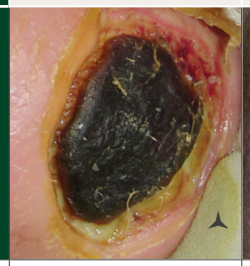
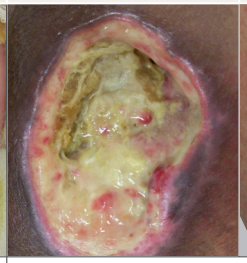
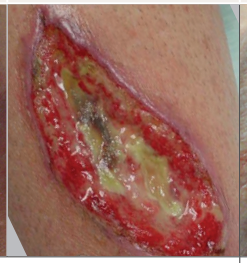
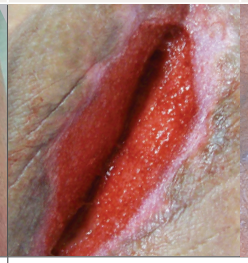
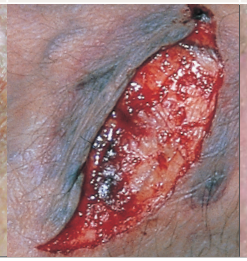
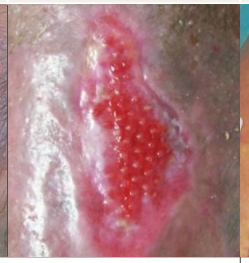
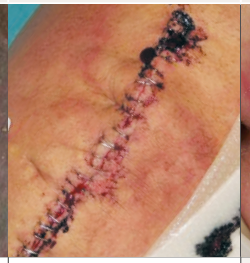
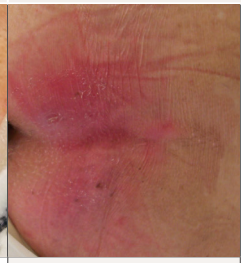
Hospice of the Piedmont **PAC** Wound Dressing Selection Guide[1]

HOSPICE of the PIEDMONT

Description	Eschar (Colors may vary)	Predominantly Slough (Possible Infection)	Granulating/ Mixed Wound Tissue	Granulating and/or Epithelializing	Skin Tear	Epithelializing	Surgical Incisions	Skin at Risk (no injury)
Wound Appearance								
Exudate Level	Moderate to None	High ← → to Moderate		Moderate ← → to Low			Moderate to None	When used as part of an individualized comprehensive prevention protocol[1] cover with:
Suggested Products and Change Rates	**Deep Filler Choices:** Normlgel® Ag (Up to 3 days) Mesalt® (Daily or according to clinical practice) **Cover Choices:** Bordered Mepilex® Border Flex (Up to 7 days) Mepilex® Border Flex Lite (Up to several days)* **Do Not** debride stable heel eschar. Float heels, keep dry, monitor.	**Deep Filler Choices:** Exufiber® (Up to 7 days) Melgisorb® Plus (When saturation is reached) Mesalt® (Daily or according to clinical practice) **Cover Choices:** Bordered Mepilex® Border Flex (Up to 7 days) Non-Bordered Mepilex® Up (Up to several days)* Mextra® Superabsorbent (Up to several days)*		**Deep Filler Choices:** Exufiber® (Up to 7 days) Melgisorb® Plus (Up to 7 days) Mesalt® (Daily or according to clinical practice) **Cover Choices:** Bordered Mepilex® Border Flex (Up to 7 days) Mepilex® Up (Up to several days)* Mextra® Superabsorbent (Up to several days)*	**Cover Choices:** Contact Layer Mepitel® / Mepitel® One Secure with secondary absorptive/ cover dressing and change PRN. (Up to 14 days) OR Bordered Mepilex® Border Flex (Up to 7 days) or Mepilex® Border Flex Lite (Up to several days)*		**Cover Choices:** Bordered Bordered Negative Pressure Therapy	**Prophylactic Use[2]** Bordered Mepilex® Border Flex (Up to 7 days) For anatomic sites other than sacrum or heel. Mepilex® Border Sacrum (Up to several days)* Mepilex® Border Heel (Up to several days)* Consider Use of: Z-flo® Fluidized Positioner **Under Fixed Devices** Mepilex® or Mepilex® Lite or Mepilex® Transfer
Important!	**Consult MD/WOC Nurse/Wound Care Team for eschar management**							
Notations	Consider using Normlgel® Ag, Mepilex® Ag, Exufiber® Ag+, Melgisorb® Ag or Mepilex® Transfer Ag for antimicrobial effect.							
	✪ Fixation: **Mepitac®, Mefix® or Tubifast®** ✪ Compression - **Mepi® Press 2 or Setopress®** ✪ Firm support - **Tubigrip®**			✪ **Safetac®** dressings DO NOT require use of skin barrier products. ✪ **Mepitel®** may be used as a contact layer with NPWT ✪ Contact layers must be secured with an appropriate secondary dressing				

