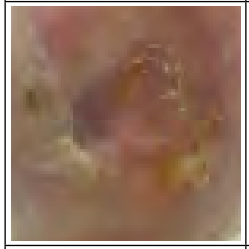
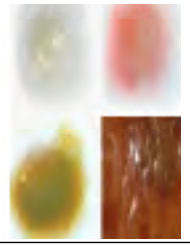
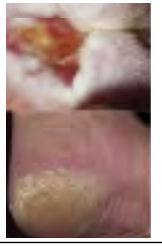
T.I.M.E.S Pathway

PRIMARY CARE DONCASTER

NHS South Yorkshire Integrated Care Board Doncaster Place

NHS Rotherham Doncaster and South Humber NHS Foundation Trust

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

	T - Tissue					I - Infection	M - Moisture	E - Edges	S – Surrounding Skin
	Epithelialisation	**Granulation**	**Over Granulation**	**Slough**	**Necrosis**				
Definition	Final stage of wound healing, with new skin cells migrate across the wound surface. It appears as pale pink/white and is very delicate and fragile.	Tissue that fills the wound as it is healing. It is firm to the touch, painless and does not bleed easily.	Presents as dark red or a pale bluish/purple uneven mass rising above the level of the surrounding skin, increasing the risk of infection.	Dead cells in the wound bed and is yellow/white in colour. It generally has a soft texture, is thick and adheres to the wound bed.	Dead or devitalised tissue that is black/brown, acting as a culture, providing an ideal breeding ground for bacteria and prevents healing.	An invasion by proliferating microorganisms to a level that invokes a local and/or systemic response.	Wound moisture/exudate is fluid that leaks out of blood vessels as part of the inflammatory phase of healing.	Measure the wound bed width, length, depth and any tracking or undermining areas (cm).	The surrounding skin / periwound maybe affected by wound related factors.
Image									
Treatment	No wound cleansing required	Follow the Wound Bed Preparation Pathway				Follow the Wound Infection Pathway	Follow the Wound Bed Preparation Pathway		
	Emollients, barrier protectants (Medi derma S range) and transparent films (C-view) can be used to protect newly formed tissue.	**Nil to Minimal exudate:** UrgoStart Border *(can stay in place for up to 7 days)*	**Nil to Minimal exudate:** Reassess as wound is unlikely to be over granulating with nil to minimal exudate	**Minimal to Moderate exudate:** Comfeel OR UrgoClean Ag covered with Suprasorb P Sensiflex *(can stay in place for up to 7 days).*	**Patient has confirmed or suspected Peripheral Arterial Disease to the affected limb:** Continue the plan from the Vascular Service / Refer to the Vascular Service.		**Dress the wound with a primary dressing as per the Tissue Type section and adapt the secondary dressing if required to:** • EmSorb Max Superabsorbent Pad with Safe soft Bandage. • PICO 7/14 • NPWT	N/A	**Maceration:** Medi-derma S barrier film stick to the peri wound edges.
		Moderate to Heavy exudate with LESS than 2 cm depth: Suprasorb P Sensiflex *(can stay in place for up to 7 days).*	**Moderate to Heavy exudate day 1 – 14:** UrgoClean Ag covered with Suprasorb P Sensiflex OR Safe Soft Bandage. *(can stay in place for up to 7 days).*	**Moderate to Heavy exudate:** Flaminal Forte OR Cutimed Sorbact Ribbon covered with Suprasorb P Sensiflex *(can stay in place for up to 7 days).*	**Nil to Minimum exudate:** Comfeel OR Intrasite Gel *(can stay in place for up to 7 days).*				**Dry Skin:** Emollients as per your organisation guidance.

Treatment

Emollients, barrier protectants (Medi derma S range) and transparent films (C-view) can be used to protect newly formed tissue.	**Moderate to Heavy exudate with MORE than 2 cm depth:** Use a wound filler of either Cutimed Sorbact Ribbon OR Flaminal. Cover with Suprasorb P Sensiflex *(can stay in place for up to 7 days).*	**Moderate to Heavy exudate if no improvement after day 14:** Fludroxycortide tape 4mcg per cm2 *(only use for 21 days).*		**Moderate to Heavy exudate:** UrgoClean Ag OR Flaminal Forte with an appropriate secondary dressing to secure e.g. Suprasorb P Sensiflex or Safe Soft Bandage. *(can stay in place for up to 7 days).*		Renasys	N/A	

Document all wound assessments accordingly in the relevant documentation using the TIMES acronym.

Documentation and Referral

No onward referrals are required.	**If there is no improvement after 14 days of treatment refer to:** • **DBTH inpatient** - The Skin Integrity Team (SIT) • **Communality Tier 1 or 2** - to Community Tier 3 • **Community Tier 3/ District Nurses** - to The Tissue Viability and Lymphoedema Service (TVALS) • **Community patients with a Diabetic Foot Ulcer** - to The Podiatry Foot Protection Service.	**If there is no improvement after 21 days of treatment refer to:** • **DBTH inpatient** - The Skin Integrity Team (SIT) • **Communality Tier 1 or 2** - to Community Tier 3 • **Community Tier 3/ District Nurses** - to The Tissue Viability and Lymphoedema Service (TVALS) • **Community patients with a Diabetic Foot Ulcer** - to The Podiatry Foot Protection Service.	**If there is no improvement after 14 days of treatment refer to:** • **DBTH inpatient** - The Skin Integrity Team (SIT) • **Communality Tier 1 or 2** - to Community Tier 3 • **Community Tier 3/District Nurses** - to The Tissue Viability and Lymphoedema Service (TVALS) • **Community patients with a Diabetic Foot Ulcer** - to The Podiatry Foot Protection • Service.	*Follow the Wound Infection Pathway.*	As per the Tissue Type referral recommendations.

If the named product on this pathway is not available a temporary second line product is available to use. This can be found within the main text of the Doncaster Wide Wound Care

Reference: Kalan L, Schultz G, Malone Met al (2023) Slough: Composition, analysis and effect on healing. Wounds International. Nichols, E. (2015) Describing a wound from presentation to healing. Wound Essentials. 10 (1). Harris A, Rolstad BS (1994) Hypergranulation tissue: a non - traumatic method of management. Ostomy Wound Manage 40 (5): 20 - 2, 24, 26 - 30. Johnson S, (2007) Haelan Tape for the treatment of over-granulation tissue. Wounds UK, Vol 3, no 3, 70 - 74. Wounds UK (2013) Best Practice Statement. Effective exudate management. London: Wounds UK.
Developed by the Skin Integrity Team and the Tissue Viability and Lymphoedema Service 2024. Updated September 2026. For review by July 2029