

Gloucestershire Wound Care Dressing Guidance

Created in 2024 next routine review 2026.

Gloucestershire Wound Care Dressing Guidance

Summary

To provide practitioners with evidence-based guidance on wound management & products. The Wound Care Dressing Guidance will provide advice on a wide range of wound types including indications, contraindications and appropriate use of products.

Created by

GHC Tissue Viability Team in Collaboration with the ICB, and GHFT

Permission granted to reference Surrey Guidelines/images from Pauline Robinson, Head of Tissue Viability, CSH Surrey for the Wound Management Formulary Group.

Redesigned & updated by Gloucestershire Health & Care Tissue Viability Team.

This Wound Care Dressing Guidance is a new edition for 2024. The updated version was led by the ICB Medicine Optimisation Nurse Specialist and Tissue Viability Team with representatives from the GHC/GHFT & the multidisciplinary teams – including Pharmacists, Podiatry, Complex Leg Wound Service, District Nurses and members of our working group.

This guidance is designed to promote seamless care across all care sectors, ensure best practice and optimise appropriate management of a wide variety of wounds.

The aim of the Wound Care Dressing Guidance is to provide practitioners with evidence-based guidance on wound processes and considerations.

Please note;

- We do not expect this guidance to be printed, however if it is necessary, do so in colour to ensure the best clarity.
- Use in line with Trust Pathways & Guidelines and refer to relevant specialist services/service criteria as indicated.
- Free samples of dressings/products should not be accepted & not used for patient care.
- Please refer to the BNF for contra-indications and side effects for all products suggested & use in line with manufacturers guidance & indications for use.
- Where 'off formulary' products are required, please complete an exemption form, found in the Formulary.

Upon discharge from an acute hospital, one week's supply of dressings should accompany the patient home, or if treatment is of short duration, enough to complete treatment.

Likewise, those patients with a planned admission to hospital should bring an appropriate supply of current dressings where possible.



**Browse NICE
guidance by
conditions and
diseases.**



**Guidance from
the NWCSF.**

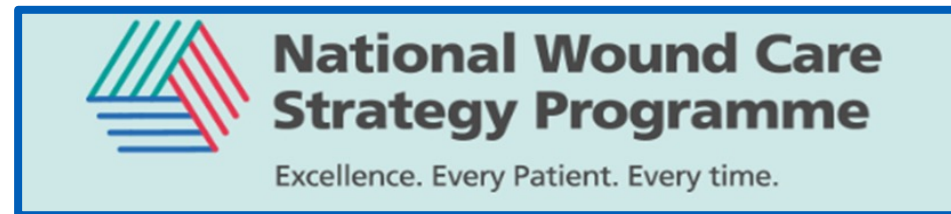
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Introduction

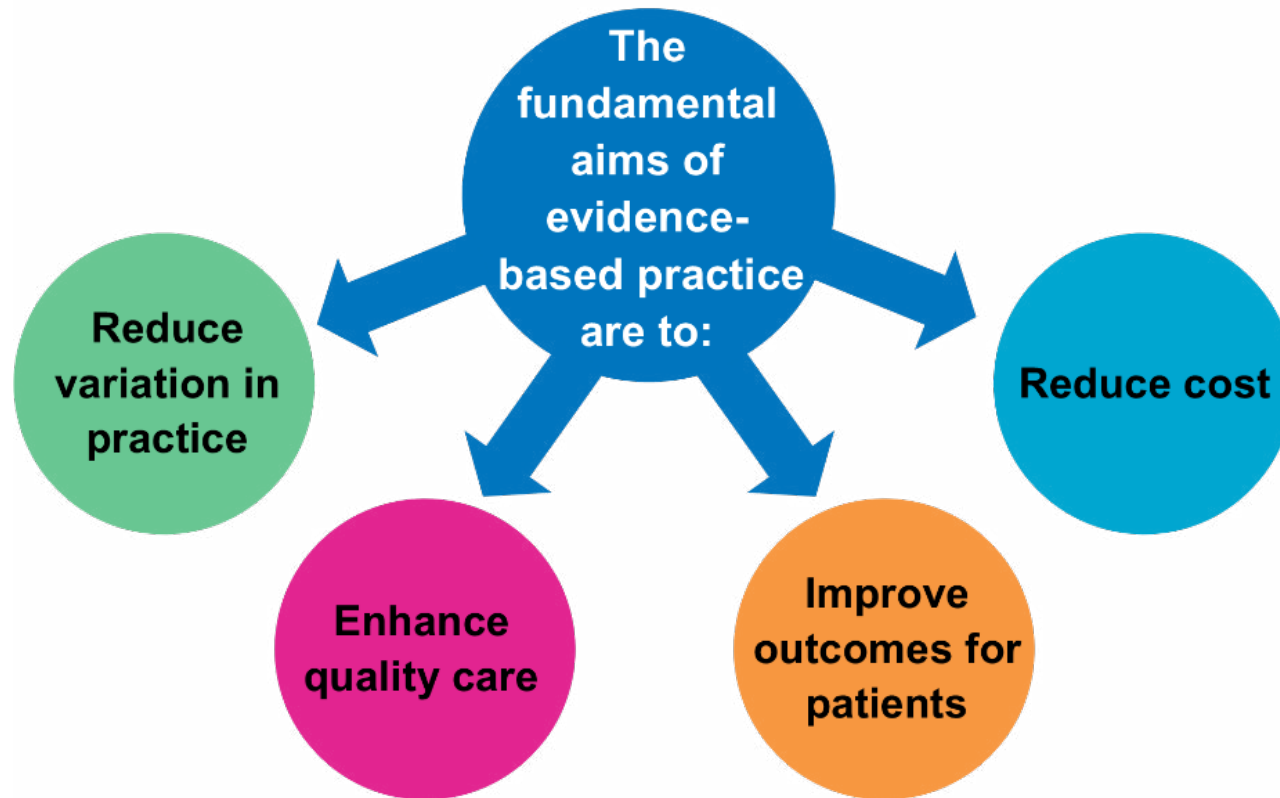
Wounds can be prevalent (common) in all patient groups, and often become more difficult to manage in those with comorbidities and long-term health conditions. Inappropriate and unnecessary dressing changes can have a negative impact on both patient wellbeing and healthcare resources. Wounds present a substantial burden to healthcare systems in comparison to other health conditions while evidence-based wound care remains relatively low priority. Managing 3.8 million patients with a wound was estimated to cost the NHS £8.3 billion annually.

