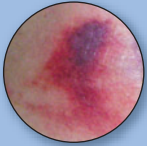





# PRESSURE ULCER GUIDELINES FOR TOPICAL TREATMENT

The following are suggested guidelines for treatment of pressure ulcers using products from Swiss-American Products, Inc. and are intended to supplement facility protocols and may be incorporated into the facility's specific plan of care for treatment of pressure ulcers. **Be sure to refer to your facility's pressure management protocols and Risk Assessment Tool.**

**IF YOU HAVE AN EMERGENCY, CONTACT 9-1-1 IMMEDIATELY.** Clinical Support is available during normal business hours 8:00-5:30 Central Time. Call our 24-hour desk at 1-800-224-0646 to request a consult.


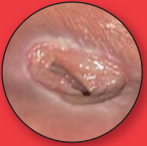


PRESSURE ULCER	WOUND DEPTH	WOUND DESCRIPTION	TREATMENT AND FREQUENCY	RATIONALE
<b>SUSPECTED DEEP TISSUE INJURY (SDTI)</b>				
	No visible depth	<p>Purple or maroon localized area of discolored <u>intact</u> skin, blood-filled blister or deep bruising. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler than adjacent tissue.</p> <p>Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. Deep tissue injury may be difficult to detect in individuals with dark skin tones.</p>	<p>Offload area completely with positioning or off-loading devices. Address mobility and nutritional issues.</p> <p style="text-align: center;">— AND —</p> <p>Gently apply <b>Nuvase® Calming Cream</b> to area twice daily.</p> <p style="text-align: center;">— or —</p> <p>Apply <b>Elta® Film</b> dressing to the entire area — may overlap dressings to fully cover. Change every five to seven days or as necessary.</p> <p>Assess daily.</p> <p>If / when skin opens: see following suggestions depending on wound assessment.</p>	<p>May help to resolve ischemic damage over time.</p> <p>Optimize person’s recovery ability.</p> <p>Moisturizes and decreases effects of inflammation.</p> <p>Transparent dressings help protect, reduce friction, and allow for easy visualization of the wounded area.</p>
<b>STAGE I</b>				
<p>(Partial Thickness)</p> 	No visible depth	<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. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.</p>	<p>Cleanse area and pat dry. Gently apply <b>Nuvase Calming Cream</b> twice daily.</p> <p style="text-align: center;">— or —</p> <p><b>If friction and shear are factors:</b> Apply <b>Elta Film</b> dressing. Change every five to seven days or as necessary.</p> <p>Assess daily.</p> <p>Offload area to protect from pressure.</p>	<p>Promote dermal and epidermal repair.</p> <p>Protect area from friction and shear.</p> <p>Consider pillows and/or heel-lift devices to properly “off-load” pressure areas.</p>
<b>STAGE II</b>				
<p>(Partial Thickness)</p> 	Blister — small amount of fluid contained	<p>Intact serous filled blister. Top layer of skin intact and is often shiny.</p> <p>If bruising is present, deep tissue injury is suspected.</p>	<p>Offload area — protect from pressure</p> <p style="text-align: center;">— AND —</p> <p>Cover with protective dressing i.e. <b>Elta Soft Touch Composite Island Dressing</b>.</p> <p style="text-align: center;">— or —</p> <p><b>Elta Film</b> dressing. Change every five to seven days.</p> <p>Assess daily.</p>	<p>Epidermis is compromised and fragile.</p> <p>Fluid to be reabsorbed.</p>
	Blister — large amount of fluid contained	<p>Intact serous filled blister. Top layer of skin intact and is often shiny.</p> <p>If bruising is present, deep tissue injury is suspected.</p>	<p>Apply <b>Elta Soft Touch non-adherent non-bordered</b> dressing to area, (depending on location) secure with roll gauze.</p> <p>Change every two to three days.</p> <p>Assess daily.</p>	<p>If blister ruptures, wound bed will be protected and drainage will be contained.</p>


