Mölnlycke®

Skin Protection and Wound Management

Guide for the Bedside Clinician

This guide provides helpful information and resources for the prevention of pressure injuries and the management of wounds. The material presented is solely for informational and educational purposes. Although the guide may contain information on Mölnlycke's products and/or demonstrate certain techniques, Mölnlycke does not provide any medical advice and this guide should not be perceived as medical advice.

Table of Contents

01

Introduction

This guide is intended to be a bedside clinical decision-making tool. It includes basic information on wound assessment, identification, and care of the skin.

For more complete information, refer to the clinical support tools in the “Learn More About Wounds” section or contact your Mölnlycke representative.

YOUR MÖLNLYCKE REPRESENTATIVE:

NAME

PHONE

EMAIL

02

Prevention

02 PREVENTION

Skin Protection Measures

There are basic skin protection measures that may reduce your patient's/resident's risk of injury.

Inspect skin daily

Moisturize skin twice daily

Use breathable fabrics & products

Cleanse skin daily & after incontinence

Apply skin barriers after incontinence care

Pad & protect at-risk areas

Pressure Injury Prevention (PIP)

Skin Protection Basics

1. Risk assessment, such as the Braden Scale
2. Head to toe skin assessment
3. Reduce risk factors (e.g., immobility, incontinence, etc.)
4. Patient/resident, family and staff education
5. Evaluate PIP program and outcomes, adjust as needed

Pressure Injury Risk Assessment

Braden Scale for Predicting Pressure Sore Risk

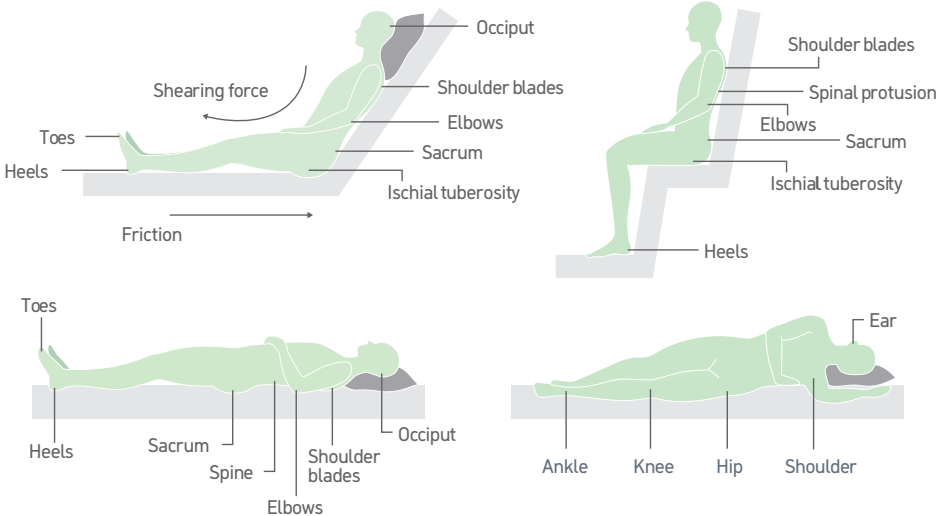
It is the most common pressure injury risk assessment scale in the U.S. and consists of six categories of risk. The sum of all subscale scores represents the total score and the level of risk. **Both the total score and the subscale scores should guide intervention.**

Sensory Perception Ability to respond meaningfully to pressure-related discomfort	1. COMPLETELY LIMITED Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** Limited ability to feel pain over most of body.	2. VERY LIMITED Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. **OR** Has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	3. SLIGHTLY LIMITED Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. **OR** Has a sensory impairment which limits the ability to feel pain or discomfort in extremities.	4. NO IMPAIRMENT Responds to verbal commands. Has no sensory deficit which would limit pain or discomfort.
Moisture Degree to which skin is exposed to moisture	1. CONSTANTLY MOIST Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. VERY MOIST Skin is often, but not always, moist. Linen must be changed at least once a shift.	3. OCCASIONALLY MOIST Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. RARELY MOIST Skin is usually dry; linen only requires changing at routine intervals.
Activity Degree of physical activity	1. BEDFAST Confined to bed.	2. CHAIRFAST Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. WALKS OCCASIONALLY Walks occasionally during day, but for very short distances with or without assistance. Spends most of each shift in bed or chair.	4. WALKS FREQUENTLY Walks outside room at least twice a day and inside room at least once every two hours during waking hours.

Mobility Ability to change and control body position.	1. COMPLETELY IMMOBILE Does not make even slight changes in body or extremity position without assistance.	2. VERY LIMITED Makes occasional slight changes in body or extremity position but is unable to make frequent or significant changes independently.	3. SLIGHTLY LIMITED Makes frequent though slight changes in body or extremity position independently.	4. NO LIMITATION Makes major and frequent changes in position without assistance.
Nutrition Usual food intake pattern	1. VERY POOR Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. **OR** Is NPO and/or maintained on clear liquids or IV for more than 5 days.	2. PROBABLY INADEQUATE Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. **OR** Receives less than optimum amount of liquid diet or tube feeding.	3. ADEQUATE Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy) per day. Occasionally refuses a meal, but will usually take a supplement when offered. **OR** Is on a tube feeding or TPN regimen, which probably meets most of nutritional needs.	4. EXCELLENT Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products per day. Occasionally eats between meals. Does not require supplementation.
Friction & Shear Degree of physical activity	1. PROBLEM Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	2. POTENTIAL PROBLEM Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. NO APPARENT PROBLEM Walks occasionally during day, but for very short distances with or without assistance. Spends most of each shift in bed or chair.	

TOTAL SCORE:	9 SEVERE RISK	10-12 HIGH RISK	13-14 MODERATE RISK	15-18 MILD RISK

A comprehensive skin assessment should include visualization of bony prominences, under medical devices, in skin folds, and in the hair.



Support Surfaces

- Consider patient weight and weight distribution in determining the need for a bariatric mattress and appropriate bed frame.
- When choosing between a mattress or overlay, consider fall/entrapment risk associated with the use of overlays.
- Consider risk for developing new pressure injuries and history of previous pressure injuries.
- Consider fall risk when determining the need for a low bed.
- Ensure that the support surface is functioning properly and used correctly. Minimize the number and type of layers between the patient and the support surface.
- Support surfaces are only one element of a comprehensive pressure injury prevention program; they should not be considered a stand alone intervention.

Support surface is a specialized mattress or mattress overlay or chair cushion designed for the management of tissue loads, micro-climate, and/or therapeutic functions. (NPIAP, 2018)

Types of Support Surfaces for Beds and Wheelchairs

→ **Overlays:**
Air, Foam, Viscous Fluid, Gel

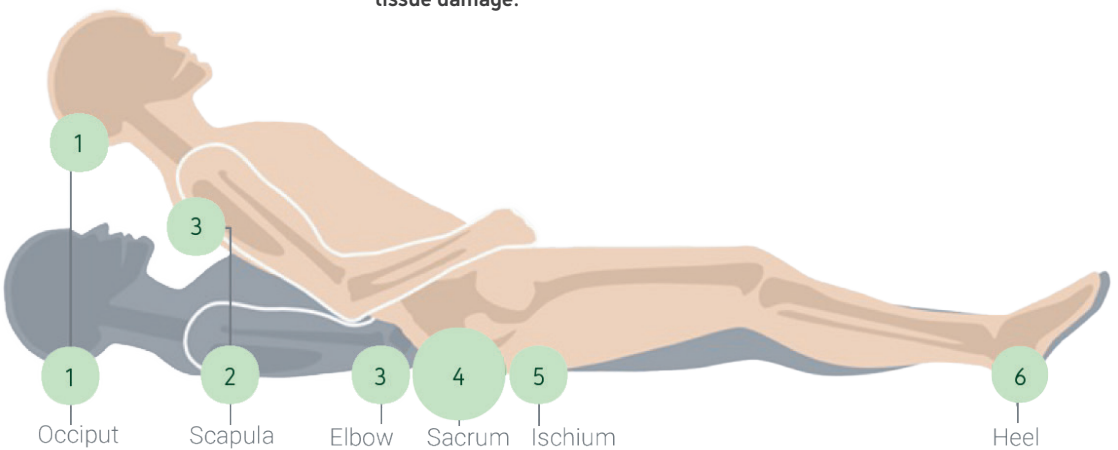
→ **Mattresses:**
Air/Foam, Foam, Air, etc.

→ **Integrated Bed Systems:**
Air Fluidized

Pressure Injuries

WHAT IS A PRESSURE INJURY?

