Integrated Local Services

Community Preferred Dressings List

Guy's and St Thomas' NHS Foundation Trust

Including:

Wound Management Guide
Pressure Ulcer Prevention Pathway
Moisture Associated Skin Damage Pathway

Tissue Viability Nurse contact details:

Tel: **0203 049 8855**
Email & External Referrals: **gst-tr.TVNreferrals@nhs.net**
Internal Referrals via EPIC: **Order Ref110**

convatec — forever caring —
medi
Flen Health advanced skin healing
B BRAUN SHARING EXPERTISE
Smith+Nephew
h&r healthcare A MEDIQ COMPANY
CDMedical
HARTMANN Helps. Cares. Protects.

Skin Prep

Dressing Pack	Nurse-It	S/M	351-2407	£0.55	Contains apron, paper sterile field, gloves, swabs, forceps, paper towel, disposable bag and compartment tray.
		M/L	336-9170	£0.55	
Sterile Gauze Swabs	7.5cm	Pack of 5	325-3234	£0.42	If additional sterile gauze is required.
Non Sterile Gauze Swabs	10cm	Pack of 100	325-3236	£1.48	For cleansing of leg ulcers if required.
Irrigating Solutions	Tap Water			£0.00	Lined bucket filled with warm water to wash lower limbs
	Clinipod	25 x 20ml		£4.23	Sodium Chloride 0.9%
Antimicrobial Wound Preperation	Prontosan solution (Bbraun)	350ml	324-8572	£5.22	Deeper cleansing of wounds and biofilm removal
					Soak gauze swabs in Prontosan, place on wound for 5 mins at dressing change
Foam and Spray Cleanser	MEDIDerma Pro Foam & Spray Incontinence Cleanser	250ml	399-6923	£5.95	Foam & spray modes allow for easy application to even difficult to reach areas
Barrier creams	MEDIDerma-S Total Barrier Cream	28g	388 3121	£2.98	Pea to Palm sized amount, Do NOT over apply & ensure the skin is visible through the cream.
		92g	341-3325	£5.95	
	MEDIDerma-S Total Barrier Film Spray	30ml	389-7121	£5.35	Allow to dry for 5-30 secs, apply 24-72h depending on frequency of cleasning & severity of incontinence.
	MEDIDerma-S Total Barrier Film applicator	1ml (5s)	362-8724	£3.70	Apply at each dressing change to protect the peri wound if required
	MEDIDerma Pro Skin Protectant ointment	115g	416-8498	£3.99	Thin uniform coating of 1mm, more liberal applicaton of 3mm if severe MASD
Adhesive removers	Lifteez Non sting Medical Adhesive remover (Mediderma)	50ml	389 7147	£6.75	Removal of dressing or device from fragile skin. Spray on porous dressing for removal. Non-Porous, lift edge of dressing with gradual spray underneath.
Emollients	Dermol 500 lotion *	500ml	232-2808	£6.04	To soak and wash infected legs, for up to 3 weeks and then revert to Epimax ointment
	Epimax Cream	500g	393-4270	£2.72	First choice as a Soap Substitute or as an Emillolient.
	Epimax ointment	500g	406-9498	£3.19	First choice as a Soap Substitute or as an Emillolient.
	50:50 ointment	500g	253-4238	£3.92	Effective for Leg ulcers when reducing frequency of dressing changes as greasier.
	Flexitol cream 10%	500g	366-5650	£12.36	Maintenance dose for Hyperkeratosis
	Flexito cream 25%	500g	367-5931	£15.55	For treatment of Hyperkeratois

Refer to Joint Emollient Guideline http://www.lambethccg.nhs.uk/news-and-publications/meeting-papers/south-east-london-area-prescribing-committee/Documents/Clinical%20guidelines%20and%20pathways/1.%20SEL%20Emollient%20Guide%20Adults%20and%20children%20June%202018.pdf

Primary Dressings (Require a secondary dressing)

