

Hard-to-Heal Wound Management Pathway and Care Plan



Does your patient have the following signs and symptoms

- Wound remains static despite optimal wound management and health support
- Poor quality granulation tissue/friable hypergranulation
- Signs of local infection such as: increased exudate, low-level chronic inflammation and erythema
- Wound not responding to appropriate antimicrobial treatment
- History of antibiotic failure or persistent or recurring wound infection
- Wound containing a "foreign" material (e.g. fibrin, necrosis and/or slimy surface substance) on wound surface

International Wound Infection Institute (IWII) Wound infection in clinical practice. Wounds International 2016 & 2022

WOUND HYGIENE STEPS







No Complete wound assessment & implement standard wound management protocol

Implement Wound Hygiene..

Yes)

Wound hygiene should be performed following a holistic assessment & when the objective is to kickstart healing by removing and minimising all unwanted materials, including biofilm, devitalised tissue & foreign debris, from the wound

AGREED PLAN TO BE DELIVERED FOR EACH STEP

Goal: Cleanse the wound bed to remove devitalised tissue, debris and biofilm. Cleanse the peri-wound skin to remove dead skin scales and callus, and to decontaminate it.

Method - Use a Prontosan soak on the wound bed for 5-15 minutes as per wound presentation (see Prontosan Wound Preparation Pathway).

Note: Cleanse 10-20cm from wound edge or area that has been covered by device or dressing. For leg ulcers suitable for leg washing, please use a lined bowl of warm water to clean leg prior to ultilising Prontosan soaks.

Goal: Remove as much loose tissue, slough, debris and biofilm in the wound bed at every dressing change.

Method - Select an appropriate debridement pad from the left and irrigate with Prontosan (note UCS wipes do not need Prontosan added).

Use the products in a circular motion with as much pressure as the patient can tolerate to remove any visible debris to the wound bed.

Dependent on skill of clinician:

TVNs may consider larval therapy or sharp debridement.

Note: Please refer to Tissue Viability for conservative sharp debridement or for diabetic foot wounds refer to Specialist Podiatry for sharp debridement.

Goal: Remove as much 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.

Method - Select an appropriate debridement pad from the left and irrigate with Prontosan (note UCS wipes do not need Prontosan added) .

Dependent on skill of clinician:

TVNs may consider larval therapy or sharp debridement.

Secondary dressing options if required:

Note: Please refer to Tissue Viability for conservative sharp debridement or for diabetic foot wounds refer to Specialist Podiatry for sharp debridement.



*Aquacel® Ag+ Extra^{™ or} Aquacel® Ag+ Ribbon

Required Primary Dressing

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REFASHION

STEP 3 -



*If AQUACEL® $Ag + Extra^{TM}$ dressing is not appropriate consider other primary dressing with antimicrobial and anti-biofilm properties.





OR











Please **SCAN** QR code or refer to the Tissue Viability Webpage for the formulary

All the above steps **MUST** be completed at each dressing change as agreed. Increase or decrease the intensity of the implementation of each step depending on patient's tolerance and wound progression. Re-assess every 2–4 weeks and discontinue the use of any antimicrobial products when goals are achieved and the wound is showing signs of healing. All Antimicrobials products **MUST** not be used long-term, please refer to Tissue Viability for further clinical advice.