Wound Dressing Formulary and Guidance 2019/20

Written by Gill Wicks, Nurse Consultant Tissue Viability Lead
Formulary compiled by the Tissue Viability Team and the NSI Groups
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INTRODUCTION

These wound dressing recommendations consist of an agreed limited list of dressings with specific prescribing advice. These dressing recommendations are used throughout Wiltshire Health and Care LLP and NHS Wiltshire CCG including GP’s, Practice Nurses and Nursing Homes.

These wound dressing recommendations promote rational prescribing by encouraging the safe, effective, appropriate and economic use of dressing therapy.

Decisions about the use of a particular product were made after considering the efficacy, safety, patient acceptability and cost of the product or dressing. Treatment recommendations are selected on the grounds of current clinical opinion, clinical effectiveness, evaluation and current research including randomised controlled trials.

The product groups

- film dressings
- low adherent dressings
- low absorbent dressings
- alginates
- hydrogels
- gelling fibre dressings
- hydrocolloids
- foam dressings
- carbon dressings
- antibacterial dressings
- compression including bandaging and Velcro wrap systems

The information about each recommended product will include:

- classification
- name and manufacturer
- characteristics of the dressing
- indications for use
- method of application
- cautions
The dressings will refer to the wound types below. The wound types are explained fully in the Tissue Viability Wound Assessment and Management Policy 2019.

**Wound types**
- epithelialising
- granulating
- sloughy
- maturing
- necrotic
- infected
- fungating
- malodorous
- trauma

This information is issued on the understanding that the accuracy relates to the current available resources at the time of compilation. Please note that wound dressing products are often developed or altered by the manufacturers, therefore current product guides or instructions should be followed in all instances.

Any product to which the patient is known to be sensitive must not be used.

All products listed are available via NHS Supply Chain and FP10. All products are also available via Formeo for the Leg Ulcer team.

<table>
<thead>
<tr>
<th>It is fundamental that dressings with active pharmacies are not mixed, i.e. iodine and honey. This will alter the pharmacy and the practitioner will not know the exact pharmacy they are putting on the wound.</th>
</tr>
</thead>
<tbody>
<tr>
<td>To reduce costs, dressing stocks used by the nursing staff on community hospital wards and the community teams will be ordered from NHS Supplies.</td>
</tr>
<tr>
<td>All wound care products are single use only and any residual dressing must be disposed of. The only exceptions to this are honey in a tube and Flaminal Hydro and Forte. Honey can remain open for 7 days, Flaminal can be recapped and used until the expiry date.</td>
</tr>
</tbody>
</table>

2
<table>
<thead>
<tr>
<th>PRODUCT</th>
<th>DRESSINGS</th>
<th>STOCKED SIZES (cm)</th>
<th>GUIDANCE FOR USE AND COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocolloid Film Container</td>
<td>9x6, 9x11</td>
<td>Lightly exuding wounds to aid debridement and granulation. Caution with wearing or dressing that as an actuating dressing may encourage growth of aerobic bacteria. May cause maceration if wound is highly exuding. May cause overgranulation.</td>
<td></td>
</tr>
<tr>
<td>Inodine Tulle</td>
<td>3x4, 9x5x5</td>
<td>To keep dry necrotic tissue dry.</td>
<td></td>
</tr>
<tr>
<td>Hydrogel</td>
<td>Kerafool Cool (Non-Adhesive)</td>
<td>0.6x, 1.2x0.5</td>
<td>Hydrogel sheet. For hydration and debridement. Can be used on painful wounds, burn/taul, superficial wounds and wounds that require the removal of slough. Effective on skin tears and minor trauma wounds where there is no risk of infection.</td>
</tr>
<tr>
<td>Cleaning Devices</td>
<td>Prontosan Infection Rod</td>
<td>These can be used to gently clean skin around the wound and between toes. Reflective in the removal of hyperkeratin. May be used to clean a sloughy or necrotic wound. Not to be used on healthy granulating tissue.</td>
<td></td>
</tr>
</tbody>
</table>

**Biotherapy**


**Antimicrobial**

- Medichoney Tulle
- Medichoney Neutrofilm (Aptanone Tulle)
- Acrilone: For infected wounds and for debridement.
- Sialfene Non-Adherent: For infected wounds only. Neutrofilm dressing with an adhesive layer that is designed to bind bacteria under moist wound conditions. The dressing can be used folded or unfolded.
- Flaxinal Hydro: Flaxinal Fette: For treatment and removal of biofilms.

**Bleeding**

- Kalsiost: For bleeding wounds only as a haemostat.

**Cool**

- Charcoal Dressing: Carbonflex: 10x20, 10x25, 10x29. Absorbent carbon dressing for malodorous wounds. Can be used as a primary dressing (Carbonflex) or a secondary dressing (Clinisorb). Refer to exitus pathway for correct usage. Change at least weekly depending on indicator for change. Ensure correct removal technique is used (stretch and lift or wet swab). Shower and bath proof. Bacteria proof.
- Clinisorb: 10x20, 10x29. A non-adherent dressing. Apply directly to wound. Requires secondary dressing. For protection and wounds with a low amount of exudate.

**Arthroscopy**

- Foam Dressings: Allevyn Non-Adhesive: 3.6x7.5, 10x10, 12.5x12.5, 17.5x17.5. Allevyn Gentle Border: 5.2x7.5, 7.5x10, 15x12, 30x20, 30x30. Allevyn Life: 10.3x10, 12.5x12.5, 15x12.5, 15x20, 17.5x17.5, 20x20, 25x25. Tagadex foam adhesive: 6.9x6.9, 10x10, 14x14, 16x16, 16x20, 20x20. For difficult to dress areas or if wear time is an issue due to compliance. Waterproof. This is not first line use.
- High Absorbency: Kerallan Care: 5x5, 10x10, 10x12, 10x12, 10x20, 10x30, 20x20, 30x30. Kerallan Care Border: 10x24, 10x24, 16x24, 20x24. For highly exuding wounds and can be used under compression.

**Wound Contact Layer**

- Albynman: 3x3, 7x7, 8x10, 10x10, 10x15, 15x15. Apply directly to wound. Requires secondary dressing. For protection and wounds with a low amount of exudate.

**Vapour Permeable Film**

- Clear Film: Form, 5, 10, 20, 50. Form, 10, 20, 50, 100. Vapour permeable film. Lightly exuding fluid may accumulate under dressing. Can also be used as secondary dressing. May also be used as fixation for non-adhesive foams. Waterproof and bacteria proof.

**Barrier**

- Secura: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 20, 20, 30. Prevents maceration and general skin protection. Ensure correct application. One application lasts 72 hours DO NOT OVER APPLY.

**Emollients**

- Dressing Fracs: Nafrax: Contains: Apon, vinyl glove, bag, sleeve, grove w/polyurethane film and paper towel. Gloves in X, M.

**Type 1 retention Bandages**

- 1-Like (long): Dressing retention bandage. Knitted elastomer and viscose cotton polyamide bandage. For light support and dressing retention.

**Tubular Bandages**

- Chiffon: 7.5x10, 7.5x15, 17.5x10.

**Multi-layer Compression Bandages**

- K-20 [K]: For ankle circumference: 10-25cm, 15-35cm.
- K-20 Reduced [K]: 20cm, 25cm, 30cm, 35cm, 40cm, 45cm, 50cm, 55cm, 60cm.

**Veno Compression System**

- Actico: Short, Standard, Long. For venous and mixed venous leg sizes.
# Bacterial Burden Theranostic Tool

**Use these guidelines to:**
- To support clinical judgement in conjunction with relevant trust policies/protocols inc. infection control, wound formulary and wound management.
- Help determine if a wound is contaminated / colonised, critically colonised or infected.
- Note that high risk patients (including those with diabetes or compromised immune / circulatory systems) may not display the signs & symptoms of critical colonisation or infection described below and may present with more subtle signs.

<table>
<thead>
<tr>
<th>LOCAL SIGNS &amp; SYMPTOMS</th>
<th>Contamination &amp; Colonisation</th>
<th>Critical Colonisation</th>
<th>Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healing</td>
<td>Wound healing / progressing as expected</td>
<td>Healing has slowed / or stopped (non-progressing wound)</td>
<td>Healing compromised</td>
</tr>
<tr>
<td>Wet wound</td>
<td>Normal exudate for patient / wound type</td>
<td>Increased exudate</td>
<td>Copious / purulent exudate</td>
</tr>
<tr>
<td>Dry wound</td>
<td>Minimal or no exudate</td>
<td>Increased exudate</td>
<td>Wound exuding</td>
</tr>
<tr>
<td>Pain</td>
<td>No change</td>
<td>Increased / changed pain</td>
<td>Increased / changed pain</td>
</tr>
<tr>
<td>Erythema</td>
<td>Erythema not usually present ¹</td>
<td>Erythema not usually present ¹</td>
<td>Local Infection</td>
</tr>
<tr>
<td>Other factors</td>
<td>Also consider: abnormal/changed odour, discoloured/friable tissue, presence of necrotic or sloughy tissue, pocketing &amp; bridging</td>
<td></td>
<td>Systemic infection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SYSTEMIC SIGNS &amp; SYMPTOMS</th>
<th>Contamination &amp; Colonisation</th>
<th>Critical Colonisation</th>
<th>Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healing</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Wet wound</td>
<td>No</td>
<td>Chronic Wound (High risk patient)</td>
<td>No</td>
</tr>
<tr>
<td>Dry wound</td>
<td>No ²</td>
<td>Chronic Wound (High risk patient)</td>
<td>No ²</td>
</tr>
<tr>
<td>Pain</td>
<td>No change</td>
<td>Consider antibiotics</td>
<td>Yes</td>
</tr>
<tr>
<td>Erythema</td>
<td>Erythema not usually present ¹</td>
<td>Consider swabbing</td>
<td>Yes</td>
</tr>
<tr>
<td>Other factors</td>
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<tr>
<td>Systemic antibiotics</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Wound Swabs for M, C &amp; S</td>
<td>No ²</td>
<td>No ²</td>
<td>Yes</td>
</tr>
<tr>
<td>Standard formulary dressing</td>
<td>Antimicrobial dressing as per Trust Formulary</td>
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</table>

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<tr>
<th>Other Actions</th>
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<tbody>
<tr>
<td>• Treat / optimise co-existing morbidities</td>
</tr>
<tr>
<td>• Assess wound for critical colonisation/infection at every dressing change</td>
</tr>
<tr>
<td>• Debride sloughy/necrotic tissue ³</td>
</tr>
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<tr>
<td>• Consider referral to Tissue Viability</td>
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<tr>
<td>• Refer to surgeons if necrotising fasciitis suspected</td>
</tr>
<tr>
<td>• Refer to Tissue Viability</td>
</tr>
<tr>
<td>• Consider referral to microbiology</td>
</tr>
<tr>
<td>• Treat / optimise co-existing morbidities</td>
</tr>
</tbody>
</table>

¹ Some wounds (if chronic or < 72 hours old or) may have an erythematous border due to the inflammatory processes of wound healing; the erythematous border should be < 1cm
² Wound swabs: screen for MRSA as per trust policy
³ Keep lower limb wounds dry until assessed by a specialist (i.e. Tissue Viability, Diabetic Podiatry, Vascular Team etc.) – do not attempt to debride.
EXUDATE PATHWAY 2019/2020

ASSESS AND RECORD EXUDATE LEVEL

DRY
Little or no fluid on dressing

LOW
Low levels of exudate
No peri-wound maceration

MODERATE
Small amounts of fluid on wound dressing marked
Possible peri-wound skin maceration

WET/SATURATED
Excess fluid on wound dressing
Peri-wound skin maceration
Strike through on dressing

1 X WEEKLY DRESSING CHANGES

2-3 X WEEKLY DRESSING CHANGES

4-7 X WEEKLY DRESSING CHANGES

FOAMS SHOULD NOT BE USED MORE THAN 3 X PER WEEK

KerrLite Cool / Border
Allevyn Gentle Border
Allevyn Non-Adhesive

Allevyn Life

KerrMax Care / Border

Do not add additional moisture for artificially compromised patients until the blood supply has improved.

