Sage Products LLC believes that evidence-based interventions lead to improved clinical outcomes. Our market-leading, innovative products solve real problems in the healthcare industry and are backed by proven clinical evidence. They make it easier for nurses to deliver essential patient care, helping to prevent healthcare-acquired infections and skin breakdown.
Pressure Ulcer Prevention

Comfort Shield® Barrier Cream Cloths
Prevalon® Heel Protector
Prevalon™ Turn & Position System
Prevalon™ Seated Positioning System

Simple Interventions. Extraordinary Outcomes.
Incontinence-Associated Dermatitis (IAD): a risk factor for pressure ulcers

IAD is defined as “an inflammation of the skin that occurs when urine or stool comes into contact with perineal or perigenital skin.” IAD is also a major risk factor for pressure ulcers.

IAD is often grouped with pressure ulcers, but they are not one and the same. A pressure ulcer is defined as “any lesion caused by unrelieved pressure resulting in damage of underlying tissue.” Essentially, skin damage from a pressure ulcer occurs from the inside out, but IAD starts on the surface and works inward. Therefore, “IAD should be distinguished from wounds caused by differing etiologies, such as full-thickness wounds (caused by pressure and shear) or linear lesions (caused by a skin tear).”

IAD risk factors:
- Fecal incontinence
- Frequency of incontinence
- Poor skin condition
- Pain
- Poor skin oxygenation
- Fever
- Compromised mobility
- Double (urinary and fecal) incontinence
- Tissue tolerance impairments
- Moisture
- Alkaline pH

REFERENCES:
IAD prevalence

Studies at long-term care facilities show IAD prevalence can range from 5.6% to 50%, while incidence rates range from 3.4% to 25%. In acute care, one 976-patient study found 20.3% of patients were incontinent. IAD prevalence for incontinent patients was 54% at three hospitals, affecting 11% of the general patient population.

“...Patients with fecal incontinence were 22 times more likely to have pressure ulcers than patients without fecal incontinence.”

“...The odds of having a pressure ulcer were 37.5 times greater in patients who had both impaired mobility and fecal incontinence than in patients who had neither.”
Inadequate barrier application: a gateway to Incontinence-Associated Dermatitis (IAD)

Multiple steps associated with traditional methods of incontinence care often mean barrier application is overlooked. Protecting the skin of incontinent patients is just as important as cleansing and moisturizing, and failure to apply a proper barrier can lead to Incontinence-Associated Dermatitis (IAD), a known risk factor for pressure ulcers.

One study shows 54% of incontinent patients suffered from IAD, while 21% had two or more peri-skin injuries.

Barriers severely underutilized
Compliance to a comprehensive protocol can help prevent skin injuries. But tubed barriers can make compliance difficult.

- A study of 76 protocols found barriers should cost 23.5 cents for each application, but facilities actually spend only 10 cents per day per incontinent patient.

REFERENCES:
Comfort Shield® Barrier Cream Cloths deliver proven IAD prevention and treatment

Comfort Shield Barrier Cream Cloths provide easy, all-in-one incontinence care. Each premoistened, disposable cloth delivers one-step perineal cleansing, moisturizing and deodorizing—all while treating and protecting skin with 3% dimethicone. The barrier is in the cloth, so you can be assured it is applied every time. Plus, our Peri Check™ Guide helps promote early identification of IAD through increased communication with staff.

One-step:
Clean + treat + protect

Shield Barrier Cream Cloths are soft, skin-friendly and guarantee barrier application every time they’re used. Keeping the skin protected means IAD and other skin problems can be prevented.

PROVEN IAD TREATMENT—SEE THE DIFFERENCE!

DAY 1
72-year-old patient with severely denuded, blistered skin and extreme pain from incontinence.

DAY 4
After only 3 days using Shield Barrier Cream Cloths, patient’s skin vastly improved; no discomfort.

REFERENCES: 1. Sluser S, Consistency the key for treating severe perineal dermatitis due to incontinence. Poster presented at Clinical Symposium on Advances in Skin and Wound Care (ASWC), Las Vegas, NV, 2005 Oct.
PROFESSIONAL GUIDELINES

2009 EUROPEAN PRESSURE ULCER ADVISORY PANEL AND NATIONAL PRESSURE ULCER ADVISORY PANEL¹
Prevention and Treatment of Pressure Ulcers

Skin Care

12. “Protect the skin from exposure to excessive moisture with a barrier product in order to reduce the risk of pressure damage.”

GLOBAL IAD EXPERT PANEL²
Prevention and Management of IAD

“After cleansing, skin should be protected to prevent IAD”.

“The performance of an individual product is determined by the total formulation and not just the skin protecting ingredient(s)”.

