NHS
Oxfordshire
Clinical Commissioning Group

Oxford Health NHS
NHS Foundation Trust

Wound Management

ADVICE & PRESCRIBING GUIDANCE 2015

Review Date 2018

CONTENTS

INTRODUCTION

This formulary and clinical guideline was produced by the Oxfordshire wound formulary group whose membership includes representatives from Oxfordshire CCG (medicines management), general practice and Oxford Health (Tissue viability and Community nursing). It was approved by the Area Prescribing Committee Oxfordshire (APCO) in March 2015.

This 2015 edition replaces the previous 2009/10 and will be only available as an electronic document which can be downloaded and printed off if preferred. Please take time to read through this document as there have been changes to some of the product categories.

It is important that within the NHS we are able to justify our clinical decisions and expenditure on wound management products. In Oxfordshire we currently spend £1.8 Million annually on dressings, bandages and tapes; therefore this wound management formulary has been developed with the explicit aims of:

- Promoting evidence based practice by providing a framework within which it is safe to practice.
- Promoting continuity of care
- Promoting rational prescribing
- Encouraging safe, effective and appropriate use of dressings
- Promoting cost effectiveness

Product selection should be based upon a comprehensive and holistic assessment of the patient and their wound. Once the wound aetiology and the intended treatment outcome have been confirmed, an appropriate product can be selected. If a patients wound fails to progress as expected then a referral to tissue viability should be considered.

This formulary is designed to provide clinical staff with a comprehensive guide to wound dressings and have been selected using available evidence gathered from a number of sources. This has included a review of the clinical evidence, local clinical evaluations and feedback of current usage. Dressings in this formulary are for general use, with the exception of those that are indicated as 'restricted use'. This category of dressings should only be prescribed following advice from Tissue Viability. The service can be contacted on either:

tissueviability@oxfordhealth.nhs.uk for oxford health staff or, oxfordhealth.tissueviability@nhs.net

For TV Admin - Tel: 01865 904959 /904271. Fax - 01865-261757.

Prescribing outside this formulary must be justified by specific patient need. Off formulary prescribing will be monitored by the formulary group and support offered to clinicians in order to explore other alternatives.

We plan to update the formulary every 3 years, and welcome comments and suggestions for improvement. The formulary will be held on both the CCG and Oxford Health's clinical intranet sites.

Education and training is offered across Oxfordshire in relation to all aspects of tissue viability including the selection of dressings and can be booked either through the L&D portal (Oxford Health staff).

Or via Email: cpd@oxfordhealth.nhs.uk

Phone: 01865 902 734

The formulary group wish to thank the clinicians who have supported the evaluation process over the past 18 months in order for us to rationalise our product inclusions. These have been representatives from community nurses, practice nurses, community hospitals, podiatry, older adult mental health and children's services.

Other Considerations

Children

Children's skin is different and heals at different rates to adults, and therefore whilst working predominantly within this product guidance, on occasion some children may need alternative dressings considered. The Community Children's Nurses can be contacted for advice as they provide a county wide service.

Community Children's Nurse,
Tel: 01865902700

Secondary Care Links

At present the products available within primary care and secondary care differ. We are working hard to align prescribing aspirations with the subsequent availability of products within the resources available, There has been a Tissue Viability integrated working group set up between oxford health and Oxford University Hospitals trust to promote strong links across the services.

To contact the hospital tissue viability team email tissueviabilityteam@ouh.nhs.uk

Patients Requiring Specialist Podiatry input (i.e. Diabetic Patients)

There may be different wound care requirements for load bearing wounds, diabetic foot ulcers and the arterial leg. We strongly urge you to seek specialist advice from podiatry or Tissue Viability in relation to this group of patients.

USING THIS FORMULARY

This formulary has been divided in to three categories:

1. **Dressings that can be obtained from ONPOS** - On line Non-Prescription Ordering Service
2. **Dressings that require a prescription (FP10)**
3. **Dressings that are 'restricted' and require approval from tissue viability first**

Dressings available from ONPOS

Non restricted dressings can be ordered using the PIN numbers allocated to your teams. Orders should reflect the teams clinical case load/ wound types.

Please refer to the 'Best practice guidelines for wound formulary/ ONPOS use'.

Dressings requiring a prescription

These dressings do not require tissue viability approval but a clear rationale for use should be documented within the patients notes. When requesting/ or prescribing these products please consider the following:

- The size of the wound – To avoid wastage, ensure that the dressing matches the wound size.
- Treatment duration – Calculate the number of dressings required for the planned treatment/ treatment objective (i.e. A 2 week course of an antimicrobial). Do not over order.
- Repeat prescriptions – Do not add dressings to a repeat prescription list. This contributes to stock piling
- Patient specific – Dressings should not be prescribed (patient specific) if being added to a cupboard stock

Restricted products

For ONPOS users, the majority of products within the restricted category will be listed within the system. Your order, however, will be blocked until you have liaised with tissue viability and a clear rationale provided for use. Requests should be patient specific and should form part of a clear plan of care. Tissue viability will be happy to support you in making these clinical decisions.

For Non ONPOS users, please contact tissue viability on either tissueviability@oxfordhealth.nhs.uk or oxfordhealth.tissueviability@nhs.net BEFORE dressings are prescribed in order to ensure that the request meets the criteria for use.

There are a number of symbols which provide specific information. These are:

Step Down

This will show what options on the formulary are available to step down to.

Step Up

This will show what options are available to step up to on the formulary if your current product is not clinically effective.

Cautions

This show's you issues that may occur when using this product.

Points to Consider

Hints and tips about how to use the products.

For those clinicians who do not have access to ONPOS (Community hospitals, in-patient mental health wards) E procurement codes and PIP codes (prescription codes) have been provided to assist correct ordering.

WOUND CATEGORIES

1. Epithelialising

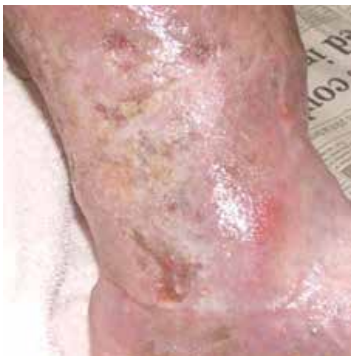
Definition

When the wound is showing an evidence of a pink margin to the wound or isolated pink islands on the wound surface this is the start of epithelialisation. This usually happens once the granulation tissue is up to the level of the surrounding skin. The cells at the edge multiply and begin to migrate into the injured area. Uninjured hair follicles also act as islands of epithelialisation. The tissue is pink to white in colour with a smooth surface appearance.

Dressings should be non-adherent and maintain a LOW level of moisture at body temperature. NB. High levels of moisture kept on epithelial tissue will cause a breakdown of these cells and begin the granulation stage again and could cause over-granulation.

Treatment Aim

- To complete healing process
- Prevent damage to new epithelium.



2. Clean and Granulating

Definition

Granulation is the healing phase of tissue repair. New blood vessels are formed in the form of delicate loops of capillaries which have 'budded' away from the damaged blood vessels in the wound. These loops grow into and fill the wound cavity. The cells known as fibroblasts migrate into the wound area and synthesise collagen fibres, which in turn form a network to support the new capillary loops.

Appearance

Bright and granular in appearance Granular tissue is very delicate and is easily damaged and made to bleed.

Treatment Aim

- Promote granulation by removing excess exudate and prevent damage to delicate granulating tissue.

Appropriate Dressings

Your dressing choice should be to protect these new loops of capillaries and should provide for moist wound healing. Remember that too much exudate, especially chronic wound exudate, can drown and destroy new cells and tissue

Recommendations

- Avoid wiping the surface of the wound. This could damage new cell growth
- "Strawberry jam" colour is good, "Raspberry jam" colour be cautious, this could signify local infection
- Heavily exuding granulating wounds potentially needs further investigation.
  (Refer to the exudate pathway)

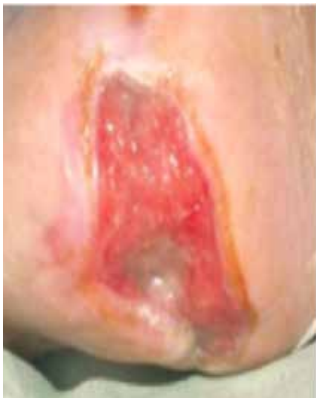
Hypergranulation (Over-Granulation) Tissue

An abundance of granulation tissue that becomes proud or protrudes from the wound is commonly known as hyper- or over-granulation tissue (also termed 'proud flesh'). In many cases the presence of this tissue is not detrimental to wound healing and can be left untreated. Problems arise when the hypergranulation tissue delays healing by preventing re-epithelialisation-sometimes the presence of such tissue can increase exudate levels and cause wound discomfort. In addition, hypergranulation tissue can bleed easily.

