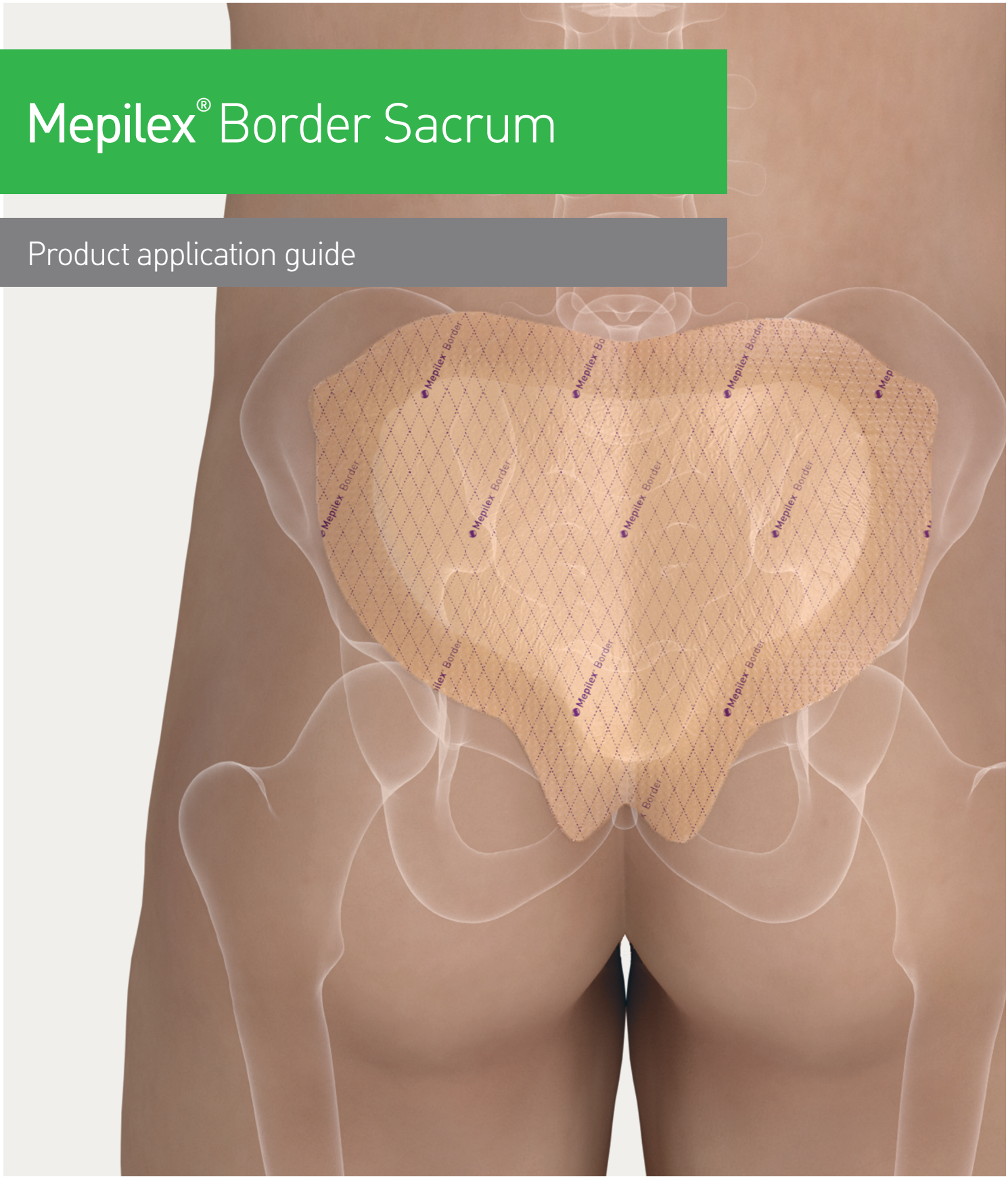
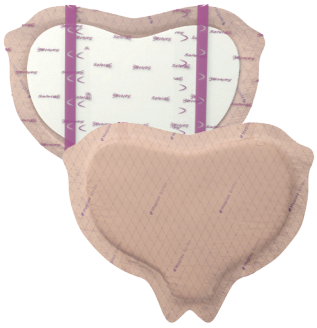
Mepilex® Border Sacrum

Product application guide



Mepilex® Border Sacrum

Mölnlycke®



Benefits

- ✓ Less pain and trauma upon removal[1,2]
- ✓ Specifically designed for sacral wounds
- ✓ Handling tabs for ease of application and removal
- ✓ Absorbs moderate to high amounts of exudate[3]
- ✓ Optimised protection and sealing at gluteal cleft

For prevention

Mepilex® Border Sacrum has been demonstrated to help prevent pressure injuries, redistribute shear and friction on tissues, and maintain optimal skin microclimate during wear time[4,5,6].

