


Developed by the British Columbia Provincial Nursing Skin & Wound Committee in collaboration with NSWOCs & Wound Clinicians from: 	
Title	<b>Guideline: Wound Dressing Selection for Adults &amp; Children</b>
<b>DST Indications for Use</b>	<ul style="list-style-type: none"> <li>This decision support tool is used to determine the appropriate dressing for healable, non-healing, or non-healable wounds of all wound etiologies.</li> <li>This decision support tool is not to be used to determine the appropriate dressing for incisions healing by primary intention. Refer to <a href="#">Guideline: Assessment &amp; Treatment of Surgical Wounds Healing by Primary and Secondary Intention in Adults &amp; Children</a>.</li> <li>This document is to be used in conjunction with the <a href="#">Guideline: Wound Management for Adults &amp; Children</a>.</li> <li>Refer to wound etiology specific guidelines and guideline summaries (found at <a href="http://www.clwk.ca">www.clwk.ca</a>) for more detail regarding care plans and wound treatment plans.</li> <li>This clinical guideline focuses solely on the role of the nurse, as one member of the interprofessional team providing client care.</li> </ul>
<b>British Columbia Practice Level</b>	<ul style="list-style-type: none"> <li>Nurses in accordance with their scope of practice as determined by the British Columbia College of Nurses and Midwives (BCCNM).</li> <li>Nurses in accordance with health authority / agency policy and standards.</li> <li>Clients with wounds require an interprofessional holistic approach to provide comprehensive, evidence-based management including assessment and treatment of wounds.</li> </ul>
<b>Background</b>	<ul style="list-style-type: none"> <li>The dressing is only one part of the wound treatment plan.</li> <li>Appropriate dressing selection can improve client outcomes, decrease pain and be cost-effective.</li> <li>The BC Provincial Wound, Ostomy &amp; Continence Formulary includes a number of categories and subcategories of wound care products as no one category or subcategory of dressing is appropriate for all wounds regardless of their etiology.</li> <li>As a wound heals it moves through the phases of wound healing. A number of different dressings may be used over the trajectory of healing.</li> <li>Changes to the type of dressing(s) used on a particular wound are made in response to changes in the wound, periwound and/or client.                             <ul style="list-style-type: none"> <li>Changes are NOT made because of individual nurse / physician / health care provider preferences.</li> <li>The rationale for all changes made must be documented.</li> </ul> </li> <li>Dressings have different functions and are supplied in a variety of sizes and forms (e.g. gel, ropes, sheet, ribbon).</li> <li>The <a href="#">Product Information Sheets</a> (PISheets), found at <a href="http://www.clwk.ca">www.clwk.ca</a>, outline key points, indications, precautions, contraindications, directions for use and sizes available for wound care products used in British Columbia Health Authorities.</li> </ul>
<b>Bookmarks</b>	<a href="#">Assessment</a> <a href="#">Principles of Dressing Selection</a> <a href="#">Principles of Dressing Change Frequency</a> <a href="#">Interventions</a> <a href="#">Client Care Management</a> <a href="#">Wound Care Management</a> <a href="#">Client Education and Resources</a> <a href="#">Transition / Discharge Planning</a> <a href="#">Client Clinical Outcomes</a> <a href="#">Quality Assurance Indicators</a> <a href="#">Documentation</a> <a href="#">Definitions</a>

	<a href="#">Bibliography and References</a> <a href="#">Document Creation/Review</a> <a href="#">Appendix A – Dressing Form and Function</a>
<b>Related Documents</b>  Found at <a href="http://www.clwk.ca">www.clwk.ca</a>	<a href="#">Quick Reference Guide: Wound Dressing Selection for Adults &amp; Children</a> Quick Reference Guide: Wound Dressing Selection for Neonates (under development) Quick Reference Guide: Removing Medical Adhesives (under development) Quick Reference Guide: Dressing Application for Difficult-to-Dress Locations (under development) <a href="#">Guideline: Wound Management for Adults &amp; Children</a> <a href="#">Guideline Summary: Wound Management</a> <a href="#">Wound Assessment &amp; Treatment Flow Sheet</a> and <a href="#">Documentation Guideline</a> <a href="#">Guideline: Assessment, Prevention &amp; Treatment of Wound Infection</a> <a href="#">Procedure: Wound Packing</a> <a href="#">Procedure: Wound Cleansing</a> <a href="#">Product Information Sheets (PISheets)</a>

## **Assessment and Principles of Dressing Selection & Frequency of Dressing Change**

### **Assessment**

Prior to selecting a dressing, complete a thorough client and wound assessment, as outlined in the [Guideline: Wound Management for Adults & Children](#). When choosing a wound dressing consider the following:

1. Assess for Client and Family Concerns.
  - a. Personal hygiene (i.e. bathing or showering routine).
  - b. Activities and impact on dressings (e.g. swimming, sports, work).
  - c. Financial concerns (i.e. ability to purchase dressing supplies if required).
  - d. Client and/or family ability and motivation to understand and adhere to treatment plan (e.g. attend appointments as required, dressing self-care).
  - e. Explore culture and traditions that may impact dressing selection.
2. Assess for Presence of Wound Pain.
  - a. Assess for the presence of wound pain at dressing changes.
  - b. Assess for the presence of wound pain not related to dressing changes.
3. Assess Client Specific Risk Factors for Wound Healability.
  - a. Presence of moisture close to wound / periwound (e.g. incontinence with a sacral wound).
  - b. Medical conditions that may impact tissue perfusion.
  - c. Poor personal hygiene.
  - d. Living environment and how it impacts health and healing (e.g. no access to water, inadequate or lack of housing).
  - e. Allergies or sensitivities (e.g. specific dressings, latex, silicone, dressing components).
4. Assess the previous dressing and consider:
  - a. Dressing function is appropriate for needs of wound.
  - b. Moisture balance, appropriate for the wound, is maintained.
  - c. Wear time of dressing is as expected.
  - d. Dressing is still necessary.
  - e. Dressing did not harm wound bed or periwound skin.
5. Complete a Wound Assessment: (For more information refer to [Wound Assessment & Treatment Flow Sheet](#) and [Documentation Guideline](#)).
  - a. Assess the following:
    - i. Location (i.e. wound is in a crevice or in a difficult to dress area such as coccyx).

- ii. Wound measurements (length, width, depth).
  - iii. Undermining or sinus/tunnels.
  - iv. Wound bed tissue type (e.g. granulation, slough, eschar).
  - v. Wound bed underlying structures (e.g. muscle, cartilage, bone, tendon).
  - vi. Wound bed foreign body (e.g. hardware, surgical mesh).
  - vii. Exudate characteristics (e.g. serous, serosanguineous).
  - viii. Exudate amount (e.g. scant, small, moderate, large/copious).
  - ix. Presence of odour after cleansing.
  - x. Characteristics of wound edge (e.g. attached, rolled).
  - xi. Condition of periwound skin (e.g. intact, excoriated, indurated, erythema).
- b. Assess for signs and symptoms of wound infection and consider potential for wound infection. (For more information refer to [Guideline: Assessment, Prevention & Treatment of Wound Infection](#)).