The National Health Service (NHS) recognised that there is a need for national recommendations and therefore the National Wound Care Strategy Programme (NWCSP) was established.



NWCSP vision was to develop recommendations which support excellence in preventing, assessing, and treating people with wounds to optimise healing and minimise the burden of wounds for patients, carers and health and care providers.

Implementing evidence-based wound care will reduce costs when compared with cheaper alternatives that are unsupported by robust clinical evidence.



Evidence-based practice is associated with;

**improved
clinical
outcomes**

**patient
safety**

**quality of
care**

There is limited use of evidence-based practice in wound care, and ritualistic and paternalistic practice is commonplace.

Evidence points to marked unwarranted variation in the UK wound care services, underuse of evidence-based practices and overuse of ineffective practices.

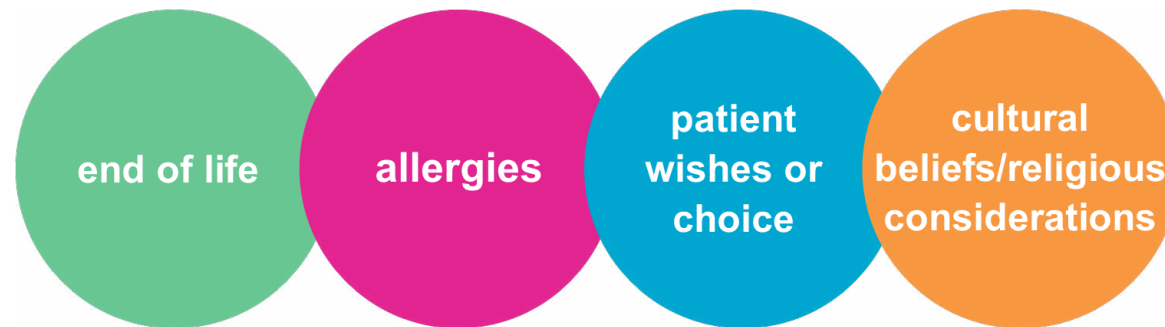


Reducing unwarranted variation

Unwarranted variation in the assessment and treatment of wounds, due to underuse of evidence-based practices and ineffective use of interventions, can lead to poor patient outcomes and increased cost.

However, some variation may be necessary, as every patient is unique, with different needs, preferences, and choices.

There may need to be some flexibility in exceptional circumstances, such as;



Ensuring patient comfort is a priority. In some cases, *symptom management* may take priority over healing. For example – to relieve symptoms of the wound, or side effects caused by treatment that will make the individual more comfortable but won't necessarily heal the wound.



Wherever possible, self-care should be encouraged for patients deemed suitable.

Some patients are more willing/able to engage in self-care than others, so should be assessed – both physically & mentally – as having capacity & capability to do so. Clinicians should engage in honest, open & realistic conversations around patient preferences, goals & expectations in terms of their wound.



REMEMBER the importance of your wound assessment, the importance of identifying any underlying cause (aetiology) & addressing this wherever possible.

General Health Information

Address skin tone bias – Assessment should include an awareness of skin tone in order to monitor any changes to the skin. (e.g. darker skin tones).

Factors affecting systemic blood supply to the wound – Vascular or arterial disease, smoking, anaemia, diabetes, respiratory disease (e.g. COPD), cardiovascular disease.

Factors affecting local blood supply to the wound – Pressure, shear, diabetic foot ulcers (DFU), etc.

Factors affecting susceptibility to infection – Diabetes, burns, severe acquired immune defects e.g. HIV

Medication affecting wound healing – Steroids, chemotherapy, Methotrexate, anticoagulants, high dose anti-inflammatory drugs, Nicorandil, etc

Allergies and/or skin sensitivities to wound management products – Irritation, redness, blistering, itching, allergic reaction.

Information provided to patients/carers – Available resources e.g., shared care leaflet.

Factors affecting skin integrity – Intrinsic factors (e.g. malnutrition, age/frailty, smoking*) Extrinsic factors (e.g. pressure, immobility) Obesity, skin conditions such as eczema or psoriasis, varicose eczema (VE).

Impact of the wound on quality of life – Physical, emotional, social factors, pain, etc.

Mental Health – Address any factors as required.

Smoking* – Cigarette smoking is a key risk factor for poor wound healing, with a greater risk of infection and scarring.

Wound Baseline Information

Number of wounds – Document clearly.

Location of the wound – Use correct anatomical locations e.g. buttock, trochanter, sacrum.

