NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

SEPTEMBER 2025

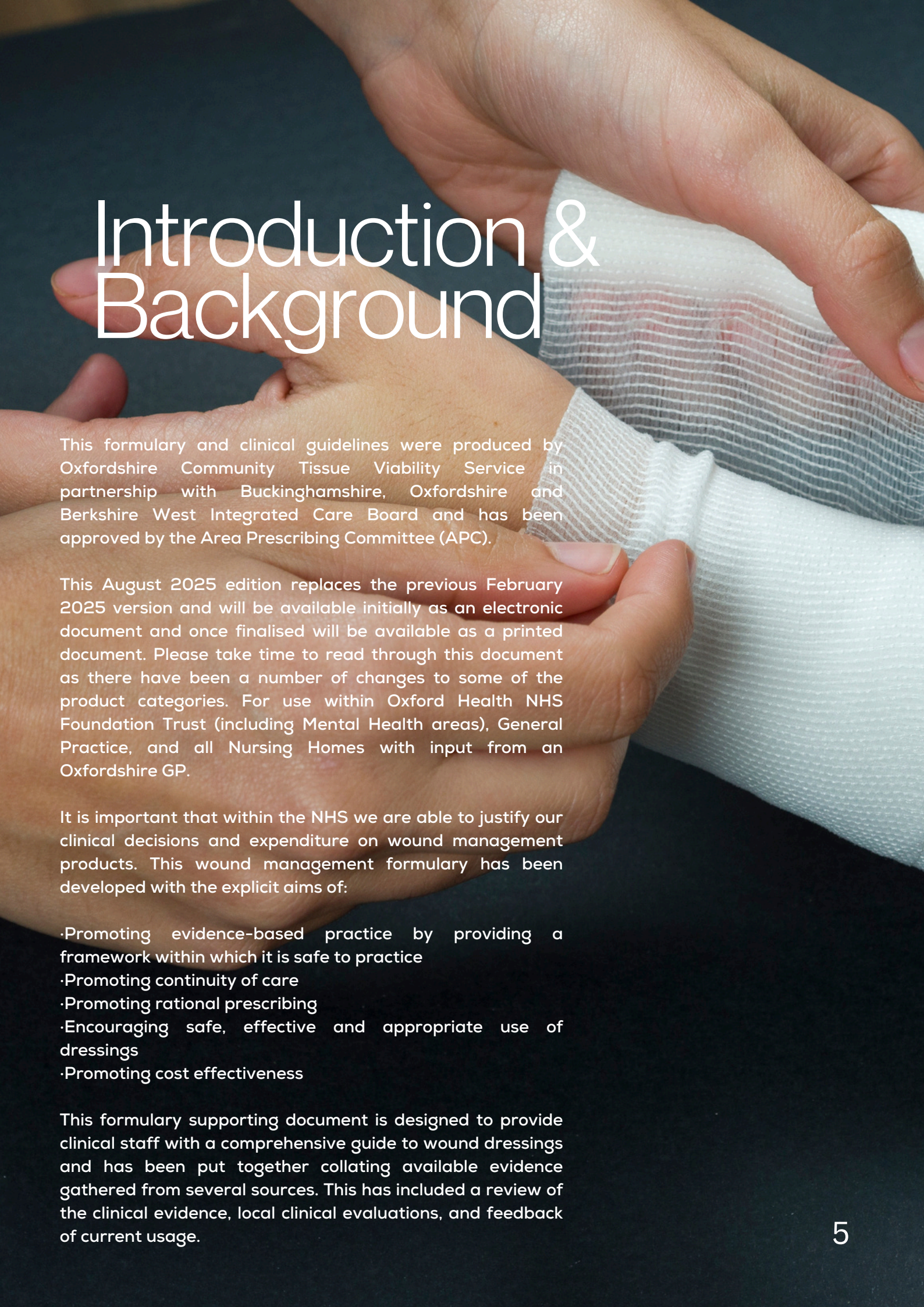
Wound Care Formulary

OXFORDSHIRE EDITION - SEPTEMBER 2025

Contents

Contents

Contents



Introduction & Background

This formulary and clinical guidelines were produced by Oxfordshire Community Tissue Viability Service in partnership with Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and has been approved by the Area Prescribing Committee (APC).

This August 2025 edition replaces the previous February 2025 version and will be available initially as an electronic document and once finalised will be available as a printed document. Please take time to read through this document as there have been a number of changes to some of the product categories. For use within Oxford Health NHS Foundation Trust (including Mental Health areas), General Practice, and all Nursing Homes with input from an Oxfordshire GP.

It is important that within the NHS we are able to justify our clinical decisions and expenditure on wound management products. 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

This formulary supporting document is designed to provide clinical staff with a comprehensive guide to wound dressings and has been put together collating available evidence gathered from several sources. This has included a review of the clinical evidence, local clinical evaluations, and feedback of current usage.

How to use the formulary

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 made. The service can be contacted on:
Tissueviability@oxfordhealth.nhs.uk

It is recommended that clinicians maintain a sound knowledge base in order to feel confident when prescribing from this formulary. Education and training are offered across Oxfordshire in relation to all aspects of Tissue Viability including the selection of dressings.

A variety of care pathways and guidelines have also been developed to assist clinicians in the appropriate selection of products in practice, such as:

- The Assessment and Management of Bacterial Loading in Wounds Tool (AMBL2)
- Wound Biofilm Care Pathway
- Skin Barrier Management Pathway
- Wound Exudate Pathway
- Skin Tear Pathway
- Lower Limb Care Pathway
- Varicose Eczema Pathway
- Hosiery & Wrap Formulary
- Hypergranulation Pathway
- Haematoma Pathway
- Burns Pathway

Copies of these pathways, this formulary and details of our annual training program can be found on our website at www.oxfordhealth.nhs.uk/tissue-viability.

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 Nursing Team can be contacted for advice as they provide a county wide service on 01865 902700. Throughout the formulary, where it is known that products are suitable for use on children, you will see this symbol:
Otherwise, please check with Tissue Viability prior to use.

Secondary Care Links

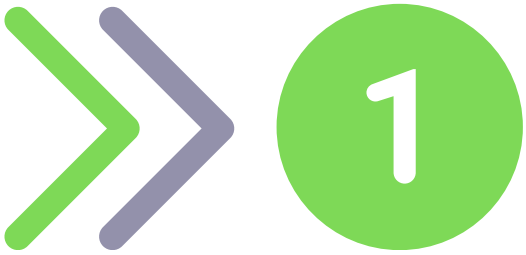
At present, the products available within primary care and secondary care may differ. The OUH & OHFT Wound Formulary Comparison Guidance document suggests suitable alternatives. If someone is discharged from the OUH with dressings not on this formulary, in the first instance refer to this document. If you are unsure of a suitable alternative community-based option, please contact Tissue Viability for advice at tissueviability@oxfordhealth.nhs.uk. OUH Tissue viability can be contacted at tissueviabilityteam@ouh.nhs.uk.

Podiatry

For patients requiring specialist podiatry input (any wound to the foot below the malleolus, or to the diabetic foot including the malleolus), 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. In cases of venous disease and chronic oedema, a referral to Podiatry and Tissue Viability may be appropriate.

Dressing categories

For ease, this formulary has been split into dressing categories. Each category will list the dressings and each dressing will be colour coded. The colour codes will relate to how each dressing can be obtained. Please see the table below which demonstrates this:



GREEN

Wound care products which are suitable for initiation and continuation in primary care. Primary care clinicians take full responsibility for use of products in this category.

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

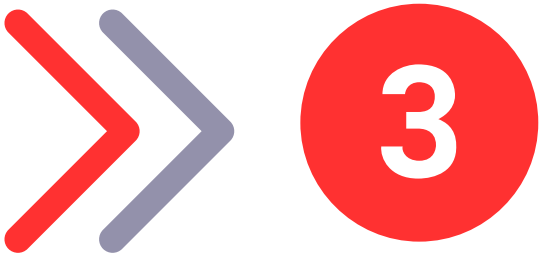
Any stock should be based on commonly used dressings and sizes and should not exceed a 2-week stock level. You will need to agree minimum and maximum stock levels. Admin to order.

AMBER

Wound care products which are suitable for initiation and continuation in primary care but use is restricted for the care of specific patients for whom an NHS number and rationale for use must be recorded. Primary care clinician's take full responsibility for use of products in this category.

These can be ordered via HALO using the Team's PIN but require the submission of the patient's NHS number and rationale for request. This will enable an audit trail and use of these products will be monitored by the Formulary Group and Medicines Management.

Calculate the number of dressings required for the planned treatment/ treatment objective (eg., a 2 week course of an antimicrobial). Do not over order. To avoid wastage, ensure that the dressing matches the wound size. Requests should be for no more than a 2 week period.



RED

Wound care products that are only available from a Tissue Viability Nurse following assessment by Tissue Viability. Tissue Viability Nurses will arrange supply to clinician via order platform.

When requesting Sorbion, you must complete the Sorbion request form.

Hints and tips

SYMBOLS EXPLAINED

- 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 shows you issues that may occur when using this product.
- Points to consider – This will show you any hints and tips about how to use the products.

GOOD STOCK MANAGEMENT

- Calculate the number of dressings required for the planned treatment/treatment objective (e.g. a 2-week course of an antimicrobial).
- Do not over order.
- To avoid wastage, ensure the dressing matches the wound size.
- Requests should be for no more than a 2-week period.

HALO ACCESS

For those clinicians who do not have access to HALO (Community hospitals, in-patient mental health wards, community children's nurses etc.) E-procurement codes and PIP codes (prescription codes) have been provided to assist correct ordering. Please note that not all sizes or products listed within the formulary are available to all services.

Assessment

All patients need to receive a comprehensive holistic assessment that reflects the intrinsic and extrinsic factors which have the potential to impact on wound healing. This should be undertaken upon patient presentation to the caseload and completed within two weeks.

Patient assessment should include:

- Past and current medical history (including a review of blood tests).
- Current and past drug therapies that may impact on healing.
- Identification of factors which have the potential to delay healing (this may include malnutrition, certain co-morbidities such as diabetes, immobility, frailty, smoking, pressure, lifestyle factors, concordance with treatment, pain and anatomical location of the wound).
- Quality of life/impact of wound on patient's life and wellbeing.
- Pain assessment using a validated pain assessment tool.

Wound assessment should include:

- Type of wound and aetiology.
- Wound duration.
- Location of wound.
- Size of wound – To include surface area in cm^2 (using Opsite Flexigrid mapping) and depth in mm. Undermining should be measured with a probe and documented using the clock face method.
- Assessment of surrounding skin (Dry, moist, fragile, eczematous, oedematous)
- Wound photograph - refer to wound photograph guidance here.
- Wound bed assessment based on TIMES acronym (please refer to page 13 for further information).

Wound swabbing should not be routine but only undertakin when there are signs of spreading systemic infection (Cellulitis, pyrexia, patient feels unwell) prior to the commencement of antibioitcs. Refer to AMBL2 tool for further information.

If a patient has a leg ulcer, a holistic vascular assessment should be undertaken within 2 weeks of presentation to caseload using the Oxford Health Lower Limb Assessment form and completion of doppler (ABPI readings + pedal pulse sounds or waveforms).

Following assessment, there should be a documented wound aetiology (cause) or wound status. The patient and their carer, if they permit, should be informed of the outcomes of the assessment and will be supported in the decision making for potential management options.

