Woundcare Formulary

Companion and guide

2020

Norwich, North, South and West Norfolk CCGs

Version 8 – Replaces version 7.0

Woundcare Formulary 2020

This document is used to provide wound care in line with NICE guidance across the 4 CCGs in Norfolk. All items on this formulary are available through the ONPOS Direct Supply service, which should be used wherever possible. FP10 prescribing is not preferred.

Below is a list of changes from the previous version with the full formulary beginning on page 21. Other changes include updated company names after rebrands since the last formulary was published.

Please ensure all patient care plans reflect the current formulary at each review.

Product type	Previous formulary choice	New formulary choice
Antimicrobial	Algivon	Algivon Plus
Surgical tape	Chemipore	Clinipore
Polyabsorbent Fibre	Sorbsan Ribbon with probe	UrgoClean Rope with probe
Non-silicone foam	Biatain	Allevyn
Superabsorbent	Kliniderm	Eclypse

Items removed
Zipzoc Stockings
Dressing pads
Sorbaderm - All

Product type	Change made
Low Adherent	Added Softpore – SECOND LINE ONLY
Barrier products	Added Medi Derma-S
Hydrofibre	Kerracel added

Woundcare Guide 2020

The guide was developed and published by NCH&C Tissue Viability Nurses.

This wound care formulary companion provides clinical staff with a comprehensive guide to wound dressing products. Wound care products are selected using the best available evidence gathered from a number of sources. Current usage locally, along with experience of use of the products has also been considered.

The dressings suggested are adequate for the majority of situations. Alternatives should only be used on the recommendation of the Tissue Viability Nurse or following discussion with team leader.

This formulary will assist the practitioner in a variety of settings including GP Practices to select a wound care product, following a full assessment using the appropriate clinical guidelines for the type of wound being managed.
Whilst the formulary focuses on wound care products, holistic wound care must include holistic assessment of the patient, management of the surrounding skin, an understanding of the underlying cause, accurate documentation and continuous monitoring and evaluation of the patient.

Tissue Viability Nurses
Libby Gray – Norwich, North Norfolk, South Norfolk
Rachel Sweeney – West Norfolk

1. DEFINITION OF A WOUND

Wounds develop when surface skin is damaged; the body immediately starts the healing process to repair damaged tissue. Healing occurs via either:

- primary closure
- secondary closure
- delayed primary closure (also known as tertiary indention)

Primary closure- when the wound edges are in proximity to each other and there is little or no tissue loss, edges can be apposed without tension, using adhesive strips, sutures, staples or clips. As long as there are no factors to delay healing, these wounds should heal quickly.

Secondary closure- when primary closure is not possible the wound should be left open to granulate / epithelise. In secondary closure, healing is significantly delayed.

Delayed primary closure- when the closure is delayed due to local adverse wound conditions, e.g. uncontrolled bleeding, risk of infection the wound would then be closed as per primary intention.

2. STAGES OF HEALING

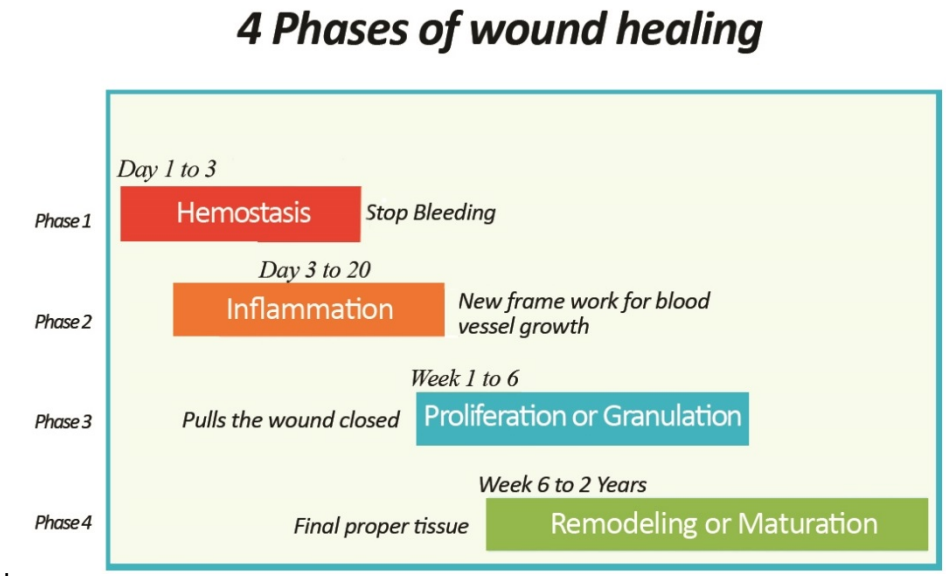
Wound healing follows a pathway of the following 4 stages, interruption or delay in any one of these stages results in a static non-healing wound. Wounds which fail to heal within 12 weeks are classified as chronic.

The vascular phase/ Haemostasis - contraction occurs at the end of damaged blood vessels to minimise blood loss, the clotting process begins to temporarily close the wound.

The inflammatory phase- this phase is detected by the presence of localised heat, swelling, erythema and discomfort this should not be confused with infection. Exudate is produced to facilitate healing; it has anti-microbial properties

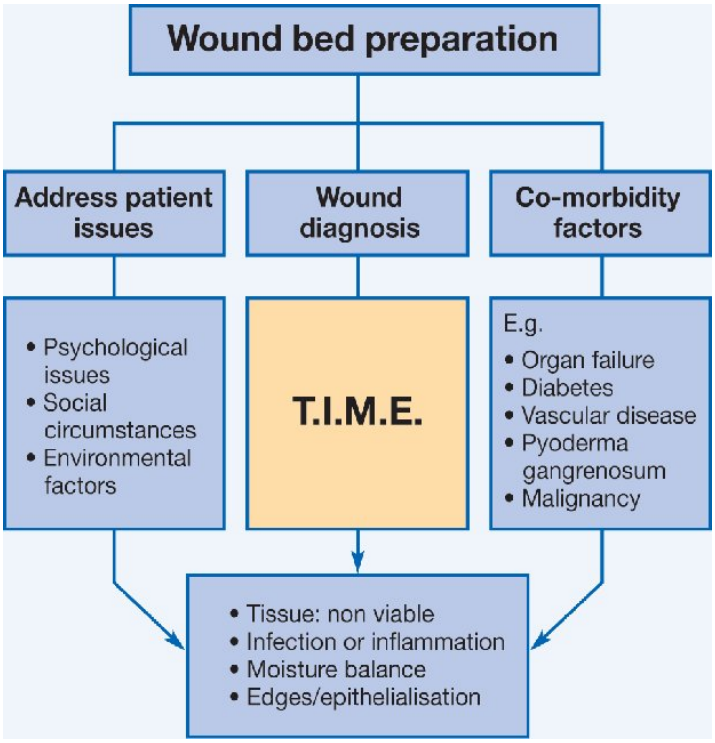
Proliferative/Granulation phase- during this phase, as the wound granulates connective tissue fills in the wound; the wound will begin to contract bringing the edges together to allow the re-growth of epithelial cells across the surface of the wound forming a continuous layer.