Potential causes of hypergranulation

The exact mechanisms for hypergranulation are unclear, but it has been suggested that it occurs when the wound fails to progress from the proliferative phase of wound healing. This can be associated with wound inflammation, infection or friction. The presence of hypergranulation tissue can sometimes indicate malignancy within a wound.

Therefore, if you are not achieving your wound management aim within a reasonable period of time, then seek further advice.



3. Sloughy

Definition

Slough is devitalised tissue formed when dead cells and/or bacteria accumulate in the wounds. It is yellow/white in colour due to the high number of leucocytes present in the wound and can be dry or moist in consistency. The removal of slough can reduce both odour and exudate.

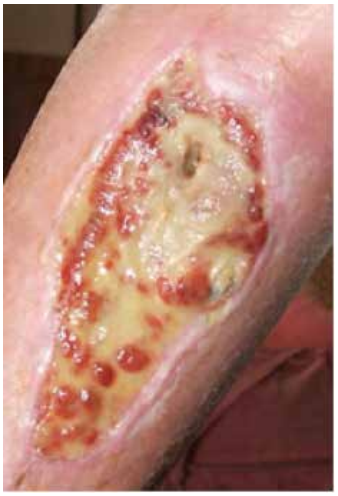
A yellow fibrous layer can appear in the wound bed that is not slough. This tissue can remain in the wound bed and will not be detrimental to wound healing. It is made up of a collagen-rich matrix secreted by fibroblasts and it provides scaffolding for new blood vessels and granulating tissue. Caution should also be taken as fascia, tendon, or bone can have the appearance of slough to the inexperienced clinician. Unless the causative factor of the dead tissue is identified and removed necrosis and slough will continue to be present in the wound.

Treatment Aim

- To de-slough/debride
- Remove excess exudate.
- To avoid infection.

Dressing Choice

To enable easy debridement, the dressing should loosen and liquefy the slough. The dressing also needs to maintain moisture at the wound bed. A dressing that 'wicks' the exudate away and prevents it from macerating the surrounding skin can be very effective in speeding up wound healing.

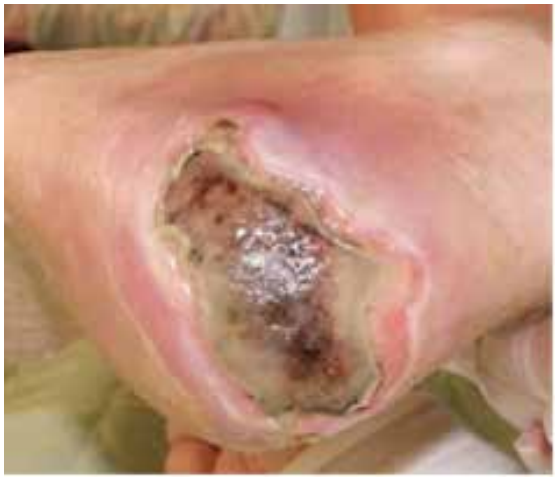


4. Necrotic

Definition

Necrotic wounds are black or dark brown in colour. It is devitalised, (dead) tissue. The presence of necrotic tissue within a wound will delay the healing process and can promote infection especially if it becomes moist. Necrotic tissue lacks leucocytes which are required to deal with dead tissue and bacteria. In most wound situations necrotic tissue needs to be removed as quickly as possible. If arterial disease is present advice should be sought from Tissue Viability on a management plan. This particularly applies to pressure ulcers on the heels.

Unless the causative factor of the dead tissue is identified and where possible removed, necrosis and slough will continue to be present in the wound.



Treatment Aim (Dependent on Wound Aetiolgy)

- To rehydrate and debride.

OR

- To dehydrate and keep dry

Caution re the diabetic foot:

The use of dressings which donate moisture should be avoided. Patients with diabetes that have foot ulcers should be referred URGENTLY to Podiatry at OCDEM.

Non diabetic patients with necrotic foot ulcers/wounds should be referred to the local NHS Podiatry team for assessment.

5. Contaminated, Colonised and Infected

Definition

The diagnosis of wound bed colonisation or local infection is a clinical diagnosis. The majority of wounds are contaminated with microorganisms such as MRSA, Pseudomonas aeruginosa and Anaerobes and yet most will progress through the normal phases of healing.

- Wound swabbing should NOT be undertaken unless systemic antimicrobials (antibiotics) are indicated. The diagnosis of wound bed colonisation/ wound bed infection is a decision based upon a thorough clinical assessment in which distinct symptoms have been identified .The AMBL tool is available to aid diagnosis. The use of wound swabbing is not advocated as a first line diagnostic tool and therefore should be avoided as routine
- Wound colonisation or local wound bed infection should be treated with a topical antimicrobial dressing in the first instance. The use of systemic antimicrobials (antibiotics) should be reserved for treating systemic or localised soft tissue infection. For those patients who are immunocompromised, systemic antimicrobials (antibiotics) may be considered in line with local prescribing guidelines.
- Topical antimicrobial dressings are indicated for bacterial colonised or local wound bed infection management. The maximum period for application is two weeks. Antimicrobial therapy can be stopped before this time if the colonised state is abated. Within primary care honey-impregnated dressings are advocated as first line treatment with iodine based dressings as second line.
- An evidence-based wound dressing formulary is available to guide topical dressing therapies and is available within this document. It is important clinicians are familiar with the products recommendations for use and would be encouraged to seek support from tissue viability or the representatives from the dressing manufacturer if unsure regarding use.

Guidelines for the effective diagnosis and management of local wound bed infection and bacterial colonisation (found on Tissue viability intranet page).

Recommendations

Please refer to the antimicrobial section of this formulary for direction regarding antimicrobial dressing selection.

6. Fungating Malignant Wounds

Definition

Fungating malignant wounds affect a significant number of people with cancer. They are caused by infiltration of the skin from a local tumour, haematological malignancy or metastatic spread from a primary tumour. These lesions are characterised by a process of both ulcerative (crater-like) and proliferative (nodular) growth that can cause extensive damage to the skin and surrounding structures.

The presence of a Fungating malignant wound can have a severe impact on patients and their families, greatly affecting quality of life. The management issues vary for each patient and strategies should be targeted according to the patient's priorities.

Treatment Aim

Before dressing selection can be made it is first necessary to identify the purpose and principle aim of the proposed treatment as healing may not be a realistic option.

The goal of care is to maintain and improve quality of life through symptom control.

- Treat or mask odour. Odour may be caused by bacterial activity.
- Reduce volume of exudate- when exudate is caused by a high bacterial load, a dressing regime that includes antimicrobials may help to reduce the volume of exudate. There are a various dressings that have a high absorbency capacity available within this formulary.
- Reduce inflammation e.g. reducing sensitising agents. – Such agents are lanolin, latex, and preservatives.
- Care of surrounding skin – barrier films, or a dressing such as a hydrocolloid as a protecting 'collar' that the dressing covering the wound can be adhered to.
- Managing clinical infection may require the use of a dressing that has bacterial reduction abilities as an adjunct to systemic antibiotics therapy.
- Pain management – pain associated with dressing change can be so bad that patient may require a potent analgesia. The dressing of choice should be one that is easily removed without causing pain and trauma.