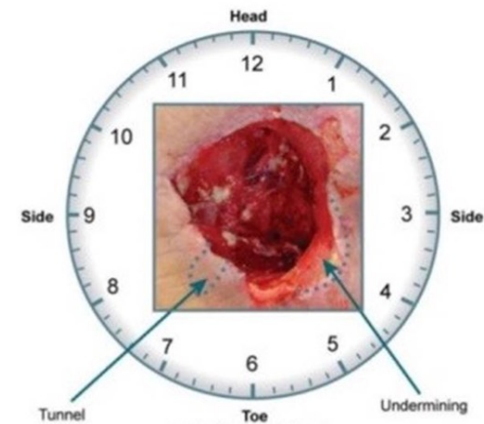
Wound type and classification – e.g. Venous leg ulcer, burn, traumatic, pressure ulcer – include category

Wound duration – Document clearly

Overall aim – To trigger appropriate referral/further assessment or re-assessment of non-healing wounds

Treatment aim – e.g. Healing and/or symptom control e.g. reduction in odour, exudate, reduce pain, increase mobility. Realistic outcomes should be included.

Planned re-assessment date – Document clearly



Wound Assessment

Maximum width, length, depth – Consistent wound measurement helps to monitor wound progress.

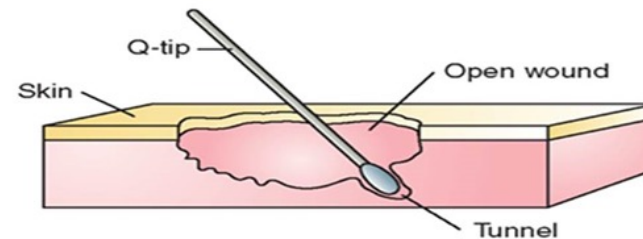
Undermining/tunnelling – Use clock face with the patients head as 12 o'clock and feet as 6 o'clock. E.g. 'undermining at 9 o'clock to depth of 20mm.

Wound bed tissue type – Epithelial, granulation, slough, necrotic, bone, tendon.

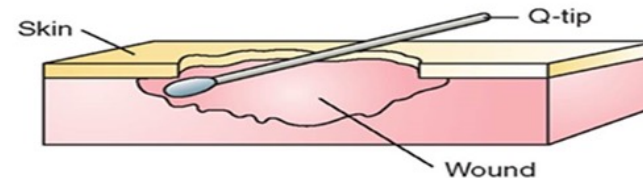
Wound bed tissue amount – After cleansing, document percentage of each type of tissue e.g. 20% slough, 70% granulation, 10% epithelial.

Wound photography – As per Local Guidance & Protocols

A. Tunneling



B. Undermining



TIMERS framework for managing hard to heal wounds. Treat underlying cause & risk factors

T: Tissue	I: Inflammation/infection	M: Moisture	E: Edges	R: Repair
Observation: Devitalised tissue	Observation: Inflammation and/or infection, bioburden	Observation: Incorrect moisture balance	Observation: Edge, rolled, epibole, callus. Poor advancement of wound edge	Observation: Slow, stalled closure failing conservative therapy
Debridement Autolytic Sharp Surgical options if qualified to do so. Mechanical including. Debridement pads Larvae Concentrated surfactants	Treatment options; Antimicrobials Antibiotics Biofilm pathway Bacterial binding dressings Surfactants	Treatment options; NPWT Compression therapy Absorbent dressings	Treatment options; Debridement Wound fillers Periwound protectants	Treatment options; NPWT Growth factors O2 therapy Stem cell therapy Skin graft
Outcome: Clean wound bed, debride devitalised tissue	Outcome: Inflammation, infection & biofilm controlled	Outcome: Manage moisture Wound environment conducive to healing	Outcome: Reduced wound size. Epithelialization.	Outcome: Wound closure, repair tissue
S: Social & patient related factors				
Social situation Patient understanding Patient adherence Patient choice Psychosocial	Engage the patient with the wound care plan		Patient education Understanding belief systems Motivational literacy Active listening Psychoeducation Patients own goals Patient/family/care giver education	

Wound Associated Symptoms

Evidence of wound pain

Wound pain frequency/type

Wound pain severity

Exudate amount

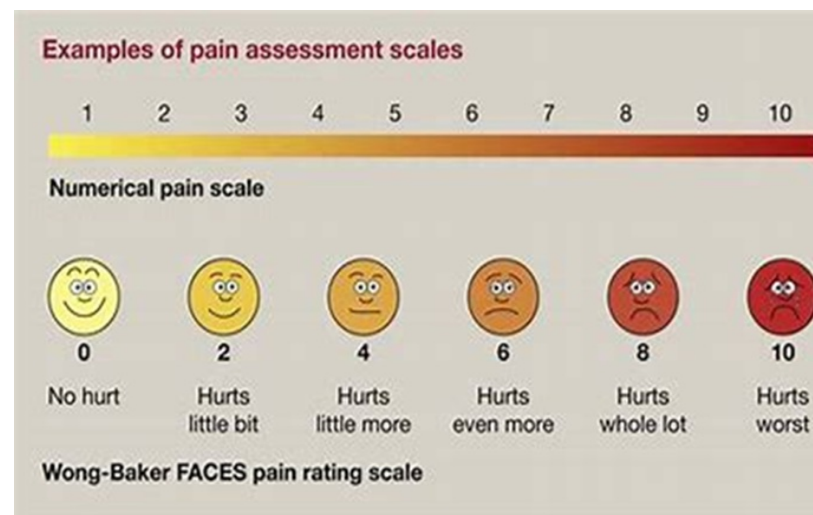
Exudate consistency/type/colour

Odour

Signs of local infection

Signs of spreading/systemic infection

Is wound swab indicated? Refer to trust guidance.



Specialist Referral & Input

Referral to specialist services – Document/date your referral e.g. Tissue Viability, Complex Leg Wound Service, Gloucestershire Leg Ulcer Service (GLUS), Vascular, Dermatology, Podiatry – as per referral criteria and local guidelines.

Consider the need for further investigations – e.g. Doppler/ABPI/TBPI, duplex/bloods/swabs, further imaging.