Low adherent dressings	Atrauman (Hartmann)	7.5 x 10cm	369-7547	£0.42	Non-adherent polyester mesh wound contact layer. Suitable for fragile skin that is likely to tear easily.
		10 x 20cm	281-3046	£0.97	
		20 x 30cm	324-8697	£2.65	
Alginate:	Kaltostat (Convatec)	5 x 5cm	007-0789	£1.04	Kaltostat is haemostatic and useful for bleeding wounds.
		7.5 x 12cm	022-7033	£2.27	Remove when bleeding stops.
		10 x 20cm	022-7058	£4.45	Can be used to pack cavities rather than using KerraCel.
Hydrocolloid-fibrous	KerraCel (3M)	5 x 5cm	402-0517	£0.63	For moderate to highly exuding wounds.
		10 x 10cm	402-0525	£1.50	Will require a secondary dressing.
		15 x 15cm	402-0533	£2.78	
	KerraCel Ribbon (3M)	2.5 x 45cm	402-0541	£1.96	For use with cavity wounds – do not pack too tightly.
Hydrogels	Intrasite gel – with applicator (Smith+Nephew)	8g	210-2929	£1.97	Hydrogels are NOT suitable for ischemic and diabetic feet, infected or heavily
		15g	004-2895	£2.64	
	Intrasite conformable - sheet (Smith+Nephew)	10 x 10cm (7.5g)	267-8043	£1.97	Hydrogel sheets – for shallow wounds and where gels may be difficult to keep in place.
		10 x 20cm (15g)	267-8084	£2.66	
Paste Bandages	Ichtopaste (6/2%) (Evolan)	7.5cm x 6m	033-2668	£4.01	Patch test before use.
	Viscopaste PB7 (10%) (Evolan)	7.5cm x 6m	033-2734	£3.97	Do not use for cavity wounds.

Antibacterial /Antimicrobial

AlginoGel	Flaminal Forte (Flen Health)	15g	324-2963	£8.44	For treament of moderate to highly exuding wounds (5 in a box)
	Flaminal Forte (Flen Health)	50g	344-9592	£27.96	Ensure the wound bed is covered with 4-5mm of flaminal gel.
	Flaminal Hydro (Flen Health)	15g	324-2971	£8.44	For treatment of dry to low exuding wounds to add moisture. (5 in a box)
	Flaminal Hydro (Flen Health)	50g	344-9600	£27.96	Ensure the wound bed is covered with 4-5mm of flaminal gel.
Antimicrobial gel	Prontosan gel x	50g	378-1796	£12.75	Can be left inplace to continue cleansing and help prevent biofilm reformation.
Honey	Activon Tube (Honey)	25g	319-3729	£2.54	Honey is useful for application to deep/cavity wounds.
	Activon Tulle (Honey)	5 x 5cm	304-0631	£2.33	Tulle dressings impregnated with honey are suitable for shallow wounds. Tulle
		10 x 10cm	304-0623	£3.85	
	Algivon Plus (Honey)	5 x 5cm	374-9496	£2.54	Algivon Plus is an alginate dressing impregnated with honey. Do not use for dry wounds.
		10 x 10cm	374-9512	£4.41	
Iodine	Iodoflex paste (Smith+Nephew)	5g (6 x 4cm)	073-1547	£4.54	Caution with patients with thyroid issues
		10g (8 x 6cm)	014-9617	£9.07	
Silver dressings	Aquacel Ag+ Extra (Convatec)	5 x 5cm	386-2703	£2.13	Use silver dressings for a maximum of 2 weeks, then contact TVN if no improvement.
		10 x 10cm	386-2695	£5.07	

Silver dressings	Aquacel Ag+ Ribbon (Convatec)	1cm x 45cm	386-2729	£3.34	Aquacel Ag ribbon for cavity wounds.
		2cm x 45cm	386-2737	£5.10	
	Atrauman Ag (Hartmann)	5 x 5cm	321-4533	£0.59	Generally is expected that no more than 5 dressings will be needed for each wound.
		10 x 10cm	321 4541	£1.34	
	Acticoat Flex 3 (Smith+Nephew)	5 x 5cm	351-0781	£3.87	For use under S&N Renaysis TNPWT for infected wounds
		10 x 10cm	351-3256	£9.45	Box of 5 dressings

Odour absorbing dressings

Odour absorbing dressings	Clinisorb (Clinimed)	10 x 10cm	018-2667	£2.06	Clinisorb can be cut to size.
		10 x 20cm	018-2857	£2.74	Use as the outermost layer
		15 x25cm	018-2873	£4.42	

Adhesive Dressings

Vapour permeable dressings	Tegaderm Transparent Film Dressing (3M)	12 x 12cm	242-8951	£1.16	Stretch opposite corners for easy removal, Can be left in place up to 7 days.
		15 x 20cm	003-8703	£2.50	
Low absorbent dressing	Cospmopor Adhesive (Hartmann)	5 x 7.2cm	374-0115	£0.09	For clean surgical wounds.
		8 x 10cm	374-0123	£0.19	
		8 x 15cm	3740131	£0.31	
		10 x 20cm	374-0149	£0.50	
Silicone Foam Adhesive	Kliniderm Foam Silicone Border (HRHealthcare)	7.5 x7.5cm	394-7231	£0.97	
		10 x 10cm	394-7249	£1.27	For light to moderately exuding wounds.
		12.5 x 12.5cm	394-7256	£1.85	Do not cover foams with occlusive dressings.
		15 x 15cm	394-7264	£2.79	Kliniderm Silicone for patients with frail and sensitive skin that are liable to tear.
		15 x 20cm	394-7280	£4.81	
	Kliniderm silicone Non Adhesive (HRHealthcare)	5 x 5cm	394-7215	£0.95	
		10 x 10cm	394-7223	£1.95	
Foam Adhesive	Tegaderm Foam Adhesive (3M)	10 x 11cm	304-1589	£2.44	Tegaderm may be preferred for wounds in awkward areas.
		14.3 x 15.6cm	304-1605	£4.46	
Super absorbent adhesive dressing	RespoSorb Silicone Border (Hartmann)	8 x 8cm	427-9477	£1.45	For heavily exuding wounds
		10x10cm	427-9485	£1.53	Can increase wear time.
		12.5x12.5cm	427-9550	£2.25	
		17.5x17.5cm	427-9543	£4.14	
		18x18cm (sacrum)	427-9576	£4.70	
		23x23cm (sacrum)	427-9584	£6.50	

