Wound Dressing Formulary & Guidance 2023/2024

Formulary compiled by WHC Tissue Viability & Lymphoedema Team

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Introduction

These wound dressing recommendations consist of an agreed limited list of dressings with specific prescribing advice. These dressing recommendations are used throughout Wiltshire Health and Care LLP and NHS Wiltshire ICB including GP's, Practice Nurses and Nursing Homes. Tissue Viability Wound Assessment and Management Policy 2022.

These wound dressing recommendations promote rational prescribing by encouraging the safe, effective, appropriate and economic use of dressing therapy.

Decisions about the use of a particular product were made after considering the efficacy, safety, patient acceptability and cost of the product or dressing. Treatment recommendations are selected on the grounds of current clinical opinion, clinical effectiveness, evaluation and current research including randomised controlled trials.

The product groups

- Film dressings
- Low adherent dressings
- Low absorbent dressings
- Alginates
- Hydrogels
- Gelling fibre dressings
- Hydrocolloids
- Foam dressings
- Carbon dressings
- Antibacterial dressings
- Compression including bandaging, hosiery and Velcro wrap systems

The information about each recommended product will include:

- Classification
- Name and manufacturer
- Characteristics of the dressing
- Indications for use
- Method of application
- Cautions

The dressings will refer to the wound types below. The wound types are explained fully in the Tissue Viability Wound Assessment and Management Policy 2022.

Wound types

- Epithelialising
- Granulating
- Sloughy
- Maturing
- Necrotic
- Infected
- Malignant wounds/fungating lesions
- Malodorous
- Trauma

This information is issued on the understanding that the accuracy relates to the current available resources at the time of the compilation. Please note that wound dressing products are often developed or altered by the manufacturers, therefore current product guides or instructions should be followed in all instances.

Any product to which the patient is known to be sensitive must not be used.

All products listed are available via NHS Supply Chain or Formeo. All products are also available via Formeo for the Leg Ulcer Clinics/Clubs.

It is fundamental that dressings with active pharmacies are not mixed, i.e Iodine and honey. This will alter the pharmacy and the practitioner will not know the exact pharmacy they are putting on the wound.

To reduce costs, dressing stocks used by the nursing staff on community hospital wards and the community teams will be ordered through NHS Supply Chain.

All wound care products are single use only and any residual dressing must be disposed of. The only exception to this is honey in a tube, Prontosan Gel X, Prontosan Irrigation Solution, Flaminal Hydro and Forte. Honey can remain open for 7 days. Flaminal can be recapped and used until the expiry date. Prontosan Gel X and Solution for 90 days after opening.

THINK Clinical Nurse Specialist Tissue Viability (Community)

This assessment tool is intended to provide community staff with guidance as to when a patient should be referred to the Tissue Viability Department. Staff should use the tool combined with their clinical judgement.

- All patients with category III and IV pressure ulcers for verification
- All patients with complex surgical wound dehiscence
- All patients with Cellulitis/infected wounds not responding to treatment
- Patients with wounds requiring Negative Pressure Wound Therapy (NPWT) (unless under the care of podiatry)
- Complex wound care advice/support
- Complex hospital discharges associated with wounds e.g. NPWT
- Specific Tissue Viability educational requirements
- Any patients where the clinician has concerns regarding the assessment, diagnosis, management, healing progress or deterioration of a wound

N.B. Please ensure patients with Diabetes and foot wounds are referred to the Diabetic Podiatrist.

- Patients with category II pressure ulcers that are not responding to usual management
- Patients with non complex wounds with delayed healing or deterioration
- Patients with Incontinence Associated Dermatitis (IAD)/ moisture lesions that are not responding to usual management
- Patients with highly exudating wounds for management advice
- Patients with painful wounds which are not responding to analgesia
- Patients with wounds requiring larvae therapy if support is required

N.B. Please ensure patients with Diabetes and foot wounds are referred to the Diabetic Podiatrist.

RARELY REFER

- Patients with category I and II pressure ulcers which are healing
- General wound care advice – use NSI's/ refer to Tissue Viability policies

Tissue Viability
REFERRAL
CRITERIA

THINK Clinical Nurse Specialist Lymphoedema (Community)

This assessment tool is intended to provide community staff with guidance as to when a patient should be referred to the Lymphoedema Service. Staff should use the tool combined with their clinical judgement.

ILF Best Practice Stages of Chronic Oedema/Lymphoedema

Stage 0 A sub-clinical stage where swelling is not evident despite impaired lymph transport. This stage may exist for months or years before oedema becomes evident. No swelling present.

Stage I This represents early onset of the condition where there is accumulation of tissue fluid that subsides with elevation. The oedema may be pitting at this stage. Less than 20% swelling and usually none or very early skin changes may be present.

Stage II Limb elevation alone rarely reduces swelling and pitting is manifest. Less than 20% swelling (mild) or between 20-40% swelling (mild to moderate). Skin changes of chronic inflammation may be present, Cellulitis or hyperkeratosis.

Late Stage II There may or may not be pitting present at tissue fibrosis more evident. Maybe moderate swelling 20-40%, or more than 40% (severe). Usually accompanied by skin changes and infections.

Stage III The tissue is hard (fibrotic) and pitting is absent. Skin changes such as thickening, hyperpigmentation, increased skin folds; fat deposits and warty overgrowths develop. Swelling is over 40% (severe). The term 'elephantiasis' is commonly used with this stage of Lymphoedema.

For guidance on the management of patients with Chronic Oedema/Lymphoedema please refer to the Lower Limb Management Pathway.

ALWAYS REFER

- Late stage II and stage III patients who have no interventions in place or whose condition has deteriorated
- All patients showing signs of complications with Chronic Oedema e.g. Skin changes, wet legs, Hyperkeratosis.
- Patients with wet legs/leg ulcers that have not responded to treatment.
- All patients with Chronic Oedema and Cellulitis that have had more than 2 episodes in a year
- Complex hospital discharges associated with Chronic Oedema
- Specific Lymphoedema educational requirements
- Any patients where the clinician has concerns regarding the assessment, diagnosis, management, of patients with Chronic Oedema/Lymphoedema

N.B. Please note patients that have had repeat episodes of Cellulitis with Chronic Oedema please seek advice from the Lymphoedema Service.

- Patients with stage I and II Chronic Oedema and not responding to usual management
- Patients with stage I and II Chronic Oedema that have had repeat episodes of Cellulitis
- Patients who need compression garments that are not on the Hosiery Formulary or who are difficult to measure

RARELY REFER

- Patients with very mild Oedema stage 0 or I
- Arterial complications
- General Oedema advice – use NSI's

Lymphoedema REFERRAL CRITERIA

Wiltshire Health & Care 2023/2024 Wound Management Formulary

	Product	Dressing	Stocked Sizes (cm)	Guidance for Use & Comments
NECROTIC & SLOUGHY	Hydrocolloid	Comfeel Plus Contour Comfeel Plus Transparent	6x8, 9x11 5x7, 10x10, 15x15	Lightly exuding wounds to aid debridement and granulation. Caution with existing infection or diabetic feet as an occlusive dressing may encourage growth of anaerobic bacteria. May cause maceration if wound is highly exuding. May cause over granulation.
	Iodine Tulle	Inadine	5x5, 9.5x9.5	To keep necrotic tissue dry.
	Hydrogel	KerraLite Cool (Non-Adhesive) KerraLite Cool Border	6x6, 12x8.5, 18x12.5 8x8, 11x11, 15x15	Hydrogel sheet. For hydration and debridement. Can be used on painful wounds, burns/scalds, superficial wounds and wounds that require the removal of slough. Effective on skin tears and minor trauma wounds where there is no risk of infection.
	Cleaning Devices	Prontosan Debridement Pad	These can be used to gently clean skin around the wound and between toes. Effective in the removal of hyperkeratosis. May be used to clean a sloughy or necrotic wound. Not to be used on healthy granulating tissue.	
	Biotherapy	Larvae	For wound debridement. Available on FP10. Contact Tissue Viability Team for guidance.	
INFECTED	Antimicrobial Sloughy wounds	Medihoney Tulle Medihoney Alginate (Apinate) Activon Tube Medihoney Hydrogel (HCS) Actilite	5x5, 10x10 5x5, 10x10 Rope dressing 1.9x30 20g tube Non-adhesive 6x6, 11x11 Adhesive 7.2x7.2, 11.5x11.5 5x5, 10x10, 10x20	For infected wounds and for debridement. Prevention and post-infection due to low level of honey.
		Silvercel Non-Adherent Flamazine	5x5, 11x11, 10x20, 2.5x30.5	For infected wounds only. Alginate dressing with silver. Requires secondary dressing. Sustained release. Leave in place 3-5 days. Maximum use is 2 weeks then review. Prescription only medicine.
		Iodoflex (Cadexomer Iodine)	5g unit 10g unit	Has antimicrobial, desloughing and absorbing capabilities. Change every 3 days or when colour is white. Requires secondary dressing. Thyroid function test monthly.
		Prontosan Liquid PHMB Prontosan Gel X PHMB	350ml 50g	For treatment and removal of biofilms.
		Cutimed Sorbact	4x6, 7x9, Ribbon 2x50	DACC-coated, hydrophobic, antimicrobial wound contact layer designed to blind bacteria under moist wound conditions. The dressing can be used folded or unfolded
		Flaminal Hydro Faminal Forte	15g 15g	Flaminal will clean the wound bed and aid debridement of slough. Can be used on dry wounds (Hydro) or wet wounds (Forte) if contaminated or infected.

…Wiltshire Health & Care 2023/2024 Wound Management Formulary…continued…

		Product	Dressing	Stocked Sizes (cm)	Guidance for Use & Comments
	BLEEDING	Bleeding	Kaltostat	5x5, 7.5x12	For bleeding wounds only as a haemostat.
	ODOUR	Charcoal Dressing	Carboflex	10x10, 8x15, 15x20	Absorbent carbon dressing for malodorous wounds. Can be used as a primary dressing (Carboflex) or a secondary dressing (Clinisorb) over wound packing. Odour in wounds may be an indication of anaerobic activity requiring elimination. Consider using antimicrobials. Charcoal is ineffective when wet.
			Clinisorb	10x10, 10x20	
	ABSORBENCY	Foam Dressings	Allevyn Non-Adhesive	5x5, 10x10, 10x20, 20x20, 10.5x13.5 (heel)	Refer to Exudate Pathway for correct usage. Change at least weekly depending on indicator for change. Ensure correct removal technique is used (stretch and lift or wet swab). Shower and bath proof. Bacteria proof. If a foam is being changed more than 3 times per week consider a super absorbent pad i.e. KerraMax Care.
			Allevyn Gentle Border Allevyn Life	7.5x7.5, 10x10, 12.5x12.5, 17.5x17.5 10.3x10.3, 12.9x12.9 15.4x15.4, 21x21 17.2x17.5 (sacral) 21.6x23 (sacral)	
			Tegaderm Foam Adhesive	6.9x6.9, 10x11 14.3x15.6 (oval) 19x22.5 (oval)	For difficult to dress areas or if wear time is an issue due to compliance. Waterproof. This is not first line use.
		High Absorbency	KerraMax Care KerraMax Care Border	5x5, 10x10, 10x22, 20x22, 20x30, 20x50 16x16, 16x26, 26x26	Primary dressing. KerraMax Care pads are for highly exuding wounds and can be used under compression.
		Gelling Fibre	KerraCel	5x5, 10x10, 15x15, 2x45	Use for moderate to highly exuding wounds. Forms a soft gel when saturated facilitating easy removal. Can stay in place for 7 days. Requires secondary dressing.
		Wound Contact Layer	Atrauman	5x5, 7,5x10, 10x20, 20x30	Apply directly to wound. Requires secondary dressing.
		Low Absorbent Dressing	365 Non-woven Island Dressing	5x7.2, 8x10, 8x15, 10x10, 10x15, 10x20, 10x25	For protection and wounds with a low amount of exudate.
		Vapour Permeable Film	Clear Film (Richardson)	6x7, 10x12, 15x20	Lightly exuding. Fluid may accumulate under dressing. Can also be used as secondary dressing. May also be used as fixation around non-adhesive foam. Waterproof and bacteria proof.

