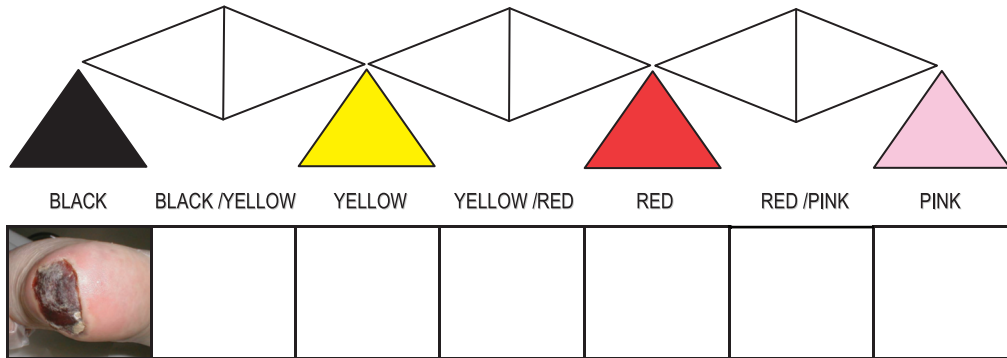


# How to use the wound healing continuums

**Diagram 1 - The Wound Healing Continuum**



**STEP ONE – The Wound Healing Continuum**

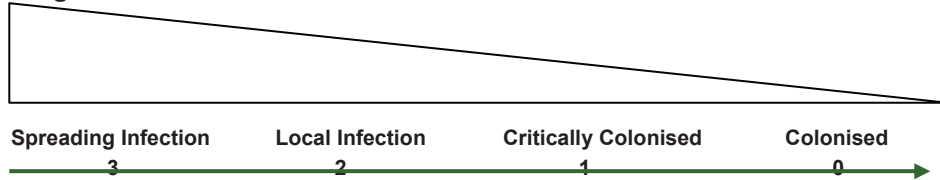
This is an aid to understanding the type of tissue present in the wound and how it should progress. Thought of as a continuum of colour changes (See diagram 1) from black to pink, it correlates with the healing stages of the wound. Not all wounds progress across the whole spectrum e.g. not all wounds will have a black stage.

**USING THE WOUND HEALING CONTINUUM**

Identify the colour of the wound that is furthest to the left of the continuum. For example, if the wound contains yellow slough and red granulating tissue it would be defined as a yellow/red wound. The management plan would focus on the removal of the yellow, sloughy tissue and promotion of red granulation tissue.

As this objective is achieved, the patient can progress along the wound healing continuum towards the right and therefore a pink / healing status.

**Diagram 2 - The Wound Infection Continuum**



This Wound Infection Continuum is a simple sliding scale to aid clinical decision-making regarding the level of bacterial colonisation of a wound.

A patient may never move to the furthest point on the right (Colonised) on the continuum during their entire treatment. However, lower bacterial levels found in colonised wounds generally lead to better healing. The status of a wound, which has Spreading Infection, Localised Infection or is Critically Colonised, should be considered when developing a treatment plan.

**STEP TWO – The Wound Infection Continuum**

There are four criteria which work from left to right with the most severe, "Spreading Wound Infection" on the left (Diagram 2). The continuum moves right, through "Local Infection", "Critical Colonisation", to "Colonisation."

**USING THE WOUND INFECTION CONTINUUM**

Spreading infection can be a life threatening condition. Local signs & symptoms associated with a spreading soft tissue infection includes; spreading redness (>2cm around wound margin), very high exudate levels, pain, malodour, heat in the surrounding tissues & blistering.

Localised infection is characterised by <2cm of redness around the wound margin, symptoms similar to spreading infection may also be present but to a lesser degree.

Critical colonisation is characterised by delayed healing, malodour, raised exudate levels, & dark red granular tissue. However, the wound will not present as if locally infected.

A Colonised wound is the normal healing state of a wound. A reduction in wound size over a two-week period would suggest an acceptable level of colonisation.

**Diagram 3 - The Wound Exudate Continuum**

	Viscosity		
Volume	High 5	Medium 3	Low 1
High 5			
Medium 3			
Low 1			

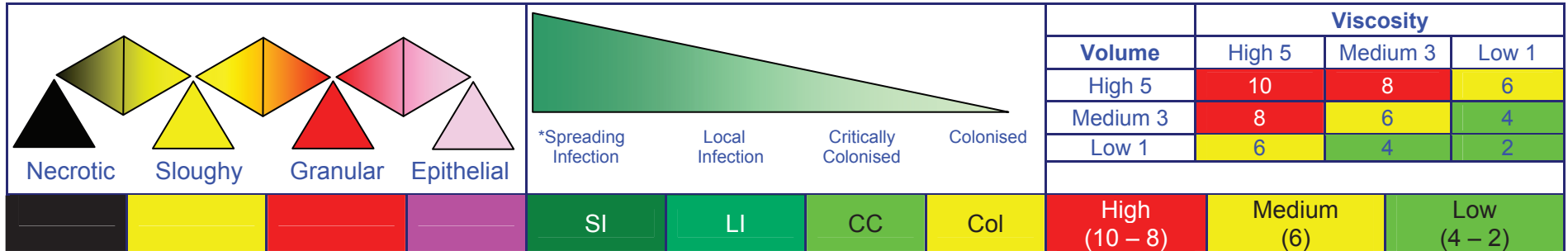
This guideline is written for use in NHS Hartlepool, NHS Stockton and North Tees & Hartlepool NHS Foundation Trust Community Services Division. It is based on the best evidence available at the time of publication. This guidance includes evidence-based recommendations from which it is intended decisions can be made for use in daily practice.

