NOVA SCOTIA
PROVINCIAL WOUND PROGRAM
QUICK REFERENCE GUIDE

VERSION 1.0
2025

Provincial Wound Program
HEALTH ASSOCIATION NOVA SCOTIA

Long Term Care Provincial Wound Formulary

NOVA SCOTIA
Seniors and Long-Term Care

LTC Provincial Wound Formulary
June 2024
updated Jan 2025

Effective June 2024, all wound care products can no longer be ordered through a pharmacy and should be ordered directly through the igility group purchasing wound care order site www.igilitygpo.ca

EXUDATE MANAGEMENT

Note: Do not use foam dressing on feet. Do not use with hydrogels.

Foam	**Lite Silicone Foam Use: Scant amount of exudate. Indicated for up to 7 days or when exudate reaches within 0.5 cm from the edge of dressing.**		
	66800835	Allevyn Gentle Border Lite 10 cm x 10 cm	10/Box
	66800840	Allevyn Gentle Border Lite 15 cm x 15 cm	10/Box
	Border Silicone Foam Use: Moderate-large amount of exudate and skin tears. Indicated for up to 7 days or when exudate reaches within 0.5 cm from the edge of the dressing.		
	66800270	Allevyn Gentle Border 10 cm x 10 cm	10/Box
	66800272	Allevyn Gentle Border 12.5 cm x 12.5 cm	10/Box
	66800959	Allevyn Gentle Border 17.1 cm x 17.9 cm	10/Box
	Border Silicone Foam Use: Moderate to high amount of exudate and skin tears. Quadrilobe/4 lobes. Indicated for up to 7 days or when exudate is visible in 3 out of 4 lobes.		
	66801068	Allevyn Life 12.9 cm x 12.9 cm	10/Box
	66801069	Allevyn Life 15.4 cm x 15.4 cm	10/Box
	66801070	Allevyn Life 21 cm x 21 cm	10/Box
	Post-Op Silicone Foam Use: Post-op for Low to Moderate amount of exudate or frequent dressing changes. Indicated to stay in place for up to 7 days or when exudate reaches within 0.5 cm of dressing edge.		
	66800900	Allevyn Gentle Border Post-op 10 cm x 20 cm	10/Box
	66800264	Allevyn Gentle Border Post-op 10 cm x 25 cm	10/Box
	Non-Border Silicone Foam Use: Moderate amount of exudate, requires secondary fixation. Indicated for up to 7 days or when exudate reaches within 1.5 cm of dressing edge.		
	66802129	Allevyn Non Border 10 cm x 10 cm	10/Box
	66802131	Allevyn Non Border 15 cm x 15 cm	10/Box
	Non-Silicone Polyurethane Foam Use: For moderate amount of exudate. Indicated up to 7 days or when exudate reaches 0.5 cm of dressing edge.		
	66000044	Allevyn Adhesive Classic 12.5 cm x 12.5 cm	10/Box
	66000045	Allevyn Adhesive Classic 17.5 cm x 17.5 cm	10/Box
Alginate	**Calcium Alginate Use: Packing of wounds and additional absorption to manage moderate - heavy exudate under cover dressing. Indicated up to 7 days or if exudate begins to pool in the wound or if cover dressing becomes saturated.**		
	66000520	Algisite M 10 cm x 10 cm	10/ Box
	66000522	Algisite M 2 cm x 30 cm	5/Box

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ANTIMICROBIAL

Provide broad action and can be highly effective in killing microorganisms. For wounds that improve, antimicrobial dressings should be continued for 14–21 days.

Antimicrobial

10% Povidone Iodine Non-Adherent Sheet Use: For wounds with minimal exudate, or to assist in the drying of wounds. Indicated up to 7 days or when fading of color occurs. Requires a cover dressing.		
P01481	Inadine Dressing 5 cm x 5 cm	25/Box
P01512	Inadine Dressing 9.5 cm x 9.5 cm	25/Box
Cadexomer Iodine Use: For sloughy moist wounds and management of biofilm. Effective up to 3 days or when Iodosorb turns yellow/grey. Requires a cover dressing.		
66060630	Iodosorb Ointment 10 gm tube	4/Box
66001286	Iodosorb Powder 3 gm sachet	7/Box
Silver Alginate Use: For moderate - heavy amount of exudate. Caution: Do not use on dry wounds or wounds with minimal wound exudate. Indicated up to 7 days or when cover dressing is saturated.		
CAD230	Silvercel Adherent Alginate Rope 2.5cm x 30.5cm rope	5/Box
CAD050	Silvercel Adherent Alginate 5cm x 5cm	10/Box
CAD011	Silvercel Adherent Alginate 11cm x 11cm	5/Box
Nanocrystalline Silver Mesh Use: Can be used for all types of wounds, burns, and under NPWT. Indicated for 3-7 days.		
66800545	Acticoat Flex 7 Rope 2.5 cm x 60 cm	5/Box
66800399	Acticoat Flex 3 10 cm x 10 cm (3-day wear)	12/Box
66800397	Acticoat Flex 7 12.5 cm x 12.5 cm (7-day wear)	5/Box
Polyester Mesh containing Silver Sulphate Use: Prevent wound trauma, low-moderate amount of exudate. Indicated up to 7 days.		
509341	UrgoTul Ag/Silver Contact Layer Dressing 10 cm x 12.5 cm	10/Box
0.2% Polyhexamethylene Biguanide (PHMB) Use: Gauze dressing for wound packing, tunnels, open surgical wounds. Indicated up to 7 days or when cover dressing is saturated.		
Z7831AMD	AMD PHMB Packing Strips 0.63 cm x 0.91.4 m (1/4 inch)	10/Box
Z7832AMD	AMD PHMB Packing Strip 1.27 cm x 0.91.4 m (1/2 inch)	10/Box
Z7833AMD	AMD PHMB Packing Strip 2.51 cm x 0.91.4 m (1 inch)	10/Box
Z3332	AMD Kerlix Rolls 11.4 cm x 3.7 m	1 roll
Methylene Blue/Gentian Violet Use: To assist with removal of slough/eschar. Note: Pre-moisten dressing 5-10 mins prior to application. Requires cover dressing to keep this dressing moist.		
HB2214	Hydrofera Blue Classic 5 cm x 5 cm	10/Box
HB4414	Hydrofera Blue Classic 10.2 cm x 10.2 cm	10/Box
HBT0906	Hydrofera Blue Classic 9 mm tunneling dressing	10/Box
Charcoal and Silver Use: For malodourous wounds; contains silver. NOTE: Do not cut, product can be folded to size.		
MAS105	Actisorb Ag 220 Charcoal 10.5cm x 10.5cm	10/Box

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Protective	**Non-Adherent Cover Use: Cover and protect areas. Indicated up to 7 days. Note: Does not promote moist wound healing.**		
	7135	Primapore Adhesive Non-Woven Wound Dressing 8.3 x 6 cm	50/Box
	66000317	Primapore Adhesive Non-Woven Wound Dressing 10 x 8 cm	20/Box
	66000318	Primapore Adhesive Non-Woven Wound Dressing 15 x 8 cm	20/Box
Super-Absorbent	**Super-Absorbent Dressing Use: For absorbing high amounts of exudate. Indicated for up to 7 days. Can use either side of the dressing, the dressing pad needs to overlap the edge of the wound. Do not cut the dressing.**		
	PRD500-025	Kerramax Care Super-Absorbent Dressing 5 cm x 5 cm	10/Box
	PRD500-050	Kerramax Care Super-Absorbent Dressing 10 cm x 10 cm	10/Box
	PRD500-100	Kerramax Care Super-Absorbent Dressing 13.5 cm x 15.5 cm	10/Box
	PRD500-120	Kerramax Care Super-Absorbent Dressing 10 cm x 22 cm	10/Box
	PRD500-380-B10	Kerramax Care Super-Absorbent Dressing 20 cm x 30 cm	10/Box
Skin Protectant	**Liquid Protective Film Use: For protection of intact or damaged skin from wound exudate. Provides an effective film barrier for up to 4 days when used alone or under non-adhesive dressings. Allow liquid to be fully dried before application of cover dressing.**		
	66800709	No Sting Barrier Film Spray 28 ml (single person use)	1 bottle
	59420600	No Sting Barrier Film Wipe 1 ml	50/Box
	Adhesive Remover Use: to assist with the removal of adhesive dressing and tapes. Wipe off after use.		
	37436	Allkare wipe (adhesive remover)	50/Box
Antiseptic	**Chlorhexidine Gluconate (CHG) 2% Solution Compounded with 70% Alcohol Use: To achieve and maintain dry, stable eschar e.g. arterial wounds. Apply with friction for 30 seconds and reapply every 3 days. Do not apply to open wounds.**		
	101.07	Soluprep antiseptic wipe – For larger area	100/Box
	102.03	Soluprep antiseptic swab – For smaller areas	50/Box
	Betadine Povidone Iodine 10 % Use: On dry or open eschar to maintain an intact covering of a wound and eschar. apply daily. Discard open bottle after 30 days.		
	1034105	Povidone Iodine (Betadine) 115 ml	1 bottle
Wound Cleanser	**BIHOCL Pure Cleanse Antimicrobial Cleansing Solution Use: A safe and non-cytotoxic, antimicrobial cleansing solution for wounds, skin, and burns. Use in place of saline to cleanse wounds with each dressing change.**		
	33055-118DC	BIHOCL Pure Cleanse Hypochlorous Acid Wound Cleanser 118ml	1 bottle
	Normal Saline Use: For wound cleansing. Hold tip of the container 10-15 cm (4-6 inches) from the wound and squeeze solution over wound bed in a sweeping motion using all the solution. Discard the bottle after use.		
	T168000	100 ml Normal Saline- single use	25/case

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Compression Wraps	**Edema Wear Tubular compression stocking provides mild longitudinal compression (~10--20mm/Hg). Use: Stocking should be worn all day/all night and the stocking should be removed/ repositioned at least once a day. The stocking can be left in place for up to one week and washed in cold water and hang to dry. Can be reused up to 6 months.**		
	CA600001	Edema Wear Small up to 45cm/ Navy (foot to knee). **Each package contains 2 stockings.**	1 package
	Compression Therapy: Non-Elastic/Short-Stretch Wrap Use: Can apply for up to 7 days given slippage does not occur and/or, if a wound is present, the wound exudate is managed. PLEASE NOTE: Only health care professionals who have successfully completed additional education for compression therapy (as per organizational policy) may apply compression wrap.		
	3M2094	Coban 2 Layer Short Stretch Compression 10cm x 2.7 m	1/Box
	3M2794	Coban 2 Lite Layer Short Stretch Compression 10cm wide	1/Box
Wound Contact Layer			
Non-Adherent Contact Layer	**Petrolatum Impregnated Dressing Use: For prevention of wound bed trauma by decreasing adherence of the secondary dressing. Can be left in place for up to 7 days. Requires a cover dressing that covers the wound, plus at least 2 cm of peri-wound skin.**		
	2012	Adaptic Non-Adhering Dressing 7.6 cm x 7.6 cm	50/Box
	2015	Adaptic Non-Adhering Dressing 7.6 cm x 20.3 cm	24/ Box
Wound Hydration			
Hydrogel	**Intrasite Gel -Water based Amorphous Gel Use: Add/maintain moisture in wounds with necrotic tissue to enhance autolytic debridement. Cover with moisture retention dressing. Do not leave dressings in place for longer than 2 days.**		
	7308	Intrasite Gel 8G - single use only	10/ Box
Other			
	DUP59901	Cotton Tip Applicators	100 Bag
	195-7144301	Hypafix Conformable Adhesive Retention Tape 5 cm x 10 m	1 roll
	195-7144302	Hypafix Conformable Adhesive Retention Tape 10 cm x 10 m	1 roll
	7143616	Easifix Cohesive 8cm x 20 m	1 roll

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Prevention
Requires pressure injury risk assessment and documentation by Nursing, Physio, or Occupational Therapy.

Preventative

Offloading Heel Boots		
MDT823330P	Heel Medix Advanced Petite 12.7 - 27.9 cm	1 boot
MDT823330	Heel Medix Advanced Standard 27.9 - 48.2 cm	1 boot
Positioning Wedge		
MSC50023	Comfort Glide Positioning Wedge - 30° Foam Wedge	6 per case
MSC50024	Comfort Glide Positioning Wedge (XL) - 30° Foam Wedge	2 per case
Transfer Sheets A 2-piece system. Need to order both the draw sheet and fitted sheet.		
PTD-56	Swift Glide Draw Sheet (for mattresses 36" to 39" wide x 76” to 84” long)	1 sheet
PTD/LS/S	Swift Glide Fitted Sheet	1 sheet
PTD-56/BA/Y	Swift Glide Bariatric Draw Sheet (for mattresses 42” to 54” wide x 76” to 80” long)	1 sheet
PTD/LS/S/BA/Y1	Swift Glide Bariatric Fitted Sheet	1 sheet

igility

For more information contact group.purchasing@igility.ca

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For wound care exceptions contact Woundcare@healthassociation.ns.ca

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Long Term Care Wound Product Function Summary

LONG TERM CARE
Wound Product Function Summary

EXUDATE MANAGEMENT

SILICONE FOAM

	When do I use it?	Caution
ALLEVYN GENTLE BORDER LITE 	For a scant amount of exudate. Indicated to stay in placed up to 7 days or when exudate reaches within 0.5cm of the edge of the dressing.	• Do not use foam on feet. • Do not use with hydrogels • Do not use for protection in LTC unless authorized • Do not use with hypochlorite solution • Do not use with known sensitivity or allergy to polyurethane.
ALLEVYN GENTLE BORDER 	For low to moderate exudate, or frequent dressing changes. Can be used for skin tears. Indicated to stay in placed up to 7 days or when exudate reaches within 0.5cm of the edge of the dressing.	
ALLEVYN LIFE 	For moderate to large amounts of exudate. Can be used for skin tears. Indicated to stay in place up to 7 days or change when exudate visible in 3 out of 4 lobes.	
ALLEVYN NON-BORDER 	For moderate amounts of exudate and a wound contact layer which prevents adherence to the wound bed. Requires secondary fixation. Indicated to stay in place up to 7 days or when exudate reaches within 1.5cm of the dressing's edge.	
ALLEVYN GENTLE BORDER POST-OP 	For post- op wounds with low to moderate exudate, or frequent dressing changes. Indicated to stay in place up to 7 days or when exudate reaches within 0.5cm of the edge of the dressing.	

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		When do I use it?	Caution
FOAM	**ALLEVYN ADHESIVE CLASSIC** 	Non-silicone polyurethane adhesive for use when silicone is not effective. For wounds with moderate amounts of exudate. Indicated to stay in place up to 7 days or when exudate reaches within 0.5cm of the edge of the dressing.	• Do not use on fragile skin due to potential of skin stripping • Do not use with hypochlorite solution, hydrogels or with sensitivity to polyurethane
ALGINATE	**ALGISITE M** 	Calcium Alginate for packing of wounds and additional absorption to manage moderate to heavy exudate under cover dressing. Promotes hemostasis. Indicated up to 7 days or if exudate begins to pool in the wound or if cover dressing becomes saturated.	• Do not overpack wound and ensure there is a “tail” for removal of packing • Should remain within the edges of the wound to prevent maceration
ANTIMICROBIAL			
IODINE	**INADINE** 10% Povidone Iodine Non-Adherent Sheet 	For shallow wounds with minimal drainage or to aid in drying wounds. Wear time varies but can be left in place up will 7 days depending on amount of exudate. Requires a cover dressing. Fading of the color of the product indicates the loss of antimicrobial efficacy and indicates when the dressing should be changed. Note: Do not apply Inadine to the wound with backing paper still attached. Cut to size.	• If using to keep wound dry, do not use with foam dressings i.e., Allevyn. • May increase the possibility of hypothyroidism when used in combination with lithium.
	IODOSORB OINTMENT Cadexomer Iodine 	For topical treatment of hard to heal (suspected biofilm) exuding wounds, including sloughy wounds.	• Do not use on dry necrotic tissue • Do not use when moist

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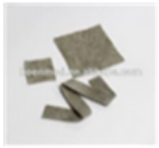
		When do I use it?	Caution
IODINE	**IODOSORB POWDER** Cadexomer Iodine	Change at least every 3 days, depending on amount of exudate. Should be changed when Iodosorb turns yellow/grey. Requires a cover dressing. Note: Dried Iodosorb can look like a scab. Soak with NS to aid in removal. If Iodosorb is drying out between dressing changes, consider choice of cover dressing or another treatment as there is not enough exudate in the wound to activate the Iodosorb.	• Wound healing principles do not apply (i.e., poor perfusion) • Do not use more than 50gm per dressing change or a maximum of 150gm per week. The duration of treatment should not exceed 3 months • Iodosorb may increase the possibility of hypothyroidism when used in combination
SILVER	**SILVERCEL ALGINATE AG** 	For wounds with moderate to large amounts of exudate and to fill empty space. Add layers for extra absorption under a foam dressing. Promotes hemostasis. May be used on infected wounds or wounds at risk of infection. Can be used under compression. Wear time will depend on the amount of exudate, typical wear time is up to 4 days. Requires a cover dressing.	• Should remain within the edges of the wound to prevent maceration • Over packing undermining or sinus tracts can lead to tissue necrosis • The “tail” will facilitate the removal of packing. • Do not use on dry or lightly exuding wounds or to control heavy bleeding
	ACTICOAT FLEX 3 & ACTICOAT FLEX 7 Nanocrystaline Siler Mesh  	For wounds with small to moderate amount of exudate. For all wound types, including burns and under NPWT. Acticoat Flex 3 can be left in place up to 3 days. Acticoat Flex 7 can be left up to 7 days. Note: Do not use with NS (suggest sterile water).	• Protect from light once opened • Do not use with oil-based products such as petrolatum or paraffin • Do no use with a known sensitivity or allergy to silver or polyester.

