

Wound Dressing Guidelines 2015



This guideline has been produced by the South Tees Tissue Viability Team, for use within South Tees Hospitals NHS Foundation Trust, Primary and Secondary care settings. It is based on the best evidence available at the time of publication. This guidance includes evidence-based recommendations from which it is intended decisions can be made for use in daily practice.

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Wound Dressing Guidelines – November 2015

The aim of this evidence based guideline is to aid the practitioner in the choice of dressings and not to remove clinical expertise or skill of any individual. It should be noted that patients should be assessed holistically and treatment planned appropriately for their individual needs.

Type, Indications & Comments	Dressing Name	Sizes (cm)	Tariff Cost (p)	NHS Supplies Cost (p)
Sterile Dressing Packs				
All packs contain:- Compartment tray; 1 pair Nitrile Gloves (S,M or L); Gauze Swabs; Measure tape; sterile field, Disposable bag Large Apron in Multipack & Community wound care pack.	Multi-Pack (Rociale)	1	46	–
	Or Wound care pack	1	£7	30
	Community Wound care pack (365 Healthcare)	1	£7	31
Adhesive Tape				
<i>Fabric based</i>	Chemifix	5 x 5m	125	47
		10 x 5m	210	96
		5 x 10m	140	74
		10 x 10m	210	147
<i>Paper-based</i>	Chemipore (5m role only)	1.25cm	27	18
		2.5cm	45	23
		5cm	95	42
<i>Soft Silicone</i>	Siltape ONLY for fragile skin or for pressure ulcer prevention	2 x 3m	560	612
		4 x 1.5m	560	612
Solutions for Cleansing				
Use at room temperature.	Normasol	25ml	26	13
		100ml	£7	41
Sodium Chloride 0.9%.	Irripod	20ml	23	20
Foam Cleansers				
For use as an alternative to soap and water for cleansing skin following contamination with urine, faeces, perspiration where there is high risk of skin breakdown.	Proshield Foam & Spray cleanser	235 ml	651	744
	Vernacare – Senseset Foam (Only available through NHS Supplies)	150ml	£7	96
		300ml	£7	152

Skin Protectives

Used only when it is deemed clinically necessary to protect vulnerable skin.

Indicated for use on intact skin and skin that is damaged as a result of incontinence.	Proshield Plus	115g	978	1108
Used to prevent skin damage from incontinence.	Sorbaderm barrier cream (Unbroken skin)	2g sachet 28g 92g	33 356 719	40 396 776
Cream will act as a moisturiser as well as providing protection.	Sorbaderm no sting barrier film	28ml spray 1ml 3ml	599 89 144	732 96 158

Post-Operative Dressing

Low absorption capacity and only suitable for lightly exuding superficial wounds.	Non-woven Island dressing (365 Healthcare)	6 x 8 8 x 10 8 x 15 10 x 15 10 x 20 10 x 25	4 6 7 9 12 14	3 5 6 7 10 12
A post-op dressing with Safetac soft silicone wound contact layer. Has greater absorbency. To be used on patients with fragile skin. Can be left in place for up to 14 days so please ensure it is applied correctly.	Mepilex Border Post-Op – Acute ONLY	6 x 8 9 x 10 9 x 15 10 x 20 10 x 25 10 x 30	Ðƒ Ðƒ Ðƒ Ðƒ Ðƒ Ðƒ	121 187 224 244 284 378

Film Dressing

Only to be used on non to lightly exuding wounds but NOT ON infected wounds.	C-View	6 x 7 10 x 12 12 x 12 15 x 20 10 x 25 20 x 30	38 102 109 236 Ðƒ Ðƒ	27 60 66 167 124 210
Film dressing with Safetac soft silicone wound contact layer.	Mepitel Film Use only for friable skin	6.5 x 7 10.5 x 12 10.5 x 25 15.5 x 20	49 131 255 324	55 150 290 368

Film Dressing with Absorbent Pad

Use on superficial, shallow wounds such as cuts, abrasions, post operative wounds.	C-View Post-Op	6 x 7 8.5 x 9.5 8.5 x 15 10 x 12 10 x 20 10 x 25 10 x 35	40 54 68 110 102 160 260	19 59 75 76 105 105 176
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Knitted Viscose Primary Dressing

Suitable for dry or lightly exudating wounds such as superficial cuts, abrasions & burns.	N-A Ultra	9.5 x 9.5	33	38
		19 x 9.5	63	81

Absorbent Pad

Basic dressing pad when wound needs to be dressed frequently.	Dressing Pad (Bastos Viegas)	20 x 20	ƆƆ	21
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Super Absorbent Dressings

<p>Primary or secondary dressings suitable for medium to heavy exuding wounds.</p> <p>Useage: Frequency of dressing changes dependant on level of exudate.</p> <p>May be used as primary or secondary dressing.</p>	Kliniderm Super Absorbent	7.5 x 7.5	ƆƆ	28
		10 x 10	49	39
		10 x 20	69	56
		20 x 20	99	111
		20 x 30	149	166
	KerraMaxCare	5 x 5	100	105
		10 x 10	127	97
		10 x 22	167	109
		20 x 22	295	194
		Multisite	323	340
	Adhesive	20 x 30	337	258
		20 x 50	450	474
		16 x 16	429	493
		16 x 26	678	779
		26 x 26	975	1120
	Sorbion Sachet Multi Star	8 x 8	299	341
		14 x 14	489	557
	Sorbion Sana Gentle	8.5 x 8.5	199	220
		12 x 12	249	275
12 x 22		449	496	
22 x 22		799	882	

Soft Silicone & Polymer Wound Contact Dressings

For use on superficial or acute traumatic wounds where dressing adherence is a risk.
A secondary absorbent dressing is required (changed as necessary).

