Rotherham Doncaster and South Humber NHS Foundation Trust

Wound care and tissue viability policy manual

DOCUMENT CONTROL:

- **Version:** 4.2
- **Unique Reference number:** 493
- **Approved by:** director of corporate assurance
- **Date approved:** 28 October 2026
- **Document Author:** Clinical nurse specialist, tissue viability
- **Title of Accountable Director:** chief nursing officer
- **Date issued:** 29 October 2026
- **Review by date:** 31 May 2029

Contents

1. Document summary 4
2. Introduction and aim 5
3. Procedures 7
3.1 First to dress initiative procedure 7
3.1.1 Non-registered clinicians 7
3.1.2 Registered clinician responsibilities 7
3.1.3 Infection control 7
3.1.4 Professional accountability: community 7
3.1.5 Wrap pack 7
3.1.6 Housebound patients 8
3.1.7 Wound care formulary 8
3.2 Pressure ulcers, prevention, detection and treatment procedure 8
3.2.1 Assessment of pressure ulcer risk 8
3.2.2 Surface 8
3.2.3 Keep moving 9
3.2.4 Incontinence 10
3.2.5 Nutrition 10
3.2.6 Giving information 10
3.2.7 Guidelines for specialist patient groups 10
3.2.8 Categorisation of pressure ulcers 11
3.2.9 Documentation of pressure ulcer 12
3.2.10 Treatment of pressure ulcer 12
3.3 Wound photography using smartphone or digital device 12
3.3.1 Principles 12
3.3.2 Assessment 12
3.3.3 Risk management 12
3.3.4 Consent 13
3.3.5 Taking photographs 13
3.3.6 Storage of photographs 13
3.3.7 Quality improvement 13
4. Responsibilities 13
5. Training 15

6. Monitoring Arrangements 16
7. Related documents and associated references 16
8. Appendices 17
8.1 Appendix A skincare protocol for incontinence associated dermatitis (IAD) primary care 17
8.2 Appendix B pressure ulcer risk primary or secondary evaluation tool (Purpose T) 17
8.3 Appendix C react to RED patient and carer leaflet 18
8.4 Appendix D food first 18
8.5 Appendix E eating, drinking and swallowing awareness in dementia 19
8.6 Appendix F prevention of medical device-related pressure ulcers (MDRPU) 19
8.7 Appendix G debridement larval therapy pathway 19
8.8 Appendix H Doncaster community wound care formulary 19
8.9 Appendix I wound management guideline (TIMES) 19
8.10 Appendix J repositioning schedule 19
8.11 Appendix K preparation for taking images of wounds 19

1. Document summary

1.1 What is this policy about?

- This policy tells colleagues how to care for people who have a wound or who may be at risk of skin damage.
- It helps colleagues give safe and consistent care in community and inpatient services.

1.2 What must colleagues do?

- Colleagues must follow the wound care formulary and the agreed care pathways. They must only provide care that they are trained and competent to give.
- Colleagues must assess the person and their wound, choose the right dressing and record the care provided. They must ask a registered clinician or specialist service for help when a wound is complex, gets worse or does not heal.

1.3 First care for a wound

- The first-to-dress procedure explains what colleagues can do when they first find a wound. A trained member of colleagues may clean and cover a simple wound using the approved dressing pack.
- A registered clinician must assess the person before more dressings are provided. Colleagues must get urgent advice if there is heavy bleeding, a possible head injury, something inside the wound or any other serious concern.

1.4 Preventing pressure ulcers

- A pressure ulcer is damage to the skin caused by pressure or rubbing. Colleagues must check whether a person is at risk and make a care plan.
- The care plan may include checking the skin, helping the person change position, using a suitable mattress or cushion, keeping the skin clean and dry, and supporting the person to eat and drink well.
- Colleagues must act quickly if they see redness, a blister, broken skin, swelling, heat, pain or a change in skin colour.

1.5 Taking photographs

- A photograph can help colleagues assess and review a wound. Colleagues must explain why a photograph is needed and get consent.
- Colleagues must use an approved Trust device, protect the person’s privacy and save the photograph in the correct clinical record. Temporary copies must be deleted.

1.6 Recording and reporting care

- Colleagues must record assessments, treatment, photographs, consent, changes and referrals clearly. Pressure ulcers at category 2 or above must be reported through the Trust incident management system, Radar.
- Colleagues must follow safeguarding procedures if they are worried that a person has not received safe or suitable care.

To note For specialist advice, colleagues can contact the Tissue Viability and Lymphoedema Service from 8.30 am to 4.30 pm, Monday to Friday, on 01302 566 999. Referrals are made using the service referral form in SystmOne.

2. Introduction and aim

Chronic wounds are a national concern. The number of people living with chronic wounds is increasing, along with the cost of providing care (Wounds UK, 2018).

NHS England set up a clinical reference group, which later became a project board. The board oversaw several workstreams under the Leading Change, Adding Value programme (NHS England, 2016a).

