Please note, the red and amber status in this booklet relates to recommended professional/specialist oversight for certain products and should not be confused with the prescribing status as set out by the local health economy formulary.
Please refer to the wound care section of the net formulary to check the prescribing status of the product as appropriate
http://www.shropshireandtelfordformulary.nhs.uk/default.asp

All silver dressings are classified as Amber on the formulary as requested by APC

Shropshire, Telford & Wrekin
Sustainability and Transformation Partnership

Shropshire

Wound Management Formulary and Clinical Pathways

CONTENTS

PRESCRIBING OFF FORMULARY

Should there be an occasion that a product is required that is not on the wound care formulary, it is essential that the Tissue Viability Service is contacted to discuss the request and authorise form on: shropcom.tissueviability@nhs.net

NEGATIVE PRESSURE WOUND THERAPY (NPWT)

On discharge from Royal Shrewsbury Hospital and Princess Royal Hospital (RSH and PRH) patients with Negative Pressure Wound Therapy must be transferred onto a community NPWT pump - this can be done by referring the patient to the Tissue Viability Service and the pump exchange can take place as part of the TV assessment.

TISSUE VIABILITY REFERRAL FORM

PATIENT DETAILS

Patient's Name:		Date of Referral:	
Address & Postcode:		NHS Number:	
		D.O.B:	
Reason for referral:			
Present wound treatment:			

WOUND DETAILS

Wound Location:						
Pressure Ulcers: (please circle / highlight)	**Multiple Category 2**	**Category 3**	**Category 4**	**Unstageable**	**Suspected Deep Tissue Injury**	**Moisture Associated Skin Damage**
Wound Type (please circle/ highlight)	**Negative Pressure Wound Therapy**	**Surgical Wound**	**Malignant/ Fungating Wound**	**Trauma/ Skin Tear**	**Lymphoedema**	
	Diabetic Foot Ulcer	**Burn**	**Leg Ulcer (state type)**		**Date of last ABPI:**	
					Left:	**Right:**
Wound dimensions (cm)	Length		Width		Depth	
Wound bed (as a percentage)	**Necrotic/Black**			**Sloughy/Yellow**		
	Granulating/Red			**Epithelialising/Pink**		
Is the wound infected?	**YES**	**NO**	If yes, document signs of infection			
Frequency of nurse visit/dressing change						
Clinical Image taken and sent to TV Team?	**YES**	**NO**				

REFERRER DETAILS

Name		**Please email this referral form along with a current wound image to: shropcom.tissueviability@nhs.net**
Contact No		**Please note we will reject all incomplete referrals or referrals with missing information. Once accepted your referral will be triaged in the first instance.**
Team & Base		

SELECTING A DRESSING

When selecting a dressing you should consider the following

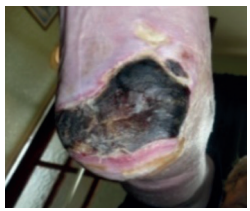
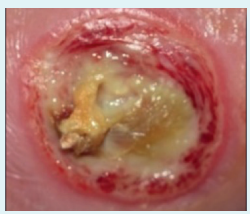
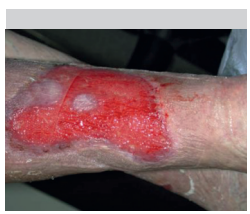
- Treatment aim
- Treatment objective
- Type of wound bed
- Position and size of wound
- Level of exudate
- Condition of peri-wound area (surrounding skin)
- Presence of odour
- Comfort and cosmetic appearance
- Frequency of dressing change

When applying a dressing you should consider the following

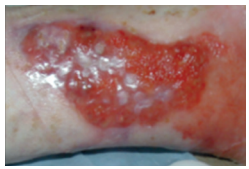
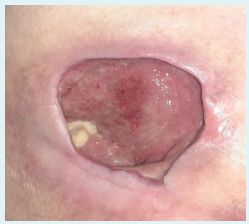
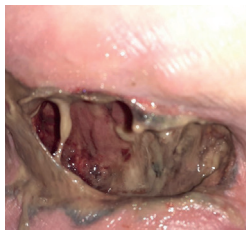
- Is this an appropriate dressing format and size?
- How does this dressing work?
- When should it be used?
- Are there any contra-indications for its use?
- Does the patient have any known allergies or sensitivities?
- What is the method of application and removal?
- Is a secondary dressing required?
  - If yes, which dressing is appropriate?
- Is the dressing correctly positioned and secured in place?

Practitioners must follow the manufacturer's recommendations and any contra-indications

WOUND BED PREPARATION

	OBJECTIVE	EXAMPLE DRESSING
NECROTIC 	• Refer to Debridement Pathway • Rehydrate eschar (hard dead tissue) • Reduce odour • Assess if safe to debride • If on the foot, protect until lower limb assessment has been performed	Amorphous or sheet Hydrogel
SLOUGHY 	• Refer to Debridement Pathway • Aid removal of devitalised tissue by autolysis (natural removal) • Reduce bacterial load • Identify wound base • Reduce odour • Promote healing	UrgoClean, UrgoStart Plus Pad, Hydrogel, Flaminal, Iodoflex
GRANULATING 	• To promote and protect angiogenesis and therefore wound healing • Manage exudate to avoid maceration • Maintain optimum moist environment • Minimise frequency of dressing changes to promote healing	Foam, Wound Contact Layer, UrgoStart Contact, UrgoStart Plus Pad or Border

WOUND BED PREPARATION

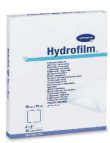
	OBJECTIVE	EXAMPLE DRESSING
EPITHELIALISING 	• To promote and protect new tissue • Maintain a moist environment • Minimise dressing frequency	Foam, Wound Contact Layer, UrgoStart Contact, UrgoStart Plus Pad or Border
CAVITY 	• Debride devitalised tissue • Manage exudate • Manage odour • Manage pain • Identify cause e.g. pressure • Heal by secondary intention (from base up)	UrgoStart Contact or UrgoStart Plus Pad, UrgoClean, Aquacel Extra Consider the use of rope / ribbon and ensure the dressing is in contact with the wound bed
INFECTED 	• Follow ***Wound Infection Framework*** • Reduce bacterial load • Prevent spreading infection • Prevent sepsis • Manage exudate • Manage odour • Promote healing	Refer to Wound Infection Framework

WOUND DRESSING FORMULARY

- For all dressings, avoid selecting dressings for patients who have a known sensitivity to any of the ingredients

All dressing or treatments that appear in the 'amber' filled box require discussion with Team Leader or Case Load Holder before use

All dressings or treatments that appear in a 'red' filled box are for specialist use only or use following specialist recommendation

DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
NON-ADHERENT DRESSING						
MEPITEL ONE 	6 x 7 9 x 10 13 x 15	Primary wound contact layer Will require a secondary dressing	• Exuding wounds • Protective layer on non-exuding wounds • With negative pressure wound therapy systems	• Imprints can occur when used on burns treated with meshed grafts if the product is not used properly		
MELOLIN 	7.5 x 5	Absorbent perforated film-faced dressing	• Light to moderately exuding wounds			
FILM DRESSING						
HYDROFILM 	10 x 15 15 x 20	Vapour-permeable adhesive film dressing with a high moisture vapour transmission rate	• Dry, non-infected wounds • Retention of lines • Fixation of secondary dressings	• Should not be used on clinically infected, bleeding or highly exuding wounds		

