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

Wound Formulary

HANDBOOK

March 2022

Wound Formulary March 2022

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

Introduction

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

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

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

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

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

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

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

General References sources: BNF, SHIP Guidelines for Antibiotic Prescribing in the Community 2018, Journal of Wound Care Handbook www.woundcarehandbook.com, www.worldwidewounds.com, www.evidence.nhs.uk, www.nice.org.uk, www.sign.ac.uk www.tissueviabilityonline.com , www.ewma.org, www.britishjournalofnursing.com, www.wounds-uk.com/pdf/content_9364.pdf, Drug Tariff February 2022

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Product Type	Product Name	Size	Cost/ Dressing	Comments
1. NON/LOW ADHERENT DRESSINGS	Atrauman®	5x5cm 7.5x10cm 10x20cm 20x30cm	35p 36p 83p £2.28	Knitted polyester dressing impregnated with neutral triglycerides. May not be suitable for patients with sensitivities to coconut or its derivatives. Consider Tricotex® for patients with coconut allergy. 1. Consider Mepitel® for large skin tears where the skin flap needs immobilising. 2. Tricotex® is suggested as an alternative for simple non adherent dressings NB An Exception reporting form will be needed in both instances. **Please store flat to avoid sticking** **Choice of dressing for use under topical negative pressure is determined by local specialist advice**
	Softpore®	6x7cm *(3x4cm)* 10x10cm *(5x6cm)* 10x15cm *(5x10cm)* 10x20cm *(5x15cm)* 10x25cm (5x20cm) 10x30cm *(5x25cm)* 10x35cm *(5x30cm)*	6p 13p 20p 35p 40p 49p 58p	Not to be used on fragile skin. For minor superficial wounds where all that is required is protection from friction. Can be used as a post op dressing which may stay in place 3 – 5 days. Wound contact pad size in brackets
2. ADHESIVE FILM Vapour permeable film	Hydrofilm®	6x7cm 10x12.5cm 10x15cm 10x25cm 12x25cm 15x20cm 20x30cm	24p 44p 56p 86p 91p £1.02 £1.69	Dry, non-infected wounds; retention of lines; fixation of secondary dressings. NB: management of IV sites – refer to local guidelines

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Product Type	Product Name	Size	Cost/ Item	Comments
Management of critically colonised and infected wounds Appendice 4a, 4b, 4c and 4d for Wound Infection Continuum, Check List, Wound Infection Flowchart and guidance on choice of dressings. All antimicrobial dressings should be used for two weeks only. Expert specialist advice and guidance should be sought if antimicrobial dressings are required for a longer period. NB: some antimicrobial dressings to be cut to size of wound. Do not apply to intact skin except for Medihoney HCS				
3. TOPICAL ANTIMICROBIALS **a. Iodine based**	Inadine®	5x5cm 9.5x9.5cm	34p 50p	Non-adherent dressing impregnated with 10% povidone-iodine. Colour change indicates when to change dressing. Management and prevention of infection in ulcers, minor burns and minor traumatic skin injuries. Not effective in medium to heavy exudate.
	Iodoflex®	5g 10g	£4.34 £8.66	Cadexomer dressing with iodine. For the treatment of chronic exuding wounds. Not to be used on dry necrotic tissue. **Can apply up to 50g per dressing change, cover with secondary dressing; change when paste is saturated. Do not exceed 150g Iodoflex® paste in one week or more than 3 months single course of treatment. BE AWARE OF CONTRAINDICATIONS FOR USE.** See SPC and BNF https://bnf.nice.org.uk/wound-management/iodine.html
b. Honey	Medihoney® Antibacterial Medical Honey	20g (single use only)	£4.03	Medical honey. Useful on sinus wounds. Indicated for infected or critically colonised wounds. Can be effective if malodour present, as a desloughing agent or in the treatment of necrotic wounds.
	Medihoney® Tulle dressing	10x10cm	£3.03	Strong woven dressing impregnated with antibacterial honey, sterile. For superficial wounds.
	Medihoney® Antibacterial Honey Apinate	5x5cm 10x10cm 1.9x30cm	£2.04 £3.46 £4.28	Non-adherent, non-absorbent, protease modulating matrix, sterile. Contains calcium and antibacterial Honey
	Medihoney® HCS Adhesive	6x6cm 11x11cm 11x11cm	£2.28 £4.55 £3.11	An all-in-one dressing that combines 63% Medihoney in a hydrogel dressing with a superabsorbent polymer. The adhesive dressing does not require a secondary dressing. For dry to moderately exudating wounds. Other sizes for specialist use only

Product Type	Product Name	Size	Cost/ Item	Comments
c. Topical Antimicrobials (cont) PHMB	Suprasorb X + PHMB®	5x5cm 9x9cm 14x20cm 2x21cm	£2.70 £5.37 £12.22 £7.61	Light to moderately exuding, superficial and deep, critically colonised and infected wounds. Bio-cellulose dressing impregnated with broad-spectrum antimicrobial (PHMB (polyhexamethylene biguanide 0.3%). Can be effective if the wound is infected and painful.
d. Irrigation	Prontosan®	350ml bottle 40ml x 24 pod	£5.09 £15.11 (24 pods)	Wound irrigation solution containing Betaine which is a gentle effective surfactant which penetrates, disturbs and removes biofilm and wound debris, and PHMB to help control bacterial levels on the wound. **Note: for single patient use the 350ml bottle is more cost effective and has a shelf life of 8 weeks once opened. Prontosan® pods should be reserved for acute use only.**
	Prontosan®	30ml gel	£6.80	Cleansing, decontamination and moisturising of acute and chronic skin wounds, first and second degree burns. (Impregnated with dialkylcarbamoyl chloride)
e. Antimicrobial wound contact layer	Cutimed Sorbact® swab	4x6cm (11x16cm) 7x9cm (17x27cm)	£1.76 £2.93	DACC-coated, hydrophobic, antimicrobial wound contact layer designed to bind bacteria under moist wound conditions. The dressing can be used folded or unfolded. Primary dressing for contaminated, colonised or infected superficial or deep wounds including superficial wounds, traumatic wounds, postoperative or dehisced wounds, ulcers (venous, arterial, diabetic, pressure) and fungal infections. Suitable for fungal infections in the groin, skin folds, or between digits.
f. Silver	Durafiber Ag®	5x5cm 10x10cm 15x15cm 2x45cm 4x10cm 4x20cm 4x30cm	£1.88 £4.47 £8.41 £4.48 £2.72 £3.54 £5.30	A highly absorbent, non-woven, silver gelling fibre dressing composed of a blend of cellulose-based fibres. Dressing fibres coming into contact with exudate swell and form a soft cohesive gel sheet. Exudate is locked in the dressing structure. Use as a primary dressing for moderately to highly exuding wounds where there is infection.