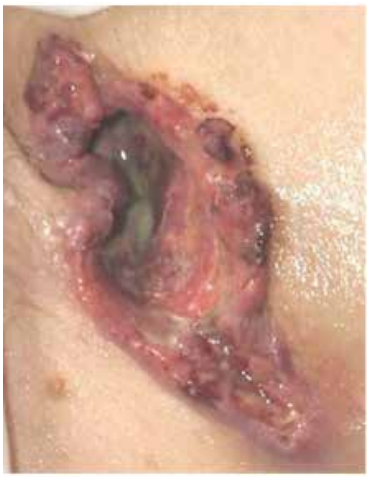
Managing Bleeding Fungating Wounds

The tissue in fungating tumours is very friable. Simple measures can reduce the risk of bleeding:

- Careful washing. Do not use swabbing technique
- Choose a non-adherent dressing
- Avoid fibrous dressings, e.g.: alginates which adhere to friable tissue
- If bleeding occurs do not use digital pressure as this may damage delicate tissue and cause further bleeding
- Consider infection as a possible cause for bleeding and treat as indicated. If bleeding becomes a problem consider the following:
- Adrenaline soaks (caution re systemic uptake)
- Sucralfate suspension. (Named patient basis). See Prodigy Guidance. Leaves pink chalky residue which can be flushed off at next dressing change
- Spongostan (haemostatic sponges used in theatre). Patients can be given these for self-treatment.

Dr Patricia Grocott, Senior Research Fellow, King's College London

We recommend that symptoms such as bleeding are discussed with the MacMillan nurses before treatment decisions are implemented.



Dressings Available from ONPOS

Symbols explained:

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Cautions
This show's you issues that may occur when using this product.

Points to Consider
Hints and tips about how to use the products.

Dressing Packs

Cautions
Aviod wiping the wound with gauze when cleansing as this can damage new cell growth. Wounds should be irrigated or in the case of leg ulcers, washed in a bowl of water.

Points to Consider
Dressing packs provide a sterile field for new dressings to be opened on to and include the items required for optimising asepsis. Non sterile gloves should be used to remove old dressings and for washing and creaming legs. If additional gauze is required, do not open a new dressing pack but use gauze from the list below.

Non sterile gauze should be used in the majority of cases. Sterile gauze is only recommended on on post operative wounds (within 48 hours) or in cases where patients may be at greater risk of infection (i.e. Diabetes). Gauze only provides a minimum absorption of exudate and therefore a Zetuvit E Pad should be considered for those light to moderately exuding wounds.

Description	size	Pip codes	E-procurement
Softdrape	large	Nws-0167	EJA047
Softdrape	Medium	Nsw-0166	EJA046
Softdrape	Small	Nsw-0165	EJA045
Non Sterile Gauze	10x10 (x pack of 5)	N/A	EGJ043
Sterile Gauze	10x10 (x pack of 5)	N/A	EGJ045

Contact Layer

Atrauman or Tricotex

Adaptic touch (Refer to restricted use section)

Store Atrauman horizontally to prevent oils from migrating down to bottom of dressing

These dressings have no absorbency of their own and are designed to be used with a secondary dressing depending on the level of absorbency required; they rely on the low adherent property of knitted viscose. They are designed for use under compression bandaging or as a first line contact layer for many uncomplicated wounds.

Atrauman is a non-medicated ointment coated tulle which prevents granulation tissue from penetrating the dressing, minimising pain and trauma on removal.

Description	size	Pip codes	E-procurement
Atrauman	5cm x 5cm	281-3012	EKA024
Atrauman	7.5cm x 10cm	281-3038	EKA032
Atrauman	10 cm x 20cm	281-3046	EKA036
Atrauman	20cm x 30cm	324-8697	EKA016
Tricotex	9.5cm x9.5cm	028-0438	EKG111

Perforated dressing with adherent border

Non adherent with more absorbent pad

Caution on fragile skin due to adhesive borders

these are adhesive 'island' dressings suitable for low exuding wounds

Softpore is showerproof but if a water proof alternative is required consider Hydrofilm Plus (film with pad).

Description	size	Pip codes	E-procurement
Softpore	6cm x 7cm	304-0920	EIJ023
Softpore	10cm x 10cm	304-0938	EIJ013
Softpore	10cm x 15cm	304-0946	EIJ014
Softpore	10cm x 20cm	304-0953	EIJ024
Softpore	10cm x 30cm	304-0979	EIJ026
Hydrofilm Plus	5cm x 7.2cm	342-4322	ELW291
Hydrofilm Plus	9cm x 10cm	342-4330	ELW2952
Hydrofilm Plus	10cm x 20cm	342-4355	ELW304
Hydrofilm Plus	10cm x30cm	342-4371	ELW250

Absorbent Dressings

Zetuvit E Pads - When used for chronic wounds e.g. leg ulcer, non-sterile pads should be first line

Xupad sterile should only be used on post op wounds up to 48 hours and on patients who are immunosuppressed and high risk of infection e.g. diabetic foot.

Sorbion Sachet Extra is a super absorbent dressing capable of holding large amounts of exudate but at the same time wicking moisture away from the skin. Sorbion Sachet Extra can be used as a primary dressing on moderate to highly exuding wounds and can be left on for up to 4 days. If sorbion is sticking leave on longer or put Atrauman underneath. Ensure size is correct you only need a 3cm border around the wound and do not layer.

Sorbion XL is cheaper than using two 30x20 pads

Biatain super adhesive is an adhesive border for high friction areas like the sacrum – do not use under bandages. Biatain super adhesive should be used as a primary dressing. This dressing has a super absorbent pad within a hydrocolloid border. It is most suitable for use on moderately exuding wounds which anatomically cannot easily be secured with bandages. Examples include: pressure ulcers on the sacrum, hips or ischial tuberosities, non-infected diabetic/ foot ulcers and surgical wounds. It can be used as a primary dressing and is showerproof. The recommended wear time is up to 7 days dependent on exudate levels. Change when clinically indicated, usually when exudate reaches 1 to 2 cms from the edge of the pad, which is clearly visible on the outer layer. Do not use on fragile skin, under compression and bandaging or on highly exuding wounds. To remove, gently take the corner and stretch the dressing horizontally, which will break down the adhesive making it kinder to remove.

Zetuvit E pads.

Sorbion Sachet Extra ,Biatain super adhesive.

Do not cut Sorbion Sachet Extra or Biatain Super Adhesive.

Biatain Super Adhesive- To remove dressing stretch and pull the border horizontally to release the adhesive. For exudate management advice refer to the exudate management pathway.

Description	size	Pip codes	E-procurement
Zetuvit E Non Sterile	10cm x10cm	328-6085	EJA021
Zetuvit E Non Sterile	10cm x 20cm	328-6093	EJA022
Zetuvit E Non Sterile	20cm x 20cm	328-6101	EJA023
Zetuvit E Non Sterile	20cm x 40cm	328-6119	EJA024
Xupad Sterile	10cm x 12cm	360- 9401	EJA092
Xupad Sterile	10cm x 20cm	329-1671	EJA093
Xupad Sterile	20cm x 20cm	329-1663	EJA094
Xupad Sterile	20cm x 40cm	329-1689	EJA095
Biatain Super Adhesive	10cm x 10cm	290-2054	ELY103
Biatain Super Adhesive	12.5cm x 12.5cm	290-1999	ELY104
Biatain Super Adhesive	12cm x 20cm	302-9592	ELY105
Biatain Super Adhesive	15cm x 15cm	290-2021	ELY114
Biatain Super Adhesive	20cm x 20cm	294-1029	EJA094
Sorbion Sachet Extra	5cm x 5cm	379-5846	EJE103
Sorbion Sachet Extra	7.5cm x 7.5cm	372-2212	EME066
Sorbion Sachet Extra	10cm x 10cm	372-2220	EME067
Sorbion Sachet Extra	10cm x 20cm	372-2238	EME068
Sorbion Sachet Extra	20cm x 20cm	372-2246	EME069
Sorbion Sachet Extra	20cm x 30cm	Restricted	EME070
Sorbion XL	45cm x 25cm	Restricted	EME099

Alginates

When wound exudate reduces and dressing starts to stick to the wound bed change to a non-adherent

Add more absorbent secondary dressing

They should not be used on dry or necrotic wounds

They should not be used in combination with hydrogels as they render each other inactive.

Do not pack alginates into deep cavities/ sinuses where the true depth is unknown due to the danger of this leading to retained dressings' Alginate residue requires irrigating off before a new dressing is applied.

