# Appendix 1
## Table of wound dressings

| | Pink (epitheliasing) | Red (granulating) | Yellow (soughy) | Black (necrotic/eschar) | Signs of infection | Fungating / malodourous |
|---|---|---|---|---|---|---|
| **Low exudate** | ***Low adherence*** (e.g. Jelonet®)<br><br>***Vapour-permeable film/membrane*** (e.g. Mepore Film®, Tegaderm®)<br><br>***Soft polymer*** (e.g. Mepilex®)<br><br>***Hydrocolloid*** (e.g. DuoDERM Signal®, Granuflex®) | ***Low adherence*** (e.g. Jelonet®)<br><br>***Soft polymer*** (e.g. Mepilex®)<br><br>***Hydrocolloid*** (e.g. DuoDERM Signal®, Granuflex®)<br><br>***Foam*** (e.g. Allevyn®, Biatain Adhesive®) | ***Hydrocolloid*** (e.g. DuoDERM Signal®, Granuflex®)<br><br>***Hydrogel*** (e.g. Intrasite Gel®) | ***Hydrocolloid*** (e.g. DuoDERM Signal®, Granuflex®)<br><br>***Hydrogel*** (e.g. Intrasite Gel®) | ***Honey*** (e.g. Actilite®, Activon Tulle®)<br><br>***Iodine*** (e.g. Inadine®)<br><br>***Silver*** (e.g. Acticoat®, Aquacel AG®) | ***Activated charcoal non-absorbent*** - (e.g. Carbopad VC®) |
| **Moderate exudate** | ***Soft polymer*** (e.g. Mepilex®)<br><br>***Foam*** (e.g. Allevyn®, Biatain Adhesive®)<br><br>***Alginate*** (e.g. Kaltostat®, Sorbsan®) | ***Hydrocolloid*** (e.g. DuoDERM Signal®, Granuflex®)<br><br>***Foam*** (e.g. Allevyn®, Biatain Adhesive®)<br><br>***Alginate*** (e.g. Kaltostat®, Sorbsan®) | ***Hydrocolloid*** (e.g. DuoDERM Signal®, Granuflex®)<br><br>***Alginate*** (e.g. Kaltostat®, Sorbsan®) | ***Hydrocolloid*** (e.g. DuoDERM Signal®, Granuflex®)<br><br>***Foam*** (Allevyn®, Biatain Adhesive®)<br><br>***Hydrocolloid-fibrous*** (e.g. Aquacel®, UrgoClean®) | ***Honey*** (e.g. L-Mesitran® soft ointment)<br><br>***Iodine*** (e.g. Idoflex®, Iodosorb®)<br><br>***Silver*** (e.g. Algisite AG®, Alleyvn AG®, Aquacel AG®) | ***Activated charcoal absorbent*** (e.g. CarboFLEX®) |
| **Heavy exudate** | | ***Hydrocolloid*** (e.g. DuoDERM Signal®, Granuflex®)<br><br>***Alginate*** (e.g. Kaltostat®, Sorbsan®)<br><br>***Foam*** (e.g. Allevyn®, Biatain Adhesive®) | ***Alginate*** (e.g. Kaltostat®, Sorbsan®)<br><br>***Capillary-acting*** (e.g. Vacutex®)<br><br>***Hydrocolloid-fibrous*** (e.g. Aquacel®, UrgoClean®) | | ***Honey*** (e.g. Medihoney Antibacterial Honey Apinate®)<br><br>***Silver*** (e.g. Algisite AG®, Alleyvn AG®, Aquacel AG®) | |

## Wear times for dressings

The wear times for each dressing depends both on the type of dressing and the wound itself. Most dressings can be worn for 3 – 7 days but this depends on the level of exudate and the characteristic of the dressing. Some silicone based dressings may be worn for up to 10 days. If you are unsure what length of time a dressing should be worn, you should check with a tissue viability nurse or the dressing manufacturer.