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DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
NON-WOVEN DRESSING						
COSMOPOR E 	5 x 7.2 8 x 10 10 x 20	Self-adhesive, island wound dressing with non-adherent absorbent pad	• Postoperative wound treatment • Minor injuries, e.g. in first aid.			
HYDROCOLLOIDS						
DUODERM EXTRA THIN 	7.5 x 7.5 10 x 10	Sterile, thin hydrocolloid dressing	• Dry to lightly exuding wounds			
GRANUGEL 	15g	Sterile gel: hydrocolloids, clear & viscous	• Partial- and full-thickness wounds			
FLAMIGEL RT 	100g	Gel containing hydrocolloid, arginine, purified water, macrogol, branch chain fatty acid (BCFA), methyl-p-hydroxybenzoate (E218), propyl-p-hydroxybenzoaate (E216) and disodium EDTA	• Protective gel for skin at risk of damage from radiotherapy: radiation-induced dermatitis	* **Avoid** application to the eyes or eyelids * **Avoid** use on ulcerations or infected areas without consulting a doctor		

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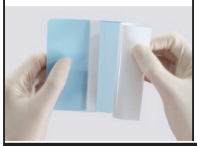
DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
HYDROGELS						
ACTIFORMCOOL SHEETS 	5 x 6.5 10 x 15	Non-adhesive, ionic hydrogel sheet	• Suitable for painful wounds • Skin conditions including burns, scalds, radiation therapy damage • Can be used under compression	* **Avoid** covering cavities or sinuses • Wound may become dryer than expected due to rapid absorption • Change if discoloured or opaque		
HYDROFIBRE						
AQUACEL EXTRA 	5 x 5 10 x 10 15 x 15	Non-woven pad Absorbs wound fluid and transforms into a soft gel	• Leg ulcers, pressure ulcers, diabetic ulcers, surgical, donor sites, abrasions, lacerations, first-degree, second-degree burns, traumatic wounds, painful wounds • Wounds that are prone to bleeding			
AQUACEL EXTRA RIBBON 	1 x 45 2 x 45	Non-woven **ribbon** Absorbs wound fluid and transforms into a soft gel	• Sinus, tracking or undermining wounds			
AQUACEL® FOAM ADHESIVE 	10 x 10 12.5 x 12.5 Heel 19.8 x 14 Sacral 24 x 21.5	Adhesive or non-adhesive Hydrofiber foam with waterproof outer, multi-layered absorbent pad Adhesive with silicone adhesive border	• Leg ulcers, pressure ulcers, diabetic ulcers, surgical, donor sites, abrasions, lacerations, first-degree, second-degree burns, traumatic wounds, painful wounds			

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DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
DEBRIDEMENT / DESLOUGHING						
URGOCLEAN 	**Pad** 6 x 6 10 x 10	**Available in a pad and a rope format** Slough-trapping, poly-absorbent fibre with TLC healing matrix to promote wound healing and enable pain-free dressing changes	• All non-infected sloughy wounds • Can be cut and used under compression	• Refer to Debridement Pathway		
UCS CLOTHS 		A sterile, pre-moistened, single-use debridement cloths	• **A class 2b medical device** • All wound types or skin that wound benefit from manual debriding to remove hyperkeratosis	• Refer to Debridement Pathway		
DEBRISOFT LOLLY 		Debridement device - Monofilament Fibre NICE technologies guidance (MTG17) states that the case for using this dressing on acute and chronic wounds in the community is supported by the evidence	• Removal of superficial slough, debris, biofilm • To aid assessment • For cavity wounds, awkward areas such as skin folds	• Prior autolytic debridement treatment for stubborn slough or hard necrosis • Refer to Debridement Pathway		
LARVAL THERAPY **PRESCRIPTION ONLY** 		For debriding and cleansing wounds with aseptically developed larvae in a finely woven polyester pouch	• Debridement of chronic wounds and dehisced surgical wounds	* **Avoid:** * Wounds that have a tendency to bleed or are close to major blood vessels * Use on patients on anti-coagulants where relevant clotting marker is not within clinical range • Caution with wounds over/ adjacent to exposed organs or leading to a body cavity		

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DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
ALGINATES						
ACTIVHEAL ALGINATE 	5 x 5	Absorbent calcium sodium alginate dressing	• Moderate to heavily exuding wounds • Can also be used to control minor bleeding in superficial wounds	• Not indicated for use to control heavy bleeding		
ABSORBENT FOAMS						
BIATAIN NON-ADHESIVE 	5 x 5	Soft, conformable, non-adhesive polyurethane foam dressing with vapour-permeable film backing	• Moderate to heavily exuding wounds • Can be used under compression bandaging	• Do not use with oxidising solutions, e.g hydrogen peroxide • **For Podiatry use only**		
MEPILEX BORDER COMFORT 	7.5 x 7.5 10 x 10 12.5 x 12.5	Bordered foam dressing and a film backing	• Moderate to heavily exuding wounds			
MEPILEX HEEL 	13 x 20	A highly conformable foam dressing shaped to fit the heel	• Low to moderately exuding wounds			

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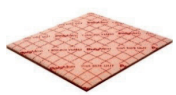
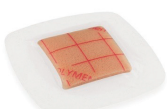
DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
ABSORBENT FOAMS						
MEPILEX BORDER SACRUM 	16 x 20	Bordered foam dressing shaped to conform to the sacrum	• Moderate to heavily exuding wounds			
MEPILEX XT 	10 x 11	A highly conformable foam dressing that absorbs both low and high viscosity exudate	• A wide range of exuding acute and chronic wounds			
FOAM LITE 	8 x 8 10 x 10	A thin, conformable, waterproof outer polyurethane film, an absorbent foam pad and a perforated gentle silicone adhesive	• A wide range of exuding acute and chronic wounds • Step down product once exudate reduces	• Not compatible with oil-based products or emollients such as petrolatum • Do not use in combination with oxidising agents such as hydrogen peroxide or hypochlorite solutions.		
POLYMEM  	**Non Adhesive** **8 x 8 (SATH Oncology only)** **10 x 10 (SATH Oncology only)** 13 x 13 17 x 19 **Adhesive** 5 x 5 5 x 7.6 15 x 15 16.5 x 20.9 18.4 x 20	A hydrophilic, polyurethane matrix with a mild, non-toxic wound cleanser, a smoothing moisturiser, a superabsorbent and semi-permeable film-backing. Designed to facilitate healing, relieve pain and reduce inflammation. For all wound types, including painful wound	• For dry to moderately exuding wounds • Leg ulcers, pressure ulcers, diabetic ulcers, surgical, donor sites, abrasions, lacerations, first-degree, second-degree burns, traumatic wounds, painful wounds			