These dressings can be used to help manage high levels of exudate (particularly in cavity wounds) or for assisting soft debridement. Alginates require a secondary dressing.

Description	size	Pip codes	E-procurement
Urgosorb	5cm x 5cm	298-3278	ELY096
Urgosorb	10cm x 10cm	293-8413	ELY172
Urgosorb	10cm x 20cm	293-8439	ELY098
Urgosorb rope	30cm	293-8421	ELY099

Hydrocolloids

Actiform cool

Atrauman or Tricotex with Absorbant pad

An adhesive dressing used to facilitate rehydration and autolytic debridement of dry, sloughy or necrotic wounds.

Risk of skin stripping on removal

Consider stretching technique to remove dressing

Do not use on lower limb unless –lower limb assessment has been completed. Do not use on a diabetic foot.

Description	size	Pip codes	E-procurement
Hydrocoll Border	5cm x 5cm	285-9650	ELM065
Tegaderm Hydrocolloid	10cm x 10cm	222-3907	EML087
Tegaderm Hydrocolloid	15cm x 15cm	222-3915	Not on EPROC
Tegaderm Hydrocolloid - Sacral	16cm x 17.1cm	311-9799	ELM148
Tegaderm Hydrocolloid - Oval	10cm x12cm	012-0212	ELM084
Tegaderm Hydrocolloid - Oval	13cm x 15cm	048-4279	ELM373
Tegaderm Hydrocolloid Thin - Oval	10cm x 12cm	222-3931	ELM029
Tegaderm Hydrocolloid Thin - Oval	13cm x 15cm	222-3923	ELM026
Tegaderm Hydrocolloid Thin Square -	10cm x 10cm	269-0980	ELM027

Debridement

Hydrocolloids

Actiform cool or Urgoclean

Honey - see antimicrobial section,

Cut Actiform Cool to wound size to prevent periwound maceration

Urgoclean- ensure correct size you only need 2cm border around the wound

If odour is high consider Honey as an option. Refer to antimicrobial section.

Do not debride lower limbs until until arterial status has been established/

Urgoclean should not be used on dry necrotic tissue.

Autolytic debridement is the standard way of debridement

Debridement can be complex, if you are not achieving your objectives contact Tissue viability for advice.

Use Actiform cool for debriding dry, necrotic wounds

Use Urgoclean for assisting debridement of wetter wounds – this product will help manage exudate levels as well as assisting debridement.

Description	size	Pip codes	E-procurement
Actiform cool	5cm x 6.5cm	315-5553	ELE083
Actiform Cool	10cm x 10cm	304-8352	ELE055
Urgoclean pad	6cm x 6cm	367-8877	ELZ404
Urgoclean Pad	10cm x 10cm	367-8885	ELZ405
Urgoclean Pad	15cm x 20cm	367-8893	ELZ406
Urgoclean Rope	2.5cm x 40cm	372-5272	ELZ454
Urgoclean Rope	5cm x 40cm	367-8901	ELZ407

Films

Care is required on removal as they are liable to cause trauma especially on elderly patients or those with delicate skin. This can be minimised by stretching the dressing horizontally.

These are thin semi-permeable sheets of polyurethane which allow gaseous diffusion but are impermeable to bacteria and wound exudate.

They may be used on epithelialising wounds

Use on top of hydrogels as a secondary dressing.

They are sometimes used to protect the skin from sheer and friction.

Description	size	Pip codes	E-procurement
C-view	6cm x7cm	276-1310	EKW095
C-view	10cm x 12cm	276-1328	ELW094
C-view	12cm x12cm	314-4748	ELW151
C-view	15cm x 20cm	276-1336	ELW096

Surgical Tape

Omnifix is unobtainable from E-procurement. Use Hyperfix instead (available in a 10M roll. E-proc code EHR113) if no access to ONPOS.

Avoid direct contact with skin if at all possible

Paper tape is to be used on padding and bandages

Consider other fixative methods such as films/ bandages/ tubular/ stocking

Description	size	Pip codes	E-procurement
Clinipore	2.5cm x 5m	299-0109	ENV027
Omnifix	10cm x 10m	286-9352	HYPERFIX

Sub-Bandage Wadding

This is used to shape the limb and will provide padding over bony prominences.

Description	size	Pip codes	E-procurement
K-soft	10cm x 3.5cm	266-8374	EPA028

Retention Bandages

Tubular retention bandages

If used on lower limbs always bandage toe to knee and use a 10cm width bandage

Always use with padding underneath e.g. wool

Description	size	Pip codes	E-procurement
Easifix K	7.5cm x 4m	349-2147	EDB061
Easifix K	10cm x 4m	349-2154	EDB067
K-Lite	10cmx x4.5m	239-3635	ECA100

Tubular Bandages

Compression (would need assessment and Doppler)

Elasticated tubular bandages are not graduated so cause foot oedema

Layering should be used with caution

Although not 1st line graduation can be achieved by using various sizes of Comfigrip Contact Tissue Viability for guidance.

Actifast should not be used in conjunction with compression therapy (Either under or over bandages). If a liner needs to be applied under wool because the patient has eczema or a known sensitivity to wool then please use comfinette. This is much more conformable than blue/ yellow line. This is only available via ONPOS or E proc and cannot be obtained on FP10.

Description	size	Pip codes	E-procurement
Comfigrip	D-1m	289-1901	EGA097
Comfigrip	E-1m	289-1893	EGA098
Comfigrip	F-1m	289-1877	EGA099
Comfigrip	G-1m	289-1885	EGA100
Actifast	Red -1m	285-6490	EG079
Actifast	Blue- 5m	285-6573	EGP086
Actifast	Yellow-5m	285-6623	EGP089
Comfinette	56 x 20m		EGJ043
Comfinette	78 x 20m		EGJ045

Bandages Compression

K-Lite

Reduced compression

Discuss with TV

Compression should not be applied until a full lower limb assessment and Doppler has been carried out. This should be performed by a competent clinician who has received training in Leg Ulcer Management.
For further information refer to local Leg Ulcer Guidelines.

See leg ulcer guidelines to ensure competency knowledge and practice is maintained (oxford health intranet)

Different width bandages are linked with chronic oedema and lymphoedema treatment contact TV for support.

All standard lower leg bandages should be 10cm width.

For a latex free bandage (short stretch) use Rosidal K

Description	size	Pip codes	E-procurement
Full Compression (ABPI 0.8-1.3)			
Actico Cohesive	8cm x 6m	314-0886	EBA023
Actico Cohesive	10cm x 6m	271-5431	EBA016
Actico Cohesive	12 cm x 6m	314-0894	EBA033
KTwo (top brown layer)	18cm - 25cm	327-4610	ECA152
KTwo(top brown layer)	0 short	327-4628	ECA276
KTwo (top brown layer)	25cm - 32cm	333-8498	ECA164
KTwo (bottom white layer)	18cm - 25cm	327-4669	ECA277
KTwo (bottom white layer)	18cm - 25cm (short)	327-4677	ECA278
KTwo (bottom white layer)	25cm - 32 cm	333-8506	ECA279
KTwo 2 Layer Compression Bandage Kit	18cm - 25cm	327-4685	ECA152
KTwo 2 Layer Compression Bandage Kit	18cm - 25cm (short)	327-4693	ECA151
KTwo 2 Layer Compression Bandage Kit	25cm -32 cm	333-8480	ECA164
Reduced Compression (ABPI -0.6-0.8)			
Ko-Flex	10cm x 6m	266-8366	ECD018
Ko-Flex Long	10cm x7m	325-7151	ECD028
Latex Free			
Rosidal K	8cm x 5m	214-5910	EBA058
Rosidal K	10cm x 5m	214-5902	EBA040
Rosidal K	12 cm x 5m	214-5894	EBA059
Toe Bandaging			
Mollelast Bandage	4cm x4m	344.3983	EBA064

DRESSINGS AVAILABLE ON FP10 (prescription). Not restricted.

Skin Care

Cleansing

Sterile saline is not available from ONPOS.
There is no evidence to suggest that using saline is any more effective than tap water. Studies have shown that using tap water does not increase the risk of wound infection. All chronic wounds are usually heavily colonised with bacteria and therefore using sterile solutions is not advocated.