The workstreams responded to the main gaps in wound care and included:

- An economic case study analysis resulting in the publication of Betty's story (NHS England 2017)
- Development of a framework for lower leg management, moved forward to "Leg Matter Campaign"
- Quality indicators for wound assessment 2017 to 2019 (CQUIN framework NHS England 2016b)
- Minimal data set (MDA) for wound assessment (Coleman et al. 2017)
- Advice for commissioners when commissioning for wound care services
- Recommendations for minimal level of education for practitioner involved in wound care: moved forwarded to pressure ulcer core curriculum (NHS Improvement June 2018)
- Stop the pressure (May 2017)
- React to RED evaluation of pilot (Lisle J, Collins J May 2017) This followed the development a training package to promote a collaborative approach to pressure ulcer prevention (Five Year Forward View NHS England 2014) and RDASH was a pilot site.
- National Institute for Health and Care Excellence (NICE) (2020) Leg Ulcer Guidance

The work of the National Wound Care Strategy Programme identified significant variations in wound care approaches. Local scoping in 2019 confirmed that this is the case in Doncaster.

A wound care alliance has been created in Doncaster with the aim to reduce variations in care. The Doncaster Wound Care Alliance consists of the following parties:

- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBHFT)
- Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)
- Doncaster NHS South Yorkshire Integrated Care Board
- Primary Care Doncaster
- Fly Coast Medical Service Ltd (FCMS)

A joint Doncaster wound care formulary has been developed by the:

- Skin Integrity team, Doncaster and Bassetlaw Teaching Hospitals

- Tissue viability and lymphoedema services, Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)
- Podiatry foot protection service lead, Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)
- Senior medicines management, Doncaster NHS South Yorkshire Integrated Care Board

This policy explains how colleagues must provide wound care within the Doncaster Wound Care Alliance framework. It supports a consistent, evidence-based approach that follows local policies, pathways and national NHS guidance. Colleagues who provide wound care must complete the level of education and competency assessment needed for their role. The education programme has three levels, known as tiers 1, 2 and 3, based on the complexity of care that the practitioner provides.

Wounds are grouped into four levels of complexity in the Doncaster Wide Formulary (2025):

- Tier 1: acute healing wounds, less than 14 days old with healthy granulation and epithelial tissue managed by the general practice, adult community nursing, ward colleagues, or children's community nursing service (CCN).
- Tier 2: chronic healing wounds more than 14 days old with 50% or more healthy granulation and epithelial tissue managed by the general practice, adult community nursing, ward colleagues, or children's community nursing service (CCN).
- Tier 2 lower limb (LL): chronic healing leg ulcer that has had a comprehensive lower limb assessment and diagnosis within a tier 3 or 4 service previously, with more than 14 days old with 50% or more healthy granulation and epithelial tissue and managed by general practice, adult community nursing, ward colleagues, or children's community nursing service (CCN).
- Tier 3: non-healing wounds 50% or more devitalised, slough or necrotic tissue managed by the general practice, adult community nursing, ward colleagues and a specialist service, for example, Skin Integrity team, tissue viability and lymphoedema service, vascular service, Podiatry, children's community nursing service (CCN).
- Tier 4: complex non-healing wounds 50% or more devitalised, slough or necrotic tissue managed by a specialist service only, for example, Skin Integrity team, tissue viability and lymphoedema service, vascular service, podiatry, children's community nursing service (CCN).

A wound is a break in the normal continuity of body tissue, usually caused by injury. Wounds most often affect the skin, but they can also affect nerves, bones or internal organs.

In the North Lincolnshire and Rotherham localities tissue viability and wound care services are provided by North Lincolnshire and Goole NHS Foundation Trust and Rotherham NHS Foundation Trust. The tissue viability and wound care services provided are a combined hospital and community service.

3. Procedures

Only colleagues who have completed the education and competency assessment required for their role may provide wound care. Colleagues must follow the pathways approved by the Doncaster Wound Care Alliance and work within their competence.

3.1 First to dress initiative procedure

Use the first to dress procedure when a patient first needs a wound dressing or when the wound changes and a different dressing is needed. It applies in community services, clinics, needle exchange and day hospital services, Tickhill Road Hospital and other relevant inpatient areas. Colleagues must use the current Doncaster wound care formulary, including Appendix H, and the linked pathways. The procedure supports professional judgement and does not replace it.

3.1.1 Non-registered clinicians

A non-registered clinician may apply one initial dressing from the community core bag or inpatient stock when this is within their assessed competence. This may include an abrasion, skin tear, category 1 or 2 pressure ulcer, skin reaction or trauma caused by a dressing, moisture damage, leaking leg-ulcer bandages, a surgical wound without enough dressings, or injection-site trauma or abscess. A registered clinician must assess the patient before further dressings are supplied.

Report the wound, action taken and any concerns to a registered clinician as soon as possible and before the end of the shift. Use handover, telephone contact or a SystmOne task, as appropriate. Seek immediate clinical advice if the injury is unclear, there may be a head injury or loss of consciousness, bleeding continues, sutures may be needed, a foreign body is present, tetanus protection may be needed, or you are unsure how to manage the wound. Record the care in SystmOne, follow the wound-cleansing and wrap-pack guidance, and complete the required training.

