Wound Care Guideline and Formulary

Classification :	Guideline
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Authors Job Title:	Tissue Viability Specialist Nurses
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Guideline to be followed by (target staff):

To be read in conjunction with the following documents:

Milton Keynes University Hospital NHS Foundation Trust. *Incident reporting policy and procedure (including serious incident procedure).* RM/GL/17. Version 9.1, 2019.

Milton Keynes University Hospital NHS Foundation Trust. *Pressure ulcer prevention guidelines*. NURSING/GL/45. Version 2, 2019.

Milton Keynes University Hospital NHS Foundation Trust. *Wound assessment and care plan*. DOC84. Version 1.0, 2015.

Are there any eCARE implications? Yes

CQC Fundamental standards:

Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.
The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

This Wound care Guideline and Formulary has been written by Milton Keynes University Hospital NHS Foundation Trust. This guideline has been developed to support healthcare professionals to ensure standardised quality evidence-linked practice is delivered across the Trust.
This guideline and formulary and its recommendations are evidence linked rather than evidence based as there is lack of evidence from well controlled randomized trials evaluating the clinical and cost effectiveness of wound care products. Recommendations are based on expert opinion and clinical evidence.

Executive Summary

The following wound management guideline has been developed to aid clinicians to appropriately identify, assess and manage wounds.
This guideline ensures that the most effective and efficient wound dressing is chosen and reflects the usage of wound care products for patients at Milton Keynes University Hospital and in the wider Milton Keynes community to ensure integrated pathways of care. This guideline must be followed at every assessment of a patient presenting with a chronic/acute wound.

Definitions

Anaerobe	Bacteria that thrive in an oxygen free environment. They bury under necrotic tissue and provide some of the pungent odours in these wounds.
Angiogenesis	The production of new blood vessels. In wounds, new vessels grow into a loop and have an appearance of deep red granules - this is called granulation tissue and is a feature of healing.
Anti-bacterial	A substance with bactericidal or bacteriostatic properties "kills" or "inhibits bacteria
Autolysis	The body's natural ability for removing necrotic tissue as it uses its own enzymes to breakdown devitalised tissue (lyse). In wound care autolysis is encouraged through the use of "moist wound dressings."
Autonomic Neuropathy	A degenerative disorder of the autoimmune system which leads to reduced blood flow and loss of the sweating response in the feet, often associated with diabetics.
Contamination	Organisms are present in the wound exudate but not multiplying or clinically affecting the host.
Debridement	Taken from the French débrider to remove adhesions. The removal of devitalised or contaminated tissue can occur in many ways. It can be sharp (scalpel, scissors), chemical or enzymatic, larval therapy or Debridement through autolysis.
Degloving injury	The epidermis is torn away exposing the dermis or lower structures. It can often occur in patients who have received long-term steroid therapy or through trauma
Eschar	Hard necrotic tissue found in pressure ulcers generally. The tissue has been occluded of blood and dies. It then dehydrates, hardens, and becomes eschar. Requires debridement before healing can occur.
Epithelialisation	When the wound bed has completed the proliferation stag and is level with the surface, epithelial tissue will begin to migrate over the wound. This will appear as pink/pale mauve coloured tissue that is fragile and may require further protection.
Erythema	Redness of the skin, as seen in inflammation surrounding wounds or on areas where prolonged pressure has occluded the local blood supply resulting in inflammatory changes.
Excoriated	The skin has become traumatised, worn away or abraded. Often occurs in the presence of maceration and can be due to inappropriate dressings which cause wetness around the wound margins or incontinence.
Exudate	Serous fluid that has passed through the walls of a damage or over extended vein. It is exacerbated when oedema or hydrostatic pressure present. Bacteria indirectly vaso-permeability and this results in increased exudate production. Some exudate is necessary for a moist wound environment. Exudate varies in consistency from a thin watery fluid to a thick tenacious fluid.

Friction	It is a contributing factor in the formation of pressure ulcers and occurs when resistance is met as one surface moves over another. Friction can be increased by moisture, such as urine of perspiration.
Granulation	The growth of new tissue formed within the collagen matrix in a wound. The appearance will be a deep pink base with red lumps over the surface. These lumps are capillaries that have grown up through the wound matrix and have united in loops to give the wound bed the appearance of granules ~ hence the name.
Haemostasis	The process leading to the reduction of blood flow from a damaged blood vessel.
Maceration	The softening of tissue that has remained wet or moist for a prolonged period, resulting in the skin becoming white and soggy making it less resilient to tissue breakdown. Macerated tissue is in danger of excoriation and increased risk of pressure ulcer formation.
Necrosis	Death of tissue or an organ in response to injury, disease, or occlusion of blood flow.
Occlusive Dressing	An impermeable or semi-permeable wound dressing which completely covers a wound. Protecting the wound from the external environment, preventing microbial invasion, and maintaining wound temperature. They are thought to provide a low oxygen environment that may have a positive influence on angiogenesis, as the new capillary buds grow towards a region of low oxygen tension.
Oedema	An unnatural collection of fluid in interstitial spaces of tissue which can occur anywhere in the body.
Osmosis	The movement of fluid through a semi permeable membrane (cell wall) from an area of low concentration to an area of high concentration, until the concentration of both solutions is equal. It is possible for cells to take in fluid until they burst.
Over-granulation	Granulation tissue continues to fill the wound bed until it is proud of the wound, preventing epithelial tissue from migrating across the surface.
Purulent	Forming, consisting of or containing pus.
Pus	A product of inflammation most frequently caused by infection. It contains numerous used leukocytes, liquefied by enzymes and cellular debris.
Shear	The friction caused when two or more surfaces pull against each other e.g., skin and sheets
Skin Graft	Skin that is harvested from one part of the body to cover a defect in another.
Slough	Devitalised tissue (dead white cells, bacteria, rehydrated necrotic tissue), which has a yellow/white/grey hue.
Strike-through	Evidence of wound exudate appearing on the outer surface of the dressing, indicating the need for dressing change.
Toxin	A substance that has a detrimental effect on living cells.

1.0 Roles and Responsibilities:

All Clinical Staff:

- It is the responsibility of all staff, with appropriate training, to comply with the guideline.
- It is the responsibility of all managers to ensure staff are given an opportunity to attend appropriate training, to comply with the guideline.
- Locality managers will ensure that approved resources are available.
- It is the responsibility of the Tissue Viability Nurse to provide the necessary training and resources to ensure staff are best informed on best practices.

Procurement and Supplies:

- It is the responsibility of Purchasing and Supplies to ensure that only approved formulary dressings are ordered for clinical areas.

2.0 Implementation and dissemination of document

This guideline will be accessible to all staff via the Trust documentation share point site accessible on the Trust intranet.

Reference to this guideline is embedded within all education and training provided.

This review and any future review will be disseminated from Nursing Midwifery Board throughout the clinical divisions and monitored by ward sister/charge nurse or clinical managers.

3.0 Processes and procedures

Essential elements of a Wound Assessment

Accurate wound assessment is essential to the realistic planning of goals and interventions for patients with wounds. However, the assessment process has several individual components that must be systematically considered.

3.1 Classification of the wound

Although there are many types of wounds there are four main groups:

- **Mechanical** – Surgical and traumatic wounds
  Abrasions An abrasion can be defined as a scraped area on the skin or on a mucous membrane, resulting from injury or irritation. Abrasions are superficial injuries normally caused by friction between the skin and a blunt object. These wounds can often be left to scab over and they often heal without scarring.
  Cut A 'cut' can be defined as a wound made by cutting. Cuts are usually straight wounds with well-defined wound edges, caused by a sharp object. These wounds are often closed using sutures, topical skin adhesives or adhesive strips and usually heal without complication.
  Lacerations A laceration can be defined as a torn, jagged wound. Lacerations are often caused by a blunt instrument or force. There is also often bruising associated with the wound.
  Penetrating Wounds They can be defined as a forceful injury caused by a sharp, pointed object that penetrates the skin. A puncture wound is usually narrower and deeper than a cut or scrape. Puncture wounds have an increased risk for infection because they are difficult to clean and provide a warm, moist place for bacteria to grow.

Bites can be caused by dogs, cats, spiders, snakes, and humans. The expected tissue trauma will be different depending on the type of bite. These wounds will require a very thorough clean prior to closure. If the wound is heavily contaminated with debris, it may need to be left open for a few days whilst antibiotics are given to the patient. The wound can then be closed. The patient may require a tetanus booster.
Skin Tears A skin tear is simply defined as a traumatic wound resulting from separation of the epidermis from the dermis. Skin tears are a specific type of laceration that mostly affect older people with fragile skin because of the ageing process, medications, or dermatological conditions. The skin tear occurs due to the force of shear or friction occurring that separates the layers of skin. There tends to be change in the deposition of subcutaneous tissue in specific areas such as the face, dorsal aspect of the hand and shins.

- **Chronic** – Leg ulcers, pressure ulcers and diabetic foot ulceration.
  A chronic wound is a wound that does not heal in an orderly set of stages. Wounds that do not heal within 3 months are considered chronic. For example, chronic wounds often remain in the inflammatory phase. These wounds cause patients severe emotional and physical stress as well as creating a significant financial burden on patient and the whole of the health care system. Examples of chronic wounds may be pressure ulcers, diabetic wounds, and leg ulcers.

- **Burns, chemical or thermal injuries** – these may be classified further by depth of injury. Burns and Chemical Injuries Thermal, chemical electrical and those caused by radiation. Burns and scalds may be classified to three types depending on the degree of tissue damage. They are most described as:
  1. Superficial (first degree) burns, involving the epidermis and superficial layers of the dermis Wound Management Guidelines Page 4 of 12 Version 1.0 September 2016
  2. Deep dermal (second degree) burns, in which most of the surface layers of the epithelium is destroyed, together with much of the layer beneath
  3. Full thickness (third degree) burns, in which all the elements of the skin are destroyed.

- **Malignant** – primary cancerous lesions such as basal cell, squamous cell, and melanomas

3.2 Assessment of the wound bed

Accurate classification of the type of tissue within the wound bed is essential when selecting the appropriate wound management product.

Term	Definition
Anti-microbial	A general term for drugs, chemicals, or other substances that either kill or slow the growth of microbes. Among the antimicrobial agents are antibacterial drugs, antiviral agents, antifungal agents, and antiparasitic drugs.
Debridement	The process of cleaning an open wound by removal of foreign material and dead tissue, so that healing may occur.
Diabetic foot ulcer	A foot affected by ulceration that is associated with neuropathy and/or peripheral arterial disease of the lower

	limb in a patient with diabetes.
Epithelisation	Epithelialisation is characterised by the proliferation and migration of epithelial cells across the wound surface.
Exudate	Fluid, such as pus or clear fluid, that leaks out of blood vessels into nearby tissues. The fluid is made of cells, proteins, and solid materials. Exudate may ooze from cuts or from areas of infection or inflammation.
Granulation	Granulating tissue is composed of collagen and "ground substance" and contains new capillary loops that give granulation tissue its characteristic red colour.
Leg ulcer	A loss of skin below the knee on the leg or foot which takes more than 6 weeks to heal.
Pressure ulcer	A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear.
Slough	Slough refers to moist necrotic tissue. This type of devitalised tissue is soft, moist, and often stringy in consistency and is usually yellow, white, or grey in colour.
Necrosis	A necrotic wound contains tissue that has become devitalised due to damage to its blood supply, for example from pressure or trauma. When this tissue becomes dehydrated it forms a hard, black leathery layer over the wound, commonly called an eschar.

Ongoing assessment of the tissue type and volume (quantify in %) is important in ensuring appropriate product selection.

3.3 Assessment of surrounding skin

Assessment should identify whether the skin is erythematous (reddened), excoriated, indurated (hardened), or macerated.

- **Erythema** – redness of the skin around a wound can be indicative of heavy colonization or infection. Erythema around a pressure ulcer may also be indicative of ongoing pressure damage.

- **Excoriation** – stripping of the upper layers of the epidermis because of prolonged exposure to toxins on the surface areas of the skin – can occur when there is excessive wound fluid.
- **Induration** – a change in the texture rather than the color of the skin, it becomes hard and less supple often present around infected wounds.
- **Maceration** – excessive moisture in the skin resulting in the tissues becoming waterlogged. Untreated will lead to tissue excoriation.

3.4 Identifying primary treatment objectives.

- **Wound cleansing –** Does the wound need to be cleaned and if so, with what? It is accepted that wounds should be cleansed with normal saline, except for some chronic wounds, i.e., leg ulcers. Routine cleansing is not recommended for clean wounds.
- **Debridement –** dressings can perform autolytic debridement by rehydrating necrotic tissue. Bio surgical debridement may be appropriate by using larval therapy. Large volumes of necrotic tissue may require surgical debridement to facilitate rapid removal.
- **Control of exudate –** wound exudate is produced as a normal part of the healing process. During the inflammatory response blood vessel walls dilate and become more porous allowing leakage of protein rich fluid into the wounded area. Managing exudate and maintaining a wound environment that is moist but not wet is a constant challenge. Appropriate dressing selection is paramount in dealing with exudate volume and maximizing dressing wear time.
- **Minimizing the effects of infection –** identification of infection within the wound environment is vitally important. The presence of infection may lead to the rapid deterioration in the wound and may lead to systemic sepsis if left untreated. Please refer to the management of infected wounds section for further guidance.
- **Dressing wear time –** to optimise dressing performance and maximise wear time. Practitioners must familiarise themselves with the individual dressing characteristics to ensure that each product selected is able to manage the individual characteristics such as exudate volume, odor, and control of pain.

