Best Practice Statement

Development of a formulary

wound care alliance UK
moving forward together

This document was funded with an unrestricted educational grant from ConvaTec Ltd. The views expressed in this publication are those of the authors and do not necessarily reflect those of Wounds UK and ConvaTec Ltd

To reference this document cite the following:
Best Practice Statement: Development of a Formulary. Wounds UK, Aberdeen, 2008

CONTENTS

Foreword

When a wound dressings formulary has been developed following a stringent process to determine quality and cost-effectiveness by a suitably qualified group of healthcare professionals from diverse backgrounds, it plays an integral role in wound management practice.

Alongside the dressings formulary, it is necessary to have an ongoing education program to ensure that all included wound dressings and their application, removal and appropriate use are optimised to the benefit of both patient and healthcare professional.

A dressings formulary needs to be fluid and dynamic, to ensure it meets the needs of patients and their wounds. Consequently regular audit is a clinical necessity, to monitor which dressings are being used, in what quantities and whether their use is appropriate. Audit results aid the direction of education and training and aid the multi-disciplinary team responsible for the dressings formulary, in the decision making process of which dressings remain within a formulary or perhaps need to be replaced.

This document has been produced and reviewed by the members of Wound Care Alliance UK (formerly Tissue Viability Nurses Association and Wound Care Society), for use by healthcare professionals responsible for either the production or the review of a wound dressings formulary.

It has been developed following the key principles of best practice (listed below). This helps to ensure that the highest standards of care are delivered across all care settings, and by all care professionals:

- Best Practice Statements (BPSs) are intended to guide practice and promote a consistent and cohesive approach to care.
- BPSs are primarily intended for use by registered nurses, and the staff who support them, but they may also contribute to multidisciplinary working and be of guidance to other members of the healthcare team.
- Statements are derived from the best available evidence, including expert opinion at the time they are produced, recognising that levels and types of evidence vary.
- Information is gathered from a broad range of sources to identify existing or previous initiatives at local and national level, incorporate work of a qualitative and quantitative nature, and establish consensus.
- Statements are targeted at practitioners, using language that is both accessible and meaningful, and is presented in an easy to read table format.

By using this document it is hoped that a relevant wounds dressing formulary can be created which includes a range of clinically- and cost-effective products to meet the patient's wound care requirements, regardless of care setting.

.

Introduction

A wound dressings formulary is a clinical and financial necessity and the development and maintenance of such a formulary is the responsibility of every NHS Trust in both primary and secondary care. How the NHS budget is spent is widely regarded as a matter for government and the Department of Health (DOH), however, it should be remembered that this budget is generated by the taxpayer, and as a result, expenditure is also the local responsibility of all who work within the NHS from chief executive to nurse.

Within the UK, the devolvement of the NHS budget fluctuates according to political and financial constraints. The bulk of the NHS budget is currently held within primary care and primary care trusts (PCTs) are reminded by the DOH in the guidance *Primary Care Prescribing and Budget Setting* (Department of Health, 2008), that they are obliged to earmark realistic amounts to underpin prescribing by general practitioners and nurses. PCTs have a statutory obligation to provide funding for clinical decisions, including the prescription of wound dressings, recommend from the National Institute for Clinical Excellence (NICE), contained in the document Technology Appraisal Guidance (2001). Both primary and secondary care are subject to the same financial constraints and an obligation to provide effective and cost-efficient wound care, so the need for local trusts and health boards to work together in developing a formulary is obvious.

The provision of drug treatments for conditions such as breast and renal cancer within NHS trusts and health boards has recently been the cause of much heated debate, with accusations of a postcode lottery levelled at some PCTs because they hold the budget and therefore make the decision whether or not particular treatments will be funded. Similarly, wound dressings are expensive, with many costing far more than frequently used drugs such as diuretics. Consequently their use needs to be stringently regulated so that only appropriate clinically and cost-effective dressings are used. To achieve this aim, wound dressings should be included in a specialist section on wound management within the formulary of every NHS trust/health board in both primary and secondary care.

Health economics

Those responsible for the creation, or review, of a wound dressings formulary should have an understanding of the health economics which drive this process and be able to use the appropriate means of decision making. Often the term 'cost-effectiveness' is loosely used to convey some indication of relative costs associated with a treatment, in the context of a defined clinical outcome, for example, cost to achieve healing or debridement. However, there is a danger that cost-effectiveness can be misused, to refer only to the relative unit cost of a dressing, or a compression system.

While reviews by Bennett et al (2004), Simon et al (2004) and Posnett and Franks (2007) provide details of the costs of management for pressure ulcers and leg ulcers, these articles focus upon the total costs of care and do not address the relative costs of different treatments.

Economic evaluation is the comparison of two or more alternative courses of action, usually treatments, in terms of both their costs and consequences, e.g. healing (Drummond, 2005). Economists usually distinguish between several types of economic evaluation, depending upon how consequences are measured:

- Cost minimisation analysis
- Cost benefit analysis
- Cost-effectiveness analysis
- Cost-utility analysis.

In a cost minimisation analysis (CMA), the effectiveness of the comparators in question must be proven to be equivalent. Thus the 'cost-effective' comparator is simply the one

which costs less (as each achieves the same outcome). In a cost-benefit analysis (CBA), costs and benefits are both valued in cash terms. Cost effectiveness analysis (CEA) measures outcomes in 'natural units', such as wound area reduction, ulcer-free days, or life years gained. Finally, a cost-utility analysis (CUA) measures outcomes in a composite metric of both length and quality of life, the quality adjusted life year (QALY). A final approach which is sometimes classed as an economic evaluation is a cost of illness study. This is not a true economic evaluation as it does not compare the costs and outcomes of alternative courses of action. Instead, it attempts to measure all the costs associated with a particular disease or condition. These will include direct costs (where money actually changes hands, e.g. health service use, patient co-payments and out of pocket expenses), indirect costs (the value of lost productivity from time off work due to illness), and intangible costs such as the amount of pain suffered by a patient with a wound.

The process of wound dressing selection for a formulary is complicated due to the multitude of wound dressings available. It is vital that the trust/health board appoint a multidisciplinary team member to be responsible for the evaluation process to ensure that the process is driven forward and does not fail due to a lack of identified responsibility. The decision to include any dressing within a wound care formulary needs to be reached by a multi-disciplinary team, including healthcare professionals with clinical skills and procurement officers and pharmacy purchasers with economic training and skills.