Care plans

Every patient should have a current wound care plan in place that clearly sets out the management objective/s. These should be:

- Specific
- Measurable
- Achievable
- Realistic
- Timely

The care plan should be developed and regularly updated in partnership with the patient and, where applicable, their carer or family, ensuring they are actively involved and supported in setting treatment goals.

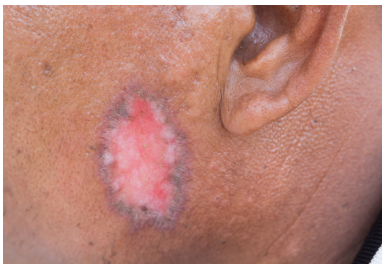
Treatment and management regimes should be based on wound bed status and the issues identified in the assessment. In addition to wound dressings, the underlying causes of wound related factors such as high exudate or pain should be addressed. High compression should always be considered for lower limb wounds where clinically indicated.

Healing may not be the primary objective in each case. This should be based on the wound assessment and in discussion with the patient and their carers. Wounds that are unlikely to heal should be identified and a palliative wound plan agreed with the patient. Care plans should reflect the priorities for the patient and may include objectives such as pain management, odour reduction, exudate control etc.

TIMES Wound Assessment

Wound bed preparation is a systematic approach to managing wounds, focusing on optimising the wound environment to promote healing or facilitate other treatments. It is useful to use the TIMES framework as an assessment tool to help determine wound bed health. This will help inform decision making on product selection as part of your wider wound management care plan.

T - TISSUE

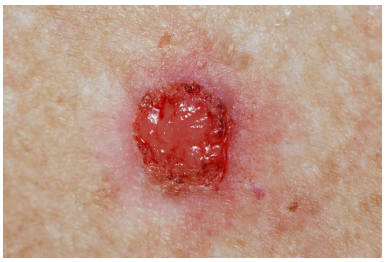


EPITHELIAL

White/ pale pink, smooth tissue forming at wound edges or in isolated islands on the wound surface. A vulnerable stage of healing so moisture balance & protection from dressing adherence is essential.

TREATMENT OBJECTIVE
To protect and maintain optimal moisture balance.

SUGGESED DRESSINGS
Contact layer, hydrocolloid, film.

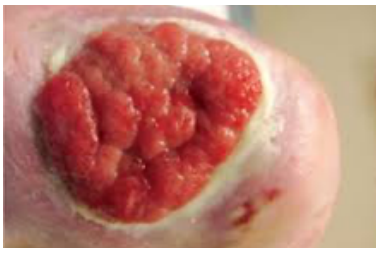


GRANULATION

Bright, granular tissue within the wound bed. Should be a 'strawberry jam' colour. Granulation tissue is very fragile & should be protected from external factors such as adherent dressings, pressure, or poor bandaging.

TREATMENT OBJECTIVE
To promote granulation tissue and protect.

SUGGESED DRESSINGS
Contact layer, hydrocolloid, gelling fbre.

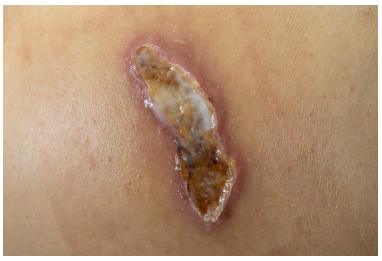


HYPERGRANULATION

An abundance of granulation tissue that becomes proud of the main wound. May be associated with infection, inflammation, unmanaged exudate, or friction. Can sometimes indicate malignancy.

TREATMENT OBJECTIVE
Manage infection, inflammation, exudate of friction.

SUGGESED DRESSINGS
Refer to Hypergranulation Pathway.

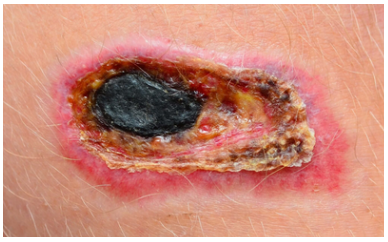


SLOUGH

Devitalised tissue due to the accumulation of dead cells & bacteria in the wound. Yellow due to presence of leucocytes. Can be thick & dry or thinner/stringy and wetter. Removal is essential to prevent infection & reduce odour.

TREATMENT OBJECTIVE
To debride, to reduce bacterial load. It is vital to remove non-viable tissue or debris to restore a viable wound base.

SUGGESED DRESSINGS
Gel sheet, hydrocolloid, gelling fibre, mechanical debridement.



NECROSIS

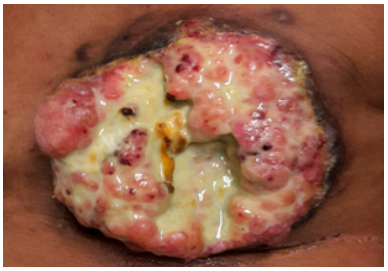
Devitalised (dead) tissue that is mainly associated with tissue ischaemia. Is black/ brown in colour, often with a dry/ hard surface. In most cases, debridement should be undertaken to prevent wound/ systemic infection, *however advice should be sought from podiatry or Tissue Viability before attempting debridement of the foot, or in a limb with arterial disease.

TREATMENT OBJECTIVE

To debride (if indicated), to reduce risk of infection, to protect (if debridement not indicated).

SUGGESED DRESSINGS

Gel sheet, hydrogel, honey, contact layer.
If conventional debridement methods (i.e. dressings) are ineffective, sharp debridement or larvae therapy may be indicated, Referral to Tissue Viability is necessary.



FUNGATING MALIGNANT WOUND

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 OBJECTIVE

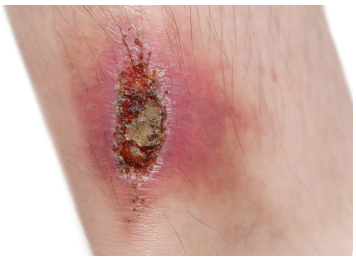
Before dressing selection can be made it is first necessary to identify the purpose and principle aim of the proposed treatment as healing may not be a realistic option. The goal of care is to maintain and improve quality of life through symptom control.

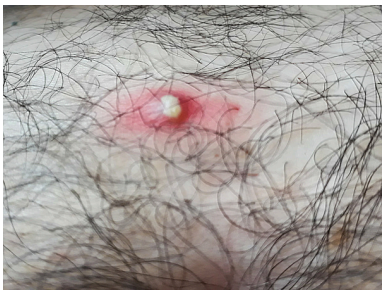
SUGGESED DRESSINGS

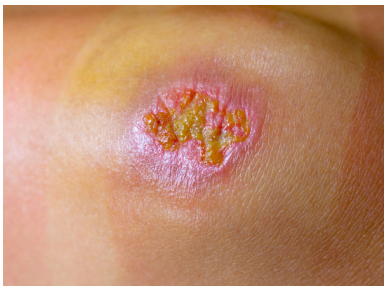
Select dressing based on wound management priorities for the following common symptoms:

- **Odour** – may be caused by bacterial activity. Treat or mask.
- **Exudate** – may include managing bacterial load. Refer to Exudate Management Pathway.
- **Inflammation** – avoid sensitising agents e.g. Lanolin, Latex and preservatives.
- **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.
- **Wound bed infection** – see antimicrobial formulary.
- **Pain** – choose a dressing that can be easily removed to minimise pain and trauma. Consider use of adhesive remover and analgesia for dressing changes.
- **Bleeding** – consider irrigating instead of cleansing with gauze. Avoid adherent or fibrous dressing e.g. gelling fiber. Consider infection as a possible cause for bleeding and treat as indicated. If bleeding is problematic, contact Tissue Viability for further advice.

I - INFECTION







INFECTION

The diagnosis of wound infection should be based on clinical assessment using the AMBL2 tool. For persistent or recurring wound infections where Biofilm is suspected, refer to the Biofilm Wound Care Pathway.

Most wounds are contaminated with a range of microorganisms (Pseudomonas, Staphylococcus A, E-Coli etc.) and yet most will progress through the normal phases of healing without the need for antimicrobial treatment.

Systemic antibiotics are not indicated unless there is the presence of cellulitis (erythema extending >2cm from wound margin) or the patient is systemically unwell. For those with diabetes or compromised immune/circulatory systems, systemic antibiotics may be considered in line with national/ local prescribing guidelines.

Routine wound swabbing should not be undertaken unless systemic antibiotics are being prescribed, in line with Trust diagnostic tools.

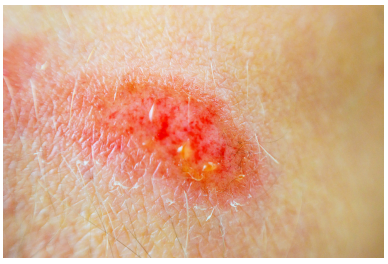
Fungal infection may be present within wounds, particularly those on the feet and toes when associated with chronic oedema. Treatment for this should be considered and if swabbing, a request for fungal screening needs to be included on the microbiology form.

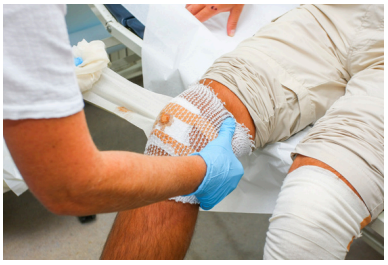
SUGGESED DRESSINGS

Refer to the antimicrobial section within the formulary.

1. First line - Medical Grade Honey
2. Second line - Cadexomer Iodine
3. Third line - Cutimed Sorbact Contact or Flaminal

M - MOISURE





MOISTURE

Exudate is produced as a normal part of the healing process to prevent the wound bed drying out, to provide essential nutrients and growth factors for healing, and to assist tissue repairing cells to migrate.

- **Serous** - Amber or straw coloured. Considered 'normal' unless excessive.
- **Serosanguineous** - Pink due to presence of red blood cells.
- **Purulent** - Indicates infection. Cloudy, milky, yellow, tan, brown, sometimes green. Often thicker and may be malodorous. Could be pink if red blood cells present.

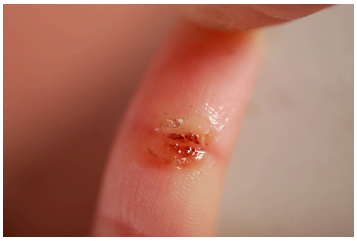
Exudate produced by chronic wounds such as leg ulcers can be detrimental to healing, prolonging the inflammatory phase, and causing harm to both the wound and the peri-wound skin. It is essential that exudate production/ levels are considered as part of your holistic wound assessment so that an effective management plan can be implemented.

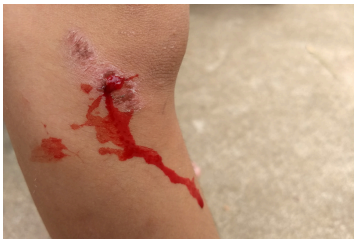
Dressings will only form part of this plan. Unless the underlying cause such as oedema or infection, are addressed, exudate will continue to be a problem. Please refer to the wound exudate pathway for further guidance.

SUGGESTED DRESSINGS

Dressing choice and dressing change frequency should be based on exudate levels. Moisture may need to be donated or excess exudate managed. Dressings should be stepped up and down as appropriate.