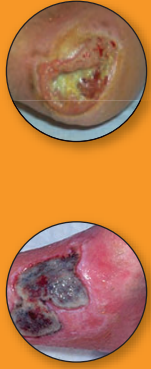
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PRESSURE ULCER	WOUND DEPTH	WOUND DESCRIPTION	TREATMENT AND FREQUENCY	RATIONALE
<b>STAGE II (continued)</b>				
<p>(Partial Thickness)</p> 	Abrasion/shallow crater	Shallow open ulcer with a red pink wound base, without slough or bruising. No to light exudate.	<p><b>Elta Dry Hydrogel TD</b> dressing. Change every three to five days or as necessary.</p> <p>Assess daily.</p>	<p>Promotes moist wound healing environment.</p> <p>Protects wound bed.</p>
	Abrasion/shallow crater	Shallow open ulcer with a red pink wound base, without slough or bruising. Moderate to heavy exudate.	<p><b>Elta Dry Hydrogel</b> dressing. Change every three to five days or as necessary. — or —</p> <p><b>Elta Soft-Touch Bordered Hydrophilic Foam Dressing.</b> Change daily or as necessary.</p> <p>Assess daily.</p> <p><b>Infection MUST be ruled out; consult MD or APRN</b></p>	<p>Promotes moist wound healing environment.</p> <p>Protects wound bed.</p> <p>Absorbs exudate.</p>
<b>STAGE III-IV</b>				
<p>Full Thickness</p>   	Shallow depth	No to light exudate	<p>Apply <b>Elta Dry Hydrogel TD</b> dressing on flexible areas. Change every three to five days or as necessary. — or —</p> <p><b>Elta Dry Hydrogel</b> dressing. Change every three to five days or as necessary.</p> <p>Assess daily.</p>	<p>Promotes moist wound healing environment.</p> <p>Protects wound bed.</p> <p>Absorbs exudate.</p>
	Shallow depth	Moderate to heavy exudate	<p><b>Elta Dry Hydrogel</b> dressing. Change every two to three days or as necessary. — or —</p> <p><b>Elta Alginate</b> dressing, cover with <b>Elta Soft Touch Composite Island Dressing.</b> Change every one to two days as necessary.</p> <p>Assess daily.</p> <p><b>Infection MUST be ruled out; consult MD or APRN</b></p>	Absorbs exudate.
	Moderate depth	No to light exudate	<p>Apply <b>Elta Hydrogel Impregnated Gauze</b> dressing to wound bed, cover with <b>Elta Soft Touch Composite Island Dressing.</b> Change daily or as necessary.</p> <p>Assess daily.</p>	<p>Donates moisture to wound bed.</p> <p>Protects wound bed.</p> <p>Absorbs small amount of exudate.</p>
	Moderate depth	Moderate to heavy exudate	<p><b>Elta Alginate</b> dressing or rope. Apply <b>Dermavase® Moisture Barrier</b> to protect peri-wound skin from possible maceration. Cover with <b>Elta Soft-Touch Bordered Hydrophilic Foam Dressing.</b> Change daily or as necessary. — or —</p> <p>For malodorous or heavily draining wounds, apply dry hypertonic sodium chloride-impregnated dressing* to wound bed and cover with <b>Elta Soft-Touch Bordered Hydrophilic Foam Dressing.</b> Change daily or as necessary.</p> <p>Assess daily.</p> <p><b>Infection MUST be ruled out; consult MD or APRN</b></p>	<p>Wicks and contains exudate.</p> <p>Enhances autolytic debridement.</p>

