NHS
North Cumbria Integrated Care
NHS Foundation Trust

Community Wound Management Formulary

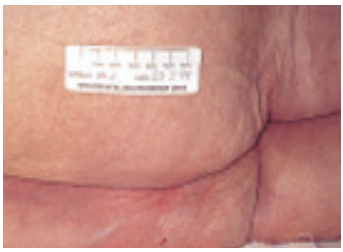
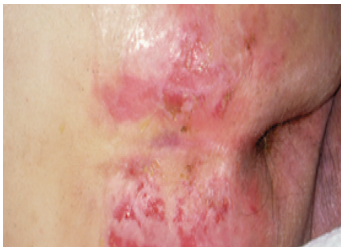
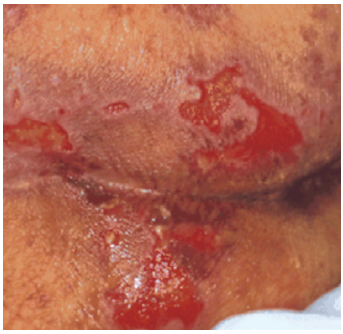
2024

Incontinence skin care pathway

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

Step down

Step up

	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**

Do not use any other creams or sprays with Cavilon

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	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	Apply an even coat to the entire area to be treated
 3M™ Cavilon™ Advanced Skin Protectant	2x per week	
 Medi-derma Pro Skin Protectant	After every wash	Clean with the spray then apply the cream

Advanced.

Moisture Associated Skin Damage (

Asses

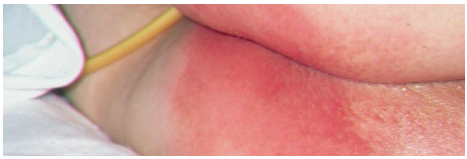
Carry out a full holis
Consider: mobility, nutritional status,
Moisture specific: continence, exce
Patients with moisture lesions are at high risk of developing pressure ulcers t

Is the skin dam

1 Incontinence Associated Dermatitis (IAD)

Source of MASD: Urine and / or faeces

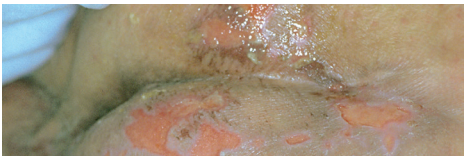
Erythema and inflammation of the skin, erosion and denudation can occur as result of exposure to urine and faeces



2 Intertriginous Dermatitis (MASD within skin folds)

Source of MASD: Perspiration +/- friction

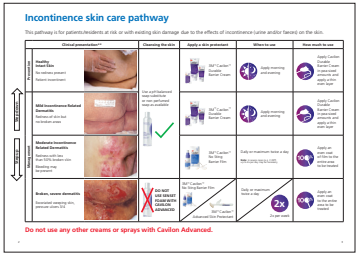
Mild, mirror image erythema on each side of the skin fold. May have erosion and denudation as result of exposure to chronic perspiration and possibly friction



Manag

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, discon**

If you require further clinical support please contact the North Cum

(MASD) Pathway A

sment

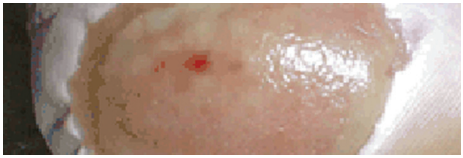
tic assessment.
, personal hygiene, sensitivities.
essive perspiration, skin folds.
therefore follow the pressure ulcer prevention pathway and trust policy.

age caused by:

3 Periwound Dermatitis

Source of MASD: Exudate +/- adhesive skin stripping

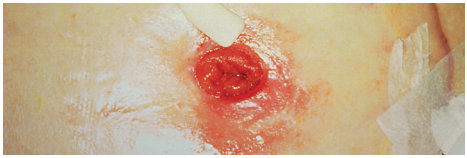
Erythema and inflammation of skin within 4cm of wound edge, may show denudation or erosion



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



ement

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

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

bria Integrated Care NHS Foundation Trusts Tissue Viability Team.

