Basingstoke, Southampton and Winchester
District Prescribing Committee and
Portsmouth and South East Hampshire
Area Prescribing Committee

Wound Formulary

HANDBOOK

October 2016

Wound Formulary October 2016 Version 7(1)

Ratified by the Basingstoke, Southampton and Winchester District Prescribing Committee and Portsmouth and South East Hampshire Area Prescribing Committee

Introduction

Dressings are only one component of wound care and, on their own, will not heal wounds. It is assumed that each healthcare professional will be responsible for ensuring they are up to date with current wound/skin care practice and ensure they are familiar with the products selected for use.

The purpose of the Hampshire wide Wound Formulary is to provide a list of dressings, bandages, hosiery and topical applications, which based on the evidence available, should be selected for approximately **90%** of prescribing in this area.
There may be a small number of occasions when, after using the Wound Formulary 1st and 2nd line, you consider a non-formulary product may be appropriate.

In secondary/acute care settings there may be differences due to availability and procurement routes which will be highlighted where known- please refer to local protocols. These dressings can be switched to formulary equivalents once the patient is discharged to primary care, unless a particular dressing is requested by a TVN or clinical specialist.

The Wound Formulary is a working document with input from all disciplines across nursing, pharmacy and podiatry within acute and primary care. The Wound Formulary Group continues to meet to provide a forum for the evaluation of new and current products and to document the evidence available for inclusions to the Wound Formulary for consideration by the District Prescribing Committee.

Product selection has been based on evidence of efficacy (although there is little research evidence available), manufacturers literature, practical experience of use and cost effectiveness. The recommendations have been developed by collaboration between health professionals from primary care and secondary care.

In the Wound Formulary we have provided an Exception Reporting form (available electronically) for use when non-formulary products are used. The information that you provide will be reviewed by the Wound Formulary Group and will be taken into consideration when the formulary is revised and updated. The Wound Formulary Group requires feedback/comments/rationales on the form. (See last section at bottom of page).The group also value any comments you have regarding this edition of the formulary.

NB Not all products are available in secondary care. Please refer to local policy.

General References sources: BNF Sept 2016: 70, SHIP Guidelines for Antibiotic Prescribing in the Community 2014, Journal of Wound Care Handbook www.woundcarehandbook.com, www.worldwidewounds.com, www.evidence.nhs.uk, www.nice.org.uk, www.sign.ac.uk, www.tissueviabilityonline.com/, www.ewma.org, www.britishjournalofnursing.com, www.wounds-uk.com/pdf/content_9364.pdf, Drug Tariff December 2016

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Product Type	Product Name	Size	Cost/ Dressing	Comments
1. NON/LOW ADHERENT DRESSINGS	Atrauman®	5x5cm 7.5x10cm 10x20cm 20x30cm	27p 28p 63p £1.74	Knitted polyester dressing impregnated with neutral triglycerides. May not be suitable for patients with sensitivities to coconut or its derivatives. Consider Tricotex® for patients with coconut allergy. 1. Consider Mepitel® for large skin tears where the skin flap needs immobilising. 2. Tricotex® is suggested as an alternative for simple non adherent dressings NB An Exception reporting form will be needed in both instances. **Please store flat to avoid sticking** **Choice of dressing for use under topical negative pressure is determined by local specialist advice**
	Softpore®	6x7cm *(3x4cm)* 10x10cm *(5x6cm)* 10x15cm *(5x10cm)* 10x20cm *(5x15cm)* 10x25cm (5x20cm) 10x30cm *(5x25cm)*	6p 13p 20p 35p 40p 49p	Not to be used on fragile skin. For minor superficial wounds where all that is required is protection from friction. Can be used as a post op dressing which may stay in place 3 – 5 days. Wound contact pad size in bracketts
2. ADHESIVE FILM Vapour permeable film	Hydrofilm®	6x7cm 10x12.5cm 10x15cm 10x25cm 12x25cm 15x20cm 20x30cm	23p 42p 53p 82p 87p 97p £1.61	Dry, non-infected wounds; retention of lines; fixation of secondary dressings. NB: management of IV sites – refer to local guidelines

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Product Type	Product Name	Size	Cost/ Item	Comments
Management of critically colonised and infected wounds Appendice 4a, 4b and 4c for Sign Checker, Flow Chart and guidance on choice of dressings. All antimicrobial dressings should be used for two weeks only. Expert specialist advice and guidance should be sought if antimicrobial dressings are required for a longer period. NB: some antimicrobial dressings to be cut to size of wound. Do not apply to intact skin except for Medihoney HCS				
3. TOPICAL ANTIMICROBIALS **a. Iodine based**	Inadine®	5x5cm 9.5x9.5cm	33p 49p	Non-adherent dressing impregnated with 10% povidone-iodine. Colour change indicates when to change dressing. Management and prevention of infection in ulcers, minor burns and minor traumatic skin injuries. Not effective in medium to heavy exudate.
	Iodoflex®	5g 10g	£4.13 £8.25	Cadexomer dressing with iodine. For the treatment of chronic exuding wounds. Not to be used on dry necrotic tissue. **Can apply up to 50g per dressing change, cover with secondary dressing; change when paste is saturated. Do not exceed 150g Iodoflex® paste in one week or more than 3 months single course of treatment. BE AWARE OF CONTRAINDICATIONS FOR USE.** See SPC
b. Honey	Medihoney® Antibacterial Medical Honey	20g 50g	£3.96 £9.90	Medical honey. Useful on sinus wounds. Indicated for infected or critically colonised wounds. Can be effective if malodour present, as a desloughing agent or in the treatment of necrotic wounds.
	Medihoney® Tulle dressing	10x10cm	£2.98	Strong woven dressing impregnated with antibacterial honey, sterile. For superficial wounds.
	Medihoney® Antibacterial Honey Apinate	10x10cm 1.9x30cm	£3.40 £4.20	Non-adherent, non-absorbent, protease modulating matrix, sterile. Contains calcium and antibacterial Honey
	Medihoney® HCS Adhesive	6x6cm 11x11cm 11x11cm	£2.24 £4.47 £3.06	An all-in-one dressing that combines 63% Medihoney in a hydrogel dressing with a superabsorbent polymer. The adhesive dressing does not require a secondary dressing. For dry to moderately exudating wounds. Other sizes for specialist use only