Hydrocolloids	Granuflex bordered (Convatec)	6 x 6cm		£1.92	Allow 2.5cm over wound edge.
		10x10cm		£3.64	Granuflex – may produce malodour on contact with exudate
		15 x 15cm		£6.95	Can be warmed gently before use to make more malleable.
	Duoderm – Extra thin (Convatec)	7.5 x 7.5cm	027-7798	£0.87	Can be left in place for up to 7 days.
		10 x 10cm	027-7897	£1.44	Do not use on diabetic or ischaemic feet.
		15 x 15cm	027-8036	£3.11	

Absorbent & Superabsorbent Pads

Absorbent Pads	Zetuvit E Non Sterile Pads	10 x 10cm	328-6085	£0.07	Non-sterile pads should be used in most cases.
		20 x 20cm	328-6101	£0.16	Do not use Zetuvit E under compression bandaging.
		20 x 40cm	328-6119	£0.30	
Superabsorbent Pads	Kliniderm SuperAbsorbent Padding (HrHealthcare)	10 x 10cm	394-7132	£0.50	Kliniderm should only be used in highly exudating wounds.
		10 x 15cm	394-7124	£0.71	Kliniderm is thin, so suitable for use under compression bandaging.
		20 x 20cm	394-7157	£1.01	
		20 x 30cm	394-7165	£1.53	
		20 x 40cm	404-9508	£2.04	
Superabsorbent Pads	DRYMAX Super Absorbent Padding (CD Medical)	10 x 11cm	421-3369	£0.91	More absorbent than Kliniderm superabsorbent.
		11 x 20cm	421-3377	£1.09	Second line product or for more highly exuding wounds.
		20 x 20cm	421-3385	£1.93	
		20 x 30cm	421-3393	£2.44	
		37 x 56cm	421-3401	£5.02	

Retention Bandages

Retention bandages	Hospiform (Hartmann)	10cm x 4m	283-4802	£0.21	Retention bandage
	Profore #1 (Smith+Nephew)	10cm x 3.5m	246-1663	£0.77	Cotton wool layer, for protection and absorption.
	Profore #2 (Smith+Nephew)	4.5m	258-5750	£1.47	
Tubular Bandage	Tubifast – Blue Line (Monlycke)	7.5cm x 3m	327-6433	£2.26	For tubular bandages 5m and 3m lengths are less wasteful than 1m
		7.5cm x 5m	327-6441	£3.77	Consider if blue (7.5cm) line size will suffice before prescribing a yellow (10cm) line
	Tubifast – Yellow Line (Monlycke)	10.75cm x 3m	327-6466	£3.71	6m per month should be enough for most patients.
		10.75cm x 5m	327-6474	£6.09	

Surgical adhesive tapes

Surgical adhesive tapes	Scanpor tape (BIO Diagnostics)	2.5cm x 10m	013-6077	£0.96	Some patients are allergic to adhesive tapes.
		5cm x 10m	014-8155	£1.83	

Surgical adhesive tapes	Hypafix (BSN Medical)	2.5cm x 10m	281-3036	£1.80	Hypafix may be left in position for prolonged periods.
		5cm x 10m	035-2047	£2.86	Hypafix is more suited for securing dressings, catheters and draining tubes in position
		10cm x 10m	038-6326	£4.99	

Compression Bandages (Refer to GSTT Leg Ulcer pathway)

http://gti/resources/inpatient_services/tissueviability/wound-management/leg-ulcer-management/leg-ulcer-care-pathway.pdf

