Developed by the British Columbia Provincial Nursing Skin & Wound Committee in collaboration with NSWOCs/Wound Clinicians from:

Title	**Procedure: NPWT Dressing Application - SNAP**
Document Indications for Use	This Negative Pressure Wound Therapy (NPWT) dressing procedure is used with the **disposable** 3M/KCI SNAP device and in conjunction with the Guideline: Negative Pressure Wound Therapy (Reusable/ Disposable) for Adults & Children.

British Columbia Practice Level	• In order to carry out NPWT, Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs), and Licenced Practical Nurses (LPNs), in accordance with the British Columbia College of Nurses and Midwifes' scope of practice for their specific designation, must:
	  ○ Have Health Authority (HA) and/or agency policy in place to support their designation in providing NPWT.
	  ○ Have a HA approved NPWT decision support guideline.
	  ○ Successfully complete the additional education for monitoring/managing the NPWT system.
	  ○ Successfully complete additional education for NPWT dressing application.
	  ○ Have client specific NPWT orders from a Physician/NP/NSWOC/Wound Clinician.
	  ○ For LPNs, follow an established NPWT wound treatment plan.
	• Clients undergoing NPWT require an interprofessional approach to provide comprehensive, evidence-based assessment and treatment.

Background	SNAP is a single-use, disposable mechanically-powered NPWT device (no batteries or power cord) Used for open wounds and skin grafts less than 13 x 13 cm in area with small amount of depth (3cm or less) and shallow undermining/sinus tract/tunnel:
	  ○ The Canadian version of SNAP comes with a pre-set Pressure Setting of 125 mmHg; the Therapy Setting is set to Continuous.
	  ○ Has an integrated exudate containment unit which can manage less than 20mLs/day; if greater exudate amounts are anticipated then consider an alternative NPWT device.
	  ○ The blue foam dressing must be changed a minimum of twice (x 2) in 7 days.
	  ○ The cover dressing is a hydrocolloid dressing with integrated tubing port. A hydrocolloid ring is used to aid in gaining an airtight seal.
	  ○ The SNAP device does not have any audible alarms and relies on a red visual indicator to display when the containment unit is full of exudate or there is a dressing leak.
	  ○ SNAP has not been studied in the pediatric population; consider size/weight of child.
	  ○ For disposal, the device should be recycled as electrical or electronic equipment.
	General Safety Considerations for NPWT Medical Devices
	• Defibrillation: when defibrillation is required in the area of the NPWT dressing, remove the dressing or place the paddles in an alternate position; ensure that the NPWT device is at least 2 meters away from the paddles.
	• Electrodes or Conductive Gel: do not place EKG or other electrodes/conductive gels in contact with the NPWT dressing/device.
	• Magnetic Resonance Imaging (MRI) environment:
	  ○ The NPWT machine itself **cannot** go into the MRI environment. If a canister is present, disconnect it from the machine and ensure that all tubing clamps are open to allow any exudate to flow into the canister.
	  ○ If the NPWT dressing (interface and/or foam) does not contain silver, then the dressing may remain in place. If the MRI is to be done in the area of the wound, consult Radiology Department regarding the need to remove the dressing.
	  ○ If the NPWT dressing is comprised of a silver-based interface or Granufoam Silver foam or is a Prevena dressing, consult with the MRI Radiology Department; depending upon the MRI magnetic field environment, the silver-based dressing may need to be removed.
	• Diagnostic Imaging: Silver-based interfaces, Granufoam Silver foam or Prevena dressings may impair visualization with certain imaging modalities; consult with the Radiology Department regarding the need to remove the dressing.
	• Hyperbaric Oxygen Chamber environment: the NPWT dressing should be removed and a different type of dressing used for the duration of the HBO treatment period.
	• Cell phones or similar products could affect the NPWT device; move the NPWT device away 2 meters (6.5 feet) away from the device if interference is suspected.
	• Do not connect NPWT dressings to wall suction.