M - MOISTURE





MOISTURE-DONATING DRESSINGS

- Duoderm Extra Thin
- Kerralite Cool
- ActivHeal Hydrogel

NON-ADHESIVE ABSORBENT DRESSINGS

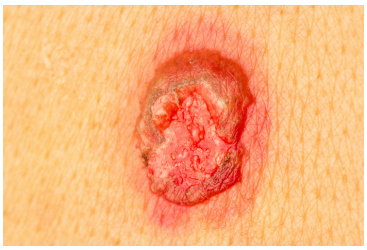
- **Low levels of exudate** - Xupad Sterile
- **Moderate to high levels of exudate** - Kliniderm Super Absorbent
- **High levels of exudate** - if Klinidern Superabsorbent has been tried and found inadequate - Cutimed Sorbion Extra. This is only available via referral to Tissue Viability who will supply.

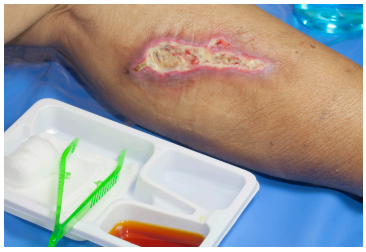
ADHESIVE ABSROBENT DRESSINGS

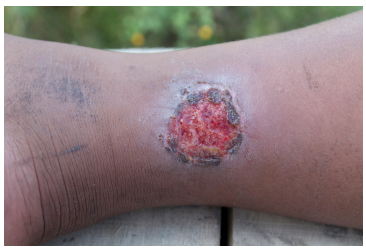
• **RespoSorb** - for use on moderately exuding wounds which anatomically cannot easily be secured with bandages. Examples include: pressure ulcers on the sacrum, hips or ischial tuberosities, non-infected diabetic/foot ulcers and surgical wounds.

• **Kliniderm Foam Silicone Border** - for use on skin tears, low to moderately exuding wounds under compression hosiery, low to moderately exuding wounds on anatomical sites that can't be secured with a bandage and when wound pain/skin pain is an issue.

E - EDGES







EDGES

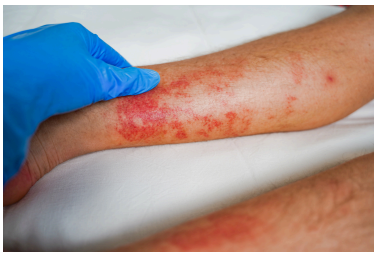
The edges of a wound are extremely important as it is from here that the new epithelial cells are formed and migrate across the wound as healing progresses. It is therefore important to protect the edges from trauma and to ensure that the moisture balance is correct. Too wet and the epithelial cells can't attach and duplicate, too dry and they can't migrate across the wound bed.

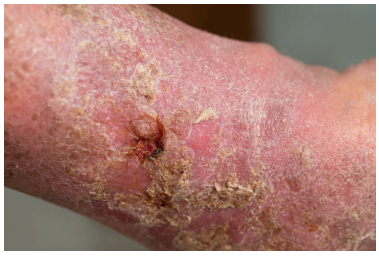
The edges of a wound can develop a build-up of dressing residue and dried exudate/ wound debris. This can prevent the attachment and migration of epithelial cells so must be removed. This can be achieved with good wound cleansing/ bowl washing and the use of an emollient to soften the residue. A debridement pad may assist this process, or it can be lifted carefully using a pair of forceps. Once removed, reapply an emollient ointment up to the wound edges to help protect from further problems.

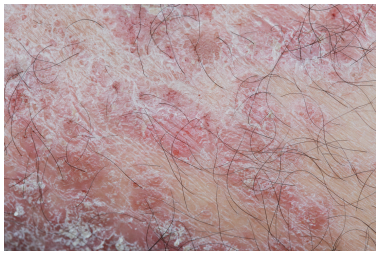
Rolled edges - where the wound edges have rolled or curled under. Migration of epithelial cells is not possible, so these wounds are likely to be static. Occasionally, rolled edges may signify malignancy so a referral to Tissue viability is advised when this condition has been identified.

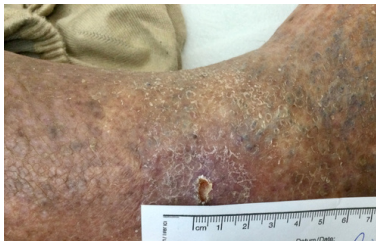
SUGGESED DRESSINGS

- Primary dressings need to be non-adherent and should not cause friction/movement over the wound edges.
- Use Exudate Management Pathway to select a suitable absorbent dressing.
- Mechanical debridement pad to debride slough and crusts on the edges.
- Refer to the emollient formulary and Skin Barrier Pathway









SURROUNDING SKIN

Care of the surrounding skin to a wound is equally as important as the wound itself.

Management of skin conditions, such as:
- Oedema
- Varicose eczema
- Irritant dermatitis
- Xerosis (dry skin)
- Excoriation and maceration

The latter two are usually due to poorly controlled exudate. Chronic exudate contains proteases: enzymes that can lead to a breakdown of healthy peri-wound skin. Skin can soften appearing white, soggy, and wrinkly (maceration) and can become infected with bacteria or fungi. This is worsened by infrequent dressing changes.

A lack of skin cleansing can lead to a build-up of bacteria and an increased risk of cellulitis and wound bed infection. Xerosis (dry skin) leads to itch and then trauma from scratching. This again, can result in skin infection and a deterioration in the wound.

Hyperkeratosis (dry, crusty plaques) on the skin is a symptom of venous disease. This must be removed as if left, it harbours bacteria/ fungi and can cause cellulitis.

SUGGESED DRESSINGS

Oedema
The use of therapeutic compression (dependant on lower limb/ doppler assessment) will help reduce oedema and restore health to the skin.

Varicose eczema
Refer to the Varicose Eczema Pathway
(Balneum Intensiv Cream).

Xerosis (Dry skin)
Refer to the emollient section of the formulary (Epimax Cream, Epimax Ointment, Imuderm Cream, Balneum Intensiv Cream and Hydromol Intensive).

Hyperkeratosis & skin cleansing
Regular bowl washing, using an emollient (Epimax Ointment) as a soap substitute and a clean flannel with gentle circular motions will generally remove the hyperkeratosis. It is essential to also use a leave on emollient (Epimax Ointment, Imuderm Cream, Balneum Intensiv Cream, Hydromol Intensive Cream) after washing to help soften the plaques.

Excoriation & maceration
Consider increasing absorbency of dressings and frequency of dressing changes (refer to Exudate Pathway). Protect peri-wound skin (Epimax Ointment, Medi Derma-S film barrier foam applicators. Refer to Skin Barrier Pathway).

Cleansing

Wound cleansing is defined as actively removing surface contaminants, loose debris, unattached, non-viable tissue, microorganisms and/or remnants of previous dressings from the wound surface and its surrounding skin. Wounds that are healing in an orderly and timely manner require only minimal, gentle cleansing to avoid disrupting granulation and reepithelialisation. Conversely, chronic or hard-to-heal wounds with devitalised tissue or suspected biofilm require vigorous therapeutic cleansing to dislodge loose devitalised tissue, microorganisms, or debris from the wound bed. Wound cleansing options include:

- Sterile saline/water
- Potable tap water
- A wound irrigation solution with both surfactant and antiseptic properties.

There may be cases when wound cleansing is not indicated. For example, the management of a diabetic foot or an ischaemic/gangrenous limb. In times of doubt, advice should be sought from Tissue Viability, podiatry or the specialist team leading on the patients care.

Sterile normal saline (available via HALO) or sterile water are used in clinical situations requiring a sterile solution. There is no evidence to suggest that using saline is any more effective than tap water in cleansing acute or chronic wounds. Studies have shown that using tap water does not increase the risk of infection. (Fernandez and Griffiths, 2012).

Maturation is the final stage of wound healing where epidermal cells migrate across the wound bed from the wound edges. If a wound edge is not prepared (i.e. debris, callus, devitalised tissue etc is present), the epithelial cells will not migrate and a dressing will not be effective as it will not be in direct contact with the base of the wound bed. Thorough cleansing and mechanical debridement of both the wound beds and edge are required for healing.

Debridement

Wound debridement is a critical component of wound care that involves the removal of devitalised tissue to promote optimal healing. This may occur naturally however, in some cases, may require assistance.

Autolytic
The most conservative type of debridement. A natural method that uses the body's own enzymes and moisture to break down devitalised tissue. This process is facilitated by maintaining a moist wound environment through the use of dressings such as hydrogel sheets or hydrocolloids to assist the process.

Enzymatic
Involves the topical of application enzymes (e.g. Flaminal) to breakdown and remove devitalised tissue. These enzymes selectively digest devitalised tissue without harming viable tissue.

Mechanical
The removal of devitalised tissue using physical forces. This technique can involve the use of sterile gauze and water or specialised devices like Alprep Debridement Pad to disrupt biofilms.

Biological
Also known as larval therapy. Appropriate in large wounds where a painless removal of necrotic tissue is needed. Sterile larvae are contained within teabag-like containers and secrete powerful enzymes to break down devitalised tissue without harming healthy granulation tissue.

Sharp
The use of sterile instruments such as scalpels or curettes to remove devitalised tissue. This technique can only be performed by trained and experienced clinicians with appropriate certification. This is particularly useful for wounds with moist, necrotic tissue or in the presence of underlying infection to remove biofilm. Contact Tissue Viability for further information.

Debridement of necrotic heels should not be attempted until the patient's arterial status to the foot has been established. This should be determined by undertaking a holistic vascular assessment - lower limb assessment form + doppler (ABPI readings + pedal pulse sounds or waveforms). Further guidance on holistic vascular assessment can be found on the Tissue Viability website.

Dry necrosis with no autolysis must remain in situ to feet or lower legs if the patient has impaired arterial supply, unless advised by the vascular team.

Reviews

Ongoing evaluation of wound healing should be performed through continuous monitoring and formal re-assessment should be undertaken every 4 weeks to ensure that the treatment objective/s are being met. Evaluation and re-assessments should be documented in the patients notes.

Guidelines recommend that a wound should reduce in size by approximately 40% within a 4-week period Patients whose wounds are failing to progress as expected (i.e. 40% reduction of wound surface area at 4 weeks) signal the need for reassessment and review of the factors that can contribute to delayed wound healing such as pressure and shear forces, unmanaged infection, ischaemia, inadequate nutrition, comorbidities such as diabetes and poor patient concordance. If you are able to identify the factor(s) for delayed wound healing (i.e. infection) and are able to correct it, continue with management plan.

If you are unable to identify and correct these factors contributing to delayed wound healing, a referral should be completed to Tissue viability.. If a wound remains unhealed at 12 weeks, it is generally considered chronic and warrants a more comprehensive interdisciplinary and holistic approach. A referral should be completed to Tissue Viability by completing the Tissue Viability Referral Form.

Ultimately, timely and systematic wound reassessment allows clinicians to identify non-healing wounds early, adjust interventions proactively and improve healing trajectories and patient quality of life.

Skin care & emollients

The objective 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 and moisture lesions.

Emollients work by applying a greasy layer over the skin to reduce transepidermal water loss (TEWL). They need reapplying regularly (ointments less frequent than creams) for effect. Emollients containing urea have an additional mode of action. Urea is particularly important for older skin as natural moisturising factors are lost with age. The urea enables cells in the top layer of the Epidermis to absorb fluid. This keeps them well hydrated (like a grape instead of a sultana). The cells become more closely knitted together repairing the natural barrier function of the skin which reduces TEWL.

These emollient choices and guidelines are specific to Tissue Viability and 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 or dermatological conditions.