Actico – Inelastic (L&R)	Actico – Inelastic	8cm x 6m	314-0886	£3.52	Confirm ABPI Doppler reading before applying compression therapy.
		10cm x 6m	271-5431	£3.65	Actico is a short stretch bandage suitable for patients with chronic
		12cm x 6m	314-0894	£4.66	oedema and lymphoedema.
Actico 2c kit (L&R)	(2 layer system)	10cm(18-25cm)	376-5203	£8.71	Application technique is more important in achieving healing.
		10cm(25-32cm)	376-5211	£9.80	
K-Two (URGO)	Full Compression kit	10cm(18-25cm)	043-5891	£8.67	K-Two reduced kit is for where ABPI is <0.8 please discuss with TVN team first.
		10cm(25-32cm)	327-4685	£9.47	Refer to GSTT Leg Ulcer pathway
	Reduced Compression kit	10cm(18-25cm)	333-8480	£8.67	Latex free options are avaliable
		10cm(25-32cm)	360-2869	£9.47	
Profore – multi layer compression bandaging (Smith+Nephew)	Profore #1	3.5m	246-1663	£0.77	Profore is available in kits for ankle circumference 18-25cm, 25-30cm and >30cm.
	Profore #2	4.5m	258-5750	£1.47	
	Profore #3	8.7m	258-5768	£4.28	
	Profore #4	2.5m	246-1671	£3.54	

Compression Wraps

Medi	Juxtalite, Juxtacure, Juxtafit wraps.	S, M, L, XL, XXL		Variable	Leg compression with medi | medi UK
L&R	Ready wrap	S, M, L, XL, XXL		Variable	ReadyWrap® adjustable compression garments | L&R Medical (lohmann-rauscher.co.uk)
Jobst	Farrow wrap	XS,,S,M,L		Variable	JOBST FarrowWrap

Compression Hoisery

Medi,	Medi hosiery range	S, M, L, XL, XXL, MTM	Variable	hosieryhunter.mediuk.co.uk
L&R.	Activa hoisery & LU Kits	S, M, L, XL, XXL,MTM	Variable	Compression Hosiery | L&R Medical (lohmann-rauscher.co.uk)
Sigvaris	Compression hoisery range	S, M, L, XL, XXL, MTM	Variable	Below Knee | Sigvaris.com

Topical Negative Wound Pressure Therapy

RENASYS TOUCH, Smith+Nephew	Renasys – F Foam Dressing Kit with soft port	Small	378-6720	£25.43	Use only if discussed with TVN or referred from hospital. Order 5 at a time for kits (box size). Reassess after 1 month. If more adhesive film is needed e.g. in case of leakage, use Tegaderm film dressing.
		Medium	378-6712	£29.54	
		Large	378-6704	£35.04	
	Renasys G Gauze Dressing Kit with soft port	Small	378-6431	£21.67	
		Medium	378-6449	£27.17	
		Large	378-6456	£34.48	
	Renasys Touch Canister with solidifier	300ml	402-8783	£30.05	Change once per week.
		800ml	404-2891	£41.81	There is an 800 ml size available for highly exuding wounds.
	Renasys Adhesive Gel Patch		373-8036	£3.69	pack of 10
	SENSAT.R.A.C. (Trac Pad)		378-6464	£11.45	
	Renasys Y Connector (for use with soft port)			£3.55	

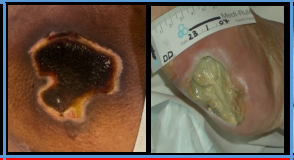
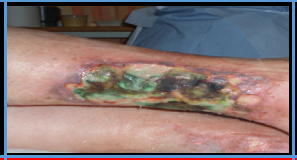
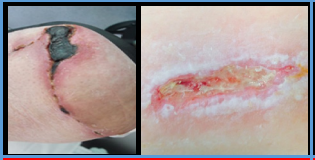
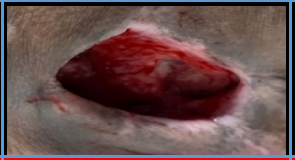
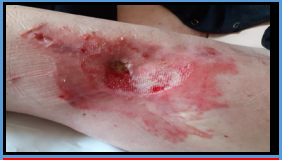
TVN Authorised Recommendations

Commonly recommended off formulary products and ordering information

Betnovate RD *	Betamethasone valerate 0.025% ointment	100g		£3.15	Venous eczema (as part of a reducing regime)
Cavilon Advanced		0.7ml, 2.7ml			Specialist barrier film dressing/ skin protectant
Debridement Pad	Alprep pad (Coloplast)	7 x 9cm	417-1146	£6.67	optimum wound bed preparation.
Eosin 2% *		100ml		£19.52	Non healing skin lesion, wet/bleeding.
Flamazine *	Sulfadiaine Silver 1% cream	50g, 250g, 500g.	£3.85/£10.32		Silver cream, useful for Leg ulcers and Burns
Fucibet cream *	Betamethasone valerate 0.1% / Fusidic acid 2% cream	30g		£6.38	Venous eczema (Treatment)
HydroClean Advance	(Hartmann) Multisizes avaliable 4cm round, 5.5cm round, 7.5x7.5cm				For debriding necrotic wounds
Octenilin irrigation solution		350ml	348-9069	£4.95	(when Prontosan not effective)
Octenisan wash lotion *		500ml	341-8233	£8.99	(antimicrobial for chronic wounds/LU)
PICO 14	Multi sizes avaliable 10x20, 10x30, 10x40, 15 x 15, 15x20, 15x30,20x20, 25x25cm		15x15cm	£206	Step down from TNWPT, Static, non healing wounds
PICO 7			15x15cm	£131	Consult TVN prior to considering.
Prontoderm foam	Treatment of sensitive skin, no rinsing required	200ml		£3.93	Ready-to-use foam for antimicrobial cleansing of the whole body, MDRO decolonisation
Revamil Balm	Steroid Alternative	2g sachet, 15g or 50g	47p/£3.55/7.75		Alternative to steroid cream/ointment