Protect peri-wound by using Secura.

Tegaderm Foam is available for awkward to dress places and for protection against incontinence.

KerrMax Care can be layered for extra absorbency and can be used under compression.

KerraCel should only be used on cavity wounds.

Consider NPWT Refer to TV if required.

For more information please contact the Tissue Viability Team on 01225 711351

SEE FORMULARY BOOKLET OR POSTER FOR PRODUCT SIZES
<table>
<thead>
<tr>
<th>Pressure Ulcer Category</th>
<th>Diagram</th>
<th>Picture</th>
<th>Definition</th>
<th>Required response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category I</strong></td>
<td><img src="image1.png" alt="Diagram" /></td>
<td><img src="image2.png" alt="Image" /></td>
<td>Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Dark pigmented skin may not have visible blanching; its colour may differ from the surrounding area</td>
<td>Review risk assessment. Check that pressure relief is appropriate. Rewrite care plan. Commence SSKIN bundle tool. Commence wound assessment and protect area with protective dressing. Monitor as this wound may deteriorate rapidly.</td>
</tr>
<tr>
<td><strong>Category II</strong></td>
<td><img src="image3.png" alt="Diagram" /></td>
<td><img src="image4.png" alt="Image" /></td>
<td>Partial thickness loss of dermis presenting as a shallow open ulcer. May also present as an intact or open / ruptured blister. This category should not be used to describe moisture associated skin damage, maceration or excoriation.</td>
<td>Review risk assessment. Check that pressure relief is appropriate. Rewrite care plan and commence a wound assessment. Report as IR1 stating the origins of the wound. Protect area with protective dressing. Monitor as this wound may deteriorate rapidly.</td>
</tr>
<tr>
<td><strong>Category III</strong></td>
<td><img src="image5.png" alt="Diagram" /></td>
<td><img src="image6.png" alt="Image" /></td>
<td>Full-thickness skin loss, bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.</td>
<td>Review risk assessment. Check that pressure relief is appropriate. Rewrite care plan. Report as IR1 stating the origins of the wound. Assess wound and dress appropriately. Refer to tissue viability service for verification and advice.</td>
</tr>
<tr>
<td><strong>Category IV</strong></td>
<td><img src="image7.png" alt="Diagram" /></td>
<td><img src="image8.png" alt="Image" /></td>
<td>Full thickness tissue loss with exposed bone, tendon and muscle. Slough or eschar may be present. Often including undermining and tunnelling.</td>
<td>Review risk assessment. Check that pressure relief is appropriate. Write care plan. Report as IR1 stating the origins of the wound. Assess wound and dress appropriately. Refer to tissue viability service for verification and advice.</td>
</tr>
<tr>
<td><strong>Suspected deep tissue injury</strong></td>
<td><img src="image9.png" alt="Diagram" /></td>
<td><img src="image10.png" alt="Image" /></td>
<td>This occurs when a patient has long term pressure damage to the skin and presents as a purple or maroon localised area of discoloured intact skin. If this breaks down then the deterioration to a deep pressure ulcer may be rapid, even with optimal treatment.</td>
<td>Review risk assessment. Check that pressure relief is appropriate. Write care plan. Monitor carefully as this could rapidly deteriorate. Refer to tissue viability service for verification and advice.</td>
</tr>
</tbody>
</table>
INFECTION PATHWAY

INFECTED WOUNDS

First Line Honey

- Medihoney Tulle, Medihoney Alginate (Apinate) and Activon Honey in a tube.

Other Choices

- Silvercel, Iodoflex, Cutimed Sorbact, Prontosan Gel X, Prontosan Liquid

Odour Management

- Carboflex (primary dressing) or Clinisorb (secondary dressing)

Please refer to the antimicrobial section of the Formulary.

Please contact the Tissue Viability team if concerned about a wound’s complexity.
These guidelines are secondary to establishing and addressing the cause of the moisture associated skin damage/excoriation.

**Healthy Skin**
- Patient has incontinence; healthy, intact skin; no erythema.

**Prophylaxis:**
- Use non-soap cleanser or soap substitute to cleanse skin.
- Secura D barrier cream/Aproderm (FP10).
- Replace pads etc. as soon as they become wet/soiled.
- Establish and address the cause of the incontinence.

**Moist Skin**
- Skin is moist; erythematous areas; no broken areas.

**Excoriation:**
- Use Dermol 500 after every episode of incontinence.
- Apply Secura D/Aproderm barrier cream or Medihoney barrier cream after every episode of incontinence.

**Broken**
- Skin is wet; spreading, erythematous rash; up to 50% of affected skin broken; oozing/bleeding may be present.

**Ulceration:**
- Consider faecal management system/urinary catheter.
- Use Proshield cleanser/Proshield Plus.
- If fungal infection present use Timodine and apply:
  - 1-2 times daily for 1 week only.
  - Generously to cleansed skin.
  - 2 finger-tips worth to each buttock.
  - Consider referral to Continence Service.

**Extensive Erythema**
- More than 50% skin is broken (moisture lesions); oozing and/or bleeding may be present.

**No response to treatment:**
- Refer to Tissue Viability.
- Consider faecal management system/urinary catheter.

Reference: IAD Protocol, Royal United Hospital with thanks.
THINK Tissue Viability Specialist Nurse

This assessment tool is intended to provide community staff with guidance as to when a patient should be referred to the Tissue Viability Department. Staff should use the tool combined with their clinical judgement.

ALWAYS REFER

- All patients with Category III and IV pressure ulcers for verification.
- All patients with complex surgical wound dehiscence.
- All patients with Cellulitis/infected wounds not responding to treatment.
- Patients with wounds requiring Negative Pressure Wound Therapy (NPWT) (unless under the care of podiatry).
- Complex wound care advice/support.
- Complex hospital discharges associated with wounds e.g. NPWT.
- Specific Tissue Viability educational requirements.
- Any patients where the clinician has concerns regarding the assessment, diagnosis, management, healing progress or deterioration of a wound.

N.B. Please ensure patients with Diabetes and foot wounds are referred to the Diabetic Podiatrist.

SOMETIMES REFER

- Patients with Category II pressure ulcers that are not responding to usual management.
- Patients with non-complex wounds with delayed healing or deterioration.
- Patients with Moisture Associated Skin Damage (MASD) that is not responding to usual management.
- Patients with highly exuding wounds for management advice.
- Patients with painful wounds which are not responding to analgesia.
- Patients with wounds requiring larvae therapy if support is required.

N.B. Please ensure patients with Diabetes and foot wounds are referred to the Diabetic Podiatrist.

RARELY REFER

- Patients with Category I and II pressure ulcers which are healing.
- General wound care advice – use NSI’s/refer to Tissue Viability policies.
**THINK Lymphoedema Specialist Nurse**

This assessment tool is intended to provide community staff with guidance as to when a patient should be referred to the Lymphoedema Service. Staff should use the tool combined with their clinical judgement.

**ILF Best Practice Stages of Chronic Oedema/Lymphoedema**

**Stage 0** A sub-clinical stage where swelling is not evident despite impaired lymph transport. This stage may exist for months or years before oedema becomes evident. No swelling present.

**Stage I** This represents early onset of the condition where there is accumulation of tissue fluid that subsides with elevation. The oedema may be pitting at this stage. Less than 20% swelling and usually none or very early skin changes may be present.

**Stage II** Limb elevation alone rarely reduces swelling and pitting is manifest. Less than 20% swelling (mild) or between 20-40% swelling (mild to moderate). Skin changes of chronic inflammation may be present, Cellulitis or Hyperkeratosis.

**Late Stage II** There may or may not be pitting present with tissue fibrosis more evident. Maybe moderate swelling 20-40%, or more than 40% (severe). Usually accompanied by skin changes and infections.

**Stage III** The tissue is hard (fibrotic) and pitting is absent. Skin changes such as thickening, hyperpigmentation, increased skin folds; fat deposits and warty overgrowths develop. Swelling is over 40% (severe). The term ‘elephantiasis’ is commonly used with this stage of Lymphoedema.

---

**For guidance on the management of patients with Chronic Oedema/Lymphoedema please refer to the Lower Limb Management Pathway**

---

**ALWAYS REFER**

- Late Stage II and Stage III patients who have no interventions in place or whose condition has deteriorated.
- All patients showing signs of complications with Chronic Oedema e.g. skin changes, wet legs, Hyperkeratosis.
- Patients with wet legs/leg ulcers that have not responded to treatment.
- All patients with Chronic Oedema and Cellulitis that have had more than 2 episodes in a year.
- Complex hospital discharges associated with Chronic Oedema.
- Specific Lymphoedema educational requirements.
- Any patients where the clinician has concerns regarding the assessment, diagnosis, management of patients with Chronic Oedema/Lymphoedema.

N.B. Please note patients that have had repeat episodes of Cellulitis with Chronic Oedema please seek advice from the Lymphoedema Service.

---

**SOMETIMES REFER**

- Patients with Stage I and II Chronic Oedema and not responding to usual management.
- Patients with Stage I and II Chronic Oedema that have had repeat episodes of Cellulitis.
- Patients who need compression garments that are not on the Hosiery Formulary or who are difficult to measure.

---

**RARELY REFER**

- Patients with very mild Oedema Stage 0 or I.
- Arterial complications.
- General Oedema advice – use NSI's.
Consider Wave Forms

- Triphasic – healthy signal
- Biphasic – reduced signal
- Monophasic – unhealthy signal

Clinical Presentation

0.6 and below
Arterial

- Rest pain
- Hairless limb, thickened nail growth
- Gangrene
- Threatened Limb
- Critical Ischaemia

0.6 - 0.8
Mixed aetiology

- Non healing ulcer
- Limb pain
- Claudication
- May have venous signs and arterial signs.
- Recurrent infection

0.8 - 1.4
Venous

- Warm limb, good pulses,
- Skin changes i.e. Haemosidrin staining or Lipodermatosclerosis
- Varicose veins
- Varicose eczema

> 1.4
Possible diabetes

Elevated reading:
Has the patient rested?
Consider elevated readings due to Diabetes or Arteriosclerosis.

DO NOT COMPRESS
Refer to Vascular Studies

Ankle Brachial Pressure Index
Lower Limb Management Pathway

Does your patient have swelling in their legs?

No

Venous Leg

Has it been present for less than 12 weeks?

Mild Venous Oedema

Yes

Has it been present for more than 12 weeks?

