NHS FORTH VALLEY
Wound Management Guidance and Formulary
1st Edition V6 September 2022

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This document can, on request, be made available in alternative formats

Consultation and Change Record – for ALL documents

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Section A

INTRODUCTION TO THE WOUND MANAGEMENT FORMULARY

The Wound Management Formulary was developed by members of the NHS Forth Valley Wound Management Group. This group consists of specialist practitioners, nursing and pharmacy staff from the Acute and Primary Care settings; taking into account patient comfort, safety, cost effectiveness and clinical benefits of the product in line with the **Scottish National contract where 1st Ranked products must be used unless there is a justifiable clinical reason to use 2nd or 3rd Ranked products. These products should be the first choice for both Primary and Acute Care**.
The Wound Management Formulary has been approved by the Director of Nursing, NHS FV and the Area Drug and Therapeutics Committees.

The principle aim is to rationalise and standardise wound care products throughout NHS Forth Valley, encouraging seamless care and to assist nursing staff in the selection of appropriate dressings.

New products can be evaluated as they are developed and the need arises – the process for this can be seen on Appendix 6.

Please note the sizes of dressings chosen for inclusion to the formulary are the current most popular sizes stocked by stores, there may be other sizes available if required, in certain circumstances. All products listed in the formulary are GP/DN prescribable unless otherwise stated. Please remember to prescribe generically as prescriptions cannot be dispensed when trade names alone have been written.

Please note:
Products highlighted in this formulary may only be used within the licensed indications within the SPC (specific product characteristics) i.e. only use each product under the guidance of the product information leaflet. SPC are available at www.medicines.org.uk

On discharge from hospital one weeks supply of dressings should accompany the patient home, or if treatment is of short duration, enough to complete treatment. Likewise those patients with a planned admission to hospital should bring to the ward a small supply of current dressings where possible.
It is recognised that nursing and clinical practice is an evolving process, and members of the working group would welcome any information and advice which is considered necessary to update the Formulary in light of changes in practice and developments in wound care.
Please contact the under noted for advice, guidance or any comments you may have: -

Tissue Viability Service
NHS Forth Valley
Tel 01324 673747 or fv.tissueviability@nhs.scot

Grateful thanks to Wound Management Group Core members who attended meetings and contributed to the development of the formulary document.

SECTION A

ACCOUNTABILITY AND RESPONSIBILITY

As healthcare professionals using this formulary you must:

- Use your professional knowledge, judgement and skills to make a decision based on evidence for best practice and the person's best interests. You need to be able to justify the decisions that you make for choosing wound care products.
- Ensure any advice you give is evidence based when suggesting healthcare products or services
- Have the knowledge and skills for safe and effective practice when working without direct supervision
- Recognise and work within the limits of your competence
- Keep your knowledge and skills up to date throughout your working life
- Take part in appropriate learning and practice activities that maintain and develop your competence and performance
- Keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been
- Complete records as soon as possible after an event has occurred
- Complete NATVNS Wound care assessment and treatment chart (separate chart for each wound a patient may have) NATVNS Adapted Wound Assessment Chart March 2021 – Scottish Wound assessment and Action Guide (SWAAG) **A copy can be accessed here for information but should be ordered via Stationery Stores using ING 1973. (Acute and community hospitals)**
- Ensure any entries made in someone's paper records are clearly and legibly signed, dated and timed
- Ensure any entries made in someone's electronic records are clearly attributable to you
- Where wound care is multi-professional and shared, ensure all involved are informed of any significant change in status and/or dressing regime as soon as possible after the contact has occurred

SECTION A

THE PHYSIOLOGY OF WOUND HEALING

Acute and chronic wounds have distinct differences. Some of the basic differences (excluding the microbiological/cellular differences) are:

ACUTE WOUNDS	CHRONIC/HARD TO HEAL WOUNDS
• Short duration	Unhealed within 6 weeks of formation
• No underlying pathology	Underlying pathology
• Normal inflammatory stage	Prolonged inflammatory Stage
• Usually heals without Complication	Variety of complications may arise
• Acute wound fluid supports cell Proliferation	Chronic wound fluid does not support cell proliferation

(Cutting & Tong 2003)

The literature cites many descriptive models of healing. Whichever model is followed, it is essential to have an understanding of the basic process as this will influence decisions made in the day to day management of the wound.

Most models suggest that the mechanics of dermal wound healing fall largely into four overlapping phases:

1. **Haemostasis**

Bleeding starts the process of haemostasis. Blood vessels contract, platelets aggregate and a clot is formed. Leucocytes are attracted to the injured area.

2. **Inflammation**

Prostaglandins and proteins are released, which cause vasodilation and inflammation. Neutrophils (whose function is phagocytosis of bacteria) and macrophages (which control the healing process) proliferate in the wound.

3. **Granulation**

New supporting tissue is formed like a scaffold, along with new blood vessel development, which is known as angiogenesis, and the wound begins to contract.

4. **Epithelialisation**

New skin cells emerge from the dermal edge and hair follicles, slowly bringing the wound edges together.

Healing By Primary or Secondary Intention

Wound healing by **primary intention** is when the edges of the wound can be brought together, eg a surgical wound which has been sutured, clipped or glued. The first three phases of healing are usually short but scar maturation may take a few months.
Wound healing by **secondary intention** occurs when the edges of a wound cannot be approximated, eg a leg ulcer. This type of wound heals by a combination of proliferation and wound contraction. The granulation and epithelialisation phases of this type of wound may take months to complete.

SECTION A

HOLISTIC APPROACH TO WOUND HEALING

Wound healing is a complex and interlinked series of biochemical processes that encompass the actions of various cells in different cellular environments involving oxygen, temperature, pH, growth factors and enzymes.

When the cells are healthy and the environment is within normal homeostatic parameters, the healing processes proceed predictably and without incident.

When the cells and their environments are compromised by alterations in local or systemic conditions, the healing process is impaired and the wound does not heal in an orderly or timely fashion.

Wound management and the selection of cleansing agents and dressing products is an important part of the healing process. It is, however important to remember that although this is a necessary component, it is not in itself the only part to consider when dealing with a patient with a non healing wound.

An awareness of the physical and psychosocial factors which delay wound healing is necessary. The assessment process should extend to identifying the intrinsic (e.g., nutrition, chronic disease processes) and extrinsic factors (e.g. pressure, friction, shear) which may influence an individual's healing rate. Some of these factors will be easily identified and corrected, others may not.

Nurses are in a unique position within the multi-disciplinary team to be able to holistically assess patients and their wounds and to develop realistic treatment objectives.

The Wound Assessment must be completed by a registered nurse or other healthcare professional with appropriate knowledge and experience. The individual needs to take into account whether the wound needs cleansed, the size, the tissue type, the exudate levels, odour, expected wear time of dressings.
Findings and decisions made should be documented in the wound chart – use a separate chart for each wound.

WOUND PHOTOGRAPHY

Photographs can be an important part of effective wound assessment – they can provide objective visual confirmation to the written record and can provide evidence of healing rates, capturing therapeutic efficacy.
Current legal opinion recommends that written informed consent should be sought from individual patients (or carer if appropriate) or parent/guardian in the case of children under 16, when seeking to take photographs for the purpose of monitoring wounds. See appendix 3 for consent form.

Consideration needs to be given to ensure all images remain confidential and stored in such a way that confidentiality is not breached, this includes sharing of images with the wider team.

When photographing a wound it is important to be able to assess the dimensions of the wound also. Disposable measuring tapes should be placed on the skin next to the wound prior to taking photograph. If close up photographs are required of specific wounds, there should be a secondary photograph which enables the particular body part to be identified.

The patient has the right to withdraw consent for wound photography at any time. The withdrawal should be fully documented in the patient records and any historic images that have been kept should be removed from electronic records or struck through if on paper form making it clear that the images cannot be used.

REFERENCES

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Flanagan, M. (1997) Wound Management Edinburgh, Churchill Livingstone.
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www.tissueviabilityonline.com
Institute of Medical illustrators, (2007) Clinical Photography in wound Management Guidelines.

CONSENT FOR WOUND PHOTOGRAPHY

NAME:_____CHI NO._____

Address:_____Date of Birth_____

_____

Wound Type/Presenting Problem_____

Informed Patient Consent – to be completed by patient/relative/carer.

Clinical photographs form an important part of your medical records and every care is taken to ensure that only authorised staff involved in your care have access to them. There are three levels of consent available to you (A, B, C).

Your choice of consent level will not affect your treatment in any way.

Please tick or cross one box in every section	Agree	Disagree
A. Medical Records I consent to photographs being used for monitoring Treatment; a copy will be placed in my health records.	☐	☐
B. Teaching I consent to the photographs being used to teach medical, Dental, nursing and healthcare staff and students.	☐	☐
C. Publication I am happy to be contacted to give written consent if my images are requested for medical publications. A separate Form will need to be signed for each specific publication.	☐	☐

I confirm that I (CAPITALS)_____ consent to have a photograph taken. The purpose of this has been explained to me.
Date: _____

I understand that I have the right to withdraw consent at any time.

Sign (Patient) _____

Sign – Relative/Carer _____ Relationship to Patient _____

Address (if different from above) _____

I have fully explained to patient/carer the nature and purpose of this consent, including the different levels of consent and possible ways the photographs may be used.

Name _____ Designation _____

Signature _____ Date _____Time _____

SECTION A

MOIST WOUND HEALING

This concept dates back to the 1940s but did not gain credibility until 1962 when George Winter's now infamous experiment examined the healing time of wounds exposed to air, compared with wounds covered with polyurethane. The wounds which were covered healed almost twice as fast as those exposed to air.
Although this theory was applied to acute wounds, the significance of these findings in chronic wounds has been debated with little agreement about healing rates in the literature (Miller, 1998; Parnham, 2002).
However, other benefits for creating a moist environment in chronic wound healing have been cited, such as enhancement of autolytic debridement and reduction in pain during wear and on removal of dressings (Hollinworth, 2005).
Maceration may occur where there is excessive moisture on the wound bed. Excessive moisture can excoriate the surrounding skin and cause extension of the wound. Correct choice of dressing is essential to achieve a balance between a wound that is too wet and one that is too dry.
Wound fluid contains essential **growth factors** necessary for epidermal growth. **Proteolytic enzymes** found in wound fluid have been shown to be beneficial to wound healing but are thought to be present in excessive numbers in chronic wounds (Wysocki *et al.* 1993). At present, there is no biochemical test to measure an excess of proteases in order to prove this is the cause of delayed healing.

MOIST WOUND HEALING IN ISCHAEMIC WOUNDS

It is important, when attempting to promote moist wound healing in ischaemic wounds, to be aware that wounds with an underlying ischaemic cause are prone to infection. The presence of necrotic/sloughy tissue, which contain greater quantities of bacteria, increase the risk of infection (Leaper & Ellis, 2002) when moistened and rehydration of the tissue is attempted. Where there is underlying ischaemic disease, and revascularization or restoration of the blood supply is not suitable, moist wound healing may not be appropriate. Devitalised necrotic tissue has a propensity to continually accumulate and may be impossible to resolve (Falanga, 2002) particularly with additional pathophysiology such as Diabetes.

The bacterial release can overwhelm the wound, causing deterioration and expansion to the wound itself as well as risking systemic infection.
Where individuals have severe arterial impairment, moist wound healing is often best avoided and the area kept as dry as possible. EG with the use of inadine or iodoflex dressing.
In the case of ulceration to digits, it is advisable to separate digits from one another to prevent the spread of inter-digit ulceration particularly between the toes.

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Cutting, K. & Tong, A. (2003) *Wound Physiology and Moist Wound Healing*. Holsworthy: Medical Communications UK Ltd.
Falanga, V. (2002) Wound bed preparation and the role of enzymes: a case for multiple actions of therapeutic agents. Wounds: A Compendium of Clinical Research and Practice 2002; 14:2.
Hollinworth, H (2005)The management of patients' pain in wound care. *Nursing Standard Tissue Viability Supplement.*20(7) 65-73.
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Section A

NUTRITION IN WOUND MANAGEMENT

Nutrients contain a composition of chemicals which are obtained from the foods we eat in order to provide our cells with growth, maintenance and repair. Therefore good nutrition is vital in wound healing and one of the essential components when considering the prevention and management of wounds.

Malnutrition

Malnutrition is the condition in which a deficiency or excess of energy, protein and other nutrients cause significant effects on body tissue, body function and clinical result. Unintentional weight loss, the need for consistency altered diet or oral problems with eating are all predictors of malnutrition which could hinder wound healing.

Malnutrition and specific nutrient deficiencies can lead to poor health, a reduced immune response and subsequent tissue damage with delayed wound healing and increased susceptibility to wound or systemic infection. Physical appearance alone will not always identify such patients.

A deficit in nutritional intake means that energy, protein, vitamin and mineral intakes are low at a time when requirements are increased. Muscle mass is lost as protein breakdown occurs to provide energy. Protein can also be lost in vast amounts through exuding wounds, dependant on the size and amount of fluid exuded.

A decreased nutritional intake can result in weight loss and the loss of the protective cushioning effect of fat. Dehydration can also cause dry fragile skin which again further impacts on the body's ability to repair wounds.

A low energy intake is associated with a reduced availability of other nutrients such as Vitamin C, Zinc and Iron which have a vital role in wound healing.

Providing sufficient energy will prevent dietary or tissue protein being used as an energy source and therefore reduce these effects and adequate protein will optimise wound healing. To promote wound healing patients should choose foods high in energy and protein. Foods rich in protein include, milk, eggs, cheese, yoghurt, lean meat or poultry and fresh or tinned fish.

Nutritional Screening

On admission to hospital patients should undergo initial nutritional assessment using the Malnutrition Universal screening tool (MUST). MUST is a 5 step process to identify adults who are undernourished, at risk of malnutrition or obese. It also includes guidelines that can be used to develop a care plan.

Where risk of malnutrition is detected, appropriate care plans must be initiated and be repeated at least weekly if there is any significant change in condition. Any nutritional inadequacy should be identified and corrected at an early stage to minimise the complications associated with them. Patients identified at risk of nutritional inadequacy with a high MUST score should be referred to the Dietetic Department for further assessment regarding their nutritional needs and management

The MUST screening tool is used in Forth Valley Royal and all out-lying community hospitals. The next page details the current version of MUST**.**

Obesity

Being obese can cause additional issues associated with wound healing. These patients will likely have reduced mobility, increased pressure placed on the wound along with reduced vascular supply within the adipose tissue making the wound healing process increasingly difficult. However, as good nutrition is required to aid wound healing it is not recommenced to reduce protein and calorie intake in obese and overweight patients.

Diabetes

It is important that people with diabetes ensure their blood sugars are well controlled. Hyperglycaemia increases the risk of localised and systemic infection which in turn delays the wound healing process.

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Maidenhead: Bapen, 2000.
Terranova A. The Effects of Diabetes Mellitus on wound healing. *Plast Surg Nurs*. 1991, 1, 20-5.
Malnutrition: Food fact sheet https//www.bda.uk.com/resource/malnutrition. 2019

SECTION A

WOUND CLEANSING

MODE OF ACTION

Wounds may be irrigated with a gentle stream of warm tap water or warm normal saline. The purpose of wound irrigation is to gently remove loose debris and surface contamination from the wound bed. As a general rule, routine cleansing of wounds to remove bacteria or to reduce infection is unlikely to be effective (Miller and Gilchrist 1997)
A study by Griffiths et al (2001) confirms that there is no statistically significant difference between the healing and infection rates in wounds cleansed with tap water or Normal saline. It is recognised that wound healing requires the bactericidal activity and growth factors present in wound exudate. Removal of this fluid and drying of wounds can deplete the healing tissue of vital components and contradicts the principles of moist wound healing (Davies 1998).

INDICATIONS

- **Chronic wounds -** if wound exudate is excessive, gentle removal of the exudate surrounding the wound using a gentle stream of warm saline and removal of debris with a soft gauze swab is all that is required.
- **Surgical wounds -** showering or bathing is usually adequate to cleanse a simple surgical wound (Neues 2000).
- **Leg Ulcers -** Frequently patients with leg ulcer have bandages insitu for up to a week at a time. It is good practice and therapeutic for patients to soak their legs and feet in a basin of warm tap water, before redressing. This promotes patient comfort, removes exudate and allows reviewing of the wound for accurate assessment. (SIGN 2010)
- **Acute wound -** Wound cleansing using a gentle stream of warm normal saline to clear the wound of visible debris to enable proper assessment is all that is required.

If it is not necessary to clean a wound – don't

Access Wound Cleansing Pathway: Sept-23rd-2020-Wound-Cleansing-Guide-NATVNS.pdf

CONTRA-INDICATIONS

Irrigating wounds does not completely remove bacteria. Cotton wool/gauze should not be used over the wound surface as fibres can be shed which may adhere to the wound surface and become *incorporated into wound tissue, acting as a foreign body which may impede healing.*

Wound Bed Preparation

PRONTOSAN IRRIGATION SOLUTION AND GEL – B BRAUN

PRODUCT DESCRIPTION

Ready to use solution or gel containing polyhexanide (PHMB) a powerful antimicrobial agent and betaine, a surface active solution that helps in removing difficult wound coatings.

INDICATIONS

Suitable for wound bed preparation to remove biofilm and absorb wound odours.

CONTRA- INDICATIONS

Should not be used if it is known or suspected that patient may be allergic to one of the ingredients. Should not be used on the Central Nervous System or the meninges, in the middle or inner ear or in the eyes.

APPLICATION

Irrigate the wound with prontosan solution and apply as a gauze soak for a minimum of 10 minutes. If applying gel apply thin layer film over wound bed at least 3mm thick. Prontosan gel – fluid consistency - suitable for deep wounds and cavities where a little is required. Prontodan Gel X – Highly viscous, use when a thicker consistency required or to cover larger surface area

FREQUENCY OF USE

Should be carried out at each dressing change. Prontosan is for individual patient use. Should be disposed of 8 weeks after opening.

PRESENTATION

Available as Wound Irrigation Solution – 40ml ampoules
350ml bottles

GEL – 30ml cartridge bottles
GEL X – 250g
GEL X – 50g

Use of combined biguanide polyhexanide and betaine surfactant solution and gel to aid delayed healing in complex, recalcitrant chronic wounds.

REFERENCES:

Burnett CL, Bergfeld WF, Belsito DV et al (2012) Final report of the Cosmetic Ingredient Review Expert Panel on the safety assessment of cocamidopropyl betaine (CAPB). *Int J Toxicol* 3(4 Suppl): 77S–111S

Bradbury S, Fletcher J (2011) Prontosan Made Easy . Wounds International 2 (2**)**
Cairns SA, Minhas U, Riddell AD, Leaper DJ, Harding KG (2009)

Department of wound Healing, Cardiff University UK
Collier M, Hofer P (2017) Taking wound cleansing seriously to minimise risk

Vowden P, Vowden K, Carville K (2011) Antimicrobial dressings Made Easy. Wounds International 2(1).

MECHANICAL DEBRIDEMENT PRODUCTS

UCS DEBRIDEMENT CLOTH – MEDI

Description

UCS debridement is a sterile, **pre-moistened** single-use cloth that can be used to debride wounds, as well as cleansing periwound skin. Its active ingredients include aloe vera barbadensis leaf juice, allantoin and poloxamer. It is a class 2B medical device and is available on prescription in the UK.
The mild cleansing solution within the cloth enables it to moisten and soften the skin without damaging healthy cells, while effectively removing soft sloughy tissue and debris from the wound bed, thereby accelerating the healing process.
Also effective in softening and subsequent removal of dry skin plaques and hyperkeratosis.

Indications and contraindications

Indications

- Chronic and acute wounds
- Ulcers of all types
- Pressure ulcers
- First and second-degree burns
- Peri-stomal skin
- Ports of entry of catheters, PEG/PEJ
- To remove encrusted bandages from wounds
- Hyperkeratosis.
- Interdigitally

Contraindications

- If there is a high risk of haemorrhage, the wound bed should not be touched.

How to Use

Tear open the sterile UCS packet to access the cloth
Use each area of the cloth to gently work into or around the wound to allow the fluid to penetrate the skin, enabling debris to be removed.
Both sides of the cloth can be used
UCS is gentle, soft and effective debridement.

Individual sterile foil packs	10 per box	Box code: DT500

DEBRISOFT DEBRIDEMENT PAD/ LOLLY

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Debrisoft is made of soft, polyester fibres that are secured and knitted together. These fibres are cut at a special angle, length and thickness to effectively cleanse/debride skin and the wound bed.
Debrisoft is a rapid, highly effective, safe and easy method of debridement for superficial wounds containing loose slough and debris and also including biofilm.
Debrisoft® can also be used to clear the wound bed in advance of the initial wound assessment or to aid accurate pressure ulcer categorisation
Debrisoft can also be effective in removal of hyperkeratosis from the skin.

Debrisoft ® Lolly
Comprises of monofilament polyester fibres with a blue X-ray detectable polypropylene thread. The Debrisoft ® Lolly is intended for the debridement of deep – including surgically invasive – to superficial wounds for wound bed preparation. It is used to absorb exudates, debris and keratoses during debridement.

Indications

- Leg ulcers. Debrisoft gently removes debris and superficial slough from leg ulcers thus removing bacteria and helping promote healing.
- Pressure ulcers. Assessment, categorisation and treatment of pressure ulcers can be improved with Debrisoft.
- Diabetic foot ulcers. ...
- Hyperkeratosis. ...
- Acute wounds.
- Chronic wounds

Contraindications/precautions

- Debrisoft should not be used on patients with known sensitivity to any components of the product (it is 100% polyester)
- Debrisoft is not a wound dressing so should not be used as such
- If emollients have been used, skin should be washed before using Debrisoft
- Debrisoft may not effectively debride dry, necrotic material or tethered, adherent slough. In such cases, treatment with autolytic debridement before using Debrisoft may improve its efficacy. On very sloughy wounds or thick hyperkeratosis more than one treatment with Debrisoft may be required to achieve complete removal of debris and dead tissue

How to use

1. If emollient has been applied, wash the area to remove it, as skin that is well-impregnated with emollient may cause the Debrisoft to glide across the surface of the wound/skin without removing the debris (Gray et al, 2011).
2. Open the Debrisoft single use, sterile pack.
3. Fully moisten the soft fleecy side of Debrisoft with tap water or saline – 30mls for pad, 15mls for Lolly
4. With light pressure and using a circular motion, use the soft fleecy side of Debrisoft to gently debride the wound and/or skin for approximately 2–4 minutes.
5. Use a new piece of Debrisoft for each separate wound/area of skin.
6. Dispose of the used Debrisoft in normal clinical waste.
7. It may be necessary to use Debrisoft on more one than one occasion to achieve optimal results.

Debrisoft® Ordering information

PAD 10CM X 10CM -5 PACK - REF CODE 31222, PIP CODE 358-1287, HOSPITAL CODE ELZ354

LOLLY – 5CM X 2.7CM – 5 PACK – REF CODE 33224, PIP CODE398-5124, HOSPITAL CODE ELZ728

PAD SINGLE PACK 13CM X 20CM REF 34323 PIP CODE 409-0351 HOSPITAL CODE ELZ964

Preparation	Procedure	Rationale
Gentle showering of wound area during routine social hygeine	Once shower is warm – gently irrigate wound with warmed water using showerhead	Ensures free flowing warm, clean water. Safe removal of exudate, loose slough and wound dressing residue.
Bucket lined with polythene bag and filled with warm water for lower limbs	Gently wash limb. Dry skin surrounding wound prior to application of new dressing	Ensures safe removal of exudate, loose slough and wound dressing residue. It incorporates social hygiene into wound management procedure.
Sodium Chloride 0.9% solution pods/sachets – warm by running under warm water	Irrigate wound area with warmed Sodium chloride 0.9% solution. If slough not easily removed by irrigation , further hydration with appropriate wound dressing products may be necessary	Maintain optimum temperature for wound healing. Safe removal of exudate, loose slough and wound dressing residue
Prontosan Irrigation Fluid – for compromised wounds only eg chronic or infected wounds. If necessary warm bottle (350mls) or pods(40ml) under warm water	Use gauze swabs soaked in Prontosan Solution and laid on wound bed for 5 minutes at dressing changes then discard	Deeper cleansing of wounds and biofilm removal

Wound Cleansing Guidelines

Sodium Chloride 0.9% Normasol sachets, 25ml sterile topical irrigation solution – containing 0.9% sodium chloride.
Prontosan wound Irrigation solution- 40ml ampoules or 350ml bottle (last for 8 weeks once opened)

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Fletcher J, Ivinis N (2015) Is it time to review how we clean leg ulcers? Wounds Uk 1 (4) 42-48
White R et al (2016) Leg Ulcer care – should we be washing the legs and taking the time for effective skin care. Wounds UK 12 (1). Access at: content_11729.pdf (woundsme.com)

SECTION A

WOUND SWABBING

Swabs should only be sent for laboratory analysis when the wound displays clinical signs of infection. i.e. Increased pain, exudate, odour or increased size of wound, unhealthy wound bed e.g. greyish/dusky appearance. Infection delays wound healing and on a more serious level can lead to further tissue breakdown, extension of the wound, increased patient discomfort and septicaemia.

This concurs with the SIGN Guidelines (2010).

Infection is defined as “A higher level of bacteria sufficient to cause an observable tissue reaction” Ayton (1985)

It is important to distinguish between infection and colonisation, Ayton (1985) Colonisation is an increased level of bacteria, but insufficient to cause a tissue response ie. No observable evidence of infection.

There is no justification for taking a swab “just to see what is there”, results will always display organisms which may not be necessarily causing harm or having any adverse effects on healing. *Therefore routine microbiological investigation is not justified.* The exception to this is when screening for a specific organism e.g. MRSA

TO CLEANSE OR NOT TO CLEANSE?

In a search of available literature, the majority of the authors advocate the cleansing of wounds prior to obtaining a swab. This concurs with recommendations from microbiologists at FVRH. The rationale for this is to remove any excess surface exudate, revealing underlying bacteria. If a wound was not cleansed before swabbing, results would display colonised bacteria.

PROCEDURE FOR OBTAINING WOUND SWABS.

Rotate swab gently over infected area, place swab into transport (charcoal) medium, send to laboratory as soon as possible – this helps prevents early demise of bacteria. Once obtained wound swabs should not be stored in refrigerator, if they cannot be sent to laboratory straight away, they should be stored at room temperature for no longer than 24 hours.
On the laboratory form include all clinical details about patient, wound, recent treatment and exact site of wound, to enable accurate processing and reporting of the specimen.

