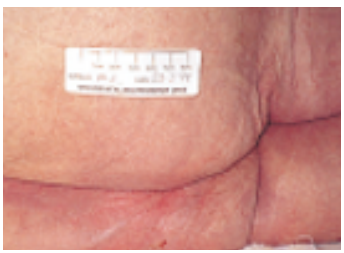
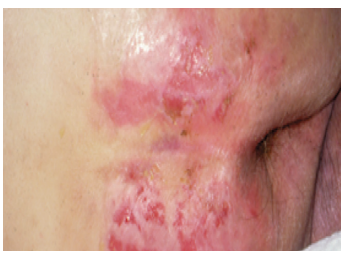
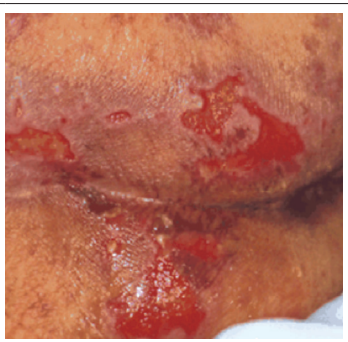
NHS
North Cumbria Integrated Care
NHS Foundation Trust

Community Wound Management Formulary

2020

Incontinence skin care pathway

This pathway is for patients/residents at risk or with existing skin damage d

	Clinical presentation**		Cleansing the skin
Prevention	**Healthy Intact Skin** No redness present Patient incontinent		Use a pH balanced soap substitute or non perfumed soap as available 
Management	**Mild Incontinence Related Dermatitis** Redness of skin but no broken areas		
	Moderate Incontinence Related Dermatitis Redness with less than 50% broken skin Bleeding may be present		
	Broken, severe dermatitis Excoriated weeping skin, pressure ulcers 3/4		 **DO NOT USE SENSET FOAM WITH CAVILON ADVANCED**

Step down

Step up

Do not use any other creams or sprays with Cavilon A

e due to the effects of incontinence (urine and/or faeces) on the skin.

Apply a skin protectant	When to use	How much to use
 3M™ Cavilon™ Durable Barrier Cream	Apply morning and evening	Apply Cavilon Durable Barrier Cream in pea-sized amounts and apply a thin even layer
 3M™ Cavilon™ Durable Barrier Cream	Apply morning and evening	Apply Cavilon Durable Barrier Cream in pea-sized amounts and apply a thin even layer
 3M™ Cavilon™ No Sting Barrier Film	Daily or maximum twice a day **Note**: in severe cases (e.g. C.Diff) up to 4x per day may be necessary	100% Apply an even coat of film to the entire area to be treated
 3M™ Cavilon™ No Sting Barrier Film	Daily or maximum twice a day	100% Apply an even coat to the entire area to be treated
 3M™ Cavilon™ Advanced Skin Protectant	2x 2x per week	
 Proshield® Plus Skin Protectant	After every wash	Clean with the spray then apply the cream

ı Advanced.

Moisture Associated Skin Damage (M

Assessr

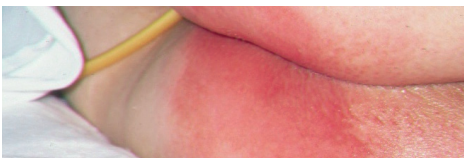
Carry out a full holistic
Consider: mobility, nutritional status, p
Moisture specific: continence, excessi
Patients with moisture lesions are at high risk of developing pressure ulcers the

Is the skin dama

1 Incontinence Associated Dermatitis (IAD)

Source of MASD: Urine and / or faeces

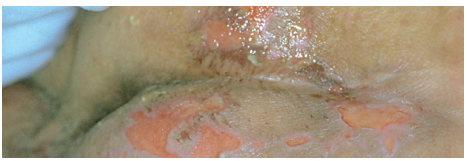
Erythema and inflammation of the skin, erosion and denudation can occur as result of exposure to urine and faeces



2 Intertriginous Dermatitis (MASD within skin folds)

Source of MASD: Perspiration +/- friction

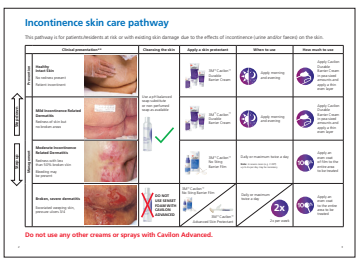
Mild, mirror image erythema on each side of the skin fold. May have erosion and denudation as result of exposure to chronic perspiration and possibly friction