Chronic Oedema

Does your patient have 1 or more of the following:

- Doppler - ABPI = 0.8 - 1.4 and completion of vascular assessment document
- No skin folds
- No Oedema in toes & feet
- Normal leg shape
- Skin changes i.e. Haemosiderin staining as in the picture above

Management

- Skin care (see Lower Limb Skin Care Formulary)
- Leg washes as per protocol and emollient therapy
- Compression hosiery (please refer to Formulary)

Does your patient have a leg ulcer?

IF YES – SEE REVERSE

Does your patient have 1 or more of the following:

- Pitting Oedema
- Stage I or II Lymphoedema
- Doppler - ABPI = 0.8 - 1.4
- Oedema is reduced by elevation at times
- No skin folds
- Mild Oedema in toes & feet
- Normal leg shape
- Mild skin changes i.e. Lipodermatosclerosis

Management

- Skin care (see Lower Limb Skin Care Formulary)
- Leg washes as per protocol and emollient therapy
- Compression hosiery (consider Actico, asover leaf, to reduce Oedema first)
- If complex or concerning, refer to the Lymphoedema service

Refer to WH&C Community Lymphoedema Service

The patient’s management will be joint care working, supported by the Community Lymphoedema service

Does your patient have a leg ulcer/wet leg(s)?

IF YES – SEE REVERSE
Lower Limb Management Pathway

Assess all patients clinical history e.g. Venous Leg Ulcers, Cellulitis, DVT, Surgery, Trauma, family history

Leg Ulcer without Oedema

Venous Leg Ulcer

- Doppler - ABPI = 0.8 - 1.4 and completion of vascular assessment document
- No skin folds
- No Oedema in toes & feet
- Normal leg shape

Management
- Skin care
- Leg washes as per protocol
- Ointment, emollient or cream
- Wound care – as per care plan/Formulary
- Compression

Options:
- K2 application
- Jobst Ulcer Kit
- Juxtaures
- K2 reduced ONLY indicated for those patients with mixed aetiology, (ABPI 0.5 – 0.8) with Tri-Phase signals, Patients with Diabetes or Rheumatoid Arthritis.
- Patients with BMI > 30 consider Actico 10cm toe to knee

Leg Ulcer/Wet Legs with Oedema

- Pitting & non-pitting Oedema
- Stage I or II Lymphoedema
- Doppler - ABPI = 0.8 - 1.4
- Oedema settles at elevation at times
- No skin folds
- Oedema in toes & feet
- Normal leg shape
- Mild skin changes

Management
- Skin care
- Leg washes as per protocol
- Ointment, emollient or cream
- Wound care – as per care plan/Formulary
- Compression
- For patients who are complex or have Diabetes or Rheumatoid Arthritis refer to the TV or Lymphoedema team

Options:
- Actico bandaging 10cm toe to knee
- Jobst Ulcer Kit
- ACS/Yelcro wrap under the guidance of Lymphoedema Specialist Nurse

Refer to WH&C Community Lymphoedema Service

All compression bandaging competencies MUST be signed off and training regularly updated
<table>
<thead>
<tr>
<th>ABPI:</th>
<th>Blood flow</th>
<th>Ulcer type</th>
<th>Arterial sounds</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;1.4</td>
<td>Elevated Result</td>
<td>Consider Diabetes</td>
<td>Tri or Biphasic</td>
<td>Reduced compression</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Monophasic</td>
<td>No compression, refer to Vascular Studies</td>
</tr>
<tr>
<td>0.8 – 1.4</td>
<td>Normal</td>
<td>Venous</td>
<td>Tri or Biphasic</td>
<td>Full compression</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Monophasic</td>
<td>Start with reduced compression</td>
</tr>
<tr>
<td>0.6 – 0.8</td>
<td>Moderate Ischaemia</td>
<td>Mixed Aetiology</td>
<td>Tri or Biphasic</td>
<td>Reduced compression, refer to Vascular Studies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Monophasic</td>
<td>No compression, refer to Vascular Studies</td>
</tr>
<tr>
<td>0.4 - 0.6</td>
<td>Significant Ischaemia</td>
<td>Arterial</td>
<td></td>
<td>No compression, refer to Vascular Studies</td>
</tr>
<tr>
<td>&lt;0.4</td>
<td>Critical Ischaemia</td>
<td>Arterial</td>
<td></td>
<td>Urgent referral to Vascular Studies</td>
</tr>
</tbody>
</table>
## Hosiery Formulary

### Stage 0 (at risk)
- Early signs of venous disease with/without leg ulcer and no swelling. No skin folds. This stage can be present for years before oedema is evident.

### Stage I
- Early signs of venous disease with mild oedema which reduces with elevation. Pitting may be present. No skin folds.

### Stage II
- Oedema present more than 12 weeks (chronic oedema). Limb elevation rarely reduces. No skin folds; good limb shape, no trophic or dermal swelling, pitting oedema manifests.

### Late Stage II & Stage III
- Late Stage II - Pitting may be present, chronic oedema present and skin changes. Elevation rarely reduces the oedema. Stage III - Tissue hardening does not reduce with elevation. Folds present, complex patients, post historical wounds and the obese patient.

---

### Venous Disease
- Circular Knit Off The Shelf (OTS)
  - **Class I RAL (18 - 21mmHg)**
  - Juzo Soft: Open or closed toe
  - Mediven Elegance: Closed toe
  - Mediven for Men: Closed toe
  - Mediven Active: Closed toes

- **Activa Class I**
  - British Standard 1411/HIGH COMPRESSION
  - NB: Only choose if unable to tolerate options above

### Increase in Fabric Stiffness
- **Circular Knit OTS**
  - Class I RAL (18 - 21mmHg) OR Class II RAL (23 - 32mmHg)
  - Juzo Soft: Open or closed toe
  - Mediven Elegance: Closed toe
  - Mediven for Men: Closed toe
  - Mediven Active: Closed toes

- **Circular Knit OTS** providing a stiffer compression
  - Juzo Dynamic
  - Mediven Plus

### Venous & Lymphatic Disease
- **Circular Knit OTS** providing a stiffer compression
  - Class I RAL (18 - 21mmHg) OR Class II RAL (23 - 32mmHg)
  - Juzo Soft/Dynamic
  - Mediven Elegance/Plus

- **Flat Knit MTM**
  - Class I RAL (18 - 21mmHg)
  - Class II RAL (23 - 32mmHg) OR Class III RAL (34 - 46mmHg)
  - Juzo Expert or Expert Strong Mediven

Please contact either the supplier representative or the Lymphoedema Service if you require advice or have a query.

---

BSN Jobs UlcerCare stocking liner pack 40mmHg
Venous disease ABPI >0.8

INCREASE IN FABRIC STIFFNESS

Chronic Oedema/Lymphoedema

- Use liners where patients find it difficult to apply their hosiery, or due to skin integrity being fragile.
- BSN Jobst Liners 17mmHg
- Activa Liners 10 mmHg

Consider BSN Jobst Ulcer Kit if the patient has a VLU or follow the Lower Limb Pathway.

- Use liners where patients find it difficult to apply their hosiery, or due to skin integrity being fragile.
- BSN Jobst Liners provide 17mmHg
- You can layer hosiery e.g. Class I with another Class I on top to help with donning issues.

- Use liners where patients find it difficult to apply their hosiery, or due to skin integrity being fragile.
- You can layer flat knit garments e.g. Class I with a Class II to help with donning issues.

TOP TIPS

- All hosiery can be machine washed and tumble dried; do not use fabric softener.
- Make sure your patient does not roll the top of their garments over.
- Patients should have one to wash and one to wear.
- Review regularly and Doppler every six months.
- If patient is non-compliant or has donning issues remember you can always go up a size or two.
- If patient has swelling, ensure that hosiery is re-commenced as soon as they have no pain and are on antibiotics.
- Call the supplier representative or the Lymphoedema Service if you ever need advice or support.

Medi 2-in-1 FP10
Juzo Applicator Open toe only - included in order
Juzo Easy Fit FP10
Ezy As Frame and handles separate on FP10
Credenhill Magnide FP10
Sigvaris Rolly FP10
Patient to provide
## Diabetic Foot Care Pathway

### LOW RISK
- Normal sensation.
- Normal foot pulses.

**Manage in GP Practice**
- Annual Check.
- Education on self-care and monitor/check footwear.

### MODERATE RISK
- Reduced sensation.
- Reduced foot pulses.

**REFER to Local Community Podiatry Services**
- Annual Check.
- Education on self care and monitor/check footwear.
- Insoles if needed
- Podiatry Review 3-6 months

### HIGH RISK
- Reduced sensation.
- Reduced foot pulses AND history of ulceration or amputation, presence of co- morbidities

**REFER to Local Community Podiatry Services.**
- More intensive follow up.
- Specialist Orthotic or footwear provision.
- Podiatry Review 1-3 months

### ULCERATED
- NEW Foot Ulceration

1. **Review** and refer within 24hrs to **Acute Diabetic Foot MDT Team.**
2. **REFER** to Local Community Podiatry Services.

**Advanced Wound Assessment and management within MDT.**
- Wound Management plan and review intensively.

### EMERGENCY
- Critical Limb Ischaemia, Gangrene, CHARCOT Foot

**REFER to Acute Diabetic Foot MDT Team same day OR A+E Out of Hours vascular emergencies need to be referred to Hub**

**Intensive review.**
- In-patient management.
- Surgical, Vascular and Diabetes Review.
Contact Details

Community Podiatry Central Administration – 01249 456638/Fax 01249 456516

Diabetic Foot ACUTE MDT Clinics

- **Salisbury District Hospital (SDH)**
  - Mon/Tues/Fri
  - 01722 336262 x 4279 /Fax 01722 337912

- Dr Martin Smith
  - Cons. Endocrinologist
  - x 4229

- Lorraine Ba-Tin
  - Advanced Practitioner Podiatrist (Diabetes)
  - x 4279

- Orthotics
  - x 4175

- **Great Western Hospital, Swindon (GWH)**
  - Mon to Fri
  - 01793 604020 (bleep 2614)

- Matt Cichero
  - Diabetic Foot Co-ordinator
  - Fax 01793 604508

- Podiatrist
  - Advanced Podiatrist (High Risk Foot)

- **RUH Bath (RUH)**
  - Wed-Thurs
  - 01225 824061/824101. Fax 01225 824529

- Dr Marc Atkin
  - Cons. Endocrinologist

HOW TO REFER: Phone / Letter/ Fax

SDH: Referral Form on ICID
GWH: Intranet
RUH: Intranet

- Author: l.ba-tin@nhs.net (2016)

References: https://www.nice.org.uk/guidance/ng19/chapter/Key-priorities-for-implementation
## WOUND DRESSING GUIDE