Continuity of care

In addition to each individual trust creating its own formulary it is important that an understanding is reached locally between primary and secondary care trusts, regarding a consistent approach to wound dressings. A wound dressing formulary which is confluent between hospital and community is beneficial to patients, nursing staff, clinicians and NHS trust/health board. For example, if on discharge from hospital a patient was supplied with appropriate quantities of wound dressings for their needs, patients and community nurses would benefit, from both the provision of wound care dressing and continuity of care which the patient has a right to expect. Inadequate provision of wound dressings on discharge from hospital can lead to a delay in care, while dressings are sought via prescription, or an inappropriate/inadequate dressing is applied temporarily, which may possibly lead to wound deterioration. This arrangement may need to be facilitated by a realignment of funding between primary and secondary care, which may be done simply by establishing an agreement that the patient's wound dressings accompany them both into and out of hospital, either by prescription by their community nurse before admission or by the tissue viability nurse (TVN)/doctor in secondary care upon discharge.

Nurses working within secondary care have access only to those wound dressings included within their Trust formulary. Specialists such as the TVN may prescribe outside the formulary only with the agreement of the formulary pharmacists and using only a list of wound dressings agreed by the Medicines Management Committee, therefore they do not have access to the whole range of wound dressings included on Drug Tariff.

However, healthcare professionals who are independent prescribers do have access to all the wound dressings on Drug Tariff, so need to understand their organisational responsibility to work within the confines of a wound dressing formulary, using their prescribing rights to utilise wherever possible dressings which have been agreed upon and to not indulge personal preferences in prescribing outside the formulary. Instances will arise when a particular wound dressing which is not included within the formulary will need to be prescribed, however, this should be done following careful assessment and with the understanding that the

dressing's use will be carefully audited. Pressures may be exerted by patients to have a particular dressing prescribed, as the influence of the media and internet can have a profound effect on a desperate patient or relative. It is the responsibility of the healthcare professional to ensure that the patient understands their treatment and discusses whether the patient has a justifiable claim to a particular dressing. In such instances the TVN should be involved, so that a higher degree of wound healing and product knowledge can be consulted by the patient and healthcare professional. PCTs set GP-practice prescribing budgets to both meet the need of patients and represent the most efficient use of resources. Nurse prescribing costs are included within the practice budget. Consequently the prescribing by all nursing and medical professionals is monitored and audited and inappropriate prescribing identified.

Development of a formulary

An identifiable process which is fair and impartial must be employed by a trust/health board when selecting products for a wound dressings formulary, taking into consideration a variety of expertise and clinical knowledge. It must also be recognised that a wound dressings formulary should be dynamic, changing according to the emergence of new wound dressings which may supercede current dressings. However, this must be balanced with avoiding unnecessary change and recognising the need for education to underpin the use of wound dressings to ensure their appropriate use.

This document aims to guide nurses, doctors, pharmacists and procurement officers within NHS Trusts in the development of a formulary to ensure that a fair and equitable process is followed, avoiding the undue influence of industry. By following these recommendations, a relevant wound dressings formulary can be created which includes a range of clinically- and cost-effective products to serve the patient's wound requirements. It is hoped that this document will be useful to those working within wound management to alert them to the necessity of a wound dressing formulary where one does not exist, and to remind all healthcare professionals that a formulary needs to be a fluid document, one which is regularly updated and reviewed to ensure all local guidance remains appropriate.

Section 1. Identify the need for a formulary

Statement	Reason for statement	How to demonstrate statement is being achieved
❖ Both staff and patients should have access to wound care dressings that are both clinically and economically effective	❖ Using wound dressings which are not clinically and economically effective can lead to sub-optimal care/ treatment	❖ Each organisation should ensure its staff have access to a formulary which includes dressings which are clinically and economically effective. The trust/health board, its staff and patients would benefit from a formulary being in place because of better practice, care continuity, reduction in costs and improved patient outcomes, e.g. less frequent dressing changes as wound products with better fluid handling capability are used
❖ The need for a wound dressing formulary will be identified by the pharmacy department, financial director, procurement officer or tissue viability nurse following analysis of how much of the pharmacy budget is spent on wound dressings and via audit of current wound dressings to determine: »Are dressings used appropriately? »How frequently are dressings changed? »The dressing's specific characteristics, i.e. fluid handling capacity »If there are any wound aetiologies not currently served by the dressings used	❖ The NHS trust/health board has a statutory responsibility to provide funding for clinical decisions, including wound dressings (DoH, 2008), as recommended by the National Institute for Health and Clinical Excellence (NICE)	❖ The trust/health board should include clinical and cost-effectiveness within the trust/health board strategy and ensure its employees adhere to this. Audit of current practice and wound dressings should be performed regularly and its findings acted upon. A reduction should be seen in the pharmacy budget use for wound dressing provision. Improved patient wound outcomes should be noted, e.g. less frequent dressing changes as wound products with better fluid handling capability are used
❖ A lead professional for the development of the dressings formulary is selected to lead a multidisciplinary (MDT) team which will be created to develop and/or review the wound dressing formulary at regular intervals	❖ To ensure the task of developing/reviewing a wound dressing formulary is fulfilled	❖ An appropriate professional with requisite skills and knowledge takes responsibility for ensuring the wound dressings formulary is created
❖ Development of a dressing formulary can present challenges because: »Staff may be resistant to change »Routine/ritualistic practice may be in existence »Provision of education and training in appropriate dressing application will be required	❖ It is important to involve and listen to all staff likely to be affected by the development of the formulary	❖ Staff likely to be affected by the development of a formulary are informed and given the opportunity to participate in the process. A multidisciplinary team is created and has agreed time intervals to review the wound dressings formulary

Section 2. Review of an existing wound dressings formulary

Statement	Reason for statement	How to demonstrate statement is being achieved
❖ It should be established if the trust/health board has a clinical and cost-effective range of wound dressings within its formulary that are 'fit for purpose'	❖ Each NHS trust/health board has a responsibility to utilize its budget in a clinical and cost-effective manner, to deliver best practice and avoid ritualistic/routine wound management	❖ The trust board should include clinical and cost-effectiveness within the trust strategy and ensure its employees adhere to this strategy
❖ A healthcare professional, e.g. doctor, podiatrist, TVN, or nurse, voice concerns that some relevant wound dressings are excluded from the formulary or that some wound dressings do not appear to be effective	❖ A wound dressing formulary must provide a comprehensive range of wound dressings to ensure all wound aetiologies are provided for, and that they are clinically and economically effective	❖ A formal process exists by which any healthcare professional may bring their concerns to the attention of the Medicines Management Committee
❖ The wound dressing formulary should be reviewed regularly, at intervals determined by the MDT responsible for the formulary's development	❖ To ensure that there is opportunity to include new wound dressings and to review the appropriateness of existing wound dressings in the formulary	❖ At each agreed time interval the wound dressings formulary is examined, along with any formulary-related feedback from healthcare professionals working in wound care within the trust

