WOUND MANAGEMENT POLICY

POLICY

Reference	CPG-TW-TV-WMP		
Approving Body	V3.0, Harms Free Care Operational Group V3.1, Clinical Outcomes and Effectiveness Care Group (COEC)		
Date Approved	V3.0, 14.7.22 V3.1, 21.3.24		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	25th March 2024		
Version	v3.1		
Summary of Changes from Previous Version	v3.1 Appendices added for: • Removal of compression bandages (Appendix A) • Removal of wound dressings (Appendix B) v3.0 Section 4 Roles and responsibilities: • Medical Director role added to the Chief Nurse role • Head of Nursing role separated from Matron's role and linked with Clinical Directors and General Managers responsibilities • Lead Tissue Viability Nurse added to the Nurse Consultant role. Plan and oversee wound management audit at least once a year or as and when required. Work collaboratively with the Ward Leader to support an improvement plans • Harm Free Care Group responsibilities added Section 6.2 Wound Assessment • Wounds will be assessed on admission as part of the medical assessment - exposure (A -E) which will include patients in compression therapy for the management of leg ulcers but also clinical judgement • Nerve centre handheld devices will be used for immediate wound management plans and or out of hours Section 6.4 Wound monitoring and evaluation • Infected wounds must be assessed at least daily by a competent practitioner and referred to the Microbiologist on call if no improvement is seen • Infected surgical wounds will be assessed and managed as per Surgeons/Tissue Viability advice. Section 6.5 Tissue Viability Referral Criteria • Ice will be used to refer complex wounds to the tissue viability team. For urgent referrals contact directly (Contact details on intranet) Section 6.6 Safe discharge for patients with complex wounds		

	• The tissue viability team will document in the patient record when the patient needs referring to the community tissue viability service Section 7 Monitoring compliance and effectiveness • Lead Tissue Viability Nurse and Ward Leader added to the Nurse Consultants role for wound documentation audit. Frequency at least every 12 months.
Supersedes	V3.0, Issued 31st August 2022 to Review Date July 2025
Document Category	• Clinical
Consultation Undertaken	V3.1 • Members of COEC group V3.0 • Sally Palmer Nurse - Consultant Infection Control • Giles Cox - Medical Consultant • Sreebala Srinivasan - Lead Clinician Surgery
Date of Completion of Equality Impact Assessment	21/6/22
Date of Environmental Impact Assessment (if applicable)	NA
Legal and/or Accreditation Implications	To promote compliance with National Wound Care Strategy and NICE guidelines
Target Audience	TRUSTWIDE: All clinical staff involved in the assessment, care planning and monitoring of wounds
Review Date	July 2025
Sponsor (Position)	Chief Nurse
Author (Position & Name)	Nurse Consultant Tissue Viability, Stephanie Anstess
Lead Division/ Directorate	Surgery
Lead Specialty/ Service/ Department	Nursing – Tissue Viability Team
Position of Person able to provide Further Guidance/Information	The Tissue Viability Team

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
1. *Wound Management Care plan* 2. *Larvae Therapy Care Plan* 3. *Negative Pressure Wound Therapy Care Plan* 4. *Cellulitis Care Plan* 5. *Wound Care Formulary*	1. *April 2019** 2. *April 2019** 3. *April 2019** 4. *April 2019** 5. *September 2022*
Template control	June 2020

*Care plans will be reviewed when updates are required or when the printed care plans are due for re-order

CONTENTS

1.0 INTRODUCTION

A wound can be described as a break in the skin; it can be superficial or complex, closed, or open and can happen to any individual of any age causing pain and discomfort. In addition, patients with a wound are at increased risk of infection and potential sepsis. The management of wounds is a complex subject requiring appropriate knowledge and skills.

The aim of this policy is to provide the appropriate wound management strategy for patients, optimise any healing potential, and enhance patient comfort and dignity, whilst also considering cost effectiveness in line with best practice/evidence.

All patients with wounds must be assessed (and reassessed) by a competent registered healthcare professional who will undertake a comprehensive assessment of the wound, as part of the holistic assessment. This assessment must inform a plan of care for the on-going management with wound care products selected and wound management techniques chosen according to best recognised practice, with regular monitoring and evaluation of the care. This will help to ensure best practice in wound care is delivered whilst minimising the potential for inconsistent care.

