Pressure Ulcers Made Simple

AQUACEL™ Dressings

1 Assess

- Complete skin assessment: classify in accordance with EPUAP-NPUAP Pressure Ulcer Classification System[1].
- For categories 2-4 complete wound assessment:
  - Wound bed appearance (tissue type and %: slough, necrosis, granulation, suspected biofilm).
  - Size (length, width, depth, tunneling).
  - Exudate (colour, consistency, level).
  - Associated pain and/or odour.
  - Peri-wound skin condition (swelling, discolouration, maceration).
  - Signs and symptoms of infection (pain, odour, heat, redness, swelling, purulence).

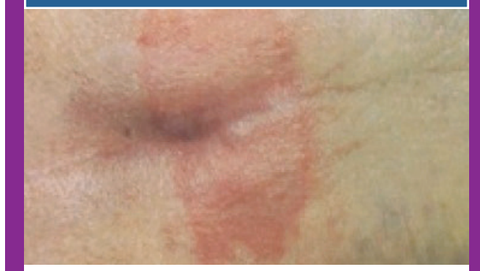
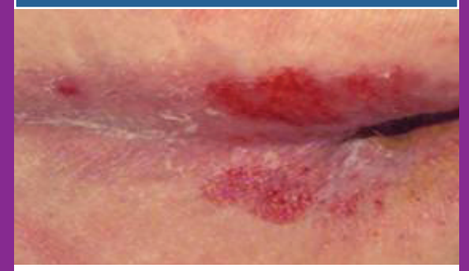
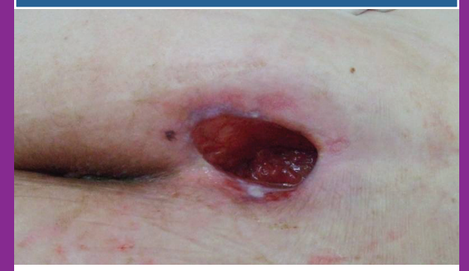
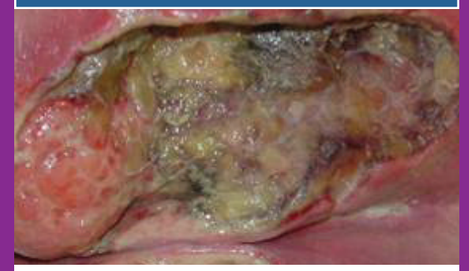
2 Manage

- Cleanse, and where necessary debride, the wound to remove barriers to healing, e.g. slough, necrosis, biofilm.
- Select a dressing that[1]:
  - Manages exudate
  - Protects peri-wound skin
  - Maintains a moist wound environment
  - Is comfortable for the patient
- Consider an anti-microbial dressing for ulcers that are infected or at risk of infection.

3 Monitor

- Re-assess the ulcer at each dressing change and document.
  - **Note:** Reverse grading should never be used to describe the healing of a pressure ulcer.[2]
- Review dressing selection considering changes in ulcer depth and symptoms.
- Consider the need to continue to protect skin integrity once the ulcer has healed.

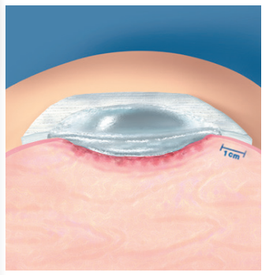
PRESSURE ULCER CLASSIFICATION[1] & DRESSING SELECTION*

CATEGORY I	CATEGORY II	CATEGORY III	CATEGORY IV
			
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching.	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 or sero-sanginous filled blister.	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.	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling.
AQUACEL™ Foam or DuoDERM® Extra Thin	AQUACEL™ Foam or AQUACEL™ Ag+ Foam†	AQUACEL™ Extra™ or AQUACEL™ Ag+ Extra™† + AQUACEL™ Foam	AQUACEL™ Extra™ or AQUACEL™ Ag+ Extra™† + AQUACEL™ Foam

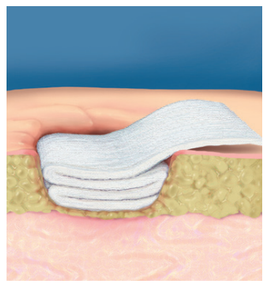
The type of dressing may change over time as the ulcer heals or deteriorates.‡

AQUACEL™ and AQUACEL™ Ag+ Ribbon Dressings are available.

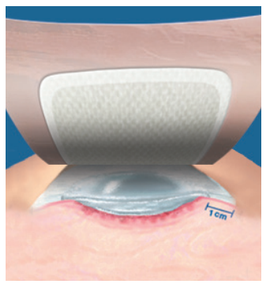
DRESSING APPLICATION TIPS*



- AQUACEL™ Extra™ and AQUACEL™ Ag+ Extra™ dressings should overlap at least 1 cm onto the skin surrounding the wound.
- For cavity wounds AQUACEL™ and AQUACEL™ Ag+ Ribbon dressings are recommended.



- When dressing deep wounds only fill to 80% to allow for dressing expansion on contact with wound fluid.
- When using AQUACEL™ and AQUACEL™ Ag+ Ribbon dressings, leave 2.5 cm length of ribbon outside of the cavity to aid removal.



Perfect Partners

- Use AQUACEL™ Foam as a cover dressing over AQUACEL™ Extra™ or AQUACEL™ Ag+ Extra dressings.
- The absorbent pad of AQUACEL™ Foam dressings should overlap the wound by at least 1 cm.

1-800-XXX-XXXX / AQUACEL.com/foam

* Please refer to pack insert for complete information on indications and usage for each product.
†Consider an anti-microbial dressing for ulcers that are infected or at risk of infection.
‡ Reverse grading should never be used to describe the healing of a pressure ulcer.

Reference: 1. European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Treatment of pressure ulcers: Quick Reference Guide. Washington DC: National Pressure Ulcer Advisory Panel; 2009. **2.** http://www.npuap.org/wp-content/uploads/2012/01/NPUAP_position_on_staging-final.pdf

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