Ordering Information

Silver / Antimicrobial

Proximel Ag

Order no.	Product name	Size	Pcs/ Pack	Pcks/ Case
15100000	Proximel® Ag	3" x 3"	10	6
15200000	Proximel® Ag	4" x 4"	10	6
15300000	Proximel® Ag	6" x 6"	5	10
15400000	Proximel® Ag	4" x 12"	5	6
15500000	Proximel® Ag	Sacrum	5	10

ColActive Plus Ag

Order no.	Product name	Size	Pcs/ Pack	Pcks/ Case
10330000	ColActive® Plus Ag	2" x 2"	10	10
10340000	Colactive® Plus Ag	4" x 4"	10	10

Sorbalgon Ag

Order no.	Product name	Size	Pcs/ Pack	Pcks/ Case
999609	Sorbalgon® Ag	1" x 12"	5	1
999610	Sorbalgon® Ag	6" x 6"	5	1
999611	Sorbalgon® Ag	4" x 4"	10	1
999612	Sorbalgon® Ag	2" x 2"	10	1

Foam Dressings

Proximel

Order no.	Product name	Size	Pcs/ Pack	Pcks/ Case
14100000	Proximel®	3" x 3"	10	6
14200000	Proximel®	4" x 4"	10	6
14300000	Proximel®	5" x 5"	10	6
14400000	Proximel®	6" x 6"	5	10
14500000	Proximel®	4" x 12"	5	6
14600000	Proximel®	Sm. Sacrum	5	10
14700000	Proximel®	Lg. Sacrum	5	10
14800000	Proximel®	Heel	5	6

PermaFoam

Order no.	Product name	Size	Pcs/ Pack	Pcks/ Case
409427	PermaFoam®	2.5" Round	10	1
409401	PermaFoam®	4" x 4"	10	1
409402	PermaFoam®	4" x 5"	10	1
409405	PermaFoam®	6" x 6"	5	1
409406	PermaFoam®	8" x 8"	3	1
409425	PermaFoam®	4" x 4" Cavity	3	1
409426	PermaFoam®	3.2" x 3.2" Trach	10	1

PermaFoam Comfort

Order no.	Product name	Size	Pcs/ Pack	Pcks/ Case
409408	PermaFoam® Comfort	4.3" x 4.3"	10	1
409412	PermaFoam® Comfort	6" x 6"	5	1
409413	PermaFoam® Comfort	8" x 8"	3	1
409422	PermaFoam® Comfort	7" x 7" Sacral	3	1
409424	PermaFoam® Comfort	6.5"x 7" Concave	3	1

Collagens

ColActive Plus

Order no.	Product name	Size	Pcs/ Pack	Pcks/ Case
10160000	ColActive® Plus	2" x 2"	10	10
10180000	Colactive® Plus	4" x 4"	10	10

Alginates

Sorbalgon

Order no.	Product name	Size	Pcs/ Pack	Pcks/ Case
49200000	Sorbalgon®	2" x 2"	10	1
49210000	Sorbalgon®	4" x 4"	10	1
49230000	Sorbalgon®	4" x 8"	5	1

Hydrocolloids

Flexicol

Order no.	Product name	Size	Pcs/ Pack	Pcks/ Case
48600000	FlexiCol®	2" x 2"	20	1
48610000	FlexiCol®	4" x 4"	10	1
48620000	FlexiCol®	6" x 7" Sacral	5	1
48630000	FlexiCol®	3.5" x 4.75" Concave	10	1
48640000	FlexiCol®	4'' x 4'' Thin	10	1
48660000	FlexiCol®	6" x 6"	5	1

Film Dressings

Hydrofilm

Order no.	Product name	Size	Pcs/ Pack	Pcks/ Case
685755	Hydrofilm®	2.4" x 2.75"	10	1
685756	Hydrofilm®	2.4" x 2.75"	100	1
685757	Hydrofilm®	4" x 5"	10	1
685758	Hydrofilm®	4" x 5"	100	1
685759	Hydrofilm®	4" x 6"	10	1
685760	Hydrofilm®	4" x 6"	50	1
685761	Hydrofilm®	6" x 8"	10	1
685762	Hydrofilm®	6" x 8"	50	1
685765	Hydrofilm®	8" x 12"	10	1

Hydrofilm Plus

Order no.	Product name	Size	Pcs/ Pack	Pcks/ Case
685770	Hydrofilm® Plus	2" x 2.8"	5	1
685771	Hydrofilm® Plus	2" x 2.8"	50	1
685772	Hydrofilm® Plus	3.5" x 4"	5	1
685773	Hydrofilm® Plus	3.5" x 4"	50	1
685774	Hydrofilm® Plus	3.5" x 6"	5	1
685775	Hydrofilm® Plus	3.5" x 6"	25	1

To learn more about our products or to place an order contact HARTMANN at 1-800-243-2294 or visit hartmannusa.com

For over 200 years, HARTMANN has been delivering effective and scientifically verified solutions to medical communities around the world. HARTMANN's Prevention & Treatment Guidelines were developed through a collaboration with multi-disciplinary expert wound management professionals and is an example of HARTMANN's continuous commitment to providing cost effective solutions to improve treatment and care.