<table>
<thead>
<tr>
<th>Wound Type</th>
<th>Aim</th>
<th>Exudate</th>
<th>Primary Dressing</th>
<th>Secondary Dressing (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Necrotic</td>
<td>Debridement and rehydration of moist / wet necrosis. <strong>Always keep dry necrotic eschar on a foot and necrotic digits dry to prevent the spread of infection.</strong></td>
<td>Low</td>
<td>Consider KerraLite Cool, Larvae or Medihoney Alginate or Prontosan Gel X Keep necrosis on foot dry by applying Inadine (this is the only use of Inadine in this Formulary).</td>
<td>Allevyn Gentle Border/ Allevyn Non-Adhesive. Use KerraMax Care if exudate levels are high.</td>
</tr>
<tr>
<td>Sloughy (consider larvae)</td>
<td>Debride, rehydration and removal of excess exudate.</td>
<td>Low</td>
<td>Kerralite Cool or Iodoflex</td>
<td>Allevyn Gentle Border/ Allevyn Non-Adhesive</td>
</tr>
<tr>
<td>Infected</td>
<td>Treat infection and remove excess exudate. Dress wound at least every 3 days.</td>
<td>Medium to heavy</td>
<td>Medihoney Tulle or Alginate, Iodoflex, Silvercel Non-Adherent or Cutimed Sorbact. Consider PHMB in the form of Prontosan or Prontosan Gel X.</td>
<td>Allevyn Life or KerraMax Care with or without border.</td>
</tr>
<tr>
<td>Malodorous</td>
<td>Reduce odour</td>
<td>Medium to heavy</td>
<td>Prevention and post infection consider Actilite</td>
<td>Carboflex</td>
</tr>
<tr>
<td>Bleeding wound</td>
<td>Stem bleeding</td>
<td></td>
<td></td>
<td>Kaltostat</td>
</tr>
<tr>
<td>Granulating</td>
<td>Remove excess exudate and promote granulation by maintaining a moist environment.</td>
<td>Light</td>
<td>Allevyn Gentle Border/ Allevyn Non-Adhesive. If the wound is a cavity, KerraCel could be used.</td>
<td>If KerraCel is primary dressing in a cavity, choose Allevyn Gentle Border/ Allevyn Non-Adhesive, Allevyn Life or KerraMax Care with or without border (if the exudate levels are heavy) as the secondary dressing.</td>
</tr>
<tr>
<td>Medium to heavy</td>
<td>Allevyn Life or KerraMax Care with or without border.</td>
<td>KerraCel if wound is a cavity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epithelialising</td>
<td>Promote healing or prevent damage by maintaining a moist environment.</td>
<td></td>
<td></td>
<td>Allevyn Gentle Border/ Allevyn Non-Adhesive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nil required</td>
</tr>
</tbody>
</table>
## ADDITIONAL PRODUCTS

<table>
<thead>
<tr>
<th>PRODUCT TYPE</th>
<th>PRODUCT NAME</th>
<th>MANUFACTURER</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing Pack (glove sizes S, M, L)</td>
<td>Softdrape (NHS SC)</td>
<td>Richardson Healthcare Ltd</td>
<td>For aseptic technique for all wound care.</td>
</tr>
<tr>
<td>Gel pad offering pressure protection</td>
<td>KerraPro pads (FP10)</td>
<td>KCI</td>
<td>White gel pads of various sizes to reduce pressure in difficult places i.e. on hands for contracted fingers.</td>
</tr>
<tr>
<td>Adhesive remover</td>
<td>Appeel adhesive removing sachets</td>
<td>Clinimed</td>
<td>Will ease the removal of adhesive on delicate skin.</td>
</tr>
<tr>
<td></td>
<td>(NHS SC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adhesive tape</td>
<td>Finepore Tape (FP10 &amp; NHS SC)</td>
<td>3M</td>
<td></td>
</tr>
<tr>
<td>Skin/wound cleanser</td>
<td>BBraun Prontosan Debridement Pad</td>
<td>BBraun</td>
<td>Will break down the Biofilm on a wound and help to remove wound debris.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description/Condition</td>
<td>Product</td>
<td>Stocked Sizes</td>
<td>Guidance for Use</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------</td>
<td>---------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Soap Substitute</td>
<td>Dermol 500</td>
<td>500ml</td>
<td>Wash legs with Dermol as appropriate</td>
</tr>
<tr>
<td>Emollient</td>
<td>ExCetra</td>
<td>500g</td>
<td>Apply liberally, daily. Contains Glycerin, light liquid paraffin, white soft paraffin</td>
</tr>
<tr>
<td>Emollient Ointment</td>
<td>50/50</td>
<td>500g</td>
<td>50% white soft paraffin and 50% liquid paraffin. Can be used under compression bandaging, particularly if bandaging is in situ for one week.</td>
</tr>
<tr>
<td>Hyperkeratosis/ Papillomatosis</td>
<td>Imuderm (5% Urea)</td>
<td>500g</td>
<td>Consider UCS wipes or BBraun debridement pad or Debrisoft short term. To be used for skin changes due to Lymphoedema.</td>
</tr>
<tr>
<td>Dry skin on feet callus/fissured skin</td>
<td>Dermatonics Once Heel Balm</td>
<td>60ml, 75ml, 200ml</td>
<td>Apply cream to clean, dry heels once per day</td>
</tr>
<tr>
<td>Red legs without infection</td>
<td>Consider the use of steroid ointment.</td>
<td>15g, 30g, 100g</td>
<td>Options may be Synalar N or Elocon Ointment</td>
</tr>
<tr>
<td>Maceration to the peri wound</td>
<td>Secura D (Aproderm for FP10)</td>
<td>Film 1ml or wipe Cream 28g or 92g</td>
<td>Film to be used every 3 days. Cream to be used daily.</td>
</tr>
<tr>
<td>Excoriation or widespread maceration</td>
<td>Sudocrem</td>
<td>30g, 60g, 100g, 125g, 175g</td>
<td>To be used appropriately for excoriation and maceration only, not on healthy skin, this is not a moisturiser.</td>
</tr>
</tbody>
</table>
2 FILM DRESSINGS (INC. BARRIER PRODUCTS)

Vapour-permeable films and membranes allow the passage of water vapour and oxygen but not water or micro-organisms. Films are only suitable for dry wounds e.g. surgical wounds or wounds with very low levels of exudate. Exudate may accumulate under this dressing and cause further tissue breakdown i.e. maceration.

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear Film</td>
<td>Richardson Healthcare</td>
<td>6 x 7, 10 x 12, 15 x 20</td>
</tr>
<tr>
<td>Secura D Barrier Cream and Secura Barrier Film</td>
<td>Smith &amp; Nephew</td>
<td>1ml Wipe Barrier Cream</td>
</tr>
<tr>
<td>Aproderm (FP10 – Primary care only)</td>
<td>Fontus Derma</td>
<td>30g 100g</td>
</tr>
</tbody>
</table>

2.1 Characteristics of the dressing

- Clear Film consists of a sterile, thin, vapour permeable, polyurethane, acrylic adhesive coated film that acts as an occlusive dressing.
- Film dressings have the ability to permit the passage of water vapour from beneath the film to the external environment.
- Secura D and Aproderm are no-sting, protective transparent barrier creams, advocated as a protective interface between the skin and bodily wastes, fluids and adhesive dressings and tapes; adhesives will adhere after applying a thin layer of barrier cream.

2.2 Indications for use

- Film dressings are only suitable for intact skin or as a secondary dressing/retention dressing.
- Secura and Aproderm can provide protection for incontinence dermatitis, stoma sites, macerated skin around venous leg ulcers, adhesion trauma/skin stripping and peri-wound areas.
2.3 Method of application
- The skin must be clean and dry prior to application of the film.
- Do not stretch the skin on application of any dressing, particularly films, as this may result in blistering.
- Can be left in place for up to seven days.
- Clear film will not adhere to itself; therefore aids application.
- Secura film requires reapplication every 48-72 hours and does not require removal before reapplication; however, if adhesives are being removed daily, the Secura may be ‘stripped off’ and may need more frequent application.
- Secura D cream can be applied daily.

2.4 Cautions
- Film dressings act as an occlusive dressing; therefore should not be used when anaerobic bacteria are suspected, usually discernible by odour.
- Excessive exudate may build up under the dressing. If this occurs replace the film; do not aspirate using a sterile syringe as there is a risk of needle stick injury to the patient and introducing infection into the wound (not applicable to Secura or Aproderm).
- Fragile skin may suffer trauma when film dressings are removed (not applicable for Secura or Aproderm, as not removed).
- Appeel is a product which breaks down the adhesive and would aid removal.
- Caution with diabetic wounds, as prone to anaerobic infection.

3 LOW ADHERENT DRESSING

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrauman</td>
<td>Paul Hartmann Ltd</td>
<td>5 x 5, 7.5 x 10, 10 x 20, 20 x 30</td>
</tr>
</tbody>
</table>

3.1 Characteristics of the dressing
- Atrauman is a low adherent rather than non-adherent dressing that is impregnated with neutral triglycerides (fatty acids). It does not contain Vaseline or paraffin.

3.2 Indications for use – choosing an appropriate low adhesive dressing
- For shallow wounds or trauma wounds when the wear time is short as there is a risk of dying out. If the dressing can remain in place for 5 days, double layer this dressing. Use as a secondary dressing as required. i.e. over Flamazine.
This dressing should not be used under Durafiber.
3.3 Method of application

- Requires a secondary dressing.

3.4 Cautions

- If wound has low exudate and the dressing is left on for longer than 3 days, Atrauman may stick to the wound, causing trauma on removal; eased by soaking with tap water or 0.9% sodium chloride prior to removal.

4 LOW ABSORBENT DRESSING

This dressing is recommended for wounds with low exudate levels, useful over surgical wounds or as a secondary dressing.

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>365</td>
<td>365 Healthcare</td>
<td>5 x 7.2, 8 x 10, 8 x 15, 10 x 10, 10 x 15, 10 x 20, 10 x 25</td>
</tr>
</tbody>
</table>

4.1 Characteristics of the dressing

- 365 island dressing is an absorbent perforated dressing with adhesive border.

4.2 Indications for use

- For low exuding wounds and post-operative wounds.
- These dressings are shower proof.

4.3 Method of application

- Apply directly to wound surface.
- Support fragile tissue on removal of this dressing; particularly surgical wounds.

4.4 Cautions

- Medium to high exuding wounds.
5 ALGINATE DRESSING

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaltostat (Haemostat)</td>
<td>ConvaTec</td>
<td>5 x 5, 7.5 x 12</td>
</tr>
</tbody>
</table>

5.1 Characteristics of the dressings
- Kaltostat consists of an absorbent fibrous fleece composed of the sodium and calcium salts of alginic acid in the ratio of 80:20. The dressing is presented as a flat non-woven pad for application to surface wounds.
- In the presence of exudate or other body fluids containing sodium ions the fibres absorb liquid and swell; calcium ions present in the fibre are partially replaced by sodium, causing the dressing to take on a gel-like appearance.
- This overlays the wound and provides a micro-environment that is believed to facilitate wound healing.

5.2 Indications for use
- This is to aid the stem of bleeding in a wound. Monitor a bleeding wound continually until bleeding stops.
- If bleeding does not cease, or is excessive, refer patient immediately to a doctor and commence regular observations including blood pressure and pulse.
- Bleeding is more likely to occur for patients on anticoagulant therapy.

5.3 Method of Application
- Place onto the surface of the wound and cover with a secondary dressing. It can be ‘tucked’ into a cavity, ensuring that the wound is not packed tightly as this may damage granulation tissue.
- Appropriate secondary dressing will be dictated by the amount of exudate. The duration of the dressing will be dictated by the exudate, however, no longer than 7 days.

