Resident in care home has a non-progressing wound – Guidance to be completed prior to escalation to CHLN, Podiatry or TVN

(Support & FAQ attached)

Care home staff	Care home liaison	Podiatry	Tissue Viability
Complete wound assessment chart, wound sizes **must** be measured and not estimated. If required, apply appropriate dressing. N.B Wound chart **must** be updated at least weekly or more frequently if wound deteriorates. Photograph the wound if facility is available and with consent from the resident. All wounds should be assessed by an RN in the first instance. Complete all records at the time and take immediate and appropriate action reflecting person centred care. Refer to podiatry in all cases if wound is present on or below ankle (if the wound is deemed to be venous in nature, podiatry will pass this back to the care home staff for management). ***Refer all Grade 2 and above pressure damage to the foot and ankle.*** MUST chart completed incorporating up to date weight SSKINS bundle completed (or care home alternative) **If pressure ulcer**: • Foot protection boots in place and fitted properly • Mattress appropriate for condition and weight (ensure mattress setting documented in nursing documentation), • Pressure redistributing Cushion in place if able to sit • Repositioning chart in place and completed 2 hourly • Ensure nursing documentation complies with NMC guidance and care home policies. • Ensure duty of candour is triggered for all avoidable, grade 3 with trigger factors and grade 4 care acquired pressure damage (refer to your local policy and see guidance document section 12). Ensure AP1 is triggered for all ungradable, suspected deep tissue injury, grade 3 or 4 care Inform GP surgery, care home liaison nurse or ANP of wound. Ensure care home manager aware of wound. Baseline observations charted Ensure decision making for wound products is clear (refer to local wound care formulary). Ensure all risks are documented and up to date. If concordance is an issue, then a person-centred care plan is in place to address this and interventions to maximise concordance are documented. Consider osteomyelitis when there is significant depth to a wound. Consider soft tissue infection and take appropriate action (see antimicrobial stewardship link on guidance document). Refer to CHLN on completion of this guidance for non-progressing wound or Podiatrist for all foot wounds. If any wound care or pressure ulcer prevention and management training needs identified care home to complete contact form: To Glasgow City CHNT PDN or CHC TVN on link: Care Home Collaborative Contact Form: Survey Powered by Webropol (webropolsurveys.com)	Care home staff should decide on type of wound. If wound cannot be managed locally by care home staff, then refer to care home liaison nurse. Care home liaison nurse will complete wound assessment chart. Wound sizes **must** be measured and not estimated Undertake and document holistic assessment in resident records and community nursing information system (CNIS). Record care delivery and support to staff in CNIS as per NHSGGC guidance. Under the Wound Assessment section in CNIS, for the safety cross tab please select the drop down box: ' Pressure ulcer present on admission to community caseload from community referral (inherited)' Document wound management plan and ensure two week supply of wound management products are arranged. **If pressure ulcer**: • Foot protection boots in place and fitted properly where appropriate. • Mattress appropriate for condition and weight (record this observation in CNIS) • Pressure redistributing Cushion in place if able to sit • Repositioning chart in place and completed 2 hourly • Ensure GP surgery and care home manager is aware of wound. If non-concordance with any current wound management plans: Consider completing AP1. Escalate to care home manager. Escalate as per local policy – HSCP/ASP. Ensure care plan in place and communicated. Ensure any non-concordance and solutions to resolve are documented by RN. Refer to tissue viability nurse or podiatry on completion of this guidance for non-progressing wound. If any wound care or pressure ulcer prevention and management training needs identified care home to complete contact form: To Glasgow City CHNT PDN or CHC TVN on link: Care Home Collaborative Contact Form: Survey Powered by Webropol (webropolsurveys.com)	Care Home role Refer to podiatry in all cases if wound is present on or below ankle (if the wound is deemed to be venous in nature, podiatry will pass this back to the care home staff for management). **Complete wound assessment chart, wound sizes must be measured and not estimated.** **Photograph the wound if facility is available and with consent from the resident.** Referral will be received at podiatry hub. Specialist podiatrist attends care home (target two working days). **Podiatrist role** Assess, photograph and grade the wound. Development of appropriate management plan. Review of pressure redistribution plan if appropriate. Discussion with care home nursing colleagues after initial assessment. Wound chart completed and summary of treatment and management plan documented in the resident's care plan Ongoing podiatry input if required, i.e. Debridement/additional off-loading. Discharge plan and contact information for any future escalation when discharged from podiatry care.	On receipt of referral form the tissue viability nurse will review resident within four working days in partnership with care home liaison nurse. Complete wound assessment chart, wound sizes **must** be measured and not estimated. Document a management plan in resident records and community nursing information system (CNIS). Review of pressure redistribution plan if appropriate. Ongoing tissue viability input if required, ie. Debridement/additional off-loading equipment advice, etc. Discharge plan and contact information for any future escalation when discharged from tissue viability service.

