

Barnsley Wound Care Formulary 2026-2027

This Wound Care Formulary supports the Barnsley place wound care policy and has been devised by the SWYT tissue viability lead in consultation with tissue viability teams, specialist nurses, podiatrists, dermatologists and pharmacists. The contents are based on the best practice evidence at the time. The formulary is being updated in line with the SYICB TVSIG procurement project.

Barnsley tissue viability team

Community - 01226 644575

BHNFT – 01226 736126

Barnsley Podiatry Team

Community Podiatry – 01226 644575

BHNFT (Diabetic Foot Clinic) - 01226 435678

Immediate and Necessary Wound Care

Immediately escalate to the relevant clinical specialist, those with the following 'RED FLAG' symptoms / conditions:

- Acute infection (e.g., increasing unilateral erythema, swelling, pain, pus, heat)
- Symptoms of sepsis - **Initiate SEPSIS Screening Tool**
- Signs or symptoms of acute or suspected chronic limb threatening ischaemia (e.g., PAD in combination with rest pain, gangrene, or lower limb ulceration >2 weeks duration) - **Referral to vascular specialist**
- Suspected acute deep vein thrombosis (DVT) - **Seek medical attention**
- Suspected skin cancer - **Referral to dermatology services**
- Bleeding varicose vein

Red flags present:

Consider other causes and refer to appropriate specialist:

Tissue Viability, Podiatry, Dermatology, Vascular, Diabetes, Cardiology, End of life, Cancer Specialists.

Immediate and necessary care should include:

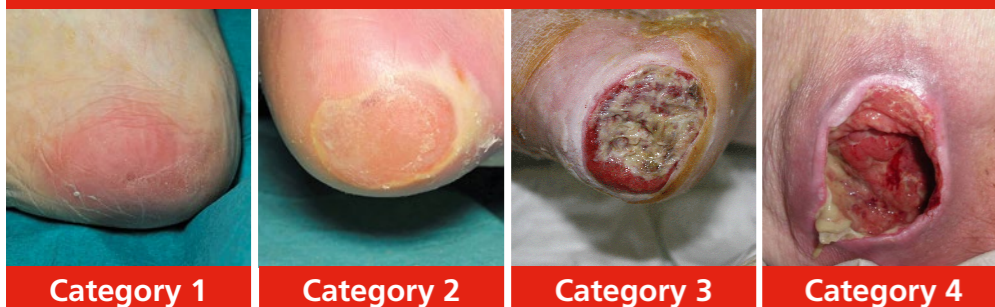
- Wound and skin cleansing
- Redress Wound following the Wound Management Flow Chart and Protocol Dressings
- Complete Wound Assessment Template

No red flags:

Immediate and necessary care should include:

- Wound and skin cleansing
- Redress Wound following the Wound Management Flow Chart and Protocol Dressings
- Complete Wound Assessment Template

Pressure ulcer classification



The **aSKING care bundle** is a tool to guide and document pressure ulcer prevention and management and is aimed at reducing the risk of patient harm, which is often preventable.

The **PURPOSE-T tool** is a vital resource in the prevention of pressure ulcers, enabling healthcare providers to identify at-risk patients and implement appropriate preventive measures. Its evidence-based approach and structured assessment process make it a valuable addition to clinical practice aimed at reducing the incidence of pressure ulcers. By utilising PURPOSE-T, healthcare professionals can enhance patient care and improve outcomes for those at risk of developing pressure ulcers.

Protocol 1

Melolin
EmFilm S / 365 transparent film
EmFilm Plus
Empore

Protocol 2

Lomatuelle Pro
Duoderm Extra Thin
EmFilm S

Protocol 3

1st line - Advancis honey range
Actilite, Algivon Plus, Activon Tube

Enzyme Alginogel - Flaminal Forte/ Hydro

Protocol 4

1st line - Advancis Honey Range
Algivon Plus, Algivon Ribbon, Activon Tube

Enzyme Alginogel - Flaminal Forte/ Hydro

Antimicrobial gauze packing / wound filler

1st line - AMD Gauze
2nd line - Cutimed Sorbact

Protocol 9 - Tissue Viability / podiatry/ dermatology

TNP - Activac or Avelle

SAD - Convamax super absorbent adhesive

AM Dressing - Aquacel Ag+ Extra Inadine (PVP-I) * National alert contraindications specialist use only

AM barrier dressing - Acticoat 3&7

Hydrophilic Polyurethane Matrix dressing - PolyMem Max

Hidradenitis Suppurativa dressing - Hidra Wear range.

Combined AM & antibiofilm dressing - 1st Line - Urgoclean AG

Enhanced foam - UrgoStart Plus Border (*working towards NICE guidance compliance for leg ulcers and diabetic foot ulcers).

Hydrophilic Polyurethane Matrix dressing - PolyMem Max

Hidradenitis Suppurativa dressing - Hidra Wear range.

Follow the Therapeutic Wound Cleansing pathway.

