Supplemental Table 1.

**DELPHI CONSENSUS ACHIEVED AMONG 41 CONTRIBUTORS ON 32 WOUND BED PREPARATION (WBP) 2024 STATEMENTS**

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| **WBP 2024 statements with 100% “strongly agree” consensus** |
| 10C. Establish timely and effective communication that includes the patient and all interprofessional wound care team members for improved healthcare system wound outcomes. |
| **WBP 2024 statements with 100% “strongly agree” or “agree” consensus** |
| 1C. Triage the most important causes/comorbidities to treat immediately and design targeted intervention(s) within locally available support systems/resources.  2A. Assess pain using a pain scale with a targeted plan for nociceptive and/or neuropathic pain management.  2B. Identify activities of daily living that may affect healing outcomes.  2D. Empower patients using sustainable educational interventions that include their support system. When possible, use the patient’s primary language and consider their cultural background, religion, accepted behaviors, taboos, and beliefs.  4A. Document wound progress from baseline to establish measurable healing trajectories (paper-based and/or photoimaging, if available).  4C. Reassess and document wounds regularly at appropriate intervals over time with available resources. Document and maintain confidentiality of the data.  6A. Treat local/superficial wound infection (three or more NERDS criteria) with topical antimicrobials.  7C. Determine if wound packings are needed for healable wounds. It could be wet (donate moisture) or dry (absorb moisture).  7D. Establish a targeted moisture reduction protocol in maintenance and nonhealable wounds to reduce bacterial proliferation.  8A. Consider that healable wounds should be at least 20% to 40% smaller by week 4 to heal by week 12. If factors are present that affect healing time (poor glycemic control, for example) additional healing time may be required.  8B. Allocate additional time to healing beyond 12 weeks in healable wounds if there are limited available resources and continue with consistent care.  8C. Prioritize referral to specialist centers (when available) for diagnostic testing and/or a skin biopsy, especially when faced with severe resource restrictions.  9B. Decide on adjunctive therapies through an interprofessional team approach and include a prior risk-to-benefit analysis.  10A. Facilitate evidence-informed, culturally competent, and equitable care for all patients. |
| **WBP 2024 statements with more than 95% “strongly agree” or “agree” consensus** |
| 1A. Assess for adequate arterial perfusion to ensure proper wound healing (palpable foot pulse[s] and/or multiphasic arterial foot artery sounds with an 8 MHz Doppler).  1B. Identify all underlying causes.  2C. Assess patients for (harmful) lifestyle habits that may impact wound healing (eg, smoking, alcohol, and other substances).  3B. Adjust practice if adequate blood supply is present for wound healing but the patient is unable to adhere to the plan of care and/or the healthcare system does not have the required resources. This is a maintenance wound.  4B. Cleanse wounds with tepid (preboiled) potable water, saline, or low-toxicity antiseptic agents. Consider soaks, compresses, and irrigation, where appropriate.  6B. Manage deep and surrounding wound infection (three or more STONEES criteria) with systemic antimicrobials and concurrent topical antiseptics.  7A. Maintain moisture balance in healable wounds with hydrogels, films, hydrocolloids, hydrofibers, alginates, and foams.  7B. Institute moisture reduction with fluid-lock mechanisms in healable wounds using superabsorbents to wick moisture away from the surface (diaper technology).  10B. Improve provider skills for wound management competency to enhance patient outcomes. |
| **WBP 2024 statements with more than 90% “strongly agree” or “agree” consensus** |
| 1D. Prioritize redistribution of pressure for foot wound(s) and choose appropriate compression for leg/foot edema based on arterial perfusion.  3A. Determine if adequate blood supply is present for wound healing and that appropriate treatment is available to address the underlying cause(s). This is a healable wound.  3C. Determine alternative wound treatment(s) if blood supply is inadequate and/or the underlying cause cannot be corrected. This is a nonhealable wound.  5A. Healable wounds/cause corrected: Consider active sharp surgical debridement to bleeding tissue with adequate pain control only if it is within your scope of practice. This is undertaken with guidance from advanced wound care expertise only. If not available, consider conservative (sharp) debridement.  5B. Maintenance wounds/nonhealable wounds: Consider conservative (sharp) debridement with adequate pain control only if it is within your scope of practice. Only remove loose hanging slough/debris when indicated and without causing any bleeding.  6C. Consider initiating anti-inflammatory agents in wounds with persistent ongoing inflammation (could be topical dressings or systemic medication).  9A. Consider locally constructed active modalities according to the required mechanism of action and the specific indications for initiating an adjunctive therapy to support wound healing. |
| **WBP 2024 statements with more than 85% “strongly agree” or “agree” consensus** |
| 5C. Determine if alternative debridement modalities for healable wounds are available (eg, autolytic, mechanical, enzymatic, and maggot/biological options). |

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