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PRESSURE ULCER	WOUND DEPTH	WOUND DESCRIPTION	TREATMENT AND FREQUENCY	RATIONALE
<b>STAGE III-IV (continued)</b>				
<p>Full Thickness</p>   	<p>Deep ulcer</p>	<p>No to light exudate</p>	<p>Apply <b>Elta Hydrogel</b>, cover with <b>Elta Soft Touch Composite Island Dressing</b>. Change daily or as necessary.</p> <p style="text-align: center;">— or —</p> <p>Apply <b>Elta Hydrovase®</b> hydrogel, cover with <b>Elta Soft Touch Composite Island Dressing</b>. Change daily or as necessary.</p> <p style="text-align: center;">— or —</p> <p>Apply <b>Elta Hydrogel Impregnated Gauze</b> dressing to wound bed, cover with <b>Elta Soft Touch Composite Island Dressing</b>. Change daily or as necessary.</p> <p><b>NOTE:</b> If wound is deep and dead space is noted after applying one of the above primary dressings, fill in remaining space with gauze before securing with a secondary dressing. Change every one to three days depending on drainage.</p> <p>Assess daily.</p>	<p>Donates moisture to wound bed.</p> <p>Promotes a moist wound healing environment.</p>
	<p>Deep ulcer</p>	<p>Moderate to heavy exudate</p>	<p>Apply <b>Elta Alginate</b> dressing or <b>Elta Alginate</b> rope packing, cover with <b>Elta Soft Touch Composite Island Dressing</b>. Change daily.</p> <p style="text-align: center;">— or —</p> <p>Apply <b>Elta Alginate</b> dressing or <b>Elta Alginate</b> rope packing to wound. Apply <b>Dermavase Moisture Barrier</b> to protect peri-wound skin from maceration. Secure with <b>Elta Soft-Touch Bordered Hydrophilic Foam Dressing</b>. Change daily.</p> <p style="text-align: center;">— or —</p> <p>For malodorous, heavily draining wounds, apply dry hypertonic sodium chloride-impregnated dressing<sup>+</sup> to wound bed and cover with <b>Elta Soft-Touch Bordered Hydrophilic Foam Dressing</b>. Change daily.</p> <p><b>NOTE:</b> If wound is deep and dead space is noted after applying one of the above primary dressings, fill in remaining space with gauze before securing with a secondary dressing. Change every one to three days depending on drainage.</p> <p>Assess daily.</p> <p><b>Infection MUST be ruled out; consult MD or APRN</b></p>	<p>Wicks and absorbs exudate.</p> <p>Protects wound bed.</p> <p>Promotes moist wound healing environment.</p>



PRESSURE ULCER	WOUND DEPTH	WOUND DESCRIPTION	TREATMENT AND FREQUENCY	RATIONALE
<b>UNSTAGEABLE — DEPTH UNKNOWN</b>				
	<p>Depth unknown; to be determined</p>	<p>Ulcer base is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black).</p> <p><b>Do not apply occlusive dressings if infection is present.</b></p> <p><b>Note: Do NOT debride stable eschar heel ulcers.</b></p> <p>Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.</p>	<p>If the area is not infected and is dry, apply small amount of <b>Elta Hydrovase</b> hydrogel and cover with <b>Elta Dry Hydrogel TD</b> dressing. Change every two to three days or as necessary. Assess daily. — or —</p> <p>If drainage is present, use wet to dry dressings for three to five days. Assess daily. — or —</p> <p>Utilize collagenase [RX], cover with gauze dressing. Change daily. — or —</p> <p>Sharp debridement (<b>Performed by Qualified Clinician</b>): Use sterile instruments; assess pain, lab test results (PT/PTT as indicated) and circulatory status first.</p> <p>Assess status of eschar daily.</p> <p>Keep area dry and offloaded.</p>	<p>Autolysis promotes "self digestion" of non-viable tissue.</p> <p>Enzymatic agent promotes sloughing of non-viable tissue and clean wound bed.</p> <p>Sharp/Conservative debridement must be done by a qualified clinician.</p> <p>Stable heel ulcers with eschar should not be debrided. Always offload heels. Debride once the area becomes <b>unstable</b>, pending circulation assessment.</p> <p>Please note: foam dressings are not considered "offloading devices".</p>
	<p><b>Stable eschar</b> on an arterial insufficiency compromised limb</p>	<p>Dry, adherent, intact eschar without erythema or fluctuance.</p> <p><b>Note: Do NOT debride stable eschar in these wounds.</b></p>	<p>May protect wound with dry dressing and roll gauze. If dressing is used, change as necessary.</p> <p><b>Do NOT attempt debridement of ANY kind.</b></p> <p>Assess wound and eschar status daily.</p>	<p>No debridement should be attempted without adequate circulation for healing.</p>
<b>INFECTED WOUNDS</b>				
	<p>Variable depth(s)</p>	<p>Low to heavy exudate. May have purulent drainage. — or —</p> <p>May be foul smelling. — or —</p> <p>May be a clean wound that is unresponsive to treatment.</p>	<p><b>Physician involvement is essential for possible systemic antibiotic therapy.</b></p> <p>AVOID occlusive dressings. Monitor daily for signs and symptoms of sepsis and worsening condition.</p> <p>Consider a two-week trial of <b>Elta SilverGel®</b> or <b>SilverGel® Impregnated Gauze</b> dressing. Apply gauze sheeting or ¼" of SilverGel to entire wound surface. Cover with <b>Elta Soft-Touch Composite Island Dressing</b>. Change daily. Assess daily. — or —</p> <p>For malodorous, heavily draining wounds, apply dry hypertonic sodium chloride-impregnated dressing* to wound bed and cover with <b>Elta Soft-Touch Bordered Hydrophilic Foam Dressing</b>. Change daily. Assess daily.</p> <p><b>NOTE:</b> If wound is deep and dead space is noted after applying one of the above primary dressings, fill in remaining space with gauze before securing with a secondary dressing.</p> <p>Assess daily.</p>	<p>Use of occlusive dressings on infected wounds can promote growth of anaerobic bacteria, therefore use of these dressings are contraindicated.</p> <p>In order for silver dressings to be fully effective, it is important that all wound surfaces make contact with the silver product.</p> <p>SilverGel works best in wounds with little to moderate levels of exudate.</p> <p>Dressing changes will be dependent on amount of drainage and absorptive properties of product.</p>