Product Type	Product Name	Size	Cost/ Item	Comments
4. ODOUR CONTROL ***NB: charcoal is not effective once wet***	Clinisorb®	10x10cm 10x20cm 15x25cm	£2.01 £2.68 £4.31	Sterile activated charcoal cloth sandwiched between layers of nylon/viscose rayon cloth. Apply as a secondary dressing over an appropriate primary dressing. Exudate will reduce the dressing's effectiveness. Can be cut to size. Can be used in the management of malodorous wounds such fungating wounds, pressure ulcers, leg ulcers and diabetic foot ulcers. May wish to consider using Anabact® (non-formulary).

Product Type	Product Name	Size	Cost/ Item	Comments
5. ALGINATES NB: Kaltostat® On contact with a bleeding wound, promotes haemostasis but should not be left in place. Local guidance is to leave for 10 mins and then remove. Kaltostat® is non-formulary. *NB: use only where you can see the base of the wound as fibres/dressing can be left in situ'*	Suprasorb A® Suprasorb A® Rope	5x5cm 10x10cm 2g(30cm)	66p £1.29 £2.40	Calcium alginate primary dressing for use in shallow, moist wounds. For management of moderately or heavily exuding wounds. Secondary dressings are required to support the alginate in situ and maintain a moist environment. Is easily removed by irrigation. For exudate management and wound healing of large open or cavity wounds.
6. GELLING FIBRE DRESSING	Exufiber®	5x5cm 10x10cm 15x15cm 20x30cm 1x45cm 2x45cm 4.5x10cm 4.5x20cm 4.5x30cm	86p £2.08 £3.90 £9.05 £1.65 £1.87 £1.13 £1.66 £2.51	For infected/heavily exudating wounds. Do not use on a dry or low exudating wound. Requires secondary dressing. Strong polyvinyl alcohol (PVA) fibres that are entangled together in all directions, as well as mechanically secured to each other, providing high wet integrity (Hydrolock®Technology). Locking properties of the PVA technology, and the even space between the fibres, minimises free fluid inside the product, give it high absorption and retention capacity. Apply in a cavity wound or on shallow wounds. Should overlap the wound margins.

Product Type	Product Name	Size	Cost/ Item	Comments
7. HYDROGEL **NB: cut to size and do not place on intact skin**	IntraSite Conformable®	10x10cm 10x20cm 10x40cm	£1.92 £2.60 £4.64	Primarily indicated for treatment of necrotic and sloughy wounds, e.g. leg ulcers, pressure ulcers and non-infected diabetic foot ulcers. Effective for desloughing and debriding wounds. For dry 'sloughy' or necrotic wounds, lightly exudating wounds, granulating wounds and cavities. Not suitable for infected or heavily exudating wounds. Secondary Dressings required. IntraSite Conformable® is a hydrogel sheet. It has the added advantage of being bacteriostatic due to its propylene glycol content. It can be shaped to fit the wound so reducing the risk of maceration.
Non adhesive	KerraLite Cool®	6x6cm 8.5x12cm	£1.82 £2.68	Consider when pain is a significant factor.
Adhesive		8x8cm 11x11cm 15x15cm	£2.10 £2.80 £4.46	Soothing, debriding and moisture-balancing gel dressing. Manages wound exudate levels and protects against wound dehydration and external bacterial contamination. The gel provides both cushioning and absorption For use on chronic wounds, painful wounds, and skin conditions such as leg ulcers, radiation therapy damage, burns and scalds. May be used on low-exuding and non-exuding wounds to assist in autolytic debridement by hydration of necrotic and sloughy tissue and for absorption of exudate.

Product Type	Product Name	Size	Cost/ Item	Comments
8. FOAM DRESSING	Kliniderm® Foam Silicone	7.5x7.5cm 10x10cm	94p £1.23	For use on moderately exuding wounds.
Adhesive	Border	12.5x12.5cm 15x15cm 10x20cm 15x20cm	£1.79 £2.70 £3.15 £4.65	A soft, conformable absorbent polyurethane foam dressing with an adhesive silicone wound contact layer and a moisture permeable film backing. Foam dressings should be left in place for up to 7 days. Their mode of action means exudates will be visible but this does not mean the dressing requires changing. Change when strike through 1cm from edge.
Non adhesive	Kliniderm® Foam Silicone	5x5cm 10x10cm 10x20cm 15x15cm 20x20cm	78p £1.68 £2.58 £3.11 £4.44	**Foam dressings should not be used for pressure relief**
Adhesive	Biatain® Silicone	7.5x7.5cm 10x10cm 12.5x12.5cm 15x15cm	£1.53 £2.26 £2.76 £4.10	A soft, absorbent polyurethane foam pad with a vapour-permeable film backing and a silicone adhesive border.

Product Type	Product Name	Size	Cost/ Item	Comments
9. HYDROCOLLOIDS Sterile, thin hydrocolloid dressing.	DuoDERM® Extra Thin	5x10cm 7.5x7.5cm 10x10cm	81p 85p £1.41	To aid debriding, promote granulation, occlusive barrier. For light to medium exudating wounds ONLY. Ensure correct size of dressings applied; overlap the wound by at least 2cms N.B. Odour from the dressing constituents can be a concern to patients. Not suitable for infected wounds unless observed frequently. **Not indicated routinely on diabetic foot wounds- contact local Diabetic/Foot Protection Team for advice.**
	Comfeel® Plus Ulcer	4x6cm 10x10cm 15x15cm	£1.01 £2.56 £5.50	Absorbent hydrocolloid dressing with added alginate for absorption, a vapour-permeable film backing and bevelled edge.
10. PASTE BANDAGES	Ichthopaste®	7.5x6m	£3.92	Chronic eczema/dermatitis where occlusion is indicated. Zinc paste and ichthammol bandage. Ensure any residue is removed before rebandaging. Patch testing required prior to use. To be applied as per manufacturer's instructions and not as a primary dressing or as a patch.