Remember – the key to successful wound management should;

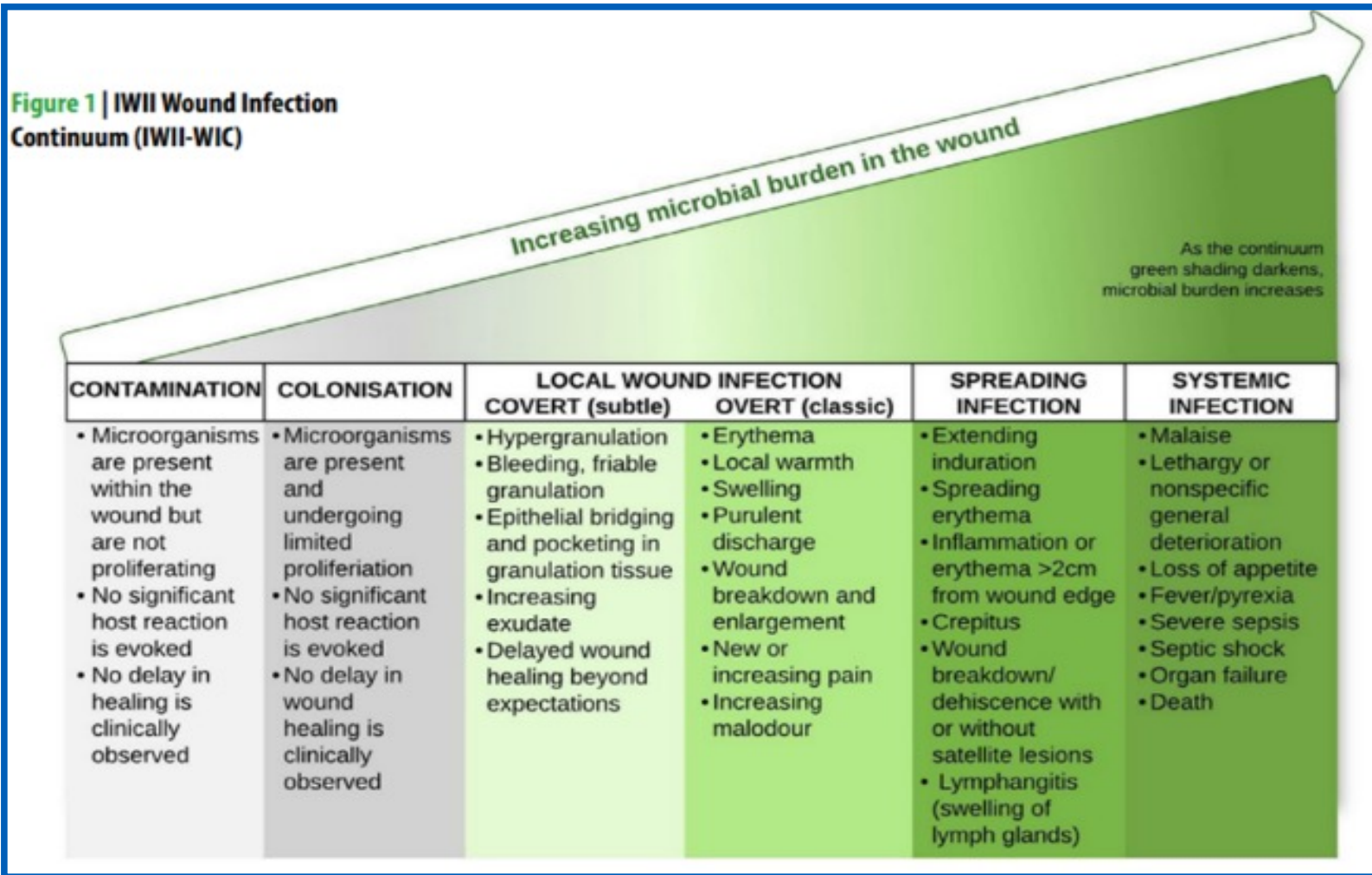
- Identify correct underlying aetiology (cause) of the wound as different wound types require different treatments.
- Treat any underlying modifiable risk factors that contributes to delayed healing.

[Referrals & Services | G-care \(glos.nhs.uk\)](https://www.glos.nhs.uk)

[Gloucestershire Podiatry Referral Form > Glos Health & Care NHS Foundation Trust \(ghc.nhs.uk\)](https://www.ghc.nhs.uk)