Product Type	Product Name	Size	Cost/ Item	Comments
c. Topical Antimicrobials (cont) PHMB	Suprasorb X + PHMB®	5x5cm 9x9cm 14x20cm 2x21cm	£2.57 £5.12 £11.64 £7.25	Light to moderately exuding, superficial and deep, critically colonised and infected wounds. Bio-cellulose dressing impregnated with broad-spectrum antimicrobial (PHMB (polyhexamethylene biguanide 0.3%). Can be effective if the wound is infected and painful.
d. Irrigation	Prontosan®	350ml bottle 40ml pod	£4.78 £14.18 (24 pods)	Wound irrigation solution containing Betaine which is a gentle effective surfactant which penetrates, disturbs and removes biofilm and wound debris, and PHMB to help control bacterial levels on the wound. **Note: for single patient use the 350ml bottle is more cost effective and has a shelf life of 8 weeks once opened. Prontosan pods should be reserved for acute use only.**
	Prontosan®	30ml gel	£6.38	Cleansing, decontamination and moisturising of acute and chronic skin wounds, first and second degree burns. (Impregnated with dialkylcarbamoyl chloride)
e. Antimicrobial wound contact layer	Cutimed Sorbact® swab	4x6cm (11x16cm) 7x9cm (17x27cm)	£1.65 £2.75	DACC-coated, hydrophobic, antimicrobial wound contact layer designed to bind bacteria under moist wound conditions. The dressing can be used folded or unfolded. Primary dressing for contaminated, colonised or infected superficial or deep wounds including superficial wounds, traumatic wounds, postoperative or dehisced wounds, ulcers (venous, arterial, diabetic, pressure) and fungal infections. Suitable for fungal infections in the groin, skin folds, or between digits.
f. Silver	Durafiber Ag®	5x5cm 10x10cm 15x15cm 2x45cm 4x10cm 4x20cm 4x30cm	£1.79 £4.26 £8.01 £4.27 £2.59 £3.37 £5.05	A highly absorbent, non-woven, silver gelling fibre dressing composed of a blend of cellulose-based fibres. Dressing fibres coming into contact with exudate swell and form a soft cohesive gel sheet. Exudate is locked in the dressing structure. Use as a primary dressing for moderately to highly exuding wounds where there is infection.

Product Type	Product Name	Size	Cost/ Item	Comments
4. ODOUR CONTROL ***NB: charcoal is not effective once wet***	Clinisorb®	10x10cm 10x20cm 15x25cm	£1.91 £2.54 £4.09	Sterile activated charcoal cloth sandwiched between layers of nylon/viscose rayon cloth. Apply as a secondary dressing over an appropriate primary dressing. Exudate will reduce the dressing's effectiveness. Can be cut to size. Can be used in the management of malodorous wounds such fungating wounds, pressure ulcers, leg ulcers and diabetic foot ulcers. May wish to consider using Anabact® (non formulary).

Product Type	Product Name	Size	Cost/ Item	Comments
5. ALGINATES NB: Kaltostat® On contact with a bleeding wound, promotes haemostasis but should not be left in place. Local guidance is to leave for 10 mins and then remove. Kaltostat® is non-formulary. *NB: use only where you can see the base of the wound as fibres/dressing can be left in situ'*	Suprasorb A® Suprasorb A® Rope	5x5cm 10x10cm 2g(30cm)	63p £1.23 £2.28	Calcium alginate primary dressing for use in shallow, moist wounds. For management of moderately or heavily exuding wounds. Secondary dressings are required to support the alginate in situ and maintain a moist environment. Is easily removed by irrigation. For exudate management and wound healing of large open or cavity wounds.
6. GELLING FIBRE DRESSING	Exufiber®	5x5cm 10x10cm 15x15cm 2x45cm 4.5x10cm 4.5x20cm 4.5x30cm	85p £2.05 £3.85 £1.85 £1.12 £1.64 £2.48	For infected/heavily exudating wounds. Do not use on a dry or low exudating wound. Requires secondary dressing. Strong polyvinyl alcohol (PVA) fibres that are entangled together in all directions, as well as mechanically secured to each other, providing high wet integrity (Hydrolock®Technology). Locking properties of the PVA technology, and the even space between the fibres, minimises free fluid inside the product, give it high absorption and retention capacity. Apply in a cavity wound or on shallow wounds. Should overlap the wound margins.

Product Type	Product Name	Size	Cost/ Item	Comments
7. HYDROGEL **NB: cut to size and do not place on intact skin**	IntraSite Conformable®	10x10cm 10x20cm 10x40cm	£1.82 £2.46 £4.40	Primarily indicated for treatment of necrotic and sloughy wounds, e.g. leg ulcers, pressure ulcers and non-infected diabetic foot ulcers. Effective for desloughing and debriding wounds. For dry 'sloughy' or necrotic wounds, lightly exudating wounds, granulating wounds and cavities. Not suitable for infected or heavily exudating wounds. Secondary Dressings required. IntraSite Conformable® is a hydrogel sheet. It has the added advantage of being bacteriostatic due to its propylene glycol content. It can be shaped to fit the wound so reducing the risk of maceration.
Non adhesive	KerraLite Cool®	6x6cm 8.5x12cm	£1.75 £2.57	Consider when pain is a significant factor. Soothing, debriding and moisture-balancing gel dressing. Manages wound exudate levels and protects against wound dehydration and external bacterial contamination. The gel provides both cushioning and absorption For use on chronic wounds, painful wounds, and skin conditions such as leg ulcers, radiation therapy damage, burns and scalds. May be used on low-exuding and non-exuding wounds to assist in autolytic debridement by hydration of necrotic and sloughy tissue and for absorption of exudate.

Product Type	Product Name	Size	Cost/ Item	Comments
8. FOAM DRESSING	Kliniderm® Foam Silicone	7.5x7.5cm	£1.18	For use on moderately exuding wounds.
		10x10cm	£1.63	
Adhesive	Border	12.5x12.5cm	£2.33	A soft, conformable absorbent polyurethane foam dressing with an adhesive silicone wound contact layer and a moisture permeable film backing.
		15x15cm	£3.95	
		10x20cm	£3.20	
		15x20cm	£5.00	
				Foam dressings should be left in place for up to 7 days. Their mode of action means exudates will be visible but this does not mean the dressing requires changing. Change when strike through 1cm from edge.
Non adhesive	Kliniderm® Foam Silicone	5x5cm	95p	
		10x10cm	£1.95	
		10x20cm	£3.49	
		15x15cm	£3.95	**Foam dressings should not be used for pressure relief**
		20x20cm	£6.50	
Adhesive	Biatain® Silicone	7.5x7.5cm	£1.46	A soft, absorbent polyurethane foam pad with a vapour-permeable film backing and a silicone adhesive border.
		10x10cm	£2.15	
		12.5x12.5cm	£2.63	
		15x15cm	£3.90	

Product Type	Product Name	Size	Cost/ Item	Comments
9. HYDROCOLLOIDS Sterile, thin hydrocolloid dressing.	DuoDERM® Extra Thin	5x10cm 7.5x7.5cm 10x10cm	76p 81p £1.33	To aid debriding, promote granulation, occlusive barrier. For light to medium exudating wounds ONLY. Ensure correct size of dressings applied; overlap the wound by at least two cms N.B. Odour from the dressing constituents can be a concern to patients. Not suitable for infected wounds unless observed frequently. **Not indicated routinely on diabetic foot wounds- contact local Diabetic/Foot Protection Team for advice.**
	Comfeel® Plus Ulcer	4x6cm 10x10cm 15x15cm	96p £2.46 £5.27	Absorbent hydrocolloid dressing with added alginate for absorption, a vapour-permeable film backing and bevelled edge.
10. PASTE BANDAGES	Ichthopaste®	7.5x6m	£3.60	Chronic eczema/dermatitis where occlusion is indicated. Zinc paste and ichthammol bandage. Ensure any residue is removed before rebandaging. Patch testing required prior to use. To be applied as per manufacturer's instructions and not as a primary dressing or as a patch.