3.1.2 Registered clinician responsibilities

A registered clinician may apply the first dressing and the first replacement dressing without a prescription when this is clinically appropriate. Assess the patient and wound, select treatment from the formulary, provide or arrange ongoing care, document the decision and refer to another service when needed.

3.1.3 Infection control

Keep first-to-dress stock in community core bags or inpatient dressing cupboards. Store, use and dispose of products in line with the Trust’s infection prevention and control and waste-management requirements.

3.1.4 Professional accountability: community

Registered clinicians remain professionally accountable for their assessment, decisions, care and records and must follow their professional code.

3.1.5 Wrap pack

The wrap pack contains simple dressings for safe initial care. Prepare by identifying the wound, choosing the most suitable dressing, making the patient comfortable, cleaning your hands and opening the pack without touching sterile items. Cleanse the wound with the supplied solution and gauze. Apply the dressing without touching

the surface that will contact the wound. Use the formulary to select a product for intact or broken skin.

3.1.6 Housebound patients

For a housebound patient, refer to the single point of access on 03000 218 996 for district nursing review within 5 to 7 days. If the patient is not housebound, refer to their GP or practice nurse. A dressing may stay in place for up to 7 days if clinically appropriate but change it sooner if needed.

3.1.7 Wound care formulary

Use the Doncaster Wound Care Formulary to assess the wound, plan care, choose a dressing and review progress. Non-registered clinicians must follow the agreed pathway and refer for registered-clinician assessment. Registered clinicians must assess the wound, review the dressing plan and refer to a specialist service when needed.

3.2 Pressure ulcers, prevention, detection and treatment procedure

A pressure ulcer is damage to the skin or underlying tissue caused by pressure or pressure combined with shear. It may occur over a bony area or under a medical device and may appear as intact skin or an open wound. Most pressure damage can be prevented. This procedure mainly applies to community services and Tickhill Road Hospital, but other inpatient services must use it when assessment shows a risk.

Use the ASSKING approach: assess risk; check surfaces; inspect skin; keep the person moving; manage incontinence and moisture; support nutrition and hydration; and give clear information. Develop an individual care plan that reflects the patient's risks, needs, choices and ability to take part in care.

3.2.1 Assessment of pressure ulcer risk

A qualified nurse must complete the first risk assessment at the start of care. For planned inpatient admissions, complete it within 6 hours, or within 12 hours if the patient's mental health prevents earlier assessment. For community patients, complete it at the first visit. Start prevention immediately if the patient is immobile, unconscious, critically ill or otherwise at high risk.

Use PURPOSE T version 2 with clinical judgement. The green pathway is for a person with no ulcer and no current risk. The amber pathway is for a person at risk and requires a prevention plan. The red pathway is for a person with a category 1 or worse ulcer, or scarring from an earlier ulcer, and requires prevention and treatment plans. Review risk whenever the patient's condition, mobility, continence, nutrition or care changes. Refer to dietetics, physiotherapy, occupational therapy, continence or other services when needed.

3.2.2 Surface

3.2.2.1 Pressure relieving devices

Choose mattresses and cushions from a full assessment of risk, comfort, mobility and ability to reposition. Consider a dynamic mattress when a patient cannot reposition and two-hourly repositioning is not possible. Equipment supports, but does not replace, repositioning and skin inspection. Check fire risk, including smoking,

before equipment is supplied. Authorised trained colleagues may order community equipment from the approved loan service. Inpatient wards must use the equipment available through local arrangements.

3.2.2.2 Equipment selection

Check the existing bed, mattress, chair and cushion before selecting equipment. At-risk patients and patients with category 1 or 2 pressure damage should have at least a high-specification foam mattress. Increase support if damage develops, risk rises or the condition worsens. Reduce support only after reassessment shows that risk, mobility or condition has improved. Report equipment failure, misuse, delay or failure to follow instructions through the Trust incident-reporting system.

Explain the options, benefits and risks to the patient. If a patient with capacity refuses equipment or treatment, record the discussion and use the informed-refusal process. Review the decision regularly. If capacity is in doubt, complete and record a capacity assessment and follow the Trust's mental-capacity and best-interests process. Complete a bedrail risk assessment when bedrails are considered.

3.2.2.3 Electric profiling beds

Electric profiling beds can reduce friction and shear and support safer movement. Check that there is enough space and a safe electricity supply. Use the knee break where appropriate to reduce sliding. Follow cleaning instructions, record prescribed equipment, check it at each visit and make sure carers know what to do if an alarm sounds. Check foam mattresses at least monthly for collapse or damage. Replace torn covers because the foam may be contaminated. Assess all moving and handling tasks using the task, load, individual, environment and equipment approach.