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Product Type	Product Name	Size	Cost/ Item	Comments
11. BANDAGES				
a) Light weight conforming bandages				
Padding	Ultra Soft®	10cmx 3.5m	39p	Sub compression padding bandage used to protect the limb and for shaping if required.
	Ultra Lite®	10cmx4.5m	86p	This bandage should be used as an alternative to K Lite where there are symptoms of, or identified arterial disease present in the lower leg.
	K-lite®	10cmx4.5m	£1.05	For 2nd-line use after Ultra Lite®
Elasticated viscose stockinette	CliniFast® /Comfifast®	3.5cmx1m 5cmx1m 7.5cmx1m 10.75cmx1m 17.5cmx1m	56p 58p 77p £1.20 £1.83	Red line Green line Blue line Yellow line Beige line Also available in 3m and 5m lengths for green, blue and yellow line, which may be more cost effective.

Please see Local Leg Ulcer Treatment Algorithm

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

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

11. BANDAGES (cont'd)				Cohesive short stretch bandages for single use and adapted according to ankle circumference. Can be worn for up to 7 days. Recommended in patients with an ABPI of > 0.8.
b) Short stretch compression bandages providing full and reduced compression.	Actico® (not latex free)	10cmx6m	£3.56	10cm is width for routine below knee leg ulcer bandaging. 8 and 12 cm Actico bandages are for use in patients with chronic oedema . 8cm should be applied to the foot and 12cm to the thigh.
	Actico® (not latex free)	8 cmx6m 12cmx6m	£3.43 £4.54	
	Coban® 2 layer compression system	10 cm x 3.5m	£8.40	The Coban 2 bandage system is the second line choice short stretch bandage system for patients requiring full compression where Actico is considered inappropriate, known latex allergy, or slippage may be a concern. This system is designed to be used as a kit and should not be used with other wadding or bandages. Two-layer compression system that delivers sustained, therapeutic compression. To be used as a kit comprising of the latex-free foam padding layer and a latex-free cohesive, compression bandage. After application the two layers bond to form a single-layer bandage. Can be worn for up to 7 days. Recommended in patients with an ABPI of > 0.8. 10cm is the bandage width for routine below knee bandaging.

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

11. BANDAGES (cont'd) b) Short stretch compression bandages providing full and reduced compression.	Coban® 2 Comfort Foam Layer (layer1)	10cmx3.5m	£7.68	Individual components of Coban 2 bandage kit. These may be required for the larger/ longer leg.
	Coban® 2 Compression Layer (layer 2)	10cmx4.5m	£4.95	
	Coban® 2 Comfort Foam Layer (layer1)	15cmx3.5m	£11.68	
	Coban® 2 Compression Layer (layer 2)	15cmx4.5m	£7.37	The Coban® 2 15cm width bandage should be used for bandaging the knee and thigh of patients with chronic oedema.

Please see Local Leg Ulcer Treatment Algorithm

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

11. BANDAGES (cont'd) b) Short stretch compression bandages providing full and reduced compression.	Comprilan® (Latex free)	10cmx5m	£3.59	Reusable system (washable). High cotton content. For specialist chronic oedema management.
c) **Chronic oedema**	Actico® (not latex free)	8cmx6m 10cmx6m 12cmx6m	£3.43 £3.56 £4.54	
	Comprilan® (Latex Free)	10cmx5m	£3.59	
	Coban® 2 layer compression system	Multi-layer compression bandage kit 10cm x 3.5m	£8.40	Bandages of choice for lymphoedema/chronic oedema management. Two-layer compression system that delivers sustained, therapeutic compression to be used as a kit comprising of latex-free foam padding layer and a latex-free, cohesive, compression bandage. Apply the two layers which bond to form a single-layer bandage. Can be worn for up to 7 days. Recommended in patients with an ABPI of > 0.8.
	Coban® 2 Comfort Foam Layer (layer1)	10cmx3.5m	£7.68	
	Coban® 2 Compression Layer (layer 2)	10cmx4.5m	£4.95	

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

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

Product Type	Product Name	Size	Cost/ Item	Comment
12. SUPPORT HOSIERY Hosiery for Chronic oedema/lymphoedema /prevention or maintenance of venous disease **RAL standard hosiery** **Class 1 18-21mmHg** **Class 2 23-32 mmHg**	Jobst Opaque®	Available in below knee and thigh high with a choice of silicone bands to prevent slippage at thigh 1 stocking per prescription item. Variety of colours, sizes, open and closed toe. Also available as tights.	Below Knee £28.37 per pair Thigh Length £53.90 per pair	The choice of hosiery selected, depends on therapeutic need, comfort, cosmetic appearance and ease of application. The Formulary Group deems Jobst® (Essity) to be the preferred hosiery products. These products increase the lymphatic return and (if indicated), aiding the absorption of excess limb fluid in chronic oedema.They can help in the management plan of preventing occurrence or recurrence of ulceration and associated venous conditions. They have a higher 'Stiffness Index' (which aids stimulation to lymph to encourage fluid return) and can last up to 6 months before replacing if undamaged. RAL Class 1 provides mild compression for early mild oedema with little leg distortion. Suitable for chronic oedema, early stage lymphoedema, lipoedema, prophylaxis, maintenance therapy and, palliative use. RAL Class 2 provides compression for moderate to severe chronic oedema/lymphoedema, ulcer prevention or maintenance of healing where resistant oedema has occurred and/or some shape distortion. **References:** https://www.nationalwoundcarestrategy.net/lower-limb/ Best Practice Statement Compression hosiery A patientcentric approach - Wounds UK (wounds-uk.com) Legs Matter consensus document - Legs Matter
RAL standard sock **Class 1 18-21mmHg** **Class 2 23-32 mmHg**	Jobst for men Explore®	Available in below knee closed toe in a range of colours and sizes. Available in regular and long.	Below knee £29.58 per pair	

