# BUMC Wound Dressing Selection Guide

## Wound Appearance

<table>
<thead>
<tr>
<th>Description</th>
<th>Eschar* (Colors may vary)</th>
<th>Predominantly Slough (Infection may be present)</th>
<th>Granulating/Mixed Wound Tissue</th>
<th>Fibrin (Appears yellow)</th>
<th>sDTI (suspected deep tissue injury)</th>
<th>Skin Tear</th>
<th>Epithelializing</th>
<th>Healed Wounds, Skin at Risk or Closed Surgical Incisions</th>
</tr>
</thead>
</table>

### Exudate Level
- Moderate to None
- High to Moderate
- Moderate to Scant
- None

### Depth
- Unknown
- Deep
- Deep/Shallow
- Deep/Shallow
- Shallow
- Shallow
- Shallow
- Closed

### Treatment Objective
- Debride*
- Cleanse, Debride, Absorb, Fill Dead Space
- Protect, Hydrate, Fill Dead Space
- Protect

## Suggested Products and Change Rates

### UNSTABLE ESCHAR:
- Mesal® (Daily)
- Cover Dressing: Non-adherent pad and Transparent Film
- Cover Dressing: Non-adherent pad and Transparent Film OR Alginate (up to 3 days)
- Cover Dressing: Hydrocolloid or ABD Pad and Paper Tape

### STABLE ESCHAR:
- (dry, closed)
- DO NOT debride
- heels or toes--Float heels and paint with Betadine, keep dry.

## Contact Wound Care at ext. 4400 for wound deterioration or no improvement in 3 days.

### For an Extremity: May use roll gauze and paper tape to secure primary dressing.

## Notations
- All Adhesive dressings/tapes are determined by skin integrity. Assure at least 2.5cm of clean dry skin surrounding wound edge to secure dressing.
- Change rate will vary depending on severity of wound and amount of drainage.
- All wounds to be cleansed with Normal Saline and gauze, pat dry each change.
- When pressure evident, assure offloading of heels with pillows or 4 inch foam cushion and weight shifting and/or turning every two hours.
- Dressings with Safetac® technology do NOT require use of skin barrier products.

### Individuals with wound infection or those at high risk for infection may require more frequent changes as well as adjunctive antibiotic therapy. Before any healing process can begin, two critical steps must be taken as part of a well-defined management protocol:

1. The wound assessment and 2) Management of causative and contributing factors including unrelieved pressure, shear and friction, excessive moisture and altered nutritional status.

### Debridement of eschar may be contraindicated in some situations such as dry, fused, stable eschar. Debridement is indicated if signs/symptoms of infection are present.

### Normigel—when packing wound space, impregnate gauze with Normigel, loosely fill and cover.

### Normigel, creams, or ointments may be applied over Mepitel/Mepitel One as indicated. Mepitel/Mepitel One may be left in place during wound cleansing and irrigation. Change secondary dressings as needed.

### For Pressure Relief from Device:
- Mepilex® or Mepilex® Lite (Up to 7 days)
- Skin assessment daily and Pressure Relief

### Skin Folds:
- Mepilex® Transfer for protection (Up to 7 days)
- InterDry Ag® (up to 5 days)

The suggested topical management options and change rates are the treatment choice of BUMC 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.
**Pressure Ulcer Stages with Descriptive Images**

**Suspected Deep Tissue Injury**

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. This damage is also difficult to detect in dark skin tones.

The evolution may include a thin blister over a dark wound bed, then the wound may further evolve and become covered by thin eschar. Further evolution may be rapid deterioration exposing additional layers of tissue even with optimal treatment.

**Category/Stage I**

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

This area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Category/Stage I areas may be difficult to detect in individuals with dark skin tones, and the presence of this skin discoloration may indicate “at risk” persons (a heralding sign of risk).

**Category/Stage II**

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Presents as a shiny or dry shallow ulcer without slough or bruising.

- This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.
- Bruising indicates suspected deep tissue injury.

**Category/Stage III**

Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

**Category/Stage IV**

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

**Unstageable**

Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed.

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined.

Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as “the body’s natural (biological) cover” and should not be removed.

**Categorizing/Staging of Chronic Pressure Ulcers**

Assessing the patient with a chronic pressure ulcer presents challenges since the original level of tissue destruction cannot be determined visually. Every effort should be made to obtain prior clinical records and the most thorough history possible from the patient and/or family.

A determination of the most accurate Category/Stage may be possible through assessment of identifiable wound characteristics:

- Scar tissue in the periwound area
- Rolled, contracted edges with or without undermining
- Red (granulating or hyper-granulating) or pink (non-granulating) wound tissue
- Location in relationship to underlying structures

- If the ulcer is overlying a bony structure that can be palpated, this could be documented as a Category/Stage IV ulcer
- If no depth or underlying structures can be appreciated, this could be documented as a Category/Stage III or IV

Facility, local and regional regulations should always be considered when documenting these types of wounds.

**REFERENCES:**


Pressure Ulcer illustrations courtesy of NPUAP.org

The information provided herein is not to be construed as the practice of medicine or substituted for the independent medical judgment of a patient’s treating physician. This information, 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 at 800.882.4582.

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