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Wound Product Function Summary

		When do I use it?	Caution
SILVER	**URGOTUL AG** Nanocrystaline Siler Mesh Contact Layer 	For fragile wounds with low to moderate exudate. Allows exudate to pass through to cover dressing as silver ions are released into wound bed. Requires a Cover dressing. Initially, change contact layer every 1 to 3 days may progress to leaving the contact layer in place for up to 7 days.	• Do not use with known sensitivity or allergy to ionic silver. • Do not put electrodes or conductive gels in contact with silver products.
PHMB (0.2% Polyhexamethylenebiguanide)	**AMD PHMB PACKING STRIPS**  **AMD KERLIX ROLLS** 	For wounds with signs and symptoms of local wound infection. Change at least every 3 days (as the PHMB remains effective), depending upon the amount of exudate. Note: To apply, cut to size of the wound. Apply dry. If the wound bed is dry, moisten gauze with normal saline.	• Do not use with Dakin's Solution or bleach solution as these solutions will deactivate PHMB • Do not use with ointments, creams, powders, sprays, or petrolatum-based dressings.
METHYLENE BLUE/ GENTIAN VIOLET	**HYDROFERA BLUE CLASSIC & TUNNELLING ROPE**  	Assist in the removal of devitalized tissue. Wounds with small to large amount of exudate. Can remain in place for up to 3 days. When the dressing turned white in color it indicates that the Methylene Blue/Gentian Violet has been depleted and the dressing needs to be changed. Note**:** Foam must be thoroughly moistened before using, and excess moisture squeezed out. Requires a cover dressing to maintain moisture.	• Do not allow the dressing to dry out as the firmness of the dry dressing sheet may cause a pressure injury from external pressure

LONG TERM CARE
Wound Product Function Summary

		When do I use it?	Caution
CHARCOAL	**ACTISORB AG 220 CHARCOAL** 	For malodorous wounds resulting from infection, bacterial contamination, and malignancy.	• Do not cut. Fold to size.
PROTECTIVE COVER			
ADHESIVE	**PRIMAPORE** 	Cover and protect areas to keep dry. For small to no exudate. Wear time up to 7 days.	Does not promote moist wound healing.
SUPER-ABSORBENT			
SUPER-ABSORENT	**KERRAMAX CARE** 	For absorbing and retaining high levels of exudate. Suitable for use with moderately to highly exuding pressure injuries, leg ulcers and diabetic foot ulcers. May use under compression. Can use either side of the dressing. Wear time up to 7 days.	• The dressing pad needs to overlap the edge of the wound. • Do not cut.
SKIN PROTECTANT			
LIQUID FILM & REMOVER	**NO-STING BARRIER**  	For protection of intact or damaged skin. To assist in adherence of adhesive. Provides an effective film barrier for up to 4 days when used alone or under non-adhesive dressings.	• Allow it to thoroughly dry. • Do not directly apply to open wounds.

LONG TERM CARE
Wound Product Function Summary

		When do I use it?	Caution
LIQUID FILM & REMOVER	**REMOVE** 	To assist with the removal of adhesive dressings, tapes, wafers, and hydrocolloids. Wipe off after use.	• Remove any adhesive residue with warm water or normal saline, and pat dry.
ANTISEPTIC			
2% CHG & 70% ALCOHOL	**SOLUPREP WIPE & SOLUPREP SWAB**  	May be used to achieve and maintain dry, stable eschar i.e., arterial wounds. Apply with light friction for 30 seconds and reapply every 3 days.	• Allow solution to dry for 30 seconds for dry areas and 2 minutes for moist areas.
POVIDONE IODINE	**BETADINE** 	For use on dry or open eschar to maintain an intact covering of a wound. Apply daily. Note: Discard open bottle after 30 days.	• Do not use with Santyl as iodine inactivates the enzymatic debriding effect. • Use with caution around the eye area.
WOUND CLEANSER			
WOUND CLEANSER	**BIHOCL PURECLEANSE** Hypochlorous Acid 	A non-cytotoxic, yet powerful antimicrobial cleansing solution for wounds, skin, and burns. Use in place of saline with each dressing change and cleanse wounds thoroughly.	• May alter integrity of foam dressing when gauze soaked with HCL acid remains under the foam dressing.

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		When do I use it?	Caution
WOUND CLEANSER	**NORMAL SALINE** 	Squeeze 100ml container designated (as this is the appropriate volume and therapeutic psi) for wound cleansing; hold tip of the container 10-15cm (4-6 inches) from the wound and squeeze solution over wound bed in a sweeping motion using all the solution. Use with each dressing change.	• Use caution when cleansing a wound that has sinuses and tunneling if the endpoint is of the opening is unknown. • Do not use for wounds which require a dry environment, such as wounds covered with stable, hard, dry eschar.
COMPRESSION			
LOW MODERATE COMPRESSION	**EDEMA WEAR** 	Latex-free tubular compression stocking provides mild longitudinal compression (~10-20mmHg). Stocking should be worn all day/all night and the stocking should be removed/ repositioned at least once a day. The stocking can be worn for up to one week and washed in cold water and hung to dry. Can be reused up to 6 months.	• A lower limb assessment including an APBI should be completed before compression is applied. • A prescriber's order or clinical is required to apply a compression stocking. • Do not use in the presence of uncontrolled heart failure. • Do not use in the presence of an untreated lower limb skin or wound infection.
	COBAN 2  **COBAN 2 LITE** 	Non-elastic, short-stretch compression. Can apply for up to 7 days given slippage does not occur and/or, if a wound is present, the wound exudate is managed. Note: Only health care professionals who have completed additional education for compression therapy (as per organizational policy) may apply compression wrap.	

LONG TERM CARE
Wound Product Function Summary

CONTACT LAYER

		When do I use it?	Caution
NON-ADHERENT	**ADAPTIC** Non-Adhering Sheets and Digit 	Petroleum impregnated dressing for prevention of wound bed trauma due to adherence of secondary dressing. Can be left in place for up to 7 days. Requires a cover dressing that covers the wound and at least 2 cm of peri-wound skin.	• Avoid using this product with silicone-type products as they have the same functionality. • Do not use for clients with known sensitivity or allergy to silicone.

WOUND HYDRATION

HYDROGEL	**INTRASITE GEL** Water-based Amphorous Gel 	Add/maintain moisture in wounds with necrotic tissue to enhance autolytic debridement (when moist wound healing determined to be appropriate). Cover with moisture retention dressing. Do not leave dressings in place for longer than 2 days. Single use.	• Do not use an absorptive cover dressing as gel will be absorbed into dressing. • Do not use in moist wounds. Stop use when the wound begins to produce exudate. • Do not use for dry wound healing (ie, dry stable eschar or where perfusion poor).

Provincial Wound Program
HEALTH ASSOCIATION NOVA SCOTIA

Product Information Sheets

Product Information Sheet

Actisorb Silver 220	
Classification	**Odour Control Dressing: Charcoal**
Key Points	• Activated charcoal dressing with silver, enclosed in a non-adherent nylon sleeve. • Bacteria is trapped by the activated charcoal where the silver kills bacteria. The bacterial toxins are then absorbed thereby decreasing odour. • Primary dressing requiring a secondary dressing.
Indications	• Malodourous wounds resulting from infection, bacterial contamination, and malignancy. • May be used under compression therapy.
Precautions	• Ensure etiology of odour has been determined and addressed if possible. • Has not been evaluated on pregnant/lactating individuals or neonates/infants, consult with physician/NP prior to using on these population(s).
Contraindications	• Sensitivity or allergy to silver or other components of the dressing.
Formats & Sizes	• Sheet: ○ 6.5 x 9.5 cm ○ 10.5 x 10.5 cm ○ 10.5 x 19 cm 

Directions	Rationale / Key Points
Selection	
Select size of Actisorb Silver 220 slightly larger than wound. Do not cut.	Can be folded to fit into wound. If cut, particles of activated carbon will stain wound.
For a wound with depth (more than 1 cm), choose appropriate wound filler for exudate expected and the anticipated frequency of dressing change.	Refer to Wound Packing Procedure or QR Code below.
If dressing removal is painful or traumatic to wound bed, choose a non-adherent contact layer that does not impair the action of Actisorb Silver 220 with excess ointment or grease.	Absorptive properties are most effective if in direct contact with wound bed. In most wounds, outer nylon surface enables removal without adherence or trauma to wound bed.
Choose secondary dressing based on amount of wound exudate expected and the anticipated frequency of dressing change.	
Preparation	
Cleanse wound and periwound / surrounding skin with sterile normal saline or agency approved wound cleanser.	See Wound Cleansing Procedure or QR Code below.
If an antimicrobial wound cleanser or antiseptic is used to cleanse wound, rinse wound with sterile normal saline or water.	Compatibility with antimicrobial wound cleansers and antiseptics has not been established.
Dry periwound / surrounding skin.	
If required and appropriate for secondary dressing, apply barrier film to periwound skin. Refer to Product Information Sheet for secondary dressing to determine if barrier film is appropriate.	To protect periwound skin from moisture associated skin damage and medical adhesive related skin injury. Barrier film may interfere with the function of some cover dressings, (e.g., some silicone dressings).
Application	
If wound bed is dry, moistened Acticoat Silver 220 with sterile normal saline or water prior to application.	Charcoal can be activated with wound exudate and/or sterile saline or water.

Product Information Sheet

Directions	Rationale / Key Points
If required, apply non-adherent contact layer to wound bed. For wounds with minimal depth (less than 1 cm): cover wound bed with Actisorb Silver 220. For wounds with depth (more than 1 cm) or undermining: cover wound bed with Actisorb Silver 220. Then lightly fill the dead space up to skin level with appropriate wound filler. Apply secondary dressing to cover the wound.	Absorptive properties are most effective if in direct contact with wound bed. May be folded to fit wound size. Either side of dressing may be in contact with wound bed. Use with caution in areas of undermining. Do not use in sinus tracts. Over-packing undermining can lead to tissue necrosis. Use one piece of packing whenever possible. Refer to Wound Packing Procedure or QR Code below.
Removal	
Consider using adhesive remover to remove adhesives (e.g., border dressings, tape). Gently lift the edge of the secondary dressing and remove. Remove Actisorb Silver 220.	To decrease risk of medical adhesive related skin injury (MARSI).
Frequency of Dressing Change	
May remain in place for up to 7 days.	Dressing change frequency is dependent on amount of wound exudate. May need to be changed more frequently for heavily exudating wounds.
Expected Outcomes	
Wound odour is managed. Product performs as expected.	If product does not perform as expected, notify NSWOC/Wound Clinician and then consider submitting a Supply Chain Product Concern Form.
QR Codes	
Wound Packing **Wound Cleansing**	
For further information please contact NSWOC/Wound Clinician	

Created by the British Columbia Provincial Nursing Skin & Wound Committee in collaboration with the Wound Clinicians from

Skin and Wound Product Information Sheet

Adaptic

Classification	**Layer: Petrolatum Impregnated**
Key Points	• Petrolatum impregnated cellulose acetate dressing
Indications	• For prevention of wound bed trauma by decreasing adherence of the secondary dressing
Precautions	• Avoid using this product with silicone-type products as they have the same functionality
Contraindications	• Do not use for clients with sensitivity or allergy to petrolatum • Do not use during Hyperbaric Oxygen therapy procedure
Formats & Sizes	• Sheet ▪ 7.6 x 7.6 cm ▪ 7.6 x 20.3 cm ▪ 7.6 x 40.6 cm ▪ 12.7 x 22.9 cm

Application Directions	Rationale
Cleanse/irrigate wound with sterile normal saline or agency approved wound cleanser; dry peri-wound skin.	Reduces wound debris and allows for adhesion of dressing or tape.
If required, apply skin barrier to peri-wound skin.	To protect the peri-wound skin from maceration and to improve the adhesion of the dressing or tape.
To Apply	
Adaptic can be cut to size. Choose a size that covers the wound plus at least 2 cm of peri-wound skin.	To ensure adequate adhesion to peri-wound skin.
Apply Adaptic in a single layer over the wound and smooth onto the surrounding skin to get a good seal.	Single layer allows passage of exudate through to cover dressing.
Apply appropriate cover dressing to maintain a moisture-balanced wound environment.	The choice of the cover dressing will depend upon the amount of exudate expected.
To Remove	
Carefully lift away the dressing and discard.	To avoid trauma to the wound bed.
Frequency of Dressing Change	
Will depend upon the amount of exudate. Adaptic may be left in place for up to 7 days.	
Expected Outcome	
Contact layer does not adhere to wound.	

For further information, please contact your Wound Clinician.

Skin and Wound Product Information Sheet

Allevyn Adhesive

Classification	**Cover Dressing: Foam**
Key Points	• A polyurethane foam with an outer pink side that is shower-proof, bacteria proof and prevents strike-through of exudate • Tapered bordered dressing provides for longer wear time
Indications	• For wounds with moderate amount of exudate
Precautions	• N/A
Contraindications	• Do not use for clients with known sensitivity or allergy to polyurethane • Do not use with oxidizing agents such as hypochlorite solutions (Eusol) or hydrogen peroxide • Do not use if redness or sensitivity occur
Formats & Sizes	▪ Adhesive dressing ▪ 7.5 x 7.5 cm ▪ 12.5 x 12.5 cm ▪ 12.5 x 22.5 cm ▪ 17.5 x 17.5 cm ▪ 22.5 x 22.5 cm ▪ 17 x 17 cm (sacrum) ▪ 22 x 22 cm (sacrum) 

Application Directions	Rationale
Cleanse/irrigate wound with sterile normal saline or agency approved wound cleanser; dry peri-wound skin.	Reduces wound debris and allows for adhesion of dressing or tape.
If required, apply a skin barrier to peri-wound skin.	To protect the peri-wound skin from maceration and to improve the adhesion of the dressing or tape.
To Apply	
Choose a dressing size that will ensure that the dressing extends at least 2cm beyond wound edge. Place the dressing directly over the center of the wound ensuring the white side is applied to the wound. Smooth borders onto peri-wound skin.	Incorrect sizing will adversely affect the dressing absorption functionality.
Apply directly on the wound as a primary dressing or in combination with another wound product as a secondary cover dressing.	Needs to be in contact with the wound to be most effective.
To Remove	
Gently lift the border or tape to remove the dressing.	To minimize trauma to the peri-wound skin.
Frequency of Dressing Change	
Will depend upon the amount of exudate. Change when exudate extends to within 2cm of the edge of the dressing. Can be left on up to 7 days. Sacral dressing can be left on up to 5 days.	The absorbed exudate is clearly visible through the pink backing of the dressing.
Expected Outcome	
Exudate is managed with no peri-wound skin maceration.	

For further information, please contact your Wound Clinician.

