WOUND HEALING PRODUCTS

Formulary and Guidelines

2012

Wound Healing Group
Aneurin Bevan University Health Board

This Guidelines/Formulary is available on-line at: www.gpmtc.wales.nhs.uk
Contents

A. Introduction Page 3

B. Wound Management Guidelines Page 4 - 6

C. Formulary Page 7 - 14

D. Guidance on the use of Silver Dressings Page 15

E. Guidance on the use of Silicone dressings Page 16

F. Guidance on the use of TNP Page 17

G. References and Further Guidance Page 18

H. Wound Healing Products Page 19

I. CNS Tissue Viability contact details Page 20
A. INTRODUCTION

This formulary provides information on a definitive list of dressings which will be available within the Aneurin Bevan University Health Board and provides guidance on their use. This is a collaborative document across Primary and Secondary Care.

The information has been collated by the members of the Wound Formulary Group whose members include the following:

- Dr Richard Goodwin  Chair Consultant Dermatologist
- Jayne Warren  CNS Tissue Viability
- Tracey Morgan  CNS Tissue Viability
- Alison Chandler  CNS Tissue Viability
- Liz Jeffreys  Foot and Ankle Nurse Specialist
- Trevor Batt  Principal Pharmacist Formulary/Interface
- Charmaine Juniper  Prescribing Support Pharmacist Caerphilly Locality
- Tracey Hutchings  CNS Vascular Surgery
- Theresa Maclean  Pharmacist RGH
- Gaynor Slocombe  Podiatrist
- Liz Freeman  CNS Dermatology

There are a wide range of products included in the formulary which are appropriate for specific stages of wound healing. In exceptional circumstances where a suitable dressing cannot be found on the Formulary an application for dressings or wound products not listed can be made via the chairman of the Wound Healing Group, Dr. Richard Goodwin Consultant Dermatologist, or in his absence a CNS in Tissue Viability.

N.B.

Dressings listed in Table 2 are only available if authorised by the CNS Tissue Viability or Community Band 7+. All wounds must be assessed and an authorisation form completed prior to application and placed in patients notes.

Dressings listed in Table 3 are only available if authorised by CNS in Tissue Viability and an authorisation form is completed prior to application and placed in patients notes.

The use of wound healing products in bold italics are restricted and require authorization – see TABLES 1 to 3
B. WOUND MANAGEMENT GUIDELINES

These guidelines have been written to assist staff in the management of wounds.

It is fundamental to wound management that a thorough assessment of each patient is undertaken prior to developing a management plan for any wound.

The aims and objectives of these guidelines are:

- Patient assessment
- Wound assessment
- Treatment/Dressing Selection
- Patient advocate
- Recording information
- Review date
- Patient discharge information

Patient Assessment

This should comprise:

- Chronic disease
- Nutritional status
- Immune status
- Age
- Psychological status
- Smoking
- Current and relevant previous medication
- Relevant bloods
- Social Factors
Wound Assessment

This should include:

- Previous history and treatment obtained from the patient if not recorded in the notes or referral letter
- Wound aetiology - Vascular assessment including Ankle Brachial Pressure Index. Neurological assessment where possible to establish the presence of neuropathy. It is paramount that all possible causative factors are investigated and if necessary an appropriate referral is made to the relevant specialism
- Number, size and location of all wounds.
- Pressure Ulcer Grade EPUAP (2009)
- Type and appearance of wound, e.g. colour, tissue, exudate etc
- Patient’s normal resting position in relation to the wound e.g. leg elevation
- Pain – The alleviation of pain should be promptly addressed and carefully monitored.
- Appearance of surrounding skin - Skin Care - Emollients (such as emulsifying ointment BP) are used to increase skin hydration and to help prevent the development of eczema and dry cracks and fissures on feet. See ABHB Medicines Formulary for further information on specific emollient choices.
- Waterlow Assessment.
- Skin Bundle implemented if indicated.
- Wound Chart completed.