…Wiltshire Health & Care 2023/2024 Wound Management Formulary…continued…

		Product	Dressing	Stocked Sizes (cm)	
		Barrier	Cavilon No Sting Barrier Film Mediderma S Barrier Cream Aproderm (FP10)	Film 1ml or 3ml Barrier Cream Primary Care Only	Prevents maceration and for general skin protection. Ensure correct application. One application lasts 72 hours. DO NOT OVER APPLY.
		Emollients	See Lower Limb Skin Care Formulary. Please refer to manufacturer's instructions for use.		
		Dressing Packs	Softdrape	Contains: Apron, vinyl gloves, bag, swabs, green w/proof sterile field and paper towels. Gloves small, medium and large.	
	BANDAGES	Type 2 Retention Bandage	K-Lite (Long)	Dressing retention bandage. Knitted elastomer and viscose cotton polyamide bandage. For light support and dressing retention.	
		Wool Layer	K-Soft (Long)	For absorbency, protection and to alter shape of limb.	
		Tubular Bandage	Clinifast	Blue line 7.5cmx5m Yellow line 10.75cmx5m Beige line 17.5cmx1m	
		Multi-layer Compression Bandages	K-Two (Kit) K-Two Reduced (Kit) *Both Latex Free	For ankle circumference: 18-25cm, 25-32cm	For venous and mixed aetiology leg ulcers. PLEASE REFER TO THE LOWER LIMB PATHWAY
			Actico Cohesive	8cmx6cm, 10cmx6m, 12cmx6m	
		Velcro Compression System	JuxtaCURE	Short, Standard, Long	
		Paste Bandages	Viscopaste	7.5cmx6m	

International Consensus Update 2022
International Wound Infection Institute

Wound Infection in Clinical Practice: Principles of Best Practice

IWII WOUND INFECTION CONTINUUM AND MANAGEMENT GUIDE

Increasing microbial burden in the wound

As the continuum green shading darkens, microbial burden increases

Holistic management

CONTAMINATION	COLONISATION	LOCAL WOUND INFECTION COVERT (subtle)	LOCAL WOUND INFECTION OVERT (classic)	SPREADING INFECTION	SYSTEMIC INFECTION
Assess for wound infection					
• Microorganisms are present within the wound but are not proliferating • No significant host reaction is evoked • No delay in healing is clinically observed	• Microorganisms are present and undergoing limited proliferation • No significant host reaction is evoked • No delay in wound healing is clinically observed	• Hypergranulation • Bleeding, friable granulation • Epithelial bridging and pocketing in granulation tissue • Increasing exudate • Delayed wound healing beyond expectations	• Erythema • Local warmth • Swelling • Purulent discharge • Wound breakdown and enlargement • New or increasing pain • Increasing malodour	• Extending induration • Spreading erythema • Inflammation or erythema >2cm from wound edge • Crepitus • Wound breakdown/ dehiscence with or without satellite lesions • Lymphangitis (swelling of lymph glands)	• Malaise • Lethargy or nonspecific general deterioration • Loss of appetite • Fever/pyrexia • Severe sepsis • Septic shock • Organ failure • Death

Be alert for clinical indicators of potential biofilm

- Failure of appropriate antibiotic treatment
- Recalcitrance to appropriate antimicrobial treatment
- Recurrence of delayed healing on cessation of antibiotic treatment
- Delayed healing despite optimal wound management and health support
- Increased exudate/moisture
- Low-level chronic inflammation
- Low-level erythema
- Poor granulation/friable hypergranulation
- Secondary signs of infection

Initiate biofilm-based wound care when appropriate using step-down/step-up approach (see below)

Perform therapeutic cleansing*

- Select and use a wound cleansing solution based on resources and local policy
- Use an inert cleansing solution prior to taking a wound sample
- Cleanse the wound and periwound region

Confirm microorganisms and sensitivities

- Antibiotics as per culture sensitivities
- Determine review dates

Debridement and post debridement care

Debridement usually not required

- Use a topical antiseptic cleanser or surfactant soak
- Initiation and method selected based on clinical need, goal, resources and local policy

Apply a wound dressing

- Select a wound dressing based on clinical assessment, goals of care, tissue type, exudate level, resources and local policy
- Consider either a medicated/active wound dressing or a non-medicated wound dressing with antimicrobial action, consistent with local antimicrobial stewardship policy

Following each review, document assessment and treatment, monitor progress and evaluate management

Infection Wound Care Choices

First Line Honey

Medihoney Tulle, Medihoney Alginate (Apinate) and Activon Honey in a tube.

Other Choices

Silvercel, Iodoflex, Cutimed Sorbact, Prontosan Gel X, Prontosan Liquid.

Please refer to the antimicrobial section of the Formulary.

Odour Management

Carboflex (primary dressing) or Clinisorb (secondary dressing)

Please contact the Tissue Viability Team if concerned about a wound's complexity.

Nutrition in Wound Care

Nutrition plays a very important role in the healing of wounds. Under-nourished individuals can have delayed wound healing and can be at high risk of severe skin damage i.e. pressure ulcers and at high risk of infection.

What do wounds need to heal?

Energy: Carbohydrates are broken down to provide the glucose needed for cellular activity. If carbohydrates are not available, the body will use protein. During wound healing the average energy requirement are approximately: 30 – 35 kcal/kg body weight/per day. For example, a person weight 60kg needs 1800 – 2100 kcal/day

Protein: Protein is needed for the development of collagen. Collagen is one of the main components of wound healing. Low protein can lead to a prolonged inflammatory phase/weak collagen and poor and slow wound remodelling.

Patients require 1.25 – 1.5g protein/kg body weight per day with complex wounds such as pressure ulcers. Also, those who are malnourished/at fisk of malnutrition.

Vitamins: Deficiency in vitamins (during illness or injury and stress) could lead to slower wound healing rate an increase in surgical wound dehiscence.

Fluids: Dehydration leads to reduced circulatory volume and reduced peripheral blood flow, which reduces supply of nutrients and oxygen to the wound site. Highly exuding wounds can be a major cause of fluid loss -> refer to Exudate Pathway. Dehydrated skin is fragile and susceptible to breakdown.

Nutrition Pathway

Full Assessment of Patient, *including*:
1) Wound Assessment
2) PURAT
3) MUST (Bapen)

↓

Nutritional Assessment

↓

Give food 1st advice e.g. protein and carb

↓

4 weeks

Reassess Wound Assessment, PURAT and MUST

Consider prescription of supplement 2 per day for 1 month

Monthly review or if patient deteriorates/ becomes acutely unwell

References:
- BAPEN ‘MUST’ Calculator
- RMAPP Link: https://rmapptool.com/en
- NICE Clinical Guidelines 32.2006. Link: https://www.nice.org.uk/Guidance/CG32
- BNF, 2018. Link: https://www.nutritionscience/nutrients-food-and-ingredients/protein.

Exudate Pathway 2023/2024

ASSESS AND RECORD EXUDATE LEVEL

DRY	LOW	MODERATE	WET/SATURATED
Little or no fluid on dressing	Low levels of exudate No peri-wound maceration	Small amounts of fluid on wound dressing marked Possible peri-wound skin maceration	Excess fluid on wound Peri-wound skin maceration Strike through on dressing
	1 X WEEKLY DRESSING CHANGES	2-3 X WEEKLY DRESSING CHANGES	4-7 X WEEKLY DRESSING CHANGES
KerraLite Cool / Border	Allevyn Gentle Border Allevyn Non-Adhesive	Allevyn Life	KerraMax Care / Border

FOAMS SHOULD NOT BE USED MORE THAN 3 x PER WEEK

- Do not add additional moisture for arterially compromised patients until the blood supply has improved.
- Protect peri-wound by using Cavilon.
- Tegaderm Foam is available for awkward to dress places and for protection against incontinence.
- KerraMax Care can be layered for extra absorbency and can be used under compression.
- KerraCel should only be used on cavity wounds.
- Consider NPWT Refer to TV if required.

For more information please contact the Tissue Viability Team on 01225 711351

SEE FORMULARY BOOKLET OR POSTER FOR PRODUCT SIZES

Pressure Ulcer Category	Diagram	Picture	Definition	Required response
Category I			Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Dark pigmented skin may not have visible blanching; its colour may differ from the surrounding area	Review risk assessment. Check that pressure relief is appropriate. Rewrite care plan. Commence SSKIN bundle tool. Commence wound assessment and protect area with protective dressing. Monitor as this wound may deteriorate rapidly.
Category II			Partial thickness loss of dermis presenting as a shallow open ulcer. May also present as an intact or open / ruptured blister. This category should not be used to describe moisture associated skin damage, maceration or excoriation.	Review risk assessment. Check that pressure relief is appropriate. Rewrite care plan and commence a wound assessment. Report as IR1 stating the origins of the wound. Protect area with protective dressing. Monitor as this wound may deteriorate rapidly.
Category III			Full-thickness skin loss, bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.	Review risk assessment. Check that pressure relief is appropriate. Rewrite care plan. Report as IR1 stating the origins of the wound. Assess wound and dress appropriately. Refer to tissue viability service for verification and advice
Category IV			Full thickness tissue loss with exposed bone, tendon and muscle. Slough or eschar may be present. Often including undermining and tunnelling.	Review risk assessment. Check that pressure relief is appropriate. Write care plan. Report as IR1 stating the origins of the wound. Assess wound and dress appropriately. Refer to tissue viability service for verification and advice.
Suspected deep tissue injury			This occurs when a patient has long term pressure damage to the skin and presents as a purple or maroon localised area of discoloured intact skin. If this breaks down then the deterioration to a deep pressure ulcer may be rapid, even with optimal treatment.	Review risk assessment. Check that pressure relief is appropriate. Write care plan. Monitor carefully as this could rapidly deteriorate. Refer to tissue viability for verification and advice.

Moisture Associated Skin Damage (MASD) Pathway A

NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group

Assessment

Carry out a full holistic assessment.
Observe for changes in skin tones, red, pink for paler skin tones or paler, darker, purple, dark red or yellow in patients with darker skin tones.
Consider: mobility, nutritional status, personal hygiene, sensitivities.
Moisture specific: continence, excessive perspiration, skin folds.
Patients with moisture lesions are at high risk of developing pressure ulcers therefore follow the pressure ulcer prevention pathway and trust policy.

Is the skin damage caused by:

1 Incontinence Associated Dermatitis (IAD)

Source of MASD: Urine and / or faeces

Erythema, inflammation and maceration, may cause erosion of the skin, as a result of exposure to urine and faeces (this may present as weeping skin)

2 Intertriginous Dermatitis (MASD within skin folds)

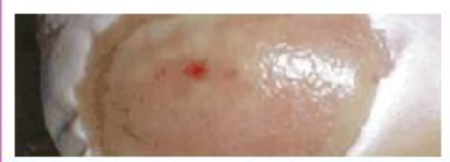
Source of MASD: Perspiration +/- friction

Mild, mirror image erythema on each side of the skin fold. May have damaged or weeping skin as result of exposure to chronic perspiration and possibly friction

3 Periwound Dermatitis

Source of MASD: Exudate +/- adhesive skin stripping

Erythema and inflammation of skin within 4cm of wound edge, may show as maceration or erosion of the skin



4 Peristomal and Peri-tube Moisture Associated Dermatitis

Source of MASD: Bodily fluids e.g. urine, faeces, gastric

Inflammation and erosion of skin related to moisture from bodily fluids such as urine, faeces, gastric fluids and saliva

Management

1 Incontinence Associated Dermatitis (IAD)

- Ensure a full continence assessment has been completed
- Refer to Incontinence Skin Care Pathway

2 Intertriginous Dermatitis (MASD within skin folds)

- Examine entire area of the skin folds, including base
- Gently lift the fold without creating or exacerbating traction and fissure formation
- Avoid products containing chlorhexidine gluconate, alcohol, or perfumes as these can be absorbed by damaged skin
- Primary treatment strategy should be to reduce moisture to the skin
- Cavilon No Sting Barrier Film to be applied every 24 hours. Frequency can be reduced to 48–72 hours in line with skin improvement
- If symptoms persist, contact TVN service and consider Cavilon Advanced

3 Periwound Dermatitis

- Refer to exudate pathway for choice of dressing and consider frequency of dressing change
- Consider the potential for wound infection
- If the wound is not healing or progressing, further investigation may be required to establish co-morbidities
- Protect peri-wound area from further breakdown, maceration and adhesive trauma. Apply Cavilon No Sting Barrier Film at every dressing change or as per protocol
- If symptoms persist, contact TVN service and consider Cavilon Advanced

4 Peristomal and Peri-tube Moisture Associated Dermatitis

- Consult Stoma Nurse specialist for guidance on appliances
- Protect peri-stomal/peri-tube area from further breakdown, maceration and adhesive trauma. Apply Cavilon No Sting Barrier Film at every pouch/appliance change or as per protocol

- Alternatively step up to Cavilon Advanced if there is high risk of damage or extensive skin loss

2 3 4 Once skin condition has resolved, discontinue use of Cavilon No Sting Barrier Film unless patient continues to be at high risk of skin breakdown

For clinical advice please contact your Tissue Viability Team following the appropriate referral protocol
For training and support on Cavilon Skin Care Products please contact 3M training/support team at MSD@mmm.com or 0330 0538938

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Bath and North East Somerset, Swindon and Wiltshire
Clinical Commissioning Group

Incontinence skin care pathway B

This pathway is for patients/residents at risk or with existing skin damage due to the effects of incontinence (urine and/or faeces) on the skin.

Step down ↑ / Step up ↓

	Clinical presentation**	Cleansing the Skin	Apply a Skin Protectant	When to use	How much to use
Prevention	**At risk of skin damage as patient is incontinent** No redness and skin intact	Always wash skin with water and a soap substitute such as Dermol 500 lotion – also after each episode of incontinence	Medi Derma S	After every 3rd wash or morning and night	Apply Medi Derma S in pea-sized amounts and apply a thin even layer
Management	**Mild** Red* but skin intact * Or paler, darker, purple, dark red or yellow in patients with darker skin tones.		Medi Derma S	After every 3rd wash or morning and night	Apply Medi Derma S in pea-sized amounts and apply a thin even layer
Management	**Moderate** Red* with skin breakdown * Or paler, darker, purple, dark red or yellow in patients with darker skin tones.		Cavilon No Sting Barrier Film	Apply daily (Does not need re-applying after each wash or incontinence episode as barrier protection will last for 24 hours)	100% Apply an even coat of film to the entire area to be treated
	Moderate to High risk – Please refer to Tissue Viability with a photograph for further advice and support				
Management	**High risk** of incontinence associated dermatitis (IAD) development e.g. liquid stool or infective diarrhoea	Cleanse the skin with a pH balanced no-rinse liquid skin cleanser or warm water and soap substitute	Step up to Cavilon Advanced or alternative, as per local protocol, for 2 weeks, then review	2x 2 x per week	100% Apply an even coat Allow to dry for at least 30 seconds or touch dry

For clinical advice please contact your Tissue Viability Team following the appropriate referral protocol.