Suitable for traumatic wounds when dressing requires regularly changing.	Atrauman	5 x 5	27	27
		7.5 x 10	28	28
		10 x 20	63	63
		20 x 30	172	172
Contains Safetac soft silicone (on one side only). Can remain in place for up to 14 days. Can be left in situ for wound inspection and wound cleaning.	Mepitel One (Silicone based)	6 x 7	159	175
		9 x 10	319	351
		13 x 15	645	710
Contains TLC Healing Matrix that promotes wound healing.	Urgotul	5 x 5	154	160
		10 x 10	307	320
		15 x 15	653	692
		10 x 40	1033	1091
		15 x 20	870	906
		20 x 30	1399	1456

Foam Dressings

For patients with sensitive skin. Five-layered absorbent foam dressing with Safetac soft silicone contact layer and film backing for moderate to highly exuding wounds . Bordered foam dressing with Safetac soft silicone contact layer and film backing for lightly exuding wounds. Conformable non bordered foam dressings with Safetac soft silicone contact layer for moderately exuding wounds . Mepilex XT has exudate channels which effectively manages even high viscous exudate . Absorbent foam dressing with shower-proof silicone adhesive border. Has TLC healing matrix in contact with wound to promote healing. Shaped Foam Dressings: May be used for awkward areas such as heel, knee or elbow.	Mepilex Border	7 x 7.5	139	152
		10 x 12.5	272	302
		10 x 20	369	416
		10 x 30	555	624
		15 x 17.5	474	524
	Mepilex Border Lite	Heel	663	794
		15 x 15 (Sac)	385	375
		18 x 18 (Sac)	477	546
		13 x 16 (Flex)	334	398
		15 x 19 (Flex)	404	482
		4 x 5	92	105
		5 x 12.5	201	230
	Mepilex Mepilex XT	7.5 x 7.5	139	159
		10 x 10	253	290
		5 x 5	121	132
Mepilex Lite	10 x 11	266	294	
	11 x 20	439	486	
	15 x 16	482	533	
UrgoTul Absorb Border	6 x 8.5	182	190	
	10 x 10	217	228	
	6.5 x 10	145	130	
	8 x 8	136	131	
	8 x 15	240	200	
	10 x 10	196	188	
	10 x 25	360	280	
	13 x 13	240	238	
	15 x 20	391	388	
	20 x 20 (Sac)	427	449	
Tegaderm Foam Adhesive (circular)	6.9 x 7.6 (Mini oval)	145	161	
	10 x 11 (oval)	237	207	
	13.9 x 13.9 (heel)	418	449	

Alginate Dressing

Highly absorbent. Forms a gel on contact with wound exudate. A secondary dressing is required. Dressing should be folded to the size of the wound. For cavity wounds pack loosely with the ribbon – using the provided probe.	Sorbsan Flat	5 x 5	81	75
		10 x 10	171	157
		10 x 20	320	323
	Urgosorb	5 x 5	88	89
		10 x 10	211	213
		10 x 20	387	391
	Sorbsan Ribbon	40cm	204	218

Gelling Fibre Dressing

Key features: *Natural haemostatic ability stops wound bleeding *Natural antimicrobial action *Accelerates wound healing *Highly absorbent	Kytocel	5 x 5	80	80
		10 x 10	192	192
		15 x 15	360	360
		4 x 10	103	103
		4 x 20	151	151
		4 x 30	227	227
		2.5 x 45 (ribbon)	194	194

Hydrofiber Dressings

Ensure dressing extends at least 2 cm beyond the wound margin by selecting an appropriate size.

For moderate to heavily exuding wounds. Should be covered with an appropriate secondary dressing. Aquacel Foam dressings are ONLY to be used when using an alginate or hydrofibre and require a secondary dressing.	Aquacel Extra	5 x 5	100	98
		10 x 10	238	234
		15 x 15	448	442
	Aquacel	4 x 10	130	139
		4 x 20	191	202
		4 x 30	287	303
		Ribbon		
		2 x 45	245	240
	Aquacel Foam Adhesive	1 x 45	183	180
		8 x 8	138	146
		10 x 10	214	224
	Aquacel Foam Non-Adhesive	12.5 x 12.5	265	277
		5 x 5	134	139
		10 x 10	253	265
			15 x 15	425

Hydrogel Dressings

For dry to moderately exuding wounds.	Kerralite Cool	6 x 6	173	198
		12 x 8.5	255	293
		18 x 12.5	368	422
	– Border	8 x 8	200	229
		11 x 11	267	288
		15 x 15	425	459

Hydrocolloid Dressings

For none to lightly exuding wounds. Useful for traumatic wounds, superficial burns, removal of foreign bodies.	Duoderm Extra Thin (Shower proof)	5 x 10	76	71
		7.5 x 7.5	80	75
		10 x 10	132	122

Honey Dressings

For *necrotic, lightly exuding, sloughy, malodorous, infected* wounds.

It is advisable to monitor blood sugar levels with diabetes. Discomfort may be experienced due to osmotic action of honey. Do not use on arterial bleeds or heavily bleeding wounds.

Antibacterial Wound Gel.	MediHoney	10g tube	269	307
		20g tube	402	475
All-in-one dressing, Medihoney & hydrogel.	MediHoney HCS – Non-adhesive – Adhesive	6 x 6	224	237
		11 x 11	447	477
		11 x 11 15 x 15	306 579	319 587
An absorbent wound contact dressing comprising of calcium alginate impregnated with Activon Honey.	Algivon Plus (Cut to wound size)	5 x 5	196	214
		10 x 10	336	367
		2.5 x 20	336	367

Antimicrobial Dressings / Products

Antimicrobial dressings may be used for critically colonised or clinically infected wounds to reduce bacterial load. Dressing selection should be dependant on tissue type, level / viscosity of exudate, size, type, position and depth of wound.

Solutions for Irrigation

For Irrigation. Use at room temperature. (Warm before use).	Octenilin	350ml bottle	460	460
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Alginate Gel

Flaminal is a hydroactive colloid dressing with alginates. Flaminal contains a biological (enzymatic) anti-microbial system. Cover the entire wound-bed with product and apply a suitable non-occlusive secondary dressing.

Lightly exuding wounds. 15g covers approx 40cm ² .	Flaminal Hydro Can be recapped for single patient use.	15g tube	761	810
Moderately exuding wounds.		15g tube	761	810
	Flaminal Forte Can be recapped for single patient use.			

Antiseptic Dressings				
For medium exudating infected / sloughy wounds. Caution in patients with severe renal impairment or history of thyroid disorders (See BNF for full details). Contra-indications: lithium therapy, thyroid disorders, pregnancy & breast-feeding (See BNF for details).	Iodoflex Paste Apply to wound surface, remove gauze backing and cover; renew when saturated (usually 2–3 times weekly, daily for heavily exuding wounds) (Change when saturated)	5g 10g 17g	406 812 1286	583 972 1538
Povidone Iodine Fabric Dressing				
Used as a primary wound contact layer for the prophylaxis & treatment of infections in superficial burns & skin loss injuries.	Povitulle Only recommended for: – podiatry use / diabetic foot ulceration – Minor Injuries & vascular departments (Change when discolours. Should not be left in place >2days)	5 x 5 9.5 x 9.5	28 42	28 42
Silver Products				
For infected wounds. Active vs. MRSA. Treatment should be limited to 1 months use. Apply all silver dressings directly to wound surface Do not use on third-degree burns or with patients with known sensitivity to silver or alginates Cover all non-adhesive anti-microbial dressings with a non-occlusive secondary dressing.				
Silver Hydrofiber				
For medium to high exudate chronic or Infected wounds. Apply directly to the wound overlapping the surrounding skin by 2 cm.	Aquacel Ag + Extra Aquacel Ag+ Ribbon	5 x 5 10 x 10 15 x15 20 x 30 4 x 10 4 x 20 4 x 30 1cm x 45 2cm x 45	195 464 875 2171 283 369 552 306 467	180 432 813 2019 295 357 536 318 470
Silver Alginate				
For critically colonised or clinically infected wounds. Alginates have haemostatic properties so can be used on bleeding wounds.	Urgosorb Silver Urgosorb Silver Rope	5 x 5 10 x 10 10 x 20 2.5 x 30	153 365 688 367	160 369 695 365
Silver Non-adherent				
For infected superficial wounds that need a non-adherent dressing.	Urgotul SSD (not to be used on a bleeding wound)	10 x 12 15 x 20	314 889	324 921

Specialist Dressings

These dressings should only be used after recommendation from a specialist in wound care.