3.5 Documentation

Current and accurate documentation of all components of the wound assessment and management plan is essential in maintaining high practice standards. The use of wound management / dressing forms should be implemented for all patients requiring wound care. Terminology should be objective and ambiguous in content.

The trust uses the ASSKING tool to focus practice and learning using a collaborative framework in the prevention, assessment, and management of pressure ulcers. The aSSKINg Care Bundle is a powerful tool as it defines and ties best practices together. The bundle also makes the actual process of preventing pressure ulcers visible to all. This minimises variation in care practices.

ASSKINg care bundle

- assess risk;
- Skin assessment and skin care;
- Surface selection and use;
- Keeping patients moving;
- Incontinence assessment and care;
- Nutrition and hydration assessment and support;
- giving information.

3.6 Choosing the appropriate dressing.

The wound healing process is physiological response to a wound which is affected by a patient's overall health. A holistic assessment should be performed to identify underlying conditions to determine the cause of the wound. The cause then needs to be investigated, treated, and managed appropriately to address underlying co-morbidities I.e., blood glucose control, nutrition etc.

The aSSKINg tool can facilitate a holistic assessment which should be performed to identify underlying conditions to determine the cause of the wound. Skillful observation of the assessing nurse is required when choosing the right dressing, which optimises the biology of healing, creating a faster healing environment. Factors that delay healing should also be corrected or eliminated e.g., correction of anemia, referral to dietician.

Hand Washing and Personal Protective Equipment (PPE)

Handwashing is the single most important measure in the prevention of cross infection. Please refer to the infection prevention policy and guidelines for more information. Gloves and Apron must be always worn for wound care and must be changed after contact with each patient and at the end of each procedure. Wash hands after removing gloves.

Dressings do not heal wounds.

The wound healing process is a physiological response to a wound which is affected by a patient's overall health.

A holistic assessment should be performed to identify underlying conditions to determine the cause of the wound. The cause then needs to be investigated, treated, and managed appropriately to address any co-morbidities such as diabetic control, nutrition etc.

Most dressings in this formulary are designed to remain on the wound for 3 to 7 days, refer to the manufacturer's instructions for specifics. Infected, necrotic, fungating and sloughy wounds may need to be changed more frequently.

Wound care Video - https://1drv.ms/v/s!ApjzJJ15Gl3XjD7DAJlNY6xsD6Xi?e=kt0iyv

3.7 Changes to prescribed Treatment of Care.

Whenever a change in the care, or treatment, of a patient is prescribed, either by an appropriate practitioner or in the plan of care by the assessing nurse, the following must apply: -

Research based knowledge must be always used to support a professional decision to change a treatment. The treatment should not be changed due to nurse preference.

The NMC Code of Conduct should be always adhered to.

All treatment changes should be in consultation with the patient and prescribing practitioner, preferably face to face. Always relate to them the rationale for change.

All changes to treatment or planned care must be documented. Also contact with the prescribing practitioner needs to be in the patient's documentation, signed and dated.

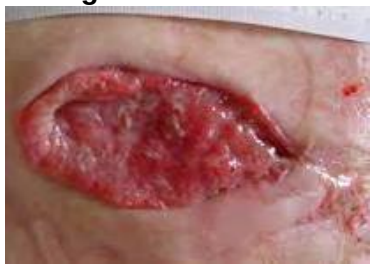
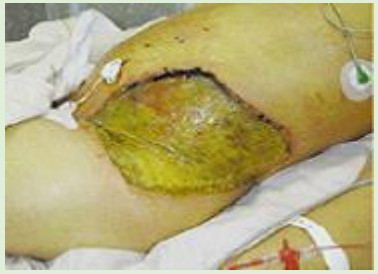
Any disagreements/controversy over a prescribed treatment should be brought to the attention of the Tissue Viability Service

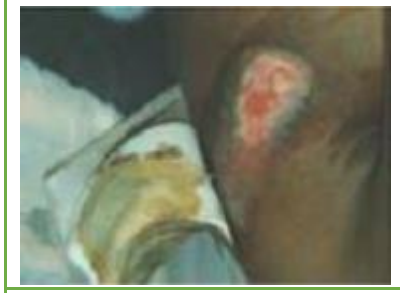
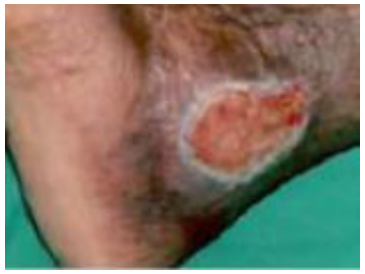
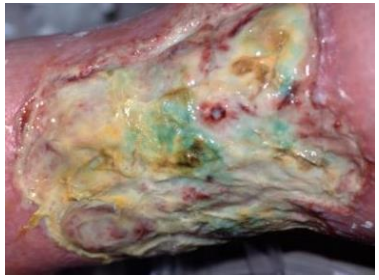
The Ideal Dressing Should:

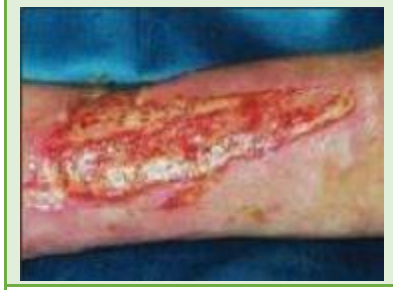
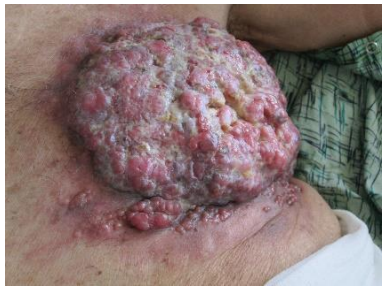
Objective	Evidence
Maintain a moist environment	Accelerates epidermal migration and dermal repair.
Remove excess exudate, preventing leakage	Excess exudate can macerate healthy tissue surrounding the wound.
Provide thermal insulation	A drop in temperature below 37° C delays mitotic activity for up to four hours.
Act as a barrier to micro-organisms	"Strike-through" of exudate allows passage for bacteria in to and out of the wound.
Be non-adherent, easily removed without trauma, leaving no foreign particles in the wound	Adherent dressings may cause trauma to new tissue; capillaries can grow through gauze and will be torn when removed.
Be non-toxic, non-allergenic, non-sensitising	Although not demonstrated in human studies, laboratory evidence has shown that some antiseptics and hypochlorites are toxic to certain cells.

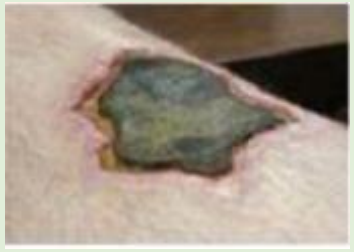
Note: This formulary is a recommendation of appropriate products. All patients must be assessed holistically and the limitations of dressings considered.
For example not all dressings are appropriate for weight bearing areas such as heels and elbows
CAUTION: When treating wounds on lower limbs avoid using Hydrocolloid or Hydrogel until Peripheral vascular status is known.
If blister present apply Inadine.

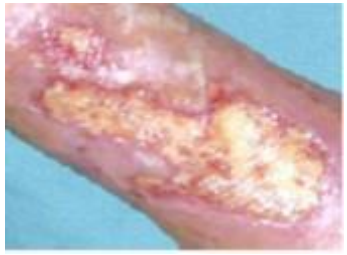
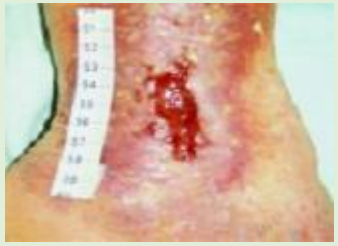
Section 5 Complex Wounds

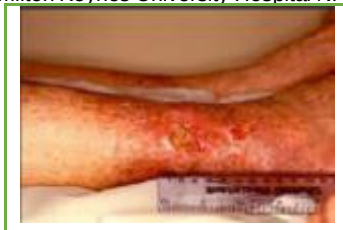
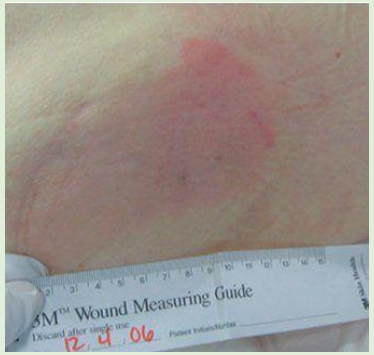
Wound type	Description	Management Aims	Treatment options	Comments
Dehisced Wound 	Post-operative complication where suture material/clips are unable to keep wound edges together resulting in exposure of subcutaneous tissue	• Management of exudate • Removal of devitalised tissue • Protection of surrounding skin • Promote granulation • Reduce pain and anxiety	**Low Exudate** Aquacel and Mepilex Border **High Exudate** Aquacel and Absorbent pad	**Also consider** Management of raised pressure within body cavities secondary to coughing/vomiting Pain control Possible herniation Secondary closure Suitability for Vacuum assisted closure (VAC) therapy Correction of malnutrition
Over granulation 	Granulation tissue which protrudes above the level of surrounding skin thus preventing re-epithelialization	• Prevent further over granulation • Promote re-epithelialization • Manage wound exudate	**1st Choice** • Mepilex Border **2nd Choice** • Typharm – **Haelan tape** 50cm & 200cm length or **Haelan ointment 60g tube**	Consider discontinuing hydrocolloids and assessing for signs of infection. May require Antimicrobial dressing.
Malodorous Wounds 	Infection/heavy colonisation by aerobic/anaerobic bacteria. Presence of devitalised tissue acting as focus for bacteria. Uncontrolled odour.	• Reduce level of bacteria and eliminate and infection. • Debridement • Improve quality of life by control of odour using barrier methods	Swab/biopsy of wound for bacterial screen Systemic antimicrobials Appropriate wound management e.g. Clinisorb **Low Exudate** • Honey with a foam dressing **Moderate to High** Aquacel and or Mepilex Border. **Odour Control** Clinisorb charcoal or Metronidazole gel	

Contaminated Wound 	Organisms present but not multiplying Clinical Signs: Positive Swab/Biopsy	Prevent infection	Maintain good asepsis Use antimicrobial solution to cleanse. Apply honey with a foam dressing.	Wound infections should be treated with systemic anti-bodies. **Iodine products should be used with caution on patients with known thyroid problems**. Chronic wounds such as leg ulcers and pressure ulcers are colonised with a variety of bacteria which do not always lead to clinical infection. Optimising patient condition will reduce likelihood of infection. Ensure good hydration and nutritional intake.
Colonised 	Multiplication of organisms but no host reaction. **Clinical Signs:** Positive swab/biopsy	Prevent infection Reduce bacterial load Prevent bacterial growth	Maintain good asepsis Apply appropriate product based on wound bed assessment	
Critically Colonised 	Bacterial growth interferes with healing but does not invade surrounding tissue or cause inflammation. **Clinical Signs:** Pain, Excess exudate, static healing	Resolve deep infection. Reduce bacterial load. Treat symptoms. Prevent septicemia.	Maintain good asepsis Use antimicrobial solution to cleanse Apply antimicrobial dressing like Silver(AG)/Honey with a foam or absorbent dressing, selection dependent on exudate levels.	

