Wound Care Guidelines and Dressing Formulary

Background

The Wound Care Guidelines have been written by the Tissue Viability Team and is based on a wide range of clinical evidence and peer reviews.

The Woundcare Steering Group for Cambridgeshire and Peterborough is a group of district nurses, practice nurses, Tissue Viability Nurses (TVN), General Practitioners, clinical management and members of the Medicines Optimisation Team (MOT) have selected the dressings for the Wound Care Formulary.

The present products were selected on the current clinical evidence and cost consideration. A multidisciplinary steering group meets four times a year to review any clinical evidence on new products as well as its cost implication. Any suggestions on new products can be made by contacting either the Tissue Viability Nursing team or the Medicines Optimisation Team using the contact details.

Contact details

Medicines Optimisation Team

E-mail: cpicb.prescribingpartnership@nhs.net

Tissue Viability Team

Tel: 0330 726 0077

Email: cpm-tr.tissueviability@nhs.net

The Formulary

Three prescribing classifications:

Green	**Dressings for both Primary and Secondary care use**.
Amber	Provide on the **Advice** of a Specialist or Tissue Viability Nurse only. **Primary Care can provide treatment as long as it's been recommended**.
Red	Specialist **only** dressings. To be ordered for individual patients by Tissue Viability Nurse (Hospital or Community TVN's). **Not to be prescribed in Primary Care**.

Patient scenario examples	**Formulary Dressings (Green)**	**Formulary Dressings - Restricted requested on the advice of TVN (Amber)**	**Formulary Dressings - Restricted Hospital Only (Red)**
Housebound Patient - seen by District nurse	District Nurse stock system Cambridgeshire via NHS Supply Chain. Peterborough via usual procurement route.	Advice only dressings. Provide via NHS Supply chain on the advice of a Specialist or Tissue Viability Nurse only.	Not to prescribe in Primary Care. To be issued directly by the Specialist Team in hospital or community TVNs.
Resident in care home (with nursing)	Care home stock system (via NHS Supply Chain).	Advice only dressings. Provide via NHS Supply chain on the advice of a Specialist or Tissue Viability Nurse only.	Not to prescribe in Primary Care. To be issued directly by the Specialist Team in hospital or community TVNs.
Resident in care home (without nursing) - seen by District Nursing Team	District Nurse stock system. For Cambridgeshire - via NHS Supply Chain. For Peterborough - via usual procurement route.	Advice only dressings. Provide via NHS Supply chain on the advice of a Specialist or Tissue Viability Nurse only.	Not to prescribe in Primary Care. To be issued directly by the Specialist Team in hospital or community TVNs.
Resident in care home (without nursing) - seen by Practice Team	Practice Stock system (via NHS Supply Chain)	Advice only dressings. Provide via NHS Supply chain on the advice of a Specialist or Tissue Viability Nurse only.	Not to prescribe in Primary Care. To be issued directly by the Specialist Team in hospital or community TVNs.
All other patients (who don't fit the criteria above) seen by Practice Team	Practice Stock system (via NHS Supply Chain)	Advice only dressings. Provide via NHS Supply chain on the advice of a Specialist or Tissue Viability Nurse only.	Not to prescribe in Primary Care. To be issued directly by the Specialist Team in hospital or community TVNs.

Contents

Wound Assessment and Management Guidelines

1. Scope

Cambridgeshire and Peterborough Foundation Trust, general practices and nursing homes for those caring for patients with wounds and Cambridgeshire Community Services (children services).

2. Purpose

To ensure the correct assessment and management of patients with wounds.

3. Introduction

- Choosing a wound dressing depends greatly on a holistic assessment of the patient and their wound; the patient should be at the centre of all care decisions made.
- Wound assessment should be a systematic process accurately documented on the wound assessment and management care plan.
- Dressings should be selected from the Trust Wound Care Formulary unless otherwise advised by a specialist.
- Patients with complex needs should be referred to the most appropriate speciality.

4. Responsibilities

All health care professionals involved in the direct assessment and management of wounds.

5. Wound assessment

- A documented holistic and wound assessment should be done as soon as possible after admission to the caseload.
- The evaluation does not need to be completed at every dressing change if there is little change in the wound condition but document “no change in wound condition”. Dressing change must be recorded.
- Progress of the wound must be fully reassessed and documented.
- Any deteriorating wound must have a full re-assessment/evaluation completed and action taken.
- In the case of a hard to heal wound (chronic wound at 2-4 weeks), the wound should be reassessed weekly (every two weeks at a minimum).

5.1. Completion guide for wound assessment

Patient details & date of initial assessment

All details must be completed.

Type of wound

See drop down menu.

How long has the wound been present?

Write length of duration, not the date when the patient came on caseload unless they coincided.

Factors which may delay wound healing

Use drop down menu, add extra information as appropriate (check patient's medical notes).

Medications

Use all relevant boxes, add extra information as appropriate.

Date referred to

Tick all relevant boxes; discuss referrals with colleagues and GPs. Do not over-refer to similar specialities, e.g. plastics, dermatology, tissue viability (see general wound care guidelines below for appropriate routes of referral).

Drawing/photograph

Please illustrate wound. Use your digital wound management system or photography (verbal or written consent) – tape measures are available in the dressing packs. Write date, patient initials only and the NHS patient's number four (4) last numbers on the tape measure. Take a minimum of two photographs: one to situate the wound on the body and one closer to the wound. Download and attach to SystmOne or protected system used.

Location of wound/s

Please indicate on body map where the wound is situated.

Wound dimension

Please use your digital wound management system or measure as accurately as possible or indicate if this is an estimation.

- Length = head to toe furthest points, measured in centimetres.
- Width = side to side furthest points, measured in centimetres.
- Depth = may be estimated as very difficult to assess safely and accurately. A sterile gloved finger or wound swab can be used to probe.
- Category PU = if the wound is a pressure ulcer please indicate its category.
- Undermining = area tracking, measure with a probe and indicate direction.

Wound bed

Please estimate percentage of different tissue type in each box.

Suture/clips

Specify and indicate removal date.

Exudate levels

Please complete using the following guidelines:

- High = needs daily or more dressing changes and saturated each time.
- Moderate = needs dressing changes every 2-3 days and soiled but not soaked.
- Low = needs weekly or less dressing changes and dressing dry or minimally soiled.

Wound edges/surrounding skin

Please indicate as outlined.

Pain

Please assess patient and indicate action. Please refer for medical intervention/pain team.

Clinical signs of infection

Please indicate and swab if necessary. If the patient is at risk of developing an infection, ensure that daily vital signs are taken.

Local infection:

- Delayed healing,
- Wound breakdown, deterioration
- Increased erythema /inflammation
- Increase amount and /or change in character of exudate (purulent)
- Odour
- Increased local warmth.
- Oedema/induration
- Pain or tenderness
- Bleeding, friable granulation tissue
- Discoloration of tissue

Systemic signs:

- Increased temperature
- Rigor
- Feeling unwell
- Elevated glucose in patient with diabetes
- Pain
- Septic shock
- Organ failure

Infection must be diagnosed in the context of the patient's history and risk factors as classic signs of infection may be muted or absent in wound chronicity, immunosuppression, steroid therapy and malnutrition.

Treatment objectives

These objectives should be suitable for most patients, but a more individualised care plan may need to be added. Use the appropriate objectives according to the phases of healing.

1. Patient comfort – although could be used for most patient's wound care it is more suitable for "end of life" patients where no active treatment (e.g. debridement) may not be suitable. Can be associated with odour control.
2. Absorption: for wound with large exudate where the main objective is containing the fluid.
3. Infection control: for infected wound. It can be associated with odour control.
4. Odour control: see above.
5. Debridement: active treatment.
6. Promote granulation: active treatment – post or concurrent to debridement.
7. Promote epithelialisation: active treatment – concurrent to granulation.

Cleansing solution

Please document saline or water. Other solutions are not recommended unless required for a specific clinical need. Clean thoroughly surrounding skin, wound edges and wound to remove some slough (non-viable tissues), dressing debris and exudate reducing the opportunity for microorganisms and biofilms to proliferate and promote healing.

Dressing choice

Choose from the Wound Care Formulary, review wound progress or deterioration and document the rationale for dressing changes during period of care.

Frequency of dressing change

Please document, dependent on exudates, dressing used and progress of wound.

Signed/print name/designation

This is a legal requirement and must be accompanied by printing name legibly if using paper.

TIMERS – Principles of Improved Wound Healing (Wound Bed Preparation)

Clinical Observations	WBP clinical actions	Impact of your clinical actions	Clinical outcomes
T Tissue non-viable or deficient	Debridement (episodic or continuous) • Autolytic, sharp surgical, enzymatic, mechanical or biological	Restoration of wound base and repair of the damaged tissue	Viable wound bed
I Infection or inflammation	Remove infected foci Topical/systemic antibiotics Topical antimicrobials Anti-inflammatories	Reduced bacterial counts and/ or controlled biofilm and inflammation Lower Inflammatory cytokines Lower protease activity Increase growth factor activity	Resolution of bacterial imbalance, Reduced inflammation Improved biofilm control
M Moisture imbalance	Apply moisture balancing dressings *or* Compression *or* NPWT (negative pressure wound therapy) *or* Other methods of removing fluid	Maceration avoided Reduction in excessive fluid Reduced oedema Desiccation avoided Restored epithelial cell migration	Moisture balance
E Edge of wound non advancing or undermined	Re-assess cause Debridement Peri wound protectant Other corrective therapies	Migrating keratinocytes and responsive wound cells. Restoration of appropriate Protease profile.	Advancing edge of wound Reduce size
Regeneration and Social factors	Skin grafts, biological agents, NPWT Social situation, patient choice	Epithelialisation Engage patient	Repair tissue/wound closure

Adapted from: Schultz et al (2003) *Wound Bed Preparation.* Wound Rep Reg Vol 11 pp1-28. Leaper D et al (2012). *Extending the TIME Concept.* Int Wound. 9 (Suppl) 21:1-19. Atkin L et al (2019) *Implementing Timers.*J Wound Care: 28 (3 Suppl 3): S1- S49

Antibacterial Guidelines

- Evidence concerning the efficacy of topical antimicrobial agents in the management of wounds remains equivocal.
- Independent and better designed and comparative trials to assess efficacy and cost implications are needed.
- Reports of resistance are still limited but misuse of these products, **especially silver products must be avoided.**
- **Reassess the management of all wounds treated with antibacterial products after two weeks.**
- **Consider the clinical effectiveness (has the wound progressed?) as well as the cost effectiveness of the product.**
- Inadine dressings remain a useful tool and should continue to be used where appropriate.
- (CPFT staff- ONLY use Inadine on the foot unless there is a clear rational for use on other anatomical sites).
- Please refer to the BNF and individual product literature for information on contraindications and cautions.