Separate guidance is available for these areas:

- For dry skin please refer to Oxfordshire CCG Emollient Prescribing Guidelines and Formulary
- For dermatological guidance please refer to your GP or specialist service
- To protect skin from moisture please follow the Skin Barrier Management Pathway

Emollients are currently not available on HALO 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.

Emollients

Application of emollients

- Dot on generously to limbs (or apply onto gloved hands) and then apply in long downward strokes in the direction of hair growth and allow to soak in. Do not rub it in.
- To use as a soap substitute - apply emollient to entire limb/foot before placing in water. Allow the ointment or cream to soak off by gently stroking the limb with a gloved hand and long downward strokes. To remove plaques, use a clean flannel and gentle circular motions.
- If topical steroids are also being used for treating areas of varicose eczema, a gap should be left between applying the emollient and the 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. If the skin is very dry apply the emollient first then wait 10 minutes and apply the steroid ointment.

Precautions

- Preparations contained in tubs should be removed with a spoon or spatula to reduce bacterial contamination of the emollient.
- Not suitable for use alongside adhesive dressings.
- Prior to using an emollient for the 1st time apply a test application to the inside of the forearm for 24 hours to check the sensitivity.

If you suspect a reaction to the emollient, discontinue its use. Document the circumstances, photograph the reaction, and discuss with Tissue Viability. Consider referral to Dermatology for patch testing and complete a yellow card if confirmed as a reaction to the emollient.

Fire hazard with paraffin

Warning: Paraffin-based emollients are flammable. Dressings and clothing that have contact with paraffin-based products are easily ignited by a naked flame. Patients treated with large quantities of paraffin-based products (100g or more per application) should be warned of the potential fire risk 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. Further information can be found at: www.gov.uk/drug-safety-update/paraffin-based-skin-emollients-on-dressings-or-clothing-fire-risk.

Aqueous cream

Aqueous cream carries a higher risk of causing skin irritation, possibly due to its sodium lauryl sulphate (SLS) content. Its use is no longer recommended either as a leave on emollient or as a washing product. Recent studies have shown that the application of aqueous cream weakens the epidermal barrier and increases transepideral water loss. Thus, rather than restoring the skin barrier, it appears to cause more damage. Aqueous cream should not be prescribed (Oxfordshire CCG Emollient Prescribing Guidelines and Formulary, February 2020).

On-formulary emollients

1. Epimax ointment

(Yellow soft paraffin 30%, liquid paraffin 40%, emulsifying wax 30%)

A first line emollient therapy for dry skin conditions containing 30% yellow soft paraffin, 40% liquid paraffin and 30% emulsifying wax. It works by providing a layer of lipid on the skin to prevent water evaporation. 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 is too greasy to be used under compression hosiery. Apply up to twice a day. Suitable for children over the age of one month.

2. Epimax cream

(Liquid paraffin 6%, white soft paraffin 15%)

May be more acceptable to patients if Epimax ointment is too thick and greasy or occlusive. It is also more suitable under compression hosiery. Contains light liquid paraffin 6.0% and white soft paraffin 15% in a cream base which forms an occlusive film, although less thick than an ointment, which reduces transepidermal water loss. Requires more frequent application - up to 4 times a day. Suitable for children over the age of one month.

3. Imuderm cream

(Urea 5%, glycerol 5%)

A step-up emollient if Epimax ointment and Oilatum cream are inadequate, or alternatives are unacceptable to the patient. It contains urea 5% and Glycerine 5% which help to replace natural moisturising factors in the skin barrier which decline with age. Apply twice daily. Not to be used on broken skin, as the urea can sting.

4. Balneum Intensiv cream

(Urea 5%, ceramide 0.1%)

Contains 5% urea but also 0.1% ceramide. Ceramide is a lipid lamella mimicking agent which, along with the urea, helps repair the skin's own natural barrier function. It is a step up emollient from Imuderm and particularly indicated for aging, dry, problem skin including varicose eczema and hyperkeratosis. It can be applied daily. Not to be used on broken skin, as the urea can sting. Suitable for children over the age of 12 years.

5. Hydromol intensive

(Urea 10%)

Useful as a step-up emollient from Imuderm or Balneum, for very problematic dry skin conditions such as hard, stubborn keratotic plaques. 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. Apply thinly twice daily. Can take between two and four weeks to take effect. Suitable for 1 month old and above.

Product categories

SOAP SUBSTITUTES AND EMOLLIENTS

	PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
SOAP SUBSTITUTES	Epimax ointment	125g	406-9514	N/A
	Epimax ointment	500g	408-2945	N/A
EMOLLIENTS	Epimax original cream	100g	393-4262	N/A
	Epimax original crem	500g	393-4270	N/A
	Imuderm cream	500g	386-6324	N/A
	Balneum Intensiv cream	500g	350-9536	N/A
	Hydromol Intensive	30g	348-4755	N/A
	Hydromol Intensive	100g	348-1637	N/A

Product categories

CLEANSING SOLUTIONS

SALINE SOLUTION

- Tap water
- Sterile saline - sodium chloride 0.9%
- For clinical situations requiring a sterile solution.
- Suitable for use on exposed underlying structures such as tendons.

	PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
SALINE	Sal-E Pods	20ml	N/A	N/A
	Normasol	25ml	149-161	MRB358

Product categories

CLEANSING SOLUTIONS

OCTENLIN IRRIGATION SOLUION

- Tap water
- Octenilin is a wound cleansing solution with both surfactant and antiseptic properties.
- Only to be used as part of the Biofilm Wound Care Pathway.
- Surfactants are cleansing agents that contain a substance which lowers the surface tension between the wound bed and the fluid, or between two liquids. Surfactants assist separation of loose, non-viable tissue by breaking bonds between non-viable tissue/debris and the wound bed. Topical antiseptic agents are manufactured in combination with a surfactant to capitalise on these properties and increase penetration of the antimicrobial agents across the wound bed.
- Use in combination with either gauze or a debridement pad to vigorously clean the wound bed and/or peri-wound skin.
- Once opened the bottle can be re-capped and re-used as long aseptic non-touch technique has been used. Use within 8 weeks of the opening date. Ensure the open date is written on the bottle.
- Do not use in wounds with exposed bone, cartilage or tendon. Should not be used on the eyes, ears, nose, urinary bladder and in the abdominal cavity.
- To prevent the introduction of bacteria, ensure that the tip does not come into contact with the wound or any other surface.
- Protect the product against exposure to direct sunlight.
- You do not need to soak the wound for 10 minutes or remove the solution after application.

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Octenilin wound irrigation solution	350ml	438-9069	MRB443

Product categories

BARRIER PREPARATIONS

- Skin protectors are used to create a barrier to protect skin from maceration and excoriation, caused by moisture from incontinence or exudate from wounds. The use of modern dressings should reduce the need for skin barriers in most wounds.
- For correct use of barrier products please refer to the Skin Barrier Management Pathway
- Complete emollient therapy should be used before stepping up to the use of barrier creams and films.
- Barrier cream (for intact skin) or film (for broken skin) or Medi Derma PRO for severe skin damage or where Medi Derma-S is not effective.
- Creams should not be used for peri-wound skin where film foam applicators should be used.
- DO NOT mix barrier creams and ointments as they interact with each other and will cause further breakdown and maceration of the skin.
- All products should only be used for a short period of 2 to 3 weeks. If the skin has not recovered in this time, please contact Tissue Viability for advice.

BARRIER FILM

MEDI DERMA-S FILM BARRIER FOAM APPLICATOR
MEDI DERMA-S FILM BARRIER AEROSOL SPRAY

- 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. Please prescribe the correct size for the surface area to be treated:
- 1ml covers the size of an A5 sheet paper
- 3ml covers the size of an A3 sheet paper

BARRIER CREAM

MEDI DERMA-S BARRIER CREAM

- Provides gentle barrier protection on intact skin or mild skin damage by forming a protective waterproof barrier, preventing irritation from bodily fluids, adhesive products and friction.
- Suitable to use on neonatal and paediatric patients.
- Alcohol, fragrance, latex, parabens and phthalates free.

BARRIER CREAM

ACTIVON MANUKA HONEY BARRIER CREAM

- For vulnerable, intact and mildly irritated/damaged skin at risk of fungal infection.
- An effective barrier against perspiration, urine, faeces and wound exudate that lasts up to 24 hours.
- Will provide a moisture barrier for up to 24 hours, depending on wear and levels of moisture. Reapply as frequently as required, based on clinical discretion.
- Assists with the prevention of moisture associated skin damage.
- Contains 25% medical grade Manuka honey to assist in the prevention and treatment of sore/inflamed skin and promotes healing.
- Contains cocoa butter to aid with moisture retention.
- Breathable to assist in the prevention of skin maceration.
- Use a pea sized amount of cream to cover an area the size of a palm. Do not over-apply.

PROTECTANT OINTMENT

MEDI DERMA PRO SKIN PROECTANT OINTMENT
MEDI DERMA PRO FOAM & SPRAY CLEANSER

- Consists of two products used together.
- The ointment which is the barrier product and contains silicone, and a spray which is a cleanser required to remove the ointment as water is ineffective. Both products will need to be prescribed.
- May be suitable to use on category 2 pressure ulcers in combination with moisture from urinary or faecal incontinence, when the use of dressings is either contraindicated or not feasible. Please discuss suitability with Tissue Viability first.

	PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
BARRIER FILM	Medi Derma-S film barrier foam applicator	1ml	362-8716	ELY532
	Medi Derma-S film barrier foam applicator	3ml	362-8724	ELY533
	Medi Derma-S film barrier aerosol spray	50ml	389-7139	ELY561
BARRIER CREAM	Medi Derma-S barrier cream tube	28g	388-3121	ELY563
	Medi Derma-S barrier cream tube	90g	341-3325	ELY538
	Medi Derma-s barrier cream sachet	2g	341-3317	ELY536
	Activon honey barrier cream	100g	435-4411	ELZ85134
CLEANSER & OINTMENT	Medi Derma PRO skin protectant ointment	115g	399-6931	ELY607
	Medi Derma PRO foam & spray cleanser	250ml	399-6923	ELY608

Product categories

BASIC ITEMS

Dressit Dressing Packs
Clinimed Gauze Swabs

DRESSING PACKS

DRESSIT

- 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.
- DressIT Sterile Dressing Pack - Sterile pack containing: 1 pair of disposable latex-free examination gloves, large plastic apron, a sealable disposable bag, a paper towel, an absorbent swab, a sterile field, and 4 x 4 ply swabs.

GAUZE

CLINIMED GAUZE SWABS

- 100 4-ply non-sterile non-woven swabs.
- For general clean procedures on intact skin only.
- Not intended for packing in wounds, or direct use on broken skin or cleaning wound beds.
- Sterile gauze to cleanse wound beds. Please note this is available to order via HALO ordering platform.

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
DressIt sterile dressing packs - pack of 10	S/M	324-3961	EVH039
DressIt sterile dressing packs - pack of 10	M/L	301-0675	EVH039
CliniMed non-woven swabs, non-sterile, 4 ply, pack of 100	10cm x 10cm	N/A	N/A

Product categories

CONTACT LAYERS

Atrauman
Activeheal Silicone Wound Layer

ATRAUMAN

- Atrauman has no absorbency of its own and is designed to be used with a secondary dressing depending on the level of absorbency required.
- First line contact layer for many uncomplicated wounds.
- Store Atrauman horizontally to prevent oils from migrating down to bottom of dressing.
- Please ensure paper is removed from both sides of the dressing.