3.2.2.4 Seating pressure relief

Assess the chair, cushion, posture, comfort, transfers, mobility and the site and severity of any pressure damage. A patient using a pressure-relieving mattress also needs suitable seating. Explain the risks of sitting for long periods. For a high-risk patient, normally limit sitting to no more than 2 hours at a time unless the individual plan says otherwise. Seek advice from occupational therapy, physiotherapy or wheelchair services when seating is difficult.

3.2.2.5 Risk assessment and skin inspection

Confirm the patient's identity, introduce colleagues, explain the assessment and treatment, gain valid consent and record the discussion. Keep skin clean and appropriately dry, avoid accidental damage and protect privacy and dignity. Record refusal and explain the risks. For a person at risk, inspect the skin after repositioning and use findings to set the repositioning interval. Record pain, skin findings, positions and effectiveness of the plan. Non-blanching redness indicates category 1 pressure damage and needs action.

3.2.3 Keep moving

Encourage patients to change position themselves when they can. Consider approved lateral-turn equipment when help is needed. Use the 30-degree tilt where suitable to reduce pressure on the hip and use safe moving equipment to reduce friction and shear.

3.2.4 Incontinence
Assess and manage moisture caused by urine, faeces, sweat or wound fluid. Follow the current formulary pathways for incontinence-associated dermatitis and moisture-associated skin damage. Seek advice from continence services when needed.

3.2.5 Nutrition
Malnutrition and dehydration increase pressure-ulcer risk. Complete a MUST assessment at the first assessment. Encourage a balanced diet and enough fluids, normally 6 to 8 drinks or about 1.5 litres a day unless clinically restricted. If appetite is poor, support an enriched diet. Offer practical help, adapted equipment or feeding support when needed. Refer to dietetics or another relevant service if intake is poor, swallowing is difficult or the patient is nutritionally compromised. Use the palliative-care nutrition information when appropriate.

3.2.6 Giving information

3.2.6.1 Education for colleagues within the trust.
Colleagues must complete the pressure-ulcer education tier set for their role by the service manager. The tiers are based on the National Wound Care Strategy Programme capabilities and build on each other. They describe knowledge and skills, not job title or pay band.

3.2.6.2 Pressure ulcer awareness education tier 1
Tier 1 gives general awareness of skin care, risk factors, early signs, ASSKING, wound photography and how to get help. It is suitable for colleagues who give health-promotion advice but do not provide ongoing wound care.

3.2.6.3 Pressure ulcer awareness education tier 2
Tier 2 builds on tier 1 and supports colleagues to see, treat and refer. It covers skin anatomy, pressure damage, initial protection using the wrap pack, local pathways, referrals and incident reporting. It is suitable for colleagues who provide first-line care but not ongoing specialist wound care.

3.2.6.4 Pressure ulcer awareness education tier 3
Tier 3 supports autonomous assessment, complex decisions, care planning, equipment use, pressure-ulcer categorisation, multidisciplinary working, incident review and duty of candour. It is for colleagues whose core role includes ongoing wound assessment, treatment and advice.

Give patients and carers information they can understand and involve them in skin checks where possible. Record the information given, their understanding, any capacity assessment and any refusal. Revisit an informed refusal at least monthly or sooner if circumstances change.

3.2.7 Guidelines for specialist patient groups

3.2.7.1 Critically ill patients
If the patient cannot be turned for clinical reasons, review the support surface and use smaller, more frequent position changes were safe. Use slide sheets to reduce shear. If a cavity wound is packed, record the number and position of dressings and do not pack tightly.

3.2.7.2 Bariatric obese patients
Inspect all skin folds with enough assistance. Check for pressure caused by devices, skin-to-skin contact and tissue weight as well as bony areas. Use suitable positioning aids and a bed that safely supports the patient's weight and allows turning without contact with side rails.

3.2.7.3 Patient receiving palliative care
Agree a flexible repositioning plan based on comfort, tolerance, clinical need and the patient's wishes. Record the reasons for decisions. Comfort may take priority at the end of life. Protect vulnerable areas, manage pain, odour and wound fluid, and use longer-wear dressings where suitable. Give prescribed pain relief before movement or dressing changes when needed.

3.2.7.4 Spinal cord injured patients
Refer for specialist wheelchair and seating assessment. Restrict sitting when an ulcer is on a sitting surface. Balance pressure relief against the risks of bed rest, including loss of strength, respiratory problems, isolation and psychological harm. Consider specialist surgical advice where appropriate.

3.2.7.5 Patients with dementia
People with dementia may have added risks from reduced mobility, frailty, poor intake, dehydration, incontinence, reduced blood supply, restlessness, medicines and difficulty reporting pain. Use personal care as an opportunity to inspect pressure areas, explain care simply and involve carers appropriately.

3.2.8 Categorisation of pressure ulcers

3.2.8.1 Assessing the ulcer
Complete an initial and ongoing wound assessment and use the recognised pressure-ulcer classification. Record whether the ulcer was present when care began or developed during Trust care. Category 1 is non-blanching redness of intact skin. Category 2 is partial-thickness skin loss or a blister. Category 3 is full-thickness skin loss into subcutaneous tissue. Category 4 is full-thickness tissue loss with exposed or directly palpable deeper structures.