2.0 POLICY STATEMENT

The aim of the document is to ensure clinical staff are aware of and adhere to the standards expected of them to provide safe and effective wound care. It is relevant to all Sherwood Forest Hospitals NHS Foundation Trust staff and staff employed through other agencies working on a temporary basis, who provide care for patients with wounds.

The Trust aims to provide excellence in wound care. Nursing and medical staff are responsible and accountable for delivery of safe and cost-effective wound care across the Trust. They must ensure the following:

- A comprehensive and timely holistic wound care assessment
- A continuous process of assessment planning, implementation and evaluation of care using evidence-based care
- Completion of wound assessments and care on the wound management care plan (WMCP) by Registered Nurses and Midwives with accurate measurements and descriptions to ensure objective assessment is obtained and care and progress can be evaluated.

3.0 DEFINITIONS/ ABBREVIATIONS

Trust:	Sherwood Forest Hospitals NHS Foundation Trust
Staff:	All employers of the Trust including those managed by a third party on behalf of the Trust
TVT	Tissue Viability Team
TVN	Tissue Viability Nurse
TVLN	Tissue Viability Link Nurse
AHP	Allied Health Professionals
WMCP	Wound Management Care Plan

4.0 ROLES AND RESPONSIBILITIES

All employees working in clinical areas have an individual responsibility to maintain knowledge of the basic principles of wound management and adhere to the wound management policy.

4.1 The Chief Nurse and Medical Director

- Overall responsibility for ensuring that the Trust has in place clear processes for managing risks associated with the wound management
- Ensure that appropriate arrangements are in place to enable safe and effective care and that employees are fully aware of their statutory, organisational and professional responsibilities and that these are fulfilled

4.2 Heads of Nursing, Clinical Directors and General Managers

- Responsible for ensuring that this policy is implemented throughout their areas of management.
- Provide the necessary management arrangements and ensure structures are in place so clinical teams have the required knowledge, skills and equipment to enable them consistently to provide safe, evidence based wound care and harm free care

4.3 Consultant Medical Staff

- Assess and review the patient's wounds as part of their holistic assessment
- Ensure that their teams are aware of this policy and provide collaborative multi-disciplinary working to ensure the policy is adhered to
- Perform surgical procedures and expert medical intervention as required to promote appropriate wound management.
- Medical/Surgical teams to liaise directly with the TVT for urgent/complex wound management

4.4 The Deputy Chief Nurse

- Provide senior management support and day to day leadership for effective wound management.
- Ensure that senior management receive regular information and reports (via the Harms Free Operational Group) to inform decision-making and to provide assurance that this policy is being implemented across the organisation.

4.5 Harm Free Care Operational Group

The HFCG will meet regularly in accordance with defined terms of reference and will be responsible for:

- Developing, reviewing, and monitoring the application of the wound care policy
- Monitoring and reviewing relevant audit results, analysing incident trends and identifying specific areas that require additional training or targeted improvement action
- Evaluating the effectiveness of wound prevention measures and effective wound management standards within the Trust
- Learning related to the prevention of wounds and wound care throughout the Trust

4.6 The Tissue Viability Nurse Consultant and Lead Tissue Viability Nurse

- Provide expert clinical, professional, and managerial advice for wound management across the Trust

- Develop, implement, and evaluate evidence-based strategies and policies for wound management, whilst ensuring economic value
- Plan and oversee the development and delivery of education and training of all staff groups and evaluate the effectiveness
- Plan and oversee audit of wound care management at least once a year or, as and when required. Work collaboratively with the Ward Leader to support any improvement plans
- Escalate concerns related to wound care to the Harms Free Care Operational Group and to the Nursing, Midwifery and Allied Health Professional Committee

4.7 Matrons

- Responsible for ensuring that this policy is implemented throughout their areas of management.
- Required to ensure that staff understand the expectations of them and are both competent and confident to implement the policy requirements
- Ensure Ward Leaders are supported to enable the ward staff provide wound management in line with the policy

4.8 Sisters/ Charge Nurses

- Responsible for ensuring the staff in their services are aware of this policy and have the required knowledge and skills to deliver the wound care standards within it
- Ensure improvements are made to services where deficiencies are identified through audit, or monitoring processes, complaints, and investigations
- Support staff to attend teaching on wound management
- Support the TV Champion and provide the resources to fulfil their role