REFERENCES

Scottish Intercollegiate Guidelines Network (SIGN 120) The care of Patients with Chronic Leg Ulcer(2010)

Ayton M (1985) Wounds that won’t heal. Nursing Times 81(Suppl):16-19

Cooper R (2010) Infection: assessment & Diagnosis – Ten Tips for Taking a Wound Swab. Wounds International 1 (3)

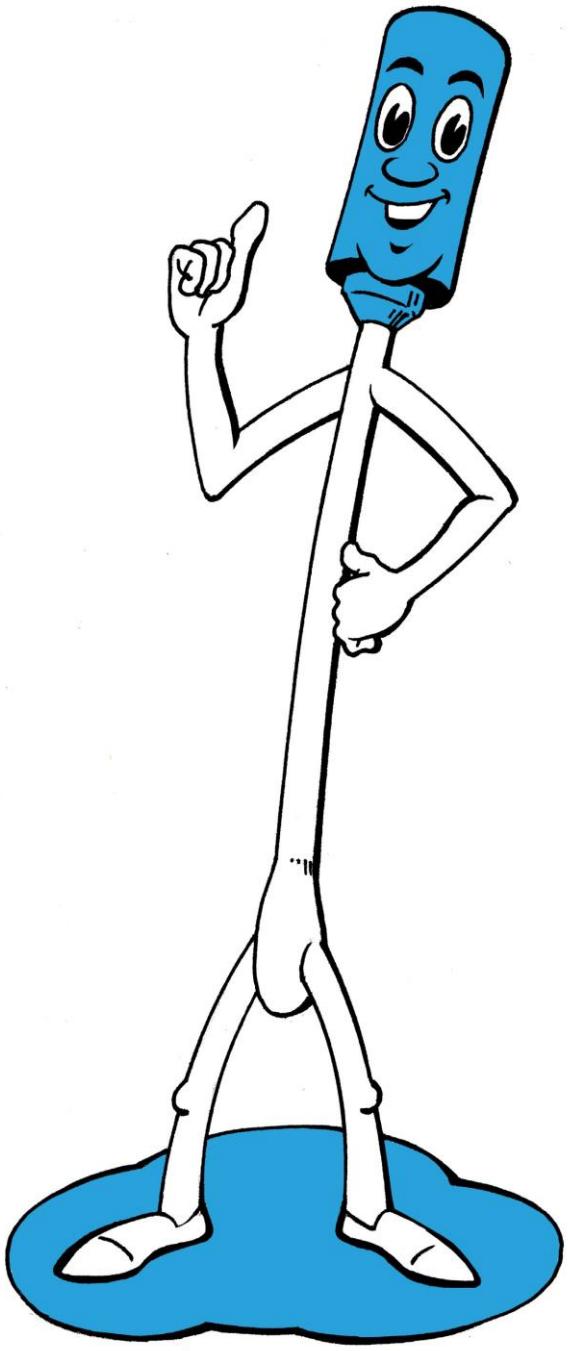
Pattern H (2010) Identifying Wound Infection: Taking a wound swab. Wound essentials 5 (p64)

Fernandez R, Griffiths R, Ussis C. (2002) The Cochrane Database of systematic Reviews.

Hansson C, Hoborn J, Moller A, Swanbeck G. The microbial flora in venous leg ulcers without clinical signs of infection. *Acta Derm Venereol* 1995; 75(1): 24-30.

Bowler PG, Duerden BI, Armstrong DG. Wound microbiology and associated approaches to wound management. *Clin Microbiol Rev* 2001; 14(2): 244-69.

WOUND SWABS!



DO NOT routinely take wound swabs if …

- **WOUND IS A CHRONIC ULCER**
- Pressure ulcer
- Wounds are more than one month old
- Sinuses and fistulae
- Stoma sites

The above wounds will be colonised with the patient's own flora or environmental organisms. Swabs from these wounds will always have growth! Hence, these wounds SHOULD NOT be swabbed or treated with antibiotics, unless there are clinical signs or symptoms of infection.
Treatment of these cases will result in the emergence of antibiotic resistance. Refer to Tissue Viability team for wound management advice.

Take a wound swab if …

- **EVIDENCE OF SPREADING CELLULITIS**
- Clinical signs of infection – raised temperature, raised WCC
- Immunosuppression with wound deterioration (diabetes, steroids, malignancy)
- Discharging surgical wounds - particularly overlying prosthetic material.

Poster reproduced by kind permission of H Hodgson Lead Tissue Viability Nurse GG&C Health Board

SECTION A

REDUCING PAIN AT DRESSING CHANGES

Patients' requirement for analgesia must be accurately assessed prior to the removal of the dressing. A specialist referral may be required to treat pain from underlying pathologies and wound pain. However basic principles of good pain management should be utilised until specialist advice is available. The use of entonox, a self administered analgesic gas comprising oxygen and nitrous oxide may be favoured for its rapid onset analgesia. This gas is used for the duration of the procedure and not recommended for prolonged use or general pain relief (EWMA position document)

METHODS TO REDUCE ANXIETY AT DRESSING CHANGE

- Provide adequate analgesia prior to dressing change
- Explanation to patient of what to expect
- Identify what the patient recognises to be triggers of pain
- Invite the patient to be involved as much as he/she wishes i.e. removal of dressing themselves
- Encourage slow rhythmic breathing during the procedure
- Offer the patient "time out" during the procedure and negotiate a signal e.g. raise hand, clap
- Use of distraction e.g. music
- Ensure all materials are ready and easily accessible, prior to dressing change.

DRESSING SELECTION CRITERIA

- Appropriate for the type of wound
- Maintains moist wound healing whilst managing exudate
- Does not adhere to the wound bed
- Reduce friction at the wound surface
- Minimises pain and trauma on removal
- Reduce the need for frequent dressing changes
- Provides patient comfort

(EWMA position document 2003, TVNA Best Practice Statement 2004)

DRESSING REMOVAL

- Avoid unnecessary stimulus, such as drafts from windows, poking/prodding, unnecessary touch
- Ensure " Methods" detailed above are employed.
- Consider the manufacturer's instructions to release the adhesive
- Soaking an adherent dressing with warm saline or tap water prior to removal, (patient may do this themselves or in the shower if feasible).
- Patient may wish to remove own dressing

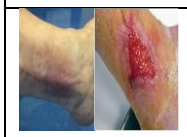
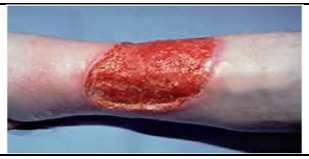
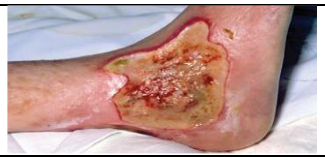
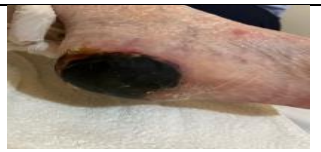
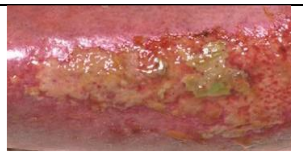
APPLICATION OF NEW DRESSING

- Ensure wound cleansing methods, as detailed above, are employed
- Work gently and swiftly to apply dressing

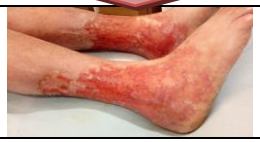
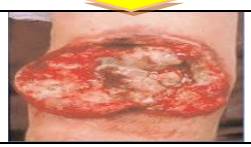
REFERENCES

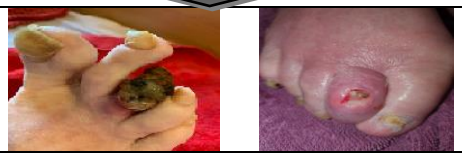
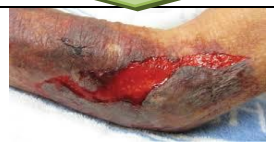
European Wound Management Association EWMA (2003) Position Document - Pain at wound dressing changes EWMA London
Tissue Viability Nurses Association TVNA (2004) Best practice Statement - Minimising Trauma and Pain in Wound Management issue 1 TVNA Scotland

QUICK GUIDE TO WOUND DRESSINGS – CONSULT WOUND MANAGMENT FORMULARY FOR FULL LIST ASSESS WOUND

EPITHELISING	GRANULATING	SLOUGHY	NECROTIC	INFECTED
				
OBJECTIVES: TO PROTECT AND PROMOTE NEW TISSUE GROWTH	**OBJECTIVE:** ENCOURAGE ANGIOGENISIS AND PROMOTE GRANULATION TISSUE	**OBJECTIVE:** TO DEBRIDE SLOUGH AND MANAGE EXUDATE LEVELS	**OBJECTIVES:**TO REHYDRATE ESCHAR **NB: IT MAY NOT BE APPROPRIATE TO BREAK NECROSIS DOWN** **e.g. palliative, vascular or diabetic wounds**	**OBJECTIVES:** TO REDUCE BACTERIAL LOAD **NB: IF SPREADING INFECTION (e.g. CELLULITIS) SYSTEMIC ANTIBIOTICS MAY BE REQUIRED**
EXUDATE LEVELS	EXUDATE LEVELS	EXUDATE LEVELS	EXUDATE LEVELS	EXUDATE LEVELS

LOW EXUDATE	LOW EXUDATE	MOD TO HIGH EXUDATE	LOW EXUDATE	MOD TO HIGH EXUDATE	LOW EXUDATE	MOD TO HIGH EXUDATE	LOW EXUDATE	MOD TO HIGH EXUDATE
FORMULARY DRESSING CHOICE <u>EXAMPLES</u> - CONSULT WOUND MANAGEMENT FORMULARY FOR FULL LIST AND MODE OF ACTION								
PRIMARY – ATRAUMAN OR DUODERM EXTRA THIN **OR** KLINIDERM FOAM SILICONE BORDER	**PRIMARY -** ATRAUMAN OR VISCOPASTE **SECONDARY -** SOFT SWABS OR KLINIDERM FOAM SILICONE BORDER	**PRIMARY –** URGOCLEAN PAD AQAUCEL FOAM ADHESIVE, **SECONDARY -** KLINIDERM SUPER ABSORBENT/ KERRAMAX CARE TEGADERM FOAM ADHESIVE	**PRIMARY –** HYDROCLEAN ADVANCED ACTIVEHEAL HYDROGEL & ATRAUMAN OR VISCOPASTE **SECONDARY –** SOFT SWABS OR KLINIDERM FOAM SILICONE BORDER	**PRIMARY –** URGOCLEAN PAD FOR SUPERFICIAL AQUACL EXTRA FOR CAVITY **SECONDARY –** KLINIDERM SUPER ABSORBENT PAD / KERRAMAX PAD TEGADERM FOAM ADHESIVE	**PRIMARY –** ACTIVEHEAL HYDROGEL AUTRAUMAN OR VISCOPSATE **SECONDARY -** DUODERM EXTRA THIN. SOFT SWABS OR KLINIDERM FOAM BORDER OR KILIDERM FOAM SILICONE	**PRIMARY –** URGOCLEAN PAD FOR SUPERFICIAL AQUACEL EXTRA FOR CAVITY **SECONDARY –** KILINIDERM SUPER ABSORBENT PAD OR KERRAMAX CARE PAD OR TEGADERM FOAM ADHSIVE	**PRIMARY -** FLAMINAL HYDRO OR FLAMINAL FORTE L-MESITRAN OINTMENT OCCLUDE WITH ATRAUMAN OR VISCOPASTE INADINE **SECONDARY –** SOFT SWABS OR KLINIDERM FOAM BORDER OR KILIDERM FOAM SILICONE	**PRIMARY –** AQUAFIBRE AG MEDIHONEY APINATE IODOFLEX **SECONDARY –** KLINIDERM SUPER ABSORBENT OR KERRAMAX CARE OR TEGSADERM FOAM ADHESIVE

CAVITY		EXCORIATED/ LEAKY LEGS		FUNGATING	
					
OBJECTIVES – PROMOTE GRANULATIONFOR BASE UP – SECONDARY INTENTION		**OBJECTIVES –** REDUCE INFLAMMATION, REDUCE EXUDATE, REDUCE DISCOMFORT & ITCH		**OBJECTIVES –** MANAGE SYSMPTOMS e.g. BLEEDING, PAIN, EXUDATE AND MALODOUR	
EXUDATE LEVELS		EXUDATE LEVELS		EXUDATE LEVELS	
LOW EXUDATE	MOD TO HIGH EXUDATE	**LOW EXUDATE**	**MOD TO HIGH EXUDATE**	**LOW EXUDATE**	**MOD TO HIGH EXUDATE**
FORMULARY DRESSING CHOICE <u>EXAMPLES</u> - CONSULT WOUND MANAGEMENT FORMULARY FOR FULL LIST AND MODE OF ACTION					
PRIMARY – URGOCLEAN ROPE **SECONDARY –** KILINIDERM SUPER ABSORBENT PAD OR KERRAMAX CARE PAD KLINIDERM FOAM BORDER TEGADERM FOAM ADHSIVE CONSIDER NPWT – ACTI VAC	**PRIMARY –** AQUACEL EXTRA AQUAFIBRE AG **SECONDARY –** KILINIDERM SUPER ABSORBENT PAD OR KERRAMAX CARE PAD KLINIDERM FOAM BORDER TEGADERM FOAM ADHSIVE CONSIDER NPWT – ACTI VAC	**PRIMARY –** VISCOPASTE STRIPS MAY REQUIRE POTENT STEROID CREAM ON A REDUCING REGIME OCCLUDE WITH ATRAUMAN OR VISCOPASTE STRIPS **SECONDARY –** KLINIDERM SUPERABSORBEN PADS OR KERRAMAX CARE PADS COMFINETTE, LANTOR & CREPE MAY REQUIRE TO BE ASSESSED FOR COMPRESSIION GARMENTS	**PRIMARY –** AQUACEL EXTRA AQUAFIBRE AG VISCOPASTE STRIPS MAY REQUIRE POTENT STEROID CREAM ON A REDUCING REGIME OCCLUDE WITH ATRAUMAN OR VISCOPASTE STRIPS **SECONDARY –** KLINIDERM SUPERABSORBEN PADS OR KERRAMAX CARE PADS COMFINETTE, LANTOR & CREPE MAY REQUIRE TO BE ASSESSED FOR COMPRESSIION GARMENTS	**PRIMARY –** KLINIDERM SILICONE WOUND CONTACT DRESSING **FOR ODOUR –** ACTISORB SILVER 220/ CARBAFLEX MEDIHONEY APINATE **TO MANAGE BLEEDING** – COVAWOUND ALGINATE **SECONDARY -** KLINIDERM SUPER ABSORBENT OR KERRAMAX CARE OR TEGSADERM FOAM ADHESIVE, LIGHT BANDAGIN GIF LEGS AFFECTED	**PRIMARY –** KLINIDERM SILICONE WOUND CONTACT DRESSING **FOR ODOUR –** ACTISORB SILVER 220/ CARBAFLEX MEDIHONEY APINATE **TO MANAGE BLEEDING** – COVAWOUND ALGINATE **SECONDARY -** KLINIDERM SUPER ABSORBENT OR KERRAMAX CARE OR TEGSADERM FOAM ADHESIVE, LIGHT BANDAGIN GIF LEGS AFFECTED

ARTERIAL / DIABETIC TOES	SKIN TEARS
	
OBJECTIVES – KEEP DRY, PROMOTE AUTOLYTIC DEBRIDEMENT. DRESS TOES INDIVIDUALLY	**OBJECTIVES –** RE-ALIGN VIABLE TISSUE IF POSSIBLE PREVENT ANY FURTHER SKIN DAMAGE
EXUDATE LEVELS	**EXUDATE LEVELS**
LOW EXUDATE	**LOW EXUDATE**
FORMULARY DRESSING CHOICE EXAMPLES - CONSULT WOUND MANAGEMENT FORMULARY FOR FULL LIST AND MODE OF ACTION	
KEEP DRY! **PRIMARY -** INADINE IODOFLEX **SECONDARY –** SOFT SWABS TUBIFAST TOE DRESSING (01 OR 12) **SEEK ADVICE FROM DIABETOLOGIST /PODIATRY/ VASCULAR OR TVS**	**PRIMARY –** KLINIDERM SILICONE WOUND CONTACT DRESSING **SECONDARY –** KLINIDERM FOAM SILICONE BORDER KLINIDERM FOAM SILICONE PAD UNDER COMFINETTE, LANTOR & CREPE

TISSUE VIABILITY SERVICE REFERRALS

The Tissue Viability Service (TVS) provides an advisory and supportive role for the care of patients with varying tissue viability problems (e.g. wound care, pressure area care, leg ulcers, and therapeutic equipments).

Service availability is between the hours of 08:30 and 16:30 Monday to Friday (Excluding Public Holidays) on 01324 673747

When nurse is considering referral to Tissue Viability Service (TVS) for:

- Wound Care Advice
- Pressure Ulcer - **grade 3 and above**
- Leg Ulcer
- TNP Advice
- Skin Care Advice

For guidance in the first instance refer to TVS Wound Management Formulary available at:

Wound Management Formulary

The formulary covers a wide range of wound/tissue viability issues and is a handy tool to support staff choose appropriate treatment and/or wound dressings.
For PU damage consult pre formed illustrated care plans

Is referral to TVS still required?

NO

Continue with on-going monitoring and treatment of patient by ward staff. Document fully in completed Wound Assessment Chart which should then be stored in patient's ward notes.

YES

Complete Referral to Tissue Viability Service form. Available at:

TVS Referral Form

Once completed, email with wound photograph attached to

fv.tissueviability@nhs,scot

Following Triage from TVN, the ward will be contacted on telephone number provided on referral form to discuss patient and offer advice on a treatment plan tailored for their specific needs. TVN will then document advice given in patient's *Morse Nursing Record and email copy of treatment plan to nurse on provision of email address.

OR TVN will arrange a visit if this is also required

*** NB: Morse Nursing records are available to view as read only documents on Clinical Portal via Nursing and A.H.P's link.**

SECTION B

SKIN CARE

Care of the Surrounding Skin

The principles of good skin care depend on:

- Keeping the skin clean and dry
- Avoiding the excessive use of soap
- Using showers in preference to baths where possible
- Keeping the skin moisturised

Assessment

The state of the skin surrounding a wound should be assessed at each wound dressing change. Refer to assessment form - appendix 2A – 2D

Observe for the following:

- Dry skin: may break down and provide a portal for infection
- Maceration: caused by poor management of exudates
- Inflammation: consider contact sensitivity to dressings or infection

Emollients

Emollients are moisturisers that soothe and hydrate the skin. They are indicated for all dry or scaling disorders. Most are best applied after washing but their effects are short-lived so they must be applied frequently and regularly to maintain improvement. They should continue to be applied even after improvement occurs. **NB**- Emollients should be applied in the direction of hair growth to prevent folliculitis. Some ingredients may rarely cause sensitisation and this should be suspected if an eczematous reaction occurs.

There are different types of products available. These include ointments, creams, lotions and gels. Effectiveness depends upon the correct choice of product and correct use. Choice will depend on:

- The severity of the condition
- Patient preference
- The site of application
- Cost of preparation

Ointments: Ointments are greasy and generally insoluble in water so can be difficult to wash off and do not suit all patients. They are recommended as the first choice for formulation in most skin conditions and are particularly useful for chronic dry conditions. Examples: Liquid Paraffin/White Soft Paraffin Ointment 50:50%.

Creams: Creams are emulsions of oil and water and often contain an antimicrobial preservative. They are therefore more likely to cause both irritant and allergic reactions. For this reason creams are best avoided first line but are often more cosmetically acceptable for some patients. Creams can be better than ointments for some acute conditions due to a cooling effect as they evaporate from the skin. Example: Diprobase.

Gels: Gels also have a high water content and produce a cooling effect on evaporation from the skin. They are suitable for use on the face and scalp. Example: Doublebase.
Barrier Preparations:
Wounds which are heavily exuding or have friable surrounding skin are at risk of excoriation, epidermal stripping and maceration. A barrier can be used on the surrounding skin prophylactically to protect the skin. Barrier preparations should be reapplied at dressing changes. Examples: Cavilon cream or Cavilon barrier spray - Check Wound Management Formulary for up to date skin barrier products

N.B. Sudocrem should not be used as a barrier against incontinence.

Patient Skin Care Leaflet:

GOOD SKIN CARE WEARING COMPRESSION HOSIERY – Re-Order from Central Stores – code PIL/1290/SS

REFERENCES

Penzer R. (2012) A Best Practice Statement for Emollient Therapy. Dermatological Nursing 11 (4)

White R et al (2012) Best Practice Statement – Care of the Older Persons Skin (2nd edition) London. Wounds UK, 2012

SECTION B –

SKIN CARE - EMOLLIENTS

HYDROMOL

Hydromol Ointment feels soft, and rubs easily into the skin.

It leaves a protective barrier to seal water into the skin.

Free from preservatives, it moisturises, softens and protects, for the treatment of dry skin and eczema.

Prescribing Information

Hydromol Ointment is a medical device and may be prescribed as an appliance as listed in part IXA of the Drug Tariff. It is therefore prescribable from the Nurse Prescribers' Formulary for NHS patients by nurse prescribers, community practitioners, district nurses and health visitors.

Presentation: All purpose ointment containing Cetomacrogol Emulsifying Wax, Yellow Soft Paraffin and Liquid Paraffin.

Indications: For the symptomatic management of eczema, psoriasis and other dry skin conditions.

Dosage and Administration: Emollient - Apply liberally and as often as required to the affected area. Bath additive - Melt Hydromol Ointment in warm water in a suitable container, add mixture to the bath. Soap substitute - Use as required when washing.

Contra-indications: Hypersensitivity to any of the ingredients.

Warnings & Precautions: Avoid eyes. Beware of slipping in bath. Patients using large quantities of any paraffin based product such as Hydromol Ointment, should regularly change clothing or bedding impregnated with the product and keep away from naked flames as there is a fire hazard.

Side-effects: None known.

Legal Category: Class I Medical Device.

Packs and basic NHS price: Tubs: 125g - £2.92, 500g - £4.96, 1kg - £8.20 & Tube: 100g - £3.20.

Patients having this product applied should be informed of its potential flammable properties and must not sit close to fires or sources of heat and refrain from smoking.

Do not smoke or go near naked flames - risk of severe burns. Fabric (clothing, bedding, dressings etc) that has been in contact with this product burns more easily and is a serious fire hazard. Washing clothing and bedding may reduce product build-up but not totally remove it.

PARAFFIN 50% & WHITE SOFT PARAFFIN 50% OINTMENT

AN EMOLLIENT, WHICH HAS A THICK GREASY CONSISTENCY.

MODE OF ACTION

Restores the epidermal barrier and prevent allergens from entering the skin.

INDICATIONS
Suitable for many patients with dry skin conditions

CONTRA- INDICATIONS

May cause sensitisation and should be discontinued if an eczematous reaction occurs. A note of any allergic reaction should be documented in patient records.

METHOD OF USE

Should be used sparingly and applied thinly over dry areas. For external use only.

PLEASE NOTE

Patients having this product applied should be informed of its potential flammable properties and must not sit close to fires or sources of heat and refrain from smoking.

SIZES AVAILABLE THROUGH FORMULARY

200g containers

REFERENCES:

Wingfield,C. .(2011) SKIN CARE IN THE OLDER PERSON: A FOCUS ON THE USE OF EMOLLIENTS. 16, 10 PG 470-478.

Best Practice in Emollient therapy- a statement for healthcare professionals (2012) 11, (4) s17.

Emollients Factsheet (2016) National Eczema Society. Available at www.eczema.org Accessed September 2016

OLIVE OIL
An emollient, which has a runny consistency.

MODE OF ACTION

Forms a film preventing moisture loss and restoring skin flexibility.

INDICATIONS

Use as an emollient, suitable for patients with dry skin.

CONTRA- INDICATIONS

May cause sensitisation and should be discontinued if reaction occurs. A note of any allergic reaction should be documented in patient records.

METHOD OF USE

Apply sparingly as can be messy and result in soiling of clothing.

SIZE AVAILABLE THROUGH FORMULARY
Pack Size – 92ml bottle

SECTION B

Skin Barrier Preparations

Cavilon No Sting Barrier Film – 3M

Cavilon No Sting Barrier Film is the only terpolymer based alcohol-free barrier film, it is pain free on broken skin & provides up to 72 hours protection before re-application & is non - cytotoxic.

MODE OF ACTION

This forms a waterproof, breathable (non stinging) transparent protective coating on the skin to protect from friction, adhesive trauma and bodily fluids (such as urine and/or faeces and wound exudate.)

INDICATIONS

Protecting the skin from around stoma sites, periwound protection from exudate, damaged caused by rubbing and friction, protecting skin from adhesive tapes, dressings & appliances, protecting & treating red excoriated skin caused by incontinence.

CONTRAINDICATIONS

Not to be used on infected skin or in conjunction with any other topical medication, Keep away from eyes

METHOD OF USE

- Skin should be clean & dry prior to application.
- apply a uniform coating of the film over the entire treatment area
- when using spray bottle, hold nozzle 10-15cm away from skin, apply in an even coating over entire treatment area while moving the spray in a sweeping motion
- If applying to areas where there are skin folds or other areas of skin to skin contact ensure the skin contact areas are separated and allow coating to dry before returning skin to the normal position

FREQUENCY OF USE

Normally it should be reapplied every 48-72 hours (or every 2-3 day) however if applying to a more significant skin injury then re-apply more frequently (every 12-24 hours

If using around a wound or stoma then reapplication is needed after each adhesive dressing/stoma pouch change

3M PRODUCT CODE	DECRPTION	SIZE	PACK SIZE	NHS CODE	PIPCODE
3343E	FOAM APPLICATOR (STERILE)	1ml	25	ELY038	
3343P	FOAM APPLICATOR (STERILE)	1ml	5		252-8941
3345E	FOAM APPLICATOR (STERILE)	3ml	25	ELY190	
3345P	FOAM APPLICATOR (STERILE)	3ml	5		252-8958
3346P	SPRAY BOTTLE (PUMP ACTION)	28ml	12		252-8966

References
Guest JF, Taylor RR, Vowden P, Journal of wound car, 2012:21 (8) 389-98 Relative cost –effectivness of a skin protectaant in managing leg ulcers in the UK
Gray M, Beeckman D, Bliss D, FaderM, Logan S, et al JWOCN 2021:39 (1):61-74 Incontinence – associated dermatitis

BARRIER CREAM

CAVILON DURABLE BARRIER CREAM – 3M

A highly concentrated moisturising barrier cream for **intact skin** providing long lasting protection from bodily fluids.

MODE OF ACTION

INDICATIONS

- As a barrier against irritation from bodily fluids
- Protection of intact skin from damage associated with incontinence
- As a moisturiser for severely dry skin
- Does not clog incontinence pads and will allow medical adhesives to adhere to the skin
- Easily absorbed allowing essential monitoring of the skin

CONTRA- INDICATIONS

May increase the adherence of some adhesive products. Persons with fragile skin should avoid using the cream under adhesive products
Not to be used on infected areas of the skin - for example fungal infections.
Not to be used if there is a known allergic sensitivity to the ingredients.

METHOD OF USE

- Skin should be clean and dry prior to application of Cavilon barrier cream
- Apply Cavilon barrier cream sparingly (in pea sized amounts) to spread a thin layer over entire affected area.
- If the skin feels oily, too much has been applied.

FREQUENCY OF DRESSING CHANGES

- When incontinence is a problem, it should be re-applied after every third or fourth incontinent episode.
- When used to moisturise severely dry skin, apply daily or as needed

SIZES AVAILABLE THROUGH FORMULARY

Size	Product code	Comment
2g sachet – box of 20	3026	HOSPITAL USE
28g tube – single tube	**3027**	COMMUNITY USE
92g tube – single tube	**3028**	COMMUNITY USE

REFERENCES:

Bale S, Tebble N, Jones V, Price P. (2004) The benefits of implementing a new skin care protocol in nursing homes. Journal of Tissue Viability 2004; 14(2)44-50
Grove G Houser, T, Zerweck C (2010) Comparison of the effectiveness and wash-off resisatance of four dimethicone skin barrier creams. Poster presentation Clinical symposium on Advanced Wound Care.
Hart J, (2002) Assessment of the incontinence pad blocking potential of Cavilon DBC compared with Sudocrem and Zinc and Castor oil. Nursing Scotland 2002, Issue July/August

SECTION B

NATVNS *BEST PRACTICE IN THE PREVENTION, ASSESSMENT AND MANAGEMENT OF SKIN TEARS*

INTRODUCTION

Skin tears are viewed as an increasing problem by healthcare practitioners and if appropriate treatment is not given, these injuries may become chronic wounds with prolonged healing subsequently causing unnecessary pain and distress (Jones & Millman 1983). Traditional management of skin tears can cause new damage and slow down the healing process (Meuleneire, 2002). This type of injury usually occurs in immature skin (neonatal) and in the elderly. As our population changes and the number of elderly people increases, therefore whether we are caring for patients in their own home, a care home or hospital, we need to be aware of best practice in prevention, assessment and management of skin tears. This document summarises the current evidence.