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DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
ANTIMICROBIALS: SILVERS						
URGOCLEAN AG 	6 x 6 10 x 10	Poly-absorbent fibre pad with TLC-Ag healing matrix to cleanse the wound from slough, exudate and bacteria Designed to disrupt and breakdown biofilm, and prevent its reformation	• All wounds at risk of or with signs of local infection • Can be used with a secondary dressing or under compression • Can be used for a 7-day wear time	• Refer to Wound Infection Framework		
URGOTUL AG / SILVER 	10 x 12	Flexible and conformable antimicrobial contact layer, consisting of a non-adherent TLC-Ag Healing Matrix impregnated with silver particles	• Suitable for all types of infected wounds with or without exudate. Wounds with higher levels of exudate use with a secondary dressing	* **Avoid** use on patients undergoing MRI Scans, contact with electrodes or conductive gels during electronic measurement procedures • Refer to Wound Infection Framework		
AQUACEL AG PLUS EXTRA 	**Pad** 5 x 5 10 x 10 15 x 15 **Ribbon** 1 x 45 2 x 45	Soft, sterile non-woven pad or ribbon dressing made from a layer of 1.2% ionic silver-impregnated Hydrofiber, enhanced with anti-biofilm technology, stitched together with cellulose strengthening fibres. Absorbs wound fluid, disrupts and breaks down biofilm to expose and kill bacteria, while preventing biofilm reformation	• Primary dressing for moderately to highly exuding wounds that are infected or at increased risk of infection	• Refer to Wound Infection Framework		
ACTICOAT FLEX 3 	5 x 5 10 x 10	Low-adherent polyester layer coated with nanocrystalline silver	• Partial- and full-thickness wounds such as burns, recipient graft sites, surgical sites, pressure ulcers, venous leg ulcers and diabetic foot ulcers. • Can be used on infected wounds. • Can in combination with negative pressure wound therapy (NPWT) for up to 3 days • The dressing's antimicrobial barrier properties remain effective for a minimum of 3 days			

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DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
ANTIMICROBIALS: IODINE BASED						
INADINE 	5 x 5 9.5 x 9.5	Non-adherent dressing with 10% povidone-iodine	• Management and prevention of infection in ulcers, minor burns and minor traumatic skin injuries.	* **Avoid** use after radio-iodine or if the patient is being treated for kidney problems, is pregnant; breastfeeding; or Duhring's herpetiform dermatitis (a rare skin disease). Must be used under medical supervision: in patients with any thyroid diseases; in newborn babies and infants up to the age of 6 months as povidone-iodine may be absorbed through unbroken skin Colour change indicates when to change dressing		
IODOSORB 	**Ointment** 10g 20g **Powder** 3g	Sterile dark-brown paste ointment and powder. Cadexomer, polyethylene glycol and iodine	• To remove excess exudate and slough, reduce bacteria on the wound surface • Can be used under compression therapy	* **Avoid** use on children, pregnant or lactating women or people with thyroid disorders or renal impairment		
IODOFLEX 	5g 10g 17g	A sterile dark-brown paste dressing with gauze backing on both sides. Comprises cadexomer, polyethylene glycol and iodine	• To remove excess exudate and slough from the wound bed, and reduce bacteria on the wound surface • Can be used under compression therapy	* **Avoid** use on dry necrotic tissue * **Avoid** use on children, pregnant or lactating women or people with thyroid disorders or renal impairment		
ANTIMICROBIALS: HONEY						
ACTIVON 	**Tube** 25g **Tulle** 5 x 5 10 x 10	100% medical-grade Manuka honey Knitted viscose mesh impregnated with 100% Manuka honey	• Antimicrobial properties • Can be applied to any wound type, especially useful in cavity wounds • Tube can be used to top up other dressings in the Activon Manuka honey range	* **Avoid** if known allergy to bee venom		

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DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
ANTIMICROBIALS: DACC						
CUTIMED SORBACT SWAB 	4 x 6 7 x 9 Packing Sphere	Sorbact-technology-coated, hydrophobic, antimicrobial wound contact layer designed to bind bacteria under moist wound conditions.	• For contaminated, colonised or infected wounds • Suitable for fungal infections in the groin, skin folds, or between digits • The dressing can be used folded or unfolded	• Do not use in combination with ointments and creams as the binding effect is impaired • Refer to Wound Infection Framework		
ANTIMICROBIALS: PHMB						
KERLIX 	**Super Sponges** 15.2 x 17.1 **Gauze Roll** 11.4 x 3.7 (1pk) 11.4 x 3.7 (5pk) 11.4 x 3.7 (20pk)	Gauze sponges or rolls impregnated with 0.2% PHMB	• Moderate to heavily exuding wounds • Packing • Can be used in combination with negative pressure wound therapy • Can be used as a secondary dressing to prevent bacterial penetration through and bacterial growth within the dressing			
ANTIMICROBIALS: ALGINATE GEL						
FLAMINAL HYDRO 	15g 50g (Specialist Use Only)	Alginate gel with antimicrobial enzymes: glucose oxidase and lactoperoxidase	• Low to moderately exuding wounds			
FLAMINAL FORTE 	15g	Alginate gel with antimicrobial enzymes: glucose oxidase and lactoperoxidase	• Moderate to heavily exuding wounds			

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DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
ANTIMICROBIAL: CLEANSING SOLUTIONS						
OCTENILIN 	350ml	Wound irrigation solution containing: octenidine and ethylhexylglycerin	• Removal of necrotic tissue, biofilm and fibrinous films • Prevents bacteria and fungi growing in the solution and the wound dressing • **Also for moistening wounds, wound dressings and wound pads.**	* Not for injection under pressure onto tissue or into the blood circulation		
PROTEASE INHIBITORS						
URGOSTART RANGE 	**UrgoStart Plus Pad** 6 x 6 10 x 10	**Available in Contact format or Pad with or without border.** Poly-absorbent fibre pad with TLC-NOSF healing matrix that reduces excess metalloproteinases and the polyabsorbent fibres bind, trap and retain exudate, slough and debris. **NICE 2019** medical technology guidance (MTG42) states that evidence supports the case for adopting UrgoStart dressings to treat diabetic foot ulcers and venous leg ulcers	• All wounds at risk of delayed healing • Leg ulcers, diabetic foot ulcers, pressure ulcers, and long-standing acute wounds • For all stages of healing. To be used from day 1 until complete healing • UrgoStart Pad & UrgoStart Contact can used with a secondary dressing or under compression • Can be used for a 7-day wear time	* **Avoid** cancerous wounds or fistula which may reveal a deep abscess • UrgoStart Plus Border: Cannot be cut • UrgoStart Plus Pad & UrgoStart Contact can be cut		

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DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
ABSORBENT PADS						
ZETUVIT E 	**Sizes for both Sterile & Non-Sterile** 10 x 10 10 x 20 20 x 20 20 x 40	Highly absorbent cellulose pad with fluid-repellent backing	• Moderate to highly exuding wounds • Sterile & Non-Sterile			
SUPER ABSORBENTS						
CONVAMAX 	12.5 x 12.5 20 x 20 20 x 30	A superabsorber dressing with superabsorbent polymers that locks the exudate into a gel	• Moderate to highly exuding wounds • Fluid is retained, even under compression	* **Avoid** use on the eyes, mucous membranes or in wound cavities * Do not use on third-degree burns * Do not use on patients with arterial bleeds and heavily bleeding wounds		
ODOUR CONTROL						
CLINISORB 	10 x 10 10 x 20	Sterile activated charcoal cloth sandwiched between layers of nylon/viscose rayon cloth	• Malodorous wounds such as fungating wounds, pressure ulcers, leg ulcers and diabetic foot ulcers • Apply as a primary or secondary dressing	• Store away from direct sunlight at ambient temperature and humidity • Exudate will reduce the dressing's effectiveness • Can be cut to size		

