HSC Health and Social Care

Northern Ireland Wound Care Formulary

2nd Edition
April 2011

Wounds cause pain and discomfort to many people in Northern Ireland. Management of wounds requires considerable resources in terms of treatment, products and staff time.

The aim of the Northern Ireland Wound Care Formulary is to provide practitioners with up-to-date, evidence based guidance on wound management products. The Formulary provides for a wide range of wound types, descriptions and advice on the most appropriate product(s) to use.

The products selected for use in the formulary have been evaluated by the Regional Wound Management Products Group (RWMPG) using STEPS methodology, with product selection based on a systematic review of the most recent clinical evidence, risk assessment and budgetary impact analysis for both primary and secondary care.

In the management of wounds, accurate wound assessment is essential. The RWMPG recommends that all clinical areas have an appropriate protocol in place for wound assessment.

It is recognised that there are factors other than dressing choice which influence wound healing and as such a holistic approach to patient care should be taken.

The members of the RWMPG hope that you find this Formulary useful and welcome your comments for incorporation into future updates. Comments should be forwarded to:

Medicines Management Information Team, 2nd Floor, BSO, 2 Franklin Street Belfast, BT2 8DQ. E-Mail: medicines.management@hscni.net

This Formulary should be used as an educational tool, to promote evidence-based practice and cost effective prescribing in the management of wounds across Northern Ireland. It is available electronically on the following website:
www.hscboard.hscni.net/medicinesmanagement/index.html

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Disclaimer:
The information contained within this Formulary is intended for use by healthcare professionals, within primary and secondary care in Northern Ireland. We have made every effort to check that the information is accurate at the time of publication. The HSC Board does not accept any responsibility for loss or damage caused by reliance on this information.

Wound Assessment

The systematic assessment of a wound is essential, as it provides baseline data on which to evaluate wound status or progress and the efficacy of the treatment regime. The following acronym **B.E.S.S.S.O.P.** may be useful

B Bed
E Exudate
S Site
S Size
S Surrounding Skin
O Odour
P Pain

Assessment and evaluation should be carried out regularly and the process should be clearly documented.

RECORD	RATIONALE
BED	The appearance of the wound bed indicates both the stage of healing and the health of the wound. Assessment of the wound bed tissue type often provides the rationale behind the main treatment objective. One of the most effective ways to describe tissue type is by its colour. In general: Black = Necrotic / Eschar Yellow = Sloughy Red = Granulating Pink = Epithelialising The type of tissue on the wound bed can be further quantified through percentages, e.g. 50% red / granulation + 50% yellow / slough. **Note** Yellow tissue is not always indicative of slough. It may be subcutaneous tissue, tendon or bone. Red tissue may indicate other deep tissue e.g. muscle.

EXUDATE	Knowledge of the level and type of wound exudate is extremely important. Exudate and the type of tissue on the wound bed will influence dressing choice. Level / amount of exudate may be described as: • **Dry** – the wound does not produce exudate • **Low** – the wound bed is moist i.e. there is scant or small amount of exudate • **Moderate** – the surrounding skin is wet and there is exudate in the wound bed • **High** – the surrounding skin is saturated (may be macerated) and the wound is bathed in fluid Wound exudate may be described as: • **Serous** – clear fluid with apparent absence of blood, pus or other visible debris • **Sanguinous** – bloody, appearing to be composed entirely of blood • **Serosanguinous** – blood mixed with obvious quantities of clear fluid • **Purulent** – pus-like in appearance, cloudy yellow and viscous
SITE	It is important to record the site of the wound for the following reasons: • To differentiate between wounds • The position of a wound may suggest its aetiology
SIZE	The accurate measurement of the physical size of the wound is vital for assessing the progress of healing. Although there are many different ways of measuring wounds, the most simple and accessible methods include: (a) Ruler-based assessment (b) Transparency tracings (c) Photography with written informed consent according to Trust Policy • In general, cavity wounds may be gently probed to establish the extent of undermining and / or depth of hidden extensions **Caution should be exercised where the wound overlies delicate structures, e.g. bowel** • Measurements should be recorded in metric (mm/cm) • Weekly measurements are usually sufficient, or when a change in the wound occurs