The Maturation phase- this stage begins approx. 20 days after injury; this phase can last for a significant period of time. Scar tissue becomes flatter, paler and smoother over time as the blood supply decreased. Scar tissue is not as strong as normal skin.



3. WOUND ASSESSMENT

It is of the greatest importance that a thorough wound assessment is done at **EVERY** interaction with the patient. The wound needs to be assessed as a whole including the ***Wound bed, Wound Edge & Periwound skin***. This will allow for correct product selection and up to date care plans at every dressing change, giving the wound a chance to heal more quickly and improving patient outcomes and quality of life. The correct assessment tools must be used and accurate record keeping is essential. This results in quicker healing and improved patient experience



World Wide Wounds

Holistic Approach / Assessment
A full assessment that takes into account the whole patient and wound - Intrinsic factors: Age, Infection, diseases underlying complications/conditions (Diabetes, illness etc.), nutrition, drug therapies, Pain, Doppler/ABPI, smoking, lifestyle Psycho/social concerns, wound aetiology, Location, Moisture/Exudate, Size/depth, Appearance of wound/peri-wound area, wound staging

Steps of Wound Assesment

- Full assessment of the wound area – Tissue type, Infection Continuum, Moist Wound Healing, Exudate, Edge of wounds, Pain and surrounding skin
- Measurement
- Record keeping and care plans
- Referral pathways

Reassessment
Carried out at each visit to establish progression of wound healing, care pathways and outcomes.

4. HOW TO CHOOSE A DRESSING

Wound dressings assist healing by creating the optimum conditions for the wound to heal therefore careful consideration needs to be given to product selection. A thorough and accurate wound assessment is of the greatest importance before selecting a dressing. A sound rationale should be given in relation to the assessed wound and the chosen product.

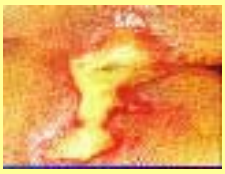
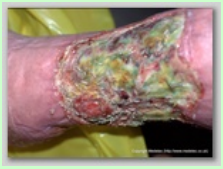
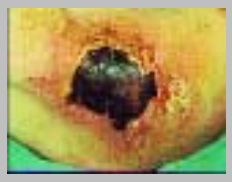
5. HOW TO USE THE FORMULARY GUIDE

- Identify / classification of wound (Red, Pink, Yellow, Green, Black). Most wounds are likely to have elements of more than one ‘stage’ of wound healing; choose the section that is most relevant to progressing wound healing at this time.
- Choosing a dressing appropriate to wound type and exudate level
- Only use approved combinations of products. Most dressing in the formulary are primary dressings and can be used directly onto the wound. **Do not** use additional dressing unless there is clinical justification such as a wound contact layer (e.g. atrauman) under a silicone foam.
- Check manufacturers’ instructions for individual products. These contain lots of useful information.

6. KEY MESSAGES

- Start the appropriate level of management for the wound type and stage of healing in accordance with the Trust Wound Care Guidelines using the EWMA Wound Bed Preparation acronym TIME. (T = Tissue, I = Inflammation/Infection, M = Moisture, E = Edges)
- Review the wound at each dressing change documenting the TIME observations on the wound assessment care plan
- In accordance to the Wound Bed Preparation process the wound classification and size should change over time. Use measuring devices at least every four weeks to evidence the progress or non-progress of a wound and document on wound care plan.
- Do not over prescribe excessive quantities or issue repeat prescriptions for wound care products.
- For housebound patients **A maximum of 7 days' supply should be sufficient**. This avoids wastage and prompts the opportunity for formal review of the wound.
- Antimicrobial dressings should only be used where 1) there are clinical signs and symptoms of infection, **and discontinued when the infection is resolved or if there is no improvement after 14 days** or 2) a patient with a non-responsive chronic wounds is following the biofilm pathway. Consider alternative antimicrobials or strategies if infection is still present (e.g. oral antibiotics). Wound swabs must be taken if an infection is not resolving or the patient is systemically unwell.
- The BNF advises against the use of silver dressings for acute wounds as there is some evidence that they may delay wound healing. They should not be routinely used for management of uncomplicated leg ulcers.
- Dressings prescribed on FP10 for individual patients must not be used for any other patient or for stock.

7. WOUND TYPES AND DRESSING SELECTION

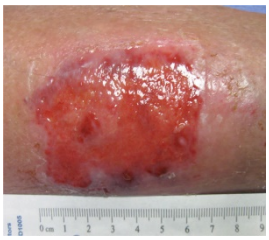
WOUND TYPE	DESCRIPTION	AIM OF TREATMENT
	**Red (Granulating)** Granulation is the process by which the wound is filled with highly vascular, fragile connective tissue	Exudate management Promote moisture balance Protect
	**Pink (Epithelialising)** Epithelialisation is the process by which the wound is covered with new skin cells	Promote epithelialisation and wound maturation Protect
	**Yellow (Sloughy)** Slough contains exudate and dead cells (N.B. yellow tissue may be tendon or bone). The presence of slough slows healing and leads to infection.	De-slough / debridement Provide clean wound bed for granulation Management of exudate Preserve healthy tissue
	**Green (Infected)** Infection in wounds prevents healing. Consider systemic antimicrobial if infection goes beyond wound area or antimicrobial dressings not worked.	Reduce bacterial burden / growth to reduce pain/discomfort and promote healing Antimicrobial Action
	**Black (Necrotic)** Necrotic wounds contain dead tissue. **Be aware of vascular status of wound (if no blood supply must be kept dry).**	Debridement and management of devitalised tissue Exudate management Rehydration to promote autolytic debridement

7.1 RED (granulating)

Aim of treatment - manage exudate levels and promote granulation by creating a moist wound healing environment. To protect newly formed tissue and surrounding skin

