ACTIVON BARRIER CREAM PRODUCT EVALUATION

Please follow the Information for Use (IFU) for indications for use, including Activon Barrier Cream NOT being used on patients allergic to bee venom, honey or cocoa butter.

Contra-Indications:

Do NOT use on infected area of skin, open wounds or deep puncture wounds, where there are any known allergies or sensitivities to the ingredients or on neonates (less than one year old).

Warnings and Precautions:

Do NOT use on uncovered areas of skin during phototherapy treatment.

PART 1 – Pre Treatment

Date: ☐

Healthcare Professional Name: ☐

Healthcare Professional Job Title: ☐

Place of Work (please select): Acute ☐ Community ☐ Nursing Home ☐ Hospice ☐

Other - please specify area: ☐

Data Protection

The information obtained from this evaluation will be entered into a database which be managed by Advancis. All data storage will follow all legal obligations relevant to Advancis. No data will be disclosed or transferred to a third party and if you have any further questions please contact your local Advancis representative.

Consent gained from patient: Yes ☐ No ☐ (please obtain)

Patient ID Number: ☐ Age: ☐

Sex: Male ☐ Female ☐ Prefer not to say ☐

PART 2 – Initial Assessment

Is the patient allergic to bee venom, honey or cocoa butter?

Yes ☐ No ☐

If yes, do not continue with this evaluation.

Co-Morbidities and Relevant Clinical History

Please provide details:

Initial Skin Status

Is MASD (Moisture Associated Skin Damage) present?

Yes ☐ No ☐

Is the skin irritated?

Yes ☐ No ☐

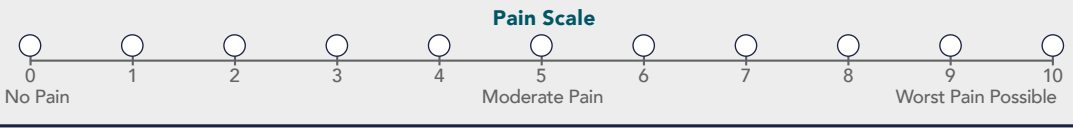
Is the skin vulnerable?

Yes ☐ No ☐

Did the patient experience pain on application of previous regime? Yes ☐ No ☐

If the patient experiences pain in the at risk area, please record the level of pain on a scale of 1-10:

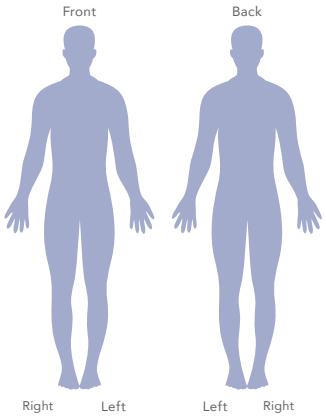
Where 0= no pain
10= high level pain



Location of the At Risk Area

Using the body outlines on the right hand side, please mark the location of the at risk area.

Please specify in words the location of the at risk area:



Previous Management

Product name:

How many daily applications:

PART 3 – Regime Change

Instructions for Use:

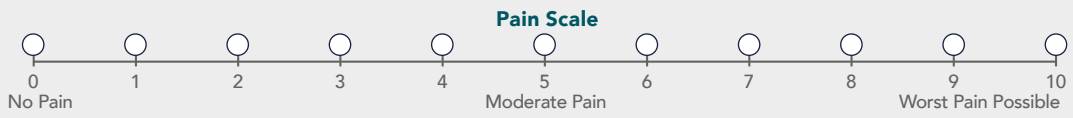
1. Ensure that the skin is clean and dry prior to application. 2. Apply a thin, uniform coating over the whole area to be protected, or where the ostomy pouch, adhesive device or dressing will be applied. 3. Pea to Palm application: Use a pea sized amount of cream to cover an area approximately the size of your palm. Do NOT over-apply. 4. Remove any excess with a clean tissue. 5. If application, once fully dry, apply the ostomy pouch, adhesive device or dressing as normal. 6. Reapplication is recommended as and when required. When used with adhesive dressings or devices, reapply at each dressing or device change.

How many applications per day: _____

Did the patient experience pain on application or during use? Yes ☐ No ☐

If the patient experiences pain related to the wound, please record the level of pain on a scale of 1-10:

Where 0= no pain
10= high level pain



Please rate Activon Manuka Honey Barrier Cream

Criteria	Excellent	Good	Fair	Poor
Ease of application	☐	☐	☐	☐
Drying time	☐	☐	☐	☐
Longevity on skin	☐	☐	☐	☐
Patient satisfaction	☐	☐	☐	☐
Skin condition of application area (before using Activon Manuka Honey Barrier Cream)	☐	☐	☐	☐
Skin condition of application area (after using Activon Manuka Honey Barrier Cream)	☐	☐	☐	☐
Overall performance	☐	☐	☐	☐

Please describe any skin changes below:

Did you experience any incidences of faecal incontinence while using this product?

Yes ☐ No ☐

Did the skin feel moisturised after using this product?

Yes ☐ No ☐

Did you experience any stoma leakage on at risk area while using this product?

Yes ☐ No ☐

Did you experience any, or worsening of, Moisture Associated Skin Damage while using this product?

Yes ☐ No ☐

Did you experience any incidences of urinal incontinence while using this product?

Yes ☐ No ☐

Did you experience any skin maceration while using this product?

Yes ☐ No ☐

Did you experience any incidences of sweat on at risk area while using this product?

Yes ☐ No ☐

Did this product provide an effective moisture barrier?

Yes ☐ No ☐

Did you experience any incidences of exudate on at risk area while using this product?

Yes ☐ No ☐

Please describe any further comments below:

PART 4 – Consent

Please sign and date below to confirm consensus.

Clinician

Print name:

Signature:

Date:

Thank you for your participation in the evaluation.

Submit

Advancis Medical is a trading name of Brightwake Ltd
Lowmoor Business Park, Kirkby-in-Ashfield
Nottingham, NG17 7JZ, England
Tel: +44 (0)1623 751500 | Email: info@advancis.co.uk

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