A pressure injury, also referred to as a pressure ulcer or bedsore, is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as either intact skin or an open ulcer and may be painful. It occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. **Pressure injuries are staged to indicate the extent of tissue damage.**

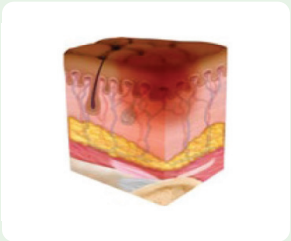


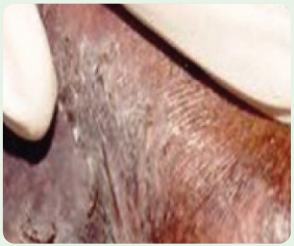
Stage 1

Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes.

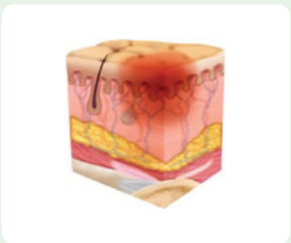
Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

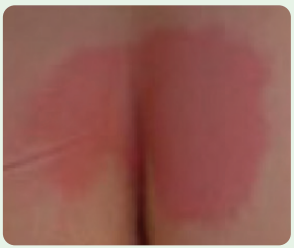
DARK SKIN





LIGHT SKIN



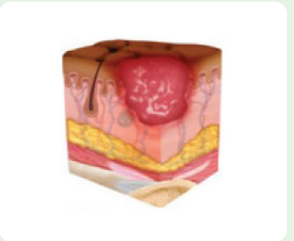


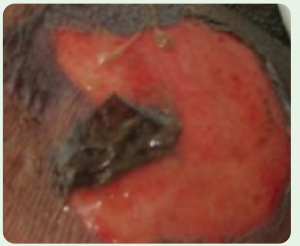
Stage 2

Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.

These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.

DARK SKIN





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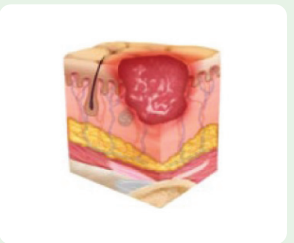
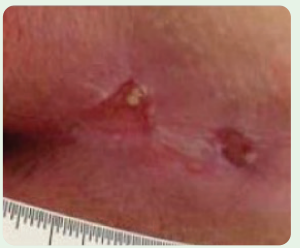


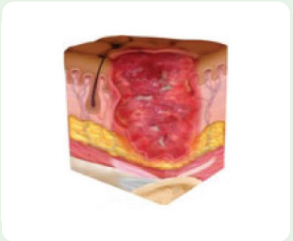


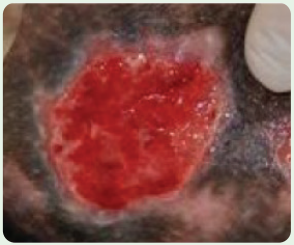
Stage 3

Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage or bone is not exposed.

If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

DARK SKIN





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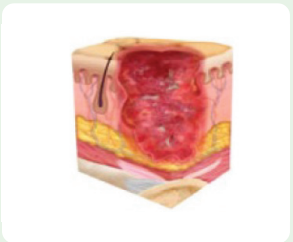
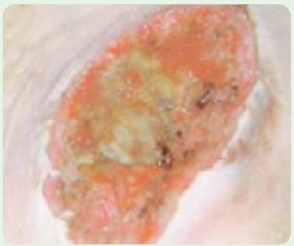


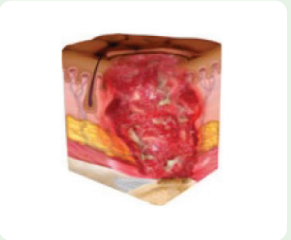


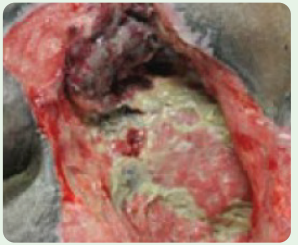
Stage 4

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.

If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

DARK SKIN





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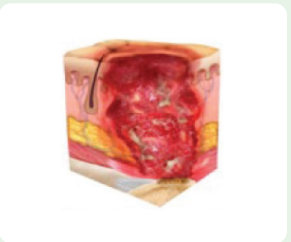
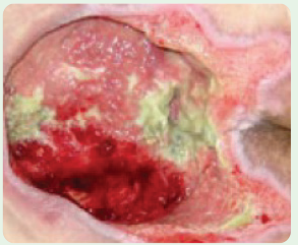


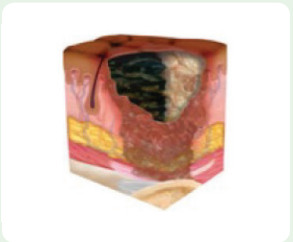


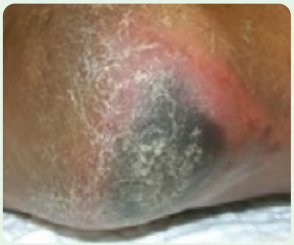
Unstageable

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.

Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be softened or removed.

DARK SKIN





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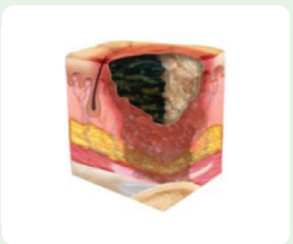
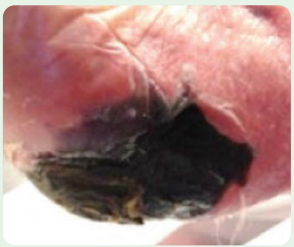


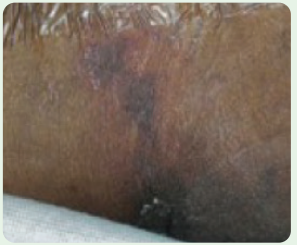


Deep Tissue Pressure Injury

Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin.

This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.

DARK SKIN



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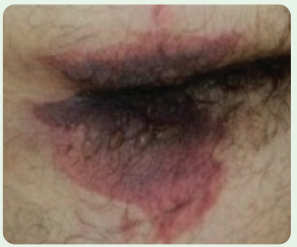


Medical Device Related Pressure Injury (MDRPI)

This describes an etiology. To stage, use the staging system.

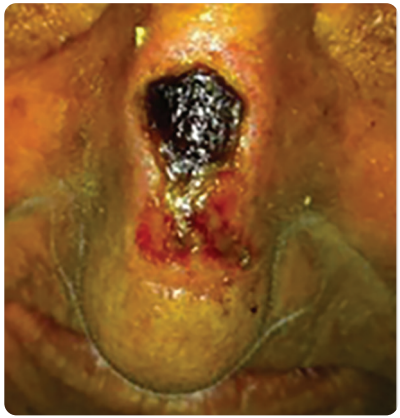
DEFINITION:

Stage 3 is not to be used on ears or bridge of the nose due to tissue layers:

Ears:
Stages 1, 2, 4, US, DTPI

Bridge of Nose:
Stages 1, 2, 4, US, DTPI

Mucous Membrane:
See Mucosal Membrane PI



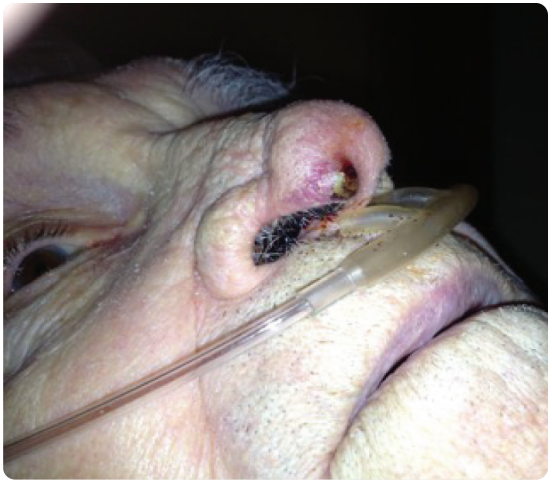
Device pressure injury (PI) results from medical devices, equipment, furniture, and everyday objects that have applied pressure to the skin, either as an unintended consequence of their therapeutic use or inadvertently due to unintended skin-device contact.

When the device utilized is for therapeutic or diagnostic purposes, it is referred to as a Medical Device Related Pressure Injury.

Mucosal Membrane Pressure Injury

Deep Tissue Pressure Injury

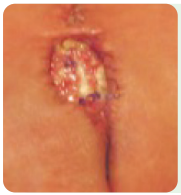
Due to the anatomy of the tissue these injuries cannot be staged.



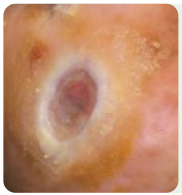
DEFINITION:

Mucosal membrane pressure injury is found on mucous membranes that line the respiratory, gastrointestinal and genitourinary tracts with a history of a medical device in use at the location of the injury.