SURROUNDING SKIN	The condition of the skin surrounding the wound provides important information about underlying disease and the effectiveness of current treatment regimes, e.g. pink / purple tissue on the edges may indicate epithelialisation; maceration may be indicative of an ineffective dressing regime.
ODOUR	Wound odour may be caused by infection, necrotic tissue or the use of certain dressings. The cause must be established and where possible rectified, e.g. treat infection, remove necrotic tissue (if appropriate), change dressing regime. Odour is very subjective and difficult to quantify. The following terms may be useful to describe odour: • None • Smell only noticeable on dressing removal and disappears when the dressing is discarded • Smell noted prior to dressing removal • Smell fills the room
PAIN	Although pain is subjective, its location, frequency and severity can be helpful in determining the presence of underlying disease, infection, the exposure of nerve endings, the efficacy of local wound care and psychological need. Visual or verbal rating scales can help patients to communicate the level of pain that they are experiencing.

Selecting a Dressing

When selecting a dressing the following should be considered:

- Treatment objective(s)
- Type of wound bed
- Site and size of wound
- Level of exudate
- Condition of surrounding skin
- Presence of odour
- Comfort and cosmetic appearance
- Frequency of dressing change

Never apply a dressing in ignorance. Ask yourself...

- How does this dressing work?
- When should it be used?
- Are there any contra-indications to its use?
- Does the patient have any known allergies?
- What is the method of application and removal?
- Is a secondary dressing required? If **yes,** which dressing is appropriate?

Practitioners should follow the manufacturer's recommendations, contra-indications, precautions and warnings.

Remember that you are accountable for the decisions you make!

Necrotic Wounds

Description:

Necrosis is a term used to describe dead tissue, e.g. eschar and slough. Within the field of wound care, the term tends to be used to describe dead tissue which is black / brown in colour.

Aim of Treatment:

Debridement

Management Techniques:

- Sharp debridement (only with appropriate training)
- Dressings which promote autolysis, e.g. hydrogels, hydrocolloids
- Larvae (if necrosis is soft / wet)

As necrotic tissue can impair wound healing, removal is necessary for several reasons:

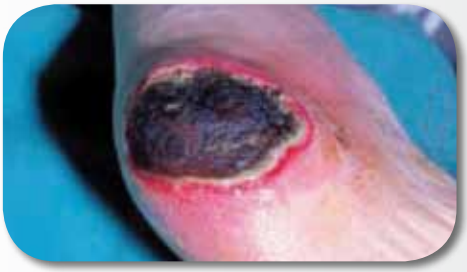
- To elicit the full extent / size of the wound
- To elicit what lies beneath, e.g. pus, bone or tendon
- If the necrotic tissue becomes colonised with bacteria it will produce an unpleasant odour

In some cases it is not appropriate to remove necrotic tissue, e.g. where there is ischaemia or the patient has been deemed unsuitable for reconstruction following assessment by the vascular surgeon.

If there is no blood supply, keep it dry.

Warning! Sharp debridement should not be undertaken by healthcare professionals unless appropriate training and experience have been gained.

The choice of dressing will depend on the depth of the wound and the amount of exudate, anatomical location, clinical need and patient preference.



