Skin Protection & Wound Management

GUIDE FOR THE BEDSIDE CLINICIAN

Mölnlycke®

This guide provides helpful information and resources for the prevention of pressure injuries and management of wounds. The material presented is solely for informational and educational purposes. Although the guide may contain information on Mölnlycke's products and/or demonstrate certain techniques, Mölnlycke does not provide any medical advice and this guide should not be perceived as medical advice.

Table of Contents

This guide is intended to be a bedside clinical decision-making tool. It includes basic information on wound assessment, identification, and care of the skin.

For more complete information, refer to the clinical support tools in the "Learn More About Wounds" section or contact your Mölnlycke representative.

Your Mölnlycke Representative:

Name: _____

Phone: _____

Email: _____

Pressure Injury Prevention (PIP)

- Skin Protection Measures
- Skin Protection Basics
- Pressure Injury Risk Assessment
- Support Surfaces
- Pressure Injuries/Ulcers
- Medical Device-Related Pressure Injury
- Mucosal Membrane Pressure Injury
- Wounds That Should Not Be Staged

Skin Protection Measures

There are basic skin protection measures that may reduce your patient's/resident's risk of injury.

Inspect skin daily

Moisturize skin twice daily

Use breathable fabrics & products

Cleanse skin daily & after incontinence

Apply skin barriers after incontinence care

Pad & protect at-risk areas

Pressure Injury Prevention (PIP)

Skin Protection Basics

1. Risk assessment, such as the Braden Scale
2. Head to toe skin assessment
3. Reduce risk factors (e.g., immobility, incontinence, etc.)
4. Patient/resident, family and staff education
5. Evaluate PIP program and outcomes, adjust as needed.

Pressure Injury Risk Assessment

Braden Scale For Predicting Pressure Sore Risk

It is the most common pressure injury risk assessment scale in the U.S. and consists of six categories of risk. The sum of all subscale scores represents the total score and the level of risk. **Both the total score and the subscale scores should guide intervention.**

Sensory Perception Ability to respond meaningfully to pressure-related discomfort.	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. **OR** Limited ability to feel pain over most of body.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. **OR** Has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. **OR** Has a sensory impairment which limits the ability to feel pain or discomfort in extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit pain or discomfort.
Moisture Degree to which skin is exposed to moisture.	1. Constantly Moist Skin is kept moist almost constantly by perspiration,urine, etc. Dampness is detected every time patient is moved or turned.	2. Very Moist Skin is often, but not always, moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry; linen only requires changing at routine intervals.
Activity Degree of physical activity.	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or nonexistent. Cannot bear own weight weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day, but for very short distances with or without assistance. Spends most of each shift in bed or chair.	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours.

Braden Scale For Predicting Pressure Sore Risk (cont.)

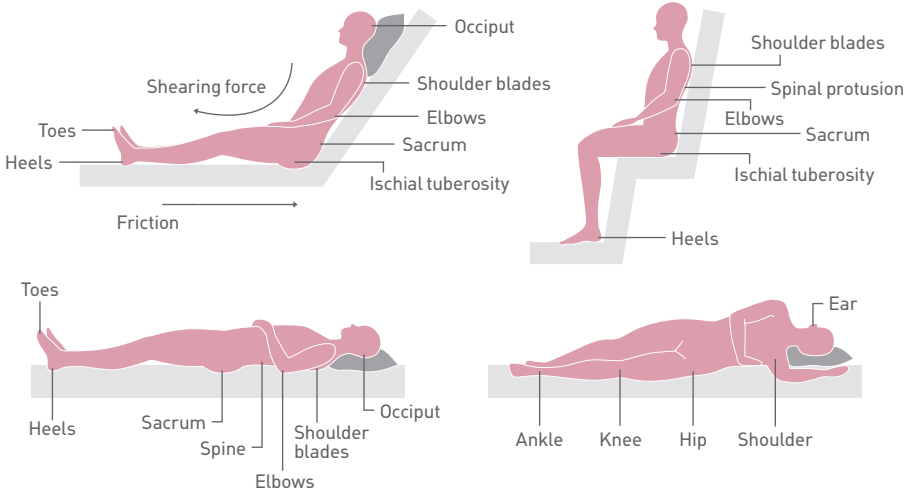
Mobility Ability to change and control body position.	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but is unable to make frequent or significant changes independently.	3. Slightly Limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitation Makes major and frequent changes in position without assistance.
Nutrition Usual food intake pattern.	1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairyproducts) per day. Takes fluids poorly. Does not take a liquid dietary supplement. **OR** Is NPO and/or maintained on clear liquids or IV for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy productsper day. Occasionally will take a dietary supplement. **OR** Receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy) per day. Occasionally refuses a meal, but will usually take a supplement when offered. **OR** Is on a tube feeding or TPN regimen, which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products per day. Occasionally eats between meals. Does not require supplementation.
Friction and Shear	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	2. Potential Problem Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	

© Copyright Barbara Braden and Nancy Bergstrom, 1988. All rights reserved. Reprinted with permission.

SEVERE RISK: Total score 9
HIGH RISK: Total score 10-12
MODERATE RISK: Total score 13-14
MILD RISK: Total score 15-18

TOTAL SCORE:

A comprehensive skin assessment should include visualization of bony prominences, under medical devices, in skin folds, and in the hair.



Support Surfaces

Considerations:

- Consider patient weight and weight distribution in determining the need for a bariatric mattress and appropriate bedframe.
- When choosing between a mattress or overlay, consider fall/entrapment risk associated with the use of overlays.
- Consider risk for developing new pressure injuries and history of previous pressure injuries.
- Consider fall risk in determining the need for a low bed.
- Ensure that the support surface is functioning properly and used correctly. Minimize the number and type of layers between the patient and the support surface.
- Support surfaces are only one element of a comprehensive pressure injury prevention program; they should not be considered a stand alone intervention.

Support surface is a specialized mattress or mattress overlay or chair cushion designed for the management of tissue loads, micro-climate, and/or therapeutic functions. (NPIAP, 2018)

Types of Support Surfaces for Beds and Wheelchairs

Overlays: Air, Foam, Viscous Fluid, Gel

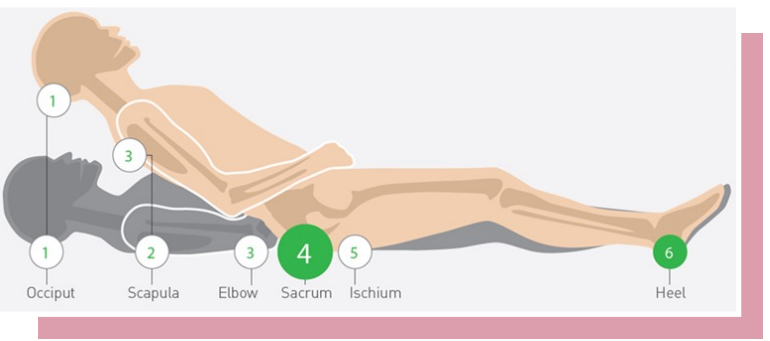
Mattresses: Air/Foam, Foam, Air, etc.

Integrated Bed Systems: Air Fluidized

Pressure Injuries/Ulcers (PI)

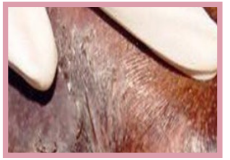
What is a pressure injury?