Product Type	Product Name	Size	Cost/ Item	Comments
11. BANDAGES				
a) Light weight conforming bandages				
Padding	Ultra Soft®	10cmx 3.5m	39p	Sub compression padding bandage used to protect the limb and for shaping if required
	Ultra Lite®	10cmx4.5m	85p	This bandage should be used as an alternative to K Lite where there are symptoms of, or identified arterial disease present in the lower leg.
	K-lite®	10cmx4.5m	£1.01	For 2nd-line use after Ultra Lite®
Elasticated viscose stockinette	CliniFast® /Comfifast®	3.5cmx1m 5cmx1m 7.5cmx1m 10.75cmx1m 17.5cmx1m	56p 58p 77p £1.20 £1.83	Red line Green line Blue line Yellow line Beige line Also available in 3m and 5m lengths for green, blue and yellow line, which may be more cost effective.

Product Type	Product Name	Size	Cost/ Item	Comments
Please see Local Leg Ulcer Treatment Algorithm **ALL healthcare professionals must ensure their competencies for applying compression bandaging are up to date** Arterial screening (i.e. Doppler ultrasound) must be undertaken before compression hosiery or bandaging is commenced. Note that arterial screening must be repeated periodically if compression therapy is ongoing. Ref: Local Leg Ulcer Guidelines/Standard Operating Procedures				
11. BANDAGES (cont'd) b) Short stretch compression bandages providing full and reduced compression.	Actico® (not latex free)	10cmx6m	£3.38	Cohesive short stretch bandages for single use and adapted according to ankle circumference. Can be worn for up to 7 days. Recommended in patients with an ABPI of > 0.8. 10cm is width for routine below knee leg ulcer bandaging.
	Actico® (not latex free)	8 cmx6m 12cmx6m	£3.25 £4.31	8 and 12 cm Actico bandages are for use in patients with chronic oedema . 8cm should be applied to the foot and 12cm to the thigh.
	Coban® 2 layer compression system		£8.24	The Coban 2 bandage system is the second line choice short stretch bandage system for patients requiring full compression where Actico is considered inappropriate, known latex allergy, or slippage may be a concern. This system is designed to be used as a kit and should not be used with other wadding or bandages. Two-layer compression system that delivers sustained, therapeutic compression. To be used as a kit comprising of the latex-free foam padding layer and a latex-free cohesive, compression bandage. After application the two layers bond to form a single-layer bandage. Can be worn for up to 7 days. Recommended in patients with an ABPI of > 0.8. 10cm is the bandage width for routine below knee bandaging.
	Coban® 2 Lite compression system		£8.24	The Coban 2® Layer Lite Compression System is designed to be comfortable for patients less tolerant of compression therapy and/or who require reduced compression therapy. This system is designed to be used as a kit and should not be used with other wadding or bandages. 10cm is the width for routine below knee bandaging.

Please see Local Leg Ulcer Treatment Algorithm

ALL healthcare professionals must ensure their competencies for applying compression bandaging are up to date

Arterial screening (i.e. Doppler ultrasound) must be undertaken before compression hosiery or bandaging is commenced. Note that arterial screening must be repeated periodically if compression therapy is ongoing. Ref: Local Leg Ulcer Guidelines/Standard Operating Procedures

11. BANDAGES (cont'd) b) Short stretch compression bandages providing full and reduced compression.	Coban® 2 Comfort Foam Layer (layer1)	10cmx3.5m	£7.45	Individual components of Coban 2 bandage kit. These may be required for the larger/ longer leg.
	Coban® 2 Compression Layer (layer 2)	10cmx4.5m	£4.79	
	Coban® 2 Lite comfort foam layer (layer 1)	10 cmx2.7m	£5.81	Individual components of Coban® 2 Lite bandage kit. These may be required for the larger/longer leg.
	Coban® 2 Lite compression layer (layer 2)	10cmx3.5m	£4.59	
	Coban® 2 Comfort Foam Layer (layer1)	15cmx3.5m	£11.32	The Coban® 2 15cm width bandage should be used for bandaging the knee and thigh of patients with chronic oedema.
	Coban® 2 Compression Layer (layer 2)	15cmx4.5m	£7.14	

Please see Local Leg Ulcer Treatment Algorithm **ALL healthcare professionals must ensure their competencies for applying compression bandaging are up to date** Arterial screening (i.e. Doppler ultrasound) must be undertaken before compression hosiery or bandaging is commenced. Note that arterial screening must be repeated periodically if compression therapy is ongoing. Ref: Local Leg Ulcer Guidelines/Standard Operating Procedures				
11. BANDAGES (cont'd) b) Short stretch compression bandages providing full and reduced compression.	Coban® 2 Lite comfort foam layer (layer 1)	15cmx2.7m	£8.77	The Coban® 2 Lite 15cm width bandage should be used for applying reduced compression to the knee and thigh of patients with chronic oedema.
	Coban® 2 Lite compression layer (layer 2)	15cmx3.5m	£6.22	
	Comprilan® (Latex free)	10cmx5m	£3.37	Reusable system (washable). High cotton content. For specialist chronic oedema management.
c) **Chronic oedema**	Actico® (not latex free)	8cmx6m 10cmx6m 12cmx6m	£3.25 £3.38 £4.31	
	Comprilan® (Latex Free)	10cmx5m	£3.41	
	Coban® 2 layer compression system	Multi-layer compression bandage kit	£8.24	Bandages of choice for lymphoedema/chronic oedema management. Two-layer compression system that delivers sustained, therapeutic compression to be used as a kit comprising of latex-free foam padding layer and a latex-free, cohesive, compression bandage. Apply the two layers which bond to form a single-layer bandage. Can be worn for up to 7 days. Recommended in patients with an ABPI of > 0.8.
	Coban® 2 Comfort Foam Layer (layer1)	10cmx3.5m	£7.45	
	Coban® 2 Compression Layer (layer 2)	10cmx4.5m	£4.79	The Coban 2® Layer Lite Compression System designed to be comfortable for patients less tolerant of compression therapy and/or reduced ABPI(ankle brachial pressure index).

ALL healthcare professionals must ensure their competencies for applying compression bandaging are up to date Arterial screening (i.e. Doppler ultrasound) must be undertaken before compression hosiery or bandaging is commenced. Note that arterial screening must be repeated periodically if compression therapy is ongoing. Ref: Local Leg Ulcer Guidelines/Standard Operating Procedures				
Product Type	**Product Name**	**Size**	**Cost/ Item**	**Comment**
12. SUPPORT HOSIERY **Class 1** Light (mild) Support Compression at ankle 14-17mmHg	Activa®	 Below knee Thigh length	 £7.52 £8.24	The make of hosiery selected depends on comfort, cosmetic appearance and ease of application. Activa® (Activa Health Care) are deemed the preferred products by the Formulary Group.
Class 2 Medium (moderate) Support Compression at ankle 18 – 24 mmHg		Below knee Thigh length	£11.00 £12.24	
Class 3 Strong Support Compression at ankle 25-35mmHg		Below knee Thigh length	£12.47 £14.51	For recurring leg ulceration and gross varices.
Kit	Activa® Leg Ulcer Hosiery Kit	1 Stocking and 2 liners	£22.90	Available as small, medium, large, extra large and extra extra large. Useful for active ulceration to apply full compression for patients who can't tolerate bandaging. Assessing and measuring as per single hosiery products.
Accessories	Activa ® Liner Pack Acti-Glide® Compression hosiery application system	3 Liners	£16.84/£17.17 £14.62	Liner pack available in all sizes, open and closed toe. Supply of single unit only.
Waterproof Protector	LimbO®	Standard and short leg	£10.56	Available as slim, normal and large build.