INTERNATIONAL CONSENSUS

An international consensus panel have defined skin tears as "A skin tear is a traumatic wound caused by mechanical forces, including the removal of adhesives" (International skin Tears Advisory Panel ISTAP 2018). They most commonly occur at the extremes of age, in critically ill or medically compromised individuals and in those who require assistance with personal care (Carvell et al, 2007, Irving et al 2006, Belton 2008). Prevention of skin tears where possible should be our priority. When skin tears occur, accurate assessment and appropriate management will minimise further trauma and preserve viable tissue.

PREVALENCE OF SKIN TEARS

The evidence on prevalence and incidence of skin tears is limited and generally dated.

In long term care: **2.23-92%**, although estimates vary and may be lower (Strazzieri et al, 2017; LeBlanc, 2017; LeBlanc et al, 2013; Sanada et al, 2015; Skiveren et al, 2017; Woo et al, 2015)

In the community: **4.5-19.5%** in known wounds in all age groups (Carville and Lewin, 1998; LeBlanc et al, 2008)

In acute care: **6.2-11.1%** (Chang et al, 2016; Hsu and Chang, 2010; McErlean, 2004; Santamaria et al, 2009)

In palliative care: **3.3-14.3%** (Amaral et al, 2012; Maida et al, 2012)

In intensive care and operative theatres: prevalence is unknown

The work carried out in Australia led by Carville et al (2007) to state that skin tears are perceived to be common wounds and occur more frequently than pressure ulcers. To date there are no prevalence data available for the UK therefore the true extent of patients requiring hospital attendance or the resource impact or cost to the patient of the NHS due to skin tears is still not fully known.

AGE RELATED SKIN CHANGES ASSOCIATED WITH SKIN TEARS

Changes to the skin due to the ageing process make the skin more vulnerable.
These changes include:
Thinning of the epidermis (top layer of the skin) and dermis (middle layer of the skin)

Shrinkage of subcutaneous / fatty tissue (bottom layer of skin)

Small blood vessel walls widen, shrink and become disorganised

Decrease in collagen (natural protein component of the skin) amount and quality

Reduced sebum (natural lubricant) production

Pre-term and newborn infants have immature skin and are also vulnerable to skin tears.

OTHER FACTORS TO CONSIDER

Immunological status and malnutrition, circulation and oxygen intake may also impact on fragility of the skin (Meulenire, 2002.)

BEST PRACTICE IN PREVENTION OF SKIN TEARS

Prevention of skin tears starts with **early identification** of individuals who are at risk. Based on available evidence the consensus statement of an international panel suggests the following strategies should be part of prevention

1 Assess for risk upon admission to healthcare service and whenever the individuals condition changes and document in care plan
2 Implement a systematic prevention protocol (points 3-10)
3 Have individuals at risk wear long sleeves, long trousers or knee high socks
4 Provide shin guards/leg protectors for those individuals who experience repeat skin tears on shins
5 Ensure safe patient handling techniques and equipment/environment
6 Involve individuals and families in prevention strategies
7 Educate registered and non registered staff and care givers to ensure proper techniques for providing care without causing skin tears
8 Consult dietician to ensure adequate nutrition and hydration
9 Keep skin well lubricated by applying hypoallergenic moisturiser at least 2 times per day. Encourage the patient or their carers to apply emollient.
10 Protect individuals at high risk of trauma during routine care from self-injury LeBlanc & Baranoski (2011)

Stephen-Hayes & Carville (2011) also give practical advice on maintaining a safe environment to minimise the risk of skin tears which includes
Ensure adequate lighting and position small furniture (night tables, chairs) to avoid bumps or knocks. Remove rugs and excessive furniture.
Upholster or pad sharp borders of furniture or bed surroundings with padding and soft material
Use appropriate aids when transferring patients and adopt good manual handling techniques according to local policy

Never use bed sheets to move patients as this can contribute to damage by causing dragging effect on the skin. Always use lifting device or slide sheet
Where possible reduce or eliminate pressure, shear and friction using pressure

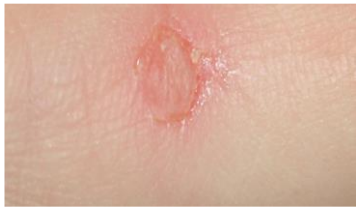
relieving devices and positioning techniques. Include these points where relevant in the patients care plan

BEST PRACTICE IN ASSESSMENT AND MANAGEMENT OF SKIN TEARS

The most important aspect of assessment and management is to minimise further trauma and preserve viable tissue.

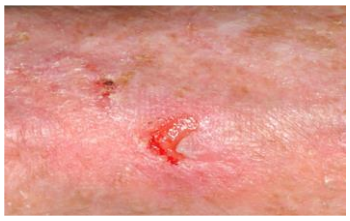
The most important aspect of assessment and management is to minimise further trauma and preserve viable tissue. It is important to classify the type of skin tear as this will determine the severity of the skin tear and aid in planning appropriate treatment. The International Skin Tears Advisory Panel (ISTAP) Classification System is a validated classification tool recommended by the National Association of Tissue Viability Nurse Specialists (Scotland) for use throughout Scotland.

TYPE 1 no skin loss



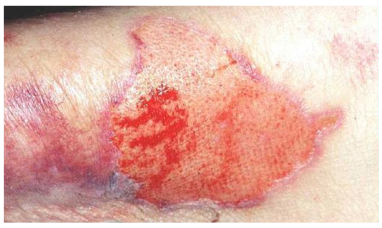
Linear or flap tear which **can** be repositioned to cover the wound bed

TYPE 2 partial flap loss



Partial flap loss which **cannot** be repositioned to cover the wound bed

TYPE 3 total flap loss



Total flap loss exposing entire wound bed.

RECOMMENDATIONS FOR MANAGEMENT OF SKIN TEARS

A skin tears / first aid trauma box containing an appropriate dressing should be available in the care setting. The following are the additional recommendations for management of skin tears:

Apply aseptic technique

Assess the wound and the skin flap and determine the category of skin tear using a validated documentation system (ISTAP)

Cleanse the skin tear following assessment using sterile saline or water at body temperature to remove debris and any residual haematoma

Manage infection / inflammation

Depending on healthcare setting, a tetanus immunoglobulin may be administered

Approximate the skin flap by gently easing the flap back into place using dampened cotton bud or gloved finger

If the skin flap is difficult to align, consider applying using a sterile moistened non-woven swab for 5-10 minutes first to rehydrate the skin flap

Encourage moist wound healing by applying a dressing such as soft silicone-based mesh or foam dressing, lipido-colloidal based mesh and foam dressing, calcium alginate, adsorbent clear acrylic and skin glue, hydrogel or gelling fibre

Avoid the use of adhesive strips. Sutures or staples are generally not recommended; however they may be required in the treatment of deep, full thickness skin tears

If possible, dressings should be left in place for several days to avoid disturbing the flap If an opaque dressing is used, mark an arrow to indicate the preferred direction of removal and record in notes Compression therapy should be considered if wound is on the lower leg. Before applying compression, a full leg assessment including vascular assessment e.g. ankle-brachial pressure index (ABPI) – should be carried out

Dressings should be held in place with stocking-like products (e.g. tubular viscose retention bandage) Pain assessment should be carried out and appropriate analgesia should be provided

Complete formal wound assessment form

Document in care plan, complete accident / incident documentation and where relevant

WHEN TO REFER

If the skin tear is extensive or associated with a full thickness injury, significant and or uncontrolled bleeding or haematoma formation, a surgical/plastic surgery review may be required (Stephens-Hayes & Carville, 2011).
If the skin tear is on the lower leg and fails to progress consider early referral to local leg ulcer clinic or vascular nurse specialist for leg ulcer assessment. Referral to Tissue viability specialists may also be indicated if the wound fails to progress to healing.

BEST PRACTICE IN ONGOING MANAGEMENT

At each dressing change the dressing should be gently removed in the direction indicated by the arrow. If it does not remove easily, consider the use of saline soaks or silicone-based adhesive removers Mudge & Orsted (2010). The wound flap may be friable so care should be taken to prevent disturbing it. The wound should be observed for signs of infection and any changes in the colour of the tissue of the flap which may indicate that it is becoming non-viable (Stephen-Hayes & Carville, 2011).

CONCLUSION

Skin tears are common wounds, particularly at the extremes of age. We should be aware of the risk factors associated with skin tears and where ever possible minimise risk to patients. When a patient develops a skin tear, the use of a skin tear classification system will aid our decision making, and ensure we are all using the same language to describe lesions. Treatment regimes should be structured on best available evidence.

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Beldon, P. (2008) Classifying and managing pretibial lacerations in older people. British Journal of Nursing Tissue Viability Supp, **17**; 11: S4 -S18 Carville C, Lewin G (1998) Caring in the community: a prevalence study. Prim Intent **6**:54-

Carville K, Smith JA (2004) Report on the effectiveness of comprehensive wound assessment and documentation in the community. Prim Intent **12**:41-48

International skin Tear Advisory Panel (2018) Best Practice Document – The prevention and management of skin tears in aged skin

Irving V, Bethell E, Burtin F (2006) Neonatal wound care: minimising pain and trauma. Wounds **2**;1:33-41

Jones P, Millman, A. (1983) Wound healing and the aged patient. Journal of Surgical Res **35:**1428.

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LeBlanc K, Baranoski S, Regan M (2011) Skin Tear Survey (unpublished data) Payne RL, Martin MC (1993) Defining and classifying skin tears:need for a common language. Ostomy and Wound Management **39**;5:16-26

Meuleneire F (2002) Using a soft silicone-coated net dressing to manage skin tears. Journal of Wound Care **11**;10

Malone ML, Rozario N, Gavinski M, Goodwin J (1991) The epidemiology of skin tears in the institutionalised elderly. J Am Geriat Soc **39**;6:591-595

O'Regan A (2002) Skin tears; a review of the literature. Wound Counc Enterostomal Ther J **22**;2:26-31

Sibbald RG, Krasner DL, Lutz JB, et al (2009) The SCALE Expert Panel: Skin Changes At Life's End. Final Consensus Document. October 1. Stephen-Hayes J, Carville K (2011) Skin tears Made Easy. Wounds International **2**;4. Available from http:/www.woundsinternational.com Voegell D (2010) Basic essentials: why elderly skin requires special treatment. Nurs Res Care **12**;9:422-429.

SKIN TEAR MANAGEMENT FLOWCHART

OBTAIN HISTORY AND CONSIDER CAUSE

ASSESS PAIN AND CONSIDER ANALGESIA

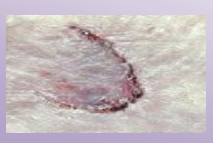
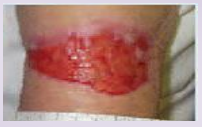
CHECK TETANUS STATUS

CONTROL ANY BLEEDING - REFER TO MEDICAL STAFF, GP, NHS24 IF ANY CONCERNS

ANY POSSIBILITY OF BONE INJURY THEN CONSIDER X-RAY

YES → REFER TO A&E OR RELEVANT SPECIALTY

NO → ASSESS USING ISTAP SKIN TEAR CLASSIFACTION

TYPE 1 NO SKIN LOSS	TYPE 2 PARTIAL SKIN LOSS	TYPE 3 TOTAL FLAP LOSS
		

SKIN TEAR FRAMEWORK

ASSESS - CLEANSE – APPROXIMATE WOUND EDGES (IF POSSIBLE)

APPLY SILICONE OR NON ADHERENT CONTACT LAYER (Atrauman) TO MAINTAIN APPROXIMATION
APPLY SECONDARY ABSORBENT LAYER IF REQUIRED, TUBULAR RETENTION STOCKINETTE AND WOOL AND CREPE BANDAGES OR SILICONE DRESSINGS FOR SMALL WOUNDS, MARK DRESSING FOR DIRECTION OF REMOVAL AGAINST DIRECTION OF SKIN FLAP. LEAVE DRESSING INPLACE FOR 5 DAYS

DOCUMENT ASSESSMENT AND MANAGEMENT OF WOUNDS ON A VALIDATED TOOL
PROVIDE PATIENT WITH INFORMATION/DOCUMENTATION OF CARE OF WOUND, DRESSING SUPPLIES, CORRESPONDENCE LETTER TO THE APPROPRIATE HEALTH CARE PROFESSIONAL OF CONTINUING CARE

IF AN INPATIENT OR RESIDENT – REPORT INCIDENT THROUGH FORMAL REPORTING SYSTEMS AND GAIN CONSENT AND INFORM NEXT OF KIN

AVOID ADHESIVE DRESSINGS, WOUND CLOSURE STRIPS, SUTURES AND IODINE BASED DRESSING

THIS FLOW CHART REFLECTS ON THE CONSERVATIVE MANAGEMENT OF SKIN TEARS, HOWEVER SOME SKIN TEARS (TYPE 3) MAY REQUIRE SPECIALIST MEDICAL/SURGICAL INTERVENTIONS (REVIEW OF ANTI-CLOTTING MEDICATION, DEBRIDEMENT OR SKIN GRAFTING) IF IN DOUBT PLEASE SEEK MEDICAL ADVICE

REF: NHS FORTH VALLEY - SKINTEAR GUIDELINES 2020

REF: Van Tiggelen H. (2018) International Skin Tear Advisory Panel (ISTAP)

VERSION 1 March 2022 – review March 2025

Section C

WOUND DRESSINGS

WOUND CONTACT LAYERS

ATRAUMAN - HARTMANN

MODE OF ACTION

A low adherent non-medicated knitted polyester dressing, impregnated with neutral triglycerides(vegetable based fatty acid) which prevents adherence to the wound bed. It does not contain vaseline or paraffins.

INDICATIONS

Primary dressing for use on dry or lightly exuding, superficial wounds such as lacerations or abrasions.
Wear time is dependent on condition of wound and level of exudate

CONTRA-INDICATIONS

Not suitable for heavily exuding wounds

METHOD OF USE

Apply directly to the wound surface, with a secondary dressing.
(Atrauman can be used as a secondary dressing over hydrogel, when attempting to de-slough wounds).

FREQUENCY OF USE

Dressings should be changed according to the nature and condition of the wound. Removal can be assisted by the use of warm saline/tap water.

SIZES AVAILABLE THROUGH FORMULARY

Sizes	Pack Size
5 cm x 5 cm	10
7.5 cm x 10 cm	10
10 cm x 20 cm	30

NB DRESSINGS REQUIRE TO BE STORED FLAT

References:

Burton F (2004)An evaluation of non-adherent wound contact layer for acute traumatic and surgical wounds . Journal of wound Care 13 (9); 371-3
Stephen-Haynes J (2009) the use of Atrauman non-adherent wound dressing in tissue viability. British Journal of Community Nursing, 14 (3).

SECTION C

WOUND DRESSINGS

PARAFFIN GAUZE DRESSING
JELONET – SMITH&NEPHEW

A sterile, semi-occlusive dressing consisting of a weave fabric of cotton and viscose impregnated with white soft paraffin. The dressing contains not less than 175g of paraffin base per square metre of cloth. Jelonet dressings are individually wrapped in aluminium peel pouches.

MODE OF ACTION
The dressing is used as a primary wound contact layer, the paraffin being present to reduce adherence of the dressing to the surface of the wound. Can also be used to keep hydrogel in-situ.

INDICATIONS
Used for treatment of minor abrasions/clean superficial wounds eg. partial thickness burns, skin grafts. Also used as a transfer medium for skin during grafting.

CONTRA-INDICATIONS
Not suitable for moderate or heavily exuding wounds.
Do not use in cavity wounds

METHOD OF USE
- Irrigate the wound with warmed normal saline/tap water.
- Open the aluminium peel pouch and remove the paraffin gauze dressing.
- Apply the dressing directly on to the surface of the wound.
- Several layers can be used to prevent dressing drying out and adhering to wound bed.
- Cover the paraffin gauze with a secondary non-adherent dressing and secure with tape or a bandage as appropriate.

FREQUENCY OF DRESSING CHANGES
Frequent changes are necessary to prevent drying out and incorporation in granulation tissue. There may be some adherence of the dressing to the wound due to the sticky nature of the paraffin. This should be removed from the wound by irrigation with warmed sterile normal saline before application of a new dressing.

SIZES AVAILABLE THROUGH FORMULARY

Size	Pack Size
10cm x 10cm	10

References

McIntosh CD, Thomson C E (2006) Honey dressing versus paraffin tulle gras following toe nail surgery. Journal of /wound Care 13 (3)

SECTION C

WOUND DRESSINGS

PASTE BANDAGE – VISCOPASTE – EVALON PHARMA

Paste bandages consist of an open weave cloth impregnated with zinc oxide paste. Single use packs.

MODE OF ACTION

Paste bandages act as a buffer between fragile inflamed skin and the turns of a compression bandage. Paste bandages provide a moist healing environment, absorb exudate and assist in separating thick slough from the wound. (Anderson, 1995)

INDICATIONS

Paste bandages are used in the treatment of leg ulcers, venous dermatitis and weeping atopic eczema. There are occasions where paste bandages may be recommended for other types of wounds and can be applied directly as a pad. Several types of paste bandage are available - the choice of bandage should be made by the prescriber and is dependent on the wound/skin condition. Can be used to occlude certain primary dressings onto a wound.

CONTRA-INDICATIONS

Occasionally patients are sensitive to the ingredients of paste bandages especially preservatives or lanolin.

BANDAGE SELECTION

Viscopaste PB7
10% zinc oxide

METHOD OF USE

- Apply from the base of the toes to below the knee, directly on to the Skin, without tension. No other primary dressing is required.
- The bandage should be pleated, and never completely encircling the leg, this allows for expansion should the leg swell
- A few extra layers over the ulcer promotes a warm, moist environment.
- Ensure the patient is aware of the need to report any signs of irritation or skin reaction.

FREQUENCY OF DRESSING CHANGES

May be left in situ for up to 7 days in the case of a leg ulcer or changed every two-three days in the treatment of skin conditions/superficial wounds.

SIZES AVAILABLE THROUGH FORMULARY

Single application packs of all the above 7.5cm x 6m
PGD for this product is available on the NHS Forth Valley Intranet

REFERENCES
Anderson I. (1995) Zinc as an aid to healing. Nursing Times 91(30): 68-70
Williams C(1999) Examining the range of medicated and paste bandages. British Journal of Nursing Vol 8, no 15 pp 1019-102

SECTION C

WOUND DRESSINGS

KLINIDERM SILICONE WOUND CONTACT LAYER – H&R HEALTHCARE

Kliniderm® silicone wound contact layer is a Gentle, transparent and flexible one-sided soft silicone contact layer with a porous structure that allows exudate to pass through easily into a secondary dressing. The dressing is non-adherent to the wound site, preventing skin stripping and discomfort during dressing changes

MODE OF ACTION

Kliniderm silicone wound contact layer creates a low adherence to healthy tissue surrounding a wound and not wound bed, to allow healing of blisters and other superficial wounds and skin tears. The perforations allow passage of exudate.

INDICATIONS

Skin tears, Diabetic foot ulcers, Pressure ulcers, Leg ulcers, First / second degree burns, Surgical wounds, Traumatic wounds. Can also be used as a protective layer on non-exuding wounds, on areas with fragile skin and with Negative Pressure Wound Therapy

METHOD OF USE

Clean the wound area according to local protocols. Ensure the peri-wound skin is dry. Select a suitable size so that the dressing overlaps the wound margins by at least 1cm. larger wounds may require more overlap. Gently apply directly onto the wound site, peel off the carrier film of the dressing and gently smooth down the wound edges to ensure good adhesion. Cover the contact layer with an appropriate secondary absorbent dressing such as Kliniderm superabsorbent or protective bandages if wound on a leg.

FREQUENCY

Kliniderm silicone wound contact layer Can be left in place for up to 14 days depending on the wound condition, Steroid creams, secondary dressings can be changed more frequently without disturbing the silicone dressing dressing.

CONTRA- INDICATIONS

Known sensitivity to the dressing.

SIZES AVAILABLE THROUGH FORMULARY

Sizes	Pack sizes	product code
5cmx7.5cm	10	40514880
7.5cm x 10cm	10	40514881
10cm x 18cm	10	40514882
20cm x 30cm	5	40514883

REFERENCES
King B, Barret S, Welch D (2021) A clinical evaluation of 21 patients using Kliniderm silicone wound contact layer. Wounds UK 17 (1)
Gardner S (2021) Evaluation of Kliniderm Silcone contact Layer on patient with T-Cell Lymphoma. Poster presentation

SECTION C

WOUND DRESSINGS

PRIMARY WOUND DRESSINGS

ALGINATE DRESSING- ACTIVHEAL - ALGINATE

Activheal™ Alginate (Alginate Dressing) is a **primary wound dressing from calcium sodium alginate**

MODE OF ACTION

Forms a soft, conformable gel when in contact with exudate. Conforming to the contours of the wound to provide a micro-environment that facilitates wound healing. Can be used for its Haemostatic properties to control minor bleeding

INDICATIONS

Activheal Alginate dressing may be applied to moderate to heavily exuding wounds like partial thickness burns, donor sites, leg, pressure, arterial, diabetic and venous stasis ulcers, post-surgical incisions, trauma wounds and most other granulating wounds. The Alginate rope dressing may be applied to moderate to heavily exuding cavity wounds. Activheal Alginate dressing may be used under compression. The Alginate displays natural haemostatic properties, controlling blood loss and helping to activate the platelet cascade thus allowing the wound to progress to the next stage of wound healing

CONTRA – INDICATIONS

Activheal Alginate dressing **should not** be used on dry or lightly exuding wounds or on patients with sensitivity to calcium alginate or with other known allergic skin conditions. Activheal Alginate dressing **should not** be used on heavily bleeding wounds.

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METHOD OF USE

1. Cleanse wound as required 2. Select a size of the dressing that is slightly larger than the wound. The Alginate rope dressing should be used in deep wounds. 3. dressing may be trimmed or folded to fit the wound size. 4. Apply the dressing to the wound surface, deep wounds should be loosely packed with the Alginate rope dressing, ensuring the dressing does not overlap the wound margin or surrounding skin. 5. Cover and secure the Actiheal Alginate dressing with a non-occlusive or semi-occlusive secondary dressing.

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FREQUENCY OF DRESSING CHANGES

Dressing changes should be dictated by the level of exudate or if there is any strike through to the outer dressing. Can remain in place for up to 7 days depending on wound conditions.

SIZES AVAILABLE THROUGH FORMULARY

Sizes	Pack Sizes	Product Code
5 x 5 cm	10	66076937
10 x 10cm	10	66076934
10cm x 20cm	10	66076935

References 1. IRVINS, N. (2019) A case series evaluating CovaWoundTM Alginate as a primary dressing for moderate to highly exuding wounds of differing aetiology in the lower limb. Poster presentation, Wounds UK, Harrogate, 2019. 2. SMTL test data available at www.covalon.co.uk and SMTL information available at http://www.smtl.co.uk/about-smtl-1.html, 2020. 3. AGARWALL, A. (2011) Polymeric materials for chronic wound and burn dressings. In: FARRAR, D. Advanced Wound Repair Therapies, 1st ed. Cambridge: Woodhead Publishing, p186-208. Available at www.sciencedirect.com/topics/chemistry/haemostatic, 2020. 4. Instructions for Use CovaWound™ Alginate, 2020

HYDROGEL

Activheal Hydrogel – Advanced Medical Solutions

- ActivHeal® Hydrogel is an amorphous gel with a high water content (> 80%), High viscosity that gently increases the moisture level within the wound, encouraging moist wound healing through autolytic debridement.

MODE OF ACTION

- **Debriding action**
  Activheal Hydrogel Gel rehydrates necrotic tissue and, by its gentle yet effective action, aids debridement.
- **Desloughing action**
  Activheal HydroGel loosens and absorbs slough and exudate without damaging fragile granulation tissue.
- **Creates a moist wound healing environment**
  Activheal Hyrogel increases moisture content at the wound surface, helping prevent eschar formation. By keeping fragile granulation tissue moist and allowing the migration of epithelialising cells, Activheal Hydrogell helps to create an optimal moist wound management environment. which facilitates healing and can be utilized during the entire healing process

INDICATIONS

Activheal Hydrogel is used to create a moist wound healing environment. For the treatment of pressure ulcers, leg ulcers, shallow cavity wounds, diabetic ulcers, graft and donor sites, post op surgical wounds, lacerations and abrasions.

CONTRA-INDICATIONS

Known sensitivity to Activheal HydroGel or any of its ingredients. The Gel should be used with care in the vicinity of the eyes and in deep wounds with narrow openings (e.g. fistulas) where removal of the gel may be difficult.

NB if using on wounds that are to receive Larvae Therapy – ensure FULL removal of the gel from the wound bed as it contains propylene glycol which can affect larvae viability or growth. (Thomas &Jones 1999)

METHOD OF USE

cleanse wound site, as appropriate.

To open the ActivHeal® Hydrogel tube, unscrew the white lid and discard the white ring by dropping the ring from the tube, ensuring it is away from the patient and their wound. Pierce the foil of the tube by screwing the white lid back onto the tube until the foil is completely pierced.

Apply the Hydrogel to the wound to a depth of 5mm. . ActivHeal® Hydrogel is extremely viscose and cohesive which ensures easy application. Ensure that the gel does not cover healthy skin, as this can cause maceration. ActivHeal® Hydrogel should be secured with an appropriate occlusive or semi occlusive secondary dressing.

FREQUENCY OF DRESSINGS CHANGE

The dressing should be changed every 2-3 days or as indicated by the clinical condition of the wound.

SIZES THROUGH FORMULARY

Sizes	Pack sizes	Product code
8 g	10	10011131

Dyson, M et al(1998) Comparison of the effects of moist and dry conditions on dermal repair. Journal of Investigative Dermatology 91:5, 435-439
Roberts A (2006) A retrospective review of two wounds debrided with Acivheal Hydrogel. Poster Presentation. The Great Western Hospital, Swindon
Thomas S Jones M (1999) The use of sterile maggots in Wound Management Ipswich Wound Care society

Winter, GD (1962) Formation of the scab and rate of epithelialisation of superficial wounds in the skin of a young domestic pig. Nature 193:

HYDROCLEAN ADVANCED DEBRIDEMENT DRESSING- HARTMANN

Hydro-Responsive Wound Dressing (HRWD) offering rapid wound debridement

MODE OF ACTION

HydroClean Advance provides physical autolytic debridement: with the attributes of autolytic debridement and the benefits of mechanical debridement. Hyro responsive wound dressing that cleanses, debrides, desloughs and absorbs

INDICATIONS FOR USE

For use on majority of acute and chronic wounds including leg ulcers (venous, arterial & mixed) diabetic foot ulcers, acute wounds, surgical wounds, burns, donor sites, malignant/fungating wounds, traumatic wounds (skin tears) and abrasions (road rash)

CONTRAINDICATIONS

None listed

Do not use Hydroclean on patients with intolerance to any of its components

METHOD OF USE

Easy to apply and remove because it is thin and light. The dressing can stay on the wound for up to 3 days (depending on wound condition) Secondary dressings are not always required. Heavily exuding wounds may be covered with superabsorbent pad in order to absorb exudate in excess. Flexible and fits perfectly to round body parts. Always place HydroClean advance with the label on top.