Manage

1 Incontinence Associated Dermatitis (IAD)

- Ensure a full continence assessment has been completed
- Refer to Incontinence Skin Care Pathway



2 Intertriginous Dermatitis (MASD within skin folds)

- Examine entire area of the skin folds, including base
- Gently lift the fold without creating or exacerbating traction and fissure formation
- Avoid products containing chlorhexidine gluconate, alcohol, or perfumes as these can be absorbed by damaged skin
- Measures to ensure the continued drying of the skin fold must be a primary treatment strategy
- Cavilon No Sting Barrier Film to be applied every 24 hours. Frequency can be reduced to 48–72 hours in line with skin improvement
- If symptoms persist contact TVN service

2 3 4 **Once skin condition has resolved, discontin**

If you require further clinical support please contact the North Cumbr

(MASD) Pathway A

essment

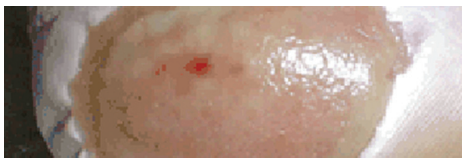
olistic assessment.
us, personal hygiene, sensitivities.
ccessive perspiration, skin folds.
s therefore follow the pressure ulcer prevention pathway and trust policy.

mage caused by:

3 Periwound Dermatitis

Source of MASD: Exudate +/- adhesive skin stripping

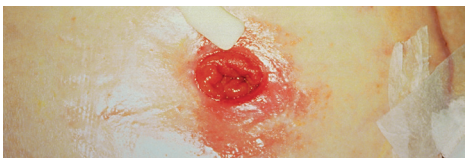
Erythema and inflammation of skin within 4cm of wound edge, may show denudation or erosion



4 Peristomal and Peri-tube Moisture Associated Dermatitis

Source of MASD: Bodily fluids e.g. urine, faeces, gastric

Inflammation and erosion of skin related to moisture from bodily fluids such as urine, faeces, gastric fluids and saliva



gement

3 Periwound Dermatitis

- Base dressing choice on exudate levels
- Consider the potential for wound infection
- If the wound is not healing or progressing, further investigation may be required to establish co-morbidities
- Protect peri-wound area from further breakdown, maceration and adhesive trauma. Apply Cavilon No Sting Barrier Film at every dressing change or as per protocol

4 Peristomal and Peri-tube Moisture Associated Dermatitis

- Consult Stoma Nurse specialist for guidance on appliances
- Protect peri-stomal/peri-tube area from further breakdown, maceration and adhesive trauma. Apply Cavilon No Sting Barrier Film at every pouch/ appliance change or as per protocol

ontinue use of Cavilon No Sting Barrier Film unless patient continues to be at high risk of skin breakdown

mbria Integrated Care NHS Foundation Trusts Tissue Viability Team.

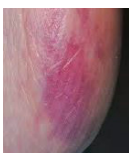
Making Pressure Ulcer Categorisation Easier

Ask the patient/carer if they know the cause of the skin damage

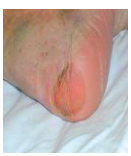
Is it over a pressure point or has pressure been applied by a medical device?

- **NO** → Unlikely to be a pressure ulcer. Complete wound assessment form.
- **YES** → **Is the patient's skin broken?**
  - **NO** → Is skin:
    - Red, non-blanching – category 1 pressure ulcer
    - Intact serous filled blister – category 2 pressure ulcer
    - Deep red, maroon or purple – deep tissue injury
  - **YES** → **Is the skin damage superficial?**
    - **YES** → Category 2 pressure ulcer
    - **NO** → **Can the wound bed be viewed?**
      - **YES** → Full thickness skin loss without exposure of bone, tendon or muscle. Slough and/or eschar may be present but do not obscure the depth of tissue loss – category 3 pressure ulcer.
      - **YES** → Full thickness skin loss with exposed bone, tendon or muscle. Slough and/or eschar may be present on some parts of the wound. Undermining/tunnelling often occur. Osteomyelitis possible – category 4 pressure ulcer.
      - **YES** → Unstageable pressure ulcer

