



Wound Management Guide and Dressing Formulary 2021

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Introduction

This Wound Management Guide and Dressings Formulary contains details of the agreed dressings resulting from work of the Pan Avon Working Group, which incorporated representation from Bristol, North Somerset and South Gloucestershire (BNSSG) acute, and community organisations plus involvement from NHS supply chain and NHS procurement. The formulary has been developed to benefit from cost efficiencies of all the organisations working together to agree on one formulary to be used across all sectors. The added advantage for the patient is that there should be seamless care regarding wound care products.

The dressing choices offered are found to be effective for the majority of patients with wounds

This Formulary should be used in association with the:

- Aseptic Non Touch Technique (ANTT) policy and guidelines
- Prevention of pressure injuries guidance
- Lower limb guidelines and pathways (2020)
- Diabetic foot ulceration standards of care
- Biofilm pathway

Aims

- Best practice in wound management
- To guide practitioners to select appropriate dressing choice after holistic assessment.
- Standardisation of appropriate products
- Cost effectiveness

Wound Management

Dressings are applied to wounds for many reasons:

- To facilitate rapid and cosmetically acceptable healing
- To reduce pain
- To prevent or combat infection and manage biofilm
- To contain exudate
- To remove or contain odour
- To provide maximum comfort for the patient

Wound healing is a dynamic process and the characteristics of a dressing required by the wounds can change as the wound moves through the different phases of the healing process. The wound healing continuum will aid clinical decision-making regarding appropriate dressings at each stage of wound healing.

Using the formulary

All wounds should be holistically assessed. The underlying pathology that may compromise wound healing should be identified and addressed where possible.

A diagnosis of wound aetiology is essential as treatment pathways differ according to the aetiology of the wound.

The dressings in the formulary are suitable for the majority of wounds and for each wound stage there are product choices to accommodate practitioner and patient preference.

A selection of dressings that might be needed in specific specialist cases is also available on request to the wound care service

Avoid using layers of dressings as far as possible. Most dressings are designed as wound contact layers in their own right. Putting them on top of one another only reduces their effectiveness and is wasteful.

The dressings chosen should promote minimal interference with wounds and frequency of changes should normally reflect the maximum wear time.

Dressings should be ordered on line using the Formeo (Bristol and North Somerset) or Solo (South Gloucestershire) ordering system. No more than a week's supply of dressings should be left in the patient's home, as the wound requirement will change as it moves through the healing process.

New Products and Review of the Formulary

The formulary will be updated as required but some changes to the dressings available on the template will occur annually. The changes will reflect current best practice.

New products can be proposed to a Pan Avon Formulary Product review panel which will then trial and evaluate whether the product should be added to the current formulary.

Dressing Samples

Manufacturers' sales representatives often offer staff 'samples' of dressings. Samples should not be used to treat NHS patients and all offers should be declined. All products discussed by reps should be on the formulary. Reps should only visit you every 6/12.

Skin tears

The updated 2018 ISTAP definition of a skin tear:

"A skin tear is a traumatic wound caused by mechanical forces, including removal of adhesives.

Severity may vary by depth (not extending through the subcutaneous layer)"

Skin tears are often under-recognised and misdiagnosed in clinical practice. In order for skin tears to receive optimal treatment, accurate identification and classification are essential; therefore, an accurate definition of skin tears is a crucial starting point.

There is often confusion in terminology, thus a need exists for standardisation of terms and definitions. In practice, skin tears are often referred to under the general terms of 'laceration' or 'cutaneous laceration'. However, a skin tear is a specific injury that is very different from a general laceration (which is defined by soft tissue tearing). Skin tears are traumatic wounds that may result from a variety of mechanical forces such as shearing or frictional forces, including blunt trauma, falls, poor handling, equipment injury or removal of adherent dressings. In already fragile or vulnerable skin (e.g. in aged or very young skin), less force is required to cause a traumatic injury, meaning that incidence of skin tears is often increased. Skin tears can occur on any part of the body but are often sustained on the extremities such as upper and lower limbs or the dorsal aspect of the hands.

Further reading - Best Practice recommendations for the prevention and management of skin tears in aged skin. Leblank et al (2018) Wounds international. Available to download www.woundinternational.com

Skin tears on the lower limb should be treated following the lower limb guidelines and pathways.

Classification used for this pathway

The updated 2018 ISTAP definition of a skin tear:

Type 1: Skin loss



Linear or flap tear which can be repositioned to cover the wound bed

Type 2: Partial flap loss



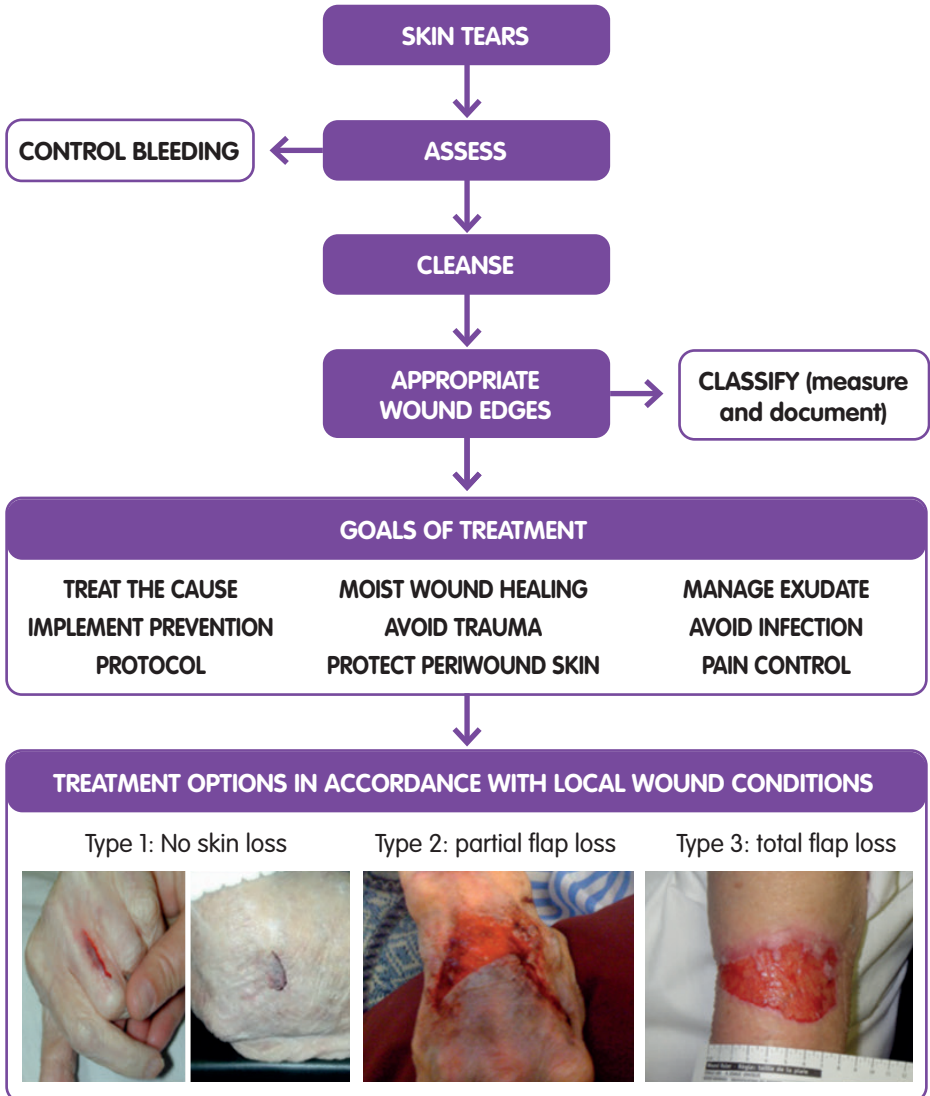
Partial flap loss which cannot be repositioned to cover the wound bed

Type 3: Total flap loss



Total flap loss exposing the wound bed

Skin Tears ISTAP Classification



Product selection guide

Product categories	Indications	Skin Tear type	Consideration
Non adherent dressings (e.g. silicone mesh Sifflex or petrolatum mesh atrauman.	Dry or low exudate	1,2,3,	Maintains moisture balance for multiple levels of wound exudate, atraumatic removal, will need secondary dressing cover.
Foam dressing Allevyn and Allevyn Gentle	Moderate exudate, longer wear time (2-7 days) depending on exudate levels.	2, 3,	Caution with adhesive border foams, use non adhesive versions when possible to avoid periwound trauma. Or use silicone version.
Hydrogels or hydrogel sheet Flaminal, Purilon and Actiform Cool.	Donates moisture to dry wounds	2,3,	Maintains moisture balance for multiple levels of wound exudate, atraumatic removal, gels will need a secondary dressing.

