Milton Keynes Clinical Commissioning Group

Wound Formulary

Nursing Homes

January 2018

Reviewed by Sue Teasdale, Tissue Viability Nurse, on behalf of the Pharmaceutical Advisers MKCCG January 2018 Review date: January 2021

Introduction

The Wound Management formulary and guidance has been produced by the Tissue Viability Team (CNWL) in consultation with Milton Keynes CCG Medicines Management team. This formulary is designed to provide clinical staff with a comprehensive guide to wound dressings, they have been selected using available evidence gathered from a number of sources. This has included a review of the clinical evidence, local clinical evaluations and feedback of current usage. Dressings in this formulary are for general use, with the exception of those that are indicated as under the separate formulary listings where TVN advice only is indicated. This category of dressings should only be prescribed following advice and assessment from the Tissue Viability Team.

The Wound formulary has been designed to be predominantly procured through a non-prescription ordering system via an online ordering system (ONPOS). The system is a cost effective system which reduces wastage also ensures that patients have ready access to wound dressings when required, without the need for a FP10 prescription.

The process of dressing selection is complex and influenced by many factors, least of these the process of wound healing and the use of the correct dressing for the appropriate wound type. A Treatment plan should be implemented following a comprehensive wound assessment and reassessment taking into account underlying disease and contributory factors.

For patient failing to progress to healing or require prescribing outside of the Wound formulary should be referred to the **Tissue Viability Service for further guidance**.

Objectives

1. For all healthcare professionals in Primary & Community Care to follow a holistic approach towards wound assessment, thereby enabling appropriate selection of dressings in accordance with wound type.
2. To encourage good clinical practice that is research and evidence based.
3. To provide Healthcare Professionals with an up to date reference tool.
4. To promote a rational approach towards prescribing wound care products in Primary & Community Care.
5. To highlight cost-effective and safe practice in the treatment for a wide variety of wounds.
6. To provide a rationale for choosing wound care products.
7. Formulary to be used in conjunction with local approved guidelines.

Guidance Notes

Sterile dressing Packs

Sterile dressing packs should not be routinely used as the complete contents are rarely required. Sterile packs should only be used for patients who have a large cavity wound or are immunocompromised
The principles of ANTT using a non-touch technique following handwashing and wearing of a clean plastic disposable apron as per infection control guidance, and a clean plastic tray designated for the purpose. Sterile gauze packs are available to be used however; gauze is not a primary or secondary dressing and must not be used in this way or laid on the patient's skin as it can cause maceration and trauma on removal.

Hand Washing

Hand washing is the single most important measure in the prevention of cross infection. Please refer to your Infection Prevention Policy and Guidelines for more information.

Gloves

Wash hands before applying gloves. Gloves must be worn for wound care at all times and must be changed after contact with each patient and at the end of each procedure. Wash hands after removing gloves.

Plastic Aprons

Plastic aprons must be worn for every dressing procedure and should be discarded after each individual use.

Manufacturer's Instructions

Before applying any wound care product, familiarise yourself with manufacturer's instructions for use and the indicators for use. Adherence to the manufacturer's storage instructions for individual products is very important to ensure clinical efficacy. Instructions for use for each individual dressing can be found in the box of the dressings.

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Wound Cleansing

The aim of wound cleansing is to create optimum local conditions for uncomplicated wound healing. Therefore all solutions should be warmed to body temperature before applying to the wound bed.

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

Sterile saline indications
Use a sterile irrigation solution for acute wounds, burns, immuno-compromised patients, patients with renal failure and wounds exposing bone or ligaments, toe nail removal and diabetic foot ulcers.

Prontosan
Prontosan is a The surfactant component (betaine)of the cleansing agent reduces surface tension and aids removal of debris and bacteria by irrigation, this is should not be used routinely and used as part of the infection pathway.