ALL healthcare professionals must ensure their competencies for applying compression bandaging are up to date

Arterial screening (i.e. Doppler ultrasound) must be undertaken before compression hosiery or bandaging is commenced. Note that arterial screening must be repeated periodically if compression therapy is ongoing. Ref: Local Leg Ulcer Guidelines/Standard Operating Procedures

Product Type	Product Name	Size	Cost/ Item	Comment
12. SUPPORT HOSIERY (cont'd) **Hosiery for Chronic oedema/lymphoedema**				These products increase the venous and lymphatic return by aiding the absorption of excess limb fluid. They can help in the management of recurring ulcers and when conventional hosiery not containing oedema of limbs. They have a higher 'Stiffness Index' (aids stimulation to lymph to encourage fluid return) and can last up to 6 months before replacing if undamaged.
Class 1 **18-21mmHg** **Class 2** **23-32 mmHg** **Class 3** **34-46mmHg**	**ActiLymph®**	Available below and above knee with a wide or regular silicone band to prevent slippage at thigh 1 stocking per prescription item. Variety of colours, sizes, open and closed toe.		Provide light compression for early mild oedema with little leg distortion. Suitable for chronic oedema, lymphoedema, lipoedema, prophylaxis, maintenance therapy, palliative use. Provide medium compression for moderate to severe chronic oedema and lymphoedema, where resistant oedema occurs and some shape distortion. Provides strong compression and should be used for maintenance of severe chronic oedema and lymphoedema, where resistant oedema persists, history of recurring ulceration or where lymphatic damage is considerable and when use of lower classes has proved ineffective. **References:** MORRIS, A. (2004) Cellulitis and Erysipelas. *Clinical Evidence* 12: 2271-7 Available online: www.clinicalevidence.com/ceweb/conditions/skd/1708/1708.jsp need to update these references MOFFAT, C. (2003) Lymphoedema:an underestimated health problem. *Quality Journal of Medicine.* 96: 731-8

Product Type	Product Name	Size	Cost/ Item	Comment
13. ADHESIVE TAPES Non-woven synthetic	Clinipore®	2.5cmx5m 5cmx5m	59p 99p	
	Chemifix®	5cmx5m 10cmx5m	£1.25 £2.10	To be used only when Clinipore® is deemed unsuitable.
14. ABSORBENT DRESSINGS	Zetuvit E® Sterile	10x10cm 10x20cm 20x20cm 20x40cm	21p 25p 39p £1.11	Absorbent and protective. Used as a secondary dressing. NB community nurses can obtain Surgipads® from central stores.
Hyper-absorbent Adhesive Dressing	Allevyn Life®	12.9x12.9cm 15.4x15.4cm	£2.51 £3.06	For use on high exudating wounds where a wear time of 5 – 7 days is required.
Super Absorbent Dressing	Flivasorb®	10x10cm 10x20cm 20x20cm 20x30cm	88p £1.05 £1.86 £2.35	

Product Type	Product Name	Size	Cost/ Item	Comments
15. MISCELLANEOUS				
Sterile Skin Closures	Leukostrip®	6.4x76mm	£6.38	Available on FP10, more cost effective than Steri-strip®.
Dressing Packs	Polyfield® Nitrile® Patient Pack		52p	Sterile dressing pack containing powder-free nitrile gloves, laminate sheet, 7 non-woven swabs, towel, apron and disposable bag.
	Nurse It® dressing packs		55p	Pair of powder-free latex vinyl gloves, 7 non-woven swabs, 1 compartment tray, disposable forceps, laminated paper sterile field, large apron, paper towel and white polythene disposable bag.
Non-woven Fabric Swab	sterile (5 pack)	7.5x7.5cm	27p	Use for general purpose swabbing and cleansing.
Sodium Chloride	Clinipod®	20ml x 25	£4.80	**Normal Saline** – is the irrigation solution of choice. All irrigation solutions should be applied at body temperature. Tap water only to be used according to local policy for leg washing and all chronic and acute wounds will be cleansed with a sterile, single use solution, if required.
Gauze and Cotton Tissue	Gamgee® Drug Tariff (Pink)	500g	£5.45	**Gamgee® -** For use to absorb large amounts of exudate. Not to be used as primary dressing. If used in leg management always pad OUTSIDE the bandage to maintain adequate pressures (if compression) to the leg. Can be cut to size if required.

Product Type	Product Name	Size	Cost/ Item	Comments
15. MISCELLANEOUS (cont'd)				Please refer to local formulary/dermatological guidance for detailed product list and advice. Table of all the products can be found in MIMS and includes the potential sensitisers. http://www.mims.co.uk/Tables/882437/Emollients-Potential-Skin-Sensitisers-Ingredients/
Skin Protectant	LBF® Sterile No Sting Barrier Film	5x1ml 5x2ml	£3.82 £5.07	To protect surrounding skin in high exudate wounds to prevent maceration. For use over excoriated skin and around stomas. Use in moist areas where it is difficult to get dressing adhesion. When used appropriately LBF® reduces wound trauma. The 2ml LBF stick, when evaluated was found to provide adequate coverage in comparison to a 3ml stick. *(Medi Derma S may be selected at the discretion of local trusts following guidance from their procurement team)*
Potassium permanganate	Permitabs®	30	£11.45	Adjunct therapy only. Short-term treatment for wet weepy, infected or eczematous legs. One tablet dissolved in 4 litres of water. Indicated for short term use only. **Maximum of 2 weeks** in conjunction with assessment to ascertain cause of infection or weeping and treat underlying cause. **Warn patients about staining. If treating feet suggest using white soft paraffin around the toe nails to reduce staining.** Please see document at link below for further guidance http://www.southernhealth.nhs.uk/knowledge/clinical-support-services/medicines-management/forms/

APPENDIX 1

ASEPTIC NON TOUCH TECHNIQUE

Refer to organisational policy

APPENDIX 2
PROTOCOL FOR TAKING SWAB FROM A SUSPECTED INFECTED OR NON-HEALING WOUND

Bacteriological swabs should only be taken when there is clinical evidence of infection in a wound (see appendix 4) For example

1. Spreading cellulites **and/or**
2. New or increased pain not accounted for by underlying arterial disease **or**
3. Patient is systemically unwell possibly with abnormally high or low temperature, raised pulse, raised respiration or raised white blood cell count

Clean the wound with a sterile solution to remove debris, slough, pus or other foreign material. Swabs should be taken from the deepest part of the cleaned wound. Gently pass the swab over the area in a zig zag motion ensuring it is turning in a circular motion so the entire swab is covered. Swab from the centre to the outside of the wound and ensure that if there is any exudate present it is thoroughly absorbed onto the swab.
Send the swab to the pathology department as soon as possible including the following information:

1. Patient name, date of birth and NHS number
2. Location of the patient, identity of who has taken the swab and where the results should be directed
3. Site where the swab was taken from
4. Clinical indicators for taking the swab
5. Any antibiotics the patient may be on currently or recently
6. The clinical investigation required
7. Wound history and other treatment tried
8. Any relevant co-morbidities or current diseases

Record the taking of the swab in the patient's notes. It is the practitioner's responsibility, as the patient's advocate, to access the results and liaise with the medical staff to act on the swab result if indicated.