The NHS Fife formulary[3] recommends the following:
Non-Adherent = depends on exudate/ strike through
Hydrocolloid = min 3 days but up to 7 in low exudate
Foam dressing = 3 – 7 days
Hydrofibre = up to 7 days
Hydrogel = up to 3 days for sloughy or necrotic wounds and 7 days for clean granulating wounds
Alginate = dependent on level of exudaute
Malodourous (clinisorb up to 5 days, carboflex up to 3 days)
Silicone not in Table 1 but up to 10 days.
Silicone foam – up to 7 days.
Iodine (iodoflex – up to 72 hours)

## Assessment before provision of compression hosiery

Expert opinion: if below-knee compression hosiery is being considered for a patient a full holistic assessment is required to see whether this would be of benefit. For all classes of hosiery this would ideally include ABPI measurement to determine if there was any arterial disease present. Class 1 hosiery can be bought over the counter but people with peripheral vascular disease should not use it. If you are recommending it as a minimum, ensure the person has a warm, well-perfused foot with good capillary return and palpable pedal pulses. People with a history of varicose ulcers or prescribed Class 2 hosiery need ABPI; this should be repeated annually. Up to date guidelines on ABPI are available at:

https://www.wounds-uk.com/resources/details/best-practice-statement-ankle-brachial-pressure-index-abpi-practice

# Appendix 2
# Wound Assessment Chart[43]

NHS Fife

| WRITE, IMPRINT OR ATTACH LABEL | |
|---|---|
| Surname ..... | CHI No ..... |
| Forenames ..... | Sex ..... |
| DoB ..... | |
| Location ..... | |

## Assessment Chart for Wound Management

For multiple wounds complete formal wound assessment for each wound. Add Inserts as needed.

**Factors which could delay healing:** *(Please tick relevant box)*

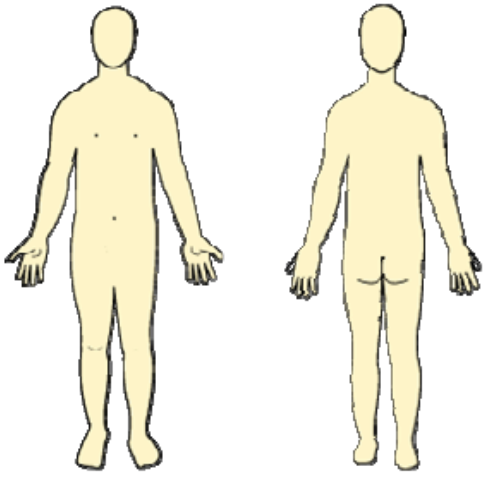
| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Immobility | ☐ | Poor Nutrition | ☐ | Diabetes | ☐ | Incontinence | ☐ |
| Respiratory / Circulatory Disease | ☐ | Anaemia | ☐ | Medication | ☐ | Chemotherapy | ☐ |
| Wound Infection | ☐ | Previous History of MRSA Infection | | | ☐ | | |
| Inotropes | ☐ | Anti-Coagulants | ☐ | Oedema | ☐ | Steroids | ☐ |

Other .....

Allergies & Sensitivities .....

**Body Diagram**

Front Back



Mark location with 'X' and number each wound

| Type of Wound | Total number & duration of each type of wound |
|---|---|
| Leg Ulcer ..... | |
| Surgical Wound ..... | |
| Diabetic Ulcer ..... | |
| Pressure Ulcer ..... | |
| Other, specify ..... | |

**Feet Diagram**

Right Left

Mark location with 'X' and number each wound

**Date referred to:**

TVN .....Physiotherapist.....

Podiatrist.....Dietician.....

Other (please specify).....