Treatment/Dressing Selection

- Reference to the Wound Healing Group Formulary is essential. For products in table 2 and 3 please contact appropriate personnel

- To optimise healing in the majority of wounds a moist environment is desirable. This encourages the breakdown of fibrin and dead tissue and prevents tissue dehydration. It also promotes the interaction of growth factors which results in formation of new capillaries and new granulation tissue. However patients with Peripheral Vascular Disease with wounds on their extremities should not be treated with autolytic debriding agents. THESE WOUNDS SHOULD BE KEPT DRY
There is no such thing as an ‘ideal’ dressing. Dressing selected should include the following characteristics:

- Maintain a moist environment
- Adequately manage excess exudate
- Allow gaseous exchange
- Provide thermal insulation and mechanical protection
- Non-allergic and non-sensitising
- Impermeable to micro-organisms
- Acceptable to patient and pain minimising
- Clinically/cost effective
- Non inflammable
- Non adherent

Patient engagement and communication
This is a key role for any health professional treating a patient. An explanation of the nature and type of wound, and the expected actions of the selected dressing should be conveyed to the patient. It is essential to obtain informed consent from the patient or their legal representative prior to any intervention. This must be clearly documented in the patient’s records. It must be clear that the treatment options, expected outcomes, any possible adverse events and alternatives to the suggested treatment are explained and understood by the patient or their legal representative. It is essential that the level of concordance of the patient to a proposed treatment/management plan is established as this will influence the effectiveness of the plan.

Recording Information
The ABHB Wound Management Chart should be completed to record all information relating to wound management. It is a legal requirement that all interventions are fully documented in the patient’s treatment record e.g. medical notes, nursing notes or patient records.

Review Date
A date for re-assessment should be agreed with the nurse/doctor.

Patient Discharge Information
If a patient is admitted to or discharged from hospital with a wound, instructions should be provided on the plan of care and a wound chart completed.
C. FORMULARY

To assist in the correct selection of wound dressing this formulary has been designed around the ‘type’ of wound rather than individual dressings. After reading the ‘Wound Management Guidelines’ the clinician should consult the formulary section.

Note: Products listed in bold italics are for restricted use only.

Wound type classifications:

1. Inflamed Foot
2. Epithelialising Wounds
   2.1 Superficial, clean, low exudate
   2.2 Clean, with medium exudate
3. Granulating Wounds
   3.1 Clean, surgical wounds with tissue loss
   3.2 Chronic wounds with low/moderate exudate
   3.3 Chronic open wounds with moderate/high exudate
   3.4 Chronic cavity wounds
4. Wounds with slough
   4.1 Dry
   4.2 Moist
   4.3 Cavities
5. Black Necrotic Wounds
   5.1 Superficial
   4.2 Extensive and deep
6. Infected and Malodorous Wounds
   6.1 Shallow
   6.2 Cavities
   6.3 Heavy exudate
   6.4 Malodorous
7. Miscellaneous
   7.1 Miscellaneous for general use
   7.2 Miscellaneous for restricted use
1. Inflamed Foot

Listed below are several commonly seen causes of this condition:

- **Cellulitis** (Infection)
- **Eczema** can cause a similar appearance (i.e. from venous stasis or contact sensitivity to dressings)
- **Venous hypertension**
- **Ischaemia**

- **Cellulitis** is usually preceded 6 to 12 hours by a feeling of malaise and flu-like symptoms, with or without pyrexia. The redness will often spread visibly over 24 hours. Blood tests for elevated CRP, ESR and White Cell count should be taken. Treatment requires systemic antibiotics and leg elevation. This condition is rarely bilateral and other conditions should be considered.

- **Eczema** on the foot or lower leg may sometimes look very similar to cellulitis, but does not cause symptoms of malaise or pyrexia. It is commonly caused by venous stasis. Occasionally an allergic contact dermatitis to topically applied medications, dressings or bandages may be responsible. Treatment of eczema requires leg elevation and or compression bandaging as well as topical emollients and topical steroid. If allergic contact dermatitis is suspected then patch tests will be required to determine exactly which product is responsible.

- **Venous Hypertension** may have a similar presentation to cellulitis and can present bilaterally. If the patient’s general medical condition permits, compression therapy should be considered.

- **Ischaemia** classically presents as very painful (Rest Pain on elevation) and absent foot pulses.
2. Epithelialising Wounds

Epithelial cells from the wound margins or hair follicles in the dermis proliferate and grow over the already granulated tissue.

