Torbay and South Devon
NHS Foundation Trust

Email: foi.tsdft@nhs.net
Our Ref: TSD8914

3 November 2026

Dear Sir/Madam

Request for Information

We are writing to confirm that we have now completed our search for the information you requested.

A copy of the information is below:

I am writing to you under the Freedom of Information Act 2000 to request the following information from your organisation's 'first presentation/emergency care services (e.g. urgent care/Accident & Emergency/Minor Injuries unit).

I am wishing to establish how patients with pretibial injuries are managed if they attend emergency care services.

A pre-tibial injury is a type of wound occurring on the shin or front of the lower leg, specifically the area where the tibia (shinbone) lies. These wounds are frequently caused by trauma, such as a fall or knock, and the thin skin in this region can tear easily, especially in older individuals. They and can range in severity from a skin-tear (pretibial laceration) to a degloving injury or haematoma.

Please may you provide me with:

1. **Name of the organisation and region**
   Torbay and South Devon NHS Foundation Trust

2. **Which of the following first presentation/emergency care services does your organisation provide?**

   - **Type 1 A&E department (Increasingly referred to as an Emergency Department) = A consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.**

   - **Type 2 A&E department = A consultant led single service or Emergency Department (e.g. ophthalmology, dental) with designated accommodation for the reception of patients. Type 3 A&E department = These are now**

referred to as Urgent Treatment Centres (UTCs). These are GP-led, open at least 12 hours a day, every day, offer appointments that can be booked through NHS 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments for which people attend A&E.

- **Type 4 Other non-UTC that continue to operate as MIUs, UCC, WICs**

- **Type 5 Ambulatory Emergency Care Service**
  The Trust provide:
  - Type 1 Emergency Department
  - Type 3 UTC
  - Type 4 MIU

3. **How many patients with pretibial injuries does your first presentation / emergency care service see annually?**
   The table below shows approximate annual attendances for pretibial injuries at the services listed above. Since switching to Epic for electronic patient records, we cannot retrieve 2026/2027 data using the same search criteria.

Financial Year	Attendances
2019/20	53
2020/21	62
2021/22	60
2022/23	82
2023/24	77
2024/25	59
2025/26 (ytd)	22

4. **Does your first presentation/emergency care service have a protocol/ policy/ pathway/ clinic for the conservative (non-surgical) management of people with pretibial wounds? If yes – please specify which**
   The Trust does not have a specific protocol / policy / pathway / clinic for conservative management of people with pretibial wounds. However, please see our wound management guidelines attached.

5. **At discharge what follow up care is provided for these patients (e.g. do you refer to: GP; Community Nurse; Community Wound Clinic; bring them back to a trust led clinic (please specify clinic type)**
   At discharge we advise patients see their GP nurse normally within 3-7 days depending on the wound/patient needs. If clinically indicated, we will contact the GP or district nurse service to follow up.

   If clinically indicated, we may also ask the patient to return to the first presentation service for a wound review prior to follow up/referral. This may be a scheduled

MIU/ED/UTC review or more rarely a soft tissue review clinic led by the orthopaedic outpatients service.

6. **Are patients routinely assessed for suitability for compression therapy (e.g. ABPI/TBPI) in this pathway/clinic? (yes/no/don't know/refer on to other speciality for compression)**
   Within the Trusts first presentation services, patients are not routinely assessed for suitability for compression therapy. For certain significant wounds we will refer to our Trusts tissue viability service, who may consider compression therapy, based on their review.

The information supplied to you continues to be protected by the Copyright, Designs and Patents Act 1988. You are free to use it for your own purposes, including any non-commercial research you are doing and for the purposes of news reporting.

If you wish to discuss any of the above, please contact us, quoting the FOI reference number above.