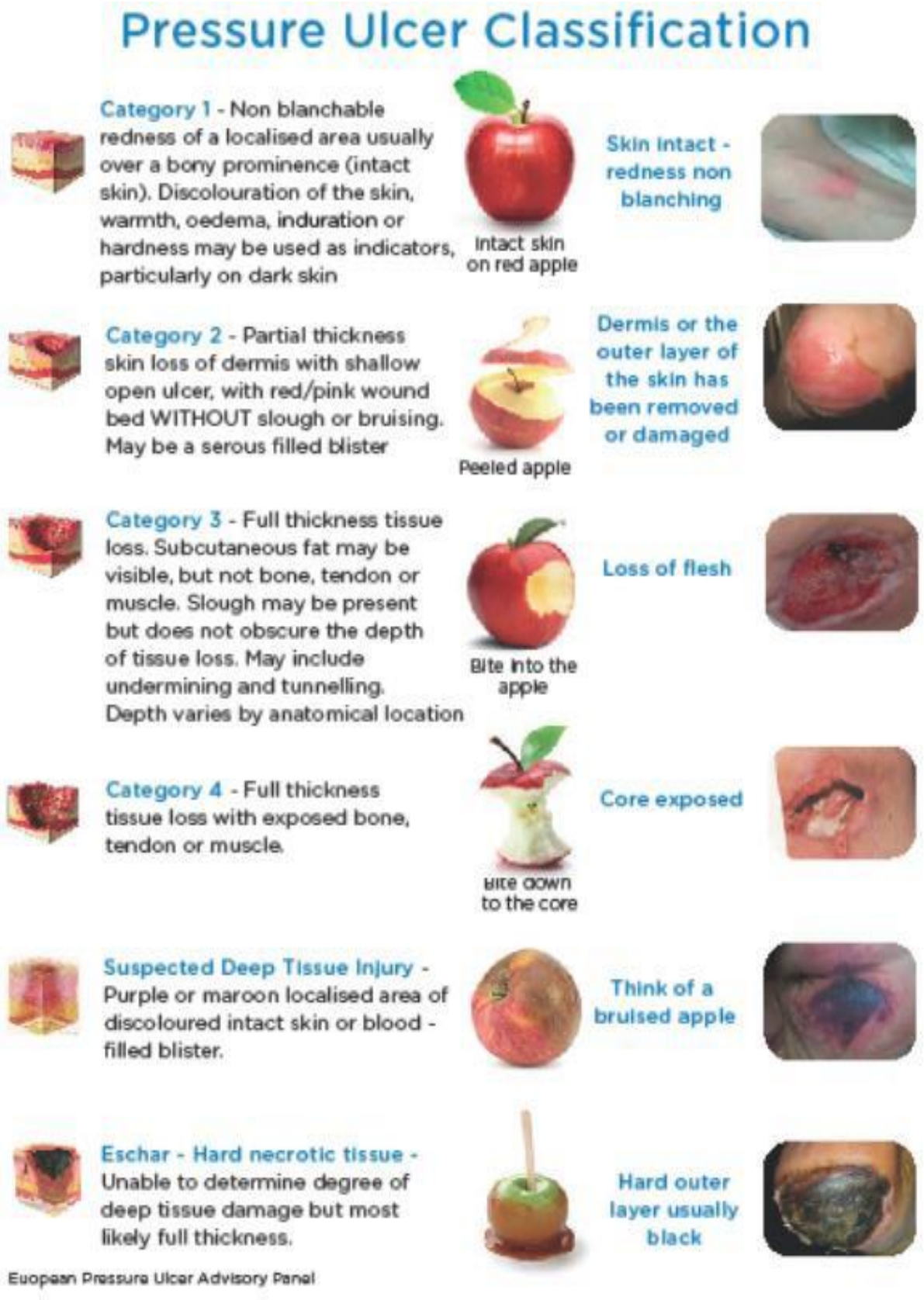
Infected 	Deposition and multiplication of bacteria with host reaction. **Clinical Signs:** Pain, Erythema, inflammation, pyrexia, Pus, Odour, Excess exudate, static healing.	Resolve deep infection Reduce bacterial load Treat symptoms, Prevent septicemia. To consider use of systemic antibiotics if clinical signs indicate.	Maintain good asepsis Use antimicrobial solution to cleanse Apply antimicrobial dressing like Silver(AG)/Honey or Flaminal Forte wound gel with a foam or absorbent dressing, selection dependent on exudate levels.	
Fungating 	Complication of cancer and may develop in patients with advanced disease. Caused by direct infiltration of the skin by a tumour or metastatic deposit. Can be painful and produce high levels of exudate. Can bleed and be malodourous.	To control odour, bleeding and to manage excess exudate. To manage patient comfort. May require psychological support.	Maintain good asepsis. Use antimicrobial solution to gently cleanse area. **Flaminal Forte** antibacterial wound gel to the base of the wound **No Bleeding** Apply Aquacel extra as first contact layer **Bleeding** Apply Kaltostat alginate dressing to help stem the bleeding as first contact layer **Odour** Charcoal activated dressing can be used to help assist odour. **Metronidazole gel** can be used alongside with the Flaminal Forte to help reduce the malodour effectively **Friable surrounding skin** Protect with Cavilon film non sting barrier film.	Kaltostat dressing absorbs naturally, therefore should be cut or folded to the shape of the wound to avoid maceration Of surrounding skin. Forms A viscous gel and can therefore, be removed in one piece.

			Cover with silicone foam adhesive.	
Necrotic / Eschar 	Predominately dry black or yellowish brown. Necrosis / Eschar is formed when healthy tissue dies and becomes dehydrated.	**Active Management** Prepare wound bed for healing. The following techniques can be used. <u>Autolytic debridement</u> rehydrating tissue using dressings which donate moisture. Care to be taken to surrounding healthy skin to avoid maceration. Should not be used on diabetic wounds or wounds with arterial insufficiency. <u>Sharp Debridement</u> Remove devitalised tissue by trimming away the necrotic tissue. Often require more one treatment. <u>Surgical Debridement</u> Performed under general or local anaesthetic to remove all necrotic tissue, often creates a larger wound but will heal much faster. <u>Larval Therapy</u> Sterile maggots are applied to debride necrotic tissue. The maggots do not consume healthy tissue. Only to be applied under specialist instruction.	**Active Management** Maintain good asepsis Use antimicrobial solution to cleanse Apply hydrating dressing like Honey / Flaminal Hydro with a foam dressing a s a secondary layer. **Conservative Management** Maintain good asepsis Use antimicrobial solution to cleanse. Apply Inadine dressing with a foam dressing a s a secondary layer.	**Do not debride diabetic foot ulcers or heel pressure ulcers – aim to keep dry until specialist input is sought.**

		Conservative Management It may not always be appropriate to break down necrosis e.g., palliative patient or arterial involvement).		
Sloughy 	A mixture of dead white cells, dead bacteria, rehydrated necrotic tissue and fibrous tissue. Predominantly yellow in colour, can be tan or grey in colour. Maybe adhered to wound bed or loose and/or stringy.	To de-slough, promote autolysis and remove excess exudate to avoid infection and prepare wound bed for healing.	Maintain good asepsis Use antimicrobial solution to cleanse **Superficial** Apply Flaminal Forte and Aquacel extra with an absorbent / foam / silicone dressing. **Cavity** Insert Flaminal Forte, insert Aquacel Ribbon / Aquacel Extra to gently fill cavity to promote healing upwards and inwards.	
Granulating 	Granulating tissue is usually deep pink in colour at the base with red 'lumps' over the surface due to capillary budding. Tissue is fragile and easily disrupted by dressing adherence if inappropriate dressing applied	To promote granulation by managing exudate levels to effectively prevent damage and infection to delicate granulating tissue. Maintain moist, warm, clean healing environment.	Maintain good asepsis Use antimicrobial solution to cleanse **Superficial** Apply NA ultra with a foam / silicone dressing. **Cavity** Aquacel Ribbon can be used to fill cavity to promote healing upwards and inwards.	
Epithelializing	Wound bed is usually shallow, pink in appearance. Fragile.	Maintain moist, warm, clean healing environment.	Maintain good asepsis Use antimicrobial solution to cleanse	

			Apply NA ultra with an absorbent pad / foam / silicone dressing.	
Reddened 	Tissue which is likely to break down if not protected from pressure and/or friction.	To promote skin health and protect.	Good skin care using QV range or Cavilon Barrier Products. Observe closely.	

Pressure Ulcer Classification



Requested advice for leg ulcers – please follow the below advice before referring to Tissue Viability - available on the trust intranet under tissue viability

1. Remove all bandages including compression bandages **within 6 hours** of admission to ward.
2. Assess leg ulcers and condition of skin including heel and document accurately.
3. Contact the District Nurse or Nursing Home to determine dressing regime already implemented. Follow this regime EXCLUDING COMPRESSION BANDAGES. Apply cotton tubular bandage.
4. Obtain wound swab for MC&S.
5. Strict skin care using emollients and warm tap water at each dressing renewal.
6. Encourage patient to elevate legs.

IF UNABLE TO CONTACT THE DISTRICT NURSE, PLEASE FOLLOW THE FOLLOWING DRESSING REGIME:

1. Strict skin care, washing legs with warm tap water and QV Gentle wash cleanser 250mls. Moisturise skin with QV Intensive Ointment 450mls
2. NA Ultra as primary dressing. Aquacel Extra as secondary dressing.
3. If ulcers are infected, obtain a wound swab then apply Cutimed Sorbact Swab as a primary dressing and a Surgipad. If ulcers are very wet Eclypse pad.
4. Secure with Blueline/ Yellowline bandage. Plus size patients may require Beige tubular bandage. Ensure heels are checked daily and document.
5. If legs are very wet and oedematous, please encourage patient to elevate legs as much as possible, ideally on bed.
6. Compression bandaging will not be applied whilst an inpatient unless recommended and applied by MKUHFT Tissue Viability.

Please observe condition of skin integrity to heels and document accurately
Refer to Tissue Viability if after all the above has been completed, there is no improvement after 5 days.

Management of lower limb cellulitis

1. Obtain wound swab for MC&S – ensure correct antibiotic therapy is being delivered.
2. Strict skin care, washing legs with warm tap water and QV Gentle wash cleanser. Moisturise skin with QV Intensive Ointment – medical team can prescribe.
3. NA Ultra as primary dressing and Surgical Pad.
4. Secure with Blue line/Yellow line tubular bandage. Plus size patients may require Beige tubular bandage. Ensure heels are checked daily and document.
5. If legs are very wet and oedematous, please encourage patient to elevate legs as much as possible, ideally on bed.

Please observe condition of skin integrity to heels and document accurately
Refer to Tissue Viability if after all the above has been completed, there is no improvement after 5 day.

QV Emollients Pathway

NHS Milton Keynes University Hospital NHS Foundation Trust

REMEMBER: Keeping your patient's skin moisturised will help prevent pressure ulcers & skin tears.

QV Gentle Wash

Soap-free foaming cleanser which helps to maintain skin's natural protective properties.

Use for; All dry skin, lower limbs, leg ulcers, lymphoedema, hyperkeratosis.

QV Cream

Rich, non greasy & highly concentrated moisturising cream.

Use as often as required to moisturise all areas.

QV Intensive Ointment

Water and sting free.

Use as often as required for very dry & sensitive skin.

REMEMBER! For the above conditions, it's crucial to wash with QV Gentle Wash

QV

Provides 24 Hour Moisturisation · Low Irritant Formula · Free From Lanolin & Propylene Glycol · Free From Fragrance & Colour · Dermatologically Tested · PH Balanced

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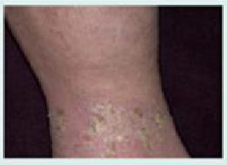
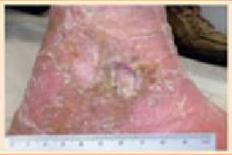
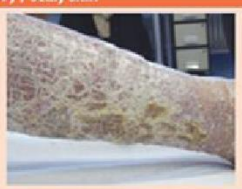
The QV range can be obtained on prescription by the doctor on the ward

Clinical presentation	Cleanse		Moisturise - Hydrate and protect		
Normal / dry skin			What to use		When to apply
	Cleanse with QV Gentle Wash, (a pH balanced soap alternative)		Hydrate and protect with QV Cream		At least once a day
Dry / cracked skin with ulcer					
	Cleanse with QV Gentle Wash, (a pH balanced soap alternative) or QV Intensive Ointment		Hydrate and protect with QV Intensive Ointment		At least twice a day
Dry / scaly skin					
	Cleanse with QV Gentle Wash, (a pH balanced soap alternative) or QV Intensive Ointment		Hydrate and protect with QV Intensive Ointment or an emulsifying ointment		At least twice a day

QV Emollients Pathway

NHS Milton Keynes University Hospital NHS Foundation Trust

REMEMBER: Keeping your patient's skin moisturised will help prevent pressure ulcers & skin tears.

QV Gentle Wash

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Use for; All dry skin, lower limbs, leg ulcers, lymphoedema, hyperkeratosis.

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REMEMBER! For the above conditions, it's crucial to wash with QV Gentle Wash

QV

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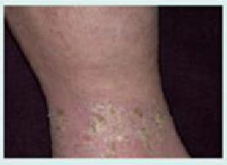
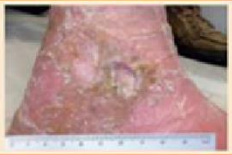
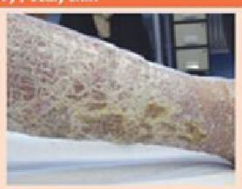
The QV range can be obtained on prescription by the doctor on the ward

Clinical presentation	Cleanse		Moisturise - Hydrate and protect		
Normal / dry skin			What to use		When to apply
	Cleanse with QV Gentle Wash, (a pH balanced soap alternative)		Hydrate and protect with QV Cream		At least once a day
Dry / cracked skin with ulcer					
	Cleanse with QV Gentle Wash, (a pH balanced soap alternative) or QV Intensive Ointment		Hydrate and protect with QV Intensive Ointment		At least twice a day
Dry / scaly skin					
	Cleanse with QV Gentle Wash, (a pH balanced soap alternative) or QV Intensive Ointment		Hydrate and protect with QV Intensive Ointment or an emulsifying ointment		At least twice a day

Diabetic foot ulcers

Tissue viability advice regarding a diabetic ulcer(s)

1. Remove any bandages **within 6 hours** of admission to ward.
2. Assess ulcers and condition of skin including heel and document accurately.
3. Contact the District Nurse or Nursing Home to determine dressing regime already implemented.
4. Obtain wound swab for MC&S.
5. Ensure osteomyelitis is ruled out by referral for X-ray investigation by medical team.
6. Strict skin care using emollients on surrounding skin to prevent cracks in skin.
7. Offload patients from direct pressure on diabetic ulcers **– refer to podiatry and orthotics**
8. Do not mobilize patient directly on wound unless has been assessed and have appropriate equipment in place

Care Plan if no plan already in place

1. Strict skin care, washing legs with warm tap water and QV Gentle wash cleanser 250mls. Moisturise skin with QV Intensive Ointment 450mlsand Cavilon barrier cream to skin surrounding the ulcers if macerated.
2. Use Inadine as primary dressing. Aquacel Extra as secondary dressing if the wound is very wet.
3. If ulcers are infected, obtain a wound swab then apply Cutimed Sorbact Swab as a primary dressing and a Surgipad. If ulcers are very wet Eclypse pad or.
4. Secure with Blueline/ Yellowline bandage. Plus size patients may require Beige tubular bandage. Ensure heel(s) checked daily and document.
5. If legs are very wet and oedematous, please encourage patient to elevate legs as much as possible, ideally on bed.
6. Please refer to on site diabetic foot clinic for review

Refer to Tissue Viability if after all the above has been completed, there is no improvement after 5 days.

