South East London
Integrated Care System

Lewisham Primary Care Woundcare Formulary & Wound Management Guidance

For use by
General Practice staff

Introduction

The aim of this wound management formulary is to guide the clinician in their assessment and choice of dressing so that an optimum wound healing environment can be achieved.

This wound care formulary and guide is intended to be used by healthcare professionals requesting dressings for the management of wounds in Lewisham.

This guide is designed to help you get the best outcomes for your patients. It is hoped that the information will assist all practitioners to provide a consistent approach and high quality wound care management.

The document will address key aspects of wound management and help direct you to the best dressings for the job.

Updated by the SEL ICB Lewisham Primary Care Nursing team and the SEL ICB Lewisham Medicines Optimisation team.

Remember!

Dressings do not heal wounds!

Dressings can only facilitate healing by managing wound bed conditions that may be preventing/delaying the healing. Some types of wounds or ulcers require specific management to promote healing; for instance, pressure ulcers or neuropathic foot ulcers require offloading over the site, venous leg ulcers require compression bandaging. All people with a wound need to receive a healthy, balanced nutritional intake. A thorough assessment of both the patient and their wound with consideration of factors that might be delaying healing is key to wound treatment decisions.

The dressing selection chart on pages 14-15 is designed to:

- Support improved decision making and meet clinical need.
- Optimise product use and reduce waste.
- Promote timely access to a suitable wound management product.

Please note
Drug Tariff and NHS Supply Chain (NHSSC) product prices are correct at the time of publication August 2023.

Review date September 2025.

Contents

Key Messages

- Make sure the dressing choice matches the wound bed and level of exudate.
- Document the CAUSE of the wound and how this is addressed through the treatment plan.
- Ask about pain at every dressing change until resolved.
- Use a dressing pack to facilitate best practice in infection control and wound measurement.
- Use the **Step-Up, Step-Down** approach to ensure a better use of dressings is linked to rationale.

- Review the wound regularly and prescribe the most suitable and least expensive dressings.
- Any wound on the lower leg must be reviewed for early intervention compression hosiery.
- Generally the wound bed and size will change over time. To avoid waste and facilitate prompt wound evaluation do not order excessive quantities of dressings.
- If wound healing does not progress as expected, seek advice.
- Antimicrobial dressings should only be used where there are clinical signs and symptoms of infection and discontinued if there is no improvement after 14 days. They should not be routinely used for the management of uncomplicated leg ulcers.
- Avoid long term use of antimicrobials. Seek advice on cause of recurrent infection.
- Refer all foot wounds to the foot health service for assessment.

Improving Wound Management and Outcomes

A consistent approach to wound management is essential. This document focusses on helping the clinician choose the most suitable approach and dressing so that:

- Patient outcomes are improved.
- Dressing products are used wisely.
- Clinician's time is used wisely.
- Red flags or concerns are identified early.
- Referral pathways are accessed in a timely manner.

A registered nurse should assess the wound regularly and advise the HCA who is undertaking the dressing changes.

Patient Centred Management

It is essential to ensure that patients are involved in decisions that affect their life and choice of treatments.

Support patients to take an active part in their treatment and prevention plan.

Patient Experience: Creating Bespoke Care

Alongside these choices and clinical decisions, we need to be alert to the fact that this is a wound that will affect a person's life. This may be the first wound of this type for them or a repeated issue, both of which will create significant concerns for the person in front of you.

They may be shocked by the pain or the slowness of healing. Make sure you ask about the impact this wound and the treatment plan is having on their lives, their family and their work. This will help you provide a personalised treatment plan that will include self-management or shared care.

Wound Management Principles

The purpose of a dressing is to:

1. Provide a comfortable environment for the patient and wound bed.
2. Contain the exudate.
3. Cause minimal trauma or distress.
4. Protect the wound.
5. Prevent or combat infection.
6. Contain odour.
7. Manage some of the pain

Nutrition and other contributors to wound management

It is important to discuss diet and nutrition with the patient. A poor diet can be factor for delayed wound healing. Malnutrition has been related to decreased healing and increased wound infection. Refer to dieticians if necessary.

Gentle exercise helps blood flow. Encourage walking and some stretches. Low mobility decreases healing and can cause blood clots to form.

Smoking has been a known contributor to delayed wound healing. Speak to the patient about smoking cessation and direct them to the Stop smoking Lewisham website. www.smokefreelewisham.co.uk/services/iquit

Dementia

Older people in general are at higher risk of pressure ulcers, particularly if they have difficulty moving. Dementia makes this risk even higher, especially as it progresses. This is because of problems that a person with dementia may have with:

- **Pain** - pain reduces mobility and apeptite, which can be contributory factors
- **movement and walking** - people with dementia may have difficulty changing position without help. This can be when they are moving between their bed, a chair, or repositioning themselves while sitting or lying down.
- **frailty** - this causes the loss of protective fat and muscle mass, and also means the skin can become thinner.
- **poor diet and dehydration** - not eating and drinking well can weaken the skin and make it less able to heal itself.
- **incontinence** - moisture from leaks can damage the skin.
- **poor blood supply** - both arterial disease and venous disease increase the risk of ulcers and delay wound healing. Further vascular assessment may be required to facilitate wound healing.
- **agitation or restlessness** - rubbing of clothes, often over the heels or elbows, damages the skin and makes ulcers more likely.
- **medication** - some medicines can cause the person to be more sleepy or the skin to dry out.
- **communication** - the person may be less able to tell someone that they are in pain or want to move. (Pressure ulcers and bedsores | Alzheimer's Society (alzheimers.org.uk)
- **mental health and learning difficulties, addiction** - all present with problems around compliance, think about all of these when you are assessing the patient.