## Principles of Dressing Selection



1. If unfamiliar with products review appropriate [Product Information Sheets](#) (PISheets) which outline key points, indications, precautions, contraindications, directions for use and sizes available for wound care products used in British Columbia Health Authorities. For dressings to perform optimally they must be used as directed.
2. Determine safety in client age group (pediatric, neonate, or frail elderly) before using dressing products.
3. Dressings come in a variety of forms (e.g. gel, foam, gauze) and are designed to perform different functions which include:
  - Protecting the wound.
  - Maintaining a moist wound environment by adding, maintaining or absorbing moisture.
  - Maintaining or promoting a dry wound environment for wounds with dry eschar.
  - Providing thermal insulation.
  - Promoting / supporting autolytic debridement.
  - Adhering to or not adhering to the periwound skin (e.g. adhesive, non-adhesive dressings).
  - Conforming to either wound depth or sinus/tunnels or undermining.
  - Recruiting or activating critical cells involved in the healing process.
  - Managing or preventing bioburden and infection.
  - Managing or eliminating wound odour.

To determine the appropriate dressing, it is necessary to identify the form and function that is required to meet the needs of the client and the required wound interventions (e.g. support autolytic debridement, maintain moisture balance).

4. Dressings are separated into categories and subcategories based on form and function. In BC the following categories and sub-categories are used:

Categories	Sub-Categories
Antimicrobial Agents	Chlorhexadine, Honey, Iodine, Methylene Blue/Gentian Violet, PHMB, Silver
Biochemical Modifiers	Collagen Cellulose, Extra Cellular Matrix
Cover (Secondary) Dressings	Acrylic, Composite, Foam, Hydrocolloid
Non-Adherent Contact Layers	Lipido-colloid, Paraffin, Petrolatum, Silicone
Odour Control Dressings	Charcoal
Pain Control Dressings	Ibuprofen
Scar Therapy	Silicone Dressing, Silicone Gel
Wound Fillers	Calcium Alginate, Gelling Fibre, Hydrogel, Hydrophilic, Hypertonic, Isotonic
Zinc Dressings	Wrap, Tubular

The above does not include dressings used for specific therapies such as negative pressure wound therapy or high voltage pulse current (e-stim). [Appendix A](#) outlines the form and function of the dressing products available on the BC Provincial Wound Formulary organized by product category and subcategory.

5. For healable wounds, the goal of the dressing is to optimize the wound environment so that healing progresses. In most cases, the initial goal of treatment is to promote / support autolytic debridement to facilitate a clean wound bed. The dressing chosen must optimize moisture balance to achieve this goal.
  - Do not debride (including autolytic debridement) arterial, mixed or diabetic ulcers unless ordered by NSWOC/Wound Clinician or Physician/NP. In many cases (e.g. dry eschar on the foot) the goal is to keep the wound dry.
6. The needs of the wound, based on the assessment, will help determine the appropriate dressing. For example, if a wound is deep and has large amounts of purulent drainage, the dressing will need to have the capacity to absorb large amounts of exudate, fill the dead space, and address the wound bacterial load.
7. The needs and risk factors of the client, client choice, lifestyle and cost-effectiveness are considered when choosing dressings.
8. Dressings are single-client use only.
9. Ensure that the dressing is appropriately sized to cover the wound bed, protect the periwound skin, absorb exudate and prevent tension on skin from adhesives.
  - Refer to the [Product Information Sheet](#) (PISheet) for details on correct sizing of dressing products.
  - Avoid using dressings that are too small or too large, as this can lead to client discomfort, delays in wound healing, and product waste.
  - The [Quick Reference Guide: Prevention of Wound Infection – Saving Dressing Pieces](#) outlines the process for saving and using dressing pieces.
10. Different products and dressings can achieve the same treatment goal. There is usually more than one appropriate dressing for each wound.
11. Sometimes, dressings are used in combination with other wound dressings and products. When using dressings in combination, ensure that the products do not interact with, interfere with or counteract one another. For example:
  - Don't use hydrogel to hydrate the wound bed and Mesalt to remove wound drainage.
  - Don't use two antimicrobial dressings (e.g. silver and iodine) at the same time.
12. A primary dressing comes in direct contact with the wound bed. A secondary dressing covers a primary dressing and may be called a cover dressing. Not all primary dressings require a secondary or cover dressing.
13. Semi-occlusive dressings are recommended for healable wounds. The use of transparent film or some tapes to cover the entire surface of a semi-occlusive dressing will result in the dressing being occlusive, which may have a negative impact on wound healing.
14. If the wound and client assessment findings indicate that a change in dressing product is required, make the change and document the rationale for change.
15. Ideally, dressings are held in place with adhesives that do not cause trauma to the wound and surrounding skin. Repeated application and removal of some adhesive dressings and tapes can result in Medical Adhesive Related Skin Injury (MARSII).

16. Depending on the client and the type of aseptic technique being used for dressing changes sterile or non-sterile dressings may be appropriate.
17. If a product does not perform as outlined in the PISheet discuss with NSWOC/Wound Clinician and consider submitting a [Product Concern](#).

### **Principles of Dressing Change Frequency**

1. Dressing change frequency is based on assessment of the client, wound and dressing.
2. Wounds may require frequent dressing changes (daily or more often) for a number of reasons including:
  - High exudate levels
  - Infection
  - Monitoring
  - Promotion of wound cleansing and autolytic debridement.
3. Change dressings that are saturated, soiled, loose or slipping regardless of the suggested dressing change schedule.
4. Choose dressing with absorption capacity suitable for amount of wound exudate expected.
5. Minimizing dressing change frequency can contribute to cost-effectiveness when using more expensive dressing products.
6. Select dressings to minimize dressing change frequency to maintain wound thermal insulation / regulation.
7. Standard routine and work flow should not impact dressing change frequency.
8. All dressings have a manufacturer recommended wear time (refer to appropriate [PISheet](#)). Dressings will not perform as expected and may increase the risk of infection if left in place longer than recommended.

### **Interventions**

Client considerations, the needs of the wound bed and peri-wound skin and available resources all influence decision making around dressing selection. Refer to Quick Reference Guides: [Wound Dressing Selection for Adults and Children](#) and Wound Dressing Selection for Neonates (under development). Consider the following when selecting a wound dressing.