ACTIVHEAL SILICONE WOUND LAYER

- Silicone on both sides.
- Step-up product from Atrauman to be used when dressing adherence is a problem.
- Can be used on nil to heavily exuding wounds (with an effective absorbent secondary dressing), very fragile skin, malignant/fungating lesions or burns.
- Also suitable if required for lining VAC therapy dressings.
- Can be cut.
- Can be left in place for up to 7 days if appropriate for the wound.
- Has no absorbency of its own and is designed to be used with a secondary dressing depending on the level of absorbency required.
- Atrauman

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Atrauman	5cm x 5cm	369-7539	EKA000
Atrauman	7.5cm x 10cm	369-7547	EKA020
Atrauman	10cm x 20cm	281-3046	EKA036
Atrauman	20cm x 30cm	324-8697	EKA016
ActivHeal Silicone Wound Contact Layer	5cm x 7.5cm	399-7459	ELA849
ActivHeal Silicone Wound Contact Layer	10cm x 10cm	399-7442	ELA835
ActivHeal Silicone Wound Contact Layer	15cm x 15cm	399-7475	ELA837
ActivHeal Silicone Wound Contact Layer	10cm x 20cm	399-7487	ELA 836

Product categories

PROTEASE INHIBITORS

Urgostart Contact Layer
Urgostart Plus
Urgostart Plus Border

- Protease inhibitors are effective in the management of chronic wounds where elevated proteases (enzymes) may be contributing to delayed healing.
- All other causes of delayed healing should be ruled out and treated before considering this product, including infection, ischaemia, diabetes, anaemia, chronic oedema, and unmanaged venous disease.
- Refer to UrgoStart Treatment Tool for further information.

PROTEASE INHIBITOR

URGOSTART CONTACT

- Atrauman.
- Non-adhesive, non-occlusive, and highly conformable contact layer impregnated with a healing matrix.
- Suitable for granulating and epithelialising wounds.
- Use with a secondary absorbent dressing for exuding wounds.
- Can be left in situ for up to 7 days according to the condition of the wound bed and exudate levels.
- Not to be used on infected wounds or wound beds with necrosis or more than 30% slough.
- Contraindications include: Infected wounds, wounds on mucous membranes, fistula wounds, malignant wounds or those with known hypersensitivity to carboxymethlycellulose.

PROTEASE INHIBITOR

URGOSTART PLUS

- Atrauman
- Soft-adherent pad with poly-absorbent fibres that traps and retains exudate, slough and debris.
- Indicated for sloughy, granulating and epithelialising wounds with low to moderate levels of exudate.
- Allows gentle, pain-free removal .
- Contraindications include: Infected wounds, mucous membrane wounds, malignant wounds, fistula wounds, epidermolysis bullosa wounds, necrotic wounds, haemorrhagic wounds or those with known hypersensitivity to carboymethylcellulose.

PROTEASE INHIBITOR

URGOSTART PLUS BORDER

- Atrauman
- Soft-adherent pad with poly-absorbent fibres that traps and retains exudate, slough and debris with a shower-proof silicone backing and adhesive border.
- To be used on venous leg ulcers under a leg ulcer hosiery kit only.
- Indicated for sloughy, granulating and epithelialising wounds with low to moderate levels of exudate.
- Allows gentle, pain-free removal .
- Can be left in situ for up to 7 days according to the condition of the wound bed and exudate levels.
- Contraindications include: Highly exuding wounds, wounds with weakened peri-wound skin, necrotic wounds, mucous membrane wounds, malignant wounds, fistula wounds, epidermolysis bullosa wounds, haemorrhagic wounds, known sensitivity to carboxymethylcellulouse.

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
UrgoStart Contact	5cm x 7cm	339-8971	EKB081
UrgoStart Contact	10cm x 10cm	386-1390	EKB087
UrgoStart Contact	15cm x 20cm	386-1382	EKB088
UrgoStart Plus	6cm x 6cm	406-4432	ELZ884
UrgoStart Plus	10cm x 10cm	406-4440	ELZ885
UrgoStart Plus	15cm x 20cm	406-4457	ELZ886
Urgostart Plus Border	8cm x 8cm	406-4390	ELZ879
Urgostart Plus Border	10cm x 10cm	406-4408	ELZ880
Urgostart Plus Border	13cm x 13cm	406-4416	ELZ881
Urgostart Plus Border	15cm x 20cm	406-4424	ELZ882

Product categories

DEBRIDEMENT DRESSINGS

Urgoclean
Duoderm Exra Thin
Aquacel Extra
Activheal Hydrogel
Kerralite Cool

- Debridement can be complex. If you are not achieving your objectives contact Tissue Viability for advice.

URGOCLEAN

- For assisting debridement of moist wounds.
- Should not be used on dry/necrotic tissue or heavily exuding wounds.
- Ensure correct size. You only need 2cm border around the wound.
- Not suitable for babies under 4 months old.

DUODERM EXTRA THIN

- Suitable as a primary dressing for dry to lightly exuding chronic wounds such as leg ulcers, superficial pressure ulcers and acute surgical wounds, abrasions, lacerations and minor burns.
- Can be used as a secondary dressing over hydrogel if additional moisture retention is required.
- Dressing can be cut but should extend 3cm beyond the wound.
- Remove if leakage, irritation, or infection is present.
- Often creates odour which can be mistaken for infection. Clean wound and use AMBL2 Tool to assess for infection.
- Contraindications include known sensitivity to the dressing or its components.

ACTIVHEAL HYDROGEL

- Hydrogel contains a high water content which makes the gel effective in rapidly assisting the debridement process in dry, necrotic or sloughy wounds by facilitating rehydration and autolysis of dead tissue.
- Indicated for use on chronic and acute wounds, pressure ulcers, leg ulcers, diabetic foot ulcers, superficial burns and surgical wounds.
- Apply approximately 5mm thickness onto the wound bed.
- Can be left in place for up to 3 days.
- Avoid contact with peri-wound skin.
- Do not use on full-thickness burns (previously called third degree burns).
- Do not use on infected wounds.
- Contains gelatine, please consider patient beliefs and religion.

AQUACEL EXTRA

- AQUACEL EXTRA™ can be used on sloughy wounds to aid in autolytic debridement.
- For dry wounds, it can be pre-moistened with sterile saline prior to application.
- Designed to micro-contour to the wound bed, which helps eliminate dead space where bacteria can grow. It locks in wound exudate and bacteria, supporting infection control.
- Helps protect the peri-wound skin by minimising lateral spread of fluid, helping to reduce maceration, and maintaining a moist wound healing environment by balancing fluid levels.
- It's stitch-bonded for added strength, retaining its integrity upon removal.
- Can be worn for up to 7 days, or changed earlier if clinically indicated.
- Dressing can be cut but should extend 1cm beyond the wound.

KERRALITE COOL

- Hydrogel sheet for assisting debridement of dry to low exuding wounds.
- Moisture balancing dressing that dynamically manages fluid by donating or absorbing fluid as required.
- Provides a cooling sensation to the skin upon application, helping to minimal wound pain.
- Cut to wound size to prevent peri-wound maceration.
- Change regularly to ensure dressing does not dry out and adhere to wound bed.

DEBRIDEMENT DRESSINGS

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
UrgoClean	6cm x 6cm	367-8877	ELZ404
UrgoClean	10cm x 10cm	367-8885	ELZ405
KerraLite Cool	6cm x 6cm	379-3452	EME081
Kerralite Cool	8.5cm x 12cm	379-3437	EME082
ActivHeal Hydrogel	8g tube	377-9956	ELA369
ActivHeal Hydrogel	15g tube	301-6847	ELG018
Aquacel Extra	5cm x 5cm	367-3282	ELY377
Aquacel Extra	10cm x 10cm	367-3290	ELY378
Aquacel Extra	15cm x 15cm	367-3308	ELY379
Aquacel Extra Ribbon	1cm x 45cm	361-5978	ELY368
Aquacel Extra Ribbon	2cm x 45cm	240-8565	ELY013
DuoDERM Extra Thin	7.5cm x 7.5cm	027-7798	ELM311
DuoDERM Extra Thin	10cm x 10cm	027-7897	ELM050

Product categories

MECHANICAL DEBRIDEMENT

Alprep Debridement Pad
UCS Debridement Cloth

ALPREP DEBRIDEMENT PAD

- First-line option for mechanical debridement.
- Used for mechanical debridement of devitalised tissue in wound beds and in the management of wound biofilms as part of the Biofilm Wound Care Pathway. Please refer to AMBL2 tool and the BWCP.
- The open structure of the dark grey foam is for loosening. The light grey softer foam is for absorbing and capturing.
- If used as part of Biofilm Wound Care Pathway, use in conjunction with Octenilin Wound Irrigation Solution. Use circular motions for a minimum of two minutes followed by application of a primary topical antimicrobial dressing as per the Biofilm Wound Care Pathway.
- Can cause bleeding in friable wound beds which indicative of the presence of a biofilm.
- If the pad is insufficiently moistened, the patient may experience pain.
- Not to be used for the removal of hyperkeratosis and skin plaques on legs where bowl washing with a clean flannel and an emollient is advised.
- Sharp debridement - contact Tissue Viability
- Autolyic debridement with dressings e.g. UrgoClean or Duoderm Extra Thin.

UCS DEBRIDEMENT CLOTH

- Second-line option for mechanical debridement.
- Used for mechanical debridement of devitalised tissue in wound beds in anatomically challenging places, such as in between the toes or small cavities where the Alprep Debridement Pad cannot reach.
- Both sides of the cloth can be used in a gentle polishing motion in the wound and surrounding skin.
- Contains a surfactant cleansing solution.
- Does not contain latex, alcohol, parabens or glycerine.
- Do not use as a substitute for bowl washing.

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Alprep Debridement Pad	One size	415-3631	ELZ1202
UCS Debridement Cloth	One size	384-4271	ELZ746

Product categories

LARVAL DEBRIDEMENT

BIOMONDE BIOBAG

- Flaminal, Kerralite Cool, Acivheal Hydrogel or Honey.
- For rapid debridement of large areas of necrosis or thick slough, particularly where the risk of sepsis or osteomyelitis is high
- Do not use on load bearing areas unless the patient can be immobilised.
- Can cause excoriation of the peri-wound skin if not protected.
- Tissue Viability will assist in arranging the prescription with delivery to a local pharmacy and provide guidance and training on application.

LARVAL DEBRIDEMENT

PRODUCT	SIZE	PIP-CODE EPROCUREMENT
BioMonde Biobag	Various sizes	Available via Tissue Viability

Product categories

PASTE BANDAGES

PASTE BANDAGES

ICHTHOPASTE

- Ichthopaste bandage is made from an open woven cloth impregnated with a paste containing Zinc Oxide and Icthammol. Provides anti-bacterial and anti-inflammatory properties, as well as soothing the skin to reduce irritation and itch.
- To be used as the primary contact layer for the treatment of varicose eczema, applied using either a patch or pleating method to allow for leg swelling.
- Not to be used if known sensitivity or allergy to Zinc Oxide, Icthammol or any of the other ingredients.
- Consider patch testing prior to use for those with sensitive skin.
- Not recommended for use on diabetic foot ulcers.
- Not to be applied in conjunction with topical steroid.
- Contains porcine gelatine, consider patent beliefs and religion. Contact Tissue Viability if an anterative is required.

