CLINICAL PROTOCOL FOR WOUND MANAGEMENT AND WOUND MANAGEMENT STANDARDS

RATIONALE

The aim of this document is to provide the appropriate management strategy for optimum wound healing, patient comfort and cost effectiveness in line with best practice/evidence.

All wounds must be assessed and reassessed by a competent registered health care professional who will undertake a comprehensive assessment of the wound (site, size, surface, grade and appearance, exudate type and volume, state of surrounding skin and level of wound pain)

TARGET GROUP

The procedures apply to all registered and non-registered health professionals within the Trust to provide wound care

TRAINING

All staff in the Trust are required to comply with mandatory training as specified in the Trusts Mandatory Training Matrix. Clinical Staff are also required to comply with service specific mandatory training as specified within their service training matrix.

RELATED POLICIES

Please refer to relevant Trust policies and procedures, particularly the procedures for pressure ulcer care and leg ulcer care.

TRUST WOUND CARE STANDARDS

- Complete one wound assessment form per wound to show progression of wound improvement or deterioration.

- Complete initial assessment and record baseline observations including respiration rate, pulse, temperature, blood pressure and urinalysis using the National Early Warning Score tool

- Reassessment of the wound should be undertaken at every dressing change, and documented on the Trust Wound Assessment Chart at a minimum standard of weekly or more frequent depending on wound presentation using clinical
judgement.

- Supplementary information should be recorded on the evaluation forms, e.g. equipment or dressings to be ordered, etc.

- All initial wounds to be assessed and measured within the appropriate timeframe stated on the referral, or when clinically indicated using clinical judgement

- Wounds must be swabbed if any signs of wound infection evident

- Swab results must be followed up and recorded on the wound assessment form

- All infected wounds (confirmed following a swab) must have topical Prontosan applied for a 15 minute soak at each intervention applied directly onto the wound (N.B. once opened Prontosan has an eight week shelf life)

- Antimicrobial dressings must be reviewed and re-evaluated after 2-4 weeks of use

- The Tissue Viability Service must be contacted for specialist advice before further antimicrobial dressings are used following 2-4 weeks of application

- Pain must be assessed and evaluated at each visit, and recorded on the evaluation form.

- All wounds remaining on the caseload longer than two weeks must be photographed and monthly thereafter, or as clinical need indicates

- In the context of this protocol, the Malnutrition Universal Screening Tool (MUST) assessments should be completed for the following patients:
  - All complex cases
  - All pressure ulcers
  - All leg ulcers
  - Other wounds based on the health care professional's clinical judgement to best meet the patient’s holistic needs

- Nutritional status to be reassessed at least monthly or earlier if needed depending on clinical need and MUST score

- Following MUST screening an appropriate individual nutritional care plan should be commenced and placed in the patient’s notes and the Care Pathway to Identify and treat adults at risk of malnutrition should be followed. This should be monitored and regularly evaluated.

- Always refer to the Trust’s Clinical Protocol for the Malnutrition Universal Screening Tool (MUST). The MUST will help identify adults who are malnourished, at risk of malnutrition or obese and screening should only occur if there is a clinical concern (NICE 2006)
WOUND CLASSIFICATION

A wound maybe defined as a defect or break in the skin that results from physical, mechanical or thermal damage, or that develops as a result of the presence of an underlying medical or physiological disorder” (Thomas 1990)

ACUTE WOUNDS

Abrasions (grazes) are superficial wounds, generally caused by friction as a result of brief or indirect contact between the skin and a harder or rougher surface. Abrasions are generally confined to the outer layers of the skin.

Lacerations (tears) are more severe than abrasions and involve both the skin and the underlying tissues.

Penetrating wounds maybe caused by knives, bullets or may result from accidental injuries caused by any sharp or pointed object. Internal damage can be considerable depending upon size and depth of penetration, and/or the velocity of the bullet or missile

Bites caused by animals, insects or humans may become infected by a range of pathogenic organisms including Spirochetes, Staphylococci, Streptococci and various gram positive bacilli. If untreated these infections may have serious consequences, involving fascia, tendon and bone.

