The TIMERS Framework

A practical tool for managing patients with wounds

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Scan the QR code to view the Wound Care page on the Sironca care and health website.

Tissue - non-viable/ devitalised or healthy?

The appearance of a wound bed indicates the ‘health’ of the tissue. Devitalised/ dead tissue (e.g. thick fibrous yellow slough as photographed) provides an ideal environment for microbial growth and biofilms to form.

Necrotic tissue, often black in appearance, is another form of devitalised tissue, caused by tissue death from reduced or no blood perfusion.

Granulation tissue (red in colour as photograoged) and epithelial tissue (pinky/ red in colour) are both healthy tissue types and signs of wound healing.

Actions:

- Debride devitalised tissue (slough/ necrosis) if appropriate.
- Do not debride foot wounds without completing a Doppler assessment to check the patient’s vascular status first. Consider appropriateness of debridement if a patient is approaching the end of life.
- Seek advice from the Wound Care Service (WCS) or podiatry if unsure.
- All wounds on the foot must be referred to podiatry if diabetic.
- If wound bed is clean and granulating, manage moisture effectively.

Examples of debridement include moisture donating dressings, debridement pads/ cloths, larvae therapy, or conservative sharps debridement by a specialist e.g. TVN/ podiatrist. Compression will also aid debridement, for leg ulcers.

Infection, inflammation or biofilm

Infection/ biofilm will delay healing and can increase pain, exudate and odour. It's important to differentiate between the different types of infection:

Local infection and biofilm is contained within the wound and immediate peri wound region (less than 2cm).

Spreading infection (see photo above), also known as cellulitis, is when the infection starts to invade the surrounding tissue.

Systemic infection is when the infection spreads throughout the whole body and patients often present as being unwell at this point e.g. fever/ pyrexia.

Actions:

- Monitor vital signs for all types of infection - escalate as appropriate.

- Local infection and biofilm can be treated topically with antimicrobial dressings. Please refer to the Sirona Wound Management Guide & Dressing Formulary, available: https://remedy.bnssg.icb.nhs.uk/adults/dermatology/tissue-viabilitywound-care-service/. Antibiotics and wound swab are not indicated. Wound hygiene/ debridement will play a vital role in managing local infection and biofilm – use debridement cloths/ pads for this.

- Spreading infection (photo above)/ systemic infection - Treat with antibiotics and consider swabbing wound, especially if no response to broad spectrum antibiotics. Antimicrobial dressings can also be used to treat alongside antibiotics.

Moisture imbalance

Exudate is a normal part of wound healing; it contributes to autolysis (removal of devitalised tissue). Dry wound beds such as the necrotic wound to the left, can impede the healing process; therefore, moisture donating dressings may be required to donate moisture to the wound bed. Please refer to the Sirona Wound Management Guide & Dressing Formulary.

However, high exudate levels can also impede healing, breaking down vulnerable new wound tissue and macerating (photo to the left) or excoriating the peri wound skin.

Actions:

- For high exuding wounds - use a superabsorbent dressing to manage exudate and a barrier film to protect the wound edges.
- Consider dressing frequency, this may need to be temporarily increased to manage exudate.
- Always consider compression for lower limb wounds/ conditions and ensure an appropriate emollient is used for lower limb management.
- For dry wounds e.g. dry necrosis – use moisture donating dressing, unless the wound is on the foot (a Doppler is required to check vascular status first). Take caution using moisture donating dressings on diabetic foot wounds and ensure the patient has been referred to podiatry.

Edge of wound

Healthy wounds epithelialise from the edge. If there is a lack of epithelial presence at the wound edges, the wound edges are failing to reduce in size or there are rolled edges (photo to left) present, this indicates that wound healing is not progressing as it should.

Edges may also be undermining - use a sterile wound probe to measure this.

Actions:

- Protect the wound edge with a skin barrier film, or an emollient if on the lower limbs.
- Consider wound hygiene/ debridement if there is a build-up of dry skin/ callous at the wound edge, as this will hinder healing.
- Consider referral to the Wound Care Service if undermining wound edges are not progressing.
- Refer back to **Tissue**, **Infection/ Inflammation/ Biofilm** and **Moisture imbalance**, to ensure all previous factors have been assessed and are being managed appropriately.

Repair/ Regenerate/ Refer

If a wound is slow or failing to heal, advanced therapies or onwards referral may need to be considered. Onwards referrals may include plastics/ dermatology/ vascular/ wheelchair services/ orthopaedics.
Ensure all other factors within TIMERS have been considered and refer to the Wound Care Service for further assessment.

Advanced therapies include:

- Negative pressure therapy e.g. VAC/ PICO
- Larvae (maggot) therapy for debridement

Surrounding skin

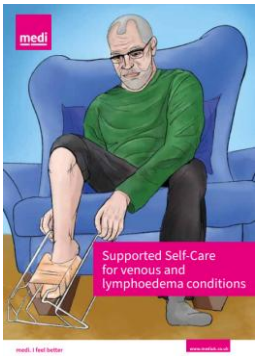
Taking care of the surrounding skin is equally as important as managing the wound bed. In some cases, it will be a skin condition you are managing rather than a wound.

The photo to the left show's excoriation to the surrounding skin, from exudate not being managed effectively. This requires a barrier film.

Actions

- Dry skin requires good essential skin care, including emollient therapy and possible debridement.
- Macerated skin indicates poor moisture management - refer to moisture imbalance actions.
- Excoriated skin (photographed above) indicates poor moisture management - refer to moisture imbalance actions.
- Oedema of the lower limbs requires assessment for compression.
- Inflamed skin e.g. varicose eczema may require topical steroids.
- Cellulitic skin/ spreading infection will require antibiotics.
- Incontinence associated skin damage should be managed with barrier products. Please see further guidance in the Sirona Wound Management Guide & Dressing Formulary

Social factors and Supported Self care



Patient engagement increases the likelihood of wound healing. To engage a patient in their care, they need to understand the treatment they are receiving so may need it explained further. Avoid medical jargon as this can be confusing.

Setting goals using shared decision making will empower patients. Discuss shorter term goals before the overall end goal. For example, reducing the exudate levels, or improving the tissue type in the wound bed, before achieving full wound healing.

Supported self-care should be promoted at every opportunity.

Remember to assess the whole patient, not just the ‘hole’ (wound). Including pain, environmental factors, nutrition, mobility, equipment.

Contact the Wound Care Service

Email: sirona.wcs@nhs.net
Tel: 0117 9449733
Our referral form can be located:
https://remedy.bnssg.icb.nhs.uk/adults/dermatology/tissue-viabilitywound-care-service/

The TIMERS Table References

Wounds UK, 2016.

European Wound Management Association, 2012.
Strohal et al, 2013.

Dowsett C (2004) TIME in Context. The Wound Bed Preparation ‘Care Cycle’.

Let us know what you think and get involved

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*Calls from landlines are charged up to 10p per minute; calls from mobiles vary, please check with your network provider. This is not a premium-rate number.

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