### **Client Care Management**

1. Address client concerns
  - a. Consider dressings that address the wound characteristics that negatively impact the client's quality of life (e.g. odour, pain, large amounts of wound exudate).
  - b. Choose dressings that support the client's activities of daily living (e.g. dressing thin enough to accommodate footwear, dressing change frequency to accommodate work schedule).
  - c. Ensure client is aware of and approves of dressing composition before applying (e.g. allergies, sensitivities, vegan composition).
  - d. If possible, choose dressings that accommodate client preferences (e.g. shower proof dressing for daily shower, weekly dressing change).
  - e. Choose dressings that support the client's culture and traditions.
  - f. Consider dressings that allow for self-care if client/family is willing and able.
  - g. If the client is required to purchase their own dressings and supplies consider the cost-effectiveness of appropriate dressings.



2. Consider a dressing and interventions that prevent and alleviate pain:
  - a. Apply a non-adherent contact layer to avoid pain and trauma to the wound bed.
  - b. Gently pack / fill dead space. Do not over pack.
  - c. Select a cover dressing that manages the expected exudate amount and minimizes the dressing change frequency.
  - d. Avoid pain and trauma to the wound bed by moistening any dressings that are adhered to the wound bed prior to removal.
  - e. Carefully remove adhesive dressings and tape to avoid Medical Adhesive Related Skin Injury (MARS). Quick Reference Guide: Safely Removing Medical Adhesives (under development) outlines methods for removal of medical adhesives.
  - f. Have client assist with dressing removal.
  - g. Consult with a Physician/NP/NSWOC/Wound Clinician prior to using a pain control dressing such as Biatain IBU.

## Wound Care Management

1. Consider the wound location:
  - a. Select dressing products that are conformable or adaptable to the wound bed and periwound skin.
  - b. For secondary (cover) dressings, consider the effect of gravity and place the dressing to allow for the direction of flow of wound exudate.
  - c. Wound treatment may differ depending on the wound location (e.g., eschar on lower limb is often kept dry while eschar in other locations may be moistened to promote autolytic debridement).
  - d. It is difficult to secure a dressing to wounds in some anatomical locations. Difficult-to-dress areas include: head, ears, axillae, joints, hands and digits (fingers, toes), sternum, the peristomal area, buttocks and sacrum, feet and heels. Refer to Quick Reference Guide: Dressing Application for Difficult-to-Dress Locations (under development) for recommendations/suggestions for applying dressings to these areas. Below are principles to consider when applying dressings to some difficult-to-dress locations.
    - i. For superficial/shallow wounds in some difficult-to-dress locations (e.g. **sacrum or coccyx**) consider using Hydrophilic Paste Dressing (e.g., Triad).
    - ii. Apply dressings to **joints**, with the joint in neutral position to ensure joint mobilization as needed (consult Physiotherapy). Ensure that dressings with one-way stretch are applied to allow the joint to bend with the stretch of the dressing.
    - iii. **Hand** dressings should be conformable and support movement, if movement is allowed (consult Physiotherapy).
    - iv. When securing dressings to **digits or limbs** ensure that the dressing will not impair circulation. Secure dressings loosely to allow for swelling, especially for lower limbs. Tape is never applied circumferentially. If wrapping circumferentially to secure the dressing use a product with stretch (e.g. stretch gauze roll).
    - v. **Digit** (finger and toe) dressings should support movement if allowed. Consider specific digit dressings (e.g. Adaptic Digit). Digits should be dressed individually to reduce skin to skin or wound to wound or skin to wound contact.
    - vi. Use semi-occlusive dressings with caution on **lower limbs** especially those with ischemia. Breathable dressings (e.g. gauze, abdominal pads) will allow a wound to remain dry or dry out.
    - vii. **Foot** dressings are often challenging due to the small size of the dressing areas as it prohibits absorption of large amounts of exudate, and puts the periwound skin at risk of maceration. Dressings may need to be changed more frequently. Dressings need to fit in the clients' protective or therapeutic footwear (i.e. diabetes, arthritis).
    - vi. **Peristomal** wounds (i.e. wounds next to or around a stoma) require dressings that go under, or next to the ostomy pouching system. A calcium alginate or gelling fibre may be applied to a small wound next to the stoma with the pouching system placed over top. When the

wound is adjacent to the ostomy pouching system use an appropriate dressing and consider the position of the ostomy pouching system. Consult NSWOC for direction.

- e. Cutting and/or reshaping a dressing may be required to apply a dressing to some difficult-to-dress locations.
  - i. Refer to [PISheet](#) and/or consult with NSWOC / Wound Clinician before cutting any dressing.
  - ii. Caution should be taken when cutting a dressing (form) as the function may change.
  - iii. Do not cut absorbent dressings that contain 'super-absorbent' beads, powders, or granules (e.g. Mextra Superabsorbent) as this allows particles to be released into the wound.
  - iv. Use sterile and sharp scissors to avoid shredding the dressing edges.
  - v. Do not cut the dressing over the wound bed to avoid spreading dressing particles into the wound bed.
  - vi. Cut adhesive dressings with the peelable back in place and round-off cut edges to reduce the risk of harm to the periwound skin. Keep the peelable back as a template for cutting future dressings.
2. Consider the wound measurements:
  - a. Length and width: Select a dressing appropriate to length and width of wound (e.g. 5 x 5 cm, 10 x 10 cm, or 15 x 15 cm). The size and shape of the wound is needed when cutting the wound contact layer to fit. Generally, the secondary or cover dressing should extend 2-3cm beyond the wound. Refer to [PISheets](#) for product specific information.
  - b. Depth: Use the largest possible size of packing material available for the size of the wound and wherever possible, use only one (1) piece or length of packing to loosely fill the cavity.
3. Consider the presence of undermining, and sinus / tunnels: (For more information refer to [Procedure: Wound Packing](#)).
  - a. Choose a dressing product that fits the size of the opening to the undermining or sinus / tunnel (e.g. ¼, ½, or 1 inch).
  - b. Choose a product that fills the dead space based on the wound measurements. The product should loosely fill the dead space and be conformable to undermining, sinus / tunnel area.
  - c. Always leave a 'tail' of packing materials either clearly visible in the wound cavity or on the periwound skin. Use an adhesive skin closure strip (e.g. Steri-Strip) or paper tape to secure the packing 'tail' to the periwound skin.
  - d. Wounds with packing require a secondary (cover) dressing.
  - e. Packing materials may include the following:
    - Gauze (dry or moistened with normal saline or hydrogel).
    - Impregnated ribbon dressings.
    - Gelling fibre dressings.
    - Calcium alginate dressings.
    - Antimicrobial dressings.
    - Negative wound pressure therapy (NPWT) foam and gauze dressings.
4. Consider the wound bed:
  - a. Tissue type: Use the wound assessment findings and determine the clinical objectives to select the appropriate dressing product based on the predominant tissue type.
    - i. Granulation tissue is firm, moist, pink/red, pebbled tissue and is evidence of normal wound healing. Select a dressing that will maintain a moist wound environment and protect the tissue.
    - ii. Non-granulating tissue is moist, red/pink, non-pebbled tissue and is present in non-healing wounds. Select a dressing that manages the wound exudate and address the cause of the non-granulating tissue if possible.
    - iii. Slough is yellow, grey, green or brown dead tissue. It can be wet or dry and firmly or loosely attached to the wound bed. Select a dressing that manages expected amount of wound exudate and promotes moist wound healing by supporting autolytic debridement. For

wounds with slough below the knee consult with NSWOC/Wound Clinician/MD/NP before promoting autolytic debridement.