Any systemically unwell patient should have a NEWS score (or similar) to assess for signs of sepsis.

Infection is not implied by the mere presence of organism. The microbiology result must be taken into account along with the clinical indicators for infection.

Ref: Patten,H. (2010) Identifying wound infection: Taking a swab. Wound essentials.64-66
Antibiotic Prescribing in Community 2014 Pg 54 & 55

Best Practice in Older Person's Skin Care

(Best Practice Statement: *Care of the Older Person's Skin.* London: Wounds UK, 2012. Download from www.wounds-uk.com)

Aim: To Maintain the Integrity of the Skin

As a person ages, changes in the skin occur, increasing skin vulnerability to a variety of damage. Older skin is less able to regenerate & protect, increasing the risk of skin breakdown

Dry & vulnerable skin

Older skin is thinner and dryer making it vulnerable to splitting and bacterial invasion and the dryness is often a cause of itching. Emollients applied twice daily are seen as the first line of treatment and will help rehydrate and maintain skin integrity. Traditional soaps dry the skin out, increasing the problem.
Emollient therapy is recommended as best practice for care of older person's skin and should be used as an alternative to soap. Adequate quantities should be used according to the patient's need (refer to BNF for types of preparations and quantities)

Total emollient therapy (Lawton, 2009)	
Soap substitutes	Soap is an irritant and can make the skin itchy. Soap substitutes cleanse effectively but do not leave the skin feeling dry. Products containing SLS (eg. Aqueous cream) should not be used as a soap substitute.
Bath oils*	Add to bath water to help moisturise the skin. Bath additives leave a layer of oil after bathing**Warning: bath oils can make the bath slippery. Risk assess patient and environment for suitability.*
Moisturisers	Moisturisers are 'leave on' emollients. They are available as: **Ointments**: they have the highest oil content and are greasy. They can be messy to apply, leave the skin looking shiny and stain clothes. They are suitable for very dry skin and may be best applied at night. Ointments usually work by occlusion. **Creams**: they are quickly absorbed and more cosmetically acceptable. Creams are good for daytime use and work by occlusion or 'active' humectant effect, but are much less effective than ointments. **Lotions**: the lightest and least greasy emollients (contain less oil). They are not suitable for dry skin conditions.

Damage related to moisture from maceration & incontinence
Excess fluid on the skin from wounds, sweating, urine and/or faecal incontinence and peri-stomal exudate are likely to increase the damage to the skin causing maceration. Excessive moisture due to urine/faecal incontinence can lead to skin damage presenting as a moisture lesion. A protective skin barrier is required as prevention, please see page 20.

Product choice for an individual patient involves consideration of patient preference, consistency required, ingredients including potential allergens, suitable packaging and cost. The products of choice are therefore ones which are effective, the patient finds acceptable and is prepared to use on a regular basis. Refer to local formulary/dermatological guidance for more detailed product list and advice. Table of all the products can be found in MIMS and includes the potential sensitisers.
http://www.mims.co.uk/Tables/882437/Emollients-Potential-Skin-Sensitisers-Ingredients/

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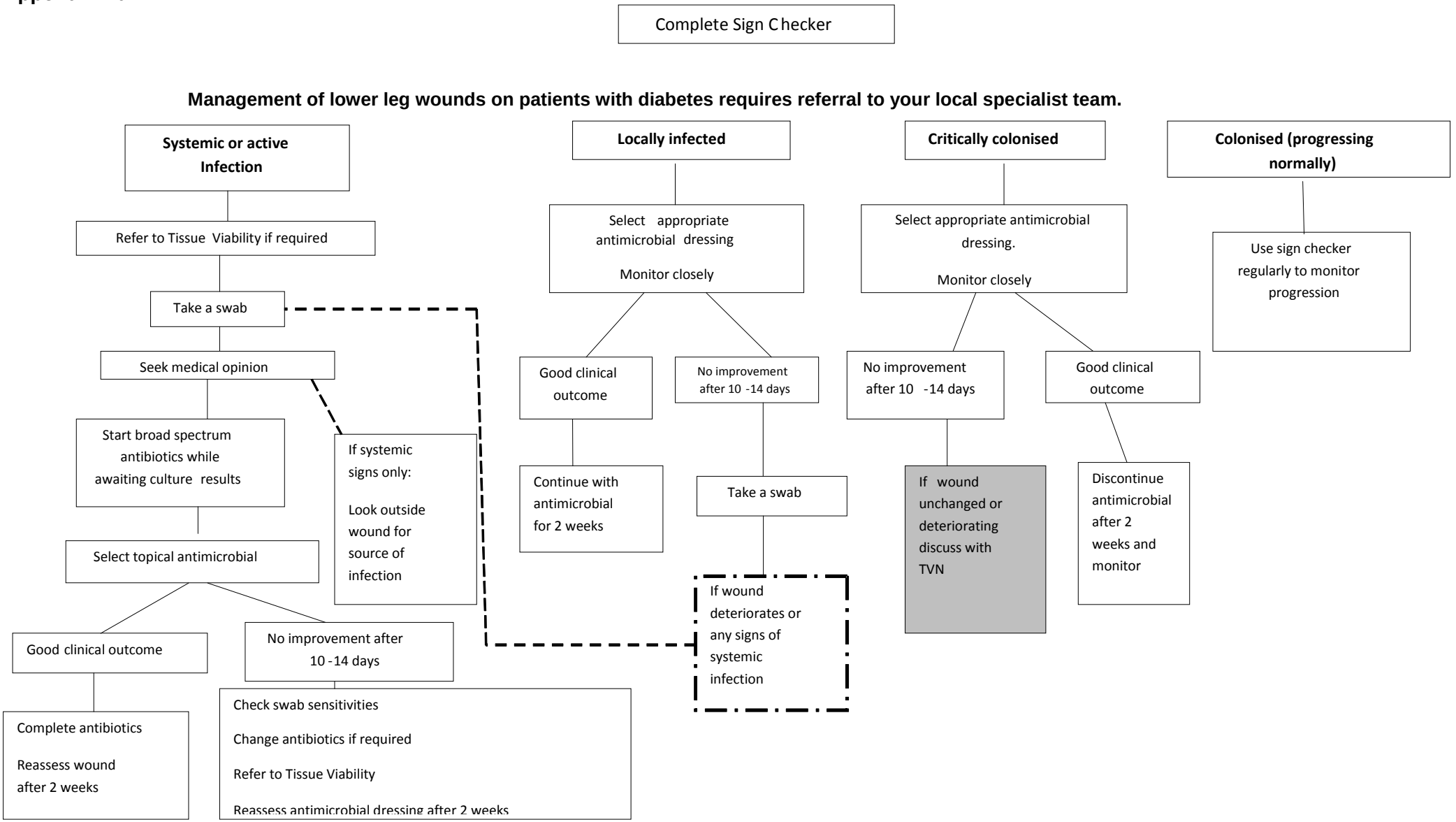
Appendix 4a