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DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
RETENTION, LIGHT SUPPORT & SUB BANDAGE WADDING						
K-Band 	10 x 4m	Lightweight knitted fabric containing viscose and nylon Highly conformable	• Dressing retention			
MOLLELAST 	4 x 4	Conforming bandage	• Dressing retention, • Individual bandaging of fingers and toes			
K-Soft 	**K-Soft** 10 x 3.5m **K-Soft Long** 10 x 4.5m	An absorbent, non-woven, sub-bandage wadding	• Used to reshape the leg to ensure correct pressures are achieved when applying compression • Protect the bony prominences • First layer of the K-Four multilayer compression bandage system • Used to reduce potential pressure damage when used under compression bandages and orthopaedic casting material			
Cellona 	5 x 2.75m 7.5 x 2.75m 10 x 2.75m	Synthetic undercast padding	• Padding layer for use under compression bandages and casts			

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DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
TUBULAR BANDAGES						
Comfifast Multistretch 	7.5 x 10m *(Blue Line)* 10.75 x 10m *(Yellow Line)* 17.5 x 1m *(Beige Line)*	Range of elasticated viscose stockinette	• Dressing retention			
COMPRESSION BANDAGES						
UrgoKTwo Kits 	Ankle Kit Size, 10cm width 18 – 25 25 – 32	Two-layer compression bandage system **(40mmHg)**	• Treatment of venous leg ulcers, venous oedema and lymphoedema • Provides sustained graduated compression for up to 7 days	* **Avoid** patients with arterial disease ABPI <0.8, Diabetic microangiopathy, Ischaemic Phlebitis, Septic thrombosis		
Urgo KTwo Reduced 	Ankle Kit Size, 10cm width 18 – 25 25 – 32	Two-layer compression bandage system **(20mmHg)**	• Treatment of mixed aetiology leg ulcers, venous oedema and lymphoedema • Provides sustained graduated compression for up to 7 days	* **Avoid** patients with arterial disease ABPI <0.6, Diabetic microangiopathy, Ischaemic Phlebitis, Septic thrombosis		
K-Lite 	10 x 4.5m 10 x 5.25m (Long)	Lightweight knitted bandage consisting of viscose, nylon and elastomeric yarn	• Provides light support for sprains and strains • Type 2 bandage • For the prevention of oedema • Is the second layer of the K-Four multilayer compression bandage			

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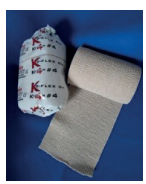
DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
COMPRESSION BANDAGES						
K-Plus 	10 x 8.7m 10 x 10.25 (Long)	White knitted fabric consisting of viscose, nylon and elastomeric yarn. A light-blue line runs along the middle of its length to aid 50% overlap when bandaging.	• Type 3a light compression bandage • Donates up to 20mmHg of sub-bandage pressure at the ankle • Is the third layer in the K-Four multilayer compression system	* **Avoid** patients with arterial disease ABPI <0.8, Diabetic microangiopathy, Ischaemic Phlebitis, Septic thrombosis		
KO-FLEX 	10 x 6m 10 x 7m (Long)	A water-resistant, vapour-permeable, knitted fabric consisting of cotton, acrylic and elastomeric fibres	• Type 3a bandage • Ko-Flex is the fourth and top layer of the K-Four multilayer compression bandaging system • Provides compression of up to 20mmHg on a 18–25cm circumference ankle • Can be used to apply light pressure to support sprains and strains, or during rehabilitation following orthopaedic surgery	* **Avoid** patients with arterial disease ABPI <0.8, Diabetic microangiopathy, Ischaemic Phlebitis, Septic thrombosis		
ACTICO 	8 x 6m 10 x 6m 12 x 6m	Cohesive, inelastic (short-stretch) compression bandage	• Treatment and management of venous leg ulcers, lymphoedema and chronic oedema • To be applied after padding • Not suitable for ankle circumference of <18cm unless padding is used to increase it to ≥18cm.	• Only use under strict medical or vascular specialist supervision. • Caution required when cardiac overload is suspected and/or diabetes, advanced small vessel disease, arterial disease, renal failure or rheumatoid arthritis is present. • An ABPI of between 0.5>0.8 or above 1.3 requires further investigation before use		
MEDICATED BANDAGES						
Viscopaste PB7 	7.5 x 6m	Zinc paste bandage	• Padding layer for use under compression bandages and casts	• For the treatment and management of venous leg ulcers and their associated skin conditions • For use in dermatology to treat chronic eczema and dermatitis • Can be used as a primary contact layer under compression therapy systems		

All dressing or treatments that appear in the 'amber' filled box require discussion with Team Leader or Case Load Holder before use

All dressings or treatments that appear in a 'red' filled box are for specialist use only or use following specialist recommendation

DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
SKIN PROTECTANTS						
Medi Derma – S Non-Sting Film Applicator 	1ml 3ml 30ml Pump Spray	Intended as a primary barrier against irritation from bodily fluids Any Patient Group Barrier properties to protect damaged and intact skin	• Medi Derma-S Barrier Film is a silicone-based, long-lasting, non-sting medical grade liquid which forms a protective uniform film when evenly applied to the skin • Protect from harmful effects of moisture, irritants and from skin damage that may be caused from the application of adhesive wound dressings or pouches	• Refer to MASD Pathway		
Medi Derma – S Barrier Cream 	2g Sachet 28g Cream 90g Cream	Any Patient Group, Continence Care, Elderly Patients, Moisture-Associated Skin Damage (MASD), Neonatal & Paediatrics, Palliative or End of Life Care, Skin Care for Stoma, Wound Care Damaged and intact skin	• Medi Derma-S Barrier Cream provides gentle barrier protection on intact skin or for mild skin damage • The long-lasting and quick drying formulation provides a protective layer to the skin and is suitable for use during episodes of incontinence	• Refer to MASD Pathway		
Medi Derma Pro Foam Spray Cleanser 	250ml	Foam & Spray Incontinence Cleanser	• To be used on moderate / severe skin damage • Used in conjunction with Medi Derma Pro Foam	• Refer to MASD Pathway • Discuss with Tissue Viability Team		
Medi Derma Pro Skin Protectant Ointment 	115g	Skin Protectant Ointment Provides maximum barrier protection on moderate/severe skin damage	• To be used on moderate / severe skin damage • Used in conjunction with Medi Derma Pro Foam	• Refer to MASD Pathway • Discuss with Tissue Viability Team		
Cavilon Advanced Skin Protectant 	2.7ml	Durable transparent polymer-cyanoacrylate barrier in a disposable applicator	• Protection of intact or damaged skin from bodily fluids • Prevention and reversal of all forms of moisture associated skin damage	* **Avoid** use on full-thickness wounds, eyes or infected skin • Extremely flammable until completely dried on the skin		

All dressing or treatments that appear in the 'amber' filled box require discussion with Team Leader or Case Load Holder before use

All dressings or treatments that appear in a 'red' filled box are for specialist use only or use following specialist recommendation

DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
IRRIGATION FLUID						
Saline Pods 	20ml	Sterile saline (0.9% w/v sodium chloride in water) contained within individual pods	• Cleansing and topical irrigation of traumatic and surgical wounds and burns.	• Single-use only • Do not use if product leaking or unclear • Not to be used with other irrigation fluids containing silver, lead or mercurial • Not for injection		
EMOLLIENT/WASH						
Zerobase 	500g pump dispenser 50g	An emollient cream with 11% liquid paraffin	• To provide symptomatic relief for red, inflamed or dry skin • In cases of eczema, can also be applied before a bath to stop the skin drying further • Can be used as an alternative to soap			
ZERODERM 	125g 500g	A rich, non-greasy 3-in-1 moisturiser, wash and bath additive containing 70% paraffin	• A rich, moisturiser, wash and bath additive			
NON-WOVEN SWABS						
Clinimed 	10 x 10 (100pk)	Non-woven swabs				

All dressing or treatments that appear in the 'amber' filled box require discussion with Team Leader or Case Load Holder before use

All dressings or treatments that appear in a 'red' filled box are for specialist use only or use following specialist recommendation

DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*		
DRESSING PACKS						
Softdrape 	**Glove sizes:** Small Medium Large	Universal aseptic dressing pack latex-free, includes Vitrex gloves	• For use when cleansing wounds and handling infectious wounds			
TAPES						
Scanpore 	2.5 x 5m	Highly permeable, hypoallergenic, colophony-free, non-woven, synthetic, skin-friendly, adhesive tape	• Securing dressings • For patients with skin reactions to other plasters and long-term use			
Hypafix Tape 	2.5 x 10m 5 x 5m	A skin-friendly, non-woven tape	• Used for wide-area dressing fixation • Fixation of dressings, instruments, probes and catheters • Highly conformable and easy to apply			

All dressings or treatments that appear in a 'red' filled box are for specialist use only or use following specialist recommendation

WOUND FORMULARY - SPECIALIST USE ONLY - ADVANCED WOUND THERAPIES

All patients on NPWT or coming out of hospital on NPWT must be referred to Tissue Viability

CATEGORY	SIZE
RENASYS-F **SMALL FOAM**	1 Soft Port dressing 1 Foam dressing 10cm x 8cm 1 Transparent film 20cm x 30cm
RENASYS-F **MEDIUM FOAM**	1 Soft Port dressing 1 Foam dressing 20cm x 13cm 2 Transparent film 20cm x 30cm
RENASYS-F **LARGE FOAM**	1 Soft Port dressing 1 Foam dressing 25cm x 15cm 3 Transparent film 20cm x 30cm
DRAIN KITS	Discuss with TVN

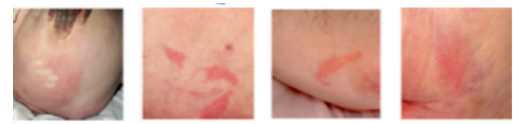
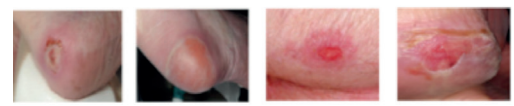
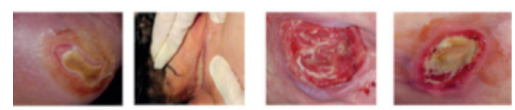
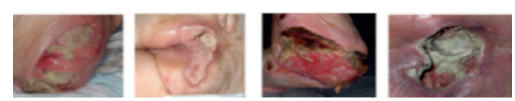
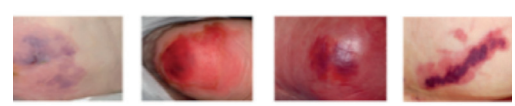
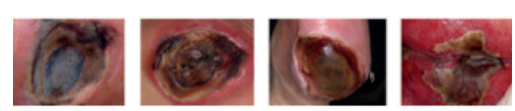
CATEGORY	SIZE
RENASYS-G **SMALL GAUZE**	Soft Port dressing 1 Non-adherent gauze 7.5cm x 7.5cm 1 Antimicrobial gauze 15cm x 17cm 1 Transparent film 20cm x 30cm 1 Saline bullet, 1 skin prep wipe, 1 wound ruler
RENASYS-G **MEDIUM GAUZE**	Soft Port dressing 2 Non-adherent gauze 7.5cm x 7.5cm 2 Antimicrobial gauze 15cm x 17cm 1 Transparent film 20cm x 30cm 1 Saline bullet, 1 skin prep wipe 1 wound ruler
RENASYS-G **LARGE GAUZE**	1 Soft Port dressing 2 Non-adherent gauze 7.5cm x 20cm 1 Roll antimicrobial gauze 11.4cm x 3.7cm 2 Transparent film 20cm x 30cm 1 Saline bullet, 1 skin prep wipe, 1 wound ruler
RENASYS G **300ML CANISTER**	Frosted 300ml canister with volume markings Integrated bacterial filter and solidifier

All dressings or treatments that appear in a 'red' filled box are for specialist use only or use following specialist recommendation

DRESSING	SIZE	INDICATIONS	APPLICATION	COMMENTS & AVOID*	
NEGATIVE PRESSURE WOUND THERAPY					
Pico 7  	10 x 20 10 x 30 10 x 40 15 x 15 15 x 20 15 x 30 20 x 20 20 x 25 25 x 25 Multisite 15 x 20 20 x 25	Single-use, portable negative pressure wound therapy (NPWT) system **NICE** medical technologies guidance support the use of PICO for closed surgical incisions	• Manages low to moderate volumes of exudate • Provides therapy for up to 7 days • Examples of appropriate wound types include: chronic, acute, traumatic, subacute and dehisced wounds, partial-thickness burns, ulcers, flaps, grafts, and surgically closed incision sites • Delivers negative pressure of -80mmHg • Consists of 1 pump, 2 sterile dressings, sterile retention strips and 2 AA batteries	* **Avoid** • Malignancy except in palliative care • Previously confirmed or untreated osteomyelitis • Non-enteric and unexplored fistulas • Necrotic tissue with eschar present • Eexposed arteries, veins, nerves or organs • Exposed anastomotic sites • Emergency airway aspiration; • Pleural, mediastinal or chest tube drainage; and surgical suction • Always refer to instructions for use for information on indication, application and contraindications Specialist Use or following advice from TVN service	
Pico14  	10 x 20 10 x 30 10 x 40 15 x 20 15 x 30 25 x 25 Multisite 15 x 20 20 x 25	Single-use, portable negative pressure wound therapy (NPWT) system **NICE** medical technologies guidance support the use of PICO for closed surgical incisions	• Manages low to moderate volumes of exudate • Provides therapy for up to 7 days • Examples of appropriate wound types include: chronic, acute, traumatic, subacute and dehisced wounds, partial-thickness burns, ulcers, flaps, grafts, and surgically closed incision sites • Delivers negative pressure of -80mmHg • Consists of 1 pump, 2 sterile dressings, sterile retention strips and 2 AA batteries	* **Avoid** • Malignancy except in palliative care • Previously confirmed or untreated osteomyelitis; • Non-enteric and unexplored fistulas • Necrotic tissue with eschar present • Exposed arteries, veins, nerves or organs • Exposed anastomotic sites • Emergency airway aspiration; • Pleural, mediastinal or chest tube drainage; and surgical suction • Always refer to instructions for use for information on indication, application and contraindications • Specialist Use or following advice from TVN service	

PRESSURE ULCER CATEGORIES

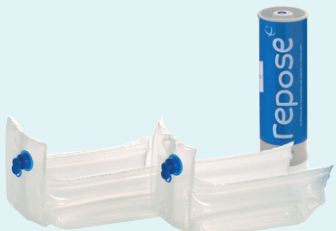
All Pressure Ulcers MUST be reported via DATIX

