

Transforming wound
and lymphoedema care



Accelerate

Wound management: Getting it right first time!

Guidance for clinicians in the community

NHS
East London
NHS Foundation Trust



acceleratecic.com



Introduction

The aim of this wound management guide is to help the clinician in their assessment and choice of dressing so that an optimum wound healing environment can be achieved.

This guidance is intended to be used by healthcare professionals requesting prescribed dressings for the management of wounds in Tower Hamlets.

This guide is designed to help you get the best outcomes for your patients. It is hoped that the information will assist all practitioners to provide a consistent approach and high quality wound management and care.

The document will address key aspects of wound management and help direct you to the best and most appropriate dressing, bandage or hosiery so that healing is optimised.

Remember!

Dressings do not heal wounds!

Dressings can only facilitate healing by managing wound bed conditions that may be preventing/ delaying the healing. Some types of wounds or ulcers require specific management to promote

Developed in partnership with community practitioners working in Tower Hamlets.

healing; for instance, pressure ulcers or neuropathic foot ulcers require offloading over the site, venous leg ulcers require compression bandaging.

We also need to remember that all people with a wound need to have a healthy, balanced nutritional intake as part of their management plan.

A thorough assessment of both the patient and their wound with consideration of factors that might be delaying healing is key to wound treatment decisions.

The dressing selection chart on pages 18 - 19 is designed to:

- Lead to better conversations with your patient and support self-management where possible
- Support improved decision making and meet clinical need
- Optimise product use and reduce waste
- Promote timely access to a suitable wound management product
- Assist nurse or medical prescribers in choice of dressing or treatment modality

Please note

Product prices are correct at the time of publication September 2020.

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Key messages

- Document the CAUSE of the wound and how this is addressed and monitored through treatment plan
- Make sure the dressing choice matches the wound bed and level of exudate
- Ask about pain and its impact at every dressing change until resolved. Monitor through measurement
- Use a dressing pack to facilitate best practice in infection control and wound measurement
- Use the **STEP-UP, STEP-DOWN** approach to ensure a better use of dressings is linked to rationale
- Review the wound regularly and prescribe the most suitable and least expensive dressings
- Any wound on the lower leg must be reviewed for early intervention compression hosiery
- Generally the wound bed and size will change over time. To avoid waste and facilitate prompt wound evaluation do not prescribe excessive quantities or issue long term repeats. A maximum of 14 days supply should normally be sufficient
- If wound healing does not progress as expected, seek advice from the Accelerate Team
- Antimicrobial dressings should only be used where there are clinical signs and symptoms of infection and discontinued if there is no improvement after 14 days. They should not be routinely used for the management of uncomplicated leg ulcers
- Avoid long term use of antimicrobial dressings. Seek advice on cause and prevention of recurrent infections



Improving wound management and outcomes

A consistent approach to wound management is essential. This document focusses on helping the clinician choose the most suitable approach and dressing so that:

- Treatment plan is appropriate for the wound diagnosis and cause of the non-healing
- Patient outcomes are improved
- Dressing products are used wisely
- Clinician's time is used wisely
- Red flags or concerns are identified early
- Referral pathways are accessed in a timely manner

Patient centred management

It is essential to ensure that patients are involved in decisions that affect their life and choice of treatments.

To enable supported self-management, plan a joint strategy that includes developing:

- Knowledge
- Skills
- Confidence

Goal setting in simple steps is integral to this process.

When wounds are slow healing or long-term, it is important that there is appreciation of what may make the situation worse and the early warning signs or triggers.

Support patients to take an active part in their treatment and prevention plan.

Patient experience: creating bespoke care

Alongside these choices and clinical decisions, we need to be alert to the fact that this is a wound that will affect a person's life. This may be the first wound of this type for them or a repeated issue, both of which will create significant concerns for the person in front of you.

They may be shocked by the pain or the slowness of healing. Make sure you ask about the impact this wound and the treatment plan is having on their lives, their family and their work. This will help you provide a personalised treatment plan that will include self-management or shared care.

Discuss the likely cause of the non-healing and how this is addressed through the treatment plan.

Self-management remains possible alongside weekly support. Good understanding is essential if shared care is to be effective.

Wound management principles

The purpose of a dressing is to:

1. Provide a comfortable environment for the patient and wound bed
2. Contain the exudate
3. Cause minimal trauma or distress
4. Protect the wound
5. Prevent or combat infection
6. Contain odour

Wound assessment and review

Taking a structured approach to assessment and documentation is Best Practice.

Please note the following:

1. Baseline information
 - a. Cause or diagnosis
 - b. Wound type
 - c. Location
 - d. Duration
2. Assessment information
 - a. See TIMES
 - b. Pain: type, frequency and duration
3. Management plan
 - a. Rationale for dressing choice and frequency
 - b. Communication plan
 - c. Patient partnership

Creating better outcomes through TIMES

Create a TIMES framework so that all aspects of wound bed preparation are managed and issues are identified.

TIMES Framework

- **TISSUE**
Tissue assessment. Does the granulation tissue need protecting, or is there necrosis, eschar or slough which need debriding.
- **INFECTION/INFLAMMATION**
Is infection present that can delay wound healing, or critical colonisation or biofilm that can result in a wound becoming static and non-healing.
- **MOISTURE IMBALANCE**
A wound requires the right environment to heal (moist); high levels of exudate may cause maceration or extensive excoriation from wound exudate, especially on the leg. If the wound is too dry it will also delay epithelialisation.
- **EDGE OF WOUND**
Non-healing, undermined or excessively raised or granular. Refer for advice.
- **SURROUNDING SKIN**
This particularly relates to the lower limb skin care e.g. hyperkeratosis, varicose eczema. Do not ignore surrounding skin.