If you are unhappy with the way in which we have handled your request, please contact the Data Protection and Freedom of Information Lead in the first instance. If you wish to make a formal complaint, you should write to our Complaints Manager at Torbay and South Devon NHS Foundation Trust, First Floor Bowyer Building, Torbay Hospital, Torquay TQ2 7AA or by email to tsdft.feedback@nhs.net

If you are not content with the outcome of your complaint or the internal review, you may apply directly to the Information Commissioner for a decision. Generally, the Information Commissioner will only make a decision once you have exhausted the complaints and/or internal review process provided by us. The Information Commissioner can be contacted at: The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF or through this link https://ico.org.uk/global/contact-us/

Yours sincerely,

Freedom of Information Team

Document Type:	Guideline	
Reference Number : **0069**	Version Number: **8**	Next Review Date: **31/08/2028**
Title:	**Wound Management**	
Document Author:	Consultant in A&E Medicine	
Applicability:	All patients over 16 years of age	

Emergency Staff should be specialists in wound management. These notes are given as a guidance to Junior Staff on wound management, to set some Departmental policies and to give some indications as to how records should be kept. Notes such as "Laceration left hand, clean and suture T.T." are all too common in Accident and Emergency Departments but are totally inadequate.

HISTORY

Please note down:

a) When the accident happened
b) How it happened exactly
c) (Sometimes) Where and Why it happened (especially in cases which there may be litigation or criminal proceedings)
d) Hand dominance where appropriate
e) Occupation

EXAMINATION

Please note down:

a) Type of wound eg linear laceration, flap (distally or proximally based) skin loss (superficial or full thickness)
b) Site of wound (be specific)
c) Size of wound (length of laceration, area of abrasion.)
d) Depth of wound eg superficial, deep – please specify if it goes through the full thickness of skin
e) Nature of wound, clean, dirty, infected, tidy, untidy
f) In hand lacerations **always** examine and note tendon and nerve function distal to laceration
g) In medico-legal cases (eg NAI, assaults) it is important to comment of the age and colour of bruises.

THESE MAY ALL BE NOTED ON A DIAGRAM. Photographs may be useful to document wounds especially in cases of assault. If photographs are to be taken then written consent should be obtained from the patient.

X RAYS

These are used:-

a) To detect Fractures

b) To detect radio-opaque foreign bodies. All patients in whom there is a possibility of a glass foreign body should be X rayed. State on the X ray request that you are looking for a foreign body, as different exposures may be necessary. There is no point X raying for vegetable matter e.g. rose thorns as these will not show up. An ultrasound may be useful in these cases. A skin marker at the site of the puncture wound would be helpful in locating foreign bodies (these can be put on by the radiography staff). Dressings must be removed prior to x-ray as they will obscure the view.

To detect joint involvement. If the patient has a deep laceration in the vicinity of a joint then a horizontal beam X ray showing air in the joint is proof that the laceration extends into the joint.

CLEANING

All wounds must be cleaned. Even if the wound does not need suturing it may be necessary to anaesthetist it in order to clean it properly. Grease and oil should be removed with Swarfega. Potentially infected wound can be cleaned with chlorhexidene. Excise all foreign material, dead and severely traumatised tissue.

DIRTY WOUNDS - especially at the front of the knee.

Clean as above. It is frequently best to leave the wound open and to review in 3/4 days for consideration for delayed primary suture.

LOCAL ANAESTHETIC

Do not forget that the maximum safe dose of 2% lidocaine is 10ml in the average male. Use 1% Lidocaine as a routine. For wounds you expect to remain painful you can use a mixture of lidocaine and bupivicaine as this has a prolonged length of action.

SKIN CLOSURE

The skin must be closed without tension. Steristrips/skinlink or glue are useful for certain wounds. Usually patients will be referred back to their GPs for the sutures to be removed. If you think that it is necessary for the patient to be seen again in the Emergency department they should be referred to the review clinic.

SPLINTAGE AND REST

Wounds over joints will usually heal faster if the joint is splinted. Patients with wounds of the leg and foot should be instructed to keep the leg elevated and patients with major wounds of the hands should be given a high sling and instructions on hand elevation.