Foam – suitable for radiotherapy induced skin reactions

Light to moderate exudate. Dressing contains a tissue-friendly wound cleansing agent and glycerol.	Polymem (non-adhesive)	8 x 8	159	170
		10 x 10	247	287
		13 x 13	412	450
		17 x 19	608	832
		Roll	1310	1473

Debridement Products

A sterile moistened cloth contains a mild cleansing solution to aid debridement and removing hyperkeratosis.	UCS (10 sachets in box)	sachet	325	325
Removes wound debris, necrotic material, slough and even long standing hyperkeratotic tissue.	DebriSoft A maximum of 2 dressings can be ordered.	10 x10	635	711

Activated Charcoal Dressings – do not cut the dressing

For use on wounds which require management of malodour.	Odolock	10.5 x 10.5 10.5 x 19	175 240	175 240
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Foam with PHMB

Foam dressing is impregnated with 0.5% Polyhexamethylene Biguanide (PHMB), a highly effective, low toxicity antiseptic. The dressings are effective against gram +ve and gram -ve bacteria.	Kendall™ AMD Foam Dressings	10 x 10	471	555
		8.8 x 7.5cm	423	397
		0.4mm hole	329	330
		0.7mm hole	329	330
		DISC 2.5cm		

Anti-microbial Impregnated Gauze Dressing

A gauze dressing coated with a fatty acid derivative (DACC) designed to bind bacteria.	Cutimed Sorbact Swab	4 x 6 7 x 9	163 279	193 313
	Cutimed Sorbact Gel	7.5 x 7.5 7.5 x 15	263 443	186 307

Protease Modulator

Suitable for all chronic wounds clear of necrotic tissue and visible signs of infection.	Promogran Prisma	28cm ² 123cm ²	631 1798	707 2010
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Bandages

Compression Therapy for Venous Leg Ulcer Management

A **full leg ulcer assessment** must be carried out before using any compression system to assess for arterial disease. The most important aspect of venous leg ulcer management is application of compression therapy. Compression therapy is applied using either bandages or hosiery.

Full Compression Bandages

Short Stretch Bandage

Suitable for venous leg ulceration, oedema and lymphoedema. Applied at full stretch and 50% overlap over padding.

NB. 10cm is the standard size. When performing Lymphoedema bandaging, 8cm to be applied to the foot & 12cm to the thigh.	Actico Cohesive	8cm x 6m	309	389
		10cm x 6m	321	417
		12cm x 6m	409	507
For use on 'regular' shaped legs. Supplied as a kit comprising of a comfort layer and Actico.	Actico2C	18-25cm	795	954
		25-32cm	895	1074

Long Stretch Bandage – Two Layer System

Two-layer system combining elastic & inelastic components that work together to provide sustained graduated compression for up to 7 days. (also available in latex free).

K-Two	Ankle sizes 18-25cm	809	941
	25-32cm	884	1029

Multi-layer Compression Bandaging – K-Four

Supplied as a kit or may also order the separate components if preferred.

NB. Components K-Soft & K-Lite may be used for patients that are not suitable for compression to protect, absorb exudate & hold dressings in place.

Ankle less than 18cm K-Soft x2, K-Lite, K-plus, Ko-Flex	Full kit	714	799		
	Ankle size 18-25cm	Full kit	683	794	
		K-Soft	10cm x 3.5m	45	56
		K-Lite	10cm x 4.5m	100	76
		K-Plus	10cm x 8.7m	227	203
	Ko-Flex	10cm x 6.0m	301	348	
	Ankle size 25-30cm	Full kit	683	775	
		K-Soft long	10 x 4.5cm	57	71
		K-Lite long	10 x 5.25cm	114	130
		K-Plus long	10 x 10.25m	262	307
		Ko-Flex long	10cm x 7m	345	398
	Ankle size greater than 30cm	Full kit	941	1079	

Reduced Compression for Mixed Aetiology

Kit may be used or the separate components as appropriate to patient.
– K-Soft, K-Lite, Ko-Flex (or K-Plus).

K-Four Reduced Compression 18cm+	18cm +	447	513
	18-25cm	809	920
K-Two Reduced	25-32cm	884	1004

Compression Hosiery

Compression hosiery may be used as an alternative to compression bandages if concordance or patient independence is an issue. Full assessment should be completed prior to application.

Full Compression Hosiery Systems

A two-layer compression hosiery kit that can serve as a viable alternative to four-layer bandages in the management of uncomplicated leg ulcers. Each pack contains 1 x class 3 open toe stocking, plus 2 x 10mmHg liners.

Suggested brands: Comfipression Leg ulcer kit Activa Leg Ulcer Kit Carolon
 Altipress 40 Leg Ulcer kit Mediven Jobst

Liners may be also be used in place of reduced compression bandages if patient concordance is an issue. May start with one liner and build up to two.

Suggested brand: Comfipression Liner Kit (contains 3 liners) Closed toe in white (cost £9.85).

British Standard Hosiery

British standard hosiery helps manage and prevent various venous leg conditions where limb swelling is not apparent.

Class	Strength	Indication
Class 1	14 – 17mmHg	Superficial or early varices & prevention of deep vein thrombosis while travelling
Class 2	18 – 24mmHg	Medium varices. Treatment & prevention of venous leg ulcers & associated conditions
Class 3	25 – 35mmHg	Gross varices; post thrombotic wound insufficiency; treatment of venous leg ulcers and prevention of recurrence

Suggested Brands: Activa Altiform Duomed Soft

RAL (European) Standard Hosiery

European class hosiery plays an important role in managing conditions with chronic oedema including lymphoedema. It has a stiffer profile than British standard hosiery.