Critically Colonised or Infected Wounds SIGN CHECKER

Please use in conjunction with local Antibiotic Guidelines

✓✓✓✓ Sign Checker ✓✓✓✓							
Systemic Infected	✓	Locally Infected	✓	Critically Colonized	✓	Colonized	✓
↑ redness >2cm & pain		Local redness <2cm or small flare & pain		No change (at ≥2 weeks) & no cellulitis		Expected progress (expected inflamm.)	
Wide heat/swelling		Local heat/swelling					
Rapid onset new site necrosis		New necrosis on wound bed		Thick slough not responding		Necrosis/thick slough but debriding	
Extension		Extension					
Blistering or satellites							
↑ wetness		↑ wetness		Continuing wetness		Wet/moist as stage of healing	
Purulence		Purulence		Purulence		Exudate as stage of healing	
Haemorrhagic patches/spots				Blue green exudate			
↑ necrotic tissue		↑ necrotic tissue		Fast returning slough		Light mobile slough	
↑↑ CRP		↑↑ CRP					
↑ WBC		↑ WBC					
Pyrexia/Rigor							
Confusion (elderly)				Malodour		↓ size in last 1-2 wks	
Bacteraemia				Discoloured granulation		Normal granulation	
Lymphangitis/adenitis				Friable granulation		Epithelial tissue	

Appendix 4b


Complete Sign Checker
Management of lower leg wounds on patients with diabetes requires referral to your local specialist team.
Systemic or active Infection
Refer to Tissue Viability if required
Take a swab
Seek medical opinion
Start broad spectrum antibiotics while awaiting culture results
Select topical antimicrobial
Good clinical outcome
Complete antibiotics
Reassess wound after 2 weeks
No improvement after 10 -14 days
Check swab sensitivities
Change antibiotics if required
Refer to Tissue Viability
Reassess antimicrobial dressing after 2 weeks
If systemic signs only:
Look outside wound for source of infection
Locally infected
Select appropriate antimicrobial dressing
Monitor closely
Good clinical outcome
Continue with antimicrobial for 2 weeks
No improvement after 10 -14 days
Take a swab
If wound deteriorates or any signs of systemic infection
Critically colonised
Select appropriate antimicrobial dressing.
Monitor closely
No improvement after 10 -14 days
If wound unchanged or deteriorating discuss with TVN
Good clinical outcome
Discontinue antimicrobial after 2 weeks and monitor
Colonised (progressing normally)
Use sign checker regularly to monitor progression

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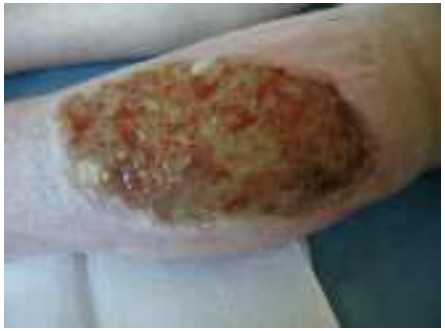
Appendix 4c

Diabetes Foot Ulceration – **Refer** all patients with an active ulcer **within 24 hours** to your local Diabetes Foot Protection team. Early referral to specialist teams for diabetes management, offloading, debridement and appropriate wound-care, which all are key to achieve the best outcome.



Critically Colonised or Infected Wounds

Management of lower leg wounds on patients with diabetes requires referral to your local specialist team.
Management of foot ulcers on patients with or without diabetes requires referral to your local specialist team.

Description
See SIGN checker and flow chart for identification

Aim To reduce critical colonisation or infection to reduce wound bio-burden and infection. It is expected that all nursing staff will familiarise themselves with the products suggested and their appropriate use. This guide is intended for first line treatment/product consideration. It is not considered as an exhaustive list or to be applicable for all patients. All healthcare professionals are expected to use their clinical judgement when assessing patients and wounds.

Presentation - refer to SIGN checker.

Treatment – Primary dressing – Low to moderate exudate **– Inadine** or **Cutimed Sorbact** or **Medihoney range** or **Suprasorb X and PHMB**
Moderate to high exudate **– Iodoflex** or **Cutimed Sorbact** or **Medihoney range or Durafiber Ag**

Secondary dressing – absorbent dressings such as **Zetuvit E (sterile) or Flivasorb**

Factors to consider – Clinisorb for odour control

Other factors to consider
Antimicrobial dressings should be used initially for two weeks only; if after reassessment the need for further antimicrobial use is indicated, this should be actioned and documented in the patient's notes together with the rationale.

Note: inflammation around wound edges is an expected part of the inflammatory process of wound healing in acute wounds and may be evident for up to three days post wounding. Patients who are immuno-compromised, diabetics or elderly may not show the classic signs of infection.

Please refer to local Sepsis guidelines or NICE Guidelines https://www.nice.org.uk/guidance/ng51?unlid=280104107201611917351

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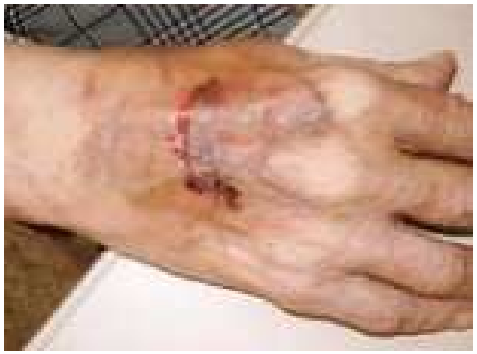
Appendix 5 Product Selection Tools

Diabetes Foot Ulceration – **Refer** all patients with an active ulcer **within 24 hours** to your local Diabetes Foot Protection team. Early referral to specialist teams for diabetes management, offloading, debridement and appropriate wound-care which all are key to achieve the best outcome.

<table>
<tr>
<td>  </td>
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Skin Tears

Presentation- Superficial or traumatic wound, where the skin rips, commonly occurs in the elderly and the dehydrated

Aims- Promote atraumatic removal prevents infection, cover and protect

Treatment – Clean with **normal saline**

Where skin flap can be realigned gently reposition skin back with gloved finger and apply **Atrauman with gauze pad secured with Comfifast/Clinifast,** secondary dressing **Softpore or Kliniderm/ Biatain Silicone**
Where the edges cannot be aligned apply **Kliniderm/ Biatain Silicone**

Factors to consider – Date dressing and place an arrow on dressing to show direction for removal.
Remove dressing after 24 to 48 hours to check wound for infection

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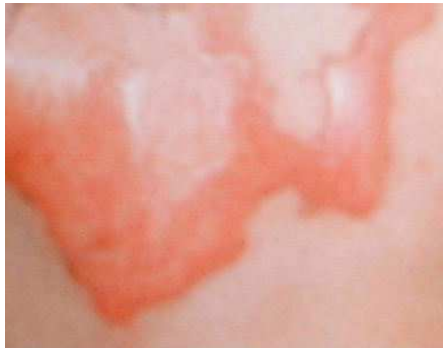
<tr>
<td>  </td>
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Superficial Burns/Scalds

Presentation – Partial thickness- Red inflamed skin, potentially with blistering

Aims – To cover and protect & minimise scarring

Treatment – Cover with **Atrauman and gauze pad/Flivasorb** as secondary dressing or **Kliniderm/Biatain Silicone** whilst seeking further advice from TVN