Fernandez, R.S., Griffiths, R.D. & Ussia, C. (2001). Wound cleansing: Which solution: What technique? Primary Intention. 9, 2. 51 – 58
Hall, S. A review of the effect of tap water versus normal saline on infection rates in acute traumatic wounds Journal of Wound care Vol 16, no 1, January 2007.

Emollients

The object of emollient therapy is to correct some of the factors that contribute to dry skin, to restore the skin barrier and thereby reduce the likelihood of skin problems, such as eczema, infection, skin tears & moisture lesions. Please refer to Oxford Health Tissue Viability Skin Care Guidelines for further information.

These emollient choices and guidelines are specific to tissue viability and are for the suggestive use on lower limbs and peri wound skin only. This section does not address management of dry skin to other areas of the body, dermatological conditions, or protecting skin from moisture. Separate guidance is available for these areas:

- For dry skin please refer to Oxfordshire CCG primary care guidelines for the management of dry skin (March 2014) http://occg.oxnet.nhs.uk/generalpractice/clinincalguidelines/dermatology/eczema/ocg primary care guidelines for the management of dry skin emollients v2.pdf
- For dermatological guidance please refer to your GP or specialist service
- To protect skin from moisture please follow the pathway for the treatment of skin that is damaged and excoriated by moisture File:///\\ombh.nhs.uk\g_data\oxfordshire\tissue viability\9.amnesty\pathway for the treatment of skin that is damaged and excoriated by Moisture v4.docx

Emollients are not available on ONPOS or E-procurement and need to be prescribed as patient specific on FP10. The choice of an appropriate emollient will depend on the severity of the condition, patient preference, and the site of application.

Product	Rationale
Hydromol ointment	1st line choice for use on lower limbs and peri wound skin
Oilatum cream	Can be used if ointment is too occlusive & under hosiery
Balneum cream	Step up emollient if Hydromol is inadequate. Contains 5% urea
Hydromol intensive	10% urea for problematic dry skin, such as cracked heels or very stubborn kerratotic plaques, where alternatives have failed.
Balneum plus	To manage itch if 1st line & step up products have failed

Hydromol Ointment

A first line emollient therapy for dry skin conditions. It can be used as a soap substitute

as well as a leave on emollient, on broken skin or moisture lesions, for protection of peri wound skin and for hyperkeratosis as it softens plaques. When used as a soap substitute it aids in the removal of plaques by gentle washing with a flannel. It is the emollient of choice for use under compression bandaging but may be too greasy under compression hosiery. Apply up to twice a day.

Contains; 32% yellow soft paraffin, 42.5% liquid paraffin, 25.5% cetomacragol emulsifying wax. It works by providing a layer of lipid on the skin to prevent water evaporation. It is fragrance free but does contain cetosteryl alcohol which is a possible skin sensitiser.

Description	Size	Pip code
Hydromol Ointment	125g	294-1409
	500g	294-1391
	1kg	346-0292

Oilatum Cream

May be more acceptable to patients if Hydromol ointment is felt to be too thick, greasy or occlusive. Also more suitable under compression hosiery. Needs more frequent application - up to four times a day.

Contains Light Liquid Paraffin 6.0% and White Soft Paraffin 15.0% in a cream base which forms an occlusive film, although less thick than an ointment, which reduces trans-epidermal water loss.

Also contains cetostearyl alcohol and potassium sorbate which may cause local skin reactions

Description	Size	Pip code
Oilatum Cream	50g tube	372-3772
	150g tube	280-3237
	500ml pump	281-5611
	1050ml pump	322-8798

Balneum Cream

A step up emollient if Hydromol or Oilatum cream are inadequate, or alternatives are unacceptable to the patient. It contains urea 5% and ceramide 0.1%. Both of these ingredients help to replace essential elements which maintain the skin barrier, and which decline with age (see Oxford Health Tissue Viability Skin Care Guidelines for further information for further information). Apply once or twice daily. Not to be used on broken skin, as the urea can sting, but can be used on fragile eczematous skin. Patients with a confirmed hypersensitivity to peanut or soya should not use the product as it contains refined soya oil.

Description	Size	Pip code
Balneum Cream	50g pump	350-9544
	500g pump	350-9544

Hydromol Intensive

Useful for very problematic dry skin conditions such as cracked heels or very stubborn kerratotic plaques. However, emollients such as Hydromol and good skin washing should be considered as a first line approach before Hydromol intensive is considered. Apply thinly twice daily.

It contains 10% Urea which is a keratin softener, and white soft paraffin, which forms an occlusive layer over the skin preventing the evaporation of water. It has a powdery texture and due to the urea content it can sting. Can take between 2 and 4 weeks to take effect.

Description	Size	Pip code
Hydromol Intensive	30g tube	281-1503
	100g tube	235-8356

Balneum plus Cream

This is to be used if itch is unrelieved by fist line or step up product and after possible causative factors have been assessed. Contains urea 5% and lauromacrogols 3%. Lauromacrogols have anaesthetic properties for relieving itch. Should be applied twice daily. Total effect may take up to 4 weeks

Description	Size	Pip code
Balneum plus cream	100g tube	235-8356
	500g pump	281-1503

Application of emollients

- Dot on generously to limbs and then apply in long downward strokes, in the direction of hair growth and allow to soak in. Do not rub in.
- As a soap substitute - Apply emollient to entire limb/foot before placing in water

and allow ointment or cream to soak off but gently stroking the limb with a gloved hand with long downward strokes. To remove plaques, use a flannel and gentle circular motions.

- If topical steroids are treating areas of varicose eczema, a gap should always be left between applying emollient and topical steroid (use ointments rather than creams). Ideally for half an hour. If this is not possible in practice, identify whether dryness or irritation of the skin is the predominant concern. If the skin is very red and sore, apply the steroid ointment first, wait 10 minutes, then apply the emollient; or if skin is very dry apply the emollient first, then wait 10 minutes and apply the steroid ointment.

Precautions

- Emollient preparations contained in tubs should be removed with a clean spoon or spatula to reduce bacterial contamination of the emollient.
- Not suitable for use alongside adhesive dressings.
- Prior to using an emollient for the first time apply a test application to the inside of the forearm for 24 hours to check for sensitivity.
- If you suspect a reaction to the emollient, discontinue its use. Document the circumstances, photograph the reaction & discuss with Tissue Viability. Consider referral to Dermatology for patch testing & complete a Yellow Card if confirmed as a reaction to the emollient.

Fire hazard with paraffin-based emollients

Patients treated with large quantities of paraffin-based products (100g or more per application) should be warned of the potential fire risks associated with smoking or being near smokers, and about regularly changing clothing or bedding impregnated with paraffin based products (preferably on a daily basis). There is no suggestion that use of paraffin-based products should be stopped or limited (MHRA Drug Safety Update Jan 2008; Vol 1, Issue 6: 10).

Aqueous cream

There is sound evidence that aqueous cream BP should be avoided, both as a leave-on emollient and as a washing product. It contains approximately 1% SLS (Sodium Laurel Sulphate) which is known to be profoundly irritant. Recent studies have shown it weakens the skin barrier and actually increases trans epidermal water loss. Rather than restoring the skin barrier it actually appears to cause more damage. SLS is used as a skin irritant in patch testing, and is therefore an ingredient that should never be included in an emollient formulation (Moncrieff, G et al (2013), Use of emollients in dry-skin conditions: consensus statement. Clinical and Experimental Dermatology, 38: 231–238). MRHA has issued a warning on use of Aqueous cream for eczematous skin. (MRHA, Drug Safety Update 2013 Vol 6, Issue 8). Aqueous cream has been black listed in Oxfordshire and should not be prescribed.

This guidance was developed through consultation with Oxfordshire CCG Medicines Management team, George Moncrieff (GPSI dermatology) and Julie Van Onselen (Dermatology Nurse Specialist, Bicester GPSI Dermatology Clinic). The formulary products have been approved by APCO.

Barrier Creams and Films

Comprehensive emollient therapy should be used before stepping up to the use of barrier creams and films

Barrier cream or film dependent on whether skin is intact or broken

DO NOT mix' barrier creams and ointments as they interact with each other and will can cause further breakdown and maceration of the skin.