Formulary

Retention Bandages	Mollelast (finger & Toe), K-Band, K-Lite
Paste Bandage	Ichthopaste, Viscopaste PB7
Specialist Use Only	Hydroclean, Flaminal Hydro, Sorbion, Cutimed Sorbact, Iodosorb, Iodoflex, Larvae, Eclypse, Cavilon Advanced, Medi-honey Barrier Cream
Protease Modulator	Urgostart Plus
Wound Cleanser	Octenilin
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	Acti-glide
Waterproof dressing protection	Limbo
Dressing Packs	Polyfield Patient Pack, Dressit
Skin Protection	Cavilon Cream, Cavilon No-Sting Barrier Film, Medi-Derma Pro Protectant & spray
Compression Hosiery, Leg Wraps, Liners & Ulcer Kits	Refer to Lower limb Pathway https://staff.cumbria.nhs.uk/application/files/5016/7846/6335/Lower_limb_North_Cumbria_Pathway_Booklet_Additions-6th_Feb_23.pdf

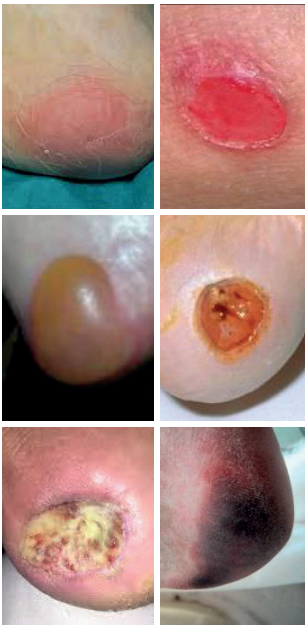
Pressure ulcer or foot ulcer?

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

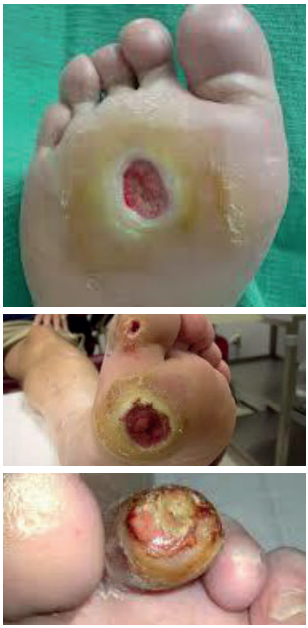


Typical causes for pressure ulcers:

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

All pressure ulcers must be reported as a clinical incident.

Foot Ulcer

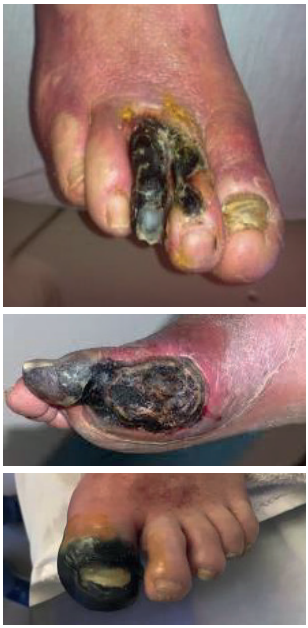


Typical causes for foot ulcers:

- 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



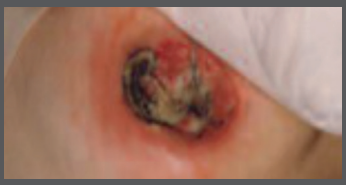
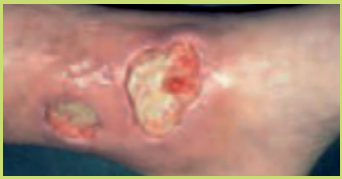
Typical causes for ischaemic/arterial ulcers:

- 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 Acu

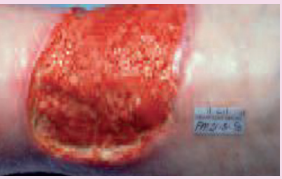
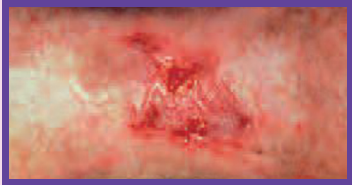
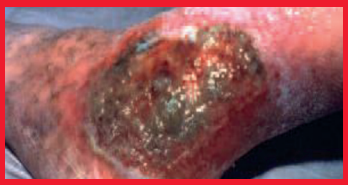
Tissue Type	Necrotic		Sloughy		Gr
					