4.9 The Tissue Viability Team

- Be an expert resource and exemplary role model in relation to wound care
- Provide expert clinical advice, education and support to clinical staff and the multi-disciplinary team
- Monitor wound care standards and support teams to achieve them
- Undertake wound care audit once a year
- Maintain a supportive tissue viability champions network
- Liaise with medical and surgical teams when interventions are required

4.10 Tissue Viability Champions and AHPs

- Be responsible, accountable and role model the delivery of high-quality wound care
- Establish a system to effectively disseminate all relevant wound management information to staff within their work area
- Act as a liaison between the TVT and the clinical environment cascading best practice
- Undertake wound care audit once a year with the Tissue Viability Team
- With the support of the Sister/ Charge Nurse and TVN, ensure that all staff in their work environment are aware of and adhere to this policy
- Escalate wound management concerns in their clinical area to ward Sister/Charge Nurse/Matron/TVN

4.11 Ward Nurses, Clinic Nurses, Ward Midwives and Clinic Midwives

- Have a responsibility to maintain the knowledge and skills needed for safe and effective wound care
- Will complete management and evaluation of wounds on a day-to-day basis, adhering to the wound care policy
- Will maintain own competencies within wound care
- Will seek advice/ escalate concerns to experienced clinical staff
- Will make appropriate and timely referrals to the Tissue Viability Team

4.12 Ward Nursing Associates and Clinic Nursing Associates

- Have a responsibility to maintain the knowledge and skills needed for safe and effective wound management.
- Will complete assessment and management of wounds on a day-to-day basis, adhering to the wound care policy
- Will maintain own competencies within wound care
- Will seek advice/ escalate concerns to experienced clinical staff
- Will make appropriate and timely referrals to the Tissue Viability Team

5.0 APPROVAL

- Following consultation, version 3.0 has been approved by the Harms Free Operational Group 14.7.22
- Following consultation, version 3.1 has been approved by the Clinical Outcomes and Effectiveness Care Group

6.0 DOCUMENT REQUIREMENTS (NARRATIVE)

Prior to undertaking any examination, treatment and care clinicians must ensure that the appropriate consent has been gained. Where relevant the associated documentation must be completed, or the information recorded in the medical notes. For further information see the Trust's "Consent Policy".

6.1 Patient assessment

- All patients will have a comprehensive assessment of their health status in relation to their wound management
- Factors adversely affecting wound healing will be identified
- Nutrition status will be screened and analysed to ensure appropriate nutritional requirements are met. This may include urgent referrals to the Dietician where the patient has a complex wound compounded by unmet nutritional needs.

6.2 Wound Assessment (s) – *each wound will be assessed separately*

- See Appendix A – Removal of wound dressings
- Wounds will be assessed on admission as part of the A-E medical assessment, which will include patients with compression bandaging for leg ulceration. Where the patient

has a diagnosis not related to sepsis and is not at risk of pressure ulcers, use clinical judgement to decide if the compression bandages can stay on. Record decision making in the notes. Please see also Appendix B Removal of Compression Bandaging for further advice

- It is imperative for patients with suspected sepsis, that their wounds are assessed for signs of infection and the possible source of sepsis, in order to ensure appropriate antimicrobial treatment and monitoring.
- The type of wound will be identified and recorded
- The age and history of the wound will be recorded including previous microbiology results e.g MRSA
- All wounds will be assessed and (reassessed) by a competent healthcare professional who will undertake an assessment, which will include:
    - Site
    - Size length, width, depth and details of any undermining
    - Wound bed description
    - Exudate volume and description
    - Odour
    - Peri - wound condition
    - Signs of infection
    - Pain
- All wounds will be photographed within 1-2 working days. The Nerve Centre handheld device may be used for immediate wound management decisions and or out of hours. This must be followed up with professional photographs taken by clinical illustration, within the 1-2 days. For hospital acquired wounds or patients with safeguarding concerns the photographs must also be taken by the clinical illustration department as soon as possible, which may require the out of hours clinical photography service
- On admission a wound swab will be taken for MRSA screening**. If however a wound infection is suspected a wound swab will be taken and sent for microscopy, culture and sensitivity and the presence of MRSA will automatically be checked (so a separate swab is not required).**
- The microbiology results will be followed up and the wound care plan updated accordingly.
- Patients who have had their compression bandages left in tact must have an MRSA at the time of the first dressing change.