Bookmarks	Equipment and Supplies Procedure: Applying / Reapplying NPWT SNAP Dressing Procedure: Removing a NPWT SNAP Dressing Procedure: Changing the Canister Managing SNAP Alerts Client Showering Transition/Discharge Planning Client/Family Education and Resources Documentation Bibliography/References Document Creation
Related Documents	Guideline: Negative Pressure Wound Therapy (Reusable/Disposable) for Adults & Children Guideline: Wound Management for Adults & Children Procedure: Wound Cleansing Procedure: Wound Packing Additional Education Requirements/Competencies: NPWT Monitoring/Managing E-Learning Module: NPWT Monitoring/Managing Additional Education Requirements/Competencies: NPWT Dressing Application (under development) E-Learning Module: NPWT Dressing Application (under development) Documentation Tool: NPWT Safety/Monitoring Check Flow Sheet Client Health Education Resource (CHER): NPWT SNAP

Equipment and Supplies

The dressings are supplied in two sizes: 10cm x 10cm; 15cm x 15cm. When choosing a dressing, add an additional 2 cm to the overall area to accommodate for the dressing's mechanisms of action. Choose the SNAP Bridge dressing if needing to off-load the port.

SNAP Supplies to be ordered separately:

- 60 mL cartridge with integrated exudate containment and 1 black activation/reset key
- Dressing: Blue foam wound filler and hydrocolloid cover dressing with port and tubing attached
- SNAP SecureRing (hydrocolloid)
- Securement device strap (small, medium, large)

Dressing Change Supplies

- Personal protective equipment (i.e., safety glasses, gloves, gown, and mask as required)
- Major dressing tray
- Sterile normal saline at least 100 mL, at least at room temperature
- Sterile scissors
- Sterile gloves - 1 pair
- Clean gloves - 1 pair
- Ruler/measurement guide - paper
- Foam tip measuring probe or metal probe or cotton tipped applicator
- Alcohol swab(s)
- Procedure pad(s)
- Skin film barrier wipe
- Camera
- Pen/Marker

Pre-Soak Supplies

- 50-60 mL slip-tip syringe
- Sterile normal saline at least at room temperature
- Clean gloves - 1 pair
- 1 sterile 4 x 4 dressing
- Sterile scissors
- Alcohol swab(s)
- Procedure pad(s)
- Lidocaine 1% (without epinephrine), if ordered

Additional Supplies

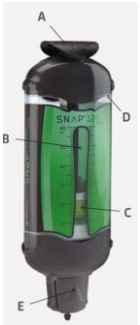
- Additional supplies as pre the Pre-Printed Order (PPO) or in the written care plan.
- PHMB woven gauze or packing ribbon
- Meshed non-adherent contact layer
- Extra transparent film drape for peri-skin protection
- Adhesive remover
- Non-sterile ostomy strips, rings, paste, if needed for filling in folds and creases

Procedure: Applying / Reapplying a NPWT SNAP Dressing **Click here for the Procedure: Removing a SNAP Dressing**	
Steps	**Key Points**
1. Review the Orders: • Read the NPWT order and overall care plan. • Review client allergies/sensitivities to products.	
• Prepare the client: • Assess client's pain/anxiety for appropriate medication(s) required and allow time for the medication(s) to take effect. • Position client for the procedure.	The client undergoing NPWT may experience pain and anxiety. Provide pain management strategies, medications, education, reassurance and position for comfort.
2. Set-up for the procedure: • Gather the supplies. • Perform hand hygiene; put on clean gloves. • Set up the sterile dressing tray; designate one side of the sterile field for cutting the wound filler(s). • Add any additional supplies. • Ensure a permanent marker is available and place outside the sterile field. • Take down and remove the current dressing. • Protect the tubing end of the device. • Perform hand hygiene and don clean gloves.	Perform hand hygiene to avoid contamination. Add all sterile supplies to sterile field.
3. Clip peri-wound/surrounding skin hair, if needed: • Using scissors or clippers, clip the hair in the area where the dressing is to be applied. Clip as close to the skin surface as possible. • Avoid shaving whenever possible.	Hair can make it difficult to achieve an airtight seal and may cause pain during drape removal. Shaving is not recommended as this can cause skin irritation and may lead to folliculitis but, if needed, then shave in the direction of the hair follicles.
4. Cleanse and assess: Wound: • Use a 15 cm foam tipped applicator, metal probe or sterile cotton tip applicator to explore the depth & direction of undermining, sinus tracts/tunnels. • Cleanse the wound and peri-skin with at least 100 mL of NS. Use moistened gauze and forceps to remove loose slough/debris. • Complete a full wound assessment. • If taking photos for documentation, remove gloves, perform hand hygiene, take photos & then put on clean gloves.	If the undermining, sinus tract/tunnel end cannot be probed (is beyond 15cm), do not irrigate or pack these areas. Cleansing the wound/skin graft aids in removal of exudate and promotes visualization of wound bed tissues. Cleansing the wound and peri-skin ensures all loose hairs is removed and not retained in the wound Measurements taken provide an objective assessment of wound healing. Measurements must be compared to previous measurements to ensure that wound healing is occurring, if this is the goal.

