Wound Bed Preparation

T.I.M.E.S Chart

	TISSUE	INFECTION	MOISTURE	EDGE	SKIN
WOUND CONDITION	Non viable tissue or slough present	Increased exudate, surface discoloration, increased odour, high bacterial counts.	Heavy exudate or dry wound bed with risk of maceration or desiccation.	Non-advancing or undermining wound with prolonged inflammation.	Surrounding skin dry, scaley,eczma macerated, or otherwise compromised
CLINICAL ACTION	Assessment and debridement of non viable tissue when safe to do so	Assess aetiology and need for topical/ systemic abs.	Assessment of aetiology and management of wound exudate. Restore moisture balance	Assessment of non- advancing wound edges. Consider further debridement. Consider other therapies.	Assess peri-wound condition
OBJECTIVE	Viable wound bed restored	Bacterial balance and reduced inflammation with increased growth factor activity	Desiccation and maceration avoided. Optimum moisture level. Epithelial migration.	Restoration of bacterial and moisture balance to encourage epithelial advancement.	Healthy peri-wound skin
PRODUCT SELECTION					

Adapted from European Wound Management Association (EWMA). Position Document: Wound Bed Preparation in Practice. London: MEP Ltd, 2004; Wound Bed Preparation: TIME in Practice, Dowsett C & Newton H, WOUNDS UK. 2005;1:58–70; Extending the TIME concept: what have we learned in the past 10 years? Leaper DJ, Schultz G, et al. Int Wound J 2012; 9 (Suppl. 2):1–19.