Sacral Pressure Injury Prevention Considerations:

- Assess patient for pressure injury risk.
- If patient is at risk, apply Mepilex Border Sacrum.
- Inspect skin under dressing daily or per facility protocol by carefully lifting the border edge and repositioning following inspection.
- Change dressing per facility protocol (dressing should be changed if rolled, soiled, saturated, displaced or compromised).

For treatment

Mepilex Border Sacrum is designed for a wide range of exuding wounds such as sacral pressure injuries. May also be used on dry/necrotic wounds in combination with gels.

Patients with faecal incontinence:

- Consult with physician; consider placement of faecal containment or management device.
- Consider applying strip paste to adherent side of dressing where the foam and border meet and where dressing comes closest to anus.
- After dressing is securely in position, apply liquid skin barrier to outside of Safetac® technology border and onto intact skin.

Mepilex® Border Sacrum ordering information‡

Product code	Size	Pcs/box
282050	16 x 20 cm	5
282450	22 x 25 cm	5

‡ Packaged sterile in single packs

References: 1. White R. et al. Evidence for atraumatic soft silicone wound dressing use. Wounds UK, 2005. 2. White R. A multinational survey of the assessment of pain when removing dressings. Wounds UK 2008; Vol 4, No 1. 3. Barry, L. Wound dressing Testing - BS EN 13726-1 Fluid Handling Capacity. Surgical Materials Testing Laboratory, Bridgend, United Kingdom Report No: 10/3299/1 4. Bill, B. et al. Wound dressing shear test method (bench) providing results equivalent to humans. For Mölnlycke Healthcare. 5. Black J. et al. Consensus statement: Global evidence based practice recommendations for the use of wound dressings to augment pressure ulcer prevention protocols - August 2012 6. Call, Eet al. Enhancing Pressure Ulcers Prevention Using Wound dressings: What are the modes of action. Int Wound J: doi: 10.111/iwj.12123

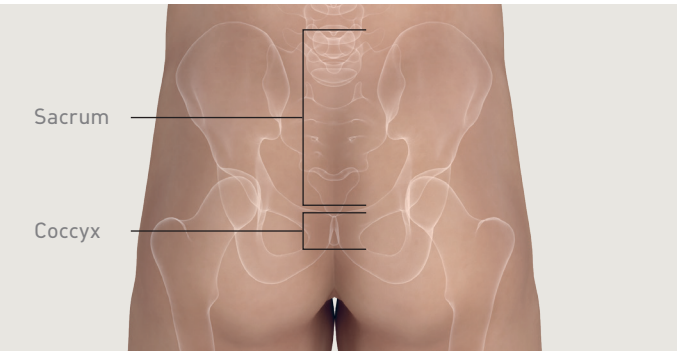
Find out more at www.molnlycke.com.au

Mölnlycke Health Care, 12 Narabang Way, Level 4, Belrose, NSW, 2085 Ph: 1800 005 231 www.molnlycke.com.au

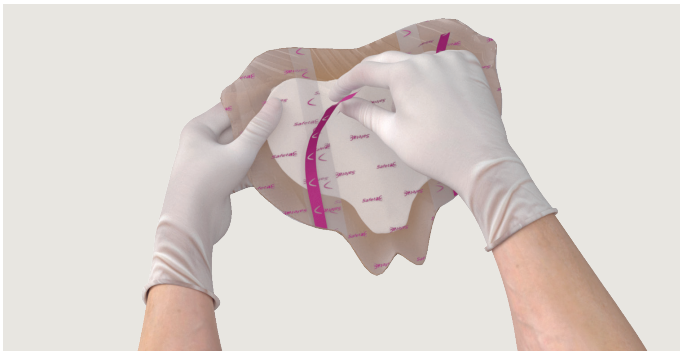
Mölnlycke®

Product application guide

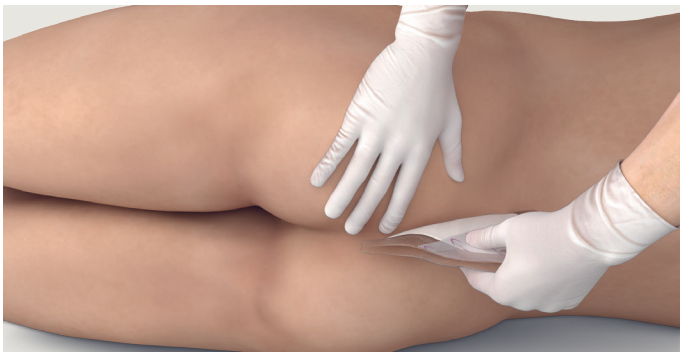
Prepare the area: Cleanse intact skin. Dry the surrounding skin thoroughly. Ensure that skin is free of dimethicone, skin sealants and emollients. Use of skin barrier under dressing is not necessary.