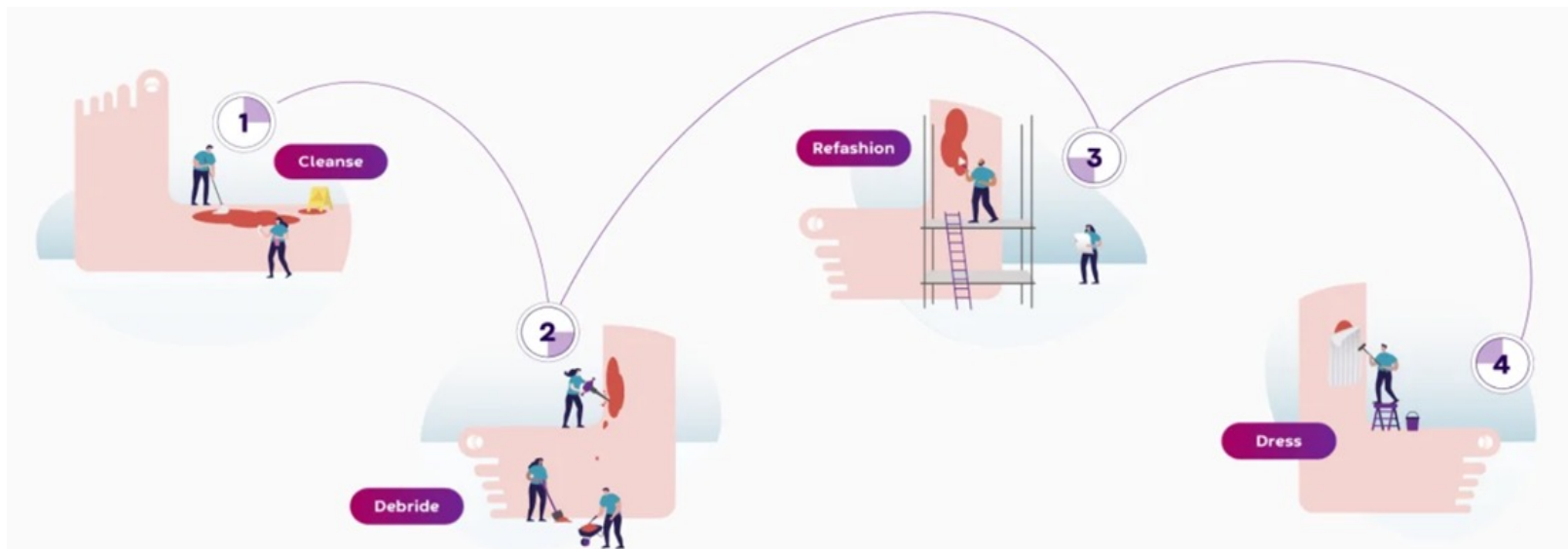
Figure 1 | IWII Wound Infection Continuum (IWII-WIC)



Wound Hygiene - Wound Cleansing

The Importance of Cleansing of wound and periwound.

Cleanse the wound bed sufficiently to loosen superficial devitalised tissue, wound debris, foreign debris and biofilm. **Cleanse** the periwound skin to remove scales and callus, and to decontaminate the area. Using gentle force where necessary and as tolerated, cleanse the skin located 10–20cm around the wound, complying with local guidance when cleansing 'clean' (farthest from the wound) and 'dirty' areas (nearest the wound or the wound itself). Ideally, use an antiseptic or antimicrobial wash or surfactant solution to aid surface and periwound cleansing. (Atkin et al 2020 Journal of Wound Care)



<https://www.convatec.com/advanced-wound-care/professional-education/wound-hygiene-homepage/wound-hygiene/>

Dressing Selection Tips

Dressings do not heal wounds!

There is no 'magic' dressing that will heal all wounds. Dressings, if chosen appropriately, create an optimal healing environment that will facilitate healing.

Select a dressing based on the condition of the wound bed, exudate type/levels/consistency, and presence of localised/spreading infection. Avoid complex combinations of dressings.


If any underlying causes are not treated, i.e. pressure/off-loading, venous insufficiency, malnutrition and optimisation of co-morbidities then the wound is unlikely to heal.


Effective wound management requires holistic assessment, taking into patient factors and the presentation of the wound at time of care planning.


Remember, it needs to be the right dressing, for the right patient, at the right time.

Wound Type & Dressing Selection Tool


This section uses 'generic' headings for dressings. Please refer to the Formulary for the brand names.

EPITHELIALISING WOUNDS	Description	Aim of Management & Treatment	Dressings to Consider	Tips & Cautions
	<p>New epithelial tissue is pink or white in colour and migrates from the wound edges or from remnants of hair follicles within the wound bed ('islands' of epithelial tissue).</p> <p>Epithelial cells only migrate over healthy (living) granulation tissue. This process occurs quicker in warm, moist environments.</p>	<p>Maintain moist/warm environment to aid epithelial migration.</p> <p>Manage exudate.</p> <p>Protection.</p>	<p>Basic wound contact layer Low adherent dressing</p> <p>Adhesive dressing with pad Consider for low exudate</p> <p>Foam dressings Consider for moderate exudate</p>	<p>If exudate levels start to increase, re-assess the patient and the wound. This may be an indication the wound is not healing as expected.</p> <p>Increased exudate can be a sign of unmanaged oedema, colonisation, or infection.</p> <p>It is unusual for epithelialising wounds to have moderate to high exudate levels.</p>

GRANULATING WOUNDS	Description	Aim of Management & Treatment	Dressings to Consider	Tips & Cautions
	<p>Granulation is the process in which the wound is filled with vascular connective tissue & is usually red and moist. It consists of newly developed capillaries which develop into new blood vessels, delivering oxygen/nutrients to the newly formed tissue in the wound.</p> <p>Unhealthy granulation tissue is darker and friable (bleeds more easily).</p>	<p>Maintain moist/warm environment.</p> <p>Promote granulation.</p> <p>Manage exudate.</p> <p>Protect surrounding skin.</p>	<p>Basic wound contact layer Low adherent dressing</p> <p>Simple adhesive dressings Consider for low exudate</p> <p>Foam dressings Consider for low/moderate exudate.</p> <p>Super Absorbent pad/dressing Consider for high exudate</p>	<p>Remember to assess the exudate type, consistency and colour as this is one of the indicators of how well the wound is healing. Remember the dressing change indicator & aim to maximise dressing wear time.</p> <p>Could this be hypergranulation or overgranulation? Consider other aetiology (malignancy)</p>

