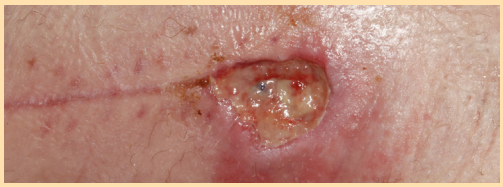
Pathway for Sloughy Wounds

Aim: - To remove slough and provide a clean base for granulation

Definition

Slough consists of dead cells in the wound bed and is yellow/white in colour.

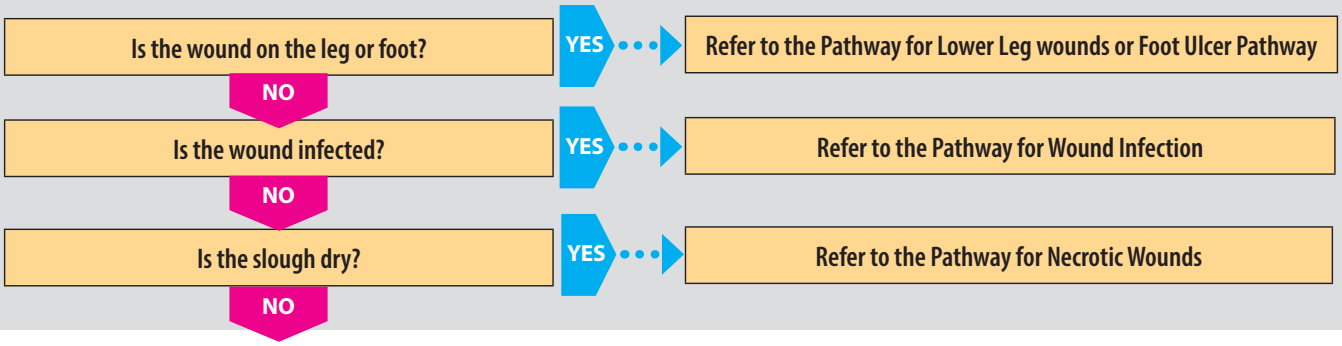
It generally has a soft texture, it can be thick and adheres to the wound bed or patchy over the surface of the wound. (Nichols, E. Wound Essentials 2015).



Step 1: Undertake wound cleansing in accordance with the Wound Cleansing Policy and consider using Prontosan Debridement pad to support soft mechanical debridement.

Step 2: Undertake a holistic wound assessment in order to determine the type of wound exudate and establish the dressing options.

Step 3: Dress the wound following the below recommendations per the local formulary:



Exudate Levels	Primary Dressing	Secondary Dressing	Application advice
Minimal to Moderate with no depth.	Comfeel Plus	NA	• Apply to the wound ensuring a 1cm border from the wound margins. • Can be left in place for up to 7 days or change if the dressing is marked with exudate within 1 cm from the edge of the dressing or the dressing is dislodges.
Moderate to High with LESS than 2 cm depth.	Flaminal Forte.	Comfeel Plus	• Apply s thick layer (4-5mm) of Flaminal Forte to the wound bed and cover with a Comfeel Plus ensuring the Comfeel Plus is 1cm border from the wound margins 1 cm from the edge of the dressing or the dressing is dislodged.
Moderate to High with MORE than 2 cm depth	Cutimed Sorbact Ribbon (Dialkylcarbamoyl chloride)	Biatain Silicone 3DFIT	• Loosely cover/pack the wound with Cutimed Sorbact Ribbon and cover with Biatain Silicone 3DFIT. • Can be left in place for up to 7 days, however change if the dressing is marked with exudate within 1 cm from the edge of the dressing or the dressing is dislodged.

Step 4: Document all wound care assessments accordingly and complete onward referrals if required.

Has there been an improvement in the last 14 days?

NO

Ensure a referral has been completed and sent:

- DBTH inpatient to The Skin Integrity Team.
- Communality Tier 1 or 2 to Community Tier 3.
- Community Tier 3/District Nurses to TVALS.
- Community patients with a Diabetic Foot Ulcer to The Podiatry Foot Protection Service.

YES

Step 5: Reassess as per dressing application advice.

If the named product on this pathway is not available a temporary second line product is available to use. This can be found within the main text of the Doncaster Wide Wound Care Formulary Document.

Reference: Nichols, E. (2015) Describing a wound from presentation to healing. Wound Essentials. 10 (1).

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