Inadine™ (3M/KCI)

Non-adherent dressing impregnated with 10% povidone iodine ointment

- Suitable for superficial, low exudate wounds.
- Useful for drying ischaemic wounds.
- Dressing colour fading from dark brown to white indicates loss of antibacterial efficacy and needs to be changed.

Iodoflex™ (Smith & Nephew)

Cadexomer (starch) iodine (0.9%) paste. Iodine released is proportional to the exudate absorbed by the starch in the dressing.

- Suitable for sloughy, exuding wounds.
- Mouldable to shape of wound.
- Dressing colour fading from dark brown to white indicates loss of antibacterial efficacy and needs to be changed.
- Can be left in place for 3 days.

Other Antimicrobials

Honey: Activon ™ Manuka Honey tube or Activon ™ Tulle (Advancis)

- Suitable for sloughy wounds, will debride effectively.
- Might cause minimal discomfort at first due to osmotic effect.
- Controls odour very effectively.
- Cut to size so the tulle can be in direct contact with the wound base or use viscous honey (tube).
- Dressing colour will fade as the honey is absorbed.
- No toxicity.
- Can be used long term.
- Although the honey is not absorbed into the blood stream, we advise monitoring the levels of patients with diabetes.

Cutimed Sorbact® (3M/KCI)

- Bacterial binding dressing (no chemically or pharmacologically active substance).
- Must be applied to moist wound and be in contact with wound bed.
- Suitable for all exudating wounds with a secondary dressing.
- No toxicity, no bacterial resistance, no allergy.
- May appear to make wound worse in the first few days before wound start to progress towards healing.
- Do not use in combination with ointments and creams as binding effect is impaired.
- Useful for fungal infection in skin folds and groins.
- In some cases, it could be used in prevention of local infection if patient is at high risk – contact TVN to discuss.

Silvercel™ (3M/KCI) Silver impregnated alginate dressing

- Useful for debriding wounds.
- Useful to control odour and bleeding.
- Pack wound lightly.
- Do not change daily. The silver in the dressing is active for 3 days.
- Known sensitivity to silver and alginates.
- Use only if other antibacterial dressings have been tried or are inappropriate.

Acticoat™ (Smith & Nephew) Nanocrystalline silver coated low adherent dressing

- Only available via TVN if recommended by the Tissue viability team.
- Rapid release/ fast action silver.
- Suitable to control over granulation.
- **Use only if other antibacterial dressings have been tried or are inappropriate.**
- Use for 2 weeks then review.

Toxicity of silver on the healing process is still unclear but caution and overall reduction in its usage is recommended. Contact Tissue Viability Nurses if prolonged use is necessary as other alternative products may be more suitable.

Wound Care Guidelines

Guideline 1: Necrotic Wounds

Aim: To aid debridement by providing a moist environment

Is the wound on the heel or foot? → Yes → Refer to guideline 2 (Black heels/ toes)

No ↓

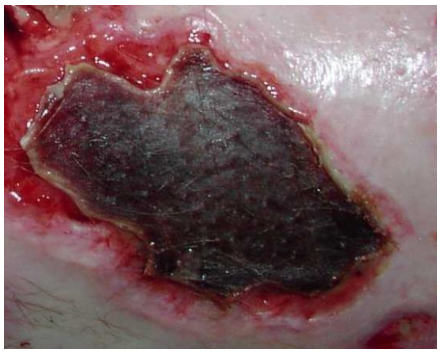
Is the wound infected? → Yes → Refer to Guideline 5 (Infected Wounds)

No ↓

Is the wound exudate

		Dressing Choice	Wound Care
Low	Yes	Hydrogel (Activheal®) **and** Hydrocolloid (Granuflex®)	Hydrogel (Activheal®) **and** Hydrocolloid (Granuflex®)
Medium	Yes	Hydrofibre (Aquacel®) **and** Hydrocolloid (/ Granuflex®)	Loosely pack/ cover wound with hydrofibre. Cover with hydrocolloid. Change as above.
Large	Yes	Hydrofibre (Aquacel®) **and** Foam (Tegaderm® foam / ActivHeal® foam/ UrgoTul® Absorb Border) or Padding	Loosely pack/ cover wound with hydrofibre. Cover with foam or padding and secure. Change as above.

Notes



Depth: May be difficult to assess fully until necrosis has lifted.

Surrounding Skin: If wound exuding or skin is fragile, protect with no sting barrier film.

Nutrition: Assessment must be carried out and appropriate referral made.

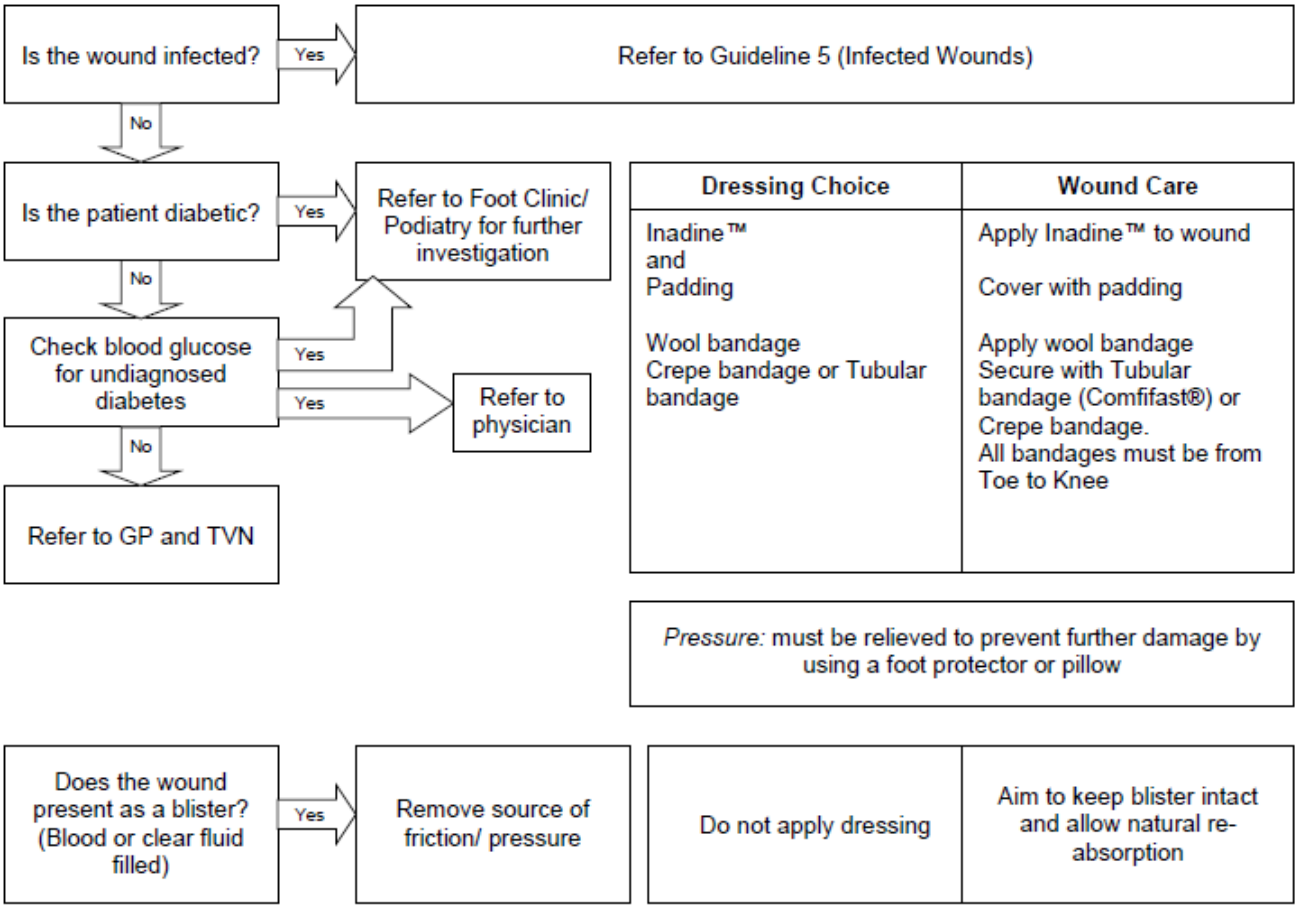
Hydrofibre: if using in a cavity or sinus (where the end of the sinus can be identified/felt) ensure that the hydrofibre tail end is secured outside the wound. Document number of pieces in and out.

Specialist Input: Sharp debridement must be carried out by a doctor or Tissue Viability Nurse only.

Seek further advice for patients with diabetes or arterial problems.

Guideline 2: Black Heels/Toes/Diabetic foot

Aim: To protect and maintain infection free



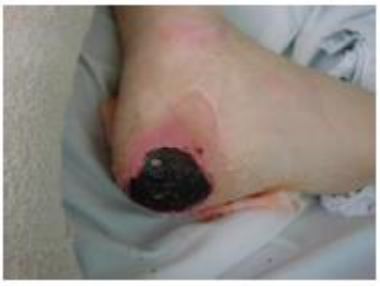
Notes

Bandages: Compression bandages must be applied with caution for patients with diabetes or arterial problems.

Surrounding Skin: If wound is exuding or skin is fragile, protect with no sting barrier film.

Nutrition: Assessment must be carried out and appropriate referral made.

Specialist Input: Seek further advice for patients with diabetes or arterial problems.



If allergy to inadine/iodine or product is unavailable, refer back to podiatry.

Guideline 3: Sloughy Wounds

Aim: To aid debridement of slough by providing a moist environment

Is the wound infected? → Yes → Refer to Guideline 5 (infected wounds)

↓ No

Is the slough dry? → Yes → Treat as necrotic (Guideline 1)

↓ No

Is the wound exudate		Dressing Choice	Wound Care
Low	Yes	Hydrogel (Activheal®) **and** Hydrocolloid (Granuflex®)	Apply gel to base of wound. Cover with hydrocolloid. Change when exudates marking is visible 1cm from edge of dressing or if leaking / dislodged.
Medium	Yes	Hydrofibre (Aquacel®) **and** Hydrocolloid (Granuflex® or UrgoTul Absorb Border)	Loosely cover/ pack wound with hydrofibre. Cover with hydrocolloid. Change as above.
Large	Yes	Hydrofibre (Aquacel®) **and** Foam (Tegaderm foam / ActivHeal® foam/ UrgoTul Absorb Border) or Padding or Superabsorbent dressing	Loosely cover/ pack wound with hydrofibre. Cover with foam or padding and secure. Change as above.

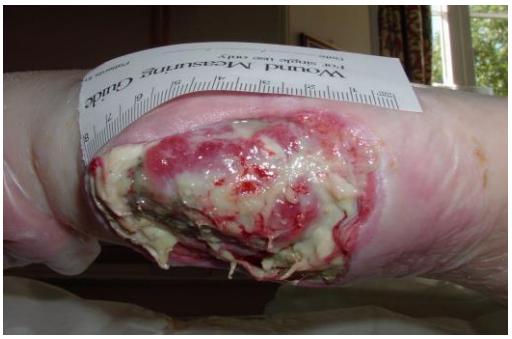
Notes

Slow/static debridement: consider larvae therapy.