Top tips on wound management

1. Use structured approach, see page 4
2. Assess the wound and surrounding skin - see TIMES framework page 5
3. Ensure the reason for the slow healing is identified so that treatment objectives can be defined. The aetiology of the wound must be clear and should help determine the treatment.
4. Choose the right dressing that meets the patient and wound bed needs now
5. Consider lifestyle issues
6. Prioritise objectives of the patient
7. Review and refer on if non-healing

Top tips on dressing choice

1. Be aware of the difference in costs between dressings. **Step-Up** to the silicone based or foam products: the extra costs are required for painful wounds or fragile skin. **Step-Down** from silicone or foam to simple dressings when wound is healing
2. If they are non-healing, why? What support do they need? Are they known to Tissue Viability?
3. Be alert when dressings are required daily - refer early for advice. If this does not reduce quickly, they are at risk of infection due to uncontrolled exudate and/or oedema in the leg

4. Dressings can often be left in place for up to 7 days. However, wounds commonly need dressing twice weekly for comfort or to ensure the compression therapy is optimised
5. Any wound on the lower leg requires light compression support to speed healing and prevent traumatic wounds becoming an ulcer - see page 10

Top tips on wound irrigation

1. Sterile saline and dressings for 48 hours post-op
2. Warm tap water or showers are preferable to saline in most wounds
3. Antimicrobial irrigation only where infection is present or recurrent infection is a high risk - please adhere to the guidance on soaking times

Top tips for measuring wounds

Measuring wounds is best practice and an essential part of monitoring progress:

1. Please use the measuring tool in the dressing packs
2. Measure the 'longest length' - this is simple and achieves a more consistent approach
3. Taking regular photographs helps in communication and evaluation for patients and clinicians

When is specialist advice required?

Seek help when:

1. The cause of the wound or non-healing is not understood. If there is no diagnosis or aetiology, then a rationale for treatment cannot be developed. This in itself creates delay
2. The wound is very painful and not improving.
3. All principles of TIMES have been followed and still the wound fails to reduce in size
4. The surgical wound has large amounts of frank pus
5. The exudate remains high. The patient has an extended period of requiring frequent dressing changes
6. The person is not able to tolerate the treatment required



To optimise dressing use; exudate or pain may dictate a change in product.

Spotting the unusual and getting help early

This is usually focussed on the rarer causes of wounds or ulcers and require prompt referral to dermatology for medical management such as:

1. Necrotic and very painful ulceration on the legs, rapid deterioration from a 'bite' like lesion. [Could be Pyoderma Gangrenosum or vasculitic ulceration]
2. Recurrent abscesses often in the groin or underarm. These may leave tracts that weep pus. [Could be Hydradonitis Supprativa]
3. A wound that fails to heal, raised edges or crusty wound bed. [could be Basal Cell Carcinoma or Squamous Cell Carcinoma]
4. Hypergranulation - If the wound bed is raised BUT continues to decrease in size, this is not hypergranulation and can be ignored
5. Sometimes the wound bed can be very granular when it is healing fast; the wound bed can be swollen with oedema. True hypergranulation is associated with a friable/bleeding wound bed with jelly like appearance. This is more common in surgical wounds or burns - seek advice

Sepsis

Sepsis is a potentially life threatening situation and needs to be identified early.

The body normally releases chemicals into the bloodstream to fight an infection. Sepsis occurs when the body's response to these chemicals is out of balance, triggering changes that can damage multiple organ systems.

If sepsis progresses to septic shock, blood pressure drops dramatically. This may lead to death.

Who is at greater risk?

- Older people
- Those with multiple co-morbidities
- Those on immuno-suppression medication

What signs and symptoms to look out for?

- Rapid breathing and heart rate
- Fever or shivering
- Muscle ache
- Not passing urine
- Confusion or disorientated

Action

Treat as a medical emergency.

Document observations and communicate with GP and family.

Common wound types which need help

Surgical wounds:

Surgical wounds heal by either primary intention or secondary intention.

Primary

When the wound edges are brought together by suture/staples or glue. Most surgical wounds will heal within 14 days by primary intention.

If there is any redness or inflammation (normal for the first 3-5 days), or there is an increase in pain or the wound fails to remain closed then consider wound infection and treat as per clinical guidelines.

Dressing recommendation?

A simple island dressing in most cases.

Dehiscence of wounds - A partially or totally separated suture line causing a cavity wound breakdown usually around 5- 10 days post operatively. Most commonly caused by poor suturing technique, haematoma or wound infection.

If cavity now present manage as cavity wound, treat any infection and refer back to the surgical team if frank pus is present or non-healing.

Secondary

When a wound is expected to close by secondary intention, it has been left open for the tissue to heal from beneath through the normal phases of wound healing.

If the wound fails to make progress once you have assessed using the TIMES framework then refer back to the surgical team plus refer to Accelerate for advice.

Dressing recommendation?

This depends on the depth of the excision, pain and exudate. You may need to step up from a simple island dressing by adding a gelling fibre or stepping up further to a foam for absorption. Make sure you step back down when conditions improve.



Negative Pressure Wound Therapy

Negative Pressure Wound Therapy (NPWT) is also known as Topical Negative Pressure (TNP) or Vacuum Assisted Closure (VAC). NPWT is a medical device used in the management of acute and chronic wounds.

Common wound types that use this therapy are

- Amputations
- Graft or flap surgery
- Abdominal incisions

This is a therapeutic modality that uses a suction pump, tubing and a dressing (foam or gauze) to remove excess exudate and promote healing in acute or chronic wounds.

The therapy involves the controlled

application of sub-atmospheric pressure to the local wound environment using a sealed wound dressing connected to a vacuum pump.

This therapy can be used very successfully in the hospital environment but can be more difficult at home. People rest less at home and are often under pressure to be 'up and about'. Thus to ensure the therapy can be used safely and therapeutically at home, please ensure the Wound Care Specialists are involved at assessment and review.

The products to deliver this therapy are available through the Dressing Optimisation Scheme.

Pilonidal sinus excision wounds

- This is a surgical wound and treated accordingly
- Dressing regime based on exudate, pain and ability to self-manage
- Meticulous hair removal at the edges. Remove carefully with a razor
- Long-term recurrence is reduced by regular use of hair removal creams

- The pilonidal excision wound mostly heals within a few weeks of excision. Occasionally they prove more problematic

To note:

A pilonidal sinus is characterised by an epithelial track in the natal cleft and generally contains hairs.

The disease is more prevalent in males. The hair

follicle is irritated, becomes blocked, thereby causing an abscess. Recurrent infection must be managed with dermatology advice.