For training and support on Cavilon Skin Care Products please contact 3M training/support team at MSD@mmm.com or 0330 0538938.

Important considerations

- Ensure a full continence assessment has been completed
- Refer to TVN if infection is suspected. Cavilon Skin care products should not be used on infected skin
- **Follow the step up and step down approach – always ensure the product used is appropriate to the condition of the patient's skin and if no improvement after 72hrs consider stepping up the pathway**

**IAD Severity Categorisation Tool taken from Beeckman D et al. Proceedings of the Global IAD Expert Panel. Incontinence-associated dermatitis: moving prevention forward. Wounds International 2015.

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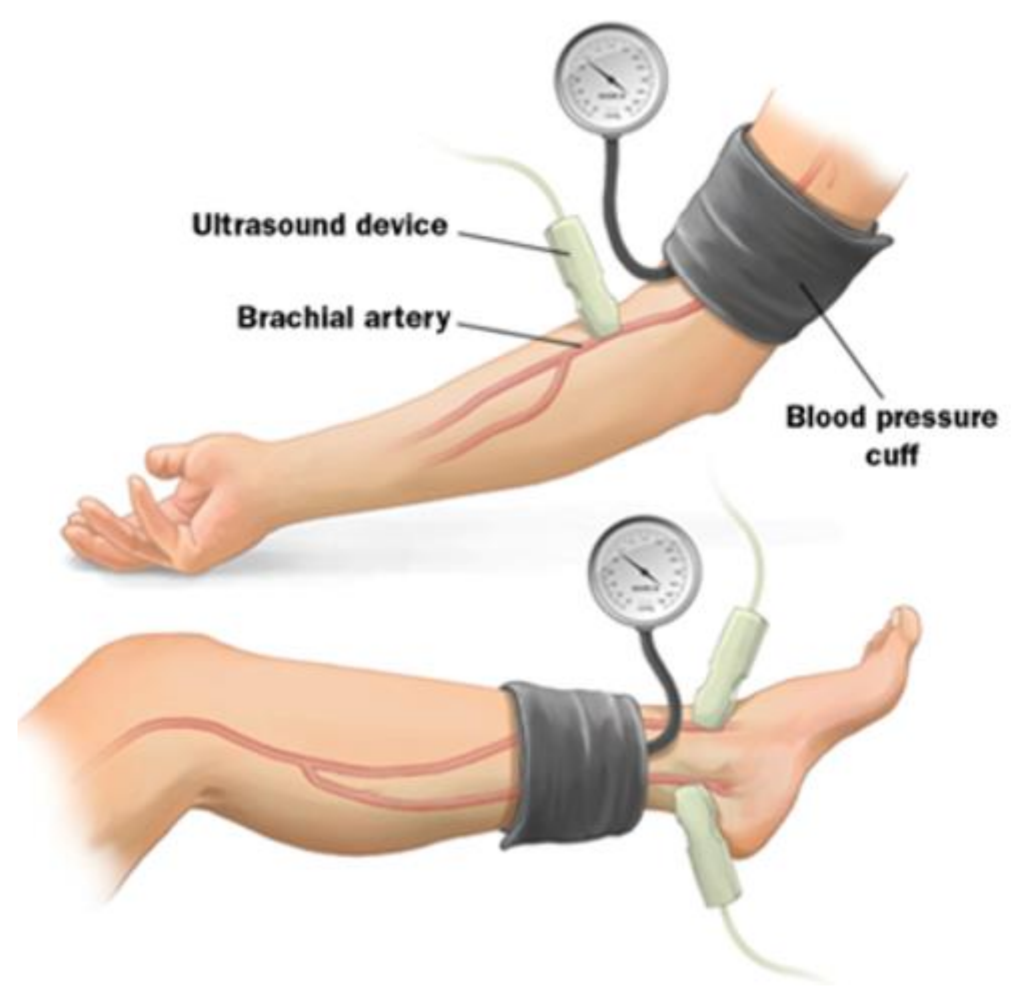
Where to Perform an Ankle Brachial Pressure Index

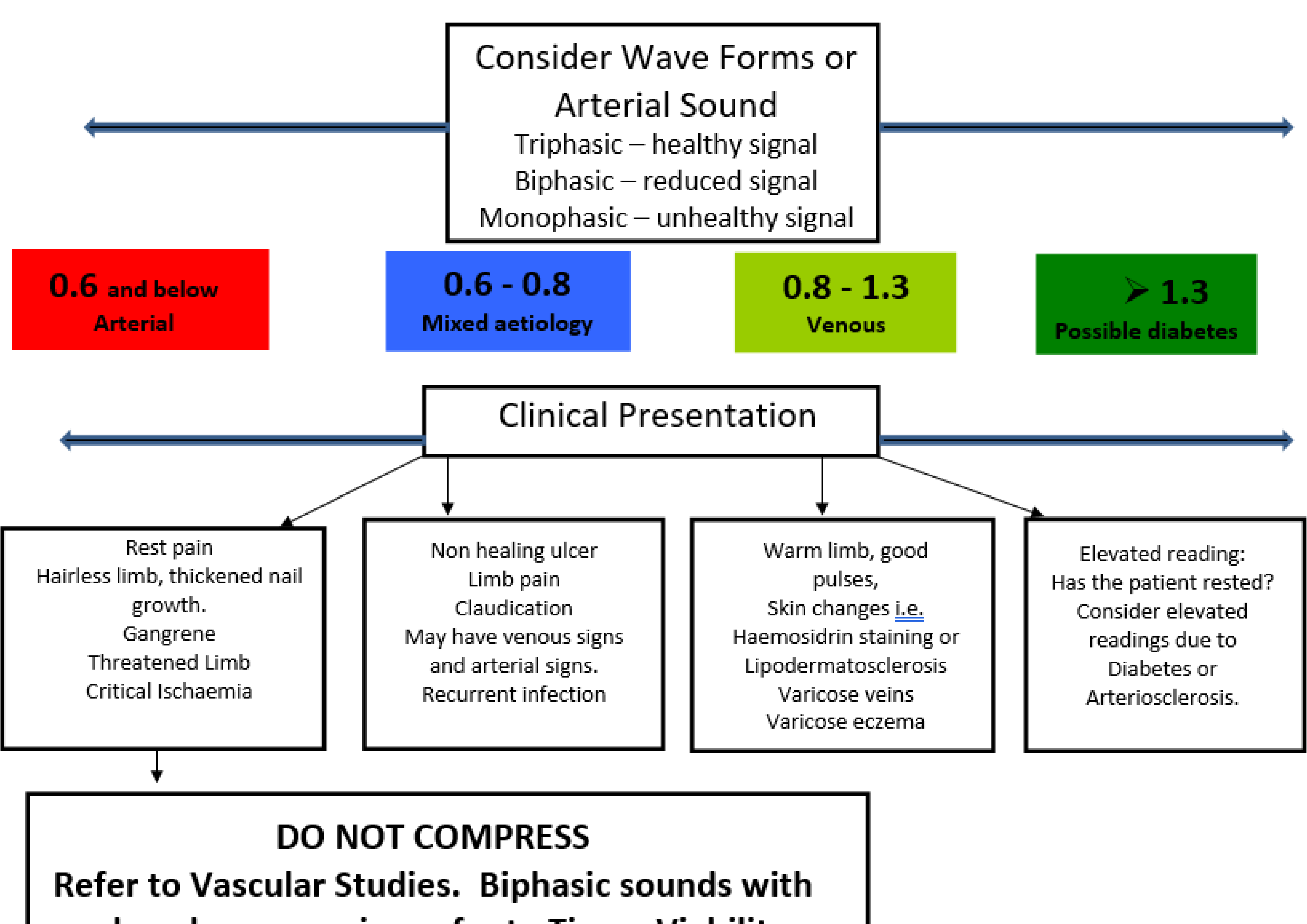


$$ABPI = \frac{\text{Highest Leg Pressure}}{\text{Highest Brachial Pressure}}$$

Do not forget to listen to the pulsatile sounds:

- Monophasic
- Biphasic
- Triphasic

Ankle Brachial Pressure Index



Ankle Brachial Pressure Index

ABPI:	Blood Flow	Ulcer Type	Arterial Sounds	Treatment
> 1.3	Elevated Result	Consider Diabetes	Tri or Biphasic Monophasic	Reduced compression No compression, refer to Vascular Studies
0.8 – 1.3	Normal	Venous	Tri or Biphasic Monophasic	Full compression Start with reduced compression
0.6 – 0.8	Moderate Ischaemia	Mixed Aetiology	Tri or Biphasic Monophasic	Reduced compression, refer to Vascular Studies No compression, refer to Vascular Studies
0.4 – 0.6	Significant Ischaemia	Arterial		No compression, refer to Vascular Studies
<0.4	Critical Ischaemia	Arterial		Urgent referral to Vascular Studies

LEG ULCER TREATMENT PATHWAY

DETERMINE A SHARED GOAL WITH THE PATIENT

Leg Ulcer Assessment, including ABPI
- History
- Examination
- Indicators/ Investigators
- Diagnosis
- Interventions or Plan of care

Skin Care
- Ensure lower limbs are washed in a bowl using a liner and dried thoroughly (especially between toes)
- Use Dermol 500 and a good emollient (see skin care pathway)
- Discontinue Dermol 500 once healed
- Protect peri-wound using Cavilon or Sudocrem

Wound Prep / Biofilm
- Consider all chronic wounds to have a biofilm
- Establish infection risk (looking at PMH) and active infection within the wound
- Consider Prontosan soak for infected and chronic wounds
- Consider Prontosan debridement pads for wound bed

Patient Education
- Educate patient on ongoing care of their legs e.g patient info leaflet and self-care
- Venous disease can be present in both legs, hosiery used in non-ulcerated leg
- Daily calf muscle exercises
  - Elevate your legs
  - Eat a healthy balanced diet
  - Wear sensible footwear
- Only remove bandages if advised by nurse
- Prevent recurrence - Hosiery for life
- Lifestyle advice

LEG ULCER ASSESSMENT A full patient assessment must be documented within the case notes.

Initial assessment – **any wound to the lower limb not progressing within 2 weeks of occurrence.**
- Complete the leg ulcer assessment in the patient's notes or on SystmOne
- Full holistic assessment – establish diagnosis of underlying ulcer aetiology
- Doppler assessment
- Pain management
- Ensure correct primary dressing, exudate management product and secondary dressing/bandaging is correct (as per guides overleaf)
- Skin care
- Establish shared goals with the patient
- Provide education & written information
- **Create clear personalised plan with review and re-assessment dates and document all on SystmOne**
- Leg ulcer assessment to be completed again at 12 weeks

→

Wound Assessment Review - **Complete every 2 weeks throughout treatment. Ensure the wound assessment is completed on SystmOne and wound is photographed.**
- Are the primary dressings working?
- Is the patient comfortable with current management?
- Does anything need to change?
- Start discussing long term management
- Review compression bandage type for appropriateness

Signs of Venous Disease	Signs of Arterial Disease
Haemosiderin Staining	Pain on Elevation
Ankle Flare (Telangiectasia)	Thin, Shiny, Hairless Limb
Lipodermatosclerosis	Cold Pale Skin
Hyperkeratosis	Pales on Elevation
Warm Foot	Thickened Nails
Lymphorrhoea	Dusky Skin

→

CHANGE TREATMENT
- If patient develops spreading infection - Remove compression and treat with oral ABx. Once patient is responding to treatment, reapply compression as soon as possible.
- If patient is not responding to treatment at reviews – Use dressing selection guide for recommended treatment times and re-assess.
- Consider changes to patient's condition or lifestyle - Is there a need for an onward referral?
- If patient is non-compliant – ensure a risk and consequences care plan is completed

Document rationale and decisions clearly on SystmOne

↓

Once healed
- Remain in bandaging for 4 weeks to prevent re-ulceration of newly healed skin
- Maintain good skin care
- Provide education around long term management and prevention
- Measure for hosiery with reference to hosiery formulary.
- Consider how the patient will apply and remove - Do they need a POC, application aids or family to help?