A pressure injury, also referred to as a pressure ulcer or bedsore, is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as either intact skin or an open ulcer and may be painful. It occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. **Pressure injuries are staged to indicate the extent of tissue damage.**



Stage 1

Dark

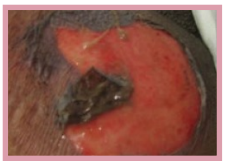


Light

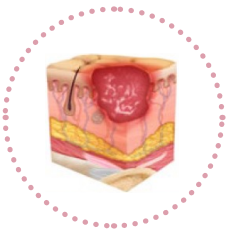
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. **Color changes do not include purple or maroon discoloration; these may indicate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

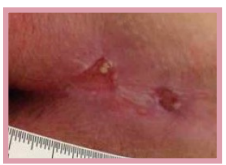
Stage 2

Dark



Light

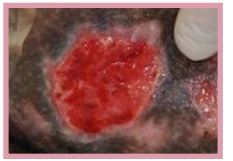




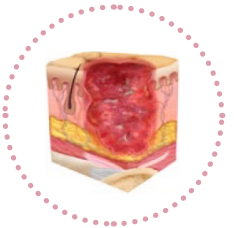
Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. **These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.**

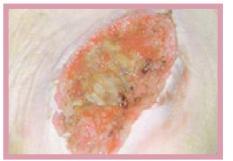
Stage 3

Dark



Light



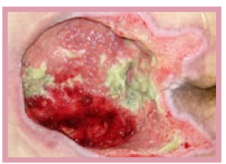


Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. 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

Dark

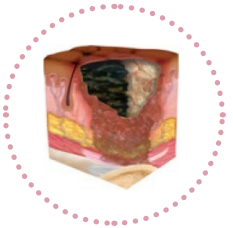
Light

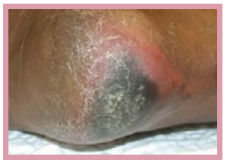


Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. **If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.**

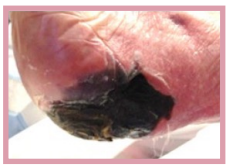
Unstageable

Dark





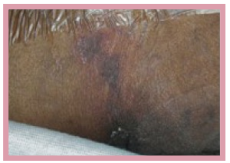
Light



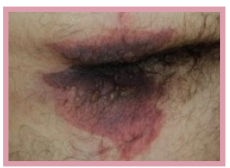
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. **Stable eschar (i.e., dry, adherent, intact without erythema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

Deep Tissue Pressure Injury

Dark



Light



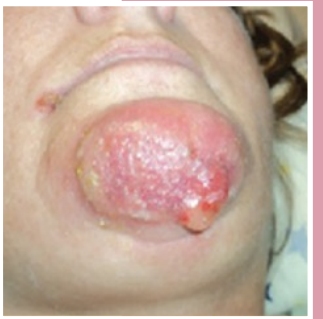
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly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

Medical Device Related Pressure Injury (MDRPI)

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

DEFINITION:

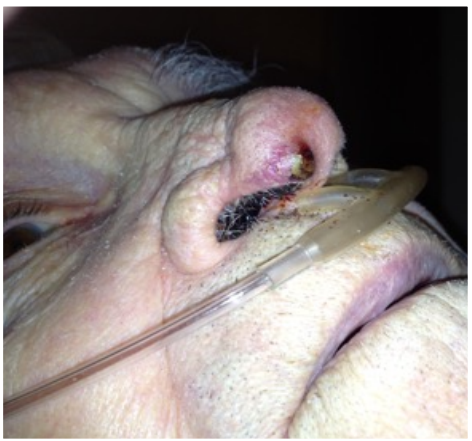
- Stage 3 is not to be used on ears or bridge of the nose due to tissue layers:
  - Ears: Stages 1, 2, 4, US, DTPI
  - Bridge of Nose: Stages 1, 2, 4, US, DTPI
- Mucous Membrane: See Mucosal Membrane PI
- Device pressure injury (PI) results from medical devices, equipment, furniture, and everyday objects that have applied pressure to the skin, either as an unintended consequence of their therapeutic use or inadvertently due to unintended skin-device contact.
- When the device utilized is for therapeutic or diagnostic purposes, it is referred to as a medical device-related PI.



Mucosal Membrane Pressure Injury

Deep Tissue Pressure Injury

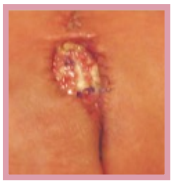
Due to the anatomy of the tissue these injuries cannot be staged.



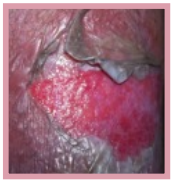
DEFINITION:

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.

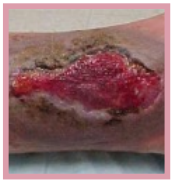
Wounds That Should Not Be Staged



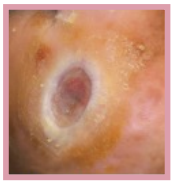
Surgical Wound
A surgical wound that may be intentionally left open to heal or one that opened after a complication of surgery.



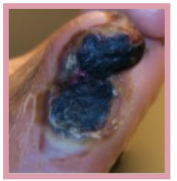
Skin Tear
Traumatic injury that results in separation of the epidermis from the dermis.



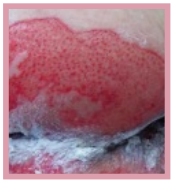
Venous Ulcer
A wound caused by venous hypertension. Often found on the medial aspect of the lower extremity.



Diabetic/Neuropathic Ulcer
Often located on the plantar surface of the foot. May be caused by loss of protective sensation, increased shear and pressure, or structural changes in the foot. May appear initially as a callus.



Arterial Wound
A wound caused by ischemia from arterial insufficiency. May be found between toes, on tips of toes, or along sides of foot. May involve large portions of distal tissue.



Incontinence-Associated Dermatitis
An inflammation of the skin caused by prolonged contact with urine or stool. Redness, edema, blistering, or skin erosion may be seen.

Managing Pressure Injuries

Basic Pressure Injury Care

Pressure injury management products are intended to support best practice. In addition to assessing the patient's/resident's risk, it is important to intervene to mitigate each identified risk. At a minimum, measures must be taken to protect the **S.K.I.N.**

S urface

- Appropriate support surface (bed and chair)
- Elevate for risk or actual injury

K eep Turning/Moving

- Regular repositioning (bed and chair)
- Offload at-risk bony prominences

I mprove Moisture Management

- Prompt incontinence care
- Skin protection from excessive moisture

N utrition and Fluids

- Drink an adequate amount of fluids
- Eat a balanced diet

Wound Management

Although preventing injury is ideal, wounds do occur. When this happens, the key is to provide an optimal wound healing environment and minimize the risk of complications.

- M.O.I.S.T. Wound Bed Preparation Basics
- Understanding Wounds
  - Pressure Injuries
  - Venous Leg Ulcers
  - Arterial Ulcers
  - Diabetic Foot Ulcers
  - Traumatic Wounds
  - Skin Tears
  - Moisture-Associated Skin Damage

Wound Bed Preparation Basics

M.O.I.S.T. is a model for optimizing wound management at the point of care. It serves to remind clinicians of practice and product best practices, and is applied after thorough assessment and in conjunction with supporting therapies. The steps of M.O.I.S.T. can be used in the order the clinician decides is most appropriate.

M oisture balance

O xygen balance

I nfection control

S upport wound environment

T issue management

Moisture balance

- Moist but not wet
- Stable temperature
- Protection from cellular distortion

Mepilex® Border Flex

Mepilex® Border Sacrum

Mepilex® Border Heel

Mepilex®

Mepilex® Lite

Exufiber®

Melgisorb®

Oxygen balance

- Revascularization and compression therapy
- Wound dressings or spray
- Hyperbaric oxygen therapy

Hyperbaric Oxygen Therapy (HBOT)

Infection control

Manage local infections

Antiseptics

Wound dressings with antimicrobial effects

Mepilex® Border Ag

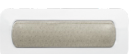
Mepilex® Border Sacrum Ag

Mepilex® Ag

Mepitel® Ag

Exufiber® Ag+

Melgisorb® Ag



Mepilex® Border Post-Op Ag

Normlgel® Ag

Support wound environment

All Wounds: Optimize nutrition, encourage exercise, promote smoking cessation

Pressure Injury: Redistribute pressure and shear, interface friction, manage moisture

Diabetic Foot Ulcer: Offload

Arterial Ulcer: Address perfusion

Venous Leg Ulcer: Compression

Other (Traumatic, Surgical, Atypical, Unknown): Address underlying detriments

Mepilex® Border Flex

Exufiber®/ Exufiber® Ag+

Mepilex®/ Mepilex® Ag

Tubigrip®

Setopress®

Z-Flex™ Heel Boot

Tissue management

- Wound cleansing
- Wound debridement
- Negative pressure wound therapy

Normlgel® Ag+

Exufiber®/ Exufiber® Ag+

Mesalt®

Melgisorb® Ag+

Avance® Solo - ciNPT

Understanding Wounds

There are many types of wounds.

Understanding and addressing underlying contributors is the key to effective wound management.

For each wound type, we will describe care components and provide appropriate product solutions.

