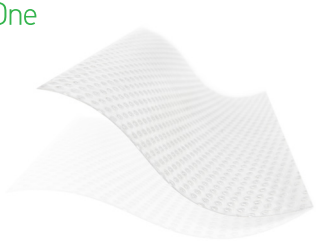
Ordering information

Epaderm® Cream
Epaderm® Ointment

- A clinically proven emollient and skin cleanser
- Non-greasy formulation absorbs quickly into the skin
- Suitable for all ages, including babies

Mepitel® One



Safetac TECHNOLOGY

- Highly transparent, one-sided soft silicone net
- Minimises pain and trauma at dressing changes[2]
- Can remain in place for up to 14 days to ensure undisturbed wound healing[3]
- Needs secondary absorbent dressing
- Needs extra fixation

Mesoft®

- A soft nonwoven material with low fibre release
- Absorbs more fluid and exudate compared to gauze
- Use for cleansing or as a secondary dressing

Mesorb®

- Needs extra fixation
- A soft, highly absorbent dressing
- Its fluid-repellent strike-through barrier helps prevent exudate from soiling clothes and bed linens

Mepilex® Border Flex

Safetac TECHNOLOGY

- Flexible showerproof all-in-one dressing
- Minimises pain and damage at dressing changes[4]
- Contains foam and superabsorbent fibres for high absorption and retention[5]
- Proprietary Flex Technology (Y-shaped Flex cuts) enables 360 stretch for improved stay-on-ability and conformability[6-8]
- The Exudate Progress Monitor on the semi-transparent backing film helps track and record fluid without disturbing the wound[9]

Mepilex® Border Ag

Safetac TECHNOLOGY

- Showerproof all-in one dressing
- Minimises pain and damage at dressing changes[4]
- For moderately to highly exuding wounds
- Combines excellent exudate management properties with effective antimicrobial action[10]

Mepitel® Film

Safetac TECHNOLOGY

- A gentle, transparent breathable film dressing for skin protection and fixation
- Minimises pain and damage at dressing changes[2]

Tubifast®
TwoWay Stretch®

- Tubular elastic bandage of viscose
- Holds dressings securely, without constriction or compression
- 5 different widths
- Cut to size

Proving it every day

At Mölnlycke®, we deliver innovative solutions for managing wounds, improving surgical safety and efficiency and preventing pressure ulcers. Solutions that help achieve better outcomes and are backed by clinical and health-economics evidence.

In everything we do, we are guided by a single purpose: to help healthcare professionals perform at their best. And we're committed to proving it every day.

Mölnlycke Health Care would like to acknowledge the following people for their work in developing this guide:
Kimberly LeBlanc, MN, RN, CETN (C), PhD (student), President of ISTAP and Karen Campbell, PhD, RN, MScN, President-Elect at ISTAP.

References:
1. Leblanc K. et al. Best practice recommendations for the prevention and management of skin tears in the aged skin. Wounds International, 2018. Available to download from www.woundsinternational.com. **2.** David F. et al. A randomised, controlled, non-inferiority trial comparing the performance of a soft silicone-coated wound contact layer (Mepitel One) with a lipidocolloid wound contact layer (UrgoTul) in the treatment of acute wounds. International Wound Journal, 2017. **3.** Brolmann F.E. et al Randomized clinical trial of donor-site wound dressings after split-skin grafting. British Journal of Surgery, 2013. **4.** White R., A Multinational survey of the assessment of pain when removing dressings. Wounds UK 2008; Vol 4, No 1. **5.** External test lab report SMTL15/4863/2. Data on file. **6.** ProDerm study report 16.0180-23. Assessment of Wearing Properties of Wound Dressings on the Knees. Data on file. **7.** ProDerm study report 16.0180-23. Assessment of Wearing Properties of Wound Dressings on the Elbows. Data on file. **8.** ALTEN Finite Element Modelling simulation. Laboratory report no. PD-530246. Data on file. **9.** Mölnlycke Health Care. Mepilex Border Flex– Estimation of spreading area using dot pattern on backing film. Report no. PD-528872. Data on file. **10.** External lab report: NAMSA 09C 29253 01/09C 29253 02. Data on file.

Find out more at www.molnlycke.com

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Mölnlycke®

Treating skin tears

It's all about the outcome

Mölnlycke®

A significant problem

and how to assess, treat and prevent it

Skin tears are acute wounds with a high risk of becoming complex chronic wounds. They are a significant problem for patients and the healthcare professionals who treat them. With limited published guidance or evidence, these wounds are often misdiagnosed or mismanaged, which may lead to complications including pain, infection and delayed healing[1].

Estimates of skin tear prevalence differ around the world, but recent studies suggest that they actually occur more frequently than pressure ulcers, with an estimated incidence rate of approximately 15% among patients over the age of 65. It is even estimated that the incidence of skin tears will become one of the largest problems in wound care with an increasing elderly population, although the critically ill, neonates and paediatric populations are also at risk[1].

An incident rate of

15.5%

among patients over 65 years[1].

Associations and causes[1]

- Majority occur on upper limbs (80%)
- Physical environment
- Limited mobility
- Removal of adhesives, dressings or tapes
- Drugs and medications

Who is at risk?

Skin tear risk assessment pathway[1]:

Skin tear risk assessment

Patient – Wound – Environment

Risk categories

Skin:
Extremes of age, dry/fragile skin, previous skin tears.

Mobility:
History of falls, impaired mobility, dependent activities of daily living, mechanical trauma.

General health:
Comorbidities, polypharmacy, impaired cognition (sensory, visual, auditory) and malnutrition.