Negative pressure

What is VAC therapy?

Vacuum assisted closure (VAC), also known as negative pressure wound therapy (NPWT) is used on hard to heal/ large/ highly exuding wounds. Wounds which are unmanageable with conventional dressings eg. Would need multiple dressings to pack, or are requiring daily dressing changes due to exudate volume, or a static wound, could be considered for VAC therapy.

Wounds suitable for VAC therapy:

VAC can be used on various wound aetiologies, including;

- Pressure injuries
- Surgical wounds, often dehiscent surgical wounds
- Diabetic foot ulcers
- Traumatic wounds
- Pilonidal sinuses



How does it work?

Negative pressure is created by suction, like a vacuum. The mechanisms of action for VAC Therapy include drawing wound edges together, removing infectious materials and wound fluids, promoting perfusion, maintaining a closed, moist wound healing environment and promoting granulation tissue formation.

ACTI VAC pumps are portable and charged via the mains, patients need to be able to carry them with them at all times and be able to plug them into a power source to charge eg. Over night. Exudate is collected in a canister attached to the pump.

Contraindications for VAC therapy include;

- Malignancy of wound
- Presence of necrotic/ devitalised tissue in wound bed
- Untreated osteomyelitis
- Unexplored and high output fistulas
- Ischaemia/ absence of blood supply

PICO (7 or 14) is a single use negative pressure, battery powered system, lasting up to 7 or 14 days. The pump fits into the palm of a hand/ pocket. Used for wounds with low to moderate exudate with up to 2cm depth. For wounds with 0.5-2cm depth, a wound filler eg. PICO gauze should be considered. PICO can be used on various wound aetiologies, like VAC therapy.

Wound exudate is managed in the dressing; there is no canister inside the pump, therefore not suitable for highly exuding wounds.



Larvae Therapy, also known as ‘Maggot Therapy’

Larvae therapy involves the use of larvae of the greenbottle fly, which are placed into a wound to remove necrotic, sloughy and/or infected tissue which will improve the condition of a wound and allow the process of healing to begin.

How does Larvae Therapy work?

The larvae feed on dead tissue by releasing a mixture of natural enzymes and components into the wound. The enzymes break down non-viable tissue into a liquid that the larvae digest, also removing bacteria. Exudate levels will increase during this process. This process is so effective that larvae can often clean a wound within a few days.

When should larvae therapy be used?

- It is not a first line treatment for all wound types.
- An ideal treatment for rapid debridement of sloughy/necrotic category 3 and 4 pressure injuries prior to the application of topical negative pressure therapy.
- Other wound types i.e. surgical wounds, traumatic wounds that are struggling to debride with standard formulary dressings may also be appropriate.

Biobag (similar to a teabag) – there are 5 sizes of Biobag allowing for use in small to moderately large wounds. The larvae remain in the position the Biobag is placed. Multiple bags can be placed in a single wound. A Biobag is not always the most effective therapy for wounds with irregular shapes or undermining/tunnelling areas.



Contra-indications

Larvae **should not** be used on:

- Wounds that have a tendency to bleed easily or are close to large blood vessels
- Patient's on anticoagulants with clotting markers below acceptable clinical range.
- Wounds with dry necrotic eschar, rehydration is required first.

Larvae **should be used with caution** on: (seek wound care service support)

- Wounds such as sinuses or fistulas
- Wounds over adjacent exposed organs or leading to a body cavity.

How to access larvae therapy

- Discuss with your wound care specialist nurse who will be able to support in choosing the right size biobag of larvae required **and/or**

- Discuss with your non-medical prescriber (NMP) or the patient's general practitioner (GP). You will need to provide them with accurate details of what is required they may not be familiar with prescribing larvae therapy.
- The best place to find the most up to date information is at <https://biomonde.com/en/>

Larvae therapy remains in situ for 4 days, requiring daily visits for maintenance of outer dressings. Occasionally more than 1 course will be required; you should make this assessment on day 3 so that a further course can be arranged without a gap in treatment.

Measuring a wound

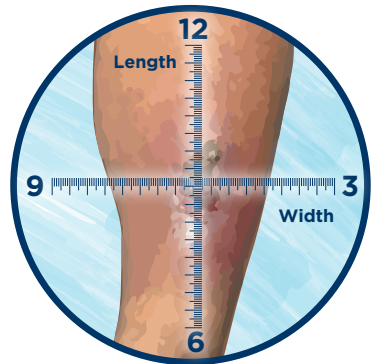
Length, width and depth (L x W x D) of a wound should be recorded to monitor progress of a wound.

Measurements should be taken using a head to toe orientation. Using a clock face is an easy way of recording measurements, where 12 o'clock is the direction of a patient's head and 6 o'clock is in the direction of their feet.

From 12 – 6 o'clock records the length of the wound and from 9 – 3 o'clock records the width.

For wounds with depth, a probe will need to be used.

Tracing can also be used to assist with monitoring progress of a wound, taking measurements and describing the measurements or wound bed.



Hypergranulation

Hypergranulation, overgranulation or proud tissue is most commonly seen in chronic wounds healing by secondary intention.

For a wound to heal normally, the bed of the wound needs to granulate upwards and fill the void, so that the edges of the wound (epithelial cells) can grow and spread over the top of the granulation tissue.

However, epithelial cells are only able to grow horizontally; therefore if the granulation cells have grown higher than the epithelial cells, epithelisation cannot occur. The result is prolonged wound bed exposure, therefore increasing the risk of wound infection.

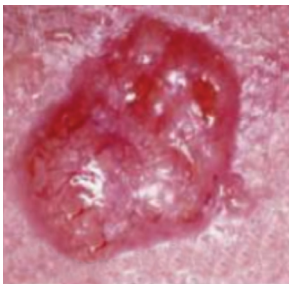
It is generally believed that the hypergranulation is precipitated by a kind of altered inflammatory response. It is an excess of granulation tissue, usually recognised clinically by its friable, red often shiny and soft appearance that protrudes above the surrounding skin.

Malignancies

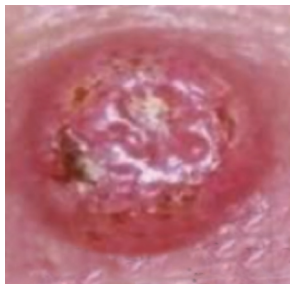
Can sometimes resemble hypergranulation tissue, therefore examine any suspected cases carefully and look for the signs which could indicate a malignancy requiring an urgent referral to Plastics or dermatology. Basal Cell carcinoma (BCC) Squamous cell carcinoma (SCC) Malignant melanoma (MM).

Indications of Malignancies

1. The tissue has been present for many months or years
2. The tissue is hard to touch
3. May have a cauliflower appearance
4. Tissue has grown beyond the wound margins
5. It does not respond to suggested treatments for hypergranulation.



Basal cell carcinoma



Squamous cell carcinoma



Malignant melanoma

Cause of hypergranulation	Extra considerations	Treatment	Practical tips	Further practical tips
Infection or increased bacterial load	When a wound is infected it enters an inflammatory phase, increasing exudate.	Treat as per guidelines for bacteria burden and infection of wounds	First line silver, step up to superabsorbent	Step down after 2 weeks or use
Foreign bodies/ irritants in the wound bed	What has allowed this foreign body into the wound? Hair? Remove, shave if needed. Dressing? Remove Eliminate it happening again.	Observe for any undissolved sutures, or one that may have been left in. Remove.		Encourage patients not to poke prod or contaminate the wound bed.
Friction usually related to tubing, eg, SP catheters	Ensure that you have identified the cause, clothing, footwear, especially on surgical sites.	Remove cause of friction where possible.	If there is excess exudate due to the friction, manage this appropriately keyhole dressings, absorbent dressings, no occlusion.	Use haelan tape daily Use Mometasone furoate 0.1% on atrauman with a keyhole dressing.
Poorly managed exudate	If on the leg is compression indicated.	Check cause of excess exudate and treat. Eg Infection Friction Need to compress if lower limb.	Review absorbent pad and step down or up as needed.	
Occlusion	Commonly caused by interactive dressings, hydrocoilds or occlusive dressings	Film dressings can allow for some moisture vapour, but not if built up with many layers of different dressings.	Switch to a non-occlusive dressings, stop using hydrocolloids and stop layers dressings.	Atrauman as a primary dressing with a pad can be used. Layering reduces vapour permeability.

Treatment of hypergranulation

Prevention as with many issues in wound care, carrying out a thorough and holistic assessment can help to identify risks which may contribute to the development of hypergranulation tissue. Good wound bed management such as regulation of bacterial loading, debridement cloths, exudate control, avoidance of dressing adherence/friction etc will help to reduce the likelihood of hypergranulation tissue developing.