HARTMANN USA, Inc.
Rock Hill, SC 29730
1-800-243-2294

hartmannusa.com

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HARTMANN

Going further for health

Wound Management

HARTMANN

Prevention & Treatment Guidelines

Pressure Ulcers

6 Steps for Pressure Injury Prevention

1 Take Initiative
The first step to making a facility-wide impact on pressure injury prevention is to work with key staff to **follow a prevention program.**

2 Identify Risk Factors & Interventions
Assess and identify at-risk individuals using a validated assessment tool, such as the Braden Risk Assessment Scale. **Implement specific prevention interventions** based on the assessment.

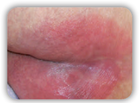
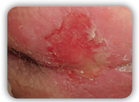
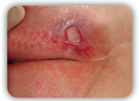
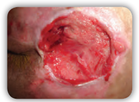
3 Cleanse and Moisturize
Use gentle, pH-balanced products to **moisturize skin** and protectants to mitigate the impact of moisture-associated skin damage (MASD).

4 Maintain Nutrition
Encourage **adequate fluids** and a **balanced diet.** Consider **nutritional supplements** as needed to help ensure skin integrity.

5 Turn and Reposition
Regularly turn and reposition immobile or at-risk individuals.

6 Apply Prophylactic Foam
Place **foam dressings** on the **sacrum, heels and under medical devices** to prevent friction and injury.

Treating Pressure Injuries / Ulcers

	What You See	How it Looks	What to Do	What to Use
Deep Tissue Injury (DTI)	Discolored, intact skin due to damage of underlying soft tissue. Usually a purple or maroon hue.		• **Eliminate pressure** • **Protect intact skin** • **Re-stage once wound opens**	• **Skin protectant** • **Foam dressing**
Stage 1	Intact skin with a localized area of non-blanchable erythema. May appear differently in darkly pigmented skin.		• **Eliminate pressure** • **Protect intact skin**	• **Skin protectant** • **Foam dressing**
Stage 2	Partial thickness skin loss of dermis presenting with a shallow, open area and red-pink wound bed. Slough/eschar is not present.		• **Eliminate pressure** • **Cleanse skin regularly** • **Protect open area** • **Manage drainage**	• **Barrier cream** • **Hydrocolloid** • **Foam Dressing**
Stage 3	Full thickness tissue loss involving damage to subcutaneous tissue. Bone, tendon or muscle is not visible. Slough/Eschar may be present in wound bed.		• **Eliminate pressure** • **Debride, if indicated** • **Manage drainage** • **Fill wound depth**	• **No/Small Drainage** Hydrocolloid • **Moderate/Heavy Drainage** Foam dressing/Alginate • **Non-Healing/Infection** Silver/Antimicrobial
Stage 4	Full thickness tissue loss with exposed bone, tendon, muscle. Slough/Eschar may be present in wound bed.		• **Eliminate pressure** • **Debride, if indicated** • **Manage drainage** • **Protect open area** • **Fill wound depth**	• **No/Small Drainage** Hydrocolloid • **Moderate/Heavy Drainage** Foam dressing/Alginate • **Non-Healing/Infection** Silver/Antimicrobial
Unstageable	Surface of wound is covered with slough or eschar. Wound cannot be staged until necrotic tissue is removed.		• **Eliminate pressure** • **Debride slough/eschar (do not debride intact heels)** • **Manage drainage** • **Fill wound depth**	• **Autolytic Debridement** Hydrocolloid Foam for drainage Alginate for drainage

Assessment, Treatments & Principles of Wound Bed Preparation (T.I.M.E.)

Wound Assessment & Documentation Checklist

1 Type
Pressure, arterial, venous, diabetic, other

2 Location
Anatomical site and directional terms (right, left, medial, distal)

3 Stage
Classify severity of wound based on wound type

4 Size
Length, width and depth in cm

5 Exudate
Type, color, odor, amount (minimal, moderate, heavy)

6 Pain
Location, severity, frequency, treatment, effectiveness of treatment

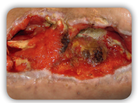
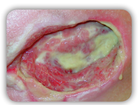
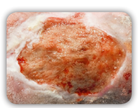
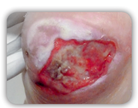
7 Wound Bed
Tissue type (epithelial, granulation, slough, eschar)

8 Tunneling & Undermining
Using clock method

9 Periwound
Wound edges and surrounding tissue

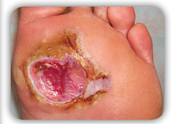
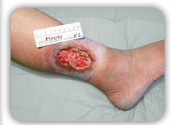
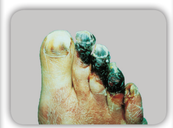
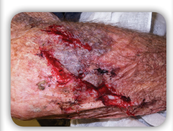
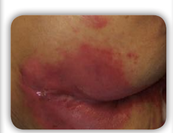
Treat What You See & T.I.M.E.