**Assessors signature:** .....

**Date:** .....

## Formal Wound Assessment

**Complete on initial assessment and thereafter complete at every dressing change**

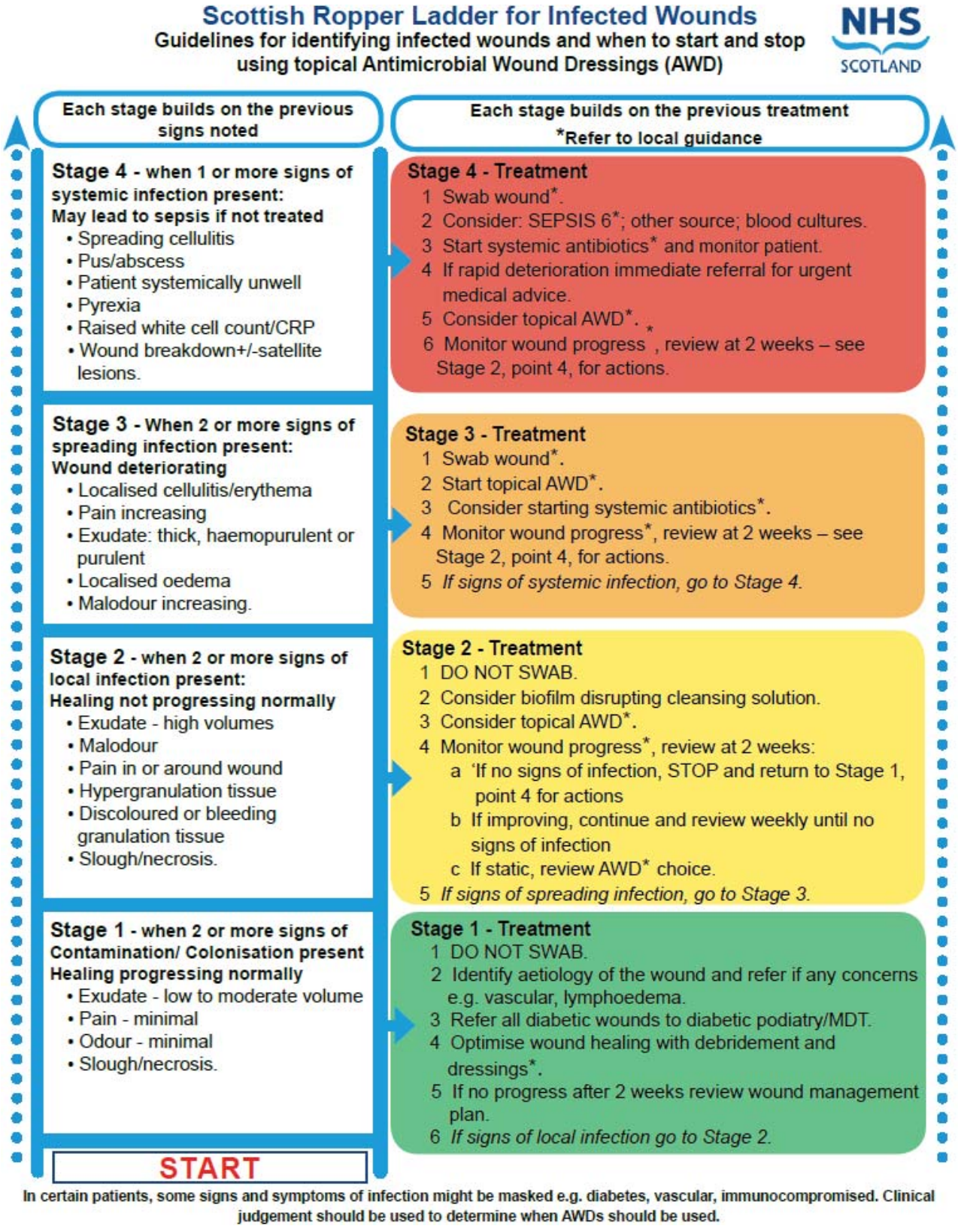
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Date of Assessment | | | | | | | | |
| Number of wound | | | | | | | | |
| **Analgesia required** *(Refer to local pain assessment tool)* | **Yes/No** | **Yes/No** | **Yes/No** | **Yes/No** | **Yes/No** | **Yes/No** | **Yes/No** | **Yes/No** |
| Regular/ongoing analgesia | | | | | | | | |
| Pre-dressing only | | | | | | | | |
| **Wound Dimensions (enter size)** | | | | | | | | |
| Length (cm/mm) | | | | | | | | |
| Width (cm/mm) | | | | | | | | |
| Depth (cm/mm) | | | | | | | | |
| Or trace wound circumference | | | | | | | | |
| Is wound tracking/undermining | | | | | | | | |
| Photography | | | | | | | | |
| **Tissue type on wound bed ( enter percentages)** | | | | | | | | |
| Necrotic (Black) | | | | | | | | |
| Sloughy (Yellow/Green) | | | | | | | | |
| Granulating (Red) | | | | | | | | |
| Epithelialising (Pink) | | | | | | | | |
| Hypergranulating (Red) | | | | | | | | |
| Haematoma | | | | | | | | |
| Bone/tendon | | | | | | | | |
| **Wound exudate levels/ type (tick all relevant boxes)** | | | | | | | | |
| Low | | | | | | | | |
