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Wound Assessment for Nursing Homes

Using the **T I M E** acronym to assess a wound bed[1, 2]

T (tissue)

Identify Tissue Type	Appearance	Implication for Wound	Action/Goal
Necrotic	**Black/brown**	Delays healing	Remove from wound bed
Slough	**Yellow/green**	Medium for bacteria	Remove from wound bed
Granulation	**Red**	Needed for healing	Promote moist wound environment
Epithelial	**Pink**	Needed for wound closure	Protect

Exceptions: it is not advised to remove dry stable eschar of heels or gangrene that is absent of infection[3].

I (infection/inflammation)

All wounds will have some level of microbial activity. This does not always indicate a need for antibiotic therapy.
The Contamination Infection Continuum[4].

Microbial Activity	Description	Signs	Action
Contaminated ↓	Non-proliferating microbes on the surface of the wound only.	No delay to healing.	Monitor and keep clean (antimicrobials not indicated).
Colonised ↓	Microbials have successfully grown/divided but proliferation is limited. Microbes remain on the surface of the wound only.	No delay to healing.	Monitor and keep clean (antimicrobials not indicated).
Local infection ↓	Proliferating bacteria on surface and has spread to the wound bed triggering a host response.	**Early Signs:** Hyper or friable granulation tissue, increased pain and odour, wound breakdown or enlargement. **Overt Signs:** New/increasing pain, delayed wound healing (beyond expectations) erythema, local warmth, purulent discharge.	Topical antimicrobial and effective debridement.
Infection (spreading/ systemic)	Proliferating bacteria on wound surface, in wound bed that has now invaded surrounding wound tissue which can spread systemically.	**Spreading infection:** Wound breakdown +/- satellite lesions, lymphangitis, crepitus, malaise, loss of appetite. A systemic infection can cause severe sepsis, septic shock, organ failure or even death.	Topical antimicrobial, effective debridement and need for antibiotics. If systemic infection is suspected, it is important to rule out other infection sources.

M (moisture)

A warm moist environment is ideal to promote healing. Too much or too little moisture will delay healing.

How to assess moisture level at dressing change

Dry: No exudate on dressing
Low: Minimal amount of exudate on dressing
Moderate: Exudate contained in dressing
High: Dressing saturated, exudate not contained

Exceptions for a warm moist environment: Ischaemic wounds, stable dry eschar, fungating wounds & immunocompromised patients.

E (edges)

The surrounding skin must be in good condition for the wound edges to contract.

If the edges are:

Healthy → Moisturise and protect
Dry → Moisturise and protect
Excoriated → Apply barrier cream and a more absorbent dressing
Macerated → Need for more frequent dressing change & a more absorbent dressing
Red (Erythema) → If present- ask why? Is it related to moisture/pressure or do you suspect an infection?

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Dressing Selection

Use **T I M E** to identify the needs of the wound bed and form a rationale for dressing choice

Many dressings have dual functions - use this list as a guideline.*

Each patient and their wound require an individualised assessment

Objective	Dressing Choice
To Aid Granulation	Dressing selection will depend on wound depth and exudate levels - Dressing should aid a moist & clean environment and control exudate levels. Examples: Hydrocolloids/Hydrofibres/Mesh dressings.
To Debride	Hydrogels/Hydrofibres/Cadexomer Iodine/Honey/Enzymatic.
To Hydrate	Hydrocolloids/Hydrogels.
To Reduce Bacterial Burden	Antimicrobial dressings.
To Absorb	Hydrofibres/Alginates/Foams/Wound pads.
To Protect	Foam/Films/Membranes.

*This guideline should be used to aid decision making but does not replace the need for clinical judgment in the care of individual residents with wounds.

For further information or guidance please contact 1800 923 404 or email TVNreferrals@nutricia.com

1. Health Service Executive (2018) National Wound Management Guidelines
2. Dowsett C, Newton H (2005) Wound Bed Preparation TIME in Practice. Wounds UK 1.3 58-70
3. Lloyd Jones M (2015) Should necrotic tissue always be debrided. Wound Essentials. 10. 2. P26-29
4. International Infection Institute (2016) Wound infection in clinical practice. Wounds international