Section 3. Formation of a multidisciplinary team to drive the development of the formulary

Statement	Reason for statement	How to demonstrate statement is being achieved
❖ The individual healthcare professional responsible for wound management practice should establish a knowledgeable MDT to include: »TVN »Doctor »Formulary pharmacist »Procurement officer »Member of medicines management committee »Podiatrist »Ward/community nurse »Member of clinical audit department »A patient/relative/carer	❖ To ensure a robust, clinical and cost-effective process involving all relevant professionals using, and patients/carers affected by, the wound dressings formulary	❖ Members of the MDT are publicly known and minutes from the meeting are available for scrutiny by any member of the trust
❖ Each member of the MDT will be transparent and impartial in their input and will declare all interests in any companies	❖ To ensure no member of the MDT is unduly influenced by industry	❖ All members of the MDT will sign a formal declaration stating that they will be fair and equitable in the process of examining products for the wound dressings formulary
❖ A member of the MDT will be designated chair or lead person	❖ To ensure the process is organised and that all members of the MDT fulfil their role	❖ An appropriate clinical professional will be designated chair/lead and will attend every meeting and ensure a fair, equitable process is followed
❖ The membership of the MDT should be reviewed at regular intervals	❖ Members may leave the trust, lose interest or have more pressing clinical obligations	❖ Members are obliged to attend meetings or leave the MDT to avoid the creation/development of the formulary being disrupted

Statement	Reason for statement	How to demonstrate statement is being achieved
❖ The MDT should agree a plan of action which includes: »Delegation of responsibility according to clinical/financial skills	❖ A systematic approach is required to ensure a robust and equitable process	❖ The MDT meeting minutes should reflect appropriate delegation of work within the relevant specialist knowledge of each individual group member
»Realistic timelines for each action	❖ It is important to recognise that members of the MDT have other clinical roles to fulfill	❖ Timelines will be realistic and goals achieved
»Generation of an information action plan to inform relevant professionals of the Trust's intention to create a wound dressings formulary and how each professional will be expected to contribute to its development. To include: › Nursing staff › Medical staff › Pharmaceutical staff › Procurement staff › Clinical audit department › Clinical governance committee.	❖ It is imperative that all staff understand their individual clinical and organisational responsibilities to deliver appropriate and cost-effective care. Involvement in the process of forming a wound dressing formulary allows individuals to engage in the process and feel a sense of ownership	❖ The MDT will inform trust staff of formulary development via: »Announcements at senior staff meetings and cascading information »Posters and suggestion cards to inform trust personnel of formulary development to be distributed in: › Wards/outpatient departments › Community nurse bases › Practice nurse offices › Podiatry base › GP surgeries › Pharmacy department › Doctor's mess › Announcements in trust newsletter(s) and via ALLSTAFF email ❖ Trust staff will participate by making suggestions and volunteering to evaluate wound dressings
»An agreed audit cycle (*Appendix 1*)	❖ To ensure a robust and logical process according to clinical governance standards	❖ An audit form will be designed by members of the MDT (an example of an audit cycle for use is given in *Appendix 1*)
»Plan of education for members of the trust using wound dressings, e.g. doctors, nurses, podiatrists	❖ To ensure wound dressings are used appropriately	❖ Staff will be able to competently use dressings and future audits will demonstrate their appropriate use

SECTION 4. DEVELOPING AN ACTION PLAN FOR FORMULARY DEVELOPMENT (CONT...)

Statement	Reason for statement	How to demonstrate statement is being achieved
» Process of informing clinical governance group	❖ To ensure the process of clinical evaluation is approved by Clinical Governance Committee as being ethical	❖ Approval will be given by Clinical Governance Committee
» Reaching agreement regarding the process of clinical evaluation and inclusion/exclusion of dressings (*Appendix 2*)	❖ To ensure a robust and equitable action plan is agreed and a transparent evaluation of selected wound dressings occurs	❖ An action plan will be documented a within the groups minutes and available for any interested party within the trust/health board

Section 5. Performing audit to identify patterns of current dressing use

Statement	Reason for statement	How to demonstrate statement is being achieved
❖ Before selecting new products for potential inclusion within the formulary, it is important to establish current practice (Morgan, 2000) by performing an audit of current dressing use	❖ Audit will identify which wound types are being treated, and with which dressings	❖ An audit form of wound dressings and wound aetiologies will be devised by the MDT (*Appendix 3*)
❖ Relevant trust staff will be made aware by members of the MDT via email and posters of the need to audit current practice using wound dressings and of how audit will influence the selection process for the wound dressing formulary	❖ Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change (NICE, 2002)	❖ All staff when asked will be aware of the need for audit of current dressing practice, and the formulary selection process
❖ An audit form (*Appendix 3*) will be developed by the MDT and distributed to all relevant members of trust staff to determine the current use of wound dressings and the volume and nature of wounds being treated within the trust	❖ To ensure a consistent approach to audit and aid interpretation of findings	❖ All relevant staff will have access to a copy of the audit form and will have received instruction on its use
❖ The audit form (*Appendix 3*) should enable the collection of information on: » Each generic category of dressing used within the trust, e.g. hydrocolloids, and which types of dressings within the category are currently used » How often the wounds are being treated » Whether any combinations of treatments are being used, e.g. hydrogel and hydrocolloid » The numbers of each type of wound being treated, e.g. venous leg ulcers	❖ Before selecting wound dressings for a formulary it is important to establish current practice (Morgan, 2000) and to determine any gaps in knowledge or training provision	❖ The audit report will include the entire variety of wound dressings used and the types of wounds being treated currently within the trust. The audit may identify areas of good/poor practice, highlighting those areas where staff are knowledgeable and those were training is required