Key Points on Wound Cleansing
1. Gloves should be worn in the presence of bodily fluids.
2. Irrigation is the preferred method of cleansing a deep wound or sinus.
3. Gently wash chronic wounds in warm tap water.
4. Do not irrigate bleeding wounds or wounds with exposed nerve endings.
5. Do not use gauze, paper towels or cotton wool on the wound bed.
6. Clean surrounding skin with gauze to remove dried on exudate.
7. Dry, ischaemic wounds should not be cleansed but kept dry.
8. Routine cleansing of clean, granulating wounds is not required and can traumatise fragile new skin.

Wound healing

Dressings Do Not Heal Wounds

The wound healing process is a physiological response to a wound which is affected by a patient's overall health.

A holistic assessment should be performed to identify underlying conditions to determine the cause of the wound. The cause then needs to be investigated, treated and managed appropriately to address underlying co-morbidities i.e. Blood glucose control, nutrition etc.
For patients with a lower leg wound a Leg Ulcer Assessment including Doppler should be undertaken to determine the aetiology of the leg ulceration. Venous leg ulcers should be managed with the application of compression is suitable with a simple dressing.

Dressings should be chosen according to the wound presentation and for specific management goals using the **T.I.M.E.S** framework (Tissue, Infection/Inflammation, Moisture (Exudate), Edge of wound, Surrounding skin).

Appropriate Dressing Changes

Most dressings in this formulary are designed to remain on the wound for 3 to 7 days, refer to manufactures instruction for use. Infected, necrotic and sloughy wounds may need to be changed more frequently (See antimicrobial guidelines)Where a dressing has to be changed more frequently for a long period of time, it is likely that it is an inappropriate dressing for that particular wound or there is an underlying factor that has not been taken into consideration. If a dressing adheres to the wound bed there is not enough moisture for healing to take place and a more suitable dressing needs to be applied.

Diabetic foot wounds need to be monitored closely and the care of these patients should be managed by a multidisciplinary team. Dressings may need to be changed more frequently than non-diabetic wounds.

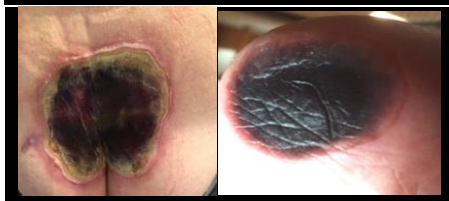
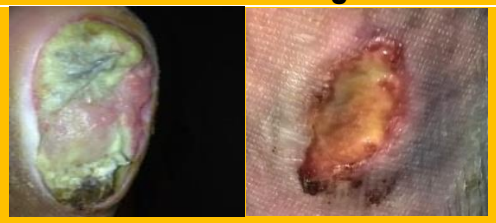
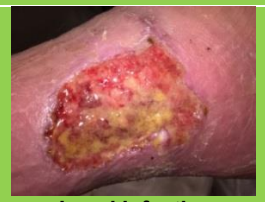
Secondary Dressings

A secondary dressing should only be required if applied over a cavity wounds which is deeper than 2cm in depth or using an antimicrobial, the used of contact layers under Foam dressings should not be used as this compromises the effectiveness of the dressing

Cavity Wounds

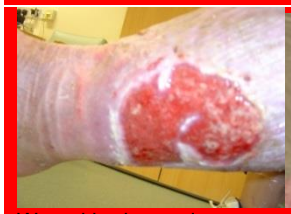
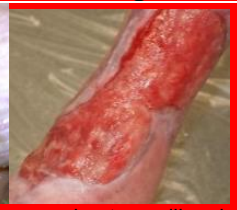
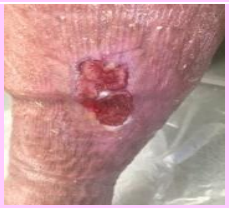
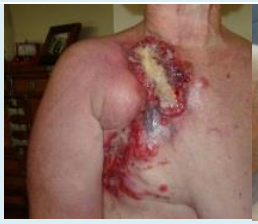
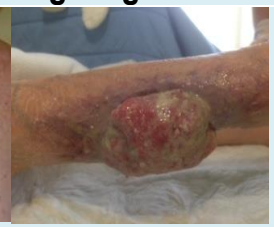
All cavity wounds should be carefully probed using a sterile probe to establish the depth of the wound bed. If unable to find the wound bed then the wound may require further investigation to exclude a sinus or involvement with deep tissue and bone. Refer to a general surgeon for further investigation.