Skin protectors are used to create a barrier to protect skin from maceration and excoriation, caused by moisture from incontinence or exudates from wounds. The use of modern dressings should reduce the need for skin barriers in the majority of wounds.

Please prescribe the correct size for the surface are to be treated.

Aerosol - Only to be used on moisture lesions with a large surface area where a non-touch technique is required. This should not be used for peri-wound skin as it may contaminate the wound bed. In this instance use the foam applicator

1ML - Size of A5 paper

3ML - Size of A3 paper

All products should only be used for a short period of 2-3 weeks. If the skin has not recovered in this time please contact Tissue Viability for advice.

For correct use of barrier creams please refer to' Pathway for the treatment of skin that is damaged and excoriated by moisture 'available via the Tissue Viability intranet page.

Description	size	Pip codes	E-procurement
Derma-s barrier cream			
Sachets	20g	341-3317	60338 (pack of 480)
Tube	90g	341-3325	ELY538 (pack of 24)
Derma-s no sting barrier film.			
Foam applicator	1ml 3ml	362-8716 362-8724	ELY532 (pack of 120)ELY454 (pack of 120)
Aerosol spray	50ml	389-7139	ELY561
Medihoney barrier cream,			
Sachet	2g x20	369-1276	ELY374
Tube	50g	338-7644	ELY289
Proshield plus see restricted section			

Antimicrobial Formulary

This formulary refers to the topical management of local (wound bed) infection.

Treatment should be commenced following the diagnosis of local (wound bed) infection. This can be assisted by using the Assessment and Management of Bacterial Loading (AMBL) tool.

The maximum time any one dressing should be used is two weeks during which the wound state should be re-assessed regularly.

If there is still evidence of local wound bed infection after 2 weeks, seek advice from community tissue viability team. tissueviability@oxfordhealth.nhs.uk or oxfordhealth.tissueviability@nhs.net

Dressings detailed within this formulary are available on FP10 and should be single patient use only. Select the number of dressings required for a two week period based on frequency of dressing changes.

First line choice should be medical grade honey. There are a number of dressings available and should be chosen based on wound type. These include:

- Actilite
- Algivon plus/ and ribbon
- Algivon standard
- Medihoney gel sheet
- Medihoney antibacterial wound gel

Second line choice (If honey not tolerated or contraindicated) – Cadexomer iodine, a slow release product and is only appropriate for use on locally infected wounds with moderate to high exudate levels. Products include:

- Iodosorb paste
- Iodoflex

TOPICAL ANTIMICROBIAL DRESSINGS

Healthcare professionals should refer to the Oxford Health guidelines: the effective diagnosis and management of local wound bed infection and bacterial colonisation to aid clinical judgement and effective patient diagnosis.

If localised wound bed infection or colonisation has been clinical diagnosed using the AMBL (assessment and management of bacterial loading) tool, the use of a topical antimicrobial dressing is indicated. The maximum time any one dressing should be used is two weeks during which the wound state should be re-assessed regularly.

Prior to use it is important a clinician is familiar with the modality, indications of use and contraindications of the antimicrobial dressing you are considering.

Those antimicrobial dressings detailed within this formulary are available on FP10 and should be single patient use only. The prescription request should detail: dressing name and composition, size, number of individual dressings required and where able, the PIP code.

NOTE: - these products are only available on prescription. Clinicians should order a specified number of individual dressings to meet the required treatment period. Pharmacy dispensaries have the ability to and should split boxes to avoid over ordering costs. This should be made clear on the prescription.

FIRST LINE OPTION: MEDICAL GRADE HONEY

Honey is a broad-spectrum topical antimicrobial with varying therapeutic properties which include:-

- Bacterial cells require water to survive. Through the osmotic effects of honey, water is drawn from the bacteria cells and therefore damages their infrastructure.
- Honey produces Hydrogen Peroxide the components of which decomposes bacteria and renders them ineffective
- Honey support moist wound healing and therefore can create an environment for autolytic debridement of devitalised tissue and reduce wound odour. Therefore honey can play a significant role in would bed preparation by managing bacterial load.

Note: - this should only be considered as part of an antimicrobial treatment plan for treating local wound bed infection or colonisation.

Recommended dressing options include:

Actilite

Viscose gauze impregnated with 99% manuka honey and 1% manuka oil. This product offers antibacterial protection whilst promoting a moist wound healing environment.

Best suited to;- superficial, low exuding wounds requiring bacterial loading management or basic debridement. Such as Leg ulceration, category two pressure ulcers

Size	Pack Size	PIP Code	e-Proc Code
10cm x 10cm	10	335-4917	EJE042
10cm x 20cm	10	335-4925	EJE040

Algivon Plus

A reinforced, soft alginate dressing impregnated with 100% manuka honey. The reinforced alginate fibres enable a sustained, slower release of honey whilst maintaining the integrity of the dressing.

Best Suited to:-moderate-high exuding wounds such as cavity pressure ulcers or large circumferential leg ulceration. Due to its conformability, this product could be used to debride large areas of necrosis or slough in line with reducing bacterial loading.

Size	Pack Size	PIP Code	e-Proc Code
5cm x 5cm	5	374-9496	ELS206
10cm x 10cm	5	374-9512	ELS195

Algivon standard alginate

Similarly to Algivon plus, this product is a soft alginate impregnated with 100% manuka honey. The difference between the two is that Aligvon Plus has reinforced alginate fibres which can mean for certain wound surfaces the product is more conformable and less likely to break apart.

There is a misconception that as the honey does not fill the entire dressing it is less effective. The initial location of the honey is predominately due to manufacturing processes. As the honey warms against the wound bed it spreads across the entire dressing and delivers the correct amount of antimicrobial required.

Algivon Plus Ribbon

This product holds the same profile as Algivon Plus but is available as a reinforced, soft alginate ribbon. The ribbon is conformable and therefore shapes within cavities and sinuses meaning the wound can be packed easily. This product can also be used on anatomically challenging wound beds to reduce the need for tailoring other dressings.

A reinforced, flexible probe is available with the product to aid application.

It is advisable to measure and clearly document the wound cavity depth and/or sinus length by use of a wound probe along with the length of ribbon inserted into the wound.

Best suited to:- Large cavity, undermining or sinus wounds requiring light packing for exudate management and bacterial loading management, challenging anatomical wound beds such as dehisced abdominal wounds or sacral pressure ulcers.

Note: - Clinicians should not pack cavity or sinus wounds where the wound bed is not fully visible (blind) or the length/ direction of sinus tracking is unobtainable. To avoid risks associated with retained dressing products packing such wounds is not advocated. Patients should be investigated further to determine underlying structure involvement or deep seated infection prior to treatment. Please see advice from Tissue Viability is concerned.

Size	Pack Size	PIP Code	e-Proc Code
2.5cm x 20cm	5	374-4653	ELS551

Medihoney Gel Sheet

A non-adherent wound dressing comprising of 80% medihoney antibacterial honey and 20% sodium alginate. This product resembles a putty-like, conformable dressing and therefore is ideal for anatomically challenging wound beds such as cavity pressure ulcers.

Best Suited to;- Mild to moderately exuding wound beds and autolytic debridement of large of areas of slough or necrosis.

Size	Pack Size	PIP Code	e-Proc Code
5cm x 5cm	10	340-3995	ELE065
10cm x 10cm	10	340-4001	ELE064

Medihoney Antibacterial Wound Gel

This product has been formulated combining 80% honey with waxes to provide a high viscosity gel that is easy to apply. To ensure the product is in full contact with the wound bed a layer of approximately 3mm in depth should be applied.

Best suited to:- leg ulcers, exit/entry site infections, surgical incision sites such as episiotomies.

Note: - this product is not absorbed by the body therefore will need irrigating or washing off at each dressing change. This is to help prevent residue build-up on the wound bed.

Urgosorb alginate dressing or ribbon can be saturated with this product to aid anatomically challenging wound management. .