SECTION 6. COLLECTION OF EVIDENCE TO SUPPORT DRESSING USE

Statement	Reason for statement	How to demonstrate statement is being achieved
❖ Audit of current wound dressing use will identify the commonly used current wound dressings for which supporting evidence should be sought	❖ Wherever possible healthcare professionals have a responsibility to employ best possible evidence-based care	❖ All the current wound dressings in use will be identified via audit (*Appendix 3*). The most commonly used wound dressings will emerge
❖ If inappropriate practice regarding wound dressings is identified by audit, training will be implemented to ensure a standard of wound management practice	❖ Inappropriate use of wound dressings may lead to the patient's wound/skin coming to harm	❖ An agreed standard of wound management practice will be achieved and audited regularly
❖ An agreement should be reached within the MDT regarding the levels of evidence that are acceptable and relevant, e.g randomised controlled trials where possible, cohort studies, series of case reports	❖ A consensus among the MDT and agreement by the Clinical Governance Committee is necessary to provide a robust, ethical process	❖ An agreement will be reached by the MDT and Clinical Governance Committee regarding acceptable levels of evidence
❖ A search should be made of the supporting nursing, medical and podiatry literature for each product, to include all agreed levels of evidence	❖ To ensure that all agreed levels of evidence are found and examined by members of the MDT using NHS database search to include OVID, Medline, Athens. A manual search of journals should be carried out if appropriate	❖ Agreed evidence will be collated and examined by the MDT. The clinical experience of healthcare professionals using current wound dressings will be considered
❖ Wound dressing company representative whose products are included on NHS Purchasing and Supply Chain Agency (PASA) will be invited to submit supporting evidence for their wound dressings	❖ To ensure all relevant evidence is collected	❖ Company literature can be considered when relevant.
❖ If a commonly used wound dressing emerges from the audit, but has little supporting evidence, its use should be evaluated	❖ The evaluation process may highlight hitherto undiscovered clinical application/cost-effectiveness. To ignore such a product ignores the clinical experience of the healthcare professionals	❖ The most commonly used wound dressings identified by audit will be identified and evaluated
❖ A short list of wound dressings for evaluation will emerge post audit and examination of clinical literature will provide one or more examples of each generic group of wound dressings	❖ It is pragmatic to reduce the amount of wound dressings for evaluation and questionable whether any formulary requires more than two of each generic group of wound dressings within a formulary	❖ The short list of dressings for evaluation will include at least one from each generic group of wound dressings

Section 7. Analysis of evidence

Statement	Reason for statement	How to demonstrate statement is being achieved
❖ Wound dressings most commonly used by nursing staff are included within the dressings formulary – provided there is sufficient clinical and cost-effective evidence to support this decision	❖ To reassure users that their opinions have been heard and they are not excluded from the wound dressings formulary process	❖ The most commonly used dressings will be included within the evaluation process. It is likely that they have been selected by staff because they have proven to be efficacious when used on a variety of wounds
❖ Wound dressing company representative whose products are included on NHS Purchasing & Supply Chain Agency (PASA) and which has been identified as being useful by Trust staff, will be invited to present their products and the supporting evidence to the MDT	❖ PASA has already included those products which have supporting evidence for their clinical and cost-effectiveness or which are niche products requiring specialist application	❖ Company representatives will attend a planned meeting to present their products
❖ The MDT will decide, based on the supporting evidence available and following analysis of the trust audit, the number and types of different wound dressings required and in which clinical specialty the dressings will be evaluated, particularly if the trust has a niche speciality	❖ A niche speciality, e.g. plastic surgery may use a wound dressing not used elsewhere in thetrust and will be the most appropriate setting for that dressings evaluation	❖ Representation of all care settings, general and speciality will be approached to participate in the evaluation process