Black Necrotic Wounds

Wound Type	Recommended Dressing	Size	Pack Size ✳	Notes
Dry / Low Exudate	**Hydrogel**			
	*Askina® Gel	15g	5	*Applied via nozzle applicator. Not recommended for heavily exuding wounds. Secondary dressing required. All hydrogels can be used to hydrate tendon and bone. Intrasite Conformable® is not recommended for neonates. Hydrates necrotic tissue.
	ActivHeal® Hydrogel	15g	10	
	Intrasite Conformable®	10 x 10cm	10	
		10 x 20cm	10	
		10 x 40cm	10	
	Actiform® Cool	5 x 6.5cm	5	
		10 x 10cm	5	
		10 x 15cm	3	
		20 x 20cm	3	
Low / Moderate Exudate	**Foam**			
	ActivHeal® Non-Adhesive Foam	5 x 5cm	10	
		10 x 10cm	10	
		10 x 17.8cm	10	
		20 x 20cm	10	
	ActivHeal® Foam Adhesive	7.5 x 7.5 cm	10	
		10 x 10cm	10	
		12.5 x 12.5cm	10	
		15 x 15cm	10	
		20 x 20cm	10	
	ActivHeal® Foam Heel	12 x 18cm	5	NB Heel dressings are **NOT** pressure - relieving devices.
	Tegaderm® Foam Adhesive Heel	13.9 x 13.9cm	5	
	Hydrocolloid			
	Duoderm® Extra Thin	3.8 x 4.4cm	10	Occlusive dressing. Not recommended for very heavily exuding wounds. Not recommended for clinically infected wounds or the diabetic foot. Can produce a distinctive odour. No secondary dressing required.
		7.5 x 7.5cm	5	
		10 x 10cm	10	
		15 x 15cm	10	
		5 x 10cm	10	
		5 x 20cm	10	
		9 x 25cm	10	
		9 x 35cm	10	
	Tegaderm® Hydrocolloid	10 x 12cm	5	
		13 x 15cm	5	
		16.1 x 17.1cm	6	

✳ Pack size information is provided for community pharmacy ordering purposes. Individual prescriptions may be issued for smaller quantities as appropriate.

Sloughy Wounds

Description:

Slough is a term used to describe the accumulation of dead cellular debris on the wound surface. It tends to be yellow in colour due to the presence of large amounts of leucocytes.

Warning! Yellow tissue is not always indicative of slough. You may be looking at subcutaneous tissue, tendon or bone.

Aim of treatment:

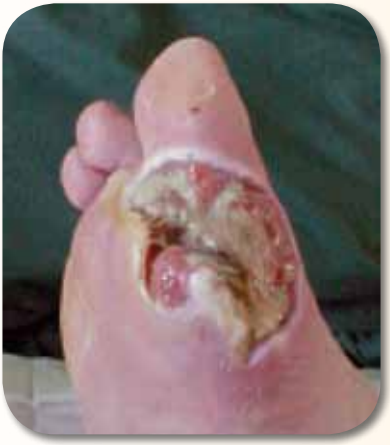
- Debridement
- Manage exudate

Management Techniques:

- Sharp debridement
- Dressings which promote autolysis, e.g. hydrogels
- Dressings which manage exudate, e.g. alginates
- Larvae

Warning! Sharp debridement should not be undertaken by healthcare professionals unless appropriate training and experience have been gained.

The choice of dressing will depend on the depth of the wound and the amount of exudate, anatomical location, clinical need and patient preference.



Yellow Sloughy Wounds

Wound Type	Recommended Dressing	Size	Pack Size ✶	Notes
Dry / Low Exudate	**Hydrogel**			
	*Askina® Gel	15g	5	*Applied via nozzle applicator. Not recommended for heavily exuding wounds. Secondary dressing required. All hydrogels can be used to hydrate tendon and bone. Intrasite Conformable® is not recommended for neonates.
	ActivHeal® Hydrogel	15g	10	
	Actiform Cool®	5 x 6.5cm	5	
		10 x 10cm	5	
		10 x 15cm	3	
		20 x 20cm	3	
	Intrasite Conformable®	10 x 10cm	10	
		10 x 20cm	10	
		10 x 40cm	10	
	Honey			
	Actilite®	10 x 10cm	10	The glucose levels of patients with diabetes may need to be monitored due to the high level of sugars in the dressing. Contra-indicated in patients with known sensitivity or allergy to honey, bee stings or bee products.
		10 x 20cm	10	
	Activon® Tube	25g	12	
	Activon® Tulle	5 x 5cm	5	
		10 x 10cm	5	
Low / Moderate Exudate	**Foam**			
	ActivHeal® Non-Adhesive Foam	5 x 5cm	10	NB Heel dressings are **NOT** pressure - relieving devices.
		10 x 10cm	10	
		10 x 17.8cm	10	
		20 x 20cm	10	
	ActivHeal® Foam Adhesive	7.5 x 7.5 cm	10	
		10 x 10cm	10	
		12.5 x 12.5cm	10	
		15 x 15cm	10	
		20 x 20cm	10	
	ActivHeal® Foam Heel	12 x 18cm	5	
	Tegaderm® Foam Adhesive Heel	13.9 x 13.9cm	5	