Larvea - Biomonde Larvea biobag
Hypergranulation tissue - Follow the Hypergranulation tissue reference guide.

Debridement - Pad
Prontosan Debridement pad
Wipes - USC wipe

Malodorous wounds Refer to protocols 3 and 4
Refer to Posie pathway

Moisture associated skin damage – Follow the MASD pathway.
Self-harm wounds – Follow the self harm pathways.
Post OP dressings Mepilex Border Post OP
Maternity -Leukomed Sorbact

Protocol 5

Actiheal Hydrogel

Protocol 6

Actiheal Hydrogel
Actiform Cool
Biatain Fibre
Kytocel

Protocol 7

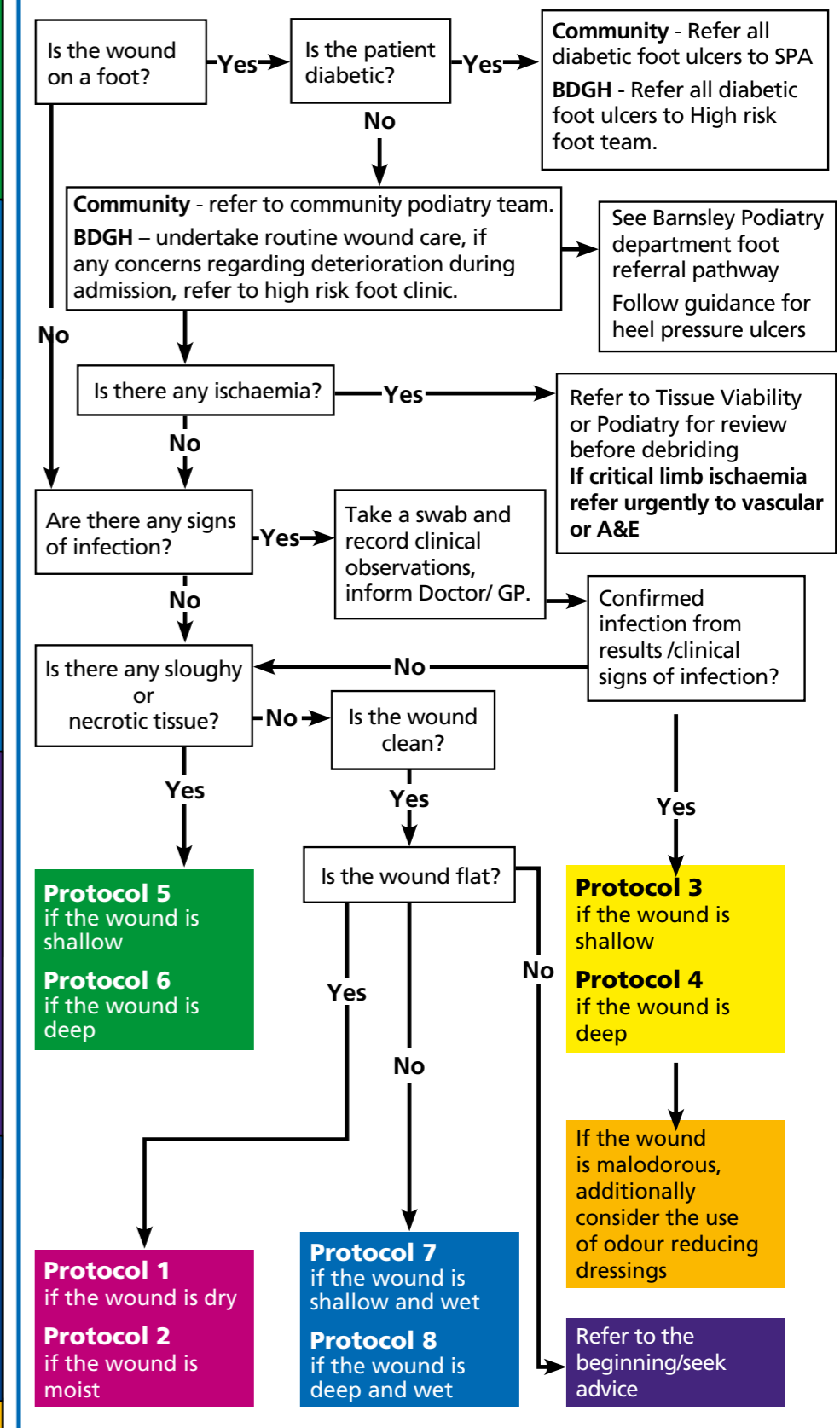
Suprasorb P sensitive
Urgo Absorb border – Skin Tear Pathway only

Resposorb (nee Zetuvit ,Zetuvit +silicone),
Biatain Silicone foam border/ non border

Protocol 8

Moderate to high levels exudate
Hydrocellular dressing-
Resposorb silicone
Superabsorbant CrystaLock Dressing -
Eclipse Non Backed

Wound management flow chart



If you require a copy of this information in any other format or language please contact your line manager.