The aim of dressings for this type of wound is to maintain a moist wound healing environment.

2.1 Superficial, clean, low exudate

<table>
<thead>
<tr>
<th>Semi-permeable films:</th>
<th>Leukomed T and Leukomed T Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocolloid sheet:</td>
<td>Comfeel Plus Transparent, Comfeel Plus, DuoDERM Extra Thin, Tegaderm Hydrocolloid</td>
</tr>
<tr>
<td>Hydrogels:</td>
<td>Hydrosorb, Activheal hydrogel, Intrasite Conformable Actiform Cool</td>
</tr>
<tr>
<td>Non Adherent Primary dressings:</td>
<td>Atrauman, Cosmopore E, Silflex, Mepitel One</td>
</tr>
</tbody>
</table>

2.2 Clean, medium exudate

<table>
<thead>
<tr>
<th>Hydrofibre:</th>
<th>Aquacel Extra</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary dressing</td>
<td>Atrauman, Cosmopore E, Silflex, Mepitel One</td>
</tr>
<tr>
<td>Hydrocolloid sheet:</td>
<td>Comfeel Plus, Tegaderm Hydrocolloid</td>
</tr>
<tr>
<td>Polyurethane foam:</td>
<td>Activheal, Allevyn Gentle range, Mepilex range (NOT Ag)</td>
</tr>
</tbody>
</table>
3. Granulating Wounds

When there is significant dermal tissue damage, the resulting wound requires the production of collagen forming granulation tissue. It is common for such a wound to also produce varying quantities of exudate. The types of wound within this group can be sub divided according to the degree of exudate. Granulating wounds also include surgical wounds left to heal by secondary intention.

3.1 Wounds with low/medium exudates

<table>
<thead>
<tr>
<th>Primary dressing</th>
<th>Atrauman, Cosmopore E, Silflex, Mepitel One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocolloid sheet:</td>
<td>Comfeel plus transparent, Comfeel plus, DuoDERM Extra Thin, Tegaderm Hydrocolloid</td>
</tr>
<tr>
<td>Hydrofibre</td>
<td>Aquacel Extra</td>
</tr>
<tr>
<td>Hydrogels:</td>
<td>Activheal hydrogel, Hydrosorb, Intrasite Conformable, Actiform Cool</td>
</tr>
<tr>
<td>Polyurethane foam:</td>
<td>Activheal, Allevyn Gentle range, Mepilex range (NOT Ag)</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Activon Honey range, Advadraw</td>
</tr>
</tbody>
</table>

3.2 Wounds with high exudates

| Hydrofibre             | Aquacel Extra                               |
| Primary dressing       | Atrauman, Silflex, Mepitel One              |
| Polyurethane foam      | Biatain, Allevyn Gentle range               |
| Miscellaneous          | Advadraw                                    |

3.3 Cavity wounds

| Hydrofibre             | Aquacel Extra                               |
| Hydrogel:              | Activheal hydrogel, Intrasite Conformable,    |
| Miscellaneous          | Activon Honey range, Advadraw               |
| Polyurethane Foam      | Allevyn Cavity, Cavi-Care                   |
4. Wounds with Slough

Wounds can frequently be covered by a viscous yellow/brown material, which is commonly referred to as slough.
The constituents of slough can vary but is normally a mixture of necrotised tissue, fibrin and bacteria containing pus. Also present will be leucocytes and deoxyribonucleoprotein.
Certain elements present in the slough will frequently cause an inflammatory response to the skin surrounding the wound.
The reservoir of slough and necrotised tissue can act as the ideal environment for bacteriological infection of the wound. The bactericidal activity of leucocytes can be severely inhibited by the slough ‘mixture’.
Wound cleansing therefore becomes a priority if infection is to be avoided. The following products are designed to minimise the risk.