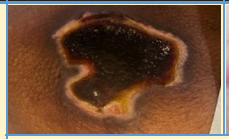
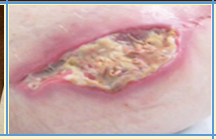
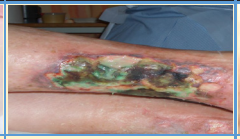
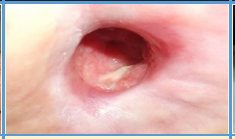
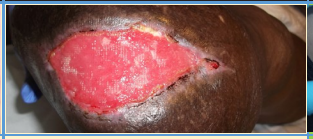
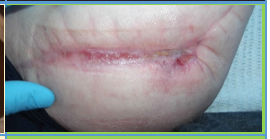
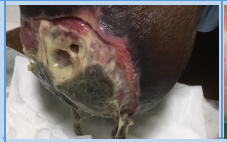
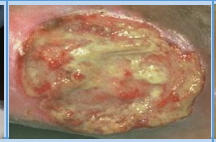
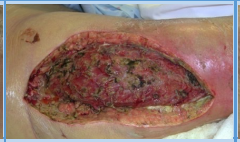
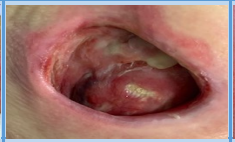
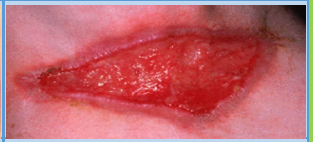
Guy's and St Thomas' NHS Foundation Trust

WOUND ASSESSMENT

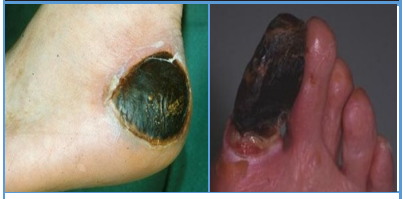
	TISSUE Viable/Non-Viable	INFECTION & Inflammation	MOISTURE Imbalance	EDGE OF WOUND	SURROUNDING SKIN
					
Assess	Is there Devitalised Necrotic or Sloughy tissue in the wound bed? Is there Granulation or Epithelial tissue to wound bed?	Are there signs of infection such as redness oedema, heat and pain?	Is the wound too wet or too dry? What colour and consistency is the exudate?	Is there Undermining, Tunnelling or Rolled edges?	Is there erythema or excoriation to the peri wound?
Deterioration	**Changes to Tissue:** Increased Slough or Necrosis, Friable Granulation Tissue. Increased Wound Dimensions.	**Signs of Infection:** Malodour Increased pain High levels of exudate Friable granulation tissue Deterioration of wound Pt clinically unwell	**Change in Exudate:** Amount— Low / high, Colour— clear / discoloured, Viscosity— thinner /thicker.	**Delayed Healing:** Static dimensions Lack of new healthy tissue/ presence of rolled edges indicates the wound is not progressing normally	**Changes in Skin Appearance:** Colour, Temperature, Dry skin /Maceration Excoriation, Inflammation?
Action	**Debride devitalised tissue.** Use Dressings (autolytic) Refer to TVN/Podiatry for sharp debridement.	Do you need an Antimicrobial Cleanser, Dressings or Antibiotics?	**Dry:** Add moisture with a gel **Wet:** Manage exudate with a superabsorbent	If the wound is not progressing as expected, reassess TIMES and refer to TVN	**Good skin care:** Emollient, Barrier film, Gentle dressing or adhesive remover to protect skin. Remove excess dry skin.