Wound assessment	Dressing type	Dressing name	Instructions / contraindications	Secondary dressing
Low Exudate	Wound Contact	Atrauman	Non-adherent, primary wound contact layer for a wide variety of wounds, including infected wounds. Do not use under other primary dressings.	Xupad and K-Band
	Hydrocolloid	Duoderm extra thin	Hydrocolloid film, light to moderately exuding wounds that are granulating or wounds that have areas of slough or necrosis. DO NOT use on Full-thickness burns and dry wounds or Diabetic feet. For wounds with more exudate or requiring some debridement	None
	Silicone	Silflex	Silicone wound contact layer. **For fragile skin only**. Skin tears, abrasions, surgical wounds, burns, lacerations, leg ulcers, pressure ulcers. Use absorbent dressing on top if exudate levels require it. DO NOT use if allergic to Silicone.	Retain with basic island dressing or K-band.
Moderate Exudate	Alginate	Kendall Calcium Alginate	Soft, conformable, absorbent alginate dressing. Moderate or heavily exuding wounds that are granulating or with areas of slough. Can be used as haemostat to control bleeding of minor wounds. DO NOT use on dry wounds, surgical implantations or to control heavy bleeding.	Biatain Adhesive or Biatain non adhesive with K-band or Biatain Silicone (for patients with fragile skin)
	Super Absorbent	Xupad	First line when used as a secondary dressing - only to be used on certain wound types like surgical, sternal wounds, leg ulcer with no compression	K-Band
	Foam	Allevyn Adhesive	Indicated for exudate absorption and the management of partial- to full-thickness wounds. Some typical wounds are: ulcers (venous, arterial, diabetic, pressure), donor sites, surgical incisions, surgical excisions and burns (first- and second-degree). Contraindicated for use on third-degree burns. Do not use **any** Allevyn product with oxidizing agents such as hypochlorite solutions (e.g., Dakin's) or hydrogen peroxide, as these can break down the absorbent polyurethane component of the dressings. Mod –high exuding wounds.	None
	Silicone Foam	Biatain Silicone	Soft, absorbent foam, with gentle silicone adhesive border. Can be used under compression therapy. Moderately to highly exuding wounds including leg ulcers, pressure ulcers, partial thickness burns, donor sites, postoperative wounds and skin abrasions. DO NOT use with oxidising solutions e.g. hydrogen peroxide. Ensure that evaporating solutions are completely dried off before dressing application. **ONLY for use with patients with fragile skin**	None
High Exudate	Super Absorbent	Eclypse	Moderate to heavily exuding wounds: Leg ulcers, pressure ulcers, sloughy or granulating wounds, post-operative or dehisced wounds, fungating wounds, donor site management. -Do not use Eclypse on arterial bleeds or heavily bleeding wounds Do not use as a secondary dressing (see Xupad)	K-Band or compression therapy.
	Super Absorbent	Biatain Super	Highly absorbent, non-adhesive wound contact layer with a hydrocolloid component for adhesion. Highly exuding wounds including leg ulcers, pressure ulcers, non-infected diabetic foot ulcers, second-degree burns, surgical wounds and skin abrasions. Can be used under compression therapy.	None

7.2 PINK (epithelialising)

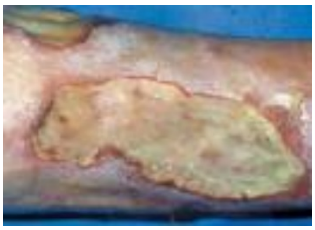


Aim of treatment - promote epithelialisation and protect newly formed tissue.

Wound assessment	Dressing type	Dressing name	Instructions / contraindications	Secondary Dressing
Low Exudate	Foam	Allevyn Adhesive	Soft, absorbent, conformable foam with skin-friendly adherent contact layer dressing. Can be used under compression therapy. Moderate to highly exuding wounds including leg ulcers, pressure ulcers, partial thickness burns, donor sites, postoperative wounds and skin abrasions. DO NOT use with oxidising solutions e.g. hydrogen peroxide. Fluid handling may be affected under compression bandaging	None
	Silicone Foam	Biatain Silicone	Soft, absorbent foam, with gentle silicone adhesive border. Can be used under compression therapy. Moderately to highly exuding wounds including leg ulcers, pressure ulcers, partial thickness burns, donor sites, postoperative wounds and skin abrasions. DO NOT use with oxidising solutions e.g. hydrogen peroxide. Ensure that evaporating solutions are completely dried off before dressing application. **ONLY for use with patients with fragile skin**	None
	Foam	Allevyn Non-Adhesive	Soft, Absorbent, conformable non-adhesive foam dressing. Can be used under compression therapy. Moderately to highly exuding wounds including leg ulcers, pressure ulcers, second-degree burns, donor sites, postoperative wounds and skin abrasions. DO NOT use with oxidising solutions e.g. hydrogen peroxide.	K-Band
	Wound Contact	Atrauman	Non-adherent, primary wound contact layer for a wide variety of wounds, including infected wounds. Do not use under other primary dressings.	Xupad & K-Band
	Island Dressing	Adpore	Adhesive dressing. Low to moderately exuding wounds.	None
	Silicone	Silflex	Silicone wound contact layer. **For fragile skin only**. Skin tears, abrasions, surgical wounds, burns, lacerations, leg ulcers, pressure ulcers. Use absorbent dressing on top if exudate levels require it. DO NOT use if allergic to Silicone.	Xupad and K-Band
	Hydrocolloid	Duoderm extra thin	Hydrocolloid film, light to moderately exuding wounds that are granulating or wounds that have areas of slough or necrosis. DO NOT use on Full-thickness burns and dry wounds or Diabetic feet. For wounds with more exudate or requiring some debridement	None
Moderate Exudate	Foam	Allevyn Adhesive	Soft, absorbent, conformable foam with skin-friendly adherent contact layer dressing. Can be used under compression therapy. Moderate to highly exuding wounds including leg ulcers, pressure ulcers, partial thickness burns, donor sites, postoperative wounds and skin abrasions. DO NOT use with oxidising solutions e.g. hydrogen peroxide. Fluid handling may be affected under compression bandaging	None
	Silicone Foam	Biatain Silicone	Soft, absorbent foam, with gentle silicone adhesive border. Can be used under compression therapy. Moderately to highly exuding wounds including leg ulcers, pressure ulcers, partial thickness burns, donor sites, postoperative wounds and skin abrasions. DO NOT use with oxidising solutions e.g. hydrogen peroxide. Ensure that evaporating solutions are completely dried off before dressing application. **ONLY for use with patients with fragile skin**	None

	Foam	Allevyn Non - Adhesive	Soft, Absorbent, conformable non-adhesive foam dressing. Can be used under compression therapy. Moderately to highly exuding wounds including leg ulcers, pressure ulcers, second-degree burns, donor sites, postoperative wounds and skin abrasions. DO NOT use with oxidising solutions e.g. hydrogen peroxide.	K-Band
	Super Absorbent	Xupad	Superabsorbent dressing. Superficial, heavily exuding acute and chronic wounds.	K-Band
High Exudate	Silicone Foam	Biatain Silicone	Soft, absorbent foam, with gentle silicone adhesive border. Can be used under compression therapy. Moderately to highly exuding wounds including leg ulcers, pressure ulcers, partial thickness burns, donor sites, postoperative wounds and skin abrasions. DO NOT use with oxidising solutions e.g. hydrogen peroxide. Ensure that evaporating solutions are completely dried off before dressing application. **ONLY for use with patients with fragile skin**	None
Excessive Exudate	Super Absorbent	Biatain Super	Highly absorbent, non-adhesive wound contact layer with a hydrocolloid component for adhesion. Highly exuding wounds including leg ulcers, pressure ulcers, non-infected diabetic foot ulcers, second-degree burns, surgical wounds and skin abrasions. Can be used under compression therapy.	None
	Super Absorbent	Eclypse	Moderate to heavily exuding wounds: Leg ulcers, pressure ulcers, sloughy or granulating wounds, post-operative or dehisced wounds, fungating wounds, donor site management.Do not use Eclypse on arterial bleeds or heavily bleeding wounds **Do not use as a secondary dressing**	K-Band or compression therapy

7.3 YELLOW (sloughy)

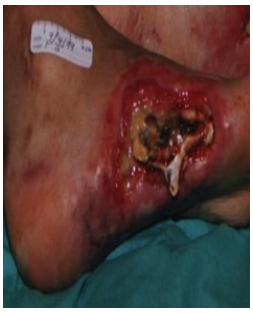


Aim of treatment - remove slough and prevent infection. Dressing will need to assist wound bed debridement and manage exudate level.