Diabetes

Patients with diabetes with poor glycaemic control are at greater risk of developing foot wounds and wounds generally may be slow to heal due to peripheral neuropathy, poor peripheral arterial supply and or greater risk of becoming infected.

Check for diabetes if there are risk factors or slow healing wounds.

Wound Assessment and Review

Taking a structured approach to assessment and documentation is best practice.

Please note the following:

1. Baseline information

a. Cause or diagnosis.
b. Wound type.
c. Location.
d. Duration.

2. Assessment information

a. See TIMES.
b. Pain: type, frequency and duration.

3. Management plan

a. Rationale for dressing choice and frequency.
b. Communication plan.
c. Refer to specialism if appropriate:
eg. Foot Health Service.

Creating Better Outcomes through TIMES

Create a TIMES framework so that all aspects of wound bed preparation are managed and issues are identified.

TIMES Framework

TISSUE

Tissue is non viable: is there necrosis, eschar or slough which needs debriding?

INFECTION/INFLAMMATION

Is infection present that can delay wound healing, or critical colonisation or biofilm that can result in a wound becoming static and non-healing?

MOISTURE IMBALANCE

A wound requires the right environment to heal (moist); high levels of exudate may cause maceration or extensive excoriation from wound exudate, especially on the leg. If the wound is too dry it will also delay epithelialisation.

EDGE OF WOUND

Non-healing, undermined or excessively raised or granular. Refer for advice.

SURROUNDING SKIN

This particularly relates to the lower limb skin care e.g. hyperkeratosis, varicose eczema. Do not ignore surrounding skin.

Top Tips on **Wound Management**

1. Use structured approach, see page 6.
2. Assess the wound and surrounding skin. See TIMES page 6.
3. Ensure the reason for the slow healing (see page 5) is identified so that treatment objectives can be defined.
4. Choose the right dressing that meets the patient and wound bed needs.
5. Consider lifestyle issues.
6. Prioritise objectives for the patient.
7. Review and refer on if non-healing.

Top Tips for **Measuring Wounds**

Measuring wounds is best practice and an essential part of monitoring progress. Use photos inline with practice consent and confidentiality policies

1. Please use the measuring tool in the dressing packs.
2. Measure the 'longest length'; this is simple and achieves a more consistent approach.

to optimise dressing use; exudate or pain may dictate a change in product.

Top Tips on **Dressing Choice**

1. Be aware of the difference in costs between dressings. **Step-Up** to the silicone based or foam products: the extra costs are required for painful wounds or fragile skin. **Step-Down** from silicone or foam to simple dressings when wound is healing.
2. **Do not put dressings on repeat prescribing, dressings should be ordered via the NHSSC platform.**
3. Be alert when dressings are daily. If this does not reduce quickly, they are at risk of infection due to uncontrolled exudate and/or oedema in the leg.
4. Dressings can often be left in place for up to 7 days. However, wounds commonly need dressing twice weekly.
5. Do not rehydrate foot wounds and do not use any occlusive dressings on foot wounds. Advise patients to keep the wound dry. Refer promptly to the foot health services.
6. Wounds on the lower leg require light compression support to speed healing and prevent traumatic wounds becoming an ulcer. See page11.

Top Tips on **Wound Irrigation**

1. Sterile saline and dressings for 48 hours post-op.
2. Warm tap water or showers are preferable to saline in most wounds.

When is Specialist Advice Required?

Seek Help When:

1. The cause of the wound or non-healing is not understood. If there is no diagnosis or aetiology, then a rationale for treatment cannot be developed.
2. The wound is very painful and not improving.
3. All principles of TIMES have been followed and still the wound fails to reduce in size.
4. The surgical wound has large amounts of frank pus.
5. The exudate remains high. The patient has an extended period of requiring frequent dressing changes.
6. The person is not able to tolerate the treatment required.
7. Refer all foot wounds promptly to the foot health service for triage by a podiatrist using the foot health application form and email to LG.FootHealthService@nhs.net.

Spotting the Unusual and Getting Help Early

This is usually focussed on the rarer causes of wounds or ulcers and require prompt referral to dermatology for medical management such as:

1. Necrotic and very painful ulceration on the legs, rapid deterioration from a ‘bite’ like lesion. [Could be pyoderma gangrenosum or vasculitic ulceration].
2. Recurrent abscesses often in the groin or underarm. These may leave tracts that weep pus. [Could be hydradonitis supprativa].
3. A wound that fails to heal, raised edges, cauliflower appearance, excessive bleeding or crusty wound bed. [Could be basal cell carcinoma or squamous cell carcinoma].

Common Wound Types Which Need Help:

Surgical Wounds:

Surgical wounds heal by either primary intention or secondary intention.

Primary

When the wound edges are brought together by suture/ staples or glue. Most surgical wounds will heal within 14 days by primary intention.

If there is any redness or inflammation (normal for the first 3-5 days), or there is an increase in pain or the wound fails to remain closed then consider wound infection and treat as per clinical guidelines.

Dressing Recommendation?
A simple island dressing in most cases.

Dehiscence of wounds - A partially or totally separated suture line causing a cavity wound breakdown usually around 5-10 days post operatively. Most commonly caused by poor suturing technique, haematoma or wound infection.

If cavity now present manage as cavity wound, treat any infection and refer back to the surgical team if frank pus is present or non-healing.