Contributory factors:

- Sedentary occupation
- Family history
- Obesity

Burns

All burns except small and superficial must be seen in Plastic Services via A & E.

- De-roof if the blister is greater than 1cm by lancing or piercing with a sterile blade or needle.
- The original burn may appear to heal but the area is crusty and raw. Consider whether this is an inflammatory reaction: use topical steroid under a non-adherent dressing and evaluate effect.
- Complex burn - any person under 5 or over 60.

Dressing Recommendations?

This depends on depth of injury, pain and site. A silicone based non-adherent dressing is required initially with a suitable secondary dressing that addresses both comfort and exudate management.

Ensure aseptic technique followed. Post healing, instruct to moisturise to reduce irritation and scarring.

Lacerations and trauma

Skin tears - aim to draw skin flaps together with either Steri-Strips or silicone dressing as soon as possible. Cover with a secondary dressing and mark the direction in which the dressing should be taken off so as not to open the skin flap on dressing change.

These can heal slowly in older skin. On the lower leg, traumatic wounds can simply become ulcers due to the effect of gravity or poor blood supply.

Pressure ulcers

See pages 15 - 17.

Getting it right!

Effective treatment plan for lower leg wounds

The pre-tibial region is a common site for injuries and lacerations. In the older person, healing is slow due to the site, skin fragility and reduced blood supply to the area.

Lacerations are often managed with SteriStrips or via Minor Injuries. A haematoma may require debridement.

All wounds on the lower limb are at risk of slow healing; significant and swift deterioration to ulceration can happen in the presence of wet wounds or oedema. Mild compression significantly reduces the risk of wound infection and aids healing. Refer to fast compression pathways for lower limb wounds.

Weeping legs or lymphorrhoea from uncontrolled oedema need to be managed swiftly if cellulitis and/or admission are to be prevented. Refer to easy steps to manage wet legs fast!

Apply Viscopaste, a dressing pad, wadding and double KLite as a minimum or mild compression if no overt peripheral disease. Refer to the Accelerate Lymphoedema Team.

Please refer to:

- Accelerate - pathway for lymphorrhoea and chronic oedema
- Accelerate - pathway for wounds on the lower leg and ankle

Foot ulcers

Foot ulcers are managed by Foothealth services and all referrals must initially be sent to this service for assessment and review.

Common foot ulceration

- Foot ulcers related to the presence of diabetes. This leads to neuropathy and/or ischaemia
- Ischaemic foot ulcers due to Peripheral Arterial disease (PAD)
- Ulceration due to foot deformity

As with all wounds, it is essential that the cause of the wound and the cause of the non-healing is identified.

If the limb has neuropathy, then pain will not be a significant issue but the patient will be unaware of the pressure or rubbing on their foot. Thus offloading, taking away the direct pressure is essential.

If the foot has deformities or is changing in shape, this will create new areas of pressure such as over clawed toes. To prevent this localised pressure, new shoes or specific off-loading products need to be used.

If the patient has PAD, then referral to the Vascular Team is essential so that surgical options for increasing arterial flow is identified.

The Wound Care Team will be involved where there is:

- Foot ulceration related to Vasculitis, Sickle Cell Disease or other dermatological disorders.
- Foot ulceration due to venous disease, especially atrophie blanche
- Mixed foot ulceration in the presence of oedema and where compression is required as part of a therapeutic intervention

Expertise must be sought for any type of foot ulcer so that the risk of amputation is swiftly reduced.

Three steps to healing for leg wounds

A wound on the lower leg needs additional support to heal simply because:

- It is on the leg and affected by gravity!
- The person may be on their feet all day in their daily life and work
- Mild oedema in the limb is a common feature either in the older age group or obesity

Compression is not just for the classic venous ulcer. Any wound on the lower leg responds very well to mild compression. This will speed healing time, reduce nursing workload and reduce the use of dressings. Know when to Fast Track to Accelerate Leg Ulcer Clinics (Step 3) or Vascular Services.

Step 1: Risk assessment

You **must** tick **each** of the following

1. Do you have a diagnosis or history of trauma to the leg? Laceration, sutures, surgery, haematoma
2. Is the person's sensation intact? They can be diabetic but neuropathy must be excluded
3. There are no signs of ischaemia - there is good peripheral perfusion, a warm limb, no discolouration to the toes
4. Their limb is an appropriate shape and build - they have a normal limb profile for below knee measurements i.e. the ankle is smaller than the calf

If you ticked all of these, go to Step 2. If you didn't tick all boxes, go to Step 3.

Step 2: Management

1. British Class 1, 14-17mmHg or wadding and figure 8 Profore 3 up to 20mmHg pressure
2. Review progress at least weekly. Measure wound length for monitoring progress
3. Provide simple non-adherent dressings and dressing pad as required. Provide from stock at weekly review if self-managing
4. The wound should heal in 2-4 weeks. If not, move swiftly to Step 3
5. If the wound is too wet or painful for this management, or is deteriorating, move swiftly to Step 3
6. Assess and review pain and impact on life at each review. Seek advice early if life and mobility is affected
7. Advise ongoing use of light compression sock when healed

Step 3: Full leg assessment

Complete a full lower limb assessment:

1. Wound deteriorates or has high exudate despite mild compression of up to 20 mmHg
2. Non-healing in 2-4 weeks
3. Cannot tick all 4 criteria in Step 1 because:
 - Ulcer has no specific trauma history thus spontaneous
 - Wound necrotic and very painful
 - They have an element of neuropathy
 - Non-palpable pulse
 - Leg misshapen or significant oedema present

Action by registered clinician:

- Complete leg assessment and ABPI
- Formulate a Treatment Plan
- Refer to Accelerate Team for ongoing review, shared care or management through the Leg Ulcer Clinics.

Being alert to pressure ulcers in primary care

Pressure ulcers in primary care are fairly uncommon. However, when encountered they are a significant event that are at very high risk of rapid deterioration. Do not underestimate the speed of deterioration if the underlying cause is not managed. In those with deteriorating health, speed of referral is critical and thus there is a need for all nurses to know what they are managing.