Topical Steroids

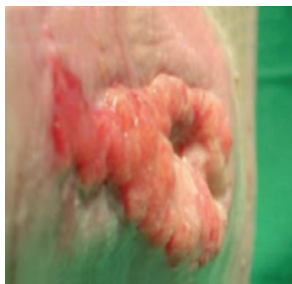
This should not be used first line management for hypergranulation and should only be considered when all other treatment options have been explored. Steroids can be effective at dampening down the inflammatory response. A week's application of a potent steroid, Mometasone furoate 0.1%, may need to be applied onto atrauman, and then review is a good second line. It is advisable that you contact the WCS to discuss their use, if there has been no improvement, after trying measures already suggested.

Haelan tape is available and licensed for use in cases such as Granulomas and hypergranulation, but again please discuss with WCS.

Drain sites with hypergranulation:



Side view of hypergranulation:



Wound assessment

The physical characteristics of and symptoms associated with each wound should be assessed using the relevant parameters from a chosen wound assessment tool.

The location of each wound should be recorded accurately, using appropriate anatomical language.

Photography is recommended and should be used according to local policies and following appropriate patient consent. Photographs should be labelled to avoid confusion.

Consistency of wound measurement technique is important for wound size monitoring.

Wound bed condition and amount/type of exudate will play a dominant role in selecting the wound dressing(s) and dressing change frequency.


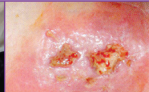




Diagnosis of infection is usually based on clinical signs and symptoms; routine swabbing should be avoided.

Symptoms, such as pain, should be explored to determine severity, timing and triggers/ relievers



TIMERS wound assessment tool

Please refer to the Sirona TIMERS framework leaflet for more information:

The TIMERS Table Removing the barriers to wound healing					
					
Tissue, non-viable or deficient The appearance of a wound bed indicates the 'health' of the tissue. Devitalised tissue (eg. thick fibrinous slough) provides an ideal environment for microbial growth and biofilms to form.	Infection, inflammation or biofilm Bacterial burden and biofilm can build which will delay healing and can increase pain, exudate and odour. Bacterial burden or biofilms can still be present without infection present. This can also delay wound healing.	Moisture imbalance Exudate is a normal part of wound healing: it contributes to autolysis (removal of devitalised tissue). Dry wound beds can impede the healing process. However, high exudate levels can also impede healing, breaking down vulnerable new wound tissue and macerating the periwound skin. Actions: High exuding wounds – use a superabsorbent dressing and a barrier film from formulary. Consider compression for lower limbs. Dry wounds – use moisture donating dressing unless on lower limb. Wounds on the lower limb need a vascular assessment to check circulation before debriding. Do not use moist dressings on Diabetic feet. Refer to WCS or podiatry for support.	Edge of wound Healthy wounds epithelialise from the edge. If there is a lack of epithelial presence at the wound edges, the wound edges are failing to reduce in size or there are rolled edges present, this indicates that wound healing is not progressing as it should.	Repair/ Regenerate/ Refer If a wound is slow or failing to heal, advanced therapies may need to be considered. Ensure all other factors within TIMERS have been considered and refer to the Wound Care Service for further assessment.	Surrounding skin Surrounding skin can be affected by the wound management or treatment plan in place. Surrounding skin forms part of the holistic assessment, as this could affect the wound healing process.
Actions: Debride if appropriate. Do not debride lower limb wounds without Doppler assessment, seek Wound Care Services (WCS) advice if unsure. Examples of debridement include: moisture donating dressings, debridement cloths, larvae therapy. If a leg ulcer, compression will aid debridement.	Actions: Commence antimicrobial dressing from dressing formulary. Review after two weeks of use. Also consider use of larvae and if clinical signs of infection, will need antibiotics for infection. Use a debridement cloth to disrupt biofilms, this will break the biofilms up and allow antimicrobial dressings to work effectively.		Actions: Refer back to T, I and M , to ensure all previous factors have been assessed. Consider biofilm presence, debridement, protecting the wound edges. Ensure correct treatment plan being followed. Liaise with WCS if wound is static.	Advanced therapies include: – Negative pressure therapy eg. VAC/ PICO – Oxygen therapy eg. Natrox/ Granulox Onwards referral to plastics/dermatology/vascular may also need to be considered.	Actions Check for excoriation, maceration, dry and scaly skin. Address cause of skin issues eg. Adhesive irritating skin, sensitivities to dressings, leg being bandaged, lack of essential skin care. Address issues eg. Washing and creaming skin, using a barrier cream or film, debride dry skin.

Photography in wound care

Clinical Photography relates to any photographs or videos taken by clinicians in practice that are used to support/evidence a patient's care.

Wound photography has the potential to validate and enhance the wound assessment process by providing useful information regarding the current status/healing progress of a wound (Jacob 2019). To ensure photographs can be confidently utilised in clinical decision making and care planning it is imperative that they are high quality images which are clearly labelled and capture as much information as possible (Sperring & Baker 2014).

Tips to achieving gold standard photography in practice.

- Ensure the appropriate consent is gained prior to any wound photography and documented clearly in the patient's record (this should be done every time).
- Be prepared; take the time to plan so as to maximise the accuracy of the photographs. You may require more than one person to position the patient comfortably to facilitate this.
- **Make it count!** Consider lighting, positioning and where possible try to ensure the patient is in a consistent position to enhance reliability of images.
- **Always** use a Sirona provided device to take photographs, never use personal phones/devices.
- Clearly label each photograph and Include; Patient Initials and last 4 digits of the NHS number, date photograph taken, nurses initials, location of wound (this information can be written on the measuring tool).
- In addition, include a distanced photograph (approx 1m) to give a sense of perspective to the body, this will limit confusion of the location of the wound and enhance accuracy of documentation.
- Photographs should be taken regularly throughout a care episode to provide a clear timeline to enhance and support documented wound assessments.
- Ensure that photographs are promptly uploaded to the patients electronic records and then deleted from the mobile device/camera.(Estacado & Black 2019, Jacob 2019 Sperring & Baker 2014)

Responsibilities in Clinical Photography

Wound photographs will form part of a patient's medical record and are legal documents. It is important therefore that any person/s involved in producing such images understands their accountability and responsibility for the use and management of this data (Hampton & Kilroy-Findley 2016). This includes; Consent, Privacy and Dignity, General Data Protection Regulation (GDPR) and Record Keeping.

*Refer to the Sirona Care and Health Policies and Procedure documents for further information

Biofilms

What is a biofilm?

Biofilms are complex colonies of bacterial populations encased in a protective extracellular polymeric substance (EPS), which helps them to adhere to a suitable surface. They are tolerant to antimicrobial agents including antibiotics and antimicrobials (WUWHS 2016).

Should you cleanse a wound if it looks clean?

Biofilms are not visible to the naked eye.

Wounds must be clean to heal. Preparation of the wound bed, including regular cleansing and debridement supports the disruption of biofilms (WUWHS 2016, Murphy et al 2020).

What is physical debridement of a wound bed?

A biofilm in a wound bed is like dental plaque on your teeth. They can cause problems if left unattended which can lead to wound bed deterioration and delayed wound healing. We brush our teeth regularly to debride dental plaque so we need to be doing the same for wound beds. Undertaking regular debridement using a 'biofilm based wound care' strategy will support reduction of wound biofilms and increasing healing (Medi UK 2020)

Type of physical debridement pads/cloths:

- Dry non-woven gauze swab – Use the swab to firmly brush over the wound bed to remove debris and disrupt biofilms.
- UCS cloth – The cloth has unique loop technology to capture and disrupt the biofilm within the wound bed, rather than redistributing the bacteria to another part of wound bed cleansed. UCS contains a surfactant – use a vigorous circular action for 3-5 minutes on the wound bed.
- Debrisoft Pad/Lolly - Uses monofilament fibre technology™. Each pad/lolly has millions of fibres that are cleverly designed to lift, bind and remove bacteria and biofilms (L&R Medical Ltd 2020). Debrisoft should have 20 – 40mls surfactant (Octenalin) added – use a vigorous circular action for 3 -5 minutes on the wound bed.

DO NOT IMMERSE these products in a bowl of water.