Rationale	**Debride, rehydrate and remove eschar.**		**Remove slough. Provide clean base for granulation tissue.**		**Prom healt**
	Primary dressing	**Secondary dressing**	**Primary dressing**	**Secondary dressing**	**Prima dress**
Exudate Level Low	Algivon Actiform Cool Duoderm Extra Thin Polymem Activheal Hydrogel Suprasorb X + PHMB	Tegaderm Foam /Adhesive Tegaderm Silicone Foam/Bordered Mepilex/Bordered/ XT(Acute)	Algivon Actiform Cool Polymem Duoderm Extra Thin Urgoclean AG Kytocel (C) Aquacel Extra/ ribbon (A)	Tegaderm Foam / Adhesive Tegaderm Silicone Foam/Bordered Mepilex/ Bordered/ XT (A)	Urgotu Activo Kytoce Polym Mepite Duode Thin Urgotu Aquac ribbon
Exudate Level Low/Moderate	Vascular & Podiatry only Inadine Cutimed Sorbact				Over-g – Refe Over-g Pathw websit
Exudate Level Moderate	Algivon Polymem Silvercel Non-Adherent Suprasorb X + PHMB Kytocel (C) Aquacel Extra/ ribbon(A)	Tegaderm Foam / Adhesive Tegaderm Silicone Foam/Bordered Mepilex/ Bordered/ XT (A)	Algivon Silvercel Non-Adherent Polymem Urgoclean AG Kytocel (C) Aquacel Extra/ ribbon (A)	Tegaderm Foam/ Adhesive Tegaderm Silicone Foam/Bordered Mepilex/ Bordered/ XT (A)	Algivo Activo Polym Kytoce Silverc Adher Aquac ribbon Mepite
Exudate Level High	Algivon Kytocel (C) Silvercel Non-Adherent	Tegaderm Foam/ Adhesive Tegaderm Silicone Foam/Bordered Mepilex/Bordered/ XT (A) Zetuvit Plus Silicone Border Drymax	Algivon Kytocel (C) Silvercel Non-Adherent Aquacel (A) Urgoclean AG	Tegaderm Foam/ Adhesive Tegaderm Silicone Foam/Bordered Mepilex/Bordered/ XT (A) Zetuvit Plus Silicone Border Drymax	Kytoce Aquac Algivo Kytoce Silverc Adher

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

Debridement option: Debrisoft® Debridement Pad /UCS cloth.