Wound assessment	Dressing type	Dressing name	Instructions / contraindications	Secondary Dressing
Low Exudate	Hydrogel	ActiFormCool	Non-adhesive hydrogel sheet that will either donate or absorb moisture, depending on the moisture level of the wound. As a primary dressing to assist in autolytic debridement by hydrating necrotic and sloughy tissue. Secondary dressing required. Suitable for painful wounds and skin conditions such as leg ulcers, burns, scalds and radiation therapy damage. Can be used under compression. Not suitable for heavily exuding or infected wounds.	Allevyn Adhesive or Allevyn non adhesive with K-band or Biatain Silicone (for patients with fragile skin)
	Honey Dressing	Activon Tube	Can be used directly on the wound or as a top up. It can be used to debride ad de-slough, eliminate odours and provides a moist wound healing environment. Suitable for use on infected wounds or where bacterial resistance is suspected. Can be used in cavities- washed out with saline solution. Use only as antimicrobial dressing when infection present. Monitor patients with diabetes. **Only to be used with critical colonisation NOT to be used prophylactically – 2 week challenge**	
	Alginate	Flaminal Hydro	Alginate gel containing antimicrobial enzymes. Debrides the wound and manages moisture balance. Lightly to moderately exuding wounds.	
	Hydrocolloid	Duoderm extra thin	Hydrocolloid film, light to moderately exuding wounds that are granulating or wounds that have areas of slough or necrosis. DO NOT use on Full-thickness burns and dry wounds or Diabetic feet. For wounds with more exudate or requiring some debridement	None
	Hydrocolloid	Granuflex Border	Adhesive hydrocolloid. Chronic wounds, pressure ulcers, leg ulcers. Do not use on Diabetic feet	None
Moderate / High Exudate	Hydrogel	ActiFormCool	Non-adhesive hydrogel sheet that will either donate or absorb moisture, depending on the moisture level of the wound. As a primary dressing to assist in autolytic debridement by hydrating necrotic and sloughy tissue. Suitable for painful wounds and skin conditions such as leg ulcers, burns, scalds and radiation therapy damage. Can be used under compression.	Biatain Adhesive or Biatain non adhesive with K-band or Biatain Silicone (for patients with fragile skin)
	Honey Dressing	Algivon	Creates a moist healing environment and effectively eliminates wound odour while providing antibacterial action. Suited to debriding and de-sloughing shallow wounds or where the exudate levels have started to decrease. Diabetics must be monitored when using this product. **Only to be used with critical colonisation NOT to be used prophylactically – 2 week challenge**	
	Antimicrobial	Iodoflex Paste	Dressing with Iodine for the treatment of chronic exuding wounds. Use only as an antimicrobial dressing when infection present. Short-term use only. May need irrigation to remove. Caution in patient with kidney disease or taking thyroxine or lithium. **Should not be used on dry necrotic tissue.** Do not use on children, pregnant or lactating women or people with thyroid disorders, taking lithium or renal impairment. **Only to be used with critical colonisation NOT to be used prophylactically – 2 week challenge**	

	Hydrofibre	KerraCel	Not a haemostat. Suitable for use on moderate and heavily exuding wounds (chronic or acute). Gelling fibers absorb exudate from the wound, forming a gel and moist environment.	
	Alginate	Flaminal Forte	Alginate gel with antimicrobial enzymes. Debrides the wound and manages moisture balance. Moderately to heavily exuding wounds.	
	Hydrocolloid	Granuflex Border	Adhesive hydrocolloid. Forms a gel in the presence of exudate to facilitate rehydration; promotes autolytic debridement. For use when bordered dressing required. Chronic wounds, pressure ulcers, leg ulcers. Do not use on Diabetic feet	None
Malodorous Wound	Odour Absorbent	Clinisorb	Use under appropriate dressings. Eliminate cause of odour where possible/ Effectiveness reduced by high levels of exudate. Do Not apply directly to the wound bed.	Biatain Adhesive or Biatain non adhesive with K-band or Biatain Silicone (for patients with fragile skin)

7.4 GREEN (infected)



Aim of treatment – reduce bacterial lead, manage exudate and odour

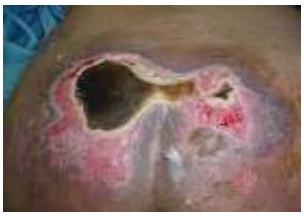
Only use antimicrobial dressing for wounds with signs of localised clinical infection. Do not use prophylactically. Consider need for oral antibiotics.

MRSA INFECTED WOUNDS – FOLLOW THE MRSA PROTOCOL

DO NOT use topical antibiotics unless advised to do so, e.g. topical metronidazole

Wound assessment	Dressing type	Dressing name	Instructions / contraindications	Secondary Dressing
Low Exudate	Honey	Activon Tube	Can be used directly on the wound or as a top up. It can be used to debride and de-slough, eliminate odours and provides a moist wound healing environment. Suitable for use on infected wounds or where bacterial resistance is suspected. Can be used in cavities- washed out with saline solution. Monitor patients with diabetes. **Only to be used with critical colonisation NOT to be used prophylactically – Maximum of 2 weeks use**	Allevyn Adhesive or Allevyn non adhesive with K-band or Biatain Silicone (for patients with fragile skin)
	Low Alginate Gel	Flaminal Hydro	Alginate gel containing antimicrobial enzymes. Debrides the wound and manages moisture balance. Lightly to moderately exuding wounds.	
	Silver Wound Contact	Atrauman AG	Non-adherent wound-contact layer. Use as a primary wound contact dressing when infection present. Only use on chronic wounds with exudate (does not work on dry wounds); **Only to be used with critical colonisation NOT to be used prophylactically – Maximum of 2 weeks use**	
Moderate / High Exudate	Honey	Algivon	Creates a moist healing environment and effectively eliminates wound odour while providing antibacterial action. Suited to debriding and de-sloughing shallow wounds or where the exudate levels have started to decrease. Diabetics must be monitored when using this product. **Only to be used with critical colonisation NOT to be used prophylactically – Maximum of 2 weeks use**	Allevyn Adhesive or Allevyn non adhesive with K-band or Biatain Silicone (for patients with fragile skin)
	High Alginate Gel	Flaminal Forte	Alginate gel with antimicrobial enzymes. Debrides the wound and manages moisture balance. Moderately to heavily exuding wounds.	
	Antimicrobial	Iodoflex Paste	Dressing with Iodine for the treatment of chronic exuding wounds. Use only as an antimicrobial dressing when infection present. Short-term use only. May need irrigation to remove. Caution in patient with kidney disease or taking thyroxine or lithium. **Should not be used on dry necrotic tissue.** Do not use on children, pregnant or lactating women or people with thyroid disorders, taking lithium or renal impairment. **Only to be used with critical colonisation NOT to be used prophylactically – Maximum of 2 weeks use**	
	Silver Wound Contact	Atrauman AG	Non-adherent wound-contact layer. Use as a primary wound contact dressing when infection present. Only use on chronic wounds with exudate (does not work on dry wounds); **Only to be used with critical colonisation NOT to be used prophylactically – Maximum of 2 weeks use**	