BURNS AND CHEMICAL INJURIES

There are several different types of burns: thermal, electrical and radiation. Thermal injuries are the most common. Burns and scalds (thermal) maybe classified into three types depending upon the degree of tissue damage.

Superficial

(first degree) burns involve only the epidermis and superficial layers of the dermis and usually result from exposure to prolonged low intensity heat.

Deep dermal

(second degree) burns, in which most of the surface epithelium is destroyed together with much of the dermal layer beneath. Only some isolated epidermal elements in the deep layer remain visible such as those within hair follicles and sweat glands.

Full thickness

(third degree) burns, in which all the elements of the skin are destroyed

CHRONIC WOUNDS

Chronic wounds are the hard to heal wounds which are often linked to patients with
multiple co-morbidities and may never heal such as:

- Pressure ulcers which are usually caused by the sustained application of surface pressure over a bony prominence, which inhibits capillary blood flow to the skin and underlying tissue. If the pressure is not relieved it will ultimately result in cell death followed by tissue necrosis and breakdown.

- Leg or foot ulcers, which maybe venous, ischaemic, mixed aetiology or traumatic in origin.

- Diabetic foot ulcers (require urgent referral to appropriate healthcare professional)

- Dermatological conditions

- Malignant/fungating wounds

WOUND HEALING MECHANISMS

Irrespective of the nature or type of wound, the same biochemical and cellular procedures are required to facilitate the healing process. Such methods of healing are:

Primary Closure

Primary closure is the usual method of choice for most clean surgical wounds and recent traumatic injuries. By a surgical technique the edges of the wound are individually sutured with the individual layers being brought together.

Secondary Intention

In wounds that have sustained a large amount of tissue loss as a result of surgery, trauma or chronic ulceration, it may be impossible to bring the edges of the wound together. This is when the wound is left to heal by secondary intention.

Delayed primary closure

This is carried out when in the opinion of the surgeon, primary closure maybe unsuccessful (due to the presence of strikethrough, a poor blood supply to the area, or the need for the application of excessive tension during closure). In these circumstances the wound is left open for about three to four days before closure is completed.

Grafting and flap formation

A skin graft is a portion of skin (composed of dermis and epidermis) that is removed from one anatomical site and placed onto a wound elsewhere on the body. If successful, grafting will ensure that the wound will heal rapidly, thus reducing the chance of infection. The disadvantage of this technique is that the patient has two wounds instead of one and the donor site can be more painful than the original wound.
INITIAL AND ONGOING WOUND ASSESSMENT

Assessment should include information from different sources. It should bring together general and specific information on the patient, the skin, the circulation and the wound itself, only in this way can an accurate diagnosis be made.

Holistic assessment of the patient is an essential part of the wound care process.

WOUND BED PREPARATION

The aim of wound bed preparation (WBP), a process described by Falanga (2000), is to create an optimal wound-healing environment. The core precept of WBP is to focus on both the wound and the patient as a whole. This approach will frequently require a multidisciplinary and structured approach to care delivery.

Necrotic tissue

Wound containing dead tissue:

- It may appear hard, dry and black.
- Dead connective tissue may appear grey.
- Eschar with time may soften by autolysis and bacterial liquefaction.
- The presence of dead tissue in wounds delays healing.
- Necrotic tissue in Ischaemic leg ulcers should be left dry – moist wound healing is not promoted with this wound aetiology.

Slough

Slough is formed by an accumulation of dead cells in the wound exudate. It is light yellow in colour and must not be confused with infected tissue or pus.

Granulation tissue

Healthy red tissue, which occurs during the proliferative phase of wound healing. Fibroblasts migrate to the wound to produce collagen fibres. The tissue is well vascularised and bleeds easily.

Epithelial tissue

The process by which the wound surface is covered by new epithelium, this begins when the wound has filled with granulation tissue. The tissue is pink, almost white, and occurs on top of healthy granulation tissue.