FREQUENCY OF DRESSING CHANGES

The dressing can stay on the wound for up to 3 days (depending on wound condition)

SIZES AVAILABLE THROUGH FORMULARY

DRESSING SIZES	PACK SIZES	HARTMANN CODE	PIP CODE
HYDRO CLEAN ADVANCE with silicone strips on wound side			
4cm round	10	609 662	401 1540
4cm x 8cm oval	10	609 664	418 6441
5.5cm round	10	609 666	401 1557
7.5cm x 7.5cm	10	609 668	401 1565
10cm x 10cm	10	609 672	401 1573
8cm x 14cm	10	609 674	418 6433
10cm x 17cm	10	609 676	418 6425
HYDROCLEAN ADVANCE CAVITY with 2 equal sides without silicone for gentle coverage of entire wound surface			
4cm round cavity	10	609 162	401 1581
4cm x 8cm oval cavity	10	609 164	418 6417
5.5cm round cavity	10	609 166	418 6409
7.5cm x 7.5cm cavity	10	609 168	401 1599
10cm x 10cm cavity	10	609 172	418 6391
3cm round cavity	10	609 609	401 5581

REFERENCES

Atkin L and Ousey K (2016) Wound bed preparation: A novel approach using Hydrotherapy. British Journal of Communiyt Nursing 21 (12)

Hodgson H et al (2017) A multicentre, clinical evaluation of a hydro-responsive wound dressing: the Glasgow experience. THE JOURNAL OF WOUND CARE 26 (11)

SECTION C – PRIMARY DRESSINGS CONTINUED

HYDROCOLLOID DRESSING- DUODERM EXTRA THIN- CONVATEC

A sterile, non-adherent polyurethane foam, bonded onto a polyurethane film, which acts as a carrier for the hydrocolloid base. It is an occlusive dressing which is impermeable to water, water vapour, oxygen and bacteria. Patient can therefore bathe with the dressing in-situ.

MODE OF ACTION

When the dressing comes into contact with wound exudate, the matrix of hydrocolloid particles absorb liquid and swell to form a gel at the wound interface. The moist environment created promotes removal of sloughy tissue and encourages granulation. The dressing also provides pain relief by keeping nerve endings moist.
The choice of dressing will depend upon type and characteristics of the wound on assessment.

1. Duoderm Extra-Thin

- Superficial wounds.
- Prevention of skin breakdown at pressure areas.

INDICATIONS

- Suitable for management of light to moderately exuding wounds.
- Removal of soft yellow slough
- Assisting in the removal of dry, black, necrotic tissue
- Treatment of granulating wounds

CONTRA-INDICATIONS

- Heavily infected wounds.
- Wounds containing small sinuses or tracts.
- Very heavily exuding wounds, at least initially, as the dressing will require frequent changing

METHOD OF USE

Irrigate the wound with warm tap water or sterile normal saline. Ensure the surrounding skin is dry. Lightly press the dressing into position over the wound. Allow a minimum overlap of 2-3cm from the wound margin, to ensure good adhesion to the surrounding skin. Smooth and mould the dressing into place.
Granuflex and Duoderm are adhesive and impermeable, no secondary dressing is required.

FREQUENCY OF DRESSING CHANGES

As the dressing interacts with the wound a gel forms. The gel is yellow and may resemble pus. It also has a characteristic odour, which may be confused with infection. The nurse and patient should be aware of this and should not be concerned as both should disappear on cleansing to reveal a healthy wound bed. The dressing should be changed when leakage occurs. Dressings can be left in place for up to 7 days, depending on exudate levels.

SIZES AVAILABLE THROUGH FORMULARY

DUODERM EXTRA THIN

Sizes	Pack sizes
10 x 10cm	10
15cm x 15cm	10

Sizes	Pack sizes
10 x 10cm	10
15 x 15 cm	10

ADDITIONAL SIZES ARE AVAILABLE ONLY FOR NURSE PRESCRIBERS IN THE COMMUNITY

Burgos A, Gómez MJ, García L et al. Cost, efficacy, efficiency and tolerability of collagenase ointment versus hydrocolloid occlusive dressing in the treatment of pressure ulcers: a comparative, randomised, multicentre study. Clin Drug Invest. 2000 May;19(5):357-365

Sieggreen MY, Kline RA. Arterial insufficiency and ulceration: diagnosis and treatment options. Adv Skin Wound Care: 2004 Jun;17(5):242-251

MEPORE - MOLNLYCKE

A low absorbent, Perforated, viscose non-woven gauze dressing with an adhesive border. It has low adherence, is permeable, flexible and conformable.

MODE OF ACTION
Consists of absorbent, low adherent pad with adhesive border.

INDICATIONS
Covering for very lightly exuding wounds such as surgical wounds, incisions, cuts and abrasions.

CONTRA-INDICATIONS
- **Known sensitivity to acrylic adhesives**
- **Burns.**
- **Exuding wounds**
- **Fragile skin.**
- **DO NOT USE ON SKIN TEARS TO HANDS/ARMS/LEGS – SEE SKIN TEAR SECTION**

METHOD OF USE
1. Remove overlapping films from adhesive border.
2. Position dressing on skin. Without stretching, gently smooth over skin.

FREQUENCY OF DRESSING CHANGES
On a post-operative wound, may be left in-situ for 3-4 days. Requires to be changed when any "strike-through" is visible on the dressing.

PLEASE NOTE

All adhesive dressings should be removed with care, to prevent trauma/skin stripping particularly when used on fragile oedematous skin. Consider using adhesive remover.

SIZES AVAILABLE THROUGH FORMULARY

Sizes	Pack sizes
7cm x 8cm	55
9cm x 20cm	30
9cm x 25cm	30
9cm x 30cm	30
9cm x 35cm	30
10cm x 11cm	40
11cm x 15 cm	40

ADDITIONAL SIZES ARE AVAILABLE FOR HOSPITAL USE ONLY

References: David Gray, Richard White, Fiona Russell, Pam Cooper (2002) Achieving Value for Money? Evaluation of two wound dressings. British Journal of Community Nursing 7(10) : 535 - 540

SECTION C – PRIMARY DRESSINGS CONTINUED

HYDROFIBRE DRESSINGS – SUPERFICIAL WOUNDS/NARROW CAVITY WOUNDS – URGO CLEAN PAD/ URGO CLEAN ROPE. URGO

LARGE DEEP CAVITY WOUNDS – SEE - AQUACEL EXTRA - CONVATEC

URGO CLEAN

A sterile, non-adherent, slough-trapping, poly-absorbent fibre dressing with the TLC healing matrix to promote wound healing and enable pain-free dressing changes. The slough trapping fibres (poly-absorbent) bind and trap the slough within the dressing, providing safe and effective desloughing. UrgoClean is available in a pad and a rope format.

UrgoClean® (Urgo Medical) is a dressing pad suitable for sloughy and exuding wounds. It consists of a pad or ribbon of polyacrylate non- woven fibres, with an acrylic core that absorbs exudate and entraps slough. By doing so creates a gel to maintain a moist wound healing environment

The pad can be used to debride superficial wounds, the rope can be used to pack narrow cavities.

UrgoClean Rope is a hydro-desloughing absorbent rope dressing comprising of **hydro-desloughing** polyacrylate fibres with an acrylic core. **UrgoClean Rope** is packaged with a sterile probe.

INDICATIONS

All non-infected sloughy, exuding wounds.

FOR LARGE AND DEEP CAVITIES SEE AQUACEL

CONTRA-INDICATIONS

Known sensitivity to any of the components of the dressing.
Dry or necrotic wounds

Sizes Available

Sizes	Pack Sizes
6cm x 6cm	
10cm x 10cm	
15cm x 15cm	
20cm x 15cm	
2.5cm x 40cm	

SECTION C – PRIMARY DRESSINGS CONTINUED

HYDROFIBRE DRESSING AQUACEL EXTRA - CONVATEC

MODE OF ACTION
It is a soft sterile non-woven pad or ribbon dressing, composed of hydrocolloid fibres. It is highly absorbent and absorbs fluid within the structure of its fibres. As exudate is absorbed it converts to a soft gel sheet, providing a moist wound healing environment. It maintains its integrity and doesn't disintegrate during handling, allowing easy, atraumatic removal.

INDICATIONS
Primary dressing for moderate to heavily exuding larger cavity wounds. Likelihood of skin maceration around the wound is reduced, due to the high absorbency of the product.

CONTRA INDICATIONS
Should not be used in patients with a known sensitivity to this product or its components.
If wound infection is present this dressing may be used, but with frequent evaluation.

METHOD OF USE
Should be placed directly on to the wound surface, overlapping the surrounding skin by 1cm
Cavity wounds should be loosely packed with the aquacel squares, layering if necessary. A secondary dressing should be applied to retain the dressing.

FREQUENCY OF DRESSING CHANGES
The absorptive properties are greater than alginates, allowing increased wear time and subsequently fewer dressing changes (Armstrong and Ruckley, 1997). Dressings may be left insitu up to 7 days, but requires more frequent changes if exudate is heavy.

SIZES AVAILABLE THROUGH FORMULARY

SIZES	PACK SIZES
5CM X 5CM	10
10CM X10CM	10
1cm x 45cm ROPE NB Aquacel only not available in the Extra	5

When prescribing, please ensure standard **Aquacel Extra** is selected and NOT Aquacel Ag Extra.

References

Armstrong S, Ruckley CV (1997) Use of a fibrous dressing in exuding leg ulcers. Journal of Wound Care. 6, (7): 322-4
Convatec wound care - Reference guide Nov 2000
Aquacell products information.
Fife C E, (2012) Aquacel Extra Hydrofibre dressing, A novel CMC Dressing. Poster Presentation. Ostomy Wound Management 1-9.

SECTION C CONTINUED – SECONDARY WOUND DRESSINGS

SEMI-PERMEABLE ADHESIVE FILM DRESSING
TEGADERM FILM – 3M HEALTHCARE

A semi-permeable adhesive sterile film consisting of a thin polyurethane membrane coated with a layer of acrylic adhesive. The dressing is transparent, hypoallergenic and waterproof.

MODE OF ACTION
Film dressings are permeable to water vapour and oxygen and thus allow the underlying skin to 'breathe'. They also produce a moist environment at the wound surface which enhances the rate of wound healing.

INDICATIONS
- Relatively shallow wounds e.g. graft donor sites, minor burns and abrasions and lacerations.
- As a protective cover over IV catheter sites
- As a semi occlusive dressing over topical anaesthetic cream to improve absorption.

CONTRA-INDICATIONS
Not recommended for:-
- deep cavity wounds
- third degree burns.
- wounds showing evidence of clinical infection
- moderate to heavily exuding wounds

METHOD OF USE
1. Irrigate the wound with warmed sterile normal saline. Ensure that the surrounding skin is dry.
2. Open the package and remove the sterile dressing. The film is enclosed between two liners – a printed sheet of paper on the adhesive surface and a more rigid thin card on the outer non-adhesive surface.
3. Remove and discard the central card on the non-adhesive surface. This provides a 'window' allowing precise placement of the dressing.
4. Peel the paper liner from the dressing exposing the adhesive surface.
5. Position the dressing over the wound. In order to ensure a good adhesion the dressing should be allowed to overlap 4-5cm from the margin of the wound onto the surrounding dry skin.
6. Remove the remaining card frame from the dressing and smooth down the dressing edges.

FREQUENCY OF DRESSING CHANGES
The wound site should be checked daily and the dressing changed if leakage occurs. In general, Tegaderm dressings should not be left in position for longer than 7 days.

SIZES AVAILABLE THROUGH FORMULARY

Sizes	Pack sizes
12cm x 12cm	10
6cm x 7cm	10
15cm x 20cm	10

References:
Akita S, Akino K, Imaizumi T et al (2006) a polyurethane dressing is beneficial for split thickness skin-graft donor wound healing. Burns 32 (4) 447-51Harle S, Korhonen A et al. (2005) A randomised clinical trial of two different wound dressing materials for hip replacement patients. Journal of Orthopaedic Nursing 9 :205-21

SECTION C – SECONDARY WOUND DRESSINGS

FOAM DRESSINGS
NON ADHESIVE – KLINIDERM FOAM H&R HEALTHCARE

Kliniderm® foam is a soft, flexible, polyurethane foam dressing with a waterproof film backing and is suitable for use under compression bandaging.

INDICATIONS

Non adhesive foam dressing indicated for moderate to heavily exuding chronic and acute wounds. Such as leg ulcers, surgical wounds , pressure ulcers. They require a secondary dressing to secure.

CONTRA-INDICATIONS

None known

METHOD OF USE

SELECT A SUITABLE SIZE SO THAT THE DRESSING OVERLAPS THE WOUND MARGINS BY AT LEAST 2CM. CUT THE DRESSING TO SIZE IF NECESSARY
Gently apply directly onto the wound site and press the adhesive border to secure dressing. If using the non-border or heel variant, ensure the dressing is applied to the wound with the pink side up and secure in place with an appropriate retention bandage or tape

Removal: to remove, gently peel back the dressing until its completely removed from the wound.

FREQUENCY OF DRESSING CHANGES

Determined by the condition of the wound – no longer than 7 days insitu

SIZES AVAILABLE THROUGH FORMULARY

Sizes	Pack Sizes
5cm x 5cm	10
10cm x 10cm	10
10cm x18cm	10
15cmx15cm	10
20cm x 20cm	10

References:
Barrret S, King B,Welch D (2021) A clnical evaluation of 25 patients using kliniderm foam. Wounds UK 17 (2)

SECTION C - WOUND DRESSINGS

KLINIDERM FOAM SILICONE BORDER – H&R HEALTHCARE

Gentle, conformable and comfortable Kliniderm foam silicone is a soft, conformable absorbent polyurethane foam dressing

MODE OF ACTION

The dressing has absorbent foam which absorbs fluid into the dressing and prevents the wound bed from drying out and surrounding skin becoming macerated. It has superabsorbent fibres which locks exudate into the dressing. There is a vapour permeable polyurethane film which acts as a barrier to fluid and microorganisms and the MVTR helps maintain optimal moisture balance and the silicone adhesive conforms gently to the skins surface and provides patients with a gentle and comfortable dressing change experience.

INDICATIONS

Suitable for low to moderately exuding wounds. Kliniderm foam silicone dressings are indicated for chronic and acute wound such as: Pressure ulcers, Diabetic foot ulcers, Leg ulcers, Post-operative wounds, Oncology wounds, Skin abrasions, Superficial and partial thickness burns, Donor sites, Traumatic wounds and Skin tears.

Especially useful in fragile, thin skin

CONTRA – INDICATIONS

Do not use on patients who have a known allergies to any components of this product. Not to be used on heavily exuding wounds

METHOD OF USE

Clean the wound area according to local protocols. Ensure the peri-wound skin is dry

Select a suitable size so that the dressing overlaps the wound margins by at least 2cm. Gently apply directly onto the wound site and press the adhesive border to secure the dressing
Removal: to remove, gently peel back the dressing until its completely removed from the wound.

FREQUENCY OF DRESSING CHANGE

Dependant on the level of exudate. Kliniderm foam silicone may be left in situ for up to 7 days. Monitor and review wound progress regularly.

SIZES AVAILABLE

DRESSING SIZES	PACK SIZES	PRODUCT CODE	PIP CODE	NHS CODE
7.5cm X 7.5cm	5	40514828	394-7231	ELA741
10cm X 10cm	5	40514829	394-7249	ELA742
12.5cm X 12.5cm	5	40514830	394-7256	ELA743
15cm X 15cm	5	40514831	394-7264	ELA744
10cm X 20cm	5	40514832	394-7272	ELA745
10cm X 30cm	5	40514833	404-7320	ELA907
15cm X20cm	5	40514834	394-7280	ELA746
22.5cm X 22.5cm	5	40514837	418-7530	ELA1361

sacral				

SECTION C – SECONDARY WOUND DRESSINGS

FOAM DRESSINGS - ADHESIVE

TEGADERM FOAM ADHESIVE – 3M HEALTHCARE

A highly absorbent breathable wound dressing, made from a conformable polyurethane foam pad, additional absorbent nonwoven layers, and a top layer of transparent adhesive film. For moderate to highly exuding wounds

MODE OF ACTION

When placed in contact with the wound, the polyurethane island absorbs exudate. The wicking layer transports moisture away from the wound bed and peri- wound skin and allows evaporation through the permeable backing of the dressing.
Quickly absorbs exudate and prevents pooling and leakage onto surrounding skin, avoiding maceration. The dressings conform well to skin contours and is not easily dislodged. It's formulated to adapt to changing levels of exudate – high breathability when the wound is highly exuding and low breathability when the wound is dry.

INDICATIONS

Low to highly exuding partial and full thickness wounds such as pressure ulcers, leg ulcers, skin tears and abrasions, first and second degree burns, donor sites, neuropathic ulcers.
Can be used as a primary or secondary dressing as necessary.

CONTRA-INDICATIONS

Not for use if patient is allergic to any ingredients. Dry necrotic wounds
Clinically infected wounds, although can be used as a secondary dressing.

METHOD OF USE

Ensure the surrounding skin is dry. Remove the backing paper to expose the adhesive border. Holding the two end tabs, centre over the wound area and apply the dressing over the wound. It is important to ensure that the wound is completely covered by the central island of the dressing and that there is good adhesion to the surrounding skin by gently pressing into place. Beginning at the centre, peel away the "spoke "system paper applicators outwards whilst gently pressing down the film border.
There is no need to apply a secondary dressing.

FREQUENCY OF DRESSING CHANGES

May stay in place for up to 7 days depending on amount of exudate.
To remove use the stretch and release technique by gently stretching the adhesive border away from the centre of the dressing. This releases the adhesion and aids atraumatic removal. If there is difficulty lifting the edge of the dressing, apply tape to the edge and use this tape to lift the edge.
Care is required when removing the dressing especially the adhesive border. If removal is difficult the dressing may require irrigation or soaking with warm tap water to assist removal and avoid trauma.

PLEASE NOTE

All adhesive dressings should be removed with care, to prevent trauma/skin stripping particularly when used on fragile oedematous skin

Sizes Available Through Formulary

Available Sizes	Pack Size	Product Code
8.8X8.8CM - OVAL	10	90610 AVAILABLE IN ACUTE HOSPITAL ONLY
10X11CM - OVAL	10	90611
14X14CM - SQUARE	10	90612
14X15CM - OVAL	10	90613
19X22.2CM - OVAL	5	90616

References:
Gray D, Cooper P, Russell F, Stringfellow S (2011) 3M™ Tegaderm™ HP Foam Adhesive Dressing: a case report series. Wounds UK 7 (3).

Zehrer C, Holm D, Solfest S, Walters SA. 2014. A comparison of the in vitro moisture vapour transmission rate and in vivo fluid-handling capacity of six adhesive foam dressings to a newly reformulated adhesive foam dressing. International Wound Journal 2014. Volume 11, Issue 6, 681–690.

Peach V. Evaluating adhesive foam wound care dressings in clinical practice. 2012. Vol 8, No 3 53

AQUACEL FOAM ADHESIVE DRESSING - CONVATEC

This dressing is a combination of an Aquacel contact layer with a gentle silicone border. It comprises a protective top layer, an upper soft absorbent foam pad and an integral hydrofiber wound contact layer with a silicone border. The dressing is shower proof.

MODE OF ACTION

It can be used alone to manage shallow exuding wounds and for wounds of any depth used in conjunction with other primary dressings. It provides a moist wound environment, locks in wound exudates, microcontours to the wound bed and the silicone layer helps to reduce pain on removal of dressing. The aquacel layer absorbs wound fluid and creates a soft gel, maintaining a moist wound environment. Locks in exudates through vertically wicking, reducing the risk of maceration.

INDICATIONS

Aquacel foam is suitable for a wide range of acute and chronic wounds producing high exudate, regardless of the tissue within the wound bed. Suitable for all exuding wounds.
AQUACEL® Foam dressing is a more cost effective alternative to the combination of AQUACEL® Extra™ and an alternative foam dressing
Aquacel foam dressing should not be used as an alternative to a simple foam dressing when this will suffice.

CONTRA – INDICATIONS

Not for use if patient is allergic to any of the ingredients.
Not for use on dehydrated or dry necrotic wounds

FREQUENCY OF DRESSING CHANGE

Maximum recommended wear time is 7 days but should be changed as determined by the wound exudate**.**
NB if dressing requires changing every day then an alternative dressing requires to be considered.

SIZES AVAILABLE THROUGH FORMULARY

Size	Pack size	Product Code
8x 8cm	10	420804
10 x10cm	10	420680
12.5x12.5cm	10	420619
10cmx20cm	10	421150

References
Bishop, S*, Helen S,; David P et al (2012) A Comparison of the *in vitro*Bio-Physical PerformanceCharacteristics of SiliconeFoam **Dress**ings Used in Wound Management
Global clinical Case Study compendium (2012) clinical and quality of life benefits from next generation foam dressings – aquacel Foam

SECTION C – ODOUR ABSORBING DRESSINGS

ACTISORB SILVER 220 - SYSTAGENIX

An activated charcoal dressing impregnated with silver.

MODE OF ACTION

Charcoal attracts and traps bacteria and odour within the dressing.
The silver component has antimicrobial properties which kill bacteria.

INDICATIONS

- Malodourous wounds
- Infected wounds (useful in managing MRSA)
- Fungating lesions
- Superficial or deep cavity wounds
- Effective in wet or dry wound conditions

CONTRA-INDICATIONS

No known side effects.

METHOD OF USE

- May be applied directly to the wound surface with secondary dressing
- Gently packed into cavity wound
- Secondary dressing to absorb malodour

FREQUENCY OF DRESSING CHANGES

Initially may require changing daily. Can remain in situ for 3-7 days, with secondary dressing changed as required.

SIZES AVAILABLE THROUGH FORMULARY

Sizes	Pack size
10.5cm x 10.5cm	10

ADDITIONAL SIZES AVAILABLE ONLY FOR NURSE PRESCRIBER IN THE COMMUNITY

6.5 x 9.5 cm
10.5 x 19 cm

White r (2001) A charcoal dressing with silver in wound Infection: clinical evidence. British Journal of Community Nursing 6 (supp 3): 4-11

International Case Series (2012) Using Actisorb silver Case Studies. London. Wounds International.

White R (2013) Wound Malodour and the role of Actisorb Silver 220. Wounds UK 9 (1) 101-104

SECTION C – DRESSINGS
ODOUR ABSORBING DRESSINGS

CARBOFLEX – CONVATEC

CarboFlex® dressing is a sterile, non-adhesive dressing indicated as a primary dressing for shallow wounds or as a secondary dressing over a wound filler for deeper wounds.

MODE OF ACTION
It is a five layer dressing specifically designed to address the management problems associated with malodorous wounds, combining an absorbent wound contact layer, an activated charcoal central pad and a smooth water-resistant top layer.

INDICATIONS

CarboFlex dressing is indicated for the management of malodorous wounds.
• Chronic wounds: leg ulcers, pressure sores, diabetic ulcers and fungating lesions
• Acute wounds: lacerations and post-surgical wounds

CONTRA-INDICATIONS

Not to be used on patients with known sensitivity to the dressing or its components.

METHOD OF USE

Carefully cleanse the wound with saline and dry surrounding skin. Choose a dressing size that is large enough to overlap the wound edge by at least 3cm. For shallow wounds, CarboFlex® dressing can be used as a primary dressing. For deeper wounds, CarboFlex® dressing may be used as a secondary dressing over a suitable cavity filler. Place the fibrous (non-shiny) surface of the dressing directly onto the wound or over the cavity filler. The absorbent wound contact layer will form a soft gel when in contact with wound exudate. For wounds with very heavy levels of exudate, use an appropriate absorptive dressing such as AQUACEL® dressing as a primary dressing (either ribbon for cavities or a sheet for shallow wounds) and CarboFlex® dressing as a secondary dressing. CarboFlex® dressing can be secured in place with tape or other appropriate material.

FREQUENCY OF DRESSING CHANGES

As required dependant on strike through of exudate

SIZES AVAILABLE THROUGH FORMULARY

10cm x 10cm
15cm x 20cm
8cm x 15cm (oval)

1. Griffiths B et al Determination of malodour reduction performance in various charcoal containing dressings. Data on file, ConvaTec.
2. Walmsley R, Waring M. An investigation into the fluid handling characteristics of the wound contact layers of several odour absorbing dressings. Data on file, ConvaTec.

3. Williams, C.(2001) Role of Carboflex in the Nursing Management of Wound Odor. British Journal of Nursing 2001 vol 10 no. 2.

SECTION C – DRESSINGS

SUPER ABSORBENT DRESSING - NON ADHESIVE WITH BACKING
1ST KLINIDERM SUPERABSORBENT – H&R HEALTHCARE

MODE OF ACTION

A highly absorbent, 4 layered pad, with a hydrophilic wound contact layer, an intermediate layer, and absorbent core and a fluid repellent backing layer. Specifically developed for the management of heavily exudating wounds.

It has the ability to hold exudates within its core to help prevent transfer of fluid back onto periwound skin

INDICATIONS FOR USE

Kliniderm Superabsorbent Dressing is useful in the management of moderate to highly exuding chronic and acute wounds, where the goal of therapy is to manage the exudate efficiently.

It is a low profile dressing which can also be used under compression bandaging, as it traps wound exudate within the absorbent layers.

CONTRA- INDICATIONS

Not indicated for use on patients with a known sensitivity to any of the dressing components**.** Do not cut or tear dressing. Not to be used on dry or lightly exuding wounds, as a treatment for arterial bleeding or heavy bleeding wounds, in cavity wounds, surgical implantation or third-degree burns.

METHOD OF USE

Superabsorbent dressing which can be used as either Primary or Secondary dressing Select a suitable size so that the dressing overlaps the wound margins by at least 1.5cm

Gently apply directly onto the wound site with the white hydrophilic side of the dressing onto the wound surface

Secure with an appropriate secondary dressing, such as bandage or tape

SIZES AVAILABLE THROUGH FORMULARY

Sizes	Pack sizes
10cm X 10cm	10
10cm X 20cm	10
20cm x 20cm	10
20cm x 30cm	10
20cm x 40cm	10
60cm x 70cm	10

REFERENCES:

Barret S (2015) Cost Effective Management of Wound Exudate. Wound Essentials 10 (1)

SECTION C – DRESSINGS

2ND – KERRAMAX CARE – 3M

Product description:
KerraMax Care® is a super-absorbent heavy exudate dressing, suitable for many wound types, that helps to improve wound healing.
Use if the wound requires a superabsorbent without a backing

Indications for use:

Effective at reducing proteases.
Can be used as a primary or secondary dressing.
Stackable to increase absorption for very wet wounds.
Suitable for use under all forms of compression.
Maintains integrity, even when fully soaked in exudate.
Recommended for use under compression due to the low profile of the dressing.

Contraindications:
Do not use on low exuding wounds as it may adhere.
Precautions:
Care with removal on low exuding wounds.

Product type:
Superabsorbent dressing. Exudate and proteases are bound inside the dressing with no leakage.

Product function:
Primary and secondary dressing
Epithelialisation
Exudate management
Can be used under compression

Size	Dressings per box	PIP code	NHS Cat Number
5 x 5cm	10	398-0778	EME120
10 x 10cm	10	352-3446	EME045
10 x 22cm	10	342-3308	EME023
20 x 22cm	10	342-3290	EME024
20 x 30cm	5	352-3453	EME025
20 x 50cm	5	398-0786	EME121

References:
* University of Liverpool, Dr C.A.Cochrane, Evaluation of Matrix Metalloproteinases by Woundcare Product KerraMax Care.
An in vitro comparison of MRSA and P. aeruginosa sequestration by 5 super-absorbent wound dressings. Thomas, H & Westgate, S.J. Perfectus Biomed, EWMA Poster Presentation 2016.
Jones J and Barraud J (2014) An evaluation of Kerramx Care in the management of moderate to heavily exuding wounds. BJCN 19 (3) S48

SECTION C – DRESSINGS

KERRAMAX CARE ADHESIVE BORDER – 3M

Product description:
KerraMax Care® Border Dressing is a super-absorbent heavy exudate dressing, suitable for many wound types, that helps to improve wound healing.

INDICATIONS FOR USE
Effective at reducing proteases.
Can be used as a primary or secondary dressing.
Stackable to increase absorption for very wet wounds.
Suitable for use under all forms of compression.
Maintains integrity, even when fully soaked in exudate.
Recommended for use under compression due to the low profile of the dressing.

Contraindications:
Do not use on low exuding wounds as it may adhere.
Precautions:
Care with removal on low exuding wounds.

