





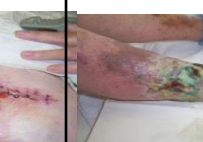




Wound Care Formulary 1st Line





Quick Reference Guide



	PINK Epithelial Tissue		RED Granulation		YELLOW Slough		GREEN Infected		BLACK Necrotic	
Description	Superficial	Superficial	Full Thickness	Superficial	Full Thickness	Superficial	Full Thickness	Superficial	Full Thickness	
Tissue Type										
Objective	Protect	Protect		Rehydrate/ Debride		Treat Infection and reduce bio burden		Rehydrate and Debride (if not a result of ischaemia)		
Primary Dressing For None-Low Exudate Levels	Non adherent Dressing <i>Atrauman or NA Dressing Ultra or Silflex</i>	Non adherent. <i>Atrauman or NA Dressing Ultra or Silflex</i>	Hydrogel <i>Aquaform</i>	Hydrocolloid <i>Duoderm or Duoderm Signal or Hydrosorb</i>	Hydrogel <i>Aquaform Hydrogel</i>	Infected wounds-should have Antibiotics specific to culture & sensitivity- Select dressings to address symptom control i.e. malodor, pain, exudate . Monitor closely		Hydrocolloids (avoid in Diabetic Foot Ulcers) <i>Duoderm or Duoderm Signal or Hydrosorb</i>	Hydrogel <i>Aquaform Medi Honey gel</i>	
Secondary Dressing	Absorbent pad <i>Telfa / or Softpore Tegaderm Pad</i>	<i>Allevyn Foam or Absorbent Zetuvit E</i>	Absorbent <i>Tegaderm + pad or Zetuvit E</i>	N/A	Absorbent pad + Film. <i>Telfa or Zetuvit+ ClearFilm</i>	Wounds that are critically colonized may benefit from antimicrobials but these should only be used short term		N/A	Absorbent pad + Film. <i>Telfa or Zetuvit+ ClearFilm</i>	
Moderate - High	Foam <i>Allevyn Foam or Allevyn Gentle if poor surrounding skin</i>	Foam <i>Allevyn Foam or Alginate Sorbsan Alginate</i>	Alginate <i>Sorbsan +Foam Allevyn Foam</i>	Alginate <i>Sorbsan +Foam Allevyn Foam</i>	Alginate <i>Sorbsan +Foam Allevyn Foam</i>	Superficial -Iodine based; <i>Inadine Silver; Atrauman Ag, Silver Flamazine</i> Full Thickness <i>Honey, Medihoney Silver-Suprasorb A + Ag</i>		Alginate <i>Sorbsan Alginate + Absorbent pad and film</i>	Hydrofiber <i>Aquacel Extra + Absorbent pad / foam</i>	
Very High	Non Adherent + Supra-absorbent <i>Eclipse or Cutimed Siltec</i>	<i>Eclipse or Cutimed Siltec</i>	Hydrofiber <i>Aquacel Extra + Eclipse</i>	Hydrofiber <i>Aquacel Extra + Eclipse</i>	Hydrofiber <i>Aquacel Extra + Eclipse Advadraw</i>	<i>Honey, Medihoney Alginate Silver-Suprasorb A + Ag + Absorbent pad / foam or supra absorbent</i>		Hydrofiber <i>Capillary dressing Advadraw + Film</i>	Hydrofiber <i>Capillary dressing Advadraw + Film</i>	

TIME - Principles of Wound Bed Preparation

Reference: Schultz, G.S, Sibbald, G.R, Falanga V, Ayello, E, Dowsett, C, Harding K, Romanelli M, Stacy MC, Teot L, Vanscheidt W (2003) Wound Bed Preparation

Examples of wound problems	T-issue loss/ type	I-nflammation / I-nfection	M-oisture Balance	E-pidermal margin
	<p>5cm x3.5cm surface wound covered in devitalised tissue – 80% necrosis, 20% slough. Consider possible deep underlying damage.</p>	<p>Dry eschar / devitalised tissue prolongs Inflammatory phase and increases potential for non healing wound and infection.</p>	<p>Dry desiccated tissue needs rehydrating and debriding (unless dry gangrene / eschar due to vascular insufficiency).</p>	<p>Desiccation slows epithelial cell migration and results in scarring if remains dry.</p>
	<p>5cmx 6cmx 1cm full thickness cavity 70% Granulation tissue, 30% slough. Waterlogged tissues reduces ability of nutrients and O2 to be transferred into cells.</p>	<p>Consider possible reasons for high exudate levels e.g. autolysis, lymphedema, or possible critical colonisation or infection should be ruled out as a possible cause.</p>	<p>Excessive fluid causes maceration of surrounding tissue. Manage moisture with absorbent/ dressings such as alginate or / hydrofibre. Consider compression.</p>	<p>Maceration of wound margins lead to further breakdown and stops epidermal migration. Protect surrounding skin edge with barrier film. Offload the affected area.</p>
	<p>7cm x5cm x0.5cm Healthy traumatic wound following surgery 100% Granulation tissue.</p>	<p>No evidence of ongoing inflammation or localised infection.</p>	<p>Maintain thermal insulation and normal moist conditions with foam dressing.</p>	<p>Epidermal migration apparent but recent change to colour of edge to purple is suggestive of autoimmune problem- Consider referral to Dermatologist to biopsy.</p>
	<p>0.5x0.5 x 9cm Sinus tract to hip bone interface. 100% devitalised tissue. Surrounding skin oedematous, indurated and painful. Consider cause e.g. exposure to pressure- review SSKIN Bundle- ? Recent surgery.</p>	<p>Increasing redness with pain, heat, exudate, odour. Monitor redness (mark affected areas >2cm erythema). Swab area and refer to GP to review general condition and consider need for antibiotics.</p>	<p>Very High and offensive exudate that is multi-purulent. Consider use of antimicrobial dressing such as honey gel or alginate or silver dressing. Increase frequency of dressings and may require supra-absorbents.</p>	<p>Narrow opening with indurated tissue indicates occult damage and likely to be undermined with extensive tissue destruction underneath. Advise patient of expected progression of wound and objectives set to manage these symptoms.</p>

Wounds are dynamic - it is crucial to maintain clear documentation of all wound assessments using objective descriptors so that changes are recorded and easy to recognise so that care and objectives can be amended to address adverse conditions