Cavities: Consider Topical Negative Pressure therapy, refer to Tissue Viability Nurse.

Very High Exudate: consider above or wound drainage bags, refer to Tissue Viability Nurse for advice.

Surrounding Skin: If wound exuding or skin fragile, protect with no sting barrier film.



Nutrition: Assessment must be carried out and appropriate referral made.

Hydrofibre: if using in a cavity or sinus (where the end of the sinus can be identified/felt) ensure that the hydrofibre tail end is secured outside the wound. Document number of pieces in and out.

Specialist Input: Sharp debridement must be carried out by a doctor or Tissue Viability Nurse only.

Seek further advice for patients with diabetes or arterial problems (vascular team).

Guideline 4: Granulating Wounds

Aim: To promote granulation and provide a healthy base for epithelialisation

Is the wound infected? — Yes → Refer to Guideline 5 (infected wounds)

No

Is the wound hyper-granulating? — Yes → Check for infection and refer to TVN for advice

No

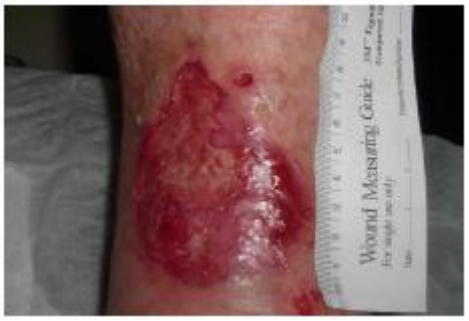
Is the wound exudate

	Dressing Choice	Wound Care
Low (Yes)	Hydrocolloid (Duoderm®) **or** Foam (ActivHeal® Foam / UrgoTul Absorb Border, Tegaderm foam ®)	Apply Hydrocolloid or Foam Change when exudates marking is visible 1cm from edge of dressing or if leaking / dislodged. Hydrocolloid can be in place 5-7 days.
Medium (Yes)	Hydrofibre (Aquacel®) **and** Hydrocolloid (Granuflex®)	Loosely pack/ cover wound with hydrofibre. Cover with hydrocolloid. Change as above.
Large (Yes)	Hydrofibre (Aquacel®) **and** Foam (ActivHeal® Foam/ UrgoTul Absorb Border, Tegaderm foam) or Padding or Superabsorbent dressing	Loosely pack/ cover wound with hydrofibre. Cover with foam or padding and secure. Change as above.

Notes

Bleeding: Use an alginate to act as a haemostat (Kaltostat®).

Cavities: Consider Topical Negative Pressure therapy, refer to Tissue Viability Nurse for advice.



Very High Exudate: Consider wound drainage bags, refer to Tissue Viability Nurse for advice.

Surrounding Skin: If wound exuding or skin fragile, protect with no sting barrier film.

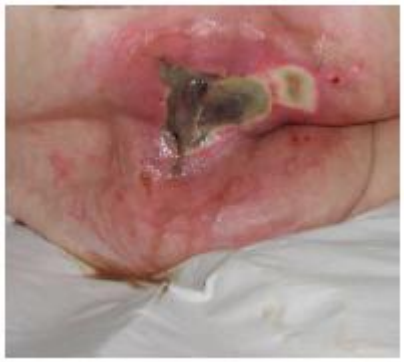
Nutrition: Assessment must be carried out and appropriate referral made.

Hydrofibre: if using in a cavity or sinus (where the end of the sinus can be identified/felt) ensure that the hydrofibre tail end is secured outside the wound. Document number of pieces in and out.

Specialist Input: Seek further advice for patients with diabetes or arterial problems.

Guideline 5: Infected Wounds

Aim: To treat infection systemically and decrease bacterial burden at the wound site



Does the wound look infected? (See notes) Yes	Take swab and treat infection with systemic antibiotics until symptoms resolve Check guidelines for use of antibacterials; follow flow chart below for dressing choice Treat wound for two weeks then review Avoid topical antibiotics	
Is the wound exudate	**Dressing Choice**	**Wound Care**
Low Yes	Iodine (Inadine™) **or** Activon Tulle or Activon Manuka Honey Tube Appropriate secondary dressing	Apply Inadine™ or Activon Manuka HoneyTube Change Inadine™ daily, Honey every 2 to 3 days.
Medium Yes	Iodine (Iodoflex™) **or** Activon Tulle®, Activon Manuka Honey Tube or Cutimed Sorbact® Cover with ActivHeal® foam / UrgoTul Absorb Border/ Tegaderm™ foam or padding	Apply Iodoflex™ **or** Activon Manuka Honey Tube to the wound or Cutimed Sorbact® Cover with foam dressing Change every 2-3 days
Large Yes		
Is wound condition unchanged after 2 weeks of above care plan? Yes	Silvercel® Cover with foam dressing or super absorbent	Cut to size of wound and apply Change every 3 days depending on odour and amount of exudate

For further antibacterial advice refer to the TV Team

Notes

Clinical signs of infection: Inflammation, swelling/oedema ,erythema (redness), increased pain, odour, pus, heat, pyrexia, friable (bleeds easily).
Surrounding Skin: If wound exuding or skin fragile, protect with no sting barrier film.
Nutrition: Assessment must be carried out and appropriate referral made.
Hydrofibre: if using in a cavity or sinus (where the end of the sinus can be identified/felt) ensure that the hydrofibre tail end is secured outside the wound. Document number of pieces used in and out.
Specialist Input: Seek further advice for patients with diabetes or arterial problems.

Guideline 6: Epithelialising Wounds

Aim: To provide a moist, atraumatic environment to complete healing

Is the wound reducing in size? — No → Refer to TVN for advice

Yes ↓

Is the wound exudate?		Dressing Choice	Wound Care
Low	Yes →	Hydrocolloid thin (Duoderm®) OR Low adherent (Atrauman®) and Foam/Cosmopor E	Apply hydrocolloid or low adherent to wound Change if exudates marking is 1cm from edge of dressing or if the dressing is dislodged Hydrocolloid can be in place for 5-7 days.
Medium	Yes →	Reassess wound as unlikely to be epithelialising and refer to appropriate guideline	Use Cutimed® Sorbact® for 2 weeks to control potential excess of bacteria
Large	Yes →	Reassess wound as unlikely to be epithelialising and refer to appropriate guideline.	Use Cutimed® Sorbact® for 2 weeks to control potential excess of bacteria

Notes

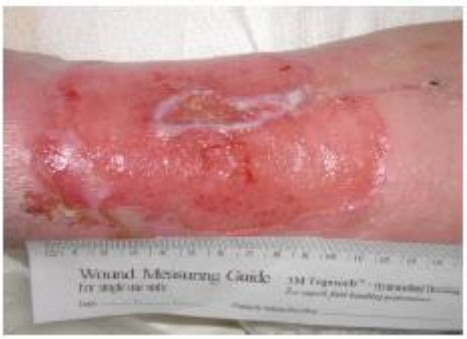
Protection: Of the wound site is essential for complete healing/ maturation.

Surrounding Skin: If wound exuding or skin fragile protect with no sting barrier film.

Nutrition: Assessment must be carried out and appropriate referral made.

Fragile/Sensitive Skin: Silflex® can be considered as alternative dressing as it can remain on the wound for 7 days.

Specialist Input: Seek further advice for patients with diabetes or arterial problems.



Guideline 7: Skin tears/ Pre-tibial lacerations

Aim: To provide a protective environment to promote healing and prevent further trauma

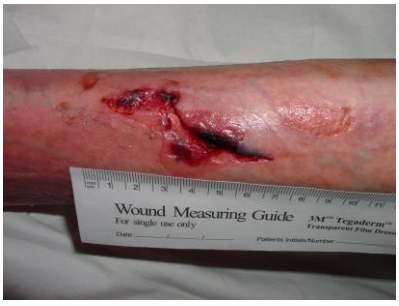
	Dressing Choice	Wound Care
Is the wound presenting a large surface area or deep tissue exposed? **Yes**	Refer to A&E or Plastic Surgeons	
No → Is the wound bleeding? **Yes**	Kaltostat® Apply Urgotul Absorb Border	Apply pressure when securing If bleeds through do not remove, apply further padding on top and refer to A&E if bleeding persists
No → Can wound edges be brought together without force **Yes**	Steri-strip not recommended for skin tears. Apply UrgoTul Absorb Border after cleansing with written arrow on the top of dressing to indicate direction of removal.	If concerns about the dusky, bruised appearance of flap: check wound after 2-3 days, otherwise it could be left for 5 days. See tissue adhesive for linear wound clean of debris and not infected. Check for signs of infection.
No → Is there partial or complete skin loss? **Yes**	Do not attempt to force edges together. Apply UrgoTul Absorb Border. Treat according to previous guideline.	If wound sloughy, consider debridement: hydrocolloid (Granuflex® or Duoderm®), can be left in place up to 5 days. Use with caution on fragile skin.
Is there a significant haematoma with or without skin trauma? **Yes**	Hydrogel (Activheal® hydrogel) - for open haematoma wounds only. Apply UrgoTul Absorb Border.	Contact TVN for alternative gel i.e. Flaminal® Hydro or Forte or Refer to A&E or Plastic surgeons for debridement of large haematoma.

Notes

Holistic assessment needed at first visit.

Surrounding Skin: If wound exuding or skin fragile, protect with no sting barrier film.

Nutrition: Assessment must be carried out and appropriate referral made.



Specialist Input: Seek further advice for patients with diabetes or arterial problems.

Lower limb injury: Apply Urgo adhesive border. If oedema is present, measure the limb for compression liner. Then Apply K-soft and K-lite bandages until liner becomes available at next visit.

