DONCASTER DISTRICT WOUND CARE FORMULARY 2015-2017
ASSOCIATED POLICIES

This Formulary should be used in conjunction with organisations’
- ‘Wound Care Policy’
- ‘Aseptic Technique & Aseptic Non-Touch Technique Policy’
- ‘Hand Hygiene Policy’
- ‘Standard Infection Prevention and Control Precautions Policy’
- ‘Waste Management Policy’

REVIEW GROUP

Stephen Davies (Chief Pharmacist RDaSH)
Sue Johnson (Lead Nurse, Wound Care DBHFT)
Tracy Vernon (Lead Nurse, Tissue Viability DBHFT)
Dawne Squires (Clinical Nurse Specialist, Tissue Viability RDaSH)
Maggie Gallagher (Team Leader)
Lynne Crawford (District Nurse, CPE)
Fiona Rawes (Diabetic Team Lead, Podiatry RDaSH)
Gill Bradley (Deputy Head of Medicines Management, Doncaster CCG)

Additional contribution from
Emma Stables (Senior Clinical Nurse Specialist, Infection Prevention and Control RDaSH)
Debra Eyre (Infection Prevention & Control Nurse Specialist Doncaster CCG)
Wendy Feirn (Head of Infection Prevention & Control Doncaster CCG)

NOTE:
This formulary is to be used to inform the initiation of dressings in the community and guide dressing selection when a patient has moved from secondary care to primary care. Particular dressings may be initiated in secondary care however they may be swapped to an equivalent in primary care (these equivalences are identified through the formulary).
## CONTENTS

### General Information
- Wound assessment: 5
- Diabetic foot ulcers: 6
- Infection prevention & control: 7
- Debridement: 9
- Restricted items: 9

### Specific scenarios
- Colonisation and clinical infection: 10
- Necrotic wounds: 11
- Sloughy wounds: 12
- Granulating wounds: 13
- Epithelialising wounds: 14
- Malodorous and fungating wounds: 15
- Other wound products: 16

Practitioners should refer to The Wound Care Handbook for specific product characteristics [www.woundcarehandbook.com/](http://www.woundcarehandbook.com/)
WOUND ASSESSMENT

Holistic wound assessment should be:-
- Patient centred.
- Accurate and precise.
- Detect the presence of complications e.g. infection
- Detect general patient factors which may delay healing e.g. nutritional status, diabetes, chronic infection and concomitant medication e.g. steroids.
- Able to provide a framework to monitor the stages of wound healing.
- Evaluate the effectiveness of any treatment.

Local wound assessment Must take into account:-
- Type and location of wound
- Stage of healing – using recognised scale e.g. pressure ulcer category 1 to 4, including ungraded
- Wound dimensions – length, width, depth, position/extent of sinuses, undermining of surrounding skin, using one of the following methods.
- Measurement should be carried out at intervals in line with organisational policy
- Cover the wound with a sterile transparent film and measure the maximum length and width
- Use a disposal paper tape to record maximum length and width
- Use a tracing chart to draw and record the entire wound area
- Use a sterile measuring probe to measure depth and extent of undermining
- Photography is a useful way of measuring when incorporating a rule or tape into the photograph so scale can be provided (rulers are available in dressing packs)
- Guidance for obtaining consent and storage of photographs are available in the Trust Policy on Consent.
- Wounds should be assessed for any local barriers to healing, and the results documented at each dressing change using the following assessment tool:

The T.I.M.E acronym is a summary of the principles of wound bed preparation. It can be used as an aide-memoir to guide practice, heal wounds quickly and help your patients have a more comfortable path to healing.

