

# TREAT WITH CONFIDENCE



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## HALYARD\* ADVANCED WOUND CARE: A LEGACY OF PROTECTION

Developing innovative, effective solutions that improve health and healthcare is O&M Halyard's purpose, and our passion.

Clinicians and decision-makers have long relied on O&M Halyard for infection control, sterile processing and surgical supplies. O&M Halyard offers a comprehensive portfolio of high-quality wound dressings that promote healing across the continuum of wound type and severity.

Based on clinical research and feedback, HALYARD\* Advanced Wound Care offers a clinically proven alternative with the potential to deliver value for healthcare systems and patients.

Proper assessment and prompt treatment with the right dressing are essential to speed wound healing, reduce complications and shorten length of stay. To that end, O&M Halyard provides not only solutions, but clinical support and industry-leading education.

### Our complete skin health portfolio addresses:

TRADITIONAL  
WOUND CARE



ADVANCED  
WOUND CARE



PRESSURE  
INJURY PREVENTION



INCONTINENCE



PATIENT CLEANSING



SKIN & OSTOMY CARE





Whether you are an accredited WOC nurse, or serve as your site's designated skin care champion, your aim is to achieve optimal clinical outcomes.

We understand that you expect clinically superior wound dressings indicated for all stages of wound type, depth and exudate. Dressings that stay in place, do not fall apart and are easy to identify and apply. Dressings that go beyond moisture control to actually promote healing.

In this, O&M Halyard is your trusted wound care partner, with the products, support and peace of mind you expect.

## Our value is derived from three fundamental strengths:



1. **Reliability.** We offer a consistent supply of products to avoid disruptions. Our distribution infrastructure and resources ensure that clinicians have the supplies they need without interruption.



2. **Standardization and efficiency.** We drive long-term cost savings despite increasing market complexities. We are expert at creating efficiencies through product standardization.



3. **Knowledge and expertise.** Our expertise and educational platforms complement your training, empowering team member performance.

The wound and skin care category is an extension of O&M Halyard's legacy of protection, thoughtfully entered to address some of healthcare's most challenging conditions, with clear benefits for patients and practitioners.

# HALYARD\* ADVANCED WOUND CARE: EDUCATION, ASSETS AND SUPPORT

The right wound care products in the hands of professionals with the right support can make a significant difference in patient outcomes. O&M Halyard is committed to providing business, clinical and educational assets that maximize the efficacy and value of our products.



## BUSINESS SUPPORT

A dedicated Advanced Wound Care team is available to advise and answer your questions. Services include a current product use and needs assessment.



## Knowledge Network\* CLINICAL EDUCATION

## CONTINUING EDUCATION

O&M HALYARD's KNOWLEDGE NETWORK\*, a robust offering of accredited education that reaches tens of thousands of clinicians each year. Wound care education, including online options, are currently available in the KNOWLEDGE NETWORK\* portfolio.



## INTELLIGENT PACKAGING

Our intelligent packaging makes it easy to quickly reach for the right product and apply it with peace of mind. Color-coding, distinctive graphics and easy-to-understand instructions reduce errors and product waste. The images and guidance clearly communicate the use, features and benefits of the package contents.



## HALYARD\* ADVANCED WOUND CARE: WOUND ASSESSMENT AND MANAGEMENT

Effective wound management is a multifaceted process that involves several critical steps: understanding the patient, evaluating the wound, knowing the characteristics of different dressings, and considering the care environment. Identifying the type of wound is important, as different wounds necessitate distinct treatment approaches. Given that not all wounds are straightforward, it is essential to thoroughly review the patient's medical, surgical and wound history, and current medications to gain insight into the wound's underlying cause. This comprehensive understanding enables healthcare providers to tailor interventions that promote optimal healing and improve patient outcomes.



### KEY COMPONENTS OF A WOUND ASSESSMENT:<sup>1</sup>

- **Wound Location:** Indicate specific anatomic locations
- **Wound Measurements:** Measure the length, width, and depth of the wound to track healing progress
- **Wound Exudate Type and Amount:** Observe the color, consistency, and quantity of exudate, typically noted on the removed dressing
- **Wound Tissue Type and Amount:** Identify the types of tissue present; epithelialization, granulation, hypergranulation, slough, eschar
- **Wound Edge/Periwound:** Examine the skin around the wound for signs of damage, maceration, granulation, epithelialization, necrotic tissue or signs of infection
- **Pain:** Assess the level and type of pain the patient experiences, as this can affect treatment choices and patient comfort.
- **Odor:** Note any unusual smells from the wound, which can signal infection or other issues
- **Effectiveness of Current Treatment:** Evaluate how well the current treatment is managing the exudate and odor, if there are any signs of trauma from the dressing and how well the wound is healing

**By assessing these factors on a weekly basis, clinicians can systematically promote timely wound healing.**

# HALYARD\* ADVANCED WOUND CARE: WOUND ASSESSMENT

## T.I.M.E.S. CLINICAL DECISION TOOL

The T.I.M.E.S tool is a helpful guide for evaluating wounds and planning effective treatment. Each letter in T.I.M.E.S stands for a key aspect of wound care:



### TISSUE MANAGEMENT:<sup>2</sup>

- **Goal:** Remove non-viable (dead) tissue and promote healthy tissue growth.
- **Action:** Identify and debride necrotic tissue to prevent infection and support healing.



### INFLAMMATION AND INFECTION CONTROL:<sup>2</sup>

- **Goal:** Reduce inflammation and prevent or treat infection.
- **Action:** Look for signs of infection (redness, heat, swelling) and use appropriate treatments, such as antibiotics or antimicrobial dressings.