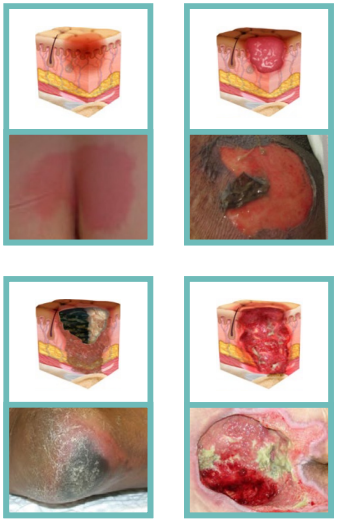
We will discuss the 6 most common wound types:

1. Pressure Injuries
2. Venous Leg Ulcers
3. Arterial Ulcers
4. Diabetic Foot Ulcers
5. Traumatic Wounds
6. Moisture-Associated Skin Damage

Pressure Injuries

What Is a Pressure Injury?

Cause	· The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear
Location	· Usually over a bony prominence · Related to a medical or other device
Appearance	· Injury can present as intact skin or an open ulcer · Can be painful
Exudate	· Zero to high · Peri-wound maceration common
Key Care Components	· Reduce pressure and shear · Fill wounds with depth · Exudate management · Maintain a moist wound base
Comments	· Early detection followed by prompt implementation of preventative measures is important · Be alert to signs and symptoms of infection and to early wound deterioration



Mepilex® Border Flex

Mepilex® Border Sacrum

Mepilex® Border Heel

Exufiber®/ Exufiber® Ag+

Melgisorb® Ag

Pressure Injury - Product Recommendations:

Mepilex® Border Flex

Mepilex® Border Flex is a five-layer, bordered foam dressing that is highly conformable due to Flex Technology. It absorbs, channels and traps exudate and allows you to track progress.

Mepilex® Border Sacrum

Mepilex® Border Sacrum effectively absorbs and retains exudate and maintains a moist wound environment. It is designed for a wide range of exuding wounds such as sacral pressure injury. It can be also used on dry/necrotic wounds in combination with gels.

Mepilex® Border Heel

Mepilex® Border Heel effectively absorbs and retains exudate and maintains a moist wound environment. The Safetac® technology layer seals the wound edges, prevents exudate leakage onto the surrounding skin, thus minimizing the risk of maceration. The Safetac® technology layer allows the dressing to be changed without damaging the wound or surrounding skin or exposing the patient to additional pain.

Exufiber®/ Exufiber® Ag+

Exufiber® is a sterile, nonwoven dressing made from highly absorbent polyvinyl alcohol fibers. In contact with wound exudate, Exufiber® transforms into a gel that facilitates moist wound healing and ease of removal during dressing changes. Exufiber® Ag+ contains silver sulphate that is evenly distributed throughout the dressing. A rapid and sustained antimicrobial effect is initiated via contact with wound fluid. Exufiber®/Exufiber® Ag is available both as a sheet and ribbon as dressings.

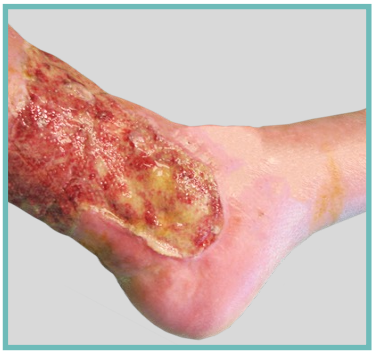
Melgisorb® Plus/Melgisorb® Ag

Melgisorb® Plus absorbs large amounts of wound exudate. When absorbing, the alginate fibers become gel-like providing a moist wound environment conducive to wound healing. The dressing can easily be removed by irrigating with 0.9% normal saline. Change when saturation is reached. Melgisorb® Ag rapid and sustained antimicrobial, sustained silver release up to 14 days.

Venous Leg Ulcers

What Is a Venous Leg Ulcer?

Cause	· Venous insufficiency
Location	· Lower leg, often medial aspect · Gaiter region (above ankle to below knee)
Appearance	· Shallow granulating or fibrinous wounds · Irregular edges · Often painful
Exudate	· High · Peri-wound maceration common
Key Care Components	· Exudate management · Compression (if perfusion adequate)
Comments	· Venous leg ulcers are NOT staged



Mepilex® Border Flex

Mepilex® Up

Exufiber®/ Exufiber® Ag+

Melgisorb® Ag

Setopress®

Tubigrip®

Venous Leg Ulcer - Product Recommendations:

Mepilex® Border Flex

Mepilex® Border Flex is a five-layer, bordered foam dressing that is highly conformable due to Flex Technology. It absorbs, channels and traps exudate, and allows you to track progress.

Exufiber®/ Exufiber® Ag+

Exufiber® is a sterile, nonwoven dressing made from highly absorbent polyvinyl alcohol fibers. In contact with wound exudate, Exufiber® transforms into a gel that facilitates moist wound healing and ease of removal during dressing changes. Exufiber® is available both as a sheet and ribbon as dressings. Exufiber® Ag+ contains silver sulphate, which is evenly distributed throughout the dressing.

Melgisorb® Plus/Melgisorb® Ag

Melgisorb® Plus absorbs large amounts of wound exudate. When absorbing, the alginate fibers become gel-like providing a moist environment conducive to wound healing. The dressing can easily be removed by irrigating with 0.9% normal saline. Change when saturation is reached. Can be left on for several days as indicated by clinical practice. Melgisorb® Ag has a rapid and sustained antimicrobial, sustained silver release up to 14 days.

Setopress®

Setopress® is a lightweight high compression bandage. To ensure correct application, a simple visual guide is permanently printed on the bandage.

Tubigrip®

Tubigrip® is a multi-purpose tubular support bandage that provides firm support in the management of sprains, strains and swelling. Product is easy to use as it can be easily applied and reapplied.

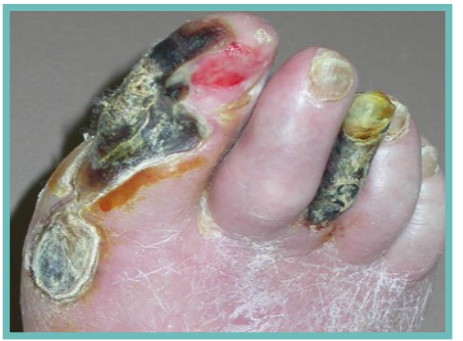
Mepilex® Up

Mepilex® Up is a highly conformable dressing that absorbs both low and high viscous exudates, maintains a moist wound environment and minimizes the risk of maceration. The dressing has a Safetac® wound contact layer that is a unique adhesive technology. It minimizes pain to patients and trauma to wounds and the surrounding skin at dressing removal. Mepilex® Up can be used under compression bandaging and in combination with gels.

Arterial Ulcers

What Is an Arterial Ulcer?

Cause	· Poor perfusion
Location	· Phalangeal heads, toe tips, or web spaces · Lateral malleolus · Mid-tibial area (shin) · Heels
Appearance	· Often deep (tendon often exposed) and necrotic · Punched-out · Low exuding · Often does not bleed
Exudate	· Low
Key Care Components	· Address perfusion (if possible) · Prevent infection
Comments	· Arterial ulcers are NOT staged



Mepilex® Border Flex

Normlgel® Ag

Mepilex® Lite

Arterial Ulcer - Product Recommendations:

(Once an assessment and classification have been completed)

Mepilex® Border Flex

Mepilex® Border Flex is a five-layer, bordered foam dressing that is highly conformable due to Flex Technology. It absorbs, channels and traps exudate and allows you to track progress.

Normlgel® Ag

Normlgel® Ag contains an antimicrobial silver compound that is an effective barrier to bacterial penetration by inhibiting the growth of broad spectrum of microorganisms.

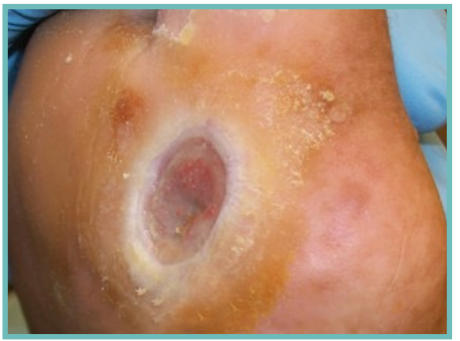
Mepilex® Lite

Mepilex® Lite is a highly conformable dressing that absorbs exudate and maintains a moist wound environment. The Safetac® technology layer seals around the wound edges, preventing the exudate from leaking onto the surrounding skin, thus minimizing the risk of maceration. The Safetac® technology layer also allows for atraumatic dressing changes. Mepilex® Lite may be cut to suit various wound shapes and locations.

Diabetic Foot Ulcers (DFU)

What Is a Diabetic Foot Ulcer?