<table>
<thead>
<tr>
<th>Wound Factors</th>
<th>Clinical Action</th>
<th>Wound Healing Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>T Tissue non-viable</td>
<td>Remove defective tissue debride if indicated (and competent to do so)</td>
<td>Viable (vascularised) wound bed</td>
</tr>
<tr>
<td>I Inflammation and/or infection</td>
<td>Remove or reduce bacterial load antimicrobial dressings debridement of devitalised tissue</td>
<td>Reduced bacterial burden and inflammation</td>
</tr>
<tr>
<td>M Moisture imbalance</td>
<td>Restore moisture balance absorb exudate, or add moisture to dry wounds</td>
<td>Optimal moisture balance</td>
</tr>
<tr>
<td>E Edge of wound non-advancing / Or undermining e.g. chronic wound with prolonged inflammation</td>
<td>Reassess T, I and M if no longer an issue consider alternative therapies to promote healing</td>
<td>Restoration of appropriate pH level and cell migration to advance wound edge if wound continues to be static after 2-4 weeks reassess intervention or refer for specialist treatment</td>
</tr>
</tbody>
</table>

WARNING: Do not attempt to re-hydrate dry necrosis in a diabetic or ischaemic wound or where the underlying aetiology is unknown, as this may encourage a ‘wet spreading’ gangrene. Keep the wound dry and appropriately dressed. Refer urgently to
- Podiatry where there is a diabetic origin
- Vascular specialist where there is an ischaemic origin
- Tissue Viability and Lymphoedema Services (TVAL for unknown aetiology

For healthy wounds, irrigation with either a sterile solution of 0.9% sodium chloride or tap water close to body temperature is appropriate. For some wounds, showering is appropriate. **Foot ulcers should be kept dry until fully healed.** Dependent on clinical condition a waterproof occlusive dressing or a waterproof protector may be used.
**DIABETIC FOOT ULCERS**

Diabetic patients with foot ulcers should be referred to the diabetic foot ulcer clinic at East Laith Gate House for assessment as per Doncaster Diabetic guidelines, unless presenting with critical ischaemia / necrosis where urgent referral to vascular / hospital admission is required. The podiatry clinic is for all patients with diabetes with any foot problems and includes regular debridement, dressings, offloading and insole therapy.

**Assessment of the Diabetic Foot Ulcers**

For successful treatment, all foot ulcers need to be assessed for the underlying cause and where possible, that cause removed or modified. Diabetic foot ulcers are commonly neuropathic or ischaemic however can be a mixture of both.

Neuropathic ulcers are usually associated with trauma from excess pressure from footwear, deformity, callus and gait. The treatment of neuropathic ulcers requires the off-loading of pressure, debridement, prevention and /or control of infection and specialist foot wear. The treatment for ischaemic ulcers should involve vascular intervention where appropriate off-loading when needed, specialist foot wear, very judicious debridement and prevention and/or control of infection.

The differences between neuropathic and ischaemic ulcers:

<table>
<thead>
<tr>
<th>SIGNS &amp; SYMPTOMS</th>
<th>NEUROPATHIC</th>
<th>ISCHAEMIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>Commonly found on pressure points on the toes and plantar surface. Often irregular with heavy callus around ulcer site with sloping edges. Can be sloughy</td>
<td>Punched-out, undercutting, sloughy surrounded by thin glassy callus and devitalised tissue</td>
</tr>
<tr>
<td>Deformity</td>
<td>Clawed toes, Charcot foot, high arch</td>
<td>No deformity</td>
</tr>
<tr>
<td>Pain</td>
<td>Painless</td>
<td>Agony</td>
</tr>
<tr>
<td>Skin temperature</td>
<td>Warm</td>
<td>Cool</td>
</tr>
<tr>
<td>Colour</td>
<td>Normal</td>
<td>Pale, cyanotic or rubour</td>
</tr>
<tr>
<td>Tests</td>
<td>Insensitive/diminished response to 10mg monofilament. Neurotip, temperature discrimination and reduced or absent reflexes</td>
<td>Doppler assessment for wave formation. ABPI for vascular status</td>
</tr>
<tr>
<td>Pulses</td>
<td>Palpable</td>
<td>Not palpable or weak</td>
</tr>
<tr>
<td>Callus formation</td>
<td>Commonly found on pressure weight bearing areas</td>
<td>Commonly found on the pressure points e.g., bony prominences of toes and borders of feet</td>
</tr>
<tr>
<td>Ulcer sites</td>
<td>Usually associated with high pressure points on the toes and planter surfaces</td>
<td>Commonly found on the pressure points, bony prominences of toes and feet</td>
</tr>
</tbody>
</table>

**Management of Diabetic Foot Ulcers**

To optimise chances of ulcer healing, treatment will be directed at the following areas:
- Multi-disciplinary management
- Debridement
- Prevention and/or control of Infection
- Pressure relief
- Vascular control
- Glycaemic control
- Education
- Secondary ulcer prevention
INFECTION PREVENTION & CONTROL IN WOUND CARE

Healthcare associated infection may cause increased morbidity and mortality. Healthcare resources are finite. Antimicrobial resistance continues to increase, therefore the management of any wound must be optimal.

