

Wound Management Formulary (Adults) and Guidance Document

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1. INTRODUCTION

This Wound Management Formulary and guidance document is designed to support clinicians employed by CHCP CIC in their assessment and management of wounds by ensuring that their choice of dressing provides the optimum wound healing environment. The information contained within this document is to be used for patients registered with a GP in the Hull CCG and East Riding of Yorkshire CCG areas.

The Wound Management Formulary is aimed at assisting clinicians to provide a consistent approach to wound management, assist in addressing key aspects of wound management and to help direct the clinician to provide the best and most appropriate care thus optimising healing and leading to:

- Improved patient outcomes
- Improved decision making to meet clinical needs
- Optimisation of product use and reduction of waste
- Timely access to appropriate wound management products
- Auditable information to direct education and training requirements
- Effective communication with patients to support self-management where possible

Wound care products detailed within this guidance were collated using a multi-professional approach including the Medicines Management Team, specialist nurses from within the Tissue Viability Service, Clinical Project Lead and Operational Management for the Integrated Nursing and Conditions Service, along with input from the Podiatry Service. This guidance is based upon best practice and the most recent research on wound management.

The Wound Management Formulary (Adults) And Guidance Document can be accessed via CHCP MyCompliance and found on the Hull and East Riding Prescribing Committee website <https://www.hey.nhs.uk/wp/wp-content/uploads/2016/03/chcpWoundManagementFormulary.pdf>

2. PURPOSE

The purpose of this document is to provide a guide for clinical staff to follow when undertaking the assessment and management of wounds.

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3. SCOPE

This document applies to City Health Care Partnership (CHCP) registered staff working in a clinical role that involves the assessment and/or management of wounds.

This guide may be used by other services and organisations both internal and external to CHCP (e.g. 0 – 19 service, Primary Care etc), however each individual team, service or organisation should be aware that the funding for the Integrated Nursing and Conditions Service is provided by the CCGs for adult wound management by CHCP Clinicians as outlined in this formulary.

4. EQUALITY, DIVERSITY & INCLUSION

City Health Care Partnership is committed to developing, supporting and sustaining an inclusive and diverse workforce that is representative of the community that it services. Equally we are committed to the provision of services that respects our increasingly diverse populations and which promotes equality and access and care. Our culture promotes equality and fairness for all in our employment and care and actively discourages any form of discrimination.

5. ABBREVIATIONS & DEFINITIONS

Abbreviations:

CHCP CIC – City Health Care Partnership

INCS – Integrated Nursing and Conditions Service

T.I.M.E – Tissue, Inflammation or Infection, Management of exudate, Edges of the wound

Definitions:

SystemOne (S1) – Electronic Patient Record System

6. PROCESS

The key to successful wound management is a comprehensive patient, limb (if relevant) and wound assessment of each individual patient. A clinician undertaking wound care should include the wound assessment tool T.I.M.E within the assessment process. This tool builds on wound bed preparation and helps to structure the clinician’s approach to wound management. It is an acronym for:

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- **T** - Tissue
- **I** - Inflammation or infection
- **M** - Management of exudate
- **E** - Edges of the wound

In addition:

- The surrounding skin and psychosocial factors must also be considered.
- Products should only be selected following holistic assessment and consideration of current clinical opinion, and the available evidence of clinical efficacy.
- Details of the management plan must be recorded in the patient’s electronic record on SystemOne.
- Products are to be ordered via Formeo whenever possible.
- When above is not possible products are to be ordered on FP10 by the reviewing CHCP prescribing clinician
- For wound care products that require ‘Clinical Reasoning’ within the Integrated Nursing and Conditions Service it is the responsibility of the assessing clinician to complete the ‘*Clinical Reasoning Questionnaire*’ within the patient record and ensure the Wound Assessment / Reassessment 2020 and Clinical Reasoning Process – SOP is followed.








REMEMBER:

DRESSINGS ALONE DO NOT HEAL A WOUND.

A DRESSING WILL FACILITATE HEALING BY ASSISTING TO PREPARE/MANAGE FACTORS WHICH MAY DELAY/PREVENT HEALING.

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6.1. Guidelines to Generic Wound Care Range

Wound Type	Necrotic	Sloughy	Granulating	Infected	Epithelialising	Fungating/ Malodorous	Cavity
Image							
Description	Necrotic wounds are characterised by black devitalised tissue.	A mixture of dead white cells, dead bacteria, rehydrated necrotic tissue and fibrous tissue.	Granulating tissue usually pink in colour at the base of the wound bed and can have a bumpy (granular) appearance.	Friable, dark red granulation tissue. Increased malodour and pain. Delayed healing. Satellite lesions.	Typified by pink /pale mauve coloured tissue	Has an offensive odour indicating infection or colonisation of bacteria. Often palliative patients may have a fungating wound.	Wound extends to tissues deep into the epidermis and dermis.
Aim	To soften and remove necrotic tissue by rehydration and debridement to allow granulation. Do not attempt debridement if arterial insufficiency is suspected Keep dry and refer vascular assessment	To soften and remove slough by rehydration and debridement.	To maintain ideal environment for granulation.	To control and manage infection. Consider biofilm	To protect epithelialising tissue until established. To promote an ideal environment for epithelialisation and contraction.	To manage odour, bleeding and exudate. Wound Bed must be protected with a non-adherent dressing to prevent adherence of other dressings). Antibiotics must be used only when appropriate)	To promote granulation from the base of the wound.