Complex wounds and/or non-healing wounds at 6 weeks to be referred to the Tissue Viability Service.

<table>
<tr><th colspan="2">Necrotic Tissue</th><th colspan="2">Slough</th><th colspan="2">Infected</th></tr>
<tr><td colspan="2">  </td><td colspan="2">  </td><td> 
Systemic infection</td><td> 
Local Infection</td></tr>
<tr><td colspan="2">Wound eschar is full thickness, dry, devitalised tissue acts as a physical barrier to epidermal cell migration, and hydration at the wound interface is significantly reduced.</td><td colspan="2">Tissue usually moist, can be yellow, tan or grey in appearance. Maybe adhered to the wound bed or loose and stringy when associated with increased wound moisture</td><td>Infection occurs when the bacteria overwhelm the host to produce an immune response. The patient is systemically unwell. Wound swab for culture and sensitivities, systemic antibiotics indicated</td><td>Subtle signs of infection, bleeding, friable granulation Wound breakdown, increase in pain, delayed wound healing
Antibiotics not required</td></tr>
<tr><td colspan="2">Aims of treatment
To rehydrate to aid debridement
DO NOT DEBRIDE DIABETIC FOOT ULCERS OR HEEL PRESSURE ULCERS aim to keep dry</td><td colspan="2">Aims of treatment
To de-slough/debride „Remove excess exudate to prepare the wound bed for healing</td><td colspan="2">Aims of treatment
Treat system infection
Local infection: To reduce the microbes to restore microbial balance to kick start the wound to heal</td></tr>
<tr><td colspan="2">Dressing choices</td><td colspan="2">Dressing choices</td><td colspan="2">Dressing choices</td></tr>
<tr><td>Superficial</td><td>Cavity</td><td>Superficial</td><td>Cavity</td><td>Superficial</td><td>Cavity</td></tr>
<tr><td>Comfeel, Duoderm thin Inadine to aid dehydration of necrotic tissue</td><td>Not applicable</td><td>Aquacel extra
Iodoflex –change every72 hours
Algivon (if Iodoflex contraindicated)
Biatian foam / silicone
Allevyn Foam / silicone,Life
Kiniderm for high levels of exudate under bandaging</td><td>Durafiber lightly pack into the cavity
Allevyn Life as a secondary dressing for Moderate levels of exudate</td><td>Prontosan soak for 20 mins
Prontosan gel,
Iodoflex- max use 3 months
Cutimed (low level)
Acticoat,flex – 2 weeks treatment then review –maximum 4 weeks

TVN Advice only</td><td>Aquacel Ag +
Acticoat Flex lightly packed into the cavity

TVN advice only</td></tr>
</table>

<table>
<tr><th>Granulating</th><th>Epithelising</th><th>Fungating</th></tr>
<tr>
<td>  
Wound bed granular appearance due to capillary budding.
Tissue is fragile and easily disrupted by dressing adherence and wound inappropriate wound cleansing</td>
<td> 
Wound bed is shallow, Epithelial cells migrate across the wound bed, form the edge of the wound, wound is pink in appearance, islands may develop from old hair follicles</td>
<td>  
Fungating wounds can cause tissue necrosis with a cauliflower like appearance; they are prone to bleeding and pain.</td>
</tr>
<tr>
<td>Aims of treatment
To maintain a moist wound healing environment; removing excess exudate</td>
<td>Aims of treatment
To protect to wound,
Maintain a moist environment to facilitate healing</td>
<td>Aims of treatment
To absorb exudate and reduce odour and pain, dressing choices for patient comfort and aesthetics
Manage and control bleeding</td>
</tr>
<tr>
<td colspan="2">Dressing choices</td>
<td colspan="2">Dressing choices</td>
<td>Dressing choices</td>
</tr>
<tr>
<td>Superficial