Moisture damage usually blanches and is linked to urine, faeces, sweat or wound fluid. Report combined pressure and moisture damage by the pressure category. Use the skin IPOC and the TIMES framework: tissue, infection or inflammation, moisture or exudate, wound edge and surrounding skin. Assess lower-limb circulation before using debridement products.

3.2.8.2 Pressure ulcer and moisture lesion differentiation
Pressure ulcers are usually linked to pressure or shear, often occur over a bony area, have clearer edges and may include deeper tissue loss or necrosis. Moisture lesions are linked to urine, faeces, sweat or wound fluid, are usually superficial, may affect skin folds or the anal cleft, and often have irregular or diffuse edges. Consider a combined lesion when both causes are present.

3.2.9 Documentation of pressure ulcer
Record the ulcer's origin, site, measurements, depth, wound bed and category in the care plan and skin IPOC. Do not reverse-grade a healing ulcer; describe it as a healing ulcer at its highest category. Report category 2 and above through the Trust incident system Radar and record the incident number in the patient record. Review Trust-acquired category 3 and 4 ulcers through the approved patient-safety review process and start duty of candour when required.

A pressure ulcer alone does not prove abuse or neglect. Consider the person's health, skin conditions, other signs of neglect, the quality and delivery of the care plan, and the views of the person and those close to them. Follow Trust safeguarding procedures when there is a concern. Record information given, understanding, capacity, decisions and refusal.

3.2.10 Treatment of pressure ulcer
A patient with a pressure ulcer needs both a prevention plan and a wound-treatment plan based on a full assessment. Refer to tissue viability and lymphoedema service (TVALS) for category 3 or 4 ulcers, deterioration, complex management, possible neglect or safeguarding concerns, or refusal of treatment where specialist advice is needed.

3.2.10.1 Liaison between care settings
Share information before transfer or discharge whenever possible. Include the patient's risk level, skin condition, equipment, moving and handling plan, wound and dressing plan, relevant communication or cultural needs, services involved and enough dressing supplies for one change while further supplies are arranged.

3.3 Wound photography using smartphone or digital device
Use digital images as part of wound assessment when they add value to care. Take an image during a planned dressing change, before applying a new dressing or after removing the old one. Do not remove a dressing only to take a photograph.

3.3.1 Principles
Obtain valid consent from the patient, a person legally able to decide for them, or a parent or guardian before taking an image. If capacity is in doubt, complete and record a capacity assessment and follow the Trust's best-interests process. Protect privacy, dignity and safeguarding. Use only a Trust-owned and approved device. Images must be clear, centred, taken at a useful angle and free from unnecessary background detail.

3.3.2 Assessment
Assess and record every wound or area of tissue damage using the Trust-approved SystmOne skin IPOC and support the assessment with a photograph. Photograph the wound at the first assessment. Repeat at least every 4 weeks during healing, and sooner if the wound changes, concerns arise, treatment changes or an image will help the patient understand the plan.

3.3.3 Risk management
Follow infection-prevention procedures when using a device in different care settings. Protect patient identity and information at all times. Obtain specific written

consent if an image will be used for education, publication or any purpose other than the patient's direct care.

3.3.4 Consent

The clinician must explain why the image is needed, gain informed consent and record it in the clinical record. If the patient cannot consent, make and record a best-interests decision in line with Trust policy.

3.3.5 Taking photographs

Use aseptic non-touch technique. Cover the patient except for the area needed and avoid showing the face, tattoos, birthmarks or other identifying features. Clean the wound and surrounding skin when appropriate. For follow-up images, use a similar position, angle, distance, background and lighting. Keep the device away from the patient and wound. Include the NHS number, date of birth, date, wound site and a sterile measuring scale where this can be done safely.

Help the patient into a comfortable position and get assistance if needed. Move the device rather than the patient where possible. Transfer the image only through the approved NHS process, confirm that it is attached to the correct SystmOne record, and then delete temporary copies from the device, email and desktop. See Appendix M for the simplified image guidance.

3.3.6 Storage of photographs

Store each photograph in the patient's main clinical record, normally as an attachment in SystmOne, as soon as possible. Delete it from the camera or mobile device after upload. Do not keep copies on a laptop, computer, email account or other location unless there is an approved and consented reason.

3.3.7 Quality improvement

Review the quality and handling of wound images through supervision, clinical-record audits and the Trust assurance and incident processes.

4. Responsibilities

4.1 Healthcare assistant and support worker

Healthcare assistants and support workers may provide wound care only when a registered clinician has assessed the patient and agreed a clear care plan. They must follow the wound care formulary pathways and record and report any change in the wound to the registered clinician, in line with local practice.