6.3 Wound Management Care Plan (WMCP)

- An individualised plan of care with appropriate goals will be completed in collaboration with the patient and the MDT and recorded in the WMCP
- The frequency of dressing changes will be determined by the patients' clinical condition, treatment goals and effectiveness - and recorded on the WMCP
- A 'mock' wound care plan can be accessed on the Tissue Viability intranet site for staff to view

6.4 Wound Monitoring and Evaluation

- Wound evaluation will be completed at each dressing change with progress or deterioration recorded and care plan revised as necessary.
- The frequency of wound assessment will be determined by the patient's clinical condition, treatment goals and effectiveness – but must be completed at least weekly as a minimum requirement, **and twice weekly for acute complex wounds**
- Infected wounds (non surgical) must be assessed at least daily, until there is evidence of the infection responding to the antibiotics. Where no or little improvement is seen the medics/surgeons will discuss with the Microbiology Team, for an appropriate management plan
- Infected surgical wounds will be assessed and managed as per Surgeons/Tissue Viability advice.
- Complex wounds must be photographed regularly, determined by the patient's clinical condition, treatment goals and effectiveness - a minimum of weekly/fortnightly

6.5 Tissue Viability Referral Criteria

Complex wounds will be referred to the TVT using the ICE system. For urgent referrals please contact directly via x3091 or mobile phone (See TV intranet).
These will include patients with:

- Complex wounds that require advanced therapy e.g. topical negative pressure, larvae therapy
- Wounds that require sharp conservative debridement
- Infected wounds- not responding to treatment
- Diabetic foot ulcers (in line with the diabetic foot team and the diabetic foot guidelines)
- A wound that falls beyond the knowledge and skills of the practitioner and their senior ward colleagues including deteriorating wounds
- Hospital acquired traumatic wounds that cause moderate to severe harm e.g haematomas, large lacerations, infected cannula sites with devitalised tissue
- Category 2- 4 PUs, unstageable PUs and suspected deep tissue injuries acquired in hospital
- Patients admitted with Category 3 and 4 PUs, unstageable PUs and suspected deep tissue injuries
- Category 2 heel pressure ulcers that require a vascular assessment
- Wounds that fail to progress or symptoms that are not controlled e.g., pain, exudate, odour
- Adult safeguarding concerns/ investigations in place relating to wound/skin management and/or pressure relief
- Poor patient concordance to wound care advice and care following appropriate ward level intervention and escalation

6.6 Safe discharge for patients with complex wounds:

- Patients discharged with wounds will have details of the wound management plan within the discharge letter along with a supply of the dressings (10 days supply)
- The TVT will record in the medical notes when the patient's wound can be managed in the community.
- The TVT will advise in the medical notes if the patient requires a referral to the community TVT.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Wound care documentation	Tissue Viability Nurse Consultant/Lead Tissue Viability Nurse – to plan and oversee. Tissue viability team, ward leader and TV champion to take part in the audit process.	Audit	A maximum of 6 patients will be audited on each ward at least every 12 months	Written report will be presented to the Harms Free Operational Group: Action plan and escalation to the Nursing, Midwifery and AHP Board if standards not achieved.

8.0 TRAINING AND IMPLEMENTATION

All staff working with patients with wounds in clinical areas will read and understand the Wound Management Policy.

The Tissue Viability department organise and deliver both formal and informal education and training across the Trust to medics, nurses and allied health practitioners. The training includes:

- Wound management study days
- Pressure area management study days
- Induction programme for registered nurses and health care support workers
- Champion nurse study days
- TV mandatory workbook learning for registered nurses, registered nursing associates mandatory training
- Ad hoc training during the provision of specialist advice regarding individual patients during the provision of clinical care
- Further education can be arranged for specific clinical areas that is tailored to meet the individual team or departmental needs
- Tissue Viability intranet site

Attendance registers of any training completed will be sent to the OLM Administration Officer: Training, Education and Development Department, King's Mill Hospital.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix C
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) and RELATED SFHFT DOCUMENTS