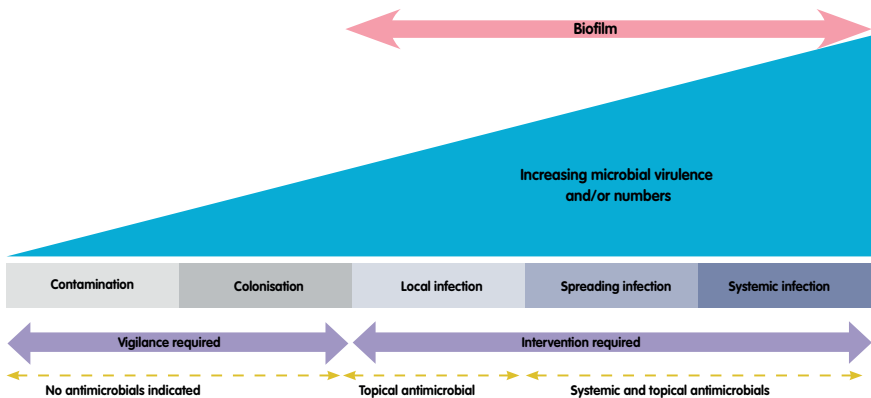
Wound infection

Wound infection is a clinical challenge that can delay wound healing. Diagnosis of wound infection should combine the clinician’s professional judgement and the clinical presentation of the wound and patient. Clinicians caring for patients with or at risk of wounds should be able to recognise signs and symptoms of wound infection.

Wound swabbing is not used to diagnose infection, but to guide antibiotic selection against the organisms causing the clinical signs of infection.

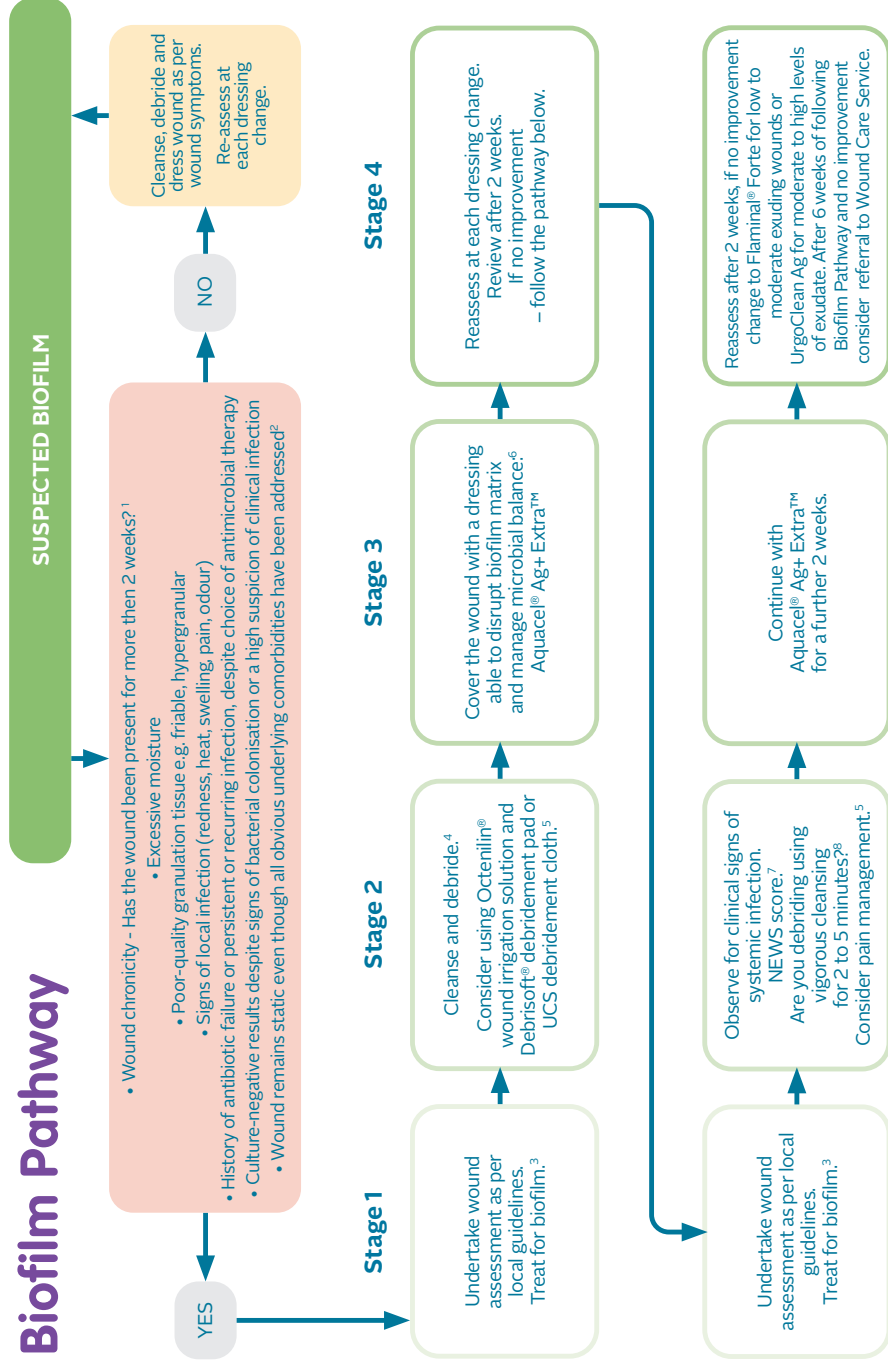
Sirona policy should be followed when using antimicrobial dressings. Antimicrobial dressings are recommended to be used for a minimum of 2 weeks duration. After 2 weeks of use, the wound(s) should be evaluated. Antimicrobial dressings should be discontinued if the signs and symptoms of infection have resolved after 2 weeks, however if signs and symptoms are still present and the wound is progressing, the antimicrobial dressing should be continued and reviewed again after 2 weeks. If no progress, an alternative antimicrobial dressing should be considered, as well as onwards referral to the Wound Care Service.

(Best Practice Statement – Antimicrobial stewardship strategies for wound management 2020)

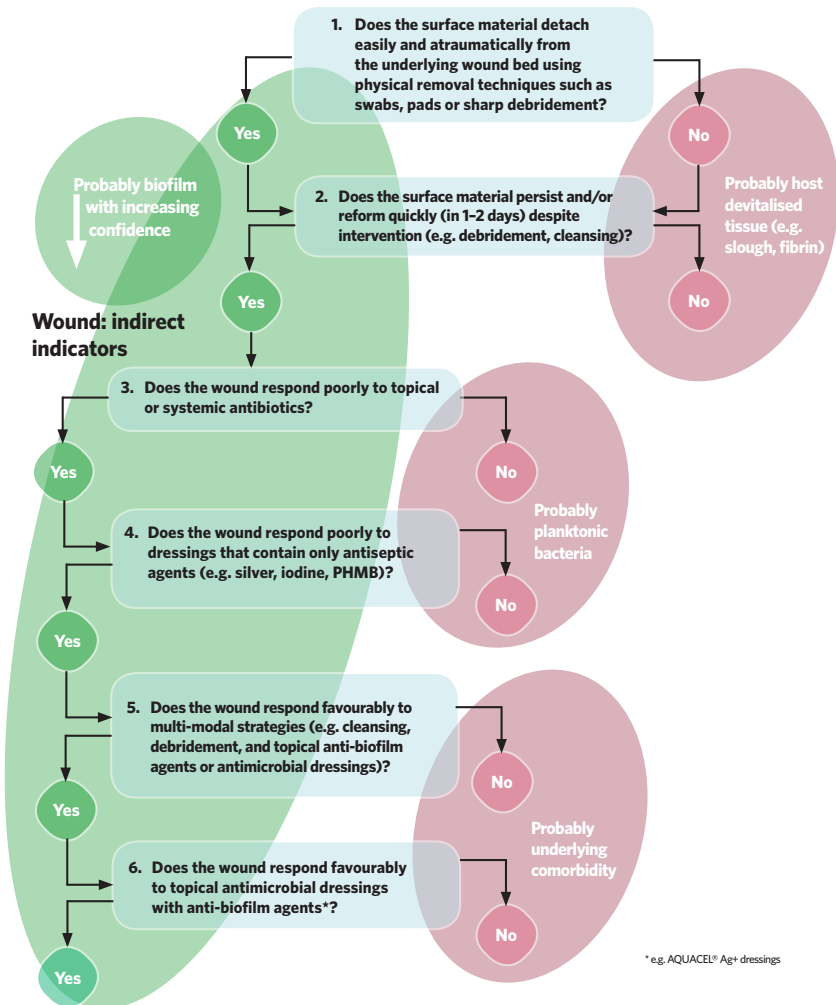


Signs and symptoms associated with stages of the wound infection continuum (IWII, 2016)					
Contamination	Colonisation	Local infection		Spreading infection	Systemic infection
All wounds may acquire micro-organisms. If suitable nutritive and physical conditions are not available for each microbial species, or they are not able to successfully evade host defences, they will not multiply or persist; their presence is therefore only transient and wound healing is not delayed	Microbial species successfully grow and divide, but do not cause damage to the host or initiate wound infection	Covert (subtle) signs of local infection: <ul style="list-style-type: none"> ■ Hypergranulation (excessive ‘vascular’ tissue) ■ Bleeding, friable granulation tissue ■ Epithelial bridging and pocketing in granulation tissue ■ Wound breakdown and enlargement ■ Delayed wound healing beyond expectations ■ New or increasing pain ■ Increasing malodour 		<ul style="list-style-type: none"> ■ Extending in duration +/- erythema ■ Lymphangitis ■ Crepitus ■ Wound breakdown/dehiscence with or without satellite lesions ■ Malaise/lethargy or non-specific general deterioration ■ Loss of appetite ■ Inflammation, swelling of lymph glands 	<ul style="list-style-type: none"> ■ Severe sepsis ■ Septic shock ■ Organ failure ■ Death