Product type:
Superabsorbent dressing. Exudate and proteases are bound inside the dressing with no leakage.

Product function:
Primary and secondary dressing
Epithelialisation
Exudate management
Can be used under compression

Size	Dressings per box	PIP code	NHS Cat Number
5 x 5cm	10	398-0778	EME120
10 x 10cm	10	352-3446	EME045
10 x 22cm	10	342-3308	EME023
20 x 22cm	10	342-3290	EME024
20 x 30cm	5	352-3453	EME025
20 x 50cm	5	398-0786	EME121

References:
* University of Liverpool, Dr C.A.Cochrane, Evaluation of Matrix Metalloproteinases by Woundcare Product KerraMax Care.
An in vitro comparison of MRSA and P. aeruginosa sequestration by 5 super-absorbent wound dressings. Thomas, H & Westgate, S.J. Perfectus Biomed, EWMA Poster Presentation 2016.
Jones J and Barraud J (2014) An evaluation of Kerramx Care in the management of moderate to heavily exuding wounds. BJCN 19 (3) S48

SECTION D

ANTIMICROBIAL WOUND DRESSINGS – 2 WEEKS USE THEN REASSESS

WOUND INFECTION

Infection may be defined as the invasion of living tissue by micro-organisms. The number of micro-organisms and their degree of pathogenicity determine the establishment of infection.
Infection delays healing. Nosocomial (hospital-acquired) infections are associated with virulent organisms and are a great cause for concern. Misuse or overuse of antibiotics leads to resistance of these and to the emergence of new bacterial strains (Bale, Harding & Leaper 2000).
Host defences usually resist all but the most pathogenic organisms but such defences are often depressed by systemic factors such as shock, immunosuppression, poor nutrition, and local factors such as ischaemia, trauma or implantation of foreign material. Rodeheaver (2001) stated that the single most important parameter to reduce the level of bacterial contamination in the chronic wound is the removal of devitalised tissue.
A major concept that has emerged is the need for strong initial combination treatment (i.e., the most effective debridement technique in conjunction with the most effective antibiofilm treatment) to rapidly and effectively reduce biofilm levels within wounds, and subsequently reduce inflammation, reactive oxygen species, and protease activities. The result will be more rapid healing of wounds, which reduces cost, as well as risk of amputation, and could lead to improved patient quality of life. (Shultz et al 2017)

This may be carried out by:

- Surgical debridement which is fast and effective but may be complicated by local pain
- Autolytic debridement using moist interactive dressings which liquefy slough and simultaneously promote granulation tissue. This process may be slow to achieve debridement.
- Biosurgical debridement, which uses sterile larvae to breakdown and remove dead tissue.

This is a fairly fast, effective method of debridement but may not be accepted by some patients (see specialist product section).

BACTERIAL COLONISATION

The mere presence of bacteria does not always indicate that a wound is infected. All chronic wounds are colonised with bacteria, usually of more than one species, and often in very large numbers (Hutchinson 1992). When healing progresses normally, these wound inhabitants rarely attract attention.

- Many patients who have chronic wounds which are colonised by bacteria progress to complete healing without any setbacks
- Some colonised wounds may become 'indolent' (where there is delayed healing) although there is no visible deterioration
- Over-use of systemic antibiotics has resulted in resistance and this has prompted a return to the debate of using topical antiseptics. Iodine and silver in their contemporary formats appear to be of clinical benefit particularly where there is heavy or 'critical' colonisation and delayed healing (White *et al.* 2001).

Critical colonisation refers to the point where a wound is unable to maintain a balance between the number of microbes and the defence systems available (White *et al.* 2001). Kingsley (2001) incorporates this notion into a wound infection continuum, extending from sterility to infection.

Sterility
↓
Contamination
↓
Colonisation
↓
Infection

At the point of critical colonisation, a wound may not show the multiple classical signs of infection but may cease to heal and become recalcitrant or indolent. For the observer to differentiate between contamination, colonisation and critical colonisation is almost impossible as there are often no visible clues.
Due to the overuse and resistance problems of systemic antibiotics, researchers have been prompted to revisit the use of antiseptics. The antibacterial action of silver and its effect on indolent wounds and burns have been established (Demling & De Santi 2001; White & Cooper 2003). For cadexomer iodine, the consensus is in favour of its use in non-healing and infected chronic wounds (Gilchrist1997; White & Cooper 2003). Once the infection or critical colonisation is reduced and the wound shows signs of healing, the dressing should be changed for one which does not have antimicrobial properties and is appropriate to the wound type.

Clinical infection is determined by whether the bacteria cause a 'host reaction' or not. The current standard infection criteria for wound infection suggested by Cutting and Harding (1994) are:

- Abscess
- Cellulitis
- Discharge
- Delayed healing
- Discolouration
- Friable, bleeding granulation tissue
- Unexpected pain/tenderness
- Pocketing/bridging at the base of the wound
- Abnormal smell
- Wound breakdown.

The above criteria have been supported by Gardner *et al.* (2001), who found increasing pain and wound breakdown to be the most sensitive indicators of wound infection.

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Resources to Guide the Management of Suspected Infection in Chronic Wounds

NHS SCOTLAND

Health Improvement Scotland published their 13th Health Technology Assessment (HTA 13) in December 2015 entitled, Antimicrobial Wound Dressings (AWDs) for Chronic Wounds. This report found that the evidence to support the use of AWDs was insufficient in terms of quality and quantity. This identified the need for a nationally agreed management algorithm to guide the use of AWDs in NHS Scotland. The Effective Prescribing and Therapeutics Branch, at Scottish Government supported the formation of a multidisciplinary short life working group (SLWG) consisting of wound specialists, podiatrists and Prescribing Advisors from across Scottish Health Boards. The group developed the following resources using best practice and expert consensus.

These resources are provided for Boards to review, as necessary, to fit with their local guidance, e.g. sepsis screening tool, local formularies for dressings and antibiotics. These resources aim to standardise a clinician's approach to wound care, reduce variance in practice, and reduce any inappropriate use of antimicrobial dressings.

Appendices:
1. Algorithm for Assessment and Management of Chronic Wounds
2. Scottish Ropper Ladder for Infected Wounds
3. AWD considerations to support best practice
4. PIL: Understanding your Chronic Wound

Algorithm for Assessment and Management of Chronic Wounds signposts to current guidance on the management of different wound types and gives advice on important considerations to be made when providing wound care. This algorithm should be used alongside any local guidance.

Scottish Ropper Ladder for Infected Wounds should be used when wound infection is suspected. The key points from HTA 13 and the SLWG are:

- Antimicrobial dressings are indicated for the short term treatment of localised infection; and in combination with systemic antibiotics for the treatment of spreading or systemic infection
- Antimicrobial dressings should not be used to heal wounds or where symptoms of infection are not present
- Where antimicrobial dressings are used, they should be reviewed after two weeks and should not normally be used longer than recommended by local policies or product information.

AWD considerations to support best practice has been developed as a decision making tool. All AWD on Scottish formularies have been included, and it is intended that NHS Boards will complete the blank template in line with their local formulary. The table should guide users to the most appropriate AWD based on the characteristics of the wound they are treating. Cost should be considered alongside patient and wound-specific factors to ensure a cost effective treatment course is selected.

Understanding Your Chronic Wound Patient Information Leaflet has been developed to provide information to patients about how they can expect their wound to be managed and information about wound infection.

Appendix 1

Algorithm for Assessment and Management of Chronic Wounds (adult)

A holistic assessment and application of best practice will support improved outcomes for patients.

Key - Process → Guidance ⇢ * refer to local guidance and pathways

1) Identify type of wound:
Diabetic Foot Ulcer
refer to diabetic podiatry/MDT

⇢ SIGN 116 - Management of Diabetes (Revised 2014)
International Consensus
Diabetic foot problems: prevention and management, NICE guidelines [NG19] (2015)

↓

Venous Leg Ulcer

⇢ SIGN 120 - Management of Chronic Venous Leg Ulcers (August 2010)
Best Practice Statement: Holistic Management of Venous Leg Ulceration (2016)

↓

Pressure Ulcers

⇢ Best Practice Statement (March 2009) Prevention and Management of Pressure Ulcers
Pressure Ulcer Prevention and Management Standards (September 2016)

↓

All other wounds

↓

2) Holistic Assessment
- Patient: co-morbidities
- Wound: exudate, viscosity
- Consider other aetiology.

⇢ General Wound Assessment Chart
Scottish Wound Assessment and Action Guide (SWAAG)
Local guidelines/pathways

↓

3) Identify if non-viable tissue present:
- Reduces effectiveness of topical agents
- Increases signs of inflammation, odour and infection.

⇢ Effective Debridement in a Changing NHS, Wounds UK (2013)

→ Yes

Consider blood supply to wound
Is it suitable for debridement?

Yes		No
Debridement Options*:		**Don't debride**
Autolytic	Mechanical	Keep dry
Larvae	Enzymatic	Refer to vascular or other relevant specialist service*
Sharp	Surgical	

↓ No

4) Identify if infection present
Using Scottish Ropper Ladder for Infected Wounds (see appendix 2)

↓

5) Choose dressing, cleansing and treatment options- based on holistic assessment above

⇢ **Refer to:**
Local wound formulary

↓

6) Formal review of patient and wound at regular intervals
Minimum of every two weeks*

→ **Healed** → Monitor and prevention strategies

→ **Not healed** → **Return to 2) Holistic assessment**
If no signs of healing after 6 weeks refer to relevant specialist service*

Resource developed by SLWG for Antimicrobial Wound Dressings consisting of Health board and speciality representatives.
1st Edition: September 2017; Review: September 2020

Medical Photography Service, NHS Lothian, October 2017

NHS SCOTLAND

Appendix 2

Scottish Ropper Ladder for Infected Wounds

Guidelines for identifying infected wounds and when to start and stop using topical Antimicrobial Wound Dressings (AWD)

NHS SCOTLAND

Each stage builds on the previous signs noted	Each stage builds on the previous treatment *Refer to local guidance
Stage 4 - when 1 or more signs of systemic infection present: May lead to sepsis if not treated • Spreading cellulitis • Pus/abscess • Patient systemically unwell • Pyrexia • Raised white cell count/CRP • Wound breakdown+/-satellite lesions.	**Stage 4 - Treatment** 1 Swab wound*. 2 Consider: SEPSIS 6*; other source; blood cultures. 3 Start systemic antibiotics* and monitor patient. 4 If rapid deterioration immediate referral for urgent medical advice. 5 Consider topical AWD*. 6 Monitor wound progress*, review at 2 weeks – see Stage 2, point 4, for actions.
Stage 3 - When 2 or more signs of spreading infection present: Wound deteriorating • Localised cellulitis/erythema • Pain increasing • Exudate: thick, haemopurulent or purulent • Localised oedema • Malodour increasing.	**Stage 3 - Treatment** 1 Swab wound*. 2 Start topical AWD*. 3 Consider starting systemic antibiotics*. 4 Monitor wound progress*, review at 2 weeks – see Stage 2, point 4, for actions. 5 *If signs of systemic infection, go to Stage 4.*
Stage 2 - when 2 or more signs of local infection present: Healing not progressing normally • Exudate - high volumes • Malodour • Pain in or around wound • Hypergranulation tissue • Discoloured or bleeding granulation tissue • Slough/necrosis.	**Stage 2 - Treatment** 1 DO NOT SWAB. 2 Consider biofilm disrupting cleansing solution. 3 Consider topical AWD*. 4 Monitor wound progress*, review at 2 weeks: a 'If no signs of infection, STOP and return to Stage 1, point 4 for actions b If improving, continue and review weekly until no signs of infection c If static, review AWD* choice. 5 *If signs of spreading infection, go to Stage 3.*
Stage 1 - when 2 or more signs of Contamination/ Colonisation present Healing progressing normally • Exudate - low to moderate volume • Pain - minimal • Odour - minimal • Slough/necrosis.	**Stage 1 - Treatment** 1 DO NOT SWAB. 2 Identify aetiology of the wound and refer if any concerns e.g. vascular, lymphoedema. 3 Refer all diabetic wounds to diabetic podiatry/MDT. 4 Optimise wound healing with debridement and dressings*. 5 If no progress after 2 weeks review wound management plan. 6 *If signs of local infection go to Stage 2.*
START	

In certain patients, some signs and symptoms of infection might be masked e.g. diabetes, vascular, immunocompromised. Clinical judgement should be used to determine when AWDs should be used.

References:

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Wounds UK Best Practice Statement. The use of topical antimicrobial agents in wound management. London: Wounds UK, 2013 (3rd Ed)

European Wound Management Association (EWMA). Position Document: Management of wound infection. London: MEP Ltd 2006

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Care of deteriorating patients. Edinburgh: SIGN; 2014.

Ruth Ropper

SECTION D WOUND INFECTION- ANTIMICROBIAL DRESSINGS

Alginate – Aquafibre Ag – ACTIVHEAL (use if a haemostat dressing is required in an infected wound)

ActivHeal Aquafiber® Ag Antimicrobial wound dressing is a sterile, non-woven pad consisting of a high M (mannuronic acid) calcium alginate and carboxymethylcellulose (CMC).

MODE OF ACTION

Silver ions are released in the presence of wound fluid. As fluid is absorbed, the alginate forms a soft gel which assists in maintaining a moist environment for optimum wound healing and allows intact removal. Silver ions released in the presence of wound exudate are an effective antimicrobial agent for up to 7 days, based on in-vitro testing, against a broad spectrum of microorganisms frequently associated with bacterial colonisation and infection of wounds.

INDICATIONS

For use in a variety of moderate to heavily exuding wounds that are infected – useful if wounds are infected and bleeding

CONTRA - INDICATIONS

Dry or lightly exuding wounds. Do not use on individuals with a known sensitivity to alginates or silver. To control heavy bleeding

FREQUENCY OF DRESSING CHANGES

Can be left in place for up to 7 days but may require changing more frequently depending on volume of wound exudate

SIZES AVAILABLE THROUGH FORMULARY

5CM X 5CM BOX OF 5, 10CM X 10CM BOX OF 10, 15CM X 15CM BOX OF 5

References
Welch D et al (2017) A Clinical Evaluation of the effect of Activheal Aquafibre Ag Dressing. Wounds UK 13 (4)

SECTION D WOUND INFECTION-ANTIMICROBIAL DRESSINGS

AQUACEL AG + EXTRA - CONVATEC

MODE OF ACTION
Similar mode of action to Aquacel outlined above.
In addition when the sodium ions from wound exudate come in contact with the dressing, the silver ions are released from the NacCMC to exert a sustained antimicrobial effect against a wide range of organisms including methicillin-resistant and Staphylococcus aureus (MRSA) and vancomycin-resistant enteroccocus (VRA), thus preventing colonisation of the dressing and providing an antimicrobial barrier to protect the wound.
The addition of the + technology is aimed at disrupting biofilm. Biofilm protects the bacteria, and by breaking down the protective slime, the antimicrobial effect of the ionic silver is exerted more quickly and more efficiently.

INDICATIONS
Primary dressing for moderate to heavily exuding wounds. Suitable for pressure ulcers, leg ulcers, lacerations and burns. Likelihood of skin maceration around the wound is reduced, due to the high absorbency of the product. Aquacel facilitates the control of minor bleeding. The ribbon is suitable for cavities, fistulae and sinus tracts.

CONTRA-INDICATIONS
Should not be used in patients with a known sensitivity to this product or its components.
Should not be used on wounds that are very dry, covered with hard black necrotic tissue.

METHOD OF USE
Should be placed directly on to the wound surface, overlapping the surrounding skin by 1cm
Cavity wounds should be loosely packed with ribbon, allowing a tail of at least 2.5cm to facilitate its easy removal.
A secondary dressing should be applied to retain the dressing.
Irrigation with saline or tap water may be required to facilitate easy removal of this dressing.

FREQUENCY OF DRESSING CHANGES
The frequency of dressing changes depends on the wound characteristics and the absorbency of the secondary dressing. Dressings may be left in situ up to 7 days, but requires more frequent changes if exudate is heavy.

SIZES AVAILABLE THROUGH FORMULARY
5cm x 5cm
10cm x 10cm
2cm x 45cm (ribbon)

References
Bowler PG, Welsby S, Towers V, Booth V, Hogarth A, Rowlands V, Joseph A, et al, (2012). Multidrug-resistant organisms, wounds and topical antimicrobial protection. Int Wound J. 9.
Metcalf D, Bowler P, (2013). Biofilm delays wound healing: A review of the evidence. Burns & Trauma.
Bowler PG, Parsons D. (2016) Combatting wound biofilm and recalcitrance with a novel anti-biofilm Hydrofiber wound dressing. Wound Medicine. 1 (6-11)
Parsons, D.; Bowler P. (2015) A real-life clinical evaluation of a next-generation antimicrobial dressing on acute and chronic wounds. Journal of Wound Care 24 (1)

SECTION D WOUND INFECTION-ANTIMICROBIAL DRESSINGS

ANTIMICROBIAL ENZYME ALGINOGEL

FLAMINAL HYDRO / FLAMINAL FORTE – FLEN HEALTH UK

MODE OF ACTION

An Alginate based gel containing two antimicrobial enzymes – glucose oxidase and lactoperoxidase, which provide antimicrobial activity without damaging healthy skin cells. Debrides and desloughs the wound, manages moisture balance and protects the wound edges.
There is no limit to the length of time flaminal can be used to treat a wound. Can be used directly onto bone, tendon or in sinus tracts.

INDICATIONS

Flaminal is indicated on a wide range of wounds where there is infection or critical colonisation present, or the potential for an acquired infection. It can be used as an alternative to silver and iodine dressings.
Flaminal Hydro is indicated for wounds that are dry, necrotic or lightly exuding.

Flaminal Forte is indicated for wounds that are moderately or highly exuding as it contains more alginate fibres

CONTRAINDICATIONS

Flaminal should not be used on patients with a known allergy to one of its components. Cannot be used on the eyelids or eye.

METHOD OF USE

Clean the wound (if necessary) and apply flaminal to the whole wound bed applying a thick layer of at least 5mm, avoiding placing right up to wound edge. Cover with secondary dressing such as a film for necrotic wounds or atraumann and secondary foam dressing.
A sterile syringe can be used to introduce flaminal to a sinus tract.
May be left in place for up to 4 days, depending on the amount of exudate. Change when the gel structure has dispersed.
After use, replace the cap as the product remains sterile until its expiry date.

N.B. If the exudates level is too low for flaminal forte, white alginate flakes will appear on the wound edges as the alginate is not being used. Do Not remove the flakes as they will prevent wound border maceration. Step down to Flaminal Hydro and as the moisture balance is restored the flakes will disappear.

SIZES AVAILABLE THROUGH FORMULARY

15G TUBES – PACK SIZE 5
50G TUBE – SINGLE

REFERENCES:
White R. Flaminal: a novel approach to wound bioburden control.(2006) Wounds UK 2(3)
De Smet K et al. (2009) Pre clinical evaluation of a new antimicrobial enzyme for the control of wound bio burden. Wounds, 21 (3): 65-73

White R (2016) The alginogel Flaminal®: an overview of the evidence and use in clinical practice. Wounds UK 10 (3)

SECTION D WOUND INFECTION-ANTIMICROBIAL DRESSINGS

FLAMAZINE CREAM 1% - SMITH&NEPHEW

A PGD for this product is available on the NHS Forth Valley Intranet for Wound Management/Dermatology specialist nurses. Otherwise this product must be prescribed by a doctor or independent prescriber.

MODE OF ACTION
Flamazine –is a whitish cream containing 1%w/w Silver Sulfadiazine. It is an antibacterial cream used to treat bacterial infections in burns and other wounds e.g. leg ulcers.

INDICATIONS
Primary dressing for wounds known, or suspected to be infected.

CONTRA-INDICATIONS
Should not be used in patients with a known sensitivity to this product, or its components, during pregnancy or breast-feeding or on newborn or premature babies during the first few months of life.
Use with caution in patients with significant renal and hepatic impairment or G6 phospate dehydrogenase deficiency

METHOD OF USE
Flamazine should be placed directly on to the wound surface, in a layer of approx 3-5mm over the wound surface. A secondary dressing should be applied to retain the dressing, paraffin tulle is helpful. In the event of a burn to the hand or finger tips after applying a layer of Flamazine apply a plastic bag or non-sterile surgical glove and hold in place with tape. Patient should be encouraged to move hand and fingers.
Irrigation with saline or tap water may be required to facilitate easy removal of this dressing.

FREQUENCY OF DRESSING CHANGES
This dressing should be changed every two to three days. Once opened pots should be disposed of after 24 hours, tubes can be used for up to seven days.
In burns replace dressings after 24 hours.

PRESENTATION AND COST
In Community - Available on GP/Nurse prescription only.

SIZES AVAILABLE THROUGH FORMULARY

Tubes of 20g, 50g, 250g

References
Smith and Nephew 2005 Flamazine cream 1.0% product information leaflet
Smith and Nephew 2004 Flamazine Cream 1.0% Summary of product characteristics United Kingdom
Edwards J (2002) Product Focus – Flamazine. Journal of Community Nursing 16 (2) 22-24
White r, Cooper R (2005) Silver Sulphadiazine: A Review of the Clinical evidence WOUNDS UK

SECTION D WOUND INFECTION-ANTIMICROBIAL DRESSINGS

HONEY DRESSINGS

The use of honey in wound care has been recorded since the earliest times and in recent years has been rediscovered by the medical profession. (Zumla & Lulat 1989).

The exact mode of action on wound healing is not fully understood but honey is described as being beneficial to wounds through its anti-inflammatory, antimicrobial and deodorising properties and also by providing a moist wound healing environment.
It has been shown to be effective against a wide range of pathogens including MRSA (Yaghoobi et al 2013)

The sugar in honey attracts water which in turn denies microbes the water they require to survive. The glucose in honey is converted into gluconic acid which makes honey acidic, ph 3.5, which also inhibits the growth of microbes. Hydrogen peroxide is also produced by this reaction. These factors are all useful in suppressing microbial growth when honey is applied to a wound.

The effectiveness of honey in wound healing has been demonstrated in trials on experimental animals and has also had positive findings in randomised controlled trials. (Molan 2006)

Until recently, the honey which has been used in wound management has been non-sterile and not intended for medical use. This has now changed and the honey dressing used are sterile and approved as Medical Devices for use on wounds.

REFERENCES

Molan P. C. International Journal of Lower Extremity Wounds. The evidence supporting honey as a wound dressing 2006 Mar; 5(1): 40-54.
Scepankova H et al (2021) Review: Role of Honey in Advanced Wound Care available at https://doi.org/10.3390/molecules26164784
Yaghoobi R et al (2013) Evidence for clinical Use of Honey in wound Healing as an anit-Bacterial, Anti Inflammatory, Anit-Oxidant and anti-viral agent: A Review: J Nat pharmacy Prod 8 (3); 100-4
Zumla S, Lulat A (1989) Honey – A Remedy Rediscovered. J R Soc Med 82(7): 384-5

SECTION D WOUND INFECTION-ANTIMICROBIAL DRESSINGS

L MESITRAN OINTMENT (TUBE) - H&R HEALTHCARE

DESCRIPTION

An antibacterial ointment which contains 48% medical grade honey, medical grade hypoallergenic lanolin, sunflower oil, codliver oil, calendula officicinalis, aloebarbadenisis, Vit C &E and zinc oxide.

INDICATIONS

Can be used directly on the wound, or as a top up to any other honey dressings. It can be used to debride and de-slough, eliminate odours and provides a moist wound healing environment. Suitable for use on infected wounds or where bacterial resistance is suspected. Suitable for using in cavities: can be washed out with warm water or saline solution.

It is important to note that only a thin layer is required for optimal effect.

CONTRAINDICATIONS

If the patient has a known allergy to bee venom. Blood sugar levels should be monitored in patients with diabetes. A stinging sensation may be experienced when applying the honey, if this unacceptable remove dressing and discontinue use.

SIZES AVAILABLE THROUGH FORMULARY

	Product code
20g tube –	104.01
50g tube –	105.01

References:

Callaghan R, Stephen- Haynes J (2011)Properties of honey: its mode of action and clinical outcomes. Wounds UK 7, 11

Molan. P December 2001 Honeyas a topical antibacterial agent for treatment of infected wounds. http://worlwidewounds.com/1998/march/Odour-Absorbing-Dressings/odour-absorbing-dressings.html

S Natarajan, D Williams, J Grey, KG Harding and RA Cooper (2001) Healing of an MRSA-Colonised, hydroxyurea induced leg ulcer with Honey. Journal of dermatological Treatment (2001) 12, 33-66.

SECTION D WOUND INFECTION-ANTIMICROBIAL DRESSINGS

HONEY DRESSINGS

ACTILITE (TULLE)– ADVANCIS MEDICAL

NON-ADHERENT VISCOSE NET DRESSING COATED WITH 99% MANUKA HONEY AND 1% MANUKA OIL

MODE OF ACTION

protects the wound by creating a barrier against wound pathogens, including antibiotic resistant strains, and therefore reducing the risk of infection. Actilite contains a combination of Manuka honey and Manuka oil. Best suited for granulating or epithelialising wounds, Actilite offers antibacterial protection whilst promoting the ideal moist wound healing environment

INDICATIONS

SUITABLE FOR ALL WOUND TYPES WHERE A PRIMARY LAYER IS INDICATED AND AN ANTIBACTERIAL EFFECT MAY BE ADVANTAGEOUS INCLUDING: CUTS, ABRASIONS, BURNS, SURGICAL WOUNDS, LEG ULCERS, PRESSURE ULCERS, DIABETIC ULCERS AND INFECTED WOUNDS.

CONTRA-INDICATIONS

Although the honey is not absorbed into the blood stream, the company advise monitoring the levels of patients with diabetes. Do not use if allergic to bee venom. Discomfort can be experienced when honey is applied, depending on sensitivity of the wound it may be necessary to consider an appropriate level of analgesic. The initial discomfort usually subsides, however if it does continue, discontinue use and irrigate the wound with saline solution

METHOD OF USE

A primary dressing which is **cut to size** and placed on the wound surface, either side of dressing can be used Can be placed either side down. A secondary dressing will be required to absorb exudates. Protect wound edges with suitable barrier cream/film

FREQUENCY OF USE

Will depend on levels of exudate. Removal may be assisted by irrigating with warm tap water or a saline solution.

SIZES AVAILABLE THROUGH FORMULARY

Sizes	Pack sizes	Product code
5 x 5cm	5	CR4281
10x10cm	5	CR3849

References:

Cooper R et al (2011) Inhibition of biofilms through the use of Manuka Honey. Wounds uk. 7 (11)
Grothier L. & Cooper R., (2011) Medihoney Dressings made easy. Wounds UK 6 (2) pp 1-4

SECTION D WOUND INFECTION-ANTIMICROBIAL DRESSINGS

HONEY DRESSINGS

MEDIHONEY APINATE – ANTIBACTERIAL HONEY DRESSING- INTEGRA LIFESCIENCES

Apinate is an absorbent, sterile, non adherent wound contact dressing which comprises of calcium alginate and medical grade honey. (leptospermum sp, including manuka)

MODE OF ACTION

The dressing provides an effective antibacterial barrier that inhibits bacterial growth including antibiotic resistant strains. It provides a moist wound environment which will absorb exudate and aid desloughing. In the presence of exudate fibres in the dressing will swell to form a gel which prolongs the action of honey at the wound site.

INDICATIONS

For use on a wide variety of wounds that are exuding, sloughy and/or malodorous. To help in the management of wounds that are locally infected or colonised by antibiotic resistant bacteria.

CONTRA-INDICATIONS

Do not use in heavily bleeding wounds or on any patients that have a known sensitivity to honey, calcium alginate or sodium alginate. Patients with diabetes should have their blood glucose monitored.

METHOD OF USE

A primary dressing which is cut to size to fit the shape of the wound, use a suitable barrier cream/film to peri wound edges. A suitable absorbent secondary dressing is required.