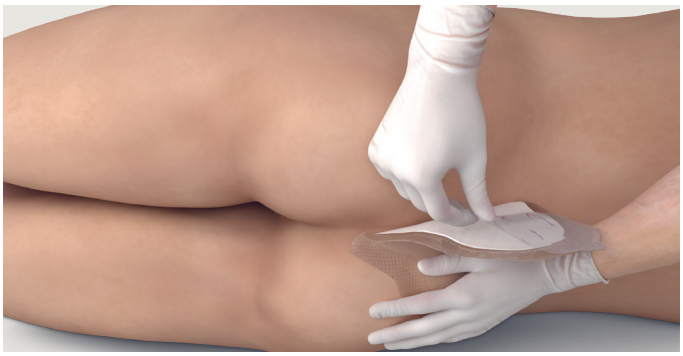
1. Area to protect. Assess the patient's anatomy and determine appropriate dressing positioning.



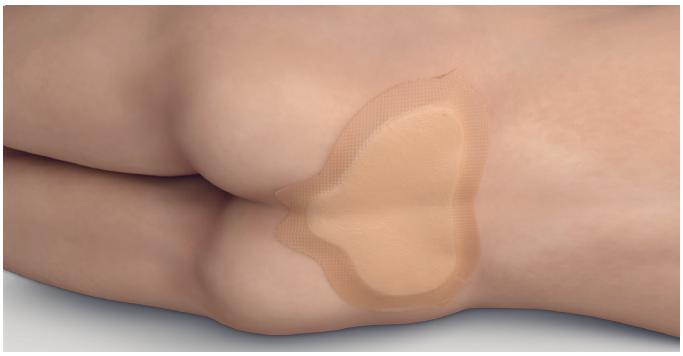
2. After skin is prepared, remove the centre release film by gently pulling on pink-lined edge.



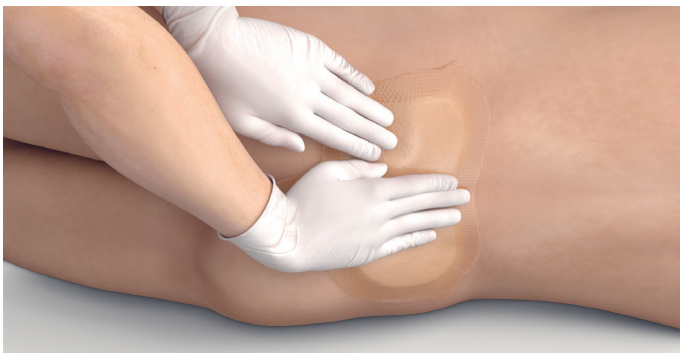
3. Hold buttocks apart. Apply dressing to sacral area and into upper aspect of gluteal cleft, with dressing 'base' positioned to cover coccyx area.



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



5. Product placement.

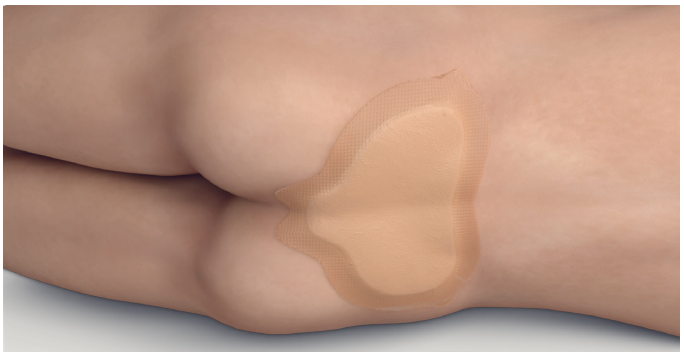


6. Press and smooth the dressing to ensure the entire dressing is in contact with the skin.

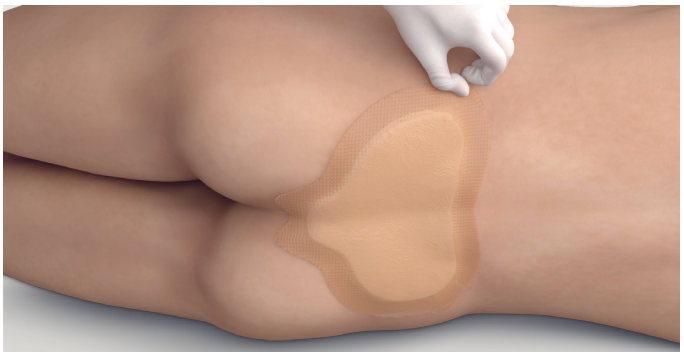
Proper fit:

- Dressing should be positioned to fit patient anatomy.
- Ensure dressing conforms to the skin and avoid gaps or air pockets.