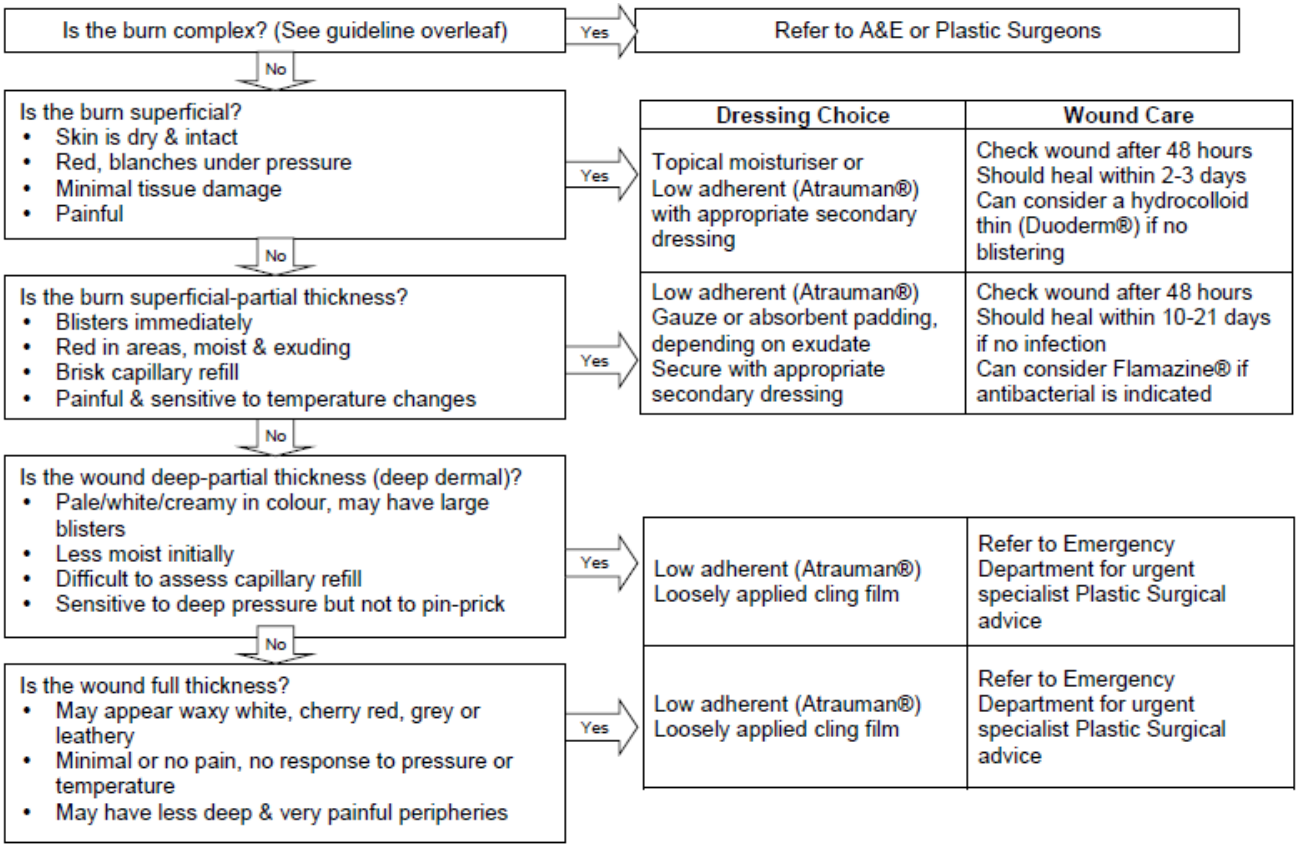
Tissue adhesive (Liquiband Optima not on FP10 or formulary): training/ competency is available from the company Advanced Medical Solutions.

Holistic assessment needed at first visit.

Surrounding Skin: If wound exuding or skin fragile, protect with no sting barrier film.

Guideline 8: Non-Complex burns (suitable for outpatient/ primary care management)

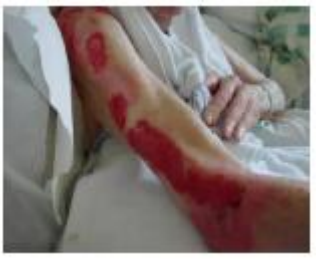
Aim: To provide a protective environment to promote healing and ensure appropriate referral for complex burns



Notes

Surrounding Skin: If wound exuding or skin fragile, protect with no sting barrier film.

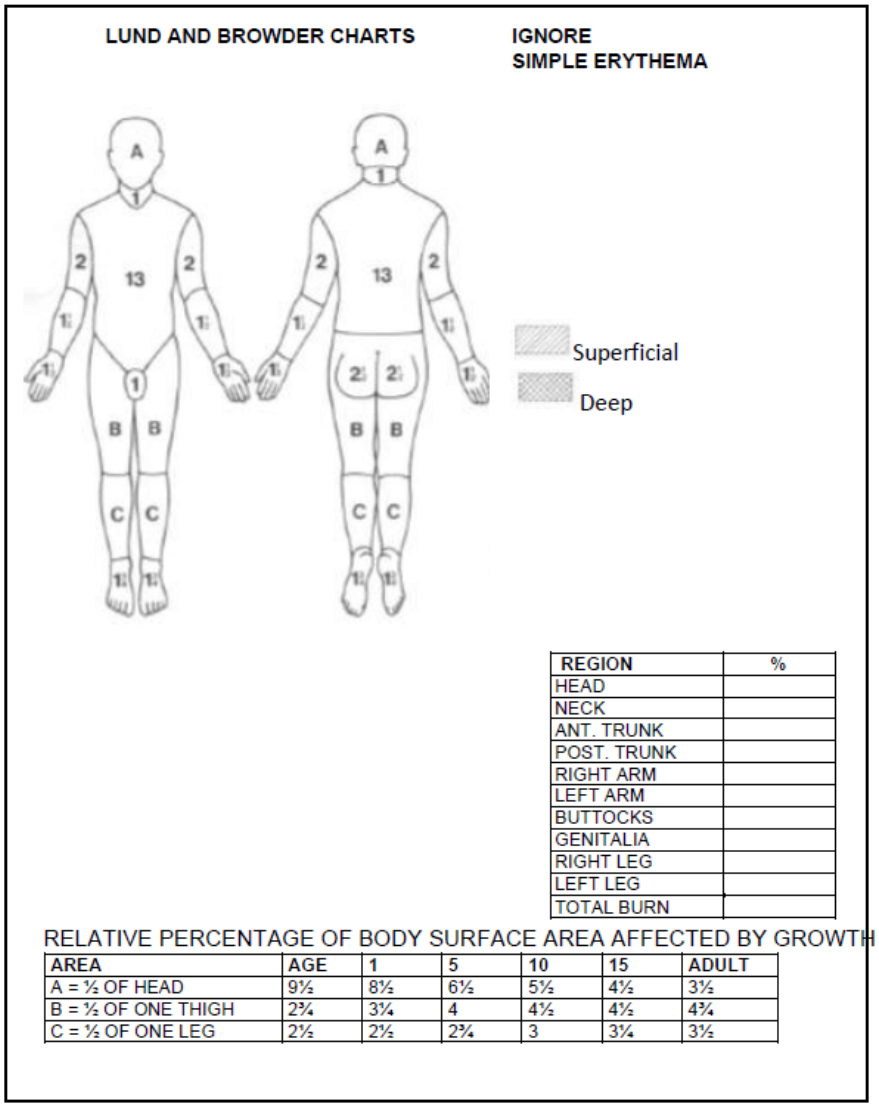
Nutrition: Assessment must be carried out and appropriate referral made.



See over for Burns assessment guidelines.

Seek further advice for:

- Patient < 5 years of age or > 60 years of age
- Patient is <16yrs & burn is dermal or full thickness involving >5% Total Body Surface Area (TBSA).
- Patient is adult & burn is dermal or full thickness involving >10% Total Body Surface Area (TBSA).
- Burn is on face, hands, perineum, feet, flexures.
- Burn is circumferential dermal or full thickness to limbs, torso or neck.
- Burn is chemical, acid, ionising radiation, high pressure steam, electrical, suspicion of non-accidental injury.
- Burn is an inhalation injury.
- Patient also has cardiac or respiratory problems, immunological conditions, pregnancy, or associated injuries.



LUND AND BROWDER CHARTS

IGNORE SIMPLE ERYTHEMA

REGION	%
HEAD	
NECK	
ANT. TRUNK	
POST. TRUNK	
RIGHT ARM	
LEFT ARM	
BUTTOCKS	
GENITALIA	
RIGHT LEG	
LEFT LEG	
TOTAL BURN	

RELATIVE PERCENTAGE OF BODY SURFACE AREA AFFECTED BY GROWTH

AREA	AGE	1	5	10	15	ADULT
A = ½ OF HEAD	9½	8½	6½	5½	4½	3½
B = ½ OF ONE THIGH	2¾	3¼	4	4½	4½	4¾
C = ½ OF ONE LEG	2½	2½	2¾	3	3¼	3½

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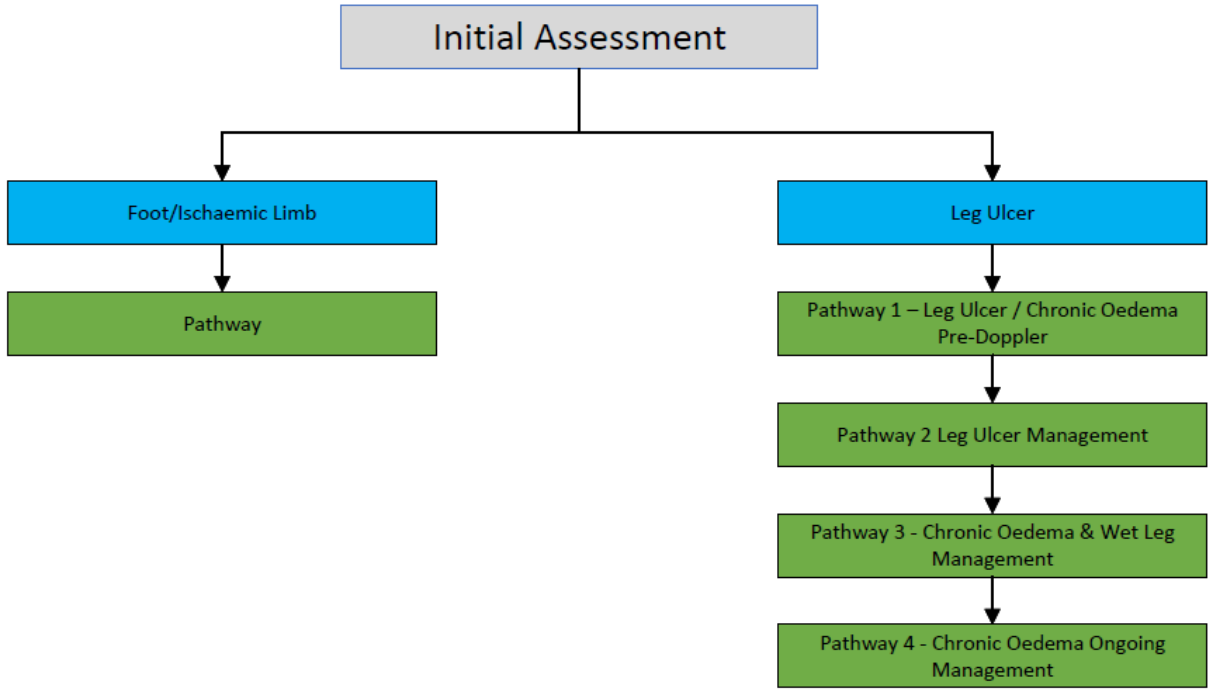
NHS Cambridgeshire and Peterborough NHS Foundation Trust