Mepitel®/Mepitel® One may be left in place during wound cleansing and irrigation. Change secondary dressings as needed. | *May be worn for several days. Change the dressing before it is fully saturated, at signs of leakage or as indicated by clinical practice.

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. **3.** National Pressure Injury Advisory Panel, European Pressure Ulcer Advisory Panel and Pan PacificPressure Injury Alliance. Preventing Heel Pressure Injuries. In: Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline: Fourth Edition. Emily Haesler (Ed.). 2025. [cited: 10.25].

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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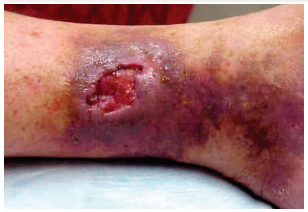
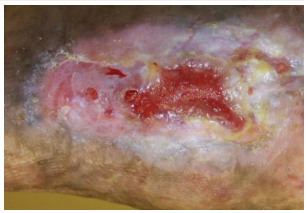
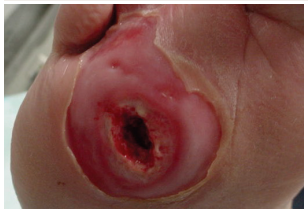
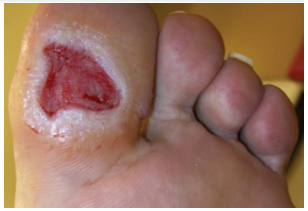
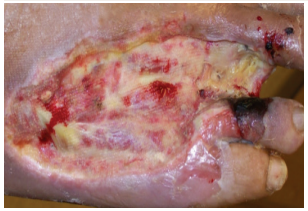
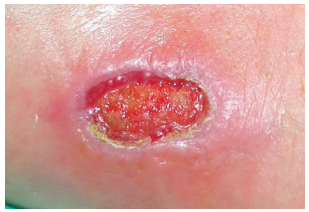
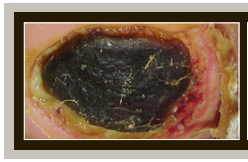
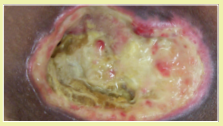
Lower Extremity Ulcers