Biofilm Pathway



Clinical Algorithm for Biofilm Identification⁸



1. Wounds UK Quick Guide, Managing Biofilm in Static Wounds. 3-4.

Reference:

1. Wounds UK (2019) Best Practice Statement: Addressing complexities in the management of venous leg ulcers. London: Wounds UK. Available to download from: www.wounds-uk.com; 9. 2. Metcalf D et al (2014) A clinical algorithm for wound biofilm identification. J Wound Care 23(3); 140. 3. International Wound Infection Institute (IWII) Wound infection in clinical practice. Wounds International 2016; 17. 4. Phillips PL, Wolcott RD, Fletcher J, Schultz GS. Biofilms Made Easy. Wounds International 2010; 1(3). Available from <http://www.woundsinternational.com>; 3. 5. 5. Murphy C, Atkin L, Swanson T, Tachi M, Tan YK, Vega de Ceniga M, Weir D, Wolcott R. International consensus document. Defying hard-to-heal wounds with an early antibiofilm intervention strategy: wound hygiene. J Wound Care 2020; 29(Suppl 3b):S1–28; 11. 17. 6. Walker M, Metcalf D, Parsons D, Bowler P et al (2015) A real-life clinical evaluation of a next-generation antimicrobial dressing on acute and chronic wounds. J Wound Care; 10. 7. Royal College of Physicians. National Early Warning Score (NEWS): Standardising the assessment of acutellness severity in the NHS. Report of a working party. London: RCP; 2012. 8. World Union of Wound Healing Societies (WUWHs) Florence Congress, Position Document, Management of Biofilm, Wounds International 2016; 10. 9. ®/™ indicates a trademark of ConvaTec © ConvaTec Inc. 2020 The printing of this Biofilm Pathway was financially supported by ConvaTec Limited. Sirona Care and Health is solely responsible for the content of the document and any recommendations. AP-031455-MRL-GB

Wound healing continuum and appropriate products:

Type / appearance / photo of wound	Assessment/ treatment of wound
<p>Black wound – Necrotic tissue on the foot</p> 	<p>Patients with Diabetes MUST be under podiatry and referred urgently to the Secondary Care Diabetic Foot Clinic</p> <p>Tissue: Necrotic tissue kept dry on feet</p> <p>Infection: Monitor especially Diabetics</p> <p>Moisture: Inadine/Atrauman - Dry</p> <p>Edge: May start to autodebride</p> <p>Refer: Check vascular status - Do NOT attempt to debride</p> <p>Surrounding skin: Moisturise, K-Soft and K-Lite toe to knee</p> <p>Ensure there is no pressure to the area. Float heels.</p> <p>Social: Information for patient / carers</p>
<p>Mixed aetiology leg ulcer pathway</p> 	<p>Patients with Diabetes MUST be under podiatry and referred urgently to the Secondary Care Diabetic Foot Clinic</p> <p>Tissue: Necrotic tissue kept dry on feet</p> <p>Infection: Monitor especially Diabetics</p> <p>Moisture: Inadine/Atrauman /Pad</p> <p>Edge: May start to autodebride</p> <p>Refer: Check vascular status Do NOT attempt to debride</p> <p>Surrounding skin: Moisturise, K-Soft and K-Lite toe to knee. Ensure there is no pressure to the area. Float heels</p> <p>Social: Information for patient / carers</p>


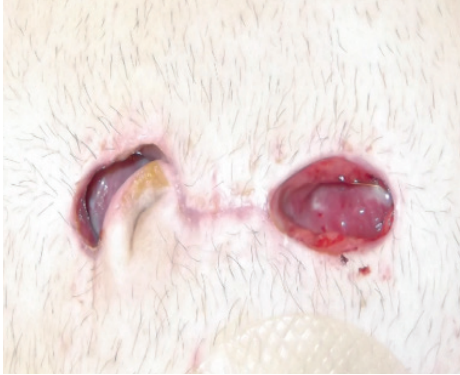
Type / appearance / photo of wound	Assessment/ treatment of wound
<p>Black – Dry necrosis on the buttocks due to pressure, or other location excluding feet</p> 	<p>Necrosis on the buttock typically over the ischial tuberosity as a result of pressure from sitting needs debridement.</p> <p>Tissue: Necrotic tissue needs debridement</p> <p>Infection: Monitor</p> <p>Moisture: Actiform cool to hydrate /Pad</p> <p>Edge: Trace to monitor</p> <p>Refer: Consider larvae</p> <p>Surrounding skin: Protect</p> <p>Social: Ensure pressure relieving equipment and repositioning is in place</p> <p>Information for patient/carers</p> <p>NB: If at end of life do not debride – keep dry</p>
<p>Black yellow wound – Necrosis and slough on the buttocks, or other location excluding feet</p> 	<p>Tissue: Necrotic and slough on buttock needs debridement</p> <p>Infection: Monitor for signs</p> <p>Moisture: Dry or low exudate Actiform cool to hydrate /Pad Once some moisture is present consider UrgoClean flat or Hydrocolloid eg. Comfeel plus</p> <p>Edge: Trace to monitor</p> <p>Refer/ Regenerate: Consider larvae</p> <p>Surrounding skin: Protect</p> <p>Social: Ensure pressure relieving equipment and repositioning is in place</p> <p>Information for patient/carers</p> <p>NB: If at end of life do not debride – keep dry</p>

Type / appearance / photo of wound	Assessment/ treatment of wound
<p>Black yellow wound – Necrosis and slough on the foot</p> 	<p>Patients with Diabetes MUST be under podiatry and referred urgently to the Secondary Care Diabetic Foot Clinic</p> <p>Tissue: Necrotic tissue kept dry on feet</p> <p>Infection: Monitor especially Diabetics</p> <p>Moisture: Inadine/Atrauman /Pad</p> <p>Edge: May start to autodebride</p> <p>Refer: Check vascular status Do NOT attempt to debride</p> <p>Surrounding skin: Moisturise</p> <p>Social: Information for patient / carers</p> <p>Ensure there is no pressure to the area. Float heels</p>
<p>Black yellow wound – Wet necrosis and slough in a cavity on the body (Not foot)</p> 	<p>Sloughy and wet necrosis in a cavity with high exudate 8-10</p> <p>Tissue: Necrotic and sloughy tissue need to debride</p> <p>Infection: Monitor for clinical signs</p> <p>Moisture: Manage exudate:</p> <p>Primary: Urgoclean rope/ flat or Aquacel Extra + ribbon/ flat</p> <p>Secondary: Zetuvit Plus / Kerramax Care secured with Hypafix</p> <p>Edge: Trace/ Measure / Probe</p> <p>Refer / Regenerate: Consider Larvae and VAC therapy</p> <p>Surrounding skin: Protect</p> <p>Social: Ensure pressure relieving equipment and repositioning is in place</p> <p>Information for patient/carers</p> <p>Ensure there is no pressure to the area.</p>

Type / appearance / photo of wound	Assessment/ treatment of wound
<p>Yellow wound – Slough non-viable tissue on the body (Not foot)</p> 	<p>Small shallow cavity with low exudate 2 – 4</p> <p>Tissue: Necrotic and sloughy tissue need to debride</p> <p>Infection: Monitor for clinical signs</p> <p>Moisture: Needs added moisture to debride: Purilon gel</p> <p>Actiform cool</p> <p>If static, bacteria may be a problem</p> <p>Flaminal hydro</p> <p>Activon honey</p> <p>Secondary dressing</p> <p>Zetuvit plus or Kerramax care secured with hypafix</p> <p>Edge: Trace/ Measure / Probe</p> <p>Refer / Regenerate: Consider Larvae and VAC therapy</p> <p>Surrounding skin: Protect</p> <p>Social: Ensure pressure relieving equipment and repositioning is in place. Information for patient/carers</p>
<p>Yellow wound – Non viable tissue on the body (Not foot)</p> 	<p>Sloughy pressure ulcer with low exudate 2 – 4</p> <p>Tissue: Sloughy tissue need to debride</p> <p>Infection: Monitor for clinical signs</p> <p>Moisture: Needs added moisture to debride:</p> <p>Actiform cool, Comfeel plus, UrgoClean flat</p> <p>If static, bacteria may be a problem</p> <p>Flaminal hydro</p> <p>Activon honey</p> <p>Secondary dressing</p> <p>Zetuvit plus or Kerramax care secured with hypafix</p> <p>Edge: Trace/ Measure / Probe</p> <p>Refer / Regenerate: Consider Larvae and VAC therapy</p> <p>Surrounding skin: Protect</p> <p>Social: Ensure pressure relieving equipment and repositioning is in place. Information for patient/carers</p>

