Hospice of the Piedmont
Incontinence Pathway
Mepilex® Border Sacrum Application

Identify at risk patient

- Immobility
- Morbid obesity (BMI < 19 or > 40kg/m²)
- > 70 years of age
- Decreased perfusion
- Braden score ≤ 18
- Patients who require HOB >30°
- Spinal cord injuries
- Diabetes
- Prolonged bedrest
- Neuropathy
- Clinical judgement

1 Is your patient **currently incontinent** of urine or loose stool?

NO

2 No Incontinence

Mepilex® Border Sacrum

- Apply Mepilex® Border Sacrum *(see application steps on back page)*
- Lift dressing to inspect skin every shift per facility protocol
- Change dressing every 3 days and PRN if rolled, soiled, saturated or compromised.
- Reassess for skin alterations, for bowel and bladder incontinence, or if change of condition
- Continue to reposition patient per facility protocol

YES

2 How many **episodes of incontinence** in 24°?

OPTION A — **IF < 2 EPISODES**

Mepilex® Border Sacrum

- Apply Mepilex® Border Sacrum
- Wipe off intact/top of Mepilex® Border Sacrum dressing if soiled
- Lift dressing to inspect skin every shift per facility protocol
- Change dressing every 3 days and PRN if rolled, soiled, saturated or compromised
- Document interventions
- Continue to reposition patient per facility protocol

OPTION B — **IF ≥ 2 EPISODES**

- Remove Mepilex® Border Sacrum
- Begin incontinence management per facility protocol
- Consult with physician; consider containment or management device
- Continue to monitor for skin integrity
- Document interventions
- Continue to reposition per facility protocol

NOTATIONS:

- Ensure dressing conforms to the skin and avoid gaps or air pockets
- May apply skin sealant along the outer edge of the border for increased prevention
- Consider applying strip paste to adherent side of dressing where the foam and border meet and where dressing comes closest to anus

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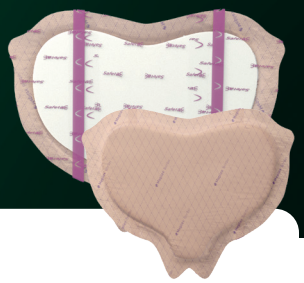
Mepilex® Border Sacrum

May aid in the prevention of pressure injury by protecting the skin from moisture, friction and shear in combination with an individualized comprehensive pressure ulcer prevention protocol.[1]

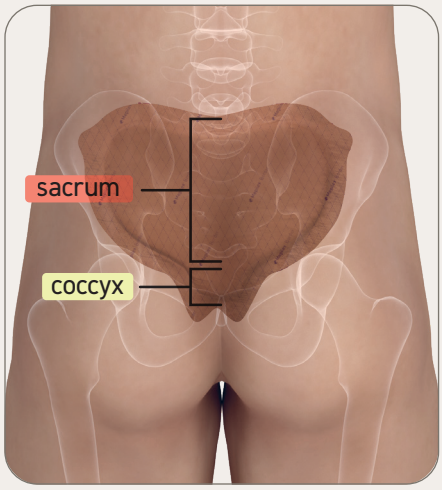


Benefits:

- ☑ Minimizes pain and trauma upon removal[2,3]
- ☑ Uniquely designed for sacral wounds
- ☑ Absorbs moderate to high amounts of exudate[4]
- ☑ Optimized protection and sealing at gluteal cleft
- ☑ Handling tabs for ease of application and removal

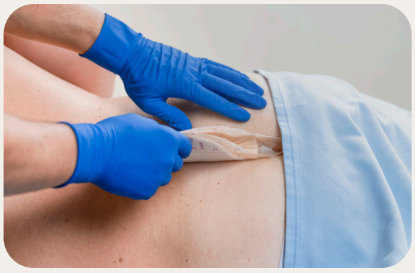
Prepare the area:

Cleanse intact skin. Dry the surrounding skin thoroughly. Ensure that skin is free of dimethicone, skin sealants, and emollients. Use of skin barrier under dressing is not necessary.

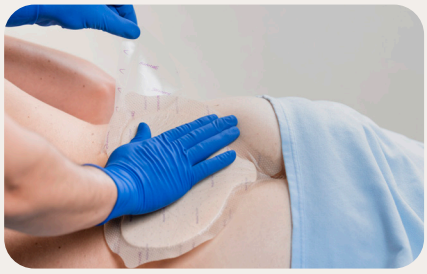


1. Area to protect. Assess the patient's anatomy and determine appropriate dressing positioning.

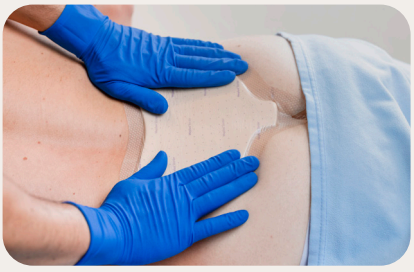
2. After skin is prepared remove the center release film.



3. Hold buttocks apart. Apply dressing to sacral area and into upper aspect of gluteal cleft, with dressing "base" positioned to cover coccyx area.



4. Remove side release films and gently smooth each side into place.



5. Press and smooth the dressing to ensure the entire dressing is in contact with the skin.

Mepilex® Border Sacrum ordering information‡

Product Code	Size
282055	6.3" x 7.9" (16 x 20 cm)
282455	8.7" x 9.8" (22 x 25 cm)

‡Packaged sterile in single packs.

References: **1.** National Pressure Injury Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Preventive Skin Care. In: Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline: Fourth Edition. Emily Haesler (Ed.). 2025. [cited: 10/14/25]. **2.** White R. et al. Evidence for atraumatic soft silicone wound dressing use. Wounds UK, 2005. **3.** White R. A multinational survey of the assessment of pain when removing dressings. Wounds UK 2008; Vol 4, No 1. **4.** Barry, L. Wound dressing Testing - BS EN 13726-1 Fluid Handling Capacity. Surgical Materials Testing Laboratory, Bridgend, United Kingdom Report No: 10/3299/1

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