- iv. Eschar is black or brown dead tissue and can be dry/stable or soft/boggy. For wounds below the knee promote a dry wound bed and do not promote autolytic debridement unless ordered by NSWOC/Wound Clinician/MD/NP. If a dressing is required for protection use a breathable cover dressing such as gauze. For wounds above the knee select a dressing that promotes moist wound healing and promotes autolytic debridement.
  - v. Hypergranulation is a beefy, bright red, overgrowth of friable tissue and is associated with bioburden, localized infection, friction, and/or excess moisture. Select a dressing that manages expected wound exudate and reduces the hypergranulation.
  - vi. Epithelializing tissue is new pink epithelial tissue over all or part of the wound bed. Select a dressing that provides protection and maintains a moist wound environment to promote epithelialization.
  - vii. Superficial pink, red tissue is found in partial thickness wounds. Select a dressing that provides protection and maintains a moist wound environment to promote epithelialization.
- b. Underlying structures:
- i. For shallow wounds, with visible tendon, cartilage, or bone, apply a single layer of a non-adherent contact layer to provide a protective interface between the structure and the secondary dressing. Non-adherent contact layers may be impregnated with silicone, antiseptics or antimicrobial products. For cavity wounds (e.g. pressure injuries) a wound filler that will not adhere to wound bed (e.g. calcium alginate or gelling fibres) may be appropriate.
  - ii. Choose dressings that maintain moisture balance. Do not allow exposed tendon or bone to dry out.
  - iii. Ensure Physician/NP and NSWOC/Wound Clinician are aware of any visible underlying structures.
- c. Foreign body:
- i. For shallow wounds, with visible hardware, surgical mesh and/or sutures protect the foreign body by applying a single layer of a non-adherent contact layer until direction is received as to the wound treatment goal (i.e. is the hardware permanent or temporary). For cavity wounds (e.g. dehisced surgical incisions or pressure injuries) a non-adherent wound filler (e.g. calcium alginate or gelling fibres) may be appropriate.
  - ii. Ensure Physician/NP and NSWOC/ Wound Clinician are aware of any visible foreign bodies.
5. Consider the characteristics of the exudate:
- a. Characteristics of exudate include: serous, sanguineous, serosanguineous, and purulent or a combination of these types
  - b. Exudate may be thin or viscous. Silicone foams are more appropriate for thin wound exudate. Other dressings (e.g. some composite dressings) absorb viscous fluids more readily.
  - c. Select an absorbent appropriately sized cover dressing that wicks exudate away from the wound bed and keeps the wound surface moist while protecting the periwound skin from moisture.
  - d. Minor bleeding (i.e. non arterial):
    - i. Cover the wound with an absorbent pad, elevate the limb (if applicable) and apply pressure to the wound until bleeding is controlled.
    - ii. If bleeding fails to stop with pressure, apply a hemostatic dressing (e.g. calcium alginate) to control bleeding. Continue to apply pressure until bleeding is controlled.
    - iii. If bleeding has not stopped within 15 minutes for clients on anticoagulant medication or within 5-7 minutes for those not on anticoagulant medications contact Physician/NP.
  - e. Major bleeding (i.e. arterial): cover the wound with an absorbent pad, elevate the limb (if applicable), apply pressure and contact Physician/NP.
6. Consider the amount of exudate: (none, scant/small, moderate, large/copious):
- a. A moist (not wet) wound bed is required for wound healing. Depending on function, dressings may add, maintain or absorb moisture to support moisture balance in the wound.



- b. Keep arterial, mixed or diabetic ulcers dry unless ordered to moisten by NSWOC/Wound Clinician or Physician/NP.
  - c. If a wound undergoing moist wound healing has no exudate add moisture (e.g. hydrogel).
  - d. If exudate is scant/small, consider selecting a product that can be left in place for longer periods of time (e.g. hydropolymer foam or silicone foam).
  - e. If exudate is moderate, consider selecting a product that can manage the expected amount of wound exudate with manageable dressing change frequency (e.g. hydropolymer foam or silicone foam).
  - f. If exudate is large/copious select a product that can be changed more frequently (e.g. gauze, abdominal pads and gauze rolls – sterile or unsterile depending on the situation). Frequent dressing changes (daily or more frequently) will be required until the amount of exudate decreases.
  - g. Do not use semi-occlusive dressings on wounds with large/copious amounts of wound exudate as they may promote periwound skin maceration.
  - h. If exudate levels increase investigate the cause, and treat the cause if required or possible.
  - i. Consult with NSWOC/Wound Clinician for consideration of a wound pouching system for large amounts of wound exudate when:
    - i. Available dressing products are unable to adequately manage amount of exudate.
    - ii. Periwound skin breakdown is present.
    - iii. Odour is of concern.
    - iv. Amount of wound exudate is not anticipated to decrease in a short period of time.
    - v. Frequent dressing changes are required to manage exudate.
  - j. Consider Negative Wound Pressure Therapy to manage copious wound exudate, if no other options are available. Consult with NSWOC/Wound Clinician.
7. Consider the presence of odour after cleansing:
- a. Investigate the cause and treat if possible. For more information refer to [Guideline: Wound Management for Adults & Children](#).
  - b. Consider using an odour control dressing to filter and trap or neutralize odour (e.g. charcoal).
8. Consider the wound edge: attached, not attached, demarcated (clear), diffuse (hard to see edge), calloused, rolled (epibole), and epithelializing.
- a. Calloused wound edges may need debridement (i.e. callous around a diabetic foot ulcer). Consult with an NSWOC / Wound Clinician.
  - b. To minimize rolled edges (epibole) pack wound appropriately (For more information refer to [Procedure: Wound Packing](#)). If rolled edges occur consult with an NSWOC/Wound Clinician.
9. Consider the periwound skin (intact, macerated, fragile, indurated, rash – fungal, allergic)
- a. Keep the periwound skin clean, dry, intact and moisturized.
  - b. If skin is macerated consider changing dressing (packing and/or cover dressing) more frequently or using a more absorptive dressing.
  - c. If needed, protect the periwound skin from adhesives and moisture by:
    - i. Applying a barrier film (e.g. No-Sting Skin Prep) to periwound skin,
    - ii. Applying a protectant (e.g. Hydraguard Cream) to periwound skin, or
    - iii. Applying a hydrocolloid or transparent film around the wound perimeter from the wound edge and including 2 cm of periwound skin (sometimes called window pane or picture framing).
  - d. Consider using Adhesive Remover to assist with removal of adhesive.
  - e. If using powder to treat a rash (e.g. fungal, allergic) use 'crusting technique'. Crusting technique is described in PISheets: [No-Sting Skin Prep](#) and [Ag+ Powder for Skin](#).
  - f. For fragile or damaged periwound skin consider using a silicone adhesive dressing, a non-adhesive dressing or silicone tape.
10. Consider the risk for and presence of infection: For more information refer to [Guideline: Assessment, Prevention & Treatment of Wound Infection](#).