Secondary

When a wound is expected to close by secondary intention, it has been left open for the tissue to heal from beneath through the normal phases of wound healing.

If the wound fails to make progress once you have assessed using the TIMES framework then refer back to the surgical team.

Dressing Recommendation?
This depends on the depth of the excision, pain and exudate. You may need to step up from a simple island dressing by adding a gelling fibre or stepping up further to a foam for absorption.

When to refer on:

If there has been no improvement with dressing changes and the wound is not healing over 4-6 weeks refer on for advice to tissue viability nurse.

Pilonidal Sinus Excision Wounds:

- This is a surgical wound and treated accordingly.
- Dressing regime based on exudate, pain and ability to self-manage.
- The cavity wound may need packing with an alginate dressing, but follow the guidance from the discharge summary
- The pilonidal excision wound mostly heals within a few weeks of excision. Occasionally they prove more problematic.

To note:
A pilonidal sinus is characterised by an epithelial track in the natal cleft and generally contains hairs.

The disease is more prevalent in males. The hair follicle is irritated, becomes blocked, thereby causing an abscess. Recurrent infection must be managed with dermatology advice.

Burns:

- All burns except small and superficial must be seen in plastic services via A & E.
- Deroof if the blister is greater than 1cm by lancing or piercing with a sterile blade or needle.
- The original burn may appear to heal but if the area is crusty and raw, consider whether this is an inflammatory reaction: use topical steroid under a non-adherent dressing and evaluate effect

Dressing Recommendations?
This depends on depth of injury, pain and site. A silicone based non-adherent dressing is required initially with a suitable secondary dressing that addresses both comfort and exudate management.

Ensure aseptic technique followed. Post healing, instruct to moisturise to reduce irritation and scarring.

Lacerations and Trauma:

Skin tears - aim to draw skin flaps together with either Steri-Strips or silicone dressing as soon as possible. Cover with a secondary dressing and mark the direction in which the dressing should be taken off so as not to open the skin flap on dressing change.

These can heal slowly in older skin. On the lower leg, traumatic wounds can simply become ulcers due to the effect of gravity or poor blood supply. See page 10.

The pre-tibial region is a common site for injuries and lacerations. In the older person, healing is slow due to the site, skin fragility and reduced blood supply to the area.

All injuries to the lower limb will deteriorate in the presence of oedema. Light compression significantly reduces the risk of wound infection and aids healing.

Lower Limb Wound Pathway (Lewisham)

A lower limb wound is below the knee and on or above the malleolus. Most are due to venous insufficiency. Robust evidence demonstrates compression therapy as extremely effective in promoting healing.

KEY MESSAGE – If safe and the patient is in agreement, utilise compression therapy

ASSESSMENT

Full leg assessment within 2 weeks of initial presentation

Red Flags

- Signs of acute infection
- Symptoms of sepsis
- Acute or chronic limb threatening ischemia
- Suspected skin cancer
- Suspected DVT

Never use compression in the presence of red flags

Red flag(s) present

Treat infections according to NICE guidelines

Immediately escalate to relevant clinical specialist

For people in the last weeks of life, seek input from MDT

No red flag(s)

POST-ASSESSMENT

Immediate and necessary care

- Refer for ABPI testing within 14 days of initial presentation (if unable to Doppler refer to leg ulcer clinic)
- **Apply class 1 compression hosiery***
- Health promotion
- Skin care
- Support patient to self-care
- Simple non-adherent absorbent dressing
- If complex (including misshapen limbs) or multiple ulcers, manage exudate, comfort and refer to leg ulcer clinic

Review effectiveness of treatment plan at weekly intervals and escalate concerns to relevant clinical specialist

At 4 weeks

Refer to leg ulcer clinic if:

- Non-healing wounds

***Class 1 compression includes:**

- British 14-17 mmHg
- RAL (European) 18-21 mmHg

Suggested brands: Medi, Activa, Jobst, Altiform, Sigvaris

Compression hosiery only to be prescribed on FP10s.

Specialist Management

• If you are competent and qualified as a tier 3 practitioner in compression therapy according to NWCS
• Complete your holistic assessment including doppler/ABPI to ensure adequate arterial supply.
• Ensure there is no other aetiology apart from venous insufficiency

Apply strong compression therapy
Review 4 weekly
If no progress in healing at 12 weeks refer to specialist

July 2023 National Wound Care Strategy Programme: (2020) Recommendations for Lower Limb Ulcers. Available at Lower-Limb-Recommendations-WEB-25Feb21.pdf (nationalwoundcarestrategy.net)

Being Alert to Pressure Ulcers

Pressure Ulcers in primary care are fairly uncommon. However, when encountered they are a significant event that are at very high risk of rapid deterioration. Do not underestimate the speed of deterioration if the underlying cause is not managed. In those with deteriorating health, speed of referral is critical and thus there is a need for all nurses to know what they are managing.