Complex wound care must not be delegated to a healthcare assistant or support worker. A complex wound includes:

- deteriorating category 3 and category 4 pressure ulcer
- deep cavity wound
- fistulae and deep sinus wounds
- deteriorating lower leg wounds that require anything but conservative or palliative care
- infected or dehisced surgical wounds

Wound care must not be delegated to a healthcare assistant or support worker if there is a significant risk of complications, such as severe pain or haemorrhage.

4.2 Registered nursing associates

Registered nursing associates may provide wound care when a registered nurse has assessed the patient and agreed a care plan. They must follow the wound care formulary pathways and record and report any change in the wound to the registered nurse.

For a complex wound, the care plan must give clear instructions and explain when and how to escalate concerns.

4.3 Registered nurses and clinicians

Registered nurses and clinicians must work within their assessed competence and scope of practice.

Registered nurses are responsible for:

- undertake initial and ongoing assessment of wound, surrounding peri-wound tissue and associated conditions
- following the identified pathway plan, implement and evaluate and record in the appropriate documentation. Monitor wound progress by reassessing a healing wound after 3 dressing changes by healthcare assistant and support workers or more frequently if wound is deteriorating or static
- if dressing plan states weekly patient will need to be reviewed by registered nurse alternate weeks
- provide support to healthcare assistants and support workers through the competencies for skin assessment and wound care
- continue to ensure support and education as required to ensure safe practice

4.4 Service managers and modern matrons

Service managers and modern matrons must make sure that colleagues know about this manual and follow its policies, procedures and guidance. They are responsible for:

- Identifying training needs and ensuring colleagues are appropriately trained in tissue viability and wound care issues.
- Ensuring colleagues have protected time to attend training and educational sessions in tissue viability and wound care.
- Ensuring compliance with the audit requirements of the policy.
- Identification of learning from incidents.

4.5 Tissue viability and lymphoedema service (TVALS)

The tissue viability and lymphoedema service (TVALS) provides advice about wound care and lymphoedema. The service is normally available from 8.30 am to 4.30 pm, Monday to Friday, by telephone on 01302 566 999. Single point of access (SPA) contact details are available as follows:

- 03000 218 996
- 0800 804 8999
- doncaster.spa@nhs.net
- Electronic referral form to nhs.net mailbox

- Task on SystmOne to the single point of contact task group (professionals only)

Any healthcare or social care professional may refer a patient to TVALS. Complete the tissue viability and lymphoedema service referral form in SystmOne.

4.6 Tissue viability and lymphoedema services (TVALS) registered nurses and healthcare assistants

TVALS registered nurses and healthcare assistants provide tissue viability, wound care and lymphoedema management in the patient's preferred place of care.

4.7 Clinical nurse specialist in tissue viability

The clinical nurse specialist in tissue viability provides expert advice to professionals, multidisciplinary teams, patients and carers. This includes advice on complex tissue viability, wound care and lymphoedema issues, treatments and interventions. The specialist may delegate work to Trust colleagues when it is safe and appropriate to do so.

- To report any breaches in policy compliance through the trusts electronic reporting system, Radar and to the Health Safety and Security Committee.
- Leading in the investigation of identified breaches of tissue viability and contributing to serious incidents (SIs) reports as required
- Managing the Tissue Viability and Lymphoedema team of registered nurses and health care assistant.

4.8 Rotherham and North Lincolnshire Localities: Rotherham care group and North Lincolnshire care group.

The Trust's principles for tissue viability and wound management apply in the Rotherham and North Lincolnshire care groups. Local tissue viability and wound care services are provided by The Rotherham NHS Foundation Trust and Northern Lincolnshire and Goole NHS Foundation Trust.

5. Training

5.1 Tissue viability and wound care for community colleagues, clinical skills and development

- Colleague groups: registered nurse, registered nurse associate, health care assistant.
- Wound care alliance modules of training:
    - aseptic technique, removal of clips and sutures
    - TIMES
    - wound healing
    - wound cleansing
    - skin tears
    - tier 1 and 2 bandaging
    - pressure ulcers
    - negative wound pressure
    - delayed healing
    - wounds with simple wound infection

    - diabetic foot wound
    - leg ulcers including ankle brachial pressure index (ABPI)
- Delivery method: practical and face to face for all training.
- Training delivered by whom: community practice educators.
- Where are the records of attendance held: electronic staff records (ESR) system.

It is each person's professional responsibility to ensure their knowledge is updated accordingly as part of his or her personal professional development plan. A refresher and updates of skills should be completed 3 yearly.

6. Monitoring Arrangements

6.1 Pressure ulcer risk assessment

- How and who by: local audit.
- Reported to: Safeguarding Assurance Group.
- Frequency: annually.