SLOUGHY WOUNDS	Description	Aim of Management & Treatment	Dressings to Consider	Tips & Cautions
	<p>Slough is devitalised tissue. It contains protein, fibrin, neutrophils and bacteria.</p> <p>Slough can be pale yellow, viscous, fibrinous tissue & can range from yellow to tan. Can cover/partially cover the wound bed. Tends to be loosely adhered or firmly attached. Wounds will naturally debride through the body's own process of autolysis to liquefy and separate devitalised/non-viable tissue from the wound bed.</p>	<p>Wound hygiene (cleansing) to disrupt the wound bed and manually debride slough.</p> <p>Debride & support autolysis.</p> <p>Manage exudate.</p> <p>Protect surrounding skin with appropriate barrier products.</p>	<p>Dependent on depth/ moisture level;</p> <p>Hydrogel For nil to low exudate</p> <p>Hydrocolloid For low exudate. Consider for superficial wounds</p> <p>Foam dressing Consider for moderate to high exudate.</p> <p>Superabsorbent pad/dressing Consider for high exudate.</p> <p>Hydrofibre dressing For absorbency and packing. Conforms to wound bed.</p> <p>Cadexomer Iodine Iodine Paste, reduce bacteria/biofilm, to debrides slough.</p> <p>Enzyme Alginogel Debrides wound, manages exudate. Reduces bacterial and fungal growth.</p>	<p>Dry adherent slough requires a dressing that donates moisture. Remember risk of maceration & excoriation. Debridement pads & cloths can be used for mechanical debridement when appropriate. Some wounds may require other methods of debridement e.g. LDT (larval debridement therapy).</p> <p>You may require a primary & secondary dressing based on your wound assessment</p>


This process can take time. Patients who are compromised e.g. with ischaemic digits, the aim would be to keep the wound dry!!!!
Think – is this slough or could it be subcutaneous tissue, tendon or bone?

NECROTIC WOUNDS	Description	Aim of Management & Treatment	Dressings to Consider	Tips & Cautions
 <p>https://g-care.glos.nhs.uk/clinical-topic/peripheral-arterial-disease-pad</p>	<p>Necrosis is a term used to describe dead tissue (eschar) and is black or brown in colour. Necrosis can be <i>dry & stable</i>, <i>dry & unstable</i> or <i>wet</i>. The management of each type differs. Necrosis can be an indication of poor blood supply or a dehydrated wound bed.</p> <p>Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.</p>	<p>If dry and on the foot – keep dry DO NOT debride or re-hydrate</p> <p>If dry/stable on lower limb – keep dry DO NOT debride or re-hydrate</p>	<p>Basic wound contact layer Low adherent dressing</p> <p>Simple adhesive dressings For low exudate</p> <p>Iodine dressings Consider to manage risk of infection</p> <p>DACC coated dressings For colonised or infected wounds with low levels of exudate</p>	<p>If wet/lifting seek specialist advice.</p> <p>Foam dressings can increase moisture/ autolysis so use with caution.</p> <p>Seek advice from your local Podiatry/Diabetic Foot Service/Tissue Viability Service.</p>

Diabetic patients with necrotic wounds to their heels and feet should be referred urgently to Podiatry/Diabetic Foot Team. Keep the area dry - DO NOT debride or hydrate.

Critical limb ischaemia (CLI) is a severe obstruction of the arteries which markedly reduces the blood flow to the extremities (hands, legs and feet) is a limb threatening condition & requires URGENT hospital admission.


Necrotic wounds to the lower extremities should not be debrided until you have an indication of a patient's vascular status. Keep the area dry - DO NOT debride or hydrate.

FUNGATING WOUNDS	Description	Aim of Management & Treatment	Dressings to Consider	Tips & Cautions
	<p>Fungating/malignant wounds can present as tumours, ulceration or lesions. They are a distressing visual sign that cancer has broken through the skin. They are complex non-healing wounds that will fail to heal unless the underlying cancer is eradicated.</p> <p>The most distressing symptoms for individuals can include pain, malodour and high exudate levels. High exudate levels are usually due to increasing bioburden.</p> <p>The impact of malignant fungating wounds on a patient's quality of life cannot be underestimated.</p>	<p>Palliative care</p> <p>Consider physical & psychological factors</p> <p>Give supportive, sensitive care & realistic expectations.</p> <p>Symptom control</p> <ul style="list-style-type: none"> Pain Odour Skin Infection Exudate/bleeding Self <p>'POSIES' Pathway</p>	<p>Absorbent & Superabsorbent dressings For high exudate</p> <p>Antimicrobial dressings For infected, malodorous wounds. For low/moderate/high exudate.</p> <p>Hydrofibre dressings For absorbency. Promotes haemostasis. Conforms to wound bed.</p> <p>Enzyme Alginogel dressings For moderate to higher exuding wounds. Defends against infection.</p> <p>Odour absorbent dressing e.g. charcoal dressings Management of malodorous wounds.</p>	<p>Refer to your local Palliative Care Team for advice and support with pain management, excessive bleeding or itching (pruritus).</p> <p>Garments can help secure dressings, e.g. crop top/ vest top for chest/breast wounds, close fitting 'cycling' type shorts for groin wounds.</p> <p>Specialist garments are available. Breast pads can be used for fungating breast wounds.</p>

Use of wound irrigation solutions may cause discomfort.


Be cautious with dressings choice – trauma on removal or actively debriding may cause bleeding or pain.

Avoid fibrous dressings as they may adhere. Honey may cause bleeding or increase pain.