Class	Strength	Indication
Low compression	14 – 18mmHg	Early / mild oedema, prevention of varicose veins in pregnancy
Class 1	18 – 21mmHg	For early / mild chronic oedema, lymphoedema where the oedema is light to moderate with little shape distortion
Class 2	23 – 32mmHg	For moderate to severe chronic oedema or lymphoedema where there may be some slight or minor shape distortion
Class 3	34 – 46mmHg	For severe chronic oedema and lymphoedema, where resistant oedema features or where lymphatic damage is considerable. Use also when lower compression has failed to control return of oedema.

Suggested Brands: Actilymph Altiven Carolon Mediven Jobst

Below knee or thigh length – use thigh length when:

- Oedema extends to thigh
- Oedema around knee joint
- Varicosities in thigh region
- Pain in knee due to arthritis

Choice between open and closed toe

Open toe stockings may be preferred for people who:

- Have arthritic or clawed toes, or fungal infection
 - Prefer to wear a sock over the compression stocking
 - Have a long foot size compared with their calf size
-
- Refer to company literature for measuring, choice of style, colour etc.
 - Use made to measure hosiery when the limb is large or irregular shaped
 - Please always allow the patient to choose their preferred style / type

Paste Bandages					
Paste bandages may be used to help improve dry, irritated skin and eczema evident with some leg ulceration. Aim to reduce irritation and increase patient comfort.					
Sterile, preservative free zinc oxide paste bandage. A two-layer, latex-free compression system that delivers continuous restorative compression.	Viscopaste		7.5 x 6m	363	486
	Coflex UBZ with Zinc 10cm (two layer kit) Comprises Layer 1 – an absorbent zinc-impregnated comfort roll to ease pain and skin irritation Layer 2 – a cohesive short-stretch bandage.		10 x 5.5m	635	724

Other Products

Retention Bandage					
Use for dressing retention 5cm for arms and 10cm for legs. To be used for toe bandaging in chronic oedema/lymphoedema.	K-Band		5 x 4m	20	12
	Mollelast		10 x 4m	28	15
			4 x 4m	30	36

Tubular Bandage					
Cost effective tubular bandages ideal for dressing retention. The range is suitable for use on fingers and toes to adult trunks. For garments available, consult Tissue Viability Service.	Comfigauz		Various sizes available	Varies with size	Varies with size
	Comfi-fast				
	Comfi-fast garments (Child sizes but able to use on adults)				
	Comfigrip				

Wound Care Protector					
Waterproof cover, for limbs, to prevent dressings and bandages becoming wet during showering or bathing.	Limbo		Various sizes available on prescription for both leg or arm use	1056	
	Seal – Tight			1050	

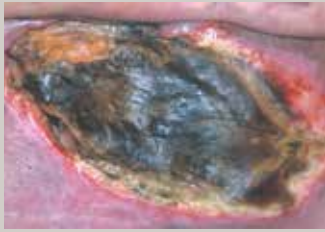




Compression Hosiery Applicator					
ActiGlide is a device to aid with application of hosiery.	Actiglide		1	1440	1640

Footwear						
Kerraped shoes may be used when other footwear will not accommodate a bandage system. They are available in a range of sizes to accommodate most foot sizes and additional bandages. Order form / measuring guides are available from Tissue Viability Service if required.	SIZE	Shoe size (base of toes)	Foot width bandage	Foot with		
	(Circum)					
	Small	2 – 5.5	7.6 – 8.6	23.8 – 27.1	1775 All sizes	1981 All sizes
	Medium	6 – 7.5	8.8 – 9.2	27.6 – 29		
	Large	8 – 10	9.4 – 10	29.5 – 31.4		
X. Large	10.5 – 13	10.1 - 10.9	31.8 – 34.2			

NB. BeneFoot is the medical shoe used within the Acute, this is £13.99 from supplies.

WOUND DRESSING SELECTION CHART

These are suggested dressings – please refer to the Formulary for further guidance

	Aims of Care	Exudate	Primary dressing
Necrotic 	Debride eschar and promote moisture balance N.B. DO NOT debride hard, black necrosis on heels or ischaemic limbs. Refer to appropriate specialist.	Low Moderate	Hydrocolloid – Duoderm Hydrogel – Kerralite C or Flaminal Hydro Honey – MediHoney V gel or HCS Honey – Algivon Plus
Sloughy 	De-slough and provide healthy bed for granulation; promote moisture balance.	Low Moderate High	Hydrogel – Kerralite C or Flaminal Hydro Iodine – Iodoflex Alginate – Sorbsan, Flaminal Hydrofiber – Aquacel Alginate – Urgosorb Foam – Mepilex XT Gelling Fibre – Kytocel
Granulating 	Provide healthy bed for epithelialisation and promote moisture balance.	Low Moderate High	Low / non-adherent – Atrauman, Urgotul, Mepitel Foam – Mepilex Border, Urgotul Absorb Border Alginate – Sorbsan, Flaminal Hydrofiber – Aquacel
Epithelialising 	Promote epithelialisation and wound maturation.	Low Moderate High	Low / non-adherent – Atraumen, Urgotul, Mepitel Foam – Mepilex Border, Urgotul Absorb Border
Infected 	Manage infection and associated wound characteristics.	Low Moderate High	Non-Adherent – Urgotul Iodine – Iodoflex Alginate – Flaminal Foam Hydrofiber – Aquacel Gelling Fibre – Kytocel Alginate – Urgosorb S