CATEGORY 1 Intact Skin, Non blanching redness (erythema) Usually occurs over bony prominences Individuals with darker skin tones observe for additional signs e.g. warmth, oedema, pain, hardness	
CATEGORY 2 Superficial skin loss, red/pink wound bed May be minimal slough with healthy tissue evident May present as a clear filled blister with no discolouration underneath	
CATEGORY 3 Full thickness tissue loss Subcutaneous fat may be visible but bone/tendon are not exposed Depth may vary depending on anatomical location	
CATEGORY 4 Full thickness tissue loss Can extend to exposed bone/tendon or muscle or they may be directly palpable Depth can vary by anatomical location	
POTENTIAL DEEP TISSUE DAMAGE A localised area of purple discolouration over intact skin, or blood blister, due to damage of underlying soft tissue. It may be painful, firm, mushy, boggy, warmer or cooler compared to the adjacent skin May develop into a category 3 or 4 but cannot be confirmed until extent of damage is evident Damage may be recoverable with effective 'off-loading' of affected area	
UNSTAGEABLE CATEGORY TO BE DETERMINED Minimal category 3 but potential 4. The wound bed is not visible due to presence of necrotic tissue Classification may not be possible until the ulcer is debrided	

HEEL OFFLOADING AND PROTECTION ADVICE

Ensure slide sheets are positioned to include heels when repositioned. Check heels daily and document any changes

HEEL OFFLOADING AND PROTECTION GUIDANCE
WHERE SHEAR AND FRICTION IS A RISK



REPOSE FOOT PROTECTOR

- Designed specifically to minimize the risk of pressure damage to heels by off-loading
- Provide effective pressure redistribution for all people at risk of developing pressure ulcers, including those assessed as very high risk
- Easy to clean and will deflate down to a compact size
- Repose is also appropriate for users with pressure related tissue damage – clinical supervision is advised where the damage is severe
- If deterioration in skin condition is noted, clinical advice should be sought and, if so advised, use of the product discontinued
- Avoid direct contact with heat and sharp objects
- Refer to instructions for inflation guide

PARAFRICTA

- Low friction silk-like material that reduces the risk of friction and shear-related skin breakdown of the feet
- People often dig their heels to push themselves up the bed which increases the risk of breakdown
- Helps prevent dressings from 'rucking up'
- Can be used in conjunction with other pressure relieving equipment
- Can be washed and reused

Important – the booties have non-slip sole to assist wearers in getting in and out of bed but MUST NOT be used as a slipper for walking

WHERE OFFLOADING IS NEEDED

HEELPRO ADVANCE HEEL PROTECTION BOOT

- Provides an ideal way to prevent and treat existing heel pressure ulceration
- Featuring wipe-clean ripstop material both inside and out, the Advance is ideal for patients with existing wounds
- Reducing pressure, friction, and shear force on the heels
- Separating and protecting the ankles
- The HeelPro Advance Heel Protection Boot is supplied in a single universal size that should be suitable for most people

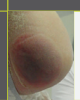
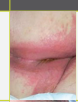
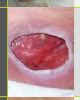
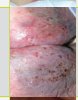
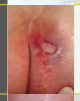
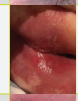
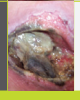
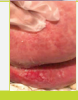
PRESSURE VS MOISTURE

Pressure Ulcers vs Incontinence-Associated Dermatitis (IAD): A Differentiation Guide

Incontinence-Associated Dermatitis (IAD)
Skin damage as a result of continuous exposure to urine and/or faeces is known as incontinence-associated dermatitis (IAD), one of the commonly recognised causes of MASD. It typically presents as localised redness, with areas of partial thickness skin loss. Whereas pressure ulcers are localised damage to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear[1].

Pressure Ulcers and Incontinence-Associated Dermatitis (IAD)
Skin damage, particularly around the sacral area, is often considered to be due to pressure damage, when in actual fact, frequently it is a result of IAD. These two conditions can present simultaneously in an individual, so must be correctly identified to plan appropriate prevention and treatment strategies.

Skin damage that is established to be as a result of incontinence, should not be recorded as a pressure ulcer, but should be referred to as MASD to distinguish it, and should be reported separately.[2]

Cause	Pressure Ulcer Established cause - Pressure and/or shear		Incontinence-Associated Dermatitis (IAD) Established cause - Continuous exposure to urine and/or faeces	
Location		Most likely over a bony prominence		Can occur over a bony prominence if moisture present - exclude pressure and shear. A linear (straight) lesion limited to the anal cleft is likely a moisture lesion. Peri-anal redness/irritation is most likely a moisture lesion due to faeces.
Shape/Edges		Regular shape with a more defined wound edge		Diffusely scattered, irregularly shaped. If a 'kissing' lesion is observed across two adjacent surfaces, at least one is likely due to moisture.
Colour		Non-blanching redness or blue/purple discolouration is likely due to pressure damage. Red granulation, soft/black necrotic or sloughy tissue in the wound bed indicates a pressure ulcer.		If redness or discolouration is uneven, moisture damage is the likely cause. Pink or white surrounding skin indicates maceration.
Depth		Can vary in depth from unbroken non-blanching erythema to full thickness tissue loss extending to tendon or bone		Superficial – Partial thickness skin loss, but may enlarge when infection is present
Necrosis		Presence of necrosis (black scab or softening blue, brown, grey or yellow tissue) indicates a pressure ulcer		Moisture lesions do not contain necrotic tissue. Where there is necrotic tissue within the IAD, this will be due to a combination of both pressure and moisture damage and should be reported as a pressure ulcer.[2]

To obtain a full copy of this guide go to: https://medicareplus.co.uk/pressure-ulcers-v-incontinence-associated-dermatitis-a-differentiation-guide/

S.M.A.R.T. SKIN MOISTURE ALERT REPORTING TOOL

References: *1. Beeckman D, Woodward S and Gray M. (2011) Incontinence-associated dermatitis: step-by-step prevention and treatment. British Journal of Community Nursing 16(8): 382-89. 2. NHS Improvement (2018) Pressure ulcers: revised definition and measurement - Summary and recommendations (June 2018).*

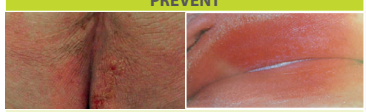
SKIN PROTECTION GUIDE - MEDI DERMA

Shropshire, Telford & Wrekin
Integrated Care System

Prevention & Management of Moisture-Associated Skin Damage (MASD) Pathway

WHAT IS THE PRIMARY TREATMENT AIM FOR SKIN BARRIER PROTECTION?

