HSC Health and Social Care

NI Wound Care Formulary

3rd Edition - January 2020

Last updated February 2025

Wound Care Formulary

The aim of the Northern Ireland Wound Care Formulary is to provide practitioners with guidance on the wound management products that are recommended for use in Northern Ireland. The formulary provides for a wide range of wound types, descriptions and advice on the most appropriate product(s) to use.

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.

We hope that you find this formulary useful and welcome your comments for incorporation into future updates. Comments should be forwarded to 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 niformulary.hscni.net

Information to note:

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. SPPG does not accept any responsibility for loss or damage caused by reliance on this information. Please refer to product literature for full details of cautions and contra-indications.

The wound management products included in this formulary are intended to meet the needs of the majority of patients and adherence to the formulary will be measured. Individual patients may require products outside the formulary but there should be a justifiable reason. Specialist products are outside the scope of this formulary.

A number of products that have been selected for the Northern Ireland Wound Care Formulary are not currently listed on the secondary care contract. Those formulary choices for which there is an alternative contract product have been highlighted for your information.

Dressing sizes selected for the Northern Ireland Wound Care Formulary are available on the Northern Ireland Drug Tariff; some sizes may not be available in secondary care.

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 quantifiedthrough 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 • To aid dressing choice

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) Disposable 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** • Cavity wounds should be lightly packed to allow for contraction and drainage. • Measurements should be recorded in metric (mm/cm) • Weekly measurements are usually sufficient, or when a change in the wound occurs • Malignant/fungating wounds are not measured as a general rule as progression of the disease is likely and measurements showing increase in size can cause anxiety.
SURROUND-ING 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 / red 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
- Showerproof
- Wipeable (if incontinent)

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.

Consider the underlying cause of the necrosis prior to debridement.

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.

Aim of Treatment:

- Debridement
- Keep avascular wounds dry

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

Other considerations:

- Necrotic digits (fingers and toes) should be kept dry.
- It may be inappropriate to debride a wound if healing is not a realistic outcome e.g. patients at end of life.

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
(which are assessed as suitable for debridement)

Wound Type	Recommended Dressing	Size	Pack Size*	Notes
Dry / Low Exudate	**Hydrogel**			
	†Activheal® Hydrogel	8g 15g	10	†Applied via tube. Hydrogels are not recommended for heavily exuding wounds. Secondary dressing required. Hydrogels can be used to hydrate viable tendons and bone Hydrogels are single use only IntraSite Conformable® is not recommended for neonates.
	IntraSite Conformable®	10 x 10cm	10	
		10 x 20cm	10	
		10 x 40cm	10	
	Honey			
	Actilite®	5 x 5cm	10	Contra-indicated in patients with known sensitivity or allergy to honey, pollen or bee venom
		10 x 10cm	10	
		10 x 20cm	10	
	Activon® Tube	25g	12	
	Activon® Tulle	5 x 5cm	5	
		10 x 10cm	5	

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

[1] Alternative product on secondary care contract

Moderate / High Exudate	**Alginate**			
	Kaltostat®	5 x 5cm	10	May be used for bleeding wounds It is good practice to record the number of cavity dressings used. Leave enough length outside the cavity to aid removal
		7.5 x 12cm	10	
		10 x 20cm	10	
		15 x 25cm	10	
	Kaltostat® Wound Packing	2g	5	
	Fibrous Hydrocolloid			
	Aquacel® Ribbon	1 x 45cm	5	It is good practice to record the number of cavity dressings used. Leave enough length outside the cavity to aid removal
		2 x 45cm	5	
	Aquacel® Extra[1]	5 x 5cm	10	
		10 x 10cm	10	
		15 x 15cm	5	
		4 x 10cm	10	
		4 x 20cm	10	
		4 x 30cm	10	
	UrgoClean® rope[1]	2.5 x 40cm	5	
		5 x 40cm	5	
	UrgoClean® Pad	6 x 6cm	10	
		10 x 10cm	10	
		15 x 20cm	10	
	Honey			
	Algivon®	5 x 5cm	5	Contra-indicated in patients with known sensitivity or allergy to honey, pollen or bee venom
		10 x10cm	5	
	Algivon® Plus ribbon	2.5 x 20cm	5	

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[1] Alternative product on secondary care contract

Sloughy Wounds

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**			
	†Activheal® Hydrogel	8g 15g	10	†Applied via tube. Hydrogels are not recommended for heavily exuding wounds.
	IntraSite Conformable®	10 x 10cm	10	
		10 x 20cm	10	Secondary dressing required.
		10 x 40cm	10	Hydrogels can be used to hydrate viable tendons and bone Hydrogels are single use only IntraSite Conformable® is not recommended for neonates.
	Honey			
	Actilite®	5 x 5cm	10	Contra-indicated in patients with known sensitivity or allergy to honey, pollen or bee venom
		10 x 10cm	10	
		10 x 20cm	10	
	Activon® Tube	25g	12	
	Activon® Tulle	5 x 5cm	5	
		10 x 10cm	5	