TETANUS PROPHYLAXIS (See G:0061)

PROPHYLACTIC ANTIBIOTICS (see also Hospital Antibiotic Policy)

These are not routinely needed as proper debridement and cleaning is of far greater importance in the prevention of wound infection. However, they should be used in the following circumstances:-

Grossly contaminated wounds with muscle damage should be given penicillin as prophylaxis against clostridial infection.

Compound fractures and joint injuries.
Wounds in which a foreign body has been left pending removal at a later date.
Bites (including dog, cat and human bites) and cat scratches. (Rx Co-amoxiclav)
Old wounds which have been sutured
Wounds where cleaning may have been inadequate (eg puncture wounds).

Usually prescribe flucloxacillin 500mg q.d.s. (erythromycin if penicillin allergy) except for bites. Add amoxicillin 500mg tds in cases of cellulitis

NOTES ON SPECIFIC WOUNDS:

Dog bites and Human Bites

These should not be closed if possible (except on the face) but should be cleaned well and dressed. Patients with deep wounds should be given Co-amoxiclav 625mg 1 t.d.s. 5/7.
Patients with significant wounds should be seen again in 2-3 days to check for infection and for consideration of delayed primary suture.

DO NOT FORGET TETANUS PROPHYLAXIS

If it is necessary to suture a bite, it must be cleaned well and the wound edges excised.
DO NOT FORGET that if a patient punches someone in the mouth and gets wound on his knuckles these are human bite injuries.

If the patient has been bitten by an animal abroad there may be a risk of rabies. For advice please contact the Duty Microbiologist. The following information will be required.

1. Name, address, age, weight of the person bitten or scratched.
2. Description of the injury with a note of the part injured.
3. Fullest possible details of where the incident took place eg town, district, province, country.
4. Date of incident
5. Details of the animal - stray pet, escaped, in custody. Had animal been vaccinated? Behaviour at the time, anything known about its condition subsequently, name and address of owner, if any. Was animal held for observation.
6. What first aid treatment was given.
7. Was the incident reported to a Doctor or the Police, at the time?
8. If animal was held for observation, did it become ill within 10 days.

Abrasions

Any dirt in abrasions must be cleaned as otherwise tattooing will result. This cleaning may require local or, on occasions, general anaesthesia.

Grease Gun and Similar High Pressure Injection Injuries

These are serious, and must be admitted under the care of the Orthopaedic or Plastic Surgeons for exploration. X ray first. The problem is that the injection wound may be very small but the grease etc may have travelled a long way subcutaneously.

Foreign Bodies:

X rays in two planes at right angles must be taken if you suspect radio-opaque foreign body. For non radio-opaque foreign bodies an ultrasound can be useful. Inexperienced staff should not explore for foreign bodies unless they can see or feel them. If you cannot do this then either seek

help or else close the wound, give prophylactic antibiotics and the foreign body can be removed electively, later under a general anaesthetic and tourniquet (for FB in limbs)

Fish Hooks
Do not forget that fish hooks have barbs. Inject local anaesthetic, cut off end of fish hook with pliers and push the hook through. **Do not** try to pull it out backwards.

Air Gun Pellets
Ask what type of airgun pellet was used. Some of the modern pellets are a composite of lead and plastic. If the plastic bit comes off it is radiolucent.

Blackthorn injuries
Blackthorn anywhere causes significant foreign body reactions and in joints cause a severe arthritis. Puncture wound in the vicinity of joints must be treated seriously.. Ask advice/explore/refer next clinic as appropriate.

Old Wounds
Wounds more that 12 hours old are potentially infected and should be sutured only when absolutely necessary and then only after excision of the wound edges. Wounds more than 24 hours old should not be sutured but should be debrided, cleaned and dressed and the patient seen in four or five days for consideration of delayed primary suture.