Size	Pack Size	PIP Code	e-Proc Code
10g	1 single patient tube	314-1207	ELZ013
20g	1 single patient tube	314-1215	ELZ507

Recommendations:-

- The duration of time honey can be left in situ is for up to 5 days. However we would recommend dressing changes are in line with clinical judgement and treatment objectives. Generally dressings should be changed at a maximum of every third day to allow the product to be effective whilst monitoring changing wound needs closely.
- Honey-based dressings have the potential to cause skin maceration due to mode of action and increase in wound bed moisture levels. Therefore ensure the product is not in contact with peri-ulcer skin, moisture levels are managed effectively with a suitable absorbent pad and a suitable emollient therapy is in progress.
- Due to the osmotic effect of honey, moisture levels at the wound bed can temporarily increase during treatment. You might consider upgrading the absorbent pad used to aid maintaining an effective moisture balance.
- Practitioners should be cautious in implementing honey-based products in those patients with known allergy to bee-related products. There is limited clinical evidence to suggest honey can cause erratic blood sugars in those patients with diabetes.
- Although rare, transient discomfort can be experienced when honey is initially applied, depending on the sensitivity of the wound it may be necessary to consider an appropriate level of analgesia. An educational leaflet to support patients during this treatment is available on the Tissue Viability Portal:

  http://apps.oxfordhealth.nhs.uk/LandDPortal/clinical-and-Professional-Development/Introduction.aspx
- Store honey at room temperature. Due to the nature of honey it can harden at cold temperatures or become more liquid at warm temperatures. Depending on consistency the products can be warmed between hands to soften or placed in the fridge for a few minutes to stiffen.
- Shop-bought honey must not be used on wounds as there is a risk of introducing micro organisms. In the preparation of wound care products, manufacturers avoid risk by sterilising the honey with gamma radiation.

SECOND LINE OPTION: CADEXOMER IODINE DRESSING

Cadexomer Iodine is a slow release product and is only appropriate for use on locally infected wounds with moderate to high exudate levels.

The release of iodine is activated by bacteria and wound exudate. Exudate is taken up and held in the absorbent molecules within the dressing and is gradually released. It is also effective at removing slough. Please take special note of dosing guidance, contraindications and length of treatment.

Iodosorb Ointment and Iodoflex Sachet dressings contain Cadexomer Iodine. They both consist of miccrospheres of chemically modified starch which contains 9% of elemental iodine which is released when the beads absorb water and swell.

Both can absorb excess exudate and debride slough from the wound bed and therefore reduce bacteria at the wound surface.

NOTE: - these products are only available on prescription. Clinicians should order a specified number of individual dressings to meet the required treatment period. Pharmacy dispensaries have the ability to and should split boxes to avoid over ordering costs. This should be made clear on the prescription.

Indications:

- To treat clinically diagnosed wound colonisation and/or localised wound bed infection.
- To debride heavily colonised, sloughy wound beds whilst addressing increasing bacterial loading.

Iodosorb ointment:-

A dark brown paste which is available in 10g and 20g tubes.

Best Suited to: - superficial wounds such as leg ulcers or within an open cavity where the wound bed is visible.

Note:- This product is not absorbed by the body. Irrigation of the wound bed using warmed tap water would be required to reduce dressing residue. Not suitable for undetermined sinus or tracking wounds.

Size in Grams of Iodine	Box Quantity	Order Codes	e-Proc Code
10g	4	66151240	EKB012
20g	2	661512230	N\A

Iodoflex Dressing:-

A dark brown paste dressing with a gauze backing on both sides available in various dressing sizes. This product can be moulded or cut to fit the wound bed.

Best suited to: - superficial or deep cavity wounds such as pressure ulcers in challenging anatomical areas or leg ulceration

Size in Grams of Iodine	Box Quantity	Order Codes	e-Proc Code
6cm x 4cm (5G)	5 sachets	6151330	EKB007
8cm x 6cm (10G)	3 sachets	66151340	EKB008
10cm x 8cm	2 sachets	66151360	EKB009

Contraindications:-

The products should not be used on dry necrotic wound beds

Do not use in those patients with known sensitivities to Iodine-based products or components

Do not use in those patients with thyroid disorders, renal impairment, lactating and/or pregnant women or children.

Note:

A single application of Iodoflex or Iodosorb should not exceed 50g (equivalent to 5 x 10g sachets/tubes in a single application and not more than 150g (equivalent to 15 x 10g sachets/tubes) in one week.

The product should be changed when they become saturated with wound exudate and all the iodine has been released. This is indicated by loss of colour.

Generally this product should be changed every 2-3 days in highly exuding wounds it might be necessary to change daily.

RESTRICTED USE SECTION

Dressings included in this section are not available to order on the ONPOS system. They should be issued on FP10. Tissue viability contact is required before proceeding. Please email **tissueviability@oxfordhealth.nhs** or **oxfordhealth.tissueviability@nhs.net** For TV Admin - Tel **01865 904959 /904271.** Fax - **01865-261757.**

Allevyn Life

This is a super absorbent dressing that will only manage low to moderately exuding wounds. Do not use on highly exuding wounds as it may result in skin maceration. Consider a step up to Sorbion S Extra if this is the case.

It is not suitable for wounds on high friction areas such as hips or sacrums.

This product has a soft silicone contact layer to protect fragile skin and damaged periwound skin.

Has a super absorbent incorporated to be used on low- medium exudate

This dressing has a super absorbent dressing incorporated within a soft silicone contact layer which allows a atraumatic/ painfree removal. It can be used on wounds where there may be fragile or damaged periwound skin when dressings cannot be secured with bandages. Examples include skin tears on arms or hands, fungating breast lesions, neck wounds.

This dressing is showerproof.

Do not use under bandages/ compression. In these cases, If a silicone contact layer is required consider Adaptic Touch.

ALLEVYN Life has a masking layer that enables you to identify when the dressing needs changing. The dressing can remain insitu for up to 7 days and does not need changing until there is 75% border coverage.

Description	size	Pip codes	E-procurement
Allevyn life	10.3x 10.3cm	373-9448	ELA607
Allevyn life	12.9 x12.9cm	373-9430	ELA608
Allevyn life	15.4 x15.4cm	373-9380	ELA609
Allevyn life sacral	17.2 x17.5cm	380-7575	ELA645
Allevyn life sacral	21.6x 23cm	380-7582	ELA646

Proshield Plus

None at present

Use on moisture lesions if standard barrier products are not effective. (eg Medi-Derma-S). Can also be used on category 2 pressure ulcers when the use of dressings is contra-indicated.

Please refer to skin barrier pathway for more information.

Description	size	Pip codes	E-procurement
Proshield plus	115g	359-8760	ELZ537

Debrisoft

Can cause bleeding in friable wound beds

If used for debriding biofilm a topical antimicrobial should be considered as a primary dressing for the following two weeks.

This product is used for mechanical debridement and the management of biofilms when other interventions have failed

Should not be used for long term treatment

Description	size	Pip codes	E-procurement
Debrisoft	10cm x 10cm	358-1287	ELZ354

Adaptic touch

Cellulose acetate mesh coated with soft tack silicone

This should not be a 1st line option. It is a step up product after trying Tricotex or atrauman and there are issues with wound adherence. It may be also be considered when there is a need to leave the non-adherent on for a longer period of time.

It may be beneficial for treating skin tears, particularly if the skin is fragile or on wounds that are particularly painful. Other wound types may include malignant/ fungating lesions or burns.

Can be used from low to highly exuding wounds together with an effective absorbent secondary dressing.

Suitable to use under VAC therapy to cover exposed organs and bone or when the granufoam is adhering to tissue.

Select a dressing size that is marginally larger than the wound to ensure the dressing can be applied to intact skin surrounding the wound margins.

If more than one piece is required, ensure dressings overlap to avoid secondary dressing adherence to the wound. Overlap should be minimised to prevent occlusion of holes. Dressing change frequency is determined by exudate levels and condition of the wound and surrounding skin can remain on for up to seven days, while the secondary dressing can be changed more frequently as required.

Description	size	Pip codes	E-procurement
Adaptic touch	5cm x 7.6cm	359-0411	ELY360
Adaptic touch	7.6cm x 11cm	759-0429	ELY353
Adaptic touch	12.7cm x 15cm	359-0437	ELY361
Adaptic touch	20cm x 32cm	359-0445	ELY362

UrgoStart Contact

Not to be used on infected wound beds with necrosis of more that 30% slough.