- Diabetic foot problems: prevention and management NICE guidelines (NG19) Update: October 2019
- Lower Limb: Recommendations for Lower Limb Ulcers. National Wound Care Strategy Programme November 2020
- National Institute for Health and Care Excellence. Pressure ulcers: prevention and management of pressure ulcers (April 2014) NICE clinical guideline 179
- Prevention and Treatment of Pressure Ulcers: Quick Reference Guide European Pressure Ulcer Advisory Panel 2014
- Surgical site infections: prevention and treatment NICE guideline (NG125) Update August 2020
- Surgical Wound: Recommendations for Surgical Wounds. National Wound Care Strategy Programme February 2021
- The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. Nursing and Midwifery Council (2018)
- The International Guideline: Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline (3rd Edition) 2019

- Wound Essentials 8 (1): Debridement consensus: Recommendations for practice 2013
- Wounds UK. Best Practice Statement. Improving holistic Assessment of Chronic Wounds July 2018
- Wounds UK (2020). Best Practice Statement: Antimicrobial stewardship strategies for wound management. Wounds UK, London.

Related SFHFT Documents:

- Consent to Examination, Treatment And Care Policy
- Photography and Video Recording Policy
- Pressure Ulcer Prevention and Management Policy
- Relevant Infection Prevention and Control Policies

11.0 KEYWORDS

- Laceration; WMCP; care; pathway

12.0 APPENDICES

Appendix A – Removal of wound dressings
Appendix B – Removal of compression bandages
Appendix C – Equality Impact Assessment Form (EQIA)

Appendix A – Removal of wound dressings

Introduction

Wound assessment should form part of a holistic patient assessment. All patients with a wound should have dressings removed to facilitate assessment on admission and as part of on-going reviews, individual to each patient. Wound dressing changes should be planned according to the patient's clinical condition, individual assessment of the wound and surrounding tissue and take into account patients' pain, infection, level and type of exudate and odour.

Wounds can be a source of sepsis and should be assessed / reassessed as soon as sepsis is suspected, i.e. on patient admission or in-patient deterioration where sepsis is suspected. Microbiological samples should be taken for culture and sensitivity during this assessment, e.g. wound swab / pus or tissue sample.

Principles of Aseptic Non Touch Technique (ANTT) should be applied to **ALL** wounds whether they are healing by primary or secondary intention. ANTT is essential to reduce the risk of contamination at the wound bed and surrounding tissue by pathogenic micro-organisms, which may be transferred from hands or equipment.

It is estimated that Surgical Site Infection (SSI) affects 1 in 3 patients globally (WHO 2016) Surgical dressings should be kept undisturbed for a minimum of 48hours post-operative, unless there are signs/symptoms that wound inspection is required at an earlier stage, for example excessive bleeding / spreading erythema.

Preparation of the area to reduce contamination with airborne bacteria

- Avoid removal of wound dressings when bed making or cleaning tasks are being performed nearby
- Windows should be closed
- Electrical fans should be turned off

Equipment required for wound dressing removal

- Personal protective equipment (gloves and plastic apron as minimum)
- Dressing trolley (pre cleaned with soap and water wipes)
- Sterile dressing pack
- Fluid for wound cleansing and /or irrigation to facilitate dressing removal, e.g. saline or Prontosan Solution if indicated
- Appropriate dressings
- Sterile scissors if required

Dressing removal procedure

- Appropriate analgesia should be given prior to the dressing procedure where indicated. Consider administering analgesia 20-30minutes prior to the dressing procedure to optimise the effects
- Explanations should be given to the patient and verbal consent obtained
- Prepare equipment by opening your sterile dressing pack onto the trolley. Using only the corners, the pack should be opened. The sterile bag within the pack can be used to rearrange the sterile field.
- Outer dressings, for example bandages can be removed first using non sterile gloves.
- Change into sterile gloves to remove dressings to the open wound.
- Carefully assess pain, exudate level and type, odour and peri-wound skin on dressing removal.

A YouTube video demonstrating how to open a dressing pack can be accessed using the link: https://youtu.be/NZsIuMdbppI

Covering the wound

The wound should be redressed with appropriate products according to Sherwood Forest Hospitals Wound Care Formulary. An individualised plan should be documented on the Wound Management Care Plan.