Reducing the risk of pressure ulcers	Know who is at risk and be alert Dhoonmoon et al. (2021)	Look at skin changes in pressure ulcer areas in darker skin tones. It may be difficult to assess but these patients are at higher risk of grade 2-4 ulcers as they are often detected much later.
The cause will be unrelieved pressure	Do Not just dress the wound! Ensure the treatment plan addresses the need to Off Load the pressure and referral is made into the Integrated Care Team	Make sure the site of the ulcer is addressed and targeted. Refer to foot health and wheelchair services
Physical deterioration	Identify why they are deteriorating physically. What has changed either medically or socially? Recent hospital admission? Pressure ulcer may have gone unnoticed prior to discharge. Heels and other bony prominences are common sites that can be detected by Practice Nurses	The new ulcer may demonstrate that their health is in decline
Neurological deficits	Are they aware of the ulceration? If not, they are at high risk of rapid deterioration	Multiple sclerosis is a leading cause of rapid onset pressure ulcers.
Infected pressure ulcers	Urgent referral required due to high risk of loss of limb or surgical procedure. Do not simply treat with antibiotics.	Urgent medical referral

Local Assessment and Reporting Instructions

All pressures ulcers must be reported. Please use: scaitgcsx@lewisham.gcsx.gov.uk

What are biofilms?

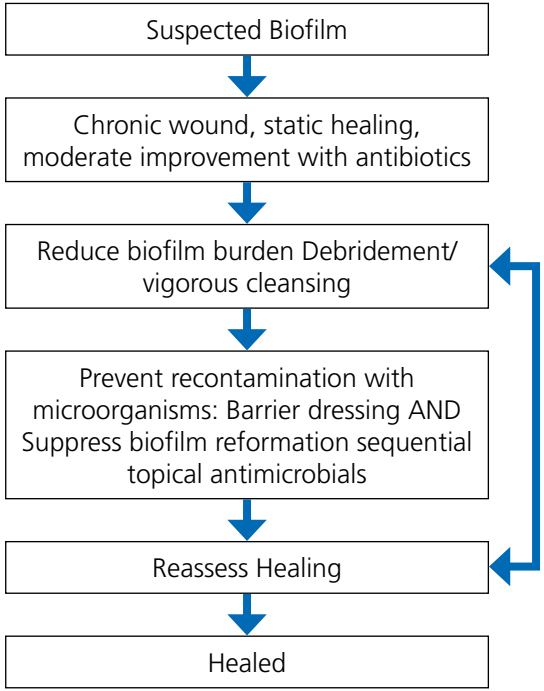
1.4.28 Biofilms are microbial communities, generally composed of bacteria, fungi, and other microorganisms. Although the organisms themselves are microscopic, once biofilms mature they often form a visible protective matrix that attaches the community to the surface. Small, underdeveloped biofilms may be difficult to identify, but as they grow larger, they are much more easily visible, often taking the appearance of a viscous, shiny film. This film protects the microorganisms living within it and prevents antibodies from reaching them.

Wound Care Effects

1.4.29 Biofims can delay wound healing and increase the risk of infection for the patient. Because the film protects the microorganisms from the body's natural immune response, it can be difficult for patients to heal on their own. As the body tries to fight the biofilm through an inflammatory response, the body may actually help the biofilm by providing nutrition in the form of exudate. This creates a situation in which the body is ineffectively fighting biofilms while damaging healing tissue and delaying wound healing. Biofilm Composition and Effects on Wound Healing | WoundSource

Biofilm

A polymicrobial community which is microscopic and invisible and can delay wound healing

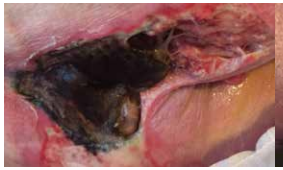
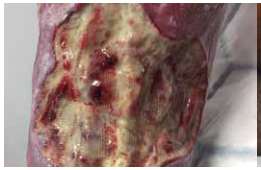


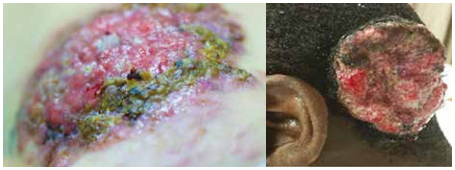
Bjarnsholt T, Eberlein T, Malone M, Schultz G. Management of wound biofilm Made Easy. London: Wounds International 2017; 8(2). Available from: www.woundsinternational.com

management-of-wound-biofilm-made-easy.pdf

Making Better Decisions: Dressing Selection Guide

The selection of a dressing is very often reliant on the wound conditions. This chart will help you identify the wound bed status and exudate level and help you select the most appropriate dressing.

	Necrotic	Sloughy
	 	 
Aim	Understand the cause then conservative debridement to aid healing.	Remove sloughy tissue by autolysis and provide a clean wound bed for granulation.
Features	Brown/Black, hard or soft tissue, +/- offensive.	Yellowish, soft, often firmly attached to the wound bed.
Action needed	Refer for advice. Mention necrosis on referral. Understand likely cause. Consider infection. For necrotic ulcers on the lower leg/foot of someone with arterial disease and/or diabetes, seek specialist advice. If accompanied by severe pain, advice may be required urgently. • On the foot: Protect with non-adherent and keep dry until specialist review. Never use hydrogels or film dressings on the foot. • Removal of necrotic tissue by rehydration – refer for advice. • If necrosis is rapidly spreading, refer urgently to A&E.	• Manage the exudate. • Refer for specialist advice if slough does not clear or exudate is unmanageable. • Lower leg wounds require review for compression therapy, see page 10. • Avoid foams on larger leg ulcers, use secondary absorbent dressing under bandage.
Dressings to be considered - primarily dependent on pain, site and level of exudate	• Do not use hydrogels or film on the feet. • Atraumatic low adherent or silicone wound contact layer. • As per 1. or: hydrocolloid; adherent film island or adhesive foam.	• Alginate, absorbent gelling fibre or foam to aid autolysis. • Consider short term anti-microbial dressing. • A range of absorbent dressings.