“Continence care wipes (i.e. 3-in-1 products) may have the advantage of simplifying care by combining products to reduce the number of steps involved, saving clinician/caregiver time and potentially encouraging adherence to the regimen”.

“A skin cleanser with a pH range similar to normal skin is preferred over traditional soaps”.

2010 WOCN GUIDELINE FOR PREVENTION AND MANAGEMENT OF PRESSURE ULCERS MANAGING INCONTINENCE³

“Combined products can be used to save time and make providing perineal care easier for the care giver. Combined products include moisturizing cleansers, moisturizer skin protectant creams, and disposable washcloths that incorporate cleansers, moisturizers, and skin protectants into a single product.” (Beeckman, et al., 2009)

REFERENCES:

Randomized controlled trial proves effectiveness

A 4-month study of 464 nursing home residents evaluated use of Shield Barrier Cream Cloths versus water and pH neutral soap. Residents using Shield saw a reduction in the prevalence of IAD from 22% to 8%, while residents using soap and water saw IAD prevalence increase from 23% to 27%. The study also found a decrease in IAD severity in residents using Shield, while no improvement was seen with soap and water.⁴

A UK study found a 54% reduction in IAD after implementing the Shield Barrier Cream Cloths.⁵

A German study found a 57% reduction in IAD after implementing the Shield Barrier Cream Cloths.⁶

Proven clinical outcomes

In a study on a high-risk patient population, patients receiving an intervention that included Shield Barrier Cream Cloths following each incontinence episode had an IAD rate of zero versus patients using multiple products who had an IAD rate of 25%. Patients using Shield had a rate of zero hospital-acquired pressure ulcers versus a rate of 83% for those using multiple products.⁷

DEVELOPMENT OF IAD AND HAPU

Control Group

Intervention Group

624 524

0/25 0/25

63% of patients who developed IAD went on to develop HAPU
Comfort Shield®
Barrier Cream Cloths
with Dimethicone

Clinically proven to help prevent IAD and HAPU when used as part of a standardized incontinence cleanup intervention/protocol.

The all-in-one skin cleansing, moisturizing, deodorizing, treatment and barrier protection with ever use that helps maximize compliance to incontinence care protocols.

- Proven barrier protection. 3% dimethicone formula was proven equivalent to traditional tube barrier creams by Northwestern University’s Department of Dermatology.¹
- Hypoallergenic, gentle and non-irritating.
- Breathable, transparent dimethicone barrier makes skin assessment easy.
- Allows the use of other products such as anti-fungals without removing dimethicone barrier.
- Helps eliminate mess of standard zinc oxide and petroleum-based barriers; makes each cleanup easier.
- Helps treat and prevent perineal dermatitis; helps seal out wetness.
- Convenient tubs contain 24 cloths for extended use.

Not all skin barrier cloths are equal

A study designed to test the effectiveness of incontinence barriers found that Comfort Shield “significantly outperformed all other products.” Comfort Shield allowed 3-5 times less artificial urine to pass through than the leading competitors.²

Barrier effectiveness and product performance characteristics should be considered when choosing skin protectant products designed for barrier effect.

REFERENCES:
Maximize compliance
Help meet IHI recommendations to keep supplies at the bedside of at-risk incontinent patients

Implementing Shield Barrier Cream Cloths and providing bedside access enhanced staff compliance to an incontinence care protocol and resulted in a near-zero rate of HAPUs. The rate was maintained over time and resulted in significant cost savings. Point-of-use access. 24-packs, 8-pack, and 3-pack all compatible with Shield Barrier Station.

REFERENCES:

REDUCE IAD, IMPROVE COMPLIANCE
Adding Shield Barrier Station reduced one facility’s IAD incidence to 0% and boosted compliance to 97%!

Peri Check™ Guide
Promote early identification of a major pressure ulcer risk factor

Comfort Shield® Barrier Cream Cloths feature Peri Check Guide peel-and-stick labels to facilitate daily skin inspection. They empower staff to observe and report skin issues to the patient’s nurse, and promote rapid response through early identification of skin breakdown and Incontinence-Associated Dermatitis (IAD), a known risk factor for pressure ulcers.

In one study, Peri Check helped reduce pressure ulcers to zero in a facility. The same study found that Peri Check improved non-licensed staff’s knowledge about pressure ulcer development and "resulted in enhanced communication between non-licensed staff and RNs.”

2009 EUROPEAN PRESSURE ULCER ADVISORY PANEL AND NATIONAL PRESSURE ULCER ADVISORY PANEL
Prevention and Treatment of Pressure Ulcers

Skin Assessment
3. “Inspect skin regularly for signs of redness in individuals identified as being at risk of pressure ulceration.”
7. "Document all skin assessments, noting details of any pain possibly related to pressure damage.”