Reducing the risk of pressure ulcers	Know who is at risk and be alert	React to Red Skin Campaign (reactoredskin.co.uk)
The cause will be unrelieved pressure	Do NOT just dress the wound! Ensure the treatment plan addresses the need to Off Load the pressure and referral is made into the Integrated Care Team	Make sure the site of the ulcer is addressed and targeted. Refer to Foot Health & Wheelchair Services
Physical deterioration	Identify why they are deteriorating physically. What has changed either medically or socially? Recent hospital admission? PU may have gone unnoticed prior to discharge. Heels are a common site to Practice Nurses to pick up on removal of sutures etc for post op knee and hips	The new ulcer may demonstrate that their health is in decline
Neurological deficits	Are they aware of the ulceration? If not, they are at high risk of rapid deterioration	Multiple sclerosis is a leading cause of rapid onset pressure ulcers.
Infected pressure ulcers	Urgent referral required due to high risk of loss of limb or surgical procedure. Do not simply treat with antibiotics.	Urgent medical referral

Local assessment and reporting instructions

All pressures ulcers must be reported.




Practice Nurses and Nursing Home staff - refer to the Accelerate team.




For housebound patients - refer to ELFT Pressure Ulcer team.

Pressure ulcer classification

Pressure ulcer definition


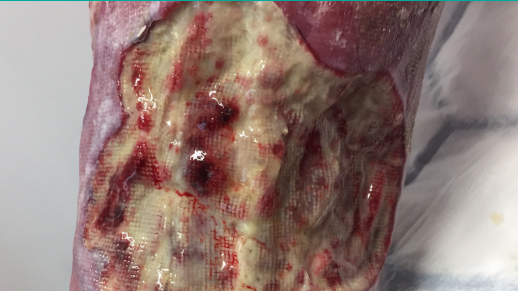


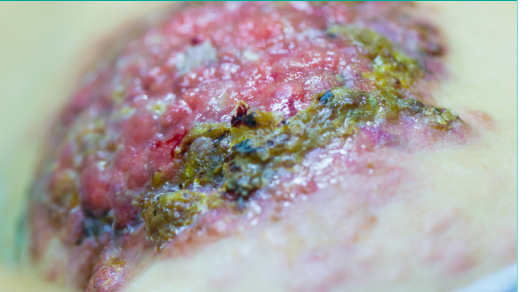
A pressure ulcer is localised damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The damage can present as intact skin or an open ulcer and may be painful. The damage occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by micro-climate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Category/ grade 1 pressure ulcer	Non-blanchable erythema of intact skin Intact skin with a localised area of non-blanchable erythema, which may appear differently or be impossible to visualise in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Colour changes do not include purple or maroon discoloration; these may indicate deep tissue pressure ulcer.	
Category/ grade 2 pressure ulcer	Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse micro-climate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARS), or traumatic wounds (skin tears, burns, abrasions).	
Category/ grade 3 pressure ulcer	Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunnelling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an unstageable pressure injury.	

Category/ grade 4 pressure ulcer	Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunnelling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an unstageable pressure ulcer.	
Unstageable pressure ulcer	Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischaemic limb should not be softened or removed.	
Suspected deep tissue pressure ulcer	Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localised area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin colour changes. Discolouration may appear differently in darkly pigmented skin. This ulcer results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.	

Making better decisions: Dressing selection guide




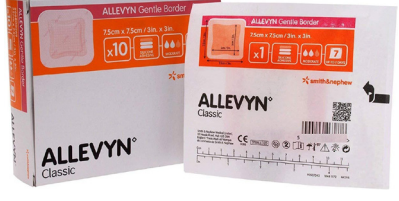

The selection of a dressing is very often reliant on the wound conditions. This chart will help you identify the wound bed status and exudate level and help you select the most appropriate dressing.

	Necrotic	Sloughy	Infected	Granulating	Fungating/malodorous
					
Aim	Understand the cause then conservative debridement to aid healing.	Remove sloughy tissue by autolysis and provide a clean wound bed for granulation.	Treat the infection as long as there is clinical evidence.	Promote granulation through protection of fragile tissue.	To manage the odour and the challenges around quality and end of life.
Features	Brown/Black, hard or soft tissue, +/- offensive.	Yellowish, soft, often firmly attached to the wound bed.	Erythema, hot, induration, malodour, bleeds easily, purulent exudate, dark wound bed, cellulitis. New pain.	Pinkish red, granular surface, moist and shiny.	The tumour can be offensive, painful and exuding.
Action needed	<p>Refer for URGENT advice. Mention 'necrosis' on referral form. Try to establish the likely cause. Consider infection or unrelieved pressure.</p> <p>For necrotic ulcers on the lower leg/foot of someone with arterial disease and/or diabetes, seek specialist advice. If accompanied by severe pain, advice may be required urgently.</p> <ul style="list-style-type: none"> On the foot: Protect with non-adherent and keep dry until specialist review. Never use hydrogels or film dressings on the foot Removal of necrotic tissue by rehydration – refer for advice If necrosis is rapidly spreading, refer urgently to A&E 	<ul style="list-style-type: none"> Manage the exudate Refer for specialist advice if slough does not clear or exudate is unmanageable Lower leg wounds require review for compression therapy, see page 10 Avoid foams on larger leg ulcers, use secondary absorbent dressing under bandage 	<ul style="list-style-type: none"> Swab after cleaning with water or normal saline Ensure the cause of this infection is understood If this is a wound on the lower leg, ensure the efficacy of compression is reviewed. The presence of any oedema causes repeat infections If rapidly spreading periwound necrosis, refer urgently to GP or A&E Mark edges of erythema for evaluation of spreading/reduction of infection Refer to Tissue Viability team 	<ul style="list-style-type: none"> Protection and management of exudate Granulation tissue should be firm. A wound bed can be raised in the presence of swelling; this can be confused with hypergranulation. So, as long as the wound continues to reduce in size, do not worry! Hypergranulation is identified when the wound is not getting smaller, but the wound bed is spongy or jelly like and friable. It bleeds easily 	<ul style="list-style-type: none"> These tumours present a variety of challenges where dressings often do not meet the need The site of the open wounds can add a particular difficulty requiring a patient review of a variety of dressings that fit the patient's requirements Ensure the patient is receiving review and support from specialist teams
Dressings to consider - primarily dependent on pain, site & exudate level	<ul style="list-style-type: none"> Do not use hydrogels or film on foot wounds Use low adherent or silicone layer Use foam or pad as required to manage exudate 	<ul style="list-style-type: none"> Alginate, absorbent gelling fibre or foam to aid autolysis Consider short term anti-microbial dressing A range of absorbent dressings 	<ul style="list-style-type: none"> This depends on site and wound bed requirements Antimicrobial, gelling fibre or foam More frequent dressings are required 	<ul style="list-style-type: none"> Any simple dressing that protects, keeps the wound comfortable and manages the exudate For hypergranulation, use an antimicrobial or topical steroid ointment. Refer for advice if no change 	<ul style="list-style-type: none"> Consider a charcoal or antimicrobial dressing that may address the odour Otherwise base the decision on their comfort, odour and exudate levels