Type / appearance / photo of wound	Assessment/ treatment of wound
<p>Yellow red wound – Cavity with some slough on the body (Not foot)</p>  <p>The first photograph shows a small, circular wound with a central cavity containing yellowish slough. The surrounding skin is red and inflamed. The second photograph shows a larger, more irregular wound with a deep cavity filled with yellowish slough and some red tissue visible at the edges. The surrounding skin is also red and inflamed.</p>	<p>Small cavity with slough</p> <p>Tissue: Sloughy tissue need to debride</p> <p>Infection: Monitor for clinical signs</p> <p>Moisture: Needs added moisture to debride:</p> <p>If low exudate 2-4 Flaminal hydro gel Honey</p> <p>If medium exudate 6 UrgoClean Rope, Aquacel Extra Secondary dressing: Zetuvit plus or Kerramax care secured with hypafix</p> <p>Edge: Trace/ Measure / Probe</p> <p>Refer / Regenerate: Consider Larvae and VAC therapy</p> <p>Surrounding skin: Protect</p> <p>Social: Ensure pressure relieving equipment and repositioning is in place. Information for patient</p>
<p>Yellow red wound – Cavity with some slough on the body (Not foot)</p>  <p>The photograph shows a wound with a central cavity containing yellowish slough. The surrounding skin is red and inflamed. A blue object, possibly a gloved finger, is visible at the bottom of the frame, likely used to hold the skin back for better visualization.</p>	<p>Tissue: Cavity wound unable to see tissue at base</p> <p>Infection: Monitor for clinical signs</p> <p>Moisture:</p> <p>High exudate 8 -10 Aquacel Ag ribbon Medium exudate 6 Cutimed Sorbact ribbon</p> <p>When it becomes too small to pack swap to Flaminal forte gel or Activon Honey Zetuvit plus or gauze secured with hypafix</p> <p>Edge: Trace/ Measure / Probe</p> <p>Refer / Regenerate: Consider VAC therapy or PICO once shallow</p> <p>Surrounding skin: Protect</p> <p>Social: Give advice regarding offloading</p>

Type / appearance / photo of wound	Assessment/ treatment of wound
<p>Yellow wound – Slough non-viable tissue on the foot</p>  <p>Patients with Diabetes MUST be under podiatry and referred urgently to the Secondary Care Diabetic Foot Clinic</p> <p>NB Caution with gels and hydrocolloids due to risk of infection</p>	<p>Diabetic foot - Thick sloughy (non-viable) tissue</p> <p>Tissue: Sloughy tissue need to debride</p> <p>Infection: High risk of infection. Monitor for subtle signs. Patients with Diabetes may not show cellulitis. Use antimicrobial</p> <p>Moisture:</p> <p>Medium to high exudate 6-10 Iodoflex or Aquacel Ag</p> <p>Low exudate UrgoClean Ag</p> <p>Secondary dressing Zetuvit plus, K-Soft K-Lite</p> <p>Edge: Trace/ Measure / Probe</p> <p>Refer / Regenerate: Consider Larvae and VAC therapy</p> <p>Surrounding skin: Protect</p> <p>Social: Ensure pressure relieving equipment and repositioning is in place. Information for patient. Advise to rest</p>
<p>Yellow red wound on the lower limb</p>  	<p>Leg ulcer – need to determine aetiology. Complete full leg ulcer and Doppler assessment.</p> <p>Tissue: Need to clean wound bed as slough present, good essential skin care and debridement</p> <p>Infection: Monitor for clinical signs of infection</p> <p>Moisture:</p> <p>Low to medium exudate</p> <p>UrgoClean flat</p> <p>Actiform cool</p> <p>If static or bacteria a problem Flaminal gel</p> <p>Honey products</p> <p>Secondary dressing – Zetuvit plus</p> <p>K-Soft and K-Lite until assessed for compression</p> <p>Edge: Trace/ Measure / Probe</p> <p>Refer / Regenerate: Consider Urgostart plus if slow to respond. Refer to lower limb pathway.</p> <p>Surrounding skin: Protect and moisturise</p> <p>Social: Information for patient. Advise to elevate when resting and wear compression if suitable</p>

Type / appearance / photo of wound	Assessment/ treatment of wound
<p>Red cavity wound</p> 	<p>Clean granulating cavity wound Tissue: Cavity wound Infection: Monitor for clinical signs Moisture: High exudate 8 - 10 Aquacel ribbon, Urgoclean rope. Flat dressings if shallow When it becomes too small to pack swap to Flaminal forte gel or Activon Honey Zetuvit plus or gauze secured with hypafix or Allevyn adhesive if will manage exudate Edge: Trace/ Measure / Probe Refer / Regenerate: Consider VAC therapy or PICO if shallow Surrounding skin: Protect</p>
<p>Red cavity wounds</p> 	<p>Tissue: Cavity wounds Infection: Monitor for clinical signs Moisture: High exudate 8 - 10 Aquacel ribbon, UrgoClean Rope. Flat dressings if shallow If sinus present Either cutimed sorbact ribbon Or Flaminal gel When becomes too small to pack swap to Flaminal forte gel or Activon Honey Zetuvit plus or gauze secured with hypafix or Allevyn adhesive if will manage exudate Edge: Trace/ Measure / Probe Refer / Regenerate: Consider VAC therapy or PICO if shallow Surrounding skin: Protect</p>

Type / appearance / photo of wound	Assessment/ treatment of wound
<p>Pilonidal sinus wound</p> 	<p>Pilonidal sinus wound. Use antimicrobial dressings as bacteria always a problem</p> <p>Tissue: Red friable tissue consistent with bacterial burden</p> <p>Infection: Monitor for clinical signs</p> <p>Moisture: High exudate 8 - 10 Aquacel Ag ribbon Medium exudate Cutimed Sorbact ribbon When it becomes too small to pack swap to Flaminal forte gel or Activon Honey Zetuvit plus or gauze secured with hypafix</p> <p>Edge: Trace/ Measure / Probe Manage hair by removing eg. Shaving or with forceps</p> <p>Refer / Regenerate: Consider VAC therapy or PICO</p> <p>Surrounding skin: Protect</p> <p>Social: Give advice regarding allowing area to recover by not sitting for long periods</p>
<p>Sinus wound</p> 	<p>Small opening – sinus wound</p> <p>Tissue: Unable to see tissue in sinus</p> <p>Infection: Monitor for clinical signs</p> <p>Moisture: Use flaminal forte or hydro gel or Activon Honey Put into a syringe to help get the gel into the wound Zetuvit plus or gauze secured with hypafix</p> <p>Edge: Probe if able Shave hair</p> <p>Refer / Regenerate: Consider underlying cause if not improving – refer to surgical team if underlying problem suspected</p> <p>Surrounding skin: Protect</p>

Type / appearance / photo of wound	Assessment/ treatment of wound
<p data-bbox="120 177 594 236">Red yellow – Slough non viable tissue on foot</p>  <p data-bbox="116 863 628 935">Patients with Diabetes MUST be under podiatry and referred urgently to the Secondary Care Diabetic Foot Clinic</p> <p data-bbox="116 948 609 995">NB Caution with gels and hydrocolloids due to risk of infection</p>	<p data-bbox="654 185 1009 256">Keep all necrotic or sloughy wounds on the foot dry until vascular assessment performed</p> <p data-bbox="654 268 969 339">Tissue: Sloughy tissue present. Do not attempt to debride unless good vascular supply</p> <p data-bbox="654 351 1009 448">Infection: High risk of infection if patient has Diabetes. Monitor for subtle signs. Patients with Diabetes may not show cellulitis. Use antimicrobial</p> <p data-bbox="654 459 997 563">Moisture: Low exudate Inadine or Atrauman before vascular assessment If vascular assessment good - debride</p> <p data-bbox="654 571 781 595">UrgoClean Ag</p> <p data-bbox="654 603 781 627">UrgoStart Plus</p> <p data-bbox="654 635 773 659">Dressing pad</p> <p data-bbox="654 667 947 707">K-Soft and K-Lite. Compression if appropriate</p> <p data-bbox="654 715 852 738">Edge: Trace/ Measure</p> <p data-bbox="654 746 835 770">Refer / Regenerate:</p> <p data-bbox="654 778 882 802">Surrounding skin: Protect</p> <p data-bbox="654 810 953 882">Social: Ensure pressure relieving equipment and repositioning is in place.</p> <p data-bbox="654 890 947 930">Consider foot lift and/or dynamic mattress</p>