SECTION 8. DRESSING EVALUATION

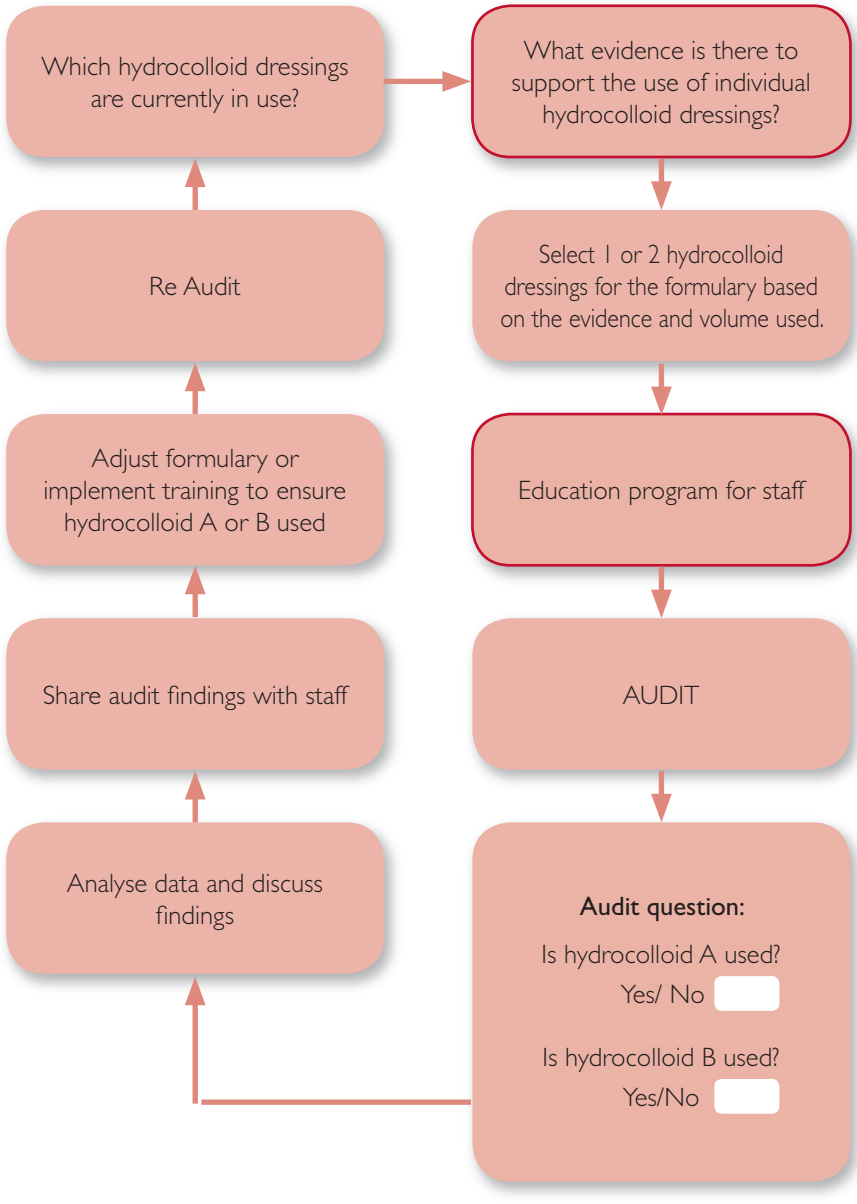
Statement	Reason for statement	How to demonstrate statement is being achieved
❖ The MDT will develop an evaluation form which includes fields for all the data required for dressing evaluation (*Appendix 4*)	❖ To ensure all relevant aspects of patient wound care are included within the evaluation and provide a true picture of the clinical performance of an individual wound dressings	❖ The evaluation form (*Appendix 4*) will provide the relevant information to evaluate each wound dressing
❖ The MDT will present the proposed evaluation process to the clinical governance committee	❖ To ensure that appropriate questions are being asked within the evaluation and that patient care is not compromised by their involvement in the evaluation process	❖ The evaluation process will be agreed by the clinical governance committee. If the evaluation process is not agreed by the Clinical Governance Committee, it must be reviewed until it meets their requirements
❖ Training is provided by members of the MDT for the nurses and other healthcare professionals involved in the evaluation process, in the use of: ⏩ Use of the evaluation tool ⏩ Need to ensure patient confidentiality ⏩ Safe storage of evaluations.	❖ To ensure staff are competent to perform evaluations and understand the need to preserve patient confidentiality	❖ All evaluation forms will be comprehensively completed. All evaluation forms will be held in a secure, locked area
❖ Representatives from dressing companies and the TVN will provide impartial advice and training on use of the relevant wound dressings which are to be included in the evaluation	❖ To avoid unwanted bias being introduced due to influence from the wound dressing company	❖ All staff will report any attempts by the wound dressing company representative to step outside the agreed protocol of behaviour
❖ A clinical evaluation process of wound dressings will be initiated, led by a TVN/wound specialist, but will also include other healthcare professionals. The evaluation process will have been agreed by the MDT and clinical governance group	❖ The evaluation process should be led by an individual with both experience and expertise in wound management to ensure the most stringent process. Evaluation of wound dressings should include the opinions of other healthcare professionals to both maintain ownership of the process and ensure no bias is introduced	❖ Evaluations of the wound dressings should be completed by a variety of healthcare professionals with different skills and depth of knowledge. A procurement officer should be included in the MDT to examine the cost-effectiveness of wound dressings via cost benefit analysis
❖ The wound dressing evaluations (*Appendix 4*) will be collated and examined by the MDT according to the various skills of individual members. The results of the evaluations will be then be considered collectively by the whole MDT. Clinical and cost-efficiency is the preferred indicator for a wound dressing. However, other particular and peculiar aspects may be acknowledged and valued, e.g. topical pain relief by a wound dressing	❖ To ensure the evaluations have recognised wound dressings which may be clinically and cost-effective and those which are not, but not excluding those wound dressings which may have an unusual or unexpected benefit to the patient/ healthcare professional, e.g. topical pain relief	❖ Agreement will be reached by the MDT regarding those wound dressings which will be removed/replaced and those for inclusion within the wound dressing formulary

Section 9. Creation of the new/revised wound dressing formulary

Statement	Reason for statement	How to demonstrate statement is being achieved
❖ Trust/health board staff will be informed of the contents of the wound dressings formulary by: »Announcements in trust/health board newsletter »Posters at ward/area/community nurse bases/GP surgeries »Cascade of information by ward managers, team leaders »Link nurse groups.	❖ To publicise the contents of the wound dressings formulary as widely as possible to ensure all relevant staff are aware of its existence	❖ All staff employed in wound care will be aware of the existence of the wound dressing formulary and have access via hard copy and trust/health board intranet sites
❖ An education program will be implemented by the tissue viability nurse and supported by the trust/health board to educate staff about the dressings in the wound care formulary. All staff employed in wound management should attend	❖ Relevant staff should be aware of the action of all wound dressings included within the formulary. It is the responsibility of individual nurses to ensure they have the requisite knowledge before caring for patients with wounds (NMC, 2008)	❖ Relevant staff attend training and are recorded on a trust/health board register. Wards are provided with relevant educational materials such as wallcharts/manuals for guidance
❖ The wound dressings formulary is published on the trust/health board's intranet	❖ To allow access by all healthcare professionals	❖ There is ready access to the document on trust /health board intranet site
❖ Regular audit of the use of wound dressings should be carried out to ensure: »Compliance with the use of formulary products »That the wound dressings in the formulary remain appropriate and fit for purpose »Wound dressings prescribed outside the formulary are due to unusual circumstances and with the agreement of the tissue viability nurse »Inclusion in the formulary is based upon the value of the product, rather than its price	❖ All staff must be aware of their clinical and organizational responsibility to use clinical and cost-effective products listed within the formulary	❖ Adherence to the formulary should be evidenced through a clear audit trail. Wound dressings prescribed outside the formulary are under unusual circumstances and always with the agreement of the TVN

Appendix 1

An example of an audit cycle that should be followed to assess the suitability of a dressing, in this case, a hydrocolloid, with potential for inclusion in the wound care formulary



Appendix 2.

Evaluation of wound management products

Appendix 3

Audit; current use of wound dressings

This is an example of an audit form that can be used to determine the current use of wound dressings and the aetiologies encountered within a Trust

Please identify all of the wound dressings & bandages you currently use regularly in your practice by placing a tick in the adjacent column

If there are any dressings not included in this form please complete the section 'other dressings' and explain your reasons.