←

When ready for hosiery:
- Check - Does it fit, is it comfortable?
- Who is looking after the legs? Provide care plan for carers or education for family, ensure emollients are on repeat prescription
- Provide patient education on prevention of infection and recurrence of ulceration
- Offer lifestyle education e.g. going to bed at night, leg elevation and increasing mobility

Don't just discharge - complete a check visit to ensure they are coping in 2-3 weeks

←

Check Visit & Discharge
- Look at leg shape and skin integrity - are they in the correct garment?
- Offer skin care advice
- Check who is doing the 6 monthly Doppler
- Ensure patient understands what to do if there is a problem and how they get new garments
- Provide patient information leaflet on compression
- Document on SystmOne

Please complete wound care plan on SystmOne

DRESSING SELECTION GUIDE

Wound/Tissue Type	Primary Dressing Choices	Reassessment
Infected/Biofilm	Silvercell Medihoney Apinate / Medihoney Tulle / Activon UrgoTul Silver	Review after 2 weeks – if infection resolved, change to primary dressing as per wound condition. If infection still present, continue for further 2 weeks, or consider changing to a different antimicrobial dressing if no improvement.
Granulating	UrgoTul Wound Contact Layer Actilite Kerracel – if highly exuding cavity wounds Kaltostat – if minor bleeding present	Review after 4 weeks – if wound dimensions have not reduced by ≥20%, move to dressings for delayed healing.
Granulating – Delayed Healing	UrgoStart Plus Pad UrgoStart Contact – if less than 30% slough	Continue with UrgoStart for up to 12 weeks unless wound becomes infected – in this case, stop UrgoStart, treat wound infection and recommence UrgoStart once resolved. After 12 weeks, if wound dimensions have not reduced by ≥40%, refer to TVN for advice. It is normal to see an increase in wound exudate when initially using UrgoStart – increase dressing change frequency as required until exudate levels decrease.
Sloughy	UrgoClean Medihoney Apinate or Activon Kerralite Cool	Review after 4 weeks – if wound dimensions have not reduced by ≥20%, move to dressings for delayed healing.
Sloughy – Delayed Healing	UrgoStart Plus Pad	If >50% slough, consider larvae therapy (with NSI/TVN approval). Continue with UrgoStart for up to 12 weeks unless wound becomes infected – in this case, stop UrgoStart, treat wound infection and recommence UrgoStart once resolved. After 12 weeks, if wound dimensions have not reduced by ≥40%, refer to TVN for advice. It is normal to see an increase in wound exudate when initially using UrgoStart – increase dressing change frequency as required until exudate levels decrease.
Lymphorrhea (Wet Legs) – with Infection	Silvercell UrgoTul Silver Medihoney Tulle Flamazine (with appropriate primary dressings)	Review after 2 weeks – if infection resolved, change to Lymphorrhea regime without infection. If infection still present, continue for further 2 weeks, or consider changing to a different antimicrobial dressing if no improvement..
Lymphorrhea (Wet Legs) – without Infection	Cutimed Sorbact Topical Steroid Therapy (with appropriate primary dressings)	Review after 4 weeks – if no improvement, refer to TVN for advice. Remember that topical steroids need to be weaned using a reducing dosage to prevent rebound eczema.
Varicose Eczema	Topical Steroid Therapy (with appropriate primary dressings) Viscopaste	

Select appropriate secondary dressings and frequency of dressing changes based on exudate pathway – Low Exudate: Allevyn Gentle Border/Allevyn Non-adhesive; Moderate Exudate: Allevyn Life/KerraMax Care/Border; High Exudate (Wet/Saturated): KerraMax Care/Border

Perform wound measurements and photographs every two weeks, or unless the wound condition deteriorates or there are any concerns.

*Refer any wounds with necrotic tissue to TVN for advice

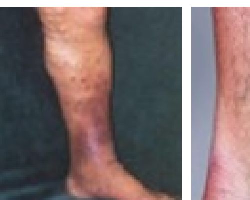
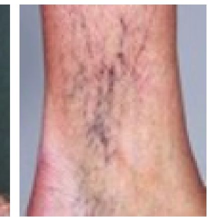
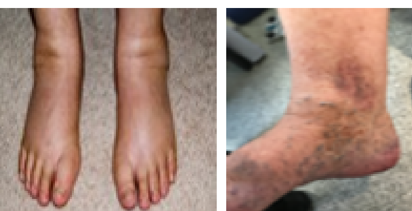
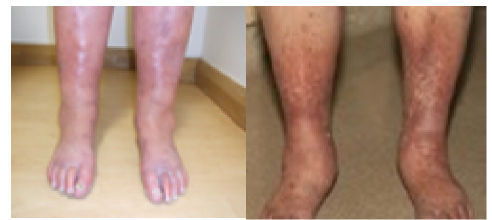
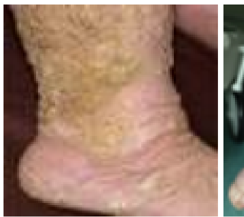
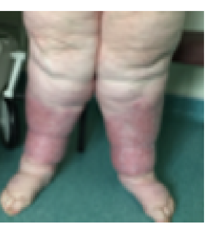
COMPRESSION SELECTION GUIDE

Arterial	ABPI < 0.4	Critical Ischaemia	No Compression	Urgent Referral to Vascular Studies via GP
Arterial	ABPI 0.4 - 0.6	Significant Ischaemia	No Compression	Refer to Vascular Studies or TVN
				Apply K-Soft/K-Lite
Mixed Venous	ABPI 0.6 – 0.8	Tri or Biphasic Sounds	Reduced Compression 20mmHg	UrgoKTwo Reduced
		Monophasic Sounds	No Compression	Refer to Vascular Studies or TVN
Venous Leg Ulcer	ABPI 0.8 – 1.3	Tri or Biphasic Sounds	Full Compression 40mmHg	UrgoKTwo Oedema present < 4 weeks
				Venous Actico Bandage Oedema present > 4 weeks
				Jobst ulcer care kit / Compression Wrap System once Oedema reduced
		Monophasic Sounds	Reduced Compression 20mmHg	UrgoKTwo Reduced
Elevated Result	ABPI > 1.3	Tri or Biphasic Sounds	Reduced Compression 20mmHg	UrgoKTwo Reduced
		Monophasic Sounds	No Compression	Refer to Vascular Studies
Chronic Oedema / Lymphoedema	Refer to Lymphoedema services for support with full Actico bandaging / compression wrap system			

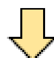
*Only apply Reduced Compression 20mmHg where Diabetes or Rheumatoid Arthritis present unless instructed by a Specialist, and carefully monitor after application

**Consider flexion position of foot in wheelchair users wearing compression - ensure adequate sub-bandage wadding is applied to prevent trauma

Hosiery Formulary

Stage 0 (at risk)	Stage I	Stage II	Late Stage II & Stage III
Early signs of venous disease with/without leg ulcer and no swelling. No skin folds. This stage can be present for years before oedema is evident.	Early signs of venous disease with mild oedema which reduces with elevation. Pitting may be present. No skin folds.	Oedema present more than 12 weeks (chronic oedema). Limb elevation rarely reduces. No skin folds, good limb shape with toe or dorsum swelling, pitting oedema manifests.	Late Stage II - Pitting may be present, chronic oedema present and skin changes. Elevation rarely reduces the oedema. Stage III - Tissue hardening does not reduce with elevation. Folds present, complex patients, post historical wounds and the obese patient.



Venous Disease — **INCREASE IN FABRIC STIFFNESS** — Venous & Lymphatic Disease

CLASS 1 (RAL 18 – 21mmHg) **CLASS II (RAL 23 – 32mmHg)** **CLASS III (RAL 34 – 46mmHg)**

CIRCULAR KNIT OFF THE SHELF (OTS)
CLASS I
Juzo Soft: Open or closed toe
Mediven Elegance: Closed toe
Mediven for Men: Closed toe
Mediven Active: Closed toes

BSN Jobs UlcerCARE
stocking liner pack 14 - 17mmHg

CIRCULAR KNIT OTS
CLASS I & II
Juzo Soft: Open or closed toe
Mediven Elegance: Closed toe
Mediven for Men: Closed toe
Mediven Active: Closed toe

Post ulcers/healing and history of Leg Ulcers go to orange box for stage II

CIRCULAR KNIT OTS providing stiffer compression
CLASS II
Juzo Soft/Dynamic
Mediven Elegance/Plus

FLAT KNIT MADE TO MEASURE (MTM)
Class ll RAL *(*23 - 32mmHg)
Juzo Expert or Expert strong
Medi Mondi.

You can use these garment types for historical leg ulcers to prevent rebound of Oedema

FLAT KNIT MTM BELOW KNEE
Class ll RAL (23 - 32mmHg) OR
Class lll RAL (34 - 46mmHg)
Juzo Expert or Expert Strong
Medi Mondi.

Please contact either the supplier representative or the Lymphoedema Service if you require advice or have a query

If patients can not tolerate Class II or III always consider Class l RAL (18 - 21mmHg)

GUIDANCE FOR HOSIERY PRODUCTS

JUZO PRODUCTS

JUZO Soft: Circular knit, fine micro-fibre fabric, open or closed toe.
JUZO Dynamic: Circular knit, more resilient fabric that the Soft, cotton fabric, open or closed toe.
JUZO Expert: Flat knit, Made to Measure (MTM), soft fabric.
JUZO Expert Strong: Flat knit, MTM. Stiffer fabric for later stages of oedema.

MEDI PRODUCTS

Mediven Elegance: Circular knit, light sheer fabric, closed toe.
Mediven for Men: Circular knit, light ribbed fabric, closed toe (larger toe space).
Mediven Active: Circular knit, medium fabric, longer length, padded foot, closed toe.
Mediven Plus: Circular knit, medium strength, open toe.
Medi Monde: Flat knit, MTM for later stages of oedema.

TOP TIPS

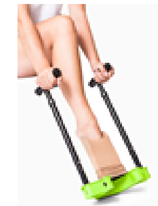
- All hosiery can be machine washed and tumble dried; do not use fabric softener.
- Make sure your patient does not roll the top of their garments over.
- Patients should have one to wash and one to wear.
- Review regularly and Doppler every six months.
- Post bandaging advise patient to wear hosiery overnight for 4 – 6 weeks.
- If patient is non-concordant or has donning issues remember you can always go up a size or two.
- If patient has cellulitis, ensure that hosiery is re-commenced as soon as they have no pain and are on antibiotics.
- Call the supplier representative or the Lymphoedema Service if you ever need advice or support.

Consider how the patient will manage the application of their hosiery (including package of care).

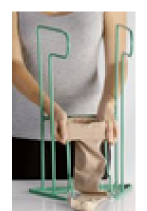
Applicator Advice

Medi 2 in1
FP10

Steve+



Juzo Easy Fit
FP10



Ezy As
Frame and handles separate on FP10

Credenhill Magnide
FP10

Sigvaris Rolly
FP10

Patient to provide

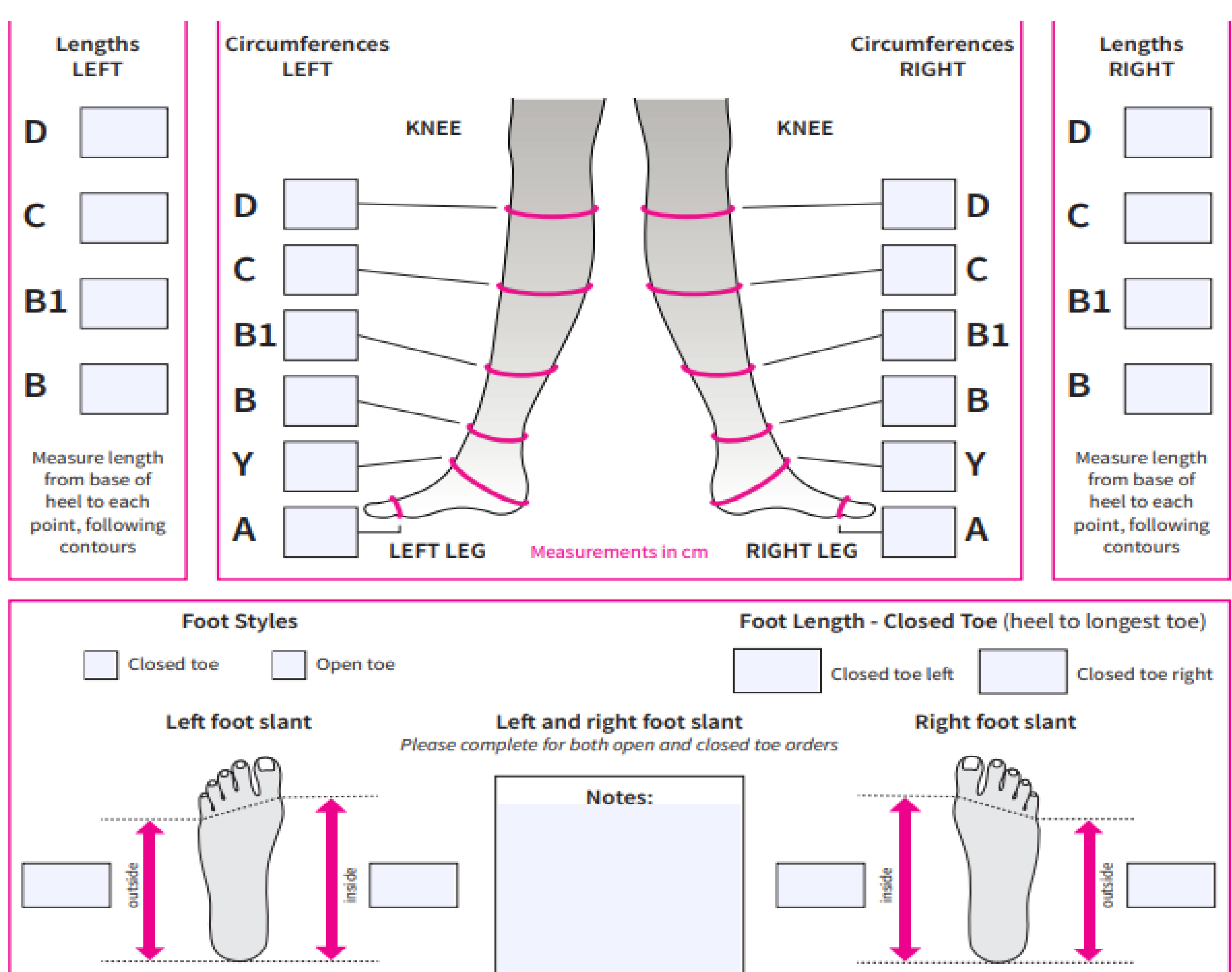
Made to Measure Guide for Hosiery

Please consider the following measurement guides for made to measure hosiery.

Companies may have different specific requirements so please check individual request forms.