5.4 Cautions
- Do not apply Kaltostat to dry (or necrotic) wounds or wounds with low exudate, as this dressing will adhere to the wound surface. If this occurs, warmed tap water or 0.9% sodium chloride can be applied to soak the dressing off.
- If these dressings adhere to the wound, then the exudate is inadequate and these dressings are inappropriate.
6 HYDROGEL DRESSINGS

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerralite Cool</td>
<td>KCI</td>
<td>6 x 6, 12 x 8.5, 18 x 12.5</td>
</tr>
<tr>
<td>Kerralite Cool Border</td>
<td>KCI</td>
<td>8 x 8, 11 x 11, 15 x 15</td>
</tr>
<tr>
<td>Aquaform</td>
<td>Aspen Medical</td>
<td>8g</td>
</tr>
</tbody>
</table>

6.1 Characteristics of the dressing

- Kerralite Cool is a soothing, debriding and moisture-balancing gel dressing. Manages wound exudate levels and protects against wound dehydration and external bacterial contamination. The gel provides both cushioning and absorption. Available in non-adhesive and adhesive options.
- Aquaform consists of an amorphous, starch-based hydrogel consisting of 95% water. This dressing is contra-indicated when infection is suspected – can support the growth of micro-organisms. It rehydrates necrotic tissue to promote debridement and removes slough to create a moist wound healing environment.

6.2 Indications for use

- Indicated for debridement of necrotic and sloughy wounds but can be used at any stage of wound healing, from necrotic tissue to the formation of granulation tissue.
- Kerralite Cool is specifically recommended for painful wounds.
- Aquaform – for use with topical analgesia i.e. Diamorphine with advice from Tissue Viability or hospice.

6.3 Method of application

- Directly into or onto wound surface.
- Apply a secondary dressing for Kerralite Cool without the border and Aquaform; this can be judged by the amount of exudate.
- Dressing should be changed at least every 1-3 days.
- Kerralite Cool – follow the manufacturer’s instructions when applying this product.
6.4 Cautions

- KerraLite Cool is contra-indicated as a covering for deep, narrow cavities or sinuses.
- Aquaform is not recommended for heavily exuding wounds, as the water content in the gel exacerbates the potential for maceration.
- Aquaform and KerraLite Cool are not recommended on dry necrosis on the foot, these wounds must be kept dry, and a Doppler carried out and referred to Tissue Viability (or Vascular Studies if the ABPI is <0.6).
- May cause maceration if secondary dressing inadequate; do not use these products prior to biotherapy, as the larvae cannot tolerate this hydrogel.
- Propylene glycol may cause sensitisation and irritation in a smaller number of patients.

7 GELLING FIBRE DRESSINGS

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>KerraCel</td>
<td>KCI</td>
<td>5 x 5, 10 x 10, 15 x 15, 2 x 45 (Rope)</td>
</tr>
</tbody>
</table>

7.1 Characteristics of the dressing

- Soft, non-woven, flat dressing composed of carboxymethyl cellulose, indicated for the management of exuding wounds.
- The non-woven gelling fibres form a soothing gel when wet to maintain a moist wound healing environment.
- The gel absorbs and locks away excess fluid, protecting peri-wound skin from maceration and sequestering harmful components found in exudate.
- KerraCel contours to the wound bed, minimizing dead space where bacteria can live.
- KerraCel retains its integrity when wet to allow removal in one piece.
- Allows fluid retention under compression.

7.2 Indications for use

- Suitable for use on moderate and heavily exuding wounds.
- Suitable for use to dress cavity wounds with medium to heavy exudate.
- Suitable for use under compression bandages.
7.3 Method of application
- Cleanse the wound and select an appropriate dressing size, so the dressing overlaps the wound margin by approximately 1cm/0.4”.
- Open the pack and lay the sterile dressing onto the wound. Either side of the sterile dressing may be used.
- Apply the dressing to the wound and cover with an appropriate secondary dressing.
- When using the ribbon in cavity wounds, leave at least 2.5cm/1” outside the wound for ease of removal. Only pack cavity wounds by 80%, as the dressing will expand to fill the space on contact with exudate.

7.4 Cautions
- KerraCel should not be used for surgical implantation or to control heavy bleeding - the dressing is not a haemostat.

8 HYDROCOLLOID DRESSINGS

Caution must be taken with diabetic foot lesions. Occlusive dressings, such as hydrocolloids, should not be used on diabetic foot lesions due to the increased risk of maceration and anaerobic infection in these wounds10, 11, 12.

8.1 STANDARD HYDROCOLLOID

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfeel Plus Contour</td>
<td>Coloplast</td>
<td>6 x 8, 9 x 11</td>
</tr>
<tr>
<td>Comfeel Plus Transparent</td>
<td></td>
<td>5 x 7, 10 x 10, 15 x 15</td>
</tr>
</tbody>
</table>

8.2 Characteristics of the dressing
- A hydrocolloid is a micro-granular suspension of various natural or synthetic polymers, e.g. gelatin or pectin, in an adhesive matrix which is interactive when in contact with wound exudate. Hydrocolloids slowly absorb fluid, leading to a change in the physical state of the dressing, forming a gel which may be cohesive and/or hydrophilic; this gel swells into the cavity.
- Provides an environment conducive to rapid debridement; thus there may be an initial increase in wound size2.
- The low pH created by the hydrocolloid as an occlusive dressing is effective in the treatment of pseudomonas13.
8.3 Indications for use
- For wounds with low exudate; appropriate for the treatment of chronic exuding wounds such as leg ulcers, pressure ulcers and acute wounds, including burns, skin donor sites, and traumatic wounds.
- Suitable for necrotic, sloughy wounds.

8.4 Method of application
- Allow a minimum of 3cm overlap (excluding border) onto surrounding intact skin.
- Warm dressing between palms of hands.
- Remove backing and maintain the warmth over the dressing for up to 2 minutes; this will encourage adherence, which is particularly relevant on difficult to dress places, e.g. heels, elbows and sacrum.
- Can stay in place for up to 7 days.

8.5 Cautions
- Caution must be taken with wounds with existing infection or diabetic feet, as an occlusive dressing could encourage the growth of anaerobic bacteria.\(^{10,11,12}\)
- The excessive moisture that can build up under an occlusive dressing may promote maceration and decreased tissue tensile strength. If this occurs, continued pressure and/or shear will produce greater tissue damage.\(^{12}\)
- May cause over-granulation – if this occurs, a more oxygen-permeable dressing should be considered, i.e. foam dressing.
### ABSORBENT DRESSINGS

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Type</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allevyn Gentle Border</td>
<td>Smith &amp; Nephew</td>
<td>Gentle border (silicone)</td>
<td>7.5 x 7.5, 10 x 10, 12.5 x 12.5, 17.5 x 17.5,</td>
</tr>
<tr>
<td>Allevyn Non-Adhesive</td>
<td>Smith &amp; Nephew</td>
<td>Non-bordered</td>
<td>5 x 5, 10 x 10, 10 x 20, 20 x 20, 10 x 13.5 (heel)</td>
</tr>
<tr>
<td>Allevyn Life</td>
<td>Smith &amp; Nephew</td>
<td>Silicone border</td>
<td>10.3 x 10.3, 12.9 x 12.9, 15.4 x 15.4, 21 x 21, 17.2 x 17.5 (sacral) 21.6 x 23 (sacral)</td>
</tr>
<tr>
<td>Tegaderm Foam</td>
<td>3M</td>
<td>Adhesive</td>
<td>6.9 x 6.9, 10 x 11, 14.3 x 15.6 (oval), 19 x 22.5 (oval)</td>
</tr>
<tr>
<td>KerraMax Care</td>
<td>KCI</td>
<td>Absorbent pad</td>
<td>5 x 5, 10 x 10, 10 x 22, 20 x 22, 20 x 30, 20 x 50</td>
</tr>
</tbody>
</table>
9.1 Characteristics of the dressings
  · Allevyn is a polyurethane foam dressing with a silicone wound contact layer aimed at low to moderate exudate levels.
  · Tegaderm foam is a polyurethane foam pad with an additional non-woven layer and a top layer of transparent adhesive foam. This film is for difficult to dress places like heels or elbows, also when urine or faeces is compromising a wound, this dressing offers effective protection as it is waterproof.
  · KerraMax Care is a superabsorbent dressing which is soft, conformable and the non-bordered version is stackable.

9.2 Indications for use

<table>
<thead>
<tr>
<th>Wound Type</th>
<th>Wound depth</th>
<th>Which Foam to Choose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low exudate levels</td>
<td>Shallow</td>
<td>Allevyn Gentle Border / Allevyn Non-Adhesive</td>
</tr>
<tr>
<td>Moderate exudate levels</td>
<td>Shallow Deep (cavity)</td>
<td>Allevyn Life KerraCel with Allevyn Gentle Border / Allevyn Life</td>
</tr>
<tr>
<td>Heavy exudate</td>
<td>Shallow Deep (cavity)</td>
<td>KerraMax Care with or without border KerraCel with KerraMax Care with or without border as secondary dressing</td>
</tr>
<tr>
<td>Friable peri-wound skin or reaction to adhesives</td>
<td></td>
<td>Allevyn Gentle Border / Allevyn Non-Adhesive or Allevyn Life depending on the exudate levels</td>
</tr>
<tr>
<td>Over-granulation</td>
<td></td>
<td>Allevyn Gentle border / Allevyn Non-Adhesive depending on the exudate levels (consider an antimicrobial as wound contact if infection suspected)</td>
</tr>
<tr>
<td>Difficult to dress places i.e. heels, elbows</td>
<td></td>
<td>Tegaderm foam ovals with adhesive border</td>
</tr>
<tr>
<td>Waterproof dressing required i.e. For swimming or for incontinence protection</td>
<td></td>
<td>Tegaderm foam with adhesive border</td>
</tr>
<tr>
<td>If patient removes the dressing</td>
<td></td>
<td>Consider Tegaderm foam with adhesive border</td>
</tr>
</tbody>
</table>

9.3 Method of application
  · KerraMax Care without a border can be used under compression bandaging.
  · Apply all absorbent dressings directly to the wound surface allow for a 2cm overlap on each side of the wound.
  · If wet cavity wound consider KerraCel.
  · No secondary dressing required for foam dressings.
  · Non-adhesive dressings will require tape or a bandage to secure.
  · May be left in place for up to 7 days, if exudate allows.
9.4 Cautions

- The adhesive on these dressings may cause reddening of the skin on first application; if this does not extend beyond the boundaries of the dressing (which would indicate an allergic reaction), apply another dressing but observe within 24 hours.

10 ODOUR ABSORBING DRESSINGS

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinisorb</td>
<td>Clinimed</td>
<td>10 x 10, 10 x 20</td>
</tr>
</tbody>
</table>

| Carboflex | ConvaTec     | 10 x 10, 8 x 15, 15 x 20 |

Carboflex is a primary dressing and is, therefore, applied directly to the wound bed. If the odour absorbing dressing is to be applied over a primary dressing, i.e. foam then choose Clinisorb. Consider the cost of using Carboflex and only apply if the wound is appropriate. See below for indications for use.