Dressing group	
Absorbent cellulose dressings	✓
Eclypse	
Eclypse Adherent	
Exu dry	
Mesorb	
Telfamax	
Zetuvit	
Absorbent, Plastic film faced dressing	
Askina Pad	
Cutisorb LA	
Interpose	
Melolin	
Release	
Skintact	
Solvaline N	
Telfa	
Telfa AMD	
Gauze dressing impregnated	✓
Actilite (honey)	
Activon Tulle (honey)	
Chlorhexidine	
Cutimed	
Cutimed Sorbact Swab	
Inadine	
Paraffin Gauze dressing	✓
Paranet	
Cuticell classic	
Jelonet	
Neotulle	
Paragauze	
Knitted viscose primary dressing	✓
Atrauman	
N/A	
N/A Ultra	
Paratex	
Setoprime	
Tricotex	
Film dressings	✓
Activ heal	
Askina Derm	
Bioclusive	
Blisterfilm	
C-view	
Episil	
Hydrofilm	
Leukomed	
Mepore Film	
Opsite Flexigrid	
Polyskin II	
Protect film	
Suprasorb F	
Tegaderm	
Vacuskin	
Adhesive film dressing with absorbent pad	✓
Alldress	
Leukomed T plus	
Mepore Ultra	
Opsite Plus	
Pharmapore PU	
PremierPore VP	
Tegaderm + Pad	
Activated Charcoal dressing	✓
Askina Carbosorb	
Carboflex	
Lyofoam C	
Sorbsan Plus Charcoal	
Clinsorb	
Alginate Dressing	✓
Activheal Alginate	
Algisite Ag	
Algisite M	
Algivon	
Algosteril	
Curasorb	
Curasorb Plus	
Curasorb ZN	
Kaltostat	
Medihoney Gel Sheet	
Melgisorb	
Sorbalgon	
Sorbsan	
Sorbsan Flat	
Sorbsan Silver Flat	
Suprasorb A	
Tegaderm Alginate	
Trionic	
Alginate with absorbent backing	✓
Sorbsan Plus	
Sorbsan Plus SA	
Sorbsan Silver Plus	
Sorbsan Silver Plus SA	
Alginate containing hydrocolloid	✓
Seasorb Soft	
Urgosorb Pad	
Urogosorb Silver	
Capillary Action Absorbent dressings	✓
AdvaDraw	
Advadraw Spiral	
Cerdak Aerocloth	
Cerdak Aerofilm	

Appendix 3 (cont...)

Sumar Lite	
Sumar Max	
Vacutec	
Cavity Dressings	✓
Acticoat Absorbent (silver)	
Activheal Alginate rope	
Activeheal aquafiber rope	
Algisite Ag (silver)	
Algisite M rope	
Algosteril rope	
Allevyn cavity	
Allevyn Plus cavity	
Aquacel ribbon	
Aquacel Ag ribbon (silver)	
Askina Foam cavity	
Biatain Ag (silver)	
Cerdak cavity	
Contreet foam filler	
Curasorb rope	
Cutimed Sorbact	
Cutimed Sorbact Tupfer	
Kaltostat	
Melgisorb cavity	
Permafoam cavity	
Seasorb Soft Filler	
Sorbgalon T	
Sorbsan Packing	
Sorbsan rope with probe	
Sorbsan silver packing	
Suprasorb A	
Tegaderm alginate	
Tielle packing	
Trionic rope	
Urgosorb rope	
Urgosorb silver rope	
Conforming cavity dressing	✓
Cavi-Care	
Honey based topical application	✓
Activon medical honey	
Medihoney anti-bacterial	
Medihoney wound gel	
Melladerm Gel	
Melladerm Plus	

Mesitran Ointment	
Mesitran ointment S	
Hydrocolloid dressings	✓
Comfeel Plus Contour	
Carbopad VC	
Granuflex Bordered	
Ultec Pro	
Activeheal hydrocolloid	
Comfeel Plus	
Duoderm Signal	
Flexigran	
Granuflex	
Hydrocoll Basic	
Nuderm	
Suprasorb H	
Tegaderm Thin	
Askina Transparent	
Comfeel transparent	
Duoderm Extra Thin	
Flexigran Thin	
Hydrocoll Thin	
Comfeel paste	
Hydrocolloid with absorbent pad	✓
Alione	
Combiderm	
Versiva	
Silvercell hydrocolloid	
Hydrocolloid with silver	✓
Contreet	
Hydrocolloid Fibrous	✓
Versiva XC	
Hydrogels	✓
Activeheal hydrocgel	
Aquaform Hydrogel	
Askina gel	
Citrugel	
Flexigran Gel	
Granugel	
Intrasite gel	
Iodflex paste	
Iodosorb ointment	
Iodosorb powder	
Nu-gel	

Prontosan gel	
Purilon gel	
Suprasorb gel	
Hydrogel sheet dressings	✓
Curagel island	
Hydrosorb comfort	
Mesitran border	
Actiform Cool	
Aquaflo	
Cerdak basic	
Hydrocoll Border	
Suprasorb H	
Coolie	
Curagel	
Gel fix	
Geliperm	
Hydrosorb	
Intrasite conformable	
Mesitran	
Mesitran mesh	
Novogel	
Suprasorb G	
Vacunet	
Polyurethane Foam dressings	✓
Activheal foam island	
Allevyn adhesive	
Allevyn Heel	
Allevyn Lite	
Allevyn Thin	
Allevyn Plus	
Biatain adhesive	
Biatain heel	
Biatain sacral	
Biatain Contour	
Copa island	
Flexipore	
Lyofoam	
Permafoam	
Permafoan Comfort	
Polymem	
Polyment Square	
Polymem oval	
Polymem sacral	
Suprasorb	

Appendix 3 (cont...)

