Algorithm for Assessment and Management of Chronic Wounds (adult)

A holistic assessment and application of best practice will support improved outcomes for patients.

1) **Identify type of wound:**
   - Diabetic Foot Ulcer: refer to diabetic podiatry/MDT
   - Venous Leg Ulcer
   - Pressure Ulcers
   - All other wounds

2) **Holistic Assessment**
   - Patient: co-morbidities
   - Wound: exudate, viscosity
   - Consider other aetiology.

3) **Identify if non-viable tissue present:**
   - Reduces effectiveness of topical agents
   - Increases signs of inflammation, odour and infection.
   - Yes
   - No

4) **Identify if infection present**
   - Using Scottish Ropper Ladder for Infected Wounds (see appendix 2)

5) **Choose dressing, cleansing and treatment options** - based on holistic assessment above

6) **Formal review of patient and wound at regular intervals**
   - Minimum of every two weeks*
   - Healed
   - Monitor and prevention strategies
   - Not healed
   - Return to 2) Holistic assessment
     - If no signs of healing after 6 weeks refer to relevant specialist service*

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**Key -**
- Process
- Guidance
- * refer to local guidance and pathways

**Guidance**
- SIGN 116 - Management of Diabetes (Revised 2014)
- International Consensus
- SIGN 120 - Management of Chronic Venous Leg Ulcers (August 2010)
- Best Practice Statement: Holistic Management of Venous Leg Ulceration (2016)
- Best Practice Statement (March 2009) Prevention and Management of Pressure Ulcers
- Pressure Ulcer Prevention and Management Standards (September 2016)
- General Wound Assessment Chart
- Scottish Wound Assessment and Action Guide (SWAAG)
- Local guidelines/pathways

**Debridement Options**: Autolytic - Mechanical, Larvae - Enzymatic, Sharp - Surgical

**Consider blood supply to wound**
- Is it suitable for debridement?
  - Yes
  - No
  - Debridement Options: Don't debride - Keep dry, Refer to vascular or other relevant specialist

**Monitor and prevention strategies**

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Resource developed by SLWG for Antimicrobial Wound Dressings consisting of Health board and speciality representatives.
1st Edition: September 2017; Review: September 2020

Medical Photography Service, NHS Lothian, October 2017
Scottish Ropper Ladder for Infected Wounds
Guidelines for identifying infected wounds and when to start and stop using topical Antimicrobial Wound Dressings (AWD)

Each stage builds on the previous stage noted

Stage 4 - when 1 or more signs of systemic infection present:
May lead to sepsis if not treated
- Spreading cellulitis
- Pus/abscess
- Patient systemically unwell
- Pyrexia
- Raised white cell count/CRP
- Wound breakdown +/- satellite lesions.

Stage 3 - When 2 or more signs of spreading infection present:
Wound deteriorating
- Localised cellulitis/erythema
- Pain increasing
- Exudate: thick, haemopurulent or purulent
- Localised oedema
- Malodour increasing.

Stage 2 - when 2 or more signs of local infection present:
Healing not progressing normally
- Exudate - high volumes
- Malodour
- Pain in or around wound
- Hypergranulation tissue
- Discoloured or bleeding granulation tissue
- Slough/necrosis.

Stage 1 - when 2 or more signs of Contamination/Colonisation present
Healing progressing normally
- Exudate - low to moderate volume
- Pain - minimal
- Odour - minimal
- Slough/necrosis.

Stage 4 - Treatment
1. Swab wound*.
2. Consider: SEPSIS 6*; other source; blood cultures.
3. Start systemic antibiotics* and monitor patient.
4. If rapid deterioration immediate referral for urgent medical advice.
5. Consider topical AWD*.
6. Monitor wound progress*, review at 2 weeks – see Stage 2, point 4, for actions.

Stage 3 - Treatment
1. Swab wound*.
2. Start topical AWD*.
3. Consider starting systemic antibiotics*.
4. Monitor wound progress*, review at 2 weeks – see Stage 2, point 4, for actions.
5. If signs of systemic infection, go to Stage 4.

Stage 2 - Treatment
1. DO NOT SWAB.
2. Consider biofilm disrupting cleansing solution.
3. Consider topical AWD*.
4. Monitor wound progress*, review at 2 weeks:
   a. If no signs of infection, STOP and return to Stage 1, point 4 for actions
   b. If improving, continue and review weekly until no signs of infection
   c. If static, review AWD* choice.
5. If signs of spreading infection, go to Stage 3.

Stage 1 - Treatment
1. DO NOT SWAB.
2. Identify aetiology of the wound and refer if any concerns e.g. vascular, lymphoedema.
3. Refer all diabetic wounds to diabetic podiatry/MDT.
4. Optimise wound healing with debridement and dressings*.
5. If no progress after 2 weeks review wound management plan.
6. If signs of local infection go to Stage 2.

In certain patients, some signs and symptoms of infection might be masked e.g. diabetes, vascular, immunocompromised. Clinical judgement should be used to determine when AWDs should be used.

References:

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Medical Photography Service, NHS Lothian, October 2017

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