Please see Local Leg Ulcer Treatment Algorithm

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

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

Product Type	Product Name	Size	Cost/ Item	Comment
12. SUPPORT HOSIERY (contd)				
Hosiery Kit	Jobst Ulcer Care® Hosiery Kit (with zip option)	1 Stocking and 2 liners	£33.26	Medical Stocking & Compression Liner. Available as small, medium, large, X large, XX large, XXX large and XXXX large.
	Jobst Ulcer Care ® Liner Pack	3 Liners	£20.08	Liner pack available in all sizes. **References:** https://www.nationalwoundcarestrategy.net/lower-limb/ Best Practice Statement Compression hosiery A patientcentric approach - Wounds UK (wounds-uk.com) Legs Matter consensus document - Legs Matter Lower Limb | AHSN Network
Class 1 BRITISH hosiery Mild Support Compression at ankle 14-17mmHg	Activa®	Below knee Thigh length	£7.92 £8.67	**Only to be used as mild compression when there is no oedema present.**
Accessories	Acti-Glide® Compression hosiery application system		£15.41	Supply of single unit only.
Waterproof Protector	LimbO®	Standard and short ½ leg	£10.56	Available as slim, normal and large build.

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Product Type	Product Name	Size	Cost/ Item	Comment
13. ADHESIVE TAPES Non-woven synthetic	Clinipore®	1.25cmx5m 2.5cmx5m 5cmx5m	36p 61p £1.02	Permeable non-woven synthetic adhesive tape
	Hypafix®	2.5cmx10m 5cmx5m 10cmx5m	£1.75 £1.50 £2.52	To be used only when Clinipore® is deemed unsuitable. A skin-friendly, non-woven tape used for wide-area dressing fixation
14. ABSORBENT DRESSINGS	Zetuvit®	10x10cm 10x20cm 20x20cm 20x40cm	23p 26p 41p £1.16	Absorbent and protective. Used as a secondary dressing. NB community nurses can obtain Surgipads® from central stores.
Hyper-absorbent Adhesive Dressing	Allevyn Life®	12.9x12.9cm 15.4x15.4cm	£2.64 £3.23	For use on high exudating wounds where a wear time of 5 – 7 days is required.
Super Absorbent Dressing	Kliniderm Superabsorbent®	10x10cm 20x20cm 10x15cm 10x20cm 20x30cm 20x40cm	49p 99p 69p 85p £1.49 £1.99	.

Product Type	Product Name	Size	Cost/ Item	Comments
15. MISCELLANEOUS				
Sterile Skin Closures	Leukostrip®	6.4x76mm	£6.73 (10x3 strips)	Available on FP10, more cost effective than Steri-strip®.
Dressing Packs	Polyfield® Nitrile® Patient Pack		52p	Sterile dressing pack containing powder-free nitrile gloves, laminate sheet, 7 non-woven swabs, towel, apron and disposable bag.
	Nurse It® dressing packs		81p	Pair of powder-free latex vinyl gloves, 7 non-woven swabs, 1 compartment tray, disposable forceps, laminated paper sterile field, large apron, paper towel and white polythene disposable bag.
Non-woven Fabric Swab	sterile (5 pack)	7.5x7.5cm	28p	Use for general purpose swabbing and cleansing.
Sodium Chloride	Clinipod®	20ml x 25	£4.80	**Normal Saline** – is the irrigation solution of choice. All irrigation solutions should be applied at body temperature. Tap water only to be used according to local policy for leg washing and all chronic and acute wounds will be cleansed with a sterile, single use solution, if required.
Gauze and Cotton Tissue	Gamgee® Drug Tariff (Pink)	500g	£5.74	**Gamgee® -** For use to absorb large amounts of exudate. Not to be used as primary dressing. If used in leg management always pad OUTSIDE the bandage to maintain adequate pressures (if compression) to the leg. Can be cut to size if required.

Product Type	Product Name	Size	Cost/ Item	Comments
15. MISCELLANEOUS (cont'd)				Please refer to local formulary/dermatological guidance for detailed product list and advice. Table of all the products can be found in MIMS and includes the potential sensitisers. http://www.mims.co.uk/Tables/882437/Emollients-Potential-Skin-Sensitisers-Ingredients/
Skin Protectant	LBF® Sterile No Sting Barrier Film	5x1ml 5x2ml	£4.08 £5.34	To protect surrounding skin in high exudate wounds to prevent maceration. For use over excoriated skin and around stomas. Use in moist areas where it is difficult to get dressing adhesion. When used appropriately LBF® reduces wound trauma. The 2ml LBF stick, when evaluated was found to provide adequate coverage in comparison to a 3ml stick. *(Medi Derma S may be selected at the discretion of local trusts following guidance from their procurement team)*
Potassium permanganate	Permitabs®	30	£23.65	Adjunct therapy only. Short-term treatment for wet weepy, infected or eczematous legs. One tablet dissolved in 4 litres of water. Indicated for short term use only. **Maximum of 2 weeks** in conjunction with assessment to ascertain cause of infection or weeping and treat underlying cause. **Warn patients about staining. If treating feet suggest using white soft paraffin around the toe nails to reduce staining.** Please see Permitabs leaflet for further information and guidance at link below http://www.southernhealth.nhs.uk/_resources/assets/inline/full/0/100606.pdf

APPENDIX 1

ASEPTIC NON TOUCH TECHNIQUE

Refer to organisational policy

APPENDIX 2

Bacteriological sampling from a wound bed should be taken using the best method available e.g. biopsy, aspiration, scraping or swab.