JOINT COMMISSION 2009 National Patient Safety Goals

Improve Staff Communication
“Create steps for staff to follow when sending patients to the next caregiver. The steps should help staff tell about the patient’s care. Make sure there is time to ask and answer questions.”
* Excerpts from the Joint Commission 2009 Hosp Nat Pt Safety Goals.

IHI 5 MILLION LIVES CAMPAIGN

2. Reassess Risk for All Patients Daily
"Adapt documentation tools to prompt daily risk assessment, documentation of findings, and initiation of prevention strategies as needed.”

3. Inspect Skin Daily
“Educate all levels of staff to inspect the skin any time they are assisting the patient … Upon recognition of any change in skin integrity, notify staff so that appropriate interventions can be put in place.”
*Processes that “can be put in place to ensure daily inspection of the skin.”

LET US HELP YOU VALIDATE YOUR SUCCESS!

Create awareness of patient skin condition and facilitate clinical intervention.

Damage from moisture and pressure ulcers are among the most common skin injuries. However, a large percentage of these injuries can be avoided. Your Sage Representative will provide a brief, yet thorough Incontinence-Associated Dermatitis (IAD) Assessment in your facility to help you:

- Identify skin issues at the two most common sites for pressure ulcers: the heels and the sacrum.
- Track your facility’s prevalence rate of IAD, a risk factor for pressure ulcers.
- Improve awareness of your facility’s compliance to protocol.
- Target effective interventions, which may improve patient outcomes.
- Illustrate the benefits of using Sage’s skin-protecting interventions both clinically and financially.

IAD Assessment Tool
For monitoring and evaluating patient skin injury

Create awareness of patient skin condition and facilitate clinical intervention.

Damage from moisture and pressure ulcers are among the most common skin injuries. However, a large percentage of these injuries can be avoided.

Your Sage Representative will provide a brief, yet thorough Incontinence-Associated Dermatitis (IAD) Assessment in your facility to help you:

- Identify skin issues at the two most common sites for pressure ulcers: the heels and the sacrum.
- Track your facility’s prevalence rate of IAD, a risk factor for pressure ulcers.
- Improve awareness of your facility’s compliance to protocol.
- Target effective interventions, which may improve patient outcomes.
- Illustrate the benefits of using Sage’s skin-protecting interventions both clinically and financially.

IAD Assessment Tool
For monitoring and evaluating patient skin injury

Create awareness of patient skin condition and facilitate clinical intervention.

Damage from moisture and pressure ulcers are among the most common skin injuries. However, a large percentage of these injuries can be avoided.

Your Sage Representative will provide a brief, yet thorough Incontinence-Associated Dermatitis (IAD) Assessment in your facility to help you:

- Identify skin issues at the two most common sites for pressure ulcers: the heels and the sacrum.
- Track your facility’s prevalence rate of IAD, a risk factor for pressure ulcers.
- Improve awareness of your facility’s compliance to protocol.
- Target effective interventions, which may improve patient outcomes.
- Illustrate the benefits of using Sage’s skin-protecting interventions both clinically and financially.

REFERENCES:
2. MacPherson SAWC 2011

One facility saw a 53% decrease in IAD over a 10-month period after implementing an IAD Prevention Strategy including the use of Comfort Shield® Barrier Cream Cleansing Cloths at the bedside.

Request additional clinical outcomes.

Protect YOUR patients’ skin before skin injury develops into a pressure ulcer.

- Incontinence is a significant risk factor for skin breakdown, such as pressure ulcers and incontinence-associated dermatitis (IAD). Applying a barrier after each episode with Comfort Shield® Barrier Cream Cloths can help prevent these conditions.
## INCONTINENCE-ASSOCIATED DERMATITIS INTERVENTION TOOL (IAD-IT)

### Skin Care for Incontinent Persons
The #1 priority is to address the cause of incontinence. Use this tool until incontinence is resolved.