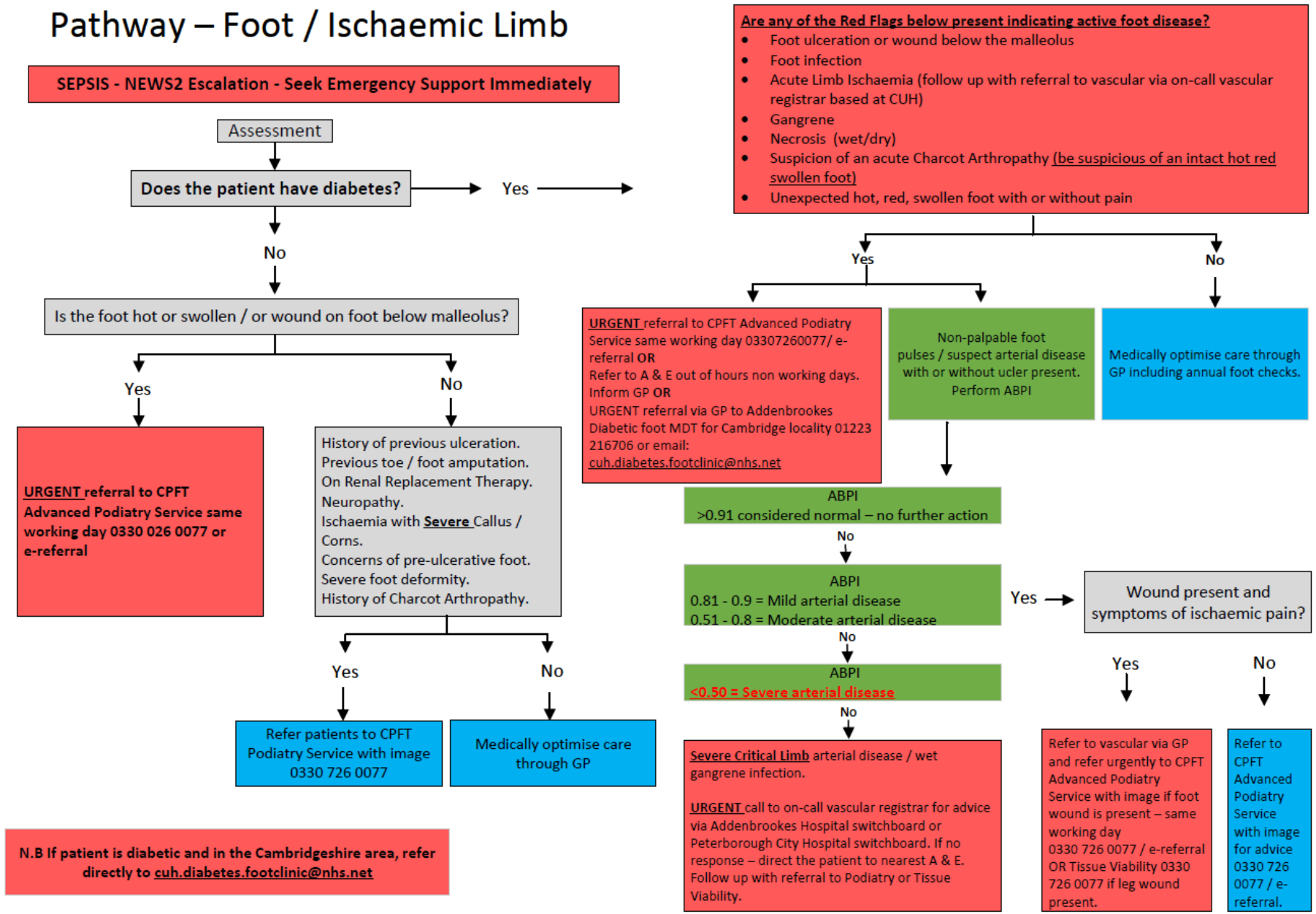
Lower Limb Clinical Decision and Referral Pathway

Definitions:

- A leg wound is a wound that originates on, just below or above the malleolus (ankle bone) but below the knee
- A foot wound is a wound that originates below the malleolus
- Diabetic foot wound any wound on the foot where the person has a diagnosis of diabetes
- Ischaemic limb is an inadequate blood supply to the limb, typically caused by atherosclerosis
- Neuropathy is a disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness
- Chronic oedema is an umbrella term for any swelling that has been present for three months or more
- Lymphorrhea (wet legs) is the flow or discharge of lymph fluid through the skin
- **Red Flag symptoms' require immediate attention from relevant specialist to reduce the risk of rapid deterioration or serious harm**



Pathway – Foot / Ischaemic Limb



Pathway 1 - Leg Ulcer / Chronic Oedema Pre-Doppler

Leg wound: A wound that originates on or above the malleolus (ankle bone) but below the knee with mild, moderate or severe oedema

Immediate & Necessary care at first contact within 14 days of referral

RED FLAG ASSESSMENT
- Acute infection of leg or foot
- Symptoms of sepsis
- Acute or chronic limb threatening ischaemia
- Suspected deep vein thrombosis (DVT)
- Suspected skin cancer
- Bleeding varicose veins

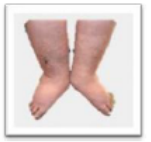
Yes

IF RED FLAGS PRESENT:
- Treat infection
- Apply dressing following the infection management pathway
- Apply K-Soft & K-Lite
- Immediately escalate to relevant clinical specialist team
- For people in the last few weeks of life, seek input from their other clinicians to agree an appropriate care plan

Regular Limb Shape

No Red Flags Present

Review Post Infection


Abnormal Limb Shape

Consider limb shape

Mild Oedema
Regular Limb Shape

Apply mild compression (<20mmHg)
- Wound bed, peri-wound and limb skin cleansing and emollient, as required
- Apply non-adherent dressing from the formulary
- UrgoKTwo Reduced multi-layer compression bandage kit 18cm-25cm ankle circumference
- UrgoKTwo Reduced multi-layer compression bandage kit 25cm-32cm ankle circumference
- JOBST® UlcerCare ™ liner (15-20mmHg) x1 liner or
- Altipress® Liner (10mmHg) x2 liners
- Work in partnership with patient on leg ulcer management & self care.

Complete full holistic limb & wound assessments including doppler ABPI within 14 days

Move to pathway 2

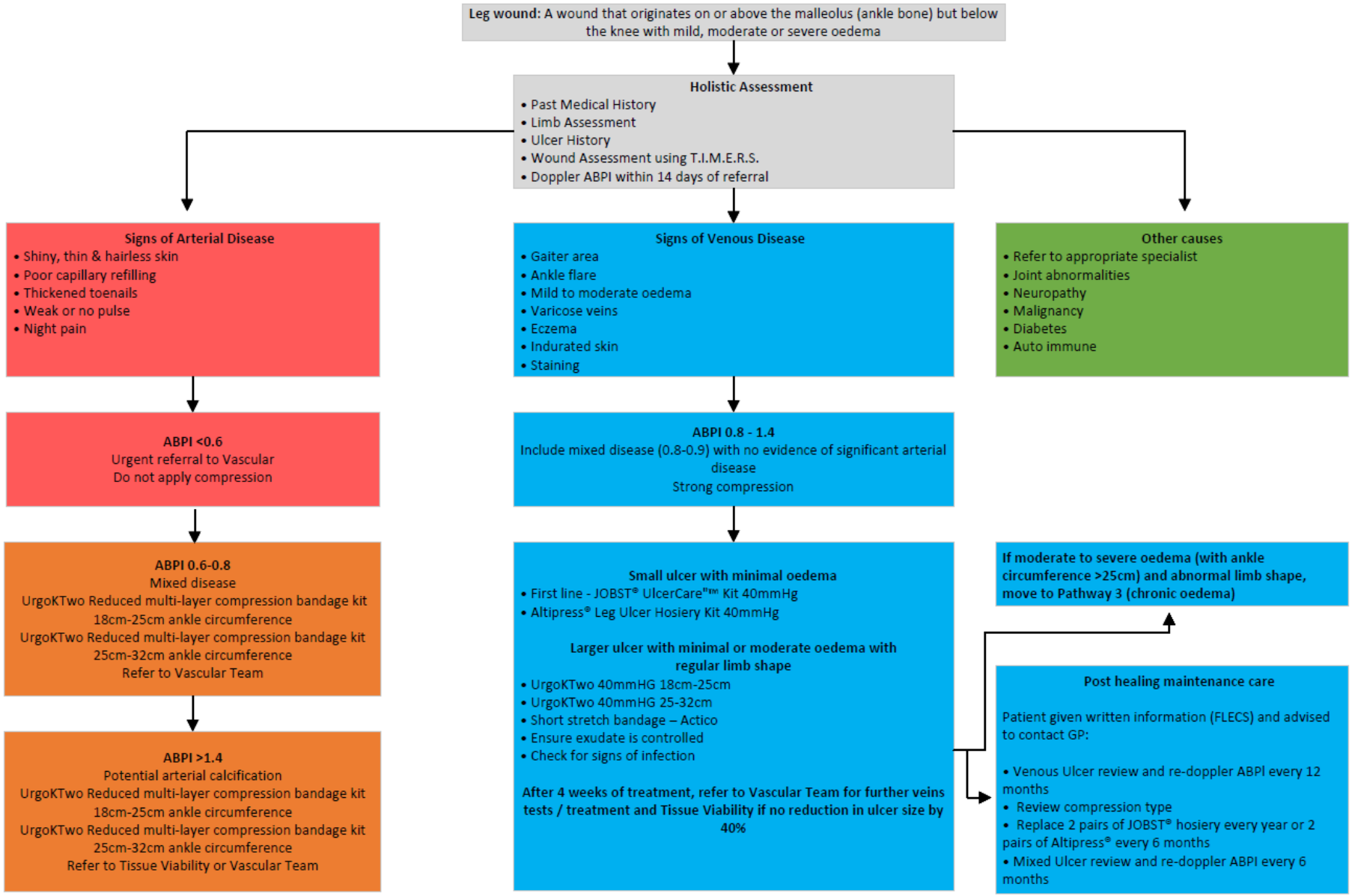
Moderate to Severe Oedema (with ankle circumference >25cm), Chronic Oedema
'Wet Leg' & or Abnormal Limb Shape

Apply strong compression (40mmHg)
- Aim is to decongest limb and reduce lymphorrhea
- Wound bed, peri-wound and limb skin cleansing and emollient, as required
- Apply non-adherent dressing from the formulary
- Apply layer of K-Soft to shape limb
- Apply 1 layer of Actico short stretch bandage
- Work in partnership with patient on leg ulcer management & self care