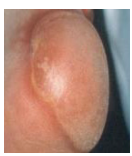
Category 1



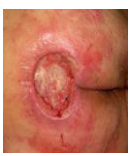
Category 2



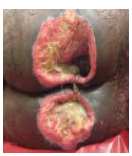
Category 2 blister



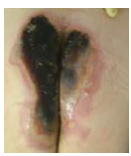
Category 3



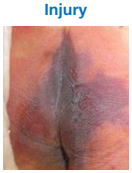
Category 4



Unstagable



Deep Tissue Injury



Think pressure ulcer if:

- Damage regular in shape
- It is over a bony prominence where pressure likely to be exerted

A wound over heels/sacrum/buttocks does not have to be a pressure ulcer

Think moisture damage if:

- History of incontinence/perspiration/clammy skin
- Damage is diffuse, superficial, generally not over bone

Complete Ulysses report and wound assessment forms for all categories of pressure ulcers and moisture lesions. If medical device related, indicate category with a 'd'. Remember to complete/update body maps.

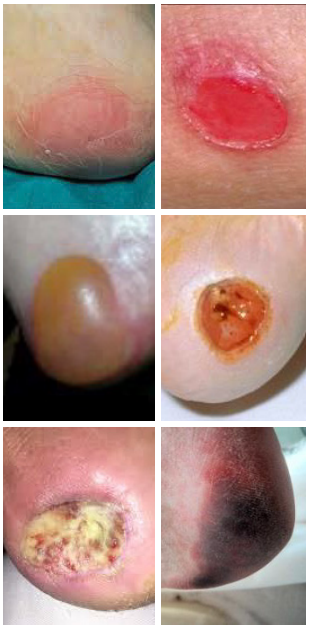
Pressure ulcer or foot ulcer?

Guide to differential diagnosis

When all individual clinical and non-clinical factors pertaining to the patient are taken into account and the predominant factor of cause is pressure, then the wound should be considered a pressure ulcer when the predominant factor is disease related, e.g. diabetes, neuropathy, arterial disease, then the wound should be considered a pressure ulcer.

Consider why the damage has occurred? What is the cause and what can you do to address the cause?

Pressure Ulcer

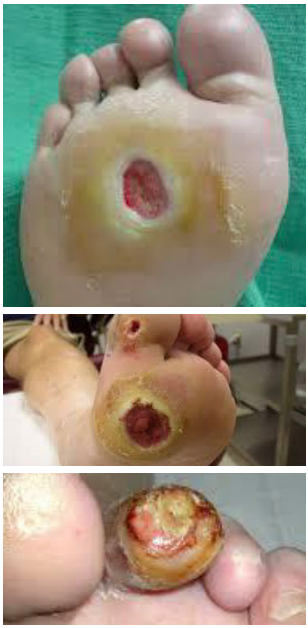


Typical causes for pressure ulcers:

- Constant/prolonged pressure from sitting or lying in one position

All pressure ulcers must be reported as a clinical incident.

Foot Ulcer

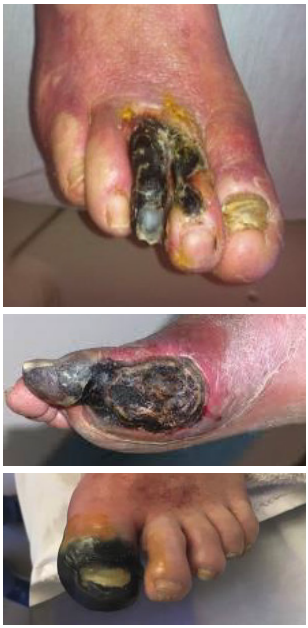


Typical causes for foot ulcers:

- Friction from poorly fitting footwear
- Trauma, burns, puncture wound
- Untreated callus
- Bony deformity
- Callus dry skin
- Heel fissure
- Diabetes neuropathy and Peripheral Vascular Disease

Not reported as a clinical incident.

Ischaemic Ulcer



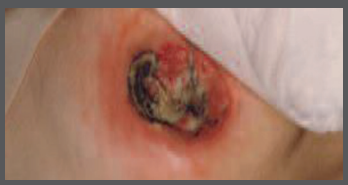
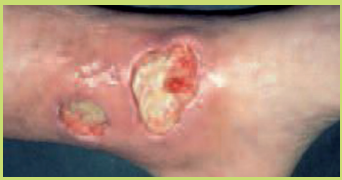
Typical causes for ischaemic/arterial ulcers:

- Tissue deprivation of oxygen and nutrients due to occlusion of the arteries caused by atherosclerosis or arteriosclerosis

An ischaemic ulcer is not a pressure ulcer However, if pressure is present, the damage may have to be reported as a pressure ulcer.