<table>
<thead>
<tr>
<th>DEFINITION</th>
<th>INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIGHERISK</strong></td>
<td>Skin is not erythematous or warmer than nearby skin but may show scars or color changes from previous IAD episodes and/or healed pressure ulcer(s). Person not able to adequately care for self or communicate need and is incontinent of liquid stool at least 3 times in 24 hours.</td>
</tr>
<tr>
<td>1. Use a disposable barrier cloth containing cleanser, moisturizer and protector.</td>
<td></td>
</tr>
<tr>
<td>2. If barrier cloths not available, use acidic cleanser (6.5 or lower), not soap (soap is too alkaline); cleanse gently (soak for a minute or two – no scrubbing); and apply a protector (e.g. dimethicone, liquid skin barrier or petrolatum).</td>
<td></td>
</tr>
<tr>
<td>3. If briefs or underpads are used, allow skin to be exposed to air. Use containment briefs only for sitting in chair or ambulating – not while in bed.</td>
<td></td>
</tr>
<tr>
<td><strong>EARLY IAD</strong></td>
<td>Skin exposed to stool and/or urine is dry, intact, and not blistered, but is pink or red with diffuse (not sharply defined), often irregular borders. In darker skin tones, it might be more difficult to visualize color changes (white or yellow color) and palpation may be more useful. Palpation may reveal a warmer temperature compared to skin not exposed. People with adequate sensation and the ability to communicate may complain of burning, stinging, or other pain.</td>
</tr>
<tr>
<td>4. Manage the cause of incontinence: a) Determine why the patient is incontinent. Check for urinary tract infection. b) Consider timed toileting or a bladder or bowel program. c) Refer to incontinence specialist if no success.</td>
<td></td>
</tr>
<tr>
<td><strong>MEDIUM IAD</strong></td>
<td>Affected skin is bright or angry red – in darker skin tones, it may appear white, yellow, or very dark red/purple. Skin usually appears shiny and moist with weeping or pinpoint areas of bleeding. Raised areas or small blisters may be noted. Small areas of skin loss (dime size) if any. This is painful whether or not the person can communicate the pain.</td>
</tr>
<tr>
<td>5. Assess skin folds, including under breasts, under pannus, and in groin.</td>
<td></td>
</tr>
<tr>
<td>6. If no improvement, culture area for possible bacterial infection.</td>
<td></td>
</tr>
<tr>
<td>7. If using zinc oxide paste, do not scrub the paste completely off with the next cleaning. Gently soak stool off top then apply new paste covered dressing to area.</td>
<td></td>
</tr>
<tr>
<td>8. If denuded areas remain to be healed after inflammation is reduced, consider BTC ointment (balsam of peru, trypsin, castor oil) but remember balsam of peru is pro-inflammatory.</td>
<td></td>
</tr>
<tr>
<td>9. Consult WOCN if available.</td>
<td></td>
</tr>
<tr>
<td><strong>SEVERE IAD</strong></td>
<td>Affected skin is red with areas of denudement (partial-thickness skin loss) and oozing/bleeding. In dark-skinned persons, the skin tones may be white, yellow, or very dark red/purple. Skin layers may be stripped off as the oozing protein is sticky and adheres to any dry surface.</td>
</tr>
<tr>
<td>10. Position the person semiprone for 30 minutes twice a day to expose affected skin to air.</td>
<td></td>
</tr>
<tr>
<td>11. Consider treatments that reduce moisture: low air loss mattress/overlay, more frequent turning, astringents such as Domeboro soaks.</td>
<td></td>
</tr>
<tr>
<td>12. Consider the air flow type underpads (without plastic backing).</td>
<td></td>
</tr>
<tr>
<td><strong>FUNGAL APPEARING RASH</strong></td>
<td>This may occur in addition to any level of IAD skin injury. Usually spots are noted near edges of red areas (white or yellow areas in dark skinned patients) that may appear as pimples or just flat red (white or yellow) spots. Person may report itching which may be intense.</td>
</tr>
<tr>
<td>Ask primary care provider to order an anti-fungal powder or ointment. Avoid creams in the case of IAD because they add moisture to a moisture damaged area (main ingredient is water). In order to avoid resistant fungus, use zinc oxide and exposure to air as the first intervention for fungal-appearing rashes. If this is not successful after a few days, or if the person is severely immunocompromised, then proceed with the following: 1. If using powder, lightly dust powder to affected areas. Seal with ointment or liquid skin barrier to prevent caking. 2. Continue the treatments based on the level of IAD. 3. Assess for thrush (oral fungal infection) and ask for treatment if present. 4. For women with fungal rash, ask health care provider to evaluate for vaginal fungal infection and ask for treatment if needed. 5. Assess skin folds, including under breasts, under pannus, and in groin. 6. If no improvement, culture area for possible bacterial infection.</td>
<td></td>
</tr>
</tbody>
</table>
PREVALENCE AND COST

The heel and ankle bone are the second and fifth most common sites for pressure ulcer development. One study found 43% of hospital-acquired pressure ulcers (HAPUs) developed on the heel. But, HAPUs are largely preventable.

HUMAN COST

- Pain
- Length of stay
- Infection risk
- Amputation

FINANCIAL COST:

<table>
<thead>
<tr>
<th>PU Stage</th>
<th>Treatment Cost £</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1,000</td>
</tr>
<tr>
<td>II</td>
<td>6,000</td>
</tr>
<tr>
<td>III</td>
<td>10,000</td>
</tr>
<tr>
<td>IV</td>
<td>14,000</td>
</tr>
</tbody>
</table>

A published study recommended patients be treated with a heel-suspending device after a minimum of 6 hours of immobility and within 24 hours of immobility to prevent plantar-flexion contractures.