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NO EXUDATE	<i>Hydrogels/sheet</i>	<i>Hydrogels/sheet</i>	<i>Low Adherent</i>	Identify wound infection as per Framework : Contaminated Colonised Local Infection	<i>Film</i>	<i>Low adherent</i> <i>Foam</i> <i>Absorbent Dressing</i> <i>Topical Antimicrobial (P)</i> <i>Odour Control</i>	<i>Fibre Dressing</i> <i>Foam</i> <i>Absorbent Dressing</i>
LOW EXUDATE	<i>Hydrogels/sheet</i>	<i>Hydrogels/sheet</i>	<i>Foam</i> <i>Absorbent Dressing</i>	Spreading Infection Systemic Treat with the appropriate topical infection management dressing and / or antibiotics	<i>Low Adherent</i> <i>Foam</i> <i>Absorbent Dressing</i>	<i>Low adherent</i> <i>Fibre Dressing</i> <i>Alginate</i> <i>Foam</i> <i>Absorbent Dressing</i> <i>Infection Management</i> <i>Odour Control</i>	<i>Fibre Dressing</i> <i>Alginate</i> <i>Foam</i> <i>Absorbent Dressing</i>
MODERATE TO HIGH EXUDATE (Do not use hydrogel on high exudating wounds)	<i>Fibre Dressing</i> <i>Foam or</i> <i>Absorbent Dressing</i>	<i>Fibre Dressing</i> <i>Foam or</i> <i>Absorbent Dressing</i>	<i>Fibre Dressing</i> <i>Alginate</i> <i>Foam</i>		<i>Foam</i> <i>Absorbent Dressing</i>	<i>Low adherent</i> <i>Foam</i> <i>Absorbent Dressing</i> <i>Infection Management</i> <i>Odour Control</i>	<i>Fibre Dressing</i> <i>Alginate</i> <i>Foam</i> <i>Absorbent Dressing</i>

Patients must have an individual holistic assessment followed by a comprehensive wound assessment to develop a treatment plan that is patient specific for their needs. All wounds must be re-assessed minimum every 4 weeks or when there are any changes in the wound. These assessments are the key to a successful outcome for patients who have acute or chronic wounds. It is the clinician's responsibility to identify intrinsic factors e.g. diabetes/ischaemia/compliance, on any wound that is acute/chronic or complex as these will influence the potential for that wound to heal. Realistic goals and outcomes must be discussed. Patient who have an identified wound infection clinicians must refer to the Wound Management Framework and have supporting evidence in the patient record on the use of products, discontinuing products and why products have not been used.






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6.2. Wound Dressing Formulary

ABSORBENT DRESSINGS:


For exudating wounds and can be used as a primary or secondary dressing.

To be used in conjunction with the CHCP Exudate Management Pathway - see Appendix 4

PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
SOFT PORE	Island dressing	Superficial and surgical wounds with no - low exudate levels			
ZETUVIT	Absorbent pad	Wet wounds with low-moderate exudate levels			
KERRAMAX CARE	Super Absorbent pad	Wet wounds with moderate exudate levels			
CUTIMED SORBION SACHET S		Suitable for high levels of exudate			
CUTIMED SORBION SACHET XL		Suitable for high levels of exudate			



ALGINATE DRESSINGS:

Not to be used on dry wounds. Assists with haemostasis. Cut to size of wound bed to avoid maceration and excoriation to surrounding skin.

PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
KALTOSTAT	Calcium-sodium alginate dressing	Bleeding wounds Sloughy wounds Moderate to high exudate levels			


FIBRE DRESSINGS:

Assists with managing exudate and debridement of wet slough. These products expand once in contact with wound exudate and turns into a gel form which helps maintain a moist environment for optimal wound healing.

PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
ACTIVHEAL AQUAFIBER EXTRA	Fibre dressing which contains calcium ions. Can remain in situ for up to 7 days depending on exudate levels.	Wounds with moderate – high exudate levels. This dressing can act as a haemostat to control minor bleeding in superficial wounds. To hydrate and debride			
DURAFIBER	A highly absorbent fibre dressing composed of a blend of cellulose-based fibres. Can remain in situ for up to 7 days depending on exudate levels.				



FILM DRESSINGS:

Contains no absorbent properties. Film dressings are made up of a thin polyurethane membrane covered by a layer of acrylic adhesive.

PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
HYDRO-FILM	Vapour-permeable adhesive film dressing with a high moisture vapour transmission rate.	Hydrofilm is primarily used for securing secondary dressings such as absorbent pads.			


FOAM DRESSINGS:

Aims to prevent dressing-related trauma, manage exudate, and minimize dressing discomfort. Can be used as a primary or secondary dressing for chronic and acute wounds.

PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
ALLEVYN ADHESIVE BORDER	Foam adhesive consisting of 3 layers; an adhesive wound contact layer, absorbent hydro cellular pad and a waterproof outer film.	For chronic and acute wounds with low to moderate exudate levels. Not suitable for dry wounds and fragile skin.			
ALLEVYN ADHESIVE GENTLE BORDER	As above but contains a border with a lower adhesive level.	For wounds with low to moderate exudate levels. Aims to avoid trauma to fragile skin.			
ALLEVYN NON-ADHESIVE FOAM	A sterile, non-adhesive hydro cellular dressing	For wounds with low – moderate exudate levels.			
ACTIVHEAL FOAM HEEL DRESSING	Non-adhesive dressing made up of low friction backing, soft absorbent foam and a wound contact layer. Shaped to fit heels.	For wounds with low – moderate exudate levels.			
SUPRASORB P SILICONE	Made up of a wound contact layer, polyurethane absorbent foam, a non-woven distribution layer, a superabsorbent polymer core and an external film backing.	For wounds with low to moderate exudate levels.			



HYDROCOLLOID DRESSINGS:

Waterproof and self-adhesive. Promotes granulation. Enables rehydration and autolytic debridement of dry, necrotic, or sloughy wounds.




PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
ACTIVHEAL HYDROCOLLOID	This dressing is made up of a thin layer of hydrocolloid laminated to a highly breathable film. Contains a mixture of synthetic polymers and hydrophilic powders, with a high moisture vapor transmission rate film backing.	For wounds with low - moderate exudate levels.			

HYDROGELS/SHEETS:


High (90%) water content dressings. Designed to hydrate wounds, re-hydrate eschar and aid in autolytic debridement.

PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
ACTIVHEAL HYDROGEL	This dressing is an amorphous gel that contains 85% water, and gently increases the moisture level within the wound and encourages moist wound healing through autolytic debridement.	Dry, necrotic, and sloughy wounds Dressing will increase moisture due to autolytic debridement.			
KERRALITE COOL	This dressing is made up of a fluid-repellent hydrogel contact layer and a polyurethane film outer layer. This dressing can assist in autolytic debridement by hydration of necrotic and sloughy tissue and for absorption of exudate.	Necrotic, sloughy, and painful wounds. Dressing will increase moisture due to autolytic debridement. Not suitable for: full-thickness wounds; heavily bleeding wounds; third-degree burns; or as a covering for deep, narrow cavities or sinuses.			




LOW ADHERENT/ATRAUMATIC DRESSINGS:*Aim to prevent trauma to granulating/friable wounds.*

PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
ATRAUMAN	Non-adherent, polyester mesh wound contact layer.	Non adherent dressing removal; promotion of healthy granulation tissue.			
ACTIVHEAL SILICONE WOUND CONTACT LAYER	Non-adherent. The silicone aspect allows atraumatic removal of the dressing.	Atraumatic removal. Suitable for painful and fragile wounds.			
BACTIGRAS (For Podiatry Use Only)	Medicated paraffin gauze containing chlorhexidine acetate 0.5%.	Suitable for: Dry fissures on feet			

ODOUR CONTROL DRESSINGS:*Assists with reducing wound odour.*


PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
ODOLOCK	Charcoal dressing which absorbs odour. This dressing is composed of pure activated carbon encased in a non-woven nylon envelope.	Malodorous wounds such as fungating carcinomas and ulcerative, traumatic and surgical wounds. DO NOT APPLY if the patient has a sensitivity to nylon. This dressing should never be cut as particles of activated charcoal may enter the wound and cause discoloration.			

PROTEASE MODULATING MATRIX DRESSINGS:


PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
URGOSTAR T CONTACT	Flexible non occlusive contact layer.	Can be used on diabetic foot ulcers, venous leg ulceration, pressure ulcers and long-standing acute wounds. DO NOT USE On infected or critically colonised wounds, cancerous wounds, fistulas, which may reveal a deep abscess.			
URGOSTAR T PLUS WITH BORDER	A superabsorbent layer, and a silicone border with waterproof backing. (Adhesive)	Non-healing wounds to aid with any stage of wound healing (from de-sloughing to complete healing wounds including leg ulcers, diabetic foot ulcers, pressure ulcers, and long-standing acute wounds.) DO NOT USE on heavily bleeding wounds, cancerous wounds, wounds that may reveal a deep abscess or infected wounds.			
URGOSTAR T PLUS		This product should be used as 1 st Line choice for Diabetic Foot Ulcers under Podiatry care			

TOPICAL NEGATIVE PRESSURE (TNP) THERAPY:

TNP is a system that uses controlled negative pressure (vacuum) to help promote wound healing.







PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
<p>PICO SINGLE USE NEGATIVE PRESSURE WOUND THERAPY SYSTEM</p>	<p>Single-use, portable negative pressure wound therapy (NPWT) system. The lightweight pump delivers negative pressure of -80mmHg and provides therapy for up to 7 days.</p>	<p>Suitable for wounds such as chronic, acute, traumatic, subacute and dehisced wounds, partial-thickness burns, ulcers (such as diabetic or pressure), flaps and grafts, and surgically closed incision sites.</p> <p>DO NOT USE on patients with malignancy in the wound bed or wound margins (except in palliative care to improve quality of life under the direction of a specialist); 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.</p>			

RENASYS NEGATIVE PRESSURE WOUND THERAPY (NPWT):




PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
RENASYS TOUCH CONSUMABLE	Canister kit Dressing kit (foam and gauze) Softport dressing kit Y connector Renasys Gauze filler	Can be used on wounds such as chronic, acute, traumatic, sub-acute and dehisced wounds; ulcers (such as pressure or diabetic); partial-thickness burns; flaps and grafts. Suitable for deep wounds with moderate – high exudate levels. Designed to provide individualized negative pressure wound therapy for highly complex wounds. DO NOT USE: on necrotic tissue with eschar present; untreated osteomyelitis; malignancy in wound (except palliative care to enhance quality of life); exposed arteries, veins, nerves or organs; non-enteric and unexplored fistulas; anastomotic sites.			

INFECTION MANAGEMENT – ANTIMICROBIALS WITH A PHYSICAL MODE OF ACTION:



To be used in conjunction with the CHCP Wound Infection Framework - see Appendix 2

PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
CUTIMED SORBACT	Sorbact-technology-coated hydrophobic antimicrobial dressing designed to bind bacteria.	Superficial wounds, traumatic wounds, post op or dehisced, leg ulcers. Suitable for fungal infections in the groin, skin folds, or between digits.			
CUTIMED SORBACT GEL	DO NOT USE with ointments and creams as the binding effect is impaired.	Superficial wounds, traumatic wounds, post op or dehisced, leg ulcers.			
CUTIMED SILTECT SORBACT	Hydrophobic, microbial-binding foam dressing	Superficial wounds, traumatic wounds, post op or dehisced, leg ulcers.			
MEDIHONEY GEL	Medical grade manuka honey.				
MEDIHONEY HCS		Superficial wounds, burns, pressure ulcers leg and foot ulcers, doner and recipient graft sites. Can be used on devilsed tissue (HSC 1 st & 2 nd degree burns)			
MEDIHONEY TULLE					

INFECTION MANAGEMENT - ANTIMICROBIALS CONTAINING SILVER:*To be used in conjunction with the CHCP Wound Infection Framework -see Appendix 2*









PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
ACTICOAT FLEX 3	Low adherent dressing. Can moisten for drier wounds. Should be left in place for 3 days	First and second-degree burns. Grafts, Surgical sites, Venous ulcers, Pressure ulcers Diabetic ulcers			
ACTICOAT FLEX 7	As above but leave in place for 7 days	First and second-degree burns Grafts, Surgical Sites, Venous ulcers, Pressure ulcers Diabetic			
AQUACEL AG	Designed to manage 3 key local barriers to healing	Leg ulcers, pressure ulcers, diabetic foot ulcers, donor sites, surgical wound, 1 st & 2 nd degree burns, exudate management in fungating wounds.			

INFECTION MANAGEMENT - OTHER ANTIMICROBIAL DRESSINGS:*To be used in conjunction with the CHCP Wound Infection Framework – see Appendix 2*

PRODUCT	DRESSING TYPE	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
IODOSORB OINTMENT	Cadexomer Iodine- based dressing use IODOSORB within the guidelines of the prescribing information (up to a maximum of 150g a week)	Removes excess exudate and slough. Can be used under compression.			
IODOFLEX DRESSING		Removes excess exudate and slough. Can be used under compression.			