For more extant guidance refer to organisational policies and NMC Minimum Professional Standards

WOUND CLEANSING
The aim of wound cleansing is the removal of gross contamination with minimal pain to the patient and minimal trauma to the tissue.

- Wound cleansing will:
  - Remove excess exudate
  - Remove slough and/or necrotic tissue
  - Remove remnants of previous dressings
  - Facilitate accurate assessment of the wound/wound bed
  - Promote patient comfort
  - For healthy wounds irrigation with either a sterile solution of 0.9% sodium chloride or tap water is appropriate. For some wounds, showering is appropriate. Foot ulcers should be kept dry until fully healed. Dependent on clinical condition a waterproof occlusive dressing or waterproof protector may be used.
  - The irrigation fluid should be close to body temperature. Care should be taken to avoid trauma to the wound or splash back.
  - Repeated cleansing may do more harm than good by causing trauma to newly produced delicate tissue by reducing the surface temperature of the wound and removing exudates which may have bactericidal properties.
  - If wiping of the peri-wound area is necessary, a non-filamented swab must be used. The wound bed itself should not be dried. Wiping the wound bed may leave fibres that could be a focal point for infection or may damage newly formed tissue.
  - The general use of antiseptics/disinfectants is not recommended, as these solutions have been shown to kill fibroblasts and therefore hamper the healing matrix.
  - A waterproof protector may be used to keep dressings dry when showering or bathing. They should be removed and the exposed skin cleansed and if appropriate dried with the cool setting of a hair dryer.

WOUND INFECTION
Wound infection is one of the commonest healthcare associated infections. Nursing staff must recognise the distinction between contamination, colonisation and infection.

- All clinical staff must recognise when the normal inflammatory process becomes abnormal and when it is due to infection.
- Contamination is when small numbers of bacteria may be detected in a wound but their presence is transient and they are not multiplying.
- In the colonised wound the levels of organisms not only increase but they have become established. An intermediate stage between colonisation and infection is also sometimes referred to as critical colonisation. This is because at the point at which an impact on wound healing may occur, there is evidence that heavy bacterial load infection may delay healing.
- True clinical infection however is defined as the process by which organisms bind to, multiply and then invade viable tissue. These responses are visible as clinical signs/symptoms and include; localised heat, pain, swelling and erythema. There may also be purulent discharge and uncharacteristic odour. The patient may also feel unwell and have a raised or even lowered body temperature.
### The infection continuum (adapted from Kingsley, 2001; WUWHS, 2008)

<table>
<thead>
<tr>
<th>Description</th>
<th>Presenting Symptoms</th>
<th>Intervention required</th>
<th>Antimicrobial dressing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contaminated</td>
<td>Presence of non-multiplying bacteria in the wound</td>
<td>Patient has no symptoms and the wound is healing normally</td>
<td>Standard wound management</td>
</tr>
<tr>
<td>Colonised</td>
<td>Presence of multiplying bacteria in the wound but no immune response</td>
<td>The patient has no symptoms and the wound is healing normally</td>
<td>Standard wound management</td>
</tr>
</tbody>
</table>
| Critically colonised/ localised infection | The immune system has been compromised and the patient is no longer able to control the multiplying bacteria | • Slight odour increased/new pain excessive or increased serous exudate  
• Localised erythema  
• Delayed healing  
• No fever | Topical antimicrobial dressing | Yes |
| Spreading/ systemic infection | The multiplying of bacteria overwhelm the immune response, resulting in clinical signs and symptoms | • Severe/increasing pain  
• Increasing erythema  
• Increasing oedema  
• Increasing wound size  
• Localised heat  
• Excessive purulent discharge  
• Wound breakdown  
• Pocketing at the base of the wound  
• Epithelial bridging  
• Friable granulation tissue  
• Discolouration of wound bed  
• Abscess forming  
• Malodour  
• Fever  
• Visible devitalising tissue | Systemic antibiotics plus topical antimicrobial dressing | Yes |