Carefully measure and document the characteristics of the wound and surrounding tissue. Select your dressing based on the Wound Assessment.

	What You See	How it Looks	What to Do	What to Use
T **Tissue Non-Viable**	• Necrotic tissue (slough or eschar present) • Pain symptoms • Depth		• **Remove necrotic tissue** autolytic debridement • **Cleanse the wound** • **Assess pain** Apply comfortable dressings • **Determine depth:** Fill wound depth	• **Autolytic Debridement** Hydrocolloid Foam dressing Alginate
I **Inflammation or Infection**	• High bacterial counts • Increased level of exudate/drainage • Delayed healing • Odor		• **Reduce bioburden** • **Cleanse wound gently and thoroughly** • **Apply antimicrobials** • **Maintain moisture balance:** Absorb heavy drainage Donate moisture to dry wound	• **Moderate/Heavy Drainage** Foam dressing Alginate • **Non-Healing/Infection** Silver/Antimicrobial
M **Moisture Imbalance**	• Heavy exudate/drainage • Excess moisture and risk of maceration • Dry wound bed		• **Identify type of exudate** • **Maintain moisture balance** Absorb heavy drainage Donate moisture to dry wound	• **No/Small Drainage** Hydrocolloid • **Moderate/Heavy Drainage** Foam dressing Alginate • **Non-Healing/Infection** Silver/Antimicrobial
E **Edge of Wound**	• Prolonged inflammation • Chronic wound • Stalled Healing • Undermining		• **Identify cause & appropriate treatment intervention** • **Maintain moisture balance** Absorb heavy drainage Donate moisture to dry wound	• **No/Small Drainage** Hydrocolloid • **Moderate/Heavy Drainage** Foam dressing Alginate • **Non-Healing/Infection** Collagen Silver/Antimicrobial

Other Wound Types

Types of Chronic & Acute Wounds and Treatments

	What You See	How it Looks	What to Do	What to Use
Diabetic Foot Ulcer	A complication of diabetic mellitus and peripheral neuropathy. Commonly occuring on areas of the foot subjected to repetitive pressure/friction such as the plantar aspect and over metatarsal heads of the foot. Large calloused areas may occur.		• **Control diabetic condition** • **Document perfusion status** • **Prevent trauma** • **Debride only with physician's order** • **Fill wound depth** • **Maintain moist wound bed** • **Offload plantar surface of foot** REFER TO TREAT WHAT YOU SEE & T.I.M.E.	• **Moderate/Heavy Drainage** Foam dressing Alginate • **Non-Healing/Infection** Silver/Antimicrobial
Venous Leg Ulcer	Caused by peripheral venous disease. Most commonly occurs proximal to medial malleolus, above inner ankle or on the lower calf.		• **Confirm diagnosis with physician** • **Document perfusion status** • **Obtain order for compression** • **Elevate legs as possible** • **Maintain moist wound bed** REFER TO TREAT WHAT YOU SEE & T.I.M.E.	• **No/Small Drainage** Hydrocolloid Apply compression as ordered • **Moderate/Heavy Drainage** Foam dressing Alginate Apply compression as ordered • **Non-Healing/Infection** Silver/Antimicrobial Apply compression as ordered
Arterial Ulcer	Caused by peripheral arterial disease. Commonly occurs on the tip and top of the toe, top of the foot or distal to the medial malleolus.		• **Confirm diagnosis with physician** • **Document perfusion status** • **Debride only with physician's order** • **Legs dependent** • **Maintain moist wound bed** • **Keep uninfected necrotic wound dry** • **Refer dry wound immediately if infection identified** • **No occlusive dressings** REFER TO TREAT WHAT YOU SEE & T.I.M.E.	• **No/Small drainage** Foam dressing non-occlusive Alginate non-occlusive
Skin Tear	Caused by shear, friction and/or blunt force resulting in separation of skin layers. A skin tear can be partial-thickness or full-thickness tissue loss. **Skin Tear Classifications** (ISTAP) • **Type 1** - No Skin Loss • **Type 2** - Partial Flap Loss • **Type 3** – Total Flap Loss		• **Control bleeding** • **Cleanse and prevent infection** • **Realign the skin flap** • **Cover and protect** • **Tetanus immunoglobulin (TIG) per policy** REFER TO TREAT WHAT YOU SEE & T.I.M.E.	• **Foam dressing** • **Alginate** ***Hydrocolloid, transparent films and closure strips are NOT recommended**
Moisture Associated Skin Damage (MASD)	Skin damage caused by sustained exposure to moisture from incontinence, wound exudate and perspiration.		• **Identify and remove cause** • **Cleanse and protect area** • **Apply barrier cream, lotion** REFER TO TREAT WHAT YOU SEE & T.I.M.E.	• **Cleansing lotions** • **Barrier creams** • **Incontinence briefs**