7.5 – BLACK (necrotic)



Aim of treatment – removal of dry necrotic tissue by wound re-hydration

Wound assessment	Dressing type	Dressings	Instructions / contraindications	Secondary Dressing
Low Exudate	Hydrogel	ActiFormCool	Non-adhesive hydrogel sheet that will either donate or absorb moisture, depending on the moisture level of the wound. As a primary dressing to assist in autolytic debridement by hydrating necrotic and sloughy tissue. Secondary dressing required. Suitable for painful wounds and skin conditions such as leg ulcers, burns, scalds and radiation therapy damage. Can be used under compression. **Not** suitable for heavily exuding or infected wounds.	Biatain Adhesive or Biatain non adhesive with K-band or Biatain Silicone (for patients with fragile skin)
	Hydrocolloid	Duoderm extra thin	Hydrocolloid film, light to moderately exuding wounds that are granulating or wounds that have areas of slough or necrosis. DO NOT use on Full-thickness burns and dry wounds or Diabetic feet.	None
Moderate Exudate	Foam	Allevyn Adhesive	Soft, absorbent, conformable foam with skin-friendly adherent contact layer dressing. Can be used under compression therapy. Moderate to highly exuding wounds including leg ulcers, pressure ulcers, partial thickness burns, donor sites, postoperative wounds and skin abrasions. DO NOT use with oxidising solutions e.g. hydrogen peroxide. Fluid handling may be affected under compression bandaging	None
	Silicone Foam	Biatian Silicone	Soft, absorbent foam, with gentle silicone adhesive border. Can be used under compression therapy. Moderately to highly exuding wounds including leg ulcers, pressure ulcers, partial thickness burns, donor sites, postoperative wounds and skin abrasions. DO NOT use with oxidising solutions e.g. hydrogen peroxide. Ensure that evaporating solutions are completely dried off before dressing application. **ONLY for use with patients with fragile skin**	None
	Foam	Allevyn Non - Adhesive	Soft, Absorbent, conformable non-adhesive foam dressing. Can be used under compression therapy. Moderately to highly exuding wounds including leg ulcers, pressure ulcers, second-degree burns, donor sites, postoperative wounds and skin abrasions. DO NOT use with oxidising solutions e.g. hydrogen peroxide.	K-Band
	Hydrocolloid	Granuflex Border	Adhesive hydrocolloid. Chronic wounds, pressure ulcers, leg ulcers. Do not use on Diabetic feet	None
High Exudate	Super Absorbent	Biatain Super	Highly absorbent, non-adhesive wound contact layer with a hydrocolloid component for adhesion. Highly exuding wounds including leg ulcers, pressure ulcers, non-infected diabetic foot ulcers, second-degree burns, surgical wounds and skin abrasions. Can be used under compression therapy.	None
	Super Absorbent	Eclypse	Superabsorbent dressing. May be used under moderate compression therapy. **Do not use as a secondary dressing**	K band

APPENDIX 1
GLOSSARY OF TERMS

1.1 WOUND TYPES

Acute - Heal 'normally' and timely (within 12 weeks)

Chronic - Complicated healing beyond 12 weeks

Diabetic foot ulcers
Underlying cause is diabetes. Caused by neuropathy (damaged nerves), poor blood supply (ischaemia - arteriosclerosis or occlusion) and/or infection (diabetic patients have a generally have a weakened immune response). Occur anywhere on the foot.

Diabetic patients developing a category 2, 3 or 4 pressure ulcers to their foot and/or heel under the care or a community team should be referred as urgent to NCH&C podiatry.

Pressure Ulcer
A localised area of tissue necrosis that develops when soft tissue is compressed between a bony prominence and an external surface (including medical devices) for a prolonged period of time. They are complex lesions of the skin and underlying structures that vary considerably in size and severity. Patients with older or frailer skin are higher risk. Graded 1 to 4

Category 1	Discolouration of the epidermis, non-blanching erythema.
Category 2	Partial thickness skin loss involving epidermis, dermis or both.
Category 3	Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue.
Category 4	Extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures with or without full thickness skin loss.

Suspected deep tissue injury
A Suspected Deep Tissue Injury (SDTI) is a purple / black or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.

Leg Ulcer
Usually determined by visible clinical signs, ABPI calculation (normal 1.0-1.3) and Doppler Assessment.

Venous leg ulcer
Caused by dysfunctional valves (injury or deterioration due to age) that allow back flow and pooling of blood that leads to tissue breakdown and ulcer formation. Appear on the tibial area of the leg and can be an irregular shape with a normal foot pulse (ABPI >0.8). Treated with compression bandaging. (40 mm Hg)

Arterial Ulcer
Caused by arteriosclerosis (hardening of the arteries) which become occluded. This leads to tissue death due to poor blood supply (nutrients and oxygen). Can occur on the gaiter or top of the foot and are usually very circular in shape, very defined wound margins and a weak foot pulse (ABPI <0.5) DO NOT COMPRESS

Mixed Aetiology
A combination of venous and arterial ulcer(s) (ABPI 0.6 to 0.8) light compression (20-40 mm HG)

1.2 WOUND ANATOMY DESCRIPTORS

Partial Thickness - Wound penetrates the Epidermis and Dermis. Generally pink and painful with no yellow tissue

Full Thickness - Wound penetrates the epidermis, dermis, subcutaneous layer.

Wound base - The bottom of the wound (depth)

Wound Edge/Margin - Perimeter of the wound (rim)

Peri-wound - Surrounding tissue usually within a 4cm radius of the wound edge

Integrity Denuded - Loss of epidermis, caused by exposure to urine, faeces, body fluids, wound exudate or friction

Lesions - Rashes – chicken pox like

Tunnelling - Channel or pathway that extends in any direction from the wound through subcutaneous tissue

Undermining/Pocketing - Tissue destruction underlying intact skin along the wound margins generally caused by shearing

Epibole - Rolled edges, curled under meaning epithelial cells cannot migrate across wound. Usually cavity like.

Callus - Fibrous or keratotic (hard) skin

1.3 WOUND COLOURS

Beefy Red – Healthy tissue, good blood flow

Pale Pink – Poor blood flow, anaemia

Purple – Engorged, swelling, high bacteria levels, trauma

Black or Brown – Non-viable necrotic tissue

Yellow – Non-viable tissue; slough

Green – Infection (highly likely to be P. Aeroginosa but can be others), non-viable tissue

White - macerated; poor blood flow

1.4 EXUDATE

Cells, fluids or other substances that accumulate/exude from cells or blood vessels through breaks in the cell membrane or small pores. Any more than 300ml in the first 24-hour period should be treated as an abnormality.

Types of Exudate/Drainage:

Serous - (white) Clear, watery fluid that has separated from its solid element.