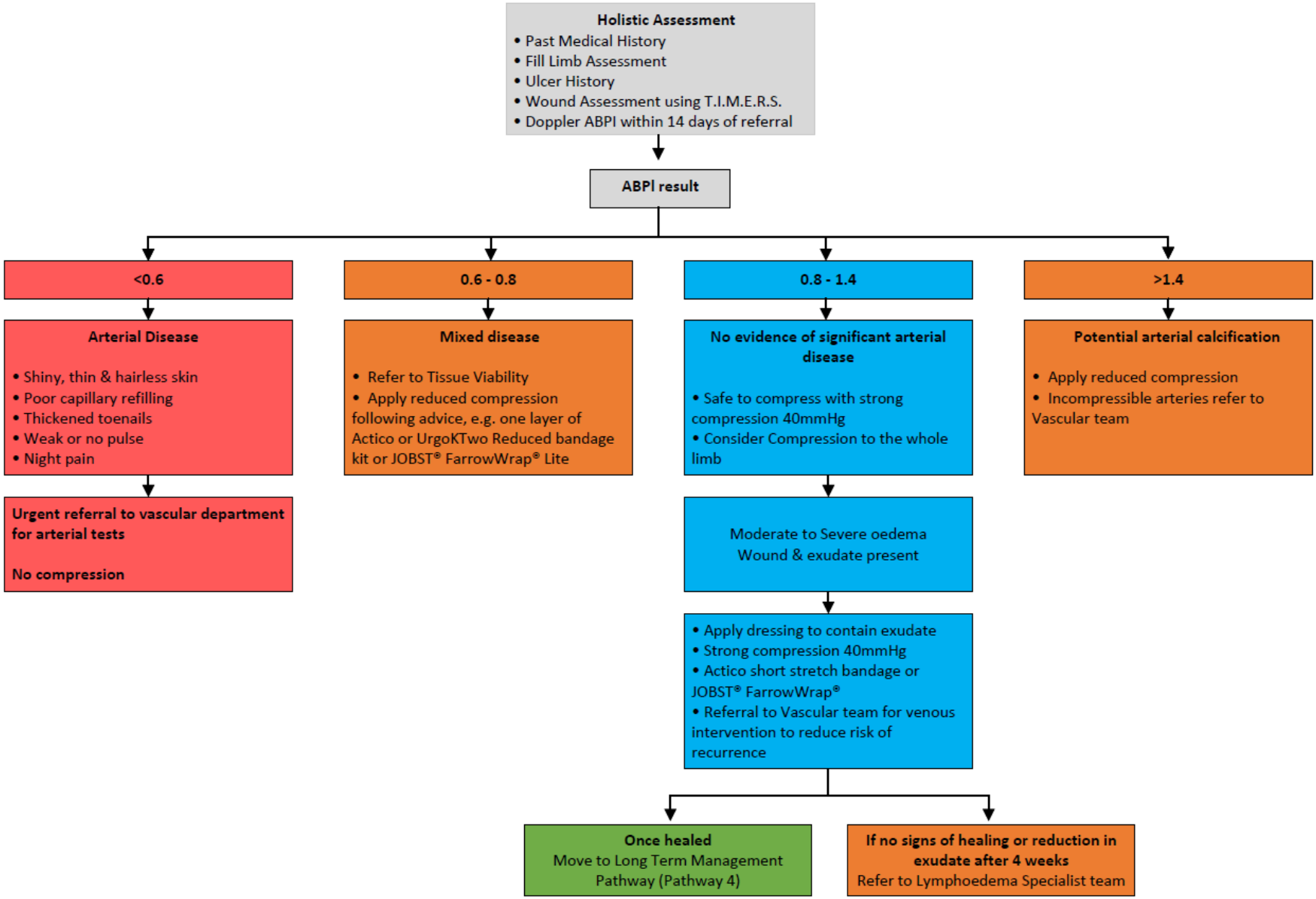
Complete full holistic limb & wound assessments including doppler ABPI within 14 days

Move to pathway 3

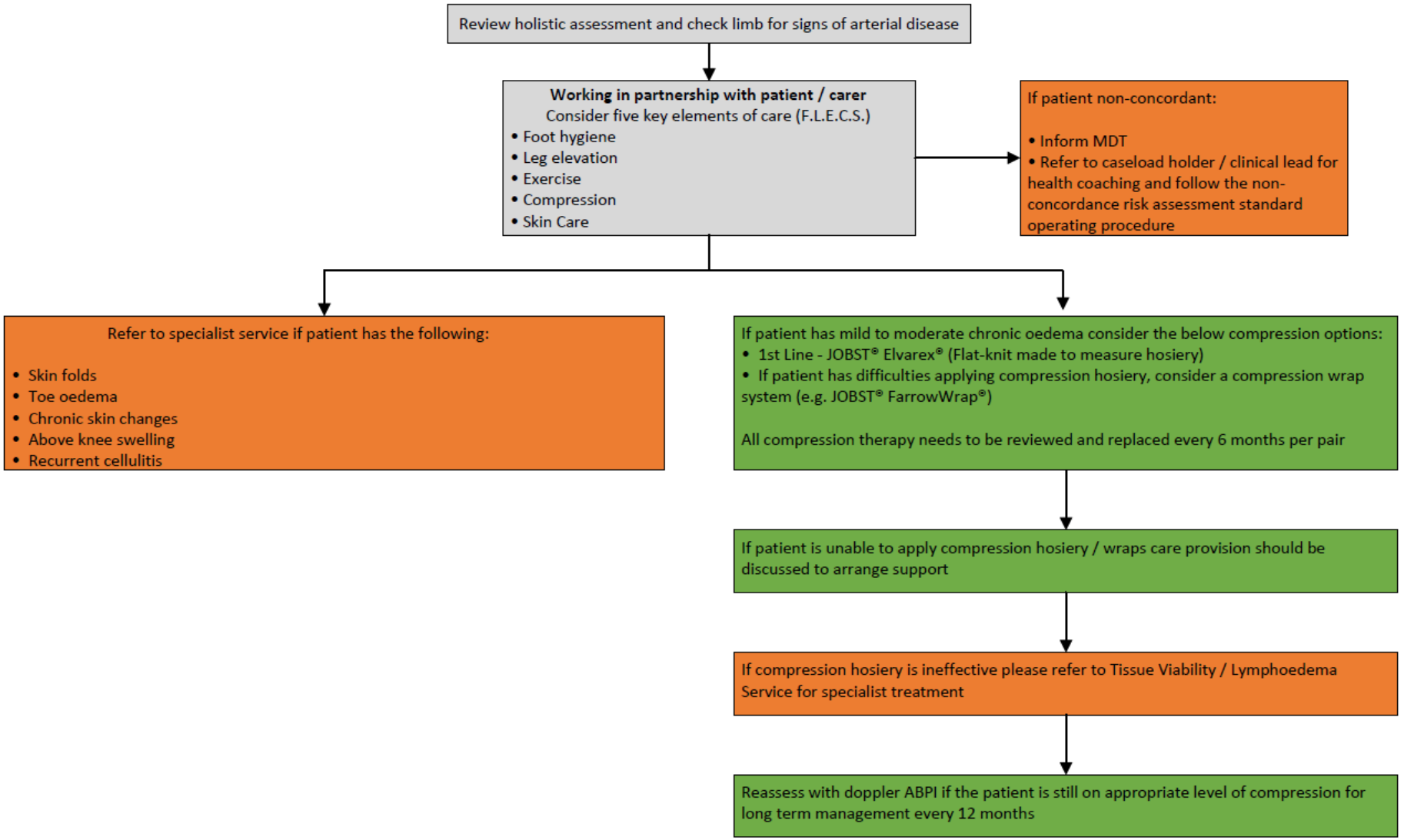
Pathway 2 - Leg Ulcer Management



Pathway 3 - Chronic Oedema & Wet Leg Management



Pathway 4 - Chronic Oedema Ongoing Management



Recommended Limb Care Plan for Patients and Carers

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Care plan agreed	Care plan agreed	Care plan agreed	Care plan agreed	Care plan agreed

Foot Hygiene-
Areas for consideration

- Washing and drying between toes
- Moisturise dry / cracking skin especially heels
- Good nail care
- Monitor / treat Athlete's foot
- Good supportive foot wear

Leg Elevation-

- Avoid long periods with legs down
- Sit with legs elevated
- Consider lying down on the bed for short period during the day
- Sleep in bed at night

Exercise-

- Regularly completing agreed workout plan
- Aim for healthy weight
- See reverse for exercises

Compression-

- Wear hosiery daily
- Wash hosiery daily
- Wear current hosiery
- Try not to wear hosiery immediately after moisturising
- Follow care instructions

Skin Care-

- Wash skin with non-scented product
- Use moisturiser daily and at night if possible
- Monitor skin changes i.e. increased redness, swelling

- For more advice about skin contact your district nurse team
- For any other problems seek medical advice from your GP

NHS no:_____ Address:_____ Signed:_____

Name:_____ _____ Print:_____

DoB:_____ _____ Date given to care provider / family:_____

On discharge from the Community Nursing Service

About your Doppler	About your current compression garment - (hosiery/wrap)	About replacing your compression garment (hosiery/wrap)
Date of Doppler_____ ABPI R leg_____ ABPI L leg_____ Sounds: Monophasic / Biphasic / Triphasic Do you need a future doppler appointment? No ☐ Yes ☐ Your repeat doppler is due_____ Please contact your GP practice to make an appointment to see your practice nurse to perform this test. If you have any concerns regarding your legs or any other changes in health status, please contact your GP surgery.	Hosiery Wrap system/Foot piece Other PIP Code Style (below knee/Tights etc) Colour Closed or open toe Size Length Make/ Brand Round Knit/ Flat Knit Number of boxes Off the Shelf/Made to measure Additional extras i.e. Silicone grip top, Zipper Lymphodema/Chronic Oedema garments	• IT IS YOUR RESPONSIBILITY TO ENSURE YOU OBTAIN YOUR HOSIERY PRESCRIPTION FROM YOUR GP OR PHARMACIST WHEN DUE FOR RENEWAL. • Please follow the manufacturer's instructions on when to replace and general care of your compression garment. • You may need to see your practice nurse for a leg assessment before you renew your garment if your health status has changed. • Your legs are now healed but it will take time for your skin and muscles to regain strength. • Often wounds reoccur in the first 3 months following healing, especially if you stop wearing your hosiery at any point. • Please continue to look after your legs and wear your prescribed compression garment. • You will need to wear your hosiery for the rest of your life unless told otherwise by a health care professional.