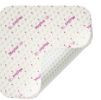
Alternate Names	· Neuropathic ulcers
Cause	· Develop with diabetes and B12 deficiency and compounded with any foot deformity or concurrent peripheral vascular disease
Location	· Plantar foot, toes, and web spaces
Appearance	· Pale to red wound bed · Infection and abscesses common · Callus peri-wound often
Drainage	· Varies · Purulent drainage may be present
Key Care Components	· Offloading · Optimize wound healing potential
Comments	· Diabetic foot ulcers are NOT staged



Mepilex® Border Flex

Mepilex®/ Mepilex® Ag

Mepilex® Lite



Mepilex® Up

Diabetic Foot Ulcer - Product Recommendations:

Mepilex® Border Flex

Mepilex® Border Flex is a five-layer, bordered foam dressing that is highly conformable due to Flex Technology. It absorbs, channels and traps exudate and allows you to track progress.

Mepilex®

Mepilex® is a soft and highly conformable foam dressing that absorbs exudate and maintains a moist wound environment. The Safetac® technology layer seals the wound edges, preventing the exudate from leaking onto the surrounding skin, thus minimizing the risk of maceration .

Mepilex® Lite

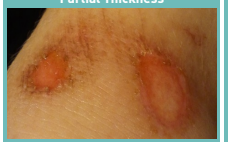
Mepilex® Lite is a highly conformable dressing that absorbs exudate and maintains a moist wound environment. The Safetac® technology layer seals around the wound edges, preventing the exudate from leaking onto the surrounding skin, thus minimizing the risk of maceration. Mepilex® Lite may be cut to suit various wound shapes and locations.

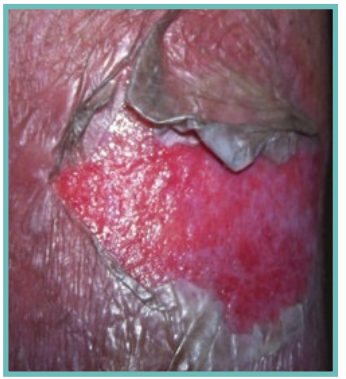
Mepilex® Up

Mepilex® Up is a highly conformable dressing that absorbs both low and high viscous exudates, maintains a moist wound environment and minimizes the risk of maceration. The dressing has a Safetac® wound contact layer that is a unique adhesive technology. It minimizes pain to patients and trauma to wounds and the surrounding skin at dressing removal. Mepilex® Up can be used under compression bandaging and in combination with gels.

Traumatic Wounds

What Is a Traumatic Wound?

Cause	· Mechanical forces, including removal of adhesives · Severity may vary by depth
Types	· Skin tears, lacerations, abrasions, burns
Appearance	**Partial Thickness**  Separation of the epidermis from the dermis **Full Thickness**  Separation of the epidermis & dermis from the underlying structures
Drainage	· Varies
Key Care Components	· Keep skin moist and supple · Protect from injury, when possible



Mepilex® Border Flex

Exufiber®/ Exufiber® Ag+

Melgisorb®/ Melgisorb® Ag

Mepilex®

Mepilex® Lite

Traumatic Wound - Product Recommendations:

Mepilex® Border Flex

Mepilex® Border Flex is a five-layer, bordered foam dressing that is highly conformable due to Flex Technology. It absorbs, channels and traps exudate and allows you to track progress.

Exufiber®/ Exufiber® Ag+

Exufiber® is a sterile, nonwoven dressing made from highly absorbent polyvinyl alcohol fibers. In contact with wound exudate, Exufiber® transforms into a gel that facilitates moist wound healing and ease of removal during dressing changes. Exufiber® is available both as a sheet and ribbon as dressings. Exufiber® AG+ contains silver sulphate which is evenly distributed throughout the dressing.

Melgisorb® Plus/Melgisorb® Ag

Melgisorb® Plus absorbs large amounts of wound exudate. When absorbing, the alginate fibers become gel-like providing a moist environment conducive to wound healing. The dressing can easily be removed by irrigating with 0.9% normal saline. Change when saturation is reached. Can be left in several days as indicated by clinical practice. Melgisorb® Ag has a rapid and sustained antimicrobial, sustained silver release up to 14 days.

Mepilex®

Mepilex® is a soft and highly conformable foam dressing that absorbs exudate and maintains a moist wound environment. The Safetac® technology layer seals the wound edges, preventing the exudate from leaking onto the surrounding skin, thus minimizing the risk of maceration.

Mepilex® Lite

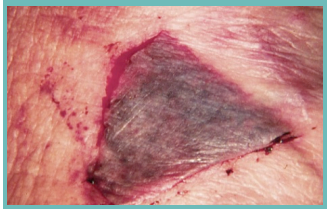
Mepilex® Lite is a highly conformable dressing that absorbs exudate and maintains a moist wound environment. Mepilex® Lite may be cut to suit various wound shapes and locations.

Skin Tears

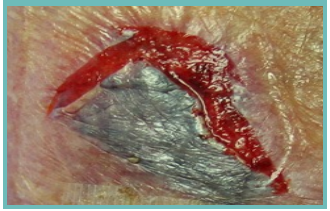
ISTAP Skin Tear Classification System

According to the system, there are three main types of skin tears:

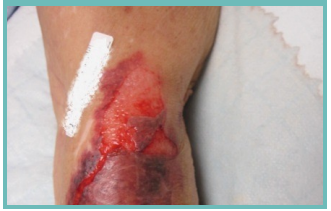
TYPE 1: No tissue loss



TYPE 2: Partial tissue



TYPE 3: Total tissue



Mepilex® Border Flex

Mepilex®/ Mepilex® Ag

Mepilex® Lite

Mepitel® / Mepitel® One

Skin Tear - Product Recommendations:

Mepilex® Border Flex

Mepilex® Border Flex is a five-layer, bordered foam dressing that is highly conformable due to Flex Technology. It absorbs, channels and traps exudate and allows you to track progress.

Mepilex®

Mepilex® is a soft and highly conformable foam dressing that absorbs exudate and maintains a moist wound environment. The Safetac® technology layer seals the wound edges, preventing the exudate from leaking onto the surrounding skin, thus minimizing the risk of maceration.

Mepilex® Lite

Mepilex® Lite is a highly conformable dressing that absorbs exudate and maintains a moist wound environment.

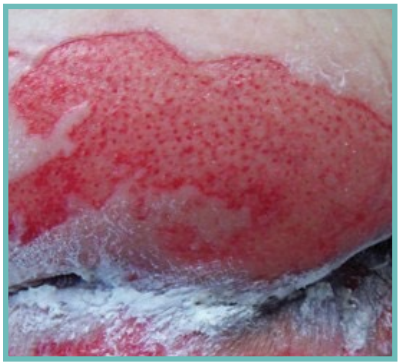
Mepitel® One/Mepitel®

Mepitel® One/Mepitel® may be left in place for up to 14 days, depending on the condition of the wound, which reduces the necessity for frequent primary dressing changes. The porous structure of Mepitel® allows exudate to pass into an outer absorbent dressing. The Safetac® technology layer prevents the outer dressing from sticking to the wound and allows for atraumatic dressing changes. The Safetac® technology layer also seals around the wound edges, preventing the exudate from leaking onto the surrounding skin, thus minimizing the risk of maceration.

Moisture-Associated Skin Damage

What Is a MASD?

Cause	· Prolonged skin exposure to moisture
Types	**1. Incontinence-associated dermatitis** · Exposure to urine or feces **2. Intertriginous dermatitis** · Exposure to perspiration · Skin folds or with wkin-skin contact **3. Peri-wound moisture-associated dermatitis** · Exposure to wound exudate (drainage) **4. Peri-stomal moisture associated dermatitis** · Exposure to ostomy/stoma effluent
Key Care Components	· Improve moisture management · Use moisture barrier creams to protect skin

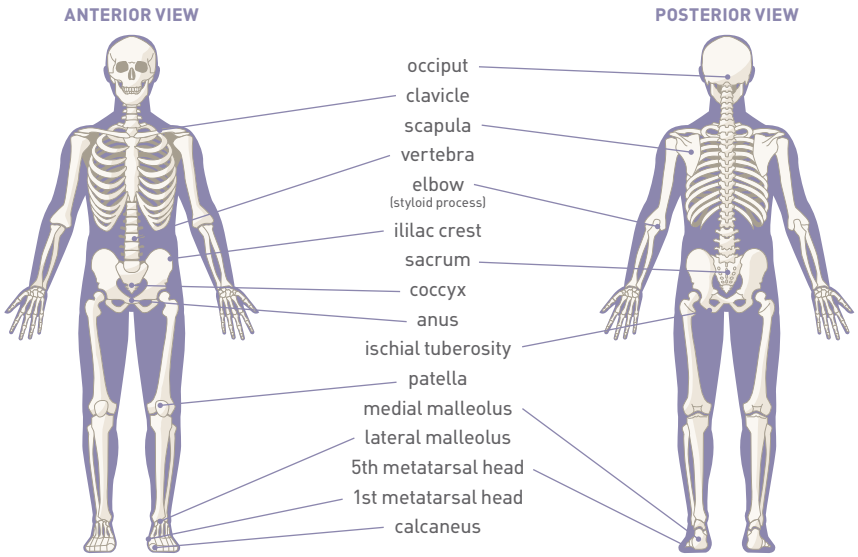


Assessment and Documentation of Wounds

Although injury prevention is optimal, wounds do occur. When they develop, the key is to provide an optimal wound healing environment and minimize the risk of complications. Assessment and intervention goals are the same for all wound types.