Skin and Wound Product Information Sheet

Allevyn Gentle Border Lite

Classification	**Cover Dressing: Foam with Silicone**
Key Points	• Coated with silicone adhesive layer for atraumatic dressing removal • Outer pink side is showerproof, bacteria proof and prevents strike through of drainage
Indications	• For wounds with small amount of exudate
Precautions	• N/A
Contraindications	• Do not use Allevyn Gentle dressings with oxidizing agents such as hypochlorite solutions (Eusol) or hydrogen peroxide • Do not use if redness or sensitivity occur
Formats & Sizes	▪ Adhesive border dressing ▪ 5 x 5cm ▪ 5.5 x 12 cm ▪ 7.5 x 7.5 cm ▪ 10 x 10 cm ▪ 15 x 15 cm

Application Directions	Rationale
Cleanse/irrigate wound with sterile normal saline or agency approved wound cleanser; dry peri-wound skin.	Reduces wound debris and allows for adhesion of dressing or tape
If required, apply a skin sealant to surrounding skin.	To protect the peri-wound skin from maceration and to improve the adhesion of the dressing or tape.
To Apply	
Choose a dressing size that will ensure that the dressing extends at least 2cm beyond wound edge Apply directly on the wound as a primary dressing or in combination with another wound product as a secondary dressing.	Incorrect sizing will adversely affect the dressing absorption functionality. Needs to be in contact with the wound to be most effective.
Place the dressing directly over the center of the wound ensuring the white side is applied to the wound.	
To Remove	
Gently lift the border to remove the dressing.	To minimize trauma to the peri-wound skin.
Frequency of Dressing Change	
Can be left on up to 7 days depending on the amount of exudate. Change dressing when exudate extends to within 2cm of the edge of the dressing.	The absorbed drainage is clearly visible through the pink backing of the dressing.
Expected Outcome	
Exudate is managed with no peri-wound skin maceration.	

For further information, please contact your Wound Clinician.

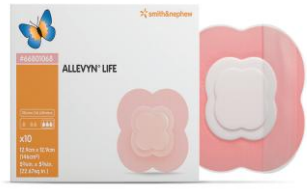
Skin and Wound Product Information Sheet

Allevyn Gentle Border

Classification	**Cover Dressing: Foam with Silicone**
Key Points	• Combines an absorbent hydrocellular pad sandwiched between a perforated silicone gel layer • Coated with silicone adhesive layer for atraumatic dressing removal • Outer pink side is shower-proof, bacteria proof and prevents strike-through of exudate • Bordered dressing provides for longer wear time
Indications	• For wounds with moderate to large amount of exudate
Precautions	• N/A
Contraindications	• Do not use with oxidizing agents such as hypochlorite solutions (Eusol) or hydrogen peroxide • Do not use if redness or sensitivity occur
Formats & Sizes	▪ Border dressing ▪ 17.5 x 17.5 cm ▪ 12.5 x 12.5 cm ▪ 7.5 x 7.5 cm ▪ 10 x 10 cm ▪ 16.8 x 17.1 cm (sacrum) ▪ Heel cup 

Application Directions	**Rationale**
Cleanse/irrigate wound with sterile normal saline or agency approved wound cleanser; dry peri-wound skin.	Reduces wound debris and allows for adhesion of dressing or tape.
If required, apply a skin barrier to peri-wound skin.	To protect the peri-wound skin from maceration and to improve the adhesion of the dressing or tape.
To Apply	
Choose a dressing size that will ensure that the dressing extends at least 2cm beyond wound edge. Apply directly on the wound as a primary dressing or in combination with another wound product as a secondary cover dressing.	Incorrect sizing will adversely affect the dressing absorption functionality. Needs to be in contact with the wound to be most effective.
Place the dressing directly over the center of the wound ensuring the white side is applied to the wound. Smooth borders onto peri-wound skin.	
To Remove	
Gently lift the border or tape to remove the dressing.	To minimize trauma to the peri-wound skin.
Frequency of Dressing Change	
Will depend upon the amount of exudate. Change when exudate extends to within 2cm of the edge of the dressing. Can be left on up to 7 days.	The absorbed exudate is clearly visible through the pink backing of the dressing
Expected Outcome	
Exudate is managed with no peri-wound skin maceration.	
For further information, please contact your Wound Clinician.	

Skin and Wound Product Information Sheet

Allevyn Life	
Classification	**Cover Dressing: Silicone Foam**
Key Points	• Multilayered dressing with a silicone adhesive contact layer, hyper-absorbent core, absorbent hydrocellular foam and a shower-proof exudate strike-proof protective top layer • Wide border and unique shape
Indications	• For wounds with moderate to large amount of exudate
Precautions	• N/A
Contraindications	• Do not use with oxidizing agents such as hypochlorite solutions (Eusol) or hydrogen peroxide • Do not use if redness or sensitivity occur
Formats & Sizes	▪ Bordered dressing ▪ 10.3 x 10.3 cm ▪ 12.9 x 12.9 cm ▪ 15.4 x 15.4 cm ▪ 21 x 21 cm ▪ 17.2 x 17.5cm(sacrum) ▪ 21.6 x 23cm(sacrum) 

Application Directions	Rationale
Cleanse/irrigate wound with sterile normal saline or agency approved wound cleanser; dry peri-wound skin.	Reduces wound debris and allows for adhesion of dressing or tape.
If required, apply a skin barrier to peri-wound skin.	To protect the peri-wound skin from maceration and to improve the adhesion of the dressing or tape.
To Apply	
Choose a dressing size that will ensure that the dressing extends at least 2cm beyond wound edge.	Incorrect sizing will adversely affect the dressing absorption functionality.
Place the dressing directly over the center of the wound ensuring the white side is applied to the wound. Apply directly on the wound as a primary dressing or in combination with another wound product as a secondary cover dressing.	 Needs to be in contact with the wound to be most effective.
To Remove	
Gently lift the border to remove the dressing.	To minimize trauma to the peri-wound skin.
Frequency of Dressing Change	
Will depend upon the amount of exudate; change when exudate extends to 75% of the foam border. Can be left on up to 7 days.	The absorbed exudate is clearly visible through the pink backing of the dressing
Expected Outcome	
Exudate is managed with no peri-wound skin maceration.	
For further information, please contact your Wound Clinician.	

ALGISITE◊ M Calcium Alginate Dressing

Natural high M-type alginate dressing[1]

Smith+Nephew

ALGISITE◊ M
Calcium Alginate Dressing

www.smith-nephew.com

Ask your pharmacist or doctor about ALGISITE

ALGISITE◊ M Calcium Alginate Dressing is a highly absorbent[2,3] dressing composed of natural high M-type materials[1]

The unique combination of fibre type and needle bonding process makes ALGISITE M Dressing different from other alginates,[1] minimising fibre shed whilst in the wound and on removal[2,4]

Features and benefits

10+

Highly absorbent

ALGISITE M Dressing forms a highly absorbent[2,3] gel on contact with wound exudate.[5] The hydrophilic fibres of ALGISITE M are capable of absorbing up to 10 times their own weight in fluid[2,9]

7 days

Up to 7 day wear time

ALGISITE M Dressing may be left in place for up to 7 days depending on the nature of the wound and level of exudate present[2]

Promotes a moist wound healing environment

The production of a gel by the action of exudate on the alginate fibres promotes a moist wound environment at the wound surface.[7] This could prevent eschar formation and promotes fast healing. The dressing allows gaseous exchange to occur,[7] which is necessary in order to maintain a healthy wound bed to promote a moist wound healing[7]

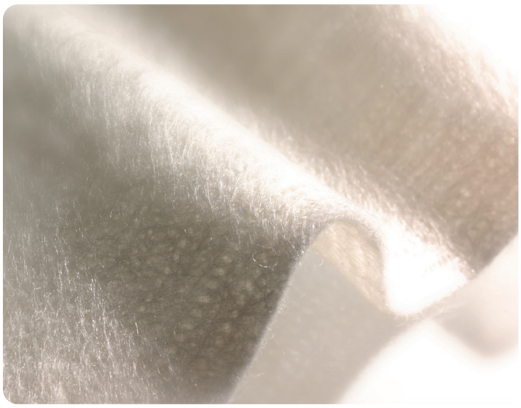
High M-type alginate

ALGISITE M Dressing is a high M-type alginate;[1] high M-type alginates have been shown to be fast gelling, softer and more elastic than G-rich alginates[8]

Indications

ALGISITE M Calcium Alginate Dressing is indicated:

- To treat pressure sores and venous leg ulcers, with moderate to heavy exudate
- To facilitate the control of minor bleeding



ALGISITE M Calcium Alginate Dressing

S+N Code	Size	Carton
66000519	5cm x 5cm	10
66000520	10cm x 10cm	10
66000521	15cm x 20cm	10
66000522	2cm x 30cm	5
66000718	10cm x 10cm	3
66000719	15cm x 15cm	3

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F +44 (0) 1482 328326

www.smith-nephew.com

For detailed product information, including indications for use, contraindications, precautions and warnings, please consult the product's applicable Instructions for Use (IFU) prior to use.

References

1. Smith+Nephew Wound Management Division. 2000. An *in-vitro* comparison of ALGISITE M versus other alginate dressings, and a hydro-fibre dressing, Aquacel™. Internal report. **2.** Thomas, S. Alginate dressings in surgery and wound management - part 1. *Journal of Wound Care*. 2000;9(2):56–60. **3.** Terrill P, Sussman G, Bailey M. Absorption of blood by moist wound healing dressings. *Primary Intention*. 2003;11(1):7–17. **4.** Angspatt A, Tanvatacharaphan P, Channasanon S, Tanodekaew S, Chokrungvaranot P, Sirimaharaj W.Comparative Study between Chitin/Polyacrylic Acid (PAA) Dressing, Lipido-Colloid Absorbent Dressing and Alginate Wound Dressing: A Pilot Study in the Treatment of PartialThickness Wound. *Journal of the Medical Association of Thailand*. 2010;93(6):694–697. **5.** Smith+Nephew 2018. Physical property testing of ALGISITE M. U/037/R2. **6.** Zachariah S. 7 day integrity testing for ALGISITE M. 2018. **7.** Yang Y, Hu H. Spacer fabric-based exuding wound dressing – Part II: Comparison with commercial wound dressings. *Textile Research Journal*. 2016;87(12):1481–1493. **8.** Clark M. Wounds International Technology Update: Rediscovering Alginate Dressings. *Wounds International* Vol 3 | Issue 2 | ©Wounds International 2012. **9.** Smith+Nephew Wound Management Division. 2000.An *in-vitro* comparison of ALGISITE M versus other alginate dressings, and a hydro-fibre dressing, Aquacel™. Internal report.

Pure, stable, and effective hypochlorous wound care solutions
proudly manufactured in Canada

BIHOCL
PURECLEANSE

Advanced care for wounds, skin, and burns

- Provides safe, effective wound irrigation
- Non-cytotoxic
- Contains no sodium hypochlorite

BIHOCL PureCleanse is a safe irrigation, moisturizing, and debridement solution formulated to actively cleanse wounds and prepare the wound bed for healing.

With no clinical contraindications for use, BIHOCL PureCleanse can be used to prepare the wound bed for healing in a safe, effective and natural way. This solution of hypochlorous acid (HOCl) acts as a preservative that inhibits microbial contamination within the solution.

Indications for Use

- Stage I-IV pressure ulcers
- Venous leg ulcers
- Diabetic ulcers
- Post-surgical wounds
- Burns
- Skin abrasions

STABLE pH

BIHOCL PureCleanse pH is maintained with high stability mimicking the body's optimal pH level to optimize the healing environment.

Visit BIHOCL.com to learn more.

BIHOCL has been tested by the National Institutes of Health (NIH) for purity and is unsurpassed in its combination of **safety**, **efficacy**, and **stability**.

Features

- A powerful combination of safety and efficacy
- Ultra-pure hypochlorous acid
- Strictly controlled pH
- Hypochlorous acts as preservative inhibiting microbial contamination within the solution
- Non-cytotoxic and no bleach or buffers
- Industry-leading product shelf life

Available Product Formats

PRODUCT CODE	APPLICATOR TYPE	BOTTLE VOLUME
33055-118DC	DISPENSING CAP	118 mL
33055-250DC	DISPENSING CAP	250 mL
33055-475DC	DISPENSING CAP	500 mL
33055-1000DC	DISPENSING CAP	1000 mL

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BIHOCL PURECLEANSE +PLUS

Instructions for Use

BIHOCL PureCleanse is used for the cleansing, irrigation, moistening and debridement of wounds, skin and burns.

1
Apply liberally to irrigate and debride wounds and peri-wound tissue.

2
To moisten a dressing, apply to the wound dressing and cover the wound bed.

Unique HOCl Technology

BIHOCL solutions are produced using innovative centrally-controlled machine learning (ML) technology. Our HOCl is produced with tight, real-time process controls that ensure adherence to pharmaceutical cGMP, Health Canada, FDA and ISO quality standards. Using patent-pending technology, and just medical-grade salt and purified water, BIHOCL products are ultra-pure, ultra stable hypochlorous solutions unsurpassed in purity, safety and efficacy.

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Created by the British Columbia Provincial Nursing Skin and Wound Committee in collaboration with the Wound Clinicians from

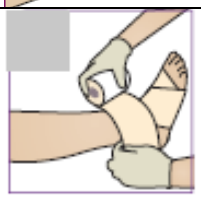
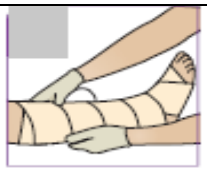
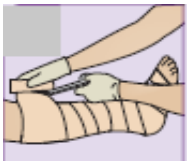
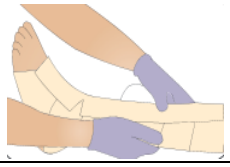
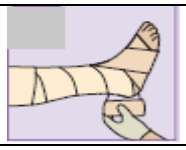
Skin and Wound Product Information Sheet

Coban 2

Classification	Compression Therapy Non-Elastic/Short-Stretch Wrap
Key Points	**For Compression Therapy in general** • A physician/NP order or clinical direction from a Wound Clinician is required to apply a compression wrap • Only health care professionals who have successfully completed additional education for compression therapy may apply compression wraps • Follow agency/Health Authority compression therapy policies/practice standard. • Refer to the Guideline: Application of Compression Therapy for further information related to indications, precautions and contraindications **For this product specifically** • A single use only, latex-free, 2-layer inelastic/short-stretch system providing high compression (30 - 40 mmHg) for up to 7 days; plus a 100% nylon stocking to for easier application of footwear
Indications	• For clients with an ABI is 0.8 or greater and requiring high compression therapy for the treatment of: ○ Venous insufficiency with or without ulcer(s) or ○ Arterial/venous insufficiency with or without ulcer(s) or ○ Lymphedema with or without ulcers(s) ○ Generalized lower limb edema
Precautions	• Compression wraps may be used: ○ Used with caution for clients whose ABI is between 0.50 and 0.89 as this value indicates moderate to mild arterial insufficiency ○ Used with caution and under an order from a Physician/NP for clients whose ABI is 1.31 or greater as this value indicates calcified arteries (often seen in clients with diabetes mellitus and/or with advanced small vessel disease) ○ Used with extreme caution and in consultation with a vascular surgeon for clients whose ABI is 0.49 or less as this value indicates severe to critical arterial insufficiency • Very thin legs and boney prominences need to be well padded to protect them from pressure • Promptly remove the wrap and notify the Physician/NP/Wound Clinician if the client develop pain or a pale, cool or numb toes or foot, or signs and symptoms of Heart Failure
Contraindications	• Do not apply in the presence of uncontrolled Heart Failure • Do not apply in the presence of an untreated lower limb skin or wound infection
Formats & Sizes	• Compression Kit 10cm ▪ Comfort Layer: 10cm x 3.5m ▪ Wrap: 10 cm x 4.5m (purple roll) ▪ Stocking • Compression Kit 15cm ▪ Comfort Layer: 15cm x 3.5m ▪ Wrap: 15cm x 4.5m (purple roll) ▪ Stocking

Application Directions	Rationale
Apply wrap in the early morning, if possible.	Edema should be minimal in the morning.
Wash or shower leg(s) with warm water using a pH-balanced skin cleanser. Moisturize intact skin with agency approved moisturizer; allow moisturizer to absorb/dry before wrapping.	To remove dead skin and resolve/prevent dry skin.
Measure the ankle circumference 10 cm from the bottom of the heel; measure the calf circumference 30 cm from the bottom of the heel.	This measurement gives a base-line assessment/re-assessment of the client's edema.
Apply an appropriate cover dressing if wound is present.	
To Apply Wrap	
Support the foot off the floor and position the foot in dorsiflexion with the calf muscle at rest.	Dorsiflexion ensures a good walking position once the wrap is on.