Steps	Key Points
Graft: • Cleanse the skin graft and peri-graft area with Normal Saline or as per Surgeon orders. • Complete a full assessment. • If taking photos for documentation, remove gloves, perform hand hygiene, take photos & then put on clean gloves. If this is a dressing reapplication, determine appropriateness of ongoing NPWT; if there are any concerns, e.g. wound/graft deterioration, notify the Physician/NP/NSWOC/Wound Clinician.	
5. Prepare the peri-skin and surrounding skin: • Use sterile forceps to apply skin barrier wipe to the peri-skin and surrounding skin, let dry. • If needed, use non-sterile ostomy strips, rings, paste for filling in any folds/creases.	Skin barrier film wipe protects the skin from adhesives, helps to maintain an airtight seal and may extend the wear time of the dressing. Ostomy rings, paste, or strips assist in levelling the peri-skin area and supports an airtight seal.
6. Transition to sterile technique: • Remove clean gloves; perform hand hygiene. • Open the NPWT SNAP dressing kit and place the kit contents on the sterile field. • Perform hand hygiene. Apply sterile gloves for the remainder of the procedure.	Instruments used to clean the wound are no longer sterile and therefore not used to aid in the activities used to fill the wound bed.
7. Apply the sterile SecureRing Hydrocolloid: • Apply the hydrocolloid ring to the peri-skin leaving approximately 1 cm space from the wound/graft edge. Ring may be cut and molded to fit; may also be used to 'level' the peri-skin area.	Application of the ring is required as it supports an airtight seal.
8. Prepare the interface layer(s), if being used: • Wound: cut the layer to fit the area requiring protection. • Skin Graft: cut layer slightly larger than the graft.	The interface layer must be meshed and are either non-antimicrobial (i.e., silicone) or an antimicrobial (i.e., silver).
9. Prepare one or both wound filler(s), as needed • Blue foam: cut to fit area. • PHMB gauze/ribbon: cut to length.	When cutting the wound filler(s) cut over the sterile field and ensure loose particles of foam/gauze are not retained in the wound bed.
10. Fill/pack the dead space or cover the graft area Wound: • Start with the shallow undermining/sinus/ tunnel and use one the following: o PHMB gauze/ribbon: lightly fill/pack the area; ensure to leave a 1 - 2 cm tail of the packing visible. If using PHMB gauze roll, fold in the gauze edges in to keep the raw edges off the wound bed. • If using, line the wound cavity with the interface: o Lay down a non-adherent contact (meshed) layer on the wound bed.	Fill/pack the undermined or sinus/tunnel to support granulation but do not over-pack the gauze or foam. Filling/packing the space too tightly may cause pressure on the new tissue and may prohibit granulation and wound contraction. The gauze tail must be visible in the wound bed and to ensure the packing is removed when the dressing is changed. Keep raw gauze edges off the wound bed.

Steps	Key Points

• Then fill/pack the wound cavity using one or a combination of the following:
  ○ PHMB gauze: fold in the gauze edges in to keep the raw edges off the wound bed.
  ○ Blue foam: Ensure foam fills the cavity.
<u>Skin Graft:</u>
• Lay the interface layer down ensuring all sutures/staples are covered.
• Then lay down the foam pieces.
	Foam touching the peri- skin will cause skin irritation, maceration or ulceration.