NA ultra
Atrauman
Biatian foam / silicone
Allevyn Foam / silicone, Lite for low levels of exudate
Do Not use foam dressings under bandaging</td>
<td>Cavity

Durafiber</td>
<td>Superficial

NA ultra
Atrauman
Biatian foam / silicone
Allevyn Foam / silicone, Lite for low levels of exudate
Tegaderm foam oval
Do not use foam dressings under bandaging</td>
<td>Cavity

Durafiber</td>
<td>Durafiber
Biatian foam / silicone
Allevyn Foam / silicone, Tegaderm foam (oval)
Kaltoststst if bleeding
Acticoat,flex – 2 weeks
Treatment then review –maximum 4 weeks

(TVN guidance)</td>
</tr>
</table>

Nursing Home Formulary –Ordered through ONPOS

Super Absorbent dressings – for lower leg wounds with high levels of exudate		
Kliniderm Supra Absorbent 10cm X 10cm 10cm X 15cm 20cm X 20cm 20cm X 30cm		**Characteristics of the dressing** A superabsorbent dressing pad, a four-layer superabsorbent dressing held together by a seal to the margins of the dressing. **Indications for use** Indicated for lower leg wounds with high level so exudate under conservative bandaging Indicated where the wounds requiring 2 x daily or daily dressings due to strikethrough of exudate onto the outer b bandaging. **Method of application** can be applied directly to the wound bed or over a primary dressing Ensure that a 1.5cm margin of the wound onto the surrounding skin Apply the white side of the dressing to the wound **Cautions** Do not use on wounds with low levels of exudate. Do not use of bleeding wounds or risk of haemorrhage. **Do not cut to dressing pad, use the correct size for the wound**
Supportive bandage for the lower limb – to be used for lower limb wounds and the management of lower leg oedema.		
K-Lite 10cm X 5.25m K-Soft 10cm X 4.5m	 	**Characteristics of the dressing** Type 2 class Supportive bandage for the lower limb, **Indications for use** To be uses for lower limb wounds and leg ulceration **Method of application** K –Soft to be applied to the limb prior to the application of bandaging Synthetic wadding to applied to the leg prior to banding, used to shape the limb and absorb exudate, protect bony prominences and use to shape the limb Apply is a spiral toe to knee - **please see bandaging guidance for application** **Cautions** Ensure the limb has sufficient padding to prevent pressure damage to the limb **SHOULD NOT BE APPLIED TO A LIMB WITH SEVERE ARTERIAL DISEASE**
Paste Bandages- For use under the direction of the TVN		
Viscopaste 7.5cm x 6m		**Characteristics of the dressing** Open wave bleached cotton bandage which is impregnated with zinc oxide10%. **Indications for use** Indicated for the management of leg ulcers and chronic eczema/dermatitis under the direction of the TVN **Method of application** Applied by pleating to prevent constriction of the limb as it dries out –**See application guidance** Can be left insitu for 1 week **Cautions** Caution in patients with sensitives to preservative, if unsure cut a small piece of bandage and apply a patch test under a dressing for 48 hours to determine if skin reaction.