Sanguineous - (pink) Fluid that contains blood.

Serosanguineous - (red) Thin, red, composed of both of serum and blood.

Brown-Green Purulent - wound is regarded as infected.

1.5 WOUND INFECTION CONTINUUM (WIC)

International Wound Infection Institute (IWII) *Wound infection in clinical practice.* Wounds International 2016

Contamination

Wound contamination is the presence of non-proliferating microbes within a wound at a level that does not evoke a host response. Virtually from the time of wounding, all open wounds are contaminated with microbes. Chronic wounds become contaminated from endogenous secretions (i.e. natural flora) and exogenous microbial sources, including poor hand hygiene practised by healthcare clinicians and environmental exposure. Unless compromised, the host defences respond swiftly to destroy bacteria through a process called phagocytosis.

Colonisation

Colonisation refers to the presence within the wound of microbial organisms that undergo limited proliferation without evoking a host reaction. Microbial growth occurs at a non-critical level, and wound healing is not impeded or delayed. Sources for microorganisms may be natural flora, exogenous sources or as a result of environmental exposure.

Local infection

Wound infection occurs when bacteria or other microbes move deeper into the wound tissue and proliferate at a rate that invokes a response in the host. Local infection is contained in one location, system or structure. Especially in chronic wounds, local wound infection often presents as subtle signs that can be considered covert signs of infection that may develop into the classic, overt signs of infection.

Spreading infection

Spreading infection describes the invasion of the surrounding tissue by infective organisms that have spread from a wound. Microorganisms proliferate and spread, to a degree that signs and symptoms extend beyond the wound border. Spreading Infection may involve deep tissue, muscle, fascia, organs or body cavities.

Systemic infection

Systemic infection from a wound affects the body as a whole, with microorganisms spreading throughout the body via the vascular or lymphatic systems. Systemic inflammatory response, sepsis and organ dysfunction are signs of systemic infection.

Biofilms - A colony of single or multiple species of bacteria protected by a glycol-calyx (sugary coating) impervious to antibiotics and antimicrobials. Usually debrided before antimicrobial treatment can begin.

Erythema - Superficial reddening of the skin, usually in patches, as a result of injury or irritation causing dilatation of the blood capillaries.

Cellulitis - A spreading bacterial infection just below the skin surface characterised by inflammation.

Oedema - Swelling from excessive accumulation of watery fluid in cells, tissues, or serous cavities.

Slough - Collection and 'curdling' of wound exudates, white blood cells, proteases etc. Custard like in appearance.

Necrotic Tissue - Black, brown and or grey non-viable tissue - dead – NO blood flow.

Granulation Tissue - New tissue that replaces dead tissue that is Beefy red, puffy, mounded and grows from base of wound. Capillary loops can sometimes be observed.

Hyper-granulation Tissue - Forms above surface and delays epithelialisation.

Excoriated - Linear erosion and loss of epidermis usually due to mechanical means (dressings etc.)

Macerated - The softening and breaking down of skin resulting from prolonged exposure to moisture cloudy white appearance to skin.

1.6 CLINICAL INTERVENTION TERMS

Pressure Relief - The art of moving/turning patients or adding supports to relieve and spread pressures from bony areas of the skin to prevent/reduce the risk of pressure ulceration.

ABPI (Ankle Brachial Pressure Index) - Measured by taking blood pressures at the brachial pulse (arm) and ankle pulse (foot) and compared to determine the ratio of blood pressure in the arms and legs.

Doppler - An ultrasonic device used to determine blood flow and vessel type. Whooshing indicates a vein, visible beats indicate an artery.

- ***Triphassic*** sounds are normal
- ***Biphasic*** sound indicates decreasing/poor vein elasticity
- ***Monophasic*** and usually denotes vessel/venous disease.

Compression Bandaging -,2,3 or 4 layer (40 mmHg regarded the gold standard) that applies compression to the venous system in the leg to assist blood return to the heart.

Debridement - Removal of necrotic, sloughy and /or callus materials from in/around a wound. Can be autolytic (Hydrogel), mechanical (sharp, scalpel or versa jet) or larvae.

Antimicrobial - A substance capable of killing or inhibiting bacteria. Concentrations must be higher than a bacterial species MIC (minimum inhibitory concentration) to work effectively. Silver, Iodine etc.

Foam - A dressing that should conform absorb and retain excess exudate (exudate management) to reduce maceration risks and promote moist wound healing. **Foams do not relieve pressure or cushioning and do not prevent pressure areas**

Hydrogel – Water based gel used to debride necrotic tissue and dry slough.

Alginate - Absorbent dressing comprised of seaweed based Calcium Alginate used to manage exudate.

Wound Contact Layer - A layer designed to go directly on to the wound that allows exudates to pass through and prevents other secondary dressings (and itself) from sticking to the wound bed.

Hydrocolloid - non-breathable and natural adherence. In the presence of exudate hydrocolloids 'gel up' promoting advanced wound healing.

Topical Negative Therapy, Vacuum Assisted Closure and Negative Pressure Wound Therapy - A vacuum created over the wound intermittently or continuously that removes wound fluid (exudate) and increases blood flow to the area promoting the inflammatory and proliferation phases of wound healing.

Macrostrain- in relation to VAC (see above) the visible stretch that occurs when the negative pressure contracts the foam, drawing wound edges together providing complete wound bed contact and evenly distributing the negative pressure, removing exudate and infectious material.

APPENDIX 2
FULL FORMULARY

Absorbent Cellulose

Product	Company	Indication	Sizes available	ONPOS Code
Eclypse	H&R Healthcare	Indicated for exudate absorption and the management of partial- to full-thickness wounds.	10cmx10cm(20pk)	EJE029
			10cm x 20cm (10pk)	CR4460
			20cmx20cm (10pk)	CR4439
			20cmx30cm (20pk)	EJE030
			60cmx40cm (10pk)	EJE034
Xupad (Cellulose)	Richardson	**First-line** superabsorbent when using as a secondary dressing	10cmx12cm(25pk)	205012
			10cmx20cm (15pk)	329-1671
			20cmx20cm (15pk)	329-1663
			20cmx40cm(8pk)	329-1689

Alginate/Hydrocolloid Fibre

Product	Company	Indication	Sizes available	ONPOS Code
Kendall Calcium Alginate (Previously known as Curasorb)	H&R Healthcare	Highly absorbent, forms gel in contact with exudate. Haemostatic and promotes autolytic debridement	10cmx10cm(10pk)	9233
			5cmx5cm (100pk)	9232a
			10cmx20cm (50pk)	9238
			15cmx25cm (50pk)	9239
			10cmx14cm (50pk)	9240
Kerracel Gelling Fibre	Crawford	Suitable for use on moderate and heavily exuding wounds (chronic or acute). Gelling fibers absorb exudate from the wound, forming a gel and moist environment.	5cmx5cm(10pk)	402-0517
			10cmx10cm(10pk)	402-0525
			15cmx15cm(5pk)	402-0533
			2.5cmx45cm(5pk)	402-0541
Urgoclean Rope with probe	Urgo	For debriding cavity wounds Polyabsorbent fibres with haemostatic and debriding properties	2.5cm x 40cm (5 per pack)	550181