- Anatomical Locations
- Assessment and Documentation of the Wound
- When to Change the Dressing
- Undisturbed Wound Healing
- Wound Care Solutions
- Mölnlycke PIM Product Videos

Anatomical Sites

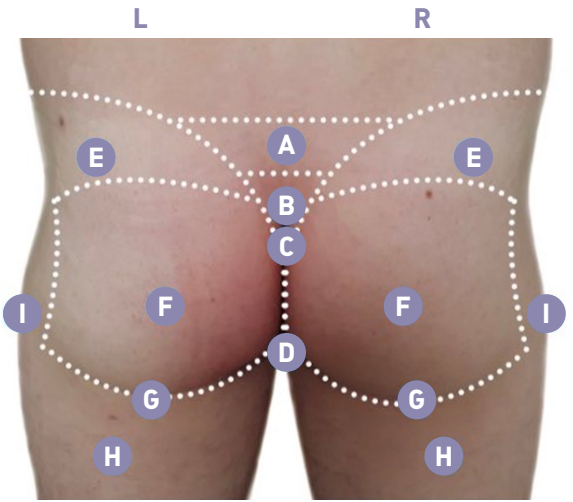


Pressure Injury stage, for example:

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- DTPI
- Unstageable

Documentation of Anatomical Locations

Anatomical Locations of Buttocks



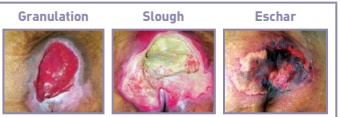
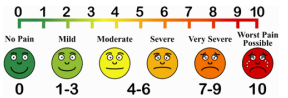
A. Sacrum
B. Coccyx
C. Intergluteal (natal) cleft
D. Perineal area
E. Sacral iliac crest
F. Buttocks
G. Ischial tuberosity
H. Posterior thigh
I. Trochanter

Adapted from a diagram by Christine T. Berke.

NHS
Barts Health
NHS Trust

Wound Assessment

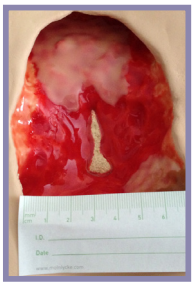
5 Step Wound Assessment

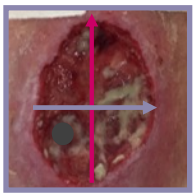
1. Tissue Type	• Percentage of each wound type 
2. Wound Exudate	• Type, volume, consistency, color, odor
3. Peri-Wound Condition	• Area extending 4cm from from wound edge
4. Pain Level	• At dressing changes • Intermittent or continuous 
5. Size	• Length, width, depth • Presence of undermining or tunneling

Wound Measurement

Wound Size

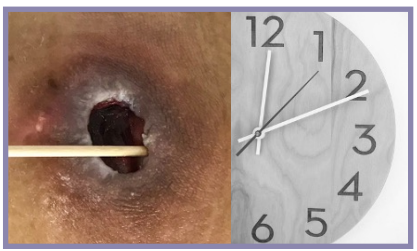
- Wounds are measured in centimeters (cm)
- Length is the longest vertical dimension
- Width is the longest perpendicular dimension
- Depth is the deepest point





Undermining & Tunneling

- Use the clock method
- 12 o'clock towards the head
- Note depth in centimeters (cm)



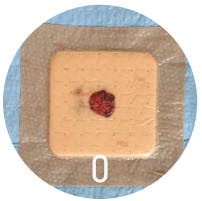
When to Change the Dressing

See more here.

Mepilex® Border Flex – Time To Change

When to change dressing according to saturation.

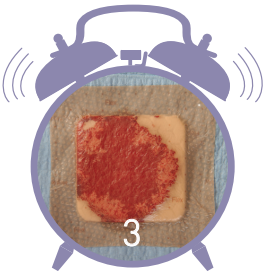
Saturation Levels



Fluid at 0 edges
Can keep in place

Fluid at 1 edges
Can keep in place

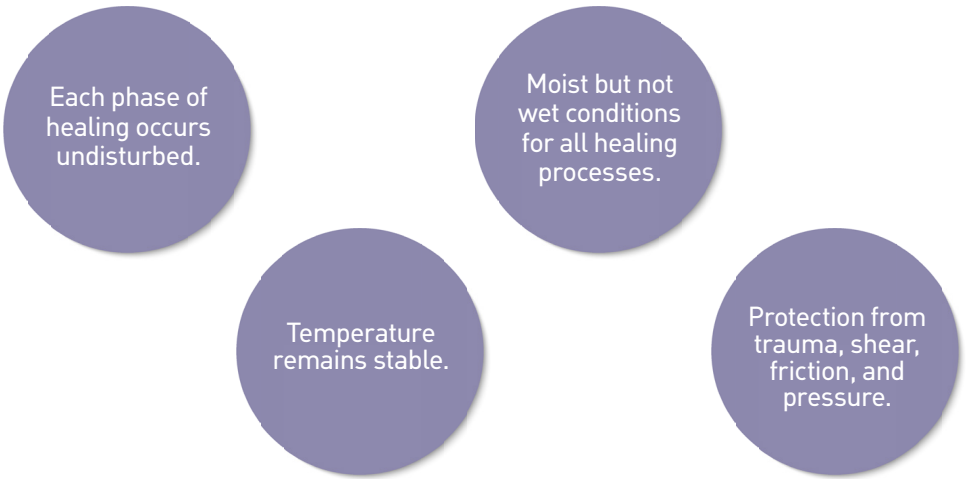
Fluid at 2 edges
Can keep in place



Fluid at 3 edges
Time to Change

Undisturbed Wound Healing

The process of allowing the wound to "rest" by alleviating unnecessary dressing changes. This protects and supports the normal processes of skin and wound healing; includes a moist wound environment, and catalyzes faster wound closure.



Tod Brindle and Pete Farmer, "Undisturbed wound healing: A narrative review of the literature and clinical considerations," Wounds International, June 3, 2019, pp. 40-48. Slide 8 taken from Undisturbed Wound Healing CE.