- a. Treat wounds with signs and symptoms of local infection with an antimicrobial dressing.
    - i. When using an antimicrobial dressing the signs and symptoms of local infection should resolve within 2 weeks.
    - ii. Ongoing assessment of the signs and symptoms of local infection is required when antimicrobial dressings are being used.
    - iii. Discontinue the use of antimicrobial dressings when the signs and symptoms of local infection have resolved.
    - iv. If the wound deteriorates or if the signs and symptoms of local infection have not resolved after 2 weeks of antimicrobial dressing use consult with NSWOC / Wound Clinician.
  - b. Consult with the Physician/NP regarding antibiotic therapy if spreading or systemic infection is suspected.
  - c. Change dressings more frequently until the signs and symptoms of local infection have resolved.
  - d. In some cases, it is appropriate to use antimicrobial dressings prophylactically (e.g. repeated wound infections, ischemia, diabetes, immunocompromise). Consult with NSWOC / Wound Clinician prior to using antimicrobial dressings prophylactically.
11. Determine need for sterile or non-sterile dressings: Depending on the client and the type of aseptic technique being used for dressing changes sterile or non-sterile dressings may be appropriate.
- a. When sterile technique is used for dressing changes sterile dressings are required.
  - b. When no-touch technique is used for dressing changes sterile dressings or dressings saved correctly may be used.
  - c. When clean technique is used for dressing changes non-sterile dressings may be used.
  - d. For more information on aseptic technique and wounds refer to [Guideline: Assessment, Prevention and Treatment of Wound Infection](#).
12. Determine dressing change frequency: Dressing change frequency is based on assessment of the client, wound and dressing and takes into consideration:
- a. Signs and symptoms of infection,
  - b. Progression of wound healing,
  - c. Client condition (i.e. acuity),
  - d. Type and function of dressing being used (i.e. longer wear dressings),
  - e. Exudate absorption capacity of the dressing,
  - f. Amount of wound exudate expected, and
  - g. Manufacturer recommended frequency of dressing change.
13. With each dressing change, consider if current wound dressing is meeting the needs of the wound bed, periwound skin and client as determined above. If current dressing is not appropriate, change treatment plan and document rationale for change.

### Client Education and Resources

1. Teach the client and/or family the following:
  - a. The importance of adhering to the wound treatment plan.
  - b. What to do if a dressing change is required in between scheduled dressing changes (e.g. dressing is soiled or falls off).
  - c. Signs of wound complications including wound deterioration, infection and increased pain.
  - d. Discuss communication strategies with health professional when wound complications occur or if wound treatment plan is not effective.
  - e. The need for regular follow-up and dressing changes with a health care provider.
2. If the client and/or family participate in wound care and dressing changes teach them:
  - a. Hand hygiene procedures.
  - b. Signs and symptoms of wound infection and strategies to prevent infection.
  - c. Wound cleansing, appropriate aseptic technique and dressing change procedure.

- d. Need for moisture balance, healing wound edges and healthy periwound skin.
- e. Reportable changes in the wound.
- f. Signs of complications including wound deterioration, infection and increased pain and the need to liaise with a health professional when these occur.

3. Provide written materials that support or reinforce client teaching.

### **Transition / Discharge Planning**

Ensure that when clients are transferred to another site/unit, program or health authority the wound treatment plan can be carried out by the receiving care area. This may require modifications to the current/existing wound care plan, in collaboration with an NSWOC/Wound Clinician.

A number of factors influence a site or unit's ability to carry out a wound care plan:

- Wound care product formulary and product availability,
- Knowledge and skill level of health care providers,
- Availability of services (e.g. home care nursing coverage daily versus once per week), and
- Agency standards and policies.

When preparing to transfer a client the sending site/unit will:

- Provide the current/established wound treatment plan (e.g. wound assessment & treatment flow sheet, Pixalere wound care plan),
- Provide current physician/NP/NSWOC/Wound Clinician orders, if appropriate,
- Provide rationale for wound care plan and any collateral information (e.g. PISheet, client history with product selection, goal of care), if available.
- For complex wounds:
  - Notify receiving site/unit of impending discharge (48 hours if possible),
  - Collaborate with the receiving site/unit to identify any barriers and mitigation strategies for the current wound treatment plan, and
  - Provide dressing products for at minimum 1-2 dressing changes, if needed, to mitigate challenges with accessing supplies.

The receiving site/unit will:

- Review the wound treatment plan to determine site/unit's ability to implement (e.g. staff knowledge and skill, availability of product),
- Determine feasibility of implementing wound treatment plan (e.g. client living situation, staffing resources),
- Collaborate with area/local NSWOC/Wound Clinician and/or sending site/unit to identify mitigation strategies if barriers to implementation of the wound treatment plan are identified,
- Order appropriate dressing products, and
- Ensure staff education is provided, as needed.

### **Client Clinical Outcomes**

1. Intended Outcomes

- a. The client's healing wound heals.
- b. The client's non-healing wound does not deteriorate and remains infection free.
- c. The client's non-healable wound may deteriorate and remains infection free.
- d. The client's pain/other wound symptoms are managed.

2. Unintended Outcomes

- a. The client's healing wound deteriorates.
- b. The client's non-healing wound deteriorates or becomes infected.
- c. The client's non-healable wound deteriorates or becomes infected.
- d. The client's pain/other wound symptoms are not managed.

## **Quality Assurance Indicators**

The following quality assurance indicators could be used by Health Authority/Agency/Facility to ensure that appropriate dressings were used.

1. The wound dressing selection was appropriate for the wound etiology, goal of care and wound and client assessment.
2. Rationale for changes to the wound treatment plan were documented and appropriate.

## **Documentation**

1. Document wound treatment plan and wound care provided as per agency guidelines. For more information refer to [Wound Assessment & Treatment Flow Sheet](#) and [Documentation Guideline](#).
2. Document changes to wound treatment plan as per agency guidelines.