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Version: 1

HEAD TO TOE CHARITY

CPFT supports the Head to Toe Charity. Visit www.cpft.nhs.uk/ourcharity for details on how you can help

Dressing Criteria

- Remove excess exudate and toxic components
- Maintain high humidity at wound dressing interface
- Allows gaseous exchange
- Provide thermal insulation
- Impermeable to micro-organisms
- Free from Toxic contaminants
- Removable without causing trauma
- Non-adherent
- Impermeable to bacteria
- Acceptable to patient
- Capable of maintaining a high humidity at the wound site while removing excess exudate
- Thermally insulating
- Non-toxic and non-allergenic
- Comfortable and conformable
- Capable of protecting the wound from further trauma
- Requires infrequent dressing changes
- Cost effective
- Long shelf-life
- Available both in hospital and in the community

Characteristics of the ideal wound dressing (Bryant R, Nix D, 2023)

Formulary Green: Can be prescribed in both secondary and primary care. Not to be prescribed on FP10 - to be issued via NHS Supply Chain

Formulary Choices

Dressings for both primary and secondary care use

Absorbent Pad: Use for absorption moderate to high exudate.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Xupad	10cm × 12cm	EJA092	205012	Pack of 25
Xupad	10cm × 20cm	EJA093	205020	Pack of 25
Xupad	20cm × 20cm	EJA094	205030	Pack of 15
Xupad	20cm × 40cm	EJA095	205040	Pack of 8

Superabsorbent Pad: Use for absorption of high to very high exudate.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Drymax Blue (Backed)	10cm x 10cm	EJA290	F60093/10	Pack of 10
Drymax Blue (Backed)	10cm x 20cm	EJA284	F60095/10	Pack of 10
Drymax Blue (Backed)	20cm x 30cm	EJA289	F60097/10	Pack of 10
Kerramax Care (Non-Backed)	10cm x 10cm	EME045	PRD500-050	Pack of 10
Kerramax Care (Non-Backed)	10cm x 22cm	EME023	PRD500-120	Pack of 10
Kerramax Care (Non-Backed)	20cm x 30cm	EME131	PRD500-380-B10	Pack of 10

Foam Adhesive: Use to absorb moderate to high exudate. Use to protect and pad vulnerable areas. Use with caution on fragile skin.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Tegaderm Foam Adhesive (Oval)	10cm × 11cm (pad 6cm × 7.6cm + 1.7cm – 2cm border)	ELA177	90611	Pack of 10
Tegaderm Foam Adhesive (Oval)	14cm × 15cm (pad 10cm × 11cm + 2cm border)	ELA178	90613	Pack of 4

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Silicone Foam Adhesive: Use to absorb moderate to high exudate. Use to protect and pad vulnerable areas. Suitable for use on fragile skin.

Dressing	Size	NPC code	Supplier Code	Unit Issue
UrgoTul Absorb Border	8cm x 8cm (wcp 4.5cm x 4.5cm)	ELA660	550866	Pack of 10
UrgoTul Absorb Border	10cm x 10cm (wcp 5.9cm x 5.9cm)	ELA661	551014	Pack of 10
UrgoTul Absorb Border	13cm x 13cm (wcp 8.4cm x 8.3cm	ELA662	550867	Pack of 10
UrgoTul Absorb Border	15cm x 20cm (wcp 9.7cm x 14.7cm)	ELA663	550868	Pack of 10
UrgoTul Absorb Border	20cm x 20cm (wcp 14.3cm x 12.6cm) (sacral)	ELA664	552852	Pack of 5

Foam Non-Adhesive: Use to absorb moderate to high exudate. Use to protect and pad vulnerable areas. CUHFT preferred brand is **Tegaderm Foam**. patients in Primary Care may be switched to equivalent size of ACTIVHEAL FOAM.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Activheal Foam (Non-Adhesive)	5cm × 5cm	ELA214	10009113	Pack of 10
Activheal Foam (Non-Adhesive)	10cm × 10cm	ELA216	10009115	Pack of 10
Activheal Foam (Non-Adhesive)	20cm × 10cm	ELA246	10009116	Pack of 10

Hydrocolloid – Thin: Use for protection of vulnerable skin under devices. Use to secure other dressings / packing. **Do not use on moisture associated skin damage**. Use on superficial wounds where absorbency not required.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Duoderm (Extra Thin Film)	5cm × 10cm	ELM317	S163	Pack of 10
Duoderm (Extra Thin Film)	7.5cm × 7.5cm	ELM311	S160	Pack of 10
Duoderm (Extra Thin Film)	10cm × 10cm	ELM050	S161	Pack of 10
Duoderm (Extra Thin Film)	15cm × 15cm	ELM051	S162	Pack of 10

Formulary Green: Can be prescribed in both secondary and primary care. Not to be prescribed on FP10 - to be issued via NHS Supply Chain

Hydrocolloid – Standard: Use for debridement of slough/ necrosis where clinically indicated. Use as protection of vulnerable skin under devices. **Do not use on moisture associated skin damage**. Use to secure other dressings/ packing.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Granuflex (Modified)	10cm × 10cm	ELM141	S150	Pack of 10
Granuflex (Bordered)	6cm x 6cm square (wcp 6cm x 6cm overall dressing 10cm x 10cm)	ELM151	S155	Pack of 5
Granuflex (Bordered)	10cm x 10cm square (wcp 10cm x 10cm overall dressing 14cm x 14cm)	ELM053	S156	Pack of 10
Granuflex (Bordered)	15cm x 15cm square (wcp 15cm x 15cm overall dressing 20cm x 20cm)	ELM155	S157	Pack of 5

Hydrofibre: Use on wounds with moderate to high exudate. Useful for cavities or uneven spaces. Can adhere if wound is too dry.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Aquacel Extra	5cm × 5cm	ELY377	420671	Pack of 10
Aquacel Extra	10cm × 10cm	ELY378	420672	Pack of 10
Aquacel Ribbon	1cm × 45cm	ELY368	420127	Pack of 5
Aquacel Ribbon	2cm × 45cm	ELY013	S7503	Pack of 5

Alginate: Haemostatic. Use to control mild-moderate bleeding.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Kaltostat	5cm × 5cm	ELS229	1004	Pack of 10

Hydrogel: Use to rehydrate dry slough and necrosis to aid debridement.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Activheal Gel	8g	ELA639	10011131	Pack of 10

Formulary Green: Can be prescribed in both secondary and primary care. Not to be prescribed on FP10 - to be issued via NHS Supply Chain

Non-Occlusive Island Dressing: Use on post-surgical wounds after 48 hours for protection. Useful for securing other dressings where occlusion is not required. **Do not use on fragile skin**.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Cosmopor E	5cm × 7.2cm	EIJ038	900870	Pack of 50
Cosmopor E	8cm × 10cm	EIJ039	900873	Pack of 50
Cosmopor E	8cm × 15cm	EIJ040	900874	Pack of 50
Cosmopor E	10cm × 20cm	EIJ041	900876	Pack of 50

Non-Adherent Wound: Contact Layer (Non-Silicone): Use on superficial wounds to protect and line. Can be used under topical negative pressure foam to protect vulnerable tissue.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Atrauman	5cm × 5cm	EKA024	499550	Pack of 50
Atrauman	7.5cm × 10cm	EKA032	499553	Pack of 50
Atrauman	10cm × 20cm	EKA036	499536	Pack of 30
Atrauman	20cm × 30cm	EKA016	499515	Pack of 10

Semi-Permeable Film: Use to secure other dressings. Use to protect superficial wounds and vulnerable areas.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Tegaderm	6cm × 7cm	ELW211	1624W	Pack of 100
Tegaderm	10cm × 12cm	ELW213	1626W	Pack of 50
Tegaderm	10cm × 25cm	ElW215	1627	Pack of 20
Tegaderm	20cm × 30cm	ELW219	1629	Pack of 10

Formulary Green: Can be prescribed in both secondary and primary care. Not to be prescribed on FP10 - to be issued via NHS Supply Chain

Postoperative Dressings: Use on post-surgical wounds immediately after surgery and for first 48 hours. Useful for securing other dressings. Use for protecting superficial wounds.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Rocialle	5cm x 7cm (wcp 2.5cm x 4cm)	ELW1079	537690ZD	Pack of 50
Rocialle	10cm x 10cm (wcp 5cm x 5cm)	ELW1077	537691ZD	Pack of 50

Bacterial Control: Use according to antibacterial guidelines

Anti-microbial - iodine: Use on infected superficial wounds. Useful for drying ischaemia areas, diabetic foot wounds.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Inadine	5cm × 5cm	EKB501	P01481	Pack of 25
Inadine	10cm × 10cm	EKB095	P01491	Pack of 10
Iodoflex Iodine Paste	5g tube	EKB007	66001301	Pack of 5

Anti-microbial - honey: Use on infected wounds. Useful for debridement and for stimulating healing in static wounds. Liquid honey can be used into sinuses/ tracts.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Activon Tulle	5cm × 5cm	EJE027	CR3761	Pack of 5
Activon Tulle	10cm × 10cm	EJE028	CR3658	Pack of 5
Activon Manuka Honey	20g tube	ELY864	CR4493	Pack of 12

Formulary Green: Can be prescribed in both secondary and primary care. Not to be prescribed on FP10 - to be issued via NHS Supply Chain

Anti-microbial - silver: Use on infected, moderate to high exudate, sloughy wounds. If not effective, **stop**, remove dressing and change to alternative.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Silvercel	11cm × 11cm	ELS150	CAD011	Pack of 10
Silvercel	5cm × 5cm	ELS149	CAD050	Pack of 10

Antimicrobial - DACC technology: Binds and removes bacteria and fungi from wounds in the presence of moisture using a physical mode of action without any chemical or pharmacological active ingredients.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Cutimed Sorbact Swab	4cm × 6cm	ELY212	72164-01	Pack of 5
Cutimed Sorbact Swab	7cm × 9cm	ELY213	72165-01	Pack of 5
Cutimed Sorbact Ribbon	2cm × 50cm	ELY218	72166-00	Pack of 20

Paste Bandages: Used for managing wet legs and varicose eczema. **CUHFT: Specialist Nurses only.**

Dressing	Size	NPC code	Supplier Code	Unit Issue
Ichthopaste	7.5cm × 6m	EFA051	4959	Each
Viscopaste	7.5cm × 6m	EFA011	4948	Each

Formulary Green: Can be prescribed in both secondary and primary care. Not to be prescribed on FP10 - to be issued via NHS Supply Chain

Dressing Retention

K-Band: Use to support dressings in place, not a compression bandage.

Dressing	Size	NPC code	Supplier Code	Unit Issue
K-Band	5cm × 4m	EDB034	810540	Pack of 3
K-Band	7cm × 4m	EDB035	810740	Pack of 20
K-Band	10cm × 4m	EDB039	811040	Pack of 20

Clinifast and Comfifast: Used to secure other dressings. Lining limbs beneath other bandaging

Dressing	Size	NPC code	Supplier Code	Unit Issue
Clinifast (Red)	3.5cm × 10m	EGP018	BA0405/B	Each
Clinifast (Green)	5cm × 10m	EGP019	BA0421/B	Each
Comfifast (Blue)	7.5cm × 10m	EGP007	F35	Each
Comfifast (Yellow)	10.75cm × 10m	EGP008	F45	Each
Comfifast (Beige)	17.5cm x 10m	EGP009	F55	Each

Barrier Cream and Film

Used to protect skin from effects of moisture. Barrier film can be used to treat superficial moisture associated skin damage.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Cavilon Barrier Film Foam Applicator No Sting Sterile	1ml	ELY038	3343E	Pack of 25
Medi Derma-S Barrier Film Foam Applicator No Sting Sterile	1ml	ELY532	MB61076	Pack of 5
Medi Derma-S Barrier Cream Non-Sterile	2g sachet	ELY536	60338	Pack of 20
Sorbaderm Barrier Cream Non-Sterile	2g sachet	ELY346	A-3026	Pack of 20

Formulary Green: Can be prescribed in both secondary and primary care. Not to be prescribed on FP10 - to be issued via NHS Supply Chain

Multilayer Bandages

Use for securing other dressings. Use for padding under K-Lite.