Factors to consider - For scalds, monitor initially as effects can continue for a few days after event

NB: monitor intensively initially and seek immediate advice from your local burns unit if burn progresses

Burns Helpline - Salisbury Plastics Trauma Team support/help-line email is: Shc-tr.PlasticsTrauma@nhs.net
If leaving an email please inform **Burns Co-ordinator via switchboard on 01722 336262 – Bleep 102**
Please seek advice if unsure, particularly if the burn is on the hand
Polymem- may be used for radiotherapy burns – for specialist use only

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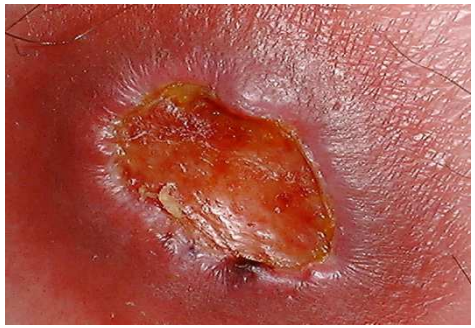
</tr>
</table>

- **Diabetes Foot Ulceration** – **Refer** all patients with an active ulcer **within 24 hours** to your local Diabetes Foot Protection team. Early referral to specialist teams for diabetes management, offloading, debridement and appropriate wound-care which all are key to achieve the best outcome.

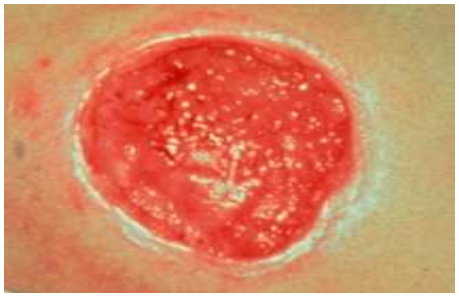


Epitheliasing Wounds

Presentation - The wound is pink in colour; the tissue is fragile with evidence of healing wound bed and/or margins

Aim - Protect new tissue and support wound closure

Treatment - Primary Dressing – cover wound with **Atrauman** or **Hydrofilm** or **Kliniderm**/**Biatain Silicone or Duoderm Extra Thin**



Granulating Wounds

Presentation- Wound could be red in colour and has a granular 'bubbly' appearance

Aim – To promote healing and support wound to epitheliasing stage

Treatment – low exudate **– Atrauman or Kliniderm/Biatain Silicone**

Treatment – moderate to high exudate - **Exufiber** with **Flivasorb** as secondary dressing

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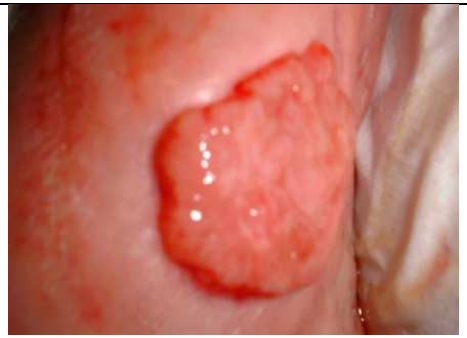
Diabetes Foot Ulceration – **Refer** all patients with an active ulcer **within 24 hours** to your local Diabetes Foot Protection team. Early referral to specialist teams for diabetes management, offloading, debridement and appropriate wound-care which all are key to achieve the best outcome.



Over-Granulating wounds

Presentation- Characterised by proud-flesh occurring after the wound bed has filled with granulation tissue

Aim – To reduce the excessive laying down of new blood vessels

Treatment - One fingertip unit of a mild topical steroid such as **Hydrocortisone** or **Haelan (Fludroxycortide)** Tape/Cream.

Kliniderm/Biatain Silicone as secondary dressing
(if bleeding or infection suspected **consider antimicrobial** as primary dressing)

Review wound after 3-4 days

Haelan® tape – SPC http://www.mhra.gov.uk/home/groups/spcpil/documents/spcpil/con1469161938832.pdf
NB: Haelan has been re-named under its generic name Fludroxycortide

Sloughy Wounds

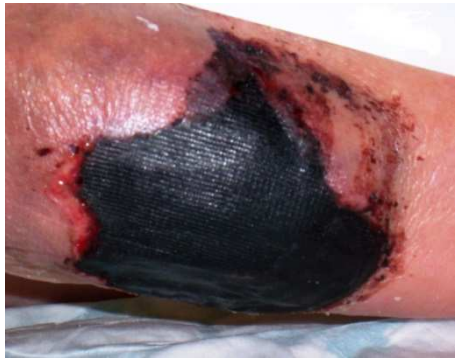
Presentation- Presence of yellow or soft brown/grey devitalised tissue

Aim - To rehydrate in order to support process of debridement and the removal of devitalised tissue
To provide a clean wound base for granulation

Treatment –primary dressing - low to moderate exudate **- IntraSite Conformable** or **KerraLite Cool** or **Comfeel Plus or (Medihoney** if wound infected)
- moderate to high exudate **– Exufiber or Suprasorb A**

Secondary dressing – low exudate - **Gauze and Hydrofilm**
moderate to high exudate - **Zetuvit E (sterile)** or **Flivasorb** for frequent dressing changes

Diabetes Foot Ulceration – **Refer** all patients with an active ulcer **within 24 hours** to your local Diabetes Foot Protection team. Early referral to specialist teams for diabetes management, offloading, debridement and appropriate wound-care which all are key to achieve the best outcome.



Necrotic Wounds

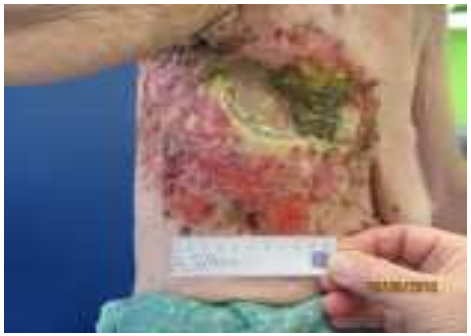
Presentation - The presence of black or yellowish brown devitalised /dead tissue

Aim - To rehydrate and 'break down' or soften devitalised tissue
To rehydrate tissue and promote debridement

Treatment – Primary dressing – IntraSite Conformable, or **Kerralite Cool**
If wound is infected
Iodoflex or Medihoney HCS
protect wound edges with LBF barrier film

Secondary dressing – absorbent dressing such as **Zetuvit E (sterile) or Flivasorb**

NB: Black, hard, dry necrotic tissue to heels to be left exposed
NB: Dressings will need reviewing daily if high exudate