Consider using		Special Notes
Primary dressing	Secondary dressing	<p>A holistic assessment is essential before choosing a wound dressing.</p> <p>Inappropriate care can lead to delayed wound healing for patients and unnecessarily high costs for the healthcare provider.</p> <p>ALWAYS use the most appropriate primary dressing (in contact with the wound and to the size of the wound) and only use a secondary dressing when necessary.</p> <p>Protect peri-wound skin if necessary to prevent excoriation.</p> <p>Frequency of dressing change depends on level of exudate. Always dress as appropriate.</p> <p>Skin tears – apply non-adherent dressing and leave for 7 days.</p> <p>Diabetic Foot – please ensure patient under care of Diabetic Podiatrist. Povitulle may be used to protect the wound.</p> <p>Leg Ulcers / compression A full leg ulcer assessment MUST be completed by a competent practitioner prior to application of compression.</p> <p>ONLY use antimicrobial dressings if the wound is confirmed as infected or critically colonised. Review treatment plan every two weeks, updating accordingly.</p>
Term Thin Cool Wound	<p>Film – C-View Film / C-View Post-Op or Mepitel Film if skin is friable</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	
Cool	<p>Film – C-View Film / C-View Post-Op or Mepitel Film if skin is friable</p> <p>Foam – Mepilex Border or Mepilex XT, Urgotul Absorb Border</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	
Aminal Forte Extra or Foam	<p>Film – C-View Film / C-View Post-Op or Mepitel Film if skin is friable</p> <p>Foam – Mepilex Border or Mepilex XT, Urgotul Absorb Border</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	
Mepitel	<p>Film – C-View Film / C-View Post-Op or Mepitel Film if skin is friable</p> <p>Foam – Mepilex Border or Mepilex XT, Urgotul Absorb Border</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	
Primary dressing Mepitel One	<p>Film – C-View Film / C-View Post-Op or Mepitel Film if skin is friable</p> <p>Foam – Mepilex Border or Mepilex XT, Urgotul Absorb Border</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	
or Mepilex XT, or	<p>Film – C-View Film / C-View Post-Op or Mepitel Film if skin is friable</p> <p>Foam – Mepilex Border or Mepilex XT, Urgotul Absorb Border</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	
Aminal Forte Extra or Foam	<p>Film – C-View Film / C-View Post-Op or Mepitel Film if skin is friable</p> <p>Foam – Mepilex Border or Mepilex XT, Urgotul Absorb Border</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	
Primary dressing Mepitel One	<p>Island Dressing – C-View Post-Op</p> <p>Foam – Mepilex Border or Mepilex XT, Urgotul Absorb Border</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	
or Mepilex XT, or	<p>Island Dressing – C-View Post-Op</p> <p>Foam – Mepilex Border or Mepilex XT, Urgotul Absorb Border</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	
Urgotul SSD	<p>Dressing Pad</p> <p>Foam – Mepilex Border or Mepilex XT, Urgotul Absorb Border</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	
Aminal Forte AG + Extra	<p>Film – C-View Film / C-View Post-Op or Mepitel Film if skin is friable</p> <p>Foam – Mepilex Border or Mepilex XT, Urgotul Absorb Border</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	
Mepitel Silver	<p>Film – C-View Film / C-View Post-Op or Mepitel Film if skin is friable</p> <p>Foam – Mepilex Border or Mepilex XT, Urgotul Absorb Border</p> <p>Super Absorbent – Kliniderm, Kerramax Care or Sorbion Sana</p>	

WOUND ASSESSMENT

Key tasks

- **Diagnose** the aetiology (type) of the wound
- Identify and address any **issues that may delay healing** (i.e. pathological, nutritional or social problems associated with wound healing)
- **Record the wound details** to provide a baseline against which planned interventions can be measured
- Set **specific and realistic goals**

Diagnosis of wound aetiology (type)

Possible aetiologies may include:

- Leg Ulceration (venous, arterial, mixed)
- Diabetic Foot Ulceration
- Pressure Ulceration
- Fungating wounds
- Burns
- Skin tears
- Laceration
- Post surgical wounds

Issues that may delay healing include:

- Pain
- Presence of slough
- Excessive exudate
- Infection
- Peri-wound dermatology problems (allergy, excoriation, varicose eczema)
- Hypergranulation
- Lymphoedema
- Inadequate nutrition
- Unrelieved pressure / trauma
- Lower leg venous hypertension
- Arterial insufficiency
- Psychological problems

Record the following details:

- The depth of the wound;
- The shape and size of the wound;
- The wound edges;
- The amount of wound exudate;
- The position of the wound
- Odour
- Pain
- Infection
- Condition of surrounding skin

Specific and realistic treatment aims may be:

- To minimise wound pain
- To debride slough / necrosis
- To manage exudate
- To promote granulation
- To promote epithelialisation
- To promote venous return
- To reduce microbial load (infection)
- To protect peri-wound skin

Please seek advice from the appropriate Specialist/Consultant/Nurse if you are unsure about the most appropriate way to manage a wound.

Wound Documentation

All wounds must be accurately assessed and documented using the appropriate Trust wound care documents.

DIAGNOSIS OF AETIOLOGY

Leg Ulceration

Definition "loss of skin below the knee on the leg or foot which takes more than six weeks to heal"¹

Assessment

- Full clinical history and physical examination
- Detailed visual examination of both legs for signs of venous and arterial disease
- Measurement of blood pressure, weight, urinalysis and Doppler assessment of ankle brachial pressure index (ABPI)

ABPI (Doppler) Right ABPI = Highest right ankle reading
Highest brachial reading

Left ABPI = Highest left ankle reading
Highest brachial reading

It is strongly recommended that ONLY staff who regularly use a Doppler, have received initial training and regular updating and have completed their competencies should carry out this procedure (RCN 2006)².

- o **Venous Leg Ulceration with adequate arterial supply (ABPI = 0.8 - 1.2)**
 - 40mmHg Multi-layer graduated compression therapy (bandaging or hosiery) to be changed weekly or more frequently if there is heavy exudate
 - On healing, life time ongoing assessment with compression hosiery
- o **Arterial Leg Ulceration or Venous Leg Ulceration with reduced arterial supply (ABPI = less than 0.6)**
 - Refer to Vascular Surgeon (if appropriate)
 - Wadding (K Soft) and Crepe bandage (K-Lite) bandaging

Ongoing Assessment

Doppler Assessment of ABPI should also be conducted when:

- An ulcer is deteriorating
- If not fully healed by 12 weeks
- When ulceration recurs
- When a patient is to commence compression therapy including hosiery
- Foot colour and / or temperature of foot change
- There is a sudden increase in ulcer size
- There is a sudden increase in ulcer pain
- Ongoing assessment (3-6 monthly)

References

1. NHS CRD (1997) Compression therapy for venous leg ulcers. *Effective Health Care Bulletin 3 (4) 1-12*
2. RCN (2006) *Clinical Practice guidelines. The nursing management of patients with venous leg ulcer*

Diabetic / Ischaemic Ulceration

Assessment

Refer to diabetes/podiatrist/vascular specialist for assessment, which should include:

- Vascular assessment
- Neurological assessment
- Assessment of foot deformity
- Ulcer assessment
 - o Neuropathic origin
 - o Ischaemic origin

Treatment

Multi-disciplinary approach

Key points in the management of diabetic foot ulcers are:

- Mechanical control (relief of pressure)
- Wound control (debridement and dressings)
- Vascular control (interventions to improve the vascular supply to the foot)
- Microbiological control

Refer patients to a multidisciplinary foot care team within 24 hours (if appropriate) if any of the following occur:

- New ulceration
- New swelling
- New discolouration (redder, bluer, paler, blacker over all or part of the foot)
- Signs or symptoms of infection (redness, pain, swelling or discharge)
- Suspected Charcot's foot

An urgent medical opinion should be sought if any of the following occur:

- Pink or pale, painful, pulseless foot (indicating critical ischaemia)
- Spreading cellulitis, lymphangitis
- Crepitus
- Systemic symptoms of infection
- Lack of response to oral antibiotics for infection
- Suspicion of bone involvement (osteomyelitis)
- Immunocompromise or physiological instability of the patient

NHS Clinical Knowledge Summary – Diabetes Foot Disease 2007

Lymphoedema – Lower Limb

Definition: the accumulation of fluid and other tissue elements in the interstitial space due to insufficiency in the transport capacity of the lymphatic system.

