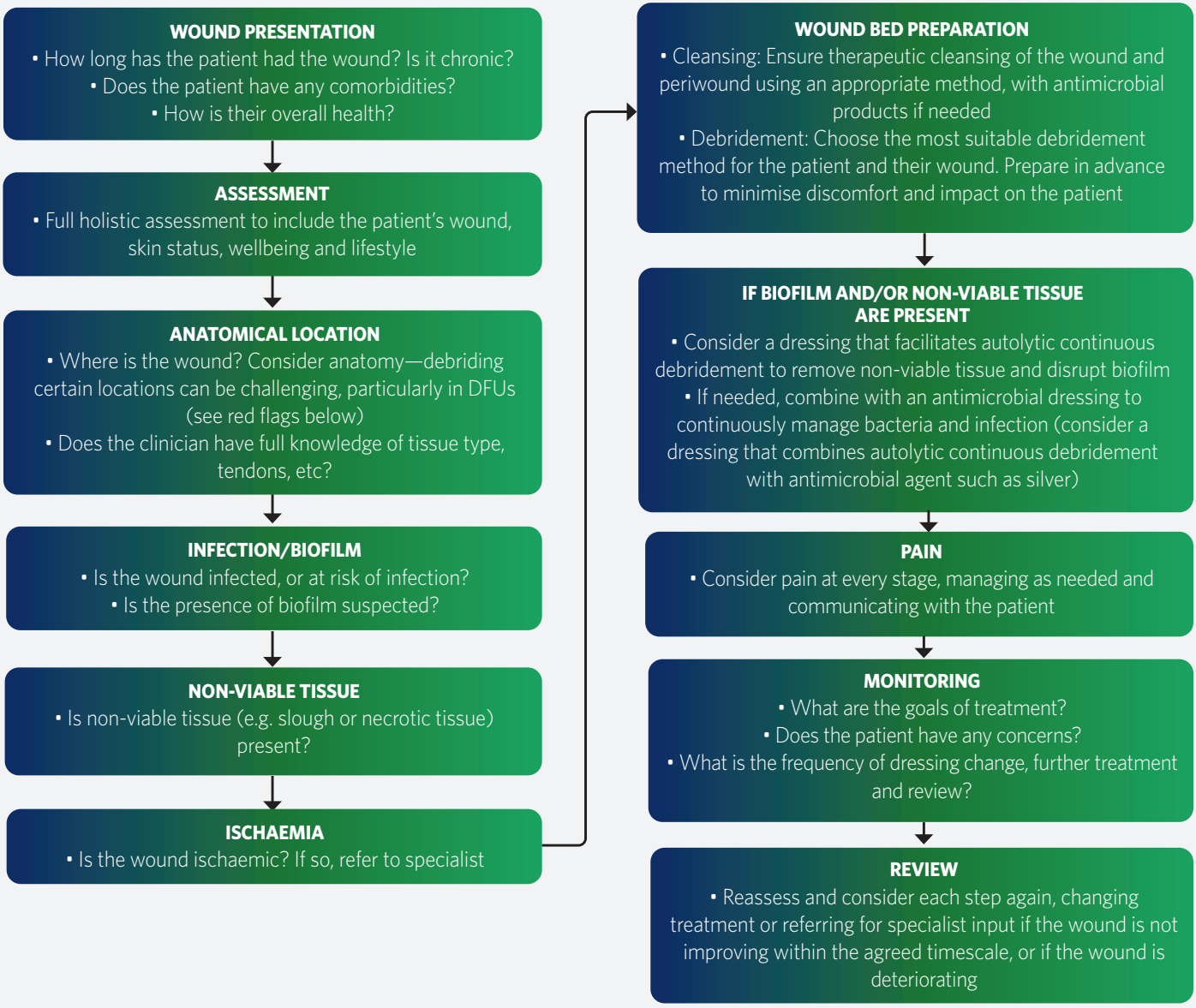
WOUND PRESENTATION
• How long has the patient had the wound? Is it chronic?
• Does the patient have any comorbidities?
• How is their overall health?
ASSESSMENT
• Full holistic assessment to include the patient's wound, skin status, wellbeing and lifestyle
ANATOMICAL LOCATION
• Where is the wound? Consider anatomy—debriding certain locations can be challenging, particularly in DFUs (see red flags below)
• Does the clinician have full knowledge of tissue type, tendons, etc?
INFECTION/BIOFILM
• Is the wound infected, or at risk of infection?
• Is the presence of biofilm suspected?
NON-VIABLE TISSUE
• Is non-viable tissue (e.g. slough or necrotic tissue) present?
ISCHAEMIA
• Is the wound ischaemic? If so, refer to specialist
WOUND BED PREPARATION
• Cleansing: Ensure therapeutic cleansing of the wound and periwound using an appropriate method, with antimicrobial products if needed
• Debridement: Choose the most suitable debridement method for the patient and their wound. Prepare in advance to minimise discomfort and impact on the patient
IF BIOFILM AND/OR NON-VIABLE TISSUE ARE PRESENT
• Consider a dressing that facilitates autolytic continuous debridement to remove non-viable tissue and disrupt biofilm
• If needed, combine with an antimicrobial dressing to continuously manage bacteria and infection (consider a dressing that combines autolytic continuous debridement with antimicrobial agent such as silver)
PAIN
• Consider pain at every stage, managing as needed and communicating with the patient
MONITORING
• What are the goals of treatment?
• Does the patient have any concerns?
• What is the frequency of dressing change, further treatment and review?
REVIEW
• Reassess and consider each step again, changing treatment or referring for specialist input if the wound is not improving within the agreed timescale, or if the wound is deteriorating