

Hospice/Palliative Care Wound Dressing Selection Guide

B/Y/R	Yellow				Red			Pink
Wound Appearance								
Description (Color and Peri-wound)	Eschar* (Colors may vary)	Predominantly Slough (Infection may be present)	Granulating/ Mixed Wound Tissue	Fibrin (Appears yellow)	Granulating and/or Epithelializing	Skin Tear	Epithelializing	Compromised Skin/Radiation Dermatitis
Exudate Level <small>(= indication of exudate level)</small>	Moderate to None 	High 	to Moderate 		Moderate 	to Scant 		None
Depth (All measurements)	Unknown	Deep	Deep/Shallow	Deep/Shallow	Deep/Shallow	Shallow	Shallow	Closed/Shallow
Treatment Objective	Debride*	Cleanse, Debride, Absorb, Fill Dead Space			Protect, Hydrate, Fill Dead Space			Protect
Suggested Products and Change Rates <small>Gently cleanse wound with NaCl at each dressing change</small>	Hypergel® and Alldress® or Mepilex® Border or Mepilex® or Mepilex® Heel (Daily) <i>Apply a thin layer of Hypergel® to eschar and cover.</i>	Mesalt® & Alldress® or Mepilex® Border (Daily) or Melgisorb® and Alldress® or Mepilex® Border (1-3 days)	<u>Deep:</u> Melgisorb® and Alldress® or Mepilex® Border (1-3 days) <u>Shallow:</u> Mepilex® Border or Mepilex® (3-7 days)	<u>Deep:</u> Minimal Exudate: Normlgel®† and Alldress® or Mepilex® Border Lite (2 days) Moderate Exudate: Melgisorb® and Alldress® or Mepilex® Border (1-3 days) <u>Shallow:</u> Mepilex® or Mepilex® Border or Mepilex® Lite (3-7 days)	<u>Deep:</u> Minimal Exudate: Normlgel®† and Alldress® or Mepilex® Border Lite (2 days) Moderate Exudate: Melgisorb® and Alldress® or Mepilex® Border (1-3 days) <u>Shallow:</u> Mepilex® or Mepilex® Border or Mepilex® Lite (3-7 days)	Mepitel®‡ (5-10 days) <i>Cover Mepitel with non-adhesive wrap/roll gauze Change wrap PRN</i> Mepilex® or Mepilex® Border or Mepilex® Border Lite or Mepilex® Lite (3-7 days) See Skin Tear Guideline	Mepilex® or Mepilex® Border or Mepilex® Border Lite or Mepilex® Lite (3-7 days) Use Normlgel® if additional hydration is needed	<u>Intact Skin:</u> Mepilex® Lite or Mepilex® Border Lite or Mepore® Film® (5-7 days) <u>Radiation Dermatitis:</u> Mepilex® Lite (3-7 days) Mepitel®* (5-10 days) Mepilex® Transfer (3-7 days) Change outer dressing as needed.
	PALLIATIVE Mepilex® Border or Mepilex® or Mepilex® Heel or Mepilex® Lite (5-7 days)		Melgisorb® and Alldress® or Mepilex® Border (1-3 days)	Consider using ● Mepilex® Ag or ● Melgisorb® Ag when antimicrobial effect is required				
Notations	<ul style="list-style-type: none"> ✦ When packing a wound with Mesalt® or Melgisorb®, loosely fill wound and cover ✦ For fungating tumors: Mepitel® or Mepilex® Transfer with absorptive cover 				<ul style="list-style-type: none"> ✦ For Additional Fixation: Mepitac® or Mefix® tape ✦ For dressing retention: Tubifast® 			

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.

† Normlgel-when packing wound space, impregnate gauze with Normlgel, loosely fill and cover.

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

Six Strategies for Minimizing Wound Pain

Wound-related pain is a concern for those who have wounds and may lead to feelings of depression and despair. There are simple steps that can be taken to effectively reduce wound-related pain which are evidence-based, evidence-informed or based on clinical expertise. The following strategies may offer solutions to the concerns of wound pain and support best clinical practice.

STRATEGY #1:

Measure pain scores before, during and after dressing changes, when possible, to appreciate the patient's response to the total wound pain experience.

- There may be significant differences in wound pain before, during and after dressing change.
- Employ strategies to address pain when experienced.
- If pain is rated moderate to severe (> 4 on a scale of 0 to 10), dressing regimen should be evaluated.
- If the patient is unable to comprehend the VAS, utilize other valid and reliable tools for pain measurement.
- Protocols and practices should address regulatory requirements and meet the unique needs of each setting.

STRATEGY #2

Employ strategies to minimize pain.

If necessary, utilize a combination of strategies to control a patient's pain. Strategies may include:

- **Pain medication:** Assess effectiveness of analgesics or topical anesthetics and adjust as needed.
- **Time-outs:** The option to ask for a "break" from the dressing change procedure may reduce anxiety and pain.
- **Imagery or Music:** Both guided imagery and music therapy may assist the patient in reducing procedure-related stress.
- **Diversion:** Engaging the patient in activities or conversations that offer a focus "off of the wound" may reduce stress and discomfort.
- **Interactive dialogue:** Opportunities to share personal stories or discuss current events may foster trust and reduce anxiety.
- **Deep breathing:** Deep breathing during painful procedures may help reduce stress.
- **Touch:** Meaningful messages can be shared through touch and assist in relaxation.

STRATEGY #3

Avoid dressings that cause wound trauma during wear time (i.e., shear/movement, poor moisture management, pressure, local irritation).

- Choose dressings that maintain a moist wound healing environment and manage wound exudate.
 - Pressure, pain and maceration may be caused from excess wound fluid.
- Choose dressings which establish a secure wound environment by minimizing movement and disruption of fragile healing tissue.
- Avoid over-packing a wound to reduce trauma to wound tissue and stimulation of nerve receptors.
- Reconsider dressing choice if irritant dermatitis is present.

STRATEGY #4

Select dressings that are known to be atraumatic on dressing removal.

- Observe for adherence of the dressing to the wound bed as this may be a source of pain.
- Utilize Safetac®, soft silicone, contact layers or dressings to reduce wound bed adherence.
- Select dressings known to be atraumatic to periwound skin on removal.

STRATEGY #5

Solicit the patient's input on interventions and changes in dressing selection and overall plan of care.

- Acknowledge and, when possible, respect patient preferences.

STRATEGY #6



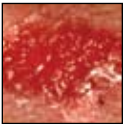
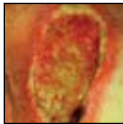

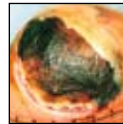
Establish dressing selection protocols based on the patients' reactions and pain measurement data.

- Evaluate how treatment regimens and dressing choices may impact pain.
- Provide dressings that assist with the management and reduction of wound related pain.

Reference: Krasner DL, McNeil M. Six Strategies for Minimizing Wound Pain: Translating results from a US Pain survey into Clinical Practice. *ECPN*. 2008 March/April; 16-21.

Definition of Pressure Ulcer Stages[†]

† National Pressure Ulcer Advisory Panel, 2007

Deep Tissue Injury	Stage I	Stage II (Partial Thickness)	Stage III (Full Thickness)	Stage IV (Full Thickness)	Unstageable
 <p>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.</p>	 <p>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.</p>	 <p>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.</p>	 <p>Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</p>	 <p>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.</p>	 <p>Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed.</p>

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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