Refer to Tissue Viability/Podiatry/Vascular as per trust guidelines

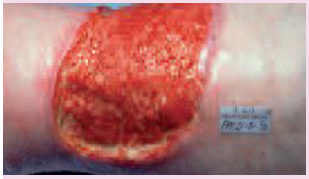
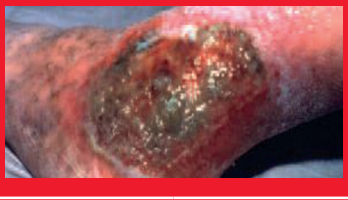
Wound Classification and Dressing Selection Acut

Tissue Type	Necrotic		Sloughy		Gra
					
Rationale	**Debride, rehydrate and remove eschar.**		**Remove slough. Provide clean base for granulation tissue.**		**Promote healthy**
	Primary dressing	**Secondary dressing**	**Primary dressing**	**Secondary dressing**	**Primary dressing**
Exudate Level Low	Algivon Actiform Cool Activon Tulle Duoderm Extra Thin Polymem Flaminal Forte	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered	Algivon Actiform Cool Activon Tulle Polymem Duoderm Extra Thin Urgoclean AG Kytocel	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered	Activon T Urgotul Cytasan Polymem Duoderm Extra Thi NA Ultra Urgotul Telfa Clea
Exudate Level Medium	Algivon Polymem Flaminal Forte	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered	Algivon Polymem Urgoclean AG Cytasan	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered	Algivon Polymem Cytasan
Exudate Level High	Algivon Flaminal Forte	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered Eclypse Zetuvit E/Plus	Algivon Cytasan	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered Eclypse Zetuvit E Zetuvit Plus	Cytasan

Note for infected wounds: '2 week Rule Review' – at 2 weeks have signs of infection gone? If yes: return to non-an

Debridement option: Debrisoft® Debridement Pad /UCS cloth.

:ute Tissue Viabilty

ranulating		Epithelialising		Infected	
					
mote granulation. Provide lthy base for epithelialisation.		**Promote epithelialisation and wound maturation.**		**Manage bacterial burden.**	
nary ssing	**Secondary dressing**	**Primary dressing**	**Secondary dressing**	**Primary dressing**	**Secondary dressing**
von Tulle otul asan mem derm a Thin Ultra otul a Clear	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered	Urgotul Polymem NA Ultra Mepitel One Tegaderm Absorbent (skin tears) CosmoporeE Telfa Clear Leukomed T Plus (surgical)	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered 365 Film	Algivon Prontosan Gel X Flaminal Forte Actisorb Silver 220 Activon Tulle Urgoclean AG Cytasan	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered
von mem asan	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered	Polymem Mepitel One	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered	Acticoat Flex 3 Algivon Activon Tulle Silvercel Urgoclean AG Cytasan	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered Eclypse
asan	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered Eclypse Zetuvit E Zetuvit Plus	Polymem	Tegaderm Foam Tegaderm Foam Adhesive Tegaderm Silicone Foam/ Bordered Eclypse	Silvercel Acticoat Flex 3 Algivon Cytasan	Tegaderm Foam Tegaderm Foam Adhesive Eclypse Zetuvit Plus Zetuvit E

on-antimicrobial dressing. If no: continue antimicrobial dressing for 2 weeks or consider alternative formulary dressing.

Skin Tear Assessment flow Chart

Control bleeding

Assess

Apply pressure and elevate the limb if appropriate.

Cleanse

Cleanse/irrigate the wound as per local protocol and remove any residual debris or haematoma; gently pat the surrounding skin dry to avoid further injury.

Approximate Wound Edges

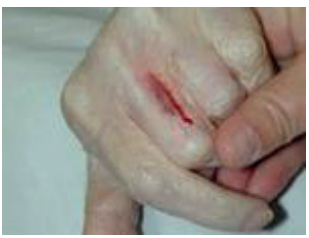
If viable; re-approximate wound edges. Ease the flap back into place using a gloved finger, dampened cotton tip, sterile tweezers.