PREVENT



Moisture-Associated Skin Damage from incontinence, saliva wound exudate or perspiration

↓

Intact Skin +/- Erythema

↓

ACUTE: Cleanse with an emollient cleanser or soap substitute
COMMUNITY: Continue with routine cleansing

Incontinence:
Prevent skin damage from incontinence with **MEDI DERMA-S Total Barrier Cream**

Wound Exudate/Perspiration:
Protect from wound exudate and perspiration with **MEDI DERMA-S Total Barrier Film**

Complete holistic assessment - looking at pressure relieving needs and continence Moisture-Associated Skin Damage

PROTECT

Mild to moderate skin damage from incontinence, saliva wound exudate or perspiration

↓

Moisture-Associated Skin Damage

↓

Increase hygiene needs

↓

Protect with **MEDI DERMA-S Total Barrier Film**

If severe skin damage or skin integrity is deteriorating, please discuss with TVN

REPAIR

Severe skin damage from incontinence, saliva wound exudate or perspiration

↓

Moisture-Associated Skin Damage

↓

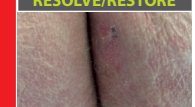
ACUTE & COMMUNITY:
Cleanse with
MEDI DERMA-*PRO* Foam & Spray Incontinence Cleanser

↓

Protect with
MEDI DERMA-*PRO* Skin Protectant Ointment

Once repaired, continue to follow pathway

RESOLVE/RESTORE



Skin hydration and maintain restored skin integrity

↓

Continue with routine cleansing

↓

Prevent with
MEDI DERMA-S Total Barrier Cream

*** In darkly pigmented skin, MASD may be more difficult to identify. Please pay attention to any skin changes where moisture may be a contributory factor ***

MPL783/MCP/MASDALGORITHM/STHT/A4/02.21.

Flaminal®
Enzyme Alginogel®

How to use Flaminal® to pack a cavity wound

How wet is the wound?

Moderate/High exudate?

FLAMINAL® FORTE

Cleanse wound if necessary

Low exudate?

FLAMINAL® HYDRO

Cleanse wound if necessary

Fill the cavity with Flaminal® for example:

using a nozzle

using a syringe

directly from the tube

Apply appropriate secondary dressing (depending on level of exudate)

Flaminal® will last 1-4 days (as long as gel structure remains intact)

Flaminal® can be used until the expiry date shown, provided the cap is replaced securely after use

www.flenhealth.co.uk
Flen Health Ltd. 1 Northumberland Avenue, London WC2N 5BW
T: +44 (0) 207 872 5460 F: +44 (0) 270 872 5611 E: info@flenhealth.co.uk

Flaminal hydro Flaminal forte Flen Health advanced skin healing

WOUND INFECTION FRAMEWORK & PATHWAY

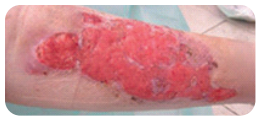
- Holistic assessment of the patient is essential to commencing antimicrobial dressings
- Assessment should include related risk factors *(e.g. underlying medical conditions, medication, nutrition and wound factors e.g. location and size, wound bed, exudate, odour, pain and condition of surrounding skin)*
- Rationale for selecting an antimicrobial dressing must be documented within the patient record patient.
- Non-infection related – investigate other causes (malignancy, non-infectious inflammatory conditions).
- **Ensure close monitoring of immunosurpressed patients (diabetes) as the clinical symptoms of infection, such as pain or erythema, may be masked**

Infection Related

Colonisation[1]

When 2 or more signs present – **Healing progressing normally**

- Exudate – low to moderate
- Pain – minimal
- Odour – minimal

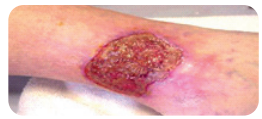


Antimicrobial dressing **NOT** indicated (Antimicrobial stewardship)

Local Infection[1]

When 2 or more signs present – **Healing not progressing normally**

- Exudate – moderate to high
- Malodour
- Pain – new or increased
- Erythema



Commence antimicrobial dressing to suit wound bed requirements

At 2 weeks, reassess wound (or earlier if clinically indicated). Is there any improvement?

Yes

Return to conventional dressing if resolved

Document

Continues to improve?

Yes

Continue with conventional dressing

Document

No

Restart Wound Infection Framework

No

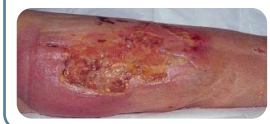
Consider Biofilm disruption/Change to another suitable antimicrobial dressing.

Document

Spreading infection[1]

When 2 or more signs present – **Wound deteriorating**

- Localised cellulitis
- Pain increasing
- Exudate – thick, haemopurulent or purulent
- Malodour increasing



Take deep wound swab (after cleansing wound)

Commence antimicrobial dressing

Consider systemic antibiotics (refer to local CCG Microguide for up to date guidance)

Observe for signs of **Sepsis**, agree a plan of escalation with patient if symptoms do not improve.

At 2 weeks have signs of infection resolved?

Yes

Return to conventional dressing

Document

No

Change to another suitable antimicrobial dressing or systemic antibiotics

Refer to relevant Specialist: TVN, GP

Document

1 – Best Practice Statement – Antimicrobial strategies for wound management. Wounds UK, 2020.
Version 1 Created by Shropshire Community Health NHS Trust July 2021
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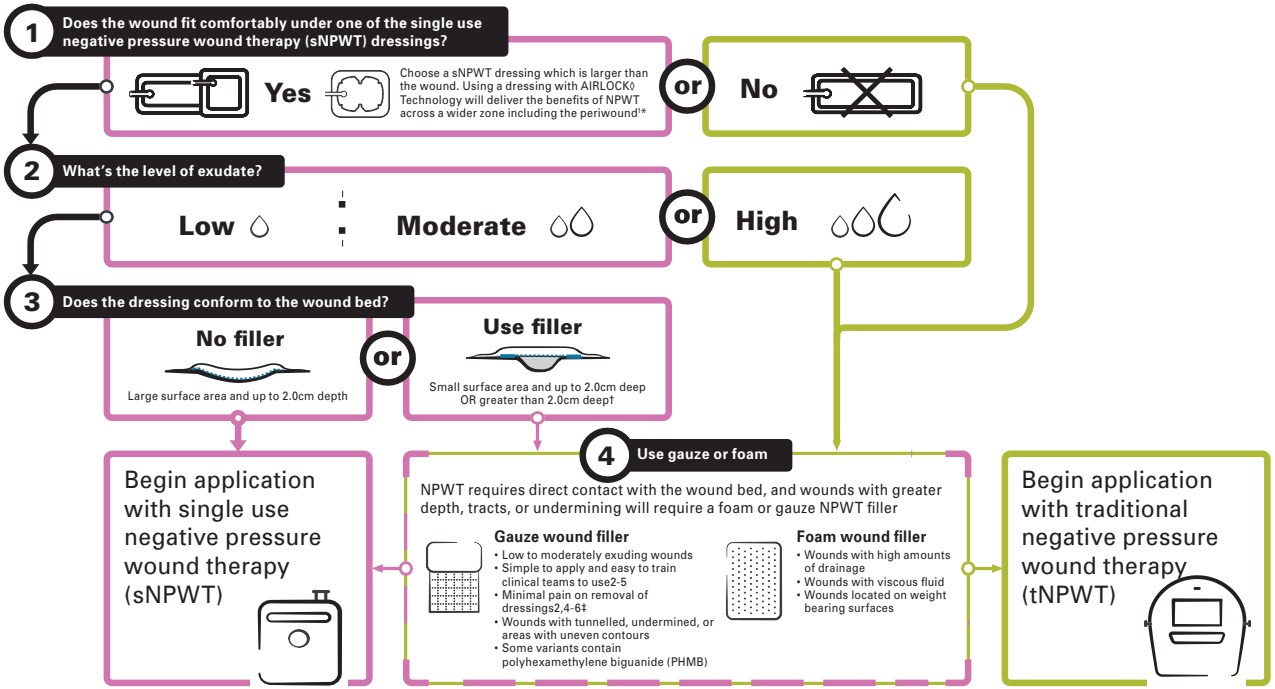
STEP DOWN PATHWAY FOR NEGATIVE PRESSURE WOUND THERAPY