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Moderate / High Exudate	**Alginate**			
	Kaltostat®	5 x 5cm	10	May be used for bleeding wounds It is good practice to record the number of cavity dressings used. Leave enough length outside the cavity to aid removal
		7.5 x 12cm	10	
		10 x 20cm	10	
		15 x 25cm	10	
	Kaltostat® Wound Packing	2g	5	
	Fibrous Hydrocolloid			
	Aquacel® Ribbon	1 x 45cm	5	It is good practice to record the number of cavity dressings used. Leave enough length outside the cavity to aid removal
		2 x 45cm	5	
	Aquacel® Extra[1]	5 x 5cm	10	
		10 x 10cm	10	
		15 x 15cm	5	
		4 x 10cm	10	
		4 x 20cm	10	
		4 x 30cm	10	
	UrgoClean® rope[1]	2.5 x 40cm	5	
		5 x 40cm	5	
	UrgoClean® Pad	6 x 6cm	10	
		10 x 10cm	10	
		15 x 20cm	10	
	Honey			
	Algivon®	5 x 5cm	5	Contra-indicated in patients with known sensitivity or allergy to honey, pollen or bee venom
		10 x10cm	5	
	Algivon® Plus ribbon	2.5 x 20cm	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.

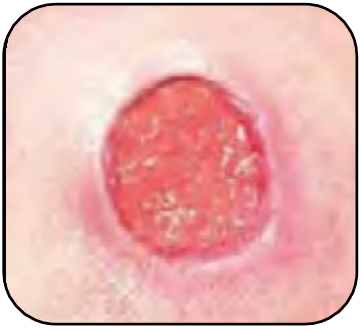
Aim of Treatment:

- 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	Notes
Dry / Low Exudate	**Hydrogel**			
	†Activheal® Hydrogel	8g 15g	10	†Applied via tube. Hydrogels are not recommended for heavily exuding wounds. Secondary dressing required. Hydrogels can be used to hydrate viable tendons and bone. Hydrogels are single use only.
	IntraSite Conformable®	10 x 10cm	10	
		10 x 20cm	10	
		10 x 40cm	10	
Low / Moderate Exudate	**Impregnated Mesh Dressing**			
	Atrauman®	5 x 5cm	10/50	Impregnated with neutral triglycerides
		7.5 x 10cm	10/50	
		10 x 20cm	30	
	N-A Ultra®[1]	9.5 x 9.5cm	40	Non adherent silicone dressing.
		9.5 x 19cm	25	
	Adaptic Touch®[1]	5 x 7.6cm	10	Non adherent silicone dressing
		7.6cmx 11cm	10	
		12.7cm x 15cm	10	
		20cm x 32cm	5	
	Silflex®	5 x 7cm	10	Non adherent silicone dressing.
		8 x 10cm	10	
		12 x 15cm	10	Remove product by stretching diagonally.
		20 x 30cm	10	

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[1] Alternative product on secondary care contract

	Foam			
	ActivHeal® Non-Adhesive Foam[1] **(First choice in primary care)**	5 x 5cm	10	
		10 x 10cm	10	
		10 x 20cm	10	
		20 x 20cm	10	
	ActivHeal® Foam Adhesive[1] **(First choice in primary care)**	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	
	Allevyn® Non-Adhesive[1] (Second choice)	5 x 5cm	10	
		10 x 10cm	10	
		10 x 20cm	10	
		20 x 20cm	10	
	Allevyn® Adhesive[1] (Second choice)	7.5 x 7.5 cm	10	
		10 x 10cm	10	
		12.5 x 12.5cm	10	
		17.5x 17.5cm	10	
		12.5 x 22.5cm	10	
		22.5x22.5cm	10	
	ActivHeal® Foam Heel[1]	12 x 18cm	5	NB Heel dressings are **NOT** pressure relieving devices
	Tegaderm® Foam Adhesive Heel[1]	13.9 x 13.9cm	5	
	Tegaderm® Foam Adhesive Soft Cloth Border	6.9 x 6.9cm	10	
	Hydrocolloid			
	DuoDERM® Extra Thin	7.5 x 7.5cm	5	Occlusive dressing.
		10 x 10cm	10	Not recommended for moderate/heavy exudate wounds
		15 x 15cm	10	
		5 x 10cm	10	Not recommended for clinically infected wounds or the diabetic foot.
		5 x 20cm	10	
		9 x 15cm	10	Can produce a distinctive odour.
		9 x 25cm	10	
		9 x 35cm	10	No secondary dressing required.