- Primary lymphoedema – due to congenital malformation of the lymph conducting system
- Secondary lymphoedema – results from damage to the lymphatic vessels or lymph nodes due to trauma, disease, surgery, infection, irradiation, immobility and dependency syndrome

Assessment

- Full clinical history and physical examination
- Detailed visual examination of both legs for signs of lymphoedema, venous and arterial disease
- Measurement of blood pressure, weight, urinalysis and Doppler assessment of ankle brachial pressure index (ABPI)
- Formal record of ankle and calf measurement

Treatment

- Good skin care (gentle hygiene with adequate moisturisation)
 - Exercise and movement
 - Multilayer inelastic compression bandaging or hosiery
- Caution in patients with:
- Acute cellulitis
 - Uncontrolled cardiac failure
 - Acute DVT
 - Untreated trunk or genital oedema
 - Latex allergies / sensitivities
 - Arterial insufficiency (ABPI <0.8 or >1.2)
 - Diabetes and rheumatoid arthritis

This Guideline has been approved for use in STHFT, South Tees CCG & HRW CCG. Review by: 12/2018

Burns

Classification (National Network for Burn Care 2012)

Depth of burn	Layers of skin affected	Examination findings
Superficial epidermal	The epidermis is affected, but the dermis is intact	Skin is red and painful, but not blistered.
Partial thickness – superficial dermal	The epidermis and upper layers of dermis are involved	The skin is pale pink and painful with blistering.
Partial thickness – deep dermal	The epidermis, upper and deeper layers of dermis are involved	The skin appears dry or moist, blotchy and red, and may be painful or painless. There may be blisters.
Full thickness	The burn extends through all the layers of skin to subcutaneous tissues	The skin is dry and white, brown, or black in colour, with no blisters. It may be described as leathery or waxy. It is painless.

National Network for Burn Care 2012: <http://www.specialisedservices.nhs.uk/burncare/>

Skin Tears

Skin tears are traumatic injuries, first defined by Payne and Martin in 1993 and more recently by an international consensus group, which can result in partial or full separation of the outer layers of the skin. These tears may occur due to shearing and friction forces or a blunt trauma, causing the epidermis to separate from the dermis (partial thickness wound) or both the epidermis and the dermis to separate from the underlying structures (full thickness wound).

The main aims of management are to preserve the skin flap and protect the surrounding tissue, reapproximate the edges of the wound without undue stretching, and reduce the risk of infection and further injury.

Malignant / Fungating Wounds

The most important aspect in the management of a fungating wound is the switch of emphasis from healing as the primary aim of wound care management to the promotion of quality of life and dignity through holistic patient assessment, communication and good symptom management.

Reduced Skin Integrity – Pressure Ulcers

Definition: A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. (EPUAP/ NPUAP 2009).

Assessment: Within 6 hours of admission to the episode of care or when there is a change in the patient's condition that changes risk.

Patients should be encouraged and taught how to inspect their own skin.

Treatment – Reduce risk of pressure damage by:

- o Repositioning as frequently as is judged appropriate according to the patient's individual needs. (An individualised repositioning schedule must be drafted for each patient judged at risk of pressure damage)
- o Minimising friction and shear through careful manual handling and the use of manual handling devices
- o Ensuring the patient is offered a correct size chair for their body shape
- o The use of pressure relieving equipment (mattresses and / or cushions)

Pressure Relieving Equipment

- The most important intervention to prevent pressure damage is regular positioning with zero pressure to any existing pressure damage so far as is possible
- All clients should receive regular reassessment of risk: a 'step up- step down' approach should be used for equipment selection

Devices to use for pressure ulcer prevention

Barrier preparation

Consider using a barrier preparation to prevent skin damage in adults who are at high risk of developing a moisture lesion or incontinence-associated dermatitis, as identified by skin assessment (such as those with incontinence, oedema, dry or inflamed skin).

– See dressing guidelines for further information.

Siltape

Siltape is made from soft silicone which is gentle on the skin, this is particularly useful in patients with very thin, friable skin which is vulnerable to damage.

It is suitable for small delicate areas such as over the bridge of the nose under oxygen masks, or around ears when using nasal oxygen.

Kerrapro

KerraPro™ Pressure Reducing Pads are made from 100% super silicone.

The KerraPro™ Range helps protect the skin in at-risk patients as part of a pressure ulcer prevention programme.

It is indicated for use on patients who are at risk of developing pressure damage on bony prominences or on areas where medical devices may cause damage to the skin due to pressure.

KerraPro should not be used as a wound dressing or directly on broken skin. The pad should be used on intact skin, on areas where damage is likely to occur or where a category I pressure ulcer is already present.

KerraPro has a natural tack which helps the adherence of the pad to the skin.



Parafricta

Parafricta® garments are designed specifically to reduce friction and associated shear, thereby reducing the potential for pressure ulcers and friction lesion development. They are compatible with, and should be used adjunctively with, methods for reducing the effects of pressure, e.g. pressure relieving mattresses and Repose® Foot Protector/Wedge.

Parafricta® garments are lined with an innovative patented fabric which is smoother and much more durable than silk, thus reducing the burning, tearing and pulling effect on skin from movement against the support surface.

Patients benefiting from the use of Parafricta® garments include those at risk of pressure ulcers or skin damage e.g. with limited ability to reposition independently (such as in orthopaedic and neuromuscular conditions); with reddened skin; with repetitive movements and with fragile skin (such as following burns or at end of life).



Slip on



Velcro closure



Brief slip on



Boxer slip on

Repose

Repose products provide effective pressure redistribution for all people at risk of developing pressure ulcers, including those assessed as very high risk. Repose is also appropriate for users with pressure related tissue damage - clinical supervision is advised where the damage is severe.

In-Line with the NPUAP_EPUAP Pressure Ulcer Treatment Guidelines 2009.



Moisture Lesions

Definition of a Moisture Lesion: Superficial skin damage caused by excessive moisture on the skin, (Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or perspiration, with pink or white surrounding skin (maceration / excoriation).

Moisture lesions present as either multiple diffuse lesions, a linear wound in the natal cleft between the buttocks or on the cheeks of the buttocks, or in skin folds as a copy or kissing lesion.

Best Practice recommends preventing a moisture lesion by keeping the skin clean, dry and well hydrated. If the skins permeability is breached, there is an increased risk of a **combined lesion**, resulting from physical damage (friction, shear and /or pressure).