FREQUENCY OF DRESSING CHANGES

Medihoney Apinate is licensed to remain in place for up to 7 days. The frequency of changes depends on how rapidly the honey is diluted by the wound exudate and may require daily dressings initially. If strikethrough occurs on the secondary dressing this may need to be changed more often to prevent maceration of peri wound skin

SIZES AVAILABLE THROUGH FORMULARY

Sizes	Pack Sizes
5cm x 5cm	10
10cm x 10cm	5

References:

Bateman S, Graham T (2007) The Use of MEDIHONEY on surgical wounds post-CABG. WOUNDS UK. Vol 3. 76 – 83.

Grothier L, cooper R (2014) Medihoney dressings made easy – Products for Practice. Wounds UK 10 (13)

SECTION D WOUND INFECTION-ANTIMICROBIAL DRESSINGS

ANTIMICROBIAL IMPREGNATED DRESSING

I INADINE – KCI

A sterile, low-adherent knitted viscose dressing impregnated with Povidone Iodine 10% in a water soluble polyethylene glycol base. The dressing is yellow / brown in colour and individually wrapped.

MODE OF ACTION

Povidone Iodine is a broad spectrum antiseptic which is present to prevent colonization of micro-organisms. As the base is water soluble, it is easily removed from the wound surface.

INDICATIONS

Used as a primary wound contact layer, for prophylaxis and treatment against a wide range of micro-organisms in superficial burns and superficial traumatic skin loss injuries. Inadine is intended for short term use and no more than four dressings should be used at one time.

CONTRAINDICATIONS

Should not be used before and after the use of radio-iodine (until permanent healing); if the patient is being treated for kidney problems, is pregnant or breastfeeding; in cases of Duhring's herpetiform dermatitis (a rare skin disease). Must be used under medical supervision: in patients with any thyroid diseases; in newborn babies and infants up to the age of 6 months as povidone-iodine may be absorbed through unbroken skin; when treating deep ulcerative wounds, burns or large injuries.

Not suitable for:

- Heavily exuding wounds.
- Patients with known or suspected sensitivity to Iodine or Povidone-Iodine.
- Deep wounds or wounds covering a large area as absorption of significant quantities of Iodine may occur.
- Medical advice should be sought in patients with thyroid disorders.
- Children under 6 months.

FREQUENCY OF DRESSING CHANGES

The Inadine dressing should be changed when the distinctive yellow-brown colour changes to white, as this is a sign of loss of antiseptic activity.

SIZES AVAILABLE THROUGH FORMULARY

Sizes	Pack sizes
5 x 5 cm	25
9.5 x 9.5 cm	10

References

Campbell N, Campbell D (2013) Evaluation of a non-adherent povidon-iodine dressing in a case series of chronic wounds. Journal of Wound Care 22(8)

SECTION D WOUND INFECTION-ANTIMICROBIAL DRESSINGS

ANTIMICROBIAL IMPREGNATED DRESSING
IODOFLEX – SMITH&NEPHEW

DESCRIPTION

Iodoflex consists of individual applications of a cadexomer iodine paste which is presented between two layers of gauze fabric which act as carriers and facilitate application.

IODOFLEX is a dual action wound management product. It offers the benefits of a broad spectrum slow release antimicrobial agent in combination with desloughing and fluid handling properties. IODOFLEX is effective at treating infection and preparing the wound bed to heal, in highly exuding chronic wounds.

Provides broad-spectrum antimicrobial activity up to 72 hours

In the presence of aqueous solutions or wound fluid, the beads in the ointment/paste take up liquid and swell, holding up to 6 times its own weight. Iodine is slowly released into the wound imparting antibacterial properties.

INDICATIONS

Iodoflex is used for the treatment of chronic exuding wounds such as leg ulcers, pressure ulcers and diabetic ulcers, particularly when infection is present or suspected.

CONTRA-INDICATIONS

- patients with known or suspected iodine sensitivity
- Hashimoto's thyroiditis
- non-toxic nodular goitre
- children

IODOFLEX should not be used:

- by pregnant or lactating women

As Iodoflex contains iodine it should not be used in patients with known or suspected iodine sensitivity. Usage is also contraindicated in patients with Hashimoto's Thyroiditis and in the case of non-toxic nodular goitre. Iodine is absorbed systemically and patients with severely impaired renal function or with a past history of any thyroid disorder are more susceptible to alteration in thyroid metabolism with chronic Iodoflex therapy. In endemic goitre there have been isolated reports of hyperthyroidism associated with Iodoflex.

METHOD OF USE

Prior to application of the dressing, one of the carrier layers is removed and the paste is placed directly in contact with the wound. The second carrier is then generally removed although this can be left in place if required. The Iodoflex wafer is then covered with a dry dressing or absorbent pad, which is secured in the normal manner. Removal is best accomplished by irrigating the wound with water or normal saline. Once the wound has been cleansed, a second dressing is applied while the area is still moist.

FREQUENCY OF CHANGE

The frequency of dressing changes will depend upon the nature of the wound. Daily changes may be required initially, but after the first few days the interval between changes can be extended until eventually the dressing is changed about three times per week. More frequent changes will be required if the paste becomes saturated with exudate as indicated by a loss of colour.

WARNINGS

Iodine is absorbed systemically especially when applied to large wounds and therefore Iodoflex should be used with care on patients who have a history of thyroid disorders.

Iodoflex should not be used on children and as iodine can cross the placental barrier and is secreted into milk Iodoflex should not be applied to pregnant women or lactating mothers.

There is a potential interaction of iodine with lithium and therefore co-administration is not recommended. Iodoflex should not be used concomitantly with mercurial antiseptics, e.g. mercurochrome and thiomersal, or taurolidine.

A single application should not exceed 50 grams and not more than 150 grams of Iodoflex should be applied during the course of one week. A single course of treatment with Iodoflex should not exceed 3 months. Iodoflex should not be used on dry wounds.

Presentation

Iodoflex dressings are available individual wrapped in aluminium foil, sterilised by irradiation.

SIZES AVAILABLE THROUGH FORMULARY

SIZES	PACK SIZES
5g (3.5cm x 6cm approx)	5 in a pack

References:

Sibbald RG, Leaper DJ, Queen D. (2011) Iodine Made Easy. Wounds International 2 (2) S1-S6.

Woo K et al (2021) Int Wound J. 2021 Oct; 18(5): 586–597

Dowsett c et al (2020) A route to more effective infection Managment: the Infection Managment Pathway

SECTION E
SPECIALIST WOUND DRESSINGS – HARD TO HEAL WOUNDS

LARVAE THERAPY- BIOMONDE

May be referred to by different names, either as, Larval Debridement Therapy, Biosurgery or Maggot Therapy.

PRODUCT DESCRIPTION
Sterile larvae (maggots) of the common greenbottle blowfly are used for cleansing/debriding of devitalized tissue and slough from wounds. Its use is advocated in chronic infected wounds due to the rising challenges posed by multi-resistant bacteria. (Thomas S 2010; Fleischmann W et al 2004)

MODE OF ACTION
Larvae produce powerful proteolytic enzymes which breakdown sloughy and soft necrotic tissue, which they ingest as a source of nutrient. When first applied to a wound they are only 2-3mm long but under favourable conditions they increase in size rapidly, reaching 8-10mm when fully grown.
It is claimed that they combat odour and infection by ingesting and killing bacteria in the wound (Thomas. et.al. 1994).
The treatment must be fully explained to the patient, verbal consent given and documented in medical/nursing records. A patient information leaflet should also be given.

Delivery – No service on a sunday, orders before 1400 hrs are delivered the next day, same day service is available at increased cost.

INDICATIONS
Can be used in the treatment of most types of sloughy, infected wounds, including leg ulcers, (both venous and arterial), pressure ulcers, burns and ulcerated areas on the feet of diabetics.

CONTRA-INDICATIONS
Should not be applied to wounds that have a tendency to bleed easily, or be introduced into wounds that communicate with the body cavity or any internal organs. In addition it is recommended that they should not be applied close to any large blood vessels, they are not recommended for wounds covered in thick adherent necrotic material.

WARNINGS AND PRECAUTIONS
On rare occasions it has been reported that the use of Larvae have caused a wound to bleed, for this reason it is recommended that the dressing is inspected daily, if bleeding has occurred the larvae should be removed and the wound re-assessed.
Increased odour and exudates are expected in the initial stages of treatment.

If exudates production is excessive, the secondary dressing may be changed daily whilst leaving the primary dressing undisturbed.

Occlusive dressings or film dressings should not be used as these will cause the larvae to suffocate, for this reason care must also be taken to ensure that the wound area is free from pressure.

Wounds must be cleansed with tepid tap water prior to the application of larvae as previous wound preparations including some hydrogels are known to adversely react with the larvae and therefore it is recommended that such preparations are removed twenty four hours prior to commencement.

SIZES

BB 50 2.5cm x 4cm
BB 100 5cm x 4cm
BB 200 5cm x 6cm
BB300 6cm x 12cm
BB400 10cm x 10cm

BioBag Ordering Guide BM48.pdf (biomonde.com)

Larvae decision making tool – BM421_UK_EN_01_1120.indd (biomonde.com)

PROCEDURE FOR OBTAINING MAGGOTS

In the Acute Sector, TVN's can help assess the wound for suitability of larvae therapy. If the medical staff and Patient are in agreement, larvae are ordered from the pharmacy department, progress can be monitored by the Tissue Viability Service and further advice given as required. Maximum recommended duration of treatment is 4 days (biofoam larvae), subsequent applications can then be applied depending on the status of the wound.

In the community the Tissue Viability Nurses assess the wound for suitability, then liaise with the GP/Patient/District Nurse, larvae are then ordered by prescription
In both instances the wound area is measured to estimate how many larvae are required.
Disposal within the Acute Hospital and clinic areas, following removal from the wound, larvae should be doubled bagged and disposed of as per the clinical waste policy procedure manual.
Within the Community, larvae should be double bagged and disposed of as per domestic waste.

HOW TO ORDER ORDER BEFORE 2PM FOR Office Hours: Monday to Friday 8:30 am – 5:00 pm NEXT DAY DELIVERY Telephone: 0345 230 1810 E-mail: orders@biomonde.com

INFORMATION LEAFLETS should be distributed to patients/families. It is anticipated that staff education will be provided if necessary prior to commencement of treatment.
Link to patient information leaflet - Patient Information Guide BM378.pdf (biomonde.com)

Reference

Thomas S, Andrews AM, Hay NP, Bourgoise S (1999) The Anti-microbial activity of maggot secretions: results of a preliminary study Journal of Tissue Viability 9 (4): 127-132
Thomas S, (2010) Maggot Therapy; Surgical Dressings and Wound Management, 563-632.
Fleischmann W et al (2004) Maggot therapy. A Handbook of Maggot Assisted Wound Healing. Thieme . ISBN 3-13-136811 – X (GTV)
Pagnamenta F (2013) Using Maggots to clean wounds – a clinical review. Wound Essentials Vol 8 No 1

SECTION E
SPECIALIST WOUND DRESSINGS – HARD TO HEAL WOUNDS

TOPICAL NEGATIVE PRESSURE/NEGATIVE PRESSURE WOUND THERAPY

Topical negative pressure (TNP) is a specialised system of wound management. Tissue Viability Service must be alerted to the fact that a patient is commencing this therapy. If required the Tissue Viability Nurses can be contacted to assess the suitability of the patient and wound, prior to ordering or applying this therapy or throughout the course of treatment including on discharge home.

MODE OF ACTION

There is limited trial based evidence to support the use of TNP in clinical practice, but anecdotal evidence and case studies from clinical papers, suggest it is an effective system that applies controlled, localised sub-atmospheric pressure to the wound site to promote wound healing. This treatment should only be used by staff trained and competent in its use.
Objectives of TNP treatment are:

- Removes excess exudates whilst maintaining a moist wound healing environment.
- Reduces bacterial count
- Promotes granulation
- Draws the wound margins closer together
- Increases blood flow to the wound

May be portable or static. Consists of an internal pump with easily adjustable controls to meet wound specific needs. The canister filter system is easily removable. The treatment must be fully explained to the patient, verbal consent given and documented in medical/nursing records. An information leaflet should also be offered to patient and their family/carers..(Overleaf Section 3.5.1)

INDICATIONS

Acute and traumatic wounds
Sub-acute wounds (i.e. Dehisced incisions)
Chronic wounds, diabetic or pressure ulcers
Meshed grafts (pre and post)
Skin flaps

CONTRA-INDICATIONS

Necrotic tissue with eschar present
Osteomyelitis (untreated)
Malignancy in the wound
Active bleeding/ Difficult wound haemostasis
Patients on anticoagulants
Care must be taken with respect to weakened, irradiated or sutured blood vessels or organs.
TNP therapy must not be used (unless indicated by surgical consultants) over, or in close proximity to exposed blood vessels or organs or fistulae to organs or body cavities.

Manufacturers guidelines should also be consulted prior to use.

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SPECIALIST WOUND DRESSINGS – HARD TO HEAL WOUNDS

(CONT)- TOPICAL NEGATIVE PRESSURE

Use of TNP therapy should only be used in conjunction with Tissue Viability Service or on the recommendation of medical staff. Costs can be expensive but vary between manufacturers. TNP should only be used by nurses competent in its use.

To order TNP the unit administrator /community nurse completes order form (appendix 4) and an order placed with CSD for the pump and consumables. Delivery is normally within 24-48 hours and made directly to the ward or health centre.
When treatment is complete CSD and TVS must be contacted immediately to uplift the pump and avoid further charges, this is done by the ward, or by the unit administrator.
If TNP therapy is required within the community please contact the Tissue Viability Service for further information.
If patient being discharged home from hospital with Vac therapy – please follow guidelines on discharge protocol – Appendix 5

METHOD OF USE

TNP therapy should be applied by nursing staff competent in its use. Tissue Viability Service can assist with first dressing initiatives and also help with further training and guidance in the therapy and dressings, to nursing staff, if required.
Clinical Representatives from the various companies can also provide training and support to staff when required.

1. Cut the foam/gauze to fit the size and shape of the wound, including tunnels and undermined areas. Do not pack tightly into the wound. NB GAUZE MUST BE PREMOISTENED BEFORE INSERTION INTO THE WOUND.
2. Trim the drape to cover the foam, plus 3-5cm border of intact skin.
3. Cut a small hole in the centre of the drape, apply on top of foam. Place the TRAC pad over this small hole.
4. With the final dressing in place switch therapy on.
5. Further film dressing can be applied to seal any wrinkles or gaps in the dressing if required.
6. Inspect the dressing frequently throughout each day to ensure foam/gauze is collapsed indicating negative pressure is active. Also monitor the surrounding skin and exudate for signs of infection or other complications. This should be documented in the wound assessment/treatment form.
7. TV Service can offer supervision and support, during treatment if required.
8. Dressings should be completely removed and re-applied every two days or sooner if TNP fails to meet the required suction pressure (normally 125 mm Hg for black foam and 75-80 mmHg for gauze)
9. Infected wounds may require the dressing changed every 12 to 24 hours.
10. If removal of the dressing is difficult, soak with normal saline solution for 15-30 mins prior to removal. If adherence is a problem consider a single layer non-adherent dressing on the wound prior to the next application, such as mepitel.

References
Safety Action Notice : Pre-vacuumed wound drainage catheters: riskmof tissue necrosis SAN (SC) 04/22 10 June 2004 Scottish Healthcare Supplies Edinburgh
Evidence note 5 - Vacuum assisted closure (V.A.C) for wound healing.November 2003 NHS QIS Glasgow

SECTION E

SPECIALIST WOUND DRESSINGS – HARD TO HEAL WOUNDS

TOPICAL NEGATIVE PRESSURE THERAPY

TNP PROCEDURE FOR ORDER/CANCELLATION

To order

An order can be placed at Central Stores Department using the TNP order form (below) and sent electronically. (If electronic copy is required, please contact Tissue Viability Service – fv.tissueviability@nhs.scot)

- Email david.logie@nhs.scot cc: kim.anderson@nhs.scot
- Provide details of place of delivery and patient's CHI No and Initials

Delivery normally within 24-48 hours

To cancel

When the treatment is complete contact central stores department **immediately** to arrange uplift. Ensure pump and charger are placed in the case prior to collection,

- Email david.logie@nhs.scot cc: kim.anderson@nhs.scot
- **Provide pump number (ATV Number) and place of collection**

Contact can be made to Tissue Viability Service for advice/support.
01324-673747

- *Please see FV NPWT Guidelines for more in depth information* Guidance for the use of Negative Pressure Wound Therapy

KCI (NPWT) BLANK ORDER FORM

Deliver to: **Patient Initials**

Address:

CHI

Postcode:

PRODUCT CODE	DESCRIPTION	QUANTITY REQUIRED
340001	Machine Rental Per Day - ACTIVAC Therapy Unit	
M8275058/5	ACTIVAC Canister With Gel 300ml - (Box of 5),	
M8275051/5	Dressing Kit Small Granufoam (Box of 5),SENSATRAC,	
M8275052/5	Dressing Kit Medium Granufoam (Box of 5),SENSATRAC,	
M8275053/5	Dressing Kit Large Granufoam (Box of 5),SENSATRAC	
M8275046/5	Simplace Foam Dressing Kit EX Small (Box of 5)	
M8275045/5	Simplace Foam Dressing Kit EX Medium (Box of 5)	
M8275068/5	Dressing Kit Small Whitefoam	
M8275067/5	Dressing Kit Large Whitefoam (Box of 5)	
413716	KCI NPWT Gauze dressing with sensatrac technology Box 5	
M8275042/5	Bridge Dressing Granufoam(Box of 5),V.A.C.	
M6275066/10	Y Connector T.R.A.C. (box of 10) VAC	
M6275026/10	VAC Gel Strips (box of 10)	
M6275033/10	White foam only – small (box of 10)	
M6275009/10	VAC DRAPE 30.5cm x 26cm (box of 10)	

Requested by: Date: Time:

Name:

SECTION E

SPECIALIST WOUND DRESSINGS – HARD TO HEAL WOUNDS

PROMOGRAN PROTEASE MODULATING MATRIX

Sterile, Freeze-dried composite of 45% oxidised regenerated cellulose and 55% collagen. Gels on contact with exudate. Inactivates proteases and protects growth factors. It has demonstrated haemostatic properties and can be used under compression therapy.

MODE OF ACTION

Matrix is an interactive therapy for wounds, for topical application. In the presence of exudate, the PROMOGRAN Matrix is transformed into a smooth biodegradable gel which easily establishes contact with all areas of the wound. In dry wounds, a saline solution must be used to hydrate the PROMOGRAN Matrix. PROMOGRAN Matrix modulates and re-balances the environment of the wound by the unique combination of the following actions: 1. The dressing absorbs exudate including Proteases 2. Collagen binds and deactivates MMPs 3. ORC binds and deactivates Elastase.

INDICATION

Matrix is indicated for the management of all wounds healing by secondary intent which are clear of necrotic tissue including: • Diabetic ulcers • Venous ulcers • Pressure ulcers • Ulcers caused by mixed vascular aetiologies • Traumatic and surgical wounds PROMOGRAN Matrix has known haemostatic properties. PROMOGRAN Matrix can be used under compression therapy

CONTRAINDICATIONS

Matrix must not be used in patients with known hyper-sensitivity to the components of this product, that is, ORC, collagen and silver. Discontinue use if any signs of sensitivity arise. PROMOGRAN Matrix is not indicated for patients with extensive burn. Precautions Systemic antimicrobial therapy should be considered when wound infection is evident. PROMOGRAN Matrix may be used, under medical supervision, in conjunction with systemic antibiotics.

METHOD OF USE

Site preparation before treatment, devitalised tissue, such as dry necrotic tissue, must first be removed by sharp, enzymatic or autolytic debridement. Dressing application for optimal effect, apply PROMOGRAN Matrix directly to the whole wound bed. For a wound with low or no exudate apply PROMOGRAN Matrix and hydrate with saline or Ringer's solution. This will initiate the gel forming process. After hydration the PROMOGRAN Matrix gel will intimately contact the wound. The biodegradable gel is naturally absorbed over time. PROMOGRAN Matrix must be covered with either - gauze, a non-adhering or a hydropolymer dressing in order to maintain a moist wound healing environment. After initial treatment, re-treat the wound with PROMOGRAN Matrix up to every 72 hours depending upon the amount of exudate.

FREQUENCY OF DRESSING CHANGES

Dressing change frequency It is not necessary to remove any residual PROMOGRAN Matrix during dressing changes as it will be naturally absorbed into the body over time. After initial treatment, retreat the wound with PROMOGRAN Matrix up to every 72 hours depending upon the amount of exudate. Do not re-use. Do not re-sterilise.

DRESSING SIZE	DRESSINGS PER BOX	NHS CODE	PIP CODE	SYSTNGENIX CODE
28cm squared	10	ELZ 001	282-4985	M772028
123cm squared	10	ELZ002	282-4993	M772123

SECTION E

SPECIALIST WOUND DRESSINGS – HARD TO HEAL WOUNDS

PROMOGRAN PRISMA WOUND BALANCING MATRIX-3M

PROMOGRANPRISMA™ Wound Balancing Matrix is a sterile medical device consisting of a white to off-white open-pored, freeze-dried regular hexagonal pad of 55% collagen, 1% silver- 44% ORC (oxidised regenerated cellulose).

MODE OF ACTION

Matrix is an interactive therapy for wounds, for topical application. In the presence of exudate, the PROMOGRAN PRISMA Matrix is transformed into a smooth biodegradable gel which easily establishes contact with all areas of the wound. In dry wounds, a saline solution must be used to hydrate the PROMOGRAN PRISMA Matrix. PROMOGRAN PRISMA Matrix modulates and re-balances the environment of the wound by the unique combination of the following actions: 1. The dressing absorbs exudate including Proteases 2. Collagen binds and deactivates MMPs 3. ORC binds and deactivates Elastase Added silver provides antimicrobial protection against bacteria and infection2

INDICATIONS

Matrix is indicated for the management of all wounds healing by secondary intent which are clear of necrotic tissue including: • Diabetic ulcers • Venous ulcers • Pressure ulcers • Ulcers caused by mixed vascular aetiologies • Traumatic and surgical wounds PROMOGRAN PRISMA Matrix has known haemostatic properties. PROMOGRAN PRISMA Matrix can be used under compression therapy

CONTRAINDICATIONS

Matrix must not be used in patients with known hyper-sensitivity to the components of this product, that is, ORC, collagen and silver. Discontinue use if any signs of sensitivity arise. PROMOGRAN PRISMA Matrix is not indicated for patients with extensive burns. Precautions Systemic antimicrobial therapy should be considered when wound infection is evident. PROMOGRAN PRISMA Matrix may be used, under medical supervision, in conjunction with systemic antibiotics. Clinicians/Healthcare Professionals should be aware that there are very limited data on prolonged and repeated use of silver containing dressings, particularly in children and neonates.

METHOD OF USE

Site preparation before treatment, devitalised tissue, such as dry necrotic tissue, must first be removed by sharp, enzymatic or autolytic debridement. Dressing application for optimal effect, apply PROMOGRAN PRISMA Matrix directly to the whole wound bed. For a wound with low or no exudate apply PROMOGRAN PRISMA Matrix and hydrate with saline or Ringer's solution. This will initiate the gel forming process. After hydration the PROMOGRAN PRISMA Matrix gel will intimately contact the wound. The biodegradable gel is naturally absorbed over time. PROMOGRAN PRISMA Matrix must be covered with either - gauze, a non-adhering or a hydropolymer dressing in order to maintain a moist wound healing environment. After initial treatment, re-treat the wound with PROMOGRAN PRISMA Matrix up to every 72 hours depending upon the amount of exudate.

FREQUENCY OF DRESSING CHANGES

Dressing change frequency It is not necessary to remove any residual PROMOGRAN PRISMA Matrix during dressing changes as it will be naturally absorbed into the body over time. After initial treatment, retreat the wound with PROMOGRAN PRISMA Matrix up to every 72 hours depending upon the amount of exudate. Do not re-use. Do not re-sterilise.

DRESSING SIZE	DRESSINGS PER BOX	NHS CODE	PIP CODE
28cm squared	10	ELZ086	320-8105
123cm squared	10	ELZ 087	320-8121

SECTION E
SPECIALIST WOUND DRESSINGS – HARD TO HEAL WOUNDS

URGOSTART PLUS - URGO

Contain poly absorbent fibres which bind, trap and retain exudate, slough and any debris present in the wound, keeping it clean throughout the healing process. This dressing has TLC – NOSF (Technology Lipido-Colloid – Nano Oligosaccharide Factor) healing matrix which has a unique mode of action to reduce healing time: inhibition of matrix metalloproteinase and promotion of angiogenesis. **May increase exudate levels on initiation and first few weeks due to the wound rebalancing (this is not an indication to stop using this dressing).**

MODE OF ACTION

Urgostart plus dressing provides absorption of exudate, creation and maintenance of a moist wound environment that promotes healing, this dressing is atraumatic and pain free on removal, it is kind to periwound skin and is comfortable and easy to reposition.

INDICATIONS

Urgostart is indicated for all stages (from desloughing stage to complete healing) of exuding wounds including leg ulcers, diabetic, foot ulcers, pressure ulcers and long standing acute wounds . There may be an increase in level of exudate when initiating Urgostart plus.

CONTRAINDICATION

Urgostart plus is not to be used on cancerous wounds or fistula wounds which may reveal a deep abscess.

Do not use if there is a known sensitivity to Urgostart products.

Do not use on heavily bleeding wounds

if any overgranulation and the wound stops progressing then re-assess and exclude any other causes (eg infection)

Do not use prontosan wound irrigation or debrisoft debridement pad when using this product

FREQUENCY FO DRESSING CHANGES

Urgostart plus can be left in place for up to 7 days but it is recommended to change the dressing every 1-2 days on initiation of treatment . Remove dressing if it becomes saturated.

METHOD OF USE

Ensure surrounding periwound is dry before application, Urgostart plus dressing can be cut to size (approx 1cm more than all around wound)Cover with secondary dressing.

SIZES	PACK SIZES	PRODUCT CODE	PIP CODE	NPC CODE
6CM X 6CM	10	552 301	406-4432	ELZ 884
10CM X 10CM	10	552 302	406-4440	ELZ 885
15CM X 20CM	10	552 305	406-4457	ELZ 886

Ref : http://www.urgostartplus.co.uk/urgoclean-aq (Urgo Medical UK 2020)
Tickle J et al (2020) Urgostart Plus in Real Life. Wounds UK. Case studies.
Augustin M et al (2021)Clinical evaluation of UrgoStart Plus dressings in real-life conditions: results of a prospective multicentre study on 961 patients. Journal of Wound Care 30 (12)

SECTION E
SPECIALIST WOUND DRESSINGS – HARD TO HEAL WOUNDS

ASKINA CALGITROL PASTE – BBRAUN For use under TVS guidance only

Askina® Calgitrol® Paste is a sterile dressing consisting of an ionic silver alginate matrix in paste form which in the presence of wound exudate maintains a moist wound environment conducive to natural healing conditions.
The high conformability allows a close contact to the wound bed.

MODE OF ACTION

Highly conformable. Allows extremely close contact to the wound bed, which is particularly valuable in difficult to manage wounds such as tunnels and sinuses

Helps prevent contamination from external bacteria.

INDICATIONS

May be used in the management of infected wounds for example grade 4 pressure ulcers, pilonidal sinuses, venous, arterial and neuropathic ulcers

CONTRAINDICATIONS

KNOWN SENSITIVITY TO ALGINATES OR SILVER; WHERE THE PRESENCE OF METALS IS CONTRAINDICATED; ULCERS RESULTING FROM INFECTION SUCH AS TUBERCULOSIS, SYPHILIS, OR DEEP FUNGAL INFECTIONS; THIRD-DEGREE BURNS

METHOD OF USE

Shake the tube prior to use and remove the outer protective film and cap. Apply a thick layer of paste to the entire surface of the wound bed and cover with an appropriate secondary dressing.
Frequency of dressing changes will be dictated by exudate levels
Calgitrol Paste may be removed by thoroughly cleansing the wound with sterile saline or Prontosan® Wound Irrigation Solution. Any patches of paste that have dried out should also be removed in this way.