Infected	Granulating	Fungating/malodorous
		
Treat the infection as long as there is clinical evidence.	Promote granulation through protection of fragile tissue	To manage the odour and the challenges around quality and end of life
Erythema, hot, induration, malodour, bleeds easily, purulent exudate, dark wound bed, cellulitis. New pain.	Pinkish red, granular surface, moist and shiny.	The tumour can be offensive, painful and exuding
• Swab after cleaning with water or normal saline. • Ensure the cause of this infection is understood. • If this is a wound on the lower leg, ensure they are reviewed for compression. The presence of any oedema causes repeat infections. • If rapidly spreading periwound necrosis, refer urgently to GP or A&E.	• Protection and management of exudate. • Granulation tissue should be firm. A wound bed can be raised in the presence of swelling; **this can be confused with hypergranulation**. So, as long as the wound continues to reduce in size, do not worry! • Hypergranulation is identified when the wound is not getting smaller, but the wound bed is spongy or jelly like and friable. It bleeds easily.	• These tumours present a variety of challenges where dressings often do not meet the need. • The site of the open wounds can add a particular difficulty requiring a patient review of a variety of dressings that fit the patient's requirements. • Ensure the patient is receiving review and support from specialist teams.
• This depends on site and wound bed requirements. • Antimicrobial, gelling fibre or foam.	• Any simple dressing that protects, keeps the wound comfortable and manages the exudate. • For hypergranulation, use an antimicrobial or topical steroid ointment. Refer for advice if no change.	• Consider a charcoal or antimicrobial dressing that may address the odour. • Otherwise base the decision on their comfort, odour and exudate levels.

Lewisham and Greenwich NHS Trust Referral Pathway for Foot Wounds

Any foot wound or any diabetic patient with any of the following (**ACT NOW**):

A – **ACCIDENT**? Recent or history of an accident or trauma?

C – **CHANGE**? Is there any new swelling, redness or change of shape of the foot

T – **TEMPERATURE**? If there is a change in temperature present? Could this be an infection or possible Charcot?

N – **NEW PAIN**? Is there pain present? Is it localised or generalised throughout the foot?

O – **OOZING**? What colour is any exudate? Is there an odour?

W – **WOUND**? Can you document the size, shape and position of the wound in the foot affected?

Refer to Lewisham foot health services within 24 hours by emailing a foot health application form and photo of the wound and foot for triage to **lg.foothealthservice@nhs.net**

An individualised treatment plan for a foot wound may involve regular treatment by a podiatrist with re-dressings by the practice nurse team. This will be communicated to the practice by the podiatrist.

Any questions please contact clinic no. as listed on foot health application form. The foot health application form can be accessed here:

Please look on DXS for Foot health referral form.

- Limb/life threatening infection
- Extensive cellulitis/ lymphangitis requiring IV antibiotics
- Patient systemically unwell, requiring IV antibiotics

Refer immediately to emergency department **and** email **lg.foothealthservice@nhs.net** to inform the foot health team.

NB. If possible patient to be referred to hospital they attend for any diabetes or vascular care.

Atraumatic Low Adherent Dressings

Used to prevent trauma to granulating or friable wounds. First line dressing for leg ulcers.

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
Atrauman	Polyester tulle impregnated with triglyceride ointment	Primary wound contact layer for a wide variety of wounds to prevent adherence	5cm x 5cm 7.5cm x 10cm 10cm x 20cm 20cm x 30cm	£0.37 £0.38 £0.86 £2.37	EKA000 EKA020 EKA036 EKA016	• First choice low adherent dressing • Can remain in place for up to 7 days • Requires a secondary dressing or absorbent pad • If adheres consider silicone alternative
N-A Ultra	Wound contact layer knitted viscose dressing with silicone		9.5cm x 9.5cm 19cm x 9.5cm	£0.35 £0.66	EKG031 EKG033	
Adaptic Touch	Non-adherent primary wound contact layer: acetate mesh with soft tack silicone	Painful or friable wound bed. For patients with burns or Epidermolysis Bullosa	5cm x 7.6cm 7.6cm x 11cm 12.7cm x 15cm	£1.16 £2.32 £4.79	ELY360 ELY355 ELY361	• Second choice low adherent for very painful or friable wounds • Can remain in place for up to 7 days • Requires a secondary dressing or absorbent pad

Absorbent Dressings for Exuding Wounds

Absorbent dressings are designed to absorb exudate. These are used in direct contact with the wound or used as a secondary dressing. Secondary dressings may require securing with retention bandages or tape. Remember to **Step-Up, Step-Down.**

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
Aquacel Ribbon	Absorbent gelling fibre	For sinuses and hidden narrow cavities	2cm x 45cm 1cm x 45cm	£2.65 £2.00	ELY013 ELY368	• 7 days wear time • Requires secondary dressing • Allow for a 1cm dressing overlap onto the skin surrounding the wound • When using a ribbon in deep cavity wounds leave at least 2.5cm outside the wound for easy retrieval • Loosely pack into cavities