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Yellow Sloughy Wounds

Wound Type	Recommended Dressing	Size	Pack Size ✳	Notes
Low / Moderate Exudate	**Honey**			
	Mesitran®	10 x 10cm	10	The glucose levels of patients with diabetes may need to be monitored due to the high level of sugars in the dressing. Contra-indicated in patients with known sensitivity or allergy to honey, bee stings or bee products.
		10 x 17.5cm	10	
		15 x 20cm	10	
	Mesitran® Adhesive Border	10 x 10cm	10	
		13 x 15cm	10	
		15 x 15cm	10	
Moderate / High Exudate	**Alginate**			
	Kaltostat®	5 x 5cm	10	Kaltostat® may be used for bleeding wounds.
		7.5 x 12cm	10	
		10 x 20cm	10	
		15 x 25cm	10	
	Kaltostat® Wound Packing	2g	5	
	Fibrous Hydrocolloid			
	Aquacel® Ribbon	2 x 45cm	5	Do not allow to dry out. Secondary dressing required. Aquacel® retains high levels of exudate (no lateral wicking).
	Aquacel®	5 x 5cm	10	
		10 x 10cm	10	
		15 x 15cm	5	
		4 x 10cm	10	
		4 x 20cm	10	
		4 x 30cm	10	
	Hydrocapillary			
	Advadraw®	5 x 7.5cm	10	Caution - should not be used on bleeding wounds. Advadraw® retains high levels of exudate.
		10 x 10cm	10	
		10 x 15cm	10	
		15 x 20cm	20	
	Advadraw® Spiral	0.5 x 40cm	10	
	Honey			
	Algivon®	5 x 5cm	5	The glucose levels of patients with diabetes may need to be monitored due to the high level of sugars in the dressing. Contra-indicated in patients with known sensitivity or allergy to honey, bee stings or bee products.
		10 x 10cm	5	

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Granulating Wounds

Description:

Granulation is the process by which the wound is filled with vascular connective tissue. Granulation tissue is usually red and moist and has an uneven granular appearance. Unhealthy infected granulation tissue often looks dark and bleeds very easily.

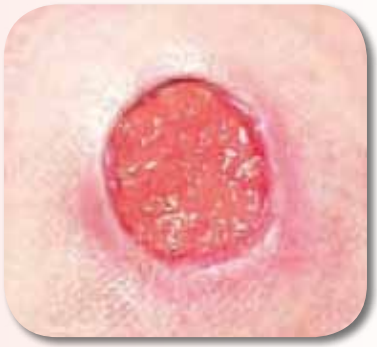
Aim of Treatment:

- Keep wound warm and moist
- Manage exudate
- Protect

Management Techniques:

- All dressings which maintain a warm moist environment can be used, e.g. hydrogels, fibrous hydrocolloid, hydrocolloids, alginates, foam dressings.

The choice of dressing will depend on the depth of the wound and the amount of exudate, anatomical location, clinical need and patient preference.