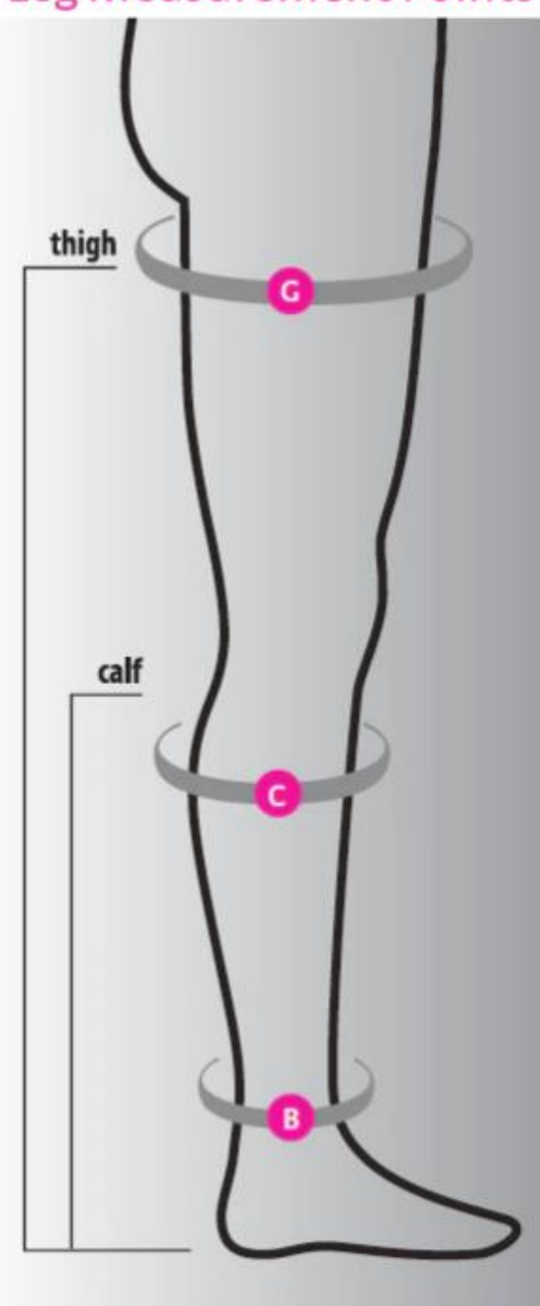
A	Arch circumference
Y	Dorsal flex circumference
B	Narrowest part of the ankle
B1	Mid calf
C	Widest part of the Calf
D	2 cm below popliteal crease

You will need measuring tape and size chart



Measuring for Compression Garments

Leg Measurement Points



What you'll need:

- Measuring tape
- Size chart
- Pencil & paper

Measuring tips:

- The best time of day to measure is in the morning.
- If possible, patient should stand while measurements are taken.
- Measurements should be taken against the skin, not too tight or loose.
- If measurements do not fall within the ready to wear sizing, a custom garment can be ordered.

Where to measure:

For knee-high stockings:

1. Narrowest part of ankle above the ankle bone (B)
2. Widest part of calf (C)
3. Length from floor to slightly below knee in a straight line

For thigh & waist-high stockings:

1. Narrowest part of ankle above the ankle bone (B)
2. Widest part of calf (C)
3. Widest part of upper thigh/groin (G)
4. Length from floor to G in a straight line

<u>Reference</u>: Measuring guide for Medi Compression Garments

Diabetic Foot Care & Referral Pathway

LOW RISK	Normal sensation. Normal foot pulses.	Manage in GP Practice.	Annual check. Education on self-care and monitor/check footwear
MODERATE RISK	Reduced sensation. Reduced food pulses.	**REFER** to Local Community Podiatry Services.	Annual check. Education on self-care and monitor/check footwear. Insoles if needed Podiatry Review 3-6 months
HIGH RISK	Reduced sensation. Reduced food pulses AND history of ulceration or amputation, presence of co-morbidities.	**REFER** to Local Community Podiatry Services.	More intensive follow up. Specialist Orthotic or footwear provision. Podiatry Review 1-3 months.
ULCERATED	NEW Foot Ulceration	1) Review and refer within 24hrs to Acute Diabetic Food MDT Team. 2) **REFER** to Local Community Podiatry Services.	Advanced Wound Assessment and management within MDT. Wound Management plan and review intensively.
EMERGENCY	Critical Limb Ischaemia, Gangrene, CHARCOT Foot	**REFER** to **Acute Diabetic Foot MDT Team** same day **OR A+E Out of Hours vascular emergencies need to be referred to Hub**	Intensive review. In-patient management. Surgical, Vascular and Diabetes Review.

Reference: www.nice.org.uk/guidance/ng19

Community Podiatry Central Administration – 01249 456638

Please email with a photograph and clinical details if concerned over a deteriorating diabetic foot ulcer.

Diabetic Foot ACUTE Clinics

Salisbury District Hospital (SDH)

Monday, Tuesday and Friday

Emergency email:
sft.diabeticmdt@nhs.net

Telephone: 01793 604 020 (bleep 2614)

Dr Martin Smith, Cons. Endocrinologist Extension: 4229

Lorraine Ba-Tin, Advanced Practitioner Podiatrist (Diabetes) Extension: 4279

Orthotics
Extension: 4175

Great Western Hospital Swindon (GWH)

Monday to Friday

Emergency email:
gwh.diabetesfootref@nhs.net

Telephone: 01793 604020 (bleep 2614)

Matt Cichero – Diabetic Foot Coordinator

Podiatrist – Advanced Podiatrist (High Risk Foot)

RUH Bath (RUH)

Wednesday & Thursday

Emergency email:
ruh_tr.diabeticfootclinic@nhs.net

Telephone: 01225 824061 / 824101

Dr Marc Atkin, Cons Endocrinologist

Author: l.ba-tin@nhs.net (2016) Reference: https://www.nice.org.uk/guidance/ng19/chapter/key-priorities-for-implementation

Wound Dressing Guide

Wound Type	Aim	Exudate	Primary Dressing	Secondary Dressing (if required)
Necrotic	Debridement and rehydration of moist/wet necrosis. **Always keep dry necrotic eschar on a foot and decrotic digits dry to prevent the spread of infection.**	Low	Consider KerraLite Cool, Larvae or Medihoney, Alginate or Prontosan Gel X. Keep necrosis on foot dry by applying Inadine (this is the only use of Inadine in this formulary)	Allevyn Gentle Border/Allevyn Non-Adhesive. Use KarraMax Care if exudate levels are high.
Sloughy (consider larvae)	Debride, rehydration and removal of excess exudate.	Low	Kerralite Cool or Iodoflex.	Allevyn Gentle Border/Allevyn Non-Adhesive.
		Medium to Heavy	Iodoflex or KerraCel if the wound is a cavity.	Allevyn Life or KerraMax Care or KerraMax Care with border.
Infected	Treat infection and remove excess exudate. Dress wound at least every 3 days.	Medium to Heavy	Medihoney Tulle or Alginate, Iodoflex, Silvercel Non-Adherent, Acticoat Flex 3 or Cutimed Sorbact. Consider PHMB in the form of Prontosan or Prontosan Gel X. Prevention and post infection consider Actilite.	Allevyn Life or KerraMax Care with or without border.
Malodorous	Reduce odour		Carboflex.	Clinisorb if other primary dressing is used.
Bleeding Wound	Stem bleeding		Kaltostat.	
Granulating	Remove excess exudate and promate granulation by maintaining a moist environment.	Light	Alleyn Gentle Border/Allevyn Non-Adhesive. If the wound is a cavity, KerraCel could be used.	If KerraCel is primary dressing in a cavity, choose Allevyn Gentle Border/Allevyn Non-Adhesive, Allevyn Life or KerraMax Care with or without border (if the exudate levels are heavy) as the secondary dressing.
		Medium to Heavy	Allevyn Life or KerraMax Care with or without border. KerraCel if wound is a cavity.	
Epithelialising	Promote healing or prevent damage by maintaining a moist environment.		Allevyn Gentle Border, Allevyn Non-Adhesive or 365 Non-woven Island Dressing.	Nil required.

Additional Products

Product Type	Product Name	Manufacturer	Recommendation
Dressing Pack (glove sizes S, M, L)	Softdrape (NHS SC)	Richardson Healthcare Ltd	For asceptic technique for all wound care
Gel pad offering pressure protection	KerraPro pads (FP10)	KCI	White gel pads of various sizes to reduce pressure in difficult places i.e on hands for contracted fingers.
Adhesive remover	Appeel adhesive removing wipes (NHS SC)	Clinimed	Will ease the removal of adhesive on delicate skin.
Adhesive tape	Finepore Tape (FP10 & NHS SC)	3M	
Skin/wound cleanser	BBraun Prontosan Debridement Pad	BBraun	Will break down the Biofilm on a wound and help to remove wound debris.

Wiltshire Health & Care: Lower Limb Skincare Formulary
Lower Limb/Chronic Oedema/Lymphoedema (with or without wound)

	Description/ Condition	Product	Stocked Sizes	Guidance for Use	Infection
	Soap Substitute	Epimax Dermol 500	500g 500ml	Wash legs with soap substitute as appropriate	Dermol 500 to be indicated if wound has a current infection or is prone to infection
	Emollient	Epimax Aproderm Colloidal Oat Cream	500g 500ml or 100ml	Apply liberally, daily. Contains soft white paraffin 15%, cetostearyl alcohol, liquid paraffin 6%. *Aproderm Contains no flammable ingredients*	Consider Prontosan AFTER washing: 10 minutes soak if recurrent or persistent infection occurs.
	Emollient Ointment	50/50	500g	50% white soft paraffin and 50% liquid paraffin. Can be used under compression bandaging, particularly if bandaging is in situ for one week.	
	Hyperkeratosis/ Papillomatosis	Imuderm (5% Urea)	500g	Consider UCS wipes or BBraun debridement pad or Debrisoft short term. To be used for skin changes due to Lymphoedema.	
	Dry skin on feet callus/fissured skin	Dermatonics Once Heel Balm	60ml, 75ml, 200ml	Apply cream to clean, dry heels once per day	
	Red legs without infection	Consider the use of steroid ointment.	15g, 30g, 100g	Options may be Dermovate or Elocon Ointment	
	Maceration to the peri wound	Cavilon	Film 1ml or 3ml Cream 28g or 92g	Film to be used every 3 days. Cream to be used daily.	
	Excoriation or widespread maceration	Sudocrem	30g, 60g, 100g, 125g, 175g	To be used appropriately for excoriation and maceration only, not on healthy skin, this is not a moisturiser.	

1 FILM DRESSINGS (INC. BARRIER PRODUCTS)

Vapour-permeable films and membranes allow the passage of water vapour and oxygen but not water or micro-organisms. Films are only suitable for dry wounds e.g. surgical wounds or wounds with very low levels of exudate. Exudate may accumulate under this dressing and cause further tissue breakdown i.e. maceration.

Product	Manufacturer	Size cm
Clear Film	Richardson Healthcare	6cm x 7cm, 10cm x 12cm, 15cm x 20cm
Cavilon No-sting Barrier Film	3M	1ml or 3ml Foam Applicators
Medi Derma-S Total Barrier Cream Non-sting	Medicareplus International	Sachets 2g Tube 28g or 90g

1.1 Characteristics of the dressing

- Clear Film consists of a sterile, thin, vapour permeable, polyurethane, acrylic adhesive coated film that acts as an occlusive dressing.
- Film dressings have the ability to permit the passage of water vapour from beneath the film to the external environment[1].
- Cavilon and Medi Derma-S are no-sting, protective transparent barrier creams, advocated as a protective interface between the skin and bodily wastes, fluids and adhesive dressings and tapes; adhesives will adhere after applying a thin layer of barrier cream.

1.2 Indications for use

- Film dressings are only suitable for intact skin or as a secondary dressing/retention dressing.
- Cavilon and Medi Derma-S can provide protection for incontinence dermatitis, stoma sites, macerated skin around venous leg ulcers, adhesion trauma/skin stripping and peri-wound areas.

1.3 Method of application

- The skin must be clean and dry prior to application of the film.
- Do not stretch the skin on application of any dressing, particularly films, as this may result in blistering.
- Can be left in place for up to seven days.
- Clear film will not adhere to itself; therefore aids application.
- Cavilon film requires reapplication every 48-72 hours and does not require removal before reapplication; however, if adhesives are being removed daily, the Cavilon may be ‘stripped off’ and may need more frequent application.
- Medi Derma-S barrier cream can be applied daily.

1.4 Cautions

- Film dressings act as an occlusive dressing; therefore should not be used when anaerobic bacteria are suspected, usually discernible by odour.
- Excessive exudate may build up under the dressing. If this occurs replace the film; do not aspirate using a sterile syringe as there is a risk of needle stick injury to the patient and introducing infection into the wound (**not applicable to Cavilon and Medi Derma-S**).
- Fragile skin may suffer trauma when film dressings are removed (not applicable for Cavilon and Medi Derma-S, as not removed).
- Appeel is a product which breaks down the adhesive and would aid removal.
- Caution with diabetic wounds, as prone to anaerobic infection therefore do no use when managing diabetic food ulceration.

2 LOW ADHERENT DRESSING

Product	Manufacturer	Size cm
Atrauman	Paul Hartmann Ltd	5cm x 5cm, 7.5cm x 10cm, 10cm x 20cm 20cm x 30cm

2.1 Characteristics of the dressing

- Atrauman is a low adherent rather than non-adherent dressing that is impregnated with neutral triglycerides (fatty acids). It does not contain Vaseline or paraffin.