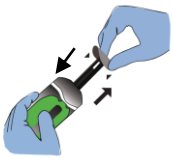
11. Ensure the fill/pack is compete: • If more than one piece of foam/gauze is used ensure that all foam and gauze edges are in contact with each other. Wound fillers may need to be overlapped.	The entire wound surface must be covered with wound filler(s) and all pieces must be in contact with each other to maintain suction and the flow of exudate.
12. Prepare and apply the cover dressing: • If using the bridge dressing, position the dressing to off-load the port. • Peel off the center protective backing. • Position the port of the dressing centrally over the blue foam and lay down dressing. • Remove one of the side's protective backing and use light pressure to seal the dressing to the peri-skin. Repeat on the other side.	The hydrocolloid dressing should be adhered to at least 1 cm of intact peri-skin. Using light pressure aids in removing small creases from the hydrocolloid dressing.
13. Prepare the dressing tubing: • Using sterile scissors cut the dressing tubing <u>straight across</u>, not on an angle, to the desired length. Keep the tubing end sterile. • Insert the tubing into the black Tube Fitting connector.	Cut the tubing straight across to ensure the tubing fits evenly onto the tubing connector. If the tubing is cut on an angle, it may cause an air leak.
14. Prepare and activate the cartridge: • Connect the Tube Fitting connector to the SNAP device. Do not remove the one-way valve cap on the end of the black connector. • To activate the therapy device, push the Activation/Reset Key into the top of the SNAP device and then pull it out. The dressing is sealed when the **green** Capacity Indicator is evident and stationary (not fluctuating) in the chamber window. • If not evident or stationary, then insert/pull out the key until a seal is obtained.	When bridging dressings, the activation/reset key may need to be pushed in/ pulled out several times to remove excess air to achieve an airtight seal.  A – Activation/Reset Key B – Chamber Window C – Capacity Indicator (Green) D – Pressure Discharge Indicator (Red) E – Tube Fitting If needed, see Managing SNAP Alerts
15. Assess for an airtight seal: • With an airtight seal the dressing will collapse and have a wrinkled appearance, be firm to the touch and no hissing sounds heard. • If not, gently press all areas of the dressing to achieve a seal, and apply additional transparent film drape, if needed. • Check the tubing connection from the dressing to the device to ensure it is secure.	If it does not collapse in less than 1 minute, there may be a dressing leak or tubing blockage.

Steps	Key Points
16. Clean up workspace: • Place the SNAP Activation/Reset key into a clean re-sealable plastic bag. • Discard the dressing tray. • Remove gloves; perform hand hygiene.	There is **only one** activation/reset key. **Do not lose the key.** Keep the key with the client at all times.
17. Document on the dressing: • Apply the documentation sticker (if available) to the hydrocolloid dressing. • Document the number of interfaces and wound filler(s) on the dressing. The following coding system may be used, if helpful: o I for Interfaces o G for Gauze o BL for Blue Foam • Write the date on the device.	If documentation sticker not available, then write the count on the dressing itself or on a piece of tape and apply to the dressing. Document the number of wound filler pieces after each dressing change. It is critical to ensure that all pieces are removed at the next dressing change.
18. Conduct the first Safety/Monitoring Check: • Check the system from the dressing to the device. • Assess colour, movement, warmth, sensation distal to the dressing if NPWT on a limb. • If tubing is a falls risk, secure accordingly.	SNAP therapy is working when the **green** Capacity Indicator is visible and stationary (not fluctuating) in the chamber window.

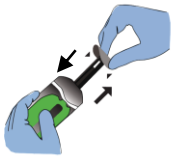
Procedure: Removing a NPWT SNAP Dressing	
Steps	**Key Points**
1. Review the chart: • Read NPWT orders and overall care plan. • Review the documented packing count.	
2. Prepare the client: • Assess client pain for appropriate medications and provide the medication(s) time to take effect.	The client undergoing NPWT may experience pain and anxiety. Provide pain management strategies, medications and reassurance.
3. Set-up for dressing removal - Open Wounds only: • Turn off the NPWT device for at least 30 minutes prior to dressing removal. • If needed, do a NS pre-soak **or** a pre-soak with Lidocaine 1% (without epinephrine) with, or followed by, the same amount of NS using one of the following pre-soak methods: Pre-soak Method #1: o Prepare a 50-60 mL slip-tip syringe with the solution. o Disconnect dressing and canister tubing, keeping ends sterile with 4x4 gauze. o Cleanse connection with an alcohol swab for 30+ seconds and let dry 30+ seconds. o Connect the syringe to dressing tubing. o Slowly instill the solution into the dressing; the dressing should budge slightly. If this does not occur, add more NS. o Remove the syringe and reconnect the dressing tubing to the canister tubing	Turning the NPWT machine off releases the suction and allows the wound exudate to collect in the foam dressing, and the increased moisture aids in releasing the foam from the wound bed. Skin Graft sites do not need the 30-minute rest period or a pre-soak; the dressing should be removed immediately after the device is turned off. Use of Lidocaine 1% without epinephrine requires a Physician/NP order. See the document bookmark Lidocaine: Physician/NP Prescribing in the Guideline: Negative Pressure Wound Therapy (Reusable/Disposable) for Adults & Children for dosage. The pre-soak method, either #1, #2, or another method, is to be determined through consultation with Physician/NP/NSWOC/ Wound Clinician.