| Moderate | | | | | | | | |
| High * | | | | | | | | |
| Serous (Straw) | | | | | | | | |
| Haemoserous (Red/Straw) | | | | | | | | |
| Purulent (Green/Brown/Yellow)* | | | | | | | | |
| **Peri-wound skin (tick relevant boxes)** | | | | | | | | |
| Macerated (White) | | | | | | | | |
| Oedematous * | | | | | | | | |
| Erythema (Red)* | | | | | | | | |
| Excoriated (Red) | | | | | | | | |
| Fragile | | | | | | | | |
| Dry/scaly | | | | | | | | |
| Healthy/intact | | | | | | | | |
| **Signs of Infection * 1 or more of these signs may indicate possible infection** | | | | | | | | |
| Heat * | | | | | | | | |
| New slough/necrosis(deteriorating wound bed)* | | | | | | | | |
| Increasing pain* | | | | | | | | |
| Increasing exudate* | | | | | | | | |
| Increasing odour* | | | | | | | | |
| Friable granulation tissue* | | | | | | | | |
| **Treatment objectives (tick relevant box)** | | | | | | | | |
| Debridement | | | | | | | | |
| Absorption | | | | | | | | |
| Hydration | | | | | | | | |
| Protection | | | | | | | | |
| Palliative / conservative | | | | | | | | |
| Reduce bacterial load | | | | | | | | |
| **Assessors Print Initials** | | | | | | | | |
| **Dressing Renewed (planned or unplanned dressing change)** | | | | | | | | |
| **Re-assessment date** | | | | | | | | |