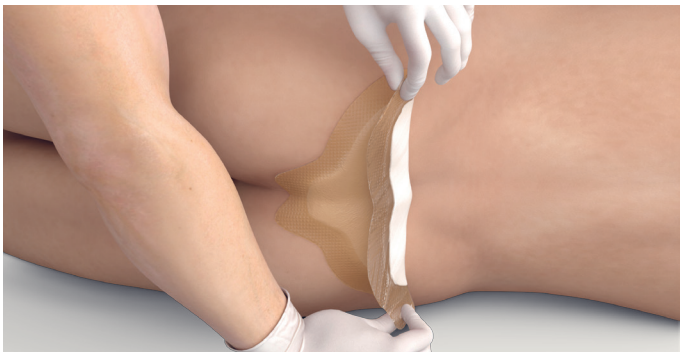
Pressure injury prevention re-application guide



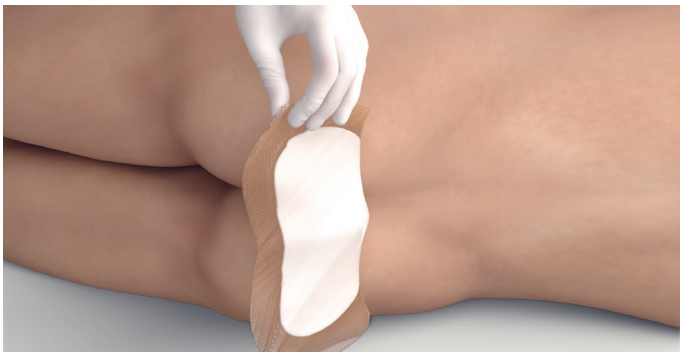
1. Assess to confirm dressing is intact and applied correctly.



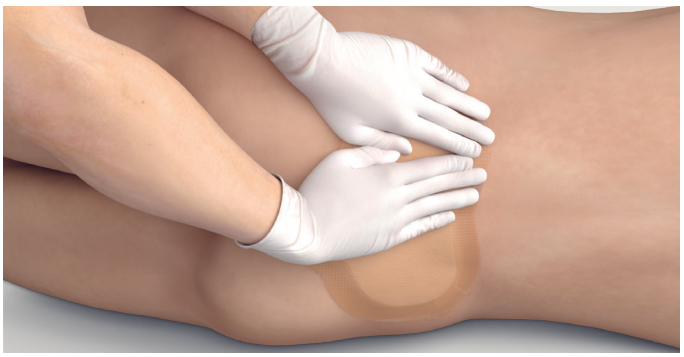
2. Gently pull handling tabs to begin to release dressing from skin.



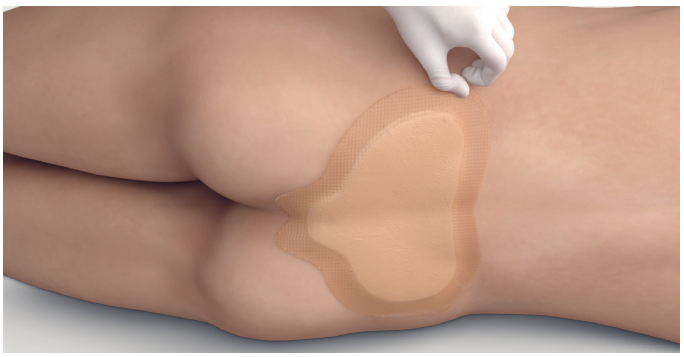
3. Continue to release dressing from skin using handling tabs until skin exposed for skin check.



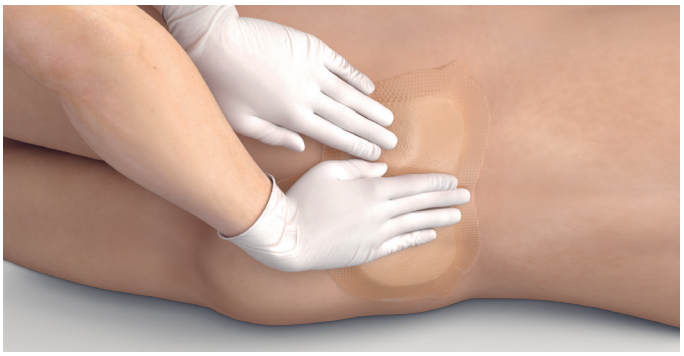
4. While maintaining dressing position at gluteal cleft, perform assessment of skin.



5. Reapply the foam and borders of the dressing.



6. Confirm dressing is replaced to its original position, making sure the border is intact and flat.



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