	Lower Extremity Venous Disease (LEVD)	Lower Extremity Neuropathic Disease (LEND)	Lower Extremity Arterial Disease (LEAD)
Definitions and Location	**Definition: LEVD**, which may also be referred to as venous insufficiency, encompasses a full spectrum of morphological and functional abnormalities of the venous system. **Wound Location:** Typical location is superior to the medial malleolus but may be present anywhere on the lower leg including the posterior calf.	**Definition: LEND** occurs as a result of damage to nerve structures. With these neurological deficits, there is an alteration in the protective mechanism with a reduced or altered perception of temperature, touch and pain. Peripheral neuropathy may have three components: motor, sensory and/or autonomic. **Wound Location:** A majority of foot wounds are located at pressure points on the plantar surface of the forefoot. Most common site is the interphalangeal joint of the great toe and first metatarsal head.	**Definition: LEAD**, which may also be referred to as peripheral vascular disease (PVD), peripheral arterial occlusive disease (PAOD) and peripheral arterial disease (PAD), refers to disorders affecting the leg arteries. **Wound Location:** May be located between toes, on tips of toes, over phalangeal heads, around lateral malleolus or at sites subjected to friction or trauma by footwear. Also may be located in the mid-tibia area (shin).
Wound Appearance	 	 	 
Wound Characteristics (clinical appearance)	**Typical LEVD wounds:** • Wound edges irregular • Wound bed » ruddy red » yellow adherent or loose slough » granulation tissue » undermining or tunneling uncommon » shallow in depth • Amount of exudate: mild, moderate, heavy • Periwound skin: macerated, crusty, scaling, hyperpigmented • Bleeding: may or may not be present	**Typical LEND wounds:** • Rounded or oblong and found over bony prominence • May be covered with callus or have surrounding callus • May resemble laceration, puncture or blister • Wound base may be necrotic, pink or pale • Depth may vary from partial thickness to bone involvement • Well defined edges • Maceration may be present • Erythema or induration may indicate infection • Exudate: usually slight to moderate; serious or clear color	**Typical LEAD wounds:** • Pain • "Punched out" appearance of wound • Dry, pale or necrotic wound base • Minimal or absent granulation tissue • Wound size usually small but may be deep • Exudate: minimal • Gangrene (wet or dry), necrosis common • Clinical signs of infection • Localized edema (may indicate infection)
Management Strategies	• Reduce or eliminate known modifiable risk factors for LEVD • Attain/maintain intact skin • Reduce edema • Manage drainage • Reduce pain • Prevent complications • Promptly identify/manage complications • Optimize potential for healing • Improve functional status and QOL • Educate and involve patient/caregiver in self-care management	• Reduce or eliminate known modifiable risk factors for LEND • Attain/maintain intact skin • Reduce shear stress and use offloading measures • Relate treatments to adequacy of perfusion status based on ABI interpretation. • Minimize trauma • Debride avascular tissue after adequate perfusion determined • Educate and involve patient/caregiver in self-care management	• Reduce or eliminate known modifiable risk factors for LEAD • Attain/maintain intact skin • Reduce pain • Prevent complications • Promptly identify/manage complications • Optimize potential for wound healing • Promote limb preservation • Improve functional status of symptomatic patients • Educate and involve patient/caregiver in self-care management **Note:** Dry, stable black eschars should not be debrided until the perfusion status can be determined.
B/Y/R	 **BLACK** Eschar and yellow adherent nonviable tissue; dry to moderate exudate	 **YELLOW** Moist necrotic slough (may be yellow, beige, or grey in appearance); moderate to large amount of exudate	 **RED** Granulating and/or epithelializing tissue; scant to minimal exudate

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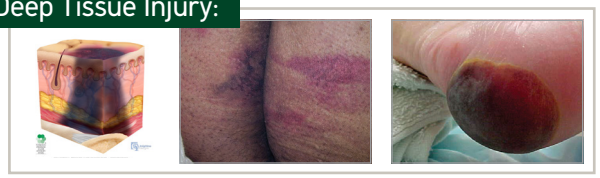
Pressure Ulcer/Injury Stages[1]

Photos: Consents and permissions on file. NPUAP photos - Used with permission of the National Pressure Ulcer Advisory Panel photos

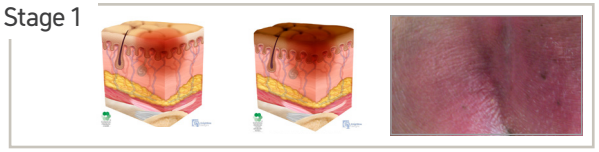
Pressure injuries/ulcers are localized damage to the skin and/or underlying tissue, usually over a bony prominences or related to a medical or other devices, resulting from prolonged pressure or pressure in combination with shear. The lesion can present below intact skin or as an open ulcer, which may be painful. Synonyms for this condition include, bedsores, decubitus ulcers, pressure sores and many more.

Deep Tissue Injury:



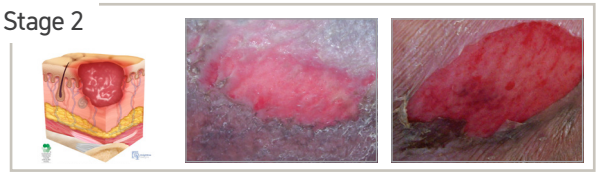
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.

Stage 1



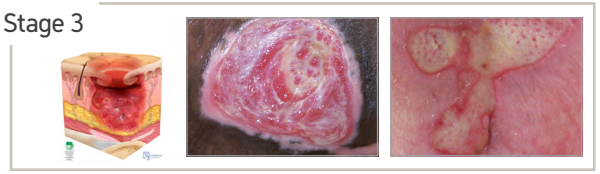
Pressure Injury: Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration;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

Stage 2



Pressure Injury: Partial-thickness skin loss with exposed dermis. 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 micro-climate and shear in the skin over the pelvis and shear in the heel.