INADINE	Povidine iodine-based dressing. BIOFILM MANAGEMENT	Ulcers, minor burns and minor traumatic skin injuries, Rubefacient in chilblains				
FLAMINAL FORTE	Alginate gels BIOFILM MANAGEMENT	Wet wounds	Can be used on acute and chronic wounds.			needs to be ordered on FP10
FLAMINAL HYDRO	<i>Products NOT available on Formeo - need to be ordered on FP10</i>	Dry Wounds				needs to be ordered on FP10

OTHER RELEVANT PRODUCTS: <i>All products to be ordered via the Formeo platform</i>					
CATEGORY	PRODUCT	TYPE OF WOUND	FIRST LINE	SECOND LINE	CLINICAL REASONING
Cleansing Agents	IRRIPOD - sterile saline pods	To be used in conjunction with CHCP Infection Management guide and Cleansing Protocol			
	OCTENILIN - Antimicrobial Cleansing Agent				
Debridement Pad	DEBRICLEAN	Supports the mechanical debridement process			

Skin Protectors	CUTIMED PROTECT	Cream, foam and spray form available			
TAPES and FIXATION	MICROPORE SURGICAL TAPE				
	Clini Tape Clear – latex free	For use when sensitivity to latex present			
	MEFIX				
	TUBULAR BANDAGE (ELASTICATED)	EESIGAUZ Cotton Stockinette All sizes for legs/arms/toes/finger http://sallis.co.uk/products/bandages/			
WOUND CARE ACCESSORIES	SOFTDRAPE DRESSING PACKS				
	ALVITA NURSEIT DRESSING PACKS				
	DRESSIT ASEPTIC PACKS	Only if other packs not available			

6.3. Compression therapy formulary

For all products relating to compression therapy please see: CHCP Lower Limb Compression Formulary City Health Care Partnership CIC, available on MyCompliance.

6.4. Wound Assessment and Clinical Reasoning Process SOP

All clinicians within the Integrated Nursing and Conditions Service must adhere to the Wound Assessment / Reassessment 2020 and Clinical Reasoning Process – SOP when using this Wound Management Formulary guidance document

All wounds should be reviewed every **4 weeks** as a minimum by a clinician with appropriate skills. Unstageable and suspected DTI ulcers need to be reviewed on a weekly basis to help identify a definite PU category.

Any changes in the management plan must be supported by a TIME assessment of the wound/s and a rationale provided within the patient record.

6.5. Wound Infection Framework

see Appendix 1

The Wound Infection Framework is designed to support all clinicians with achieving the principles of antimicrobial stewardship, including the use of the **TWO WEEK CHALLENGE** to help address issues with antimicrobial resistance.

Wounds which are dressed with a product identified on the Wound Infection Framework guidance should be reviewed every **2 weeks** as a minimum.

Any changes in the management plan must be supported by a TIME assessment of the wound(s) and a rationale provided.

6.6. Cleansing Protocol

see Appendix 2

The purpose of wound cleansing is to remove debris/remnants of previous dressings/exudate/emollients from the wound bed and surrounding skin and to aid in the management of biofilm and wound infection.

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Wounds which are on a healthy trajectory to healing with healthy granulation/epithelial tissue may not require routine cleansing.

A skin management regime should be included in the care plan for peri wound skin/surrounding skin/limb when required.

In addition, it is important that gangrenous wounds should be kept dry.

6.7. Exudate Management Pathway

see Appendix 3

The purpose of the Exudate Management Pathway is support clinicians in adopting a **STEP UP** and **STEP DOWN** approach to the choice of absorbent used to manage wound exudate. Appropriate management of exudate assists in the prevention of the breakdown to the tissue and skin surrounding a wound due to excoriation and / or maceration.

6.8. Summary

This Wound Management formulary supports the clinical decision-making process when selecting an appropriate wound product, following a holistic assessment of the patient.

Areas to consider:

- Practitioners should avoid multiple dressing use at any one time, unless specifically indicated.
- The practitioner should adhere to the manufacturer's guidelines when utilising products.
- The aetiology of the wound should always be established prior to the selection of a dressing
- For guidance regarding wound swabbing refer to Wound Infection Framework – see Appendix 1
- Use of any antimicrobial product must be supported by following the Wound Assessment / Reassessment 2020 and Clinical Reasoning Process – SOP

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- Consider any over the counter or home remedies the patient may be utilising.
- Non-medical prescribers are professionally accountable for their prescribing decision, including actions and omissions. All registered nurses are personally accountable for their practice ensuring that they: Prioritise people, Practise effectively, Preserve safety and Promote professionalism (NMC 2018).

7. TRAINING REQUIREMENTS

Any clinician undertaking wound care should have undertaken and received appropriate wound care training and be deemed competent prior to using this document.

8. APPROVAL

This guidance has been reviewed and approved by the stakeholders identified on the document checklist submitted to the Therapeutics and Pathways Group which reviewed the checklist and ratified this document.

9. REVIEW

This guidance will be reviewed every 2 years or sooner if prompted by changes in legislation or best practice requirements.