WOUND MEASUREMENT

Wound measurement is vital to monitor the healing process of a wound. The wound should be measured at its greatest length and breadth using the sterile measuring ruler in the dressing packs. The depth of the wound is measured using a sterile probe using a Clock with the head of the patient as a guide being at 12 O’clock.
EXUDATE

Exudate is produced by all acute and chronic wounds (to a greater or lesser extent) as part of the normal healing process, but this may become viscous and malodorous in infected wounds. It plays an essential part in the healing process in that it:

- Contains nutrients, energy and growth factors for metabolising cells.
- Contains high quantities of white blood cells.
- Maintains a moist environment for wound healing.

Ritualistic cleansing of wounds is not necessary; the wound only needs to be cleansed if there is debris to remove. In leg ulceration excessive exudate may be produced as a result of venous hypertension and in these cases the patient should be referred to a leg ulcer clinic for a holistic leg ulcer assessment.

COLONISATION & INFECTION

Colonisation

Many wounds, especially if chronic, are colonised by a variety of bacteria including potentially pathogenic species. These colonising bacteria may exhibit no apparent harmful effect and although many wounds become colonised by a diverse range of bacteria, infection is not an inevitable consequence. Usually, colonised wounds do not require specific antimicrobial therapy.

The exception to this is where the wound is covered with slough or eschar that may harbour significant quantities of bacteria and can act as a potential focus for microbial spread. Such eschar should be actively debrided by the appropriate healthcare professional when this intervention has been deemed necessary. To prevent the spread of microorganisms (resistant or susceptible strains), it is important that all healthcare professionals adhere to infection control standard precautions.

Bacterial load is seen to rise progressively between wounds with local contamination to those with overt infection associated with systemic signs such as pyrexia or septicaemia.

This is often represented as “The bacterial load escalator”:

![Severity of clinical signs](Image)
Infection

Infection occurs when micro-organisms cause damage to body tissues, either by their presence or through the production of poisonous substances (endo and exotoxins). A bacterial load of $>10^5$ organisms per gram usually results in infection although lower levels of virulent organisms may cause infection. A positive swab result does not necessarily mean that a wound is infected. The wound may simply be colonised. If a wound shows any of the following then the presence of infection requiring intervention should be considered:

- Cellulitis
- Abscess/pus
- Increased pain
- Increased exudate
- Malodour
- Delayed healing/deterioration
- Friable granulation tissue/bleeds easily
- Evidence of tracking
- Temperature

A wound swab needs to be taken as per Trust procedure if there are signs of clinical infection, and the results followed up and documented on the wound assessment form.

The use of Antimicrobials and Antibiotics

All wounds contain micro-organisms, yet the majority are and will not become, infected. The diagnosis of wound infection is a clinical judgement, supported by, but not led by laboratory culture results. Many problems associated with the emergence and increased prevalence of antibiotic resistance have arisen by the overuse and misuse of antibiotics. A progressive increase in bacterial load is detrimental to a wound and will eventually lead to overt infection. The clinical stages that should be used to determine a therapeutic strategy have been described by Vowden and Cooper (2006)
Algorithm for managing wound infection (From Vowden & Cooper 2006)

When systemic signs of infection are present, specific virulent micro-organisms known to adversely affect the wound are identified, or the wound fails to respond to local treatment the patient may require treatment with antibiotics as recommended by a Doctor/Consultant Microbiologists. The choice of antibiotic should be based on microbial sensitivity testing whenever possible and should be modified according to any known allergy.

The presence of a biofilm (a bacterial colony, which may consist of several separate strains of bacteria, surrounded by a protective impenetrable glyocalyx) may prevent effective treatment when antibiotics are being used as a stand-alone measure (Sibbald, 2001). Similarly wounds infected with resistant strains of bacteria such as MRSA may require additional therapy to include topical antimicrobial use such as silver or honey dressings for a maximum of 2 week use then review. For infected wounds (including all MRSA wounds) topical Prontosan should be applied for a 15 minute soak at each intervention. For further information refer to Infection Prevention and Control policies.