Occasionally it is necessary to wait for further assessments or wound treatments before the wound can be redressed eg Tissue Viability or Diabetic Foot Team assessments, Clinical Illustration, medical or surgical reviews. In this instance, consider soaking the wound with Saline or Prontosan solution applied on sterile gauze and apply the sterile sheet provided in the sterile dressing pack to cover the wound temporarily. It is not acceptable to use continence products / non sterile procedure pads / towels, or leave the wound uncovered. The wound should be redressed as soon as possible following assessments to prevent microbiological contamination and to maintain an optimum healing environment for the wound.

Appendix B – Removal of compression bandages

Introduction

Venous leg ulcers (VLU) are believed to be the most common chronic wound type in the UK. In the Burden of Wounds study, there were 278 000 patients with VLUs, equating to 1 in 170 adults having a VLU in the UK. Compression therapy is the recommended treatment for venous leg ulcers and should be used as the first-line treatment, however it is important that treatment is optimised by being used in conjunction with a holistic approach and that underlying challenges are addressed. (Wounds UK 2016,2019) The risk of harm from compression therapy must be based on individualised risk assessment of the patient. Patients admitted to secondary care settings present with acute health care needs and a thorough examination of the patient's skin and wounds is a vital aspect of a holistic assessment. Patients who become acutely unwell also have a higher risk of developing pressure damage and skin should be assessed accordingly in vulnerable patients.

Managing patients who use compression bandages

Compression bandages can and should be removed to facilitate limb assessment by any clinician. Compression bandages should only be reapplied by appropriately trained clinicians. In the absence of an appropriately trained clinician, patients requiring acute admission should be managed with soft padding bandages (ie Soffban/Formflex) and crepe applied toe to knee; limbs should be elevated and heels offloaded appropriately. People with leg and foot wounds with **red flag symptoms** should **not** be treated with compression therapy (National Wound Care Strategy Programme, 2020) The following indicate symptoms which sould be considered a 'red flag'

People with leg and foot wounds should not be treated with compression if they have any of the following red flags:

- Acute infection of leg or foot (e.g. increasing unilateral redness, swelling, pain, pus, heat)
- Symptoms of sepsis
- Acute or chronic limb-threatening ischaemia
- Suspected acute deep vein thrombosis
- Suspected skin cancer.

When should compression bandages be removed to facilitate assessment?

- **For patients with confirmed or suspected sepsis**: Bandages should be removed in the admitting area as soon as clinically possible (eg Emergency department) to facilitate assessment of any potential source of sepsis, as per the Trust Sepsis guideline
- **Where a pressure ulcer risk assessment indicates a risk of pressure damage**: ie: Anderson score above 2, PURPOSE-T screen or full PURPOSE-T assessment which indicate a risk of pressure damage; bandages should be removed within 6 hours of admission
- **Patients without risk of pressure damage or sepsis**: Bandages should be removed within 24 hours of admission, or according to clinical judgement. Clinicians should escalate to senior staff for advice where indicated.
- **Existing in-patients with clinical deterioration or new suspected sepsis**: compression bandages should be removed as soon as clinically possible as part of a holistic clinical assessment.

Recognising types of compression bandages

The following photographs indicate typical types of compression bandages used within the Trust and local community Trusts

K-Two (has printed circles visible on both layers of the bandage system)

Actico (pale beige colour, firm/tightly applied, short stretch bandage)

K plus (used alone as reduced compression, or as part of a 4 layer bangage. Pale blue stripe is visible. Often applied in figure of 8. Soft wadding and crepe are applied below this layer

Coban or K-four (beige elastic bandage, commonly used as the final layer of a 4 layer bandage system)

Referral for compression bandaging

Patients who require compression bandaging should be referred to the Tissue Viability team. Where possible and appropriate, the Tissue Viability nurses will facilitate reapplication of compression bandages in ward areas.

APPENDIX C - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Wound Management Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 21.6.22			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	no		
Gender	no		
Age	no		
Religion	no		
Disability	no		
Sexuality	no		
Pregnancy and Maternity	no		
Gender Reassignment	no		
Marriage and Civil Partnership	no		

Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	no		

What consultation with protected characteristic groups including patient groups have you carried out?

- **none**

What data or information did you use in support of this EqIA?

- **none**

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- **none**

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Stephanie Anstess

Signature:

Date:21.6.22