Burns

1. Irrigate all wounds with Octenillin solution to reduce risk of infection.
2. Apply Flaminal Hydro unless weeping excessively then use Flaminal Forte to maintain a moist wound and reduce risk of infection.
3. Apply Mepitel One and cover with Mepilex Border adhesive dressing to manage exudate. If below the knee, cover with Foam non adhesive.
4. Mepitel One has a 10-14 day wear time and it is best practice to irrigate the wound bed through the Mepitel One rather than remove it at every dressing change. The wound is fully visible through the Mepitel One if review is needed.
5. The secondary dressing should be changed at every dressing change and should be changed every 2-3 days.
6. Monitor pain, exudate, signs of infection and re refer if appropriate.
7. Please observe condition of skin and wound and document accurately

C-Section wounds

1. Initial dressing to remain in situ for 48 hours post op unless strike through or signs on infection are seen.
2. If wound is clean and dry leave open unless patient prefers covered. A Mepilex border post op dressing can be used and peeled back and reapplied to maintain regular skin inspections.
3. If wound is wet apply Aquacel extra under Mepilex border post op dressing to manage the exudate.
4. If wound appears infected – obtain swab, inform medical team and apply Aquacel Ag and cover with Mepilex border post op.
5. Any cavity of gaping area can be irrigated using a syringe and saline.
6. Pat dry with sterile gauze from dressing pack.
7. Any cavity or gaping area should be filled with Flaminal Forte. Use a syringe (take off plunger and insert flaminal forte wound gel) reapply plunger and insert wound gel to base of wound and any areas that maybe tracking. Document how many milliliters (mls) of wound gel required. This can also be used as a good indicator for wound progression.
8. Then pack with aquacel ribbon until flush with skin leaving 3cm overhang to enable easy removal on dressing change and document amount used. Careful not to over pack wound.
9. If concerned about surrounding skin Cavilon film (Cavilon stick)can be applied to protect.
10. Dressings to be changed every 2-3 days unless strike through seen before this time. Appeel can be used to remove films dressings if skin vulnerable.

Fungating wounds

1. Odour management should be addressed with a prescription of Metronidazole orally once per day or topically along Flaminal Forte
2. Clinisorb dressings may also be used if the odour is still an issue
3. Protect peri-wound skin with Cavilon Film via 'lolly' applicator.
4. Apply Flaminal Forte into the wound to manage the odour and reduce the risk of infection. Use a syringe (take off plunger and insert flaminal forte wound gel) reapply plunger and insert wound gel to base of wound and any areas that maybe tracking. Document how many milliliters (mls) of wound gel required.
5. Fill cavity with Aquacel to manage exudate, cover with Eclipse pad for very wet wounds or foam adhesive dressing.
6. If the wound is bleeding, due to friable tissue, replace the Aquacel with Kaltostat to stem the bleeding.
7. Dressings to be changed every 2-3 days unless strike through seen before this time or odour issues.

Moisture Lesions

1. Assess the cause of the moisture lesions e.g. urinary and/or faecal incontinence, skin folds in the plus size patient, pyrexia causing excess sweating.
2. Treat the causes – continence aids, catheterisation, flexi-seal, temporary stoma creation, skin hygiene, reduce temperature
3. If the skin is intact and dry, cleanse with Tena wash cream after each episode of incontinence.
4. If the skin is broken and wet, cleanse with Tena wash cream after each episode of incontinence and apply Cavilon Advance Protect **every 3 days.** Wait until this has dried before applying the continence pads/pants.

5. Do not allow your patient to sit on an open pad as this can cause damage from urine on skin being exposed to the air
6. If there is severe skin damage please refer to Tissue Viability for additional support & specialist products.
7. Please refer to the Moisture lesion poster below for more information.
8. Please be aware, severe moisture lesions can mask deep pressure damage.

Prevention and treatment of incontinence associated dermatitis

Apply a skin protectant

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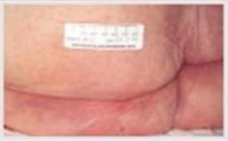
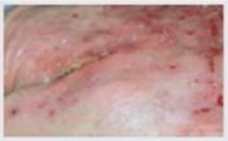
	Clinical presentation**	Clean the skin	If no improvement	When to use	How much to use
Prevention	**At risk** No redness and skin intact 	Cleanse with Tena Wash Cream after each episode of incontinence			
Management	**Mild** Red but skin intact 	Cleanse with Tena Wash Cream after each episode of incontinence	If **after 72 hours** further breakdown occurs – apply 3M™ Cavilon™ Advanced skin protectant and inform TVN	Review after first application If needed reapply after three days	Apply an even coat of film to the entire area to be treated Allow to dry
	Moderate Red* with skin breakdown 	Cleanse with Tena Wash Cream after each episode of incontinence	3M™ Cavilon™ Advanced Skin Protectant and inform TVN	Every three days	Apply an even coat of film to the entire area to be treated Allow to dry
	Severe Red* with skin breakdown 	Cleanse with Tena Wash Cream after each episode of incontinence	3M™ Cavilon™ Advanced Skin Protectant	Every three days	Apply an even coat of film to the entire area to be treated Allow to dry

! Cavilon Advanced is to be used for treatment of patients with moderate to severe skin breakdown. Cavilon Advanced can be obtained from Ward 20.

TVN Contact:
Bleep 1619
Ext: 85884/86146

*Or paler, darker, purple, dark red or yellow in patients with darker skin tones. **IAD Severity Categorisation Tool taken from Beeckman D et al. Proceedings of the Global IAD Expert Panel. Incontinence-associated dermatitis: moving prevention forward. Wounds International 2015. J457825.

Perineal Wound

1. 1st Degree tear and labial grazes – advise to keep clean and dry.
2. 2nd Degree tear – check sutures and wound site daily for signs of infection, keep clean and dry. Analgesia and laxatives to be prescribed. Swelling can be reduced by the intermittent application of cold packs. Medihoney Wound Gel can be applied twice daily and at initial suturing
3. 3rd Degree tear – check sutures and wound site for signs of infection, keep clean and dry. Analgesia and laxatives to be prescribed. Swelling can be reduced by the intermittent application of cold packs. Medihoney Wound Gel can be applied twice daily and at initial suturing
4. Broken down perineal wound – Swab for infection. Irrigate at every toileting episode. Apply Medihoney wound gel into the wound at least twice per day. Antibiotic therapy may be required, as may re-suturing of the wound.
5. If the patient is **allergic or vegan,** please use Flaminal Forte instead of the Medihoney.
6.

Skin Tears

1. Type 1 – No skin loss - flap can repositioned over the wound - Apply Mepitel One and cover with Foam non adhesive, keep in situ with tubular bandage if applicable
2. Type 2 - Partial Flap loss - cannot be repositioned to cover the whole wound bed - Apply Mepitel One and cover with Foam non adhesive, keep in situ with tubular bandage if applicable
3. Type 3 – Total Flap loss - Entire wound bed exposed - Apply Mepitel One and cover with Foam non adhesive, keep in situ with tubular bandage if applicable
4. Mepitel One has a 14-day wear time and it is best practice to irrigate the wound bed through the Mepitel One rather than remove it at every dressing change. The wound is fully visable through the Mepitel One if review is needed.
5. The secondary dressing (Foam non adhesive) should be changed at every dressing change.
6. The dressings should be changed every 2-3 days.

Skin tear protocol

ISTAP classification for skin tears[1]

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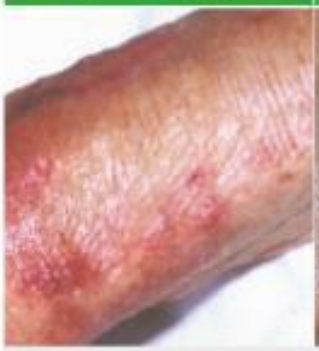
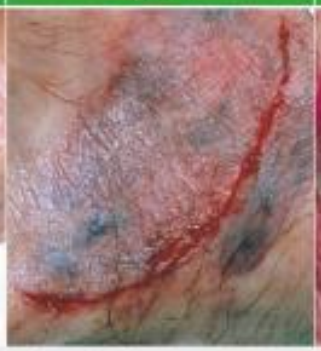
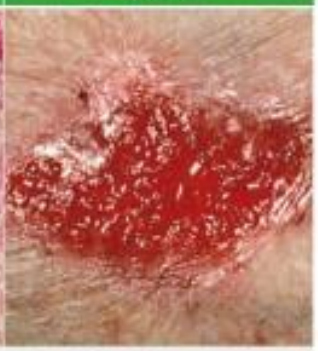
NHS Foundation Trust

For Patients with skin tears, follow these steps[2]

1. Assess wound condition, signs of infection and all wound dimensions and document accurately
2. Complete body map
3. Do not apply Steristrips or Film dressings as they cause further trauma on removal.
4. Complete wound care plan and update when changing dressings.
5. If signs of infection seen, obtain wound swab for MC&S and inform doctors caring for patient.
6. Extensive skin tears will require referral to Stoke Mandeville for plastic surgery

If unable to contact anyone, please follow the following dressing regime:

Skin at risk	Type 1	Type 2	Type 3
			
Skin at risk Mature skin is more vulnerable and prone to skin tears.	**No skin loss** Linear or flap tear that can be repositioned to cover wound bed.	**Partial flap loss** Partial flap loss that cannot be repositioned to cover the wound bed.	**Total flap loss** Total flap loss exposing entire wound bed.
Recommended Products			
Emollient 	Mepitel® One + absorbent pad 	Mepitel® One + absorbent pad 	Mepitel® One + absorbent pad 
Application Guide			
 1 Gently cleanse the wound according to local protocol.	 2 Approximate wound edges, classify the wound, measure and document.	 3a On Type 1, 2 and 3 skin tears, place non-adhesive saletac technology **Mepitel One®** over the flap in the same direction that the skin is replaced.	 3b Cover with a non-adhesive absorbent dressing, keep in situ with tubular bandage if applicable.

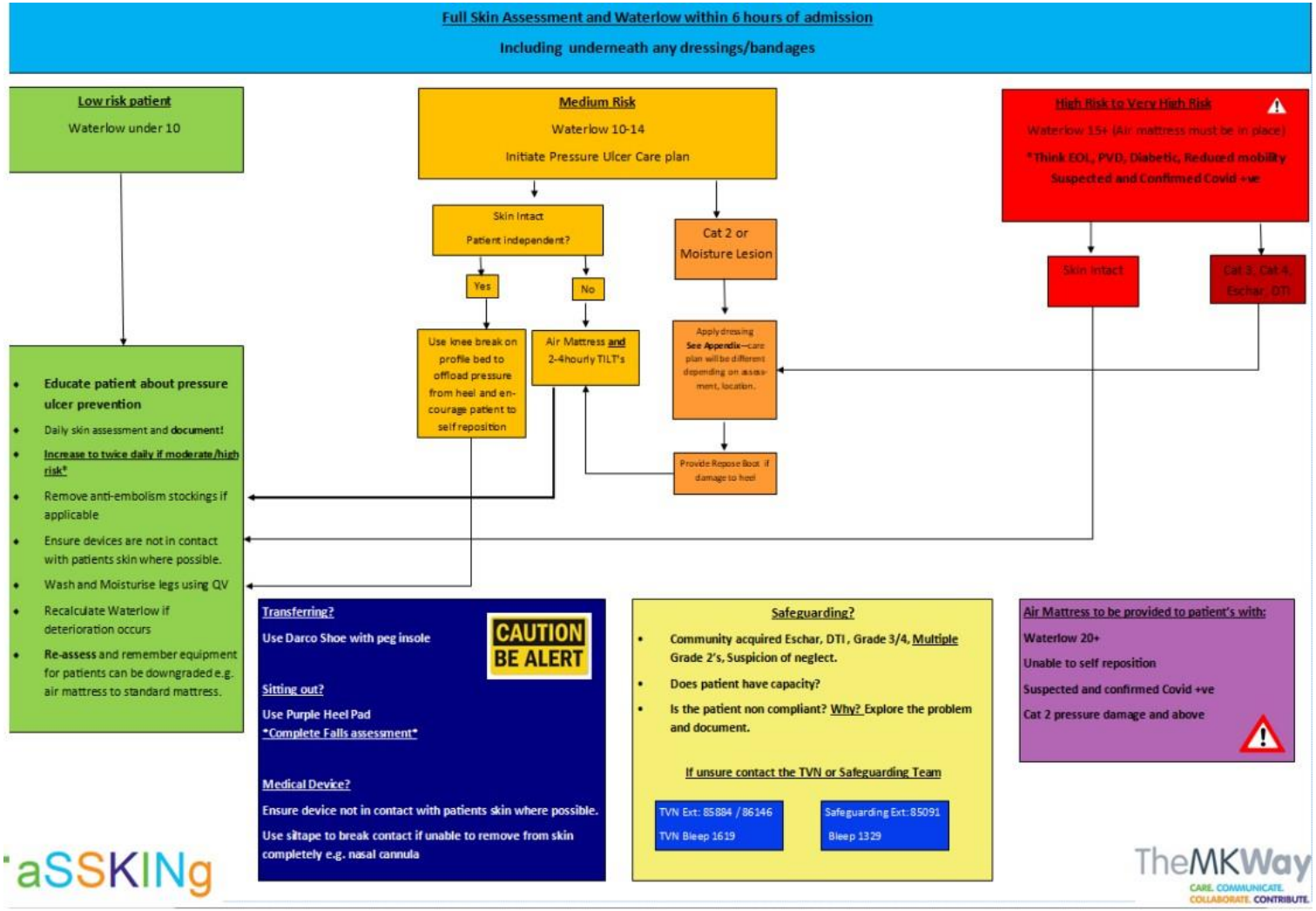
- Mepitel One® has a 14 day wear time and it is best practice to irrigate the wound bed through the Mepitel One rather than remove it at every dressing change. The wound is fully visible through the Mepitel One if review is needed.
- The secondary dressing should be changed at every dressing change. The secondary dressing should be changed every 2-3 days.