	Cause	Location	Shape	Depth	Necrosis	Edges	Colour
Pressure Ulcer	Pressure and / or shear	Bony prominences or can also develop when soft tissue is compressed by external forces / devices; e.g. nasal cannula's, urinary catheters	Circular, regular shape	Dependent on category of pressure ulcer	A black necrotic scab = category 3 or 4	Distinct edges	Non-blanchable erythema, necrosis and slough, granulation, epithelialisation
Moisture Lesion	Moisture present (incontinence, perspiration, exudate)	Skin folds, anal cleft, perianal area, sacrum (sitting in urine and faeces)	Diffused different superficial spots; kissing (copy) lesion, linear wounds	Superficial wounds / can be enlarged if infection also present	No necrosis present	Diffuse edges, irregular lesions	Red but not uniformly distributed, pink or white surrounding skin

COMBINATION LESIONS: a combination of pressure and moisture which contributes to tissue breakdown. Need to be categorised as pressure damage but awareness of other causes and treatments needed.

Moisture lesions can sometimes be mistaken for pressure ulcers (TVS, 2012). So please also use the chart above before submitting a Datix.

This Guideline has been approved for use in STHFT, South Tees CCG & HRW CCG. Review by: 12/2018



Pressure ulcer prevention collaborative "Working together to eliminate all avoidable pressure ulcers"



Pressure Ulcer Risk Assessment (PURA)

Score	0	1	2	3	4	5	6	7	8	9	10
1	0	1	2	3	4	5	6	7	8	9	10
2	0	1	2	3	4	5	6	7	8	9	10
3	0	1	2	3	4	5	6	7	8	9	10
4	0	1	2	3	4	5	6	7	8	9	10
5	0	1	2	3	4	5	6	7	8	9	10
6	0	1	2	3	4	5	6	7	8	9	10
7	0	1	2	3	4	5	6	7	8	9	10
8	0	1	2	3	4	5	6	7	8	9	10
9	0	1	2	3	4	5	6	7	8	9	10
10	0	1	2	3	4	5	6	7	8	9	10

Assess risk and skin

- Assess risk using Braden assessment tool
- Perform a head to toe skin assessment at initial assessment and repeat daily
- Pay special attention to bony prominences and areas that come into contact with devices such as catheters, masks etc.

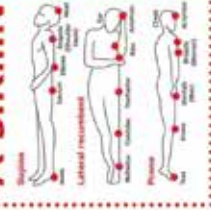
The eatwell plate



Nutrition / hydration

- Complete MUST for all patients at risk of / with pressure damage
- Follow nutritional recommendations as according to risk score
- Ensure optimal nutritional intake
 - complete diet record
- Keep patient well hydrated
 - complete fluid balance chart if required

A S.K.I.N



Support surface

- Select correct support surface (including mattress and cushion)
- Be sure patient is not lying / sitting on tubing, devices etc.
- Check equipment is working correctly
- Review the pressure ulcer risk and equipment requirements daily (step up / step down)



Incontinence / moisture

- Cleanse skin with soap substitute such as foam preparation
 - Use skin protectants or barriers
- Dressings only if appropriate
- Minimise drying and cracking – moisture
- Review continence management including pads. Consider faecal management systems







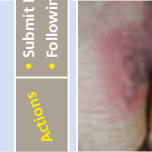
Keep moving

- Document frequency of repositioning on the FOCUS (Intentional) chart and follow this accordingly
- Reposition bed-bound persons at least every two hours and chair-bound persons every hour
- Teach chair-bound persons, who are able, to shift weight every 15 minutes
- Provide written and verbal pressure ulcer information to the patient



Use Pressure Ulcer Categorisation Tool to establish category of pressure damage then implement following actions

Definition - Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply. (NICE 2014)

<p>Category 1</p>  <p>Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.</p> <ul style="list-style-type: none"> Submit Datix Inform Nurse in charge / caseload holder 	<p>Category 4</p>  <p>Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling.</p> <p>The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.</p> <ul style="list-style-type: none"> Submit Datix Refer to TVN Inform Clinical Lead / Ward Manager AND Clinical Matron
<p>Category 2</p>  <p>Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.</p> <p>Presents as a shiny or dry shallow ulcer without slough or bruising.</p> <ul style="list-style-type: none"> Submit Datix Inform Clinical Lead / Ward Manager 	<p>Unstageable</p>  <p>Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.</p> <p>Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.</p> <ul style="list-style-type: none"> Submit Datix Inform Clinical Lead / Ward Manager AND Clinical Matron Refer to TVN Following confirmation of category by TVN, staff must submit further Datix for new category
<p>Category 3</p>  <p>Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.</p> <p>The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.</p> <ul style="list-style-type: none"> Submit Datix Refer to TVN Inform Clinical Lead / Ward Manager AND Clinical Matron 	<p>Suspected deep tissue injury</p>  <p>Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.</p> <p>Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.</p> <ul style="list-style-type: none"> Submit Datix Inform Clinical Lead / Ward Manager AND Clinical Matron Refer to TVN Following confirmation of category by TVN, staff must submit further Datix for new category

ISSUES THAT MAY COMPLICATE HEALING

Wound Pain

Assessment – Carry out a detailed pain assessment to identify type of pain

- **Nociceptive pain** is an abnormal pain response in which the usual channels and processes for feeling, transmitting and interpreting pain have gone haywire – often found in people who have had long term chronic wounds
- **Neuropathic pain** results in people having excruciating pain in their wound bed (hyperalgesia) or in the surrounding skin (allodynia) which can occur following what is normally perceived as a non-painful event (i.e. exposure to the air)

Treatment

- Minimise trauma by selecting a less adherent dressing
- Offer appropriate analgesia

Refer to Pain Control service for further advice / support

Infection

Assessment

- **Diagnose infection or critical colonisation from clinical signs and symptoms**

Signs of infection in chronic wounds

- Increased intensity and / or change in character of pain
- Discoloured or friable granulation tissue
- Increasing malodour
- Wound breakdown
- Delayed healing

The classical signs of infection may be reduced or masked by dermatological problems. (Gardner et al 2001)

- **Send a wound swab for C & S only if the wound is diagnosed as clinically infected and microbiology information is needed to inform the choice of antibiotics**

To swab a wound:

- Clean wound bed
- Moisten swab prior to use if wound is dry and swab across the granulating wound bed, rotating the swab between the fingers – avoid areas of slough
- Place swab in transport medium. **Do not refrigerate**
- Complete the request form, with as much relevant information as possible and send to the laboratory ASAP

Antimicrobial dressings

Antimicrobial dressings may be used for critically colonised or clinically infected wounds to reduce bacterial load. Dressing selection should be dependant on tissue type, level / viscosity of exudate, size, type, position and depth of wound.