Steps	Key Points
○ Let the solution rest in the dressing for at least 20 to 30 minutes. Pre-soak Method #2: ○ Prepare a 50-60mL slip-tip syringe with the solution. ○ Cleanse tubing 5 cm away from the dressing. Use an alcohol swab and let dry for 30+ seconds. ○ Cut the cleansed TRAC pad tubing and connect the syringe to the dressing tubing. ○ Slowly instill the solution into the dressing; the dressing should bulge slightly. If this does not occur, add more NS. ○ Remove the syringe from the tubing. Cover open end of tubing with a gauze/ABD pad. ○ Let the solution rest in the dressing for at least 20 to 30 minutes.	
3. Prepare for the procedure: • Gather supplies needed for dressing removal. • Position the client for the procedure. • Perform hand hygiene; don clean gloves. • Set up a sterile dressing tray with NS.	See Equipment and Supplies List
4. Check packing count on dressing: • Check the NPWT dressing for the number of interface layers and wound filler(s) used with the previous dressing change; ensure this count matched the packing count documented in the client's chart.	Counts of the interface layer(s) and wound filler(s) should match.
5. Remove the dressing: • Gently lift the edges of the hydrocolloid dressing away from the skin by pushing the skin away from the dressing. If drape not releasing, use an adhesive remover. • Gently lift off the dressing.	A peeling motion can cause epidermal stripping and irritate the peri-skin and surrounding skin.
6. Remove the interfaces/wound filler(s), if used: • Using forceps and NS, start at the wound edge and gently remove the wound filler(s), interface layer(s) and packing of the non-visible wound bed, if present. • Count all the packing pieces. If the packing count does not match to what has been documented; inform the prescribing Physician/NP/NSWOC/Wound Clinician.	If wound filler(s) are adhering to the wound bed, add NS to soak the wound filler(s). Consider use of a non-adherent interface dressing when dressing being reapplied. Retained packing pieces can increase the risk of wound infection. Report any packing miscounts in the Patient Safety Reporting system.
7. Remove gloves; perform hand hygiene.	
8. If reapplying another dressing see Procedure: Applying/Reapplying SNAP Dressing or apply an alternative dressing as per order.	For disposal, the device should be recycled as electrical or electronic equipment.

Procedure: Changing a SNAP Cartridge	
Steps	**Key Points**

• Gather supplies:
  ○ New sterile cartridge
  ○ Alcohol swab
  ○ Clean gloves
• Wash hands. Don gloves,
• Open new cartridge package.
• Cleanse the tubing connector site with the alcohol swab for 30+ seconds. Allow to dry for 30+ seconds.
• Do not remove the tubing from the Tube Fitting and do not remove the one-way value cap on the Tube Fitting. Press the release tabs on the Tube Fitting and pull it out of the cartridge.
• Using both hands, attach the new cartridge to the Tube Fitting.
• Activate the device by pushing the Activation/ Reset Key into the cartridge and then pulling it out.
• The device may need to be primed (in/out) a few times to remove all the air and obtain a dressing seal. Prime the device by pushing/ pulling the **black** Activation Reset Key in/out the cartridge several times.
	Pulling the tubing out of the Tube Fitting or removing the Tube Fitting cap will damage the device and a new device will be needed.
	 

Managing SNAP Alerts	
Alerts	**Monitor / Manage**
Cartridge Full: The **red** Pressure Discharge Indicator is visible and the **green** Capacity Indicator is visible and is stationary.	See Procedure: Changing a SNAP Cartridge.

Air Leak:
The **red** Pressure Discharge Indicator is visible
and
the **green** Capacity Indicator is not visible and/or is not stationary.
 
	Fix the air leak:
	• Ensure tubing connection is tight.
	• Press along the edges of the dressing to find areas which seem loose or have lifted. Fix the leaks by covering them with small adhesive strips.
	• The device may need to be primed a few times to remove all the air and obtain an air-tight dressing seal. Prime the device by pushing/ pulling the **black** Activation Reset Key in/out the cartridge several times.
	• If unable to fix the leak/ reset device in 2 hours:
	  ○ Remove the current dressing and apply a new SNAP dressing/device or alternative dressing.
	  ○ Notify Physician/NP/NSWOC/Wound Clinician.