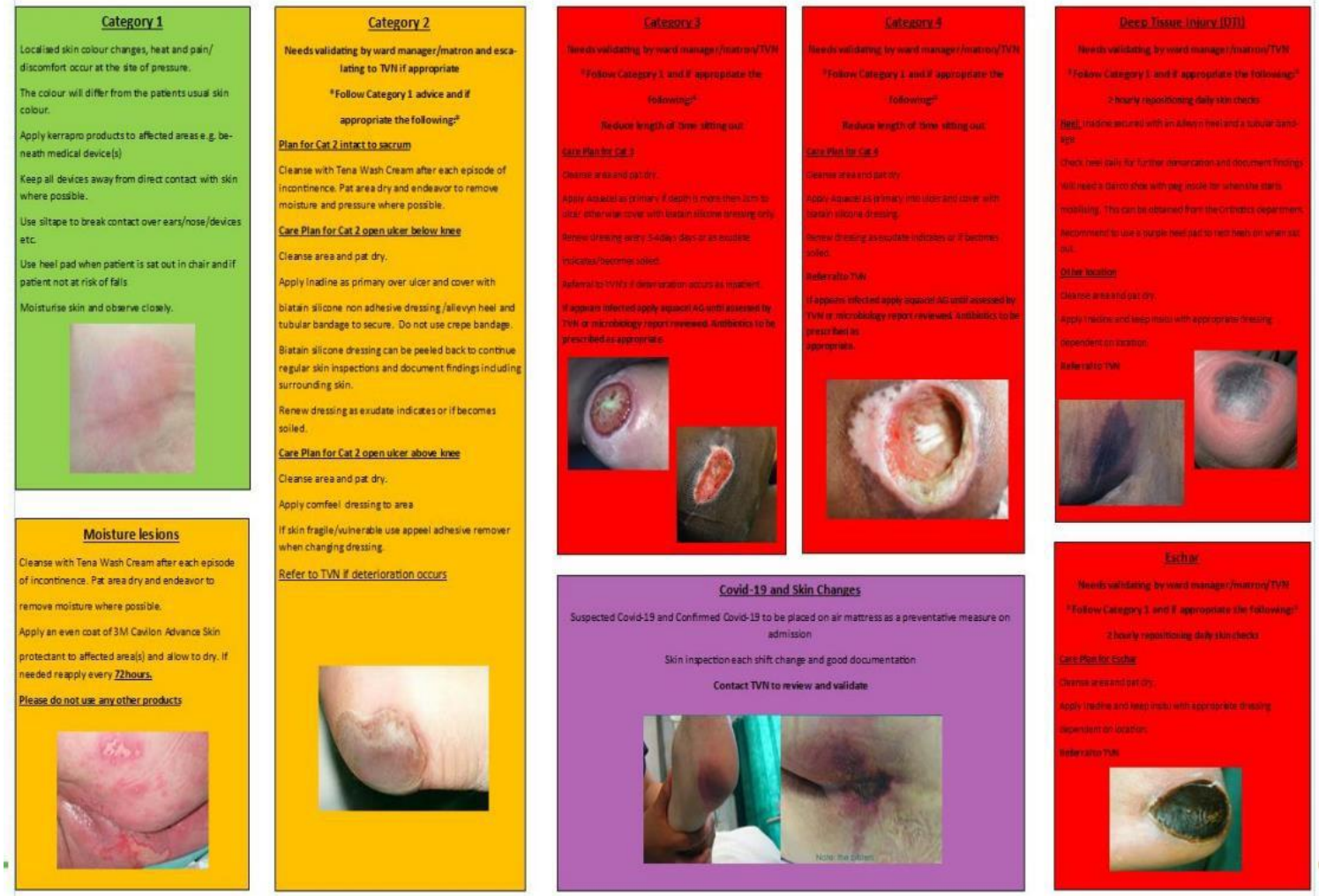
Surgical Wounds

1. Using aseptic technique
2. Cleanse wound with Octenilin if infection/suspected infection **or** normal saline for a clean healthy wound. If cavity a syringe can be used to irrigate wound.
3. Closed surgical wound – apply Mepilex Border post OP. No dressings necessary after 48 hours post op unless requested by patient for comfort reasons.
4. Open surgical wound – apply Aquacel into opening, if cavity pack with Aquacel ribbon ensuring you leave **2cm of ribbon** outside of the wound. If low exudate cover with Mepilex Border post OP. If high exudate cover with Mepilex Border.
5. Infected or suspected infected surgical wounds - apply Aquacel Ag into opening and cover with film dressing if low exudate or Mepilex Border if wetter.
6. Dressings to be changed every 2-3 days unless strike through seen before this time.

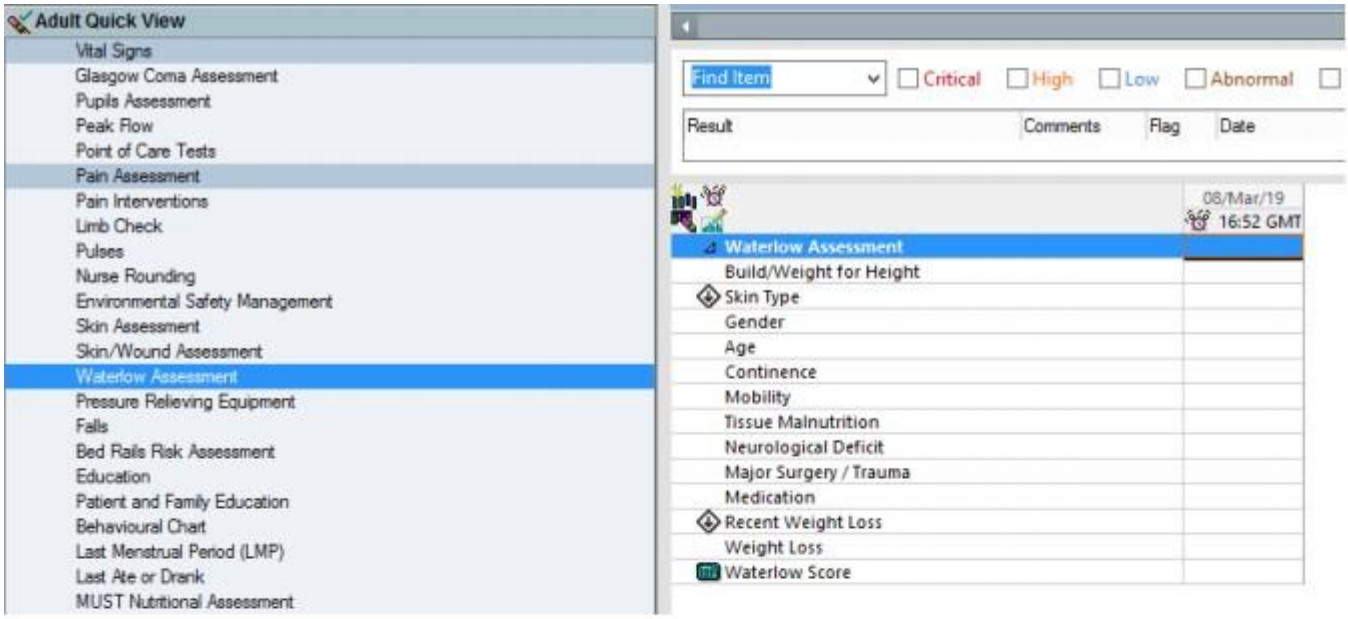
Pressure Ulcers

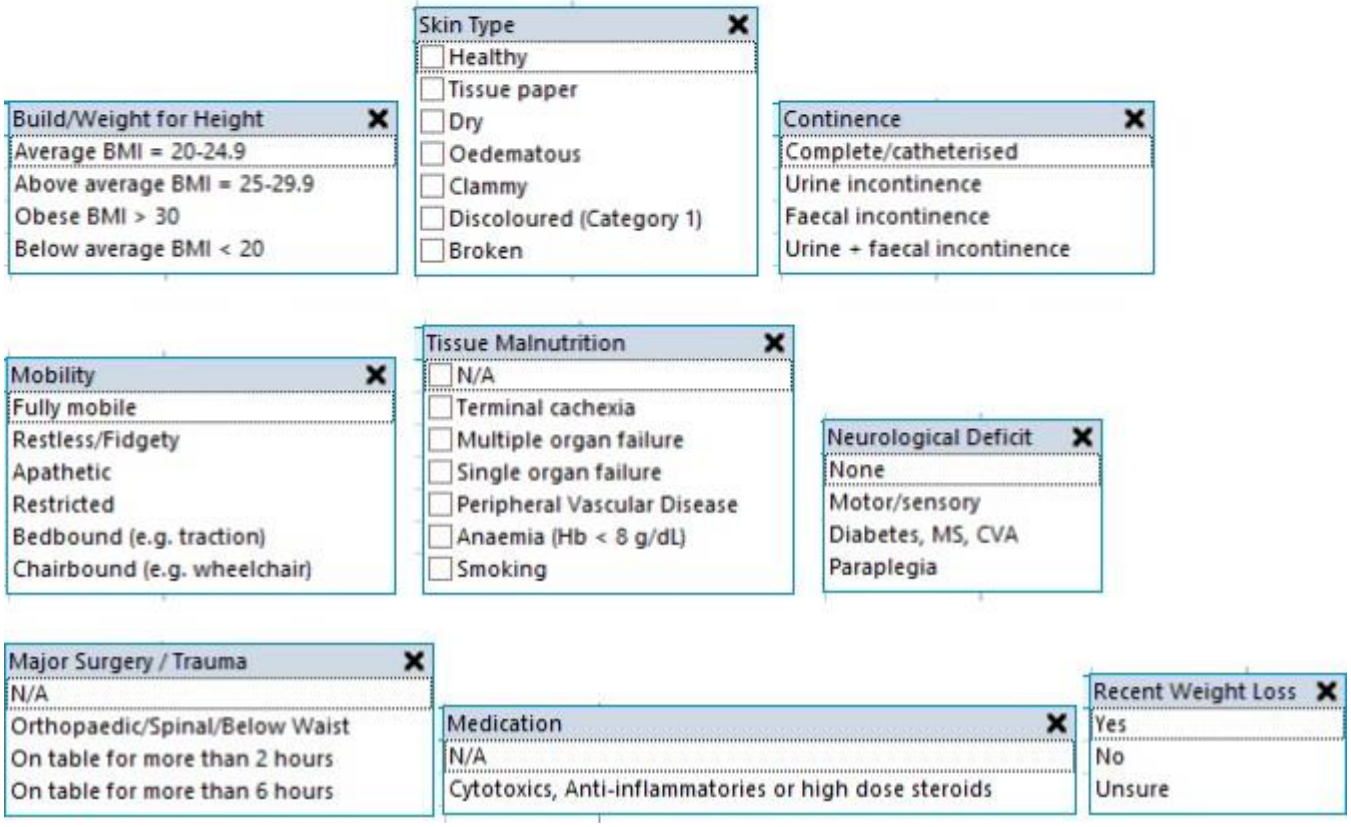
1. Using aseptic technique, Cleanse wound with Octenilin if infection/suspected infection or normal saline for a clean healthy wound. If cavity a syringe can be used to irrigate wound. If ulcers appear infected, obtain a wound swab.
2. Dressings to be renewed every 2-3 days or if become soiled.
3. Category 1 – Repose boots and offload further using the bed in a profiling position, use purple heel pad when patient is sat out of bed if not a falls risk, moisturise skin and observe closely.
4. Category 2 – use purple heel pad when patient is sat out of bed, apply Comfeel dressing if anywhere above the knee, if below the knee apply Inadine and Non adhesive Foam and secure with tubular bandage.
5. Category 3 – apply Aquacel into wound and cover with Mepilex Border Adhesive dressing – Senior sister/Matron/TVN validation and referral needed.
6. Category 4 – apply Aquacel to fill the cavity and cover with Mepilex Border Adhesive dressing – Senior sister/Matron TVN validation and referral needed.
7. Deep Tissue Injury- apply Inadine, Mepilex Heel and a tubular bandage - Senior sister/Matron TVN validation and referral needed
8. Eschar - apply Inadine, Mepilex Heel and a tubular bandage – Senior sister/Matron TVN referral needed
9. If any Category 3 or 4 appears infected, apply Aquacel Ag to prevent spread of infection until assessed by TVN & microbiology report reviewed.
10. Please observe condition of skin integrity daily and document accurately