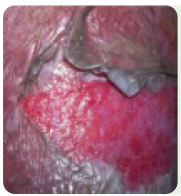
Wounds that Should Not be Staged



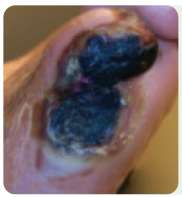
Surgical Wound
A surgical wound that may be intentionally left open to heal or one that opened after a complication of surgery.



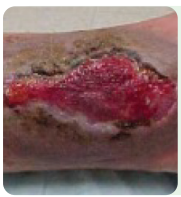
Diabetic/Neuropathic Ulcer
Often located on the plantar surface of the foot. May be caused by loss of protective sensation, increased shear & pressure, or structural changes in the foot. May appear initially as a callus.



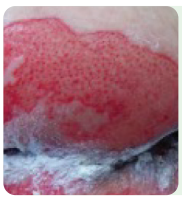
Skin Tear
Traumatic injury that results in separation of the epidermis from the dermis.



Arterial Wound
A wound caused by ischemia from arterial insufficiency. May be found between toes, on tips of toes, or along sides of foot and may involve large portions of distal tissue.



Venous Ulcer
A wound caused by venous hypertension, often found on the medial aspect of the lower extremity.



Incontinence-Associated Dermatitis
An inflammation of the skin caused by prolonged contact with urine or stool. Redness, edema, blistering, or skin erosion may be seen.

Managing Pressure Injuries

Basic Pressure Injury Care

Pressure injury management products are intended to support best practice. In addition to assessing the patient's/resident's risk, it is important to intervene to mitigate each identified risk. At a minimum, measures must be taken to protect the **S.K.I.N.**

S urface

- Appropriate support surface (bed and chair)
- Elevate for risk or actual injury

K eep Turning/Moving

- Regular repositioning (bed and chair)
- Offload at-risk bony prominences

I mprove Moisture Management

- Prompt incontinence care
- Skin protection from excessive moisture

N utrition and Fluids

- Drink an adequate amount of fluids
- Eat a balanced diet

Notes

03

Wound Management

03 WOUND MANAGEMENT

Although preventing injury is ideal, wounds do occur. When this happens, the key is to provide an optimal wound healing environment and minimize the risk of complications.

Wound Bed Preparation Basics

M.O.I.S.T. is a model for optimizing wound management at the point of care. It serves to remind clinicians of practice and product best practices, and is applied after a thorough assessment and in conjunction with supporting therapies. The steps of M.O.I.S.T. can be used in the order the clinician decides is most appropriate.

M oisture Balance

O xygen Balance

I nfection Control

S upport Wound Environment

T issue Management

Moisture Balance

- Stable temperature
- Moist but not wet
- Protection from cellular distortion

M

Mepilex® Border Flex

Mepilex® Border Flex Lite

Mepilex® Border Sacrum

Mepilex® Border Heel

Mepilex®

Mepilex® Lite

Exufiber®/ Exufiber® Ag+

Melgisorb®

Mepilex® Up

Oxygen Balance

- Revascularization and compression therapy
- Wound dressings or spray
- Hyperbaric oxygen therapy

Hyperbaric Oxygen Therapy (HBOT)

Infection Control

- Manage local infections
- Antiseptics
- Wound dressings with antimicrobial effects

Mepilex® Border Ag

Exufiber® Ag+

Mepilex® Border Sacrum Ag

Melgisorb® Ag

Mepilex® Ag

Mepilex® Border Post-Op Ag

Mepitel® Ag

Normlgel® Ag

Support Wound Environment

S

All Wounds: Optimize nutrition, encourage exercise, promote smoking cessation

Pressure Injury: Redistribute pressure and shear, interface friction, manage moisture

Diabetic Foot Ulcer: Offload

Arterial Ulcer: Address perfusion

Venous Leg Ulcer: Compression

Other (Traumatic, Surgical, Atypical, Unknown): Address underlying detriments

Mepilex® Border Flex

Exufiber®/ Exufiber® Ag+

Mepilex® / Mepilex® Ag

Tubigrip®

Setopress®

Z-Flex™ Heel Boot

Mepilex Up

Mepilex Border Flex Lite

Tissue Management

- Wound cleansing
- Wound debridement
- Negative pressure wound therapy

Mesalt®

Exufiber® / Exufiber® Ag+

Normlgel® Ag+

Melgisorb® Ag+

Avance® Solo - ciNPT

Understanding Wounds

There are many types of wounds.

Understanding and addressing underlying contributors is the key to effective wound management.

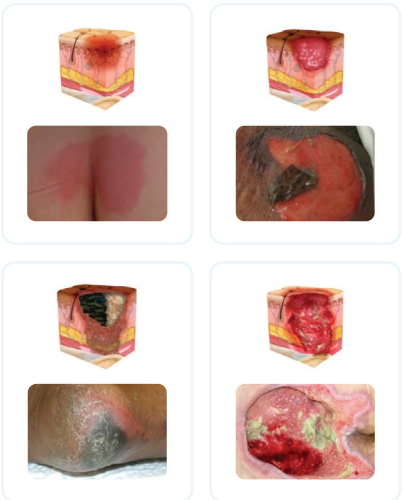
For each wound type, we will describe care components and provide appropriate product solutions.

We will discuss the 6 most common wound types:

1. Pressure Injuries
2. Venous Leg Ulcers
3. Arterial Ulcers
4. Diabetic Foot Ulcers
5. Traumatic Wounds
6. Moisture-Associated Skin Damage

What is a Pressure Injury?

Cause	• The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear
Location	• Usually over a bony prominence • Related to a medical or other device
Appearance	• Injury can present as intact skin or an open ulcer • Can be painful
Exudate	• Zero to high • Peri-wound maceration common
Key Care Components	• Reduce pressure and shear • Fill wounds with depth • Exudate management • Maintain a moist wound base
Comments	• Early detection followed by prompt implementation of preventative measures is important • Be alert to signs and symptoms of infection and to early wound deterioration



Mepilex® Border Flex

Mepilex® Border Sacrum

Mepilex® Border Heel

Exufiber®/ Exufiber® Ag+

Melgisorb® Ag+

Product Recommendations

PRESSURE INJURY

01 Mepilex® Border Flex

Mepilex® Border Flex is a five-layer, bordered foam dressing that is highly conformable due to Flex Technology. It absorbs, channels and traps exudate and allows you to track progress.

02 Mepilex® Border Sacrum

Mepilex® Border Sacrum effectively absorbs and retains exudate and maintains a moist wound environment. It is designed for a wide range of exuding wounds such as sacral pressure injury. It can also be used on dry/necrotic wounds in combination with gels.

03 Mepilex® Border Heel

Mepilex® Border Heel effectively absorbs and retains exudate and maintains a moist wound environment. The design of the Mepilex Border Heel is unique in both absorbing and distributing pressure, shear and friction.

04 Exufiber®/ Exufiber® Ag+

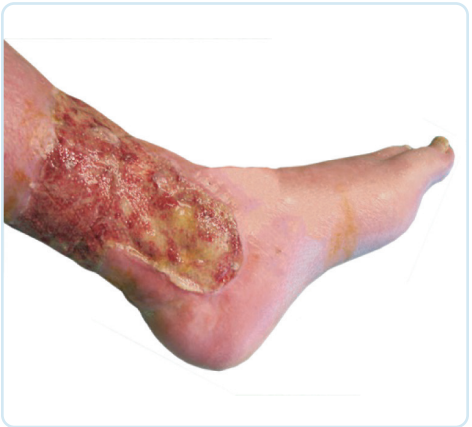
Exufiber®/Exufiber® Ag+ is a sterile, nonwoven dressing made from highly absorbent polyvinyl alcohol fibers. In contact with wound exudate, Exufiber® transforms into a gel that facilitates moist wound healing and ease of removal during dressing changes. Exufiber® Ag+ contains silver sulphate. Both available as a sheet and ribbon as dressings.

05 Melgisorb® Plus/Melgisorb® Ag

Melgisorb® Plus/Melgisorb® Ag absorbs large amounts of wound exudate. When absorbing, the alginate fibers become gel-like providing a moist wound environment. The dressing can easily be removed by irrigating with 0.9% normal saline. Change when saturation is reached. Melgisorb® Ag has a rapid and sustained antimicrobial effect.

What is a Venous Leg Ulcer?

Cause	• Venous insufficiency
Location	• Lower leg, often medial aspect • Gaiter region (above ankle to below knee)
Appearance	• Shallow granulating or fibrinous wounds • Irregular edges • Often painful
Exudate	• High • Peri-wound maceration common
Key Care Components	• Exudate management • Compression (if perfusion adequate)
Comments	• Venous leg ulcers are NOT staged



Mepilex® Up

Mepilex® Border Flex

Exufiber®/ Exufiber® Ag+

Melgisorb® Ag

Setopress®

Tubigrip®

Product Recommendations

VENOUS LEG ULCER

01 Mepilex® Up

Mepilex® Up is a highly conformable dressing, absorbs both low and high viscous exudates, maintains a moist wound environment and minimizes the risk of maceration. It can be used under compression bandaging and in combination with gels.