“All In One” dressing selection - Choosing the most appropriate dressing for the wound

Nationally more money is spent on foam dressings than any other group. Very often they are selected because of their ease of use rather than for their clinical need. This guide will highlight to you the alternatives for foam dressings, when to use them and the price differences. When selecting this type of dressing start by considering the first-line choice for its appropriateness and work through to second line and so on. Prices below are correct at time of going to print September 2020.



Adpore	Adpore Ultra	OpSite Plus	Allevyn Gentle Border	Kliniderm Foam Border
Fabric island adhesive dressing	Film island adhesive dressing	Vapour-permeable adhesive film dressing with absorbent pad	A soft conformable absorbent polyurethane foam with adhesive silicone border	A soft conformable absorbent polyurethane foam with adhesive silicone border
				
<ul style="list-style-type: none"> Minimal exudate Superficial Closed surgical wound 	<ul style="list-style-type: none"> Waterproof Lightly exuding - maybe getting strike-through on Softpore 	<ul style="list-style-type: none"> Where a gentler adhesive required, especially for longer term use 	<p>More absorbency required</p> <ul style="list-style-type: none"> Moderate exudate Add in gelling fibre for greater exudate management 	<p>More absorbency required</p> <ul style="list-style-type: none"> Moderate exudate Add in gelling fibre for greater exudate management
<p>Indications</p> <ul style="list-style-type: none"> Exudate dry or low, superficial etc. Change when strike-through of exudate visible 	<p>Indications</p> <ul style="list-style-type: none"> Surgical and superficial wounds with no or low exudate 	<p>Indications</p> <ul style="list-style-type: none"> Surgical and superficial wounds with low exudate Children may require a lighter adhesive Irritated by Adpore 	<p>Indications</p> <ul style="list-style-type: none"> Fragile skin requires silicone adhesive Additional absorbency capacity required in an all in one dressing 	<p>Indications</p> <ul style="list-style-type: none"> Fragile skin requires silicone adhesive Additional absorbency capacity required in an all in one dressing Children may prefer a lighter adhesive
<p>Cost 10 x 15cm £0.10 each</p>	<p>Cost 10 x 15cm £0.14 each</p>	<p>Cost 10 x 12cm £1.10 each</p>	<p>Cost 10 x 10cm £1.63 each</p>	<p>Cost 10 x 10cm £1.75 each</p>

Which product? The dressing formulary

All prices were correct at the time of publication of this document.

Atraumatic low adherent dressings

Used to prevent trauma to granulating or friable wounds. First line dressing for leg ulcers.

Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
Atrauman	Polyester tulle impregnated with triglyceride ointment	Primary wound contact layer for a wide variety of wounds to prevent adherence	5x5cm 7.5x10cm 10x20cm	£0.24 £0.25 £0.44	<ul style="list-style-type: none"> First choice low adherent dressing Can remain in place for up to 7 days Requires a secondary dressing or absorbent pad If adheres consider silicone alternative
Adaptic Touch	Non-adherent primary wound contact layer: acetate mesh with soft tack silicone	Painful or friable wound bed. For patients with burns or Epidermolysis Bullosa	5x7.6cm 7.6x11cm 12.7x15cm 20x32cm	£0.99 £2.58 £4.10 £5.52	<ul style="list-style-type: none"> Second choice low adherent for very painful or friable wounds Can remain in place for up to 7 days Requires a secondary dressing or absorbent pad

Alginate dressings

These dressings are not suitable for use on dry wounds. Good haemostatic properties. Cut sheets to size of wound to avoid maceration and excoriation of the surrounding skin, as any exudate with transfer laterally.

Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
Kaltostat	Calcium-sodium alginate	Moderate to high exudate. Sloughy wounds. Bleeding wounds	5x5cm 7.5x12cm 10x20cm 15x25cm	£0.57 £1.23 £2.44 £4.38	<ul style="list-style-type: none"> Requires a secondary dressing Change every 3 – 7 days depending upon wound conditions and exudate levels

Absorbent dressings for exuding wounds

Absorbent dressings are designed to absorb exudate. These are used in direct contact with the wound or used as a secondary dressing. Secondary dressings may require securing with retention bandages or tape. Remember to **STEP-UP, STEP-DOWN**.



Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
Aquacel Ribbon	Absorbent gelling fibre	For sinuses and hidden narrow cavities	1x45cm	£1.41	<ul style="list-style-type: none"> Dependent upon exudate levels Can remain in place for up to 7 days dependent on level of exudate Requires a secondary dressing
Durafibre	Absorbent gelling fibre	Can debride wet slough	5x5cm 10x10cm 15x15cm 2x45cm	£0.70 £1.69 £3.11 £1.77	<ul style="list-style-type: none"> Allow for a 1cm dressing overlap onto the skin surrounding the wound When using a ribbon in deep cavity wounds leave at least 2.5cm outside the wound for easy retrieval Loosely pack into cavities
Zetuvit Plus	Absorbent pad	Wet wounds, low to moderate exudate	10x10cm 10x20cm 15x20cm 20x25cm 20x40cm	£0.58 £0.81 £0.92 £1.26 £3.91	<ul style="list-style-type: none"> For use as a secondary dressing Change every 3 to 7 days according to need If daily dressing is required, consider a more absorbent dressing
Kliniderm	Super absorbent pad	Wet wounds, moderate exudate	10x10cm 10x18cm 20x20cm 20x30cm	£0.44 £0.79 £0.88 £1.33	<ul style="list-style-type: none"> Extend beyond the wound edge by about 2–3cm Change every 3 to 7 days according to need If daily dressing is required, seek advice
Vliwasorb	Super absorbent pad	Very wet wounds, high exudate	22x22cm	£1.62	<ul style="list-style-type: none"> Change every 3 to 7 days according to need If daily dressing is required, consider a more absorbent dressing Always seek advice for very wet wounds

Island dressings

Dressings with a lightly absorbent pad and adherent border. See pages 16-17. Remember to **STEP-UP, STEP-DOWN**.



Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
Adpore	Fabric island dressing	Surgical and superficial wounds with no or low exudate	7x8cm 10x10cm 10x15cm 10x30cm	£0.05 £0.07 £0.10 £0.27	<ul style="list-style-type: none"> Change when strike-through is evident or at 7 days whichever is sooner Can be used as a secondary dressing with Atrauman to prevent wound bed adherence Can be used as a secondary dressing with Kerracel for increased absorption
Adpore Ultra	Film island dressing	Surgical and superficial wounds with no or low exudate	10x10cm 15x10cm 10x20cm	£0.09 £0.14 £0.21	<ul style="list-style-type: none"> Change when strike-through nears edge of pad or at 7 days whichever is sooner Can be used as a secondary dressing with Kerracel Consider suitability before choosing a foam dressing
OpSite Plus	Film foam island dressing, waterproof	Surgical and superficial wounds with low exudate	8.5x9.5cm 10x12cm 10x20cm	£0.81 £1.11 £1.87	<ul style="list-style-type: none"> A kinder adhesive for longer term use Change when strike-through nears edge of pad or at 7 days whichever is sooner Can be used as a secondary dressing with Kerracel Consider suitability before choosing a foam dressing

Foam dressings

Foams are made up of a combination of hydrophilic, absorbent polyurethane foam. The outer surface is hydrophobic. They are gas permeable and help to maintain a moist wound environment whilst absorbing moderate levels of exudate. May be used as a primary or secondary dressing. **DO NOT COVER WITH FILM DRESSINGS.** Use with caution on leg ulcers as they may not be able to manage the exudate.

Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
Allevyn Gentle Border Lite	Polyurethane foam bordered	Moderate to high exudate	7.5x7.5cm 8x15cm 10x10cm 10x20cm 15x15cm	£1.13 £3.05 £1.63 £2.66 £2.76	<ul style="list-style-type: none"> Consider alternatives first such as island dressings Up to 7 days wear time or change when exudate is visible and within 1.5cm of the dressing edge Suitable for use on patients with fragile skin Can be used as a primary or secondary dressing
Allevyn Gentle Border Sacrum	Polyurethane foam bordered	Moderate to high exudate	16.8x17.1cm	£2.94	<ul style="list-style-type: none"> Consider alternatives first such as island dressings Up to 7 days wear time or change when exudate is visible and within 1.5cm of the dressing edge Suitable for use on patients with fragile skin Can be used as a primary or secondary dressing
Biatain Soft Hold	Polyurethane foam with adherent layer	Cavity wounds up to 2cm depth	10x10cm 15x15cm 10x20cm	£1.55 £2.57 £2.35	<ul style="list-style-type: none"> Primary dressing for cavity wounds up to 2cm depth due to 3D fit technology Vertical wicking of exudate
Other Foams	Mepilex or Polymem range	Epidermolysis bullosa Patients with skin irritation	Sizes and prices available on request		<ul style="list-style-type: none"> These are patient condition specific Likely to be on repeat prescribing Can be obtained by special request for highlighted patient

Hydrocolloid dressings

Self adhesive and waterproof dressings for the management of lightly exuding wounds. Facilitate rehydration and autolytic debridement of dry sloughy or necrotic wounds. Also suitable for promoting granulation tissue. Hydrocolloid wafer dressings are not recommended for heavily exuding or infected wounds. **NOT FOR USE ON DIABETIC OR ARTERIAL FOOT/LEG ULCERS.**

Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
Duoderm Extra Thin	Hydrocolloid	Low exudate	10x10cm 15x15cm	£0.97 £2.10	<ul style="list-style-type: none"> • Warm between hands before applying (improves adherence) - up to 7 days • Should extend at least 2cm beyond the edge of the wound • Can also be used as a secondary dressing over Algisite M for instance • Can be used as a protectant for peri-ulcer tissue with NPWT therapy

Film dressings

Film dressings are conformable and vapour permeable allowing the passage of water and oxygen through the dressing. For use as a secondary dressing or as a primary dressing for superficial wounds. **DO NOT USE OVER FOAM DRESSINGS AS IT REDUCES THE VAPOUR PERMEABILITY OF THE FOAM.**

Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
Hydrofilm	Film	Superficial, epithelialising, low exudate	10x12.5cm 15x20cm	£0.42 £0.72	<ul style="list-style-type: none"> • Should not be used on clinically infected, bleeding or highly exuding wounds • Maximum wear time 7 days • Removal - corner of the dressing lifted carefully from the skin then stretched horizontally away from the wound

Dressings for malodorous wounds

Where malodour is a problem, these dressings can be used to help reduce the odour.

Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and other information
Clinisorb	Absorbent wound contact layer, an activated charcoal central pad and water resistant top layer	Malodorous and fungating	10x10cm 10x20cm 15x25cm	£1.51 £2.03 £3.27	<ul style="list-style-type: none"> • Not primary contact layer • Change when becomes wet • Use as secondary or tertiary dressing

Antimicrobial dressings for infected wounds

Suitable for critically colonised or infected wounds. Systemic antibiotics are indicated in cases of overt wound infection where signs of localised or systemic infection are evident. **REFER FOR ADVICE IF USE OF ANTIMICROBIALS IS NECESSARY FOR MORE THAN SEVEN DAYS OR BIOFILM IS SUSPECTED.**

Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
Inadine	Low adherent containing 10% povidone iodine	Superficial digit wounds, intertrigo (lesions in skin folds)	10.10cm	£0.50	<ul style="list-style-type: none"> • Antimicrobial effect is short-lived • Used for its an-hydrating (drying out) properties • Change when colour changes from orange to white • Do not use if patient has thyroid disease or Iodine allergy
Activon honey	Medical-grade honey with antibacterial action	Infection or gross colonisation	25g tube	£1.64	<ul style="list-style-type: none"> • Use for 2 weeks only • Seek specialist advice if recurrent infection • Requires secondary dressing • Single patient use • Stop if pain increased

Antimicrobial dressings for infected wounds - continued					
Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
Acticoat Flex 3	Non-adherent polyethylene mesh coated with Ag Oxysalts	Infected, hyper-granulation, flat or cavity	3.5x5cm 10x20cm	£2.92 £6.82	<ul style="list-style-type: none"> Will require secondary dressing Do not use if allergic to silver - cut to size of wound and allow patient to keep the remaining sterile dressing for next visit Use for 2 weeks only If recurrent infection, seek specialist advice
Iodoflex	Cadexomer slow release Iodine paste	Infected, sloughy	5g	£7.46	<ul style="list-style-type: none"> Do not use on dry necrotic tissue or on patients with an allergy to Iodine Do not use in the vicinity of the eyes, ears, nose or mouth Do not use on children, pregnant or lactating women or on people with thyroid disorders or severe renal impairment 150g of Iodoflex can be applied per patient per week A single application should not exceed 50g Do not use for more than 3 months Change when colour changes from orange to white Stop if painful
Flaminal Forte	Enzyme Alginogel	Wet wounds	15g	£6.72	<ul style="list-style-type: none"> Use on narrow cavity wounds where packing is not possible Use if frequent packing with ribbons causes trauma on removal
Flaminal Hydro	Enzyme Alginogel	Dry wounds	15g	£6.72	<ul style="list-style-type: none"> Use on narrow cavity wounds where packing is not possible Use if frequent packing with ribbons causes trauma on removal
Aquacel AG TVN sign off	Absorbent hydrofibre silver dressing	Infected wet wounds	5x5cm 10x10cm 15x5cm 20x20cm	£2.42 £4.53 £8.67 £12.69	<ul style="list-style-type: none"> Can remain in place for up to 7 days depending on exudate levels Requires a secondary dressing Allow for a 1cm dressing overlap onto the skin surrounding the wound

Retention and compression bandages

Can be divided into retention, tubular or compression bandages. Strong compression should **ONLY** be applied following a holistic leg ulcer assessment including Doppler ultrasound to determine ankle-brachial pressure index (ABPI). Compression bandages are contra-indicated where ABPI <0.8 without specialist advice. Compression bandages should be carefully selected according to ankle circumference and clinical objectives.

COMPRESSION BANDAGES SHOULD ONLY BE APPLIED BY STAFF WHO HAVE COMPLETED LEG ULCER MANAGEMENT TRAINING AND BEEN ASSESSED AS COMPETENT IN THEIR APPLICATION.

Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
K-Soft	Sub-bandage wadding	Protection of very prominent bony sites	10cmx 3.5m	£0.38	<ul style="list-style-type: none"> Sub-compression bandage wadding Apply toe to knee in a spiral application 50% overlap without any tension For ankles measuring 18cm or less apply two layers/ additional pieces to protect bony prominences
K-Band	Retention bandage	Dressing retention	7cmx4m 10cmx4m	£0.20 £0.22	<ul style="list-style-type: none"> Do not use on lower limb
K-Lite	Retention bandage	Dressing retention	10cmx 4.5m	£1.01	<ul style="list-style-type: none"> Apply in a spiral application 50% overlap 50% stretch
Peha Haft	Cohesive retention bandage	Dressing retention	10cmx4m	£0.78	<ul style="list-style-type: none"> Can be applied full stretch for swelling management where compression is not possible
Viscopaste	Paste bandage	Wet eczema or erosions, intertrigo, wet toes	7.5cmx 6m	£3.60	<ul style="list-style-type: none"> Zinc paste bandage, patch test skin for 4 days before use Do not apply in a full spiral – the bandage is applied with either a pleat at the front or in a forwards and backwards method toe to knee. Seek advice if you are not familiar with application method. Can be used under compression
Urgo KTwo	High compression kit, elastic compression	Venous or mixed leg ulcer. ABPI > 0.8	18-25cm 25-32cm	£6.72 £7.24	<ul style="list-style-type: none"> 2 Layer compression bandage kit which can deliver 40mmHg compression Uses bandage indicators to ensure correct tension is applied

Retention and compression bandages - continued					
Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
Profore 3	Type 3a light, long stretch compression bandage	Venous or mixed leg ulcer. ABPI > 0.8	10cmx 8.7m	£3.46	<ul style="list-style-type: none"> Apply with 50% overlap in spiral or figure of eight Can be used under Profore 4 Do not use where ABPI <0.8 or active arterial disease unless under direction Can be used alone to deliver mild compression where ABPI > 0.5
Profore 4	Moderate Compression Bandage	Venous or mixed leg ulcer. ABPI > 0.8	10cmx 5.25m	£2.86	<ul style="list-style-type: none"> Four layer compression system Apply with 50% overlap in spiral Can be used over K-Plus Do not use where ABPI <0.8 or active arterial disease unless under direction
Actico	Short stretch compression bandage	Venous or mixed leg ulcer. ABPI > 0.8	8cmx6m 10cmx6m 12cmx6m	£3.09 £3.21 £4.09	<ul style="list-style-type: none"> Apply with 50% overlap in spiral Do not use where ABPI <0.8 or active arterial disease unless under direction Level of oedema or disease indicates whether applied in single or double layer

Compression hosiery				
FOR ALL OTHER HOSIERY AND WRAP MANAGEMENT, SPEAK TO THE ACCELERATE TEAM.				
Product	Dressing type	Type of wound	Size	Cost per unit
Duomed British Class 1 Compression Hosiery	Mild compression for early intervention	Lower limb trauma and mild swelling	All sizes available in black or sand and with open toe Small, medium, large, X large, XX large	Prices on application
Activa British Class 1 Compression Hosiery	Mild compression for early intervention	Lower limb trauma and mild swelling	All sizes available as unisex, ribbed or patterned closed toe sock Small, medium, large, X large	
Activa Hosiery Kits	2 layer hosiery kit	Active treatment for venous leg ulcers 40mmHg	All sizes available in black and sand 40mmHg Small, medium, large, X large, XX large	
Mediven Ulcer Kit	2 layer hosiery kit	Active treatment for venous leg ulcers 40mmHg	All sizes available in grey 40mmHg Size I, size II, size III, size IV, size V, size VI, size VII	