Moderate / High Exudate	**Alginate**			
	Kaltostat®	5 x 5cm	10	May be used for bleeding wounds It is good practice to record the number of cavity dressings used. Leave enough length outside the cavity to aid removal
		7.5 x 12cm	10	
		10 x 20cm	10	
		15 x 25cm	10	
	Kaltostat® Wound Packing	2g	5	
	Fibrous Hydrocolloid			
	Aquacel® Ribbon	1 x 45cm	5	It is good practice to record the number of cavity dressings used. Leave enough length outside the cavity to aid removal
		2 x 45cm	5	
	Aquacel® Extra[1]	5 x 5cm	10	
		10 x 10cm	10	
		15 x 15cm	5	
		4 x 10cm	10	
		4 x 20cm	10	
		4 x 30cm	10	
	UrgoClean® rope[1]	2.5 x 40cm	5	
		5 x 40cm	5	
	UrgoClean® Pad	6 x 6cm	10	
		10 x 10cm	10	
		15 x 20cm	10	

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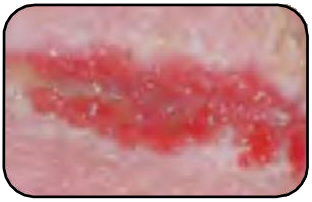
Overgranulating Wounds



Presents clinically as granulation tissue raised above the level of the surrounding skin. The presence of overgranulation delays wound healing. Over granulation is thought to be caused by an altered inflammatory response due to, e.g. a foreign body, infection, friction, poorly managed exudate and occlusive dressings. The cause needs to be identified and managed.

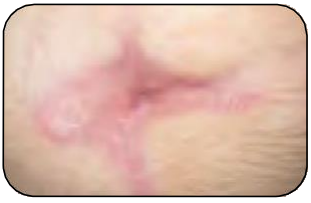
Aim of Treatment:

- 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



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**			
	Hydrofilm®	6 x 7cm	10	Careful removal necessary, otherwise skin surrounding the wound may be damaged. Dressings should be lifted and stretched away from the skin in the direction of hair growth.
		10 x 12.5cm	10	
		10 x 15cm	10	
		10 x 25cm	25	
		12 x 25cm	25	
		15 x 20cm	10	
		20 x 30cm	10	
	Silicone			
	N-A Ultra®[1]	9.5 x 9.5cm	40	Non-adherent silicone dressing
		9.5 x 19cm	25	
	Adaptic Touch®[1]	5 x 7.6cm	10	Non-adherent silicone dressing
		7.6cm x 11cm	10	
		12.7cm x 15cm	10	
		20cm x 32cm	5	
	Silflex®	5 x 7cm	10	Non-adherent silicone dressing. Remove product by stretching diagonally.
		8 x 10cm	10	
		12 x 15cm	10	
		20 x 30cm	10	

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[1] Alternative product on secondary care contract

Low / Moderate Exudate	**Foam**			
	ActivHeal® Non-Adhesive Foam[1] **(First choice in primary care)**	5 x 5cm	10	
		10 x 10cm	10	
		10 x 20cm	10	
		20 x 20cm	10	
	ActivHeal® Foam Adhesive[1] **(First choice in primary care)**	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	
	Allevyn® Non-Adhesive[1] (Second choice)	5 x 5cm	10	
		10 x 10cm	10	
		10 x 20cm	10	
		20 x 20cm	10	
	Allevyn® Adhesive[1] (Second choice)	7.5 x 7.5 cm	10	
		10 x 10cm	10	
		12.5 x 12.5cm	10	
		17.5 x 17.5cm	10	
		12.5 x 22.5cm	10	
		22.5 x 22.5cm	10	
	ActivHeal® Foam Heel[1]	12 x 18cm	5	NB Heel dressings are **NOT** pressure relieving devices
	Tegaderm® Foam Adhesive Heel[1]	13.9 x 13.9cm	5	
	Tegaderm® Foam Adhesive Soft Cloth Border	6.9 x 6.9cm	10	

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	Hydrocolloid			
	DuoDERM® Extra Thin	7.5 x 7.5cm	5	Occlusive dressing.
		10 x 10cm	10	Not recommended for moderate/heavy exudate wounds
		15 x 15cm	10	
		5 x 10cm	10	Not recommended for clinically infected wounds or the diabetic foot.
		5 x 20cm	10	
		9 x 15cm	10	Can produce a distinctive odour.
		9 x 25cm	10	No secondary dressing required.
		9 x 35cm	10	

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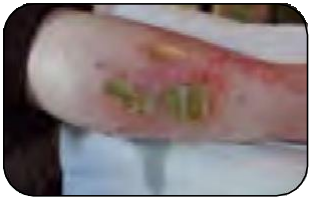
[1] Alternative product on secondary care contract

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/ sinusformation
- Localised swelling, redness or heat (new or increasing)
- Cellulitis
- Increased level of exudate / purulent discharge
- Pyrexia, increased respiration rate, rigors or tachycardia
- Friable tissue which bleeds easily
- Biofilm (Many times biofilms are not seen. They are microscopic but can present themselves as a shiny film.)

