**Wound Cleansing Policy**

Assess the wound in accordance with Trust Policy

- **Yes**
  - Has the wound been present for more than 14 days?
    - **Yes**
      - Soak gauze with Prontosan wound irrigation solution.
      - Apply soaked gauze to the wound and leave in situ for 10 minutes.
      - Remove gauze and use a clean gauze swab to cleanse the surrounding skin.
      - Is the wound heavily exuding?
        - **Yes**
          - Apply dressing as per Wound Care Formulary.
        - **No**
          - Consider using Prontosan Gel X to reduce bacterial formation. Apply up to a 3mm layer of Prontosan Gel X to the wound bed.
      - Reassess every at every dressing change in accordance with Trust Policy.
    - **No**
      - Discontinue Prontosan wound irrigation solution/gel X if signs of local spreading and systemic infection have resolved unless the patient has any of the risk factors associated with increased risk of wound infection.

- **No**
  - Are any of following factors associated with increased risk of wound infection present?
    - Characteristics of the individual
      - Poorly controlled diabetes
      - Prior surgery
      - Radiation therapy or chemotherapy
      - Conditions associated with hypoxia and/or poor tissue perfusion (e.g. anaemia, cardiac or respiratory disease, arterial or vascular disease, renal impairment, rheumatoid, arthritis, shock)
      - Immune system disorders (e.g. acquired immune deficiency syndrome, malignancy)
      - Inappropriate antibiotic prophylaxis, particularly in acute wounding
      - Nutritional deficiencies
      - Alcohol, smoking and drug abuse
    - Characteristics of the wound
      - Acute wounds
        - Contaminated or dirty wounds
        - Trauma with delayed treatment
        - Pre-existing infection or sepsis
        - Spillage from gastro-intestinal tract
        - Operative factors (e.g. long surgical procedure, hypothermia, blood transfusion)
      - Chronic wounds
        - Degree of chronicity/duration of wound
        - Large wound area
        - Deep wound
        - Anatomically located near a site of potential contamination (e.g. perineum or sacrum)
      - Both wound types
        - Foreign body (e.g. drains, sutures)
        - Haematoma
        - Necrotic wound tissue
        - Impaired tissue perfusion
        - Increased exudate or moisture
        - Colonised with MRSA
    - Characteristics of the environment
      - Hospitalisation (due to increased risk of exposure to antibiotic resistant organisms)
      - Poor hand hygiene and aseptic technique
      - Unhygienic environment (e.g. dust, unclean surfaces, mould/mildew in bathrooms)
      - Inadequate management of moisture, exudate and oedema
      - Repeated trauma (e.g. inappropriate dressing removal technique)
  - Cleanse wound in accordance with local Wound Management Practice. Reassess at every dressing change in accordance with Trust Policy.