Tegaderm adhesive	
Tegaderm Square	
Tegaderm Oval	
Teaderm heel	
Tielle	
Tielle Lite	
Tielle Plus	
Tielle Plus heel	
Transorbent	
Trufoam Square	
Trufoam Rectangular	
Polyurethane Matrix dressing	✓
Cutinova Hydro	
Protease Modulating matrix dressings	✓
Activheal aquafibre	
Aquacel	
Aquacel Ag (silver)	
Cadesorb	
Flaminal	
Flaminal Hydro	
Iodozyme	
Oxyzyme	
Promogram	
Promogram Prisma	
Sorbion Sachet S	
Tegaderm Matrix	
Silicone Gel Sheets	✓
Advasil	
Advasil conform	
Cica-care	
Dermatix clear	
Dermatix fabric	
Mepiform	
Silgel	
Silver coated dressings	✓
Actocoat	
Acticoat Absorbent	
Acticoat 7	
Acticoat moisture control	
Silver impregnated foam dressings	
Allevyn AG	
Avance A	
Biatain AG	
Polymem	
Soft polymer wound contact dressings	✓
Physiotulle	
Tegaderm contact	
Urgotul	
Urgotul duo	
Soft polymer wound contact dressings with silver	✓
Atraumen AG	
Physiotulle AG	
Urgotul silver	
Urgotul SSD	
Soft silicone wound contact dressing	✓
Mepilex transfer	
Mepitel	
Silon-TSR	
Siltex	
Soft Silicone foam dressings	✓
Allevyn gentle border	
Episil absorbent	
Mepilex	
Mepilex border lite	
Mepilex Lite	
Mepilex Sacrum	
Topical negative pressure dressing accessories	✓
Exu-fast kits	
VAC Granufoam kits	
V1sta dressing kits	
Venturi wound sealing kits	
Wound Assist TNP	
VAC freedom canister	
Venturi canister	
V1sta Cannister	
Wound assist Cannister	
Emollients & Barrier creams	✓
Emollin	
Epaderm	
Sensicare emollient cream	
Absorbent padding bandage	✓
Velband	
Surepress Padding	
Softflexe	
Ultrasoft	
Profore 1	
K-Soft	
Cellona	
Bandages	✓
K Lite	
Clinilite	
Knitfirm	
Clinipl;us	
Elset	
K-Plus	
L3	
Setopress	
Tensopress	
Surepress	
Coban	
Short stretch compression bandage	✓
Actiban	
Actico	
Comprilan	
Rosidal K	
Silkolan	
Multi-layer kits	✓
Coban kit	
System 4	
Ultra Four	
Ultra Four non-latex	
Profore	
Profore Latex Free	
Profore lite	
Profore IIte Latex free	
Proguide	
K-Four	
K-Two	
Compression hosiery	✓
Activa	
Altipress	
Carolon	
Jobst	
Mediven Ulcer kit	
Surepress Comfort kit	
UlcerTec	

Appendix 3 (cont...)

Are there any dressings which you feel strongly should or should not be included in the formulary and why?			
Name of wound dressing	Should be included?	Should not be included?	Why? E.g. Have you identified a particular strength or weakness of the dressing?

Other wound dressings		Rationale	

Appendix 3 (cont...)

This section enables the tissue viability nurse to identify training needs and to identify the types of wounds you currently manage					
Please tick all wounds you have or currently manage:	✓	Please tick all wounds for which you have attended specific training	✓	lease tick all wounds for which you have identified a training need	✓
Pressure ulcers					
Venous leg ulcers					
Arterial leg ulcers					
Mixed aetiology leg ulcers					
Diabetic foot ulcers					
Fungating wounds					
Traumatic wounds which fail to heal					
Skin tears					
Pretibial lacerations					
'Wet legs'					
Dehisced surgical wounds					
Infected wounds					
Haematoma					
Lacerations					
Puncture wounds					
Bites					
Abrasions and grazes					
Skin graft sites					
Donor sites					
Burns					
Plastic surgery wounds					

Appendix 3 (cont...)

The questions below are intended to evaluate which products are used for different types of tissue /wound aetiology.			
Wound/tissue type	Please state primary dressing normally used	Please state secondary dressing/bandaging normally used (if none, state 'none'	State expected frequency of dressing change
Pressure ulcer; on a heel (non-diabetic)/hard dry necrotic tissue			
Pressure ulcer; over the sacrum/sloughy and heavily exuding			
Pressure ulcer; over the sacrum/granulating, heavily exuding			
Dehisced surgical wound/ clean, moderate exudate			
Pretibial laceration; exposing deep dermal tissue, wound area of 5 cm^2			
Linear skin tear/clean			
Venous leg ulcer; clean and epithelialising/Low – moderate exudate			
Arterial leg ulcer/ acutely painful, dry			
Diabetic foot ulcer/ hard dry callus			
Diabetic foot ulcer/ moist and sloughy			
Haematoma/partially dried on a leg, patient on warfarin			
Fungating breast wound/ heavily exuding and malodorous			

Appendix 4. An example of a product evaluation form.

Tissue Viability Department		
Evaluation product		
All sections MUST be completed		
Photographs will be taken at weekly intervals and patient's consent for photography form included in casenotes The identified wound(s) will be mapped and wound volume estimated using Visitrak Product evaluation will taken place over 4 weeks		
Inclusion criteria	**Yes**	**No**
Patient over the age of 18 years who has been informed of the evaluation and provided consent for participation		
Patient who can be monitored throughout the 4 weeks		
Patient who is likely to comply with the evaluation requirements		
Patient with a wound type identified in the initial assessment details section below		
Exclusion criteria		
Patient refuses to enter the evaluation or is unable to understand the reason for the evaluation		
Patients who have a known sensitivity/allergy to any bee or honey products		
Patients who are non-compliant or who are unable to complete the evaluation programme (4 weeks)		
Has patient given verbal consent?		
Has the patient's verbal consent been recorded in the casenotes?		
Has the patient signed a photography consent form?		

Appendix 4 (cont...)

			Date evaluation commenced:	
Patient initials:		Patient casenote number:		
Sex	Male	Female	Age:	

Patient Information:						
Medical history:	Diabetes:		Arterial disease lower legs:		Anaemia:	
	Venous:		Possible malignancy:		Other	

Relevant medication to healing:	Steroids:		Immunosuppressants:		Antibiotics:	
	NSAIDS:				Other::	

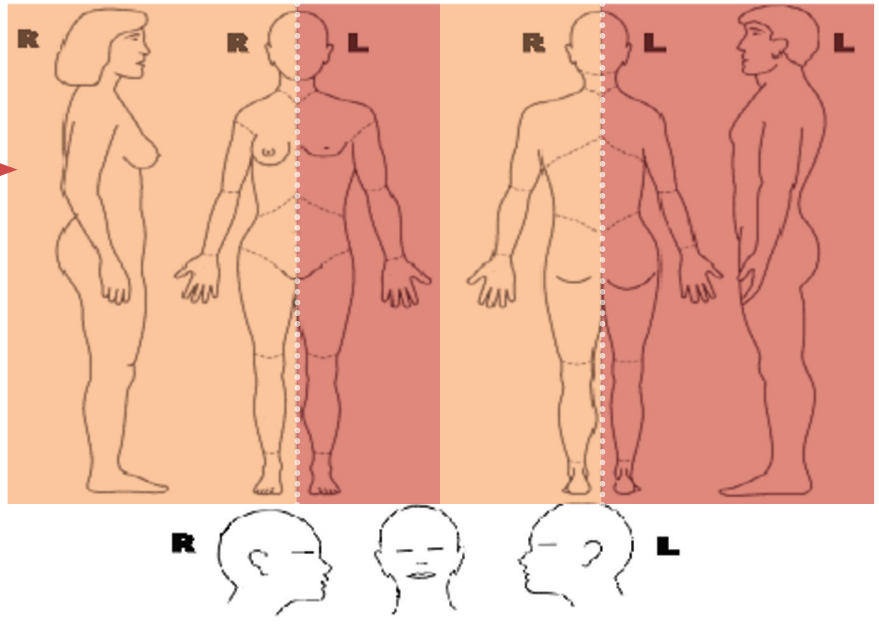
Any holistic therapies?				
Current dressing:			Duration of the wound:	
Frequency of dressing change:				
Size of dressing:				