Measure and document

Goals of Treatment

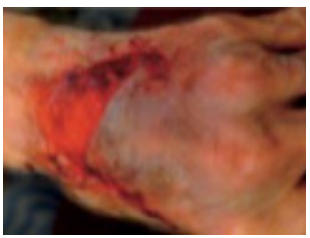
- Treat the cause
- Implement prevention protocol
- Moist wound healing
- Avoid trauma
- Protect periwound skin
- Manage exudate
- Avoid infection
- Pain control

Treatment Options in Accordance with Local Wound Conditions



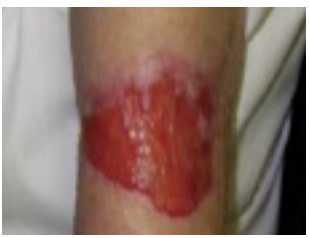
Type 1
No Skin Loss

Linear or flap tear that can be repositioned over 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 entire wound bed.

Skin Tear Product Selection Guide

Adapted from LeBlanc et al, 2016

Product Categories	Indications	Skin Tear Type	Considerations
Non-adherent mesh dressings • Mepitel One • Urgotul	Dry or exudative wound	**1,2,3**	Maintains moisture balance for multiple levels of wound exudate, atraumatic removal, may need secondary cover dressing
Foam dressing • Tegaderm Foam • Tegaderm Silicone Foam	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 peri-wound trauma (not applicable to silicone border products)
Adhesive acrylic dressing • Tegaderm Absorbent	Approximate flap and provide protection and moisture Wear time up to 60 days	**1,2**	Protects flap and provides stability without tension, absorbent and reduces dressing changes and infection risk
Gelling fibres • Kytocel	Moderate to heavy exudate	**2, 3**	Haemostatic properties, may dry out wound bed if inadequate exudate, secondary cover dressing required (both have haemostatic properties, Kytocel has licence)
Special Consideration for Infected Skin Tears			
Leptospermum honey dressings • Activon Tulle • Algivon	Antimicrobial, promotes autolytic debridement, management of malodour	**1, 2, 3**	Not to be used on patients with an allergy to honey, bee stings or bees wax
Ionic silver dressings • Acticoat Flex 3	Effective broad-spectrum antimicrobial action, including antibiotic-resistant organisms	**1, 2, 3**	Should not be used indefinitely, contraindicated in patients with silver allergy, use when local or deep infection is suspected or confirmed, use non-adherent products whenever possible to minimise risk of further trauma
Polyhexamethylene biguanide (PHMB) dressings • Kendall AMD Foam	Effective antimicrobial, comes impregnated in a variety of dressings; can be absorbent	**1, 2, 3**	

This product list is not all-inclusive; there may be additional products applicable for the treatment of skin tears.

Products NOT recommended in the management of skin tears

- Iodine based dressings
- Film/Hydrocolloid dressings
- Skin Closure Strips/ Steri-Strips
- Gauze

Exudate pathway

Underlying factors

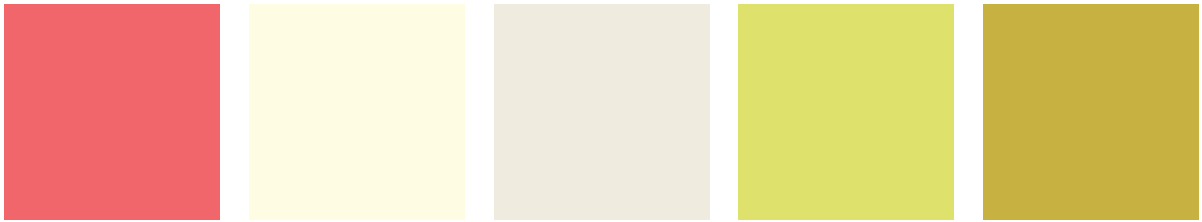
Systemic
- CCF, renal and hepatic failure
- Infection/inflammation
- Medication (NSAID, steroids)
- Obesity and malnutrition

Wound healing stage
- Inflammatory phase
- Static or delayed healing
- Autolytic debridement

Practical
- Wound position
- Concordance
- Inappropriate dressing choice

Local
- Local infection/inflammation
- Trauma
- Foreign body
- Oedema
- Sinus and fistula
- Sensitivity