### Critically colonised/localised wound - management pathway

1. Is the wound critically colonised/locally infected (see table above)
2. Use a topical antimicrobial dressing
3. Review process
   - Review the wound at each dressing change and after 2 weeks. Provide a full rationale in the patient's records as to why you have continued/discontinued treatment
   - If the wound fails to progress or deteriorates, refer for specialist advice and consider the pathway for spreading/systemic infection
4. Discontinue treatment
   - Consider this, if there has been:
     - A reduction in wound dimensions?
     - A reduction in exudate levels?
     - A reduction in pain?
5. Once bio-burden is under control and the wound is improving, a non-antimicrobial dressing should be considered.
6. Document the full rationale in the patient's record

### Spreading/systemic wound infection - management pathway

1. Is the wound showing signs of spreading/systemic infection (see table above)
2. Use a topical antimicrobial dressing
   - Follow the protocol for wound swabbing
   - Ensure antibiotic therapy complies with the local formulary [see page 9]. If not, seek advice from a medical microbiologist.
3. Review process
   - Review the wound at each dressing change and at 7 days post antibiotic initiation. Is the wound still showing two or more signs of infection?
   - If yes, check the following:
     - Review the wound using TIME or another appropriate framework
     - Is there an appropriate level of compression?
   - If yes, document the full rationale in the nursing notes and consider a further 7 days of antibiotics.
4. If, after 10 days of antibiotic treatment, there is no improvement, refer to the tissue viability team/Microbiologist
**OBTAINING A BACTERIAL SPECIMEN**

Swabbing should only be done in exceptional circumstances, where there are signs and symptoms that may indicate an infection and only after referral to an experienced colleague.

When obtaining a specimen

- The healthcare worker must ensure that they wash their hands prior to and following the procedure.
- The healthcare worker must carry out a risk assessment on the appropriateness of personal protective equipment required, and ensure that they use the correct PPE.
- If there is pus present where possible obtain a sample by aspirating the wound with a syringe.
- If the wound is dry and a dry swab is being used then it should be moistened with sterile saline; the swab should be wiped over the wound using a zig-zag motion.
- The specimen should be carefully labeled with all relevant information.
- The specimen should be sent to the laboratory as soon as possible in order to yield a good result.

**DEBRIDEMENT**

Debridement is thought to be essential for optimal healing. Callus surrounding an ulcer, together with non-viable tissue, should be removed with a sterile scalpel using an aseptic technique by an appropriately skilled / knowledgeable healthcare professional.

NB: The debridement of ulcers using scalpel technique may not be appropriate treatment in the ischaemic foot as any trauma caused may not heal.

Debridement may also be undertaken using larvae, Debrisoft or appropriate dressings that promote debridement.

**WARNING:** Do not attempt sharp or surgical debridement unless you have successfully completed the necessary course(s) and are qualified and competent in this skill.

**RESTRICTED PRODUCTS**

Initiation of the following products is RESTRICTED. These products may be initiated under specialist advice ONLY from the Tissue Viability Nursing Service.

- Kendall AMD Antimicrobial Foam
- Actilite
- Debrisoft
- Flaminal *(Forte and Hydro)*
- Larvae therapy
- Promogran / Prisma
- T.N.P. Therapy *(Venturi / VAC / PICO)*
- Vibropulse
## COLONISATION & CLINICAL INFECTION

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Product</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exudate</td>
<td>Acticoat Flex 3 or 7 Allevyn Life (except plantar ulcers) Biatain (Plantar ulcers ONLY)</td>
<td>Change dressing at strike through</td>
</tr>
<tr>
<td>Heavy Exudate</td>
<td>Durafiber</td>
<td>Change dressing at strike through</td>
</tr>
<tr>
<td>Odour</td>
<td>Acticoat Flex 3 or 7 Allevyn Life</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>Acticoat Flex 3 or 7 Allevyn Life</td>
<td>Use of analgesia prior to dressing change + usual pain management.</td>
</tr>
<tr>
<td>Foot</td>
<td>Acticoat Flex 3 or 7 Allevyn Life (except plantar ulcers) Biatain (Plantar ulcers ONLY)</td>
<td></td>
</tr>
</tbody>
</table>

### Oral antibiotics

Ulcers are always colonised and antibiotics do not improve healing unless there is an active infection (see page 7). If there are signs of an active infection, send pre-treatment swab (see page 8) and ALWAYS review antibiotics after culture results. Compliance with antibiotics should be confirmed at each dressing change.