4.1 Low Exudate
Hydrogels: Activheal hydrogel. Hydrosorb, Intrasite Conformable, Actiform Cool
Hydrocolloid sheet: Comfeel plus transparent, DuoDERM Extra thin, Tegaderm Hydrocolloid
Miscellaneous: Activon Honey range, Larvae Therapy

4.2 Medium Exudate
Hydrofibre: Aquacel Extra
Hydrocolloid sheet: Comfeel Plus, Tegaderm Hydrocolloid
Polyurethane Foamil: Activheal, Allevyn Gentle range, Mepilex range (NOT Ag)
Miscellaneous: Activon Honey range, Advadraw, Larvae Therapy

4.3 Heavy Exudate
Hydrofibre: Aquacel Extra
Polyurethane Foam: Biatain (NOT Ag)
Miscellaneous: Advadraw

The use of wound healing products in **bold italics** are restricted and require authorization – see TABLES 1 to 3
Aneurin Bevan University Health Board Wound Healing Guidelines & Formulary FOURTH EDITION – May 2012 (Revised Nov 2013)
Review date: 2015
4.4 Cavities
- Hydrogels: Activheal hydrogel, Intrasite Conformable
- Hydrofibre: Aquacel Extra
- Miscellaneous: Activon Honey range, Advadraw, Larvae Therapy
- Polyurethane Foam: Allevyn Cavity, Cavi-Care

5. Black Necrotic Wounds
The wound surface, whether superficial or cavity, is either partially or totally covered by black necrotic tissue. Where the necrotic tissue becomes dry autolysis becomes increasingly difficult. The separation of the sloughy tissue becomes more difficult and eventually ceases. The necrotic layer varies considerably in thickness and depth, from a surface wound through to deep cavity. Often layered cavities, filled with partially liquid material, form beneath the layer of the black eschar. The dressing used is dependent on the type of necrosis.

**Note:** Where ischaemic or thrombolytic aetiology is suspected it is essential that the area is kept dry and an urgent referral is made to an appropriate specialist.

5.1 Intact dry necrotic heel, digits or ischaemic wound
- Primary Dressing: Cosmopore E, Atrauman
- Antimicrobial: Inadine

5.2 Superficial
- Hydrocolloid sheet: Comfeel plus transparent, DuoDERM Extra thin, Tegaderm Hydrocolloid
- Antimicrobial: Inadine, Activon Honey range, Iodoflex
- Hydrogel: Activheal hydrogel, Hydrosorb, Intrasite Conformable, Actiform Cool
- Primary dressing: Atrauman, Cosmopore E, Siflex, Mepitel One

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5.3 Cavity
   Hydrogel: Activheal hydrogel, Intrasite Conformable
   Antibacterial: Actilon Honey range, Iodoflex, Aquacel Ag Extra, Cutimed Sorbact
   Hydrofibre: Aquacel Extra
   Miscellaneous: Advadraw, Allevyn Cavity, Cavi-Care

6. Critically colonised, Infected and Malodorous Wounds
   All wounds are susceptible to microbial colonisation, the extent of which is influenced mainly by the patient’s immune system and the wound environment. Critically colonised and infected wounds may be treated with topical antimicrobials. Infected wounds will require systemic antibiotic therapy.

   6.1 Shallow
   Anaerobic infections: Metronidazole Gel
   Broad spectrum: Inadine, Flamazine, Actilon honey range,
   Antibacterial: Aquacel Ag Extra, Iodoflex, Cutimed Sorbact, Acticoat range, Mepilex Ag range

   6.2 Cavities
   Anaerobic infections: Metronidazole Gel
   Broad spectrum: Flamazine, Actilon honey range, Aquacel Ag Extra, Acticoat range, Iodoflex, Cutimed Sorbact

   6.3 Heavily exudating wounds
   Polyurethane foam: Mepilex Ag range
   Antibacterial: Aquacel Ag Extra, Acticoat Absorbent
   Miscellaneous: Advadraw

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Review date: 2015
NB Where silver dressings are required the CNS Tissue Viability or Community Band 7+ Nurse must assess the patient and complete an authorisation form. See Silver Dressings Guidelines Page 15.

6.4 Malodorous Wounds

Infected wounds such as pressure ulcers, leg ulcers and fungating carcinomas often produce noxious odours which may be caused by anaerobic Bacteroides, Proteus, Klebsiella and Pseudomonas spp, This can be distressing to the patient and visitors. The primary aim of treatment should be to control these odours effectively.