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

Bacteriological swabs should only be taken when there is clinical evidence of infection in a wound (see appendices 4a, 4b and 4c). For example

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

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

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

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

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

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

Ref: Patten, H. (2010) Identifying wound infection: Taking a swab. Wound essentials.64-66
SCAN Guidelines for Antibiotic Prescribing in the Community 2018 page 59

Best Practice in Older Person's Skin Care

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

Aim: To Maintain the Integrity of the Skin

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

Dry & vulnerable skin

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

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

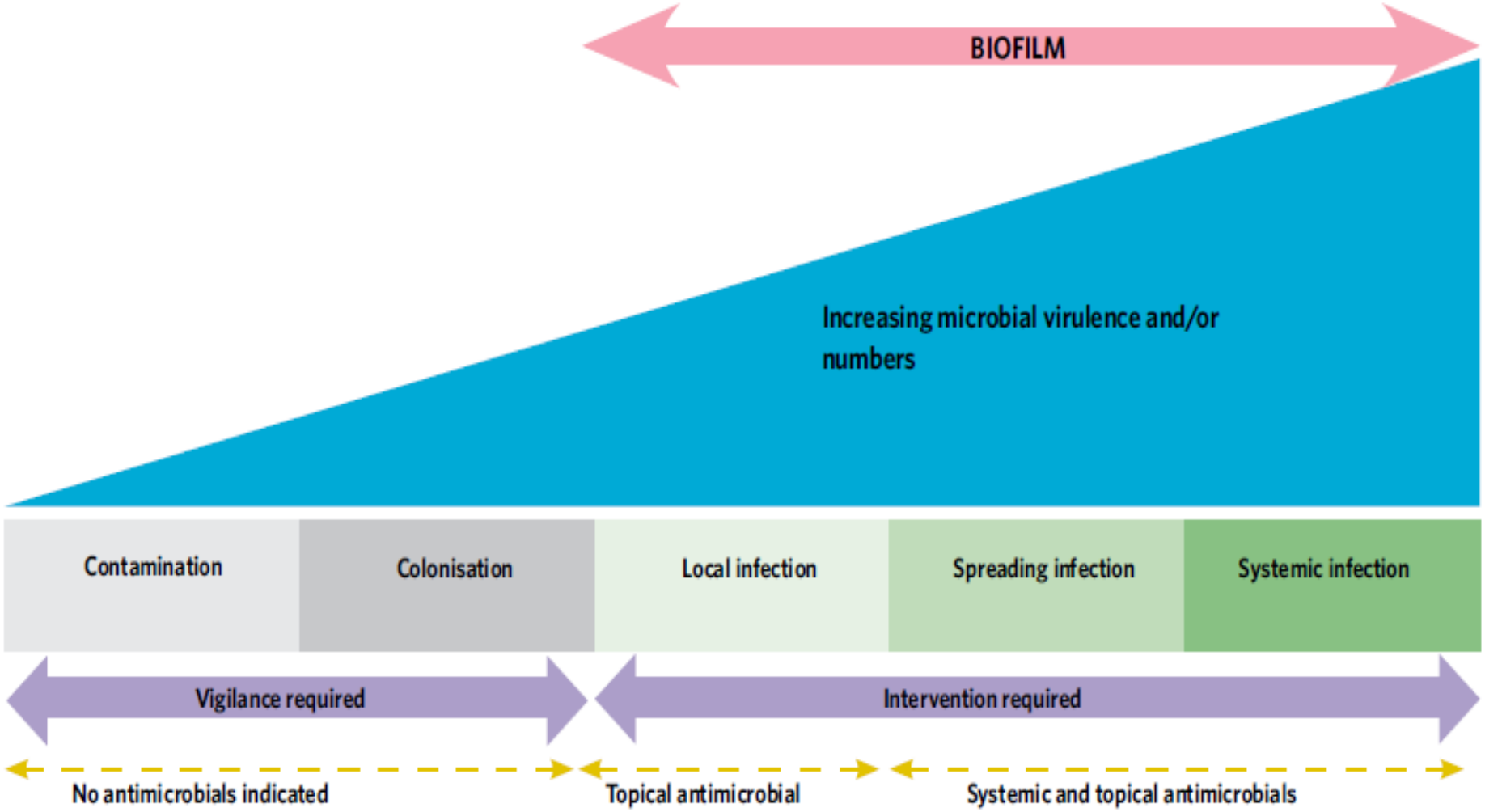
Damage related to moisture from maceration & incontinence
Excess fluid on the skin from wounds, sweating, urine and/or faecal incontinence and peri-stomal exudate are likely to increase the damage to the skin causing maceration. Excessive moisture due to urine/faecal incontinence can lead to skin damage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

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

Risk of Severe and Fatal Burns with Paraffin containing and Paraffin-free emollients – MHRA Dec 2018
Warnings about the risk of severe and fatal burns are being extended to all paraffin-based emollients regardless of paraffin concentration. Data suggest there is also a risk for paraffin-free emollients. Advise patients who use these products not to smoke or go near naked flames, and warn about the easy ignition of clothing, bedding, dressings, and other fabric that have dried residue of an emollient product on them. (See link below for more information)
https://www.gov.uk/drug-safety-update/emollients-new-information-about-risk-of-severe-and-fatal-burns-with-paraffin-containing-and-paraffin-free-emollients

Appendix 4a

Wound infection continuum



The wound infection checklist

This checklist places the signs and symptoms of the wound infection continuum categories into a checklist to act as a prompt to aid diagnosis and treatment of wounds.
It is anticipated that this will enable appropriate use of antimicrobial dressings and reduce the use of antibiotics
This is not a validated tool but based on practical experience and information from the International Wound Infection Institute Consensus Document 2016

How to use the checklist

- Identify the signs and symptoms exhibited by the patient through observation and listening to the patient's story.
- Check blood results. Initiate FBC and CRP, if no recent investigations have been undertaken, when wound enlargement /deterioration is identified.
- Tick the signs and symptoms identified ensuring that they are ticked in **every** column in which they appear
- Decide which stage of the wound infection continuum the wound falls into as follows:

    1. **A tick in the top grey *italic box* gives the best indication as to where the wound is on the wound infection continuum**
    2. **If no tick is present in the top *italic box,* then the most ticked column indicates the stage of the wound infection continuum that the wound is in**
    3. **If there is no tick in the top italic box and an equal number of ticks in more than one column the most severe wound infection continuum should be picked**