Tubular bandages

To retain dressings in lower/upper limb care and protect skin from potential irritation from K-Soft. **COMFIGRIP NOT TO BE USED IN PATIENTS WITH DIABETES AND/OR PERIPHERAL VASCULAR DISEASE. WHERE SWELLING EXISTS THIS CAN BE USED UNDER GUIDANCE, OTHERWISE CAUTION IS NEEDED.**

Product	Dressing type	Type of wound	Size	Cost per unit
Actifast	Tubular bandages 5m length	N/A	Medium green line 5cm child's lower limb/arm, adult arm, small leg Large blue line 7.5cm adult large arm, lower leg Small trunk yellow line 10.75cm large leg	£2.67 £6.26 £3.32
Comfigrip	High Compression Bandage 1m length	For light support where swelling is present	Size D 7.5cm large arm/medium ankle Size E 8.75cm large ankle/medium knee Size F 10cm large knee/medium thigh Size G 12cm large thigh	£1.43 £0.89 £1.51 £1.76

Tapes

For fixation of dressings and bandages

Product	Dressing type	Size	Cost per unit	Wear time and tips for use
Micropore	Tape	2.5cmx2.5m 5cmx5m	£1.32 £1.83	<ul style="list-style-type: none"> Useful for securing non adhesive dressings Do not fully wrap around a limb
Hypafix	Fabric adhesive tape	5x5cm 10x5cm	£1.24 £2.08	<ul style="list-style-type: none"> Do not fully wrap around a limb

Other items

A range of additional products to help you with wound management.

Product	Dressing type	Type of wound	Size	Cost per unit	Wear time and tips for use
Dressit	Dressing Pack	N/A	Small gloves Med gloves Large gloves	£0.60 £0.60 £0.60	<ul style="list-style-type: none"> Contain apron, gloves, gauze, measuring guide, bag, paper towel and sterile field sheet
Softswab (NON-STERILE)	Gauze	N/A	10x10cm (pack of 100)	£0.82	<ul style="list-style-type: none"> Do not use in direct contact with wound or as a primary dressing
Softswab (STERILE)	Gauze	Wound cleansing	7.5x7.5cm (pack of 5)	£0.26	<ul style="list-style-type: none"> Do not use as a primary dressing
SteriStrips	Skin closure strips	Skin tears and superficial lacerations	3x75mm x 5 strips	£0.89	<ul style="list-style-type: none"> Requires a secondary dressing such as Softpore or Clearpore. Not an alternative to stitches If the wound is deep and bleeding continuously, seek medical assistance immediately Review after 7 days
Irripod saline	Wound cleansing & irrigation	Any	20ml	£0.28	<ul style="list-style-type: none"> Tap water can be used for wound cleansing in wounds more than 48 hours old
Octenilin	Prophylactic antibacterial cleanser	Infected wound	20ml 350ml	£0.24 £0.47	<ul style="list-style-type: none"> Tap water can be used for wound cleansing in wounds more than 48 hours old

Understanding the Dressing Optimisation Scheme (DOS)

The aim of the DOS is to

1. Make sure every Tower Hamlets resident has the dressing or bandages they need when they need them
2. Ensure waste is minimised; every location has a stock of products, preventing a build up of unused products at home
3. Provide analysis and insight to support quality improvements and education.

How does the DOS work?

- The Scheme is funded by Tower Hamlets CCG. 90% of funding for dressings has been removed from FP10 and put into this online scheme.
- All dressings, bandages and therapies for the management of active wounds are accessible via this scheme
- The total budget is managed by Accelerate and supported by this Guide
- Accelerate reports on the quarterly spend and any cost pressures. Analysis of use is supplied regularly or on request to any location
- The scheme works on the principle of locations and the Users associated with this location place the online orders

- All Users are trained in the online system and support can be accessed
- All residents will therefore get their dressings without needing to go through FP10. They should never need to purchase wound dressings or bandages
- For housebound residents, the dressings need to be taken to them by the community nurses; there is a Home Delivery Service where significant dressings are required

What is excluded from the DOS?

- Some dressing type products are not used for wounds. These products are obtained via FP10 prescribing:
 - Tracheostomy products
 - Products for childhood eczema
 - Stoma products plus any associated film dressings or skin protection
 - Scar management products
 - Dressings used for PEGs or suprapubic catheters
- A less common reason is when a family are managing the dressing and it is easy to go via FP10

- Hosiery and compression garments for lymphoedema and venous disease. These remain on FP10

You can access the DOS as a User if

- You are a clinician directly delivering wound care and oversight within Tower Hamlets
- You work within a Tower Hamlets GP Practice
- You deliver wound care for any resident of Tower Hamlets from any clinical site, the patient's home or a Nursing Home

Frequently Asked Questions

- Q1** What if my patient needs a product not on the formulary?
- A** Request the off formulary request submission
- Q2** What if my patient at home needs a lot of dressings?
- A** Request more information on the criteria for Home Delivery of Dressings and ensure the patient is referred to the Accelerate Team for any complex wound or to ELFT Pressure Ulcer Team

- Q3** My patient will be dressing their own wound or is going on holiday. How do they get extra dressings?

- A** Simply provide what they need from your stock and make sure you continue to review their progress. If not healing, make sure a referral to Accelerate Wound Team is made

- Q4** Why is my delivery delayed?

- A** Check the delivery date on the online system and if it states delivery has occurred, check all cupboards and rooms before emailing Accelerate for support

- Q5** How can I gain access to DOS for a new member of staff?

- A** Let Accelerate know who the new User is, their email address and what location they require access to. We will set them up as a User and provide online training

For advice and support or training of new Users:

Call: 0203 819 6022 Option 2

Email: acceleratecic.acceleratedressings@nhs.net

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