**WOUND CLEANSING**

**Indications**

Wound cleansing is **NOT** indicated for most wounds and should only be performed with a specific goal or aim.
Wound:

- to remove excess exudate, slough or necrotic tissue.
- to remove remnants of old dressing material.
- to remove dirt and debris from traumatic wounds which could cause wound infection.
- to allow inspection and assessment of dirty traumatic wound.

Surrounding skin:

The skin surrounding a wound may require care including washing at dressing change to remove wound exudate and skin debris or for patient comfort.

Types of cleansing fluid

Cleansing can be achieved with either tap water or warm normal 0.9% saline. The decision to use isotonic saline is dependent on the type, depth and extent of the wound and the period of time that the fluid will remain in contact with the wound. Care should be taken if the full extent of the wound is not known.

Tap Water

Any fears regarding bacterial contamination of tap water appear to be unfounded (Angeras and Bradbard, 1992). Studies have shown no increased risk of infection if sutured wounds are washed with soap and water (Noe and Keller, 1988) or when the patient showers (Chrintz et al, 1989).

Microbiologists suggest running the tap water for a few minutes to flush out potential bacteria accumulations prior to use as a precautionary measure. Beam (2006) in an extensive review found tap water to be equally effective to saline when used as a cleansing agent.

Methods of cleansing

Wound and skin cleansing is best achieved by gentle irrigation either by showering, irrigating with a jug of warm water or saline or by irrigation with a syringe.

The patient often appreciates irrigation or short immersion of the wounded are in a bowl or bath. This practice is useful for skin care and cleansing particularly in patients with leg ulceration (Lawrence, 1997). Care must be taken to avoid prolonged immersion of the wound and cross infection. Lawrence (1997) suggests using disposable plastic bags to line the bowl. Care must be taken in the cleaning of lifting equipment and the bath if this is the chosen method of care. For further information and guidance refer to Infection Prevention and Control policies. De Smet et al (2006) have shown that there is little direct effect on the environmental bacterial contamination by wound cleansing.
DEBRIDEMENT

Modern wound care dressings facilitate autolytic debridement. Sharp debridement will only be undertaken by the Tissue Viability Service or Podiatry if clinically indicated.

PAIN

The pain associated with any wound is often underestimated. A pain assessment tool has many advantages:

- Patient has a more active role in dealing with their pain.
- The patient may feel that their pain is being taken seriously.

In wound care, accurate assessment of pain is essential with regard to choice of the most appropriate dressing. Assessment of pain before, during and after the dressing change is essential to provide vital information for on-going pain management. Patients with peripheral neuropathy (often diabetic patients) who may have reduced sensation to the foot may not be able to feel pain. In general pain experienced by patients with chronic wounds (although this is subjective as this can vary from patient to patient) fall into the following categories:

- A deep, dull constant pain.
- A superficial, burning-type pain.
- A neuralgic type pain.
- A ischaemic pain
- Pain from a cellulitis.

Whatever the cause of the patient's pain, the patient's perception of their pain should be acknowledged at every dressing change and documented on the Trust's wound assessment form and measures taken to alleviate the pain e.g. analgesia, or a possible different dressing choice.

NUTRITION

Hydration and Nutrition

It is important to encourage patients to have a varied food and fluid intake providing energy, protein, carbohydrates, fats, vitamins and minerals which will help maintain body mass and promote wound healing.

Many nutrients are involved in promoting new tissue formation; suppressing oxidation of tissues, free radical scavenging and improving wound function. Adequate nutrition helps to maintain immune competence and decrease the risk of infection.

When the diet lacks vitamins and minerals, dietary replacement can prevent further deficiency. However, supplementing these micro-nutrients in patients who are not clinically deficient has yet to be shown to be effective and may be harmful (Thomas 1997).
The MUST should be used to identify adults at risk of malnutrition and should be undertaken on any patient where there is clinical concern.

On completion of the MUST an individual care plan should then be implemented based on whether the patient is at low, medium or high risk of malnutrition (see Guide to Identifying and Treating Malnutrition for Adults). Regular monitoring and evaluation of the nutrition care plan should take place as per this guidance.