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
- 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 may require a systemic antibiotic – use clinical judgement

Think - could this be sepsis?

Refer to Primary Care Antimicrobial Guidelines and Trust Antimicrobial Guidelines

Clinically Infected Wounds

Wound Type	Recommended Dressing	Size	Pack Size*	Notes
Low Exudate	**Povidine-Iodine**			
	Inadine®	5 x 5cm	25	Should not be used in a known iodine hypersensitivity; before/after the use of radio-iodine (until permanent healing); if being treated for kidney problems; pregnant or breast-feeding; in cases of Duhring's herpetiform dermatitis. Must be used under medical supervision in patients with thyroid disease; in newborn babies and infants up to the age of 6 months as povidone-iodine may be absorbed through unbroken skin; when treating deep ulcerative wounds, burns or large injuries. Antibacterial effect is reduced in presence of pus and exudate.
		9.5 x 9.5cm	10 / 25	
	Silver			

	Urgotul® Silver	10 x 12cm	16	**Remove silver dressings prior to radiotherapy and MRI scans.** Not for routine use Not recommended for healthy wounds / granulating wounds with no signs of infection (may delay wound healing) Contra-indicated in known sensitisation to silver
		15 x 20cm	16	
	Honey			
	Actilite®	5 x 5cm	10	Contra-indicated in patients with known sensitivity or allergy to honey, pollen or bee venom
		10 x 10cm	10	
		10 x 20cm	10	
	Activon® Tube	25g	12	
	Activon® Tulle	5 x 5cm	5	
		10 x 10cm	5	

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[1] Alternative product on secondary care contract

Moderate / High Exudate	**Cadexomer-Iodine**			
	Iodoflex®	5g	5	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 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	Absorbent wound contact layer must be placed facing the wound.
		8 x 15cm	5	
		15 x 20cm	5	
	Clinisorb®[1]	10 x 10cm	10	
		10 x 20cm	10	
		15 x 25cm	10	
	Silver			
	Aquacel® Ag+ Ribbon Or Aquacel® Ag + Extra[1]	1 x 45cm	5	**Remove silver dressings prior to radiotherapy and MRI scans.** Not for routine use Not recommended for healthy wounds /granulating wounds with no signs of infection (may delay woundhealing) Contra-indicated in known sensitisation to silver
		2 x 45cm[1]	5	
		5 x 5cm	10	
		10 x 10cm	10	
		15 x 15cm	5	
		20 x 30cm	5	
	Honey			
	Algivon®	5 x 5cm	5	Contra-indicated in patients with known sensitivity or allergy to honey, pollen or bee venom
		10 x 10cm	5	

Note: Hydrocolloid dressings are not recommended for clinically infected wounds. Antimicrobial dressings have a limited place in therapy and should not be used for longer than 2-4 weeks without discussion with a local wound management specialist. They are not suitable for repeat prescribing.

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

[1] Alternative product on secondary care contract

Additional Items

Wound Type	Recommended Dressing	Size	Pack Size*	Notes
Dry / Low Exudate	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®[1]	5 x 7cm	50	Adhesive vapour permeable dressing with low 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	
	365 Transparent Island	5 x 7.2cm	50	Adhesive vapour permeable dressing with low fluid handling
		8.5 x 9.5cm	50	
		8.5 x 15.5cm	50	
		10 x 25cm	50	
		12 x 10cm	50	
		20 x 10cm	50	
		30 x 10cm	50	

Moderate / High Exudate	Mesorb®[1]	10 x 10cm	10	Absorbent dressing with fluid repellent backing. Range of super absorbent dressings available for high levels of exudate in secondary care.
		10 x 15cm	10/50	
		10 x 20cm	10	
		15 x 20cm	10	
		20 x 25cm	10	
		20 x 30cm	10	
Skin Protector	Medi Derma-S® barrier cream	Tube 28g	1	Use on intact skin or for mild skin damage Do not use on infected skin
		Tube 90g	1	
		2g sachets	20	
	Medi Derma-S® Film	Pump spray 30ml	1	Can be used on broken skin. Do not use on infected skin Extremely flammable in liquid form
		Aerosol 50ml	1	
		Applicator 1ml	5	
		Applicator 3ml	5	
	Cavilon® cream	Tube 28g	1	Use on intact skin. Do not use on infected skin
		Tube 92g	1	
		Sachet 2g	20	
		Applicator 1ml	5 / 25	Can be used on broken skin. Do not use on infected skin
		Applicator 3ml	5 / 25	
	Cavilon® Spray	28ml	1 / 12	Do not use on infected skin Extremely flammable in liquid form

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[1] Alternative product on secondary care contract

Notes