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 or bone is 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

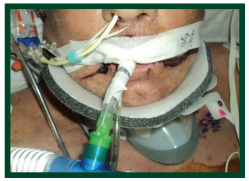
Pressure Injury: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressurxe injury will be revealed. Stable eschar (i.e., dry, adherent, intact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

Wounds **not** to be staged as Pressure Injury

Skin Tear
Surgical Wound
Incontinence Associated Dermatitis
Venous Injury
Arterial Wound
Diabetic/Neuropathic Injury

Medical Device Related Pressure Injury:

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

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

References: **1.** European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019. **2.**National Pressure Injury Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Pressure Ulcers/Injuries: Definition ad Etiology. In: Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline: Fourth Edition. Emily Haesler (Ed.). 2025.

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Wound Care Recommendations:

Part 1: Remove the Previous Dressing

Dressing removal technique is critical to prevent medical adhesive skin injury (MARSI)

1. Look at previous dressing to see if direction of removal is indicated.
2. With one hand gently lift a corner of the dressing
   - **a.** Keep this hand low and horizontal to the dressing, peel dressing back slowly
3. Place the opposite hand close to the "Peel Line"
   - **a.** Apply gentle downward pressure to the periwound surface to prevent pulling
   - **b.** Advance this hand across the area as the dressing is peeled off.
4. The use of a chemical adhesive remover may be considered. Apply at the peel line during removal.

Part 2: Cleanse the Wound

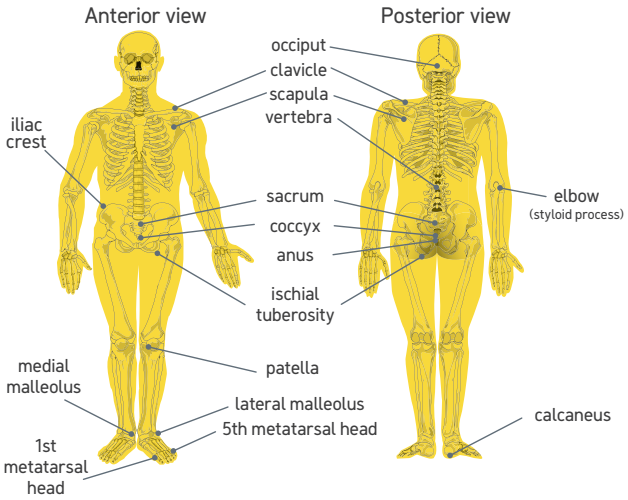
1. Select the appropriate type of cleansing fluid:
   Saline or Wound Cleanser
   - **a.** Hospital setting: An opened bottle of saline should be discarded after 24 hours.
   - **b.** Home setting: An opened bottle of saline can be stored for up to 1 month, capped in the refrigerator.
2. **Gently** clense the wound.
3. Cleanse in a sweeping pattern across the wound. Ensure that the periwound is also cleaned.

Part 3: Assess and Document the Wound

Wound Etiology, *for example:*

• Dehisced surgical incision • Pressure Ulcer

Locate wound using anatomical site provided below:



Pressure Injury stage, *for example:*

• Stage 1 • Stage 2 • Stage 3
• Stage 4 • DTPI • Unstageable

Wound measurement *(in centimeters)*:

- **a.** Length x Width x Depth
- **b.** Use the hands of a clock: 12:00-6:00 to represent the axis for length and 9:00-3:00 to represent the axis for width

Wound Tunneling/Tract:

- **a.** Use a moistened swab to probe for tunnels, or as directed by Wound Care Clinician
- **b.** Use the points on a clock to describe location of undermining or tunnelling

_____

Wound Undermining:

- **a.** Any area of wound bed erosion: use the points of the clock.
  For example:
  • Undermining noted from 2:00-4:00 position with a depth of 2.0cm

Wound edge, *for example:*

• Open (clean red margin)
• Rolled (surface cells have rolled over the edge)

Periwound, *for example:* • Normal • Macerated

Wound bed tissue type, *for example:*

• Black • Yellow • Red • Granulation • Necrotic • Eschar

Drainage/exudate amount, *for example:*

• Scant • Low • Moderate • High

Drainage/exudate type, *for example:*

• Serous • Serosanguineous • Bloody • Purulent

Odor:

Be sure to assess odor **after** the wound bed has been cleansed, and **away** from the previously removed dressing
For example: • Foul • Sweet

Pain:

- **a.** Utilize the pain assessment tool used in your facility
- **b.** Pain should be assessed before dressing change and if indicated, during and after
- **c.** Sudden onset of wound pain: requires specific detailed assessment

Skin tone:

- **a.** Using a Skin Tone Tool. Note that skin tone may differ across different areas of the body.
- **b.** It is important to note that erythema does not always appear as 'redness' in many skin.

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