- Having established what stage of the wound infection continuum is present use the wound infection flowchart to guide treatment options

CLINICAL FINDINGS SHOULD OVERIDE THIS CHECKLIST AT ALL TIMES

Ref: International Wound infection Institute. *Wound infection in clinical practice*. Wounds International 2016
Young T (2010) Managing the 'at risk' patient: minimizing the risk of wound infection. *British Journal of Nursing* (*Supplement* .S1-S12).Information within this article is adapted from the Sign Checker Tool with kind permission of Andrew Kingsley cited in Young 2010

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Appendix 4b WOUND INFECTION CHECKLIST

Signs and symptoms exhibited by individuals as wound infection emerge (Please use in conjunction with local antibiotic guidelines)

symptoms in isolation are not indicative of spreading infection

Contamination/Colonised	✓	**Local Infection** *Subtle signs*	✓	***Local infection*** *Classic signs.* *In addition to the signs noted in column "***Local infection** *subtle signs " the following signs may be present* * Diabetics and patients who are immunocompromised may not show the classic signs of infection. For these patients consider subtle signs of infection to identify early signs of infection.	✓	**Spreading Infection** Signs of local infection together with the symptoms below	✓	**Systemic Infection**	✓
Expected wound progression		***Wound enlargement/ deterioration in wound bed appearance***		***Local erythema spreading <2cm from wound margin*** ***Wound enlargement/deterioration in the wound bed***		***Erythema spreading >2cm from wound margin***		***Severe sepsis***	
		Delayed wound healing		Local swelling /warmth		Inflammation/swelling of lymph glands		Septic shock	
Necrotic tissue/thick slough present but debriding as expected		Friable/unhealthy looking granulation tissue		New /increased necrosis		Wound breakdown with or without satellite lesions		Organ failure	
		New/increased pain		Purulent discharge		Malaise/lethargy		Bacteraemia	
Mobile slough present		New/increased odour				Non-specific physical deterioration			
		Bridging and pocketing in granulation tissue				Loss of appetite			
Exudate appropriate to stage of wound healing		Overgranulation				Delayed wound healing with or without erythema			
		Thick non responsive slough or slough that is fast to return				Haemorrhagic patches/spots			
		Raised or increased White Cell Count				*Pyrexia/rigor			
Normal granulation tissue present		Raised or increased CRP				*Confusion			
		Blue/green exudate				Altered NEWS (or local scoring system)			
Epithelial tissue evident		Increased exudate which may cause dermatitis to the periwound area.				Rapid deterioration in wound bed.			
Decrease in size in 1 – 2 weeks						Blistering			

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Appendix 4c

Wound Infection Flowchart

THIS CHART SHOULD NOT BE USED FOR DIABETIC PATIENTS, PATIENTS WITH PERIPHERAL VASCULAR DISEASE OR THOSE WHO ARE IMMUNOCOMPROMISED

Diabetes Foot Ulceration *–* ***Refer*** *all patients with an active ulcer* ***within 24 hours*** *to your local Diabetes Foot Protection team.*

Early referral to specialist teams for diabetes management, offloading, debridement and appropriate wound-care, which all are key to achieve the best outcome.

As per wound formulary

Contamination / Colonised

Using 'SignChecker' regularly to monitor wound progress

Local Infection

Select appropriate antimicrobial dressing
Monitor closely

- Good clinical outcome → Discontinue antimicrobial dressing after 2 weeks and monitor
- No improvement after 10—14 days consider an alternative → If wound remains unchanged or deteriorates consider commencing antibiotics → If no improvement at 7 days take a sample from the wound bed using the best method available e.g. biopsy, scraping, swab, or aspiration

Spreading Infection

Check if recent wound swab results available.
Ensure antibiotics reflect sensitivities.
If swab was not taken, ensure one is taken now and antibiotics commenced.
Check results to ensure antibiotics are correct

- Good clinical outcome → Continue with antibiotics as appropriate. Follow local guidelines
- If improvement not noted or wound has deteriorated, check further for signs of systemic infection at each contact, i.e. *NEWS or similar. → If wound or patient deteriorates further, seek urgent medical opinion

Systemic Infection

Seek urgent medical opinion

NEWS-National Early Warning Score Royal College of Physicians (working party 2012)
SHFT Physical Observation Policy

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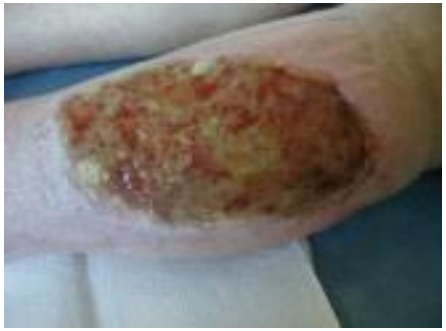
Appendix 4d

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



Critically Colonised or Infected Wounds

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

Description
See **Wound Infection Checklist** and **Sign Checker Flowchart** for identification

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

Presentation - refer to Wound Infection Checklist and **Sign Checker Flowchart**.

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

Secondary dressing – absorbent dressings such as **Zetuvit or Kliniderm Superabsorbent**

Factors to consider – Clinisorb for odour control

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

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

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

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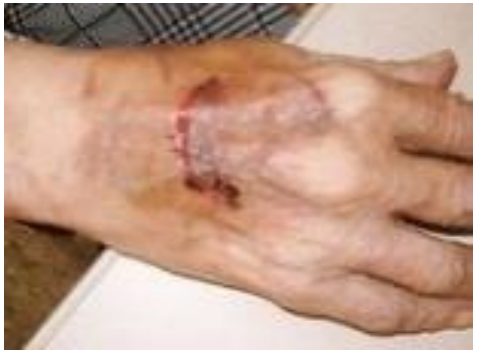
Appendix 5 Product Selection Tools

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



Skin Tears

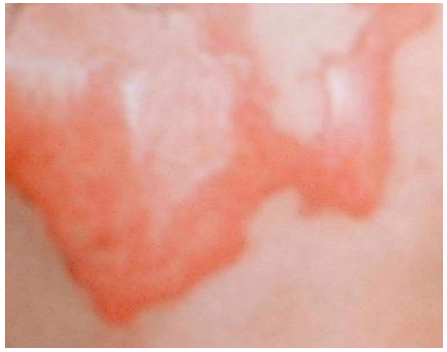
Presentation- Superficial or traumatic wound, where the skin rips, commonly occurs in the elderly and the dehydrated