In addition to nutrition, an adequate fluid intake is important. Dehydration can result in diminished healing ability since water is a major component of healthy cells. Dehydration is a major risk factor for the development of pressure ulcers as the skin becomes inelastic and fragile.

A large wound may exude significant volumes of fluid that can result in electrolyte imbalance as well as dehydration. A heavily exuding wound may also delay healing by macerating surrounding skin. When wounds are heavily exuding a cause for this should be sought, and if possible corrected. For example this may include the management of peripheral oedema by compression and/or diuretic therapy.

**DIETETIC SERVICE**

Patients with pressure ulcers graded 3-4 who are clinically stable, maintaining or gaining weight and eating a varied diet should be assessed and monitored appropriately using the MUST, and findings acted upon accordingly.

Patients with pressure ulcers graded 3-4 with a MUST score of 2 or above who are assessed as being clinically unstable, losing weight and have poor dietary intake should be referred to the Dietetic Service for further comprehensive assessment and specialist input. Please include all relevant information within the referral form to ensure patients are triaged appropriately according to their clinical need. Ring the Dietetic Service if further information is required.

The Dietetic Service should be contacted when staff have urgent enquires relating to patients’ nutritional status and related complex wounds.

**DRESSING CHOICE**

There are two different categories of dressings

1. Primary - This is in contact with the wound.
2. Secondary - This is not in contact with the wound but covers the primary dressing.

When choosing a secondary dressing ensure its compatibility with the primary wound contact layer.

**Choosing the ideal dressing**

Dressings do not heal wounds, they aid wound healing. There are many hundreds of wound products available all having slightly different properties. The ideal wound
management choice is dependent on the type, depth and colour of the wound taken in conjunction with the stage of healing and what the main objectives of treatment e.g. debridement or protection. Dressing choice will also be influenced by the level and type of exudate.

For the purpose of this document the ideal dressing is considered to be one that ensures optimal healing by:

1. Maintaining high humidity
2. Removing excess wound exudate
3. Permit thermal insulation
4. Impermeable to bacteria / can be shower proof
5. Gaseous exchange
6. Non-fibre shedding/ non-toxic
7. Non-adhesive, comfortable and conforming

Dressing selection needs to be decided in conjunction with the patient and based upon the clinical findings of the wound following a comprehensive assessment. Where possible the Wirral Wound care dressings formulary should be used unless there is a clinical reason to deviate

**CLINICAL PHOTOGRAPHY**

All wounds remaining on the caseload longer than two weeks should be photographed using Trust supplied cameras only; mobile telephones are not to be used. Further photographs should be taken monthly or if the wound deteriorates.

Images are to be printed off and not stored on Community nurse computers. Consent form 5 needs to be completed prior to clinical photography and stored in the patient’s healthcare records accordingly.

**UNPLANNED CARE**

The Registered Nurse or Minor Injuries Doctor has the responsibility for the initial assessment and management of the patient. The Registered Nurse is responsible for devising the wound care plan and for reviewing the progress of wound healing or deterioration

When a patient attends for re-dressing the Registered Nurse is responsible for reviewing the wound, amending the care plan (if needed) and completing the dressing for every third attendance if the patient has not been seen by a Registered Nurse in previous attendances.

The Health Care Assistant is responsible for patients wound management only following initial assessment by the Registered Nurse or Minor Injuries Doctor. They can only undertake the redressing of an individual patient’s wound on two sequential occasions, after which a Registered Nurse must re-assess the wound. In all situations where they are concerned about the wound or the patient’s general condition they must seek advice of a Registered Nurse.
TRUST WOUND CARE STANDARDS FOR UNPLANNED CARE

- Complete wound assessment template
- Record baseline observations using NEWS / PEWS score if required.
- Wounds must be swabbed for microbiological assessment if any signs of wound infection are evident.
- Pain must be assessed, evaluated each visit and documented on wound assessment template.
- Reassessment healing progress should be observed at every dressing change and documented.