SKIN TEARS	Description	Aim of Management & Treatment	Dressings to Consider	Tips & Cautions
	<p>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.</p> <p>A <i>flap</i> is defined as a portion of the skin (dermis/epidermis) that is unintentionally separated (partially or fully) from its original place.</p>	<p>Provide a moist wound healing environment</p> <p>Protect periwound skin</p> <p>Manage exudate</p> <p>Avoid further trauma</p> <p>Avoid infection</p>	<p>If dry Apply a hydrogel dressing.</p> <p>If wet or leaking Apply silicone wound contact layer and absorbent pad with a gentle retention bandage for the first 24hours or until fluid levels reduce.</p> <p>Thereafter, cover with a gentle adhesive bordered foam/pad dressing.</p>	<p>If the skin tear is bleeding, apply gentle pressure with a gauze swab and elevate the limb, if necessary, for a minimum of 15minutes. If skin flap is present, gently realign with a moistened gloved finger.</p> <p>Mark the dressing with an arrow to indicate the correct direction of removal. Clearly document in the notes.</p> <p>Consider using a skin barrier product to protect the surrounding skin (e.g. to prevent maceration if the wound has high exudate levels).</p>


Regular use of an emollient can help prevent further skin tears

FOR GHFT ACUTE HOSPITAL NURSES SEE TRUST SKIN TEAR PATHWAY

SURGICAL WOUNDS	Description	Aim of Management & Treatment	Dressings to Consider	Tips & Cautions
	<p>A surgical wound is a cut to the skin during an operation. It will heal by primary intention.</p> <p>They are the most commonly managed wound type (57%).</p>	<p>Absorb wound exudate.</p> <p>Provide optimum healing environment</p> <p>Protect the area until it is healed</p> <p>Prevent stitches/clips from catching on clothing.</p> <p>Manage risk of infection.</p>	<p>Basic wound contact layer Low adherence dressing.</p> <p>Foam dressings Consider for medium exudate.</p> <p>Simple adhesive dressings Consider for low exudate.</p> <p>Absorbent dressings Consider for high exudate. Antimicrobial dressing if indicated. To reduce bacteria</p>	<p>Delayed healing is a risk, due to Surgical Site Infection (SSI) or Dehiscence (SWD);</p> <p>SSI – infection at the site of surgery, usually within 1 week of surgery. This can result in;</p> <p>Surgical wound dehiscence – the separation of the margins of a surgically closed wound when closure materials are removed. A dehisced incision may, or may not, display clinical signs and symptoms of infection.</p>

SWD wounds can be serious and may require an urgent review under the surgical team & ongoing support from Tissue Viability.
Surgical Wounds – recommendations for care (nationalwoundcarestrategy.net)

BURNS	Description	Aim of Management & Treatment	Dressings to Consider	Tips & Cautions
 <p data-bbox="174 528 398 560">WWW.NHS.UK</p>	<p data-bbox="555 292 913 568">A burn is an injury caused by thermal, chemical, electrical or radiation energy. A scald is a burn caused by contact with a hot liquid or steam but the term 'burn' is often used to include scalds.</p> <p data-bbox="555 596 831 663">Considerations for admission include;</p> <p data-bbox="555 676 913 743">Deep dermal burns (>5% total body surface/adults)</p> <p data-bbox="555 756 913 823">ALL deep dermal burns in children</p> <p data-bbox="555 836 913 935">Burns to certain areas – face, hands, feet, genitalia, perineum & major joints</p> <p data-bbox="555 948 824 979">Full thickness burns</p> <p data-bbox="555 992 837 1059">Circumferential deep dermal in any age</p> <p data-bbox="555 1072 882 1139">Electrical, high pressure steam & chemical burns</p>	<p data-bbox="936 292 1151 323">Support healing</p> <p data-bbox="936 363 1249 395">Reduce risk of infection</p> <p data-bbox="936 435 1106 467">Control Pain</p> <p data-bbox="936 507 1151 539">Reduce scarring.</p> <p data-bbox="936 579 1151 611">Regain function</p>	<p data-bbox="1317 292 1666 391">Choice of dressing should be based upon the depth, area and site of the burn.</p> <p data-bbox="1317 419 1666 560">Routinely under Specialist management who may use alternative dressings and products.</p> <p data-bbox="1317 588 1644 687">Refer to Clinical Guideline & Burns Management Pathway.</p>	<p data-bbox="1697 292 2047 783">Most burns heal without any problems. Complete healing (cosmetic) is often dependent on appropriate care, especially within the first few days after the burn. Most simple burns can be managed within primary care but complex burns and all major burns warrant a specialist and skilled multidisciplinary approach for a successful clinical outcome.</p>
<p data-bbox="416 1310 1823 1342">FOR GHFT ACUTE HOSPITAL NURSES SEE TRUST CLINICAL GUIDELINE CLG029</p>				

WOUND INFECTION & BIOFILM	Description	Aim of Management & Treatment	Dressings to Consider	Tips & Cautions
	<p>Wound infection is the invasion of a wound by rapidly increasing microorganisms to a level that invokes a local, spreading and/or systemic response. Signs include; heat, redness (erythema), warmth, increased pain and exudate. Individuals who are immunocompromised, diabetic or elderly may not show the classic signs of infection.</p> <p>Biofilm indicator checklist. Does the patient have the following; Wound remains static despite optimum wound management & health support? Signs of local infection? Poor quality granulation/friable hypergranulation tissue? Signs of infection? Wound not responding to appropriate antimicrobial treatment? History of Abx failure or persistent/reoccurring wound infection?</p>	<p>To reduce Biofilm & infection risk.</p> <p>Wound hygiene (cleansing) to disrupt the wound bed and manually cleanse wound bed.</p> <p>Manage bioburden and odour.</p>	<p>Antimicrobial dressings To topically manage and reduce risk of infection.</p> <p>Hydrofibre dressings For absorbency and packing. Haemostatic.</p>	<p>Inflammation is part of the normal wound healing process. Some of these signs can mimic those of infection.</p> <p>Wound bed may contain, necrosis and/or can have a shiny/slimy appearance.</p> <p>All antimicrobial dressings should be reviewed after two weeks use.</p> <p>Biofilm is not visible to the naked eye</p> <p>Think <u>SEPSIS</u></p>

THINK SEPSIS. Slurred speech or confusion. Extreme shivering or muscle pain. Passing no urine (in a day). Severe breathlessness. It feels like you're going to die. Skin mottled or discoloured.