WOUNDS - DETAILS OF SPECIFIC AREAS

Scalp
In deep wounds, inspect the wound and put a gloved finger into the wound to detect any skull fractures. Persistent bleeding can often be stopped by very large sutures which take in the complete thickness of the scalp.

Face
It is important to get a good cosmetic result, so ask for advice if you are not happy about any wound. Ask advice about any patient with skin loss. The Facio Maxillary on-call doctor will usually suture difficult facial wounds.

DO NOT SHAVE EYEBROWS AS THEY DO NOT REGROW WELL

Significant facial lacerations in children are best sutured under a general anaesthetic. Beware of lacerations which might involve the parotid duct, tear duct, tarsal place, conjunctivae etc. Ask for advice.

If a patient has a laceration of the eyelid, beware of penetrating eye injuries.

Penetrating wounds of the upper eyelid may fracture the roof of the orbit and cause intracranial injury.

If there is a skin loss on the face - ASK FOR ADVICE.

Lips

The first suture should approximate the vermilion border on each side.

Nose and Ear
If the edge of the nostril or pinna is involved the first suture must approximate the edges to avoid a step

Mouth
Most lacerations inside the mouth can be left unsutured and the patient told to wash their mouth out with water after meals until it is healed. Significant lacerations should be sutured with Vicryl rapide. Suturing may also be needed for haemostasis.

Anterior of the wrist
Always examine all the tendons and nerves, no matter how superficial the wound seems. Altered sensation is an indicator of nerve injury until proven otherwise. Penetrating wounds should be referred for exploration.

Tendon and nerve injuries - ASK ADVICE

Palmaris longus need not be repaired.
If either radial or ulnar artery is divided and the hand has good circulation then the artery can be ligated. If both are divided or if the hand circulation is inadequate, the patient should be referred to the Plastic Surgeons. ASK ADVICE.

Pretibial Lacerations
Only linear lacerations with good quality, full thickness skin should be sutured. Others, especially flap lacerations must not be sutured. They should be cleaned and any non-viable tissue should be trimmed, haematoma removed from under the flap with irrigation and the flap straightened out, held in place with steristrips and then dressed. The leg should be bandaged, toe to knee. The patients should be instructed to keep the leg rested and elevated.

Arrange to see in one week in Review Clinic, where, if there is a problem, a second opinion should be sought with regard to the management.

Lacerations involving nail beds
The wound must be exposed and cleaned thoroughly. Often the full extent of the injury can not be determined unless the nail is removed, therefore it may be necessary, dependent on the injury, to remove the nail in order to repair the damaged nail bed. The nail must be trimmed and replaced as a dressing to the nail bed.

Vulval injuries in young girls
Usually "falling astride" injuries.

Minor and superficial injuries
- advise daily salt baths
- give gauze to wear inside pants as a dressing
- review in Clinic or GP as indicated

More MAJOR wounds

It is important that the full extent of the wound is seen. This may be difficult to do in children and it will certainly be impossible to repair wound other than under an anaesthetic. Therefore refer to duty Gynaecologist for EUA/ repair.

If you suspect sexual abuse do not do a genital examination, but refer the child to the Paediatrician.

SUTURE MATERIAL

SILK is easy to knot and to use. However it causes a tissue reaction and capillary action between the fibres may draw organisms into the wound. It should therefore not be used.

MONOFILAMENT SUTURES (e.g. prolene, ethilon) are more difficult to use but cause less tissue reaction and so are preferable.

Vicryl is an absorbable suture for use to close deep layers or in the mouth or scrotum. Vicryl rapide keeps its strength for about 10 days and is suitable for subcutaneous suturing. Plain Vicryl will hold its strength for about 3 weeks and is more used for tendon repairs etc

Below is a rough guide as to which suture should be used for each area of the body and how long sutures should be left in.

