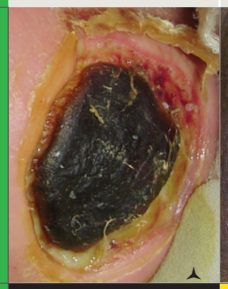
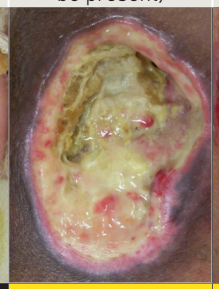
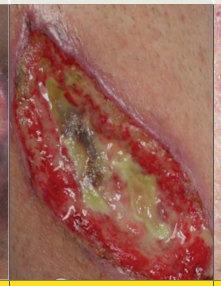
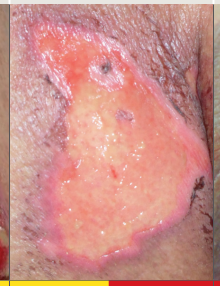
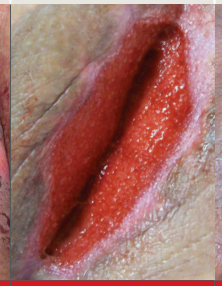
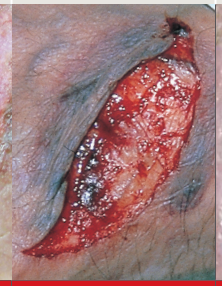
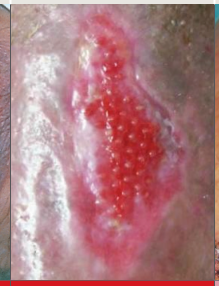
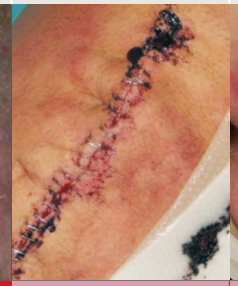
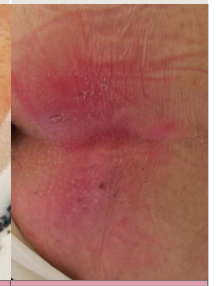
Ohio Living Home Health & Hospice Wound Dressing Selection Guide[1]

Description	Eschar (Colors may vary)	Predominantly Slough (Infection may be present)	Granulating/ Mixed Wound Tissue	Fibrin (Appears yellow)	Granulating and/or Epithelializing	Skin Tear	Epithelializing	Surgical Incisions	Skin at Risk
Wound Appearance									
Depth	Unknown	Deep	Deep/Shallow	Deep/Shallow	Deep/Shallow	Shallow	Shallow	Sutured	No injury
Exudate Level	Moderate to None	High ← → to Moderate		Moderate ← → to Scant				Moderate to None	None
Management Objective	Debride	Cleanse, Debride, Absorb, Fill Dead Space		Protect, Hydrate, Fill Dead Space				Protect	Protect/ Prevent^/Manage
Suggested Products and Change Rates	Do not debride stable heel eschar. Float heels, keep dry, monitor If stable Eschar becomes unstable: Boggy, non-intact edges,signs of infection, exudate Consult MD/ WOC Nurse/ Wound Care Team	**Mesalt®** *as Indicated* or **Exufiber®** or **Exufiber® Ag+** or **Melgisorb® Ag** Cover choices: **Mepilex® Border Flex** (Change as clinically indicated)	**Exufiber®** or **Exufiber® Ag+** or **Melgisorb® Ag** Cover choices: **Mepilex® Border Flex** (Change as clinically indicated)	Moderate Exudate: **Exufiber®** or **Exufiber® Ag+** or **Melgisorb® Ag** Cover choices: **Mepilex® Border Flex** (Change as clinically indicated) Minimal Exudate/Dry Wound: **Normlgel® Ag** Cover Choices: **Mepilex® Border Flex** (Change as clinically indicated)		**Mepilex® Border Flex** (Change as clinically indicated)		**Mepilex® Border post-op sizes** (Up to 7 days) (PRN) OR **Mepilex® Border Flex** (Change as clinically indicated)	Prophylactic Use[2] **Mepilex® Border Flex** For anatomic sites other than sacrum or heel. or **Mepilex® Border Sacrum** (PRN) ^ When used as part of an individualized, comprehensive pressure ulcer prevention protocol Fixed Devices **Mepilex®** or **Mepilex® Lite** or **Mepilex® Transfer** (PRN)
	Consider using **Normlgel® Ag** (Up to 3 days), **Exufiber® Ag+** (up to 7 days), **Melgisorb® Ag** (Up to 4 days), **Mepilex® Border Ag** for antimicrobial effect.								
	*For high exudate wounds consider use of Mextra® Superabsorbent as needed								
Notations	✪ Fixation: **Mefix®** or **Tubifast®** ✪ **Mepilex® Transfer**: Secondary dressings needed for exudate management (PRN) ✪ Firm support - **Tubigrip®**				✪ **Safetac®** dressings DO NOT require use of skin barrier products. ✪ **Mepitel®** may be used as a contact layer with NPWT				