02 Mepilex® Border Flex

Mepilex® Border Flex is a five-layer, bordered foam dressing that is highly conformable due to Flex Technology. It absorbs, channels and traps exudate and allows you to track progress.

03 Exufiber®/ Exufiber® Ag+

Exufiber®/Exufiber® Ag+ is a sterile, nonwoven dressing made from highly absorbent polyvinyl alcohol fibers. In contact with wound exudate, Exufiber® transforms into a gel that facilitates moist wound healing and ease of removal during dressing changes. Exufiber® Ag+ contains silver sulphate. Both available as a sheet and ribbon as dressings.

04 Melgisorb® Plus/Melgisorb® Ag

Melgisorb® Plus/Melgisorb® Ag absorbs large amounts of wound exudate. When absorbing, the alginate fibers become gel-like providing a moist wound environment. The dressing can easily be removed by irrigating with 0.9% normal saline. Change when saturation is reached. Melgisorb® Ag has a rapid and sustained antimicrobial effect.

05 Setopress®

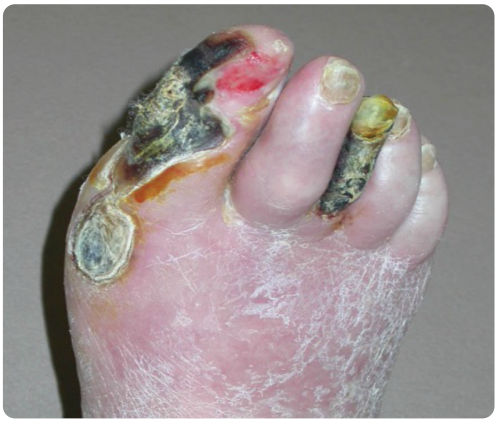
Setopress® is a lightweight high compression bandage. A simple visual guide for application is permanently printed on the bandage.

06 Tubigrip®

Tubigrip® is a multi-purpose tubular support bandage that provides firm support in the management of sprains, strains and swelling. Product is easy to use as it can be easily applied and reapplied.

What Is an Arterial Ulcer?

Cause	• Poor perfusion
Location	• Phalangeal heads, toe tips, or web spaces • Lateral malleolus • Mid-tibial area (shin) • Heels
Appearance	• Often deep (tendon often exposed) and necrotic • Punched-out • Low exuding • Often does not bleed
Exudate	• Low
Key Care Components	• Address perfusion (if possible) • Prevent infection
Comments	• Arterial ulcers are NOT staged



Mepilex® Border Flex Lite

Normlgel® Ag

Mepilex® Lite

Product Recommendations

ARTERIAL ULCER

01 Mepilex® Border Flex Lite

Mepilex® Border Flex Lite is a four-layer, bordered foam dressing that is highly conformable. It absorbs, channels and traps exudate, and allows you to track progress.

02 Normlgel® Ag

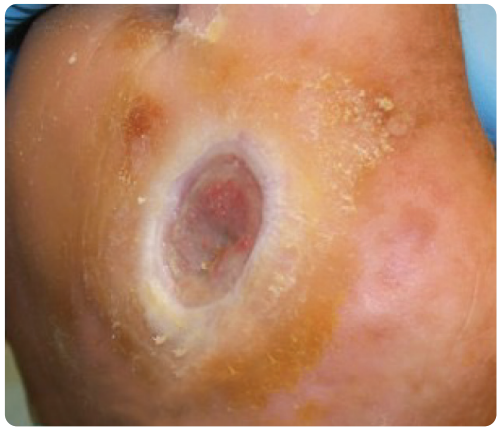
Normlgel® Ag contains an antimicrobial silver compound that is an effective barrier to bacterial penetration by inhibiting the growth of broad spectrum of microorganisms.

03 Mepilex® Lite

Mepilex® Lite is a highly conformable dressing that absorbs exudate and maintains a moist wound environment. Mepilex® Lite may be cut to suit various wound shapes and locations.

What Is a Diabetic Foot Ulcer (DFU)?

Alternate Names	• Neuropathic ulcers
Cause	• Develop with diabetes and B12 deficiency and compounded with any foot deformity or concurrent peripheral vascular disease
Location	• Plantar foot, toes, and web spaces
Appearance	• Pale to red wound bed • Infection and abscesses common • Callus peri-wound often
Drainage	• Varies • Purulent drainage may be present
Key Care Components	• Offloading • Optimize wound healing potential
Comments	• Diabetic foot ulcers are NOT staged



Mepilex® Border Flex

Mepilex® Border Flex Lite

Mepilex®

Exufiber®/ Exufiber® Ag+

Mepilex® Ag+

Mepilex® Lite

Mepilex® Up

Product Recommendations

DIABETIC FOOT ULCER

01 Mepilex® Border Flex
Mepilex® Border Flex is a five-layer, bordered foam dressing that is highly conformable due to Flex Technology. It absorbs, channels and traps exudate and allows you to track progress.

02 Mepilex® Border Flex Lite
Mepilex® Border Flex Lite is a thin version of Mepilex Border Flex, ideal for wounds without heavy exudate. It absorbs and channels exudate and allows a clinician to track progress.

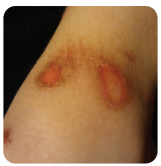
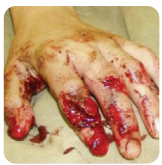
03 Mepilex®/ Mepilex® Ag
Mepilex®/ Mepilex® Ag is a soft and highly conformable foam dressing that absorbs exudate and maintains a moist wound environment. Mepilex® Ag starts to inactivate wound related pathogens within 30 minutes with sustained affect up to 7 days. Mepilex® Ag may reduce odor. May be cut to suit various wound shapes.

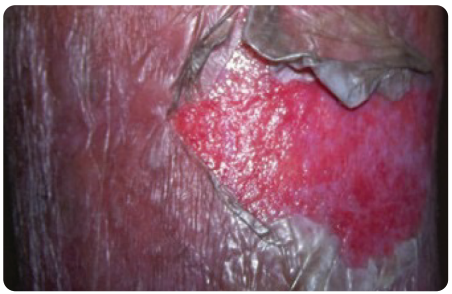
04 Exufiber®/ Exufiber® Ag+
Exufiber®/ Exufiber® Ag+Exufiber®/Exufiber® Ag+ is a sterile, nonwoven dressing made from highly absorbent polyvinyl alcohol fibers. In contact with wound exudate, Exufiber® transforms into a gel that facilitates moist wound healing and ease of removal during dressing changes. Exufiber® Ag+ contains silver sulphate. Both available as a sheet and ribbon as dressings.

05 Mepilex® Lite
Mepilex® Lite is a highly conformable dressing that absorbs exudate and maintains a moist wound environment. Mepilex® Lite may be cut to suit various wound shapes and locations.

06 Mepilex® Up
Mepilex® Up is a highly conformable dressing, absorbs both low and high viscous exudates, maintains a moist wound environment and minimizes the risk of maceration. It can be used under compression bandaging and in combination with gels.

What Is a Traumatic Wound?

Cause	• Mechanical forces, including removal of adhesives • Severity may vary by depth
Types	• Skin tears, lacerations, abrasions, burns
Appearance	**Partial Thickness**  • Separation of the epidermis from the dermis **Full Thickness**  • Separation of the epidermis & dermis from the underlying structure
Drainage	• Varies
Key Care Components	• Keep skin moist and supple • Protect from injury, when possible



Mepilex® Border Flex

Exufiber®/ Exufiber® Ag+

Melgisorb®/ Melgisorb® Ag+

Mepilex®

Mepilex® Ag+

Mepilex® Lite

Product Recommendations

TRAUMATIC WOUND

01 Mepilex® Border Flex

Mepilex® Border Flex is a five-layer, bordered foam dressing that is highly conformable due to Flex Technology. It absorbs, channels and traps exudate and allows you to track progress.

02 Exufiber®/ Exufiber® Ag+

Exufiber®/Exufiber® Ag+ is a sterile, nonwoven dressing made from highly absorbent polyvinyl alcohol fibers. In contact with wound exudate, Exufiber® transforms into a gel that facilitates moist wound healing and ease of removal during dressing changes. Exufiber® Ag+ contains silver sulphate. Both available as a sheet and ribbon as dressings.