Wound contact layer – Low adherent dressing used as a primary dressing for lightly exuding or shallow granulating wounds		
Atauman 5cm x 5cm 7.5cm x 10cm		**Characteristics of the dressing** Polyester mesh dressing impregnated with a triglyceride (fatty acid), to be used for shallow wounds as a primary contact layer under bandaging. **Indications for use** Superficial wounds with wounds , protect granulating or epithelising wounds as a primary dressing under bandaging Can be left insitu for 7 days, low level of exudate may stick to the wound requiring soaking to remove, please change to NA ultra. **Method of application** Apply directly onto the wound **Cautions** Can dry out in low level exuding wounds or left insitu greater than 5 days, if adheres to the wound change to NA ultra.
Na Ultra 9.5cm x 9.5cm 9.5cm x 19cccm		**Characteristics of the dressing** Primary wound contact layer consisting of a knitted viscose rayon sheet with a silicone coating to prevent adhesion and pain free removal. **Indications for use** See above **Method of application** Apply directly onto the wound **Cautions** Do not use if sensitive to rayon(Nylon) or silicone
Transparent Film Dressings – to be used for minor wounds or prevention of friction to bony prominences		
Hydrofilm 6cm x 7cm 10cm x 12.5cm		**Characteristics of the dressing** Adhesive, transparent, semi-permeable film dressings which are waterproof and bacteria proof **Indications for use** used as a primary dressing to cover trauma wounds or as a secondary dressing for retention purposes Transparent film dressing for minor skin tears. Can be used for area of friction i.e. heels and elbows to prevent skin damage in these areas. Film dressings can be left insitu for up to 7 days **Method of application and removal** Remove backing as indicated, apply directly onto the wound To remove, lightly stretch the dressing from 1 corner and stretch away from the skin to prevent traumatic removal **Cautions** Exudate contained under the dressing may cause maceration of the surrounding skin

Transparent Film Dressings with a pad – to be used for minor / surgical wounds		
Hydrofilm plus 5cm x 7.2cm 9cm x 10cm		**Characteristics of the dressing** Adhesive, transparent, semi-permeable film dressings which are waterproof and bacteria proof with an low adherent absorbent dressing pad Showerproof dressing, **Indications for use** Used as a primary dressing for surgical wounds or minor wounds, Can be left insitu for 7 days. **Method of application and removal** Remove by stretching the dressing form 1 corner and stretch away from the skin **Cautions**. None noted
Foam Dressings with Silicone -Indicated for skin tears or wounds with moderate level so exudate. DO NOT USE UNDER BANDAGING – First Line		
Biatain foam with silicone border 7.5cm x 7.5cm 10cm x 10cm 12.5cm x 12.5cm **Biatain foam with silicone border Lite** 5cm x 5cm 5cm x 12.5cm **Biatian adhesive** 12.5cm x 12.5cm	 	**Characteristics of the dressing** Biatain Silicone is a soft and conformable polyurethane foam dressing with a semi-permeable, water- and bacteria proof top film and a soft silicone adhesive over the entire dressing. Biatian adhesive ins a polyurethane foam dressing with a semi-permeable hydrocolloid adhesive On contact with exudate, the foam conforms to the wound bed. thus minimizing the risk of maceration and leakage and filling in the dead space of the wound Showerproof **Indications for use** Biatain Silicone indicated for use with patient with fragile skin, Biatain adhesive indicated in area requiring greater adhesion or areas of friction. Indicated for skin tears – see guidance for managing skin tears Superficial burns and wound with moderate levels of exudate For wounds with lower level of exudate use the Lite version Used as a secondary dressing for cavity wounds Can be left insitu for 7 days **Method of application and removal** Apply directly to the wound bed Do not use primary contact layer unless using an antimicrobial **Cautions** **NOT USE BIATAIN ADHESIVE ON DIABETIC or ISHAEMIC FOOT ULCERD** **DO NOT UNDER BANDAGING**