10. REFERENCES

References:

CHCP Lower Limb Compression Formulary City Health Care Partnership CIC
National Institute for Health and Care Excellence

National Prescribing Centre: www.guidelinesinpractice.co.uk/the-national-prescribing-centre/305502.article

Nurse and Midwifery Council: The Code (2018: <https://www.nmc.org.uk/>

Standards for prescribers: <https://www.nmc.org.uk/standards/standards-for-post-registration/standards-for-prescribers/>

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Wound management: <https://www.nice.org.uk/guidance/conditions-and-diseases/injuries--accidents-and-wounds/wound-management/products?Status=Published>

Wound management products and elasticated garments:
<https://bnf.nice.org.uk/wound-management/>

Wound UK: Website that has Best Practice Statements/Journal and Education that is wound related: <https://www.wounds-uk.com/>

Wound Care Handbook: <https://www.woundcarehandbook.com/>

British National Formulary (BNF) www.bnf.org

11. RECOMMENDED READING

City Health Care Partnership CIC Protocols on:

Assessment and Management of wounds in the Community Guidance Document

12. FURTHER READING

For further information regarding the variety of products available within this formulary:

- **ACTIVHEAL ALGINATE & ROPE:** <http://www.activheal.com/home/product-range/activheal-alginate.aspx>
- **ACTIVHEAL AQUAFIBRE EXTRA:** <http://www.activheal.com/home/product-range/activheal-aquafiber.aspx>
- **ACTIVHEAL NON-ADHESIVE FOAM HEEL DRESSING:**
<http://www.activheal.com/wound-care-dressing-range/foam-dressing/>
- **ACTIVHEAL HYDROGEL:** <http://www.activheal.com/home/product-range/activheal-hydrogel.aspx>
- **ACTIVHEAL SILICONE WOUND CONTACT LAYER:**
<http://www.activheal.com/wp-content/uploads/2016/11/ActivHeal-SWCL-FINAL.pdf>
- **ALLEVYN ADHESIVE:** <https://www.smith-nephew.com/key-products/advanced-wound-management/allevyn/allevyn-adhesive/>
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- **ATRAUMAN:** <https://hartmann.info/en-gb/our-products/wound-management/wound-contact-layers/impregnated-wound-contact-layers/atrauman%C2%AE#products>
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- **CLINITAPE CLEAR (Latex Free):**
<https://www.clinisupplies.co.uk/products/24/CliniTape-CLEAR-Surgical-Tape>
- **CUTIMED PROTECT:** <http://www.bsnmedical.co.uk/products/wound-care-vascular/category-product-search/acute-wound-care/medical-skin-care/cutimedr-protect.html>
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- **ODOLOCK:** <http://www.systagenix.co.uk/our-products/manage-odour/odolockandtrade-395>
- **URGOSTART CONTACT:** <http://www.urgomedical.com/products/urgostart-contact/>
- **URGOSTART PLUS RANGE:** <http://www.urgomedical.com/products/urgostart/>
- **ZETUVIT E:** <https://hartmann.info/en-gb/our-products/wound-management/absorbent-dressings/high-absorbent/zetuvit%C2%AE-e#products>
- **SOFTDRAPE DRESSING PACK:** <https://www.richardsonhealthcare.com/softdrape/>

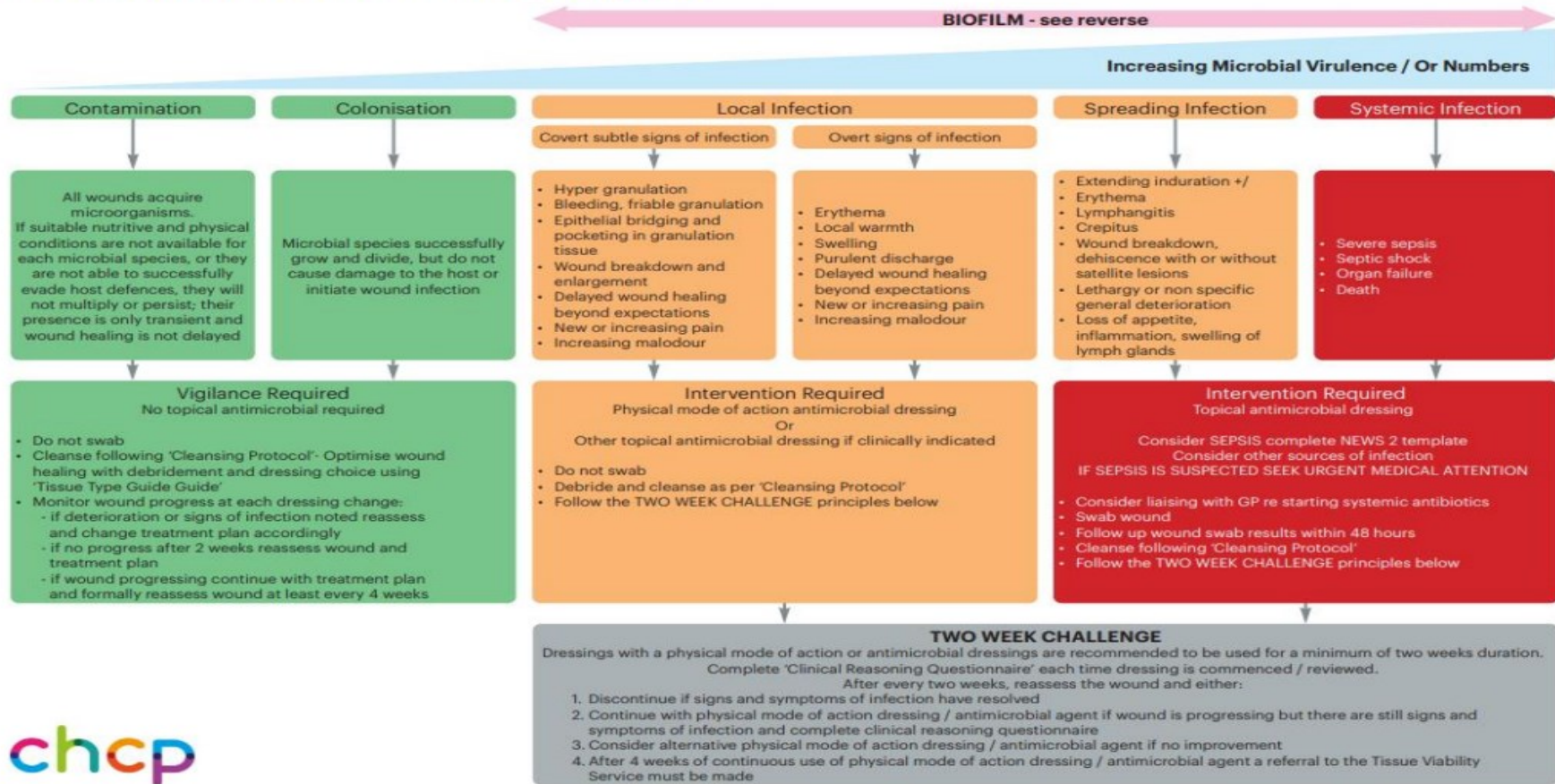
FOR ALL OTHER WOUND CARE PRODUCTS, PLEASE SEE