Wound Care Solutions

Comprehensive Wound Care Bundles

Pressure Injury Prevention and Wound Treatment

Mepilex® Border Flex

Mepilex® Border Sacrum

Mepilex® Border Heel

Mepilex® Lite

Exufiber® & Exufiber® Ag+

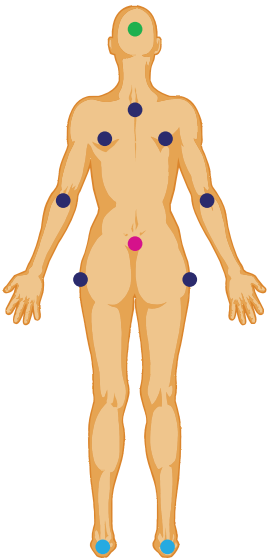
Support

Tortoise® Turning & Positioning Systems

Z-Flo™ Fluidized Positioners

Z-Flex™ Heel Boot

Mölnlycke Pressure Injury Management Product Videos



Z-Flo™ Fluidized Positioner

Mepilex® Border Sacrum

Mepilex® Border Heel

Mepilex® Border Flex

PAD UNDER MEDICAL DEVICES

Mepilex®

Mepilex® Lite

CONTINUE TURNING & POSITIONING

Z-Flex™ Heel Boot

Tortoise® Turning & Positioning Systems

Best Practice Guides

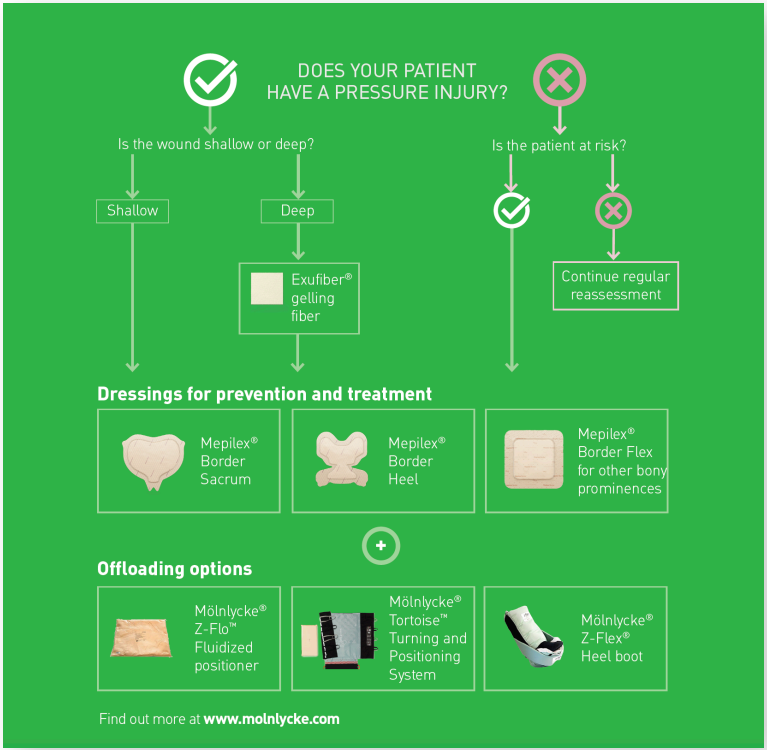
Best practice guides can assist with clinical decision-making to advance your performance and help you to achieve better patient, clinical, and financial outcomes every day.

- Pressure Injury Management Algorithm
- Skin Protection Cutting Guides
- Post-Acute Wound Dressing Selection Guide
- Medical Device Related Pressure Injury Prevention
- Wound Management Dressing Selection
- Lower Extremity Ulcer Guide
- Skin Tear Dressing Selection
- Heel Decision Tree

Call your Mölnlycke Health Care Representative to request guides or more information:

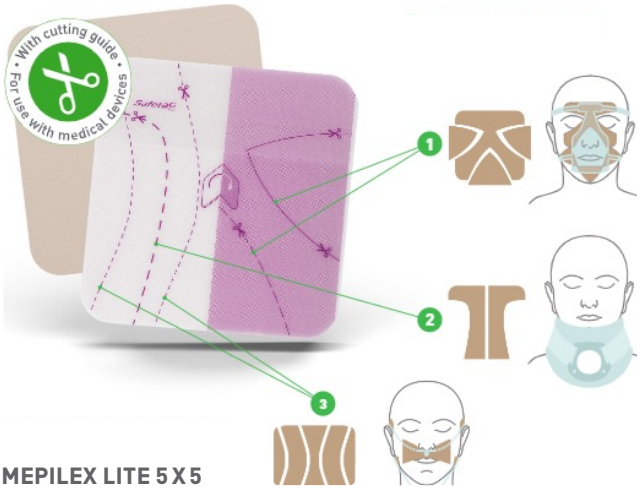
1 (800) 843-8497

Pressure Injury Management (PIM) Algorithm



Skin Protection Under Medical Devices

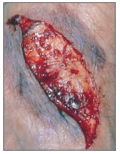
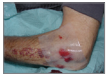
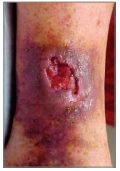
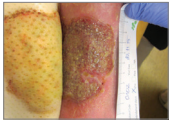
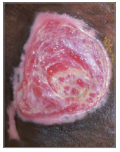
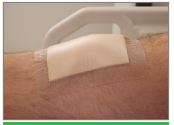
Select the dressing size appropriate to cover the affected area. Non-bordered dressings can be cut to customize shape to accommodate unique body contours and device shapes.



MEPILEX LITE 5 X 5

Post-Acute Wound Dressing Selection Guide

Post Acute Wound Dressing Selection Guide

Wound type	Clinical and Economic goal	Management tips	Suggested dressing(s)	Products in use
Skin tear 	• Protect and minimize trauma to wound and surrounding tissue • Provide savings/cost avoidance by reducing the total number of dressings used per patient or episode of care	• If the skin flap is viable, gently cleanse area and reposition the flap into place utilizing a moistened applicator • If skin flap is not viable, gently cleanse and apply atraumatic dressing per facility protocol	Mepilex® Border Flex Mepilex® Border Lite Mepitel® One Mepilex®	 
Lower extremity wounds 	• Manage exudate levels to allow for wound healing to begin. Protect peri-wound from maceration • Use dressings that can manage high fluid levels and provide longer wear time	• Gentle cleansing of wound with non-toxic cleanser • Consider antimicrobial dressings for wounds with high bacterial loads • Manage exudate for high exuding wounds • Consider adding compression for VLU management	Mepilex® Border Flex Exufiber® *used with* Mextra® Superabsorbent *or* Tubigrip®	
Pressure ulcers 	• Manage exudate and reduce pressure, shear, and control microclimate for existing pressure injuries • Manage cost by reducing the total number of dressings used per patient	• Utilize dressings to manage moderate to high exuding wounds and fill dead space • Reposition patient off pressure ulcer.	Mepilex® Border Lite Mepilex® Border Flex* *used with* Mesalt® *or* Exufiber® Melgisorb® Plus Mepore®	 *To protect tissue over bony prominences other than the sacrum or heel use Mepilex® Border Flex.

- Use of **Mepitel® Ag, Mepilex® Border Ag, Mepilex® Ag, Exufiber® Ag+** where an antimicrobial effect is needed.
- Use of **Setopress®** where therapeutic compression is needed.
- Use of **Tubigrip® or Dermafit®** where appropriate tissue support is needed.

Mölnlycke®

Medical Device-Related Pressure Injury Prevention

Medical Device Injury Protection Guide

Objective: Protect skin, absorb moisture, provide protective barrier with **Mepilex®**, and **Mepilex® Lite** [1]

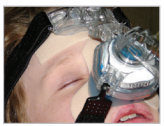
Mepilex®

Mepilex® Lite

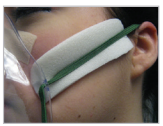
Notations:

- Fenestrate/cut product PRN to accommodate tube sites
- When cutting products, leave backing film in place. Cut to desired shape.
- Products listed on this guide are not suitable for fixation of life sustaining devices.
- Dressings with **Safetac®** technology DO NOT require use of skin barrier products.

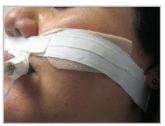
Wear time: Up to 7 days



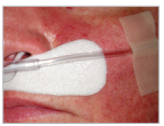
CPAP/BiPAP



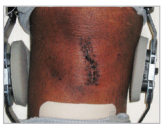
02 Mask Strap



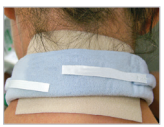
ET Tube with Tape



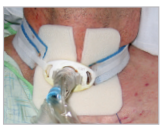
Nasal Cannulae



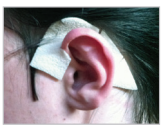
Brace/Cast



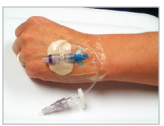
Tracheostomy Tie



Tracheostomy



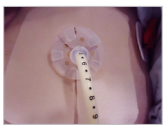
Nasal Cannulae w/ Ear Protection



IV Hub

C-Collar

Boot



G-Tube

See reverse side for **Mepilex®** cutting guide

References: **1.** EPUAP, NPIAP and PPPIA. Prevention and treatment of pressure ulcers/injuries: Clinical practice guidelines. The International Guideline 2019. Pg 181-193.

Mölnlycke®

Wound Management Dressing Selection

Wound Dressing Selection Guide Mepilex® Border Flex | Exufiber® Ag+

1. Cleanse with NS or wound cleanser and pat dry.

2. Measure wound with a wound measuring guide and document per facility protocols.

NOTE:
If the wound has dark black eschar—keep dry and consult Wound Care.