Red Granulating Wounds

Wound Type	Recommended Dressing	Size	Pack Size ✳	Notes
Dry / Low Exudate	**Hydrogel**			
	*Askina® Gel	15g	5	*Applied via nozzle applicator.
	ActivHeal® Hydrogel	15g	10	Useful for granulating cavities. Secondary dressing required.
	Intrasite Conformable®	10 x 10cm	10	Intrasite Conformable® not recommended for neonates.
		10 x 20cm	10	
		10 x 40cm	10	
	Actiform Cool®	5 x 6.5cm	5	
		10 x 10cm	5	
		10 x 15cm	3	
		20 x 20cm	3	
Low / Moderate Exudate	**Impregnated Mesh Dressing**			
	N-A Ultra®	9.5 x 9.5cm	40	Non adherent silicone dressing.
		9.5 x 19cm	25	
		19 x 19cm	5	Secondary dressing required.
	Mepitel®	5 x 7 cm	5	Mepitel® can be left in place for up to 7 days. To change more frequently than 3 days is not cost effective.
		8 x 10cm	5	
		12 x 15cm	5	
		20 x 32cm	5	
	Foam			
	ActivHeal® Non-Adhesive Foam	5 x 5cm	10	
		10 x 10cm	10	
		10 x 17.8cm	10	
		20 x 20cm	10	
	ActivHeal® Foam Adhesive	7.5 x 7.5cm	10	
		10 x 10cm	10	
		12.5 x 12.5cm	10	
		15 x 15cm	10	
		20 x 20cm	10	
	ActivHeal® Foam Heel	12 x 18cm	5	NB Heel dressings are **NOT** pressure - relieving devices.
	Tegaderm® Foam Adhesive Heel	13.9 x 13.9cm	5	

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Red Granulating Wounds

Wound Type	Recommended Dressing	Size	Pack Size ✳	Notes
Low / Moderate Exudate	**Hydrocolloid**			
	Duoderm® Extra Thin	3.8 x 4.4cm	10	Occlusive dressing. Not recommended for very heavily exuding wounds. Not recommended for clinically infected wounds or the diabetic foot. Can produce a distinctive odour. No secondary dressing required.
		7.5 x 7.5cm	5	
		10 x 10cm	10	
		15 x 15cm	10	
		5 x 10cm	10	
		5 x 20cm	10	
		9 x 25cm	10	
		9 x 35cm	10	
	Tegaderm® Hydrocolloid	10 x 12cm	5	
		13 x 15cm	5	
		16.1 x 17.1cm	6	
	Askina® Hydro	10 x 10cm	10	
		15 x 15cm	10	
		20 x 20cm	10	
Moderate / High Exudate	**Alginate**			
	Kaltostat®	5 x 5cm	10	
		7.5 x 12cm	10	
		10 x 20cm	10	
		15 x 25cm	10	
	Kaltostat® Wound Packing	2g	5	Kaltostat® can be used in bleeding wounds.
	Fibrous Hydrocolloid			
	Aquacel® Ribbon	2 x 45cm	5	Do not allow to dry out. Secondary dressing required.
	Aquacel®	5 x 5cm	10	
		10 x 10cm	10	Aquacel® retains high levels of exudate (no lateral wicking).
		15 x 15cm	5	
		4 x 10cm	10	
		4 x 20cm	10	
		4 x 30cm	10	

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Overgranulating Wounds

Description:

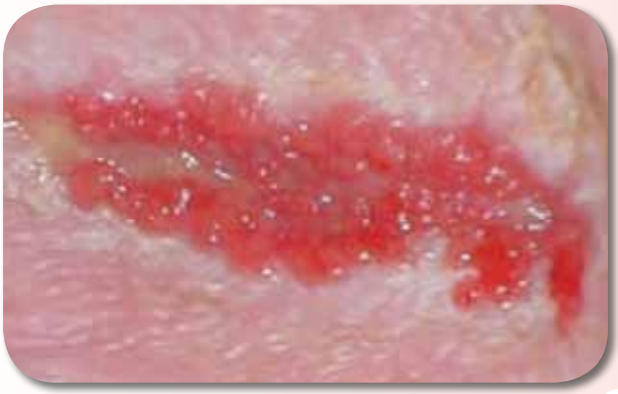
Presents clinically as granulation tissue raised above the level of the surrounding skin. The presence of overgranulation delays wound healing.