<table>
<thead>
<tr>
<th>Product and adult dose</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-MRSA</strong></td>
<td></td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; line</td>
<td></td>
</tr>
<tr>
<td>Flucloxacillin - 500mg four times a day</td>
<td>Course length is usually 7 days. Re-assess for progress at 7 days and the need to continue for a further 7 days.</td>
</tr>
<tr>
<td>If penicillin allergy</td>
<td>Clarithromycin 500mg twice a day</td>
</tr>
</tbody>
</table>

| **MRSA colonised**     | Doxycycline 100mg twice a day                                           |
| MRSA confirmed by lab results, infection not severe and admission not required | Using antibiotic sensitivities to guide treatment. Course length is 7 days. **Stop if diarrhoea.** If severe infection or no response to monotherapy after 24-48 hours, seek advice from microbiologist. |
| MRSA infected wounds - consider Larvae therapy | |

**Other considerations**

Refer to a tissue viability team or consultant medical microbiologist if there is no resolution in
- Infected wound – after 10 days post antibiotic initiation or
- Critically colonised wound – after 14 days treatment

Source data: Doncaster and Bassetlaw Antimicrobial Guidance for Primary Care 2013
Health Protection Agency Management of infection guidance for primary care
# NECROTIC WOUNDS

**Characterised by:**
- Presence of dead or de-vitalised tissue Black/Brown colouration
- Wound will not heal until necrotic tissue is removed

**Aim of treatment:**
- Hydration of wound.
- **DO NOT HYDRATE BELOW KNEE WOUNDS UNLESS CIRCULATION HAS BEEN DETERMINED**
- Removal of necrotic tissue

The dressings listed below are the preferred dressings for each of their respective type. This is not to say that choice is restricted to these only, however they should be considered and discounted before an alternative is used.

<table>
<thead>
<tr>
<th>SHALLOW</th>
<th>CAVITY</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Debridement</strong></td>
<td><strong>Primary dressing</strong></td>
<td><strong>Primary dressing</strong></td>
</tr>
<tr>
<td>Hydrogel:</td>
<td>Hydrogel:</td>
<td>Hydrogel:</td>
</tr>
<tr>
<td>Intrasite Gel</td>
<td>Intrasite Gel</td>
<td>Intrasite Gel</td>
</tr>
<tr>
<td>Intrasite Conformable Purilon (^1)</td>
<td>Intrasite Conformable Purilon (^1)</td>
<td>Intrasite Conformable Purilon (^1)</td>
</tr>
<tr>
<td><strong>Secondary dressing</strong></td>
<td><strong>Secondary dressing</strong></td>
<td><strong>Secondary dressing</strong></td>
</tr>
<tr>
<td>Film:</td>
<td>Film:</td>
<td></td>
</tr>
<tr>
<td>C-view (hospital)</td>
<td>C-view (hospital)</td>
<td></td>
</tr>
<tr>
<td>Tegaderm (community)</td>
<td>Tegaderm (community)</td>
<td></td>
</tr>
<tr>
<td><strong>Exudate Management</strong></td>
<td><strong>Primary dressing</strong></td>
<td><strong>Primary dressing</strong></td>
</tr>
<tr>
<td>As above</td>
<td>As above</td>
<td>As above</td>
</tr>
<tr>
<td><strong>Secondary dressing</strong></td>
<td><strong>Secondary dressing</strong></td>
<td></td>
</tr>
<tr>
<td>Foam:</td>
<td>Foam:</td>
<td></td>
</tr>
<tr>
<td>Allevyn Life</td>
<td>Allevyn Life</td>
<td></td>
</tr>
<tr>
<td><strong>Colonisation / infection</strong></td>
<td></td>
<td>See page 10</td>
</tr>
</tbody>
</table>

- Mixed wounds should be treated as per predominant wound type.
- Failure of the wound to respond to treatment within 7 days should lead to referral to a more experienced colleague.