Wound Type	3. Assess Depth & Drainage: Exudate Level	4. Choose Appropriate Dressing: Fill	Cover
Shallow*	Light ↔ to Moderate	*Not Required*	Mepilex® Border Flex
Shallow*	Moderate ↔ to Heavy**	Exufiber® Ag+ *(optional)*	
Deep	Light ↔ to Moderate	Exufiber® Ag+	
Deep	Heavy**	Exufiber® Ag+	

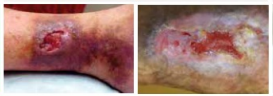
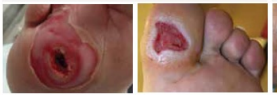
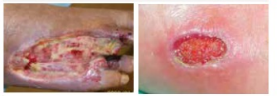
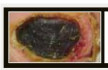
*If anti-microbial action is needed in a shallow wound, consider Mepilex® Border Ag.

****For wounds with depth and heavy drainage, consider wound care consult**

Mölnlycke®

Lower Extremity Ulcer Guide

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

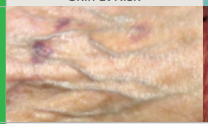
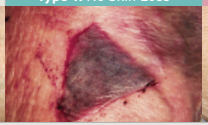
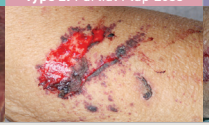
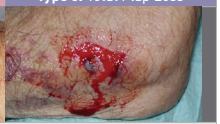
The information provided herein is not to be construed as the practice of medicine or substituted for the independent medical judgment of a patient's treating physician. This information, including but not limited to suggestions for product wear time, product selection and suggested use is based on generalizations 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 1-800-843-8477.

The Mölnlycke, Normigel, Mepilex, Allevyn, Exufiber, Mesalt, Mextra, Melgisorb, Mepitel, Mepitac, Mefix, Tubifast, Z-Flex, Tortoise, Setopress, Tubigrip Dermalit and Safetac trademarks, names and logo types are registered globally to one or more of the Mölnlycke Health Care Group of Companies. Distributed by Mölnlycke Health Care US, LLC, Peachtree Corners, GA, 30092 © 2020 Mölnlycke Health Care AB. All rights reserved. 1-800-843-8477. Z-Flo is a trademark in the United States and other countries of EdiZONE, LLC of Alpine, Utah, USA.

USMM 21000ZP 10.19 MHC-2019-48261

Mölnlycke®

Skin Tear Dressing Selection

Description	Skin at Risk	**Type 1:** No Skin Loss	**Type 2:** Partial Flap Loss	**Type 3:** Total Flap Loss
Appearance				
Management Objective	☑ Protect ☑ Stabilize tissue ☑ Provide moist wound healing environment ☑ Manage exudate			

Suggested Products

Management options for each wound condition

At Risk:

- Neonate
- Age ≥ 75
- Any patient with skin "at risk" due to comorbidities, medications or condition.

Intervention:

- Keep skin clean and free of excess moisture.
- Use lotion daily on dry skin.
- Gently remove tapes/adhesives.
- Protect fragile skin with stockinette, sleeves or pants

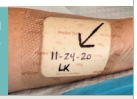
- Cleanse with NS to remove debris and clotted blood. Pat dry.
- Approximate the flap.

Mepilex® Border Flex
(Up to 7 days)

Mepilex® Border Lite
(Up to 7 days)

When using **Mepilex® Border / Mepilex® Border Flex** over a skin tear, it is recommended to keep dressing in place for at least **5-7 days** unless hematoma or infection is suspected.

Draw an arrow on the outside of the dressing to indicate which direction to REMOVE the dressing in order to protect the flap.



Notation

- Dressings with **Safetac®** technology **DO NOT** require use of skin barrier products.
- Non-bordered foam dressings may also be used: .

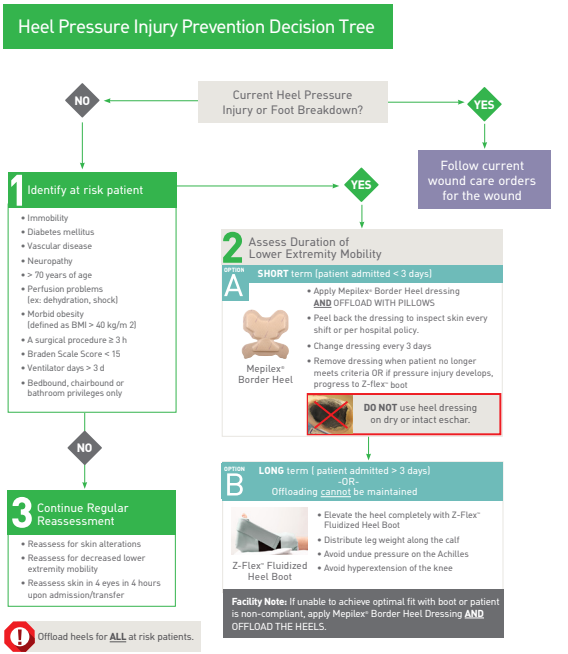
Individuals with wound infection or those at high risk for infection may require more frequent changes as well as adjunctive antibiotic therapy. Before any healing process can begin, two critical steps must be taken as part of a well-defined management protocol: 1) wound assessment and 2) management of causative and contributing factors including, shear and friction, excessive moisture and altered nutritional status.

Go to www.connect2know.com for info on wound management and FREE Nursing Continuing Education courses to support best practice across your organization.

The information provided herein is not to be construed as the practice of medicine or substituted for the independent medical judgment of a patient's treating clinician. 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 clinician 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 1-800-843-8497 or www.molnlycke.us

Mölnlycke®

Heel Decision Tree



Learn More About Wounds

Best Practice Support

Mölnlycke offers practice support and clinical decision-making resources to advance your performance and to help you achieve better patient, clinical, and financial outcomes every day.

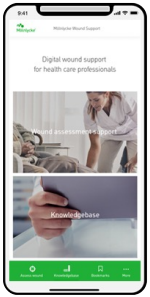
- Mölnlycke Wound Support App
- Global and Local Education
- Mölnlycke YouTube

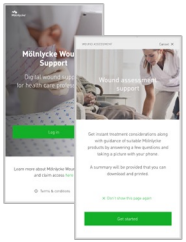
Mölnlycke Wound Support App

Download the app from Apple or Google:

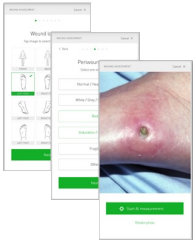
iOS: apps.apple.com/us/app/wound-support/id154438081

Android: play.google.com/store/apps/details?id=com.molnlycke.hg.woundsupport

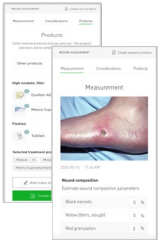




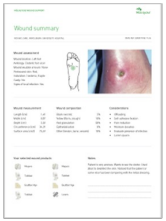
1. ACTIVATE AND INITIATE WOUND ASSESSMENT



2. DEFINE WOUND LOCATION, WOUND DATA AND TAKE PHOTO



3. RECEIVE WOUND MEASUREMENT, AND SUITABLE MÖLNLYCKE PRODUCTS



4. CREATE SUMMARY PDF

Contact Your Mölnlycke Representative

Mölnlycke Customer Care: 1-800-882-4582

Disclaimer: This app does not provide medical advice. The information, including but not limited to, text, graphics, images and other material contained in this app are informational purposes only. No material in nthis app is intended to be a substitute for indipendent professional clinical judgement, diagnosis or treatment.

Online Education Platform

A customized learning hub, designed to help you safely advance your career and knowledge while getting the best outcomes for your patients.

Global Education

- On-demand webinars
- E-learning modules
- Wound Care Voice Podcast
- Evidence and Insights
- Microworld
- Wound Talks

Local Education

- **FREE** Continuing Education Courses
- Quality Improvement Project and Evidence Support
- Clinical practice tools and templates
- Expert webinars
- Patient instructions on wound care

Pressure Injury Prevention

Wound Management

Program Development

For more details, contact your Mölnlycke representative.

Mölnlycke Customer Care:
1(800) 882-4582

Mölnlycke® YouTube

youtube.com/c/molnlyckehc/featured

- Wound care education videos
- Product application videos
- Ask a professional
- Access to other Mölnlycke channels

YouTube

Scan Here

for our YouTube page

Quick Product Reference Guide

With our extensive portfolio, we can make it easy for you to standardize your wound management formulary. This guide was designed to simplify the process by providing you with ordering information and a cross reference of comparable products.

At Mölnlycke, our products are designed with the patient, clinician and bottom line in mind. And they are supported by our many certified Molnlycke clinical specialists and sales representatives, an extensive live and on-demand educational program, and additional tools such as our Mölnlycke Wound Support app to make your job easier and more efficient.