This is a protease inhibitor, effective in the management of chronic wounds where elevated proteases (enzymes) may be contributing to delayed healing. All other causes should be ruled out and treated before considering this product including infection, ischaemia, diabetes and anaemia.

This is a non adherent, non–occlusive flexible contact layer composed of a polyester mesh with a TLC-NOSF healing matrix (hydrocolloid and lipophilic particles). It can be left in situ for up to 7 days.

Urgostart contact is first line management for patients allocated to the complex venous leg ulcer treatment pathway. Tissue viability approval is required if you are considering use on any other wound type.

When requesting a prescription please ensure that this is for Urgostart **CONTACT** and not Urgostart. On collection from pharmacy do check that that Urgostart **CONTACT** has been issued.

Description	size	Pip codes	E-procurement
UrgoStart Contact	5cm x 7cm	339-8971	EKB081
UrgoStart Contact	10cm x 10cm	386-1390	EKB087
UrgoStart Contact	15cm x 20cm	386-1382	EKB088

UrgoTul

Would be considered if the step up to Adaptic touch was not working

This product can be used with NPWT

The dressing has a lipido colloid contact layer which is atraumatic to the wound and can be left insitu for up to 7 days.

Choose a dressing that reflects the size of the wound. You only require a 1 – 2cm border. 'Do not layer'

It should be considered as a step up from Adaptic Touch for a range of wounds where pain is a particular problem, particularly at dressing changes. Can be combined with an absorbent dressing for heavily exuding wounds.

Should be used as a first line dressing for radiotherapy burns.

Description	size	Pip codes	E-procurement
Urgotul	5cm x 5cm	354 5498	EKB057
Urgotul	10cm x 10cm	354 5506	EKB058
Urgotul	10cm x 40cm	298 3260	EKB082
Urgotul	15cm x 15cm	371 9432	EKB074
Urgotul	15cm x 20cm	354 5514	EKB058
Urgotul	20cm x 30cm	354 5480	EKB060

Sorbion Sachet Multi Star

Do not use on bleeding wounds

Used for wounds requiring a super-absorbent in difficult anatomical positions e.g breast or feet.

Description	size	Pip codes	E-procurement
Sorbion Multi star	8cm x 8cm	375 3717	EJE104
Sorbion Multi star	14cm x 14cm	375 5725	EJE105

Sorbion S Sachet Drainage

Do not put on bleeding wounds

You can cut the tea bag and make into two pads to put into small difficult anatomical positions such as drain sites or peg sites that are heavily exuding only.

Description	size	Pip codes	E-procurement
Sorbion S Sachet Drainage	10cm x 10cm	354-677	EJE106

Larval Therapy

Do not use on load bearing areas unless patient can be immobilised.

Can cause excoriation of periwound skin if not protected.

Used when quick debridement is required.

Training will need to be provided.

Description	size	Pip codes	E-procurement
Larval Bags	Various Discuss with TV	/	/
Free range	Various Discuss with TV	/	/

Silicone Gel sheets

Unable to use in some dermatological conditions

For the reduction of hypertrophic scars

Self -adhesive and should be washed and re-used.

There are various products please liaise with TV for advice and support

Description	size	Pip codes	E-procurement
Cica-care	Multiple sizes	/	/
Mepiform	Multiple sizes	/	/
Silgel	Multiple sizes	/	/

Negative Pressure Wound Therapy (NPWT)

There is an agreed process in place for patients being discharged from the OUH with VAC (NPWT) therapy.

The process for VAC is on the Tissue Viability intranet page.

All referrals will need to be agreed by The Community Tissue Viability service before the patient is discharged.

Charcoal Dressing

Should not be used until all other options have been considered

Odour is usually associated with infection. Topical Antimicrobial treatment should be 1st line management before Charcoal is considered.

Description	size	Pip codes	E-procurement
Clinisorb	10cm x 10cm	018-2667	ELV051
Clinisorb	10cm x 20cm	018-2857	ELV053
Clinisorb	15cm x 25cm	018-2873	ELV055

3rd Line Antimicrobial Dressing – Cutimed Sorbact

Cutimed Sorbact is a range of primary wound contact dressings. These products have been developed for the treatment of infected wounds and fungal infections. They can be used on all types of wounds, from lightly to highly exuding and from contaminated and colonised to infected wounds.

Unlike traditional antimicrobial dressings, this range does not contain any chemically or pharmacologically active substances. It works as a 'filter' to bacteria and relies on a physical mode of action using a hydrophobic coating made from dialkylcarbamoylchloride (commonly known as DACC) to reduce the bacterial load in wounds.

This product is intended for non-invasive treatment on colonised/infected/ischemic/arterial wounds where there is clinical contraindication for the use of Honey and Iodine. Cutimed Sorbact is a restricted specialist product and can only be ordered following consultation with and via the Community Tissue Viability Team ONPOS system.

Practical Tips:

- Cutimed Sorbact is a dressing best placed against the wound bed as a primary layer
- The product should not be used in direct contact with ointments and creams containing lipids as these can inhibit the bacterial-binding properties of the dressing.
- Can be used in palliative wound management where stabilising bacterial loading is the key objective. In this situation the product can be left in situ for up to five days.
- For actively infected wounds, the product should be changed every third day in line with on-going wound assessment requirements. Please refer to Trust guidelines.
- This product range can be cut to size. However the dressing size ordered should be as close to wound surface area requirements as possible to reduce wastage.
- Although not adding additional clinical benefit, the Swab and Ribbon can be placed across peri-wound skin safely.
- There is no added clinical benefit to layering the Swab/Ribbon product and clinical efficacy will not be compromised if it is. However if wound exudate is highly viscose then a single layer may allow for uncompromised 'filtering' of wound fluid and transfer into an absorbent secondary dressing.

The dressing options are:

Cutimed Sorbact Ribbon Gauze

Best suited to: filling wound cavities where the wound bed is visible. Suitable for bacterial loading management in challenging anatomical areas such as: skin folds or between the toes.

Size	PIP Code	e-PROC
2cm x 50cm	339-9482	ELY 218
5cm x 200cm	339-9490	ELY 217

Note: Clinicians should not pack cavity or sinus wounds where the wound bed is not fully visible (blind) or the length/direction of sinus tracking is unobtainable. To avoid risks associated with retained dressing products packing such wounds is not advocated. Patients should be investigated further to determine underlying structure involvement or deep seated infection prior to treatment. Please see advice from Tissue Viability is concerned.

Cutimed Sorbact Swab

Best suited to: Primary dressing for superficial or deep contaminated, colonised or infected wounds.

Apply directly to the wound bed unfolded as a single primary layer

Size	PIP Code	e-PROC
4cm x 6cm (folded) 11cm x 16cm (unfolded)	232-4325	ELY212
7cm x 9cm (folded) 17cm x 27cm (unfolded)	232-4333	ELY213

Cutimed Sorbact Gel

A hydrogel impregnated swab combining antimicrobial action with moist wound healing.

The hydrogel component dissolves into the wound bed, donating moisture to promote autolytic debridement in sloughy or partially necrotic wounds.

Best suited to:- dry to low exuding superficial or deep wounds where debridement of devitalised tissue is required but a high risk of progressive wound bed infection exists. Avoid direct contact with peri-wound skin to avoid maceration.

Choose an appropriate secondary dressing which meets exudate levels of the wound bed but reduces the possibility of total absorption of the hydrogel

Size	PIP Code	e-PROC
7.5cm x 7.5cm	347-7015	ELY338
7.5cm x 15cm	347-7023	ELY339

ACKNOWLEDGEMENTS

Thank you to all those who gave of their time, and particularly their expert advice, to enable us to compile this document.

Oxfordshire Clinical Commissioning Group and Oxford Health NHS Foundation Trust would like to thank the following companies for their support:

- Urgo Medical
- Aspen Medical
- Paul Hartman
- Almirall
- Richardson Healthcare
- Biomonde
- Smith & Nephew
- Clinimed
- Synergy Health
- Coloplast
- Systagenix
- Derma Sciences
- Activa Healthcare
- H&R Healthcare
- 3M
- KCI
- Medicare Plus
- Advancis
- Stiefel /GSK
- Alliance Pharmaceuticals

Particular thanks to Urgo Medical for their time in facilitating the production of this Formulary.