Sizes 15g tube 100g Tube

REFERENCES

Trial C, Darbas H, Lavigne J-P, Sotto A, Simoneau G, Tillet Y, et al. Assessment of the antimicrobial effectiveness of a new silver alginate wound dressing: a RCT. J Wound Care. 2010Jan;19(1)

Wounds International. Using Askina® Calgitrol® Paste for the treatment of diabetic foot infection: case studies. London: Wounds International 2013. Available from www.woundsinternational.

SECTION E
SPECIALIST WOUND DRESSINGS- DERMATOLOGY PRODUCTS

HYPERGRANULATION

When granulation tissue 'over grows' beyond the surface of the wound, this is known as 'overgranulation'. This is also referred to as hypergranulation or 'proud' flesh.
It can be present in wounds healing by secondary intention and is clinically recognised by a friable red, often shiny and soft appearance which is raised above the level of the skin. Once it has developed, hypergranulation is a difficult condition to deal with.
Hypergranulation tissue can be classed as '**healthy**' or '**unhealthy**'.
Healthy hypergranulation tissue presents as an overgrowth of moist, pink/red tissue that may bleed easily. Healthy granulation tissue can reduce naturally and heal without intervention, although this may take longer if left untreated as the surface is moist and provides an ideal environment for bacterial colonisation and biofilm development.
Unhealthy hypergranulation tissue presents as either a dark red or a pale bluish-purple uneven mass rising above the level of the skin and can also bleed easily.
Whether the hypergranulation tissue is healthy or unhealthy the wound will not heal when the tissue is 'proud' because the epithelial tissue will be impeded from migrating across the wound's surface.

Causes

The exact aetiology of overgranulation is unknown. The literature often links infection with overgranulation but it is not clear which occurs first.
Vuolo (2010) suggests there are 3 types of overgranulation:

- Type 1: inflammatory with excessive exudate due to continued minor trauma or friction from mobility
- Type 2: occluded wound environment (possibly due to infection or chronic colonisation) (Bannerjee, 1999; Vandeputte and Hoekstra, 2006)
- Type 3: cellular imbalance – an imbalance between collagen synthesis and degradation due to the patients' pathology.

Prevention

Overgranulation is recognised as a clinical problem. The limited evidence regarding the development and management of overgranulation means that clinical judgement must be exercised in the management of each patient to ensure that removal of the tissue is not harmful.

Infection is thought to be a cause of overgranulation and a preventative measure would be to try and prevent the wound from becoming chronically colonised or infected.

Continued reassessment of the wound will alert clinicians to changes in the granulation status and immediate intervention and treatment can then be applied.

Overgranulation tissue is a common problem encountered in wound care. There are several potential options for treatment.
The steroid-impregnated tapes indicate that these can be an efficient and cost-effective treatment for overgranulation in a variety of wound types.

A number of options are available to treat overgranulation tissue, but clinical effectiveness, patient safety and comfort should be a consideration.
A strategic approach for preventing and treating overgranulation tissue ensures that patients receive the most effective and safe care.
For those presenting with an overgranulating wound it is essential to undertake a differential diagnosis, to exclude malignancy and to assess and manage infection.

Treatment

There are many treatment options for overgranulation, although research to support their use or to clearly suggest which is most effective is limited. The treatments reported in the table 2 below attempt to eliminate the causative factor and focus on reducing any bacteria present, applying pressure, reducing the occlusiveness of the dressings used, removing any overgranulation tissue and the use of steroid therapy. Dealey (2007) states that the use of silver nitrate directly reduces fibroblast production and should never be considered as a first line therapy.

Table 2: Treatment for overgranulation

Treatment option	Objective of treatment	Evidence base
Application of foam dressing	To flatten and absorb moisture	Harris and Rolstad, 1994; Williams, 1996; Rollins, 2000; Carter, 2003
Change from an occlusive to a non-occlusive dressing	To reduce moisture	Carter, 2003
Use of antimicrobials	To reduce bacteria	Leak, 2002; Lloyd Jones, 2006
Fludroxycortide Tape (Previously known as Haelan)	To reduce the production of new granulation cells. (licensed product)	Johnson, 2007; Oldfield, 2009
Fludroxycortide Cream/ ointment (previously known as Haelan)	To reduce the production of new granulation cells (although not licensed for use in overgranulation)	Johnson, 2007; Oldfield, 2009

Topical corticosteroid	Reduces the cell division and production of granulation tissue	Carter, 2003; Cooper 2007
Use of a fixative device on PEG/Gastrostomy tubes.	To reduce movement and stimulation of new granulation tissue	Best, 2004; Edwards-Jones and Leahy-Gilmartin, 2013
Silver nitrate pencil Surgical excision	Only if all else has been ineffective Undertaken in theatre as very last resort	Borkowski, 2005

Further research is required to establish exactly why overgranulation develops, as the cause will indicate the most appropriate prevention and treatment.
The ability of the clinician to assess and differentiate between healthy and unhealthy granulation is essential in making informed clinical decisions on effective treatment.

References

Best C (2004) The correct positioning and role of an external fixation device on a PEG. Nursing Times 100(18):50–1

Borkowski S (2005) G tube care: managing hypergranulation tissue. Nursing 35(8): 24

Carter K (2003) Treating and managing pilonidal sinus disease. J Comm Nurs (7): 28–33

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Dealey C (1999) The Care of Wounds. 2nd edition. Blackwell Scientific Publications, Oxford

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FIRSTLY IDENTIFY THE CAUSE:

RELATED TO WOUND HEALING

IF UNHEALTHY GRANULATION

(dark red/purplish, extremely friable tissue that is proud of wound)

Cleanse with Prontosan solution and apply soak for 10 minutes.

ASSESS FOR SIGNS/SYMPTOMS OF INFECTION

If infection suspected treat with Topical Antimicrobial Agents (as per Wound Management Formulary) +/- systemic antibiotics if necessary. Clinical signs of infection may include: heat pain erythema, swelling. If any of the above symptoms, take a wound swab for MC&S (see also Best Practice Statement – the use of topical antimicrobial agents in wound management) BEST PRACTICE STATEMENT

Cover with secondary dressing.

If no improvement continue treatment and review at 2 weeks.

IF HEALTHY HYPERGRANULATION TISSUE REMAINS

(moist pink/red soft smooth tissue that is proud of wound)

Cleanse with Prontosan Solution and apply soak for 10 minutes.

Apply FLUDROXYCORTIDE TAPE(**1**) as per manufacturer guidelines. If this is not available use the cream/ointment sparingly on a reducing regime as follows: Daily for 7 days, then alternate days for 7 days, then twice a week, then stop.

Occlude with Atrauman/Tricotex and cover with taut secondary dressing.

HYPERGRANULATION MANAGED

No further treatment required

NO IMPROVEMENT

Re-assess and Review

Seek advice/refer to Tissue Viability Service

ASSESS FOR MALIGNANCY

If suspected malignancy, refer **URGENTLY** for specialist advice – e.g. Dermatology, Plastics

MANAGE EXUDATE AND PROTECT

DO NOT treat as hypergranulation

RELATED TO PEG SITE

Ensure fixation plate is 2-3mm from skin surface

IF UNHEALTHY GRANULATION

(dark red/purplish, extremely friable tissue that is proud of wound)

Cleanse area with Prontosan Solution and apply soak for 10 minutes as each dressing change

ASSESS FOR SIGNS/SYMPTOMS OF INFECTION.

If infection suspected treat with Topical Antimicrobial Agents (as per Wound Management Formulary),) +/- systemic antibiotics if necessary. Clinical signs of infection may include: heat pain erythema, swelling. If any of the above symptoms, take a wound swab for MC&S (see also Best Practice Statement – the use of topical antimicrobial agents in wound management) BEST PRACTICE STATEMENT

Apply ACTISORB SILVER 220 to the area following cleansing.

Cover with secondary dressing.

Change daily and review after 2 weeks.

IF HEALTHY HYPERGRANULATION TISSUE REMAINS

(moist pink/red soft smooth tissue that is proud of wound)

Cleanse with Prontosan Solution and apply soak for 10 minutes.

Apply FLUDROXYCORTIDE TAPE(**1**) as per manufacturer guidelines. If this is not available use the cream/ointment sparingly on a reducing regime as follows: Daily for 7 days, then alternate days for 7 days, then twice a week, then stop.

Occlude with Atrauman/Tricotex and cover with taut secondary dressing.

HYPERGRANULATION MANAGED

No further treatment required

NO IMPROVEMENT

Re-assess and Review

Seek advice/refer to Tissue Viability Service

SECTION E
SPECIALIST WOUND DRESSINGS- DERMATOLOGY PRODUCTS

PERMITABS - Potassium permanganate soaks (ORDER FROM PHARMACY)

A mild antiseptic and astringent. It comes in the form of a solution or tablets that can be dissolved in water.

Mode of Action

To cleanse and deodorise eczematous type reactions and wounds.

Indications

Used to treat infected eczema, leg ulcers that may be weeping or blistering and external wounds.

Method of use

1. Use a clean container that is large enough for you to soak the affected area(s).
2. Line the container with a clear or light coloured bin liner bag.
3. Fill this with four litres of warm – not hot – tap water.
4. Add one 400 milligram Permitabs tablet and mix gently until it has completely dissolved. The water should turn a light pink colour. Not purple – this means it is too strong.
5. The solution is now ready to use for soaking.
6. If using on hands or feet, put Vaseline on your nails first to stop them from staining.
7. Place the affected areas into the water.
8. Soak for 10-15 minutes then remove from the water and pat dry. **Or soak a gauze dressing in the solution and apply to the skin for 10 minutes.**

Contraindications.- Important safety advice:

1. **Potentially fatal if swallowed.**
2. **The tablets must be stored away from children and vulnerable adults.**
3. **Potassium permanganate must be diluted in water before use.**
4. **Always wear disposable, protective gloves when handling potassium permanganate to avoid staining or irritation of the skin.**

What are the possible side effects of potassium permanganate soaks?

- Dryness of the skin.
- Can cause irritation or burns if the dilution is not adequate.
- Contact with eyes and mucous membranes (inside of mouth, nose, ear, genitals, and anus) may cause irritation and should be avoided.
- **Harmful if swallowed** – may cause significant side effects. If swallowed, seek medical help immediately.
- Potassium permanganate is a dye and will stain clothing, fabrics, and ceramic basins.

Frequency

It is recommended that this is done once daily until the weeping has stopped or otherwise advised.

Sizes:

Permitabs 400mg pack of 30

References

How to use potassium permanganate soaks (imperial.nhs.uk)
POTASSIUM PERMANGANATE | Medicinal forms | BNF content published by NICE
http://www.dermnetnz.org/treatments/permanganate.html

SECTION E
SPECIALIST WOUND DRESSINGS- DERMATOLOGY PRODUCTS

TOPICAL STEROID PREPARATIONS

DERMOVATE - CLOBETASOL PROPIONATE

A PGD for this product is available on the NHS Forth Valley Intranet for Tissue Viability/Dermatology specialist nurses. Otherwise this product must be prescribed by a doctor or independent prescriber.

A VERY POTENT topical corticosteroid preparation, also known as CLOBETASOL PROPIONATE.

INDICATIONS
Treatment of choice in patients with severe resistant inflammatory skin disorders unresponsive to less potent corticosteroids.

CONTRA-INDICATIONS
Should not be used when there is a known sensitivity to clobetasol propionate. or other corticosteroids. Long term use should be avoided, Adrenal suppression can occur. Atrophic changes may occur in the skin with prolonged use.

METHOD OF USE
Ensure the area to be treated is washed thoroughly with warm water in between applications.
A thin layer to be applied to the area of skin as prescribed (refer to finger tip unit chart for exact dose). Once applied occlude the area with Atrauman dressing for a more concentrated penetration. Wait 5-10 minutes before applying emollients to the area. The emollient should be smoothed gently into the skin following the lie of the hair to prevent folliculitis.
NOTE: Emollients dilute the efficacy of the steroid. In acutely inflamed conditions omit the emollient for the first few days.
Ointments are preferable to creams in inflammatory skin conditions associated with dry plaques. They have a deeper, more prolonged effect and increase the penetration of the steroid. They are also less likely to cause irritation as they do not contain preservatives.

FREQUENCY OF USE
Initial application should be 1-2 times daily for 7 days and a reducing regime implemented thereafter to reduce the risk of a ‘rebound’ effect.

APPLICATION
Refer to Finger Tip Unit chart for accurate dose application.

PRESENTATION
Available as cream and ointment.
30g and 100g.

References:
British journal of Community Nursing (2011) 16, (7), pg 329
Cameron.J. (2007) Dermatological changes associated with venous leg ulcers. 2. pg 60-66

SECTION E
SPECIALIST WOUND DRESSINGS- DERMATOLOGY PRODUCTS

ELOCON OINTMENT - MOMETASONE FUROATE 0.1%.

A PGD for this product is available on the NHS Forth Valley Intranet for Tissue Viability/Dermatology specialist nurses. Otherwise this product must be prescribed by a doctor or independent prescriber.

A POTENT topical corticosteroid ointment also known as MOMETASONE FUROATE 0.1%.

INDICATIONS
Treatment of choice in patients with leg ulcers, with associated moderate to severe contact sensitivity or stasis dermatitis. Applied to the surface of the skin to reduce the redness and itchiness caused by certain skin problems, including psoriasis and dermatitis.
If skin infection present Fucibet cream should be used in place of Elocon.

CONTRA-INDICATIONS
Should not be used when there is a known sensitivity to mometasone furoate or other corticosteroids.
Long term use should be avoided, Adrenal suppression can occur. Atrophic changes may occur in the skin in prolonged use.
Not recommended for children under the age of 2.

METHOD OF USE
A thin layer to be applied to the affected area of skin,(refer to Finger tip unit chart for exact dose). Once applied occlude with Atrauman dressing for more concentrated penetration. Wait 5-10mins before applying emollients to the area.
NOTE: Emollients dilute the efficacy of the steroid.
Ointments are preferable to creams as they have a deeper, more prolonged emollient effect and increase the penetration of steroid. They are also less likely to cause irritation as they do not contain preservatives

FREQUENCY OF USE
Initial application should be daily for 7 days and a reducing regime implemented thereafter to minimise the risk of a ‘rebound’ effect.
Twice a week when compression bandages are being used, increased to three times a week if no improvement noted.

APPLICATION
Refer to finger Tip Unit chart for accurate dose application.

PRESENTATION
Available as cream and ointment
30g and 100g tubes

References:

MeReC Bulletin,NPC, Topical Corticosteroids in General Practice (1999) (10) 6 Pg 21-24
BNF 62 September (2011)pg 728
WWW.Dermnetnz.org

SECTION E
SPECIALIST WOUND DRESSINGS- DERMATOLOGY PRODUCTS

FLUDROXYCORTIDE CREAM and OINTMENT- 0.0125% w/w- previously known as Haelan.

Product description:
A moderately potent corticosteroid cream or ointment for topical application. Creams are suitable for moist or weeping lesions whereas ointments are generally chosen for dry or scaly lesions.

Indications:
Adults and children: Eczema and dermatitis of all types including childhood and adult atopic eczema, photodermatitis, primary irritant and allergic dermatitis, lichen planus, lichen simplex, prurigo nodularis, discoid lupus erythematosus, necrobiosis lipoidica, pretibial myxoedema and erthroderma.
Overgranulated tissue (unlicensed).

Application and frequency of use:
Apply thinly to the affected area 1-2 times daily.
In Overgranulation an anecdotal reducing regime of daily application is recommended over a period of approximately 4 weeks.

Contra-indications:
Tuberculosis of the skin,facial rosacea, acne vulgaris, perioral dermatitis, perianal and genital pruritis, dermatoses in infancy including eczema, dermatitis napkin eruption, bacterial (impetigo), viral hypersensitivity to any components in the preparation. Potent corticosteroids are contra indicated in wide spread plaque psoriasis.

Special warnings and Precautions for use:
Not intended for Opthalmic use. Long term continuous therapy should be avoided in all patients irrespective of age.
Please also refer to the BNF and TYPHARM GROUP for exhaustive list.

Side Effects:
The following local adverse reactions are reported infrequently with topical corticosteroids but may occur more frequently with the use of occlusive dressings. These reactions are listed in an approximate decreasing order of occurrence; burning, itching, irritation, dryness, folliculitis, hypertrichosis, acne-form eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, miliaria, striae and thinning and dilatations of superficial blood vessels producing
telangiectasia. Prolonged use of large doses to extensive areas can result in sufficient
systemic absorption to produce generalised manifestations of steroid toxicity and may result in depression of HPA function on discontinuing treatment. Manifestations of Cushing's syndrome, hyperglycaemia and glycosuria have occurred in some patients.
Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels and absence of response to ACTH stimulation. Intracranial hypertension including bulging fontanelles, headaches and bilateral papilloedema have also been reported in children receiving topical corticosteroids. Infected skin lesions, viral, bacterial or fungal may be substantially exacerbated by topical steroid therapy. Wound healing is significantly
retarded.
Hypersensitivity reactions may occur.

Presentation: Available as a cream or ointment – 60g aluminium tube with screw cap

FLUDROXYCORTIDE TAPE (HAELAN TAPE)

A MODERATELY POTENT occlusive topical corticosteroid preparation, impregnated with 4 micrograms fludroxycortide per square centimetre.

INDICATIONS

Occlusive topical steroid**.** Adjunctive therapy for chronic, localised, recalcitrant dermatoses that may respond to topical corticosteroids.

CONTRA INDICATIONS

Chicken pox; vaccinia; tuberculosis of the skin; hypersensitivity to any components of the tape; facial rosacea; acne vulgaris; perioral dermatitis; perianal and genital pruritus; dermatoses in infancy; dermatitic napkin eruption, bacterial, viral and fungal infections.

METHOD OF USE

Haelan Tape should be applied to clean, dry skin which is free of hair. The tape need only remain in place for 12 out of 24 hours, but clinical practice has shown that 24-hour use is more advantageous.Corners should be rounded off to prevent excess pressure and rolling of the edges. The tape is cut 5mm larger than the treatment area (it is very easy to prepare a variety of dressing shapes including ‘key hole’ techniques). Remove the paper backing and apply the adhesive side of the tape to the skin. Stroke the back of the tape gently from the middle outwards to ensure contact between the tape and the skin, avoiding excessive tension as this could result in skin stripping on removal.
If longer strips are to be applied, the lining paper should be removed progressively.
If irritation or infection develops, remove tape and consult a physician.

FREQUENCY OF USE

Long-term continuous therapy should be avoided in all patients irrespective of age. Application under occlusion
should be restricted to dermatoses in very limited areas. If used on the face, courses should be limited to five days and occlusion should not be used. This is not a problem when treating overgranulation as treatment lasts a maximum of seven days.

PRESENTATION

In a cardboard dispensing box
7.5cmx20cm or 7.5x50cm

SIDE EFFECTS: SEE ABOVE UNDER HAELAN CREAM/OINTMENT

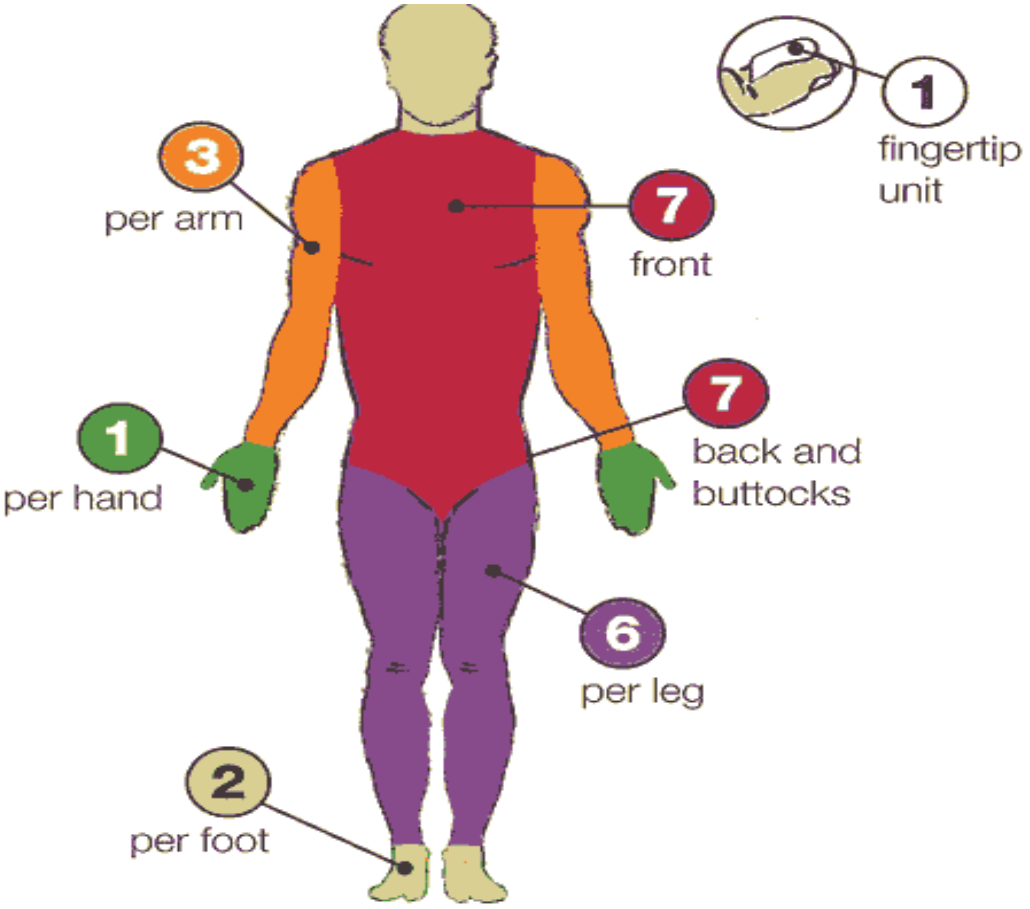
References:
Johnson S (2007) Haelan Tape for the treatment of overgranulation tissue. Wounds UK November 2016 Volume 12 Issue 4

The "fingertip unit" of topical steroids

The "fingertip unit" was original described by Long and Finlay in 1991 and is a handy guide for both doctors and patients to describe quantities of corticosteroid cream (1).
In essence, one "fingertip unit" is equivalent to 20-25 mm of cream or ointment squeezed onto the "fingertip". One "fingertip unit" is approximately 0.5 g of cream or ointment is is enough to cover the front and back of a single hand.

Fingertip units for body surfaces

The following diagram was liberated from a dosing handout by Schering-Plough Pty Ltd for
mometasone furoate 0.1% cream (Elocon):



The fingertip unit

One fingertip unit = 0.5 g of cream or ointment = two hand (palm) surfaces

Note: "hand" refers to the entire hand (i.e., palmar *and* dorsal surfaces)

For example:

An adult patient has atopic dermatitis over the trunk and back with an area equivalent in size to approximately 4 hand (palm) surfaces. The is equivalent to **2 fingertip units** or **1 g** of cream
If the cream is applied once a day and the tube contains 30 g of corticosteroid cream, then we would expect that the tube should last approximately 30 days.

Reference article (1) Long C., Finlay A. The finger tip unit... a new practical measure. *Clin Exp Dermatol1991;16:444-7*. [Link]

SECTION 3 – SPECIALIST PRODUCTS

SECTION E - STEROID LADDER

INCREASE ↑

VERY POTENT

DERMOVATE
DERMOVATE NN

POTENT

SYNALAR
SYNALAR C
BETNOVATE
BETNOVATEC
BETNOVATE N
DIPROSALIC
DIPROSONE
ELOCON
LOCOID

MODERATE

BETNOVATE RD
CALMURID HC
EUMOVATE
SYNALAR 1:4
TRIMOVATE
HAELAN
HAELEN TAPE

MILD

HYDROCORTISONE 2.5
ALPHOSYL HC
HYDROCORTISONE 1.0%
FUCIDIN H
HYDROCORTISONE 0.5%
CANESTAN HC
SYNALAR 1:10
DAKTACORT
TIMODENE

↓ DECREASE

SECTION F - THERMAL INJURY GUIDELINES – CLICK ON LINK

Tissue Viability – Departments A-Z (scot.nhs.uk)

CRITERIA FOR IDENTIFYING BURNS REQUIRING REFERRAL TO A REGIONAL BURNS UNIT:

IDENTIFYING BURNS REQUIRING REFERRAL

THE BRITISH BURN ASSOCIATION HAS IDENTIFIED THE FOLLOWING INJURIES AS THOSE REQUIRING REFERRAL TO A BURN UNIT:

- Burns greater than 10% Total Body Surface Area (TBSA) in adults
- Burns greater than 5% TBSA in children
- Burns of special areas – face, hands, feet, genitalia, perineum and major joints
- Full thickness burns greater than 5% TBSA
- Electrical burns
- Chemical burns
- Burns with an associated inhalation injury
- Circumferential burns of the limbs or chest
- Burns at the extremes of age – children and the elderly
- Burn injury in patients with pre-existing medical disorders which complicate management, prolong recovery or effect mortality
- Any burn patient with associated trauma
- Suspected 'non accidental injury' (children or elderly).

Ref: Emergency Management of Severe Burns (EMSB) Course Manual (1996) UK version for The British Burn Association

Contact Details
When phoning please ask for Specialist Registrar for Burns:

- Wallace Burns Unit at St. John's Hospital, Livingston (adults): **01506 523000**
- Royal Hospital for Sick Children (RHSC), Edinburgh (children): **0131 536 0000**

For advice

- Wallace Burns Unit at St. John's Hospital, Livingston (adults): **01506 524120**
  RHSC Nurse Led Dressing Clinic (children) Mon, Wed, Thu, Fri: **0131 536 0743**

Further Information
www.britishburnassociation.com British Burn Association
www.baps.co.uk British Association of Plastic Surgeons
www.cobis.scot.nhs.uk Care of Burns in Scotland

Please see TVS website for further information on Burns Guidelines and COBIS GUIELINES on following page

CARE OF BURNS IN SCOTLAND (COBIS)

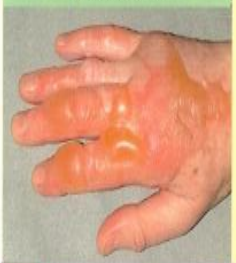
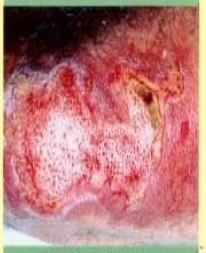
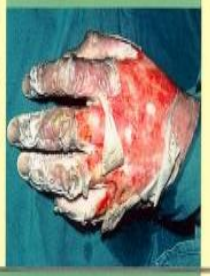
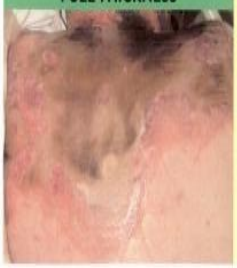
www.cobis.scot.nhs.uk

CARE of BURNS in SCOTLAND *Managed Clinical Network*

COBIS

Burns The Facts

BURNS OCCUR WHEN HOT SOLIDS, HOT LIQUIDS OR FLAMES DESTROY SOME OR ALL OF THE LAYERS OF CELLS WHICH FORM THE SKIN. DAMAGE TO THE SKIN FROM ULTRAVIOLET RADIATION, RADIOACTIVITY, CHEMICALS AND ELECTRICITY IS ALSO CONSIDERED A BURN INJURY, AS IS RESPIRATORY DIFFICULTY FOLLOWING SMOKE INHALATION.