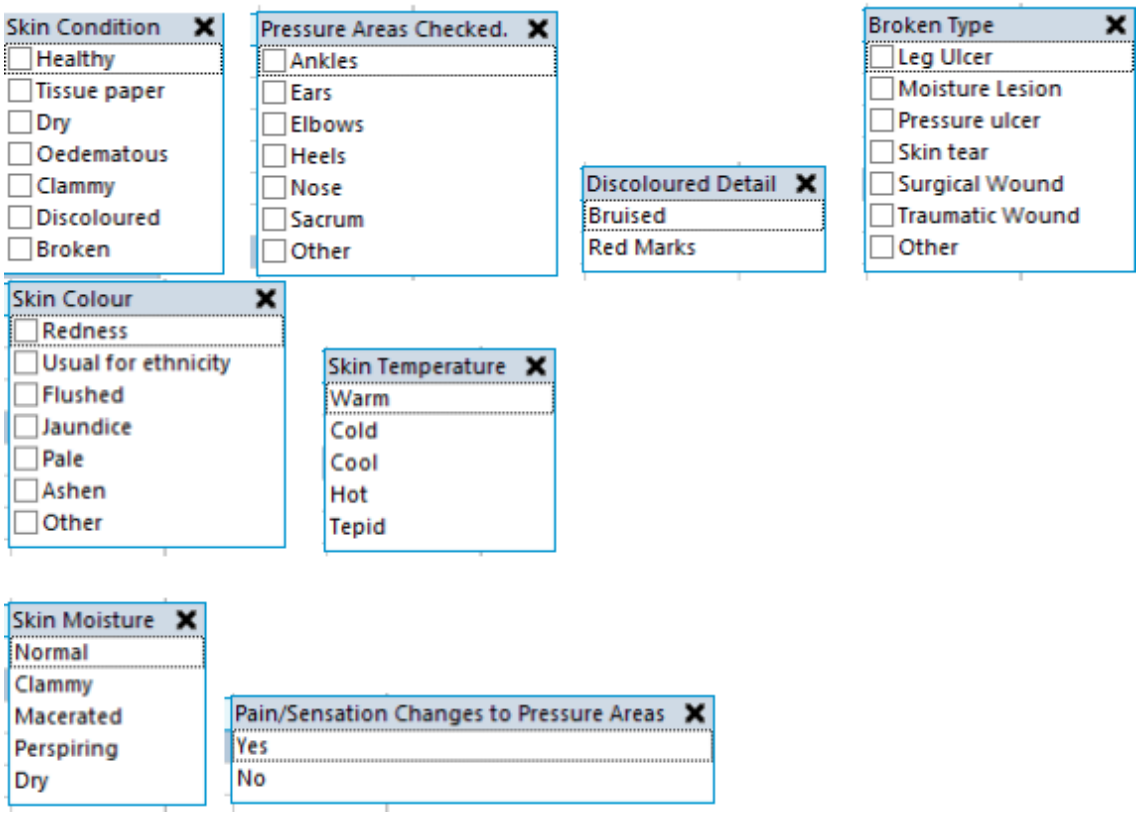
Pressure Ulcer Risk Assessment Waterlow Tool



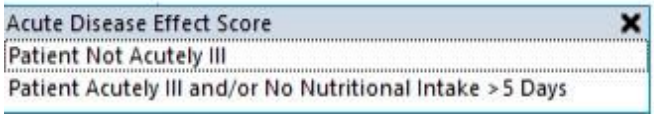


Skin Assessment on eCare

Skin Assessment	
Skin Condition	
Pressure Areas Checked.	
Discoloured Detail	
Broken Type	
Skin Colour	
Skin Temperature	
Skin Moisture	
Pain/Sensation Changes to Pressure Areas	



MUST nutritional score & Nutritional Risk Assessment



Product Information

ALWAYS READ THE MANUFACTURES INSTRUCTIONS BEFORE APPLYING ANY PRODUCT

When using a dressing for the first time only prescribe amount required for a maximum of two weeks in order to evaluate the effectiveness and suitability of the product(s). Please ensure the size of the dressing reflects the wound dimensions. Max 1cm from wound edge to end of dressing is recommended to help reduce maceration in peri- ulcer skin.

Section	Product Type
Section 1 Skin Care	**1. Soap substitutes/Skin care /Ointments** **2. Creams** **3. Adhesive tapes / Dressing Packs** **4. Adhesive remover** **5. Wound cleansing**
Section 2 Dressings	**1. Alginates / Activated Charcoal** **2. Foams** **3. Post-Op/Surgical wounds** **4. Hydrocolloids** **5. Hydrofibre / Hydrogels** **6. Iodine Products/ Low Adherent Dressing** **7. Vapour permeable films** **8. I/V films** **9. Silicone Dressings**
Section 3 Bandages	**1. Conforming/Retention** **2. Elasticised/tubular** **3. Medicated Paste** **4. 4-layer compression Systems** **5. Short Stretch**
Section 4 Dressings for use under guidance of TVN's	**1. Antibacterial / Debridement agent** **2. Antibacterial Hydrofibre** **3. Antimicrobial Barrier Dressing** **4. Capillary Dressing** **5. Superabsorbent Dressing** **6. Silver Nitrate / Honey** **7. Topical Negative Pressure** **8. PICO** **9. Larvae Therapy**

Section 1: Skin Care

An integral and important part of managing wounds is the maintenance of healthy surrounding skin, failure to maintain can increase morbidity and delay healing (Cameron 2002) Care of the skin must not be neglected by concentrating on the wound itself. Many patients with wounds have co-existing skin care problems:

- Patients with dry skin should be prescribed emollients that are applied every day.
- Emollients are available as creams, ointments and lotions for maximum benefit, patient acceptability must also be considered.
- Products containing steroids are prescribed for inflamed, itchy skin conditions and should be used sparingly on affected skin for short periods.

Skin Problem	Main Causes	Recommended Product	Comments
Maceration	Incorrect dressing use Exudate Incontinence	**Cavilon Advance Protectant 2.7ml**	For the management of Moisture Related Damage. To be applied to the sacrum every 3 days. Can be applied every 2 days if area is still bleeding. It is a product which attaches to wet, weepy, damaged skin. Protects the wounds against caustic, corrosive body fluids including liquid stool and gastric fluid Creates an environment that supports healing. Ensure that no other product is applied to the sacrum as this will clog up the film dressing and cause the wound to deteriorate further. Can be used in conjunction with Tena Wash **Ensure that the Cavilon Advanced Skin Protectant is fully dry before applying a pad as this will make the skin stick to the pad and cause a skin tear on removal of pad**
		Cavilon no sting barrier film foam applicator 1ml	Used for the treatment and prevention of skin breakdown. Also protect skin from damage caused by adhesives from tapes and dressings. Recommended every 24 to 72 hours. Can be applied to injured skin.

Dryness	Systemic dehydration Autonomic neuropathy Dermatological conditions Inappropriate dressing selection Dry skin	**QV Gentle Wash 500g** (pH balanced soap alternative) **QV Cream 100g / 500g** (Dry/cracked skin with/without ulcers) Twice daily **QV Intensive Ointment 450g** (Dry/Scaly Skin) Twice Daily	For all dry or scaling disorders. Their effects are short-lived, and they should be applied frequently even after improvement occurs. Washing helps to keep the skin in good condition by removing loose skin scales and moisturizing the skin.

Emollients provide a surface film of lipids and restore some of the barrier functions of the skin. Trapping liquid within the epidermis makes the skin softer and suppler. They may also have an anti-inflammatory and steroid sparing effect. Treatments **that may sanitise and lead to the development of contact dermatitis in a patient with venous hypertension**.

Common Sensitisers	Source	Where Found
Lanolin/Wool alcohol	Emulsifier	Creams ointments, bath additives, barrier preparations, and baby products.
Parabens (Hydroxybenzoates)	Preservatives	Preservatives that possess antibacterial and anti-fungal properties in medicaments and some paste bandages.
Cetylstearyl alcohol	Emulsifier	Difficult to avoid as found in most creams, emulsifying ointments and paste bandages containing emulsifying wax.
Thiuram and Mecapto mix	Rubber	Elastic, tubular and cohesive bandages, gloves used to apply treatment
Fragrance	Perfume	Many over the counter products including creams and baby products.

Wound Cleansing	**Octenilin wound cleanser solution and gel. (SCHULKE)** Antimicrobial and Antibiofilm Wound irrigation Wound gel	350ml bottle 20ml bellow	Removes wound coating and Biofilm. Moistens wounds and creates an ideal environment wound healing. Decreases bacterial growth in a wound bed e.g., Staphylococcus. Odour absorbent. Suitable for fissures. Application: Apply using a soaked swab or irrigation directly to wound surface. Wound gel renew every 1 – 3 days. Precautions: Do not inject, swallow, or allow solution to enter the blood stream. Comments: Once bottle of wound irrigation opened, it can be used up to 8 weeks. Octenilin wound gel can be used up to 6 weeks after opening.
Adhesive Remover	**Appeel (Clinimed)**	Appeel Sterile Straw Appeel Wipe Appeel Spray	A healthcare grade silicone based medical adhesive remover which helps to remove adhesive dressings/tapes/stoma products painlessly. Cautions: Avoid using on delicate/sensitive skin areas such as eyes, mouth, ears, nose, genitals.

Section 2: Dressings

Dressing Type	Indications	Application	Precautions	Recommended Product & Size	Comments
Alginates	The clotting cascade (Haemostasis) is initiated when calcium ions are exchanged for sodium ions in the wound bed. For donor sites and freshly bleeding wounds only	Used as a primary dressing, requires a secondary dressing. Recommended that the dressing be changed daily at first then once every 2-3 days or twice weekly.	Some patients may experience a mild burning sensation, which is usually transient.	**Kaltostat** *Convatec* 5 x 5cm 7.5 x 12cm 10 x 20cm Rope 2 grams	The dressing absorbs naturally, therefore should be cut or folded to the shape of the wound to avoid maceration of surrounding skin. Forms a viscous gel and can therefore be removed in one piece.

Dressing Type	Indications	Application	Precautions	Recommended Product & Size	Comments
Activated Charcoal	Malodorous wounds	Apply directly to the wound over a non-adherent dressing i.e., NA Ultra to reduce trauma to the skin		**Clinisorb** *Clinmed* 10 x 10 10 x 20 15 x 25	

Dressing Type	Indications	Application	Precautions	Recommended Product & Size	Comments
Foams **Molnlycke** **Mepilex Border**	Predominantly used as a secondary dressing for sloughy wounds, they can be used as a primary dressing for granulating and epithelializing wounds, which have moderate to high exudate.	Can be left in place for up to 7 days. Ensure there is a sufficient border for exudate to disperse sideways. 2-3cm for moderate exudate, 4-5 cm for heavy exudate.	**DO NOT USE FILMS TO SECURE FOAMS This prevents evaporation of excess exudate.** **Not effective on dry wounds or eschar.** Should not be used when intolerance to silicone adhesives is known or allergy to any of the dressing components.	Mepilex Border 10x10.5cm 11x20 cm 15x17.5 cm 17x20 cm Mepilex Border Sacrum 15x15 cm 16x20 cm	The wound contact surface of Mepilex/Border/Heel is coated with a layer of soft silicone called Safetac Technology®, which does not stick to the surface of a wound or cause trauma to delicate new tissue upon removal. Low potential for dermal irritation or allergic contact sensitisation, Mepilex Border/Mepilex/Mepilex Heel are suitable for dressing many types of exuding wounds including leg and pressure ulcers, and traumatic wounds resulting in skin loss. It may also be used under compression bandaging. The dressing absorbs exudate and maintains a moist wound-healing environment whilst minimising the risk of maceration
Mepilex	Predominantly used as a secondary dressing for sloughy wounds, they can be used			Foam 5x5cm 20x50cm	

Mepilex Heel	as a primary dressing for granulating and epithelializing wounds, which have low to moderate exudate.			**Heel** **13cm x20cm**	Heel - Should only be used when pain and adherence is an issue, otherwise use foam adhesive Mepilex heel is a dressing not to be used as pressure relief. However, Mepilex Border Heel can be used in this way (non- formulary, contact TVN to discuss)
Dressing Type	**Indications**	**Application**	**Precautions**	**Recommended Product & Size**	**Comments**
Post-Op/Surgical wounds **Mepilex Border Post-Op (Molnlycke)**	A self-adhesive absorbent surgical dressing designed for exuding wounds. It is intended for acute wounds, such as surgical wounds, cuts and abrasions.	Can be left in place for up to seven days depending on the condition on the wound and the surrounding skin, or as indicated by accepted clinical practice.	If you see signs of infection e.g., fever or the wound or surrounding skin becoming red, warm or swollen. Should not be used when intolerance to adhesives is known or allergy to any of the dressing components.	6cm x 8cm 9cm x 10cm 10cm x 15cm 10cm x 20cm 10cm x 25cm 10cm x 30cm 10cm x 35cm	For surgical wounds: Helps reduce the risk of surgical site infection (SSI)[38]. Supports patient mobilization[39].
Dressing Type	**Indications**	**Application**	**Precautions**	**Recommended Product & Size**	**Comments**
Absorbant Pads	For use in patients with very high levels of exudate	Use as a secondary dressing. Change when clinically indicated or exudates 1-2 cm from the edge of the dressing. Can		10x10cm 20 x 20 cm 20 x 30 cm 60 x 40 cm Boot 60 x 70 cm	Only for heavily exuding wounds.