Second Line foam		
Allevyn Gentle border 10cm X 20cm 12.5cm X 12.5cm 15cm Xx 15cm 17.5cm X 17.5cm 7.5cm X 7.5cm **Allevyn Adhesive** 12.5cm X 12.5cm 17.5cm X 17.5cm 22.5cm X 22.5cm 7.5cm X 7.5cm **Allevyn Gentle Border Lite** 7.5cm X 7.5cm 8.6cm X 7.7cm Oval	 	**Characteristics of the dressing** Hdydrocellular foam dressing, silicone adhesive with a highly permeable film (breathable) to be used on fragile skin, Adhesive to be used on wounds requiring greater security and risk of contamination **Indications for use** For use with patient with fragile skin, Indicated for skin tears **Method of application and removal** Apply directly to the wound bed Do not use primary contact layer unless using an antimicrobial Can be left intact for 7 days Indicator for change is exudate stain within 0.5cm of the foam border of the dressing. **Cautions** **DO NOT UNDER BANDAGING** **As Above**
Allevyn Life 10.3cm x 10.3cm 12.9cm x 12.9cm		**Characteristics of the dressing** Advanced hydrocellular composite foam dressing with superabsorbers and a central mesh to shield visibility of exudate **Indications for use** Chronic Wounds, pressure ulcers, wound moderate to high levels of exudate. Primary or secondary dressing Body contours **Method of application and removal** Apply directly to the wound bed as a primary or secondary dressing of a cavity wound / anti-microbial being used. The dressing can retain its shape over a body contour. **DO NOT CUT** **Caution:** **Do not use on dry necrotic tissue or heel pressure ulcers unless under the advice of the TVN**
Tegaderm foam adhesive Oval 10cm x 11cm		**Characteristics of the dressing** Polyurethane dressing foam dressing with a semi-permeable film backing **Indications for use** For wound with low level so exudate located on body contours or where difficult to dress areas Can be used on dry tissue necrosis on the heel pressure ulcers to protect **Method of Application** Apply directly to the wound as a primary dressing, remove finger backing paper to contour to the wound bed Remove as per film dressings **Caution** None identified

Gelling Fibre dressing		
Durafiber **(alternative to Aquacel)** 10cm X 10cm 15cm X 15cm 5cm X 5cm 4cm X 10cm 1cm X 45cm 2cm X 45cm		**Characteristics of the dressing** Sterile non-woven pad or ribbon dressing composed of cellulose ethyl sulphonate fibres. This highly absorbent and conformable dressing is designed to rapidly form a clear gel on contact with wound fluid. This gel absorbs excess fluid, locks exudate away from the wound to prevent maceration of the surrounding skin. Requires a secondary dressing **Indications for use** Wounds with moderate to high level of exudate Can be used to lightly pack cavity wounds to fill the dead space and absorb exudate Suitable for use under bandaging of lower leg wounds with moderate levels of exudate. **Method of application and removal** **Apply directly to the wound bed** For flat wounds Apply the dressing to the wound and allow for a 1cm / 1/3in. dressing overlap onto the skin surrounding the wound. For cavity wounds, insert in one piece, leave at least 2.5cm / 1in. outside the wound for easy retrieval. Loosely pack deep wounds 85%, as the dressing will expand to fill the wound dressing on contact with wound fluid **Can be left insitu for 7dyas depending on the levels of exudate** **Cautions** DO NOT USE ON LOW LEVEL EXUDING WOUNDS If burning of skin or irritation remove the dressing Should not be used to control heavy bleeding
Hydrocolloid - DO NOT USE ON DIABETIC FOOT ULCERS OR ISCHAEMIC FOOT ULCERS		
Comfeel plus 10cm x 10cm **Comfeel Plus Transparent** 5cm x 7cm DO NOT USE ON DIABETIC FOOT ULCERATION OR NECROTIC TOES OR HEEL DAMAGE	 	**Characteristics of the dressing** Hydrocolloid is a micro-granular suspension of various natural or synthetic polymers, e.g. gelatin or pectin, in an adhesive matrix with an alginate to increase absorption which is interactive when in contact with wound exudate; hydrocolloids slowly absorb fluid, leading to a change in the physical state of the dressing, forming a gel which may be cohesive and/or hydrophilic; this gel swells into the cavity Free from animal products. Bevelled edges to prevent rucking of the dressing. **Indications for use** For wounds with low exudate; appropriate for the treatment of chronic superficial wounds, pressure ulcers and acute wounds, including burns, skin donor sites, and traumatic wounds. Provides an environment for debridement of necrotic wounds thus there may be an initial increase in wound size. **Method of application and removal** Apply directly to the wound bed, warm between the hands prior and after application to facilitate conformability and adhesion of the dressing Apply directly to the wound bed allowing a minimum of 3 cm overlap (excluding border) onto surrounding intact skin. An opaque bubble will be visible prior to removal