\*Limited items that are not available can be outsourced, but Swiss-American Products, Inc must be contacted first.

## GENERAL ELTA® WOUND CARE INFORMATION

- FOR ALL PRESSURE ULCERS: DO NOT MASSAGE AFFECTED AREAS.
- FOR ALL PRESSURE ULCERS: ASSESS AFFECTED AREAS DAILY.
- Turn and reposition per facility protocol. Provide pressure management surfaces per facility policy.
- Manage pain and prevent painful dressing changes. Promote analgesic and non-analgesic pain relief prior to dressing changes.
- For wounds with moderate to heavy exudate: Apply **Dermavase Moisture Barrier** to peri-wound tissue to protect fragile skin and help prevent maceration. Use **Trivase® Antifungal** if fungal or yeast involvement is suspected.
- When performing a dressing change, utilize facility infection control guidelines with Universal Precautions.
- Apply **Elta Crème®** to dry skin in all non-affected areas. This will help to prevent skin breakdown.
- Cleanse all wounds with **Elta Wound Cleanser**. This product is non-cytotoxic and delivers a therapeutic irrigation at a range of 4-8 psi.
- Please note: foam dressings are not considered “offloading devices” — consider pillows and/or heel-lift devices to properly “off-load” pressure areas.
- Date and initial all wound dressings with a permanent marker and document dressing changes appropriately per facility policy.
- Reassess all wounds at least weekly and reassess the Risk Scale per facility policy.
- Screen and assess nutritional status at admission and with each condition change and/or when progress towards wound closure is not observed.
- Use adhesive products with caution on inflamed and/or reddened skin. When removing adhesive dressings from compromised skin: Wet the adhesive section of the tape. Gently lift a corner of the dressing and carefully roll the dressing back taking care not to damage the underlying tissue and wound.

## NATIONAL PRESSURE ULCER ADVISORY PANEL DEFINITIONS

(NPUAP Revision 2/07)

<p><b>Pressure Ulcer Definition:</b> A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.</p>	<p><b>Stage III:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</p> <p>The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.</p>
<p><b>Suspected Deep Tissue Injury:</b> 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. Deep tissue injury may be difficult to detect in individuals with dark skin tones.</p>	<p><b>Stage IV:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.</p> <p>The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.</p>
<p><b>Stage I:</b> 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>The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” persons (a heralding sign of risk).</p>	<p><b>Unstageable:</b> 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. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as “the body’s natural (biological) cover” and should not be removed.</p>
<p><b>Stage II:</b> 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. Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicates suspected deep tissue injury.</p>	

# SWISS-AMERICAN PRODUCTS



Elta Soft-Touch





SWISS-AMERICAN CARROLLTON, TEXAS FOR MORE INFORMATION, CALL US AT 800.633.8872 OR VISIT US ON THE WEB AT [WWW.ELTA.NET](http://WWW.ELTA.NET)

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