PASTE BANDAGING

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Ichthopaste bandagaing	7.5cm x 6m	033-2668	EFA051

ANTIMICROBIAL DRESSINGS

Actilite
Algivon Plus/Ribbon
Activon Tube
Iodoflex
Iodosorb
Cutimed Sorbact Contact
Flaminal Forte/Hydro

This section of the formulary refers to the topical management of local wound bed infection. Treatment should be commenced following the diagnosis of local wound bed infection. Please refer to the Assessment and Management of Bacterial Loading (AMBL2) Tool to assist with identification of wound bed infection.

The standard time an antimicrobial dressing should be used is two weeks, during which the wound should be reassessed regularly. If there is still evidence of local infection following two weeks of topical antimicrobial treatment, or the wound infection recurs, please refer to the Biofilm Wound Care Pathway and/or seek advice from the Community Tissue Viability Team.

INDICATIONS FOR USE	PRODUCT
First aid. For use in minor injuries where there is risk of infection or as an interim measure whilst awaiting delivery of therapeutic antimicrobial dressing. Not suitable for treatment of wounds with an active wound bed infection.	Actilite
First-line topical antimicrobial choice.	Medical Grade Honey
Second-line antimicrobial choice. A step-up from medical grade honey. First-line antimicrobial choice on the Biofilm Pathway.	Cadexomer Iodine
Third-line antimicrobial choice. Particularly suited for moderate to heavily exuding wounds such as limbs with lymphorrhoea or wet toes, or for non-invasive treatment on colonised/infected/ischaemic/arterial wounds where there is clinical contraindication for the use of Honey, Iodine or moisture-donating antimicrobial dressings.	Cutimed Sorbact Contact
Third-line antimicrobial choice. Particularly suited and reserved for, inserting into cavities, or a sinus where the wound bed cannot be seen. It is also suitable for the debridement of necrotic pressure ulcers.	Flaminal

FIRST LINE ANTIMICROBIALS

Medical grade honey

- Atrauman, Urgoclean, Aquacel Extra.
- Cadexomer iodine
- Honey is a broad-spectrum topical antimicrobial with several therapeutic properties:
- Through osmosis, water is drawn from microorganisms damaging their infrastructure.
- Honey produces hydrogen peroxide which decomposes bacteria and renders them ineffective.
- Reduces wound bed PH which inhibits the proliferation of microorganisms
- Creates an environment which aids autolytic debridement of devitalised tissue.
- 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. Ideally, dressings should be left in situ for at least 3 days to allow the product to be effective, whilst monitoring changing wound needs closely.
- Clinicians must take care to assess the risk of retained dressing products when packing sinus or cavity wounds and take steps to prevent this.
- It is advisable to measure and clinically document the wound cavity depth and/or sinus length by use of a wound probe.
- Any dressings inserted must hold their integrity upon removal. They should be 'counted in' and then 'counted out' and numbers recorded.
- Activon Tube Honey is 100% Manuka Honey and so does not need irrigation to remove it - particularly suitable for narrow sinuses.
- Packing is not advocated if the wound bed is not fully visible (blind) or the length/direction of sinus tracking is unobtainable. Patients should be investigated further to determine underlying structure involvement or deep-seated infection prior to treatment. Please seek advice from Tissue Viability if concerned.
- Due to the osmotic effect of honey, moisture levels at the wound bed can temporarily increase during treatment. This has the potential to cause skin maceration. Consider upgrading the absorbent pad used to aid maintaining an effective moisture balance and using an emollient or barrier product to protect the peri-wound skin.
- Most of the honey-based products (Algivon Plus, Algivon Plus Ribbon & Activon Tube) should not be in contact with peri-wound skin and should be cut to the shape and size of the wound. Actilite however, does not need to be cut to the dimensions of the wound.

Medical grade honey (continued)

- 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 and its use is not contraindicated in these patient.
- 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 website: www.oxfordhealth.nhs.uk/tissue-viability
- Store honey at room temperature. Due to the nature of honey, it can harden in 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 foreign microorganisms and environmental debris.
- There are several dressings available and dressing choice should be based on wound type and levels of exudate:

FIRST AID

ACTILITE HONEY

- Algivon Plus, Activon tube / cadexomer iodine
- A light, viscose net dressing coated with 99% Manuka honey and 1% Manuka oil.
- Suitable for use in: minor injuries where there is a risk of infection e.g. cut from a dirty implement, dirty graze from a fall outside or as a first aid dressing to an infected wound until Honey or Cadexomer Iodine obtained.
- Not suitable for wounds with an active wound bed infection (refer to AMBL2 Tool). Algivon Plus, Activon tube honey or Cadexomer Iodine dressings are required to treat a wound bed infection.
- Not to be used as a general prophylaxis in all wounds to prevent infection.
- Not suitable for use on skin tears (see Skin Tear Pathway).

FIRST LINE ANTIMICROBIALS

ALGIVON PLUS

- Atrauman, Urgoclean, Aquacel Extra.
- For moderate to high exuding wounds.
- A reinforced, soft alginate dressing impregnated with 100% manuka honey. The reinforced alginate fibers enable a sustained, slow release of honey, whilst maintaining the integrity of the dressing whilst being able to absorb exudate.

ALGIVON PLUS RIBBON

- Atrauman, Urgoclean, Aquacel Extra.
- The ribbon is conformable meaning wounds can be packed easily.
- Safe to use in sinuses/cavities as it maintains its integrity.
- A reinforced flexible probe is supplied with the product to aid application. It is advisable to measure and clearly document the wound cavity depth and/or sinus length using the wound probe, as well as the length

ACTIVON TUBE

- Atrauman, Urgoclean, Aquacel Extra.
- 100% medical grade manuka honey.
- Best suited for cavities/sinuses where the wound bed is not visible, ideal for debriding necrotic tissue, leg ulcers, exit/entry site infections.
- To use - twist off cap, apply liberally to the wound bed (surface or cavity) taking care not to contaminate the tip or cap of the tube and cover with an appropriate secondary dressing.
- As honey is a natural product, any remaining honey will not have any adverse effects.
- Activon Tube is a single patient use only product. Once opened, as long as the tip has not been contaminated, the tube can be sealed. Use within 90 days.

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Actilite	5cm x 5cm	379-3759	EJE079
Actilite	10cm x 10cm	335-4917	EJE042
Algivon Plus	5cm x 5cm	374-9496	ELS549
Algivon Plus	10cm x 10cm	374-9512	ELS550
Algivon Plus Ribbon	1cm x 20cm	N/A	ELS847
Algivon Plus Ribbon	2.5cm x 20cm	374-4653	ELS551
Activon Tube	20g	419-7646	ELY551

SECOND LINE ANTIMICROBIALS
Cadexomer iodine

- Honey
- Cadexomer iodine is a slow-release product and is only appropriate for use on locally infected wounds with moderate to high exudate levels.
- Iodosorb ointment and Iodoflex sachet dressings both contain cadexomer iodine. They consist of microspheres of chemically modified starch which contains 9% of elemental iodine. The release of iodine is activated by bacteria and wound exudate. Exudate is taken up and held in the absorbent molecules within the dressing. Both Iodosorb & Iodoflex absorb excess exudate and debride slough from the wound bed and therefore reduce bacteria at the wound surface.
- Please take special note of dosing guidance, contraindications, and length of treatment.
- Indications:
- To treat clinically diagnosed localised wound bed infection.
- To debride heavily colonised, sloughy wound beds whilst addressing increasing bacterial loading.
- This product should not 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.
- There is a potential interaction with lithium, resulting in an increase possibility of hypothyroidism.
- Do not use in the vicinity of the eyes, ears, nose or mouth.
- May cause a slight transient pain in the first hour after treatment. This is a sign that the product is effective. Occasionally, dressings may cause the skin around the wound edges to swell or redden, this will usually pass. if these symptoms persist or if the patient experiences any other symptoms, they should contact a healthcare professional.
- 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 in one week.
- The product should be changed when it becomes saturated with wound exudate and all the iodine has been released. This is indicated by loss of colour.
- Generally, these products should be changed every 2 to 3 days (maximum 5 days). In highly exuding wounds it might be necessary to change daily.
- These products are not absorbed by the body. Irrigation of the wound bed using body warm tap water is required to reduce dressing residue. Not suitable for undermined, sinus or tracking wounds.

SECOND LINE ANTIMICROBIALS

IODOFLEX

- Honey
- A dark brown paste dressing with a gauze backing on both sides available in a variety of sizes.
- This dressing can be cut or moulded to fit the wound bed.
- Please remove gauze on the side of the dressing in contact with the wound.
- Best suited to superficial or cavity wounds such as pressure ulcers in challenging anatomical areas or leg ulceration.

IODOSORB

- Honey
- 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.
- Apply a 2-3mm thickness (thickness of a £1 coin).
- Can be spread onto Atrauman for wet wounds.

SECOND LINE ANTIMICROBIALS: CADEOXMER IODINE

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Iodosorb ointment	10g tube	036-6658	EKB012
Iodosorb ointment	20g tube	033-3906	EKB018
Iodoflex	5g (4cm x 6cm)	073-1547	EKB007
Iodoflex	10g (6cm x 8cm)	014-9617	EKB008

THIRD LINE ANTIMICROBIALS

Flaminal forte & hydro

- Flaminal is a broad-spectrum topical antimicrobial gel containing alginate. Enzymes within the gel produce reactive oxygen radicals that destroy the cell wall of bacteria, and alginate content assists with absorption of exudate. As a gel it also facilitates autolytic debridement.
- Although suitable for a variety of wounds it is particularly suitable for inserting into cavities, or a sinus where the wound bed cannot be seen. It is also suitable for the debridement of necrotic pressure ulcers.
- Flaminal comes in two formats: Hydro & Forte and selection is based on exudate levels.
- Step down to Hydro when the wound exudate levels decrease.
- Step up to Forte when the wound exudate levels increase.
- Apply a thick layer (5mm) to the wound bed.
- A 15g tube covers approximately 40cm2.
- A 50g tube covers approximately 130cm2.
- Use in conjunction with a suitable secondary dressing.
- For wetter wounds, apply directly on to the secondary dressing first.
- Remnants from previous applications should be removed by cleansing prior to application.
- Nozzles are available from the Flen Health representative or sterile syringes can be used to help with a more precise application or insertion into cavity wounds.
- Flaminal can be left in situ for 1-4 days dependent on the exudate levels.
- Store at room temperature.
- To use - twist off cap, apply liberally to the wound bed (surface or cavity) taking care not to contaminate the tip or cap of the tube and cover with an appropriate secondary dressing.
- Flaminal is a single patient use only product, once opened use within 30 days as long as the tip has not been contaminated
- Do not use on the eyes or eyelids. Do not use if there are any known allergies to the components of Flaminal.
- For deeper wounds with exposed underlying structures, upon first application of Flaminal, monitor for reaction for 30 minutes after administration.

THIRD LINE ANTIMICROBIALS

FLAMINAL HYDRO

- Contains 3.5% alginate and is suitable for low to moderately exuding wounds.
- Low exudate levels - change every 3-4 days.
- Moderate exudate levels - change every 2-3 days.

FLAMINAL FORTE

- Contains 5.5% alginate and is suitable for moderate to highly exuding wounds.
- High exudate levels - 1-2 days inititally.