10.1 Characteristics of the dressing

- Wound odour, which cannot be resolved immediately, can be absorbed by dressings that contain charcoal. The advent of the charcoal cloth, which was first introduced by Butcher (1976) involved activated charcoal; the activated charcoal was produced by carbonising a suitable cellulose fabric by heating it under carefully controlled conditions. The surface of the carbon breaks down to form small pores, which greatly increase the effective surface area of the fibres and hence their ability to remove unpleasant smells.

- These dressings absorb the molecules released from the wound, which may be responsible for the smell. Wounds most commonly associated with odour production include leg ulcers and fungating (cancerous) lesions of all types. The metabolic processes of bacteria cause the odour; organisms frequently isolated from malodorous wounds include anaerobes such as Bacteriodes and Clostridium species and a number of aerobic bacteria, including Proteus, Klebsiella and Pseudomonas spp.

- The most effective way of dealing with malodorous wounds is to treat or prevent the infection responsible for the odour (see treatment of infected wounds below and in the infection section of the Tissue Viability Guidelines).
Clinisorb is an activated charcoal cloth, sandwiched between viscose rayon. Both surfaces are identical; it can be cut, as it does not come into contact with the wound. Applied as a secondary dressing.

Carboflex is a five layer primary dressing. The contact layer contains Kaltostat and Hydrofiber and is applied directly to the wound surface.

10.2 Indications for use
- Carboflex and Clinisorb are advocated for malodorous wounds.
- As soon as the dressing is wet, the charcoal is deactivated.
- Carboflex has an absorbent capacity (low levels) and is applied directly to a wound. This dressing contains Kaltostat and Hydrofiber in the wound contact layer and is designed to stop pinpoint bleeding, i.e. in a fungating wound.

10.3 Method of application

**Carboflex**
- Apply Carboflex directly on to the wound surface with the Kaltostat/Hydrofiber layer in contact with the wound.
- Do not cut dressing.
- Choose a dressing that overlaps the wound by 3cm.
- Can be left for 3 days but change if any strike through is evident.

**Clinisorb**
- Apply the Clinisorb dressing as a secondary dressing, over the primary dressing. Clinisorb must not come into contact with the wound. Choose a dressing that extends 3cm beyond the edge of the wound.
- Clinisorb can be used for up to one week if it does not come into contact with exudate or become wet. When any carbon dressing becomes wet, it is deactivated.

10.4 Cautions
- Clinisorb cannot be applied directly on the wound as fibres may be deposited in the wound.
11 ANTIMICROBIAL DRESSINGS: TREATMENT FOR INFECTED WOUNDS

To determine which antimicrobial to use, see table below. Antimicrobials include: medicated tulles (Inadine), Cadexomer Iodine (Iodoflex), silver dressings (Silvercel non-adherent and Flamazine), honey and topical antibiotic therapies. For the characteristics of an infected wound, see the infection section of the Tissue Viability Policy. If the wound infection does not respond or resolve within 2 weeks, consider that this may not be the appropriate dressing choice or antibiotic therapy may be necessary in conjunction with topical microbial treatments.

CHOOSING AN ANTIMICROBIAL DRESSING

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Wound Type</th>
<th>Exudate levels</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medihoney Honey Tulle and Alginate</td>
<td>Infected wounds or non-progressing wounds or wounds that require debridement.</td>
<td>Low to medium exudate</td>
<td>Will reduce the bacterial loading. Consider the increased wetness and possible increase in pain experienced. There is no time limit on this dressing. Can be used with patients with diabetes.</td>
</tr>
<tr>
<td>Actilite</td>
<td>Prevention i.e. skin tears and post infection.</td>
<td>Low</td>
<td>To prevent infection in trauma wounds if risk of infection suspected. Post active treatment for infection with Medihoney to continue antimicrobial. For infected wounds where the Medihoney is inappropriate due to the delivery i.e. stiffness/bulk of products.</td>
</tr>
<tr>
<td>Activon Tube</td>
<td>For cavities (use with KerraCel if required)</td>
<td>All exudate levels</td>
<td></td>
</tr>
<tr>
<td>Silvercel Non-Adherent</td>
<td>Infected wounds only</td>
<td>All exudate levels</td>
<td>The metallic silver is impregnated into an alginate and has increased capacity for absorbency. The silver is released from the dressing. Leave in place for 3 - 5 days.</td>
</tr>
<tr>
<td>Product</td>
<td>Description</td>
<td>Level</td>
<td>Benefits</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Inadine</td>
<td>To keep dry necrotic tissue dry.</td>
<td>Low</td>
<td>Will reduce bacterial loading on wounds where infection is a risk, i.e. abrasions. Consider sensitivity to Iodine.</td>
</tr>
<tr>
<td>Flaminal Hydro/Forte</td>
<td>Infected or non-progressing wounds</td>
<td>Hydro for dry or mild to moderate amounts of exudate. Forte for moderate to heavy amounts of exudate.</td>
<td>Will clean wound bed and aid debridement on thin lay of slough. There is no limit to the amount, or length of time Flaminal can be used to treat wounds. Flaminal is biodegradable. Flaminal can be recapped and used multi times. Single patient use.</td>
</tr>
<tr>
<td>Iodoflex</td>
<td>Chronic, exuding, Infected, sloughy, odorous, up to dermal depth</td>
<td>Low to medium</td>
<td>Will reduce bacterial loading, reduce odour and debride the wound. Consider sensitivity to Iodine.</td>
</tr>
<tr>
<td>Cutimed Sorbact</td>
<td>Infected wounds or wounds with recurrent infections.</td>
<td>Low to medium exudate levels</td>
<td>No time limit on this dressing, very effective when a long term antibacterial dressing is required, i.e. for a leg ulcer or a pilonidal sinus</td>
</tr>
<tr>
<td>Prontosan Liquid PHMB</td>
<td>All wound types if bacteria or biofilm are present or suspected.</td>
<td>The liquid should be used as a soak for 10-15 minutes during a dressing change.</td>
<td>To cleanse and reduce / remove biofilms on chronic wounds. Also effective at reducing bacteria and therefore to be considered for wounds that have recurrent infection.</td>
</tr>
<tr>
<td>Prontosan Gel X PHMB</td>
<td>Infected wounds (consider high level of water in this product).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11.1 MEDICATED TULLES

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadine</td>
<td>KCI</td>
<td>5 x 5, 9.5 x 9.5</td>
</tr>
</tbody>
</table>

11.1.1 Characteristics of the dressing
- Sterile, low adherent, knitted viscose dressing impregnated with 10% povidone iodine in a water-soluble polyethylene glycol base.

11.1.2 Indications for use
- This dressing is for keeping necrotic wounds dry only. For minor trauma or superficial wound please use Medihoney Tulle dressing.
- The dressing should be changed every 2 – 3 days because the antimicrobial properties of the dressing decrease over time.
- The dressing should be changed prior to the 2 – 3 days if the distinctive orange-brown colour changes to white; this indicates that the povidone iodine has been used up.
- **Do not use Inadine for longer than two weeks without consulting a doctor.**
- Inadine can be used in diabetic patients with a normal functioning thyroid and who are not on a drug related treatment. It is advised, however, to seek a clinician’s advice before commencing treatment, due to diabetes being susceptible to reduced kidney function and iodine being excreted via the kidneys.

11.1.3 Method of application
- For topical use only; apply directly onto the wound surface.
- Secondary dressing will be required; the nature of the wound will dictate the secondary dressing.

11.1.4 Cautions
- Do not use on deep ulcerative wounds, burns or large injuries.
- Inadine should not be used where there is a known iodine hypersensitivity, before or after the use of radio-iodine or if the patient has any renal problems.
- Consult a doctor prior to applying Inadine to a patient who is having lithium treatment, as the Inadine could indirectly affect the serum-lithium levels.
- **Do not use iodine on pregnant or breast feeding women or new born children up to the age of 6 months, as povidone iodine may be absorbed through unbroken skin.**
- Inadine should be used under medical supervision if the patient has a thyroid disease; this may involve a thyroid function test before and after treatment.
- Free iodine is very low; however, there may be some sensitivity to povidone iodine or iodine.
11.2 **CADEXOMER IODINES**

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iodoflex</td>
<td>Smith &amp; Nephew</td>
<td>5g, 10g</td>
</tr>
</tbody>
</table>

11.2.1 **Characteristics of the dressings**
- Units of sterile Cadexomer iodine paste containing iodine (0.9% w/w) in an inert base.
- The Cadexomer absorbs exudate and forms a gel providing a moist, protected, environment which is conducive to wound healing.
- Iodine acts as an anti-infective against existing infection and prevents re-infection.

11.2.2 **Indications for use**
- Use to treat chronic, infected and medium to heavily exuding wounds.
- Dressings should be changed 2 – 3 times per week or when there is loss of colour.
- Maximum single application is 50g; weekly maximum must not exceed 150g; treatment duration should not exceed 3 months.

11.2.3 **Method of application**
- Remove the paste from the protective gauze and apply directly into wound.
- A secondary dressing is required that will maintain a moist environment.
- If dressing dries out, 0.9% sodium chloride or tap water will remove the bulk of the dressing; this dressing is biodegradable so the layer in contact with the granulation can therefore remain.

11.2.4 **Cautions**
- Cadexomer dressings should not be used with patients with known or suspected iodine sensitivity or with thyroid or renal disease.
- Potential risk of interaction from lithium.
- Do not use in children or in breast feeding or pregnant women.
- Do not use on wounds with dry necrotic tissue.

See instructions for use for a full list of warnings and precautions.
11.3 SILVER DRESSINGS

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silvercel Non-adherent</td>
<td>KCI</td>
<td>5 x 5, 11 x 11, 10 x 20, 2.5 x 30.5</td>
</tr>
</tbody>
</table>

11.3.1 Characteristics of the dressing
- This is a primary dressing.
- Silvercel Non-Adherent is an alginate coated in silver which kills a broad spectrum of bacteria and aids in creating an anti-microbial environment. Silvercel absorbs wound fluid.

11.3.2 Indications for use
- See table on page 37.

11.3.3 Method of application
- Either fold into the wound or cut to size.
- Change dressing every 3 days.
- This dressing will deposit silver into the wound in its mode of action. This enables the silver to kill the bacteria. It will gradually disappear from the wound at the end of treatment with normal cleansing procedures and is not for concern.

11.3.4 Cautions
- Not compatible with oil based products, such as petroleum jelly.
- Do not use on patients who are allergic to silver.
- Do not use on patients undergoing Magnetic Resonance Imaging and avoid contact with electrode and conductive gels during electronic measurements, e.g. EEG and ECG.
11.4 ANTIBACTERIAL GEL/LIQUID

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prontosan Liquid Gel X PHMB</td>
<td>B Braun</td>
<td>50g</td>
</tr>
<tr>
<td>Prontosan Liquid PHMB</td>
<td></td>
<td>350ml</td>
</tr>
</tbody>
</table>

11.4.1 Characteristics of the Product
- Prontosan Gel X is a hydrogel which will debride the wound while offering an antimicrobial.
- Prontosan liquid is a PHMB soak to be applied to the wound, this is usually done by soaking gauze and applying and leaving in situ for 10-15 minutes.