2.2 Indications for use – choosing an appropriate low adhesive dressing

- For shallow wounds or trauma wounds when the wear time is short as there is a risk of dying out. If the dressing can remain in place for 5 days, double layer this dressing. Use as a secondary dressing as required. i.e. over Flamazine.
- This dressing should not be used under Kerracel.

2.3 Method of application

- Requires a secondary dressing.

2.4 Cautions

- If wound has low exudate and the dressing is left on for longer than 3 days, Atrauman may stick to the wound, causing trauma on removal; eased by soaking with tap water or 0.9% sodium chloride prior to removal.

3 LOW ABSORBENT DRESSING

This dressing is recommended for wounds with low exudate levels, useful over surgical wounds or as a secondary dressing.

Product	Manufacturer	Size cm
365 Non-woven Island Dressing	365 Healthcare	5cm x 7.2cm, 8cm x 10cm, 8cm x 15cm 10cm x 10cm, 10cm x 15cm, 10cm x 20cm 10cm x 25cm

3.1 Characteristics of the dressing

- 365 Island dressing is an absorbent perforated dressing with adhesive border.

3.2 Indications for use

- For low exuding wounds and post-operative wounds.
- These dressings are shower proof.

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3.3 Method of application

- Apply directly to wound surface.
- Support fragile tissue on removal of this dressing; particularly surgical wounds.

3.4 Cautions

- Medium to high exuding wounds.

4 ALGINATE DRESSING

Product	Manufacturer	Size cm
Kaltostat (Haemostat)	ConvaTec	5cm x 5cm, 7.5cm x 12cm

4.1 Characteristics of the dressings

- Kaltostat consists of an absorbent fibrous fleece composed of the sodium and calcium salts of alginic acid in the ratio of 80:20. The dressing is presented as a flat non-woven pad for application to surface wounds.
- In the presence of exudate or other body fluids containing sodium ions the fibres absorb liquid and swell; calcium ions present in the fibre are partially replaced by sodium, causing the dressing to take on a gel-like appearance.
- This overlays the wound and provides a micro-environment that is believed to facilitate wound healing.

4.2 Indications for use

- This is to aid the stem of bleeding in a wound. Monitor a bleeding wound continually until bleeding stops.
- If bleeding does not cease, or is excessive, refer patient immediately to a doctor and commence regular observations including blood pressure and pulse. Bleeding is more likely to occur for patients on anticoagulant therapy.

4.3 Method of application

- Place onto the surface of the wound and cover with a secondary dressing. It can be ‘tucked’ into a cavity, ensuring that the wound is not packed tightly as this may damage granulation tissue.
- Appropriate secondary dressing will be dictated by the amount of exudate. The duration of the dressing will be dictated by the exudate, however, no longer than 7 days.

4.4 Cautions

- Do not apply Kaltostat to dry (or necrotic) wounds or wounds with low exudate, as this dressing will adhere to the wound surface. If this occurs, warmed tap water or 0.9% sodium chloride can be applied to soak the dressing off.
- If these dressings adhere to the wound, then the exudate is inadequate and these dressings are inappropriate.

5 HYDROGEL DRESSINGS

Product	Manufacturer	Size cm
Kerralite Cool	KCI	6cm x 6cm, 12cm x 8.5cm, 18cm x 12.5cm
Kerralite Cool Border	KCI	8cm x 8cm, 11cm x 11cm, 15cm x 15cm

5.1 Characteristics of the dressing

- KerraLite Cool is a soothing, debriding and moisture-balancing gel dressing. Manages wound exudate levels and protects against wound dehydration and external bacterial contamination. The gel provides both cushioning and absorption. Available in non-adhesive and adhesive options.

5.2 Indications for use

- Indicated for debridement of necrotic and sloughy wounds but can be used at any stage of wound healing, from necrotic tissue to the formation of granulation tissue.
- KerraLite Cool is specifically recommended for painful wounds.

5.3 Method of application for use in fungating wounds

- Directly into or onto wound surface.
- Apply a secondary dressing for KerraLite Cool without the border; this can be judged by the amount of exudate.
- Dressing should be changed at least every 1-3 days.
- KerraLite Cool – follow the manufacturer's instructions when applying this product.

5.4 Cautions

- KerraLite Cool is contra-indicated as a covering for deep, narrow cavities or sinuses.
- Aquaform and KerraLite Cool are not recommended on dry necrosis on the foot, these wounds must be kept dry, and a Doppler carried out and referred to Tissue Viability (or Vascular Studies if the ABPI is <0.6).
- May cause maceration if secondary dressing inadequate; do not use these products prior to biotherapy, as the larvae cannot tolerate this hydrogel.
- Propylene glycol may cause sensitisation and irritation in a smaller number of patients.

6 GELLING FIBRE DRESSINGS

Product	Manufacturer	Size cm
KerraCel	KCI	5cm x 5cm, 10cm x 10cm, 15cm x 15cm 2cm x 45cm (Rope)

6.1 Characteristics of the dressing

- Soft, non-woven, flat dressing composed of carboxymethyl cellulose, indicated for the management of exuding wounds.
- The non-woven gelling fibres form a soothing gel when wet to maintain a moist wound healing environment.
- The gel absorbs and locks away excess fluid, protecting peri-wound skin from maceration and sequestering harmful components found in exudate.
- KerraCel contours to the wound bed, minimizing dead space where bacteria can live.
- KerraCel retains its integrity when wet to allow removal in one piece.
- Allows fluid retention under compression.

6.2 Indications for use

- Suitable for use on moderate and heavily exuding wounds.
- Suitable for use to dress cavity wounds with medium to heavy exudate.
- Suitable for use under compression bandages.

6.3 Method of application

- Cleanse the wound and select an appropriate dressing size, so the dressing overlaps the wound margin by approximately 1cm/0.4”.
- Open the pack and lay the sterile dressing onto the wound. Either side of the sterile dressing may be used.
- Apply the dressing to the wound and cover with an appropriate secondary dressing.
- When using the ribbon in cavity wounds, leave at least 2.5cm/1” outside the wound for ease of removal. Only pack cavity wounds by 80%, as the dressing will expand to fill the space on contact with exudate.

6.4 Cautions

- KerraCel should not be used for surgical implantation or to control heavy bleeding - the dressing is not a haemostat.

7 HYDROCOLLOID DRESSINGS

Caution must be taken with diabetic foot lesions. Occlusive dressings, such as hydrocolloids, should not be used on diabetic foot lesions due to the increased risk of maceration and anaerobic infection in these wounds[10, 11, 12].

7.1 STANDARD HYDROCOLLOID

Product	Manufacturer	Size cm
Comfeel Plus Contour	Coloplast	6cm x 8cm, 9cm x 11cm
Comfeel Plus Transparent		5cm x 7cm, 10cm x 10cm, 15cm x 15cm

7.2 Characteristics of the dressing

- A hydrocolloid is a micro-granular suspension of various natural or synthetic polymers, e.g. gelatin or pectin, in an adhesive matrix which is interactive when in contact with wound exudate. Hydrocolloids slowly absorb fluid, leading to a change in the physical state of the dressing, forming a gel which may be cohesive and/or hydrophilic; this gel swells into the cavity.
- Provides an environment conducive to rapid debridement; thus there may be an initial increase in wound size[2].
- The low pH created by the hydrocolloid as an occlusive dressing is effective in the treatment of pseudomonas[13].

7.3 Indications for use

- For wounds with low exudate; appropriate for the treatment of chronic exuding wounds such as leg ulcers, pressure ulcers and acute wounds, including burns, skin donor sites, and traumatic wounds.
- Suitable for necrotic, sloughy wounds.

7.4 Method of application

- Allow a minimum of 3cm overlap (excluding border) onto surrounding intact skin.
- Warm dressing between palms of hands.

- Remove backing and maintain the warmth over the dressing for up to 2 minutes; this will encourage adherence, which is particularly relevant on difficult to dress places, e.g. heels, elbows and sacrum.
- Can stay in place for up to 7 days.

7.5 Cautions

- Caution must be taken with wounds with existing infection or diabetic feet, as an occlusive dressing could encourage the growth of anaerobic bacteria[10,11,12].
- The excessive moisture that can build up under an occlusive dressing may promote maceration and decreased tissue tensile strength. If this occurs, continued pressure and/or shear will produce greater tissue damage[12].
- May cause over-granulation – if this occurs, a more oxygen-permeable dressing should be considered, i.e. foam dressing.

8 ABSORBENT DRESSINGS

Product	Manufacturer	Type	Size cm
Allevyn Gentle Border	Smith & Nephew	Gentle border (silicone)	7.5cm x 7.5cm,10cm x 10cm 12.5cm x 12.5cm, 17.5cm x 17.5cm
Allevyn Non-Adhesive	Smith & Nephew	Non-bordered	5cm x 5cm, 10cm x 10cm, 10cm x 20cm 20cm x 20cm, 10cm x 13.5cm (heel)
Allevyn Life	Smith & Nephew	Silicone border. Please note that the pad size is considerably smaller than the dressing size due to the wide border e.g 10.3cm x 10.3cm has a pad size of 5.4cm x 5.1cm	10.3cm x 10.3cm, 12.9cm x 12.9cm 15.4cm x 15.4cm , 21cm x 21cm 17.2cm x 17.5cm (sacral) 21.6cm x 23cm (sacral)

Tegaderm Foam	3M	Adhesive	6.9cm x 6.9cm 14.3cm x 15.6cm (oval) 19cm x 22.5cm (oval)
KerraMax Care	KCI	Absorbent Pad	5cm x 5cm, 10cm x 10cm, 10cm x 22cm 20cm x 22cm, 20cm x 30cm, 20cm x 50cm

8.1 Characteristics of the dressings

- Allevyn is a polyurethane foam dressing with a silicone wound contact layer aimed at low to moderate exudate levels.
- Tegaderm foam is a polyurethane foam pad with an additional non-woven layer and a top layer of transparent adhesive foam. This film is for difficult to dress places like heels or elbows, also when urine or faeces is compromising a wound, this dressing offers effective protection as it is waterproof.
- KerraMax Care is a superabsorbent dressing which is soft, conformable and the non-bordered version is stackable.

8.2 Indications for use

Wound Type	Wound Depth	Which Form to Choose
Low exudate levels	Shallow	Allevyn Gentle Border / Allevyn Non-Adhesive.
Moderate exudate levels	Shallow Deep (cavity)	Allevyn Life. KerraCel with Allevyn Gentle Border / Allevyn Life.
Heavy exudate	Shallow Deep (cavity)	KerraMax Care with or without border. KerraCel with KerraMax Care with or without border as secondary dressing.
Friable peri-wound skin or reaction to adhesives		Allevyn Gentle Border / Allevyn Non-Adhesive or Allevyn Life depending on the exudate levels.
Over-granulation		Allevyn Gentle Border / Allevyn Non-Adhesive depending on the exudate levels (consider an antimicrobial as wound contact if infection suspected).
Difficult to dress places i.e. heels, elbows		Tegaderm foam ovals with adhesive border.

Waterproof dressing required i.e. for swimming or for incontinence protection	Tegaderm foam with adhesive border.
If patient removes the dressing	Consider Tegaderm foam with adhesive border.

8.3 Method of application

- KerraMax Care without a border can be used under compression bandaging.
- Apply all absorbent dressings directly to the wound surface allow for a 2cm overlap on each side of the wound.
- If wet cavity wound consider KerraCel.
- No secondary dressing required for foam dressings.
- Non-adhesive dressings will require tape or a bandage to secure.
- May be left in place for up to 7 days, if exudate allows.

8.4 Cautions

- The adhesive on these dressings may cause reddening of the skin on first application; if this does not extend beyond the boundaries of the dressing (which would indicate an allergic reaction), apply another dressing but observe within 24 hours.

9 ODOUR ABSORBING DRESSINGS

Product	Manufacturer	Size cm
Clinisorb	Clinimed	10cm x 10cm, 10cm x 20cm
Carboflex	ConvaTec	10cm x 10cm, 8cm x 15cm, 15cm x 20cm

Carboflex is a primary dressing and is, therefore, applied directly to the wound bed. If the odour absorbing dressing is to be applied over a primary dressing, i.e. foam then choose Clinisorb. Consider the cost of using Carboflex and only apply if the wound is appropriate. See below for indications for use.

9.1 Characteristics of the dressing

- Wound odour, which cannot be resolved immediately, can be absorbed by dressings that contain charcoal. The advent of the charcoal cloth, which was first introduced by Butcher (1976)[18] involved activated charcoal; the activated charcoal was produced by carbonising a suitable cellulose fabric by heating it under carefully controlled conditions. The surface of the carbon breaks down to form small pores, which greatly increase the effective surface area of the fibres and hence their ability to remove unpleasant smells[19].
- These dressings absorb the molecules released from the wound, which may be responsible for the smell. Wounds most commonly associated with odour production include leg ulcers and fungating (cancerous) lesions of all types. The metabolic processes of bacteria cause the odour; organisms frequently isolated from malodorous wounds include anaerobes such as *Bacteriodes* and *Clostridium* species and a number of aerobic bacteria, including *Proteus, Klebsiella and Pseudomonas spp*.
- The most effective way of dealing with malodorous wounds is to treat or prevent the infection responsible for the odour (see treatment of infected wounds below and in the infection section of the Tissue Viability Guidelines).
- Clinisorb is an activated charcoal cloth, sandwiched between viscose rayon. Both surfaces are identical; it can be cut, as it does not come into contact with the wound. Applied as a secondary dressing.
- Carboflex is a five-layer primary dressing. The contact layer contains Kaltostat and Hydrofiber and is applied directly to the wound surface.