THIRD LINE ANTIMICROBIALS

CUTIMED SORBACT CONTACT

- Honey / cadexomer iodine
- A dry non-absorbent antimicrobial contact layer dressing.
- Microorganisms from the wound are attracted to the dressing, bound to the surface, and destroyed.
- Suitable for severe arterial wounds where debridement is contraindicated but an antimicrobial dressing is required.
- Best suited to moderate to heavily exuding wounds with a suitable secondary absorbent dressing.
- Cut the dressing to shape, covering the peri-wound if maceration is evident. Can be applied either side up.
- Not for use on dry wounds as this may cause the dressing to adhere to the wound.
- The dressing may require soaking off if it sticks. If this is required, it is best done by submerging the wound and dressing in a bucket of water for 5 minutes.

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Flaminal Hydro	15g tube	324-2971	ELG021
Flaminal Hydro	50g tube	344-9600	ELG025
Flaminal Forte	15g tube	324-2963	ELG022
Flaminal Forte	50g tube	344-9592	ELG023
Cutimed Sorbact Contact	4cm x 6cm (folded) 11cm x 16cm (unfolded)	232-4325	ELY212
Cutimed Sorbact Contact	7cm x 9cm (folded) 17cm x 27cm (unfolded)	232-4333	ELY213

Product categories

ANTI-ODOUR DRESSINGS

Clinisorb
Cinesteam

ANTI-ODOUR DRESSING

CLINISORB

- CliniSorb is a sterile activated charcoal cloth which is sandwiched between layers of viscose rayon and coated with polyamide. It absorbs the toxins produced by bacterial metabolism which cause odour. Odour is usually associated with infection. Topical Antimicrobial treatment should be first line management, along with exudate management, before CliniSorb is considered.
- Can be used to manage odour on a variety of wounds such as leg ulcers, pressure ulcers or fungating wounds, as a primary dressing, or if necessary, with a non-adherent contact layer underneath.
- Suitable for light to moderately exuding wounds.
- Can be cut and used either side down.
- Should not be used until all other options have been considered.
- Effectiveness can be reduced when used with heavily exuding wounds.

ANTI-ODOUR DRESING

CINESTEAM

- Cinesteam is a non-adhesive secondary dressing designed to absorb exudate and eliminate unpleasant odours. It consists of an absorbent layer together with a sachet containing cinnamon powder.
- Cinnamon absorbs unpleasant-smelling volatile compounds emanating them from the wound and masks residual odours with spice natural fragrance.
- To be applied on top of an appropriate primary dressing (it is not intended to be in direct contact with the wound). The absorbent layer (white face) should be applied facing the wound, over the primary dressing,
- Cinesteam can be left in place as long as its absorption and odour masking capabilities are satisfactory.
- Cinesteam should not to be used on patients with known sensitivity to any of its components, in particular cinnamon.
- Do not cut.
- Do not use with an active charcoal dressing, which may impair its odour masking ability.
- Do not cover with an occlusive dressing. Suitable to use under Xupad, Kliniderm Superabsorbent, Sorbion, K-Soft, K-Lite and compression bandaging.

ANTI-ODOUR DRESSINGS

PRODUCT	SIZE	PIP-CODE EPROCUREMENT
Clinisorb	10cm x 10cm	Available via Tissue Viability
Clinisorb	10cm x 20cm	Available via Tissue Viability
Clinisorb	15cm x 25cm	Available via Tissue Viability
Cinesteam	11cm x 19cm	Available via Tissue Viability

Product categories

PERFORATED DRESSINGS WITH BORDERS

Softpore
Cosmopor Transparent

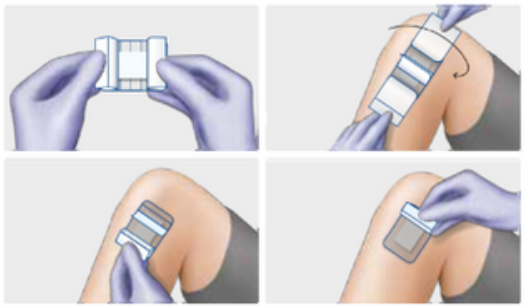
SOFTPORE

- These are adhesive island dressings suitable for low exuding wounds.
- Showerproof, breathable and hypoallergenic.
- Caution on fragile skin due to adhesive borders, and for this reason is not suitable for use on legs.
- Contact layer dressing with more absorbent pad.

COSMOPOR TRANSPARENT

- These are adhesive island dressings suitable for low exuding wounds.
- Previously known as Hydrofilm Plus.
- Waterproof transparent film with absorbent pad.
- Caution on fragile skin due to adhesive borders, and for this reason is not suitable for use on legs.
- Contact layer dressing with more absorbent pad.

4-STEP APPLICATION:



PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Softpore	6cm x 7cm	304-0920	EIJ023
Softpore	10cm x 10cm	304-0938	EIJ013
Softpore	10cm x 20cm	304-0953	EIJ024
Softpore	10cm x 30cm	304-0979	EIJ026
Cosmopor Transparent	5cm x 7.2cm	426-5583	ELW85079
Cosmopor Transparent	9cm x 10cm	426-5609	ELW85080
Cosmopor Transparent	10cm x 20cm	426-5625	N/A
Cosmopor Transparent	10cm x 25cm	426-5633	ELW85087

Product categories

FILMS

Hydrofilm Leukomed-T

HYDROFILM LEUKOMED-T

- 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. They are sometimes used to protect the skin from shear and friction.
- 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 when removing.
- Hydrofilm is not available via E-procurement. For those obtaining dressings via E-procurement, please use Leukomed-T instead.

FILMS

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Hydrofilm	6cm x 7cm	342-6665	N/A
Hydrofilm	10cm x 15cm	266-7350	N/A
Hydrofilm	10cm x 25cm	342-6236	N/A
Hydrofilm	15cm x 20cm	342-6244	N/A
Leukomed-T	8cm x 10cm	N/A	ELW1046
Leukomed-T	11cm x 14cm	N/A	ELW1054
Leukomed-T	10cm x 25cm	N/A	ELW1053
Leukomed-T	15cm x 25cm	N/A	ELW1051

Product categories

NON-ADHESIVE ABSORBENT DRESSINGS

Xupad Sterile
Kliniderm Superabsorbent
Cutimed Sorbion Sachet Extra

- Please refer to the Wound Exudate Management Pathway for advice on selection of the appropriate absorbent dressing.
- To assist Kliniderm Superabsorbent or Sorbion Sachet Extra conform around an ankle, use 2 smaller dressings placed at an angle rather than one large dressing (XL or 20cm x 40cm).
- Ensure size is correct, you only need a 3cm border around the wound and do not layer.
- Do not cut Kliniderm Superabsorbent or Sorbion Sachet Extra.
- If using tape or film to secure, only apply at the borders - do not totally occlude.

XUPAD STERILE

- First line choice for all wounds.
- The dressing should be worn with the blue backing facing away from the wound site.
- The dressing may be held in place with a suitable retention aid.
- Kliniderm superabsorbent

KLINIDERM SUPERABSORBENT

- A super absorbent dressing capable of holding moderate to high levels of exudate whilst at the same time wicking moisture away from the skin. In most cases, it can be used as a primary dressing. The outer sleeve is larger than the inner absorbent core to allow for expansion with the exudate.
- Sorbion
- Xupad sterile

CUTIMED SORBION SACHET EXTRA

- Sorbion Sachet Extra is a super absorbent dressing capable of holding high to very high levels of exudate, whilst at the same time wicking moisture away from the skin. It can be used as a primary dressing and can be left on for up to 4 days. If Sorbion is sticking leave on longer or put an Atrauman underneath.
- To request supply of Sorbion, please complete a Sorbion authorisation form and email to Tissueviability@oxfordhealth.nhs.uk. If authorised, Tissue Viability will order and arrange delivery to the clinician's base. If the patient is not known to Tissue Viability, you will be requested to complete a Tissue Viability referral form prior to provision of Sorbion Sachet Extra dressings.
- Sorbion Sachet S Drainage 10cm keyhole dressings can be cut in half in between the two absorbent cores and placed in between highly exuding oedematous toes.
- Only 2 weeks supply of dressing will be authorised during which time it is expected the cause of the high exudate levels will have been identified and management strategies to address it put in place (e.g., treat wound bed infection, application of compression or improved bandaging technique/limb shaping).
- Ensure size is correct. You only need a 3cm border around the wound.
- Do not layer.
- The pads can be stiff and do not conform well to curves of the leg and ankle. Instead of using a 20cm x 45cm, dressings, consider using two smaller dressings applied at an angle, to ensure the pads fit snugly against the
- limb. Gently scrunch to soften but do not over crush.
- Kliniderm Superabsorbent, RespoSorb Silicone Border
- Increase frequency of dressing changes

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
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
Kliniderm Superabsorbent	10cm x 10cm	394-7132	EJE228
Kliniderm Superabsorbent	10cm x 20cm	410-0087	EJE229
Kliniderm Superabsorbent	20cm x 20cm	394-7157	EJE227
Kliniderm Superabsorbent	20cm x 30cm	394-7165	EJE230
Kliniderm Superabsorbent	20cm x 40cm	404-9508	EME129
Sorbion Sachet Extra	5cm x 5cm	Available via Tissue Viability	
Sorbion Sachet Extra	7.5cm x 7.5cm	Available via Tissue Viability	
Sorbion Sachet Extra	10cm x 10cm	Available via Tissue Viability	
Sorbion Sachet Extra	10cm x 20cm	Available via Tissue Viability	
Sorbion Sachet Extra	20cm x 20cm	Available via Tissue Viability	
Sorbion Sachet Extra	20cm x 30cm	Available via Tissue Viability	
Sorbion Sachet Extra	25xm x 45cm	Available via Tissue Viability	
Sorbion Sachet S Drainage	10cm x 10cm	Available via Tissue Viability	

Product categories

ADHESIVE ABSORBENT DRESSINGS

Kliniderm Foam Silicone Border
Resposorb Silicone Border

KLINIDERM FOAM SILICONE BORDER

- Kliniderm Foam Silicone Border is a foam island dressing with a silicone adhesive border. It is specifically for use on skin tears and on low to moderate exudate leg wounds under compression hosiery. Please refer to the Skin Tear Pathway and Lower Limb Care Pathway for further guidance.
- It is only suitable for low to moderately exuding wounds as there is no super absorbent core to wick exudate away. It is not suitable for medium to highly exuding wounds as this will result in maceration to the margins and skin. Also, not suitable for high friction areas such as the sacrum, as the raised border will result in the dressing rucking up.
- Resposorb Silicone border
- Contact layer with more absorbent pad

REPOSORB SILICONE BORDER

- This dressing has a super absorbent pad with a silicone adhesive border.
- Can be used as a primary dressing.
- Suited 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.
- The recommended wear time is up to seven days dependent on exudate levels.
- The backing film is showerproof and therefore also suitable against incontinence.
- The transparent border can be cut to adapt the dressing to specific body areas.
- Oval and square dressings available.
- Do not cut the green absorbent pad.
- Sorbion
- Xupad sterile. Kliniderm silicone border if using on leg ulcer under compression hosiery

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Kliniderm Foam Silicone Border	7.5cm x 7.5cm	394-7231	ELA741
Kliniderm Foam Silicone Border	10cm x 10cm	394-7249	ELA742
Kliniderm Foam Silicone Border	12.5cm x 12.5cm	394-7256	ELA743
Kliniderm Foam Silicone Border	15cm x 15cm	394-7264	ELA744
Kliniderm Foam Silicone Border	10cm x 20cm	394-7272	ELA745
RespoSorb Silicone Border	8cm x 8cm	427-9477	EJA85046
RespoSorb Silicone Border	10cm x 10cm	427-9485	EJA254
RespoSorb Silicone Border	12.5cm x 12.5cm	427-9550	EJA255
RespoSorb Silicone Border	15cm x 15cm	427-9443	EJA85050
RespoSorb Silicone Border	17.5cm x 17.5cm	427-9543	EJA256
RespoSorb Silicone Border	16cm x 26cm	427-9501	EJA85049
RespoSorb Silicone Border	20cm x 20cm	427-9519	EJA85048
RespoSorb Silicone Border (Oval)	13cm x 15.5cm	427-9527	EJA85053
RespoSorb Silicone Border (Oval)	12cm x 23cm	427-9535	EJA85052

Product categories

BANDAGING

K-Soft
K-Lite

SUB-BANDAGE WADDING

K-SOFT

- Comprises of viscose and polyester. Latex-free. This is used to shape and protect the limb prior to application of compression or retention bandaging.
- Always apply a circumferential cuff to the malleoli and a lengthways strip to the tibial crest to provide padding and prevent pressure damage over bony prominences, even if the leg does not require re-shaping.