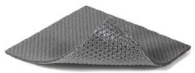
That's the Tötal Value of using Mölnlycke products.

Scan Here

for downloadable product catalogs

Product	Size	Mölnlycke #	HCPCS Code	Product Info
BORDERED FOAMS:				
 Mepilex® Border Flex	3”x3”	595200	A6212	
	4”x4”	595300	A6212	
	6”x6”	595400	A6213	
	6”x8”	595600	A6213	
Competitive Examples: Allevyn Border, Aquacel Foam, Optifoam, Comfort Foam, Tielle, Polymem, Biatain, Tegaderm Silicone Foam				
 Mepilex® Border Ag	4”x4”	395390	A6212	
	6”x6”	395490	A6213	
Competitive Examples: Allevyn Ag, Optifoam Ag, Biatain Silicone Ag foam, Comfort Foam Ag				
 Mepilex® Border Sacrum	6.3”x7.9”	282055	A6213	
	8.7”x9.8”	282455	A6213	
Competitive Examples: Allevyn Sacrum, Proximel Sacrum, Aquacel Foam Sacral Dressing, Biatain Sacral, Tegaderm, Sillcone Foam				
 Mepilex® Border Heel	8.7”x9.1”	282790	A6210	
Competitive Examples: Allevyn Life or Gentle Border Multisite, Aquacel Foam, Tegaderm Silicone Foam, ComFeel Plus				

Product	Size	Mölnlycke #	HCPCS Code	Product Info
BORDERED FOAMS CONT.:				
 Mepilex® Border Post Op Ag	4”x6”	498300	A6212	
	4”x8”	498400	A6212	
	4”x10”	498450	A6212	
	4”x12”	498600	A6213	
	4”x14”	498650	A6213	
Competitive Examples: Aquacel Surgical Ag, Allevyn Life, 3M Tegaderm Foam, ComfortFoam Border Ag				
 Mepilex® Border Post Op	4”x6”	496300	A4649	
	4”x8”	496405	A4649	
	4”x10”	496455	A4649	
	4”x12”	496605	A4649	
	4”x14”	496650	A4649	
Competitive Examples: Aquacel Surgical, 3M Tegaderm Foam, ComfortFoam Border				
NON-BORDERED FOAMS:				
 Mepilex®	4”x4”	294199	A6209	
	6”x6”	294399	A6210	
	8”x8”	294499	A6211	
Competitive Examples: Allevyn, Aquacel Foam, Optifoam, Comfort Foam, Tielle, Polymem GTL, Biatain				

Product	Size	Mölnlycke #	HCPCS Code	Product Info
NON-BORDERED FOAMS CONT.:				
 Mepilex® Ag	4”x4”	287100	A6209	
	6”x6”	287300	A6210	
	8”x8”	287400	A6211	
 Mepilex® Lite	2.4”x3.4”	284090	A6209	
	4”x4”	284190	A6209	
	6”x6”	284390	A6210	
Competitive Examples: Allevyn Lite, Optifoam Thin, CarraSmart Foam Thin				
 Mepilex® Transfer	6”x8”	294899	A6210	
	8”x20”	294599	A6211	
 Mepilex® Transfer Ag	6”x8”	394890	A6210	

Product	Size	Mölnlycke #	HCPCS Code	Product Info
NON-BORDERED FOAMS CONT.:				
 Mepilex® Up	4”x4”	212199	-	
	4”x6”	212199	-	
	6”x6”	212199	-	
	8”x8”	212199	-	
GELLING FIBERS:				
Exufiber®	0.8x17.7 Rope	709909	A6196	
	4”x4”	709901	A6196	
	6”x6”	709903	A6197	
Exufiber® Ag+	0.8x17.7 Rope	603420	A6199	
	4”x4”	603425	A6196	
	6”x6”	603423	A6197	
	8”x12”	603424	A6198	
Competitive Examples: Aquacel, Aquacel Advantage Ag, Biosorb, Kerracel, Durafiber, Opticell, Opticell Ag, Aquarite				
COMPACT LAYERS:				
 Mepitel®	3”x4”	290799	A6206	
	4”x7”	291099	A6207	
	8”x12”	292005	A6208	

Product	Size	Mölnlycke #	HCPCS Code	Product Info
COMPACT LAYERS CONT.:				
Mepitel® One	3"x4"	289300	A6206	
	4"x7"	289500	A6207	
	6.8"x10"	289700	A6208	
Competitive Examples: Adaptic Touch, KerraContact, Versatel, Dermanet GTL, Cutimed Sorbact, Conformant2				
TUBULAR RETENTION/SUPPORT:				
 Tubigrip® 1 yd. Single-Patient Box	B: Small arms	1520	A6457	
	C: Small ankles	1521	A6457	
	D: Med ankles	1522	A6457	
	E: Large ankles	1528	A6457	
	F: Large knees	1523	A6457	
 Tubigrip® 10 yds. Multi-Patient Box	G: Large thighs	1439	A6457	
	J: Small trunks	1440	A6457	
	K: Med trunks	1441	A6457	
	L: Large trunks	1442	A6457	
Competitive Examples: Tensogrip, Demagrip, Spandagrip, Medigrip				

Product	Size	Mölnlycke #	HCPCS Code	Product Info
TUBULAR RETENTION/SUPPORT CONT.:				
 Tubifast® Tubular Retention	Small limbs	2434	N/A	
	Sm/Med limbs	2436	N/A	
	Large limbs	2438	N/A	
	XL limbs	2440	N/A	
	Lg adult trunks	2444	N/A	
Competitive Examples: Surgilast, Spandage, Stockinette, Stretch Net				
TAPES & FILMS:				
 Mepitac® Tape	3/4"x 118"	298300	A4452	
	1.5"x59"	298400	A4452	
Competitive Examples: Gentac, 3M Kind, ComfiTape				
 Mefix® Tape	2"x11 yds	310599	A4450	
	4"x11 yds	311099	A4450	
	6"x11yds	311599	A4450	
Competitive Examples: MedFix, RiteFix, Hypafix, Medipore				

Product	Size	Mölnlycke #	HCPCS Code	Product Info
SUPERABSORBENT:				
 Mextra®	5”x7”	610100	A6197	
	7”x9”	610300	A6197	
	9”x13”	610500	A6198	
SUPERABSORBENT DEBRIDING AGENTS:				
Competitive Examples: Optilock, ConvaMax, HydraLock, Xtrasorb, Enluxtra				
 Mesalt®	8”x8” (4x4 folded)	286080	A6228	
	3/4””x39” (ribbon)	285280	A6226	
 Normlgel® Ag	1.5oz Tube	350450	A6248	
Competitive Examples: DermaSyn Ag, Resta SilverGel, Silvasorb gel, SilverGel				

Notes

We're here to help you, when you need us.

CALL YOUR MÖLNLYCKE HEALTH CARE REPRESENTATIVE OR CLINICAL SPECIALIST AT **1(800) 843-8497**.

Mölnlycke®

1(800) 843-8497 | WWW.MOLNLYCKE.US | 5445 TRIANGLE PARKWAY, SUITE 400, PEACHTREE CORNERS, GA 30092

Mölnlycke Health Care wound care products can serve as integral components of wound management programs. If infection is suspected, product use may be continued if proper infection treatment is initiated and if recommended by a physician.

The information provided in this brochure is not to be construed as the practice of medicine or substituted for the independent medical judgment of a patient's treating physician. Information contained herein, 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 US, LLC at 1-800-843-8497

The Mölnlycke, Mepilex, Exufiber, Mepitel, Tubigrip, Tubifast, Mepitac, Mefix, Mextra Mesalt, Normlgel, Z-Flex, Z-Flo and Safetac trademarks, names and logo types are registered globally to one or more of the Mölnlycke Health Care Group of Companies. Distributed by Mölnlycke Health Care US, LLC, Peachtree Corners, Georgia 30092. © 2022 Mölnlycke Health Care AB. All rights reserved. 1-800-843-8497.

Disclaimer: This document is not a complete guide on all matters related to reimbursement, nor does Mölnlycke Health Care guarantee that its use will result in payment for services. This information is subject to change over time, and may be incorrect at any time following publication. The reader is encouraged to independently verify data and confirm the applicability of any coding or billing practice with applicable payers prior to submitting claims. The reader is solely responsible for compliance with applicable laws.

USMM_822020 **MHC-2022-80090**