REFERENCES:
2. Walsh J, DeOcampo M, Waggoner D, Poster presented at the Symposium on Advanced Wound Care, San Antonio, TX, Apr 2006.
The experts suggest the optimal heel protector should:

- Elevate the heel off underlying support surface.¹
- Prevent foot-drop and rotation of the leg.¹
- Maintain “grip” on the foot while in place as patients may be moving the leg.¹
- Decrease friction and/or shear.¹
- Heel is visible when the device is in place.³
- No pressure on the Achilles tendon.³
- Ability to accommodate sequential compression devices, negative pressure wound therapy, tubing, traction and other essential devices.³
- Has straps that do not damage skin and are loosely applied to avoid pressure on dorsum and lateral edge of foot and the lower leg.³
- Remains in place without causing pressure to other foot surfaces.²
- A device with an anti-rotation wedge maintaining neutral position of the lower extremity to prevent hip external rotation and subsequent lateral knee and/or malleoli pressure ulcers and/or peroneal nerve compression.³
The foundation of an effective heel protector: its ability to grip the limb

Prevalon® Heel Protector was specifically designed to address the problem of patient movement and its negative effect on heel offloading. Prevalon’s unique dermasuede fabric interior gently grips the limb so it remains fully offloaded, even when the patient is moving.

Our specialized fabric and coating creates maximum grip control with the texture of fine velvet. This soft fabric contours to and cradles the leg, calf, ankle and foot to help prevent them from rotating within the boot or sliding out of the boot—maintaining effective heel offloading.

Dermasuede fabric holds the limb securely in place while preserving patient comfort. It’s also a breathable material, so the limb remains cool while inside the heel protector.

Prevalon’s unique dermasuede interior gently grips the foot

Several published studies show that a heel protector must stay in place on the foot and maintain offloading for effective prevention of heel pressure ulcers.

- A recent poster presented at the Symposium on Advanced Wound Care concluded “as patients shift, the ability of a heel protecting boot to grip the limb and retain optimal off-loading positioning is vital to the function of the device.” Furthermore, the study found evaluation of the heel protector’s grip is necessary for determining effectiveness in reducing risk of heel pressure ulcers.1

- One article found that a heel protector was “more effective in reducing heel PrU incidence if it did not dislodge during patient movement.”2

- According to another article, clinical considerations in selecting an optimal heel protector should include the device’s ability to remain in place while the patient is moving the leg.3

Prevalon’s dermasuede fabric contours to and gently cradles the leg, calf, ankle and foot to maintain effective heel offloading.

PUBLISHED STUDIES

Our specialized fabric and coating creates maximum grip control with the texture of fine velvet. This soft fabric contours to and cradles the leg, calf, ankle and foot to help prevent them from rotating within the boot or sliding out of the boot—maintaining effective heel offloading.

Dermasuede fabric holds the limb securely in place while preserving patient comfort. It’s also a breathable material, so the limb remains cool while inside the heel protector.

PREDVALON HEEL PROTECTORS’ ENHANCED ABILITY TO GRIP THE LIMB

Testing shows significantly more force is required to dislodge the Prevalon® Heel Protector from the limb than with other heel protectors.3

THREE HEEL PROTECTORS THAT EFFECTIVELY GRIP THE LIMB

PREVALON® HEEL PROTECTOR I
- Offloads the heel.

PREVALON® HEEL PROTECTOR II
- Offloads the heel.
- Reduces plantar flexion contracture risk.

PREVALON® HEEL PROTECTOR III
- Offloads the heel.
- Reduces plantar flexion contracture risk.
- Helps prevent lateral rotation, reducing risk of peroneal nerve damage.
PREVALON® HEEL PROTECTOR

FEATURES

**DERMASUEDE FABRIC INTERIOR**
- Gently grips limb so it remains fully offloaded even when patient is moving.

**LOW-FRICTION OUTER SHELL**
- Slides easily over bed sheets.
- Helps maintain patients’ freedom of movement.

**CLOSURE STRAPS**
- Secures Heel Protector I.

**VISIBLY FLOATS HEEL FOR EASY MONITORING**

**SCD COMPATIBLE**
**PREVALON® HEEL PROTECTOR**

**FEATURES**

- **DERMASUEDE FABRIC INTERIOR**
  - Gently grips limb so it remains fully offloaded even when patient is moving.

- **RIP-STOP NYLON**
  - Slides easily over bed sheets.
  - Helps maintain patients’ freedom of movement.