7. Related documents and associated references

- Royal Marsden NHS Trust Manual of Clinical Procedures
- Doncaster Wound Care Formulary
- Infection prevention and control manual
- Consent to care and treatment policy
- British National Formulary
- Nursing and Midwifery Council Code of Professional Practice 2015
- Physical health policy
- Coleman, S., Nelson, E. A., Vowden, P. et al. (2017) Development of a Generic Wound Care Assessment Minimum Data Set. Journal of Tissue Viability. 26 (4) 226 to 40.
- Furlong W (2015) Recommended frequency for ABPi review for patients wearing compression hosiery. British Journal of Nursing Volume 24, Number 20.
- Guest JF, Ayoub N, McIlwraith T. (2015) Health economic burden that wounds impose on the National health Service in UK BMJ Open 5 (12).
- Guest JF, Vowden K, Vowden P (2017) the health economic burden that acute and chronic wounds impose on an average clinical commissioning group and health board in UK J Wound Care 26(6) 292 to 303.
- International Wound Infection Institute (2016) Wound Infection in Clinical Practice.
- International Consensus (2013) Making the Case for Cost-Effective Wound Management
- Leg Ulcer infection; antimicrobial prescribing (NG152)
- NHS England (2016) A Framework for nursing, midwifery and care colleagues, Leading Change, Adding Value.
- NHS Improvement (2018) Pressure ulcer; core curriculum.
- National Wound Care Strategy Programme (2024) Pressure Ulcer Recommendations and Clinical Pathway

- PSIRF NHS England (2024) Patient Safety Incident Response Framework
- NHS Right Care scenario (2017) The variations between sub-optimal and optimal pathways; Betty's story: Leg ulcer wound care.
- Wounds International (2016) Wound Infection in Clinical Practice: Principles of best practice.
- Wounds UK (2018) Best Practice Statement; Improving holistic assessment of chronic wounds.
- Wounds UK (2020) Best Practice Statement: Management of lower limb skin tears in adults. Wounds UK, London.
- Wounds UK (2018) Best Practice Recommendations for the prevention and management of skin tears in aged skin.
- Mobile devices, social media, the internet and digital content, appropriate and acceptable use procedure
- Royal College of Nursing (RCN) position statement: Nursing colleagues using personal mobile phones for work purposes.
- K Jacob (2019) Best practice for capturing and presenting accurate wound image. Wound Uk Journal Vol:15 Issue :01
- Estacado, N and Black, J (2019) Ten top tips: wound photo documentation. Wounds International, 10(3), page 8 to 12.
- Use of digital images for wound care

8. Appendices

8.1 Appendix A skincare protocol for incontinence associated dermatitis (IAD) primary care

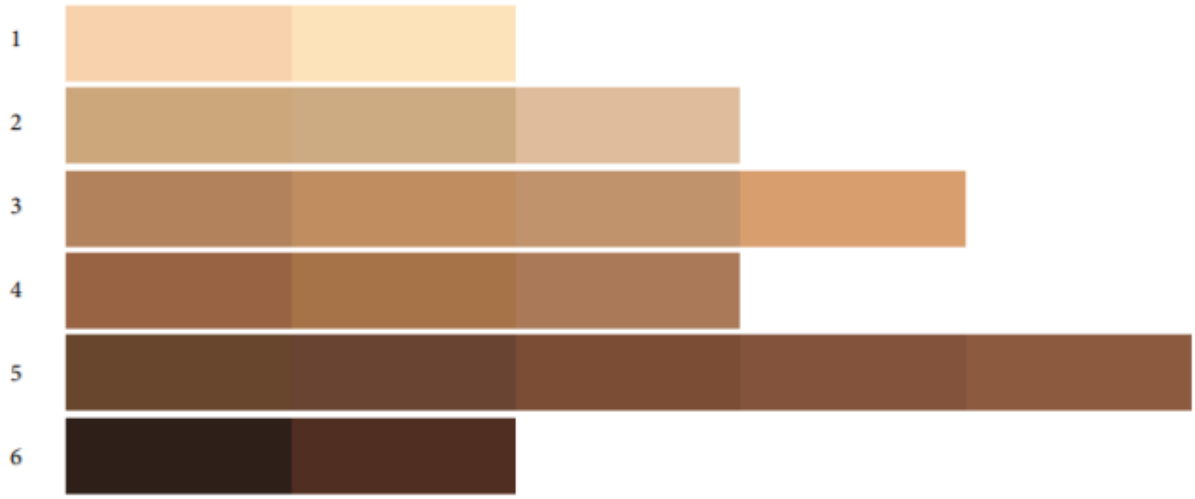
Refer to appendix C: skincare protocol for incontinence associated dermatitis (IAD) primary care (colleague access only) (opens in new window)

8.2 Appendix B pressure ulcer risk primary or secondary evaluation tool (Purpose T)

Patients wearing prescribed anti-embolic stockings for up to 23.5 hours a day, they require removal, for a maximum of 30 minutes in a 24-hour period to allow the legs and feet to be washed and skin condition and integrity observed.

Document all findings:

- colleagues should be aware of the following signs on the skin which may indicate early development of pressure ulcers.
- persistent erythema (redness)
- non-blanching hyperaemia previously identified as non-blanching erythema (redness)
- blisters
- discolouration
- localised heat
- localised oedema
- localised induration



Skin tone tool (adapted from Ho and Robinson, 2015), scale 1 to 6, going from light to dark skin tone.