03 Melgisorb® Plus/Melgisorb® Ag+

Melgisorb® Plus/Melgisorb® Ag absorbs large amounts of wound exudate. When absorbing, the alginate fibers become gel-like providing a moist wound environment. The dressing can easily be removed by irrigating with 0.9% normal saline. Change when saturation is reached. Melgisorb® Ag has a rapid and sustained antimicrobial effect.

04 Mepilex®/Mepilex® Ag+

Mepilex®/ Mepilex® Ag is a soft and highly conformable foam dressing that absorbs exudate and maintains a moist wound environment. Mepilex® Ag starts to inactivate wound related pathogens within 30 minutes with sustained affect up to 7 days. Mepilex® Ag may reduce odor. May be cut to suit various wound shapes.

05 Mepilex® Lite

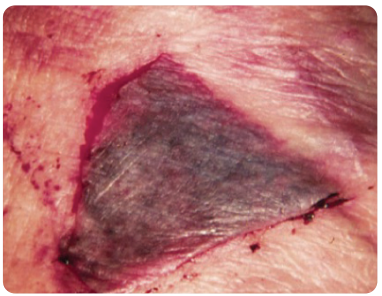
Mepilex® Lite is a highly conformable dressing that absorbs exudate and maintains a moist wound environment. Mepilex® Lite may be cut to suit various wound shapes and locations.

What Is a Skin Tear?

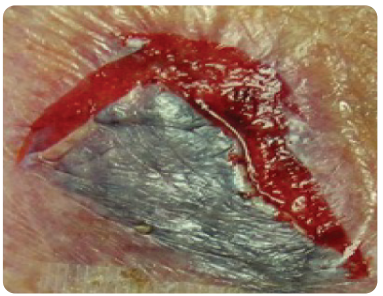
ISTAP Skin Tear Classification System

According to the system, there are three main types of skin tears:

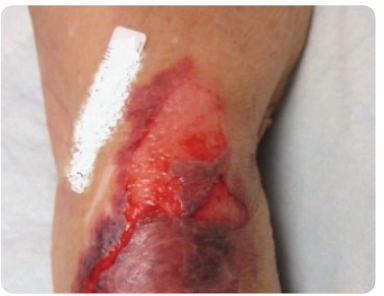
TYPE 1 No Tissue Loss



TYPE 2 Partial Tissue Flap Loss



TYPE 3 Total Tissue Flap Loss



Mepilex® Border Flex

Mepilex® Border Flex Lite

Mepilex®

Mepilex® Lite

Mepitel® One

Product Recommendations

SKIN TEAR

01 Mepilex® Border Flex

Mepilex® Border Flex is a five-layer, bordered foam dressing that is highly conformable due to Flex Technology. It absorbs, channels and traps exudate and allows you to track progress.

02 Mepilex®/Mepilex® Ag+

Mepilex®/ Mepilex® Ag is a soft and highly conformable foam dressing that absorbs exudate and maintains a moist wound environment. Mepilex® Ag starts to inactivate wound related pathogens within 30 minutes with sustained affect up to 7 days. Mepilex® Ag may reduce odor. May be cut to suit various wound shapes..

03 Mepilex® Lite

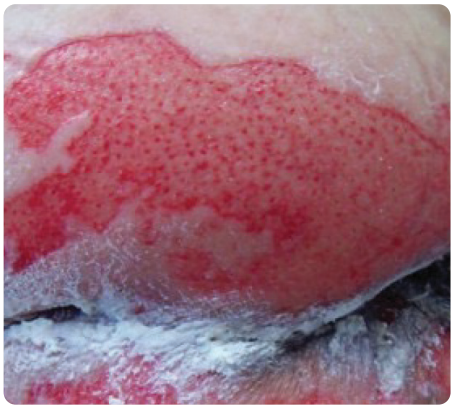
Mepilex® Lite is a highly conformable dressing that absorbs exudate and maintains a moist wound environment. Mepilex® Lite may be cut to suit various wound shapes and locations.

04 Mepitel® One/Mepitel®

Mepitel® One/Mepitel The porous structure of Mepitel® allows exudate to pass into an outer absorbent dressing. The Safetac® technology layer prevents the outer dressing from sticking to the wound and allows for atraumatic dressing changes.

What is Moisture-Associated Skin Damage?

Cause	• Prolonged skin exposure to moisture
Types	**1. Incontinence-associated dermatitis** • Exposure to urine or feces **2. Intertriginous dermatitis** • Exposure to perspiration • Skin folds or with skin-skin contact **3. Peri-wound moisture-associated dermatitis** • Exposure to wound exudate (drainage) **4. Peri-stomal moisture associated dermatitis** • Exposure to ostomy/stoma effluent
Key Care Components	• Improve moisture management • Use moisture barrier creams to protect skin



Notes

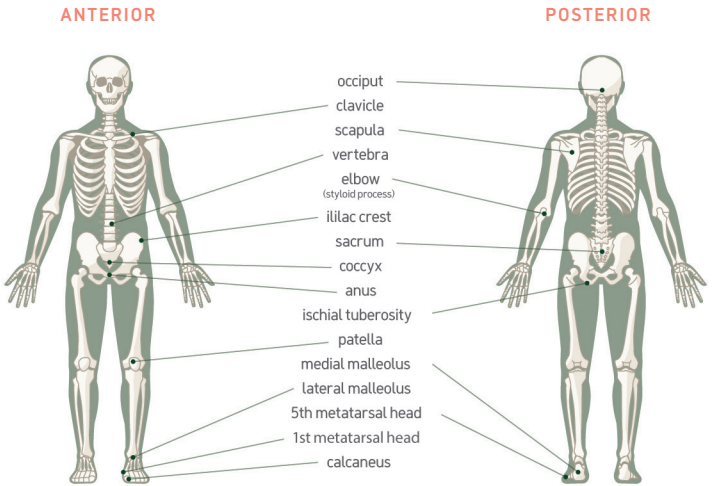
04

Assessment & Documentation of Wounds

04 ASSESSMENT & DOCUMENTATION OF WOUNDS

Although preventing injury is ideal, wounds do occur. When this happens, the key is to provide an optimal wound healing environment and minimize the risk of complications. Assessment and intervention goals are the same for all wound types.

Anatomical Sites

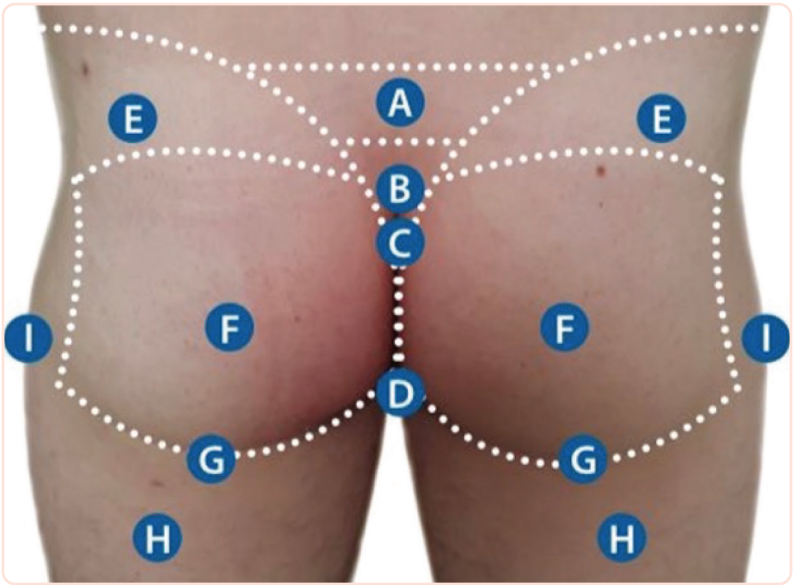


Pressure injury stage, for example:

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- DTPI
- Unstageable

Documentation of Anatomical Locations

Anatomical Locations of Buttocks



A Sacrum

B Coccyx

C Intergluteal (natal) cleft

D Perineal area

E Sacral iliac crest

F Buttocks

G Ischial tuberosity

H Posterior thigh

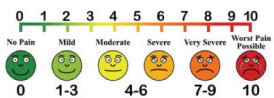
I Trochanter

Adapted from a diagram by Christine T. Berke.