		be left in place for up to 7 days.			
Hydrocolloids **Hydrocolloid Tape (Salts Healthcare) Secure plast**	Provides a suitable environment for autolysis, promotes angiogenesis, granulation and epithelialization (Cherry & Ryan 1985, Dealy 1993). Occlusive dressing with minimal absorption. Reduces shear and friction forces. To provide comfortable and leak proof seal to complex dressings	Apply directly to wound with a minimum overlap of 2cm. A secondary dressing is not usually necessary. Should be changed before leakage occurs. **Always remove with care, by lifting the edges and parallel stretching the dressing off the wound.** Apply peri wound molds and stretches to the shape of the wound Wear time maximum of 4 days	These products have limited fluid handling properties, which restrict their use to the management of wounds with low exudate. Can cause maceration to surrounding skin if inappropriately used or left in place too long. Do not use in the presence of anaerobic infection. **Hydrocolloids should be used with caution in diabetics.**	**Comfeel Plus Transparent** Coloplast 5 x 7cm 9 x 14cm 10 x 10cm 15 x 15cm 15 x 20cm Comfeel Plus **Coloplast** 4 x 6cm 10 x 10cm 15 x 15cm Sacral Tape 1.5m x 25mm Mouldable seal thin 5cm x 5cm and 10cm x 10cm	Thin Hydrocolloids for low exuding wounds e.g. Abrasions, blisters. Should not be left in place for longer than 7 days.
Dressing Type	**Indications**	**Application**	**Precautions**	**Recommended Product & Size**	**Comments**

Hydrofibre	Primary dressing for medium to high exuding wounds. Can be used on a wide range of wounds if wound dry can be moistened before application. Does not laterally wick and should **not** be cut to the shape of the wound.	Applied directly to wound, overlapping the surrounding skin by at least 1cm. Requires secondary dressing. Can be left for up to 7 days, or until strikethrough noted.	Not to be used in low exuding wounds as on removal may cause trauma. Easily removed as sheet of solid gel, if necessary, soak with saline/water before removal.	**Aquacel Extra** *Convatec* 5x5 cm 10x10 cm 15x15 cm Ribbon	Can absorb over 20 times its weight. Retains its integrity when in a gel sheet form.
Hydrogels	Used to assist debridement by rehydration and separation of eschar and other necrotic tissue (Bale 1997). Can be used throughout all stages of the healing process. Can be used for epidermal damage such as leg ulcers, burns, scalds and radiation therapy damage. It should be considered as a method of relieving wound pain.	Can be left in place for up to 3 days but may initially require daily dressing changes. Requires secondary dressing. Gauze is not appropriate as it absorbs the water in the gel, dries out and sheds fibres in the wound. Should be left in place for minimum two days and maximum of seven. When applying remove the white plastic liners leaving the blue outer liner in place.	Should not be used in conjunction with Iodine products as it reduces their effectiveness. Contra-indicated where anaerobic infection is suspected – provides environment for growth of microorganisms.	**Octenilin Wound Gel 20ml bottle** **Flaminal Hydro 15g or 50g** (low exuding wounds) **Flaminal Forte 15g or 50g** (high exuding wounds)	***(Take caution when using with vascular compromised patients)*** Do not use on moderate to high exuding wound, this can lead to maceration of surrounding skin. Maximum wear time 7 days, not to be used in cavities or sinuses. Octenilin wound gel can be used up to 6 weeks after opening. Safe and effective choice for any patient and any wound. Balance's moisture in the wound and prevents infection to speed up the healing process. All components are non-toxic to skin cells & promote natural healing.

Enzyme Alginogel	Consists of an antibacterial enzyme system embedded in hydrated alginates (debriding gel + absorbent alginate + antimicrobial enzyme system). Flaminal Hydro is indicated for slightly to moderately exuding wounds, while Flaminal Forte is indicated for moderately to highly exuding wounds. Examples of such wounds are leg ulcers, diabetic foot ulcers, superficial and deep partial thickness burns (second degree), post-surgical wounds, traumatic wounds, pressure ulcers, skin tears, wounds from radiotherapy, oncology wounds. Flaminal can be used in all age groups.	Cover Flaminal with a dressing depending on type of wound: -Slightly to moderately exuding wound: transparent film (polyurethane) or non-adherent dressing fixed by a non-adherent bandage for instance paraffin gauze. - Moderately to highly exuding: absorbent non-adherent dressing fixed by a non-adherent bandage or by a hypoallergenic, adhesive tape. Check the dressing daily at first. Flaminal can remain in place as long as the gel structure is intact (1 to 4 days, depending on the amount of exudate).- If it is leaking or if there is insufficient gel, Flaminal should be changed and a new dressing applied. At every change of dressing/ cleaning the wound:- Clean the wound and surrounding area well- Remove all dry whitish alginate flakes from the wound and only the flakes on the wound border can stay on. The flakes will prevent wound border weakening maceration	Do not use Flaminal when there is a known allergic reaction to any of the ingredients The FIRST time a patient is treated for wounds which might reach the level of bones and joints or with exposed bones and joints, the patient should be under observation for at least 30 minutes after the administration of Flaminal Flaminal cannot be used on the eyelids or in the eye	**Flaminal Hydro 15g or 50g** (slightly to moderately exuding wounds) **Flaminal Forte 15g or 50g** (moderately to highly exuding wounds)	Flaminal consists of an antibacterial enzyme system embedded in hydrated alginates (enzyme alginogel). It supports the healing of a wound in a number of ways: - Continuously debrides the wound - Keep the wound moist by covering the wound with an intact gel structure (intact= keeps its form for up to 4 days) - Offers antimicrobial protection - Safe for the skin and wound tissue (non-cytotoxic) - Reduces wound odour caused by bacteria - Helps to reduce excessive protease activity - Reduces bacteria released from a biofilm - Protects the wound border

Dressing Type	Indications	Application	Precautions	Recommended Product & Size	Comments
Iodine Impregnated Dressings	These products help to reduce bacterial count in wounds. They are effective on a wide range of bacteria, fungi and protozoal infections. Particularly useful in sloughy wounds	Apply directly to wound, no more than 4 sheets per wound. Requires secondary dressing. Change when dressing turns white, or every 2-3 days.	Iodine dressings are to be avoided in patients with known iodine sensitivity or thyroid disease, pregnancy or those taking Lithium, Not recommended in children under 2 years. Treatment duration must be no longer than 3 months.	**Inadine** *J&J* 5x5 cm 9.5x9.5 cm	Contain 10% povidone iodine suitable for wounds with low exudate. Not recommended for use on dry wounds. Iodine is rapidly deactivated in the presence of pus limiting its use as an antimicrobial.
DACC Coated Dressings	DACC naturally binds microbes to the dressing. Once bound they are irreversibly bound and can no longer colonise the wound bed. Can be used at subtle signs of wound infection or to prevent wound infection prophylactically.	Cutimed Sorbact Swabs and Ribbon can stay in place for up to 7 days. Cutimed Sorbact Gel can stay in place for up to 4 days. Recommended to change every 1-3 days.	Please use Cutimed Sorbact Swabs on moderate to high exuding wounds. Ensure that a secondary dressing is always used. Cutimed Sorbact Gel can be used for wounds with little to no exudate.	**Cutimed Sorbact Swabs** **4 x 6 folded (11 x 15 unfolded)** **7 x 9 folded (17 x 27cm unfolded)** **Cutimed Sorbact Ribbon** **2 x 50cm** **Cutimed Sorbact Gel** **7.5cm x 7.5cm** **7.5cm x 15cm**	Do not fold swab. Dressing can be laid over good tissue. Dressing can alsoi be cut. Ensure 2cm overlap of wound bed. Can be left in place for up to 7 days. Cutimed Sorbact Swab is a Primary dressing for contaminated, colonised or infected superficial or deep wounds. Also suitable for fungal infection in the groin, in skin folds (e.g. under the breast) or between digits. Loosely pack ribbon. Always use secondary dressing. Cutimed Sorbact Ribbon can be used for all types of deep or cavity wounds showing signs of infection. Also suitable for fungal infection in the groin, in skin folds (e.g. under the breast) or between the digits. For Gel, use a simple low absorbent dressing over the top to ensure that moisture stays within wound. Change

					every 2-3 days. Can be used for all types of dry, sloughy or low exuding wounds that are contaminated, colonised or infected.
Low Adherent Dressings	Primary dressings used for low exudating, granulating wounds. Suitable for use under compression bandaging systems.	Secondary dressing required, which can be changed independently leaving the N-A Ultra in position for up to 7 days.	These dressings are low adherent, caution required on removal. Soak if necessary.	**NA Ultra** ***J&J*** 9.5x9.5 cm 9.5x19 cm	Suitable for use on leg ulcers and superficial skin damage.

Dressing Type	Indications	Application	Precautions	Recommended Product & Size	Comments
Vapour Permeable Films	Sterile, thin, hypoallergenic, adhesive coated films. Transparent and suitable f or superficial low exuding wounds. Reduces effects of friction forces on the skin.	May cling to itself during application, so prepare skin prior to application. Can be left in place for up to 7 days. Always remove with care, by lifting the edges and stretching the film. 1. Peel away the upper part of the release paper and hold the film dressing at the red strip.	Can tear fragile skin and damage epithelial growth if removed incorrectly. Excessive exudate may accumulate under film causing maceration.	**365 Film Dressing** 6x7 10x12 10x14 10x25 15x20 20x100 **Short Term Per Line** 6 x 7cm **Peripheral Line** 7 x 8.5cm	Protects intact skin. Frame presentation facilitates easy application.

IV Films	Acts as a barrier to bacteria and water, but permeable to gas and water vapour.	2. Position the dressing over the insertion site and adhere the film. 3. Remove the two remaining release papers and stick the handles over the wings of the catheter. 4. Take hold of the transparent carrier at the red tab and carefully lift it off. Remove: to remove the dressing, pull off the film evenly using one of the edges.		**Central Line** 85cm x 10.5cm **PICC line** 10 x 15.5cm **S&N** **IV 3000** 7cmx3cm **IV3000** 10cmx12cm	

Dressing Type	Indications	Application	Precautions	Recommended Product & Size	Comments
Silicone Dressings **Mepitel One (Molnlycke Healthcare)**	To avoid adherence of dressing to underlying tissue if presents a clinical problem.	Primary dressing, wear time up to 14 days. Outer dressing to be renewed every 3 days	Nonabsorbent	6cm x 7cm 9cm x 10cm 13cm x 15cm 24cm x 27.5 cm	Safetac Technology® Recommended for skin tears, burns abrasions, blistering e.g., Epidermolysis Bullosa, lacerations, partial full thickness skin grafts, radiotherapy or steroid therapy Where clinically indicated, steroids or antimicrobial agents can be applied either under or over Mepitel.
Siltape (Advancis)	Fragile skin, suitable for securing dressings, securing iv lines, taping eyelids in theatre, over small incision sites and under oxygen masks, securing fistula needles, protection from damage to skin from tubing	Cut tape to size	Adheres to dry skin not moist	2cm x 3cm	Adheres to dry skin not moist

Section 3: Bandages

Type	Recommended Product	Size	Comments
Conforming Retention Bandages	**K-Band** *Urgo* **K-Soft** *(wool wadding)* *Urgo* **Crepe** Bandage*(Hospicrepe(generic)*	5cm 7cm 10cm 15cm 10 x 4cm 10 x 4.5cm	Apply lightly To retain dressing only Newer lightweight bandages are cheaper and superior to the older cotton conforming and white open wove bandages
Elasticised Tubular Viscose Stockinette	**Comfifast** Activa Small Digit Small limb Medium adult limb Large LimbTrunk child or large adult limb Trunk adult	 1m red 5m green 5m blue 5m yellow 1m beige	Particularly useful for holding dressing in place on digits and limbs Retention of primary dressings Washable for reuse
Medicated Paste Bandages	**Ichthopaste** (Zn & Ichthammol)	7.5cm x 6m	Treatment of venous ulcers where sensitisation has been a problem Use for wet ulcers with sensitive skin. Soothing, anti-inflammatory. May sensitise skin Use narrow gauge bandages e.g., Crepe instead of a retention bandage.