Skin and Wound Product Information Sheet

First Layer The foam comfort layer is to be applied with the foam side next to the skin. Do not stretch. Beginning at the fifth metatarsal head, start with a circular winding at the base of toes.	
The second circle of the comfort layer should come across the top of the foot, so that the middle of the bandage covers the articulating aspect of the ankle joint; the heel is not covered and the plantar surface of the foot does not need to be completely covered. If a small fold in the padding occurs, position the fold on either side of the Achilles Tendon.	
Proceed up the leg in a spiral wrap, minimal overlap using just enough tension to conform to the shape of the leg. Stop two finger widths below the knee. Cut off excess material and secure with tape as needed; do not apply tape to skin. Padding layer will be smoothed down when covered by the compression layer.	 
Ensure that bony prominences are adequately protected, if needed; to protect the shin area: • Cut a strip of comfort layer, the length of the toes to the knee. • Lay the piece such that it covers the top of the foot and tibial crest of the leg. • At the level of the ankle, make a slit on each side to allow the strip to conform at the ankle	To prevent undue pressure over bony prominences. 
Second Layer Apply compression layer at full stretch throughout.	
Begin with a circular wrap at the base of the toes, starting at 5th metatarsal head. The second winding should come across the foot and around the back of the heel.	
Complete two to three figures-of-eight around the ankle to ensure the entire foot/heel are covered with at least two layers.	
Proceed up the leg using spiral technique using a 50% overlap and a 100% stretch of the compression wrap.	
Stop two fingers widths below the knee**,** cut off excess material – the bandage should be even with the padding layer. Press lightly on the entire surface of the compression wrap.	To ensure the two layers adhere to each other.
The nylon stocking may be used overtop of the wrap for easier application of the client's footwear.	
To Remove Wrap	
Remove by unwrapping or by cutting the wrap with bandage scissors. If cutting, lift the bandage up from the underlying skin before cutting to avoid trauma from scissors.	Scissors will slide easily under the compression wrap if the ends of the scissors are first dipped in a moisturizer.
Frequency of Wrap Change	
Wrap can apply sustained high compression for up to 7 days given slippage does not occur and/or, if a wound is present, the wound exudate is managed.	
Expected Outcome	
Measurable improvement in the ankle and calf measurements within 1 week.	
For further information, please contact your Wound Clinician.	

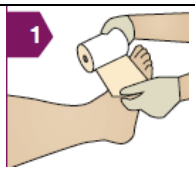
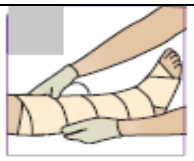
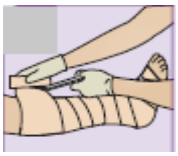
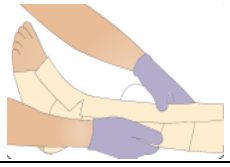
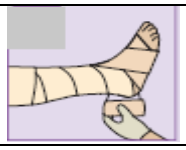
Skin and Wound Product Information Sheet

Coban 2 Lite

Classification	**Compression Therapy: Non-Elastic/Short-Stretch Wrap**
Key Points	**For Compression Therapy in general** • A physician/NP order or clinical direction from a Wound Clinician is required to apply a compression wrap • Only health care professionals who have successfully completed additional education for compression therapy may apply compression wraps • Follow agency/Health Authority compression therapy policies/practice standard. • Refer to the Guideline: Application of Compression Therapy for further information related to indications, precautions and contraindications **For this product specifically** • Single use only, latex-free, 2-layer inelastic/short stretch system providing compression (20 – 30 mmHg) for up to 7 days; plus a 100% nylon stocking to for easier application of footwear
Indications	• For clients with an ABI between 0.50 to 0.80 requiring moderate compression therapy for the treatment of: ○ Venous insufficiency with or without ulcer(s) ○ Arterial/venous insufficiency with or without ulcer(s) ○ Lymphedema with or without ulcers(s) ○ Generalized lower limb edema
Precautions	• Compression wraps may be used: ○ Used with caution for clients whose ABI is between 0.50 and 0.89 as this value indicates moderate to mild arterial insufficiency ○ Used with caution and under an order from a Physician/NP for clients whose ABI is 1.31 or greater as this value indicates calcified arteries (often seen in clients with diabetes mellitus and/or with advanced small vessel disease) ○ Used with extreme caution and in consultation with a vascular surgeon for clients whose ABI is 0.49 or less as this value indicates severe to critical arterial insufficiency • Very thin legs/bony prominences need to be well padded to protect them from pressure • Promptly remove the wrap and notify the Physician/NP/Wound Clinician if the client develop pain or a pale, cool or numb toes or foot, or signs and symptoms of Heart Failure
Contraindications	• Do not apply in the presence of uncontrolled Heart Failure • Do not apply in the presence of an untreated lower limb skin or wound infection
Formats & Sizes	• Compression Kit 10cm ▪ Comfort Layer: 10cm x 2.7m ▪ Wrap: 10 cm x 3.5m (green roll) ▪ Nylon Stocking • Compression Kit 15cm ▪ Comfort Layer: 15cm x 2.7m ▪ Wrap: 15cm x 3.5m (green roll) ▪ Nylon Stocking

Application Directions	Rationale
Apply wrap in the early morning, if possible.	Edema should be minimal in the morning
Wash or shower leg(s) with warm water using a pH-balanced skin cleanser. Moisturize intact skin with agency approved moisturizer; allow moisturizer to absorb/ dry before wrapping.	To remove dead skin and resolve/prevent dry skin.
Measure the ankle circumference 10 cm from the bottom of the heel; measure the calf circumference 30 cm from the bottom of the heel.	This measurement gives a base-line assessment/re-assessment of the client's edema
Apply an appropriate cover dressing if wound present.	
To Apply Wrap	
Support the foot off the floor and position the foot in dorsiflexion with the calf muscle at rest.	Dorsiflexion ensures a good walking position once the wrap is on.

Skin and Wound Product Information Sheet

First Layer The foam comfort layer is to be applied with the foam side next to the skin. Do not stretch. Beginning at the fifth metatarsal head, start with a circular winding at the base of toes.	
The second circle of comfort layer should come across the top of the foot, so that the middle of the bandage covers the articulating aspect of the ankle joint; the heel is not covered and the plantar surface of the foot does not need to be completely covered. If a small fold in the layer occurs, position the fold on either side of the Achilles tendon.	
Proceed up the leg in a spiral wrap, minimal overlap using just enough tension to conform to the shape of the leg. Stop two finger widths below the knee. Cut off excess material and secure with tape as needed; do not apply tape to skin. Comfort layer will be smoothed down when covered by the compression layer.	 
Ensure that bony prominences are adequately protected, if needed; to protect the shin area: • Cut a strip comfort layer the length from the toes to the knee. • Lay the piece such that it covers the top of the foot and tibial crest of the leg. • At the level of the ankle, make a slit on each side to allow the strip to conform at the ankle	To prevent undue pressure over bony prominences. 
Second Layer Apply compression layer at full stretch throughout.	
Begin with a circular wrap at the base of the toes, starting at 5th metatarsal head. The second winding should come across the foot and around the back of the heel.	
Complete two to three figures-of-eight around the ankle to ensure the entire foot/ heel are covered with at least two layers.	
Proceed up the leg using spiral technique using a 50% overlap and a 100% stretch of the compression wrap.	
Stop two fingers widths below the knee**,** cut off excess material – the bandage should be even with the padding layer. Press lightly on the entire surface of the compression wrap.	To ensure the two layers adhere to each other.
The nylon stocking may be used overtop of the wrap for easier application of the client's footwear.	
To Remove Wrap	
Remove by unwrapping or by cutting the wrap with bandage scissors. If cutting, lift the bandage up from the underlying skin before cutting to avoid trauma from scissors.	Scissors will slide easily under the compression wrap if the ends of the scissors are first dipped in a moisturizer.
Frequency of Wrap Change	
Wrap can apply sustained moderate compression for up to 7 days given slippage does not occur and/or, if a wound is present, the wound exudate is managed.	
Expected Outcome	
Measurable improvement in the ankle and calf measurements within 1 week.	
For further information, please contact your Wound Clinician.	

Product Information Sheet

EdemaWear Lower Limb Compression Application	
Classification	**Compression Therapy: Tubular Longitudinal Compression**
British Columbia Practice	• As per health authority or agency policy/or standards, prior to the first application of wrap, tubular bandage or stocking that provides 20mmHg or less compression: ○ A Lower Limb Assessment (Basic & Advanced) is to be done but an Ankle Brachial Pressure Index and/or a Toe Pressure Brachial Index is not required if pedal pulses are palpable or present with a hand-held doppler and capillary refill is normal. ○ An order is not required. • Refer to Application of Compression Therapy: Guideline for further information related to indications, precautions, and contraindications of compression therapy.
Key Points	• EdemaWear is a latex-free tubular compression stocking that provides as a single layer 15-20 mmHg (moderate) compression (the tighter the fit, the higher the compression). Compression is generated by wales of nylon fabric with transverse Lycra™ elastic fibre; the compression makes noticeable 'corn rows' which run up/down the limb. • EdemaWear Lite provides 5-10 mmHg (low) compression for clients who are unable to manage moderate compression. • Stockings are single client use and are washable and reusable for up to 4-6 months.
British Columbia Practice	• As per health authority or agency policy/or standards, prior to the first application of wrap, tubular bandage or stocking that provides 20mmHg or less compression: ○ A Lower Limb Assessment (Basic & Advanced) is to be done but an Ankle Brachial Pressure Index and/or a Toe Pressure Brachial Index is not required if pedal pulses are palpable or present with a hand-held doppler and capillary refill is normal. ○ An order is not required. • Refer to Application of Compression Therapy: Guideline for further information related to indications, precautions, and contraindications of compression therapy.
Indications	• For clients who require compression therapy for the treatment of: ○ Venous insufficiency (with or without wounds). ○ Mixed arterial / venous insufficiency (with or without wounds). ○ Lymphedema (with or without wounds). ○ Generalized edema.
Precautions	• Use the Lite version for legs with predominant boney prominences to prevent tissue damage. • Stocking should not slip down or bunched around ankles as it may cause a tourniquet effect.
Contraindications	• Do not use in the presence of uncontrolled heart failure. • Do not use in the presence of an untreated lower limb skin or wound infection.
Formats & Sizes	See table below

Stocking	Small	Medium	Large	X-Large
Regular				
Stripe colour	Navy	Yellow	Red	Aqua
Circumference	45 cm	75 cm	115 cm	150 cm
Stocking length	55 cm	86 cm	60 cm	60 cm
Use	Foot - Knee	Foot - Groin	Knee - Groin	Knee - Groin
Lite				
Stripe colour	Purple	Orange		
Circumference	60 cm	90 cm		
Stocking length	55 cm	86 cm		
Use	Foot - Knee	Foot – Groin		

Directions	Rationale / Key Points
Selection	
Prior to the client mobilizing and with the client supine, measure the circumference of the widest part of the calf or if the whole limb is to be compressed, then the thigh. Select the size of stocking based on calf or thigh measurement.	To determine appropriate size required and also provides a base-line measurement of the edema.

Product Information Sheet

Directions	Rationale / Key Points
Determine the length of stocking required by measuring from the base of the toes, following the contours of the leg, up to two finger widths below the knee or top of thigh. Cut stocking.	Compression can be applied from toes to knee or toes to thigh.
Preparation	
Wash or shower leg(s) with warm water using a pH-balanced skin cleanser. Moisturize intact skin with agency approved moisturizer; allow moisturizer to absorb/dry before putting on the stocking. Apply an appropriate cover dressing if wound present.	To remove dead skin and resolve/prevent dry skin.
Application	
Roll the stocking like a sock, apply it to the foot and then roll it up the leg. The top of the stocking should sit two finger widths below the knee or below the groin. Smooth stocking to ensure no wrinkles or creases.	Finishing the stocking two finger widths below the knee will protect the popliteal fossa from the effects of the compression.
Removal	
Remove stocking by rolling it back down the leg. The foot and leg will have 'corn row' markings from the compression; this is expected. If stocking is slipping, remove stocking: ○ Turn it inside out and reapply or ○ Cut the new stocking longer by 7.5 cm, reapply with a 7.5 cm cuff at the top of the stocking. ○ Re-measure the limb and select another size of stocking.	Reduction of edema may result in the stocking slipping. A stocking bunched around the ankle may cause a tourniquet effect. Having the outside material of the stocking next to the skin may limit the stocking from slipping.
Frequency of Application	
Stocking should be removed at night and reapplied in the morning prior to the client getting out of bed, if possible. If stocking is worn for 24hrs it is to be removed and reapplied once within the 24hrs.	Removing the stocking allows for inspection and care for the skin (washing and/or moisturizing) of the lower leg and foot. Edema in the lower legs/feet should be less in the morning if the client has had their feet up in bed for the night.
Care of Stockings	
Machine or hand wash in cold water if stocking is soiled or has lost its shape; hang to dry. Hydrogen peroxide may be to remove any blood stains, do not use bleach. Client may need two sets of stockings to allow the alternate stocking to dry after washing. Replace stocking at least every 4-6 months or when it has lost its elasticity.	Washing will help to reset the elasticity of the stocking. Bleach destroys the elasticity of the product.
Expected Outcomes	
Measurable improvement in the ankle and calf measurements within 1 week. Absence of, or minimal edema, if used for prevention/ maintenance of venous insufficiency. Product performs as expected.	If there is no measurable improvement in the amount of edema within one week, consult with Most Responsible Provider. If product does not perform as expected, notify NSWOC/ Wound Clinician and then consider submitting a Supply Chain Product Concern Form
For further information please contact NSWOC/Wound Clinician	

Skin and Wound Product Information Sheet

Hydrofera Blue Classic

Classification	**Antimicrobial: Methylene Blue/Gentian Violet Foam**
Key Points	• An absorbent polyvinyl alcohol foam (PVA) containing Methylene Blue and Gentian Violet which provides a broad-spectrum antibacterial activity effective against a variety of bacteria and yeasts • PVA foam comes as a dry, firm dressing sheet; it must be thoroughly moistened before using; it must not be allowed to dry out as the firmness of the dry dressing sheet may cause a pressure injury if external pressure is applied to the dressing area e.g. compression wrap, sitting on wound. • Choose thickness of sheet dressing based upon the amount of exudate expected for the determined dressing change frequency • Ostomy ring is a non-mouldable cut-to-fit ring which does not need to be moistened before using; film(shiny) side to be in contact with the ostomy appliance for good adhesion. • May be used with enzymatic debridement or growth factor products • Animal studies have shown gentian violet to be a potential mutagen (genotoxic). It is important to note that Hydrofera Blue Classic does not deliver medicinal substances to the skin or into the wound bed; the medicinal substances are held within the dressing.
Indications	• For wounds, first and second degree burns with moderate to large amounts of exudate which show signs and symptoms (S&S) of local wound infection
Precautions	• Do not allow the dressing to dry out • The use of the dressing should not extend beyond six months without a clinical review by Physician/NP/ NSWOC/ Wound Clinician • The use of dressing for pregnant or breastfeeding women has not been studied for safety
Contraindications	• Do not use for client with known sensitivity to ingredients • Do not use for third-degree burns
Formats & Sizes	• Thin Sheet (Standard) ▪ 5 x 5 cm ▪ 10.2 x 10,2 cm ▪ 15.2 x 15.2 cm • Thick Sheet (Heavy Drainage) ▪ 10.2 x 10.2 x 1.3 cm ▪ 15.2 x 15.2 x 1.9 cm • Tunnel Tube ▪ 9 mm x 15 cm • Ostomy Ring ▪ 6.4 cm

Application Directions	Rationale
Cleanse/irrigate wound with sterile normal saline or agency approved wound cleanser; dry peri-wound skin.	Reduces wound debris and allows for adhesion of dressing or tape.
If required, apply skin barrier to peri-wound skin.	To protect the peri-wound skin from maceration and to improve the adhesion of the dressing/ tape.
Dressing Sheet	
Dressing may be cut to fit the wound bed space if needed. Moisten the dressing with sterile saline or sterile water; if using a Heavy Drainage dressing, soak for 5-10 minutes. Squeeze out the excess using forceps or sterile gloves. Apply dressing to wound bed; if needed it may be folded or layered to fill the wound bed space. Apply appropriate cover dressing to maintain a moisture-balanced wound environment.	The dressing may cover the peri-wound skin; note that there may be mild transient staining. The entire sheet needs to be well-hydrated to ensure the dressing conform to the wound bed and holds enough moisture to prevent the dressing from drying out between dressing changes. Choice of cover dressing will depend on the amount of exudate but must ensure a moisture balance that does not allow the Hydrofera Blue dressing to dry out.
Tunnel Tube	
Moisten the one end of the tube with sterile saline or sterile	

Skin and Wound Product Information Sheet

water; squeeze out the excess using forceps or sterile gloves. Gently fill/pack the sinus tract/tunnel. If needed cut the tube but allow for at least a 2cm tail visible in the wound cavity. Moisten the exposed end with a few drops of sterile saline or sterile water. Fill the wound cavity as mentioned and apply appropriate cover dressing to maintain a moisture-balanced wound environment.	The additional 2cm is to allow for a tail. The entire tube needs to be well-hydrated to ensure the dressing conform to the sinus tract/tunnel and holds enough moisture to prevent the dressing from drying out between dressing changes. Choice of cover dressing will depend on the amount of exudate but must ensure a moisture balance that does not allow the Hydrafera Blue dressing to dry out.
Ostomy Ring	
Cleanse the wound/peri-ostomal skin with appropriate cleanser; pat the peri-ostomal skin dry. Cut the ostomy ring to fit around the ostomy. Place the film (shiny) side of the ring onto the appliance; smooth into place. Apply ostomy appliance.	The film provides a moisture-retentive covering which allows of good adhesive of the ostomy appliance.
To Remove	
Gently remove the dressing with forceps. If the dressing has adhered to the wound bed, then rehydrate it with sterile saline or sterile water and gently remove it. If the dressing adheres to the wound bed: • reassess if there is enough exudate to warrant continued use • consider a more occlusive secondary dressing • consider a light layer of hydrogel to the top surface of the dressing; gel will liquify and add moisture to the dressing	
Frequency of Dressing Change	
The initial dressing should be monitored daily to assess if the dressing has turned colour from blue to white: • if the dressing has retained its blue colour, then leave the dressing in place • if the dressing has turned white, or the blue colour has lightened, then change the dressing and continue with daily monitoring and daily dressing changes as needed until the dressing colour remains its deep blue colour. Subsequent dressing change frequency will depend upon the amount of exudate expected. Depending upon the amount of exudate; the Classic dressing can remain in place for up to 3 days. For ostomies, change the appliance as needed; reapply the ostomy ring dressing as needed.	When the dressing turned white in colour it indicates that the Methylene Blue/Gentian Violet has been depleted and the dressing needs to be changed.
Expected Outcome	
Exudate is managed with no peri-wound skin maceration. S&S of local wound or peristomal skin infection are resolved within 2 weeks.	
For further information, please contact your NSWOC/Wound Clinicians.	