NPWT clinical decision tree for open wounds



*AIRLOCK Technology is proprietary technology to PICO sNPWT Dressings. † Wounds must not contain exposed arteries, veins, nerves or organs. ‡ p=0.046; n=31; Compared to black foam in acute post traumatic wounds. Reference: 1. Brownhill R. PICO◊ Biomechanical Study. Data on file report. August 2019. DS/19/211/R. 2. Hurd T, Chadwick P, Cote J, Cockwill J, Mole T, Smith J. Impact of gauze-based NPWT on the patient and nursing experience in the treatment of challenging wounds. International Wound Journal. 2010;7(6):448-455. 3. Fraccalvieri M, Scalise A, Ruka E, et al. Negative pressure wound therapy using gauze and foam: Histological, immunohistochemical, and ultrasonography morphological analysis of granulation and scar tissues - Second phase of a clinical study. In. European Journal of Plastic Surgery. Vol 37 2014:411-416. 4. Johnson S. V1STA® – A new option in Negative Pressure Therapy. Journal of Wound Technology. 2008;1:30-31. 5. Fraccalvieri M, Ruka E, Bocchiotti M, Zingarelli E, Bruschi S. Patient's pain feedback using negative pressure wound therapy with foam and gauze. International wound journal. 2011;8(5):492-499. 6. Smith+Nephew 2009. A prospective, open labelled, multicentre evaluation of the use of VISTA in the management of chronic and surgical wounds and A prospective, open labelled evaluation of EZCare in the management of chronic and acute wounds. Internal Report. SR/CIME/010/012. November 2020.

DEBRIDEMENT PATHWAY

Purpose of Debridement is to: Remove non-viable tissue, Reduce bacterial load and minimise risk of infection, promote healing, reduce odour, allow wound drainage and to determine the extent of the wound to identify any undermining

Assess patient holistically including past medical history, allergies, medications, Doppler, psychosocial issues and nutritional status. Assess wound using TIMES algorithm and record wound site dimensions and underlying cause

Assess tissue type

Consider contraindications to determine suitability for debridement

Select debridement method

Debridement contraindicated: Conservative management

Contraindications for Debridement
- Ischaemic digits
- Fungating wounds
- Clotting disorders
- Diabetes (specialist practitioners only)

Cautions for Conservative Sharp Debridement
- Wounds in close proximity to blood vessels, nerves and tendons
- Patients receiving anti-coagulation therapy
- Peripheral arterial disease
- Wounds on hands, feet and Genitalia
- Palliative patients
- Patients unable to provide consent

Contraindications for Larval Therapy
- Wounds in close proximity to blood vessels, nerves and tendons
- Patients receiving anti-coagulation therapy
- Peripheral arterial disease
- Wounds on hands, feet and Genitalia
- Palliative patients
- Patients unable to provide consent

Methods of Debridement:
Autolytic: - Dressing choice - **Use your selected dressing for two weeks, if no improvements refer to Clinical Lead or TVN before commencing an alternative product.**
Mechanical: - UCS Cloth / Debrisoft Lolly
Biomechanical: - Larvae (under supervision of Specialist)
Conservative sharp debridement: - refer to specialist practitioner*
Surgical: - Referral on to surgeon via GP

Slough

Autolytic debridement:
- Actiform Cool
- Aquacel Extra
- UrgoClean
- Flaminal Hydro/Forte
- Duoderm
- Granugel
- Iodoflex

Mechanical debridement: UCS Cloth / Debrisoft Lolly

Biomechanical (Larval therapy): Refer to TVN

Conservative sharp debridement: Refer to Specialist Practitioner*

Necrosis

Autolytic debridement:
- Duoderm
- Granugel
- ActiformCool
- Flaminal Hydro

Conservative sharp debridement:
Refer to Specialist Practitioner*

Surgical debridement:
Refer to secondary care via GP

Haematoma

Autolytic debridement
- Granugel
- Actiform Cool
- Flaminal Hydro

Mechanical debridement with UCS Cloth or Debrisoft once autolysis has commenced

Conservative sharp debridement by Specialist Practitioner* if no progress after 4 weeks

*indicates Specialist Practitioner that is competent to perform sharp debridement skill following sharp debridement module
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*indicates Specialist Practitioner that is competent to perform sharp debridement skill following sharp debridement module
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DIABETES FOOT PATHWAY

Active

- Ulceration
- Bacterial infection/cellulitis
- Critical ischaemia or gangrene
- Unexplained red/hot/swollen foot
- Suspected Charcot foot

- Assess severity of infection
- If infection suspected cleansed wound and take a deep swab

- Limb threatening infection
- Extending cellulitis >2cm, lymphangitis, deep ulcer with purulent discharge, suspected abscess & systemic symptoms, e.g. Flu-like chills/fever

Arrange URGENT admission to acute services and notify the diabetic foot clinic

- Non-Limb threatening infection

Refer urgently to diabetes foot clinic and start empiric oral antibiotics

1. Flucloxacillin 500mg QDS if weight ≤80kg or Flucloxacillin 1gm QDS if weight >80kg*
2. Always add Metronidazole 400mg TDS initially

***If Penicillin allergy** - Doxycycline 200mg OD

- No infection

Refer urgently to diabetes foot clinic

If patients are bedbound and unable to travel to the diabetic foot clinic refer to community podiatry, using specific referral form

Key documents:
NICE NG19 (2015)
https//www/nice.org.uk/guidance/ng

National diabetes foot care audit (NDFA 2017) **https//content.digital.nhs.uk/foot care**

Further advice, information or patient leaflets:
shropcom.podiatryandfoothealthservices@nhs.net

High

- Previous amputation or ulceration
- On renal replacement therapy
- Or more than one risk factor**

Refer to podiatry via referral form and email to *Shropcom.podiatryandfoothealthservices@nhs.net*
Podiatry enquiries telephone: 01743 277681
If patients are bed bound also organise pressure relieving device

Moderate

- One risk factor** e.g.
- Loss of sensation
- Or peripheral vascular disease
- Or deformity

If callus or foot problem please refer via referral form and email to:
Shropcom.podiatryandfoothealthservices@nhs.net
Podiatry enquiries telephone: 01743 277681
If patients are bed bound organise pressure relieving device

Low

- No risk factors**
- Normal sensation
- No peripheral vascular disease
- No other risk factors
- Callus alone is considered low risk

Patient will attend GP practice for annual check

Please refer ALL diabetes foot ulcers immediately for triage
Tel: 01743 261000 ext 3055
Emergency Tel: 07843 505015
Email: sath.dfc@nhs.net

Please ensure all diabetes patients have attended their annual diabetes foot screening

Risk Factors**

- Loss of sensation (Neuropathy) - test using 10g monofilament or Ipswich touch test
- Absent foot pulses
- Significant deformity or callus
- Charcot arthropathy
- Infection and or inflammation or gangrene
- Previous amputation or diabetes foot ulceration
- CKD>stage 4

Shropshire, Telford & Wrekin
Sustainability and Transformation Partnership

Tissue Viability Service

Email Tissue Viability: **shropcom.tissueviability@nhs.net**

Telephone: **01952 670 925**

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