Aim of Treatment:

- To prevent further overgranulation

Management Techniques:

There is little evidence to support any particular treatment regimen; however foam dressings have been used. If in doubt, contact your local Tissue Viability Nurse Specialist / Wound Management Practitioner / Specialist Podiatrist.



Epithelialising Wounds

Description:

Epithelialisation is the process by which the wound is covered with epithelial cells. This process can be recognised by the presence of pink tissue which migrates from the wound edges and / or the remnants of hair follicles in the wound bed.

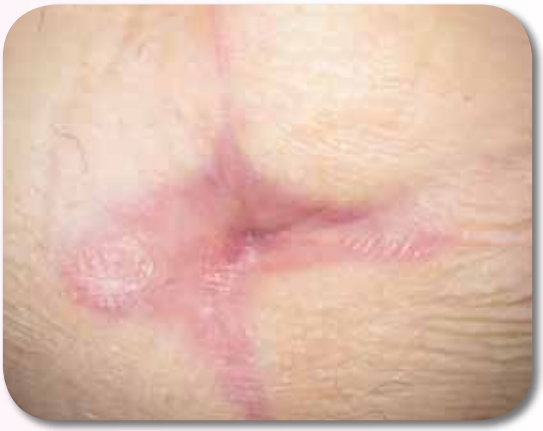
Epithelial cells will only migrate over living granulating tissue. Epithelialisation occurs 2-3 times quicker in a warm, moist environment.

Aim of Treatment:

- Keep wound warm and moist
- Manage exudate
- Protect

Management Techniques:

- All dressings which maintain a warm moist environment can be used, e.g. non-adherent dressings, vapour-permeable films, hydrocolloids, foams.



Pink Epithelialising Wounds

Wound Type	Recommended Dressing	Size	Pack Size ✳	Notes
Dry / Low Exudate	**Semi-permeable**			
	Tegaderm® Film	4.4 x 4.4cm	100	Careful removal necessary, otherwise skin surrounding the wound may be damaged.
		6 x 7cm	100	
		10 x 12cm	50	
		15 x 20cm	10	
		20 x 30cm	10	
	Silicone			
	N-A Ultra®	9.5 x 9.5cm	40	Secondary dressing required.
		9.5 x 19cm	25	
		19 x 19cm	5	
	Mepitel®	5 x 7cm	5	Mepitel® can be left in place for up to 7 days. To change more frequently than every 3 days is not cost effective.
		8 x 10cm	5	
		12 x 15cm	5	
		20 x 32cm	5	
Low / Moderate Exudate	**Foam**			
	ActivHeal® Non-Adhesive Foam	5 x 5cm	10	
		10 x 10cm	10	
		10 x 17.8cm	10	
		20 x 20cm	10	
	ActivHeal® Foam Adhesive	7.5 x 7.5cm	10	
		10 x 10cm	10	
		12.5 x 12.5cm	10	
		15 x 15cm	10	
		20 x 20cm	10	
	ActivHeal® Foam Heel	12 x 18cm	5	NB Heel dressings are **NOT** pressure - relieving devices.
	Tegaderm® Foam Adhesive Heel	13.9 x 13.9cm	5	

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Wound Type	Recommended Dressing	Size	Pack Size ✳	Notes
Low / Moderate Exudate	**Hydrocolloid**			
	Duoderm® Extra Thin	3.8 x 4.4cm	10	Occlusive dressing. Not recommended for very heavily exuding wounds. Not recommended for clinically infected wounds or the diabetic foot. Can produce a distinctive odour. No secondary dressing required.
		7.5 x 7.5cm	5	
		10 x 10cm	10	
		15 x 15cm	10	
		5 x 10cm	10	
		5 x 20cm	10	
		9 x 25cm	10	
		9 x 35cm	10	
	Tegaderm® Hydrocolloid	10 x 12cm	5	
		13 x 15cm	5	
		16.1 x 17.1cm	6	
	Askina® Hydro	10 x 10cm	10	
		15 x 15cm	10	
		20 x 20cm	10	