		On dressing removal thick pus like exudate maybe visible, this is the components of the dressing **Can be left insitu for 7days depending on the levels of exudate** **Cautions** Not to be used wounds with exposed muscle or bone or necrotic tissue on toes or the feet May cause over-granulation
Retention stocking- Only to used if unsuitable for bandaging		
Actifast – blue line Actifact Yellow line Cotton stockinette	 	**Characteristics** Elasticated 2 way stretch cotton tubular bandage for dressing retention Indication for use Can be used if unsuitable for bandaging and for dressing retention **Method of application** Ensure correct size is used for the limb size **Caution** Sensitivities to elastane **Cotton stockinette to be used under bandaging if sensitivity to K-Soft, do not use routinely**
Dressing sundries –		
Non Woven Swab Sterile Spec 28 (25 packets of 5 swabs per 1 box) Clinipore - Permeable Non-Woven Synthetic Adhesive Tape (1 per pack) Polyfield Sterile Dressing Pack (20 per pack) Small , medium, large Clinipod 25ML		Only use a dressing pack if a cavity wound, consider using sterile gauze and a blue tray using ANTT Sterile gloves are not required, ensure wear an apron. Do not use sterile saline unless cavity wound, warm tap water can be used and is not contraindicated**.**
Pressure ulcer prevention		
Devon convoluted foot and heel protector (pair) Devon convoluted utility pad (pair)		**Characteristics and indications for use** Foam positioning device for the foot that redistributes pressure as part of a pressure ulcer prevention or management of pressure damage to the foot or heel or elbow. The Utility pad can be used to offload pressure from other body locations and to prevent and manage leg contractures. Single patient use only Dispose if soiled or damaged.

Skin barrier - See Guidance document on the use of Barrier products for the prevention of IAD and moisture related skin damage.		
Medi Derma-S Barrier Film 1ml foam applicator 3ml foam Applicator		**Characteristics** Barrier Film is a silicone-based, long-lasting, non-sting medical grade liquid which forms a protective uniform film when evenly applied to the skin **Indications for use** Barrier Film provides long lasting barrier protection on **mild/moderate skin damage**. Its barrier properties protect damaged and intact skin from the harmful effects of moisture, irritants and from potential skin damage that may be caused from the application of adhesive wound dressings or wound wit high level of exudate. It is intended for use as a primary barrier against wound exudate. **Do not apply more than once a day** **Method of application** Apply to the surrounding peri-wound skin for patients at risk of skin damage from exudate or excoriated skin **Caution** Do not use of infected skin or where signs of irritation form the product.
Medi Derma-S Medical barrier cream 90g tube		**Characteristics** Barrier Cream moisturises and protects damaged and intact skin by forming a protective waterproof barrier, preventing irritation from bodily fluids, adhesive products and friction Can be used underneath incontinence pads as it does not block pad absorption **Indications for use** Use a Barrier cream to manage the associated signs and symptoms of incontinence skin damage/moisture lesions, barrier protection on intact skin or for mild skin damage **Method of application** Apply a pea size to the skin twice daily in the morning and evening **Cautions** Do not use on infected skin or signs of irritation form the product
Medi- Derma Pro skin protectant ointment – TVN Guidance **Proshield alternative)- Prescription required**		**Characteristics** **Long Lasting Protection**– Resilient, hydrophobic protective barrier from moisture associated skin damage, 'Tacky' consistency ensures the ointment adheres well to moist skin and wounds. Can be used underneath incontinence pads as it does not block pad absorption. **Indications for use** For moderate to severe moisture related skin damage, moisture lesions and Category 2 pressure ulcers to the sacrum **Method of application** Apply a thick layer to the damaged skin at each incontinent episode. **Cautions** As above