## **Definitions**

**Aseptic Technique** – Technique used to limit the transfer of microorganisms from one person to another by minimizing the microbe count and preventing cross contamination; includes sterile, no-touch, and clean technique. The decision regarding the appropriate aseptic technique is made based on the client's clinical condition, the wound etiology, the wound location, the invasiveness of the dressing procedure, the goal of care, and agency policy.

**Antimicrobials** – A general term for drugs, chemicals and other substances that either kill or slow microbe growth.

**Autolytic Debridement** – The use of the body's endogenous enzymes to slowly remove necrotic tissue from the wound bed. This can be facilitated with the use of gels and moisture retentive dressings to soften or liquefy necrotic tissue. This is a slower method, yet is less harmful to the patient and wound bed than other methods of debridement.

**Bacterial bioburden** – The presence of bacteria that is sufficient to delay or stop wound healing without causing the classic inflammatory signs and symptoms of infection.

**Children** – Clients are considered children if they are 17 years and under.

**Client** – This term includes all recipients of care regardless of setting; acute care (patient), community care (client) and long-term care (resident).

**Client/Family** – Family is two or more individuals who come together for mutual aid. Families are self-defined, and family is 'who the client says their family is'; this is individualized.

**Crusting** – A technique often used to manage raw/weepy peristomal or periwound skin by using powder (ostomy or medicated) and barrier film (wipe or spray). The technique is described in PISheets: [No-Sting Skin Prep](#) and [Ag+ Powder for Skin](#).

**Dead space** – Refers to sinus tracts/tunnels, undermining, cavity within a wound.

**Debridement** – The removal of non-viable tissue from the wound to support the development of granulation tissue which is necessary for healing to occur. Debridement takes several forms: autolytic, biological (larval), conservative sharp, enzymatic, maintenance, mechanical, and surgical/sharp debridement.

**Dressing** – A wound care product, or products, that is used in or on the wound, and periwound skin. The dressing is used to meet the interventions as identified in the wound treatment plan, such as debridement, moisture management, filling dead space, etc. The dressing is one component of a wound treatment plan.

**Note:** This is a **controlled** document. A printed copy may not reflect the current, electronic version on the CLWK Intranet ([www.clwk.ca](http://www.clwk.ca)). Any document appearing in paper form should always be checked against the electronic version prior to use; the electronic version is always the current version. This DST has been developed as a guide to support nursing practice in British Columbia, however it is not a substitute for education, experience & the use of clinical judgment  
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**Epibole** – A raised, rolled closed wound edge. May be dried, callused, or hyperkeratotic and feels hard and indurated. The rolled edge stops cell migration across the wound effectively stopping wound healing. There are many causes including hypoxia, infection, desiccation, dressing trauma, overpacking the wound, or an unhealthy wound bed.

**Epithelialization** – Takes place following the formation of granulation tissue in the base of the wound and occurs as epithelial cells migrate across this new tissue to form a barrier between the wound and the environment.

**Epithelialized tissue** – Wound bed is covered completely with new epithelial tissue.

**Eschar** – Devitalized tissue caused by cell death; is commonly black but may be other colors; it is typically thick and leathery, must be removed before healing can occur; if eschar is dry and stable it is often left intact in non-healable wounds.

**Eschar, dry stable** – Firm, dry necrotic tissue with an absence of drainage, edema, erythema or fluctuance. It is black or brown in color and is attached to the wound edges and wound base.

**Eschar, soft boggy** – Soft necrotic tissue which is black, brown, grey, or tan in color. It may be firmly or loosely attached to the wound edges and wound base; fluctuance and drainage may be present.

**Exudate** – Fluid released from the wound which may contain serum, cellular debris, bacteria, and leukocytes.

**Form** – The shape, size and structure (e.g. gel, foam, impregnated gauze etc.) of wound, ostomy and continence products.

**Formulary** – Those skin, wound, ostomy and continence products selected by Value Analysis Teams (skin and wound, ostomy and continence) for use with British Columbia Health Authorities.

**Function** – The specific role that wound, ostomy and continence products are designed to carry out (e.g. absorption, protection, antimicrobial, autolytic debridement etc.).

**Fungating** – A wound with cancerous or non-cancerous rapidly growing tissue which is cauliflower-like in appearance.

**Friable Tissue** – Fragile wound tissue that may easily bleed.

**Goals of Care** – The three goals are:

- To heal the wound - Wounds are healable when the cause can be treated, there is adequate blood flow for healing and risk factors that impede healing can be mitigated. Normal wound healing occurs in a predictable trajectory for that wound etiology.
- To maintain the wound - A healable wound that is not healing due to client, wound and/or health system barriers.
- To monitor/manage the wound - Wounds that are not able to heal due to underlying client conditions that cannot be mitigated such as insufficient blood supply, an inability to treat the cause of the wound (malignant wounds) or an inability to treat factors impacting wound healing.

**Granulation Tissue** – New connective tissue and tiny blood vessels that form on the wound bed during the healing process. It appears as firm, red, moist, pebbled healthy tissue.

**Healable Wound** – Wounds are healable when there is adequate blood flow for healing and risk factors that impede healing can be mitigated. Normal wound healing occurs in a predictable trajectory.

**Hypergranulation Tissue** – Red, moist tissue raised above the level of the skin (proud flesh).

**Infection** – Presence of replicating microbial organisms in a wound associated with host injury; may be a local, spreading, or systemic infection.

**Maintenance Wound** – A wound that is potentially healable but is impacted by client, wound and / or system barriers (lack of appropriate resources) that cannot be mitigated resulting in wound healing that is slow or stalled.



**Medical Adhesive Related Skin Injury (MARSII)** – A skin injury related to use of medical adhesive that may present as (but not limited to) irritant or allergic contact dermatitis, irritation, skin tears, dermal erosion, maceration, skin stripping, tension blisters and folliculitis.

**Non-Adherent Dressing** – A dressing which does not adhere to the wound bed and does not traumatize the wound or peri-wound skin when it is removed.

**Non-healable Wound** – Wound that is deemed non-healable due to inadequate blood supply, the inability to treat the cause (malignant wounds) or wound exacerbating factors that cannot be corrected.

**Nurse Specialized in Wound, Ostomy and Continence (NSWOC)** – A registered nurse with advanced and specialized knowledge and clinical skills in wound, ostomy and continence care who has graduated from a World Council of Enterostomal Therapists (WCWET) recognized education program.

**Nursing Diagnosis** – A clinical judgement which identifies a physical or mental condition as the cause of a client's signs or symptoms.

**Occlusive Dressing** – A wound dressing which is impermeable to water vapor and do not allow air, fluids and harmful contaminants such as viruses and bacteria to enter or exit through the dressing.

**Packing** – The process of loosely filling a wound cavity or dead space with gauze sponges, gauze strips or other appropriate packing material.