Product Information Sheet

Inadine	
Classification	**Antimicrobial Agent: Iodine – Povidone Impregnated**
Key Points	• Non-adherent viscose sheet impregnated with a polyethylene glycol base containing 10% povidone iodine (equivalent to 1% available iodine). • Provides protection to wound bed by minimizing adherence of secondary dressing. • Provides an antiseptic effect. • A primary dressing requiring a secondary dressing.
Indications	• Shallow wounds (less than 1 cm depth). • Maintenance / non-healing wounds. • Treatment of wounds with signs and symptoms of local infection. See Wound Infection Quick Reference Guide or QR Code below. • In combination with systemic antibiotics, to treat wounds with signs and symptoms of spreading infection or systemic infection. • Prophylactically to prevent infection in clients at high risk for developing a wound infection. • Suitable for use in adults and children.

Precautions	• Neonates and infants to the age of 6 months as povidone iodine may be absorbed through unbroken skin
	• Make Physician/NP aware of Inadine usage for clients:
	  ◦ Taking lithium as Inadine may increase the possibility of hypothyroidism when used in combination with lithium. Blood work should be monitored on a regular basis.
	  ◦ With renal impairment, as poor renal function is thought to be a factor in increased iodine levels in serum and urine with prolonged use and use in large wounds.
	  ◦ With thyroid disorders as they are more susceptible to thyroid metabolism changes in long-term therapy. Thyroid function should be monitored if large areas are being treated for a prolonged period of time.

Contraindications	• Sensitivity or allergy to iodine or other components of dressing. • Do not use in wounds with depth (more than 1 cm), undermining or sinus tracts. • Pregnant or breast-feeding individuals. • Duhring's herpetiform dermatitis (a specific skin disease).

Formats & Sizes	• Sheet
	  ◦ 5 x 5 cm
	  ◦ 9.5 x 9.5 cm
	 

Directions	Rationale / Key Points
Selection	
Select size of Inadine that is slightly larger than wound. If necessary, Inadine can be cut or folded to fit wound bed. Choose appropriate secondary dressing.	Easier to cut with one or two backing papers in place. The choice of secondary dressing is dependent on the amount of wound exudate expected and the frequency of dressing change.
Preparation	
Cleanse wound and periwound / surrounding skin with sterile normal saline or agency approved wound cleanser. Dry periwound / surrounding skin. If required and appropriate for cover dressing, apply barrier film to periwound skin. Refer to Product Information Sheet for cover dressing to determine if barrier film is appropriate.	See Wound Cleansing Procedure or QR Code below. To protect periwound skin from moisture associated skin damage and medical adhesive related skin injury. Barrier film may interfere with the function of some cover dressings, (e.g., some silicone dressings).

Product Information Sheet

Application	
Remove one backing paper. Peel dressing off of remaining backing paper.	Do not apply to wound with backing paper in place.
For wounds with minimal depth (less than 1 cm): cover wound bed with single layer of Inadine. Apply secondary dressing.	Applying more than one layer may block exudate from going up to the secondary dressing causing periwound maceration. Do not use in wounds with depth (more than 1 cm), undermining or sinus tracts.
Removal	
Consider using adhesive remover to assist with removal of secondary dressing. Gently lift the edge of the secondary dressing and remove. Gently lift the edge of Inadine and remove from wound bed.	To decrease the risk of medical adhesive related skin injury (MARSI). Removal may be helped by gentle stretching of dressing at diagonally opposite corners.
Frequency of Dressing Change	
Can be left in place up to 7 days and may be changed up to twice a day. The dressing changes colour from orange to white as the Povidone Iodine is used up.  	Dressing change frequency depends on amount of exudate. When Inadine turns white this indicates loss of antiseptic efficacy.
Expected Outcomes	
Wound infection resolved in 14 days. If using prophylactically, no wound infection develops. Inadine and secondary dressing do not adhere to wound bed. Product performs as expected.	If product does not perform as expected notify NSWOC/Wound Clinician and consider submitting a Supply Chain Product Concern Form.
QR Codes	
Wound Packing	**Wound Cleansing**
Wound Infection	
For further information please contact: NSWOC/Wound Clinician	

Created by the British Columbia Provincial Nursing Skin and Wound Committee in collaboration with the Wound Clinicians from

Skin and Wound Product Information Sheet

Intrasite Gel

Classification	**Hydrogel: Amorphous Gel**
Key Points	• Water based amorphous gel
Indications	▪ To add/maintain moisture in wounds with necrotic tissue to enhance autolytic debridement ▪ To maintain moisture balance in wounds that are healing
Precautions	▪ Do not use an absorptive cover dressing as gel will be absorbed into dressing
Contraindications	▪ Do not use for moderate to heavily exudating wounds
Formats & Sizes	▪ Applipak ▪ 8 g ▪ 15 g ▪ 25 g 

Application Directions	Rationale
Cleanse/irrigate wound with sterile normal saline or agency approved wound cleanser; dry peri-wound skin.	Reduces wound debris and allows for adhesion of dressing or tape.
Apply skin barrier to peri-wound ski.	Will help prevent peri-wound maceration.
To Apply	
Write name of client and date opened on the container.	Product is single-patient use only. Discard container once it has been opened for week.
Use the orange cap to snap the white tip off of the applipak's nozzle Discard the white tip. When finished, re-seal the container by securely re-applying the orange cap.	The cap must remain on the container to ensure cleanliness of the product. Product found without a cap must be discarded.
For shallow wounds: apply a thin 3mm layer of Intrasite gel to the wound bed using a sterile Q-tip. For cavity wounds: moisten gauze with normal saline, wring out well, then moisten the gauze with Intrasite gel. Line the wound cavity with the prepared gauze. For wounds with undermining or sinus tract: moisten one (where possible) gauze packing strip with normal saline, wring out well, then moisten the packing strip with Intrasite gel. Lightly fill undermining or sinus tract with the prepared strip. Leave a tail of the ribbon so that it can easily be seen.	Excess gel can cause peri-wound maceration Dry gauze will absorb the gel leaving the wound bed to dry out. The gel will help keep the gauze moist so it does not adhere to the wound. Over packing undermining or sinus tracts can lead to tissue necrosis. The tail will facilitate the removal of packing.
Cover with an appropriate cover dressing.	The choice of cover dressing is depended upon the amount of exudate expected.
To Remove	
Flush/irrigate wound with normal saline.	Intrasite Gel is water soluable, non-adherent and easily removed without harming fragile tissue.
Frequency of Dressing Change	
Will depend upon the amount of exudate. For necrotic wounds, do not leave dressings in place for longer than 2 days.	
Expected Outcome	
Measureable improvement in the size of the wound within 3 weeks.	

For further information, please contact your Wound Clinician.

Skin and Wound Product Information Sheet

Iodosorb

Category	Antimicrobial Agent: Iodine - Cadexomer
Key Points	• Broad spectrum, iodine-based, topical antimicrobial containing cadexomer (modified starch microbeads) and iodine (0.9%). In addition, the paste contains polyethylene glycol and the ointment contains poloxamer and polyethylene glycol. • Cadexomer iodine absorbs exudate, debris and bacteria as the beads swell, iodine is released, providing antimicrobial activity for up to 72 hours. • Disrupts and substantially eradicates mature biofilms. Effective deslougher. • Available in ointment, paste or powder. All formats are brown in colour and biodegradable. • Changes colour from brown to yellow/grey as iodine is released. • Safe to use for clients who have a seafood allergy.

Indications	• For the topical treatment of chronic exuding wounds.
	• For sloughy wounds with signs and symptoms (S&S) of local infection or suspected biofilm.
	  • Use ointment or paste for wounds with small to moderate exudate.
	  • Use powder for wounds with moderate to large amount of exudate.
	• May be used prophylactically to prevent infection in clients at high risk for developing a wound infection.
	• Under the direction of a NSWOC/Wound clinician, the ointment may be used for undermining and/or sinus/tunnel.
	• May be used under compression therapy.

Precautions	• Do not use more than 50gm per dressing change or a maximum of 150gm per week.
	• The duration of treatment should not exceed 3 months.
	• May cause wound discomfort within the first hour of application, which is a sign that the product is beginning to clean the wound.
	• Contact with skin around the wound edges/intact skin should be minimized.
	• May cause the immediate periwound skin to become edematous and red. This should resolve within the first few dressing changes; if not, discontinue use.
	• When used under the direction of a NSWOC/Wound Clinician for undermining and/or sinus/tunnel ensure that the ointment is completely removed from these non-visible spaces.
	• Avoid using before and after radio-iodine diagnostic tests.
	• Make Physician/NP aware of Iodosorb usage for clients:
	  ○ Taking lithium, as Iodosorb may increase the possibility of hypothyroidism when used in combination with lithium. Blood work should be monitored on a regular basis.
	  ○ With renal impairment, as poor renal function is thought to be a factor in increased iodine levels in serum and urine with prolonged use and use in large wounds.
	  ○ With thyroid disorders, as they are more susceptible to thyroid metabolism changes in long-term therapy. Thyroid function should be monitored if large areas are being treated for a prolonged period of time.

Contraindications	• Do not use on clients with known sensitivity or allergy to iodine or other ingredients. • Do not use on dry necrotic tissue. • Do not use on a client who is breast-feeding or pregnant. • Do not use on children between 0-18 years old. • Do not use in combination with mercurial antiseptics (e.g., mercurochrome) or with taurolidine. • Do not use near the ears, eyes, nose and mouth.

Formats & Sizes	• Ointment: 10, 20 or 40 gm
	• Paste
	  ▪ 4 x 6 cm (5 g)
	  ▪ 6 x 8 cm (10 g)
	  ▪ 8 x 10 cm (17 g)
	• Powder – 3 g sachet
	 

Skin and Wound Product Information Sheet

Application Directions	Rationale
Cleanse/irrigate wound with sterile normal saline or agency approved wound cleanser; dry peri-wound skin. Blot excess fluid from but **do not dry** the wound bed.	Reduces wound debris and allows for adhesion of dressing or tape. Iodosorb requires moisture to be effective.
If required, apply barrier film to peri-wound skin.	To protect the peri-wound skin from maceration and to improve the adhesion of the dressing or tape.
To Apply	
Ointment: Ensure sterility of the tip of the tube. Apply 3mm thick layer of ointment to cover dressing, wound filler (e.g., plain gauze or gelling fibre), or directly to the wound bed. If applied to cover dressing ensure that it mirrors the size of the wound (not larger).	Apply only to wound bed to decrease peri-wound skin irritation and discoloration.
Packing of wounds: Using a sterile tongue depressor or sterile gloves, thinly spread/massage the ointment onto one piece of plain ribbon gauze (if two or more pieces are needed then tie them together) or plain gelling fibre. Lightly fill/pack area with the gauze/gelling fibre. Leave a tail of the ribbon so that it can easily be seen and removed.	Over-packing undermining or sinus tracts can lead to tissue necrosis. The tail will facilitate the removal of packing.
Paste: Cut to the size of wound bed then remove the backing from one side, place Iodosorb on the wound and then remove the second backing. Can be molded to fit the wound. Minimize contact with periwound skin.	Backing pieces must be removed to allow the paste to be in direct contact with the wound bed and the cover dressing.
Powder: Cut or tear off corner of sachet. Apply the powder to a depth of 3mm ensuring that all areas of the wound bed are covered. Apply wound filler if wound has depth. Minimize contact with periwound skin.	Apply only to wound bed to decrease peri-wound skin irritation and discoloration.
Apply appropriate cover dressing to maintain a moisture-balanced wound environment.	The choice of cover dressing depends on the amount of exudate expected.
To Remove	
Gently cleanse the wound and the periwound skin to remove any remaining ointment, paste or powder which will have turned into gel; gauze or cotton tipped applicator may be needed. If the Iodosorb has dried, soak with normal saline to aid removal. For undermining/sinus/tunnel: Remove the packing and irrigate the area repeatedly to ensure that no ointment residue is left in the non-visible spaces.	Dried Iodosorb can look like a 'scab'. If Iodosorb is drying out between dressing changes consider choice of cover dressing or another treatment as there is not enough exudate in the wound to activate the Iodosorb.
Frequency of Dressing Change	
At least every 3 days, but depends on amount of exudate. Iodosorb should be changed when it becomes saturated with exudate as indicated by the change from its brown colour to yellow/grey (usually 2-3 days).	If the Iodosorb is still brown in colour when dressing is changed; the dressing is being changed too soon, or the cover dressing is not maintaining a moist wound environment or it is not the appropriate product.
Expected Outcome	
S&S of local wound infection are resolved within 2 weeks. Wound infection does not occur when product is used prophylactically.	If the expected outcome is not achieved, consult with NSWOC/Wound Clinician.
For further information, please contact NSWOC/Wound Clinician.	

QUICKGUIDE

3M™ Kerramax Care™ Super-Absorbent Dressings

Wounds INTERNATIONAL

Challenges of excess exudate

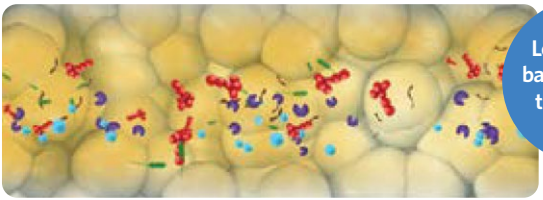
Highly exuding wounds are demanding for both clinician and patient. Excess fluid can lead to[1]:

- Difficulties achieving an optimum moisture balance
- Leakage, which is uncomfortable and can be odourous
- Maceration of wound edges and surrounding skin

Bacteria and matrix metalloproteinases (MMPs) in excess fluid can be an impediment to wound healing[1].

Solutions for managing excess exudate

3M™ Kerramax Care™ Super-Absorbent Dressings with advanced **3M™ Exu-Safe™ Technology** has a unique lateral wicking system and ability to reduce MMPs[2*] and sequester bacteria such as methicillin-resistant *Staphylococcus aureus* (MRSA) and *Pseudomonas aeruginosa*[3,4].



Locks away bacteria from the wound bed[4]

Kerramax Care Dressings are designed to manage high to very high levels of exudate:

- Can be used as either a primary or secondary dressing
- Can be folded or shaped to assist patient comfort[5]
- Can be used on either side for easy application
- Can be left in place for 7 days
- Available in a wide range of shapes and sizes, including a 20x50cm that can be wrapped around the leg easily underneath bandaging[6]
- Suitable for use under all forms of compression[6]

*as demonstrated *in vitro*

High absorption and protection for patients

Whether exudate is serous or viscous, the combination of a unique horizontal wicking and **3M™ Exu-Safe™ Technology** ensures high fluid absorption and retention[5], even under compression[3,6*].

