Skin and Wound Product Information Sheet

Mepilex Border for Pressure Injury Prevention

Classification	**Prophylactic Dressing**
Key Points	• Used to enhance, but not replace, routine pressure injury prevention strategies for the prevention of sacral/coccyx and heel pressure injuries. • Highly conformable 5-layer foam dressing with Deep Defence™ technology that redistributes pressure/shear forces, reduces friction, and balances microclimate. • Soft and conformable waterproof/showerproof foam dressing with silicone adhesive layer for atraumatic dressing removal.
Indications	• For those patients, clients or residents at risk for developing a pressure injury related to pressure, friction/shear on the sacral-coccyx or heel area.
Precautions	• Does not replace the use of other pressure injury prevention strategies (i.e. pressure risk assessment, regular positioning, appropriate pressure redistribution and support strategies). • Consult with Physician/NP/Wound Clinician prior to using foam dressings (of any kind) on ischemic lower legs/feet • Dressing should not be cut
Contraindications	• Pre-existing pressure injury on the sacral-coccyx or heel, including Pressure Injury Stage 1 • Trauma or burn to sacrum or coccyx. • Do not use with skin barriers /skin sealants or cleansing wipes containing dimethicone/silicone, emollients etc. as these reduce the effectiveness of the adhesive properties of the dressing
Formats & Sizes	• Sacrum ○ 16 x 10cm ○ 22 x 25cm ▪ Heel ○ 18 x 24cm 

Application Directions	**Rationale**
To Apply to the Sacral-coccyx Area	
Cleanse the sacral area with pH-balanced skin cleanser or warm water. Gently pat the skin dry. Do not use emollient or dimethicone/silicone ointments/barrier wipes or skin sealants in area where dressing will be applied.	Emollients, dimethicone/silicone (and other skin preparations) can reduce the adhesive properties of the silicone dressing.
Have a colleague hold the buttocks apart. Remove the dressing's center release film and apply dressing into the gluteal cleft and then sacral area. Remove the right-side release film and gently smooth this side of the dressing into place. Repeat with the left side. Run the side of a hand along the gluteal cleft to secure placement. 	It is important that the dressing 'fits' into the upper aspect of the gluteal cleft to ensure that the dressing is properly secured against incontinence episodes.
On the dressing, print "P" for Preventative dressing and add the date that the dressing was applied.	To communicate with other staff the purpose of the dressing and when it needs to be changed
To Apply to the Heel Area	
Apply the adherent part of the dressing marked 'A' to the posterior heel/Achilles tendon areas, positioning the narrowest part of the dressing at the base of the heel. Do not stretch. Remove the backing from one of the ankle flaps. Apply and smooth. Repeat with the other side.	

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Application Directions	Rationale
Gently apply the adherent part of the dressing marked 'B' under the plantar surface of the foot. Do not stretch. Remove the backing from one of the flaps with tabs. Apply and smooth border. Repeat with the other side. Press and smooth the dressing to ensure the entire dressing is in contact with the skin.	 
On the dressing, print "P" for Preventative dressing and add the date that the dressing was applied.	To communicate with other staff the purpose of the dressing and when it needs to be changed.
Daily Care	
As part of the evaluation of client's specific pressure injury prevention strategies**, once a day, peel dressing back and assess the skin**. Reapply existing dressing ensuring the border of the dressing is smooth with no wrinkles. Document assessment findings. If patient is incontinent and top of dressing is soiled, gently wipe off.	Wrinkles in the dressing are to due to sheer forces being applied to the dressing; if possible, remove these concerns e.g. lower the head of the bed. Dressing is waterproof and will not allow urine or feces to soak into the dressing.
If dressing does not stay intact for longer than 24 hours due to incontinence, discontinue the dressing and use barrier cream or alternative skin management. If a pressure ulcer develops within the area of the dressing, discontinue the prevention/protection dressing and initiate appropriate wound management. Inform OT, PT and/or Wound Clinician of the pressure ulcer occurrence.	If dressing does not stay in place it is not a cost-effective prevention strategy. Other pressure ulcer interventions will need to be considered.
To Remove	
Gently lift the border and use one hand to stabilize the skin.	To minimize trauma to skin.
Frequency of Dressing Change	
May be left in place for up to 7 days. Change the dressing should it lose its adherence e.g. edges roll, border does not 'stick', or become soiled. Replace the prevention dressing as long as patient meets selection criteria above.	As the patient's level of pressure ulcer risk improves, the dressing may no longer be required.
Expected Outcome	
Pressure injury does not develop.	
For further information, please contact your Wound Clinician.	