Paediatric Patients

While this Formulary is designed to assist in the management of adults with wounds, it is important to acknowledge this important patient group.

Many children who are unwell, who are born with rare syndromes or who live with exceptional complex health needs are cared for within the community setting.

These children have a very specific set of requirements and should not be seen as 'little adults' from a medical or tissue viability perspective. Providing wound care can be a challenging and lengthy process.

Many products that are routinely used are not licensed for use on infants (under 3 years old) or babies (under 6 months old) because the rate of absorption differs. This may lead to a simpler, more gentle approach and having to be

somewhat, creative with dressings due to product sizes.

Young children develop pressure ulcers in a very different pattern to adults with their most common site being the back of the head due to the weight ratio between the head and the body. They also suffer significantly more from device related damage and extravasation injuries. Children are born with or develop many life limiting diseases, which due to their very nature, are rarely seen in adult patients.

It is important to review the use of all wound management products to ensure they are safe and appropriate to use within the chosen age range. There is somewhat limited information for many products but some commonly used products are listed below.



FORMULARY PRODUCT	Type	Actions	Indications/use	Precautions/contraindications
Aquacel Extra Aquacel Extra Ag+	Hydrofibre	Absorb fluid Moisture control Conformability to wound bed	Special cavity presentations in the form of rope or ribbon Antimicrobial options available	Do not use on dry/necrotic wounds. Use with caution on friable tissue (may cause bleeding). Do not pack cavity wounds tightly. Can be used on neonates and upwards.
Flaminal Forte/Hydro	Alginogels	Rehydrates wound bed Moisture control Promote autolytic debridement Antimicrobial action Cooling.	Forte - for moderately to highly exuding wounds. Hydro - Dry/low to moderately exuding wounds	Should not be used where patients have a previous sensitivity reaction to alginate dressings or to polyethylene glycol. Can be used on Neonates and upwards.
Prontosan Wound Irrigation Solution. (Minimum 10-minute soak time)	Polyhexamethylenebiguanide (PHMB)	Antimicrobial action	Low to highly exuding wounds (depending on dressing presentation) Critically colonised wounds or clinical signs of infection May require secondary dressing.	Known sensitivity to PHMB. It is stated in the Instruction for Use (IFU) that 'due to insufficient clinical data, all the Prontosan ® range should only be used selectively and under close medical supervision in new-borns and infants.
Inadine	Iodine	Antimicrobial action	Critically colonised wounds or clinical signs of infection. Low to moderately exuding wounds.	Use under specialist supervision only Do not use on dry necrotic tissue Known sensitivity to iodine. Do not use on children <6 months
Atrauman	Low-adherent wound contact layer (e.g. lipid colloid silicone)	Protect new tissue growth Atraumatic to periwound skin Conformable to body contours	Low to highly exuding wounds Can be used as a carrier for topical preparations (e.g. honey)	May dry out if left in place for too long Known sensitivity to silicone.
Mepilex Lite Mepilex Border Lite Mepilex XT Mepilex Border	Foams	Absorb fluid Moisture control Conformability to wound bed	Moderately to highly exuding wounds Low adherent versions available for patients with fragile skin	Do not use on dry/necrotic wounds or those with minimal exudate.

Helpful Tips, Links & Resources

WOUNDS | UK

RESOURCES

- Best practice statements
- Case studies
- Consensus documents
- How to guides
- Made Easy
- Making the case
- Explained series
- Patient partnership
- Supplements
- Quick guides
- Videos
- Abstracts

<https://wounds-uk.com/resources/>



National Wound Care Strategy Programme

Clinical resources

Information about pressure ulcers, lower limb wounds and surgical wounds for health and care professionals, people with wounds and their carers.



Pressure Ulcers



Lower Limb



Surgical Wounds

Please follow link for more information.

<https://www.nationalwoundcarestrategy.net/clinical-resources/>



Scan the QR code to see the aetiology-specific T.I.M.E. clinical decision support tool (CDST; Schultz et al, 2003; Leaper et al, 2012; Blackburn et al, 2022).

Examples of open-ended questions to use during wound assessment

What worries you about your wound?

How does your wound affect daily living and your personal relationships?

What issue or problem do you want to address first?

What is a priority for you and your wound in the next couple of weeks/longer-term?

How do you feel about doing some of the care for your wound yourself?

What do you want to know about doing some of the care yourself?

Who else can be involved to help you manage caring for your wound?

Questions practitioners should ask themselves during holistic wound assessment and review

Be clinically curious!!



- What have I found?
- What does it mean?
- What should I be doing about it?
- What am I looking for?
- Do I need to escalate to more active treatment?
- Do I need to refer?
- When should I next review?
- What feedback/advice should I give the patient?

Questions to ask the patient and/or advocate — do you think your wound has improved?

- How has the wound pain been?
- Have you noticed any new, different or increased smell(s)?
- Have you noticed any changes in sensation (e.g. heat and/or itching)?
- Have you noticed any changes in your skin, including colour?
- Have the dressings stayed on?
- Have you been able to socialise?
- Have you been able to go to work? Is the dressing comfortable?
- Have you been able to get dressed?
- Have you been able to go outside?
- How have you slept?
- What is the worst thing about the wound for you?
- How can we help to address this?

PLEASE FIND THE GLOUCESTERSHIRE JOINT FORMULARIES HERE;

[gloUCEstershire-joint-formulary/wound-care-formulary](https://www.gloUCEstershire-joint-formulary/wound-care-formulary)

OR USE THE QR CODE





Figure 1. Eatwell Guide Source Public Health England in association with the Welsh Government, Food Standards Scotland and the Food Standards Agency in Northern Ireland (Public Health England, 2016)

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Images sourced from <https://dermnetnz.org/image-licence#use>