9.2 Indications for use

- Carboflex and Clinisorb are advocated for malodorous wounds.
- As soon as the dressing is wet, the charcoal is deactivated.
- Carboflex has an absorbent capacity (low levels) and is applied directly to a wound. This dressing contains Kaltostat and Hydrofiber in the wound contact layer and is designed to stop pinpoint bleeding, i.e. in a fungating wound.

9.3 Method of application

Carboflex

- Apply Carboflex directly on to the wound surface with the Kaltostat/Hydrofiber layer in contact with the wound.
- Do not cut dressing.
- Choose a dressing that overlaps the wound by 3cm.
- Can be left for 3 days but change if any strike through is evident.

Clinisorb

- Apply the Clinisorb dressing as a secondary dressing, over the primary dressing.
- Choose a dressing that extends 3cm beyond the edge of the wound.
- Clinisorb can be used for up to one week if it does not come into contact with exudate or become wet. When any carbon dressing becomes wet, it is deactivated.

10 ANTIMICROBIAL DRESSINGS: TREATMENT FOR INFECTED WOUNDS

To determine which antimicrobial to use, see table below. Antimicrobials include: medicated tulles (Inadine), Cadexomer Iodine (Iodoflex), silver dressings (Silvercel non-adherent and Flamazine), honey and topical antibiotic therapies. For the characteristics of an infected wound, see the infection section of the Tissue Viability Policy. If the wound infection does not respond or resolve within 2 weeks, consider that this may not be the appropriate dressing choice or antibiotic therapy may be necessary in conjunction with topical microbial treatments.

CHOOSING AN ANTIMICROBIAL DRESSING

Product Name	Wound Type	Exudate	Rationale
Medihoney Honey Tulle and Alginate **First Choice**	Infected wounds or non-progressing wounds or wounds that require debridement.	Low to medium exudate.	Will reduce the bacterial loading. Consider the increased wetness and possible increase in pain experienced. There is no time limit on this dressing. Can be used with patients with diabetes.
Actilite	Prevention i.e. skin tears and post infection.	Low.	To prevent infection in trauma wounds if risk of infection suspected. Post active treatment for infection with Medihoney to continue antimicrobial.

…Choosing an Antimicrobial Dressing…continued…

Product Name	Wound Type	Exudate	Rationale
Activon Tube	For cavities (use with KerraCel if required).	All exudate levels.	For infected wounds where the Medihoney is inappropriate due to the delivery i.e. stiffness/bulk of products.
Silvercel Non-Adherent	**Infected wounds** **Hypergranulation**	All exudate levels.	The metallic silver is impregnated into an alginate and has increased capacity for absorbency. The silver is released from the dressing. Leave in place for 3 – 5 days.
Inadine	To keep dry necrotic tissue.	Low.	Will reduce bacterial loading on wounds where infection is a risk, i.e. abrasions. Consider sensitivity to Iodine. NB: Contra-Indications – see product information.
Flaminal Hydro/Forte	Infected or non-progressing wounds.	Hydro for dry or mild to moderate amounts of exudate. Forte for moderate to heavy amounts of exudate.	Will clean wound bed and aid debridement on thin layer of slough. There is no limit to the amount or length of time Flaminal can be used to treat wounds. Flaminal is biodegradable. Flaminal can be recapped and used multi times. Single patient use.
Iodoflex	Chronic, exuding, infected, sloughy, odorous, up to dermal depth.	Low to medium.	Will reduce bacterial loading, reduce odour and debride the wound. Consider sensitivity to Iodine. NB: Contra-Indications – see product information.

…Choosing an Antimicrobial Dressing…continued…

Product Name	Wound Type	Exudate	Rationale
Cutimed Sorbact	Infected wounds or wounds with recurrent infections.	Low to medium exudate levels.	No time limit on this dressing, very effective when a long-term antibacterial dressing is required i.e. for a leg ulcer or a pilonidal sinus.
Prontosan Liquid PHMB	All wound types if bacteria or biofilm are present or suspected.	The liquid should be used as a soak for 10-15 minutes during a dressing change.	To cleanse and reduce / remove biofilms on chronic wounds. Also effective at reducing bacteria and therefore to be considered for wounds that have recurrent infection.
Prontosan Gel X PHMB	Infected wounds (consider high level of water in this product).	Prontosan Gel X is used for low-medium exudate levels	Prontosan Gel X is used like a hydrogel for debriding sloughy / necrotic wounds.

10.1 MEDICATED TULLES

Product	Manufacturer	Size cm
Inadine	KCI	5cm x 5cm, 9.5cm x 9.5cm

10.1.1 Characteristics of the dressing

- Sterile, low adherent, knitted viscose dressing impregnated with 10% povidone iodine in a water-soluble polyethylene glycol base.

10.1.2 Indications for use

- This dressing is for keeping necrotic wounds dry only. For minor trauma or superficial wounds please use Medihoney Tulle dressing.
- The dressing should be changed every 2 – 3 days because the antimicrobial properties of the dressing decrease over time.
- The dressing should be changed prior to the 2 – 3 days if the distinctive orange-brown colour changes to white; this indicates that the povidone iodine has been used up.
- Do not use Inadine for longer than two weeks without consulting a doctor.
- Inadine can be used in diabetic patients with a normal functioning thyroid and who are not on a drug related treatment. It is advised, however, to seek a clinician's advice before commencing treatment, due to diabetes being susceptible to reduced kidney function and iodine being excreted via the kidneys.

10.1.3 Method of application

- For topical use only; apply directly onto the wound surface.
- Secondary dressing will be required; the nature of the wound will dictate the secondary dressing.

10.1.4 Cautions

- Do not use on deep ulcerative wounds, burns or large injuries.
- Inadine should not be used where there is a known iodine hypersensitivity, before or after the use of radioiodine or if the patient has any renal problems.
- Consult a doctor prior to applying Inadine to a patient who is having lithium treatment, as the Inadine could indirectly affect the serum-lithium levels.
- Do not use iodine on pregnant or breast-feeding women or newborn children up to the age of 6 months, as povidone iodine may be absorbed through unbroken skin[19].
- Inadine should be used under medical supervision if the patient has a thyroid disease; this may involve a thyroid function test before and after treatment.
- Free iodine is very low; however, there may be some sensitivity to povidone iodine or iodine.

10.2 CADEXOMER IODINES

Product	Manufacturer	Size
Iodoflex	Smith & Nephew	5g or 10g

10.2.1 Characteristics of the dressings

- Units of sterile Cadexomer iodine paste containing iodine (0.9% w/w) in an inert base.
- The Cadexomer absorbs exudate and forms a gel providing a moist, protected, environment which is conducive to wound healing.
- Iodine acts as an anti-infective against existing infection and prevents re-infection.

10.2.2 Indications for use

- Use to treat chronic, infected and medium to heavily exuding wounds.
- Dressings should be changed 2 – 3 times per week or when there is loss of colour.
- Maximum single application is 50g; weekly maximum must not exceed 150g; treatment duration should not exceed 3 months.

10.2.3 Method of application

- Remove the paste from the protective gauze and apply directly into wound.
- A secondary dressing is required that will maintain a moist environment.
- If dressing dries out, 0.9% sodium chloride or tap water will remove the bulk of the dressing; this dressing is biodegradable so the layer in contact with the granulation can therefore remain.

10.2.4 Cautions

- Cadexomer dressings should not be used with patients with known or suspected iodine sensitivity or with thyroid or renal disease.
- Potential risk of interaction from lithium.
- Do not use in children or in breast feeding or pregnant women.
- Do not use on wounds with dry necrotic tissue.

See instructions for use for a full list of warnings and precautions.

10.3 SILVER DRESSINGS

Product	Manufacturer	Size cm
Silvercel Non-Adherent	KCI	5cm x 5cm, 11cm x 11cm, 10cm x 20cm 2.5cm x 30.5cm

10.3.1 Characteristics of the dressing

- This is a primary dressing.
- Silvercel Non-Adherent is an alginate coated in silver which kills a broad spectrum of bacteria and aids in creating an anti-microbial environment. Silvercel absorbs wound fluid.

10.3.2 Indications for use

- See page 48.

10.3.3 Method of application

- Either fold into the wound or cut to size.
- Change dressing every 3 days.
- This dressing will deposit silver into the wound in its mode of action. This enables the silver to kill the bacteria. It will gradually disappear from the wound at the end of treatment with normal cleansing procedures and is not for concern.

10.3.4 Cautions

- Not compatible with oil based products, such as petroleum jelly.
- Do not use on patients who are allergic to silver.
- Do not use on patients undergoing Magnetic Resonance Imaging and avoid contact with electrode and conductive gels during electronic measurements, e.g. EEG and ECG.

10.4 ANTIBACTERIAL GEL/LIQUID

Product	Manufacturer	Size
Prontosan Liquid Gel X PHMB	BBraun	50g
Prontosan Liquid PHMB	BBraun	350ml

10.4.1 Characteristics of the product

- Prontosan Gel X is a hydrogel which will debride the wound while offering an antimicrobial.
- Prontosan liquid is a PHMB soak to be applied to the wound, this is usually done by soaking gauze and applying and leaving in situ for 10-15 minutes.

10.4.2 Indications for use

- Prontosan: Removal or disturbance of a biofilm, debridement and treatment of infection.

10.4.3 Method of application

- Apply directly to wound bed and will require a secondary dressing.

10.4.4 Cautions

- Known sensitivity to PHMB.

10.5 HONEY

Product	Manufacturer	Size
Activon Tube	Advancis Medical	20g
Actilite	Advancis Medical	5cm x 5cm, 10cm x 10cm, 10cm x 20cm
Medihoney Tulle	Integralife	5cm x 5cm, 10cm x 10cm
Medihoney Alginate (Apinate)	Integralife	5cm x 5cm, 10cm x 10cm Rope dressing 1.9cm x 30cm
Medihoney Absorbent Hydrogel (HCS)	Integralife	Non adhesive 6cm x 6cm, 11cm x 11cm Adhesive 7.2cm x 7.2cm, 11.5cm x 11.5cm

10.5.1 Characteristics of the dressings

- All the honey preparations are a medical grade Manuka honey.
- Medihoney Alginate (Apinate) is an alginate impregnated with medical Manuka honey.
- Topical broad-spectrum antibacterial agent.

10.5.2 Indications for use

- Used to treat a variety of shallow wounds, where infection may prevent healing, e.g. leg ulcers, pressure ulcers etc.
- The Medihoney Tulle is for superficial wounds including trauma wounds.
- The Medihoney Alginate dressing offers more absorbency for wetter or deeper wounds.

- The Medihoney HCS is for skin tears and other minor wounds to reduce the risk of infection.
- Actilite for prevention and post infection for minor trauma/superficial wounds.

10.5.3 Method of application

- Apply directly onto wound site.
- Can be applied from daily to every third day.
- Do not allow the dressing to overlap onto the peri-wound skin as it may cause maceration (except for HCS).

10.5.4 Cautions

- A stinging sensation may be experienced as this product works by osmosis, if this is unacceptable, remove the product and irrigate the wound.
- Consider the increased wetness; as this product works by osmosis, it draws fluids from the wound, thereby potentially creating an increased wetness at the wound bed – protect the peri-wound skin.
- Do not use on wounds with active bleeding.
- Do not use on patients with a known sensitivity to calcium alginate (apinate) or bee venom.

10.6 CUTIMED SORBACT

Product	Manufacturer	Size cm
Cutimed Sorbact	BSN Medical	4cm x 6cm, 7cm x 9cm Ribbon 2cm x 50cm

10.6.1 Characteristics of the dressings

- Cutimed Sorbact is an antimicrobial wound contact layer, designed to bind bacteria under moist wound conditions.

10.6.2 Indications for use

- For contaminated, colonised or infected superficial wounds.

10.6.3 Method of application

- Method – primary dressing, can be folded or unfolded.

10.6.4 Cautions

- Do not use with ointment or creams.

10.7 FLAMINAL

Product	Manufacturer	Size
Flaminal Hydro	Flen Health	15g
Flaminal Forte	Flen Health	15g

10.7.1 Characteristics of the dressings

- Topical broad-spectrum antibacterial agent.
- Choose Flaminal Hydro for wounds that are dry or have mild to moderate amounts of exudate.
- Choose Flaminal Forte for wound that have moderate to heavy amounts of exudate.
- Provides intimate wound contact and is totally biodegradable[1].

10.7.2 Indications for use

- Used to treat a variety of shallow wounds, where infection may prevent healing, e.g. leg ulcers, pressure ulcers etc.

10.7.3 Method of application

- Apply a thick layer (5mm) of Flaminal to the wound using a sterile technique.
- Flaminal should not spill over on to the wound edge.
- Can be applied from daily to every third day.
- Once opened, it can be recapped and reused on the same patient until the expiry date.

10.7.4 Cautions

- Nil known

11 BANDAGES

11.1 COMPRESSION (Refer to the Leg Ulcer Pathway)

Product	Manufacturer	Pack Size: Ankle Circumference
JuxtaCURE	Medi UK *Wraps currently under review.*	Short Standard Long
K-Two	Urgo Latex free	18cm – 25cm 25cm – 32cm
K2 reduced	Urgo Latex free	18cm – 25cm 25cm – 32cm
K Lite	Urgo	10cm x 4.5m
K Soft	Urgo	10cm x 3.5m, 10cm x 4.5m
Actico Cohesive	Activa	10cm x 6cm for venous limb with mild oedema. 8cm x 6m, 10cm x 6m, 12cm x 6m for lymphoedema/chronic oedema patients

JuxtaCURE should be considered for patients with a venous leg ulcer if the healing is likely to be longer than 12 weeks. K2 bandaging can be used as an alternative for patients who are not suitable for JuxtaCURE.