Antimicrobial

Product	Company	Indication	Sizes available	ONPOS Code
Activon Tube Honey	Advancis	Use only as antimicrobial dressing when infection present. Monitor patients with diabetes.	25g (12pk)	CR3830(a)
Algivon Plus Honey	Advancis	Use only as antimicrobial dressing when infection present. Monitor patients with diabetes.	5cmx5cm (5pk)	374-9496
			10cmx10cm (5pk)	374-9512
Atrauman Ag Silver	Hartmann	Use only as an antimicrobial dressing when infection present.	5cmx5cm (10pk)	499571

		Only use on chronic wounds with exudate (does not work on dry wounds); **max 2 weeks use**.	10cmx10cm (10pk)	499573
Flaminal Forte Gel **Moderate exudate**	Flen Health	Contains antimicrobial enzymes. Promotes debridement and support healing environment.	50g (Single item)	344-9592
			15g (5pk)	022
Flaminal Hydro Gel **Low exudate**	Flen Health	Contains antimicrobial enzymes. Promotes debridement and support healing environment. Hydro contains less alginate for low exuding wounds.	50g (Single item)	344-9600
			15g (5pk)	324-2971
Inadine	Systagenix / KCl	Use only as an antimicrobial dressing when infection present. Short-term use only. Inactivated by high exudate. May need irrigation to remove. Caution in patient with kidney disease or taking thyroxine or lithium.	5cmx5cm (25pk)	PO1481
			9.5cmx9.5cm (25pk)	PO1512(a)
Iodoflex Paste	Smith & Nephew	Use only as an antimicrobial dressing when infection present. Short-term use only. May need irrigation to remove. Caution in patient with kidney disease or taking thyroxine or lithium. Do not use on dry necrotic tissue.	17g (2pk)	66151360
			10g (3pk)	66151340
			5g (5pk)	66151330
Iodosorb	Smith & Nephew	Use only as an antimicrobial dressing when infection present. Short-term use only. May need irrigation to remove. Caution in patient with kidney disease or taking thyroxine or lithium. Do not use on dry necrotic tissue.	10g (4pk)	66151240

Bandages – Compression

Product	Company	Indication	Sizes available	ONPOS Code
Actico Cohesive	L&R Healthcare	Short stretch bandage	Single items only 6cmx6m	0878
			8cmx6m	314-0886
			10cmx6m	5-037696-300027
			12cmx6m	314-0894
Cellona	L&R Healthcare	Padding – for use in full limb chronic oedema bandaging	15cmx2.75m (36pk)	L92868a
			10cmx2.75m (48pk)	L92867
			7.5cmx2.75m (72pk)	L92866a

Product	Company	Indication	Sizes available	ONPOS Code
			5cmx2.75m (96pk)	92840a
K-Lite Type 2	Urgo	Light support bandage	10cmx4.5m (16pk)	239-3635
K-Lite Long	Urgo	Light support bandage	10cmx5.25m (16pk)	771004 (c)
K-Soft	Urgo	Wadding	10cmx3.5m (24pk) 10cmx4.5m- long (16pk)	761003 (a)
K-Soft Long	Urgo	Wadding	10cmx4.5cm (16pk)	325-7177
UrgoKTwo Avg compression 40mmHg	Urgo	Two layer system	Single items only 18-25cm (10cm width)	327-4685
			25-32cm Long (10cm width)	3338480
UrgoKTwo Reduced compression 20mmHg	Urgo	Two layer system	Single items only 18-25cm	596653
			25-32cm	596666
			25-32cm	576666

Bandages – Paste

Product	Company	Indication	Sizes available	ONPOS Code
Ichthopaste	Smith & Nephew	Medicated bandage	7.5cmx6m (Single)	033-2668
Viscopaste	Smith & Nephew	Medicated bandage	7.5cmx6m (Single)	033-2734

Bandages – Retention

Product	Company	Indication	Sizes available	ONPOS Code
K-Band	Urgo	Retention bandage	5cmx4m (20pk)	810504
			7cmx4m (20pk)	810704
			10cmx4m (20pk)	811004
			15cmx4m (20pk)	811504

Bandages - Tubular

Product	Company	Indication	Sizes available	ONPOS Code
Comfifast	Vernacare	Tubular Bandage	Single items only 17.5cmx10 – Beige	F52b
			7.5cmx10m – Blue	F32b
			5cmx10m – Red	F12b
			3.5cmx10m - Green	F22b
			10.75cmx10m - Yellow	F42b
Comfigauze **Fingers and Toes**	Vernacare	Tubular Bandage	Singles 1.5cmx20m – 01 Finger	Z016
			2.7cmx20m – 12 Toe	Z126
Comfigrip	Vernacare	Tubular bandage	Single items Size B x10m	GBN2 (b)
			Size C x10m	GCN2 (b)

Product	Company	Indication	Sizes available	ONPOS Code
			Size D x10m	GDn2 (b)
			Size E x10m	GEN2 (b)
			Size F x10m	GFN2 (b)
			Size G x10m	GGN2 (b)

Barrier Creams/Skin Protectors

Product	Company	Indication	Sizes available	ONPOS Code
Medi Derma-S Barrier Cream	MedicarePlus	Skin Protectant	90g (Single only)	60345
Medi Derma-S Barrier Cream Sachets	MedicarePlus	Skin Protectant	2g (20pk)	341-3317
Medi Derma-S Foam Applicators	MedicarePlus	Skin Protectant	3ml (5pk)	362-8724
Medi Derma-S Barrier Film	MedicarePlus	Skin Protectant	1ml (5pk)	362-8716
Medi Derma-S Pump Spray	MedicarePlus	Skin Protectant	30ml (Single only)	389-7121

Charcoal Dressings

Product	Company	Indication	Sizes available	ONPOS Code
Clinisorb	Clinimed	For malodorous wounds. Exudate will reduce effectiveness so do not apply directly to wound bed. Consider cause of odour.	10cmx10cm (10pk)	2305

Contact Layer

Product	Company	Indication	Sizes available	ONPOS Code
Atrauman	Hartmann	Low adherence contact layer. Do not use under other primary dressings.	5cmx5cm (50pk)	499550
			7.5cmx10cm(50pk)	499553
			10cmx20cm (30pk)	499530
			20cmx30cm (10pk)	87965
Mepitel One	Molnlycke	Soft polymer dressing for fragile skin.	6cmx7cm (5pk)	289170
			9cmx10cm (5pk)	289270
N-A Ultra	Systagenix / KCI	Wound contact layer, silicone coated. Can be used as primary layer under compression bandaging.	9.5cmx9.5cm (25pk)	MNA190
			19cmx9.5cm (40pk)	MNA095

Films

Product	Company	Indication	Sizes available	ONPOS Code
Clearfilm	Richardson	Vapour-permeable film to promote healing environment for light exuding wounds. Use for retention of medical devices or as a secondary dressing.	6cmx7cm (100pk)	815067
			10cmx12cm (10pk)	815101a
			12cmx12cm (10pk)	815121
			15cmx20cm	815152