	Suture Size	**Remove**
Face	5/0 or 6/0	4-5 days can be removed even earlier and replaced with steri-strips
Scalp	3/0 or 4/0	10 days
Trunk arm	3/0	14 days
Hand	4/0	7 days for small wounds not under tension but 10/14 days for wound over a joint especially on dorsum.
Legs	3/0	14 days
Shins	Usually steri-strips	14 days
Extensor surface knee/elbow	3/0	14 days + (if a large wound, splint it)
Genitalia	3/0 Vicryl	Do not need removal

Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	0069		
Document title:	Wound Management		
Purpose of document:	Guideline		
Date of issue:	19/08/2025	**Next review date:**	31/08/2028
Version:	8	**Last review date:**	12/08/2025
Author:	Consultant in A & E Medicine		
Directorate:	Accident and Emergency		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Consultant in A & E Medicine Clinical Protocols and Guidelines		
Date approved:	12/08/2025		
Links or overlaps with other policies:	0061 Tetatanus		

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes ☐	
	Please select *Yes*	*No*
Does this document have implications regarding the Care Act? *If yes please state:*	☐	☐
Does this document have training implications? *If yes please state:*	☐	☐
Does this document have financial implications? *If yes please state:*	☐	☐
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☐	☐

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
1 January 1998	1	New	Consultants
1 January 1999	2	Revised	Consultants
1 August 2001	3	Date Change	Consultant in A & E Medicine
7 August 2003	4	Revised	Consultant in A & E Medicine
14 April 2005	5	Revised	Consultant in A & E Medicine
7 August 2005	6	Revised	Consultant in A & E Medicine, Medicines Governance Group
18 March 2010	6	Document Control Added	
13 January 2011	7	Revised	Consultant and Clinical Lead for Protocols and Guidelines Clinical Director of Pharmacy
25 September 2015	7	Date Change	Tissue Viability Nurse
23 October 2020	7	Review date extension	ED Consultant
19/08/2025	8	Reviewed without Changes	Lead Emergency Paramedic Practitioner-Minor Injury and Illness Lead

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on ICON.

https://icon.torbayandsouthdevon.nhs.uk/areas/mental-capacity-act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

NHS
Devon
Clinical Commissioning Group

NHS
Torbay and South Devon
NHS Foundation Trust

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		**Version and Date**	
Policy Author			
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users ☐	Staff ☐	Other, please state…	☐
Could the policy treat people from protected groups less favourably than the general population? ***PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below***			
Age	Yes ☐ No☐	Gender Reassignment	Yes ☐ No☐
Race	Yes ☐ No☐	Disability	Yes ☐ No☐
Gender	Yes ☐ No☐	Pregnancy/Maternity	Yes ☐ No☐
Sexual Orientation	Yes ☐ No☐		
Religion/Belief (non)	Yes ☐ No☐		
Marriage/ Civil Partnership	Yes ☐ No☐		
Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐		
Please provide details for each protected group where you have indicated 'Yes'.			
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☐		
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☐		
Does the policy encourage individualised and person-centred care?	Yes ☐ No☐ NA ☐		
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☐		
EXTERNAL FACTORS			
Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☐		
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)			
Who was consulted when drafting this policy?			
Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups)	☐
Staff ☐	General Public ☐	Other, please state…	☐
What were the recommendations/suggestions?			
Does this document require a service redesign or substantial amendments to an existing process? ***PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below***	Yes ☐ No☐		
ACTION PLAN: Please list all actions identified to address any impacts			
Action	**Person responsible**	**Completion date**	
AUTHORISATION: **By signing below, I confirm that the named person responsible above is aware of the actions assigned to them**			
Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:
For Devon CCG, please email d-ccg.equalityanddiversity@nhs.net & d-ccg.QEIA@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
This form should be published with the policy and a signed copy sent to your relevant organisation

Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes ☐ No ☐

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our GDPR page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's Data Protection & Access Policy,
- Visit our Data Protection site on the public internet.