Add Wound to Avatar → **Photograph wound** → **Measure dimensions** → **Assess TIMES** → **Document on Epic**

Tissue Types and Dressing selection

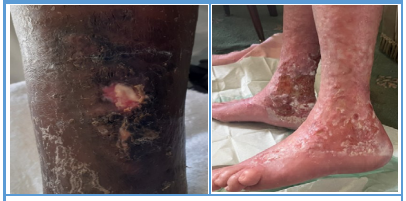
	NECROTIC	SLOUGHY	INFECTED	CAVITY	GRANULATING	EPITHELISING
DRY:						
	HYDRATE & DEBRIDE : (If NOT infected) Hydrogel Hydrocolloid **If infected use antimicrobial*		**ANTIMICROBIAL** Algino Gel (Hydro) Iodine Antimicrobial Gel Honey	**PACK (Loosely)** Algino Gel (hydro) Hydrocolloid-fibrous **If infected use antimicrobial*	**PROTECT** Hydrogel Hydrocolloid Algino Gel (Hydro) Hydrocolloid-fibrous	**HEALING = PROTECT:** Low Adherent dressing Silicone foam adhesive Hydrocolloid Vapour Permeable film
WET:						
	ABSORB & DEBRIDE Algino Gel (Forte) Hydrocolloid-fibrous		**ANTIMICROBIAL** Algino Gel (Forte) Antimicrobial Gel Iodine Silver Dressings	**PACK (Loosely)** Algino Gel (Forte) Hydrocolloid-fibrous TNWPT (VAC Therapy)	**ABSORB** Hydrocolloid Algino Gel (Forte) Hydrocolloid-fibrous Absorbent/ Super Absorbent dressing	

DIABETIC OR VASCULAR FOOT WOUNDS



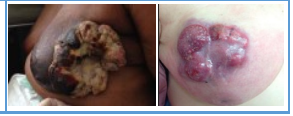
*** DO NOT DEBRIDE * Refer to Podiatry**
Low Adherent dressing or Silver Dressing.
Apply Pad and bandage to protect

LEG ULCER



COMPLETE A LEG ULCER ASSESSMENT AND ABPI
Treat Wound by Tissue Type (TIMES)
Refer to Leg Ulcer Pathway

FUNGATING WOUNDS

Pain	Low Adherent dressing, Foam or silicone	Barrier film & Adhesive remover
Odour/ Infection	Metronidazole Gel Antimicrobials	Odour Absorbing dressings
Exudate	Hydrocolloid-fibrous	Superabsorbent padding
Bleeding	Kaltostat.	

NHS
Guy's and St Thomas'
NHS Foundation Trust

COMMUNITY PRESSURE ULCER & PREVENTION MADE EASY PATHWAY

All patients at risk of pressure ulceration (PU) should have an aSSKINg assessment completed on their initial assessment.
aSSESS Risk, SKIN Check, SURFACE Rv, KEEP MOVING (Regular repositioning), INCONTINENCE Management. NUTRITION Assessment & Advice gIVEN.
Pressure risk assessments should be clearly documented on EPIC and reviewed weekly at WOUND WEDNESDAY if PU present.
Use PU aSSKINg flowsheet. Add wound to the Avatar, include photo, dimensions & TIMES assessment. Provide SSKIN Bundle to Patient & Carers

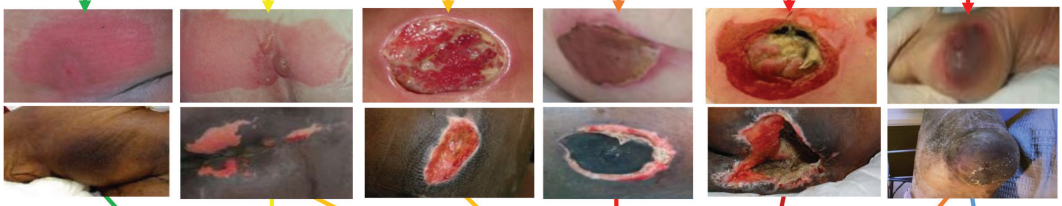
Category 1
Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be indicators, particularly on those with darker skin.

Category 2
Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.

Category 3
Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.
ALSO this includes previous UNSTAGEABLE category (with undetermined depth) as this is no longer used.

Category 4
Extensive destruction, tissue necrosis, or damage through to muscle, bone, or supporting structures with full thickness skin loss.

DTI
Purple or maroon localized area of discoloured intact skin or blood- filled blister due to damage of underlying soft tissue from pressure and / or shear



Complete INCIDENT Report,
Refer to TVN if MULTIPLE Cat 2 PU's

Complete INCIDENT Report & Refer to TVN.
If Multiple category 2, 3, 4 PU's or DTI's complete Safeguarding risk score & consider Safeguarding adults referral.

aSSKINg ADVICE Low Risk Medium risk (1x Cat2)

a	• Assess PU risk + use clinical judgement • aSSKINg Flowsheet min monthly (or condition changes)
S	• Examine skin weekly, or if visits infrequent, at every visit • Ensure barrier cream is provided & Emollient for dry skin
S	• Consider pressure relieving equipment • Utilise pillow under calves / HEELPRO boots to protect heels
K	• Educate patients and carers on repositioning regime • Reposition 2 – 4 hourly, Utilise 30° tilt & side lying position, Document on turning / repositioning chart. • Restrict chair sitting to less than 2hrs continuously for at risk patients (sacral, Ischial, spinal, buttock pressure damage)
I	• Encourage regular toileting / bedpans / convene. • Manage incontinence with appropriate products, Reassess continence needs. Provide regular pad checks & skin care.
N	• Complete nutritional assessment & MUAC / MUST • Advise re Fortified diet & Fluids, Refer to dietician if appropriate
g	• Provide SSKIN Bundle & educate carers & patients to prevent further damage