Wound Assessment

5 Step Wound Assesment

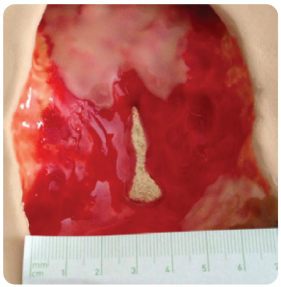
1	Tissue Type	• Percentage of each wound type
2	Wound Exudate	• Type, volume, consistency, color, odor
3	Peri-Wound Condition	• Area extending 4cm from wound edge
4	Pain Level	• At dressing changes • Intermittent or continuous
5	Size	• Length, width, depth • Presence of undermining or tunneling

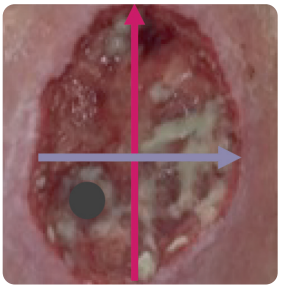


Wound Measurement

WOUND SIZE

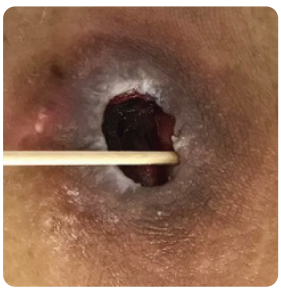
- Wounds are measured in centimeters (cm)
- Length is the longest vertical dimension
- Width is the longest perpendicular dimension
- Depth is the deepest point





UNDERMINING & TUNNELING

- Use the clock method
- 12 o'clock towards the head
- Note depth in centimeters (cm)

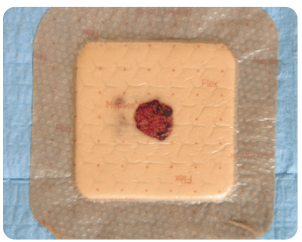


When to Change the Dressing

Mepilex® Border Flex - Time To Change

When to change dressing according to saturation.

Scan here
to learn more



Fluid at 0 edges
Can keep in place

Fluid at 1 edges
Can keep in place

Fluid at 2 edges
Can keep in place

Fluid at 3 edges
Time to Change

Undisturbed Wound Healing

The process of allowing the wound to "rest" by alleviating unnecessary dressing changes. This protects and supports the normal processes of skin and wound healing; includes a moist wound environment, and catalyzes faster wound closure.

- Each phase of healing occurs undisturbed
- Temperature remains stable
- Moist but not wet conditions for all healing processes
- Protection from trauma, shear, friction, and pressure

Tod Brindle and Pete Farmer, "Undisturbed wound healing: A narrative review of the literature and clinical considerations," Wounds International, June 3, 2019, pp. 40-48. Slide 8 taken from Undisturbed Wound Healing CE.

Product Application Videos

Mepilex® Border Flex

Scan to Watch

Mepilex® Up

Scan to Watch

Mepilex®

Scan to Watch

Exufiber® / Exufiber® Ag

Scan to Watch

Mepilex® Border Flex Lite

Scan to Watch

Mepitel® One

Scan to Watch

Mesalt®

Scan to Watch

Mextra® Superabsorbent

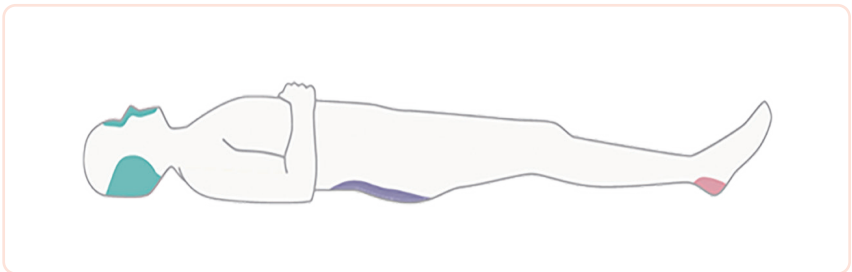
Scan to Watch

Tubigrip®

Scan to Watch

Total Protection: Head to Heel

Mitigating the root causes of pressure injuries involves preventative measures that must specifically address the extrinsic factors; Pressure, Shear, Friction and Microclimate, that contribute to Pressure Injuries.



Mepilex® Border Sacrum

Mepilex® Border Heel

Mepilex® Border Flex

Mepilex® Lite

Z-Flo™ Fluidized Positioners

Z-Flex™ Heel Boot

Tortoise™ Turning & Positioning Systems

The Simple Six for Wound Management

Mepilex®
Border Flex

1

Mepilex® Up

2

Exufiber® &
Exufiber® Ag+

3

Mesalt®

4

Mextra® Superabsorbent

5

Mepitel® One

6

Notes

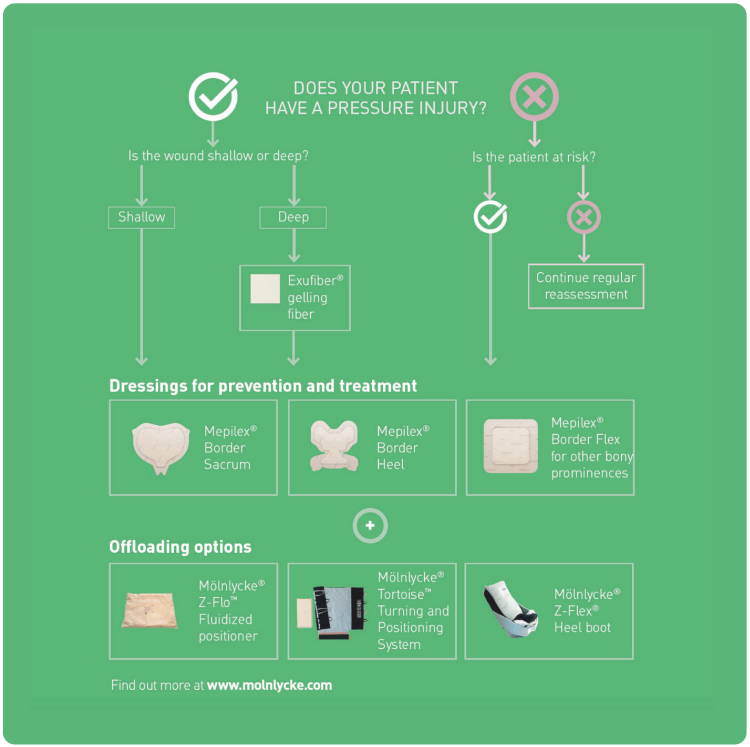
05

Best Practice Guides

05 BEST PRACTICE GUIDES

Best practice guides can assist with clinical decision-making to advance your performance and help you to achieve better patient, clinical, and financial outcomes every day.

Call your Mölnlycke Health Care Representative to request guides or more information: **1-800-843-8497**



Pressure Injury Management (PIM) Algorithm

Skin Protection Under Medical Devices

Select the dressing size appropriate to cover the affected area. Non-bordered dressings can be cut to customize shape to accommodate unique body contours and device shapes.