Exudate colour



Red pink
- Post operative
- Traumatic dressing removal
- Possible infection

Clear straw colour
- Considered normal
- Lymphatic/urinary fistula

Cloudy milky creamy
- A response to inflammation
- Possible infection

Green yellow
- Bacterial infection
- Pseudomonas aeruginosa

Yellow brown
- Presence of infection
- Liquefaction of necrotic tissue

Viscosity of exudate

Thin and watery
Low protein content
- Venous or cardiac disease
- Malnutrition
- Urinary or joint fistula

Normal
Healthy exudate is thin watery, pale yellow or light red and does not adhere to the wound bed

Thick and sticky
High protein content
- Infection or inflammatory process
- Necrotic material
- Enteric fistula
- Lymphoedema can also cause an increase

Odour
Assess exudate odour
- Remove necrotic tissue if indicated
- Reduce bioburden and manage underlying infection
- Review frequency of dressing change

Exudate levels

Dry

- This is not an ideal wound healing environment
- No visible moisture
- Consider potential dressing adherence
- Surrounding skin may be scaly, atrophic and hyperkeratotic
- Consider moisturising skin

Moist

- An ideal wound healing environment
- Dressing may be lightly marked
- Wound bed could appear glossy
- Surrounding skin may be intact and hydrated

Wet

- Dressing may be extensively marked
- Potential fragmented areas of maceration

Saturated

- Free fluid is visible on the wound
- Primary dressing is wet and strikethrough may occur
- Exudate may have begun to escape the dressing
- Risk of macerated and denuded skin

Leaking

- Primary and secondary dressings are saturated
- Exudate is escaping from the dressing onto clothes/bedding
- High risk of macerated and denuded skin

Rationale for dressings

Dry

Aim: To increase wound moisture

Consider hydrating the eschar

- Film
- Hydrogel
- Dry may be optimum for ischaemic wounds (consider vascular referral)

For low exudate

- Primary dressing: Hydrogel
- Secondary dressing: Foam adhesive Silicone foam
- Hydrocolloid thin Hydrocolloid Absorbent acrylic Film plus pad

Moist

Aim: To maintain wound moisture

Review dressing change frequency

- Primary dressing: Alginate Hydrogel
- Secondary dressing: Adhesive foam Non adhesive foam Silicone foam
- Hydrocolloid Absorbent acrylic

Wet

Aim: To decrease wound moisture and protect peri wound area

Consider dressing frequency and select dressing for its fluid handling properties

- Primary dressing: Alginate Hydrofibre
- Secondary dressing: Foam Super absorber
- Peri wound film barrier

Saturated

Aim: To decrease wound moisture and protect peri wound area

Consider dressing frequency and select dressing for its fluid handling properties

- Primary dressing: Alginate Hydrofibre
- Secondary dressing: Super absorber Adhesive foam Non adhesive foam Peri wound film barrier

Leaking

Aim: To decrease wound moisture and protect peri wound area to prevent leakage on to clothing and bedding

