change is embraced, especially when it can improve the effectiveness of patient care.

In the same way, the importance of education and training cannot be overestimated. Table 2 at the end looks at the 12 theoretical areas of health professional behaviour change and techniques that nurses can use to achieve change, looking at key factors such as skills and social influences etc.

The document concludes with a list of components for an ideal debridement service and the list includes, for example:
- Integrated service, so that patients/practitioners are able to access all methods of debridement, where appropriate for their condition
- Pathways of care, which indicate the expected timeframes for patients to receive treatment within
- Audits to measure outcomes
- MDT support where required etc (Wounds UK, 2013).

Conclusion
Debridement is an essential component of wound care. However, although debridement may not be a role undertaken by HCAs and APs, there is no doubt that many HCAs and APs are involved in wound care in some guise or another. It is therefore important for a support worker to have an understanding of what debridement is and how best the service should be provided.

This Wounds UK document is easy to read and understand and has several useful tools, such as the decision pathway for nurses considering debridement and the checklist for debridement decisions.

It has photographs that demonstrate how debridement can speed up healing and also discusses the advantages and disadvantages of the different debridement methods available.

One thing that is clear in this document is the need for safe practice, which includes the importance of assessment, the warnings not to proceed unless competent to do so and, where appropriate, not feeling that referral is a sign of failure.

These guidelines for practice have been published by Wounds UK and are available in pdf (Wounds UK, 2013). It may also be informative to read the EWMA document on debridement referenced below (Strohal et al, 2013).

References

Table 1. Types of debridement (adapted from Vowden and Vowden, 2011)

<table>
<thead>
<tr>
<th>Type</th>
<th>Mechanisms of action</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Who/where</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autolytic</td>
<td>A naturally occurring process in which the body’s own enzymes and moisture rehydrate, soften and liquify hard eschar and slough.</td>
<td>Can be used before or between other methods of debridement (e.g. a hydrogel could be applied to softened tissue before larval therapy), when there is a small amount of non-viable tissue in the wound, i.e. maintenance debridement.</td>
<td>The process is slow, increasing potential for infection and maceration.</td>
<td>Generalists and specialists can implement this</td>
<td>Debride using appropriate dressings for moist wound healing.</td>
</tr>
<tr>
<td>Mechanical</td>
<td>Traditional wet-to-dry method is not recommended in the UK. Newer methods include removing non-viable tissue from a wound using a monofilament soft pad (Debrisoft, Active Healthcare)</td>
<td>Using Debrisoft can be more selective, quick and easy. It can achieve effective removal of hyperkeratosis. Little pain is experienced. Patients can use it under supervision.</td>
<td>Not suitable for use on hard, dry eschar. Can be used as a precursor or follow-up to larval therapy or sharp debridement. Not suitable for already painful wounds.</td>
<td>Generalist and specialist. Can be done in the community, the clinic or at the bedside and is a useful addition to autolytic debridement at the dressing changes.</td>
<td>Debride using Debrisoft OR autolytically debride and organise Debrisoft for next time.</td>
</tr>
</tbody>
</table>