## Wound Treatment Plan and Evaluation of Care

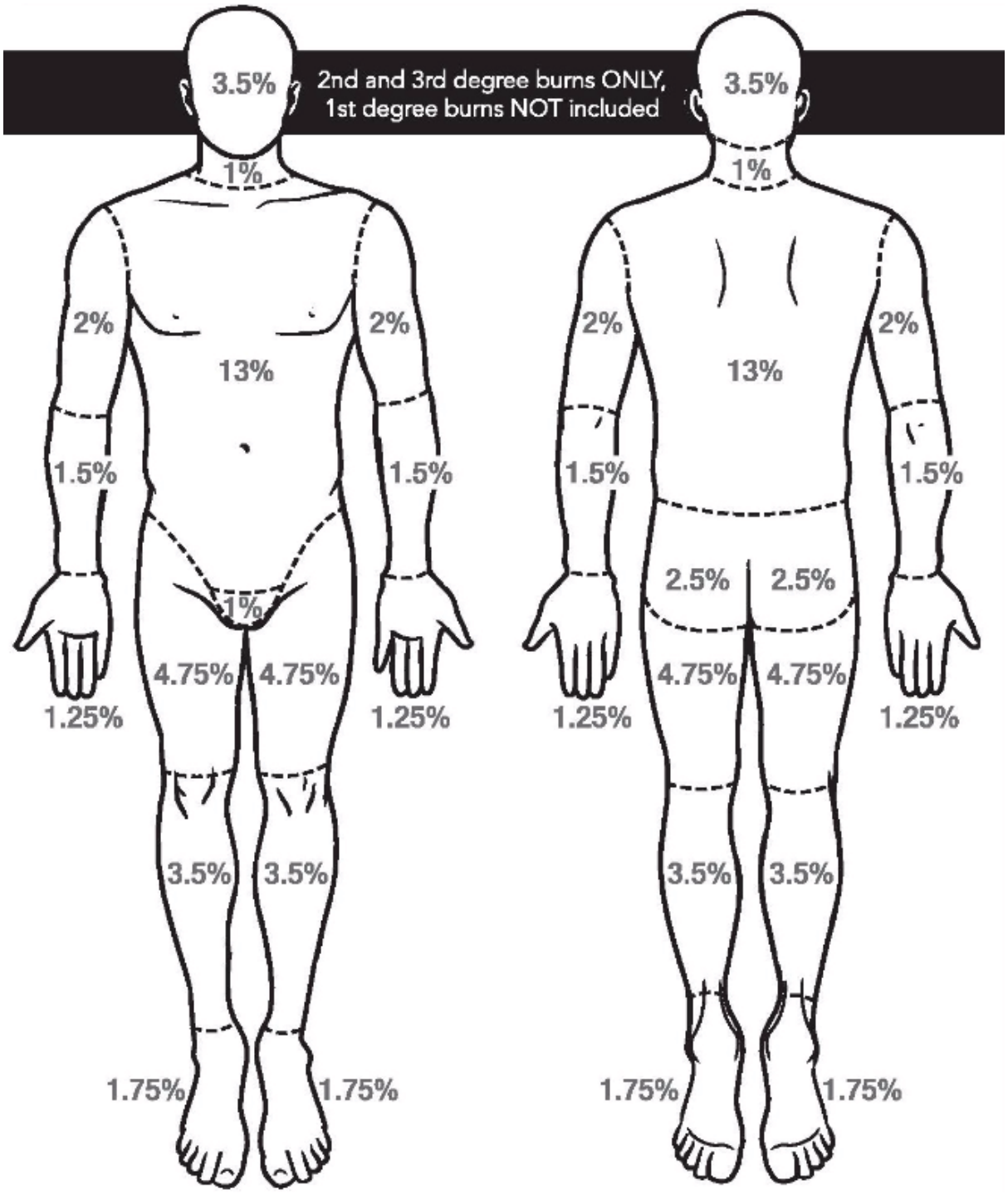
To be completed when treatment or dressing type / regime altered
**NB Please write clearly**

| Date | Wound Number | Cleansing Method, Dressing Choice & Rationale | Frequency | Evaluation & Rationale for changing dressing type | Signature |
|---|---|---|---|---|---|
| | | **Packing Yes / No (circle)**<br>**Amount .....** | | | |
| | | **Packing Yes / No (circle)**<br>**Amount .....** | | | |
| | | **Packing Yes / No (circle)**<br>**Amount .....** | | | |
| | | **Packing Yes / No (circle)**<br>**Amount .....** | | | |
| | | **Packing Yes / No (circle)**<br>**Amount .....** | | | |

# Appendix 3
# Identification and treatment of infected wounds [22]



## Appendix 4
## Chart for calculation of affected percentage of total body surface area



## Resources for professionals

Key precautions and management principles in tissue viability educational workbook http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/education.aspx

Legs matter website has resources for professionals and patients. https://www.legsmatter.org

Information for professionals on a wide range of topics including skin tears is available at https://www.wounds-uk.com

## Resources for patients

Healthcare improvement Scotland has useful patient information leaflets e.g. understanding your chronic wound
http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/infection_in_chronic_wounds.aspx

Patient information sheets on venous eczema can be found at:

British Association of Dermatologists http://www.bad.org.uk/for-the-public/patient-information-leaflets
Varicose eczema National Eczema Society www.eczema.org/varicose-eczema

Information on sunburn is available at:
NHS Choices leaflets Sunburn https://www.nhs.uk/conditions/Sunburn
Patient information on looking after a burn is found at: https://www.cobis.scot.nhs.uk/