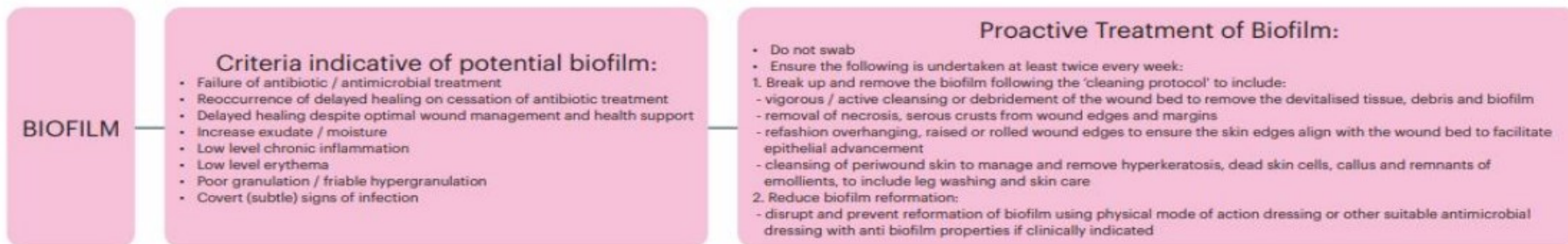
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13. Appendix 1 Wound Infection Framework

Wound Infection Framework





References:
European wound infection continuum 2016
Wound infection in clinical practice. An international consensus

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14. Appendix 2– Cleansing Protocol

Cleansing Protocol: for all Wounds



The purpose of wound cleansing is to remove debris, remnants of previous dressings, exudate and emollients. Wound cleansing will also aid in the management of biofilm and wound infection management.

Wounds which are on a healthy trajectory to healing, having healthy granulation and / or epithelial tissue may not require routine cleansing. In addition, a skin management regime should be included in the care plan for peri wound skin, surrounding skin and the whole limb.