Type / appearance / photo of wound	Assessment/ treatment of wound
<p>Pressure ulcer – Red wound</p>  <p>Patients with Diabetes MUST be under podiatry and referred urgently to the Secondary Care Diabetic Foot Clinic</p> <p>NB Caution with gels and hydrocolloids due to risk of infection</p>	<p>Heel ulcer Need to check vascular supply</p> <p>Tissue: Red granulation tissue Some hypergranulation – May need topical steroid to resolve – see page.....</p> <p>Infection: Monitor for clinical signs.</p> <p>Moisture: Medium to high exudate Aquacel extra Low exudate Atrauman If static consider antimicrobial Acticoat flex/ Iodoflex Secondary dressing Zetuvit plus K-Soft K-Lite</p> <p>Edge: Trace/ Measure</p> <p>Refer / Regenerate:</p> <p>Surrounding skin: Protect</p> <p>Social: Ensure pressure relieving equipment and repositioning is in place. Information for patient.</p>
<p>Peri wound - excoriation</p> 	<p>Consider cause of excoriation:</p> <ul style="list-style-type: none"> - Exudate not being managed - Removal of dressing/ picking - Poor skin care <p>Treatment:</p> <ul style="list-style-type: none"> - Skin barrier - Emollients and skin care - Frequency of dressing change - Super absorbent dressings

Type / appearance / photo of wound	Assessment/ treatment of wound
<p>Peri wound - maceration</p> 	<p>Consider cause of maceration:</p> <ul style="list-style-type: none"> - Exudate not being managed - Poor skin care/ debridement - Dressing not being changed frequently enough - Dressing not absorbent enough <p>Treatment</p> <ul style="list-style-type: none"> - Skin barrier - Frequency of dressing change - Super absorbent dressing - Cleansing/ debridement
<p>Peri wound – dry skin/ hyperkeratosis</p> 	<p>Consider cause:</p> <ul style="list-style-type: none"> - Lack of moisture - Lack of skin care - Build up of emollient/ adhesive on skin <p>Treatment:</p> <ul style="list-style-type: none"> - Good skin care - Cleansing/ debridement - Emollient therapy - Manage oedema if lower limb wound - Refer to podiatry if callous/ foot wound
<p>Wound edge - rolled</p> 	<p>Edges rolled towards wound bed</p> <p>May indicate:</p> <ul style="list-style-type: none"> - Chronic wound - Pressure element - Trauma - Malignancy <p>Treat as per wound bed appearance/ wound continuum, but if static, refer to Wound Care Service.</p>

Actiform Cool

What they do: Is a flat sheet hydrogel that deposits water to soften (debride) necrotic tissue, dry thick slough and dirty wounds, as this is a cooling dressing also effective on burns (radiation, chemical, heat)

Size	5cm x 6.5cm	10cm x 10cm	10cm x 15cm	Actiform Cool can be layered up (up to 3 layers). Remember to remove the transparent film in between layers but the top layer remains in situ to lock the moisture in
Unit of issue	Pack of 5	Pack of 5	Pack of 3	
Order Code	ELE083	ELE055	ELE056	



Purilon Gel

What they do: Is a liquid hydrogel that deposits water to soften (debride) necrotic tissue, thick dry slough and dry wounds, ideal for cavities. The only hydrogel that can be used immediately prior to larvae (maggot) therapy.

Size	8g
Unit of issue	Pack of 10
Order Code	ELG010



UrgoClean / UrgoClean Rope

What they do: Is a gelling fibre dressing where hydro-desloughing fibres absorb wound exudate gel, and actively debride slough. Also has haemostatic properties for haemorrhous exudate.

Size	6cm x 6cm	10cm x 10cm	15cm x 20cm	2.5cm x 40cm	5cm x 40cm
Unit of issue	Pack of 10	Pack of 10	Pack of 10	Pack of 5	Pack of 5
Order Code	ELZ404	ELZ405	ELZ406	ELZ454	ELZ407



Aquacel Extra / Aquacel Extra Ribbon

What they do: Is a hydrofibre dressing absorbing wound exudate to form a gel that traps bacteria and provides a moist wound environment, suitable for serous wounds not haemorrhous.

Size	5cm x 5cm square	10cm x 10cm square	4cm x 10cm	4cm x 20cm	2cm x 45cm
Unit of issue	Pack of 10	Pack of 10	Pack of 10	Pack of 10	Pack of 5
Order Code	ELY377	ELY012	ELY489	ELY490	ELY013



Allevyn Gentle Border

What they do: Conformable adhesive foam dressing with non-adherent silicone base layer for protection. Suitable for low - moderate exudate management

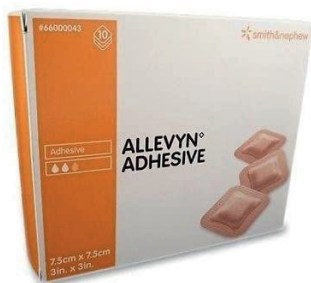
Size	5.5cm x 12cm	7.5cm x 7.5cm	12.5cm x 12.5cm	17.5cm x 17.5cm
Unit of issue	Pack of 10	Pack of 10	Pack of 10	Pack of 10
Order Code	ELA470	ELA359	ELA361	ELA358



Allevyn Adhesive

What they do: Adhesive foam dressing for protection and exudate management.

Size	7.5cm x 7.5cm	10cm x 10cm	12.5cm x 12.5cm	12.5cm x 22.5cm	17.5cm x 17.5cm
Unit of issue	Pack of 10	Pack of 10	Pack of 10	Pack of 10	Pack of 10
Order Code	ELA020	ELA113	ELA024	ELA046	ELA022



Cutimed Siltec – special order

What they do: Adhesive foam dressing for protection and exudate management.

Size	4cm x 6cm	10cm x 10cm	10cm x 20cm	15cm x 15cm	20cm x 20cm
Unit of issue	Pack of 10	Pack of 10	Pack of 10	Pack of 10	Pack of 10
Order Code	ELA212	ELA1059	ELA1060	ELA1061	ELA41062



Cutimed Siltec B – special order

What they do: Adhesive foam dressing for protection and exudate management.

Size	7.5cm x 7.5cm	12.5cm x 12.5cm	15cm x 15cm	17.5cm x 17.5cm	22.5cm x 22.5cm
Unit of issue	Pack of 10	Pack of 10	Pack of 10	Pack of 5	Pack of 5
Order Code	ELA1054	ELA1055	ELA1056	ELA	ELA1063



Comfeel Plus Transparent

What they do: This adhesive hydrocolloid gels exudate maintaining a moist wound environment, it seals and protects the wound from bacteria, heat loss maximising wound healing rate.

Size	5cm x 7cm	10cm x 10cm
Unit of issue	Pack of 10	Pack of 10
Order Code	ELM036	ELM060



UrgoClean AG

What they do: The only Anti-Biofilm silver dressing that provides complete and continuous cleaning action for all wounds at risk of or with signs of local infection. TLC Ag healing matrix allows atraumatic dressing removal.

Size	6cm x 6cm	10cm x 10cm	15cm x 20cm
Unit of issue	Pack of 10	Pack of 10	Pack of 5
Order Code	ELY609	ELY610	ELY611



Aquacel AG + extraflat sheet/ Ribbon

What they do: All the basic benefits of Aquacel plus ionic silver for wounds that are infected.

Aquacel Ag Ribbon

Size	5cm x 5cm	10cm x 10cm	2g x 45cm
Unit of issue	Pack of 10	Pack of 10	Pack of 5
Order Code	ELY109	ELY110	ELY113



Activon Tube

What they do: Honey ointment used as an antimicrobial agent to reduce bacteria, will also de-odourise offensive wounds, and debride slough similar to hydrogels (actiform cool/purilon).

Size	25g
Unit of issue	Pack of 12
Order Code	ELZ069



Acticoat Flex 3

What they do: Is a silver impregnated knitted polyester dressing, which provides 3 days of sustained antimicrobial therapy in a non-adherent dressing, dressing must be in contact with wound bed to be effective.