11.4.2 Indications for use
- Prontosan: Removal or disturbance of a biofilm, debridement and treatment of infection.

11.4.3 Method of application
- Apply directly to wound bed and will require a secondary dressing.

11.4.4 Cautions
- Known sensitivity to PHMB.
### 11.5 HONEY

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activon Tube</td>
<td>Advancis Medical</td>
<td>25g</td>
</tr>
<tr>
<td>Actilite</td>
<td>Advancis Medical</td>
<td>5 x 5, 10 x 10, 10 x 20</td>
</tr>
<tr>
<td>Medihoney Tulle</td>
<td>Integralife</td>
<td>5 x 5, 10 x 10</td>
</tr>
<tr>
<td>Medihoney Alginate (Apinate)</td>
<td>Integralife</td>
<td>5 x 5, 10 x 10, Rope dressing 1.9 x 30cm</td>
</tr>
<tr>
<td>Medihoney Absorbent Hydrogel (HCS)</td>
<td>Integralife</td>
<td>Non adhesive 6 x 6, 11x11 Adhesive: 7.2 x 7.2, 11x11</td>
</tr>
</tbody>
</table>

#### 11.5.1 Characteristics of the dressings
- All the honey preparations are a medical grade Manuka honey.
- Medihoney Alginate (Apinate) is an alginate impregnated with medical Manuka honey.
- Topical broad-spectrum antibacterial agent.

#### 11.5.2 Indications for use
- Used to treat a variety of shallow wounds, where infection may prevent healing, e.g. leg ulcers, pressure ulcers etc.
- The Medihoney Tulle is for superficial wounds including trauma wounds.
- The Medihoney Alginate dressing offers more absorbency for wetter or deeper wounds.
- The Medihoney HCS is for skin tears and other minor wounds to reduce the risk of infection.
- Actilite for prevention and post infection for minor trauma/superficial wounds.
11.5.3 Method of application
- Apply directly onto wound site.
- Can be applied from daily to every third day.
- Do not allow the dressing to overlap onto the peri-wound skin as it may cause maceration (except for HCS).

11.5.4 Cautions
- A stinging sensation may be experienced as this product works by osmosis, if this is unacceptable, remove the product and irrigate the wound.
- Consider the increased wetness; as this product works by osmosis, it draws fluids from the wound, thereby potentially creating an increased wetness at the wound bed – protect the peri-wound skin.
- Do not use on wounds with active bleeding.
- Do not use on patients with a known sensitivity to calcium alginate (apinate) or bee venom.

11.6 CUTIMED SORBACT

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cutimed Sorbact</td>
<td>BSN Medical</td>
<td>4 x 6, 7 x 9,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ribbon 2 x 50</td>
</tr>
</tbody>
</table>

11.6.1 Characteristics of the dressings
- Cutimed Sorbact is an antimicrobial wound contact layer, designed to bind bacteria under moist wound conditions.

11.6.2 Indications for use
- For contaminated, colonised or infected superficial wounds.

11.6.3 Method of application
- Method – primary dressing, can be folded or unfolded.

11.6.4 Cautions
- Do not use with ointment or creams.
## 11.7 FLAMINAL

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flaminal Hydro</td>
<td>Flen Health</td>
<td>15g</td>
</tr>
<tr>
<td>Flaminal Forte</td>
<td>Flen Health</td>
<td>15g</td>
</tr>
</tbody>
</table>

### 11.7.1 Characteristics of the dressings
- Topical broad-spectrum antibacterial agent
- Choose Flaminal Hydro for wounds that are dry or have mild to moderate amounts of exudate.
- Choose Flaminal Forte for wounds that have moderate to heavy amounts of exudate.
- Provides intimate wound contact and is totally biodegradable

### 11.7.2 Indications for use
- Used to treat a variety of shallow wounds, where infection may prevent healing, e.g. leg ulcers, pressure ulcers etc.

### 11.7.3 Method of application
- Apply a thick layer (5mm) of Flaminal to the wound using a sterile technique.
- Flaminal should not spill over on to the wound edge.
- Can be applied from daily to every third day.
- Once opened, it can be recapped and reused on the same patient until the expiry date.

### 11.7.4 Cautions
- Nil known
# 12 BANDAGES

## 12.1 COMPRESSION (Refer to Leg Ulcer Policy 2019)

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Pack Size: ankle circumference</th>
</tr>
</thead>
<tbody>
<tr>
<td>JuxtaCURE</td>
<td>Medi UK</td>
<td>Short, Standard, Long</td>
</tr>
<tr>
<td>K-Two</td>
<td>Urgo</td>
<td>18 - 25cm, 25 - 32cm</td>
</tr>
<tr>
<td>K2 reduced</td>
<td>Urgo</td>
<td>18 - 25cm, 25 - 32cm</td>
</tr>
<tr>
<td>K Lite Long</td>
<td>Urgo</td>
<td>10cm x 5.25m</td>
</tr>
<tr>
<td>K Soft Long</td>
<td>Urgo</td>
<td>10cm x 4.5m</td>
</tr>
<tr>
<td>Actico Cohesive</td>
<td>Activa</td>
<td>10 cm x 6 cm for venous limb with mild Oedema</td>
</tr>
</tbody>
</table>

JuxtaCURE should be considered for patients with a venous leg ulcer if the healing is likely to be longer than 12 weeks. K2 bandaging can be used as an alternative for patients who are not suitable for JuxtaCURE.
12.1.1 Characteristics of the bandage system
K-Two
This is a two layer bandaging system consisting of:
· First layer – K-Tech is an absorbent compression wadding, offering 20mmHg.
· Second layer – K-Press is a cohesive compression bandage, offering 20mmHg.

Actico Cohesive
· Two layer bandaging system put on at full stretch, primarily for patients with mild and Chronic Oedema.

12.1.2 Indications for use
· For patients with venous leg ulcers who have had a full assessment from a competent practitioner. This assessment must include a Doppler assessment, see the Tissue Viability Leg Ulcer Policy.

12.1.3 Method of application
· The instructions for application of the bandages are in each pack. A practitioner should attend an appropriate study day prior to administering this treatment. The systems can be left in place for up to a week.

12.1.4 Cautions
This treatment is hazardous if used by an inexperienced practitioner, as compression can cause significant damage to a patient who has not been adequately assessed. Please read the Leg Ulcer Policy.

12.2 PASTE BANDAGES

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viscopaste (PB7)</td>
<td>Smith &amp; Nephew</td>
<td>7.5cm x 6m</td>
</tr>
</tbody>
</table>

12.2.1 Characteristics of the dressing
· Open wave bleached cotton bandage which is impregnated with zinc oxide, as below. Offers protection to reddened, irritated, skin and is soothing.
· Viscopaste contains zinc oxide 10%.
12.2.2 Indications for use
- Medicated paste bandages are used in the treatment of skin conditions associated with chronic leg ulcers. e.g. eczema, inflammation.
- Can be left in place for one week.
- Can be used under compression bandaging\textsuperscript{25}.

12.2.3 Method of application
- Applied from the base of the toes to the just below the knee.
- The bandage is applied according to the manufacturer’s instructions and is always pleated at the front of the leg, to allow room for expansion of the leg due, for example, to oedema.

12.2.4 Cautions
- Many patients are sensitive to the constituents of paste bandages. It is advisable, prior to applying to the entire leg, to carry out a patch test for at least 48 hours.
- May increase the absorption of steroids due to the occlusive nature.

For a full list of precautions and warnings see Patient Information Leaflet and/or Summary of Product Characteristics
<table>
<thead>
<tr>
<th>Dressing Category</th>
<th>Dressing on Formulary</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemostat</td>
<td>Kaltostat</td>
<td>5 x 5, 7.5 x 12</td>
</tr>
<tr>
<td>Film (including Barrier Products)</td>
<td>Secura Film</td>
<td>1ml, Wipe</td>
</tr>
<tr>
<td></td>
<td>Secura D</td>
<td>Cream</td>
</tr>
<tr>
<td></td>
<td>Clear Film</td>
<td>6 x 7, 10 x 12, 15 x 20</td>
</tr>
<tr>
<td>Low Adherent Dressings</td>
<td>Atrauman</td>
<td>5 x 5, 7.5 x 10, 10 x 10, 10 x 15, 10 x 20, 10 x 25</td>
</tr>
<tr>
<td>Low Absorbent Dressings</td>
<td>365</td>
<td>5 x 7.2, 8 x 10, 8 x 15, 10 x 10, 10 x 15, 10 x 20, 10 x 25</td>
</tr>
<tr>
<td>Foam</td>
<td>Allevyn Gentle Border</td>
<td>7.5 x 7.5, 10 x 10, 12.5 x 12.5, 17.5 x 17.5</td>
</tr>
<tr>
<td></td>
<td>Allevyn Non-Adhesive</td>
<td>5 x 5, 10 x 10, 10 x 20, 10 x 20, 10 x 13.5 (heel)</td>
</tr>
<tr>
<td></td>
<td>Allevyn Life</td>
<td>10.3 x 10.3, 12.9 x 12.9, 15.4 x 15.4, 21 x 21, 17.2 x 17.5 (sacral) 21.6 x 23 (sacral)</td>
</tr>
<tr>
<td></td>
<td>Tegaderm Foam</td>
<td>6.9 x 6.9, 10 x 11, 14.3 x 15.6 (oval), 19 x 22.5 (oval)</td>
</tr>
<tr>
<td>Absorbent Dressing</td>
<td>KerraMax Care</td>
<td>5 x 5, 10 x 10, 10 x 22, 20 x 22, 20 x 30, 20 x 50</td>
</tr>
<tr>
<td></td>
<td>KerraMax Care Border</td>
<td>16 x 16, 16 x 26, 26 x 26</td>
</tr>
<tr>
<td>Hydrogel</td>
<td>KerraLite Cool</td>
<td>6 x 6, 12 x 8.5, 18 x 12.5</td>
</tr>
<tr>
<td></td>
<td>KerraLite Cool Border</td>
<td>8 x 8, 11 x 11, 15 x 15</td>
</tr>
<tr>
<td></td>
<td>Aquaform</td>
<td>8g</td>
</tr>
<tr>
<td>Gelling Fibre</td>
<td>KerraCel</td>
<td>5 x 5, 10 x 10, 15 x 15, 2 x 45</td>
</tr>
<tr>
<td>Hydrocolloid</td>
<td>Comfeel Plus Contour</td>
<td>6 x 8, 9 x 11</td>
</tr>
<tr>
<td></td>
<td>Comfeel Plus Transparent</td>
<td>5 x 7, 10 x 10, 15 x 15</td>
</tr>
<tr>
<td>Antimicrobial Dressings</td>
<td>Silvercel Non-Adherent</td>
<td>5 x 5, 11 x 11, 10 x 20, 2.5 x 30.5</td>
</tr>
<tr>
<td></td>
<td>Actilite</td>
<td>25g</td>
</tr>
<tr>
<td></td>
<td>Medihoney Tulle</td>
<td>5x5, 10x10, 10x20</td>
</tr>
<tr>
<td></td>
<td>Medihoney Alginate (Apinate)</td>
<td>4x 5, 10 x 10</td>
</tr>
<tr>
<td></td>
<td>Medihoney Hydrogel (HCS)</td>
<td>5x5, 10x10, Rope 1.9x30</td>
</tr>
<tr>
<td></td>
<td>Inadine</td>
<td>Non adhesive 6 x 6, 11x11, Adhesive: 7.2 x 7.2, 11x11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5x5, 9.5x9.5</td>
</tr>
</tbody>
</table>
### Iodoflex
- Flaminal Forte
- Flaminal Hydro
- Cutimed Sorbact
- Prontasan Liquid PHMB
- Prontosan Gel X