Photograph prior to dressing removal:	Yes	No	Length: cm	Width: cm
Photograph post dressing removal:	Yes	No	Length: cm	Width: cm
Wound mapped?	Yes	No	Wound volume:	

Initial assessment details:	Duration of the wound:		
Size of wound:	Length: cm	Width: cm	Depth: cm

Wound Type:						
	Venous leg ulcer:		Arterial leg ulcer:		Mixed aetiology:	
	Pressure ulcer:		Diabetic foot ulcer:		Diabetic surgical wound:	
	Dehisced wound:	Burn:		Donor site:	Fungating:	
	Other (state):					

Indicate site on chart



Appendix 4 (cont...)

Wound bed: (please indicate tissue types present and % of each as a % of the wound bed)					
Necrotic	%	Sloughy	%	Granulation	%
Epithelialisation	%	Other, identify…..			

Are there signs of clinical wound infection?	Yes	No	Identify by number if appropriate	

1=friable/bleeding tissue. 2=malodour. 3=change in nature of pain. 4=pocketing. 5=bridging. 6=discolouration. 7=breakdown/increase in size. 8=delayed healing. 9=pus/abscess. 10=sero/haemopurulence) 11=spreading erythema. 12=local heat.

Exudate level:	Low		Moderate		High			
Surrounding skin:	Normal		Macerated		Dry/eczema			
Pain at dressing change:	No pain		Slight		Moderate		Severe	
Response to current dressing								
	Markedly improved		Moderately improved		No improvement		Worsening	

Application of Evaluation Product								
Ease of application:	Very easy		Easy		Difficult		Very difficult	
Conformability:	Excellent		Good		Not quite		Difficult	
Pain Level (on application):	No pain		Slight		Moderate		Severe	
Identify any secondary dressing used and size:								

Appendix 4 (cont...).

Weekly dressing change (information gathered must relate to the reference wound)								
Since previous week has there been?								
	Week 1		Week 2		Week 3		Week 4	
Local adverse event	Yes	No	Yes	No	Yes	No	Yes	No
Change in treatment	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, please clarify……								
Since the previous week								
Has the dressing been changed?	Yes	No	Yes	No	Yes	No	Yes	No
If yes, how many times?								
Photo before dressing removed	Yes	No	Yes	No	Yes	No	Yes	No
Photo after dressing removed	Yes	No	Yes	No	Yes	No	Yes	No
Has the dressing adhered to the wound bed?								
No								
Minimal								
Moderate								
Adhered								
Malodour								
None								
Slight								
Moderate								
Strong								
Maceration of surrounding skin:								
None								
Minimal								
Moderate								
Severe								
Estimated level of exudate:								
None								
Slight								
Moderate								
Heavy								
Signs of clinical wound infection?	Yes	No	Yes	No	Yes	No	Yes	No
If yes, identify by relevent number(s):								
1=friable/bleeding tissue. 2=malodour. 3=change in nature of pain. 4=pocketing. 5=bridging. 6=discolouration. 7=breakdown/increase in size. 8=delayed healing. 9=pus/abscess. 10=sero/haemopurulence) 11=spreading erythema. 12=local heat								
Wound bed: please estimate percentage of tissue types present								
Sloughy	%		%		%		%	
Necrotic								
Granulation								
Epithelial								
Other, identify.....								

Appendix 4 (cont...).

Wound progress:	Improved		Same		Deteriorated			
Signs of clinical wound infection:	Improved		Same		Deteriorated		N/A	
Condition of surrounding skin:	Improved		Same		Deteriorated			
Patient comfort:	Excellent		Good		Poor			
Patient comments:								
Evaluator comments:								

Reasons for ending the evaluation (please answer all questions)					
End of evaluation period	Yes			No	
Patient discharged or transferred	Yes			No	
Patient deceased	Yes			No	
Non-compliance	Yes			No	
Patients request	Yes			No	
Evaluators decision	Yes			No	
Adverse event	Yes			No	
If Yes clarify.....					

References

Bennett G, Dealey C, Posnett J (2004) The total cost of pressure ulcers in the UK. *Age Ageing* **33:** 230–35

Department of Health (2008) Primary Care Prescribing and budget setting. Accessed 27/09/08. http://www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/DH_4000163

Drummond MF (2005) *Methods for the Economic Evaluation of Health Care Programmes*. Oxford University Press, Oxford

Morgan D (2000) *Setting up Wound Dressing Guidelines – Avoiding the Pitfalls*. World Wide Wounds. Accessed 29/06/08. http://www.worldwidewounds.com/2000/sept/David-Morgan/Wound-Dressing-Guidelines.html

National Institute for Health & Clinical Excellence (2001) Technology Appraisal Guidance on the use of Debriding Agents and Specialist Wound Care Clinics for Difficult to Heal Wounds. Accessed 27/09/08. http://www.nice.org.uk/nicemedia/pdf/woundcareguidance.pdf

National Institute for Clinical Excellence (2002) *Principles for Best Practice in Clinical Audit*. Radcliffe Medical Press Ltd, Oxford. Accessed online 21/06/2008. http://www.pdptoolkit.co.uk/Files/adobe%20files/BestPracticeClinicalAudit.pdf

Nursing and Midwifery Council (2008) *The Code; Standards for Conduct, Performance and Ethics for Nurses and Midwives*. Accessed online 28/09/08. http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=3954

Posnett J, Franks PJ (2007) The cost of skin breakdown and ulceration in the UK. In: The Smith and Nephew Foundation (2007) *Skin Breakdown — The Silent Epidemic*. Smith and Nephew Foundation, Hull

Simon D, Dix F, McCollum C (2004) Management of venous leg ulcers. *Br Med J* **328:** 1358–62

Copies of this document are available from:
www.wounds-uk.com
or by writing to:
Wounds UK
Suite 3.1
36 Upperkirkgate
Aberdeen AB10 1BA

Date of preparation: November 2008