Mepitel®/Mepitel® One may be left in place during wound cleansing and irrigation. Change secondary dressings as needed. | Image courtesy of NPUAP.org |

Reference: 1. Doughty, D and McNichol, L., Ed. Core Curriculum: Wound Management. Wound, Ostomy and Continence Nurses' Society. Philadelphia: Wolters Kluwer, 2016. 2. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019.

The suggested topical management options and change rates are the treatment choice of your facility and may not reflect the opinions of Mölnlycke Health Care or in the case of products manufactured by a company other than Mölnlycke Health Care, the manufacturer's recommended usage guidelines.

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Pressure Ulcer/Injury Stages[1]

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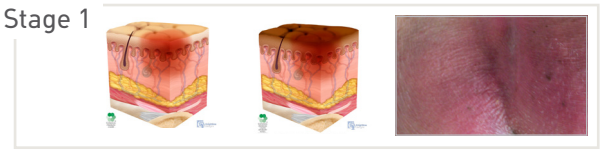
A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure 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.

Deep Tissue Injury:

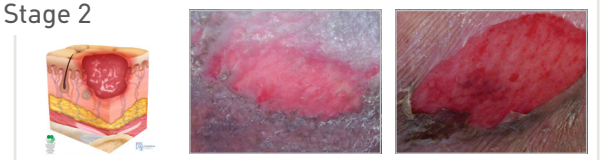
Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin 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. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Stage 1



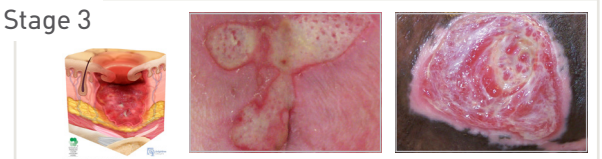
Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2



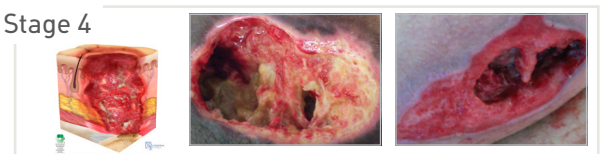
Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation 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. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3



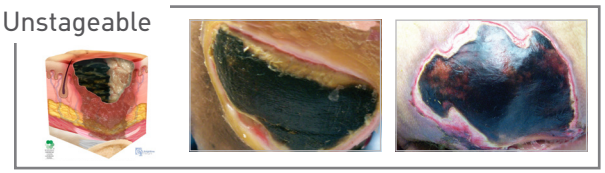
Pressure Injury: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop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

Stage 4

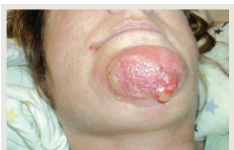


Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable

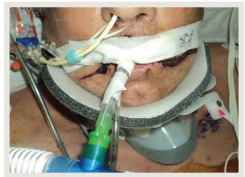


Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.



Medical Device Related Pressure Injury:

This describes the etiology of the injury. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.



Mucosal Membrane Pressure Injury:

Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these injuries cannot be staged.

References: 1. NPUAP Press Release April 13, 2016: National Pressure Ulcer Advisory Panel (NPUAP) announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury

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