3M™ Kerramax Care™ Super-Absorbent Dressings locks away:

- **Fluid**, which can cause maceration if left unmanaged[5]
- **Bacteria**, which reduces the risk of wound infection[3,4]
- **Harmful components of chronic wound fluid** that contribute to delayed healing and wound edge breakdown, such as MMPs[2].

1. Horizontal wicking system

2. High fluid absorption and retention capacity

3. Heat-sealed border, to prevent exudate leakage from the dressing[6*] and keep the dressing strong and intact

Patient experience: patient comfort

A positive patient experience can lead to reduced stress and anxiety when dealing with chronic wounds, this in turn can reduce pain and improve patient concordance with treatment[5].

In a patient study of managing highly exuding wounds in the community, **3M™ Kerramax Care™ Super-Absorbent Dressings** were evaluated for patient experience based on comfort. A total of 101 patient evaluations were completed across a range of wound aetiologies.

71% of patient evaluations scored the dressing between 8–10 compared to their previous treatment[5] (0: worse; 5: similar; 10: better)

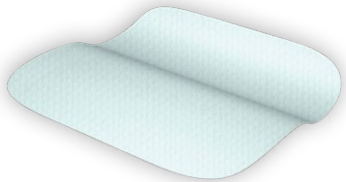
98% of clinician evaluations stated they would use Kerramax Care Dressings as their first choice[5] for the management of highly exuding wounds[5]

Where Kerramax Care sits on the 3M™ exudate management continuum

Dry to low

3M™ Kerralite Cool™ Moisture Balancing Hydrogel Dressings

Absorbent, moisture balancing hydrogel sheet dressing



Low to moderate

3M™ Tegaderm™ Absorbent Clear Acrylic Dressing

Conformable, absorbent clear dressing

Moderate to high

3M™ Tegaderm™ Silicone Foam Border Dressing

Silicone foam dressing with advanced adhesive technology

3M™ Kerracel™ Gelling Fiber Dressing

Conformable, gelling fiber dressing

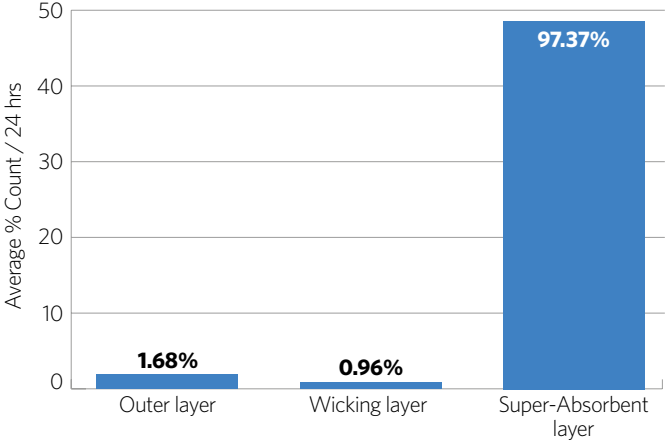
High to very high

3M™ Kerramax Care™ Super-Absorbent Dressings

Where does sequestered bacteria and MMPs reside within the dressing?

In vitro studies[3,7]* demonstrate that 3M™ Kerramax Care™ Super-Absorbent Dressings lock away bacteria within the Super-absorbent core with Exu-Safe Technology dressing core away from the outer layers in direct contact with the wound bed.

Bacterial sequestration distribution of MRSA* in Kerramax Care Dressings[3]*



98.33% of MRSA

Kerramax Care Dressings are superior in their ability to retain bacteria within the dressing compared with other super-absorbent dressings and gauze[7]*. 98.33% of MRSA was locked inside the dressing and away from the wound[3]*.

100% of MMPs

Kerramax Care Dressings retained 100% of MMP2 or MMP9 after four days compared to gauze and other super-absorbent dressings[8]*.

*as demonstrated *in vitro*

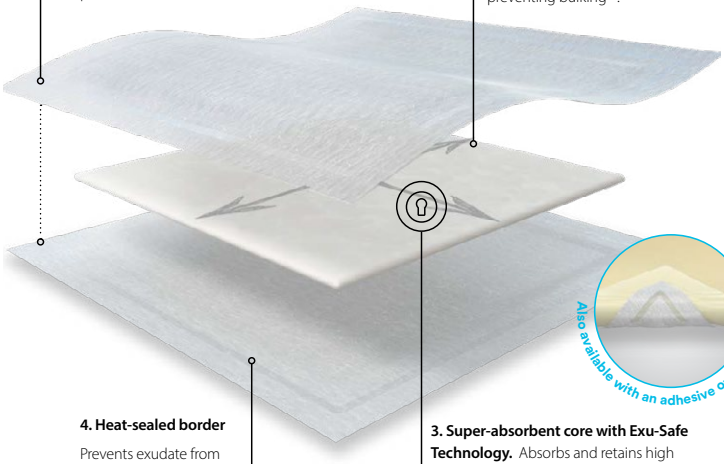
3M™ Kerramax Care™ Super-Absorbent Dressings

1. Soft, non-woven material

On both sides of the dressing, so either side can be placed on the wound whilst being comfortable for the patient[5] helping support patient compliance.

2. Unique, horizontal wicking layer

Draws up serous and viscose exudate[5], distributing it evenly, both horizontally and vertically throughout the dressing, utilising the full absorption capacity whilst preventing bulking[6,9].



4. Heat-sealed border

Prevents exudate from leaking[6*].

3. Super-absorbent core with Exu-Safe Technology. Absorbs and retains high levels of exudate and potentially harmful bacteria[4*] and MMPs[2*] away from the wound bed to facilitate healing and reduce the risk of maceration.

*as demonstrated *in vitro*

1. World Union of Wound Healing Societies (WUWHS) *Consensus Document. Wound exudate: effective assessment and management.* Wounds International, 2019. Available at https://www.woundsinternational.com/resources/details/wuwhs-consensus-document-wound-exudate-effective-assessment-and-management (accessed 16.06.21).
2. Dr. Cochrane, C.A. Evaluation of matrix metalloproteinases by wound care products. University of Liverpool, UK. July 2011.
3. Cooper, R. *An investigation into the ability of Kerramax Care™ and Kerrafoam™ to bind bacteria.* Cardiff Metropolitan University. September 2013.
4. Thomas H, Westgate SJ. *An in vitro comparison of MRSA and P. aeruginosa sequestration by five super-absorbent wound dressings.* Poster presented at EWMA, 11-13 May 2016; Bremen, Germany.
5. Hughes M. A large-scale evaluation of managing moderate and highly exuding wounds in the community. *Wounds UK* 2017;13(3): 78-85.
6. Cotton S. *The management of a chronic leg ulcer using Kerramax Care™ Super-Absorbent Dressing under compression.* Poster presented at Wounds UK; November 2015; Harrogate, UK.
7. Singh G, Thomason H. *Sequestration and retention of bacteria by superabsorbent dressings over time.* KCI. CHC R1043 (in vitro). University of Manchester & KCI Knutsford, UK. 2020.
8. Singh G, Thomason H. *Sequestration of matrix metalloproteinases (MMPs) by superabsorbent wound dressings.* KCI. CHC R1042 (in vitro). University of Manchester & KCI Knutsford, UK. 2020.
9. Rose R. *A large clinical evaluation assessing the tolerance & effectiveness of super-absorbent dressing, Kerramax Care™.* Poster presented at Wounds UK; November 2015; Harrogate, UK.

Skin and Wound Product Information Sheet

No-Sting Skin Prep

Classification	**Skin Barrier: Film**
Key Points	• Liquid protective film; provides transparent, waterproof, breathable protective layer • Alcohol-free, latex-free, fragrance-free, preservative-free
Indications	• For protection of intact or damaged skin from wound exudate, ostomy drainage, incontinent episodes; tube/drain drainage, adhesive-type dressings and friction • For sealing ostomy or medicated powders to skin surface(crusting application)
Precautions	• Product is flammable until dry • Keep out of reach of children • Avoid contact with eyes • If redness or other signs of irritation appear discontinue use
Contraindications	• Do not use for clients with known sensitive to any of the ingredients • Do not apply directly to any open wounds • Do not use for premature infants or infants younger than one month old • Do not use with Molnlycke silicone dressings
Formats & Sizes	• Wipe ▪ 1 ml • Swab stick ▪ 3 ml • Spray bottle ▪ 28 ml

Application Directions	Rationale
When using the Spray Bottle product, label with client name and date of opening. Skin should be clean and dry prior to application.	Product is single client use and may be used up until its expiry date.
To Apply	
Apply a single uniform coating of No-Sting Skin Prep over the entire area of concern. If a section of the area is missed or a second application is required, then reapply only when the first application has thoroughly dried (30 seconds).	If not allowed to dry, the barrier film will not 'set-up' properly.
If applied to an area with skin folds or other skin to skin contact, ensure that areas are kept separated until the film has dried.	If skin surface touch each other before drying the fold/area will stick together.
Allow film to thoroughly dry (30 seconds) before applying tape, dressing or device.	
To Remove	
Removal of the film is not necessary prior to reapplication.	Removal of the film is not necessary unless build-up occurs (white flakey, dry areas where film has been applied) use an adhesive remover if this occurs.
Frequency of Reapplication	
Provides an effective film barrier for up to 4 days when used alone or under non-adhesive dressings. When used under adhesive dressings, reapplication is necessary each time the dressing is changed as the film can be removed by the adhesive. For Incontinent Associated Dermatitis: when used for protection or used with non-adhesive products, reapplication is recommended: • every 24 -96 hours, depending on frequency of cleansing • every 12-24 hours, may be necessary for extreme cases; e.g., constant diarrhea. Removal of the film barrier is not required prior to reapplication.	

Skin and Wound Product Information Sheet

Crusting Application	
Apply a dusting of ostomy or medicated powder to area of concern. Spray or dab (using wipe) No-Sting Skin Prep over the powder and allow to dry.	Powder will adhere to moist areas. The film will seal in the powder and act as a cover dressing.
If the area is weepy, repeat application of powder and film to a maximum of 3 times; allow for the film to dry between applications.	
For further information, please contact your Wound Clinician.	

Skin and Wound Product Information Sheet

PHMB Gauze for Wounds
(AMD Gauze)

Classification	**Antimicrobial: Polyhexamethylene Biquanide (PHMB)**
Key Points	• Antimicrobial gauze dressings impregnated with 0.2% PHMB; ionically attracts bacteria into the dressing where they are then killed. • Effective against gram negative bacterial, gram-positive bacteria (MRSA, VRE, Pseudomonas), fungi and yeast. • PHMB woven gauze sponges, gauze bandage rolls and gauze sponges have an open cell matrix and appropriate to use with negative pressure wound therapy. • PHMB gauze sponges, rolls and packing ribbons are not radiopaque. • A fenestrated gauze version is available for use around tubes. • May be left in place for up to 3 days depending upon the amount of exudate. • If required, may be used with a silicone mesh contact layer as the openings in the mesh allows the PHMB to work.
Indications	• For wounds with signs and symptoms (S&S) of local wound infection. • May be used prophylactically to prevent infection in clients at high risk for developing a wound infection. • Safe to use on all ages including neonates.
Precautions	• N/A
Contraindications	• Do not use for clients with known sensitivity or allergy to PHMB. • Do not use with Dakin's Solution or bleach solutions as these solutions will deactivate PHMB. • Do not use with ointments, creams, powders, sprays, or petrolatum-based dressings, such as Adaptic, as they create a barrier and prevent the PHMB from attracting/killing bacteria.
Formats & Sizes	• Gauze Packing Strips ▪ 0.63 x 91.4 cm ▪ 1.27 x 91.4 cm ▪ 2.51 x 91.4 cm • Gauze Dressing Rolls ▪ 11.4 x 411.5 cm • Gauze Sponges (woven) ▪ 5.1 x 5.1 cm (2 in peel back package) ▪ 10.1 x 10.1 cm (2 in peel back package) ▪ 10.1x10.1 cm (10 in peel back package) • Super Sponges ▪ 15.2 x 17.1 cm (2 in soft pouch package) ▪ 15.2 x 17.1 cm (5 in soft pouch package) ▪ 15.2 x 17.1 cm (10 in soft pouch package)

Application Directions	Rationale
Cleanse/irrigate wound with sterile normal saline or agency approved wound cleanser; dry peri-wound skin	Reduces wound debris and allows for adhesion of dressing or tape.
If required, apply skin barrier to peri-wound skin.	To protect the peri-wound skin from maceration and to improve the adhesion of the dressing or tape.
To Apply	
Cut the gauze sponges to size of the wound, if needed. Apply dry. If the wound bed is dry, moisten the sponges with sterile normal saline or hydrogel. For packing: if using a packing strip, use the most appropriate width (e.g., 0.63 cm (¼ in) or 1.27 cm (½ in)) for the area that is to be packed. Do not cut the strip to make a smaller width. Lightly pack one piece of packing strip or gauze sponge into cavity, undermining or sinus/tunnel. If more that one packing	Dressing on peri-wound skin may cause maceration. Must be applied directly to the wound. The use of barriers will prevent the PHMB from killing bacteria. Over-packing undermining or sinus tracts can lead to tissue necrosis. Tying the packing pieces together will ensure all of the packing pieces are removed. The tail will facilitate the removal of packing.

Skin and Wound Product Information Sheet

strip or sponge is needed, tie the pieces together using sterile gloves. Leave a tail of the packing so that it can easily be seen. Tail may be secured to the peri-wound skin with tape/steri-strip. For Negative Pressure Wound Therapy, use the woven gauze and moisten the gauze with normal saline.	Cutting the packing strip into a smaller width will cause fraying which can lead to fabric being left in the wound.
Apply appropriate cover dressing to maintain a moisture-balanced wound environment.	Choice of cover dressing is based on the amount of exudate expected.
To Remove	
Using forceps, gently remove the dressing from the wound bed. If dressing adheres to the wound bed flush the wound with normal saline or water to loosen dressing.	To minimize trauma to the wound bed.
Frequency of Dressing Change	
Change the PHMB gauze/packing at least every 3 days as the PHMB remains effective for up to 3 days depending upon the amount of exudate. Wounds with moderate-large amounts of exudate will require more frequent dressing changes.	
Expected Outcome	
S&S of local wound infection are resolved within 2 weeks. If used prophylactically, a wound infection does not occur.	
For further information, please contact your Wound Clinician.	

Skin and Wound Product Information Sheet

Povidone Iodine 10% for Wound Care

Classification	**Antiseptic**
Key Points	• Antiseptic solution with a long germicidal activity.
Indications	• An antiseptic solution used on dry eschar to maintain an intact covering of a wound where the goal of healing has been determined by a Wound Clinician/physician/NP as Non-Healable or Maintenance.

Precautions	• Use with caution around the eye area.
	• Use with caution for clients who is pregnant or breast feeding.
	• Use with caution for neonates.
	• Avoid using before and after radio-iodine diagnostic tests.
	• Make Physician/NP aware of Iodine usage for clients:
	  ○ Taking lithium, as Iodine may increase the possibility of hypothyroidism when used in combination with lithium. Blood work should be monitored on a regular basis.
	  ○ With renal impairment, as poor renal function is thought to be a factor in increased iodine levels in serum and urine with prolonged use and use in large wounds
	  ○ With thyroid disorders, as they are more susceptible to thyroid metabolism changes in long-term therapy. Thyroid function should be monitored if large areas are being treated for a prolonged period of time.

Contraindications	• Do not use for clients with known sensitivity to iodine. • Do not use with any silver products as iodine inactivates the silver. • Do not use with Santyl as iodine inactivates the enzymatic debriding effect. • Do not use for a prolonged period of time for clients with thyroid disorder or who are on Lithium therapy. • Do not use on irritated or broken skin. • Do not use under an occlusive dressing. • Do not use for premature neonates or neonates weighting < 1.5kg.
Formats & Sizes	• Wipe • Stick • Bottle  

Application Directions	Rationale
Apply solution to the entire area of a clean, dry, eschared wound and 2.5 cm of the peri-wound skin. Allow to dry.	If using a bottle, bottle must be client-single use. Labeled with the client's name and the date the bottle. Discard open bottle after 30 days. Thorough "painting" of the eschar area and the surrounding skin will decrease the chances of infection and help to maintain the eschar coving by keeping it dry.
If cover dressing is required for protection, choose a gauze-like dressing.	Gauze-like dressings will assist in keeping the echared area dry.
Frequency of Application	
Reapply if/as needed.	
Expected Outcome	
Eschar area will remain dry.	