If patient has 1 or more of the identified risk factors.

High risk:
Visual impairment, impaired mobility, dependent ADLs, extremes of age, previous skin tears.

Action!

Implement risk reduction program

Prevention

Patients suffering from skin tears complain of pain and decreased quality of life. By recognising patients at risk, preventing skin injuries, and using appropriate non-adherent dressings, clinical nurses can spare patients undue pain and suffering[1].

- Patient assessment using Skin Tear Risk Assessment Pathway
- Implement a Skin Tears Risk Reduction Program
- Create a safe environment (i.e. padding of equipment, adequate lighting, and removal of excess furniture)
- Long-sleeved clothing
- Educate individuals and caregivers
- Correct moving and handling techniques – in line with local policy
- Where possible, reduce or eliminate pressure, shear and friction using pressure-relieving devices and positioning techniques
- Adequate nutrition and hydration
- Applying moisturiser twice daily can reduce the incidence of skin tears by almost 50%

Who is ISTAP?

The International Skin Tear Advisory Panel (ISTAP) serves to improve patient outcomes for skin tear prediction, assessment, prevention and management. Their wish is to impact patient lives and unite professionals. Using the ISTAP skin tear classification system ensures a common language for identifying and documenting skin tears.

Learn more about ISTAP and their Skin Tear Tool kit including the detailed pathway to assessment and treatment of skin tears on www.skintears.org.

On www.molnlycke.com, you can find an ISTAP-endorsed skin tear training module with a detailed description of how to predict, prevent, assess and manage skin tears.

ISTAP

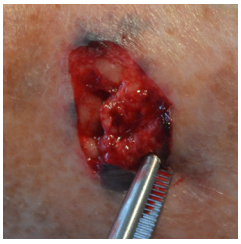
www.skintears.org

ISTAP skin tear definition:

ISTAP defines a skin tear as a traumatic wound caused by mechanical forces, including removal of adhesives. Severity may vary by depth (not extending through the subcutaneous layer)[1].

Partial-thickness
(separation of the epidermis from the dermis)

or



Full-thickness
(separation of both the epidermis and dermis from underlying structures)

Assessment and management of skin tears

The chart outlined below lists ISTAP's recommended consecutive practical steps to help assess and manage skin tears[1].

Initial treatment of the skin tear

Control bleeding

Cleanse/debride the wound

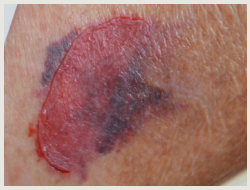
Reapproximate the skin flap

Assessment and classification:

Assess the skin tear and surrounding skin

Classify

ISTAP skin tear classification[1]



Type 1: no skin loss

Type 2: partial flap loss

Type 3: total flap loss

Goals of treatment

1. Maintain moist wound healing
2. Take care of surrounding skin
3. Treat and prevent pain
4. Be aware of local signs of infection
5. Treat oedema
6. Ensure sufficient blood flow

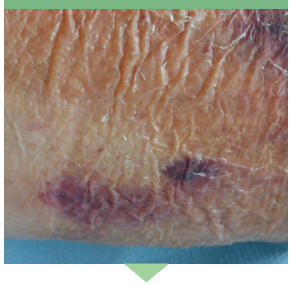
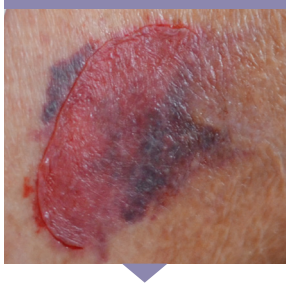
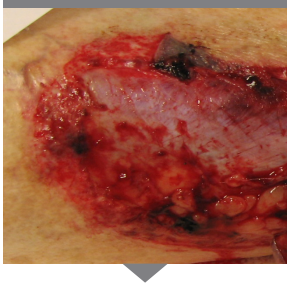
Apply the dressing

Prevention strategies

Review and re-assess

Mölnlycke® dressing selection guide specific to skin tear

When skin tears occur, it is paramount to choose wound care products that will optimise wound healing while minimising the risk of further skin damage.

Wound type	**Skin at risk** Mature skin is more vulnerable and prone to skin tears.	**Type 1: No skin loss** Linear or flap tear that can be repositioned to cover wound bed.	**Type 2: Partial flap loss** Partial flap loss that cannot be repositioned to cover the wound bed.	**Type 3: Total flap loss** Total flap loss exposing the entire wound bed.
				
Suggested product	Epaderm® Cream or Epaderm® Ointment	Mepitel® One + Mesoft® or Mesorb®	Mepitel® One or Mepilex® Border Flex	Mepilex® Border Flex
Bacterial imbalance /infected			or Mepilex® Border Ag	or Mepilex® Border Ag
Fixation /protection		Tubifast® or Mepitel® Film	Tubifast® or Mepitel® Film	
Management tips	Avoid soaps that dry the skin. Moisturise skin with emollients twice a day. Use products that are fragrance-free and hypoallergenic.	Approximate the wound edges. Mepitel One should remain over place for at least five days to allow the flap to heal over underlying tissue. The absorbent dressing over Mepitel One is changed as required, leaving Mepitel One in place. Change Mepitel One when complete re-epithelialisation is confirmed.		After dressing application: mark it with an arrow indicating direction in which to remove the dressing. If the skin is very fragile: peel the bordered dressing off from the corner.

ISTAP does **NOT** recommend the following products: adhesive closure strips, acrylate adhesive dressings, hydrocolloids and transparent adhesive films, due to risk of skin stripping[1]