South West Yorkshire Partnership NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
South Yorkshire Integrated Care Board

**Community tissue viability team**
Apollo Court Medical Centre, **Referrals, 01226 644575**

**Barnsley tissue viability team**
**01226 730000**

**CCG -Wound Care Nurse**
**01226 433798**

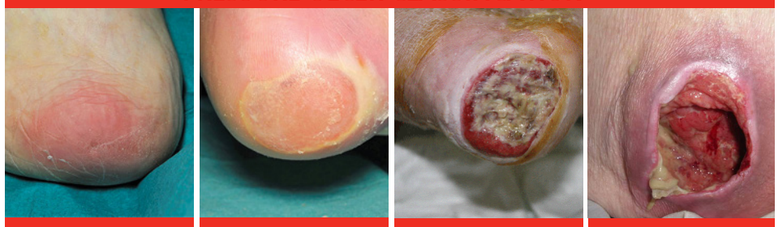
**Barnsley Podiatry Team**
Kendray Hospital, **01226 644315**
MDT foot clinic - SPA, **01226 240086**

## Lower limb care

All community patients who have a lower leg wound or weeping legs should have a Doppler test and leg ulcer assessment no later than 2 weeks from onset
Please follow the Leg Ulcer Care for Nurses guidance poster or the Chronic Oedema and Wet Legs Management Plan.

| Washing legs | Aids in the management of wounds on lower legs |
|---|---|
| Legs must be washed at every dressing change. For housebound/inpatients, line a bowl with a plastic bag or use a disposable bowl, use warm tap water and an emollient to wash the leg. Dry skin scales and hyperkeratosis can harbour bacteria. Good hygiene is an essential part of leg ulcer management | Ensure patients can maintain personal hygiene. Use wound care protectors such as Sealtight or Limbo. Special footwear can be an issued to enable the patient to mobilise safely, reducing the risk of falls. Debrisoft debridement pads are effective in removing sloughy tissue and dead skin scales when washing legs |

## PRESSURE ULCER CLASSIFICATION



CATEGORY 1 | CATEGORY 2 | CATEGORY 3 | CATEGORY 4

| | Pressure Ulcer | Moisture lesion |
|---|---|---|
| **Cause** | Pressure and/or shear | Moisture; shining wet skin |
| **Location** | Usually over a bony prominence | May be over bony prominence, in skin folds, and cleft, peri-anal redness/skin irritation |
| **Shape** | Circular or regular shape, limited to one spot. Exclude possible friction | Diffuse superficial spots or irregular shape |
| **Depth** | Partial – full thickness, from grade 2 – grade 4 | Superficial – partial thickness skin loss |
| **Necrosis** | Present in full thickness pressure damage | No necrosis or eschar present |
| **Edges** | Distinct edges with clear demarcation | Diffuse, irregular edges |
| **Colour** | Red, yellow, green, black | Redness that is not uniformly distributed |

# Barnsley
# Wound care formulary 2023

**PROTOCOL 1**
Melolin
Softpore
Tegaderm +Pad
Leukomed control – self harm pathway

**PROTOCOL 2**
Kliniderm wound contact
Lomatuelle Pro
Duoderm extra thin and
Duoderm signal
Teagderm transparent film

**PROTOCOL 3**
Inadine
Iodosorb
Actilite
Medihoney – Apinate
Flaminal Hydro/Forte

**PROTOCOL 4**
Iodosorb
Medihoney – Apinate
Flaminal Hydro/Forte

**PROTOCOL 5**
Actiheal hydrogel
Actiform cool
Biatain fibre
KytoCel

**PROTOCOL 6**
Actiheal hydrogel
Actiform cool
Biatain fibre
KytoCel

**PROTOCOL 7**
Superasorb P sensitive
Biatain silicone non/ bordered
Urgo absorb border – skin tear pathway
Vliwasorb Pro - VLUs only medium to heavy exudating.
Convamax Superabsorbant Adhesive - Lymphoedema Management Plan

**PROTOCOL 8**
KytoCel
Biatain fibre

**PROTOCOL 9**

**TISSUE VIABILITY**
TNP THERAPY
Acti VAC, Avelle
Larvae therapy
Vibropulse
Zip Zoc
Woulgan gel
Aquacel Ag+ Extra
Mediderma Pro range
PolyMem