3M/KCI Customer Service: Phone: 1-800-668-5403	

Client Showering
For clients with a skin graft, showering should wait until the dressing is discontinued to avoid any possibility of disturbing the graft. For clients with a wound, clients can shower but not have a tub bath. The shower needs to be taken immediately prior to a scheduled dressing change and the shower time should be kept short. As the device is mechanical and the clear dressing is waterproof both can get wet but should not be exposed to direct shower spray. If necessary, cover the dressing with a plastic sheet and secure with tape. After showering, gently pat both the dressing and the device to dry them.

Transition/Discharge Planning Refer to Guideline: Negative Pressure Wound Therapy for Adults & Children

- For transition between an acute site to another acute care site
- For transition between an acute care site to community care
- For transition between an acute care site to long-term care
- For transition between a community care site or a long-term care site to an acute care site

Client/Family Education and Resources

1. Acute Care:
    a. When NPWT is started, teach patient/family the rationale for and the underlying principles of NPWT, as well as, general information regarding the SNAP device being used.
    b. Prior to transition of care to Community (home/Ambulatory Care Clinic):
        - Review the Client Health Education Resource: NPWT SNAP which outlines the frequently asked questions and specific SNAP device details e.g. the management of alerts/alarms, changing the canister.
        - Identify which method the patient is to use to manage an irreparable dressing leak and put together the client's Troubleshooting Supplies bag.
2. Community Care:
    a. When the client is transitioned from Acute Care with NPWT in place or when the NPWT is started at home/ambulatory clinic, teach/reinforce with client/family the rationale and underlying principles of NPWT, as well as, review the frequently asked questions and specific information regarding the SNAP device, e.g. the management of alerts/alarms, changing the canister; see Client Health Education Resource: NPWT SNAP.
        - Review/identify the method that the client is to use to manage an irreparable dressing leak. Ensure that client has a Troubleshooting Supplies bag.
3. Long Term Care:
    a. When the resident is received back from Acute Care with NPWT in place or when NPWT is started within the long-term care site, teach/reinforce with client/family the rationale for and the underlying principles of NPWT, as well as, general information regarding the SNAP device being used

Documentation

1. With each SNAP NPWT dressing change, document on the appropriate paper or electronic documentation tool, as per agency policy, and include the following:
    a. The full wound assessment
    b. The numbers (#) of interface and wound filler packing pieces removed and replaced
    c. Document the client's response to the dressing change.
2. Document NPWT clinical outcomes and care plan revisions as they occur.
3. For Acute Care & Long Term Care, document safety/monitoring checks on the NPWT Safety/Monitoring Check Flow Sheet.

4. For Acute Care & Long Term Care, document canister fluid volume; use the Fluid Balance (In/Out) flow sheets as per unit policy.
5. Document client/family teaching provided on transition of care and the Troubleshooting Supplies given to client/family on transition to the community setting.
6. When a SNAP NPWT dressing is applied/changed in the Operating Room (OR), the following is documented in the OR record:
    - NPWT type: Open Wound, Closed Incision or Skin Graft
    - Type(s) of pieces (black foam, white foam, interfaces) placed in or removed from the wound cavity by the surgical team
    - Number of pieces placed in/removed from the wound cavity by the surgical team
7. Report NPWT adverse events in the Patient Safely Learning System, or report the safety event according to Health Authority or agency guidelines.

Bibliography/References

1. Refer to the Negative Pressure Wound Therapy for Adults & Children Guideline for the master list of references.
2. KCI (An Acelity Company). (2017). SNAP Therapy System Guideline A Reference Source for Clinicians. Retrieved from https://www.acelity.com/healthcare-professionals/instructions-for-use?country=united-states&language=english. Drawings adapted from same.

Document Creation

This guideline is based on the best information available at the time it was published and relies on evidence and avoids opinion-based statements where possible. It was developed by the Provincial Nursing Skin & Wound Committee and has undergone provincial stakeholder review.

Created By	British Columbia Provincial Nursing Skin & Wound Committee in collaboration with NSWOC/ Wound Clinicians from across all Health Authorities.
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