TYPE	INDICATOR/DESCRIPTOR	MANAGEMENT AIMS	TREATMENT OPTIONS	OTHER CONSIDERATIONS
SUPERFICIAL 	*PINK WITH BLISTERS, PAINFUL.* *CAUSES: SCALDS, FLASH, RADIATION (SUNBURN)*	- *TO BE FULLY HEALED WITHIN 2 WEEKS* - *TO PREVENT INFECTION* - *TO MANAGE EXUDATE* - *TO PROMOTE FUNCTION*	*PARRAFIN IMPREGNATED GAUZE:* *JELONET* *VASELINE GAUZE* **NB: FOR BURNS OF <2%:** *HYDRO CELLULAR DRESSING* *ALLEVYN RANGE*	*REMOVAL OF CLOTHES AND APPLICATION OF COLD WATER FOR MAXIMUM OF 20 MINUTES WILL HELP PREVENT DEEPENING OF BURN IN SCALDS. FURTHER COOLING MAY BE USED TO REDUCE INFLAMMATION AND PAIN IN MINOR BURNS.* *BLISTERS SHOULD BE DE-PROOFED OVER AREAS OF FUNCTION OR WHERE THEY MAY BURST. DE-ROOFING INVOLVES THE REMOVAL OF THE DEAD SKIN AND BLISTER FLUID, NOT JUST EXPRESSING BLISTER FLUID.*
PARTIAL THICKNESS: **SUPERFICIAL DERMAL** 	*PINK WITH PATCHY WHITE / YELLOW AREAS.* *CAUSES: SCALDS, FLASH.*	- *TO BE FULLY HEALED WITHIN 3 WEEKS* - *TO PREVENT INFECTION* - *TO MANAGE EXUDATE* - *TO PROMOTE WOUND HEALING* - *TO PREVENT EXTENSION OF BURN DEPTH*	*PARRAFIN IMPREGNATED GAUZE:* *JELONET* *VASELINE GAUZE* *HYDRO CELLULAR DRESSING:* *ALLEVYN RANGE* *ACTICOAT* *FLAMAZINE* **(APPLY ONLY ONCE DEEP DERMAL BURN HAS BEEN EXCLUDED)**	*REMOVAL OF CLOTHES AND APPLICATION OF COLD WATER FOR MAXIMUM OF 20 MINUTES WILL HELP PREVENT DEEPENING OF BURN IN SCALDS. FURTHER COOLING MAY BE USED TO REDUCE INFLAMMATION AND PAIN IN MINOR BURNS.* *BLISTERS SHOULD BE DE-PROOFED OVER AREAS OF FUNCTION OR WHERE THEY MAY BURST. DE-ROOFING INVOLVES THE REMOVAL OF THE DEAD SKIN AND BLISTER FLUID, NOT JUST EXPRESSING BLISTER FLUID.*
PARTIAL THICKNESS: **DEEP DERMAL** 	*MOTTLED PINK / YELLOW / WHITE FIXED STAINING* *CAUSES: FLAME, SCALD, CHEMICAL.*	- *TO PREVENT INFECTION* - *TO MANAGE EXUDATE* - *TO PREVENT EXTENSION OF BURN DEPTH* - *TO PROMOTE WOUND HEALING* - *TO MAINTAIN FUNCTION*	**PRE SURGICAL CLOSURE:** *PARRAFIN IMPREGNATED GAUZE:* *JELONET* *VASELINE GAUZE* *ACTICOAT* **CONSERVATIVE MANAGEMENT:** *PARRAFIN IMPREGNATED GAUZE:* *JELONET* *VASELINE GAUZE* *FLAMAZINE* *FLAMACERIUM* *INTRASITE GEL*	- *REFER/DISCUSS WITH THE REGIONAL BURNS UNIT.* - *FOR IMMEDIATE REFERRALS, COVER BURN WOUND IN CLING FILM.*
FULL THICKNESS 	*DRY WHITE OR CHARRED BLACK / BROWN, PAINLESS.* *CAUSES: CHEMICAL, FLAME, ELECTRICITY.*	- *TO PREVENT INFECTION* - *TO MANAGE EXUDATE* - *TO PREVENT EXTENSION OF BURN DEPTH* - *TO PREPARE/MAINTAIN WOUND BED FOR SURGICAL CLOSURE OR CONSERVATIVE TREATMENT* - *TO MAINTAIN FUNCTION*	**PRE SURGICAL CLOSURE:** *PARRAFIN IMPREGNATED GAUZE:* *JELONET* *VASELINE GAUZE* *ACTICOAT* **CONSERVATIVE MANAGEMENT:** *PARRAFIN IMPREGNATED GAUZE:* *JELONET* *VASELINE GAUZE* *FLAMAZINE* *FLAMACERIUM* *INTRASITE GEL*	- *REFER/DISCUSS WITH THE REGIONAL BURNS UNIT.* - *FOR IMMEDIATE REFERRALS, COVER BURN WOUND IN CLING FILM.*

GUIDELINES FOR REFERRAL TO BURNS UNIT:

SITE INVOLVEMENT FACE/HANDS/FEET; PERINIUM; ANY JOINT INVOLVEMENT OR CIRCUMFERENTIAL BURN INVOLVING LIMB, NECK OR CHEST.

ANY BURN SIZE OVER 5% IN A CHILD OR 10% IN AN ADULT.

ANY BURN WITH ASSOCIATED INHALATION INJURY.

ANY SIGNIFICANT CO-EXISTING MEDICAL CONDITION. E.G CARDIAC DISEASE; RESPIRATORY DISEASE; DIABETES/PREGNANCY; IMMUNO-SUPRESSION; HEPATIC IMPAIRMENT/MENTAL ILLNESS

ANY CHEMICAL OR ELECTRICAL INURY

ANY ASSOCIATED INJURIES.

ANY EXTREMITIES OF AGE.I.E UNDER THE AGE OF 5YRS OR OVER 60 YEARS **(NB: GRI IS AN ADULT ONLY SERVICE).**

ANY SUSPICION OF NON ACCIDENTAL INJURY.

SECTION G - MISCELLANEOUS

STERILE DRESSING PACKS

When considering prescribing/recommending a dressing pack, remember:
Dressing packs should only be used where clinically indicated e.g. aseptic technique, non touch technique and immediate post surgical wounds (NICE Guidelines 74, 2008) and all components of the pack are necessary.
Sterile dressing packs are available to order through central stores/ PECOS. The brand and contents supplied will be allocated by central stores.

PRIMARY CARE PRESCRIBING OF STERILE DRESSING PACKS

When a dressing pack is to be prescribed for a patient select the most appropriate dressing pack based on the contents required. The pack should be prescribed by brand name.

CLEAN TECHNIQUE

Evidence has shown that a clean procedure is a safe way of dressing chronic wounds as they are all bacterially colonised with environmental micro organisms. The aim here is prevent harmful contamination to the wound.
Indications for clean technique:

- any wound that has not been created surgically within 48hrs
- if the wound does not connect to a deep body cavity/organ
- if the patient is not immunocompromised/neutropenic.

eg pressure ulcers, leg ulcers, dehisced abdominal wounds.

ASEPTIC TECHNIQUE

Sterile dressing packs should be used for patients with acute surgical wounds (within 48hrs), dressings relating to insertion of or cleansing of peripheral access devices, urinary catheters and immunocompromised patients. (Refer to local policies for full guidance) Aim is to prevent/reduce the risk of microbial contamination into a wound healing by primary intention.

STERILE DRESSING PACKS

Nurse It (per pack 52p)
Powder/Latex Free Nitrile Gloves S/M
7 Non-Woven Swabs 4-ply 10cm x 10cm
1 Compartment Tray 12cm x 11cm
1 Laminated Paper Sterile Field 40cm x 40cm
1 Large Apron 80cm x 130cm
*1 Disposable Forceps 11cm
1 White Polythene Disposable Bag 46cm x 26cm
*1 Paper Towel 35cm x 40cm
1 paper measuring tape

* shows different components in packs
Note: Forceps may be obtained through PECOS.

(Scottish Drug Tariff January 2015)

TREATMENT ROOM Community Patient Prescription Request

Date: ..... Staff Name:..... GP Practice: .....

PATIENT NAME: ..... Address: .....CHI: .....

Wound type: .....

Dressings	COMMENTS *Sp*=Specialist Formulary	SIZE						QUANTITY
Atrauman		5 x 5 (10)	7.5 x 10 (10)	10 x 20 (30)				
Carboflex		10x10 (10)	15x20 (5)	8x15 (oval) (each)				
Activheal Alginate	(*Alginate*)	5 x 5 (10)	10 x 10 (10)	10 x 20 (10)	15 x 20 (10)			
Urgoclean Rope	Rope	2.5 x 40 cm	4 x 40cm					
Aquacel Extra		5 x 5 (10)	10 x 10 (10)					
Urgo Clean Pad		6 x 6cm	10 x 10cm	15 x 15cm	20 x 15cm			
Activheal Hydrogel	hydrogel	8g	15g					
Jelonet		10 x 10 (10)						
Inadine		5 x 5 (25)	9.5 x 9.5 (10)					
Iodoflex	Paste	5g (5)						
Viscopaste PB7	10% Zinc Oxide	7.5 x 6m						
Kliniderm Superabsorbent	Super Absorb 1st line	10 x 10cm (10)	10 x 20cm (10)	20 x 20cm (10)	20 x 30cm (10)	20 x 40cm (10)		
KerraMax Care	Super Absorb 2nd line	10 x 10 (10)	10 x 22 (10)	20 x 30 (10)				
Kliniderm Non Adhesive	Foam	5 x 5cm (10)	10 x 10cm (10)	10 x 18cm (10)	15 x 15cm (10)	20 x 20cm (10)		
Duoderm Extra Thin	Hydrocolloid	10 x 10 (10)	15 x 15 (10)					
Mepore		6 x 7 (60)	9 x 10 (50)	9 x 15 (50)	9 x 20 (30)	9 x 25 (30)	9 x 30 (30)	
Tegaderm Film		6 x 7 (10)	12 x 12 (10)	15 x 20 (10)				
Tegaderm Foam Adhesive		10 x 11 (10) Oval	14 x 14 (10 Square	14 x 15 (10) Oval	19 x 22.2 (5) Oval			
Kliniderm Silicone Border	***Sp***	10 x 10cm	12.5 x 12.5	15 x 15cm (10)	10 x 20cm (10)	10 x 30cm (10)	15 x20 cm	18 x 18cm (10)

		(10)	cm (10)				(10)			
Aquacel Foam Adhesive		8x8cm (10)	10x10cm (10)	12.5x12.5cm (10)	10x20cm (10)					
Kliniderm silicone wound contact Layer	***Sp***	5x7.5cm (10)	7.5x10cm (10)	10x18cm (10)	17x25cm (10)	20x30cm (5)				
Antimicrobial/ Silver	**Review indication and duration of treatment. Reassess wound every 2 weeks. NOT FOR LONG TERM USE**									
Medihoney Apinate		5 x 5 (10)		10 x 10 (5)		1.9 x 30 (10) Ribbon/Rope				
Actilite Advancis	Impregnated dressing	5 x 5 (10)		10 x 10 (5)		10 x 20cm (10)				
LMesitran Ointment	Medical Honey Tube	20g tube		50g tube						
Aquacel Ag+Extra	(***Silver***)	5 x 5 (10)		10 x 10 (10)		2 x 45 *Silver* ribbon				
TOPICAL	**COMMENTS Sp= Specialist**	**Size**								**Quantity**
Actisorb **Silver**	*Charcoal*	6.5 x 9.5 (10)		10.5 x 10.5 (10)		10.5 x 19 (10)				
Flamazine Cream **(silver)**	TOPICAL	20g		50g						
Flaminal Forte	Alginate Gel	50g								
Flaminal Hydro	Alginate Gel	50g								
Olive Oil		92ml		185ml						
Liquid Paraffin And WSP 50/50	ointment	200g		500g						
Hydromol	ointment	100g		125g		500g	1000g			
Cavilon	Barrier Cream	2g sachet (20)		28g		92g				
Cavilon	Barrier Film	28ml Spray		1ml applicator (25)		3ml applicator (25)				
STEROID										
Fludroxycortide	***Sp*** (moderate *steroid*)	Tape 7.5 x 20cm		Cream 60g / Ointment 60g						
Elocon 0.1%	***Sp*** (Potent steroid)	30g		100g						

Mometasone									
Wound Bed	**Preparation**								
Prontosan Irrigation		350ml							
Prontosan Wound Gel		50g		250g Gel X					
BANDAGES etc									
Clinifast	Tubular Size (by colour)	Red (limb)	Green (limb)	Blue (limb)	Yellow (trunk child)	Beige (trunk adult)			
	length	1m	1m	3m	5m	1m			
Cotton Stockinet	Bleached	10cm x6m							
Crepe Bandage		5cm x 4.5m	7.5cm x 4.5m	10cm x 4.5m	15cm x 4.5m				
Ultra Four	***Sp***- four layer	#1 ultra soft wool wadding	#2 ultra lite crepe	#3 ultra plus compression	#4 ultra fast cohesive				
Non-woven Fabric Swabs	Non sterile – 4 ply	10 x 10cm (100)							
Nurse It Dressing Packs		Small/Med gloves (10)		Med/Large gloves (10)					
Permeable non-woven surgical	Adhesive Tape	2.5cm x 5m (e.g. Transpore)							
Protector	Shower Boot								
Limbo	Waterproof protector	Adult half limb **Build:** Slim/Normal /Large standard / short leg							
Debridement	Physical								
Debrisoft Pad	***Sp*** dressing	10 x 10cm (5)							
Debrisoft Lolly	***Sp***	5 x 2.7cm (5)							
Medi UCS Debridement	***Sp***	Cloth							
Hydro Clean Advance		3 cm round	4cm round	5.5 cm round	4cm x 8 cm	7.5cm x 7.5cm	8cm x 14cm	10cm x 10cm	10cm x 17cm

Other Items		**See Wound Management Formulary**								

To access the full Wound Management Formulary go to : https://guidelines.staffnet.fv.scot.nhs.uk/tissue-viability/ select Wound Management Formulary

NHS FORTH VALLEY

Care Home – Wound Management

Product Prescription Request Form

(Use this form to **request prescriptions** for dressings, from GPs - in line with the Forth Valley Wound Management Formulary)

Date of First Issue	20/02/2015
Approved	20/02/2015
Current Issue Date	01/08/2022
Review Date	01/04/2024 (or as per formulary change)
Version	5
EQIA	Yes 17/10/2014
Author / Contact	Lorna Dobson/Kelly Isles/Heather
Escalation Manager	Laura Byrne
Group Committee – Final Approval	NHS Forth Valley Prescribing Group

This document can, on request, be made available in alternative formats

Consultation and Change Record – for ALL documents

Contributing Authors:	Lorna Dobson - Primary Care Pharmacist Kelly Isles – Primary Care Pharmacy Technician
Consultation Process:	NHS FV – Wound Management Group NHS FV– Primary Care Prescribing Group
Distribution:	NHS Forth Valley wide; Care homes for older people, GP Practices, Community Pharmacies

Change Record			
Date: 26.04.16	Author: L.Dobson	Change- Steripaste bandage discontinued	Version 2
Date: 31.01.17	Author : L.Dobson	Changes- Algosteril has replaced Kaltostat	Version 3
		Intrasite Gel has replaced Activheal hydrogel	
		Tegaderm Foam Adhesive has replaced Permafoam Comfort	
		Allevyn Non-Adhesive has replaced Permafoam Non-Adhesive	
		2nd Choice adhesive foam dressing Activheal removed	
		Medihoney Tulle has replaced Activon Tulle	
		Medihoney Antibacterial Medical Honey has replaced Activon Honey Ointment	
		Medline Sureprep Barrier Film has replaced Cavilon No Sting Barrier Film	
		Sorbaderm Barrier Cream has replaced Cavilon Barrier Cream	
Date: 3.4.18		Comfifast Tubular Bandages replaced by Clinifast	**Version 4**
		2nd line super-absorbent added Kerramaxcare Dressing	
Date: 14.11.18		Addition of text box for request of 'Specialist products/dressings" i.e items listed in the Specialist Products section of the NHS FV WMF	
Date: 04.11.20		Addition of Urgotul Absorb Border to "Specialist Products"	**Version 4.3**
01.08.2022	Author: Kelly Isles		**5**

Care Home – Wound Management Product Prescription Request Form

(Use this form to **request prescriptions** for dressings, from GP's - in line with the Forth Valley Wound Management Formulary) G.P. surgery – name and address……

……

Patient Name……
DOB……CHI No……

Address…… Contact telephone number ……

Nurse/AHP Name…… Signature …… Date……

Dressing type	Name	Circle required size (Pack sizes are in brackets)					Quantity
Knitted polyester with neutral triglycerides	**Atrauman**	5 x 5cm (10)	7.5 x 10cm (10)	10 x 20cm (10)			
Absorbent Perforated with adhesive border	**Mepore**	7 x 8cm (55)	10 x 11cm (40)	9 x 20cm (30)	11 x 15cm (40)		
Hyrocolloid Thin semi-permeable **Non-adhesive border**	**Duoderm Extra Thin**	10 x 10cm (10)	15 x 15cm (10)				
Hydrofibre	**Aquacel Extra**	5 x 5cm (10)	10 x 10cm (10)				
Urgo Clean Pad		6 x 6cm	10x 10cm	15 x 15cm	20 x 15cm		
Urgo Clean Rope		2.5cm x 40cm	5cm x 40cm				
Hydrogel	**Activheal Hydrogel**	8g size	15g				
Alginate	**Activheal Alginate**	5 x 5cm (10)	10x10cm (10)	10 x 20cm (10)	15 x 20cm (10)		
Foam (1st choice) Polyurethane ***Non-adhesive border***	**Kliniderm**	5 x 5cm (10)	10 x 10cm (10)	10 x 18cm (10)	15 x 15cm (10)	20 x 20cm (10)	
Foam (1st choice) Polyurethane ***Non-adhesive border***	**Kliniderm**	Heel (10 x 17.5cm Pack of 5)					
Foam (1st choice) Polyurethane ***adhesive border***	**Tegaderm Foam Adhesive**	10 x11cm (10)	14.3 x 14.3cm (10)	14.3 x15.6cm (5)	19 x 22.2cm (5)		
Hydrofibre Foam Adhesive	**Aquacel Foam Adhesive**	8x8cm (10)	10x10cm (10)	12.5x12.5cm (10)	10x20cm (10)		
Silicone foam dressing with border	**Kliniderm Silicone foam Border**	7.5cm X 7.5cm	10cm X 10cm	12.5cm X 12.5cm	15cm X 15cm	10cm x 20cm	
Silicone contact layer	**Kliniderm Silicone contact layer**	5cm x 7.5cm (10)	7.5cm x 10cm (10)	10cm x 18cm (10)	20cm x 30cm (5)		
Charcoal (odour) activated charcoal absorbent	**Actisorb Silver 220 dressing**	10.5 x 10.5cm (10)					
Paraffin Gauze Dressing	**Jelonet**	10 x 10cm (10)					

Antiseptic Impregnated Povidone Iodine	**Inadine**	9.5 x 9.5cm (10)	5 x 5 cm (25)				
Alginate and honey	**Medihoney Apinate**	5 x 5cm (10)	10 x 10cm (10)	1.9 x 30cm rope			
Gauze impregnated with Manuka Honey	**Actilite by Advancis**	5 x 5cm (10)	10 x 10cm (10)	10 x 20cm (10)			
Honey Ointment	**L Mesitran Ointment**	20g tube	50g tube				
Flaminal Forte		50g					
Flaminal Hydro		50g					
Semi-permeable adhesive film	**Tegaderm Film**	6 x 7cm (10)	12 x 12cm (10)				

Barrier film	**Cavilon**	Foam Applicator	1ml (25)	3ml (25)			
		Spray bottle	28ml				
Barrier cream	**Cavilon**	28g	92g				
Super Absorbent Dressing Pad	**Kliniderm**	10 x 10cm (10)	10 x 20cm (10)	20 x 20cm (10)	20 x 30cm (10)	20 x 40cm (10)	
Sterile Dressing Pack	**Nurse It** (with forceps)	Small/Medium gloves (10)	Medium/Large gloves (10)				
Robinson Four Layer bandage system **ULTRA FOUR** (CONTACT TVN TO ENSURE CORRECT INDICATION**)**	Layer 1 Wool padding/soft wadding bandage	**Ultra Four #1 Ultra Soft**	10cm x 3.5m (1)				
	Layer 2 Crepe Bandage	**Ultra Four #2 Ultra Lite**	10cm x 4.5m (1)				
	Layer 3 Light compression	**Ultra Four # 3 Ultra plus**	10cm x 8.7m (1)				
	Layer 4 Cohesive compression	**Ultra Four # 4 Ultra Fast**	10cm x 6.3m (1)				
Clinifast Tubular Bandages	**Limb/Trunk size** ➢	**Roll size** ➢	1 x 1m Roll	1 x 3m roll	1 x 5m roll		
	Red Line (Small limbs) 3.5cm						
	Green Line (Small/Med limbs) 5cm						
	Blue Line (Large limbs) 7.5cm						
	Yellow Line (extra large limbs) 10.75cm						
	Beige Line (adult trunk) 17.5cm						
Paste Bandage	**Viscopaste** 10% zinc oxide		1 bandage (7.5cm x 6m)				
Wound Cleansing and Irrigation: **Prontosan**	**Irrigation solution** (cleaning and irrigation)		350ml				
	Wound Gel (cleaning and moisturising)		30ml				
	Wound Gel 'X' (for larger areas- gel is too fluid)		50g				

Please complete the table below if requesting Non-Formulary or Specialist Dressings/Products

Non- formulary dressing	**Reason for request of non formulary product** (i.e TV recommendation)	**Size**	**Quantity**	**Has this information been recorded in patient's notes?**
Specialist Dressings / Products *Not for general wound management or routine prescribing*	**Reason for request of Specialist product** (i.e TV recommendation)	**Size**	**Quantity**	**Has this information been recorded in patient's notes?**

Other Items: Tape etc (order non formulary products in the table above)	**Size**	**Quantity**

Publications in Alternative Formats

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To request another language for a patient

please contact 01786 434784.

For other formats contact 01324 590886

e-mail – fv.alternativeformats@nhs.scot

The Wound Management Formulary is available at http://staffnet.fv.scot.nhs.uk/a-z/nursing/assuring-better-care/campaigns/tissue-viability/.

CONTACT TISSUE VIABILITY NURSES ON (01324)

REQUEST FOR A NON-FORMULARY DRESSING

This form should be completed by the nurse with responsibility for the patient and should be countersigned/authorised by a member of the Tissue Viability Service prior to ordering the dressing. Or be authorized by the District Nurse Caseload holder prior to the prescribing of the dressing.

Patient details

Name:	DOB:	Ward/Address:

Dressing requested

Dressing Name

Size: Quantity : Manufacturer:

Address/Contact No

Ref Code of Product (if available)

Reason for alternative dressing

Indication(please give brief description):

Reason why formulary product not suitable:

Request made by

Name:	Ward/Dept/Community Date

Request authorised by

Tissue Viability Service/District Nurse/ Caseload Holder	Yes/No
Name	

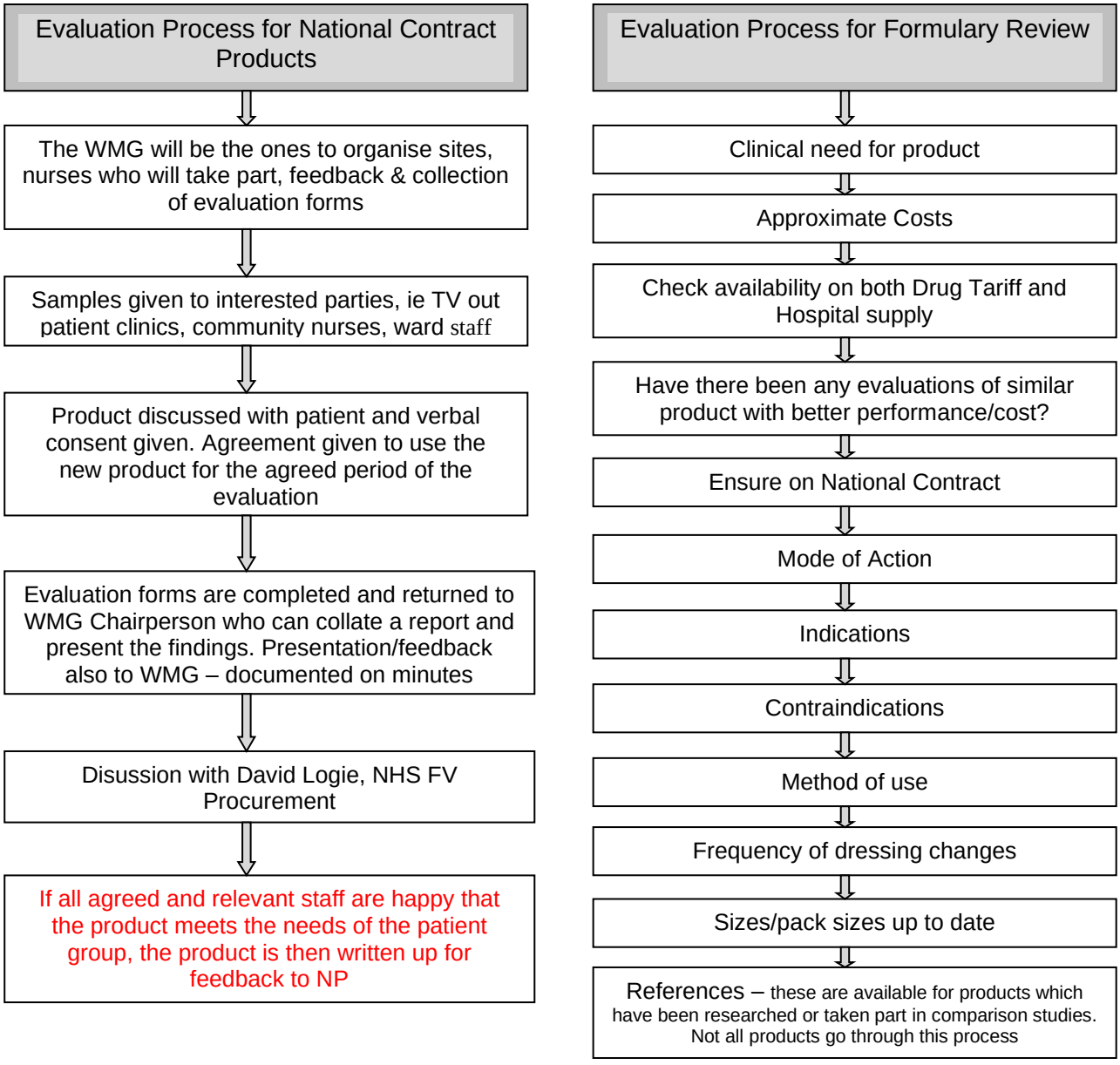
If a product is on national contract and 1st, 2nd or 3rd ranked it can be considered for inclusion to formulary, on the basis that there is a demand/evidence for use of the given product, or if the Wound Management Formulary document (WMF) is due to be reviewed / updated anyway.

New products though, are often brought to market that are not available on the national contract. It may be that the Tissue Viability Team or other health care professional raises same at the Wound Management Group (WMG) meeting as they may have been approached to evaluate same for consideration and inclusion at next contract change. If this product is to be considered, the guidance below should be followed.

A review is made by the WMG of current literature and a request to the representative who can provide further information, on quality, cost effectiveness, evidence and demonstration of product.

If TVN's, WMG & Procurement, after discussion, feel this product is appropriate for evaluation and possible use in NHS FV, a small evaluation of the product can then be organised.

Products may also be evaluated through the Formulary Review Process, the 2 flowcharts below outline the process that should be followed when undertaking the relevant evaluation.



Ultimately the product, as part of FVWM Formulary is approved by the Area D&T committee

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