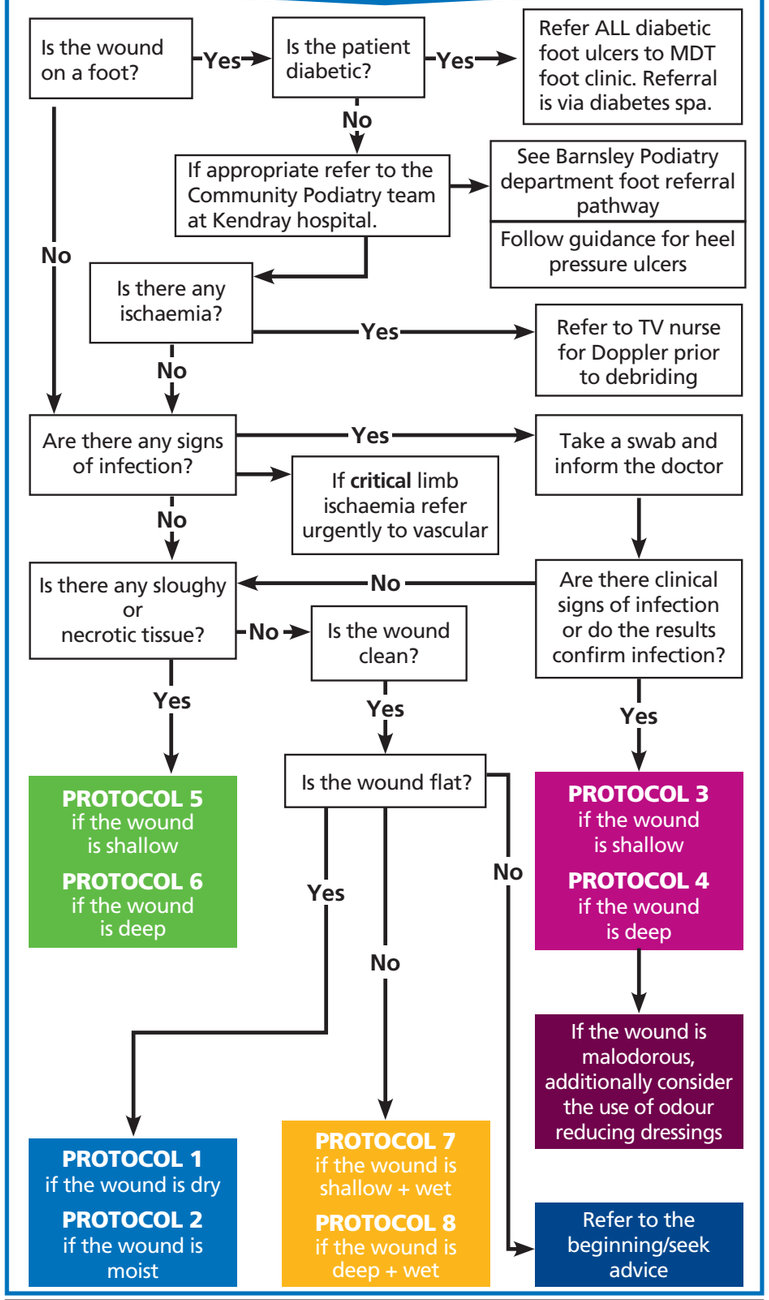
**PODIATRY**
Urgo start plus pad
Acticoat flex 3 and 7
Urgo start contact

**MALODOROUS WOUNDS**
Malignant wounds - Refer to POSIE pathway
Other wounds -refer to protocol 3+4

**CLEANSING AND DEBRIDEMENT**
Prontosan solution
Prontosan gel x
Prontosan Debridement Pad

**MOISTURE ASSOCIATED SKIN DAMAGE**
Medi derma S range – follow MASD pathway

## WOUND MANAGEMENT FLOW CHART




## REPORTING PRESSURE DAMAGE

All pressure ulcers should be reported e.g. Occurred in your care (**incidence**) or already existing when admitted into your care (**prevalence**)

With **all of us** in mind.

If you require a copy of this information in any other format or language please contact your line manager.

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