NHS
South West
Yorkshire Partnership
NHS Foundation Trust

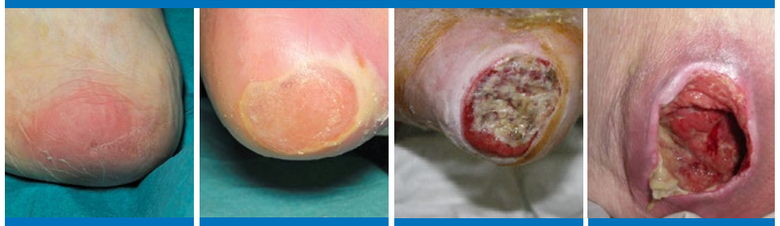
Community tissue viability team
Apollo Court Medical Centre
Referrals
Tel: **01226 644575**
Fax: **01226 785092**
BHNFT tissue viability team
Tel: **01226 433041** Bleep: **819**
online referral form via e-form gateway

Leg ulcer 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.

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 2020

PROTOCOL 1
Telfa
Melolin
Clearpore
Softpore
Leukomed Control – Self harm Pathway

PROTOCOL 2
Activheal silicone wound contact
Lomatuelle Pro
Clearfilm
Duoderm range

PROTOCOL 3
Inadine
Iodosorb
Actilite
Medihoney – Apinate
Flaminal Hydro/Forte
Prontosan solution
Prontosan Gel x

PROTOCOL 4
Iodosorb
Medihoney – Apinate
Flaminal Hydro/Forte
Prontosan solution
Prontosan Gel x

PROTOCOL 5
Activheal Hydrogel
Actiform Cool
Activheal Aquafibre Extra
Activheal Alginate

PROTOCOL 6
Activheal Aquafibre Extra
Activheal Alginate

PROTOCOL 7
Medium/Heavy Exudating
Activheal Foam contact - medium/ heavy
Kliniderm Silicone Foam Border - medium
Activheal Silicone Foam Border - medium /heavy
UrgoTul Absorb Border - Skin Tear Pathway Only
Xupad
Kliniderm Superabsorbent – medium
Vliwasorb Pro – Heavy

PROTOCOL 8
Medium/Heavy Exudating
Activheal Alginate

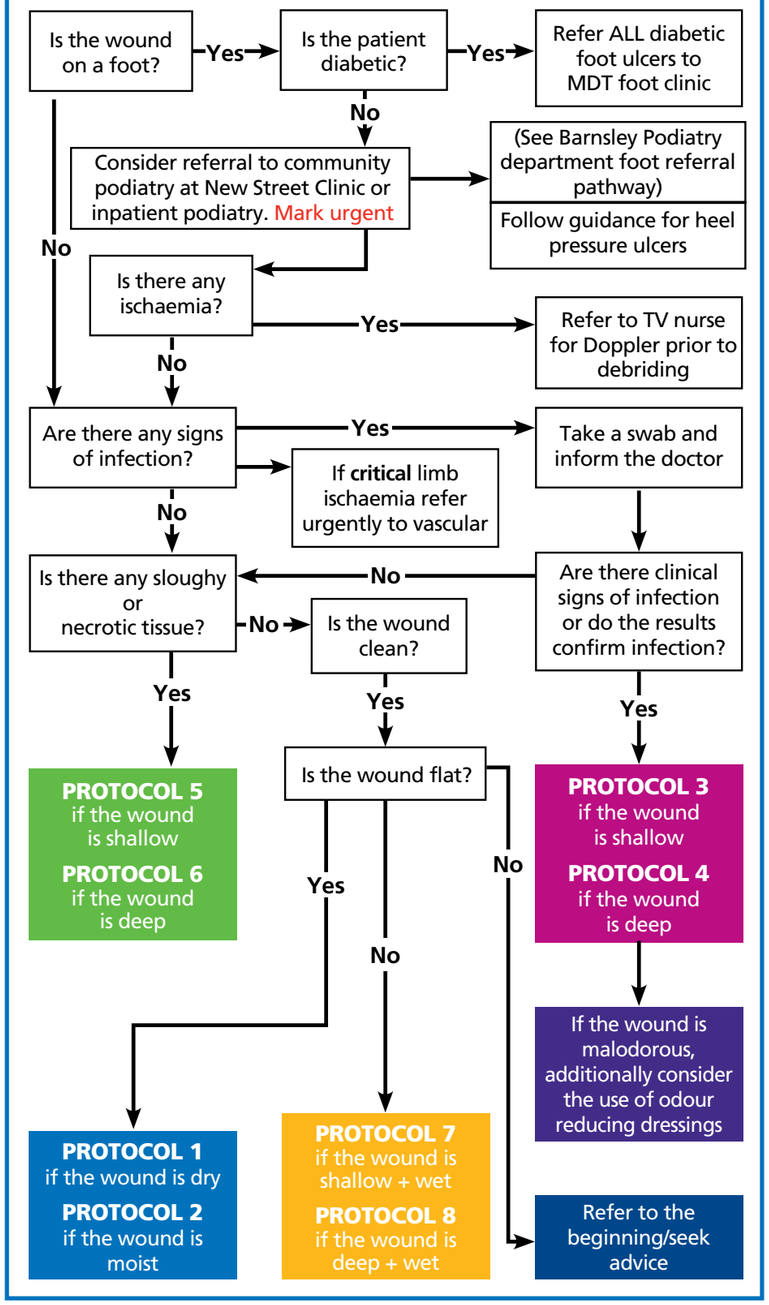
PROTOCOL 9
TISSUE VIABILITY
TNP Therapy (VAC, Avelle)
Larvae therapy
Vibropulse
Jelonet
Zip ZOC
PHMB Foam
Woulgan gel
Aquacel AG+Extra
Activheal Aquafibre AG
Tegaderm foam
Biatain 3d fit
Medi derma pro range

PODIATRY
Acticoat flex 3 and 7
Urgostart plus pad
Urgostart contact

MALODOROUS WOUNDS
Malodour is caused by bacteria – refer to protocols 3 and 4 above

MOISTURE ASSOCIATED SKIN DAMAGE
Medi Derma S range

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.

JOB NO: 1475 FEB20