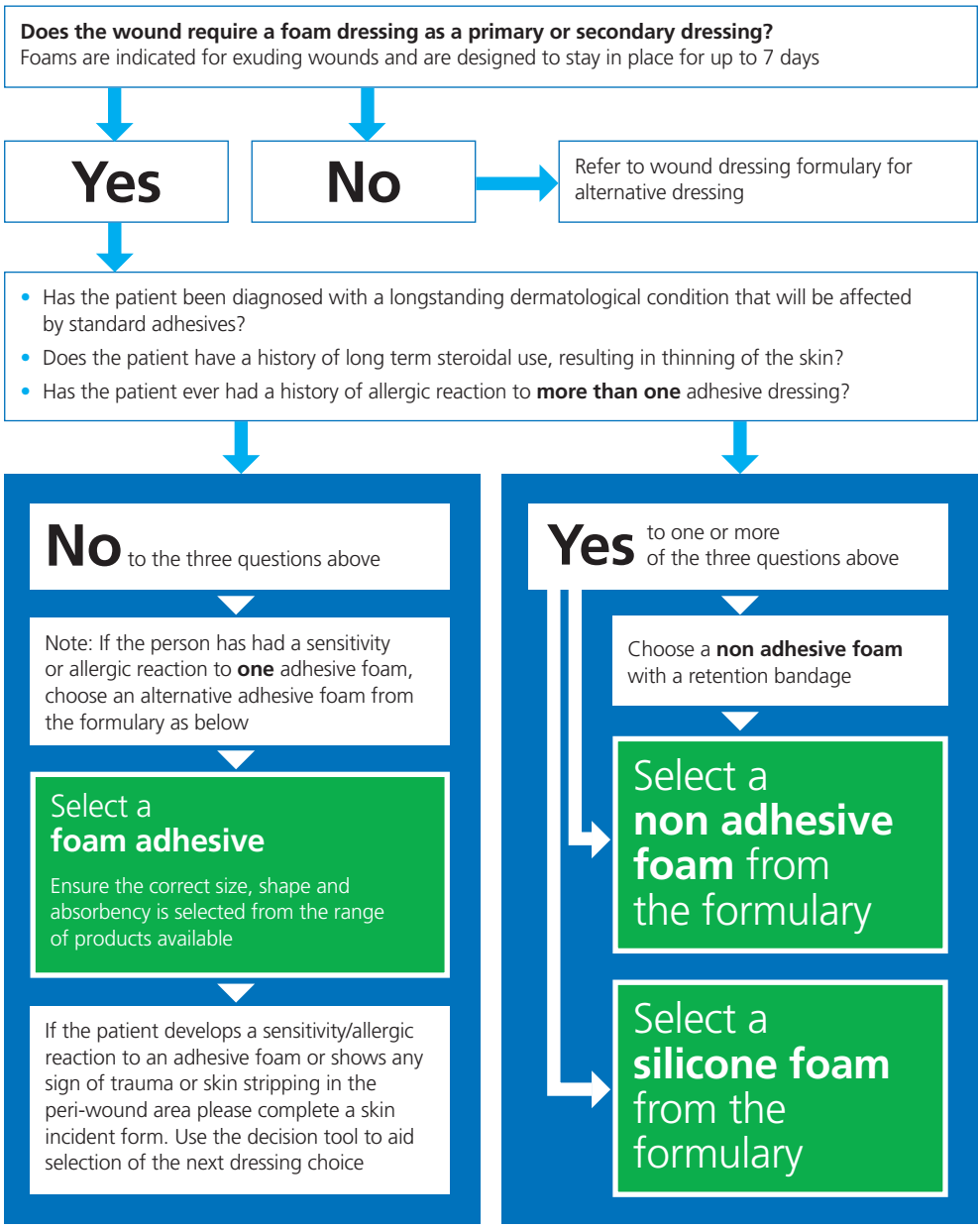
Consider frequency of dressing change and select thicker more absorbent products

- Topical negative pressure Superabsorbers Peri wound film barrier

Consider the possibility of infection and use appropriate antimicrobial/antibiotic if indicated

Foam decision tool

Use this tool to help select the most appropriate foam dressing for the wound and patient



This tool was created by Victoria Peach, Nurse Consultant Tissue Viability and its use is demonstrated on the Wounds UK poster presentation *Is it time to introduce a foam decision tool?* Presented at Wounds UK Conference, Harrogate 2013.

Formulary

Retention Bandages	Mollelast/Actiwrap (finger and toe) K-B and K-Lite
Padding	Flexiban (to use with Actico) Profore #1, (Cellona-Lymphoedema)
Tubular Bandage	Comfi-fast Comfi-fast Garments Comfigrip
Full Compression Bandages – Short Stretch	Actico
Multi-layer Compression Bandages	Coban 2 Coban 2 Lite
Compression Hosiery Applicator	Actiglide
Waterproof Dressing Protection	Limbo Sealtight
Dressing Packs	Polyfield Patient Pack Dressit
Skin Protection	Cavilon Cream Cavilon No Sting Barrier Film Proshield Plus Skin Protectant MASD Pathway – Cavilon Advanced
Compression Hosiery	Jobst Elvarex Custom Fit, Jobst Elvarex Soft Custom Fit, Sigvaris Optiform Hold Custom Fit, Sigvaris Optiform Flex Custom Fit, Haddenham (Veni, Star Cotton, microfine Toe caps), Juzo Soft, Medi, Mediven plus, Mediven Elegance, Jobst for Men, Ambition and Explore, Juzo, BSN
Protease Modulator	Urgostart Plus
Leg Wraps and Liners	Haddenham Easywrap Strong & Light, Jobst, BSN, Farrow wrap (Classic, lite, strong, 4000), Jobst Farrow Hybrid liner, Sigvaris Transition liner, Sigvaris Complete Liner, Juzo adjustable

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