MEPILEX LITE 5x5

Application

Under Non-Invasive Ventilation Mask

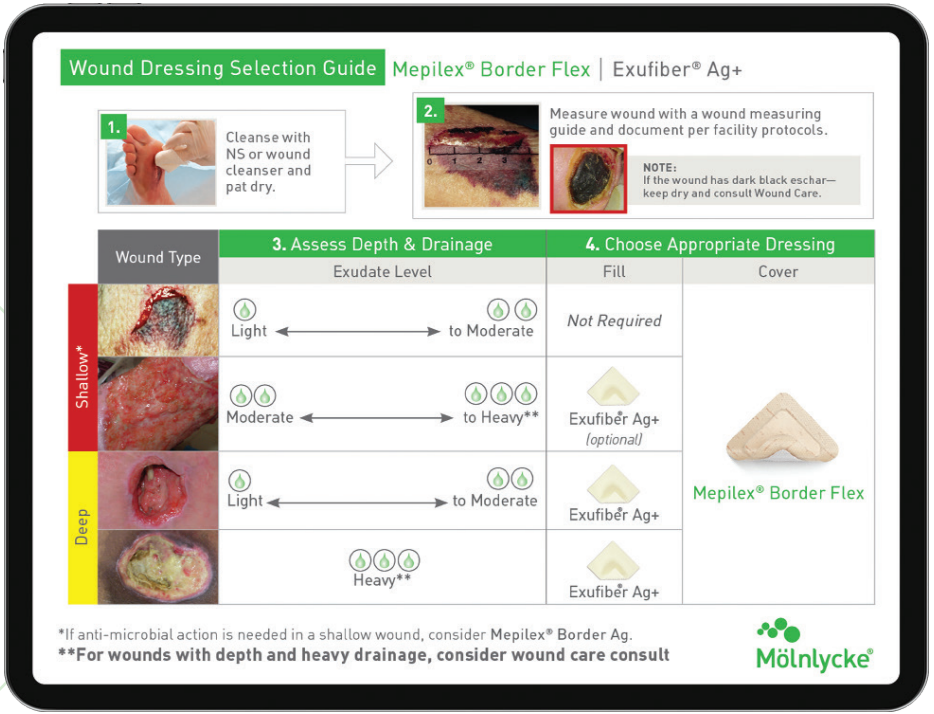
Application

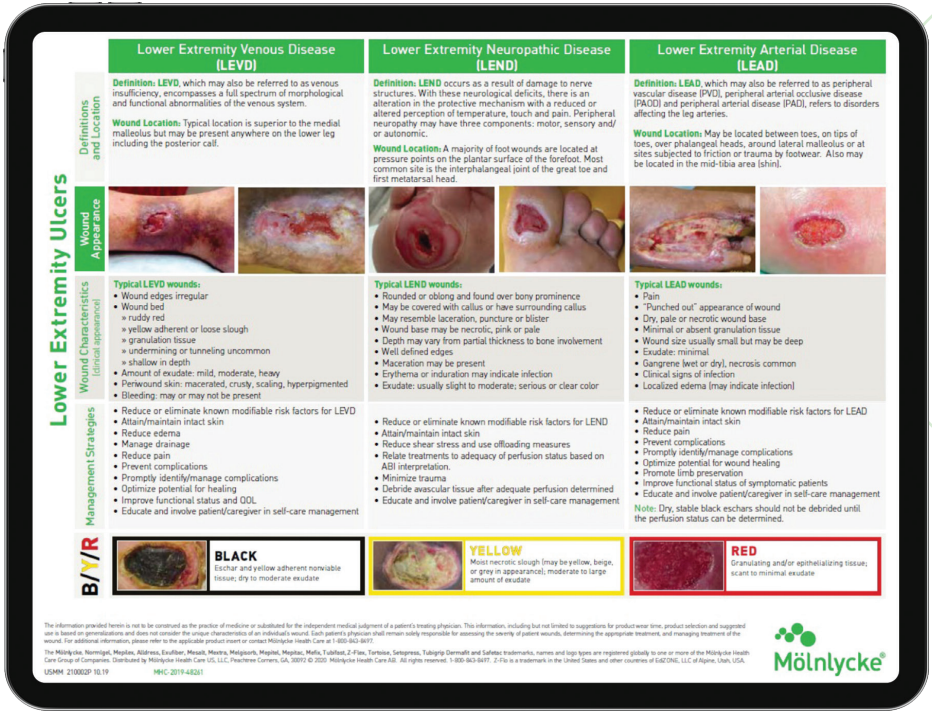
Under the “C” Collar

Application

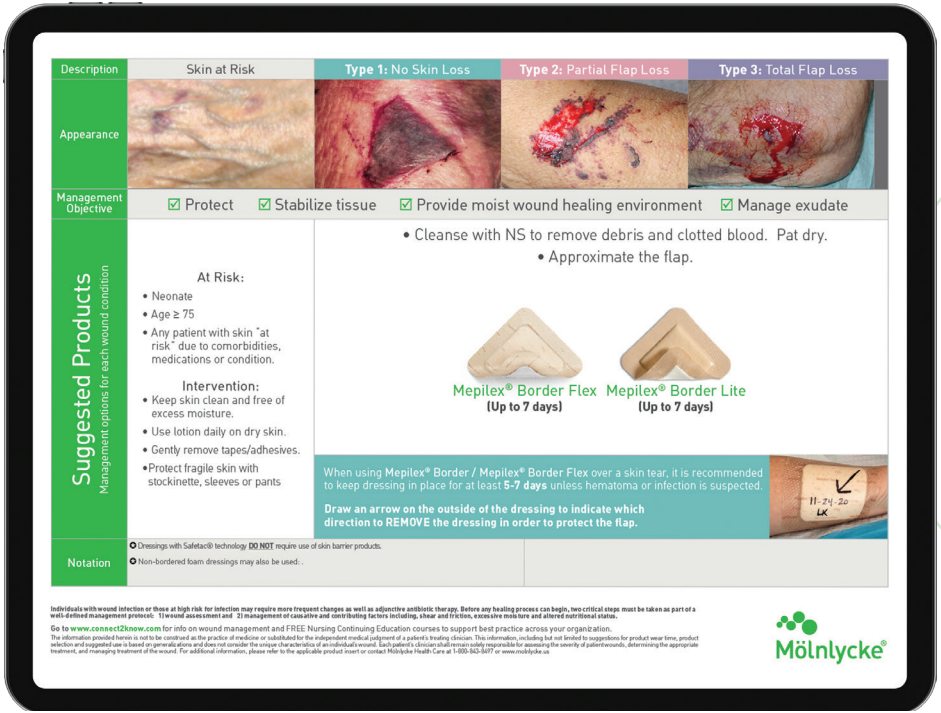
Under Oxygen Tubing

Wound Management Dressing Selection



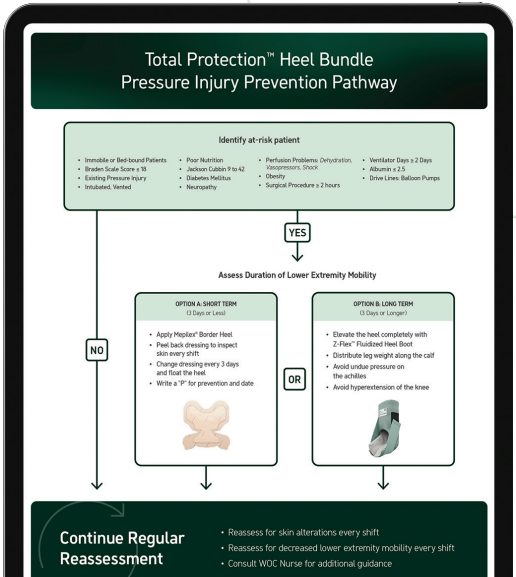


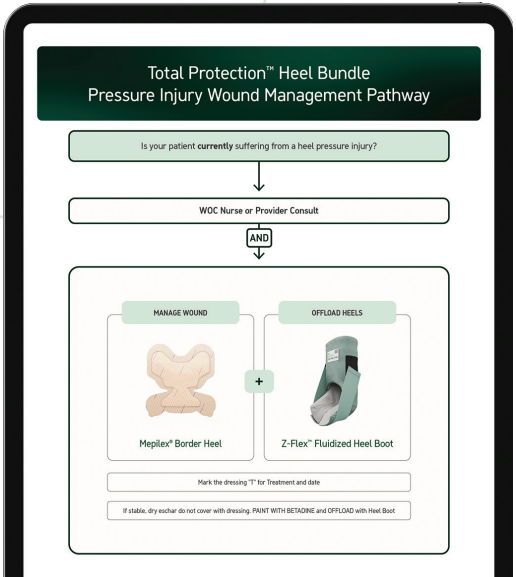
Lower Extremity Ulcer Guide



Skin Tear Dressing Selection

Heel Decision Tree





06

Learn More About Wounds

06 LEARN MORE ABOUT WOUNDS

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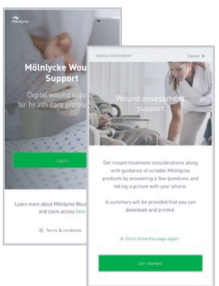
Call your Mölnlycke Health Care Representative to request guides or more information: **1-800-843-8497**

Mölnlycke Wound Support App

IOS
apps.apple.com/us/app/wound-support/id154438081

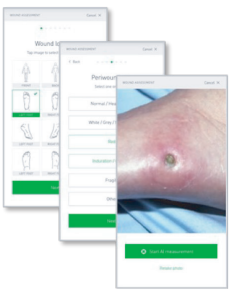
Google
https://play.google.com/store/apps/details?id=com.molnlycke.hq.woundsupport

Scan here to download the Molnlycke Wound Support app



Activate and initiate wound assessment

+



Define wound location

+

Receive wound measurement

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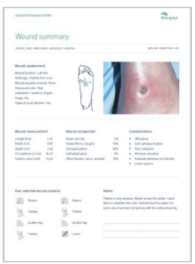

Create summary PDF

Online Education Platform

Pressure Injury Prevention

Wound Management

Program Development

Clinical Learning Hub
Powered by Mölnlycke®

http://us.clinicallearning.com

- FREE Continuing Education Courses
- Wound Care Voices Podcast
- Wound Talks
- Microworld
- Webinars
- Quality Improvement Projects
- Clinical Evidence

Scan here to learn more about our Online Education Platform

Mölnlycke® YouTube Channel

Wound care education videos

+

Product application videos

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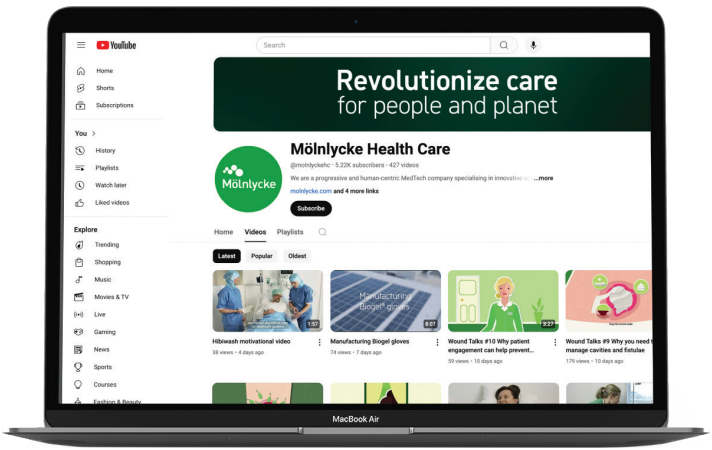
Ask a professional

+

Access to other Mölnlycke channels

Scan here for our YouTube page



Notes

07

Product Reference Guides

With our extensive portfolio, we can make it easy for you to standardize your wound management formulary. This guide was designed to simplify the process by providing you with ordering information and a cross reference of comparable products.