**Periwound Skin** – the area of skin within 4cms from the wound edge, as well as, any skin which will be covered by the dressing /securement product.

**Primary Dressing** – A wound dressing that comes directly in contact with the wound bed. Some primary dressings require the use of a secondary or cover dressing.

**Product Information Sheet (PISheet)** – PISheet(s) are developed by the Provincial Nursing and/or Interprofessional Skin & Wound Committee. PISheets are found on the British Columbia Patient Safety and Quality Council's Connecting Learners with Knowledge website <https://clwk.ca>

**Secondary Dressing** – Covers a primary dressing. Also called a cover dressing.

**Semi-occlusive Dressing** – A wound dressing which is moisture vapor permeable and protects the wound from outside contaminants and fluids, while allowing for transmission of air.

**Sinus/Tunnel** – A channel that extends from any part of the wound and tracks into deeper tissue.

**Slough** – Soft, moist necrotic tissue that is brown, tan, yellow or green in colour. It may be thin or thick and the consistency may be fibrous, stringy or mucinous. It may be firmly or loosely attached to the wound edges and base.

**Undermining** – A destruction of tissue that occurs underneath the intact skin of the wound perimeter.

**Window Pane** – Sometimes called picture framing. A technique used to protect periwound skin by applying a hydrocolloid or transparent film around the wound perimeter (from the wound edge to include at least 2 cm of periwound skin).

**Wound Healing Phases** – Wound healing occurs in four phases – hemostasis, inflammation, proliferation/repair, and maturation/remodeling. Each phase is distinct yet overlaps with the others. Refer to Appendix A in [Guideline: Wound Management for Adults & Children](#).

**Wound Treatment Plan** – All aspects of client care directed at managing the wound, including wound care, offloading, nutrition etc.

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### **Document Creation/Review**

This guideline is based upon the best information available at the time it was published and relies on evidence and avoids opinion-based statements where possible. It was developed by the Provincial Nursing Skin & Wound Committee and has undergone provincial stakeholder review.

<b>Created By</b>	British Columbia Provincial Nursing Skin & Wound Committee in collaboration with NSWOC/Wound Clinicians from across all Health Authorities.
<b>Publication Date</b>	November 2020
<b>Revision Date(s)</b>	March 2021
<b>Review Date(s)</b>	

**Appendix A – Dressing Form and Function**

Refer to product specific product information sheets (links below) for details on the indications, contraindications, directions for use, wear time and sizes available for each product.

<b>Category: Antimicrobial Agents</b>			
<ul style="list-style-type: none"> <li>• Indications:                             <ul style="list-style-type: none"> <li>○ Locally infected wounds.</li> <li>○ Wounds with spreading or systemic infection in conjunction with systemic antibiotics.</li> <li>○ Wounds at high risk to develop a wound infection.</li> </ul> </li> <li>• Must be in contact with the wound bed to be effective.</li> <li>• Use for two-weeks before deciding effectiveness (two-week challenge).</li> <li>• Most require secondary (cover) dressing.</li> </ul>			
<b>Subcategory</b>	<b>Formulary Products</b>	<b>Form</b>	<b>Function(s)</b>
Chlorhexadine	<a href="#">Bactigras</a>	Non-Adherent Contact Layer	Antimicrobial Non-Adherent
Honey – Medical Grade	<a href="#">Medihoney Apinate</a>	Calcium Alginate	Antimicrobial Absorption (moderate)
	<a href="#">Medihoney Antimicrobial Medical Honey</a>	Liquid	Antimicrobial Autolytic debridement
	<a href="#">Medihoney Antimicrobial Wound Gel</a>	Gel	Anti-inflammatory
Iodine	<a href="#">Inadine</a>	Non-Adherent Contact Layer	Antimicrobial Maintenance
	<a href="#">Iodosorb</a>	Ointment Paste Powder	Antimicrobial Autolytic debridement Absorption (small)
	<a href="#">Povidone Iodine 10%</a>	Liquid	Antimicrobial Maintenance Drying
Methylene blue / gentian violet	<a href="#">Hydrofera Blue Classic</a>	Foam	Antimicrobial Absorption (large) Autolytic debridement
	<a href="#">Hydrofera Blue Ready</a>		
Polyhexamethylene Biquanide (PHMB)	<a href="#">PHMB Foam with Border</a>	Foam	Antimicrobial Absorptive
	<a href="#">PHMB Foam with Topsheet</a>	Foam	Antimicrobial Absorption (large)
	<a href="#">PHMB Gauze</a>	Gauze	Antimicrobial Exudate transfer
	<a href="#">PHMB Transfer Foam</a>	Transfer Layer	Antimicrobial Exudate transfer
Silver	<a href="#">Acticoat for burns</a>	Sheet	Antimicrobial Anti-inflammatory
	<a href="#">Acticoat for wounds</a>		
	<a href="#">Acticoat Flex for Burns</a>	Mesh	Antimicrobial Flexible Anti-inflammatory
	<a href="#">Acticoat Flex for Wounds</a>		
	<a href="#">Ag+ Powder</a>	Powder	Antimicrobial Absorption (small)
	<a href="#">Aquacel Ag + Extra</a>	Gelling Fibre	Antimicrobial Absorptive (moderate)
	<a href="#">Biatain Ag Adhesive</a>	Foam	Antimicrobial Absorptive (moderate)
	<a href="#">Biatain Ag Non-Adhesive</a>		
<a href="#">CalciCare Silver</a>	Calcium Alginate	Antimicrobial Absorptive (moderate) Hemostatic	