LIGHT SUPPORT RETENTION BANDAGE

K-LITE

- A lightweight knitted bandage consisting of viscose, nylon and elastomeric yarn. Latex free. Provides very light support.
- If use on lower limbs always bandage toe to knee and use a 10cm width bandage (even if the skin remains intact).
- Always used with padding underneath i.e. K-soft.
- This is not to be considered as a compression bandage. If compression is required, refer to compression bandage section of the formulary.

RETENTION BANDAGING

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
K-Soft	10cm x 3.5m	266-8374	EPA028
K-Soft Long	10cm x 4.5m	325-7177	ECA174
K-Lite	10cm x 4.5m	239-3635	ECA100
K-Lite Long	10cm x 5.25m	325-7110	ECA173

Product categories

COMPRESSION BANDAGING

K-Two Reduced
K-Two
Clinistretch
Rosidal K
Coban2

- Mild (Reduced) 20mmHg compression - use K-Two Reduced (or single layer Clinistretch if ankle circumference is >25cm once K-Soft has been applied). This can be applied as immediate and necessary compression in the absence of red flags. Please refer to the Lower Limb Care Pathway for further information.
- For alternative forms of compression, please refer to Oxfordshire Hosiery & Wrap Formulary
- Strong (Full) 40mmHg compression (i.e. Clinistretch or K-Two) should not be applied until a full holistic vascular assessment has been completed - PMH, lower limb assessment and doppler. This should be performed within 2 weeks by a competent clinician who has attended the Tissue Viability Fundamentals in Lower Limb Management training. For further information refer to local guidelines.
- Follow the company product guidance for the correct application technique and Lower Limb Care Pathway to aid in product selection.
- For a latex free short stretch bandage, use Rosidal K. This is a washable bandage. K-Two and K-Two Reduced are also available in latex free versions.

K-TWO REDUCED

- Delivers 20mmHg compression.
- Two-layer compression bandage system that combines elastic and inelastic components.
- Provides graduated compression for up to 7 days.
- Can be used for immediate and necessary care - refer to Lower Limb Care Pathway for further details.
- More suitable for those with no calf muscle pump activity.
- Available in two sizes: 18cm - 25cm and 25cm to 32cm.
- 10cm width.
- Available in a latex-free version.

K-TWO

- Delivers 40mmHg compeession
- Two-layer compression bandage system that combines elastic and inelastic components.
- Provides graduated compression for up o 7 days,
- Can be used for treatment of venous leg ulcers where strong compression is recommended.
- More suitable for those with no calf muscle pump activity.
- Available in two sizes: 18cm - 25cm and 25cm to 32cm
- 10cm width
- Available in a latex-free verison.

CLINISTRETCH

- Clinistretch is a short stretch bandage which can be used for venous leg ulcers or chronic oedema management.
- Best suited for those with a good calf muscle pump activity.
- Standard lower limb bandages for venous ulceration are 10cm width.
- 12cm width available for thighs - contact Tissue Viability for support.
- 8cm width can be used for stump bandaging to decongest oedema to the toes - contact Tissue Viability for support.
- Contains latex.

ROSIDAL K

- Rosidal K is a short stretch bandage which can be used for venous leg ulcers with or without chronic oedema.
- Latex-free.
- Washable/reusable.
- Can be used for those who are mobile or immobile.
- Standard lower limb bandages for venous ulceration are 10cm width.
- Also available in 8cm and 12cm widths.

COBAN2

- Clinistretch
- For use with severe chronic oedema where limbs have significant distortion and/or there is oedema to the knee/thigh requiring decongestion. Intended for short term use only to decongest a limb prior to moving into maintenance compression hosiery/wrap.
- Please follow the Lower Limb Care Pathway and refer to Tissue Viability if you consider this to be the appropriate therapy for your patient.
- This should only be initiated by a Tissue Viability Nurse who will arrange supply of the bandages and training on bandaging technique. Application technique can be very bespoke.
- You will need to use bandaging scissors to remove this bandaging. Order via E-procurement.
- Not suitable for long term use with highly exuding wounds.
- Need changing as a minimum every 5 days.
- Latex Free.
- Available in 5cm, 10cm and 15cm widths.

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Urgo KTwo Reduced Kit (20mmHg)	18-25cm	360-2869	ECA205
Urgo KTwo Reduced Kit 20mmHg)	25-32cm	360-2877	ECA206
Urgo KTwo Reduced Kit Latex Free (20mmhg)	18-25cm	372-5264	ECA234
Urgo KTwo Reduced Kit Latex Free (20mmHg)	25-32cm	372-5264	ECA235
Urgo KTwo Kit (40mmHg)	18-25cm	327-4685	ECA152
Urgo KTwo Kit (40mmHg)	25-32cm	333-8480	ECA164
Urgo KTwo Kit Latex Free (40mmHg)	18-25cm	372-5231	ECA236
Urgo KTwo Kit Latex Free (40mmHg)	25-32cm	372-5249	ECA237
Clinistretch	8cm x 6m	403-9798	N/A
Clinistretch	10cm x 6m	403-9772	N/A
Clinistretch	12cm x 6m	403-9780	N/A
Rosidal K	8cm x 5m	Available via Tissue Viability	
Rosidal K	10cm x 5m	Available via Tissue Viability	
Rosidal K	12cm x 5m	Available via Tissue Viability	
Coban2 Comfort Foam Layer	5cm x 1.2m	Available via Tissue Viability	
Coban2 Comfort Foam Layer	10cm x 3.5m	Available via Tissue Viability	
Coban2 Comfort Foam Layer	15cm x 3.5m	Available via Tissue Viability	
Coban Compression Layer	5cm x 2.7m	Available via Tissue Viability	
Coban Compression Layer	10cm x 4.5m	Available via Tissue Viability	
Coban Compression Layer	15cm x 4.5m	Available via Tissue Viability	

Product categories

TUBULAR BANDAGING

ACTIFAST COMFINETTE

ACTIFAST

- ActiFast is a latex-free, self-supporting and conforming tubular bandage.
- Colour coded to denote size. Available in three sizes.
- 2-way stretch for conformability.
- Can be cut to size and shape.
- Can be used to secure, cover and retain dressings or to keep ointments in place.
- Safe to use where compression is contra-indicated.
- Blue line - small/medium limbs - 20-45cm.
- Yellow line - large limbs, heads and children's trunks - 35-65cm.
- Beige line - extra-large limbs and small/medium adult's trunks - 50-120cm,
- Not to be used under K-Soft when Comfinette should be used instead.
- Not to be placed over the top of compression bandaging as no clinical indication for thid

COMFINETTE

- Single use non-elasticated 100% viscose tubular bandage.
- Can be used as a bandage liner to ease the problem of contact sensitivity, to secure, cover and retain dressings or to keep ointments in place.
- Available in four sizes sizes.
- Size 1 - suitable for small fingers and toes.
- Size 12 - suitable for large fingers and toes.
- Size 56 - suitable for adult limbs.
- Size 78 - suitable for large adult limbs.

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Actifast blue line	7.5cm x 5m	285-6573	EGP086
Actifast blue line	7.5cm x 10m	285-6581	EGP137
Actifast yellow line	10.75cm x 5m	285-6623	EGP089
Actifast yellow line	10.75cm x 10m	285-6631	EGP004
Actifast beige line	17.5cm x 1m	292-4298	EGP005
Comfinette - Size 1	1.5cm x 20m	N/A	EGJ047
Comfinette - Size 12	3cm x 20m	N/A	EGJ042
Comfinette - Size 56	7.5cm 20m	N/A	EGJ043
Comfinette - Size 78	8.5cm 20m	N/A	EGJ044

Product categories

SURGICAL TAPES

SCANPOR

- Scanpor paper tape is to be used on padding and bandages.
- Scanpor is not suitable for applying directly onto skin.
- Do not apply Scanpor circumferentially to lower limb when securing bandaging or absorbent pads as this will cause a tourniquet effect and affect blood supply if swelling occurs. Use 2-3cm strips of tape to secure bandaging or a strip of K-Soft circumferentially around absorbent pads.

HYPAFIX

- Hypafix is a synthetic rubber adhesive non-woven tape, permeable to the air and water.
- Can be in direct contact with the skin.
- Hypafix can cause adhesive-related trauma to skin upon removal. Use adhesive remover to aid non-traumatic removal if necessary.

SURGICAL TAPES

Scanpor	2.5cm x 5m	011-3407	N/A
Hypafix	5cm x 5m	335-3711	EHR138

Product categories

ADHESIVE REMOVER

ADHESIVE REMOVER

LIFTEEZ AEROSOL SPRAY

- To aid in the removal of adhesive dressings which are otherwise painful to remove or risk causing skin damage. When using on Softpore or Hypafix, spray directly on top of the dressing and allow to soak in before removing the dressing.

ADHESIVE REMOVER

PRODUCT	SIZE	PIP-CODE	EPROCUREMENT
Lifteez aerosol adhesive remover	50ml	389-7147	EXC041

Product categories

NEGATIVE PRESSURE THERAPY

ACTIV.A.C.

- Negative Pressure Wound Therapy (NPWT) is an alternative method of wound management which stimulates granulation within wounds. In Oxfordshire Community it is currently only funded for use on dehisced abdominal wounds or vascular foot ulcers. Dressings should be changed 3 x week.
- Advise turning off the pump 30 minutes before dressing changes to assist in release of the foam from the wound bed.
- Patients discharged from the OUH should be sent with 2 weeks of dressing supplies.
- If they are discharged under consultant care, then the OUH should continue to supply the dressings after the initial 2 weeks.
- If the management of the VAC is discharged into Community Care, then Tissue Viability take over the overall management of the wound and supply of dressings.
- Use strips of the film dressing supplied with the black foam (and not a thin hydrocolloid) to 'picture frame' the wound to prevent suction on the healthy skin.
- Support on the dressing technique is available in District Nursing from TV ReN or ADNS; in community hospitals from TV Link Nurse or alternatively, the VAC Rep: Elaine Knight eknight@solventum.com
- A 24 hr helpline is available for both patients and clinicians to use for any problems that may be encountered 08009 808880. Further information is available on the Tissue Viability Website.

VAC

PRODUCT	SIZE	PIP-CODE EPROCUREMENT
ActiV.A.C pump, canister, dressings and accessories		Available via Tissue Viability

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