Type	Recommended Product	Size	Comments
Four-layer Bandaging System	**Profore system** Smith & Nephew	Prolite Ankle circ < than 18cm Ankle circ 18 – 25cm (latex free) Ankle circ 25 – 30cm Ankle circ > 30cm (larger leg) (4 bandages in a box – complete kit)	Application of layers of weaker bandages enables pressure to be gradually built up. Leg ulcers are a chronic condition, painful and debilitating for patients, are notoriously difficult to treat and have a high recurrence rate. Treatment costs are extremely high due to nursing time required and the low healing rates achieved. Using the 4-layer bandaging regimen to sustain compression, healing rates of 74% have been achieved at 12 weeks. **(Only to be applied by certified, competency qualified nurses in application of compression bandaging.)**
Short Stretch Compression Bandage	**Actico (cohesive)** Activa	8cm x 6m 10cm x 6m 12cm x 6m	**Venous leg ulcers and lymphoedema, Applied at full stretch over padding that protects areas of high pressure and at sites of high risk of pressure damage.** **(Only to be applied by certified, competency qualified nurses in application of compression bandaging.)**
K4 compression bandaging	K Soft K Lite K- Plus Ko-Flex	10cmx 3.5m 10cm x 4m 10cm x 8.7m 10cm x 6m	See Four Layer Bandaging System comments

Section 4: Under Guidance of TVN's

Dressing Type	Indications	Application	Precautions	Recommended Product & Size	Comments
Antibacterials **Metronidazole Gel**	Topical antibiotic gels can be used to treat malodorous wounds where anaerobic and certain aerobic* bacteria are suspected or identified.	Apply thickly to the wound 1-2 times daily. A secondary dressing is required. Use for up to 28 days.	Not recommended for routine use due to risk of developing resistant organisms. Contraindicated when pregnant or breast-feeding.	Anabact 30g Tube	(Aerobic organisms which produce offensive wound odours are proteus, pseudomonas and klebsiella.)
Debridement agent **Debrisoft (Activa Healthcare)**	Removes wound debris and necrotic material, slough and exudate and long standing hyperkeratiotic tissue from surrounding skin	Apply topically. Moisten fleece side of Debrisoft with tap water or saline. With gentle pressure cleanse the area to be treated with the soft fleece side.	Must not be used as a wound dressing Do not cut Debrisoft. Do not use if known sensitivity to product.	10cm x 10cm	Recommenced by Nice guidelines
Dressing Type	**Indications**	**Application**	**Precautions**	**Recommended Product & Size**	**Comments**
Antibacterial Hydrofibre **Aquacel AG Extra (Convatec)**	Wounds where there is infection or increased risk of infection. Burns Neoplastic wounds with exudate Diabetic foot ulcers Chronic venous ulcers Pressure ulcers	Applied directly to wound, overlapping the surrounding skin by at least 2.5cm. Requires secondary dressing. Infected or heavily colonised wounds should be inspected regularly. Remove when clinically indicated. Can be left for up to a maximum of 7 days, or until strike through noted.	Not to be used in patients with a sensitivity to Silver	5x5cm 10x10 15x15 20x30 45cm Ribbon	.

		May be moistened with saline for dry wounds			
Antimicrobial Barrier Dressing **Acticoat (S&N)**	Wounds where there is infection or increased risk of infection. Burns Diabetic foot ulcers Chronic venous ulcers Pressure ulcers	Applied directly to the wound. Requires secondary dressing. Infected or heavily colonised wounds should be inspected regularly. Remove when clinically indicated. Can be left for up to a maximum of 7 days, or until strike through noted. May be moistened with sterile water for dry wounds	Not to be used in patients with a sensitivity to Silver Only to be used in high exudate wounds.	Acticoat 5 x 5 cm 10 x 10 10 x 20 Acticoat 7 5 x 5cm 10 x 12.5 15 x 15 Acticoat absorbent 5 x 5 cm 10 x 12.5 Rope 2x30cm	Maximum wear time 3 days Maximum wear time 7 days. Maximum wear time up to 7 days Do not moisten for heavy exudate
DACC Coated Bacteria Binding Dressing	Maternity department only Bacteria Binding post-operative dressing to prevent surgical site infections.			Essity Leukomed Sorbact	TVN Guidance ONLY. Can be used within Maternity departments. Bacteria Binding post-operative dressing to prevent surgical site infections.

Dressing Type	Indications	Application	Precautions	Recommended Product & Size	Comments
Superabsorbent Dressing **Eclypse Pads and C Sorb**	Superabsorbent dressing for heavily exuding wounds such as pressure ulcers, leg ulcers of various aetiologies, diabetic foot	Primary dressing for the management of heavily exuding, superficial wounds and as a secondary dressing for deep, heavily exuding wounds	Known sensitivity to any components of the dressing Not suitable for lightly exuding wounds or as a primary dressing on	10x10cm 20 x 20 cm 20 x 30 cm 60 x 40 cm Boot 60 x 70 cm	Can be used under compression. Can remain in situ for up to 5 – 7 days

	ulcers, postoperative wounds healing by secondary intention, laparotomy wounds and fistulae. Also suitable for leaking legs and lymphorrhea.		tracking fistulae or deep tunneling wounds. The dressing must not be cut or torn		
Dressing Type	**Indications**	**Application**	**Precautions**	**Recommended Product & Size**	**Comments**
Honey	Primary dressing for all wound types providing and antibacterial action, including superficial partial full thickness and sloughy and necrotic wounds.	Apply directly to the wound bed or pack into cavity as primary dressing, will require secondary dressing. Change daily within the first few applications as increased exudate will be produced as a result of osmotic effect. Can be left in place for up to 7 Days once exudate management achieved.	Some patients find honey painful due to osmotic effect. May cause bleeding when granulation tissue is formed. Not for hard black eschars. Do not use if patients are allergic to bee venom or bee products.	Medihoney wound gel 10g or 20g Actilite Honey 10 x10cm 10 x20 cm	Honey may be preferable to antiseptics for the management of dirty or infected wounds. Although safe to use in diabetic patients it is advisable to monitor blood glucose levels.

Dressing Type	Indications	Application	Precautions	Recommended Product & Size	Comments
Topical Negative Pressure Dressing KCI, Acelity, 3M	Management of: Pressure Ulcers Leg Ulcers Cavity Wounds Heavily exuding wounds Fixation of skin grafts Preparing wounds for skin grafting Method of Action Topical negative pressure achieved through vacuum suction Removes excessive wound exudates from wound Stimulates angiogenesis & granulation tissue Reduces risk of wound infection	Always adhere to manufacturer's instructions TVN authorisation required Foam is cut to size of wound with no overlap to peri-wound skin. A seal is achieved by applying an occlusive film dressing A small hole is punctured in the film dressing and Soft port tubing attached. The tube is then attached to drainage canister Pump settings should be discussed with TVN prior to application Gauze Setting 80mmgh Foam Setting 125mmgh **Refer to VAC Standard Operating Procedure**	Ischaemic wounds Necrotic tissue/ Eschar Abdominal fistulae Haemorrhagic wounds / Active bleeding NOT FOR USE ON Malignant Wounds	There are two types of dressing: Antimicrobial Gauze: Rolls, Small, Medium, Large Squares. Polyurethane foam (black) Small Medium Large Please discuss appropriate pump, dressings and sizes with TVN if unsure. When ordering; ensure canisters and dressings are ordered.	Therapy duration should be no less than 1 week and no longer than 6 weeks TNP can be used on infected wounds. However, dressings should be changed more frequently. Normal wear time for TNP is 3 - 4days **Apply dressing liner (I.e., Mepitel One) to wound base if using Foam to ensure a non-traumatic removal of dressing**

Dressing Type	Indications	Application	Precautions	Recommended Product & Size	Comments
PICO Single use Negative Pressure Wound Therapy System (NPWT) PICO consists of a small portable pump with a life span of up to 7 days. The PICO pump generates an effective negative pressure of 80mmHg yet is small enough to fit discretely into a pocket. Battery operated pump	Management of wounds with low to moderate levels of exudate and infectious materials: Acute wounds, chronic wounds, flaps and grafts, incision sites, partial thickness burns, sub-acute and dehisced wounds, traumatic wounds, ulcers such as diabetic ulcers or pressure ulcers	Secure dressing and connect port tubing to the pump tubing. Push the orange button to start delivery of NPWT until light goes green. Change dressing every 3 to 5 days as needed.	Ischaemic wounds Necrotic tissue/ Eschar Abdominal fistulae Haemorrhagic wounds / Active bleeding NOT FOR USE ON Malignant Wounds Not suitable for management of high exuding wounds.		PICO is compatible with the standard fillers of foam and medicated gauze used with conventional NPWT if this is necessary Silicone Adhesive wound contact layer, establishes effective seal to area, airlock layer that distributes negative pressure across the dressing, absorbent layer which holds exudate away from skin.

Dressing Type	Indications	Application	Precaution	Recommended Product & size	Comments
Larvae Therapy **Please discuss with TVN prior to ordering via pharmacy** **Biomonde Contact: 0845 230 1810**	Sterile larvae may be used for the following wounds: Debridement of necrotic or sloughy wounds Infected wounds where devitalised tissue is present Osteomyelitis Leg ulcer Pressure ulcer Infected surgical wounds Diabetic foot ulceration Necrotising fasciitis Malignant wounds Presentation Vial(s) of sterile larvae Micro-porous dressings Information sheet Sterile water	Always adhere to the suppliers instructions TVN authorisation required Do not apply therapy unless your technique has been deemed competent by TVN Patients should be fully informed of all aspects of treatment – verbal consent must be obtained Larvae must be at room temperature Surrounding skin should be protected by a hydrocolloid or paste bandage Larvae are kept in place via a micro porous dressing (supplied) Micro porous dressing Secondary dressing of gauze and porous bandage The secondary dressing should be changed daily Each treatment should last 3 – 5 days and the wound reassessed. Film dressings or any occlusive dressings should never be used. Larvae must be disposed of as clinical waste Larvae treatment should be discontinued once debridement has been achieved	Sterile larvae may NOT BE USED in the following: On or near exposed blood vessels as the debridement process may undermine the vessel and result in haemorrhage	Please discuss with TVN prior to ordering for advice on quantity and dressing sizes 2 x 2cm 2.5 x 4cm 2.5 x 15cm 5 x 5cm 7 x 7cm 7 x 12cm 10 x 10cm Larvae pot (free range)	Larval treatment is an effective but expensive therapy. Multiple treatments may be necessary Treatment must be discussed with relative budget holder.

4.0 Statement of evidence/references

Please contact MKUH library service for the latest guidance to help steer this documents contact Extn: 85065

4.0 Statement of evidence/references

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5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made

5.2 Consultation History

Include staff in consultation who will be required to ensure the Guideline is embedded. This table should be completed in full even if no comments are received

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Nadean Marsh	Head Nurse Quality	17/05/2021			
Elizabeth Winter	Head Nursing Medicine	17/05/2021			
Sim Ray-Chauhuri	Vascular Consultant	17/05/2021			
Emma Coddrington	Surgical Matron	17/05/2021			
Angela Legate	Infection Control	17/05/2021			
	Surgical Nurse Practitioner				
Amanda Taylor	Breast Surgeon	17/05/2021			
Kelly Hodgson	Diabetic Advance Nurse Practitioner	17/05/2021			
Nursing Midwifery Board					
Clinical Procurement Nurse	Procurement	17/05/2021	25/05/21	No comments	Yes
Head of Pharmacy					

5.3 Audit and monitoring

How will compliance of this Guideline be evidenced?.

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Annual Pressure Ulcer Prevalence Audit				
NICE compliance assessments including: IPG467 Negative pressure dressings in open abdominal wounds	Compliance assessment	TVN	As required	NMB

CG74 Surgical Site Infections TA24 Debridement CG179 Pressure ulcer prevention and management				

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Patient care/ corporate	Department	Safeguarding/ quality
Person completing the EqIA	Esther Pearce	Contact No.	85884
Others involved:	Procurement	Date of assessment:	ongoing
Existing policy/service	Yes, update of existing wound formulary	New policy/service	

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*All staff groups delivering wound care*

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?
External partners such as community TVN, procurement, clinical product review group, clinical advisors
How are the changes/amendments to the policies/services communicated?
Wound care training, acute user, weekly message update, adhoc discussions with TVN on the wards when patients are being reviewed
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed

Review date of EqIA	

Checklist for Guideline and guidelines documentation

By submitting a document for review/approval you are confirming that the document has been checked against the checklist below to ensure it meets the Trust standards for producing Trust Documentation (for support please contact your Governance Facilitator/Patient Safety Lead.

Check	Tick
Latest template	☐
Fonts should be Arial 14 for headers 12 for main body	☐
Clear Title and replace with document title Font Arial 22	☐
Authors Job title:	☐
Authors Division:	☐
Department/Groups this document applies to:	☐
Date of approval:	☐
Review date:	☐
Approval Group/approved by (according to policy requirements):	☐
Last review date:	☐
Unique Identifier: if known (new documents will be assigned at publication)	☐
Status: Approved	☐
Version numbers are the same throughout document	☐
Scope: Who will use this document?	☐
To be read in conjunction with the following documents:	☐
Are there any eCARE implications?	☐
Latest CQC fundamental standards referenced:Trust intranet page with fundamental standards	☐
Footers completed to match main page : (on all pages)	☐
References are updated (contact the library (Jayne Plant 3077) for help if required)	☐
Consultation history includes key stakeholders required to embed document. Pharmacy are consulted if the document contains medication	☐
Audit and monitoring criteria is completed and clear (where possible reference the relevant section of the policy)	☐
Include full & correct consultation history	☐
Dissemination should be clear	☐
Check relevant hyperlinks work	☐

Completed by name:	Position:	Division	Date
			(DD/MM/YYY)