Activated Charcoal dressing: Carboflex – As a primary dressing
Antibacterial
Clinisorb – As a secondary dressing
Soaks/Wet Dressings: Metronidazole Gel
Potassium Permanganate solution, Acetic Acid (Vinegar) 1 part to 20 parts water

7. Miscellaneous

7.1 Miscellaneous Items

Kaltostat - Haemostatic
Advadraw - Positive capillary action dressing
Cavilon - Foam Applicator, Spray and Cream

7.2 Miscellaneous items for CNS Tissue Viability

Larvae Therapy
Topical Negative pressure
Prontosan – Irrigation and gel
Debrisoft – Debriding Agent
Aquacel Surgical (Orthopaedic Theatres only)
D. Guidance on use of SILVER DRESSINGS

Antimicrobial dressings containing silver should be used only when infection is suspected as a result of clinical signs or symptoms. Silver ions exert an antimicrobial effect in the presence of wound exudate; the volume of wound exudate as well as the presence of infection should be considered when selecting a silver-containing dressing.

Silver dressings remain Formulary options for managing critically colonised wounds (without resorting to oral antibiotics) but with the following restrictions:

- The wound must be seen and assessed by the TVN/community Band 7+ nurse
- Their request must be accompanied by the correct authorisation form which should be scanned into patient’s notes – see full Silver dressing guideline
- **Maximum duration of use should not exceed 2 weeks**
- They must NOT to be put on repeat prescription

The importance of picking correct dressing by Prescribing Clerk at point of prescription production should be noted – many silver dressings are only differentiated in name from standard dressings by the suffix “Ag”.

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The use of wound healing products in **bold italics** are restricted and require authorization – see TABLES 1 to 3

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Review date: 2015
E. Guidance on use of SILICONE DRESSINGS

Silicone dressings such as Mepitel One and Silflex are atraumatic non-adherent soft silicon wound dressings. The silicon coating does not adhere to the surface of the wound bed. This results in reduced pain and wound bed damage on removal. When used appropriately as a primary dressing the silicone dressing can remain in situ for up to seven to fourteen days.

Secondary dressings should be changed according to the patients needs. This may be in order to check the wound, surrounding skin or to manage exudate. If the wound requires cleansing, irrigate with warm saline but do not remove the silicone dressing.

If used in this way it will result in a cost effective treatment.

It is essential that if the primary dressing is being changed more than every 7 days an alternative product must be used.

The use of Mepitel One or Silflex may be considered in the following wound types as long as the intention is not to remove the primary dressing within 7 to 14 days. (See product information)

- Pre tibial lacerations
- Finger injuries
- Some skin tears
- Burns
- Post nail avulsions
- Skin grafts
- Open Abdominal wounds (exposed bowel)
- Fungating Wounds

If you are concerned about any of the above please contact your CNS Tissue Viability as stated in the CNS Tissue Viability Referral Document
F. Guidance on use of TOPICAL NEGATIVE PRESSURE

TNP Therapy Initiated following consultation with Consultant Surgeon/Physician and a TVN

Ensure patient’s wound is assessed for this therapy and patient is appropriately informed and consent obtained

TNP dressing is changed at least twice a week – depending on aetiology and progress of wound
These dressing changes must be carried out by an appropriately trained registered healthcare professional
Advice should be sought from TVN or Company Support Staff

TVN/Consultant review
*Secondary Care = weekly
*Community = 2 weekly
*TNP clinic twice weekly at NHH

Wound improving
Continue with TNP Therapy with guidance from TVN

No response in healing within TWO weeks
Remove and clean TNP
N.B. cancel TNP hire with KCI or Smith and Nephew and arrange collection. Have patient details and serial number available when cancelling
Initiate alternative Treatment

Optimum wound healing
G. FURTHER GUIDANCE

NICE Guidelines

The MIST Therapy system for the promotion of wound healing (MTG5 – July 2011): http://guidance.nice.org.uk/MTG5


Royal College of Nursing Guidelines (http://www.rcn.org.uk/development/practice/clinicalguidelines)

The Management of Venous Leg Ulcers (2006)
Pressure Ulcers (2005)

All Wales Tissue Viability Forum (http://welshwoundnetwork.org)

Prevention and Management of Pressure Ulcers (2011)

European Pressure Ulcer Advisory Panel (http://www.epuap.org/guidelines/)

