Pathway for Granulating Wounds

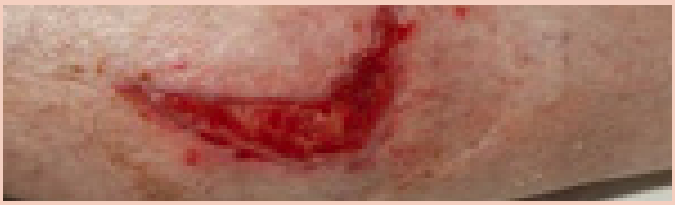
Aim: - To promote granulation and provide a healthy base for epithelisation

Definition:

Red granulation tissue fills the wound as it is healing.

It is firm to the touch, painless and does not bleed easily.

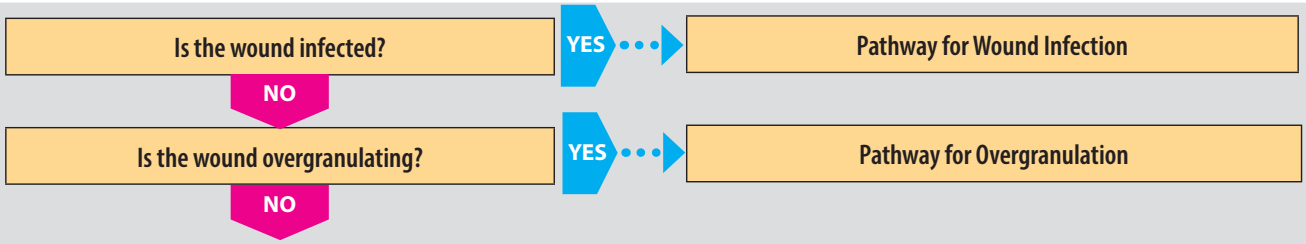
Wound infection should be suspected if the granulation tissue is dark, brick red, friable and bleeds easily (Nichols, E. Wound Essentials 2015).



Step 1: Undertake wound cleansing in accordance with the Wound Cleansing Policy and consider using Prontosan Debridement pad to support soft mechanical debridement.

Step 2: Undertake a holistic wound assessment in order to determine the type of granulation tissue and establish the dressing options.

Step 3: Dress the wound following the below recommendations per the local formulary:



Exudate Levels	Primary Dressing	Secondary Dressing	Application advice
Nil to Minimal.	Comfeel Plus.	NA	• Change if the dressing is marked with exudate within 1cm from the edge of the dressing or the dressing is dislodged. • Can be left in place for up to 7 days.
Moderate to Heavy with LESS than 2 cm depth.	Biatain Silicone 3DFIT.	NA	• Apply to the wound ensuring a 1cm border from the wound margins. • Can be left in place for up to 7 days or change if the dressing is marked with exudate within 1 cm from the edge of the dressing or the dressing is dislodged.
Moderate to Heavy with MORE than 2 cm depth.	Cutimed Sorbact Ribbon (Dialkylcarbamoyl chloride).	Biatain Silicone 3DFIT	• Loosely cover/pack the wound with Cutimed Sorbact Ribbon and cover with Biatain Silicone 3DFIT. • Can be left in place for up to 7 days, however change if the dressing is marked with exudate within 1 cm from the edge of the dressing or the dressing is dislodged.

Step 4: Document all wound assessments accordingly and complete onward referrals if required.

Has there been an improvement in the last 14 days?

NO

Ensure a referral has been completed and sent:

- DBTH inpatient to The Skin Integrity Team
- Communality Tier 1 or 2 to Community Tier 3
- Community Tier 3/District Nurses to TVALS
- Community patients with a Diabetic Foot Ulcer to The Podiatry Foot Protection Service.

YES

Step 5: Reassess as per dressing application advice.

If the named product on this pathway is not available a temporary second line product is available to use. This can be found within the main text of the Doncaster Wide Wound Care Formulary Document.

Reference: Nichols, E. (2015) Describing a wound from presentation to healing. Wound Essentials. 10 (1).

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