EN FERIDAS, OSTOMIA E CONTINENCIA CANADA

Boils Abscess

- Treat infection
- Clean saline
- One layer dressing
- Teach Family Carers
- Review weekly



Low exudate – Soft Pore Dressing



Moderate to High Exudate - Foam Dressing



Diabetic Foot Ulcers

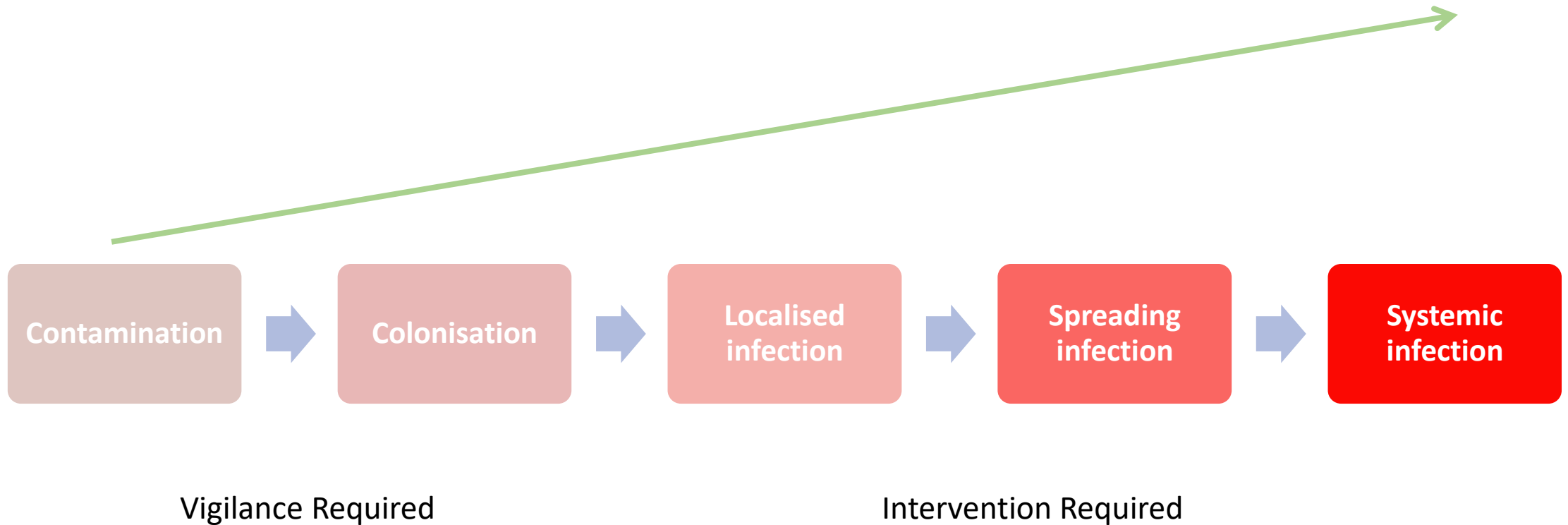
- Refer to Foot Health
- Prevent infection
- High risk of Amputation
- Often no sensation in feet
- Simple dressing
- Keep dry avoid maceration



Infection

- Micro-organisms present in all chronic wounds
- Does not indicate that the wound is infected
- Healing may not be impaired
- Host response varies
- If not responding to treatment – swab/tissue sample for microbiology

Infection: Interaction between Bacteria & Host



Infection

- Red
- Inflamed
- Painful
- Increased exudate
- Offensive smelling
- Non-healing
- Patient unwell
- Rule out Sepsis



Treatment of infection

- Optimise host resistance
- Wound debridement
- Wound cleansing
- Use of topical anti-microbials
- Increased frequency of dressing change
- Management of pain & malodour
- Systemic antibiotics

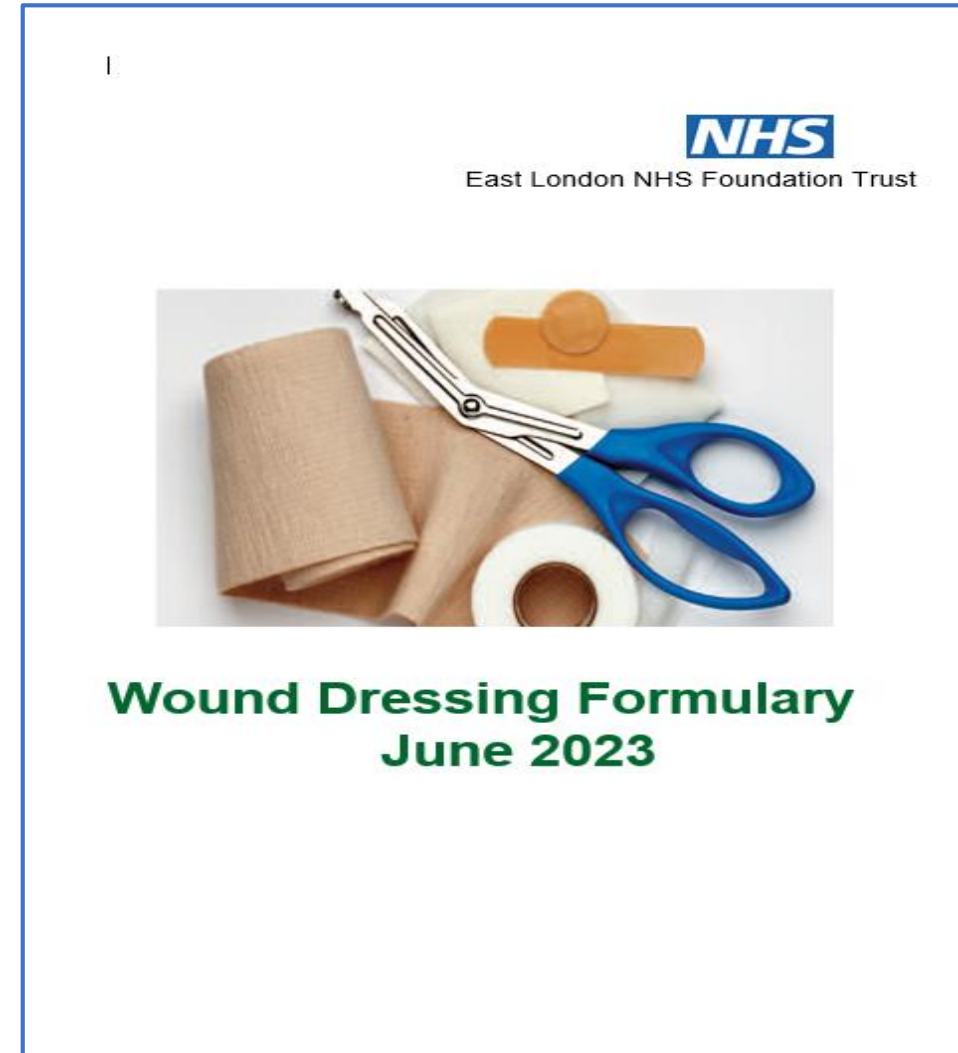


Which dressing?



Wound Dressing Formulary

- Launched in 2009 following an audit of dressings used in clinical practice.
- Reviewed every 3 years
- Based on current best practice
- Cost effective wound care
- Hints & Tips





East London
NHS Foundation Trust

Thank you.



Carole Taylor
Lead Nurse Tissue
Viability