- **EXPANDABLE STRAPS**
  - Stretches to accommodate lower limb edema.
  - No sharp edges or irritating surfaces.

- **CONTRACTURE STRAP**
  - Helps prevent plantar flexion contracture.

- **VISIBLY FLOATS HEEL FOR EASY MONITORING**

- **SCD COMPATIBLE**
PREVALON® HEEL PROTECTOR

FEATURES

VISIBLY FLOATS HEEL FOR EASY MONITORING

DERMASUEDE FABRIC INTERIOR
- Gently grips limb so it remains fully offloaded even when patient is moving.

EXPANDABLE STRAPS
- Stretches to accommodate lower limb edema.
- No sharp edges or irritating surfaces.

SIZING CHART:

<table>
<thead>
<tr>
<th>Calf Circumference (cm.)</th>
<th>Prevalon® Heel Protector Petite</th>
<th>Prevalon® Heel Protector</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>15</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>18</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>20</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>23</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>25</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>28</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CONTRACTURE STRAP
• Helps prevent plantar flexion contracture.

INTEGRATED ANTI-ROTATION WEDGE
• Helps prevent lateral foot and leg rotation, reducing the risk of peroneal nerve damage.

RIP-STOP NYLON
• Slides easily over bed sheets.
• Helps maintain patients’ freedom of movement.

CLINICALLY VALIDATED
Supported by more peer-reviewed studies than all other brands combined.¹

PROVEN RESULTS: PREVENTION AND TREATMENT FROM THE #1 BRAND OF HEEL PROTECTION

Prevalon® brings you more proven clinical studies and financial outcomes than any other brand.

Heel ulcer reduction

- A study published in JWOCN found the use of Prevalon and a heel ulcer prevention protocol led to a 95% decrease in heel pressure ulcers.

- Another study published in JWOCN demonstrated a 100% prevention of both heel pressure ulcers and plantar flexion contracture over a seven month period when using the heel protector device.

- A UK study found the early utilisation of heel protectors has shown a reduction in the number of acquired heel pressure ulcers over the twelve month period and has resulted in an overall return on investment of £55,965.

- Another UK study found a sustained 67% reduction in stage III and IV pressure ulcers to the heels. This sustained reduction was observed despite increases in patient acuity within the Trust according to a robust skin assessment conducted on all patients on admission and throughout their hospital stay. These findings suggest the use of a heel protector aid in the reduction of heel pressure ulcer incidence. Use of the heel protectors rose from 448 devices in 2009 to 3,008 in 2014, resulting in a total return on investment of £272,505.

IN VITRO (‘TEST TUBE’) RESEARCH

SYSTEMATIC REVIEWS AND META-ANALYSES

RANDOMIZED CONTROLLED DOUBLE BLIND STUDIES

COHORT STUDIES

CASE CONTROL STUDIES

CASE SERIES

CASE REPORTS

IDEAS, EDITORIALS, OPINIONS

ANIMAL RESEARCH

IN VITRO (‘TEST TUBE’) RESEARCH

A history of innovation

Sage Products has constantly improved and refined our line of Prevalon Heel Protector. From a simple engineered pillow, to the innovative and effective heel protector it is today, Prevalon has helped prevent and treat against heel pressure ulcers and plantar flexion contracture as well as increase protocol compliance.

2004
Sage’s field-based research finds pillows and other products don’t float the heel properly and don’t effectively protect against heel pressure ulcers.

2005
Sage launches the first generation Prevalon Pressure-Relieving Heel Protector.

2006
Sage launches second generation Prevalon featuring ripstop nylon outer surface, tag to help visualize proper fit, bag with printed instructions, integrated stretch panels and the Foot and Leg Stabilizer Wedge to help prevent lateral rotation.

2007
Jill Walsh publishes Evaluation of a Protocol for Prevention of Facility-Acquired Heel Pressure Ulcers in JWOCN.

2008
Sage launches Prevalon Petite for smaller patients.

2008
Decision Tree presented at 2008 SAWC Conference, clarifying when to use a heel protector.

2009
NPUAP/EPJAP releases updated Pressure Ulcer Prevention & Treatment Clinical Practice Guideline.

2009
Sage launches Prevalon with Integrated Foot and Leg Stabilizer Wedge.


2010
Sage adds additional access ports to the Standard Size Prevalon to accommodate more Intermittent Compression Devices.

2014
Sage diversifies the product line with Prevalon Heel Protector I to accommodate a variety of patient needs.

REFERENCES:
1. GHX Market Intelligence Trend Report (Dollars), 3rd Quarter, 2009 Hospital Market; Annual market represents last 4 quarters of data.
Prevent sacral pressure ulcers and healthcare worker injury

Turning and repositioning patients according to your facility’s turning schedule is crucial in preventing sacral pressure ulcers. Current methods including draw sheets and pillows have multiple challenges that present risks to patients and staff.