Support and Frequently Asked Questions

1. This referral guidance was collated to provide a clear decision making pathway for care home staff /care home liaison nurses to ensure streamlining of referrals following identification of a wound in a care home for all partnerships across NHSGG&C.

   Refer to Scottish Wound Assessment and Action Guide if support required to assess wound: Scottish Wound Assessment and Action Guide (SWAAG) (healthcareimprovementscotland.org)

2. All wounds should show signs of progress (evidence of progress towards healing, reduced size, reduction in slough and necrotic tissue) over a two week period. If not ensure all steps are completed within your column before making referral to next stage.
3. If unsure of grade of pressure ulcer refer to the Scottish Adaptation of the EPUAP Pressure Ulcer Grading Tool Link: Tissue viability grading and tools (healthcareimprovementscotland.org)
4. All wounds on ankle or below should be referred to podiatry immediately on identification. If unsure if wound is venous ulceration or not, refer to podiatry to be reviewed. This includes all grade 2 and above pressure damage.
5. For all pressure ulcers that have developed while a person is in care, a review should be undertaken with appropriate investigation, identification of learning and reporting of actions implemented, as part of ongoing improvement e.g. Red Day Review Tool (if support required with this please contact CHC TVN : Care Home Collaborative Contact Form: Survey Powered by Webropol (webropolsurveys.com)
6. AP1 should be considered for Grades: 3, 4, ungradable and *Deep Tissue Injury (that does not resolve within 2 weeks)* or high incidence/cluster of grades 2 (within a care home or on an individual resident)
7. Refer to NHSGGC Wound Formulary for dressing choice: nhsggc-joint-wound-care-formulary-2302.pdf (ggcmedicines.org.uk)
8. Recommended Footsafe Boots sizing guide
9. Video guide to boot fitting **(Click on "Browse YouTube option)** - (327) NHS Scotland FootSafe Instructional Video – YouTube
10. GP surgery/ANP/CHLN to be informed of presence of wound for logging in residents medical notes.
11. If signs of infection ensure guidelines on antimicrobial stewardship are followed. See links to:

    Scottish Ropper Ladder: 20180119-AWD-Appendix-2-Scottish-Ropper-Ladder-for-Infected-Wounds.pdf

    Resources to guide the management of suspected infection in chronic wounds (healthcareimprovementscotland.org)

    Antimicrobial Wound Dressings: 20180119-AWD-Appendix-3-Antimicrobial-Wound-Dressing.pdf

    Resources to guide the management of suspected infection in chronic wounds (healthcareimprovementscotland.org)

12. NHSGGC guidance on pressure ulcers can be found in Pressure Ulcer Prevention and Management Policy (2023). In particular significant adverse event review (SAER) / duty of candour should be considered in the following:

- All grade 4 avoidable care acquired pressure ulcers require a SAER
- All grade 3 avoidable care acquired pressure ulcers require local review unless specific additional criteria is met and triggers duty of candour legislation and a SAER. This would follow review by TVN or podiatrist who identify the following criteria:

- ✓ Antibiotic therapy due to osteomyelitis
- ✓ Surgical debridement
- ✓ Sepsis
- ✓ Pain arising from pressure ulcer lasting more than 28 days as a direct result of the pressure damage
- ✓ Increased length of hospital stay due to the pressure damage alone
- ✓ Multiple areas of pressure damage at one incident
- ✓ All ungradable pressure ulcers will be re classified as grade 3 or grade 4 by Tissue Viability or Podiatry once a grade is established regardless of how long the wound remains ungradable. They will be then follow grade 3 and 4 processes described above.

13. Link to podiatry NHSGGC website (under development) https://www.nhsggc.scot/hospitals-services/services-a-to-z/podiatry-service-information-for-patients/