Absorbent Dressings for Exuding Wounds continued

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
KerraCel	Absorbent gelling fibre	Can debride wet slough	5cm x 5cm 10cm x 10cm 15cm x 15cm	£0.62 £1.48 £2.75	ELY623 ELY620 ELY621	
Aquacel Extra	Gelling fibre dressing Two layer hydrofiber		5cm x 5cm 10cm x 10cm 15cm x 15cm	£1.07 £2.55 £4.80	ELY377 ELY378 ELY379	
C-Sorb	Non-backed non-adhesive super absorbent dressing sterile		5cm x 5cm 7.5cm x 7.5cm	£1.09 £1.15	EJA273 EJA270	
Zetuvit Plus	Backed non-adhesive super absorbent dressing sterile		10cm x 10cm 10cm x 20cm 15cm x 20cm 20cm x 25cm 20cm x 40cm	£0.90 £1.23 £1.42 £1.93 £2.99	EME046 EME047 EME048 EME049 EME128	
Kliniderm superabsorbent	Super absorbent pad	Wet wounds, moderate exudate	10cm x 10cm 10cm x 20cm 20cm x 20cm 20cm x 30cm	£0.50 £0.87 £1.01 £1.53	EJE228 EJE229 EJE227 EJE230	• Extend beyond the wound edge by about 2–3cm • Change every 3 to 7 days according to need • If daily dressing is required, seek advice
Xupad (non-sterile)	Dressing pad absorbent		10cm x 12cm 10cm x 20cm 20cm x 20cm 20cm x 40cm	£0.03 £0.04 £0.07 £0.15	EJA239 EJA240 EJA241 EJA242	
Xupad (sterile)	Dressing pad absorbent		10cm x 12cm 10cm x 20cm 20cm x 20cm 20cm x 40cm	£0.11 £0.14 £0.22 £0.39	EJA092 EJA093 EJA094 EJA095	

Island Dressings

Dressings with a lightly absorbent pad and adherent border. See pages 16-17.
Remember to **Step-Up, Step-Down.**

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
Softpore	Fabric island dressing	Surgical and superficial wounds with no or low exudate	6cm x 7cm 10cm x 10cm 10cm x 15cm 10cm x 20cm 10cm x 25cm 10cm x 30cm 10cm x 35cm	£0.06 £0.13 £0.20 £0.35 £0.40 £0.49 £0.58	EIJ023 EIJ013 EIJ014 EIJ024 EIJ025 EIJ026 EIJ027	• Change when strikethrough is evident or at 7 days whichever is sooner • Can be used as a secondary dressing with Atrauman to prevent wound bed adherence • Can be used as a secondary dressing with Kerracel for increased absorption

Foam Border Dressings

Foams are made up of a combination of hydrophilic, absorbent polyurethane foam. The outer surface is hydrophobic. They are gas permeable and help to maintain a moist wound environment whilst absorbing moderate levels of exudate. May be used as a primary or secondary dressing. Do NOT cover with film dressings. Use with caution on leg ulcers as they may not be able to manage the exudate. Do not use foam dressings on foot wounds.

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
Kliniderm Foam Silicone Border	Polyurethane foam bordered	Low to moderate exudate	7.5cm x 7.5cm 10cm x 10cm 12.5cm x 12.5cm 15cm x 20cm	£0.96 £1.26 £1.83 £4.77	ELA741 ELA742 ELA743 ELA746	• Consider alternatives first such as island dressings • Up to 7 days wear time or change when exudate is visible and within 1.5cm of the dressing edge • Suitable for use on patients with fragile skin • Can be used as a primary or secondary dressing
Suprasorb P Sensitive Border	Silicone foam dressing with boarder	Low to moderate exuding wounds	7.5cm x 8.5cm 10cm x 10cm 12.5cm x 12.5cm 15cm x 15cm 20cm x 20cm	£0.97 £1.35 £1.86 £2.79 £4.98	ELA1302 ELA1282 ELA1281 ELA1298 ELA1295	

Hydrocolloid Dressings / Hydrogels

Self adhesive and waterproof dressings for the management of lightly exuding wounds. Facilitate rehydration and autolytic debridement of dry sloughy or necrotic wounds. Also suitable for promoting granulation tissue. Hydrocolloid wafer dressings are not recommended for heavily exuding or infected wounds. **Not for use on diabetic or arterial foot/leg ulcers.**

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
Duoderm Extra Thin	Hydrocolloid	Low exudate	7.5cm x 7.5cm 10cm x 10cm 15cm x 15cm	£0.86 £1.43 £3.09	ELM311 ELM050 ELM051	• Warm between hands before applying (improves adherence). Up to 7 days • Should extend at least 2cm beyond the edge of the wound • Can also be used as a secondary dressing over Algisite M for instance • Can be used as a protectant for peri-ulcer tissue with NPWT therapy
Intrasite	Hydrogel		8g	£1.95	ELG015	

Film Dressings

Film dressings are conformable and vapour permeable allowing the passage of water and oxygen through the dressing. For use as a secondary dressing or as a primary dressing for superficial wounds. Do not use over foam dressings as it reduces the vapour permeability of the foam.

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
Hypafix Transparent	Dressing vapour-permeable adhesive film	Superficial, epithelialising, low exudate	10cm x 10m roll 15cm x 10m roll	£9.60 £12.41	ELW287 ELW626	• Should not be used on clinically infected, bleeding or highly exuding wounds • Maximum wear time 7 days • Removal - corner of the dressing lifted carefully from the skin then stretched horizontally away from the wound

Dressings for Malodorous Wounds

Where malodour is a problem, these dressings can be used to help reduce the odour.