**STEP THREE – The Wound Exudate Continuum**

The Wound Exudate Continuum is an aid to quantifying wound exudate. The viscosity as well as the volume of the exudate can be an important indicator of wound status.

The gradings are HIGH, MEDIUM & LOW for both. This allows wound exudate to be categorised by a score (See Diagram 3). For example, a low volume of medium viscosity would be a Low/Medium category and would score 4, placing it in the Low Exudate portion of the continuum. Using the continuum: - If a wound scores 8-10 points (red zone – spreading infection) it would be regarded as giving serious concern. Any wound scoring 6 points (amber zone), may indicate early signs of critical colonisation or infection and would require regular review. A wound scoring 2-4 points (green zone) would be classed as normal.

# Wound Dressing Guidelines



AIM	Attain 100% 'Epithelial' tissue		Attain a healthy bacterial wound bed				Attain exudate of 'low' volume & 'low' viscosity			
OBJECTIVE	Remove Necrotic and/or Sloughy Tissue	Promote Granulation and Epithelial tissue	Treat infection	Treat infection	Reduce bacterial levels	Maintain bacterial levels	Manage exudate	Manage exudate	Manage exudate	
TREATMENT	Autolysis or re-hydration	Use dressing to promote a moist wound healing.	*Use systemic antibiotic for Spreading Infection				No antimicrobial required	Highly absorptive products	Moderate exudate absorption	Low exudates absorption
	<p><b>NECROTIC/SLOUGHY</b></p> <p><b>HYDROGEL:</b> ACTIVHEAL</p> <p><b>HYDROCOLLOID:</b> DUODERM EXTRA THIN</p> <p><b>HONEY:</b> MESITRAN</p> <p><b>HYDROGEL:</b> ACTIVHEAL</p> <p><b>HYDROCOLLOID:</b> DUODERM EXTRA THIN</p> <p><b>HYDROFIBRE:</b> AQUACEL</p> <p><b>ALGINATE:</b> SORBSAN, URGOSORB</p>	<p><b>FOAMS:</b> ALLEVYN GENTLE, MEPILEX (EXC. HEEL/AG)</p> <p><b>FILM:</b> C VIEW</p> <p><b>HYDROCOLLOID:</b> DUODERM EXTRA THIN</p> <p><b>NON ADHERENT/ SOFT SILICONE (if required):</b> ADAPTIC TOUCH, URGOTUL</p> <p><b>LOW ADHERENT:</b> TRICOTEX, NA-ULTRA, JELONET</p> <p><b>ISLAND DRESSING:</b> SOFTPORE CLEARPORE</p>	<p><b>ANTI MICROBIAL/ ANTIBACTERIAL FIRST LINE:</b> MESITRAN, FLAMINAL FORTE, URGOSORB SILVER, URGOTUL SSD</p> <p><b>SECOND LINE:</b> AQUACEL AG, IODOSORB, IODOFLEX, INADINE, SORBSAN SILVER</p> <p><b>WOUND IRRIGATION:</b> OCTENILIN</p>					<p><b>FOAM:</b> ALLEVYN GENTLE, MEPILEX (EXC. HEEL/AG)</p> <p><b>ALGINATE:</b> SORBSAN, URGOSORB</p> <p><b>DRESSING PAD:</b> PREMIER PAD</p> <p><b>2<sup>ND</sup> LINE:</b> ECLYPSE</p> <p><b>HYDROFIBRE:</b> AQUACEL</p>	<p><b>DRESSING PAD:</b> PREMIER PAD</p> <p><b>FOAM:</b> ALLEVYN GENTLE, MEPILEX (EXC. HEEL/AG)</p> <p><b>ALGINATE:</b> SORBSAN, URGOSORB</p> <p><b>HYDROFIBRE:</b> AQUACEL</p>	<p><b>DRESSING PAD:</b> PREMIER PAD</p> <p><b>FOAM:</b> ALLEVYN GENTLE, MEPILEX (EXC. HEEL/AG)</p> <p><b>HYDROCOLLOID:</b> DUODERM EXTRA THIN</p>
Skin protector to surrounding skin may be required to prevent maceration - <b>SORBADERM</b>										

Other specialist treatments to consider after consultation with Tissue Viability Nurse:

Larvae Therapy    Topical Negative Pressure    Silicone dressings    Protease-modulating matrix

N.B. PLEASE NOTE ALWAYS CONFIRM WITH PATIENT OR GP IF ALLERGIES KNOWN TO PATIENT TO AVOID ADVERSE RESPONSE TO DRESSING CHOICE E.G USE OF MESITRAN ON PATIENT KNOWN TO HAVE HYPERSENSITIVITY TO BEE STINGS OR BEE PRODUCTS