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	<a href="#">Mepilex Transfer Ag</a>	Transfer Layer	Antimicrobial Exudate transfer
	<a href="#">Silvasorb</a>	Hydrogel	Antimicrobial Hydration
	<a href="#">UrgoTul Ag Silver</a>	Non-Adherent Contact Layer	Antimicrobial Protection
<b>Category: Biochemical Modifiers</b>			
<ul style="list-style-type: none"> <li>• Indications: <ul style="list-style-type: none"> <li>○ Stalled healable wounds.</li> <li>○ Antimicrobial version for stalled wounds with signs and symptoms of infection.</li> </ul> </li> <li>• Consult with NSWOC or Wound Clinician before using.</li> <li>• Require secondary (cover) dressing.</li> </ul>			
Subcategory	Formulary Products	Form	Function(s)
Calcium Cellulose	<a href="#">Prisma</a>	Calcium Cellulose	Antimicrobial Cellular Balance
	<a href="#">Promogran</a>	Calcium Cellulose	Cellular Balance
Extra Cellular Matrix	<a href="#">OASIS</a>	Porcine Extracellular Matrix	Cellular Balance Extracellular Matrix
	<a href="#">Endoform (Natural and Antimicrobial)</a>	Ovine Extracellular Matrix	Cellular Balance Extracellular Matrix
<b>Category: Cover (Secondary) Dressings</b>			
<ul style="list-style-type: none"> <li>• Indications: <ul style="list-style-type: none"> <li>○ To cover a primary dressing.</li> <li>○ To cover a wound when a primary dressing is not required.</li> </ul> </li> <li>• Choose based on amount of wound exudate and absorptive properties of dressing.</li> </ul>			
Subcategory	Formulary Products	Form	Function(s)
Acrylic	<a href="#">Tegaderm Absorbent Clear Acrylic</a>	Acrylic	Maintains moisture Autolytic debridement Protection
Composite	<a href="#">Aldress</a>	Composite	Moisture retentive
	<a href="#">Mesorb</a>	Composite	Absorptive (large)
	<a href="#">Mextra Superabsorbent</a>	Composite	Absorptive (copious)
Foam	<a href="#">Tielle Non-adhesive</a>	Hydropolymer Foam	Absorptive (moderate) Autolytic debridement
	<a href="#">Tielle Plus</a>	Hydropolymer Foam	Absorptive (moderate) Autolytic debridement
	<a href="#">Mepilex</a>	Silicone Foam	Absorptive (moderate) Autolytic debridement Non-Adherent
	<a href="#">Mepilex Border</a>	Silicone Foam	Absorptive (moderate) Non-Adherent
	<a href="#">Mepilex Border Flex</a>	Silicone Foam	Absorptive (moderate) Non-Adherent Flexible
	<a href="#">Mepilex Lite</a>	Silicone Foam	Maintains moisture Non-Adherent
	<a href="#">Mepilex Border Lite</a>	Silicone Foam	Maintains moisture Non-Adherent



Hydrocolloid	<a href="#">Duoderm Signal</a>	Hydrocolloid	Maintains moisture Autolytic debridement
	<a href="#">Duoderm Extra Thin</a>	Hydrocolloid	Maintains moisture Autolytic debridement
	<a href="#">Tegaderm Hydrocolloid</a>	Hydrocolloid	Maintains moisture Autolytic debridement
	<a href="#">Tegaderm Hydrocolloid Thin</a>	Hydrocolloid	Maintains moisture Autolytic debridement
<b>Category: Non-Adherent Contact Layer</b>			
<ul style="list-style-type: none"> <li>• Indications:                             <ul style="list-style-type: none"> <li>○ Painful wounds.</li> <li>○ Wounds with friable granulation tissue.</li> <li>○ Prevention of adherence of secondary dressings to wound.</li> </ul> </li> <li>• Require secondary (cover) dressing.</li> <li>• Secondary dressing may be changed without changing non-adherent contact layer.</li> <li>• Allow the transfer of wound exudate to secondary dressing.</li> </ul>			
<b>Subcategory</b>	<b>Formulary Products</b>	<b>Form</b>	<b>Function(s)</b>
Lipido-colloid	<a href="#">UrgoTul</a>	Non-Adherent Contact Layer	Non-Adherent
Paraffin	<a href="#">Jelonet</a>	Non-Adherent Contact Layer	Non-Adherent
Petrolatum	<a href="#">Adaptic</a>	Non-Adherent Contact Layer	Non-Adherent
Silicone	<a href="#">Adaptic Digit</a>	Non-Adherent Contact Layer	Non-Adherent
	<a href="#">Mepitel</a>	Non-Adherent Contact Layer	Non-Adherent
	<a href="#">Mepitel One</a>	Non-Adherent Contact Layer	Non-Adherent
	<a href="#">Mepilex Transfer</a>	Transfer Foam	Non-Adherent Exudate Transfer
<b>Category: Odour Control Dressings</b>			
<ul style="list-style-type: none"> <li>• Indications:                             <ul style="list-style-type: none"> <li>○ Wounds with odour after cleansing.</li> </ul> </li> </ul>			
<b>Subcategory</b>	<b>Formulary Products</b>	<b>Form</b>	<b>Function(s)</b>
Charcoal	<a href="#">Actisorb Silver 220</a>	Activated Charcoal	Odour Control
<b>Category: Pain Control Dressings</b>			
<ul style="list-style-type: none"> <li>• Indications:                             <ul style="list-style-type: none"> <li>○ Painful, exuding wounds.</li> </ul> </li> <li>• Must be in contact with wound bed to be effective.</li> </ul>			
<b>Subcategory</b>	<b>Formulary Products</b>	<b>Form</b>	<b>Function(s)</b>
Ibuprofen	<a href="#">Biatain IBU</a>	Foam	Pain Control Absorptive (moderate)
<b>Category: Scar Therapy</b>			
<ul style="list-style-type: none"> <li>• Indications:                             <ul style="list-style-type: none"> <li>○ Old and new hypertrophic scars.</li> <li>○ Old and new keloid scars.</li> <li>○ Newly closed wounds.</li> </ul> </li> </ul>			
<b>Subcategory</b>	<b>Formulary Products</b>	<b>Form</b>	<b>Function(s)</b>
Silicone	<a href="#">Cica-Care</a>	Gel Sheet	Scar Therapy

<b>Category: Wound Fillers</b>			
<ul style="list-style-type: none"> <li>• Indications:                             <ul style="list-style-type: none"> <li>○ Wounds with depth, undermining, sinuses / tunnels.</li> </ul> </li> <li>• Require secondary (cover) dressing.</li> </ul>			
<b>Subcategory</b>	<b>Formulary Products</b>	<b>Form</b>	<b>Function(s)</b>
Calcium Alginates	<a href="#">Kaltostat</a>	Calcium Alginate	Absorptive (moderate) Hemostatic Autolytic debridement
Gelling Fibres	<a href="#">Aquacel Extra</a>	Gelling Fibre	Absorptive (moderate) Autolytic debridement
Hydrogels	<a href="#">Intrasite Gel</a>	Gel	Hydration Autolytic debridement
	<a href="#">Intrasite Conformable</a>	Gauze	Hydration Autolytic debridement
Hydrophyllics	<a href="#">Triad</a>	Paste	Absorptive (small) Autolytic debridement
Hypertonics	<a href="#">Mesalt</a>	Gauze	Absorptive (large) Autolytic debridement
	<a href="#">TenderWet</a>	Composite	Absorptive (large) Autolytic debridement
<b>Category: Zinc Dressings</b>			
<ul style="list-style-type: none"> <li>• Indications:                             <ul style="list-style-type: none"> <li>○ Chronic eczema and dermatitis.</li> <li>○ In conjunction with compression therapy.</li> </ul> </li> <li>• Secondary (cover) dressing required.</li> </ul>			
<b>Subcategory</b>	<b>Formulary Products</b>	<b>Form</b>	<b>Function(s)</b>
Wrap	<a href="#">Viscopaste</a>	Gauze	Dermatitis treatment
Tubular	<a href="#">ZipZok</a>	Gauze	