Overgranulation / Hypergranulation

Definition: Excessive granulation that prevents re-epithelialisation

Treatment:

- Reduce moisture level at wound bed through use of a more absorbent dressing
- Consider use of topical antimicrobial (e.g. Povidone/Iodoine foam)
- Consider use of topical steroid cream or steroid tape (Haelan)

Slough

Definition: The presence of devitalised tissue within the wound bed, which is thought to increase the risk of infection and malodour and delay healing.

Treatment Options

- **Autolytic debridement** – slough separates from the wound bed as part of the healing process
 - o Dry wounds – use fluid donating dressings (e.g. hydrogels or hydrocolloids)
 - o Moist wounds – use absorbent dressings (e.g. alginates, foam)
- **Sharp debridement** – dead tissue is removed using a scalpel
 - o Sharp debridement should only be undertaken by clinicians with proven skills in this area
 - o Sharp debridement of the foot should only be undertaken by registered podiatrists or surgeons
- **Surgical debridement** – dead tissue is removed using a scalpel down to the level of a bleeding wound bed

- o Surgical debridement should only be undertaken by clinicians with surgical qualifications
- o Surgical debridement of the foot should only be undertaken by registered podiatrists or surgeons
- **Biosurgical debridement** – dead tissue is removed by the application of clinical maggots
 - o Biosurgical debridement should only be undertaken following consultation with appropriate Specialist

Excessive Exudate

Chronic wound exudate contains elevated levels of inflammatory mediators and protein-digesting enzymes and can cause excoriation

Possible causes of excessive exudate include:

- Infection
- Venous hypertension
- Heart failure
- Lymphoedema

Larvae

Larvae or Maggots are used to debride wounds quickly in comparison to conventional dressing regimes. They are effective against multiple infections and MRSA. They require Consultant or Specialist Nurse prescription and are ordered through pharmacy and require consent from the patient/and or carer.

Larvae are presented to the clinician in either a free range (loose) or contained (bio foam) package which will depend upon the wound and the needs/choice of the patient. Larvae breakdown down only necrotic and unviable tissue, they will not harm healthy tissue. As the Larvae are less than ten days old they are not adults and are therefore not developed enough in age to produce eggs within the wound. The disposal of the larvae, either free range or within the bio foam pouch is via the clinical waste disposal process as for all dressings.

Please contact appropriate Specialist Nurse/Consultant.

Negative Pressure Wound Therapy

NPWT therapy uses continuous and/or intermittent negative pressure to remove infectious materials and/or fluids from the wound bed. The manufacturers propose that NPWT therapy promotes wound healing but at present there is no robust research evidence to support this claim.

NPWT therapy may be considered as a possible treatment option for patients with chronic, acute, traumatic, subacute and dehisced wounds, partial-thickness burns, ulcers (such as diabetic or pressure), flaps and grafts **when complicated healing is anticipated** due to:

- very heavy exudate which requires very frequent dressing change (at least daily) e.g. orthopaedic trauma wounds, dehisced wounds,
- reduced arterial supply where stimulation of blood flow may enable an adequate circulation to be established. e.g. arterial leg ulcers, diabetic foot ulcers

NPWT may only be used after discussion with the Specialist Nurse/Consultant.

Peri-wound Dermatology Problems

A referral to a specialist dermatologist should be sought for any unidentifiable or complex dermatological problems. However, these more simple conditions may be managed as follows:

Eczema

Varicose eczema

- Associated with increased capillary pressure due to venous hypertension
- Often confused with cellulitis

Treatment:

- Soften any skin scales (Soak for 10-20 minutes in warm water then massage with simple bland emollient)
- If inflamed apply ointment-based topical moderately potent corticosteroid - Treatment should usually only be for a few days
- Once inflammation has subsided, replace corticosteroid ointment with simple emollient
- Reverse venous hypertension through compression therapy providing there is adequate arterial supply (Calculate ABPI using Doppler)

Exogenous eczema – e.g. irritant and allergic contact dermatitis

- Appears on second contact with allergen
- If reaction is severe may spread beyond area of direct contact
- 60% of patients with chronic leg ulcers demonstrate contact sensitivity associated with treatment

- More common in patients with co-existing stasis eczema
- Common allergens for leg ulcer patients: lanolin, topical antibiotics, cetylstearyl alcohol, cetyl alcohol, stearyl alcohol, cetostearyl alcohol, rubber, parabens (hydrobenzoates), fragrance, hydrocortisone

Emollients

Emollients form the mainstay of dermatological treatments; they are not optional extras.

The importance of using emollients liberally for acute, sub-acute or chronic skin conditions cannot be overemphasised, according to the Best Practice Statement (2009).

- They are used to help repair the skin barrier breakdown by rehydrating the stratum corneum, causing the corneocytes to swell up, which leads to an improvement in the integrity of the skin barrier (Cork and Danby, 2009)
- They also help maintain the barrier function by reducing signs of dryness, alleviating sensations such as tightness and itching, and reducing water loss through the skin by providing a lipid film on the skin surface
- They also assist in controlling thermoregulation
- The most important determinant in choosing an emollient is whether it is cosmetically acceptable (Best Practice Statement, 2009; Cork and Danby, 2009)
 - o They should suit patients' lifestyles; for example, asking them to apply a thick greasy product such as white soft paraffin during the day when they wear smart suits or silk fabrics, causing staining, would be inappropriate
 - o Water-based products such as creams or lotions to use during the day are likely to be more cosmetically acceptable
 - o In addition, if an emollient smells and feels acceptable to patients, they are more likely to use it

The Best Practice Statement (2009) described emollients as substances whose main actions are to occlude the skin surface and encourage build-up of water within the skin.

Recommended emollients:

Emollients				
To re-hydrate dry skin.	Doublebase Gel	100g	269	269
		500g	592	592
If applying to leg, ensure product is applied in downward strokes to reduce risk of folliculitis.	Dermol 500 Lotion	500ml	604	603
	Epaderm Cream	50g	170	177
		500g	695	758
Dermol lotion for irritated skin – contains an antibacterial ingredient and requires prescribing by GP.	Epaderm Ointment	125g	385	412
		500g	653	700
Add 1 -2 capfuls of bath and shower emollient to warm water in a lined bowl or bucket for washing legs when required.				

Nutrition

Assessment

- Patients judged at risk of malnutrition should be assessed using the Malnutrition Universal Scoring Tool (M.U.S.T.) to assist in the decision whether to refer to a dietician

Treatment

- If a patient is malnourished or dehydrated advice should be given to the patient/carers on how to improve nutrition
- Severely malnourished patients should be referred to the dietician for advice