Opsite Flexigrid	Smith & Nephew	Vapour-permeable film to promote healing environment for light exuding wounds.	12cmx25cm (20pk)	4632
Tegaderm IV	3M	Film dressing for securing cannulas	Peripheral (100pk)	1633 (a)
			PICC (25pk)	1650
			Central (50pk)	00685

Foams

Product	Company	Indication	Sizes available	ONPOS Code
Allevyn Adhesive	Smith + Nephew	Moderate exuding wounds requiring protective cushion. Fluid handling may be affected under compression bandaging.	7.5cmx7.5cm	66000043
			12.5cmx12.5cm	66000044
			12.5cmx22.5cm	66000744
			17.5cmx17.5cm	66150045
			22.5cmx22.5cm	66150046
Allevyn Non-Adhesive	Smith + Nephew	Moderate exuding wounds requiring protective cushion. Fluid handling may be affected under compression bandaging.	5cmx5cm	66007643
			10cmx10cm	66007637
			10cmx20cm	66007334
			20cmx20cm	66157638
Biatain Adhesive	Coloplast	Second line only due to availability. Moderate exuding wounds requiring protective cushion. Fluid handling may be affected under compression bandaging.	18cm x 28cm	3426

Foams with silicone

Product	Company	Indication	Sizes available	ONPOS Code
Biatain Silicone	Coloplast	Foam with border for use on particularly sensitive skin	7.5cmx7.5cm (10pk)	3434
			10cmx10cm (10pk)	3435
			12.5cmx12.5cm (10pk)	3436
			15cmx15cm (5pk)	3437
			17.5cmx17.5cm (5pk)	3438

Hydrocolloid

Product	Company	Indication	Sizes available	ONPOS Code
Granuflex	Convatec	Forms a gel in the presence of exudate to facilitate rehydration; promotes autolytic debridement. For use when bordered dressing required.	6cmx6cm (5pk)	S156
			10cmx10cm (10pk)	S155
			15cmx15cm (5pk)	S157
Duoderm Extra thin	Convatec	Forms a gel in the presence of exudate to facilitate rehydration; promotes autolytic debridement. For lightly exuding wounds.	5cmx10cm (10pk)	S163
			5cmx20cm (10pk)	S164

		DO NOT use on Full-thickness burns, dry wounds or diabetic feet.	15cmx15cm (10pk)	S162

Hydrogel

Product	Company	Indication	Sizes available	ONPOS Code
Actiform Cool Sheet	L&R Healthcare	Donate liquid to dry sloughy wounds; autolytic debridement. Secondary dressing required. Not suitable for heavily exuding or infected wounds.	5cmx6.5cm (5pk)	act457q
			10cmx10cm(5pk)	act413q
			10cmx15cm(3pk)	act414m
Purilon Gel	Coloplast	The match of hydrating and absorbing properties supports natural autolytic debridement and moist wound healing	8g (10pk)	3906

Low/Non-Adherent

Product	Company	Indication	Sizes available	ONPOS Code
Adpore	Medicare Plus	First line dressing for simple low to moderate exuding wounds	10cmx15cm (40pk)	62851
			10cmx20cm (30pk)	63018
			10cmx25cm (30pk)	63032
			10cmx30cm (30pk)	62912
			10cmx35cm (30pk)	62936
Adpore Ultra	Medicare Plus	Low to moderate exuding wounds – use ultra on delicate skin or when waterproof dressing required	7cmx8cm (55pk)	62950
			10cmx15cm(40pk)	92998
			10cmx20cm (30pk)	63018
			10cmx25cm (30pk)	63032
			10cmx30cm (30pk)	63056
Softpore	Richardson	Low to moderate exuding wounds – Second line only	6cmx7cm (60pk)	803067
			10cmx10cm (50pk)	803100

Silicone

Product	Company	Indication	Sizes available	ONPOS Code
Silflex	Advancis	Silicone dressing. Fragile skin wound contact layer.	5cmx7cm (10pk)	CR3922
			8cmx10cm(10pk)	CR3923
			12cmx15cm(10pk)	CR3924

Super Absorbents

Product	Company	Indication	Sizes available	ONPOS Code
Biatain Super Adhesive (formerly Alione)	Coloplast	Forms a gel in the presence of exudate to facilitate rehydration; promotes autolytic debridement. Can be used under compression.	10cmx10cm (10pk)	4610
			12.5cmx12.5cm (10pk)	4612
			15cmx15cm (10pk)	4635 (a)
			20cmx20cm (10pk)	4620
Biatain Super Non-Adhesive (formerly Alione)	Coloplast	Forms a gel in the presence of exudate to facilitate rehydration;	10cmx10cm(10pk)	4630
			12cmx20cm(10pk)	4645

		promotes autolytic debridement. Can be used under compression.	15cmx15cm(10pk)	4639
			20cmx20cm(10pk)	356-7393

Woundcare accessories

Product	Company	Indication	Sizes available	ONPOS Code
Softdrape sterile dressing pack	Richardson	For use ONLY WHEN STERILE FIELD REQ.	Small (20pk)	nws-0165
			Medium (20pk)	nws-0166
			Large (20pk)	nws-0167
Blue Dot Irrigation Fluid	CrestMedical	Irrigation solution	25x20ml	7912
Normasol (SACHETS)	Molnlycke	Irrigation solution Note: More expensive option – Only for use when required	25x25ml	014-9161
Clinipore	Clinisupplies	Permeable surgical Tape	1.25cmx5m (12pk)	AT3012 (c)
			2.5cmx5m (12pk)	AT3011 (d)
			5cmx5m (12pk)	AT3078/B
			7.5cmx5m (4pk)	AT3083/B
Debrisoft	L&R Healthcare	Debridement	10cmx10cm Pad (5pk)	31222
			5cmx2.7cm Lolly (5pk)	33224
Cotton Stockinette	Generic only	Stockinette	10cmx20cm roll Single item	N/A for generic
Liquiband Standard	Advanced Medical	Wound adhesive	0.5g (10pk)	275-9959
Steri-strips	3M	Wound Closure	6mmx75mm 3qty (Pack of 12)	R1541
Peel-Easy **Wipes only**	CD Medical	Adhesive remover	Box of 30 (ordered as single box of 30 wipes)	300715
Unisurge 4ply **Non sterile** swabs	Unisurge	Non-woven swabs	10cmx10cm 100pk (ordered as single pack of 100 swabs)	F8715-045
Unisurge 4ply **sterile** swabs	Unisurge	Non-woven swabs	10cmx10cm – Sterile packs of 5 (ordered as box of 25 sealed packs of 5 swabs)	F821034

Version	Date	Author	Status	Comment
8.0	30/8/19	HA	Draft	
8.1	13/11/19	HA	Draft	Combined with NCH&C TVN formulary guide
8.2	19/12/19	HA	Draft	Updated products and Guide content post TVN consultation Added ONPOS products code to aid selection
8.2.1	27/12/19	HA	Draft	Products refined and pressure ulcers grading amended
8.3	13/01/2020	HA	Final draft for approval	Final code changes