The Prevalon™ Turn & Position System 2.0 is an evolution in turning and positioning safety. Unlike lift slings and plastic slide sheets, the Prevalon Turn & Position System 2.0 stays under the patient at all times. It’s always ready to assist with turning, repositioning, and boosting the patient. This makes it possible for nurses and staff to achieve compliance to a q2° turning protocol while providing the best care and minimizing additional stress on the patient.

Now with enhanced microturn, the system makes it easy to comply with turning schedules while protecting staff from injury. All that is necessary to position the patient at the appropriate angle is a quick microturn, which requires 90% less exertion than traditional methods using draw sheets.¹

The newly designed Glide Sheet and Anchor Wedge System work together, creating a high-quality turn. Once placed under the patient, the wedges help to initiate patient turning.

The Prevalon Turn & Position System 2.0 requires 90% less exertion to position patients vs. draw sheets.¹

Exertion (lbf • sec)

<table>
<thead>
<tr>
<th>Product</th>
<th>Exertion Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRAW SHEETS</td>
<td>299.3 lbf • sec</td>
</tr>
<tr>
<td>SAGE TAP 2.0</td>
<td>32.6 lbf • sec</td>
</tr>
</tbody>
</table>

Produced is 9.2x more 90% Less Exertion.
PREVALON™ TURN AND POSITION SYSTEM

Patient Benefits

- Helps prevent sacral pressure ulcers by offloading the sacrum.
- Maintains 30-degree side lying position.
- Helps prevent shear and friction forces on the patient’s skin.
- Manages moisture due to incontinence and other conditions.
- Creates an optimal microclimate for the skin.

Staff Benefits

- Nurse-friendly system helps staff more easily follow best practice prevention guidelines.
- Requires fewer nurses and less time to turn.
- Reduces exertion needed to turn and boost patients. Decreases strain on staff’s hands, wrists, shoulders, and backs.
- Proven compatibility with low air loss surfaces, meaning it can remain under the patient at all times, making it easier and more convenient for nurses to comply with a q2° turning protocol.
- Minimizes the frequency of boosting and other repetitive positioning tasks.

PROVEN RESULTS: PREVENTION AND COST SAVINGS

PROVEN RESULTS:

PREVENTION AND COST SAVINGS

84%
Sacral Pressure Ulcer Reduction

90%
Less Exertion

60%
Less Time

35%
Less Staff

Patient Benefits

n Helps prevent sacral pressure ulcers by offloading the sacrum.

n Maintains 30-degree side lying position.

n Helps prevent shear and friction forces on the patient’s skin.

n Manages moisture due to incontinence and other conditions.

n Creates an optimal microclimate for the skin.

Staff Benefits

n Nurse-friendly system helps staff more easily follow best practice prevention guidelines.

n Requires fewer nurses and less time to turn.

n Reduces exertion needed to turn and boost patients. Decreases strain on staff’s hands, wrists, shoulders, and backs.

n Proven compatibility with low air loss surfaces, meaning it can remain under the patient at all times, making it easier and more convenient for nurses to comply with a q2° turning protocol.

n Minimizes the frequency of boosting and other repetitive positioning tasks.

A study demonstrated that a safe patient handling initiative including the Prevalon® Heel Protector and Prevalon™ Turn & Position System can help ensure appropriate patient repositioning for HAPU prevention, prevent caregiver injuries, and save costs associated with HAPU and healthcare worker injury.

REFERENCES:

1. Testing conducted by Sage Products LLC, data on file.
Prevalon™ Turn & Position System
2.0

FEATURES

The Low-Friction Glide Sheet works with the Anchor Wedge System to provide true friction and shear protection.

The top of the Glide Sheet has Dermasuede material, which grips the M² Microclimate Body Pad and keeps it in place.

MINIMIZE FRICTION AND SHEAR

PROTECT STAFF

The boost straps promote proper body mechanics and reduce the reliance on grip strength.

LESS EXERTION

A quick, gentle microturn positions the patient at the appropriate angle.

REFERENCES:
The M2 Microclimate Body Pad protects the patient’s skin by effectively absorbing and locking in moisture while allowing air to flow through.

MANAGE MOISTURE

The Body Wedge System reduces pressure by offloading the patient’s sacrum. The system significantly reduces the exertion needed to achieve proper side lying positioning.

REDUCE PRESSURE

The Anchor Wedge helps the patient maintain a natural position when the head of the bed is raised. It also reduces the need for boosting and minimizes shear and friction.

The only device proven compatible with all low air loss mattresses

The M2 Microclimate Body Pad protects the patient’s skin by effectively absorbing and locking in moisture while allowing air to flow through.