ute Tissue Viabilty

(A) Acute use (C) Community use

ranulating		Epithelialising		Infected	
					
ote granulation. Provide thy base for epithelialisation.		**Promote epithelialisation and wound maturation.**		**Manage bacterial burden.**	
ary sing	**Secondary dressing**	**Primary dressing**	**Secondary dressing**	**Primary dressing**	**Secondary dressing**
ul n Tulle el (C) em el One erm Extra ul tel Extra/ (A)	Tegaderm Foam/ Foam Adhesive Tegaderm Silicone Foam/Bordered Mepilex /Bordered/ XT (A)	Urgotul Polymem Mepitel One Flaminal Forte Aquacel Extra/ ribbon (A)	Tegaderm Foam / Adhesive Tegaderm Silicone Foam/Bordered Mepilex/Bordered / XT (A)	Algivon Octenilin Gel Flaminal Forte Actisorb Silver 220 Urgoclean AG Kytocel (C) Suprasorb X + PHMB Acticoat Flex 3 Urgotul Silver	Tegaderm Foam/ Adhesive Tegaderm Silicone Foam/Bordered Mepilex/Bordered/ XT (A)
granulation r to granulation ay on te		Surgical Leukomed T Plus Mepilex Surgical Skin Tears Tegaderm Absorbent	Tegaderm Film		
n n Tulle em el (C) el Non- ent tel Extra/ (A) el One	Tegaderm Foam / Adhesive Tegaderm Silicone Foam/Bordered Mepilex/ Bordered/XT (A)	Polymem Mepitel One Kytocel (C) Aquacel Extra/ ribbon(A)	Tegaderm Foam/ Adhesive Tegaderm Silicone Foam/Bordered Mepilex/ Bordered/ XT(A)	Acticoat Flex 3 Algivon Flaminal Forte Silvercel Non-Adherent Urgoclean AG Kytocel (C) Suprasorb X + PHMB Urgotul Silver	Tegaderm Foam/ Adhesive Tegaderm Silicone Foam/Bordered Mepilex/ Bordered/XT
el tel (A) n el (C) el Non- ent	Tegaderm Foam/ Adhesive Tegaderm Silicone Foam/Bordered Mepilex/Bordered/ XT (A) Zetuvit Plus Silicone Border Drymax	Polymem Urgotul Kytocel (C) Algivon Aquacel Extra (A)	Tegaderm Foam/ Adhesive Tegaderm Silicone Foam/Bordered Mepilex/Bordered/ XT (A) Zetuvit Plus Silicone Border Drymax	Silvercel Non-Adherent Acticoat Flex 3 Algivon Kytocel (C)	Tegaderm Foam/ Adhesive Tegaderm Silicone Foam/Bordered Mepilex/Bordered/ XT (A) Zetuvit Plus Silicone Border Drymax

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

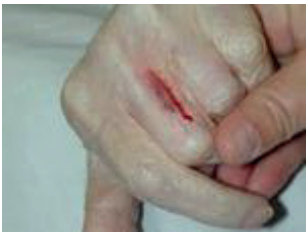
If viable; re-approximate wound edges. Ease the flap back into place using a gloved finger, dampened cotton tip, sterile tweezers.

Measure and document

Goals of Treatment

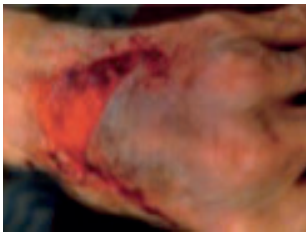
- Treat the cause
- Implement prevention protocol
- Moist wound healing
- Avoid trauma
- Protect periwound skin
- Manage exudate
- Avoid infection
- Pain control

Treatment Options in Accordance with Local Wound Conditions



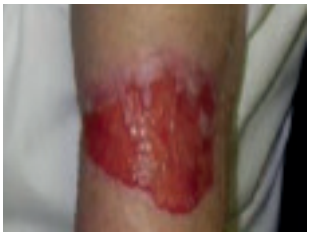
Type 1
No Skin Loss

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 • Mepilex Border • Mepilex XT	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 • Suprasorb X + PHMB	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

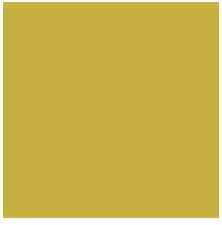
Exudate colour

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 in protein rich fluid

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

Does the wound require a foam dressing as a primary or secondary dressing?
Foams are indicated for exuding wounds and are designed to stay in place for up to 7 days

Yes

No → Refer to wound dressing formulary for alternative dressing

- Has the patient been diagnosed with a longstanding dermatological condition that will be affected by standard adhesives?
- Does the patient have a history of long term steroidal use, resulting in thinning of the skin?
- Has the patient ever had a history of allergic reaction to **more than one** adhesive dressing?

No to the three questions above

Note: If the person has had a sensitivity or allergic reaction to **one** adhesive foam, choose an alternative adhesive foam from the formulary as below

Select a **foam adhesive**

Ensure the correct size, shape and absorbency is selected from the range of products available

If the patient develops a sensitivity/allergic reaction to an adhesive foam or shows any sign of trauma or skin stripping in the peri-wound area please complete a skin incident form. Use the decision tool to aid selection of the next dressing choice

Yes to one or more of the three questions above

Choose a **non adhesive foam** with a retention bandage

Select a **non adhesive foam** from the formulary

Select a **silicone foam** from the formulary

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.