Assessment should involve a thorough inspection of the skin, and this should include finding out about the patients' baseline skin tone following the skin tone tool (adapted from Ho and Robinson, 2015). Patients with darkly pigmented skin have a high melanin concentration in the skin, which makes it difficult to detect erythema, the main indicator of pressure damage. There are other signs and symptoms that can be observed:

- purplish or bluish localised areas of skin
- temperature change, initial warmth due to the inflammatory response which will become cooler as tissue death occurs
- localised oedema due to the inflammatory response
- localised induration due to excessive inflammation and necrosis (Wounds UK 2021)

Full assessment of skin areas can often involve removal of clothing, surgical appliances and mobility aids. Assessment should not only be visual as pressure ulcers can often be felt as soft and boggy. Persistent redness (erythema) does not always lead to ulceration but must be closely observed.

Other causes of skin damage and redness may be from incontinence rather than pressure incontinence associated dermatitis (IAD) any area of abnormal skin should be examined by a registered nurse and documented.

8.3 Appendix C react to RED patient and carer leaflet

Refer to appendix C: react to RED patient and carer leaflet (colleague access only). (opens in new window)

8.4 Appendix D food first

Refer to appendix D: food first. (opens in new window)

8.5 Appendix E eating, drinking and swallowing awareness in dementia

Refer to appendix E: eating, drinking and swallowing awareness in dementia. (opens in new window)

8.6 Appendix F prevention of medical device-related pressure ulcers (MDRPU)

Refer to appendix F: prevention of medical device-related pressure ulcers (MDRPU) (opens in new window)

8.7 Appendix G debridement larval therapy pathway

Refer to appendix I: debridement larval therapy pathway (colleague access only) (opens in new window)

8.8 Appendix H Doncaster community wound care formulary

Refer to appendix H: Doncaster community wound care formulary (opens in new window)

8.9 Appendix I wound management guideline (TIMES)

Refer to appendix I: wound management guideline (TIMES) (colleague access only) (opens in new window)

8.10 Appendix J repositioning schedule

Refer to appendix J: repositioning schedule (colleague access only) (opens in new window)

8.11 Appendix K preparation for taking images of wounds

1. Explain to the patient why you wish to take a digital image and seek their verbal consent. Document consent in their notes.
2. Before starting, ensure everything necessary is to hand and if assistant is needed there are sufficient colleagues.
3. Ensure the imaging device is functioning correctly and has sufficient power and storage capacity or memory.
4. Make sure the patient is in a comfortable position, with the entire wound visible but private and personal body parts (for example, genitals, breasts) and identifiable features (such as face, tattoos or birthmarks) covered. If there are previous images, seek to replicate the previous positions.
5. Where possible use an uncultured pale or neutral background, ideally non-reflective and neutral grey or surgical drape or sterile sheet with no personal identifying items or other people visible. Ambient natural light is ideal. Avoid extremes of light or dark and minimise shadows. If flash is used document use.
6. Decontaminate your hands, put on a disposable apron from the wound care dressing pack, remove the dressing and cleanse the wound, surrounding skin and any skin or clothing that will be visible in the digital image unless this is needed for legal or safeguarding purposes. Remove gloves and decontaminate your hands.

7. Decide how many images will be needed. The recommended minimum is an image of the wound plus an image of the site of the wound, for example, leg, abdomen. Instructions for taking images of wounds
8. Use a single-use disposable measuring scale or an auto-scale (if available on the device).
9. If the digital imaging device does not automatically immediately upload the image to the patient's digital clinical record, a patient identifier, for example, the patients initials or NHS number should be visible either within the image or at the beginning and end of the image sequence.
10. Scales with colour control patch to take account of variation of skin tones are recommended.
11. Aim to take a clear, close-up photograph of the wound. Hold the camera or device at a distance so that you can photograph the whole wound if possible:

- if the wound is long, you may need to take more than one image to capture the whole wound
- for some sites, for example, the heel, it may be easier to use a mirror to view the wound (do not use the camera flash if a mirror is used)
- gentle tension on excess body tissue or the separation of skin folds may be necessary to reveal the depth of a cavity or you may need to lift the leg to photograph the heel or separate toes

12. Where possible, point the camera or device directly at the wound, for example, straight in front of the wound and not at an angle.
13. Allow the device to focus on its own (auto-focus). If needed, focus manually. This can usually be done by tapping the screen or pressing down the button slightly. You may need to move the camera or device further away if it cannot focus.
14. Check the images on the display screen. It should be in focus, unblurred well-lit and ideally with no shadows over the wound. You can try taking a picture with and without the flash (if available) to see what looks best. It is very important that the photo does not show any identifiable features, such as patients face and tattoo. If you need to take another photo until you are happy that you have a clearest photo possible.
15. Delete unsuccessful photos as you go along so you are only left with the ones that you want.
16. Decontaminate your hands and equipment before and after taking the photos.