Aims- Promote atraumatic removal prevents infection, cover and protect

Treatment – Clean with **normal saline**

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

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



Superficial Burns/Scalds

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

Aims – To cover and protect & minimise scarring

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

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

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

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

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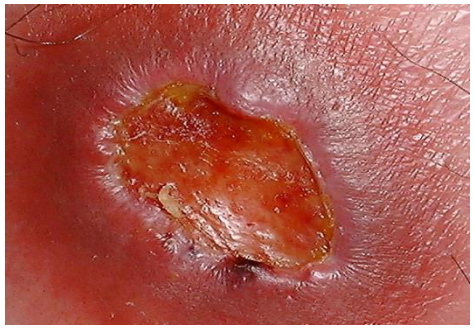
Diabetes Foot Ulceration – **Refer** all patients with an active ulcer **within 24 hours** to your local Diabetes Foot Protection team. Early referral to specialist teams for diabetes management, offloading, debridement and appropriate wound-care, which all are key to achieve the best outcome.

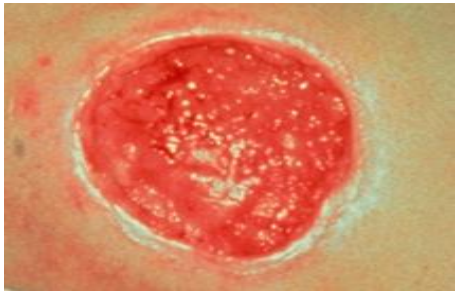


Epitheliasing Wounds

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

Aim - Protect new tissue and support wound closure

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



Granulating Wounds

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

Aim – To promote healing and support wound to epitheliasing stage

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

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

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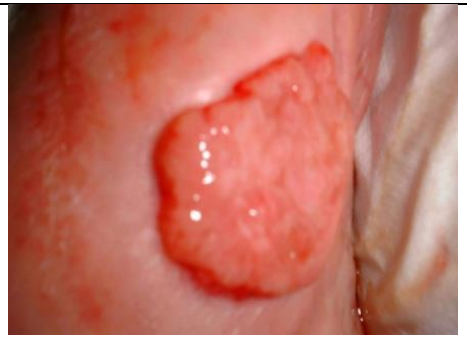
Diabetes Foot Ulceration – **Refer** all patients with an active ulcer **within 24 hours** to your local Diabetes Foot Protection team. Early referral to specialist teams for diabetes management, offloading, debridement and appropriate wound-care, which all are key to achieve the best outcome.



Over-Granulating Wounds

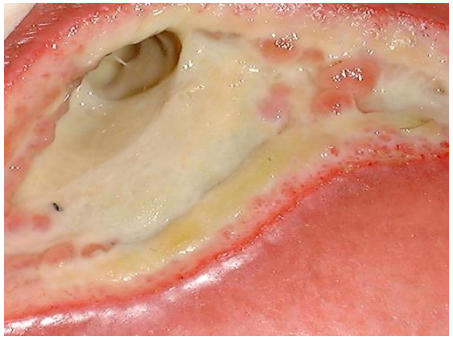
Presentation- Characterised by proud-flesh occurring after the wound bed has filled with granulation tissue

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

Treatment - One fingertip unit of a mild topical steroid such as **Hydrocortisone** or **Haelan (Fludroxycortide)** Tape/Cream.
Kliniderm Foam Silicone/Biatain Silicone as secondary dressing
(if bleeding or infection suspected **consider antimicrobial** as primary dressing)

Review wound after 3-4 days

Haelan® tape – SPC https://www.medicines.org.uk/emc/product/2694/smpc
NB: Haelan has been re-named under its generic name Fludroxycortide



Sloughy Wounds

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

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

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

Secondary dressing – low exudate - **Gauze and Hydrofilm**
moderate to high exudate - **Zetuvit** or **Kliniderm Superabsorbent** for frequent dressing changes

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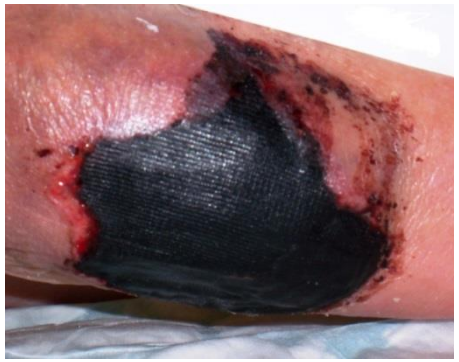
Diabetes Foot Ulceration – **Refer** all patients with an active ulcer **within 24 hours** to your local Diabetes Foot Protection team. Early referral to specialist teams for diabetes management, offloading, debridement and appropriate wound-care, which all are key to achieve the best outcome.



Necrotic Wounds

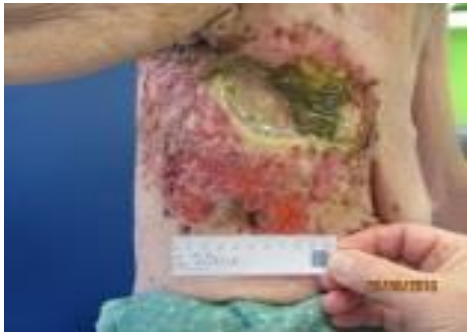
Presentation - The presence of black or yellowish brown devitalised /dead tissue

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

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

Secondary dressing – absorbent dressing such as **Zetuvit or Kliniderm Superabsorbent**