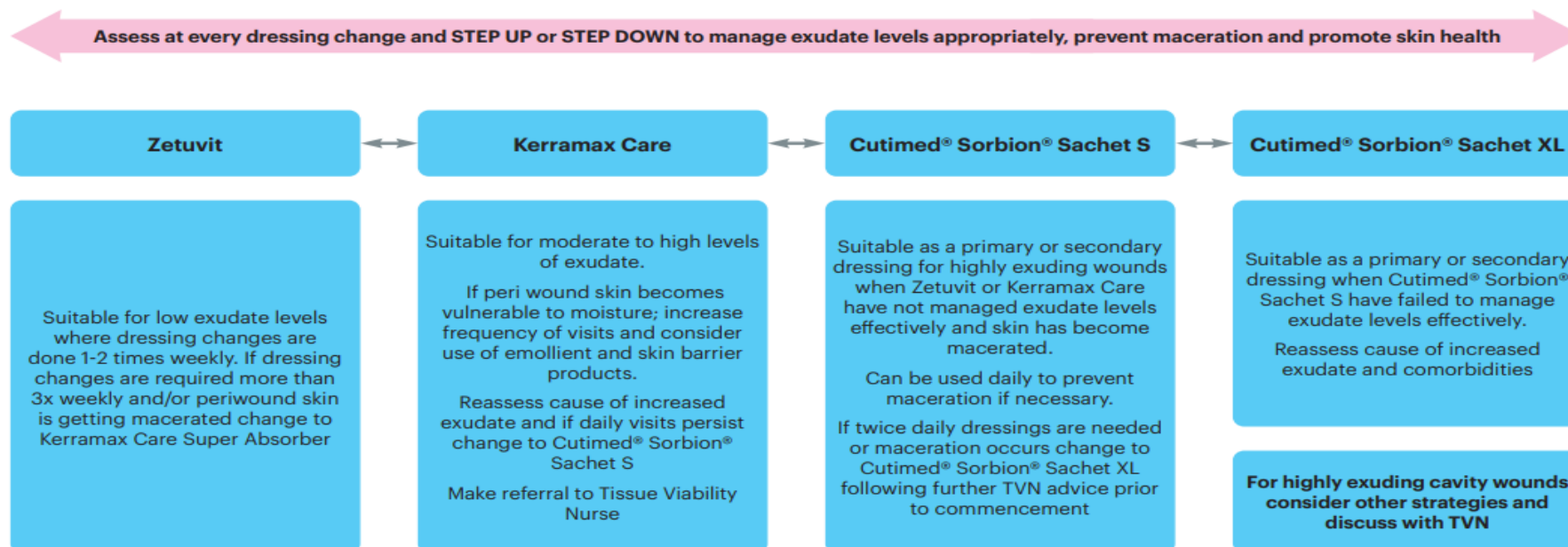
! Gangrenous wounds should be kept dry

Product	Usage	Aim
Potable water	No clinical signs of infection	To remove debris, exudate, remnants of previous dressings and emollients NB: Cleansing of the surrounding skin and limb needs to be included as part of a comprehensive care plan
Irripod Sterile Normal Saline	48 hrs post op, for diabetic foot ulcers or when exposed underlying structures are visible	
Octenilin Wound Irrigation Solution	Should be considered for infected wounds and where biofilm is suspected Review after 2 weeks of usage	To reduce the bacterial burden within the wound To disrupt and aid in removal of biofilm
Cutimed® Debriclean Debridement pad	Should be considered for infected / sloughy / necrotic wounds and where biofilm is suspected Review after 2 weeks of usage	To disrupt and aid in the removal of biofilm and debridement of the wound To remove devitalised tissue, slough, necrosis and bacterial burden from the wound bed To aid in removal of serocrusts and hyperkeratosis

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15. Appendix 3 – Exudate Management Pathway

Exudate Management Pathway



Never layer superabsorbent pads.
Do not use hydrofiber dressings on 'wet legs' when no defined wound is evident.
If skin is damaged use a skin protector, as per product guideline, for 28 days to replace hydrolipid layer.
To prevent skin damage use an appropriate skin protector as per product guideline

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Exudate Management Pathway - Supporting Information



CAUSES OF EXUDATE

Increased bioburden - High levels of exudate can be associated with increased levels of bacteria. When a wound becomes infected, exudate will increase abruptly as a result of vasodilation and extravasation.

Devitalised tissue - Slough and necrosis. Removing the tissue by debridement can result in an increase of exudate.

Underlying disease - Co morbidities such as venous disease, lymphoedema, cardiac failure or prolonged immobility can lead to oedema, particularly in the lower leg. Patients with conditions that cause oedema may also have increased wound exudate levels due to fluid overload. These conditions need treatment in order to effectively manage exudate volume.

Chronic oedema - If the patient has lymphatic failure, referral to a lymphoedema specialist to establish the cause may be appropriate. Patients with lymphoedema will benefit from compression therapy.

Heart disease - Grossly oedematous legs that leak fluid can be a symptom of chronic heart failure; diuretic therapy may be required to treat the heart failure, in conjunction with compression bandaging and leg elevation. Care must be taken to ensure that the cardiac system is not overloaded by a large quantity of fluid being suddenly pushed from the interstitial spaces of the skin into the circulation referral to a heart failure / cardiac specialist may be required.

TYPES OF EXUDATE

Serous - Clear, amber, thin and watery
Often considered normal, but may cause further tissue destruction or wound healing failure if excessive

Serosanguineous - Clear, pink, thin and watery
Due to the presence of red blood cells; this indicates capillary damage e.g. Traumatic dressing removal

Sanguineous - Thick creamy and bright red
Due to deeper wounds involving thicker layers of tissue should resolve after first few days of wounding

Purulent - Purulent Opaque, milky; sometimes green, Thick may be indicative of bacterial infection

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