Prevention and Treatment guides 2009-10

ABHB Wound Healing Group Guidance

Full documents available on Tissue Viability website or ABHB intranet:
Guidelines on the use of Silver Dressings
Guidelines on the use of TNP Therapy
Guidelines on the use of Silicone Dressings
H. WOUND HEALING PRODUCTS CLASSIFICATION

**TABLE 1**

| Cleansing Agents | Sodium Chloride 0.9% solution  
| Chlorhexidine Aqueous solution |
| Soaks/Wet Dressings | Potassium Permanganate solution (Permitabs) 
| Acetic Acid (Vinegar) |
| Antibacterial | Silver Sulphadiazine cream (Flamazine)  
| Metronidazole Gel, Inadine |
| Semi-permeable Films | Leukomed T, Leukomed T Plus |
| Hydrocolloid dressings | Comfeel Plus transparent, Comfeel Plus |
| Hydrofibre Dressings | Aquacel Extra and ribbon (NOT Ag Extra) |
| Alginate Dressings | Kaltostat sheet and ribbon for haemostatic use only |
| Hydrogels | Activheal hydrogel, Hydrosorb, Intrasite Conformable |
| Polyurethane Foam | Activheal Foam, Activheal Foam Adhesive |
| Non Adherent Primary Dressing and Secondary dressings | Atrauman, Telfa, Cosmopore E  
| Zetuvit E, Zetuvit Plus (for heavily exuding wounds only) |
| Activated Charcoal | Clinisorb |
| Miscellaneous Products | Advadraw, Cavi-Care, Allevyn Cavity, Cavilon Foam Applicator, Spray and Cream, Activon honey range, Tegaderm Tracheostomy |

**TABLE 2** For Use Under CNS Tissue Viability or Community Band 7+ authorisation only

| Antibacterial | Iodoflex, Aquacel Ag Extra, Cutimed Sorbact (gel and swab) |
| Activated Charcoal | Carboflex |
| Polyurethane Foam | Allevyn Gentle range, Biatain high exudate only |
| Non Adherent Primary Dressing | Silflex, Mepitel One |
| Hydrocolloid dressings | Duoderm Extra thin, Tegaderm Hydrocolloid |

**TABLE 3** For Use Under CNS Tissue Viability Authorisation only

| Antibacterial | Mepilex Ag range, Acticoat range |
| Polyurethane Foam | Biatain Ibu, Mepilex range |
| Miscellaneous Products | Larvae Therapy, Topical Negative Pressure, Actiform Cool, Prontosan – Irrigation and gel, Eclypse, Aquacel Surgical (Theatres only), Debrisoft |

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Review date: 2015
I. CNS TISSUE VIABILITY CONTACT DETAILS:

Jayne Warren, Clinical Nurse Specialist in Tissue Viability
Nevill Hall Hospital
Email Jayne.Warren@wales.nhs.uk Bleep 342 Tel: 01873 732159
Covering – Nevill Hall, Ysbyty Aneurin Bevan, Ysbyty Tri Cwm, Monovale and
MaIndiff Court Hospitals.
Blaenau Gwent and North Monmouthshire community

Alison Chandler, Clinical Nurse Specialist in Tissue Viability
Royal Gwent Hospital
Email Alison.chandler@wales.nhs.uk Tel: 01633 236290
Covering – RGH, County, St Woolos and St Cadocs Hospitals.

Tracey Morgan, Clinical Nurse Specialist in Tissue Viability.
Community
Email tracey.morgan2@wales.nhs.uk Tel: 01633 238967 Mobile 07879412191
Covering – YYF, Redwood, Chepstow, Llanfrechfa and Ty Sirhowy hospitals.
Newport, Torfaen, Caerphilly and South Monmouth Community.
Learning Disability Units.

ABHB Wound Healing Group gratefully acknowledge that printed copies of this
Formulary / Guidelines are only available through the financial support of the
following companies:
Admedsol (www.admedsol.com/)
Advancis (www.advancis.co.uk/)
Coloplast (www.coloplast.co.uk/woundandskincare)
ConvaTec (www.convatec.co.uk)
Mölénycke (www.molnlycke.com/gb/Wound-Care-Products)
Smith & Nephew (http://wound.smith-nephew.com/uk)