Dressing	Size	NPC code	Supplier Code	Unit Issue
K-Four K-Soft (Layer #1)	10cm × 3.5m	EPA028	761035	Pack of 24

Use for securing other dressings. Toe to knee for support of lower limb.

Dressing	Size	NPC code	Supplier Code	Unit Issue
K-Four K-Lite (Layer #2)	5cm × 4.5cm	ECA084	770545	Pack of 16
K-Four K-Lite (Layer #2)	10cm × 4.5m	ECA100	771045	Pack of 16

Long Stretch Compression – used for the management of lower limb oedema and venous leg ulceration. **CUHFT: Specialist Nurses Only.**

Dressing	Size	NPC code	Supplier Code	Unit Issue
K-Four K-Plus (Layer #3)	10cm × 8.7m	ECA162	781087	Pack of 24
K-Four Ko-Flex (Layer #4)	10cm × 6m	ECD018	791060	Pack of 18

Please note the KFOUR 4 LAYER BANDAGE SYSTEM will be discontinued as soon as the new UrgoKTwo compression system is introduced, and staff are trained to use the UrgoKTwo compression system. However, only the KPLUS and the KOFLEX layers will be discontinued. The KSOFT and KLITE will continue to be used in safe soft bandaging as they are currently in practice.

Formulary Green: Can be prescribed in both secondary and primary care. Not to be prescribed on FP10 - to be issued via NHS Supply Chain

Multi-component Compression Bandaging Kit, Two Layer System:

The UrgoKTwo compression system should only be applied if the clinician has completed the 2-day leg ulcer course, attended the theory and practical session on the application of UrgoKTwo multicomponent bandages and completed competency document for the new system.

UrgoKTwo (40mmHg): Use for the treatment in adults, of venous leg ulcers with a regular limb shape where strong compression therapy is recommended. Latex free formulations are also available.

UrgoKTwo Reduced (20mmHg): Use for the treatment in adults, of venous or mixed leg ulcers with a regular limb shape where moderate compression is recommended. Latex free formulations are also available.

Dressing (Ankle Circumference)	Size	NPC code	Supplier Code	Unit Issue
UrgoKTwo (18-25cm)	10cm	ECA152	506653	Each
UrgoKTwo (18-25cm)	8cm	ECA385	586653	Each
UrgoKTwo (18-25cm)	12cm	ECA387	526653	Each
UrgoKTwo (25 to 32cm)	10cm	ECA164	506666	Each
UrgoKTwo (25 to 32cm)	8cm	ECA386	586666	Each
UrgoKTwo (25 to 32cm)	12cm	ECA388	526666	Each
UrgoKTwo **Latex free** (18-25cm)	10cm	ECA236	516653	Each
UrgoKTwo **Latex free** (25 to 32cm)	10cm	ECA237	516666	Each
UrgoKTwo **Reduced** (18-25cm)	10cm	ECA205	596653	Each
UrgoKTwo **Reduced** (25 to 32cm)	10cm	ECA206	596666	Each
UrgoKTwo **Reduced Latex free (**18-25cm)	10cm	ECA234	576653	Each
UrgoKTwo **Reduced Latex free** (25 to 32cm)	10cm	ECA235	576666	Each

Formulary Green: Can be prescribed in both secondary and primary care. Not to be prescribed on FP10 - to be issued via NHS Supply Chain

Short Stretch Compression: Use for the management of limb oedema and venous leg ulceration. **CUHFT: Specialist Nurses Only.**

Dressing	Size	NPC code	Supplier Code	Unit Issue
Actico Activa	4cm × 6m	EBA030	88307	Each
Actico Activa	6cm × 6m	EBA031	88308	Each
Actico Activa	8cm × 6m	EBA032	88309	Each
Actico Activa	10cm × 6m	EBA016	88310	Each
Actico Activa	12cm × 6m	EBA033	88311	Each

Adhesive Surgical Tape: Use for securing bandages and supporting devices.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Clinipore	1.25cm × 10m	EHU019	AT3068/B	Pack of 24
Micropore	2.5cm × 9.14m	EHU006	1530-1	Pack of 12
Clinipore	5cm × 10m	EHU021	AT3078/B	Pack of 6

Contact Layer Silicone: To be used on superficial wounds to protect and line. Can be used to bring edges of skin tears together. Can be used under topical negative pressure to protect vulnerable tissue. Useful for use on fragile skin

Dressing	Size	NPC code	Supplier Code	Unit Issue
Silflex	5cm × 7cm	EKH028	CR3922	Pack of 10
Silflex	8cm × 10cm	EKH029	CR3923	Pack of 10
Silflex	12cm × 15cm	EKH030	CR3924	Pack of 10
Silflex	20cm × 30cm	EKH032	CR3925	Pack of 10

Miscellaneous

Non-Woven Swabs - Used for the cleansing of wounds.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Unisurge	10cm × 10cm	ENK132	F821034	Pack of 25

Formulary Green: Can be prescribed in both secondary and primary care. Not to be prescribed on FP10 - to be issued via NHS Supply Chain

Steri-strip - For surgical wounds if needed after removing sutures. Can be use for securing packing in wounds if needed. Not to be used for skin tears.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Steri-strip	3mm x 75mm	EIR203	R1540	Pack of 200

Normasol - Used for the cleansing of wounds.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Normasol	25ml	MRB358	99766774	Pack of 25

Softdrape Dressing Pack Vitrex - Latex free pack contains sterile woundcare 1 x propylene tray (12cmx10cmx2.5cm) to accommodate all components with 1 x pair examination gloves.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Softdrape Dressing Pack Vitrex	Small	EJA045	908810	Pack of 20
Softdrape Dressing Pack Vitrex	Medium	EJA046	908820	Pack of 20
Softdrape Dressing Pack Vitrex	Large	EJA047	908830	Pack of 20

RESTRICTED – ADVICE: Primary Care initiation only under the guidance of a TVN/Secondary Care. Not to be prescribed on FP10 - to be issued via NHS Supply Chain

Silicone Dressings: To be used on superficial wounds to protect and line. Can be used to bring edges of skin tears together. Can be used under topical negative pressure to protect vulnerable tissue. Useful for use on fragile and sensitive skin.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Mepitel	5cm × 7cm	EKH002	290500	Pack of 5
Mepitel	8cm × 10cm	EKH003	290700	Pack of 5

Protease Modulator Dressing: Useful for venous leg ulcers, diabetic foot ulcers (podiatry) and static hard to heal wounds.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Urgostart Plus Pad	6cm × 6cm	ELZ884	552301	Pack of 10
Urgostart Plus Pad	10cm × 10cm	ELZ885	552302	Pack of 10
Urgostart Plus Pad	15cm × 20cm	ELZ886	552305	Pack of 10

Specialist Woundcare Antimicrobial Gel

Dressing	Size	NPC code	Supplier Code	Unit Issue
Flaminal Hydro - For Low to Moderately Exudating Wounds	15g	ELG021	1013-U (BLUEHYDRO)	Box of 5
Flaminal Forte - For High to Moderately Exudating Wounds	15g	ELG022	1012-U (YELLOWFORTE)	Box of 5

RESTRICTED- To be issued directly by the Specialist Team in Hospital or community TVNs (via NHS supply chain). Not to be prescribed in Primary Care. Contact the Medicines Optimisation Team for further support.

Silicone Foam Adhesive: **CUHFT: Specialist Nurses Only.** Use to absorb moderate to high exudate. Use to protect and pad vulnerable areas**.** Patients in Primary Care may be switched to equivalent size of UrgoTul Absorb Border.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Allevyn Life	5.5cm × 5.5cm	ELA1132	66801747	Pack of 10
Allevyn Life	10.5cm × 10.5cm	ELA1117	66801748	Pack of 10
Allevyn Life	16cm × 16cm	ELA1118	66801749	Pack of 10
Allevyn Life	10cm × 20cm	ELA1119	66801751	Pack of 10

Gel (Sheets): Use to rehydrate dry wounds. Use to follow skin tear protocol. Useful in painful wounds, minor burns.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Kerralite Cool	6cm x 6cm	EME081	CWL1004	Pack of 5
Kerralite Cool	12cm × 8.5cm	EME082	CWL1005	Pack of 5
Kerralite Cool	18 × 12.5cm	EME083	CWL1006	Pack of 5
Kerralite Cool Border	8cm × 8cm	EME084	CWL1007	Pack of 5
Kerralite Cool Border	11cm × 11cm	EME085	CWL1008	Pack of 5

Contact Layer Antimicrobial: Use on superficial infected wounds, tissue viability, plastics, vascular and dermatology advice only.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Acticoat	10cm × 10cm	ELY071	66000791	Pack of 12
Acticoat	5cm × 5cm	ELY141	66000808	Pack of 5

RESTRICTED- To be issued directly by the Specialist Team in Hospital or community TVNs (via NHS supply chain). Not to be prescribed in Primary Care. Contact the Medicines Optimisation Team for further support.

Skin Protectants

Medi-Honey Barrier Cream: Helps to reduce inflammation, prevent maceration, excoriation and irritation resulting from effects of moisture on the skin.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Medi-Honey Barrier Cream	2g sachet	ELY374	800	Pack of 20

Cavilon Advanced Liquid Skin Protectant Sterile: Use for severe cases of moisture associated skin damage.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Cavilon Advanced Liquid Skin Protectant Sterile	2.7ml	ELY985	5050G	Pack of 20

Medi-Derma - Use for moisture-associated skin damage on both intact and injured skin.

Dressing	Size	NPC code	Supplier Code	Unit Issue
Medi Derma-Pro Foam & Spray Cleanser	250ml	ELY608	63582	Each
Medi Derma-Pro skin protectant ointment tube	115g	ELY607	63605	Each

References

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Further Resources

- Wounds UK
- World Wide Wounds
- European Wound Management Association

Document ratification details

Ratification Process	**Details**
Authored by:	Cambridgeshire Community Services NHS Trust Cambridgeshire and Peterborough NHS Foundation Trust Cambridgeshire and Peterborough Integrated Care Board Cambridge University Hospitals NHS Foundation Trust North West Anglia NHS Foundation Trust Royal Papworth Hospital NHS Foundation Trust
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