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



Fungating Wounds

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

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

Treatment –**Prontosan soak**

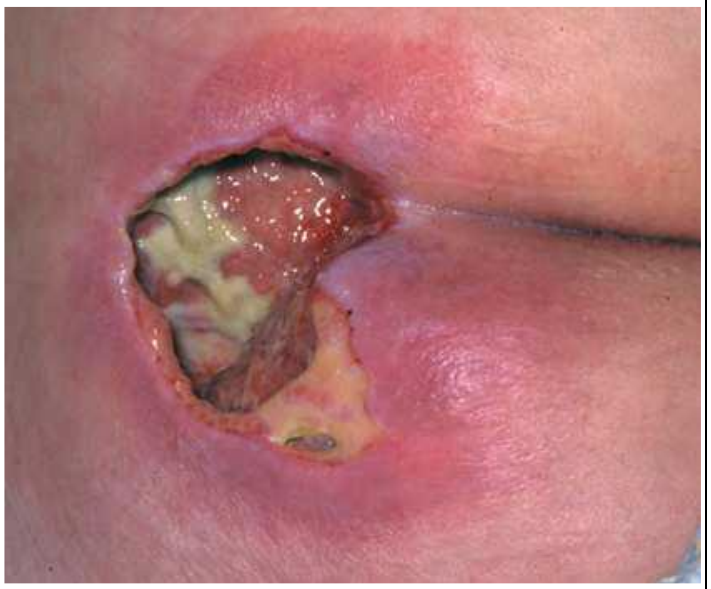
Primary dressing – low to moderate exudate **–Prontosan gel** or **Suprasorb X and PHMB** or **Medihoney HCS**
Primary dressing – moderate to high exudate- **Exufiber** or **Suprasorb X and PHMB** or **Medihoney medical honey**

Secondary dressing –**Zetuvit** or **Kliniderm Superabsorbent**

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

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

Reproduced by permission of NHS Lothian



Cavity Wounds

Presentation – A wound which is categorised by its depth and tissue involvement

This wound type may be acute or chronic

Aim

- To establish extent and depth of tissue damage
- To achieve management and free drainage of exudate
- To protect the surrounding skin
- To prevent infection or manage infection
- To remove necrosis or slough
- To promote granulation from the base of the wound.

Treatment

Treatment is dependent on the position of the wound and the amount of exudate (Dealey 2005).
'Tight' packing is to be avoided, rather layering to fill the wound space, therefore allowing free drainage of exudate

Primary dressing – Cavity fillers e.g. Suprasorb A, Exufiber
If wound is infected Medihoney antibacterial medical honey applied via syringe into the wound bed or **Durafiber Ag**

Secondary dressing – Kliniderm Foam Silicone Border/Biatain Silicone for low to moderate exudate
Kliniderm Superabsorbent or Allevyn Life adhesive for moderate to high exudate

ALL DRESSINGS APPLIED AND REMOVED FROM A CAVITY WOUND MUST BE RECORDED IN THE PATIENTS NOTES

Factors to consider

Rehydration of sloughy wounds may increase the odour and exudate levels
Negative pressure closure may be indicated, if wound exudate or depth is significant
There may be undermining with such wounds and this must be measured and documented using an appropriate wound probe

Reference: Dealey, C. (2005) The Management of Patients with Acute Wounds. *In: The Care of Wounds,* 3rd edn. Oxford: Blackwell Science

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APPENDIX 6

Contacts

NAME	TITLE	TRUST	PHONE NUMBERS	E MAIL
Monique Rosell	Tissue Viability lead (Southampton)	Solent NHS Trust	0300 1233947	snhs.tissueviability@nhs.net
Sam Haynes	Community Tissue Viability Nurse (Southampton)		07584 334963	samantha.haynes1@solent.nhs.uk
Teresa Hall	Tissue Viability Nurse (Southampton)		0300 1233947	snhs.tissueviability@nhs.net
Karen Oakley	Clinical Advisor for Pressure Relief and Tissue Viability (Portsmouth Lead)		07833 435093	karen.oakley@solent.nhs.uk
Maggie Simmonds	Tissue Viability Nurse (Portsmouth)		07876 230720	margaret.simmonds@solent.nhs.uk
Natalie Frisbee	Tissue Viability Nurse (Portsmouth)		07780 620676	natalie.frisbee@solent.nhs.uk
Graham Bowen	Clinical Service Manager	Single Point of Access for Allied Health Professionals Solent NHS Trust Podiatry	0300 3002011	graham.bowen@solent.nhs.uk
Sharon Steele	Podiatry Pathway Lead – At Risk Foot	Solent NHS Trust (East) Podiatry	07810 656019	sharon.steele@solent.nhs.uk
Fran Spratt	Tissue Viability Lead	University Hospital Southampton NHS Foundation Trust	07825 522600	frances.spratt@uhs.nhs.uk
Sue Lawton	Locality Lead Pharmacist (Southampton)	Southampton City (HSI CCG)	07899 987464	sue.lawton@nhs.net
Vicky Newman	Senior Medicines Management Technician	Southampton City (HSI CCG)	07919 014860	victoria.newman2@nhs.net
Lisa Rice	Advanced Clinical Nurse Specialist (Winchester/Andover)	Southern Health NHS Foundation Trust Team email: hampshiretvteam@southernhealth.nhs.uk	02380 673988 07747 792895	lisa.rice@southernhealth.nhs.uk
Caryn Carr	TV Lead Nurse		07789 867790	caryn.carr@southernhealth.nhs.uk
Jane Barker	Advanced Clinical Nurse Specialist		07740 852241	janebarker@southernhealth.nhs.uk
Clare Hancock	Advanced Clinical Nurse Specialist		02380 673988 07887 985101	clare.hancock@southernhealth.nhs.uk
Denise Woodd	LU Nurse Specialist and Independent Educator	NHS Portsmouth CCG (part time)	07795 822648	denwoodd@gmail.com d.woodd@nhs.net
Jess Gill	Senior Medicines Optimisation Technician	South West Hampshire (HSI CCG)	07557 499646	jessicagill@nhs.net
Pragna Thakrar	Prescribing Support Pharmacy technician	Medicines Optimisation Pharmacy Technician NHS Portsmouth CCG	07920817680	pragna.thakrar@nhs.net

Appendix 7

Signposting/Useful References

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

APPENDIX 8 Generic Exception Reporting Form (add organisational logo)

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

Please email a copy of this form (no patient data) to your local nurse specialist or prescribing advisor and keep a copy for reference.