REFERRAL CRITERIA TO MINOR INJURIES DOCTOR / A/E DEPARTMENT FROM UNPLANNED CARE

- Wound caused by glass or possibility of foreign body in wound
- Facial Lacerations
- Laceration to the eyelid
- Deep lacerations of the ear
- Deep Wounds which may require deep sutures
- Suspected tendon or nerve damage
- Penetrating stab wounds that need probing
- Wounds that have been caused by a significant crush injury
- Neurovascular deficit
- Electrical burns
- Circumferential burns
- Full thickness or deep partial thickness burns
- Burns to the genitalia or perineum
- Burns to the sole of feet
- Electrical burns
- Burns covering 10% surface or 5% surface of children
- Burns to face
- Chemical burns
- Concerns over consistence of injury and history in a child or vulnerable adult
- Injury caused by alleged assault

CONSENT

Valid consent must be given voluntarily by an appropriately informed person prior to any procedure or intervention. No one can give consent on behalf of another adult who is deemed to lack capacity regardless of whether the impairment is temporary or permanent. However such patients can be treated if it is deemed to be within their best interest. This must be recorded within the patient’s health records with a clear rationale stated at all times. Refer to Trust Patient Information and Consent Policy for further information and guidance or the Clinical Protocol for Assessing Mental Capacity and Best Interests.
TISSUE VIABILITY REFERRAL

Please see Appendix One.

WERE TO GET ADVICE FROM

Trust staff should seek advice from their Team Leader in relation to the provision of wound care and adhering to the Trust's wound care standards. When more comprehensive advice is required; the Tissue Viability Service should be contacted if available. Trust staff should contact the Dietetic service for specialist advice when clinically indicated.

INCIDENT REPORTING

Clinical incidents or near misses must be reported via the Trust’s incident reporting system.

SAFEGUARDING

In any situation where staff may consider the patient to be a vulnerable adult, they need to follow the Trust Safeguarding Adult Policy and discuss with their line manager and document outcomes.

EQUALITY ASSESSMENT

During the development of this protocol the Trust has considered the clinical needs of each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation). There is no evidence of exclusion of these named groups.

If staff become aware of any clinical exclusions that impact on the delivery of care a Trust incident form would need to be completed and an appropriate action plan put in place.

REFERENCES


Tomlinson. (1997) To clean or not to clean? Nursing Times 83 (9): 71-75

**Tissue Viability Service Referral Tree**

- **Leg Ulcer i.e. leg wound of >4 weeks duration**
- **Holistic Assessment Identify General/Local factors that affect wound healing.**
- **Pressure Ulcer Holistic assessment. Risk assessment too e.g. Waterlow Scale or Community Pressure Ulcer assessment documents. Equipment as per Community Equipment Service catalogue. E.g. Option 1 or Option 2**

- **Leg ulcer assessment refer to leg ulcer guidelines. Full assessment. Vascular assessment, Doppler ultrasound.**
- **Wound Type**
  1. Necrotic
  2. Slough
  3. Granulation
  4. Epithelialisation
  5. Infected
  6. Malignant (fungating)

- **Evaluate Wound Environment**
- **Evaluate dressing selection. Dressing appropriate to wound environment. Intrinsic/Extrinsic. Factors – Holistic review. Cost-benefit analysis. Refer back to wound guidelines and poster.**
- **Dressing selection Primary/Secondary**
- **Healing**
- **Non-Healing**
- **Infection?**
  1. Pain
  2. Swelling
  3. Redness
  4. Purulent discharge
  5. Wound deterioration
  6. Bridging
  7. Increase Exudate
  8. Malodour

- **Non-Healing venous Ulcers of 3 months refer to Venous Leg ulcer clinic at Clatterbridge.**
- **Confirm infection/Culture swab. Systemic antibiotics Refer to GP MRSA refer to microbiologist. Standard precautions. Infection Prevention and Control guidelines. Dressing selection as per guidelines.**

- **Referral to Tissue Viability Service via GP or referral form 3 Port Causeway, Bromborough, CH62 4NH. Tel: 0151 643 5330/329 Fax: 0151 514 2329**
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