11.1.1 Characteristics of the bandage system

K-Two

This is a two-layer bandaging system consisting of:

- First layer – K-Tech is an absorbent compression wadding, offering 20mmHg.
- Second layer – K-Press is a cohesive compression bandage, offering 20mmHg.

Actico Cohesive

- Two-layer bandaging system put on at full stretch, primarily for patients with mild and Chronic Oedema.

11.1.2 Indications for use

- For patients with venous leg ulcers who have had a full assessment from a competent practitioner. This assessment must include a Doppler assessment, see the Wiltshire Health and Care Leg Ulcer Policy.

11.1.3 Method of application

- The instructions for application of the bandages are in each pack. A practitioner should attend an appropriate study day prior to administering this treatment. The systems can be left in place for up to a week.

11.1.4 Cautions

This treatment is hazardous if used by an inexperienced practitioner, as compression can cause significant damage to a patient who has not been adequately assessed. Please read the Leg Ulcer Policy.

11.2 PASTE BANDAGES

Product	Manufacturer	Size
Viscopaste (PB7)	Smith & Nephew	7.5cm x 6m

11.2.1 Characteristics of the dressing

- Open wave bleached cotton bandage, which is impregnated with zinc oxide, as below. Offers protection to reddened, irritated, skin and is soothing.
- Viscopaste contains zinc oxide 10%.

11.2.2 Indications for use

- Medicated paste bandages are used in the treatment of skin conditions associated with chronic leg ulcers. e.g. eczema, inflammation.
- Can be left in place for one week.
- Can be used under compression bandaging[25].

11.2.3 Method of application

- Applied from the base of the toes to the just below the knee.
- The bandage is applied according to the manufacturer's instructions and is always pleated at the front of the leg, to allow room for expansion of the leg due, for example, to oedema.

11.2.4 Cautions

- Many patients are sensitive to the constituents of paste bandages. It is advisable, prior to applying to the entire leg, to carry out a patch test for at least 48 hours.
- May increase the absorption of steroids due to the occlusive nature.

For a full list of precautions and warnings see Patient Information Leaflet and/or Summary of Product Characteristics.

12 STANDARD FORMULARY

Dressing Category	Dressing on Formulary	Size cm *Any size not stipulated will not be available on ONPOS*
Haemostat	Kaltostat	5cm x 5cm, 7.5cm x 12cm
Film (including Barrier Products)	Cavilon Barrier Film	1ml or 3ml foam applicators
	Medi Derma-S Barrier Cream	Cream
	Clear Film (Richardson)	6cm x 7cm, 10cm x 12cm, 15cm x 20cm
Low Adherent Dressings	Atrauman	5cm x 5cm, 7.5cm x 10cm, 10cm x 20cm, 20cm x 30cm
Low Absorbent Dressings	365	5cm x 7.2cm, 8cm x 10cm, 8cm x 15cm,10cm x 10cm, 10cm x 15cm 10cm x 20cm, 10cm x 25cm
Foam	Allevyn Gentle Border	7.5cm x 7.5cm, 10cm x 10cm, 12.5cm x 12.5cm, 17.5cm x 17.5cm
	Allevyn Non-Adhesive	5cm x 5cm, 10cm x 10cm, 10cm x 20cm, 20cm x 20cm, 10cm x 13.5 cm (heel)
	Allevyn Life	10.3cm x 10.3cm, 12.9cm x 12.9cm, 15.4cm x 15.4cm, 21cm x 21cm, 17.2cm x 17.5cm (sacral), 21.6cm x 23cm (sacral)
	Tegaderm Foam	6.9cm x 6.9cm, 10cm x 11cm, 14.3cm x 15.6cm (oval), 19cm x 22.5cm (oval)
Absorbent Dressing	KerraMax Care	5cm x 5cm, 10cm x 10cm, 10cm x 22cm, 20cm x 22cm, 20cm x 30cm, 20cm x 50cm
	KerraMax Care Border	16cm x 16cm, 16cm x 26cm, 26cm x 26cm
Hydrogel	KerraLite Cool	6cm x 6cm, 12cm x 8.5cm, 18cm x 12.5cm
	KerraLite Cool Border	8cm x 8cm, 11cm x 11cm, 15cm x 15cm
Gelling Fibre	KerraCel	5cm x 5cm, 10cm x 10cm, 15cm x 15cm, 2cm x 45cm
Hydrocolloid	Comfeel Plus Contour	6cm x 8cm, 9cm x 11cm
	Comfeel Plus Transparent	5cm x 7cm, 10cm x 10cm, 15cm x 15cm
Antimicrobial Dressings	Silvercel Non-Adherent	5cm x 5cm, 11cm x 11cm, 10cm x 20cm, 2.5cm x 30.5cm

…Standard Formulary…continued…

Antimicrobial Dressings	Activon Honey Tube	20g
	Actilite	5cm x 5cm, 10cm x 10cm, 10cm x 20cm
	Medihoney Tulle	5cm x 5cm, 10cm x 10cm
	Medihoney Alginate (Apinate)	5cm x 5cm, 10cm x 10cm, Rope 1.9cm x 30cm
	Medihoney Hydrogel (HCS)	Non-Adhesive 6cm x 6cm, 11cm x 11cm Adhesive 7.2cm x 7.2cm, 11.5cm x 11.5cm
	Inadine	5cm x 5cm, 9.5cm x 9.5cm
	Iodoflex	5g or 10g
	Flaminal Forte	15g
	Flaminal Hydro	15g
	Cutimed Sorbact	4cm x 6cm, 7cm x 9cm, Ribbon 2cm x 50cm
	Prontosan Liquid PHMB	350ml Bottle
	Prontosan Gel X	50g Tube
Odour Absorbing	Carboflex	10cm x 10cm, 8cm x 15cm (oval), 15cm x 20cm
	Clinisorb	10cm x 10cm, 10cm x 20cm
Compression Bandaging	JuxtaCURE	Short, Standard, Long
	K2	For ankle circumference:18-25cm, 25-32cm
	K2 reduced	For ankle circumference:18-25cm, 25-32cm
	Actico Cohesive	8cm x 6m, 10cm x 6m, 12cm x 6m
Bandaging	K Lite	10cm x 5.25m
	K Soft	10cm x 3.5m, 10cm x 4.5m
Tubular Bandages	Clinifast	Blue line 7.5cm x 5m / Yellow line 10.75cm x 5m Beige line 17.5cm x 1m
Paste Bandage	Viscopaste PB7	7.5cm x 6m

13 EXTRA FORMULARY ITEMS FOR NURSES WITH A SPECIALIST INTEREST (NSI'S), PODIATRISTS OR TISSUE VIABILITY TEAM TO PRESCRIBE ONLY

Dressing Category	Dressing on Formulary	Size cm
Larvae	Larvae	See Biomonde website for further details.
NSI, Tissue Viability & Lymphoedema Team ONLY	Urgotul	5cm x 5cm, 10cm x 10cm
	Urgotul Silver	10cm x 12cm, 15cm x 20cm
	UrgoStart Plus Pad	6cm x 6cm, 10cm x 10cm
PODIATRY ONLY	Solvaline N	5cm x 5cm
	Mepilex	10cm x 10cm
	UrgoClean Ag	6cm x 6cm, 10cm x 10cm,15cm x 20cm
MIU ONLY	Granuflex	10cm x10cm
	Duoderm	10cm x 10cm
	Mepilex Lite	10cm x 10cm
	Adaptic Touch	10cm x 10cm

14 EXTRA FORMULARY ITEMS FOR TISSUE VIABILITY TEAM TO PRESCRIBE ONLY

Dressing Category	Dressing on Formulary	Size cm
Antimicrobial	Acticoat Flex 3	5cm x 5cm, 10cm x 10cm
MMP Modulator	Promogran Prisma (For indications for use discuss with Tissue Viability)	28cm² or 123cm²
	UrgoStart Contact	10cm x 10cm
	UrgoStart Plus Pad	6cm x 6cm, 10cm x 10cm
Cavilon Advanced	Barrier	0.7ml or 2.7ml

15 ASSESSMENT AND TREATMENT OF BURNS

It is possible that any nurse may encounter a patient who has a burn or scald, either in the ward setting or in the home. The majority of these burns are minor and can be treated either as an outpatient or in a general ward setting[26].

Burn assessment
Assessment of the depth of a burn can be difficult, as it can take several days for the depth of the burn to 'declare' itself. Always refer to a burns unit if the burns are on the hands or face, perineum, circumferential, cover more than 2% (in a child) or 3% (in an adult) body surface or if the wounds are deep dermal or full thickness burns[17]. Use the Lund and Browder assessment tool to determine the surface area of the burn.

How to make a referral to the Southmead Burns Unit:
- Direct link: https://nww.mdsas.nhs.uk/burns/
- Further information: southwestUKburnnetwork.nhs.net
- A photograph will be required, and the practitioner will advise on a treatment plan.

The practitioner should always ask for advice from the burns unit if unsure of the diagnosis of depth. **All burns should be reviewed at 24-48 hours.**

Assessment of Depth:

Depth of burn	Blistering	Appearance	Pinprick test
Superficial Dermal	Present	Pale pink Capillary refill present	Sensitive to pain
Deep Dermal	+ / -	Brick red Fixed stain / mottled	Dullness Insensitive to pain
Full Thickness	Absent	Grey / White / Brown	No sensation

Deep dermal and full thickness burns must be referred to a burns unit, either at Southmead in Bristol or Salisbury District Hospital. Apply cling film to the burn to transfer to the burns unit if possible and ensure that the patient is nil by mouth.

15.1 Burn treatment
- Remove source of heat, i.e. clothing if hot water spill.
- Irrigate with cool water, ideally for 10 minutes - a maximum of 20 minutes, due to the risk of hypothermia. This will dissipate the heat from the body tissue and can prevent further damage to the tissues[27].
- If the skin surface is broken and the patient is awaiting assessment, apply cling film, as this helps to minimise pain by protecting it from exposure to the air.

15.2 Facial burns

- Clean with normal saline.
- Leave exposed.
- Apply soft paraffin to lips.
- Refer to a burns unit.

15.3 Hands and feet

- Remove all rings.
- Ask burns unit for advice or transfer for opinion.
- For intact skin, encourage the patient to shower to clean the area – Comfeel or Atrauman are dressing options. If the burn covers a small area; another option is Yellow Soft Paraffin if a dressing is not necessary on fingers, it is essential to use a dressing that does not stick – therefore only use Atrauman if the dressing can be changed every day. If the intention is that the dressing will stay in place for longer then consider Urgotul or Urgotul ssd (if infection is likely).
- If the skin is blistered, encourage the patient to keep the burn clean by showering. The application of Duoderm is appropriate for intact blisters or protect with Atrauman – if there is no risk of adherence, then apply a secondary dressing. If there is a risk of adherence, or if the dressing is to be left in place for 5–7 days, then consider Urgotul Silver (if infection is likely).
- If the blister is large or if the blister fluid is applying pressure to the underlying tissues, consider de-roofing. In this circumstance, Flamazine could be considered (but only if the burn is being treated conservatively in the community, not if the patient is to be assessed at a burns unit, as Flamazine will mask the burn, inhibiting assessment).
- Advise on regular finger and wrist exercises.

15.4 Body and limbs

- If blisters are tense or broken, then consider de-roofing the blister (this is detached epithelium that can delay healing if left in situ).
- Dressing of choice will depend on area to be covered, position of wound and its depth (see above recommendations for hands and feet). Hydrocolloids can also be used on appropriate sized burns of any depth – the dressing must clear the wound edge by a minimum of 2cm

Medequip Pressure Reducing Equipment Choice				
Recommendation	**Weight limit**	**Equipment**	**Comment:**	**Picture**
For treatment	35 stone	**Select Medical Pure Air 8**	Sits on the bed base, self-adjusting to patient's weight. Alternating but can convert to low air loss if patient has pain or for comfort at end of life. For patients up to 35 stone who has a category III/IV or very very high risk.	
	35 stone	**Select Medical Simpulse 8**	This is the first line choice for patients at risk of pressure damage or with category II or below.	
	15 stone (125kg) Depth: Overlay - 8cm	**Propad overlay - single & double**	These products are made of castellated foam and are for patients AT RISK of developing pressure ulcers. Place overlay on top of a foam mattress but not a Softform as this offers the same pressure reduction as the Propad.	
	26 stone (165kg)	**Mercury** mattress – 17.5cm deep	For patients AT RISK of developing pressure ulcers but are able to change their own position or their position be changed frequently. Repositioning must be in a care plan and documented.	
	Cushion - 108kg Mattress - 140kg	**Propad**	Cushion and mattress available, this is a static system which reduces the pressure, effective as there is no weight limit.	
Prevention	22 stone (139kg) 7.5cm deep	**Flotech Solution**	For patients AT RISK of developing pressure ulcers. It can be used for treatment of category II plus pressure ulcers when the pressure is regularly relieved.	
		Frontier Medical ToTo	For patients who cannot reposition independently but would benefit from position changes, particularly if not having care overnight.	
		EHOB Mattress, cushion & Rise-Recliner.	For prevention of pressure ulcers, static system offering the same pressure reducing as a Propad / Softform. Please note the mattress can be inflated whilst under the patient.	
		Repose Inflatable Wedge	For prevention of pressure ulcers to heels Non-washable alterative consider HeelPro.	
		Talamade HeelPro	Prevents and manages heel pressure. Low friction cushioning.	

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