240808-189-0456
Prevalon™ Turn & Position System
XL/XXL

The larger size Glide Sheet and Microclimate Body Pad accommodate bariatric patients.

FEATURES

- REDUCE PRESSURE
- MINIMIZE FRICTION AND SHEAR

The mattress cover secures to most extra-wide hospital beds and can be used in place of a fitted/flat hospital sheet to help reduce friction.

REFERENCES:

sage.UK@sageproducts.com
The larger size wedges redistribute pressure for bariatric patients.

Includes velcro strips that attach to Low-Friction Glide Sheet, locking Body Wedges in place under the patient.

**REDUCE PRESSURE**

The only device proven compatible with all low air loss mattresses¹
Bedside chair challenges

The health benefits of sitting in a bedside chair are well documented. However, there are several challenges that make it difficult to achieve this goal. Positioning patients in the bedside chair can put clinicians and patients at risk for injury. Boosting and repositioning can put clinicians at risk for musculoskeletal disorders (MSDs) which include back pain, sciatica and rotator cuff injuries.1 Once patients are in the chair, they may become uncomfortable and lack the confidence to stay seated.

Benefits of Mobility2-4

- Improved muscle strength
- Reduced oxidative stress
- Reduced inflammation
- Positive mood changes
- Less fatigue

Safe & Secure Sitting

Slouching can lead to discomfort and falls. The Prevalon™ Seated Positioning System helps patients maintain a secure, seated posture. This provides stability and helps minimize the risks associated with slouched sitting.

Safely glide patients to the upright position

The Prevalon™ Seated Positioning System makes it easier for clinicians to safely glide patients to an optimal upright-seated position without lifting. It is uniquely engineered to keep the seated patient in place, minimizing the need for repetitive boosting and repositioning. It is also comfortable for patients, which may improve their confidence and compliance to chair sitting.

Help Improve Safety

- **FORCE**—Patient is glided into position, not lifted
- **REPETITION**—Secures patient to minimize repetitive boosting and repositioning
- **POSTURE**—Promotes proper ergonomics and body mechanics while making it easy for nurses to reposition patient

Promote Comfort and Confidence

A recently published study found that nurses were more likely to use the Seated Positioning System over traditional efforts of pulling patients upright in chairs. The use of the Seated Positioning System:

- Enhanced nurses’ confidence in not hurting themselves
- Promoted greater compliance in following their facility’s repositioning and mobilizing patient protocols
- Provided a bundled approach that focused on preventing patient falls and pressure ulcers and reduced employee injuries

Staff benefits

- **Reduces Boosting**
  Innovative one-way glide resists forward movement, ensuring patients remain in the optimal position.
- **Promotes Proper Ergonomics**
  Multi-grip handles improve healthcare worker posture and body mechanics.

Patient benefits

- **Redistributes Pressure**
  Multi-chamber air cushion provides comfort and security while allowing patient to shift in chair.
- **Manages Moisture**
  Microclimate Management Pad is effectively absorbant to protect patients’ skin while allowing air to flow through.

REFERENCES:
Changing practice in healthcare involves significant effort and above all else—data. Evaluation is critical, but as a busy clinician or supply chain professional, you may not have resources to gather, analyze and report on your own.

We can help. CustomerOne is your expert resource for customized measurement and data analysis. Our exclusive team of professionals will generate comprehensive reports tailored to your specific requirements. Reports include:

- **Executive Outcome Summary**
  A true success story—it highlights a clinical intervention with a Sage product, including pre- and post-intervention data, clinical outcomes and return on investment.

- **Return on Investment Report**
  Measures the financial impact of positive clinical outcomes and the financial value in partnering with Sage.

- **Cost Analysis**
  Compares current process cost to a proposed Sage intervention while taking into account the cost of a hospital-acquired infection/wound. Includes a break even point or projected return on investment.

- **Clinical Outcome Report**
  Measures correlations of compliance to specific clinical protocols and the clinical outcomes achieved.

- **Protocol Compliance Report**
  Measures compliance to a specific clinical protocol.

CustomerOne professionals will support all of these areas and more. You’ll receive meaningful, actionable results that can be shared with core decision-makers across your facility—all to drive change.

Let us help validate your success!
To learn more about CustomerOne call 0808-189-0456
Help reduce SSIs by addressing multi-drug resistant organisms on your patient’s skin prior to surgery with 2% Chlorhexidine Gluconate Cloth.

Comfort Bath® Cleansing Washcloths eliminate the contamination risk from bath basins.

Provide comprehensive oral care with Q•Care® Oral Cleansing and Suctioning Systems.

Help reduce the risk of staff injury with the Prevalon™ Liftaem® Mobile Patient Transfer System.