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
Carboflex	Absorbent wound contact layer, an activated charcoal central pad and water resistant top layer	Malodourous	10cm x 10cm 8cm x 15cm (oval) 15cm x 20cm	£3.48 £4.17 £7.91	ELV022 ELV021 ELV020	• Not primary contact layer • Change when becomes wet • Use as secondary or tertiary dressing • Do not use if allergic to silver if skin contact likely

Antimicrobial and Antiseptic dressings for infected wounds

Suitable for critically colonised or infected wounds. Systemic antibiotics are indicated in cases of overt wound infection where signs of localised or systemic infection are evident. **REFER FOR ADVICE IF USE OF ANTIMICROBIALS IS NECESSARY FOR MORE THAN SEVEN DAYS OR BIOFILM IS SUSPECTED.**

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
Activon Manuka honey tube	Medical-grade honey with antibacterial action	Infection or gross colonisation	20g	£2.44	ELY864	• Use for 2 weeks only • Seek specialist advice if recurrent infection • Requires secondary dressing • Single patient use • Stop if pain increased
Urgo clean Ag	A poly-absorbent fibre pad, impregnated with the TLC-Ag		6cm x 6cm 10cm x 10cm 15cm x 20cm	£2.04 £4.64 £8.75	ELY609 ELY610 ELY611	• Will require secondary dressing • Do not use if allergic to silver - cut to size of wound and allow patient to keep the remaining sterile dressing for next visit • Use for 2 weeks only • If recurrent infection, seek specialist advice
Inadine	Low adherent containing 10% povidone iodine	Superficial digit wounds, intertrigo (lesions in skin folds)	5cm x 5cm 9.5cm x 9.5cm	£0.34 £0.51	EKB501 EKB502	• Antimicrobial effect is short-lived • Used for its an-hydrating (drying out) properties • Change when colour changes from orange to white • Do not use if patient has thyroid disease, Iodine allergy or is Lithium medication
Iodoflex paste	Cadexomer slow release Iodine paste	Infected, sloughy	5g	£4.50	EKB007	• Do not use on dry necrotic tissue or on patients with an allergy to Iodine • Do not use in the vicinity of the eyes, ears, nose or mouth • Do not use on children, pregnant or lactating women or on people with thyroid disorders or severe renal impairment • 150g of Iodoflex can be applied per patient per week • A single application should not exceed 50g • Do not use for more than 3 months • Change when colour changes from orange to white • Stop if painful

Antimicrobial dressings for infected wounds - continued

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
Cutimed Sorbact Swab	Infected, fungal, colonisation		4cm x 6cm 7cm x 9cm	£1.79 £2.98	ELY212 ELY213	• Primary dressing for contamination or infected wounds specifically deep wounds • Traumatic wounds • Post operative • Dehiscence wound • Use maximum for up to 7 days, use your clinical jugdement
Aquacel Ag + Extra	Gelling fibre antimicrobial dressing silver impregnated		5cm x 5cm 10cm x 10cm 15cm x 15cm	£1.66 £3.94 £7.40	ELY514 ELY515 ELY516	

Retention and Compression Bandages

Can be divided into retention, tubular or compression bandages. Compression bandages should ONLY be applied following a holistic leg ulcer assessment including Doppler ultrasound to determine ankle-brachial pressure index (ABPI). Compression bandages are contra-indicated where ABPI <0.8 without specialist advice. Compression bandages should be carefully selected according to ankle circumference and clinical objectives.

COMPRESSION BANDAGES SHOULD ONLY BE APPLIED BY STAFF WHO HAVE COMPLETED LEG ULCER MANAGEMENT TRAINING AND BEEN ASSESSED AS COMPETENT IN THEIR APPLICATION.

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
K-Soft	Sub-bandage wadding	Protection of very prominent bony sites	10cm (3.5m length: Regular)	£0.49	EPA028	• Sub-compression bandage wadding • Apply toe to knee in a spiral application • 50% overlap without any tension • For ankles measuring 18cm or less apply two layers/additional pieces to protect bony prominences
K-Band	Retention bandage	Dressing retention	7cm width 10cm width	£0.28 £0.30	EDB035 EDB039	• Do not use on lower limb
K-Lite	Retention bandage	Dressing retention	10cm (4.5m length: Regular)	£1.07	ECA100	• Apply in a spiral application • 50% overlap • 50% stretch

Retention and Compression Bandages - continued

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
Peha-haft	Cohesive retention bandage	Dressing retention	10cm width	£0.84	EBA134	• Can be applied full stretch for swelling management where compression is not possible
Viscopaste	Paste bandage	Wet eczema or erosions, intertrigo, wet toes	7.5cm width	£3.94	EFA011	• Zinc paste bandage, patch test skin for 4 days before use • Do not apply in a full spiral – the bandage is applied with either a pleat at the front or in a forwards and backwards method toe to knee. Seek advice if you are not familiar with application method. Can be used under compression
K-Plus	Type 3a light, long stretch compression bandage	Venous or mixed leg ulcer. ABPI > 0.8	10cm (8.7m length: Regular)	£2.44	ECA162	• Apply with 50% overlap in spiral or figure of eight • Can be used under Profore 4 • Do not use where ABPI <0.8 or active arterial disease unless under direction
Profore #4	Moderate Compression Bandage	Venous or mixed leg ulcer. ABPI > 0.8	10cm x 2.5cm	£3.51	ECD007	• Four layer compression system • Apply with 50% overlap in spiral • Can be used over K-Plus • Do not use where ABPI <0.8 or active arterial disease unless under direction
Actico	Short stretch compression bandage	Venous or mixed leg ulcer. ABPI > 0.8	8cm width 10cm width 12cm width	£3.49 £3.62 £4.58	EBA032 EBA016 EBA033	• Apply with 50% overlap in spiral • Do not use where ABPI <0.8 or active arterial disease unless under direction
Coban	Cohesive bandage		5cm x4.5m 10cm x 4.5m 15cm x 4.5m	£1.50 £2.49 £4.58	ECD501 ECD503 ECD504	

Tubular Bandages

To retain dressings in lower/upper limb care and protect skin from potential irritation from K-Soft. Comfigrip Not to be used in patients with diabetes and/or peripheral vascular disease. Where swelling exists this can be used under guidance, otherwise caution is needed.