1. **Purilon** should only be used as a preparatory treatment for larvae therapy.
SLOUGHY WOUNDS

Characterised by:
- Slough - soft necrotic tissue / dead phagocytes. Yellow colouration
- Wound will not heal until slough is removed

Aim of treatment:
- To lift slough from wound
- To manage exudate

The dressings listed below are the preferred dressings for each of their respective type. This is not to say that choice is restricted to these only, however they should be considered and discounted before an alternative is used.

<table>
<thead>
<tr>
<th>SHALLOW</th>
<th>CAVITY</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debridement</td>
<td>Primary dressing</td>
<td>Primary dressing</td>
</tr>
<tr>
<td>Alginate: Aquacel Durafiber</td>
<td>Alginate: Aquacel Durafiber</td>
<td></td>
</tr>
<tr>
<td>Hydrocolloid: Comfeel Granuflex</td>
<td>Foam dressings: for easy removal of adhering dressings from surrounding skin – use water between skin and dressing.</td>
<td></td>
</tr>
<tr>
<td>Exudate Management</td>
<td>Primary dressing As above</td>
<td>Primary dressing As above</td>
</tr>
<tr>
<td>Secondary dressing Foam: Allevyn Life Versiva XC</td>
<td>Secondary dressing Foam: Allevyn Life</td>
<td></td>
</tr>
<tr>
<td>Colonisation / infection</td>
<td>See page 10</td>
<td></td>
</tr>
</tbody>
</table>

- Mixed wounds should be treated as per predominant wound type.
- Failure of the wound to respond to treatment within 7 days should lead to referral to a more experienced colleague.

1. Alginate dressing: Secondary care may initiate Sorbsan however this should be changed to Aquacel or Durafiber in community unless there are overriding clinical considerations.
GRANULATING WOUNDS

Characterised by:

- Shiny granulation tissue
- Connective tissue and capillary loops
- Bright red colouration

Aim of treatment:

- Promote granulation (distinguishing between healthy and uncontrolled granulation)
- Manage exudate

The dressings listed below are the preferred dressings for each of their respective type. This is not to say that choice is restricted to these only, however they should be considered and discounted before an alternative is used

<table>
<thead>
<tr>
<th>SHALLOW</th>
<th>CAVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debridement</td>
<td>Primary dressing</td>
</tr>
<tr>
<td></td>
<td>Alginate¹:</td>
</tr>
<tr>
<td></td>
<td>Aquacel</td>
</tr>
<tr>
<td></td>
<td>Durafiber</td>
</tr>
<tr>
<td></td>
<td>Hydrocolloid:</td>
</tr>
<tr>
<td></td>
<td>Comfeel</td>
</tr>
<tr>
<td></td>
<td>Granuflex</td>
</tr>
</tbody>
</table>

Primary dressing

Secondary dressing

Foam dressing: for easy removal of sticking dressings from surrounding skin – use water between skin and dressing.

Logical Combinations:

Light exudate:

- Alginate and film

Moderate exudate:

- Alginate and hydrocolloid

Heavier exudate:

- Alginate and foam

Exudate Management

Primary dressing

As above

Secondary dressing

Foam :

- Allevyn Life
- Versiva XC

Primary dressing

As above

Secondary dressing

Foam :

- Allevyn Life

Colonisation / infection

See page 10

- Mixed wounds should be treated as per predominant wound type.
- Failure of the wound to respond to treatment within 7 days should lead to referral to a more experienced colleague.

1. Alginate dressing: Secondary care may initiate Sorbsan however this should be changed to Aquacel or Durafiber in community unless there are overriding clinical considerations
EPITHELIALISING WOUNDS

Characterised by:
- Epithelial cells migrating from wound edge to fill deficit, plus islands of epithelial cells in the wound bed originating from hair follicle and sweat glands
- Lilac-pink colouration
- Shallow with low exudate

Aim of treatment:
- Protect wound

The dressings listed below are the preferred dressings for each of their respective type. This is not to say that choice is restricted to these only, however they should be considered and discounted before an alternative is used.