Fungating Wounds

Presentation – discharging lesions/tumour that breaks through the skin surface

Aim – complex wound requiring management of exudate, bleeding, odour and pain

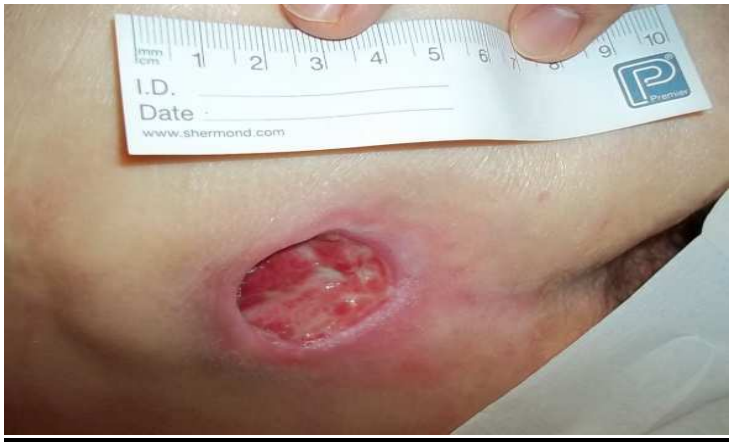
Treatment –**Prontosan soak**

Primary dressing – low to moderate exudate **–Prontosan gel** or **Suprasorb X and PHMB** or **Medihoney HCS**
Primary dressing – moderate to high exudate- **Exufiber** or **Suprasorb X and PHMB** or **Medihoney medical honey**

Secondary dressing –**Zetuvit E (sterile)** or **Flivasorb**

NB: Clinisorb for odour control is essential. Seek advice if bleeding or uncontrolled odour

Diabetes Foot Ulceration – **Refer** all patients with an active ulcer **within 24 hours** to your local Diabetes Foot Protection team. Early referral to specialist teams for diabetes management, offloading, debridement and appropriate wound-care which all are key to achieve the best outcome.



Sinus/Cavity wound

Presentation – track that extends from skin surface to an underlying cavity

Aim – establish extent and depth of tissue damage

Treatment – Cavity; **Prontosan** soak, Sinus; irrigate with **saline**

Primary dressing – Exufiber ribbon gently packed into wound or
If wound is infected
Medihoney medical honey via syringe into wound bed or
Durafiber Ag ribbon gently packed into wound bed.

Secondary dressing – Kliniderm/Biatain Silicone for low to moderate exudate
Zetuvit E (sterile) or Flivasorb for moderate to high exudate.

NB. Consider Topical Negative Pressure – contact TVN for advice

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APPENDIX 6

Contacts

NAME	TITLE	TRUST	PHONE NUMBERS	E MAIL
Monique Rosell	TV Nurse Specialist (Southampton)	Solent NHS Trust	02380608042	monique.rosell@nhs.net **Fax No. 02380538751**
Marj Woodhouse	Clinical Advisor Tissue Viability & Pressure Relief		02392007838	Marjolein.woodhouse@solent.nhs.uk
Maggie Simmons	Senior Staff Nurse Tissue Viability		07876230720	Maggie.simmons@solent.nhs.uk
Laura Evans	Senior Staff Nurse Tissue Viability		07876654320	Laura.evans@solent.nhs.uk
Kathleen Hayes	Wound Formulary Pharmacy Lead	Solent NHS Trust	07884242426	Kathleen.hayes@nhs.net
Debbie O'Brien	Manager Solent West	Single Point of Access for Allied Health Professionals Solent West Podiatry	03003002011 02380608801	debra.obrien@nhs.net
Sharon Steele	Podiatry Pathway Lead – At Risk Foot	Solent NHS Trust (East) Podiatry	07810656019	Sharon.Steele@Solent.nhs.uk
Fran Spratt	Tissue Viability Lead	University Hospital Southampton NHS Foundation Trust	07825 522 600	frances.spratt@uhs.nhs.uk
Sue Lawton	Locality Lead Pharmacist (Southampton)	Southampton City CCG	023 8029 6960 07899 987 464	sue.lawton@nhs.net
Lisa Rice	Advanced Clinical Nurse Specialist (Winchester/Andover)	Southern Health NHS Foundation Trust *Team e mail hp-tr.hampshiretvteam@nhs.net*	*02380 673988* *07747 792895*	lisa.rice@nhs.net Fax No. 02380 673977
Caryn Carr	TV Lead Nurse		07789867790	caryn.carr@southernhealth.nhs.uk Fax No. 02380 673977
Jane Barker	Advanced Clinical Nurse Specialist		07740852241	janebarker@nhs.net Fax No. 02380 673977
Clare Hancock	Advanced Clinical Nurse Specialist		*02380 673988* 07887 985101	clare.hancock1@nhs.net. Fax No. 02380 673977
Denise Woodd	LU Nurse Specialist and Independent Educator	NHS PORTSMOUTH CCG (part time)	07795 822648	denwoodd@gmail.com d.woodd@nhs.net
Jennie Fynn	Head of Medicine Management	North East Hampshire and Farnham CCG	07795 857584	jennifer.fynn@nhs.net
Caroline Bowyer	Medicines Management Pharmacist	Fareham and Gosport CCG		caroline.bowyer@nhs.net
Janet Brember	Formulary Pharmacist	NHS Portsmouth	02392 684588	janet.brember@portsmouthccg.nhs.uk Fax No. 02392 831656
Jennifer Etherington	Prescribing Support Pharmacist	NHS Portsmouth		jennifer.etherington@nhs.net
Alison Cole	Tissue Viability Lead	Portsmouth Hospital NHS Trust	Switchboard -02392 286000 Bleep 0078	alison.cole@porthosp.nhs.uk Phone/Fax No. 02392 286985
Michael Bennett-Marsden	Wound Formulary Pharmacy lead	Portsmouth Hospital NHS Trust	Switchboard -02392 286000 Bleep: 1393	Michael.Bennett-Marsden@porthosp.nhs.uk Phone/Fax No. 02392 286117
Ginny Ward	Locality Lead Pharmacist	West Hampshire CCG	07554 330566	ginny.ward@nhs.net

Appendix 7

Signposting/Useful References

www.woundcarehandbook.com	Catalogue of dressings and devices. Cost £12.99
www.wounds-uk.com	TV issues, conditions, wound types, online learning, Best practice Statements, Consensus Docs, Quick Guides, ongoing resource-free
MIMS	http://www.mims.co.uk/
BNF	https://www.bnf.org/
All woundcare/products companies will have information via their own websites or found by search engine, eg. Google.	

APPENDIX 8 Generic Exception Reporting Form (add organisational logo)

WOUND CARE FORMULARY Exception Reporting Form
Mandatory requirement when using wound and skin care products not on formulary. ***(no patient ID to be seen)***   This will aid the Formulary Group to ensure the most appropriate products are included in the Formulary and highlight products for evaluation.
Your Name, Base, Designation and Contact Details:-
Name, type and size of non-formulary product used:-
Who was the product initiated/suggested by:- (e.g. GP/hospital ward/community/practice/specialist nurse/company representative):-   **Name & base of WISH/ANTS Link Nurse/HCP/nurse specialist you discussed this with:-**
Why has this non-formulary product been chosen: - (+ Description of the wound if a dressing)
What products have already been tried and what were the results:-
OUTCOMES AND COMMENTS
STATE outcome of using non-formulary product *(please include frequency of use, increase/reduce visits, how long the product was used for, amount used and whether appropriate and successful)*
Any other comments:- *ie. Would you use this again, pt experience, other factors eg. Pain, ease of use, availability, has a formal evaluation been done and fed back etc*

Please send/fax a copy of this form (no patient data) to your local nurse specialist or prescribing advisor (see resource page in formulary for fax nos under email addresses) and keep a copy for reference.