Size	5cm x 5cm	10cm x 10cm	10cm x 20cm
Unit of issue	Pack of 5	Pack of 12	Pack of 12
Order Code	ELY291	ELY292	ELY293



UrgoTul Silver

What they do: This is an adherent, antibacterial contact layer with silver particles and hydrocolloid woven into its matrix, it delivers sustained antimicrobial activity for 3 - 4 days.

Size	10cm x 12cm	15cm x 20cm
Unit of issue	Pack of 16	Pack of 16
Order Code	EKB023	EKB024



Cutimed Sorbact

What they do: This is an antimicrobial dressing comprised of a woven hydrophobic mesh which attracts and binds bacteria to its surface, it does not deposit into the wound so no risk of resistance or side effects.

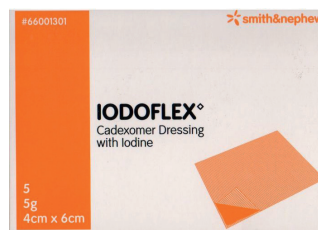
Size	7cm x 9cm gauze swab	2cm x 50cm ribbon gauze	4cm x 6cm gauze swab
Unit of issue	Pack of 5	Pack of 20	Pack of 5
Order Code	ELY213	ELY218	ELY212



Iodoflex

What they do: Is and iodine based paste dressing that conforms to the wound bed, giving sustained anti-microbial activity and some de-sloughing for 3-4 days.

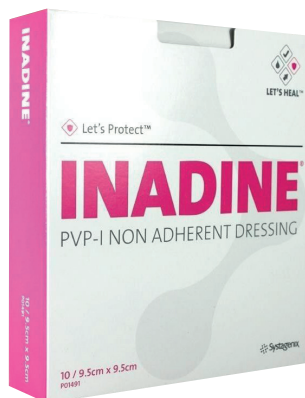
Size	5g
Unit of issue	Pack of 5
Order Code	EKB007



Inadine

What they do: This is an adhesive knitted viscous fabric dressing impregnated with Povidine iodine, gives very short term antimicrobial activity, suitable for superficial wounds with potential risk of infection

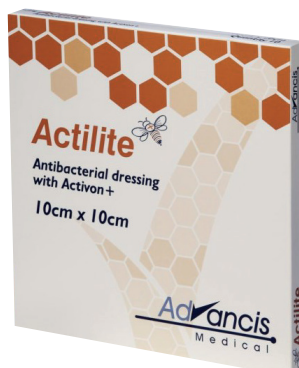
Size	5cm x 5cm	9.5cm x 9.5cm
Unit of issue	Pack of 25	Pack of 25
Order Code	EKB501	EKB502



Actilite

What they do: Non-adherent dressing coated with honey. The dressing is designed to protect a wound, reduce bacteria and allow the passage of exudate to a secondary dressing

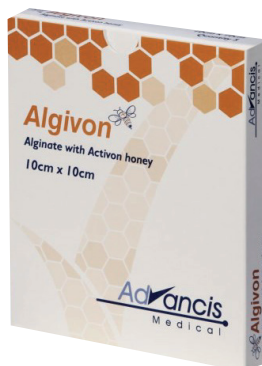
Size	10cm x 10cm	10cm x 20cm
Unit of issue	Pack of 10	Pack of 10
Order Code	EJE042	EJE040



Algivon

What they do: Algivon is a honey impregnated alginate (seaweed based dressing). The dressing is designed to reduce bacteria and provide haemostatic properties for haemorrhous exuding wounds

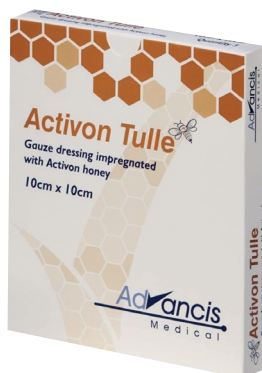
Size	5cm x 5cm	9.5cm x 9.5cm
Unit of issue	Pack of 25	Pack of 25
Order Code	EKB501	EKB502



Activon Tulle

What they do: This is an adhesive knitted viscous fabric dressing impregnated with Povidine iodine, gives very short term antimicrobial activity, suitable for superficial wounds with potential risk of infection

Size	5cm x 5cm	10cm x 10cm
Unit of issue	Pack of 5	Pack of 5
Order Code	EJE027	EJE028



Flaminal Forte

What they do: This is a hydrated (liquid) alginate with an anti-bacterial enzyme, it also debrides like honey. Very effective in piping into sinus's and difficult to pack wounds, for moderate to high exuding wounds.

Size	15g
Unit of issue	Box of 5
Order Code	ELG022



Flaminal Hydro

What they do: This is a hydrated (liquid) alginate with an anti-bacterial enzyme, it also debrides like honey. Very effective in piping into sinus's and difficult to pack wounds, for light to moderate exuding wounds.

Size	15g
Unit of issue	Box of 5
Order Code	ELG021



UrgoStart Contact

What they do: UrgoStart dressings are a unique treatment to reduce the healing times of leg ulcers, diabetic foot ulcers and pressure ulcers. They work by reducing the level of excess enzymes improving the healing of wounds. UrgoStart Contact is highly conformable and use in all awkward locations.

Size	5cm x 7cm	10cm x10cm	15cm x20cm
Unit of issue	Pack of 10	Pack of 10	Pack of 10
Order Code	EKB081	EKB087	EKB088



UrgoStart Plus Pad

What they do: UrgoStart dressings are a unique treatment to reduce the healing times of leg ulcers, diabetic foot ulcers and pressure ulcers. they work by reducing the level of excess enzymes improving the healing of wounds. UrgoStart Plus Pad also contains very absorbent fibres which help clean the wound to ensure best possible healing.

Size	6cm x 6cm	10cm x 10cm	15cm x 20cm
Unit of issue	Pack of 10	Pack of 10	Pack of 10
Order Code	ELZ884	ELZ885	ELZ886



UrgoStart Plus Border

What they do: UrgoStart dressings are a unique treatment to reduce the healing times of leg ulcers, diabetic foot ulcers and pressure ulcers. They work by reducing the level of excess enzymes improving the healing of wounds. UrgoStart Plus Border also contains very absorbent fibres which help clean the wound to ensure best possible healing combined with an adhesive border and extra absorbent layer for self-retention and increased wartime.

Size	8cm x 8cm	10cm x 10cm	13cm x 13cm	15cm x 20cm	20cm x 20cm
Unit of issue	Pack of 10	Pack of 10	Pack of 10	Pack of 10	Pack of 5
Order Code	ELZ879	ELZ880	ELZ881	ELZ882	ELZ883



Kerramax care - special order

What they do: Super absorbent dressings promote wound healing by controlling exudate, reducing the risk of infection and regulating MMP levels therefore providing the optimum wound environment for healing to occur. Can be applied directly onto the wound bed. No need for atrauman or similar.

Size	12.5cm x 12.5cm	12.5cm x 22.5cm	22cm x 22cm	22cm x 32cm
Unit of issue	Pack of 10	Pack of 10	Pack of 10	Pack of 10
Order Code	EJA218	EJA219	EJA220	EJA221



Protease reduction dressing

Super Absorbent

Clinisorb

What they do: This is an adhesive activated charcoal dressing used to manage odour from wounds.

Size	10cm x 20cm
Unit of issue	Pack of 10
Order Code	ELV053



Atrauman

What they do: This is a non-medicated, non-adhesive mesh wound contact layer, used for protection to fragile but healthy wound bed.

Size	5cm x 5cm	12.5cm x 22.5cm	22cm x 22cm	22cm x 32cm
Unit of issue	Pack of 50	Pack of 50	Pack of 30	Pack of 10
Order Code	EKA024	EKA032	EKA036	EKA016



Silflex

What they do: This is a silicone coated, non-adhesive mesh wound contact layer, used for protection to fragile but healthy wound bed.

Size	5cm x 7cm	8cm x 10cm	12cm x 15cm
Unit of issue	Pack of 10	Pack of 10	Pack of 10
Order Code	EKH028	EKH029	EKH030



Other formulary products

Premier pad	Omnifix
Zetuvit Plus	Softpore 1 size
Mediderma pro, s spray and applicators and creams	Normasol
Ichthopaste	Octenalin
Viscopaste	K-Soft
C-Fix	K-Lite
Comfinette	365 transparent film
Clinifast	Opsite post op
(Blue line / Yellow line)	UrgoKTwo (full/reduced)
Lifteez	Actico
Clinipore	UCS cloths
Debrisoft	

Specialist Products

Flaminal forte/ hydro 50g tubes	Coban 2/ Lite
K-Plus	Lomatule
Ko-Flex	Medihoney barrier cream
Cutimed Siltec & B	Suprasorb PHMB
Kerramax care	

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