For further information, please contact your NSWOC/ Wound Clinician.

Developed by the BC Provincial Nursing Skin & Wound Committee in collaboration with Wound Clinicians from:

Title	**Procedure: Wound Cleansing**
Practice Level	• Nurses in accordance with health authority/agency policy.
Background	• Wound cleansing and irrigation are defined as the application of fluid to a wound to remove exudate, slough, necrotic debris, bacterial contaminants and dressing residue without adversely impacting cellular activity vital to the wound healing process, or inoculating the underlying tissue with bacteria. Pressures between 8 and 15 psi are sufficient to cleanse or irrigate a wound. • Wound cleansing is conducted with at least 100ml of sterile normal saline (NS) or sterile water container. The type of wound cleansing solution to be used is based on the presence of undermining, sinus tracts or tunnels, necrotic slough and/or local wound infection. • Undermining, sinuses and tunnels can only be irrigated when there is a known endpoint**. Undermining, sinuses or tunnels which extend beyond 15cm (6 inches) are not to be irrigated unless directed by a Physician/NP**. Cotton tipped applicator or metal probe is 15cm. • Wound cleansing solution should be non-toxic to human tissue, remain effective in the presence of organic material, reduce the number of microorganisms in the wound, avoid sensitivity reactions, be widely available, and cost effective. • Sterile NS and sterile water are the solutions of choice for cleansing wounds and should be at least room temperature (20° C) in order to support wound healing. Containers and bottles of sterile NS and sterile water must be client specific and be discarded after 24 hours. • If fluid is instilled into a sinus, tunnel, or undermined area and cannot be removed from the area, stop irrigating and refer to a Wound Clinician or Physician/NP. • If commercially prepared sterile NS is not available then home prepared NS can be substituted (see Appendix A for procedure). • Use of potable tap water for wound cleansing is acceptable in some situations, and should be based on agency guidelines and/or direction from a Wound Clinician. • Showering may be appropriate in some situations and is preferable to tub bathing; however the decision to shower or bath should be based on agency guidelines or direction from a Wound Clinician or Physician/NP. • Do not use commercial saline-based wound cleansers or potable water to irrigate undermining, sinus tracts or tunnels. However, commercial antiseptic/antimicrobial wound cleansers may be used on the recommendation of a Wound Clinician or Physician/NP. • For wounds in which the local bacterial burden is of greater current concern than healing, antiseptic solutions such as povidone iodine or chlorhexidine may be used for cleansing based on the recommendation of a Wound Clinician or Physician/NP. Many topical antiseptic solutions are cytotoxic and will delay wound healing so should only be used until the signs and symptoms of bioburden or local wound infection are resolved.
Indications / Precautions/ Contra-indications	**Indications for wound cleansing** • Wounds which are undergoing moist wound healing. **Precautions when cleansing a wound** • Undermining, sinuses and tunnelling **can only be irrigated when there is a known endpoint**. • Commercial non-antimicrobial wound cleansers or potable water should not be used to cleanse wounds with undermining, sinuses, or tunnels. **Contraindications for wound cleansing** • Wounds which require a dry, stable environment, such as wounds covered with stable, hard, dry eschar or dry gangrene. • **Wounds with an endpoint that cannot be reached using a 15cm (6 inch) sterile Q-tip or metal probe unless under the direction of a Physician/NP or Wound Clinician.** • Wounds that have areas from which the cleansing solution cannot be retrieved. Do not use this procedure for fistula management; collaborate with a Physician/NP.

Bookmarks	
Related Documents on CLWK.ca	E-Learning Module: Wound Cleansing Guideline: Wound Bed Preparation Procedure: Wound Packing Assessment Flow Sheet: Wound Assessment & Treatment Flow Sheet

Equipment and Supplies

- Antiseptic hand cleanser if not available at the bedside
- Depending upon which aseptic technique used:
  - 2 pair of clean gloves if using no-touch or clean technique; if taking photos then bring a third set of clean gloves.
  - 1 pair each of clean and sterile gloves if using sterile technique; if taking photos then bring a third set of clean gloves.
  - Sterile dressing tray.
- For cleansing or irrigating the wound:
  - At least 100ml of the following cleansing solutions designated for wound cleansing:
    - Sterile Normal Saline(NS) in a squeezable container or a pourable container.
    - Sterile water in a squeezable container or a pourable container.
    - Potable tap water, if approved for use within the agency.
    - Topical antiseptic solution on the recommendation of a Physician/NP or Wound Clinician.
  - If using a pourable container of NS or sterile water, use a sterile 30cc or 35cc syringe and a sterile wound irrigation tip catheter; if irrigation tip catheter is not available use an 18 to 19 gauge catheter device.
  - Commercial wound cleansers may be used, if approved within the agency.
  - A disposable procedural pad and/or a kidney basin to collect fluid.
  - If required, personal protective equipment (PPE) e.g., apron, gown, eye protection, face shield.
- To conduct a wound assessment:
  - Sterile metal probe (preferable) or sterile or clean cotton tipped applicator 15cm (6 inches).
  - Wound measurement guide.
  - Camera (as per agency policy).
- To pack/dress the wound, as per the client's care plan:
  - Cover dressing.
  - Wound filler/packing material.
  - Skin barrier/protectant.
  - Sterile or clean cotton tipped applicator or sterile metal probe.
  - Sterile scissors.
  - Adhesive strip, e.g., sterile steri-strips or paper tape to secure a packing 'tail'.
  - Marker/pen to note (mark) the number of packing pieces on the cover dressing.
  - New C&S container(s)/new plastic storage bag(s) (e.g., Ziploc bag) for unused dressing piece(s).

Procedure

Steps	Key Points
Preparation and Set-up	
1. Assess client for the presence of pain or a history of pain with wound cleansing and pre-medicate if necessary.	
2. Check the dressing supplies available at the bedside or in the home. Appropriately saved dressing pieces may be used if within 2 weeks of the date on the container/re-sealable plastic storage bag (e.g., Ziploc bag). Gather all other additional supplies that are required.	Take only necessary dressing change supplies to the bedside or into the home - all supplies taken to the bedside or home cannot be returned to the dressing supply and must be discarded if not used. Saved dressing pieces must be discarded 2 weeks after date noted on container/plastic storage bag.
3. Ensure cleansing solution is at least room temperature (20^0 C).	Using a cool/cold cleansing solution to cleanse the wound can lower the wound temperature delaying healing and can cause discomfort for the client.
4. Prepare/clean work surface.	
5. Perform hand hygiene.	Follow agency policy/guidelines for hand washing.
6. Position client for procedure. If needed, position disposable procedural pad/kidney basin to catch the cleansing solution. Wear gloves if needed.	
7. Perform hand hygiene.	Follow agency policy and guidelines for hand washing.
8. Set up dressing tray using appropriate aseptic technique. If using a saved dressing piece, use no-touch technique to remove it from the C&S container/storage bag and add it to the aseptic field.	The decision regarding aseptic technique for wound care (sterile, no touch or clean) is based on the clinical condition of the client, the etiology of the wound, the location of the wound, the invasiveness of the dressing procedure, the goal of care and agency policy. The decision to use saved dressing pieces is based on the aseptic technique being used see Wound Bed Preparation Guideline.
9. If required, put on personal protective equipment as per agency policy.	Using fluid under pressure can cause splash-back.
10. Put on clean gloves.	

Wounds without Undermining, Sinus/Tunnel	
1. **Follow steps 1-10** of Preparation and Setup (above) for the dressing change.	
2. Remove the cover dressing. Using forceps or sterile gauze, gently remove the wound filler/packing from the wound. If wound filler or packing material adheres to the wound, soak the packing with sterile normal saline or sterile water before removing. If used, set aside or discard forceps as they are now contaminated.	Removing wound filler/packing that adheres to the wound bed without soaking can cause trauma to the wound bed tissue. If packing material cannot be removed, contact the Physician/NP or Wound Clinician. If wound packing adheres to the wound, reassess the amount of wound exudate and consider a different product(s).
3. Remove gloves and perform hand hygiene.	Follow agency policy/guideline for hand hygiene.
4. Put on new clean gloves.	

Steps	Key Points
Wounds <u>without</u> Undermining, Sinus/Tunnel con't	
5. Cleanse the wound using: At least 100ml squeezable container designated for wound cleansing; hold tip of the container 10-15cm (4-6 inches) from the wound and squeeze solution over wound bed in a sweeping motion. **OR** A bottle of sterile NS or sterile water; gently pour at least 100mls of cleansing solution over the wound. **OR** A 30-35cc syringe fitted with either a wound irrigation tip catheter or an 18-19 gauge device and at least 100mls of cleansing solution: • Start at one edge of the wound • Hold the end of the wound irrigation tip catheter / device 10-15cm (4-6 inches) from the wound. • Angle the wound irrigation tip catheter or device towards the wound bed • Apply full force on the syringe plunger and slowly 'sweep' across the wound bed; refill the syringe as needed. • Repeat the process from the opposite side of the wound. **OR** Commercial wound cleanser, follow manufacturer's instructions or the PISheet. Use sterile cotton gauze to gently and firmly remove any loosened slough/debris and wick any excess solution from the wound bed. Use a clean gauze for each wipe, do not reuse gauze once soiled.	Use only cleansing solutions that have agency approval. Do not allow the tip of the container or the wound irrigation tip catheter to touch the wound bed. A wound cleansing container and a 30-35cc syringe with either an 18-19 gauge device or a wound irrigation tip delivers approximately 8-15 psi of pressure which is sufficient to remove slough, bacteria, debris and exudate from the wound but does not harm granulating tissue. The smaller the diameter of the syringe the greater the psi; pressures higher than 15 psi can damage the wound bed and may drive bacteria into the deeper tissues. If commercially prepared sterile normal saline is not available, may use home prepared normal saline (see Appendix A fseeor procedure). When using commercial wound cleansers, follow the instructions on the Product Information Sheet.
6. Cleanse the peri-wound skin to remove tape residue, previous skin barrier, ointments, creams, lotions and/or dry skin.	This cleanses and protects the peri-wound skin.
7. Perform a Wound Assessment: • Measure the wound, if doing a full assessment. • Check for undermining, sinuses/ tunnels. • Assess the wound bed, exudate characteristics and amount, odour, wound edges and periwound skin. • Assess for signs and symptoms (S&S) of wound infection. • Assess the client for wound pain.	This assessment will determine if the wound is healing see Wound Assessment and Treatment Flow Sheet. If 2 or more signs and symptoms of an infection are evident and the infection is not currently being treated, take a swab for C&S and notify a Physician/NP if C&S results are abnormal see Wound Infection Guideline.
8. Remove gloves and perform hand hygiene.	Follow agency policy/guidelines for hand hygiene.
9. Take wound photos, if required.	
10. Perform hand hygiene and put on sterile or clean gloves depending on aseptic technique being used.	

Steps	Key Points
Wounds without Undermining, Sinus/Tunnel con't	
11. Complete wound dressing as per the care plan. If the wound dressing needs to be cut, use sterile scissors to cut the dressing to the appropriate size. If wound is to be packed, refer to the Wound Packing Guideline Protect with appropriate protectant or barrier product. If the dressing piece is to be saved, use no-touch technique to place the dressing piece into a C&S container or re-sealable plastic storage bag (e.g., Ziploc) see Wound Infection Guideline.	If the dressing is larger than required, the unused piece(s) of dressing may be saved for the next dressing change in a new C&S container or new re-sealable plastic storage bag that is labelled with the client's name, the current date, and the name of the dressing. Saved dressing pieces and container/re-sealable plastic storage bag must be discarded after 2 weeks.
12. Clean-up work surface. NS or sterile water bottles must be single client use only; any left-over solution should be discarded after 24 hours.	This protects against possible contamination of the bottles.
13. Remove gloves and personal protective equipment. Perform hand hygiene.	Follow agency policy and guidelines for hand hygiene.

Wounds with Undermining, Sinus/Tunnel and a Known Endpoint	
1. **Follow steps 1-10** of Preparation and Setup (above) for the dressing change.	
2. Remove the cover dressing. Using forceps or sterile gauze, gently remove the wound filler/packing from the wound. If wound filler or packing material adheres to the wound, soak the packing with sterile normal saline or sterile water before removing. If used, set aside or discard forceps as they are now contaminated.	Removing wound filler/packing that adheres to the wound bed without soaking can cause trauma to the wound bed tissue. If packing material cannot be removed, contact the Physician/NP or Wound Clinician. If wound packing adheres to the wound, reassess the amount of wound exudate and consider a different product(s).
3. Remove gloves and perform hand hygiene.	Follow agency policy and guidelines for hand hygiene.
4. Put on new clean gloves.	
5. Using a moistened sterile cotton or foam tipped applicator or sterile metal probe, gently probe undermining and/or sinus/tunnel to determine length and direction of the wound. If the cotton tipped applicator or probe does not reach the end of the undermining and/or sinus/tunnel notify a Wound Clinician or Physician/NP and do not proceed with cleansing until further direction is received.	Knowing the length and direction of the wound endpoint ensures that the cleansing solution is directed to the appropriate areas. Moistening the cotton tipped applicator with sterile NS or sterile water reduces the possibility of leaving fibres in the wound. If a15cm (6 inch) cotton tipped applicator or probe does not reach the end of the undermining and/or sinus/tunnel, refer to the Physician/NP and inform the Wound Clinician. **Do not proceed with cleansing until further direction is received**.

Steps	Key Points
Wounds <u>with</u> Undermining, Sinus/Tunnel and a <u>Known</u> Endpoint con't	
6. Draw the cleansing solution up into a 30-35cc syringe fitted with either a wound irrigation tip catheter or the catheter device e.g., straight catheter. **Do not use commercial non-antimicrobial wound cleansers or potable water to cleanse wounds with undermining, sinus/tunnel.**	An irrigation tip catheter or catheter device provides access to the base of the undermining, sinus/tunnel to ensure the area is thoroughly cleansed. If unsure about whether to use a particular wound cleanser, consult the Wound Clinician or the product information sheet. Link to CLWK Skin & Wound Product Information Sheets
7. a. Gently insert the wound irrigation tip catheter or catheter device into the undermining, sinus/tunnel and flush with gentle force until the returning fluid is clear. b. Then cleanse the wound bed: • Start at one edge of the wound • Hold the end of the wound irrigation tip catheter or catheter device 10-15cm (4-6 inches) from the wound. • Angle the wound irrigation tip catheter or catheter device towards the wound bed. • Apply full force on the syringe plunger and slowly 'sweep" across the wound bed; refill the syringe as needed. • Repeat the process from the opposite side of the wound.	Flushing will assist with removing loose tissue debris, bacteria, slough and exudate. Use at least 100ml of fluid to adequately flush all areas of the wound; larger wounds may require additional fluid.
8. Using a gloved hand, apply gentle pressure over the undermining, sinus/tunnel area and/or change the client's position to remove any retained fluid.	Retained fluid may provide a medium for bacterial growth and may soak the cover dressing prematurely.
9. Use sterile cotton gauze to gently and firmly remove any loosened slough/debris and wick any excess solution from the wound bed. Use a clean gauze for each wipe, do not reuse gauze once soiled.	Loosen debris and excess solution needs to be removed from the wound.
10. **Follow steps 5-12** of Wounds without Undermining, Sinus/Tunnel (above) to complete the dressing change.	

Wounds with Undermining, Sinus/Tunnel with an <u>Unknown</u> Endpoint	
1. **<u>Do not irrigate</u>** undermining, sinus/tunnel with an unknown endpoint **unless ordered to do so by the Physician/NP**. Cleanse only the **<u>visible</u>** part of the wound: • Use sterile cotton gauzes, moistened with sterile NS, to gently and firmly remove any loosened slough/debris and wick any excess solution from the wound bed. Use clean gauze for each wipe, do not reuse the gauze once soiled.	Do not pour NS into the wound or cleanse the wound bed using a 30cc syringe/irrigation tip catheter as these methods will introduce too much NS into wound space and potentially into the unknown endpoints of the undermining, sinus/tunnel.

Documentation

1. Document the type of aseptic technique used and the effectiveness of wound cleansing as per agency guidelines.
2. Document the wound assessment as per agency guidelines and attach wound photos to client's chart as per agency guidelines.

Definitions

Antiseptic wound cleansers - Wound cleansers containing antiseptic agents that kill, inhibit or reduce the number of microorganisms in a wound.

Antimicrobial wound cleansers - Means the same as antiseptic wound cleanser but is newer terminology.

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.

