THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Nursing Service Guideline
General

Title: **Allevyn Sacrum Foam Dressing**

Responsibility: Registered Nurse (RN)

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

Procedure:

Gather equipment:
1. Gloves
2. Allevyn Sacrum Foam Dressing (7 in or 9 in size)
3. Water or CHG wipes for cleansing skin (for preoperative patient)
4. Skin sealant if needed

1. Determine if the patient is at high risk to develop sacral or coccygeal pressure injury.
   Dressing will be used only for high-risk patients:
   a. ICU Patients - All patients unless up and walking
   b. 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
   Cachectic patients
      Hemodialysis patients
      Tetraplegic, paraplegic, or hemiplegic patients
   c. Pre-op Patients - Surgery expected to be > 4 hours and pt. is being admitted
      All cardiothoracic surgery
      Stage 1, 2, or suspected deep tissue injury on sacrum
      Cachectic patients
      Obesity = >160kg
      Hemodialysis patients
      Tetraplegic, paraplegic, or hemiplegic patients

2. Wash hands and don gloves.
3. Write date on dressing, and if dressing is used for prevention, write a "P" on the dressing.
4. Roll the patient to their side. Cleanse skin with water or CHG wipe and allow to dry. Skin must be dry for the silicone border of dressing to adhere to skin.
5. Skin sealant maybe used to protect the peri-wound skin prior to dressing application.
6. 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).

7. Remove one side of the film at a time, smoothing the dressing in place from bottom to top.

8. Remove gloves and wash hands.

9. Replace the dressing every 3 days or if soiled under the dressing.

10. 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.

11. Pull the dressing back every shift to assess the skin and then smooth the dressing back into place.

Revised by: B. Hahler, MSN, RN, CWOCN, 9/26/2019

Approved:
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References:

1. Clarke B. (2013). Positive patient outcomes: The use of a new silicone adhesive hydrocellular foam dressing for pressure ulcer prevention and treatment. WOCN 2013.
2. 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.
3. Smith & Nephew data on file report DS/12/125/DOF. Impact protection properties of ALLEVYN Life, MepilexTM Border and BiatainTM Silicone. Daubney L; June 2012.
4. Wound, Ostomy, Continence Nurse Society (2016). Guideline for prevention and management of pressure ulcers (injuries). WOCN clinical practice guideline series 2. Mt. Laurel, NJ.