(in addition to low risk)

ADVICE Medium/High/Very High Risk)

a	• Weekly Reassessment of aSSKINg & PU Risk (or as condition changes)
S	• Use TIMES assessment for dressing selection • Utilise Preferred Dressing List for guidance
S	• Provide Pressure Relieving Equipment as per Community Guidance Document.
K	• Reposition at least 2 hourly depending on assessment of patient's skin. • Restrict sitting to 45 minutes where possible for Cat 3 & 4 (including profiling bed frame) • Consider anatomical location of ulcer when sitting patient for meals
I	• Consider contacting the Continence team • Consider catheterisation or faecal management if wound is becoming contaminated
N	• Refer all patients to dietician
g	• Ensure patient is on the WOUND WEDNESDAY list & discussed with the team on a weekly basis

(in addition to low risk)

DTI

DISCOLOURED INTACT SKIN
- Refer to foot health if heels or ankles
- Leave dry and intact

BLISTERS
- Apply Protective Dressing

OFFLOADING
- Consider offloading with boots or pillows to float limbs

LOW RISK	MEDIUM RISK	HIGH RISK	VERY HIGH RISK
Waterlow 10-15, with intact skin Purpose T—Blue / Green	Waterlow 15-22, with intact skin or 10-15 if PU present Purpose T—Yellow / Blue	Waterlow >22, with intact skin or 15-22 if PU present Purpose T - Orange	Waterlow >23 with or without PU present Purpose T—Pink / Red

Pressure relieving equipment should be selected using the **PRESSURE RELIEVING EQUIPMENT COMMUNITY GUIDANCE DOCUMENT**

COMMUNITY TISSUE VIABILITY CONTACT INFORMATION:
Tel: 0203 049 8855 *Email:* GST-tr.TVNReferrals@nhs.net *EPIC Pool:* GOS COMMUNITY TISSUE VIABLITY CLINICAL STAFF

NHS
Guy's and St Thomas'
NHS Foundation Trust

PREVENTION AND MANAGEMENT OF (MASD) MOISTURE ASSOCIATED SKIN DAMAGE

All patients who are incontinent should be provided with a barrier cream and good skin care advice on their initial assessment.
To reduce the risk of pressure damage a Pressure ulcer risk assessment and aSSKINg assessment and should be completed and then reassessed as appropriate.

ASSESS PATIENT'S SKIN

PREVENTION

No MASD **BUT** incontinence

Continence management as per Local Policy

Use soap free emollient (e.g. **Epimax Ointment**) to cleanse skin + pat dry gently

PROTECTION

INCONTINENCE ASSOCIATED MASD

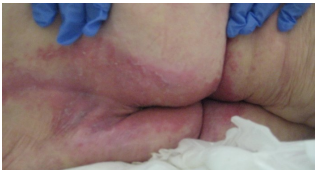
Apply **MediDerma S Cream** to wet areas after every 3rd episode of incontinence **for Protection**

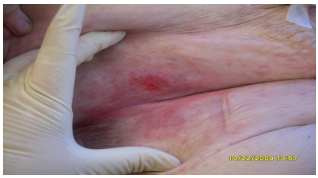
INTERIGO (SKIN FOLD) MASD

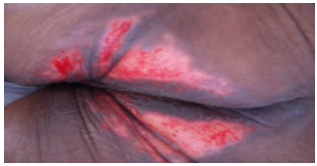
Apply **MediDerma S Cream** to affected skin folds twice daily **to protect**

PERI Wound MASD

Apply **Derma S Film Spray** to peri-wound area at each dressing change **to protect**







FEATURES OF MASD

- Moisture must be present.
- Linear shaped , between anal cleft, skin folds, peri-wound and peri-stomal areas.
- Can be present as discolouration, (blanching) with or without skin irritation.
- Single or multiple areas of skin break-down, irregular shaped or spots or a kissing lesion.
- Typically superficial but depth of lesion can extend with infection or unrelieved pressure.

Complete **aSSKINGg Assessment** to prevent deterioration due to pressure

Reposition frequently
3-4 hourly if skin is intact.
2 hourly if skin is compromised.

Document skin integrity at each visit.

IF MASD PRESENT

- *Take photograph*
- *Add to AVATAR*
- *Complete INCIDENT report*
- *Provide care plan & SSKIN bundle to patient and carers*
- *Consider fungal infection if not responding to treatment*

Consider **TVN Referral FOR ADVICE** if wound bed sloughy/necrotic or if concerned.