Product	Dressing type	Type of wound	Size	Cost per unit	Product code
Actifast	Tubular bandages 5m length	N/A	**Medium green line** 5cm child's lower limb/arm, adult arm, small leg **Large blue line** 7.5cm adult large arm, lower leg **Trunk yellow line** 10.75cm large leg	£2.99 £3.74 £6.05	EGP082 EGP086 EGP089
Tubigrip	High Compression Bandage 10m length		**Size D** 7.5cm large arm/medium ankle **Size E** 8.75cm large ankle/medium knee **Size F** 10cm large knee/medium thigh **Size G** 12cm large thigh	£3.72 £4.10 £5.03 £6.09	EGA017 EGA019 EGA021 EGA023

Tapes

For fixation of dressings and bandages

Product	Dressing type	Size	Cost per unit	Product code	Wear time and tips for use
Clinipore	Tape	1.25cm x 5m 2.5cm x 10m 5cm x 5m	£0.36 £0.75 £1.02	EHU026 EHU020 EHU028	• Useful for securing non adhesive dressings • Do not fully wrap around a limb
Hypafix	Fabric adhesive tape	2.5cm x 10m 5cm x 10m 10cm x 10m	£1.78 £2.83 £4.94	EHR030 EHR111 EHR113	• Do not fully wrap around a limb

Other Items

A range of additional products to help you with wound management.

Product	Dressing type	Type of wound	Size	Cost per unit	Product code	Wear time and tips for use
Dressit	Dressing Pack	N/A	small/medium gloves medium/large gloves	£0.69 £0.69	EVH038 EVH039	• Contain apron, gloves, gauze, measuring guide, bag, paper towel and sterile field sheet
Rocialle non-sterile gauze swabs	Gauze swab type 13 light BP 8ply	N/A	10cm x 10cm	£1.19 (100 pack)	ENI305	• Do not use in direct contact with wound or as a primary dressing
Rocialle sterile gauze swabs	Gauze swab BP 8ply	Wound cleansing	10cm x 10cm	£2.63 (30 pack)	ENI304	• Do not use as a primary dressing
Steri-strip	Skin closure strips	Skin tears and superficial lacerations	6mm x 75mm (3 strips per envelope)	£9.08 (12 envelopes)	EIR197	• Requires a secondary dressing such as Softpore or Clearpore. • Not an alternative to stitches • If the wound is deep and bleeding continuously, seek medical assistance immediately • Review after 7 days
Irripod saline	Wound cleansing & irrigation	Any	20ml - 25 ampoules per pack	£6.05	MRB742	• Tap water can be used for wound cleansing in wounds more than 48 hours old

Circular knit

- Available in a large variety of off-the-shelf colours and styles
- More affordable
- Easier to don, more breathable

Flat Knit

- Fits unique leg shapes and sizes
- Used for lymphoedema and misshapen legs
- Less lightly to cause constriction marks
- More expensive

Further reading on wound management

https://www.skillsforhealth.org.uk/wp-content/uploads/2021/05/Wound-Care-Framework-2021.pdf

https://legsmatter.org/

Care plan referral pathway Lewisham and Greenwich NHS Trust Referral Pathway for Foot Wounds

https://journals.sagepub.com/doi/pdf/10.1177/1203475417708164

www.legclub.org

https://med.virginia.edu/dom/wp[1]content/uploads/sites/210/2015/11/Wound-Care-The-Basics.pdf

https://www.shutterstock.com/search/ granulation+tissue

https://www.consultant360.com/articles/case-squamous-cell[1]carcinoma-scalp-african-man

https://www.nursingtimes.net/ clinical-archive/dermatology/skin[1]assessment-in-dark-pigmented[1]skin-a-challenge-in-pressure-ulcer[1]prevention-02-08-2010/

L. i Dhoonmoon et al. (2021) Wounds UK (2021) Best Practice Statement: Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones. Wounds UK, London. Available to download from:

www.wounds-uk.com

Self directed study links and articles

www.pastebandagesevolan.com

Ankle brachial index video assessment
https://www.youtube.com/watch?v=CVBfeD4Un4w

Inelastic bandage system
https://www.youtube.com/watch?v=FsEA7ECLtnY

Elastic bandage system
https://www.youtube.com/watch?v=9-5imSwc_IM

Paste bandage system
https://pastebandagesevolan.com/ichthopaste/

Coban 2-layer system
https://www.youtube.com/watch?v=5iGA9tCyFyA

Multi component system
https://www.youtube.com/watch?v=WjRqMOzzqV4

Betty's Story
https://www.youtube.com/watch?v=8xqJ7l7Kn5A

Early intervention with Anna Swinburn
https://www.youtube.com/watch?v=gEMUjLyGUnM

Demonstrating of different donning and doffing aids for compression hosiery
https://www.youtube.com/watch?v=EkTEKls7tHE

EWMA webinar: Dilemmas of understanding and optimising compression therapy in venous ulcers
https://www.youtube.com/watch?v=huk2Rc5p5ms

Task – Please start watching the video below from 16 mins 45 seconds to the end.

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