- **Sterile Technique** - the use of sterile gloves, a sterile field, sterile tray, sterile instruments, sterile solution and sterile dressings. Only sterile gloved hands or instruments are used for direct contact with the wound.
- **No-Touch Technique** - the use of clean gloves and a sterile field, sterile tray, sterile instruments, sterile solution and sterile dressings. Only sterile instruments are used for direct contact with the wound.
- **Clean Technique** - the use of clean gloves (single client use, non-sterile), a clean field, a clean or sterile dressing tray, clean instruments (single client use), clean solution (single client use) and clean dressings. Clean gloved hands or instruments are used for direct contact with the wound.

Cleansing solutions - Wound cleansing sprays or solutions including sterile NS, sterile water, potable tap water, commercial cleansers and antiseptic / antimicrobial topical solutions. Antiseptic / antimicrobial solutions may be used on the recommendation of a Physician/NP or Wound Clinician.

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

Client - Recipient of care: in the community-client, in residential care-resident, and in acute care - patient.

Debris - Remains of damaged or dead cells in the wound.

Fistula - An abnormal track connecting a hollow organ to the skin surface or wound bed or to another organ.

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

Irrigation -The instillation of fluid into a wound, undermining, sinus tract, or tunnel to remove slough and/or necrotic tissue.

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

Potable tap water - Tap water that has been determined by local water authorities to be safe to drink.

Product Information Sheet (PISheet) - Product Information Sheet(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

Sinus / tunnel - A channel that extends from any part of the wound and tracks into deeper tissue.

Topical antiseptic solution - A solution that kills, inhibits or reduces the number of microorganisms in a wound; usually has a broad spectrum of activity.

Undermining - A separation of tissue that occurs underneath the intact skin of the wound perimeter.

References/Bibiology

1. Anglen, J. (2001). Wound irrigation in musculoskeletal injury. *Journal of the American Academy of Orthopedic Surgeons,* 9(4), 219-226.
2. Atiyeh, B., et al. (2009). Wound cleansing, topical antiseptics and wound healing. *International Wound Journal, 6*(6), 420-430.
3. Bee, T., et al. (2009). Wound bed preparation – cleansing techniques and solutions: A systematic review. *Singapore Nursing Journal,* 36(1), 16-22.
4. Bryant, R., & Clarke, R. (2007). Skin pathology and types of damage. In: Bryant, R., & Nix D. (Eds). *Acute and Chronic Wounds: Current Management Concepts.* (3rd ed.). St. Louis: Mosby. pp. 100-129.

5. Bryant, R, A., & Nix, D. P. (2016). Principles of wound healing and topical management. In Acute & chronic wounds: Current management concepts (5th ed). St. Louis, Missouri: Elsevier. 306-324.
6. Clinical guidelines from Vancouver Coastal Health / Providence Health Care (2008), Providence Health Care: Storyboard documents (2011) and Northern Health (2009).
7. Fernandez, R., et al. (2008). Water for wound cleaning. *Cochrane Database Systematic Review, 23*(1): CD 003861.
8. Fernandez, R., et al. (2004). Effectiveness of solutions, techniques and pressure in wound cleansing. *JBI Reports, 2,* 231-270.
9. Hamilton Health Sciences: McMaster Children's Hospital. (2012, July 24). *How to make normal saline at home.* Retrieved from http://www.hamiltonhealthsciences.ca/documents/Patient%20Education/NormalSalineAtHome-lw.pdf
10. Irion, G. (2010). *Comprehensive wound management*. (2nd ed). Thorofare: Slack Inc. pp. 204-205.
11. Joanna Briggs Institute. (2009). Solutions, techniques & pressure in wound cleansing. *Nursing* Standard, *22*(27), 35-39.
12. Moore, Z., et al. (2008). A systematic review of wound cleansing for pressure ulcers. *Journal of Clinical Nursing, 17*(15), 1963-1972.
13. Rodeheaver, G., et al. (2007). Wound cleansing, wound irrigation and wound disinfection. In: Krasner D, Rodeheaver G, Sibbald R., (Eds.) *Chronic wound care: A clinical source book for healthcare professionals*. (4th ed.). Malvern, PA: HMP Communications. pp 331-342.
14. Sibbald, G., et al. (2006). Best practice recommendations for preparing the wound bed: Update 2006. *Wound Care Canada, 4*(1), 15-29.
15. Sibbald, G., et al. (2011). Best practice recommendations in wound bed preparation: Update 2011. *Wound Care Canada, 10*(3), 25-33.
16. Sussman, C., & Bates-Jensen, B. (2007). *Wound care: A collaborative practice manual for health professionals*. (3rd ed.). Philadelphia: Lippincott Williams & Wilkins. 102.
17. Tamagnini, L., et al. (1997). Bacteriological stability and growth kinetics of *Pseudomonas aeruginosa* in bottled water. *Journal of Applied Microbiology, 83,* 91-94.
18. Wound Ostomy and Continence Nurses Society. (2012). Clean versus sterile dressing technique for management of chronic wounds. *Journal of Wound Ostomy Continence Nursing, 39*(2S), S30-S34.
19. Wound Ostomy and Continence Nurses Society. (2016). Guideline for prevention and management of pressure ulcers (injuries): Wound management strategies. Mt. Laurel, NJ: Author. 66-68.

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Appendix A: Procedure for Home Prepared Normal Saline or Sterile Water

Adapted from Hamilton Health Sciences, 2012. *How to make 'Normal Saline' at home*).

Preparation for Sterile Normal Saline (NS):

Collect supplies:

- 1 large pot with lid
- 1 small pan with lid
- 1 clean glass (not plastic) bottle or jar with a lid
- Table salt
- Water
- Measuring spoon
- Measuring cup

Wash hands with soap and water or antiseptic cleanser. Dry on a clean towel.

Sterilize the Glass Bottle/Jar

1. Place the glass bottle or jar plus its lid (NOT screwed on) into the large pot and cover with tap water.
2. Place the pot on the stove, put the lid on the pot and boil the water for 15 minutes (set a timer).
3. After 15 minutes, set the pot aside to cool while the normal saline is being prepared.

Make the Normal Saline

1. Put one cup of water and ½ (one-half) teaspoon of salt (2.5ml) into the small pan.
2. Place the pan on the stove; put the lid on the pan and gently boil for 15 minutes (set a timer).

Store the Solution

1. When the large pot has cooled, pour off the water; take the bottle/jar and the lid out of the pot **without touching** the **inside** of the bottle or lid.
2. Carefully pour the NS (the boiled salt and water) from the small pan into the glass bottle or jar and put the lid on. Allow to cool to room temperate before using. Do not refrigerate.
3. Keep the NS in the bottle/jar for a maximum of **24 hours**. Throw away any unused solution; prepare new Normal Saline solution following the procedure above.

Preparation for Sterile Water:

Collect supplies:

- 1 small or large pot with lid
- 1 clean glass (not plastic**)** bottle or jar with a lid
- Water
- Measuring cup

Wash hands with soap and water or antiseptic cleanser.

Sterilize the Glass Bottle/Jar

1. Place the glass bottle or jar plus its lid (NOT screwed on) into the large pot and cover with tap water.
2. Place the pot on the stove, put the lid on the pot and gently boil the water for 15 minutes (set a timer).
3. After 15 minutes, set the pot aside to cool while the sterile water is being prepared.

Make the Sterile Water

1. Put one or more cups of water into a pan.
2. Place the pan on the stove; put the lid on the pan and boil for 20 minutes (set a timer).

Store the Solution

1. When the pot has cooled, pour off the water; take the bottle or jar and the lid out of the pot **without touching** the **inside** of the bottle or lid.
2. Carefully pour the sterile water from the pan into the bottle or jar and put the lid on. Allow to cool to room temperature before using. Do not refrigerate.
3. Keep the water in the bottle or jar for a maximum of **24 hours**. Throw away any unused solution; prepare new solution following the procedure above.

Skin and Wound Product Information Sheet

Silvercel Non-Adherent

Classification	**Antimicrobial: Silver Alginate**
Key Points	• This product is a combination of silver, alginate and carboxymethyl cellulose sandwiched between non-adherent film layers to help prevent sticking to wounds or shedding fibres • Broad spectrum topical antimicrobial dressing
Indications	• Wounds with moderate to large amounts of exudate which show signs and symptoms (S&S) of local wound infection
Precautions	• Avoid putting electrodes or conductive gels in contact with silver products
Contraindications	• Do not use for clients with known sensitivity or allergy to silver, alginates or ethylene methylacrylate (EMA) • Do not use for in conjunction with surgical implantations • **Do not use for pregnant or lactating women due to absence of specific information** • Do not use silver products in combination with oil-based products such as petrolatum or paraffin • Do not use silver products when client is undergoing MRI examination or during radiation therapy (dressing can be replaced after MRI or radiation treatment is completed)
Formats & Sizes	• Sheet ▪ 5 x 5 cm ▪ 11 x 11 cm ▪ 10 x 20 cm • Rope ▪ 2.5 x 30 cm 

Application Directions	Rationale
Cleanse/irrigate wound with sterile normal saline or agency approved wound cleanser; dry peri-wound skin.	Reduces wound debris and allows for adhesion of dressing or tape.
If required, apply skin barrier to peri-wound skin.	To protect the peri-wound skin from maceration and to improve the adhesion of the dressing or tape.
To Apply	
Apply dry. Cut the sheet dressing to the size of the wound; lightly layer to fill a cavity space. For packing: lightly pack one piece (where possible) of ribbon into cavity, undermining or sinus tract. Leave a tail of the ribbon so that it can easily be seen.	 Product on the peri-wound skin may cause maceration. Over-packing of undermined areas or sinus tracts can lead to tissue necrosis. The tail will facilitate the removal of packing.
Apply appropriate cover dressing to maintain a moisture-balanced wound environment.	The choice of cover dressing is depended upon the amount of exudate expected.
To Remove	
Gently remove the dressing with forceps or flush with normal saline.	If the dressing adheres to the wound bed, reassess whether there is enough exudate to warrant continued use this dressing.
Frequency of Dressing Change	
Will depend upon the amount of exudate. Silvercel remains effective up to 7 days.	
Expected Outcome	
S&S of local wound infection are resolved within 2 weeks.	
For further information, please contact your Wound Clinician.	

Skin and Wound Product Information Sheet

Chlorhexidine (CHG) Solution 2% w 70% Alcohol for Wound Care

Classification	**Antiseptic**
Key Points	• Chlorhexidine Gluconate (CHG) 2% solution compounded with 70% alcohol. • Antiseptic known to inhibit/kill skin colonizing flora including methicillin-resistant Staphylococcus aureus (MRSA); including gram-positive, gram-negative non-spore forming bacteria, yeast, & selective lipid envelope viruses (HIV). • Not to be used as a wound cleanser but as a procedural prep or for maintaining dry, stable eschar when Povidone Iodine can not be used.
Indications	• As a prep for Conservative Sharp Wound Debridement procedure for wounds which show S&S of a wound infection or for immunocompromised client's wounds e.g. diabetic foot ulcer. • May be used to achieve and maintain dry, stable eschar (e.g. arterial wounds) when the client is sensitive to Povidone Iodine.
Precautions	• Solution must be allowed to dry to ensure effectiveness. • Alcohol based solution is flammable. • May cause skin and eye irritation. If irritated, wash with water immediately and discontinue use. If in contact with the eyes, flush with running water 15 minutes
Contraindications	• Do not use for clients with known sensitivity to chlorhexidine.
Formats & Sizes	• Swab ▪ one swab per package • Solution ▪ 500 mL  

Application Directions	Rationale
Swab are single-use only. Discard once used. Label the 500 mL bottle with the client's name. Date the bottle.	Bottles are to be single-client use. Discard open bottles within 30 days.
For Wound Prep Pre and Post CSWD	
For solution: pour CGH solution into the dressing tray. Soak gauze dressings in the solution. Remove the gauze dressing(s) from the solution, squeeze out excess using sterile glove hand or forceps. Using either the soaked gauze or the swab, cleanse the necrotic tissue/slough wound area(s) and periwound skin. Allow solution to dry for 30 seconds for dry areas and 2 minutes for moist areas. Post-CSWD, thoroughly cleanse the area with Normal Saline to remove any residue.	Do not leave cotton gauze in the GHG solution for longer that 15 minutes as the cotton compromises the effectiveness of CHG. If skin becomes irritated, discontinue use and wash immediately with Normal Saline or tap water. Skin may become irritated with the residue of solution when under a dressing.
For Maintenance of Dry Stable Eschar	
Cleanse area with Normal Saline. For solution: pour CGH solution into the dressing tray. Soak gauze dressings in the solution. Remove the gauze dressing(s) from the solution, squeeze out excess using sterile glove hand or forceps. Using either the soaked gauze or the swab, wipe the dry, stable eschar plus the 2.5cm of the peri-wound skin. Allow solution to dry for 30 seconds for dry areas and 2 minutes for moist areas. If area is to be covered with a dressing, stocking, etc. ensure the area is thoroughly dry before covering it.	Do not leave cotton gauze in the GHG solution for longer that 15 minutes as the cotton compromises the effectiveness of CHG. Skin may become irritated with the residue of solution when under a dressing, stocking, etc. If skin irritation, occurs, discontinue use and wash immediately with Normal Saline or tap water.

Skin and Wound Product Information Sheet

Frequency of Application	
As needed for CSWD prep. For maintenance of dry, stable eschar, daily.	
Expected Outcome	
As a prep for CSWD; decreases bacterial load prior to procedure. For maintenance of dry, stable eschar; eschar remains dry and stable.	
For further information, please contact your Wound Clinician.	

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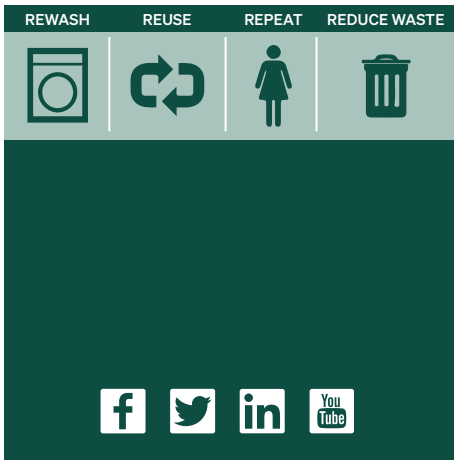

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Skin and Wound Product Information Sheet

UrgoTul Ag/Silver

Classification	**Antimicrobial: Silver - Contact Layer**
Key Points	• A non-adherent polyester mesh containing silver sulphate • Allows exudate to pass through to secondary absorbent dressing as silver ions are released into wound bed
Indications	• For fragile wounds with low to moderate exudate which shows signs and symptoms (S&S) of local wound infection • For preventing wound trauma by decreasing adherence of the cover dressing/secondary dressing • Can be used as an antimicrobial interface for Negative Pressure Wound Therapy (NPWT) • Can be used as an antimicrobial interface between a new skin graft and its cover dressing
Precautions	• N/A
Contraindications	• Do not use for clients with known sensitivity or allergy to ionic silver • Do not put electrodes or conductive gels in contact with silver products • Do not use silver products when client is undergoing MRI examination or during radiation therapy (dressing can be replaced after MRI or radiation treatment is completed)
Formats & Sizes	• Sheet ▪ 10 x 12.5 cm ▪ 15 x 20 cm ▪ 20 x 40 cm 

Application Directions	Rationale
Cleanse/irrigate wound with sterile normal saline or agency approved wound cleanser; dry peri-wound skin.	Reduces wound debris and allows for adhesion of dressing or tape.
If required, apply skin barrier to peri-wound skin.	To protect the peri-wound skin from maceration and to improve the adhesion of the dressing or tape
To Apply	
Choose a size that covers the wound and at least 2 cm of the peri-wound skin. Dressing should be cut to size prior to removing the protective plastic films.	Ensures adequate adhesion and wear time.
Remove one side of the protective plastic film and apply dressing in a single layer over the wound bed and smooth onto the peri-wound skin. Remove the remaining plastic protective film. For wounds with depth, the dressing may be applied into the cavity.	
Apply appropriate cover dressing to maintain a moisture-balanced wound environment.	The choice of cover dressing is depended upon the amount of exudate expected.
To Remove	
Using forceps, gently remove the contact layer from the wound.	To avoid trauma to the wound.
Frequency of Dressing Change	
Cover dressing change will depend upon the amount of exudate. Initially, change contact layer every 1 to 3 days depending upon the condition of the wound; may progress to leaving the contact layer in place for up to 7 days.	
Expected Outcome	
Contact layer does not adhere to wound bed. S&S of local wound infection are resolved within 2 weeks.	

For further information, please contact your Wound Clinician.