TISSUE VIABILITY CONTACT DETAILS

Tel: 0203 049 8855
Email: GST-tr.TVNReferrals@nhs.net
EPIC Pool: GOS COMMUNITY TISSUE VIABLITY CLINICAL STAFF

MANAGEMENT

Moisture lesion present

Continence management as per Local Policy

Use soap free emollient (e.g. **Epimax Ointment)** to cleanse skin + pat dry gently

TREATMENT

INCONTINENCE ASSOCIATED MASD

Apply **MediDerma S Cream** to wet areas after every 3rd episode of incontinence **to Treat skin breakdown**

INTERIGO (SKIN FOLD) MASD

Apply **MediDerma S Cream** to affected skin folds twice daily **to treat**

PERI Wound MASD

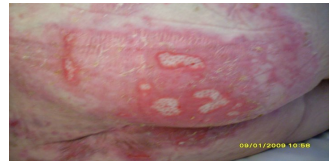
Apply **Derma S Film Spray** to peri-wound area at each dressing change **to treat**

NO IMPROVEMENT >2 weeks OR if skin is severely excoriated

STEP UP PLAN

Protect skin with **MediDerma Pro Ointment.** Gently apply thin layer to intact and irritated skin.

Apply liberally **to treat** broken skin, top up as required. (2-3 x per day)



Community TVN team – V3 June 2024

NHS

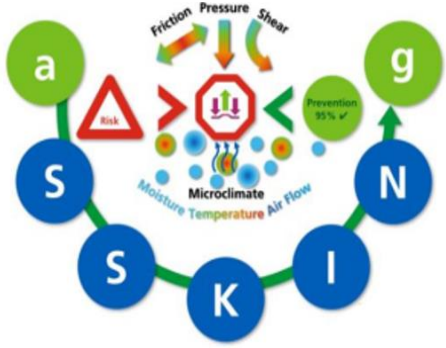
Guy's and St Thomas'
NHS Foundation Trust

PRESSURE ULCER PREVENTION
DOCUMENTATION USING aSSKINg

aSSESS
- Review PU risk regularly (Waterlow/Purpose T) & use Clinical Judgement
- Any physiological change, deterioration, clinical obs.
- Is there an infection? Are they on antibiotics?
- Inform any deterioration to any other professionals involved
- Any pain/palliative symptoms contact GP/palliative team and follow symptom control prescription / care plan
- Be aware of safeguarding policies and take appropriate action when necessary.

gIVE INFORMATION
- Ensure SSKIN Bundle including repositioning chart has been provided and explained to patient carers /family and documented
- Update the Pressure ulcer Prevention care plan and discussed this with the team.
- Email Skin Bundle pack & Repositioning regime to social services and care agency

SKIN
- Skin inspection/condition including under devices where it is safe to do so.
- Ask patient if any altered sensation *i.e. painful, itchy uncomfortable or numb?*
- Any previous known areas of pressure damage?
- Document all areas checked or if patient declined assessment
- If there is a pressure ulcer ensure this is added to the AVATAR with a photo
- Use T.I.M.E.S. to update the wound assessment
- Create a care plan for the wound.
- Examine skin weekly, or if visits infrequent, at every visit



NUTRITION
- If a patient has multiple cat 2's, a cat 3 or 4, or DTI they should be **referred to the dietician** in line with the GSTT PU policy.
- Assess MUAC/MUST?
- Is patient visibly malnourished i.e. anorexic or morbidly obese?
- Weight loss or recent change in appetite?
- Encourage fortified, high protein diet & fluids
- If supplements prescribed, are they drinking them?

SURFACE
- Document clearly what Pressure Relieving Equipment is in their home?
  i.e. Pure Air 8 mattress, Alternating cushion
- Reassess if the equipment is appropriate for patient's needs
- Use **Community Equipment Guidance Document** & refer to Bowley close if wheelchair user
- Is the equipment working? Is it in use? If not why?
- Consider if Mental Capacity Assessment (MCA) required or implement Non Concordance pathway

KEEP MOVING
- Is the patient able to reposition independently?
- Do they rely on carers to do this for them?
- Appropriate repositioning equipment in place? *i.e slide sheets.*
- Ensure repositioning chart is in place and completed by the carers?
- Is the affected site able to be offloaded during night time.
- Any pain reported when repositioning?
- Are there any issues with compliance? Consider MCA/Non Concordance pathway

INCONTINENCE
- Is the patient incontinent? Is it urine/faecal or both?
- Assess if continence appropriately managed & document
- Provide barrier cream if appropriate
- Consider catheter and faecal management products if dressing is getting contaminated
- Provide SSKIN care plan for carers and document clearly.