### Odour Absorbing
- Carboflex
- Clinisorb

### Compression bandaging
- JuxtaCURE
  - K2
  - K2 reduced
  - K Lite Long
  - K Soft Long
  - Actico Cohesive

### Tubular bandages
- Clinifast

### Paste bandage
- Viscopaste PB7

<table>
<thead>
<tr>
<th>Dressing Category</th>
<th>Dressing on Formulary</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Larvae</strong></td>
<td>Larvae</td>
<td>See Biomonde website for further information.</td>
</tr>
<tr>
<td><strong>NSI ONLY</strong></td>
<td>Urgoclean</td>
<td>5 x 6</td>
</tr>
<tr>
<td></td>
<td>Urgotul</td>
<td>5 x 5, 10 x 10</td>
</tr>
<tr>
<td></td>
<td>Urgotul SSD</td>
<td>10 x 12</td>
</tr>
<tr>
<td></td>
<td>Urgostart Contact Layer</td>
<td>5 x 7, 10 x 10, 15 x 20</td>
</tr>
<tr>
<td><strong>PODIATRY ONLY</strong></td>
<td>Melolite</td>
<td>5 x 7.5</td>
</tr>
<tr>
<td></td>
<td>Mepilex</td>
<td>10 x 10</td>
</tr>
<tr>
<td><strong>MIU only</strong></td>
<td>Granuflex</td>
<td>10 x 10</td>
</tr>
<tr>
<td></td>
<td>Duoderm</td>
<td>10 x 10</td>
</tr>
<tr>
<td></td>
<td>Mepilex Lite</td>
<td>10 x 10</td>
</tr>
<tr>
<td></td>
<td>Adaptic Touch</td>
<td>10 x 10</td>
</tr>
</tbody>
</table>

14 EXTRA FORMULARY ITEMS FOR NURSES WITH A SPECIALIST INTEREST (NSI’S), PODIATRISTS OR TISSUE VIABILITY TEAM TO PRESCRIBE ONLY
15 EXTRA FORMULARY ITEMS FOR TISSUE VIABILITY TEAM TO PRESCRIBE ONLY

<table>
<thead>
<tr>
<th>Dressing Category</th>
<th>Dressing on Formulary</th>
<th>Size cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antimicrobial</td>
<td>Acticoat Flex 3</td>
<td>5 x 5, 10 x 10</td>
</tr>
<tr>
<td>Collagen</td>
<td>Promogran Prisma (For indications for use discuss with Tissue Viability)</td>
<td>28cm² 123cm²</td>
</tr>
</tbody>
</table>

16 ASSESSMENT AND TREATMENT OF BURNS

It is possible that any nurse may encounter a patient who has a burn or scald, either in the ward setting or in the home. The majority of these burns are minor and can be treated either as an outpatient or in a general ward setting26.

**Burn assessment**
Assessment of the depth of a burn can be difficult, as it can take several days for the depth of the burn to ‘declare’ itself. Always refer to a burns unit if the burns are on the hands or face, perineum, circumferential, cover more than 2% (in a child) or 3% (in an adult) body surface or if the wounds are deep dermal or full thickness burns17. Use the Lund and Browder assessment tool to determine the surface area of the burn. Referral can be made to either Southmead Hospital in Bristol or Salisbury District Hospital.

The practitioner should always ask for advice from the burns unit if unsure of the diagnosis of depth. **All burns should be reviewed at 24-48 hours.**

**Assessment of depth:**

<table>
<thead>
<tr>
<th>Depth of burn:</th>
<th>Blistering</th>
<th>Appearance</th>
<th>Pinprick test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superficial Dermal</td>
<td>Present</td>
<td>Pale pink</td>
<td>Sensitive to pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capillary refill present</td>
<td></td>
</tr>
<tr>
<td>Deep Dermal</td>
<td>+ / -</td>
<td>Brick red</td>
<td>Dullness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fixed stain / mottled</td>
<td>Insensitive to pain</td>
</tr>
<tr>
<td>Full Thickness</td>
<td>Absent</td>
<td>Grey / White / Brown</td>
<td>No sensation</td>
</tr>
</tbody>
</table>

Deep dermal and full thickness burns must be referred to a burns unit, either at Southmead in Bristol or Salisbury District hospital. Apply cling film to the burn to transfer to the burns unit if possible and ensure that the patient is nil by mouth.
16.1 Burn treatment
• Remove source of heat, i.e. clothing if hot water spill.
• Irrigate with cool water, ideally for 10 minutes - a maximum of 20 minutes, due to the risk of hypothermia. This will dissipate the heat from the body tissue and can prevent further damage to the tissues27.
• If the skin surface is broken and the patient is awaiting assessment, apply cling film, as this helps to minimise pain by protecting it from exposure to the air.

16.2 Facial burns
• Clean with normal saline.
• Leave exposed.
• Apply soft paraffin to lips.
• Refer to a burns unit.

16.3 Hands and feet
• Remove all rings.
• Ask burns unit for advice or transfer for opinion.
• For intact skin, encourage the patient to shower to clean the area – Comfeel or Atrauman are dressing options. If the burn covers a small area; another option is Yellow Soft Paraffin if a dressing is not necessary on fingers, it is essential to use a dressing that does not stick – therefore only use Atrauman if the dressing can be changed every day. If the intention is that the dressing will stay in place for longer then consider Urgotul or Urgotul ssd (if infection is likely).
• If the skin is blistered, encourage the patient to keep the burn clean by showering. The application of Duoderm is appropriate for intact blisters or protect with Atrauman – if there is no risk of adherence, then apply a secondary dressing. If there is a risk of adherence, or if the dressing is to be left in place for 5–7 days, then consider Urgotul or Urgotul ssd (if infection is likely).
• If the blister is large or if the blister fluid is applying pressure to the underlying tissues, consider de-roofing. In this circumstance, Flamazine could be considered (but only if the burn is being treated conservatively in the community, not if the patient is to be assessed at a burns unit, as Flamazine will mask the burn, inhibiting assessment).
• Advise on regular finger and wrist exercises.

16.4 Body and limbs
• If blisters are tense or broken, then consider de-roofing the blister (this is detached epithelium that can delay healing if left in situ).
• Dressing of choice will depend on area to be covered, position of wound and its depth (see above recommendations for hands and feet).
• Hydrocolloids can also be used on appropriate sized burns of any depth – the dressing must clear the wound edge by a minimum of 2 cm.
NOTES
17  BIBLIOGRAPHY

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Weight limit</th>
<th>Equipment</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>For treatment</td>
<td>31 stone</td>
<td>Talleys Quattro Plus Air Mattress Replacement</td>
<td>Sits on the bed base, self-adjusting to patient’s weight. Alternating but can convert to low air loss if patient has pain or for comfort at end of life. For patient over 18 stone or who has a category II/III pressure ulcer. Can come with a Talleys air cushion if required.</td>
</tr>
<tr>
<td>18 stone</td>
<td>Sichil SoloXtra</td>
<td>This is the first line choice for immobile patients up to 18 stone who are at RISK and/or have a category I/II pressure ulcer.</td>
<td></td>
</tr>
<tr>
<td>15 stone (125kg)</td>
<td>Propad overlay and cushion</td>
<td>These products are made of castellated foam and are for patients at RISK of developing pressure ulcers. Place overlay on top of a foam mattress but not a Sofamor as this offers the same pressure reduction as the Propad.</td>
<td></td>
</tr>
<tr>
<td>26 stone (165kg)</td>
<td>Mercury mattress – 17.5cm deep</td>
<td>For patients at RISK of developing pressure ulcers but are able to change their own position or their position be changed frequently. Repositioning must be in a care plan and documented.</td>
<td></td>
</tr>
<tr>
<td>Unlimited weight</td>
<td>Roho by Shihoh Roho mattress and cushion – 10cm deep</td>
<td>Cushion and mattress available, this is a static system which reduces the pressure, effective as there is no weight limit.</td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td>22 stone (139kg) 7.5cm deep</td>
<td>Flotech Solution</td>
<td>For patients at RISK of developing pressure ulcers. It can be used for treatment of category II plus pressure ulcers when the pressure is regularly relieved.</td>
</tr>
<tr>
<td></td>
<td>ToTo</td>
<td>For patients who cannot reposition independently but would benefit from position changes, particularly if not having care overnight.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EHOB</td>
<td>For prevention of pressure ulcers, static system offering the same pressure reducing as a Propad / Soffom. The wedge is useful for heel protection when the Repose heel protector is not appropriate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Repose</td>
<td>For prevention of pressure ulcers to heels. Non-washable alternative consider HealzPro.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KeraPero range: KCI Many shapes and sizes available on prescription</td>
<td>To be placed on intact skin to reduce the pressure.</td>
<td></td>
</tr>
</tbody>
</table>
Measurement Guide

How and where to measure:

1. Measure the widest part of the foot from A to B to calculate foot width.

2. Measure from A to B to calculate the dressing circumference at the widest part of the foot.

What size Kerraped® do you need?

<table>
<thead>
<tr>
<th>Kerraped® Size</th>
<th>Shoe Sizes</th>
<th>Foot Width (Max cm)</th>
<th>Dressing Circumference (cm)</th>
<th>PIP Code</th>
<th>NHS Catalogue number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerraped® - Small</td>
<td>Min - 2</td>
<td>Min - 34</td>
<td>7.6</td>
<td>23.8</td>
<td>329-4741 ELY253</td>
</tr>
<tr>
<td></td>
<td>Max - 5 ½</td>
<td>Max - 39</td>
<td>8.6</td>
<td>27.1</td>
<td></td>
</tr>
<tr>
<td>Kerraped® - Medium</td>
<td>Min - 6</td>
<td>Min - 39 ½</td>
<td>8.8</td>
<td>27.6</td>
<td>329-4758 ELY252</td>
</tr>
<tr>
<td></td>
<td>Max - 7 ½</td>
<td>Max - 41 ½</td>
<td>9.2</td>
<td>29.0</td>
<td></td>
</tr>
<tr>
<td>Kerraped® - Large</td>
<td>Min - 8</td>
<td>Min - 42</td>
<td>9.4</td>
<td>29.5</td>
<td>329-4774 ELY251</td>
</tr>
<tr>
<td></td>
<td>Max - 10</td>
<td>Max - 44 ½</td>
<td>10.0</td>
<td>31.4</td>
<td></td>
</tr>
<tr>
<td>Kerraped® - Extra Large</td>
<td>Min - 10 ½</td>
<td>Min - 45</td>
<td>10.1</td>
<td>31.8</td>
<td>329-4782 ELY250</td>
</tr>
<tr>
<td></td>
<td>Max - 13</td>
<td>Max - 48</td>
<td>10.9</td>
<td>34.2</td>
<td></td>
</tr>
</tbody>
</table>

www.crawfordhealthcare.com

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Darco GmbH & Co. KG, Gewerbegebiet 18, D-82399 Raisting, Germany
Tel: +49-8807-92280

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- KCI
- L&R Medical
- Medi
- Richardson Healthcare
- Smith & Nephew
- Urgo
- 3M
- 365 Healthcare