<table>
<thead>
<tr>
<th>Debridement</th>
<th>SHALLOW</th>
<th>CAVITY</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOT APPLICABLE</td>
<td></td>
<td>Dressing selection is based entirely on the degree of exudate</td>
</tr>
</tbody>
</table>

Exudate Management

<table>
<thead>
<tr>
<th>Primary dressing</th>
<th>SHALLOW</th>
<th>CAVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thin hydrocolloid:</td>
<td>DuoDERM</td>
<td>Thin hydrocolloid:</td>
</tr>
<tr>
<td>Hydrocolloid:</td>
<td>Comfeel</td>
<td>Hydrocolloid:</td>
</tr>
<tr>
<td>Foam:</td>
<td>Allevyn Life</td>
<td>Foam:</td>
</tr>
</tbody>
</table>

Colonisation / infection

- Mixed wounds should be treated as per predominant wound type.
- Failure of the wound to respond to treatment within 7 days should lead to referral to a more experienced colleague.
MALODOROUS and FUNGATING WOUNDS

Characterised by:
- Offensive smell
- Variable exudate
- Painful

Aim of treatment:
- Determine the patient's priorities regarding treatment.
- Address analgesic needs.
- Palliative management.
- Minimise disturbance to wound

The dressings listed below are the preferred dressings for each of their respective type. This is not to say that choice is restricted to these only, however they should be considered and discounted before an alternative is used.

<table>
<thead>
<tr>
<th>Debridement</th>
<th>SHALLOW</th>
<th>CAVITY</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GENERALLY TO BE UNDERTAKEN BY A WOUND SPECIALIST ONLY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exudate Management</th>
<th>Primary Dressing</th>
<th>Secondary Dressing</th>
<th>Tertiary Dressing</th>
<th>Primary Dressing</th>
<th>Secondary Dressing</th>
<th>Tertiary Dressing</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Silflex</td>
<td>Carboflex</td>
<td>KerMax Care</td>
<td>Silflex</td>
<td>Carboflex</td>
<td>KerMax Care</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Colonisation / infection</th>
<th>SHALLOW</th>
<th>CAVITY</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOT APPLICABLE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Mixed wounds should be treated as per predominant wound type.
- Failure of the wound to respond to treatment within 7 days should lead to referral to a more experienced colleague.

Carboflex: Will treat colonising organism which might be causing odour, exudate and pain

KerraMax Care: Useful when heavy exudate - additionally can be shaped for comfort and ease of application.
### OTHER WOUND CARE PRODUCTS

<table>
<thead>
<tr>
<th>PRESENTATION</th>
<th>PACK SIZE</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BANDAGES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easifix K</td>
<td>singles</td>
<td>Retention</td>
</tr>
<tr>
<td>Clinilite</td>
<td>singles</td>
<td>Support Bandage</td>
</tr>
<tr>
<td><strong>COMPRESSION SYSTEMS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Layer 1: Flexi-Ban or K-Soft</td>
<td>singles</td>
<td>Ankle circumference: less than 18cm; 18 - 25cm; 25 - 30cm; greater than 30cm</td>
</tr>
<tr>
<td>Layer 2: K-lite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Layer 3: K-plus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Layer 4: Ko-Flex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tensopress</td>
<td>Multilayer Compression</td>
<td>Available as a kit or singles. For legs&gt;28cm</td>
</tr>
<tr>
<td>Actico</td>
<td>singles</td>
<td>Short stretch - Use only if suitably trained</td>
</tr>
<tr>
<td><strong>TUBULAR BANDAGES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinifast</td>
<td>1m singles</td>
<td>retention</td>
</tr>
<tr>
<td><strong>TAPES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinipore</td>
<td>5m x 2.5cm singles</td>
<td></td>
</tr>
<tr>
<td><strong>DRESSING PACKS [PRESCRIBE BY BRAND]</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRESSIT</td>
<td>singles</td>
<td>DBHFT and Community</td>
</tr>
<tr>
<td>Soft Drape</td>
<td>singles</td>
<td>Tickhill Road Hospital</td>
</tr>
</tbody>
</table>

Practitioners should refer to The Wound Care Handbook for specific product characteristics
[www.woundcarehandbook.com/](http://www.woundcarehandbook.com/)