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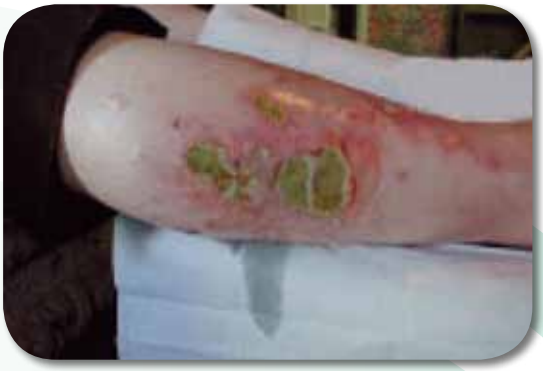
Infected Wounds

Description:

Infection occurs when pathogenic micro-organisms deposit in the wound and evoke a reaction from the host.

Signs of infection may include:



- Delayed healing / dehiscence
- Unexpected pain or increasing wound pain
- Malodour
- Abscess / sinus formation
- Localised swelling, redness or heat (new or increasing)
- Cellulitis
- Increased level of exudate / purulent discharge
- Pyrexia, rigors or tachycardia
- Friable tissue which bleeds easily

Patients who are immunocompromised including those with diabetes may not show the classic signs of infection.

Aim of Treatment:

- Patient will be free from pain, discomfort and infection
- To promote wound healing

Management Techniques:

- Standard prevention and infection control precautions, i.e. hand washing, plastic aprons and gloves
- Swab wound for 'Organisms and Sensitivities' when the wound appears clinically infected, and record all appropriate information on a microbiology form (refer to HSC Trust guidelines)
- Daily dressings unless advised otherwise, treat the wound according to the type of tissue on the wound bed
- It may be prudent to avoid all occlusive dressings if anaerobic infection is suspected or cultured

Patients with a clinically infected wound require a systemic antibiotic.

Wound Type	Recommended Dressing	Size	Pack Size ✳	Notes
Low Exudate	**Povidone-Iodine**			
	Inadine®	5 x 5cm	25	Do not use on large wounds due to absorption of iodine. Antibacterial effect is reduced in presence of pus and exudate.
		9.5 x 9.5cm	10 / 25	
	Silver			
	Urgotul® SSD	11 x 11cm	16	**Do not use dressings containing silver on patients undergoing MRI scans.**
		16 x 21cm	16	
	Honey			
	Actilite®	10 x 10cm	10	The glucose levels of patients with diabetes may need to be monitored due to the high levels of sugars in these dressings. Contra-indicated in patients with known sensitivity or allergy to honey, bee stings or bee products.
		10 x 20cm	10	
	Activon® Tulle	5 x 5cm	5	
		10 x 10cm	5	
	Activon® Tube	25g	12	
Moderate / High Exudate	**Cadexomer-Iodine**			
	Iodoflex®	5g	5	Should not be used in thyroid disorders, severe renal impairment, those receiving lithium, in pregnancy, breast-feeding and in children. No more than 50g per application and no more than 150g should be applied during the course of one week. A single course of treatment should not exceed 3 months.
		10g	3	
		17g	2	
	Iodosorb® Ointment	10g	4	
		20g	2	
	Iodosorb® Powder	3g	7	
	Charcoal			
	Carboflex®	10 x 10cm	10	Place directly on wound. Reduces odour.
		8 x 15cm	5	
		15 x 20cm	5	
	Askina® Carbosorb	10 x 10cm	10	Place white side directly on to the wound.
		10 x 20cm	10	

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Wound Type	Recommended Dressing	Size	Pack Size ✳	Notes
Moderate / High Exudate	**Silver**			
	Aquacel® Ag Ribbon	2 x 45cm	5	Aquacel® Ag retains high levels of exudate (no lateral wicking) **Do not use dressings containing silver on patients undergoing MRI scans.**
	Aquacel® Ag	5 x 5cm	10	
		10 x 10cm	10	
		15 x 15cm	5	
		20 x 30cm	5	
	Askina® Calgitrol Ag	10 x 10cm	10	
		15 x 15cm	10	
		20 x 20cm	10	
	Honey			
	Algivon®	5 x 5cm	5	The glucose levels of patients with diabetes may need to be monitored due to the high levels of sugars in these dressings. Contra-indicated in patients with known sensitivity or allergy to honey, bee stings or bee products.
		10 x 10cm	5	

Note: Hydrocolloid dressings are not recommended for clinically infected wounds.