At Mölnlycke, our products are designed with the patient, clinician and bottom line in mind. And they are supported by our many certified Mölnlycke clinical specialists and sales representatives, an extensive live and on-demand educational program, and additional tools such as our Mölnlycke Wound Support app to make your job easier and more efficient.

Scan here for downloadable product catalogs

Product	Size	Mölnlycke #	HCPCS Code	Product Info
BORDERED FOAMS:				
 Mepilex® Border Flex	3”x3”	595200	A6212	
	4”x4”	595300	A6212	
	6”X6”	595400	A6213	
	6”x8”	595600	A6213	
Competitive Examples: Allevyn Life, Convafoam, Optifoam, Comfort Foam, Polymem, Biatain, Tegaderm Silicone Foam				
 Mepilex® Border Ag	4”x4”	395390	A6212	
	6”x6”	395490	A6213	
Competitive Examples: Allevyn Ag, Optifoam Ag, Biatain Silicone Ag foam, Comfort Foam Ag				
 Mepilex® Border Sacrum	6.3”x7.9”	282055	A6213	
	8.7”x9.8”	282455	A6213	
Competitive Examples: Allevyn Sacrum, Proximel Sacrum, Aquacel Foam Sacral Dressing, Biatain Sacral, Tegaderm, Silicone Foam				
 Mepilex® Border Heel	8.7”x9.1”	282790	A6210	
Competitive Examples: Allevyn Life or Gentle Border Multisite, Aquacel Foam, Tegaderm Silicone Foam, ComFeel Plus				

Product	Size	Mölnlycke #	HCPCS Code	Product Info
BORDERED FOAMS CONT.:				
 Mepilex® Border Post Op Ag	2.5”x3”	498100	A4649	
	3.5”x4”	498200	A4649	
	4”x6”	498300	A6212	
	4”x8”	498400	A6212	
	4”x10”	498450	A6212	
	4”x12”	498600	A6213	
	4”x14”	498650	A6213	
Competitive Examples: Aquacel Surgical Ag, Allevyn Life, 3M Tegaderm Foam, ComfortFoam Border Ag				
 Mepilex® Border Post Op	2.5”x3”	496100		
	3.5”x4”	496200		
	4”x6”	496300	A4649	
	4”x8”	496405	A4649	
	4”x10”	496455	A4649	
	4”x12”	496605	A4649	
	4”x14”	496650	A4649	
Competitive Examples: Aquacel Surgical, 3M Tegaderm Foam, ComfortFoam Border				
NON-BORDERED FOAMS:				
 Mepilex®	4”x4”	294199	A6209	
	6”x6”	294399	A6210	
	8”x8”	294499	A6211	
Competitive Examples: Allevyn, Aquacel Foam, Optifoam, Comfort Foam, Tielle, Polymem GTL, Biatain				

Product	Size	Mölnlycke #	HCPCS Code	Product Info
NON-BORDERED FOAMS CONT.:				
 Mepilex® Ag	4”x4”	287100	A6209	
	6”x6”	287300	A6210	
	8”x8”	287400	A6211	
 Mepilex® Lite	2.4”x3.4”	284090	A6209	
	4”x4”	284190	A6209	
	6”x6”	284390	A6210	
Competitive Examples: Allevyn Lite, Optifoam Thin, CarraSmart Foam Thin				
 Mepilex® Transfer	6”x8”	294899	A6210	
	8”x20”	294599	A6211	
 Mepilex® Transfer Ag	6”x8”	394890	A6210	

Product	Size	Mölnlycke #	HCPCS Code	Product Info
NON-BORDERED FOAMS CONT.:				
 Mepilex® Up	4”x4”	212199	A6209	
	4”x8”	212299	A6210	
	6”x6”	212399	A6210	
	8”x8”	212499	A6211	
GELLING FIBERS:				
Exufiber®	0.8x17.7 Rope	709909	A6196	
	4”x4”	709901	A6196	
	6”x6”	709903	A6197	
Exufiber® Ag+	0.8x17.7 Rope	603420	A6199	
	4”x4”	603425	A6196	
	6”x6”	603423	A6197	
	8”x12”	603424	A6198	
Competitive Examples: Aquacel, Aquacel Advantage Ag, Biosorb, Kerracel, Durafiber, Opticell, Opticell Ag, Aquarite				
COMPACT LAYERS:				
 Mepitel®	3”x4”	290799	A6206	
	4”x7”	291099	A6207	
	8”x12”	292005	A6208	

Product	Size	Mölnlycke #	HCPCS Code	Product Info
COMPACT LAYERS CONT.:				
Mepitel® One	3”x4”	289300	A6206	
	4”x7”	289500	A6207	
	6.8”x10”	289700	A6208	
Competitive Examples: Adaptic Touch, KerraContact, Versatel, Dermanet GTL, Cutimed Sorbact, Conformant2				
TUBULAR RETENTION/SUPPORT:				
 Tubigrip® 1 yd. Single-Patient Box	B: Small arms	1520	A6457	
	C: Small ankles	1521	A6457	
	D: Med ankles	1522	A6457	
	E: Large ankles	1528	A6457	
	F: Large knees	1523	A6457	
 Tubigrip® 10 yds. Multi-Patient Box	G: Large thighs	1439	A6457	
	J: Small trunks	1440	A6457	
	K: Med trunks	1441	A6457	
	L: Large trunks	1442	A6457	
Competitive Examples: Tensogrip, Demagrip, Spandagrip, Medigrip				

Product	Size	Mölnlycke #	HCPCS Code	Product Info
TUBULAR RETENTION/SUPPORT CONT.:				
 Tubifast® Tubular Retention	Small limbs	2434	N/A	
	Sm/Med limbs	2436	N/A	
	Large limbs	2438	N/A	
	XL limbs	2440	N/A	
	Lg adult trunks	2444	N/A	
Competitive Examples: Surgilast. Spandage, Stockinette, Stretch Net				
TAPES & FILMS:				
 Mepitac® Tape	3/4”x118”	298300	A4452	
	1.5”x59”	298400	A4452	
Competitive Examples: Gentac, 3M Kind, ComfiTape				
 Mefix® Tape	2”x11 yards	310599	A4450	
	4”x11 yards	310599	A4450	
	6”x11 yards	310599	A4450	
Competitive Examples: MedFix, RiteFix, Hypafix, Medipore				

Product	Size	Mölnlycke #	HCPCS Code	Product Info
SUPERABSORBENT:				
 Mextra®	5”x7”	610100	A6197	
	7”x9”	610300	A6197	
	9”x13”	610500	A6198	
DEBRIDING AGENTS:				
Competitive Examples: Optilock, ConvaMax, HydraLock, Xtrasorb, Enluxtra				
 Mesalt®	8”x8” (4x4 folded)	286080	A6228	
	3/4””x39” (ribbon)	285280	A6226	
 Normlgel® Ag	1.5 oz tube	350450	A6248	
Competitive Examples: DermaSyn Ag, Resta SilverGel, Silvasorb gel, SilverGel				

Notes

Skin Protection & Wound Management

Guide for the Bedside Clinician

1-800-843-8497 | www.molnlycke.us | 5445 Triangle Parkway, Peachtree Corners, GA 30092

Mölnlycke Health Care wound care products can serve as integral components of wound management programs. If infection is suspected, product use may be continued if proper infection treatment is initiated and if recommended by a physician.

The information provided in this brochure is not to be construed as the practice of medicine or substituted for the independent medical judgment of a patient's treating physician. Information contained herein, including but not limited to suggestions for product wear time, product selection and suggested use is based on generalizations and does not consider the unique characteristics of an individual's wound. Each patient's physician shall remain solely responsible for assessing the severity of patient wounds, determining the appropriate treatment, and managing treatment of the wound. For additional information, please refer to the applicable product insert or contact Mölnlycke Health Care US, LLC at 1-800-843-8497

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