

NURSING SERVICE GUIDELINES GENERAL

Guideline: Allevyn sacrum foam dressing

Policy Number Superseded:

Responsibility: Registered nurse (RN)

Purpose of Guidelines: Protect patients from developing sacral-coccygeal pressure injury.



Effective Date:

January 20, 2026

Initial Effective Date:

May 2016

Procedure:

Gather equipment:

- (1) Gloves
- (2) Allevyn Sacrum Foam Dressing (7 in or 9 in size)
- (3) Normal saline or wound cleanser for cleansing skin (for preoperative patient)
- (4) Skin sealant if needed

(A) Determine if the patient is at high-risk to develop sacral or coccygeal pressure injury. Dressing will be used only for high-risk patients:

- (1) ICU patients - All patients, unless up and walking.
- (2) Stepdown/medical-surgical patients - Immobile patients.
Immobile patients.
Patients with prominent sacrum.
Scar tissue on sacral area or history of sacral pressure injury.
Obesity = >160kg.
Stage 1, 2, or suspected deep tissue injury on sacrum/coccyx.
Cathectic patients.
Hemodialysis patients.
Tetraplegic, paraplegic or hemiplegic patients.
- (3) Pre-op patients - Surgery expected to be > 4 hours and patient will be admitted.

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All cardiothoracic surgery
Stage 1, 2, or suspected deep tissue injury on sacrum
Cachectic patients
Obesity = >160kg Hemodialysis patients
Tetraplegic, paraplegic, or hemiplegic patients

- (B) Wash hands and don gloves.
- (C) Write date on dressing, and if dressing is used for prevention, write a "P" on the dressing.
- (D) Roll the patient to their side. Cleanse skin with normal saline or wound cleanser and allow to dry. Skin must be dry for the silicone border of dressing to adhere to skin.
- (E) Skin sealant may be used to protect the peri-wound skin prior to dressing application.
- (F) Remove the center piece of release film. Separate the buttocks, apply the dressing starting 1 inch above the anus and smooth it into the intergluteal cleft (assistance may be needed to separate the buttocks).
- (G) Remove one side of the film at a time, smoothing the dressing in place from bottom to top.
- (H) Remove gloves and wash hands.
- (I) Replace the dressing every 3 days or if soiled under the dressing.
- (J) Discontinue the dressing when the patient is able to move independently or if you have to replace it more than twice in a 12-hr. period. If dressing must be replaced more than twice in a 12-hr. period, use alternate dressing or skin barrier.
- (K) Pull the dressing back every shift to assess the skin and then smooth the dressing back into place.
- (L) References.

Clarke B. (2013). Positive patient outcomes: The use of a new silicone

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National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance, Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler, (Ed.) Cambridge, Media: Perth, Australia; 2014.

Smith & Nephew data on file report DS/12/125/DOF. Impact protection properties of ALLEVYN Life, Mepilex™ Border and Biatain™ Silicone. Daubney L; June 2012.

Wound, Ostomy, Continence Nurse Society (2016). Guideline for prevention and management of pressure ulcers (injuries). WOCN clinical practice guideline series 2. Mt. Laurel, NJ.

Approved by:

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