Antimicrobial dressings should not be used for longer than 2-4 weeks without discussion with a local wound management specialist.

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Additional Items

Wound Type	Recommended Dressing	Size	Pack Size ✳	Notes
Dry / Low Exudate	Atrauman®	5 x 5cm	50	Impregnated mesh dressing.
		7.5 x 10cm	50	
		10 x 20cm	30	
	Pharmapad®	5 x 5cm	150	Non adhesive low absorbent dressing.
		10 x 10cm	100	
		10 x 20cm	40	
	Premierpore®	5 x 7cm	50	Low absorbent dressing with adhesive border.
		10 x 10cm	50	
		10 x 15cm	50	
		10 x 20cm	50	
		10 x 25cm	50	
		10 x 30cm	50	
		10 x 35cm	50	
	Premierpore VP®	5 x 7cm	50	Adhesive vapour permeable dressing with fluid handling.
		10 x 10cm	50	
		10 x 15cm	50	
		10 x 20cm	50	
		10 x 25cm	50	
		10 x 30cm	50	
		10 x 35cm	50	
Moderate / High Exudate	Mesorb®	10 x 10cm	10	Absorbent dressing with fluid repellent backing.
		10 x 15cm	10 / 50	
		10 x 20cm	10	
		15 x 20cm	10	
		20 x 25cm	10	
		20 x 30cm	10	
Skin Protector	Cavilon® Sachet	2g	20	Use on intact skin.
	Cavilon® Cream Tube	28g	1	
		92g	1	
	Cavilon® Applicator	1ml	5	Can be used on broken skin.
		1ml	25	
		3ml	5	
		3ml	25	
	Cavilon® Spray	28ml	1	
		28ml	12	
	Opsite® Spray	100ml	1	

✳ Pack size information is provided for community pharmacy ordering purposes. Individual prescriptions may be issued for smaller quantities as appropriate.

These are specialist products which should be used only in line with HSC Trust or organisation policy

Dressing / Treatment	Size	Pack Size ✳	Notes
Larvae Therapy	Biofoam Dressing	Approximate No. of Larvae	For use on sloughy wounds to facilitate rapid debridement. The sundries required for loose larvae are available.
	2 x 2cm	40	
	2.5 x 4cm	100	
	5 x 5cm	250	
	2.5 x 15cm	375	
	7 x 7cm	490	
	7 x 12cm	840	
	10 x 10cm	1000	
	1 pot (loose)	300	
Topical Negative Pressure (TNP) System		Small	Can be used on heavily exuding wounds.
		Medium	
		Large	
Topical Silicone			
Mepiform®	5 x 7cm	5	Silicone gel sheet used to reduce and prevent hypertrophic and keloid scarring.
	9 x 18cm	5	
	4 x 31cm	5	
Kelo-cote® Cream	15g	1	Hypertrophic scarring.
	60g	1	
Kelo-cote® Spray	100ml	1	

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Alternative / Exception Protocol

A product listed on the alternative / exception protocol can be considered, if:

1. The normal pathway of good wound care has been adhered to; and a Formulary dressing product has been in use for a minimum of two weeks and the wound still fails to progress.
2. Patient experiences (or has history of) an adverse reaction specifically to a formulary dressing product, e.g. an allergic reaction.
3. If the patient requires the application of an alternative product not available on the Wound Care Formulary due to their current clinical status / special skin or wound care needs.

The nominated representative can request an alternative / exception protocol dressing provided the following has been taken into account; holistic assessment; intrinsic and extrinsic factors that may impede healing.

Alternative / Exception Protocol Dressings will be supplied through nominated HSC Trust Pharmacy Department (refer to local arrangements).