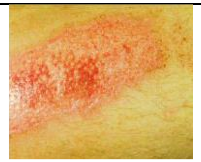
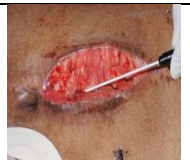
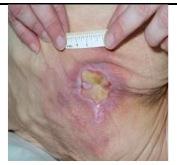
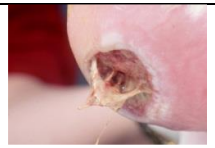
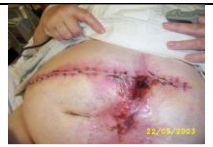
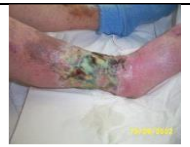
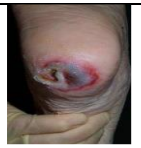
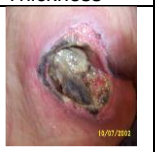
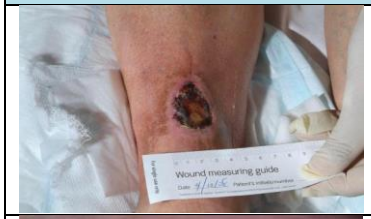
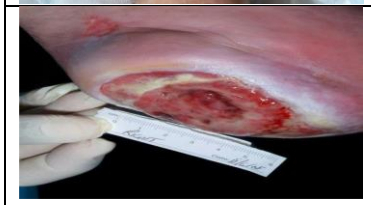
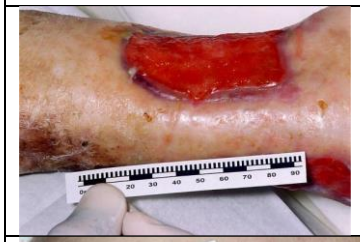
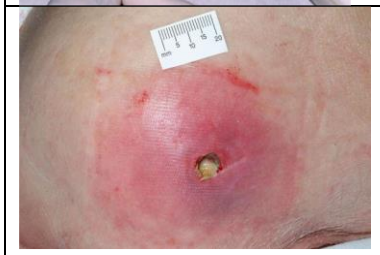
Wound Formulary 2022 1st Line Product Quick Reference Guide

	Pink Epithelial Tissue	Red Granulation		Yellow Slough		Green Infection		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 Bioburden		Rehydrate/debride (if not as a result of ischaemia)	
Primary Dressing for None-Low exudate levels	**Non-adherent:** Atrauman **or** N-A Ultra **or** Mepitel One	**Non adherent**: Atrauman **or** N-A Ultra **or** Mepitel One	**Hydrogel:** ActivHeal hydrogel	**Hydrocolloid:** DuoDERM / DuoDERM Signal **(avoid in Diabetic Foot Ulcers)** **or** Pharmagel	**Hydrogel:** Activheal hydrogel	Systemic Infected wounds-should have antibiotics specific to culture & sensitivity- Select dressings to address symptom control i.e., malodour, pain, exudate. Monitor closely		**Hydrocolloids: (avoid in Diabetic Foot Ulcers)** DuoDERM / DuoDERM Signal **or** Pharmagel non-adhesive	**Hydrogel:** Activheal Hydrogel **or** Revamil Wound Gel (Honey)
Secondary Dressing	**Absorbent Pad:** Telfa **or** Softpore **or** Yibon film dressing with pad	**Foam:** Suprasorb P sensitive **or** **Absorbent:** PremierPad	**Absorbent:** Yibon film island dressing **or** PremierPad	n/a	**Absorbent pad + Film:** Telfa **or** Premier Pad **+** 365 Film	Wounds that are critically colonized may benefit from antimicrobials, but these should only be used short term		n/a	**Absorbent pad + Film:** Telfa **or** Premier pad **+** 365 Film
Moderate to High exudate levels	**Foam:** Suprasorb P sensitive	**Foam:** Suprasorb P sensitive **or** **Alginate:** Kaltostat	**Alginate:** Kaltostat **+** **Foam:** Suprasorb P Sensitive	**Alginate:** Kaltostat **+** **Foam:** Suprasorb P Sensitive	**Alginate:** Kaltostat **+** **Foam:** Suprasorb P Sensitive	**Iodine based:** Inadine **Silver:** Atrauman Ag	**Honey:** Revamil **Silver:** Suprasorb A+Ag	**Hydrofiber or Alginate:** Aquacel Extra **or** Kaltostat **+ Absorbent pad and film**	**Hydrofiber or Alginate:** Aquacel Extra **or** Kaltostat **+ Absorbent pad and film**
Very High exudate levels	**Non-adherent + super absorbent:** DryMax Super **or** Kliniderm	**Non-adherent + super absorbent:** DryMax Super **or** Kliniderm	**Hydrofiber:** Aquacel Extra **+** Kliniderm	**Hydrofiber:** Aquacel Extra **+** Kliniderm	**Hydrofiber:** Aquacel Extra **+** Kliniderm	**Honey:** Revamil Melginate **Silver:** Suprasorb A+Ag **+** Absorbent pad / foam or super absorbent		**As above or Hydrofiber or Alginate and Foam**	**As above or Hydrofiber or Alginate and Foam**

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
	5cm x3.5cm surface wound covered in devitalised tissue – 80% necrosis, 20% slough. Consider possible deep underlying damage.	Dry eschar / devitalised tissue prolongs Inflammatory phase and increases potential for non-healing wound and infection.	Dry desiccated tissue needs rehydrating and debriding (unless dry gangrene / eschar due to vascular insufficiency).	Desiccation slows epithelial cell migration and results in scarring if remains dry
	5cmx 6cmx 1cm full thickness cavity 70% Granulation tissue, 30% slough. Waterlogged tissues reduce ability of nutrients and O2 to be transferred into cells.	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.	Excessive fluid causes maceration of surrounding tissue. Manage moisture with absorbent/ dressings such as alginate or / hydrofibre. Consider compression.	Maceration of wound margins lead to further breakdown and stops epidermal migration. Protect surrounding skin edge with barrier film. Offload the affected area
	7cm x5cm x0.5cm Healthy traumatic wound following surgery 100% Granulation tissue.	No evidence of ongoing inflammation or localised infection.	Maintain thermal insulation and normal moist conditions with foam dressing.	Epidermal migration apparent but recent change to colour of edge to purple is suggestive of autoimmune problem- Consider referral to Dermatologist to biopsy.
	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	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.	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.	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.

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