Antimicrobial TVN advice only – See Antimirobial guidance document DO NOT ORDER ROUTINLEY FROM ONPOS		
Acticoat Flex 3 5cm x 5cm 10cm x 10cm		**Characteristics of the dressing –Use only for 2 weeks and review maximum 4 weeks treatment** Antimicrobial barrier low adherent dressing which contains Nanocrystalline silver, this delivers silver quickly into the wound bed, effective against a broad spectrum of microbes and fungi – Effective for 3 days **Indications for use** Wounds showing clinical signs of local and systemic infection i.e. increased exudate, painful wound, stalled healing. May be used prophylactically for high risk patients under the direction of the **TVN, PODIATRIST** **Method of application** Ideal for packing, filling and conforming to difficult anatomical areas. Can be moistened with tap water**. DO NOT USE SALINE AS INACIVATES THE SILVER** **Cautions** Do not use on patient sensitive to silver Remove if patients are undergoing an MRI or radiation therapy
Iodoflex Paste 5g **DO NOT USE MORE THAN 150G PER WEEK** **SHOULD NOT BE USED GREATER THAN 3 MONTH** **See cautions**		**Characteristics of the dressing** CADEXOMER Iodine dressing, Iodine is contained in a starch lattice which is slowly released into the wound when in contact with exudate. Able to absorb moderate levels of exudate. **Indications for use** For patient with local or stalled healing showing signs of infection or chronic wounds failing to progress (see biofilm pathway) Can be used to deslough a wound and has a broad spectrum against bacteria and fungi. **Method of application** Remove the outer carrier dressing (gauze lattice) apply directly to the size of the wound, can be moulded to the wound. Effective for 3 days, the indicator for change is the dressing turns white leaving the starch in the wound. To remove irrigate with tap water to remove **Cautions** Do not use on dry necrotic tissue or on patients with a known sensitivity to any of its ingredients Do not use on children, pregnant or lactating women or people with thyroid disorders or renal impairment There is a potential risk of interaction with lithium, resulting in an increased possibility of hypothyroidism Do not use IODOFLEX or IODOSORB concomitantly with mercurial antiseptics and taurolidine Do not use IODOFLEX or IODOSORB in the vicinity of the eyes, ears, nose or mouth IODOFLEX or IODOSORB may cause transient smarting especially in the first hour after treatment

Prontosan Pod 40ml x 6		**Characteristics of the dressing – Use as part of the Biofilm pathway** Wound cleansing agent, acts as a The surfactant component (betaine) of the cleansing agent reduces surface tension and aids removal of debris an bacteria by irrigation. **Indications for use** To be used as part of the biofilm pathway for chronic wound with stalled healing as part of the biofilm pathway. **Method of application** Applied as a soak on gauze applied directly to the wound to be left insitu for 15 minutes **– DO NOT USE ROUTINLEY** **Cautions** Allergy or sensitivity to the products
Cutimed Sorbact Swab 7cm x 9cm		**Characteristics of the dressing** A DACC coated dressing (hydrophobic fatty acid derivative) which is hydrophobic attracts the bacteria to the dressing and binds them when in contact with moisture. **Indications for use** For use as part of the anti-microbial pathway, for chronic wounds which frequently recolonise the wound and stall healing, used prophylactically for high risk patients. **Method of application** Apply directly to the wound, folded or unfolded **Cautions** **None**
Inadine 5cm x 5cm		**Characteristics of the dressing** Non-adherent dressing impregnated with 10% Providone Iodine DO NOT USE AS A ROUTINE ANTIMICROBIAL as ineffective on contact with exudate **Indications for use** For use on areas of tissue necrosis to the feet and digits where debridement is contraindicated. provide bacterial barrier and too dry tissue to facilitate a necrotic - **Method of application** Apply directly to the wound Requires a secondary dressing **Cautions** Do not use on patient sensitive to Iodine Before or after the use of radioactive Iodine Renal and lactating women or patient with Thyroid disease **DO NOT USE ON CHILDREN**