### MOISTURE BALANCE:<sup>2</sup>

- **Goal:** Maintain an optimal moisture level in the wound.
- **Action:** Use dressings that absorb excess exudate or add moisture as needed to create a balanced environment for healing.



### EDGE OF WOUND:<sup>2</sup>

- **Goal:** Ensure the wound edges are healthy and progressing towards closure.
- **Action:** Assess the wound edges for signs of stagnation or deterioration and adjust treatment to encourage healing.



### SURROUNDING SKIN:<sup>2</sup>

- **Goal:** Protect and maintain the health of the skin around the wound.
- **Action:** Monitor the periwound area for irritation or breakdown and use protective barriers or creams as necessary.

By using the T.I.M.E.S tool, clinicians can systematically assess wounds and tailor treatments to address specific needs, ultimately promoting more effective healing.

# HALYARD\* ADVANCED WOUND CARE: WOUND ASSESSMENT

## TISSUE TYPE BREAKDOWN

Acute or chronic wounds can be classified by the depth of tissue damage. Pressure injuries, diabetic foot ulcers and burns have their own classification systems, but a standard description of wounds can be broken down into full or partial thickness.



**Full Thickness:** These wounds extend through the entire epidermis and dermis and may reach into subcutaneous tissue, affecting deeper structures such as muscles or bones. They often require more complex management due to the depth and potential for significant tissue loss.



**Partial Thickness:** These wounds involve damage to the epidermis and possibly the upper dermis but do not penetrate through the entire dermis. They typically heal more quickly than full-thickness wounds, as they involve less tissue damage and retain some of the skin's protective layers.



### HEALTHY TISSUE:

**1. GRANULATION TISSUE: Description:** This is new connective tissue and tiny blood vessels that form on the surfaces of a wound during the healing process. It appears red or pink and has a bumpy texture.

**Significance:** Indicates active healing and a healthy wound environment.

**2. EPITHELIALIZATION: Description:** The process where new epithelial cells form over a wound, appearing as a thin, pink layer.

**Significance:** Represents the final stage of healing, where the wound is closing.



### NECROTIC TISSUE:

**1. Slough: Description:** Slough is nonviable tissue of varying colour (e.g. cream, yellow, greyish or tan) that may be loose or firmly attached, slimy, stringy, or fibrinous.

**Significance:** Needs removal to promote healing.



**2. Eschar: Description:** Hard, dry, black or brown necrotic tissue that forms a thick crust over the wound.

**Significance:** Can impede healing and may require removal depending on the wound and patient condition.

## DEBRIDEMENT

**When to Debride:** Indicated when necrotic tissue is present to promote healing and prevent infection. Removing devitalized tissue will help promote healing and avoid infection.

**When Not to Debride:** Avoid debriding dry, stable eschar on the heels or in patients with poor blood supply where debridement could cause harm.

## WOUND INFECTION<sup>3</sup>

**Signs and Symptoms:** Some of the signs and symptoms of wound infection include redness, warmth, swelling, increased pain, odor, delayed wound healing, purulent discharge, and/or increased drainage. It is important to also look at the surrounding skin for signs and symptoms as well.

**Diagnosis:** Confirmed with clinical assessment and wound culture to determine the presence and type of bacteria in the wound.

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# HALYARD\* ADVANCED WOUND CARE: PRESSURE INJURY RISK ASSESSMENT

## THE BRADEN SCALE<sup>4</sup>

The Braden Scale is a widely used tool for assessing a patient's risk of developing pressure injuries. It evaluates six key factors that contribute to pressure injury risk:

- 1. Sensory Perception:** the patient's ability to sense and respond to pressure-related discomfort.
- 2. Moisture:** the degree of moisture on the skin, such as incontinence, sweat, or exudate, which can increase the risk of injury.
- 3. Activity:** the patient's level of physical activity, such as bedfast, chairfast, occasionally walks, and walk frequently.
- 4. Mobility:** the ability of the patient to change and control body position.
- 5. Nutrition:** the patient's nutritional status and dietary intake, which are crucial for skin health.
- 6. Friction and Shear:** the presence of friction and shear forces that can damage the skin or soft tissue.



**Please ensure adherence to your facility's established protocols.**

Each factor is scored from 1 to 4, except for friction and shear, which is scored 1 to 3. A lower score indicates a higher risk. The total score ranges from 6 to 23, with a score of 18 or less typically indicating a higher risk for pressure injuries. Regular assessments using the Braden Scale can help healthcare providers implement preventive measures for at-risk patients.

**For more information, visit [www.halyardhealth.com/advanced-wound-care](http://www.halyardhealth.com/advanced-wound-care)**

# HALYARD\* ADVANCED WOUND CARE: PRESSURE INJURY RISK ASSESSMENT

## PRESSURE INJURY STAGING<sup>5</sup>

A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.



**Stage 1 | Pressure Injury: Non-blanchable erythema of intact skin:** Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

**Stage 2 | Pressure Injury: Partial-thickness skin loss with exposed dermis:** Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARS), or traumatic wounds (skin tears, burns, abrasions).

**Stage 3 | Pressure Injury: Full-thickness skin loss:** Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

**Stage 4 | Pressure Injury: Full-thickness skin and tissue loss:** Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

**Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss:** Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.<sup>2</sup>

**Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration:** Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

### Additional pressure injury definitions.

**Medical Device Related Pressure Injury:** This describes an etiology. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

**Mucosal Membrane Pressure Injury:** Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

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# HALYARD\* ADVANCED WOUND CARE: PORTFOLIO

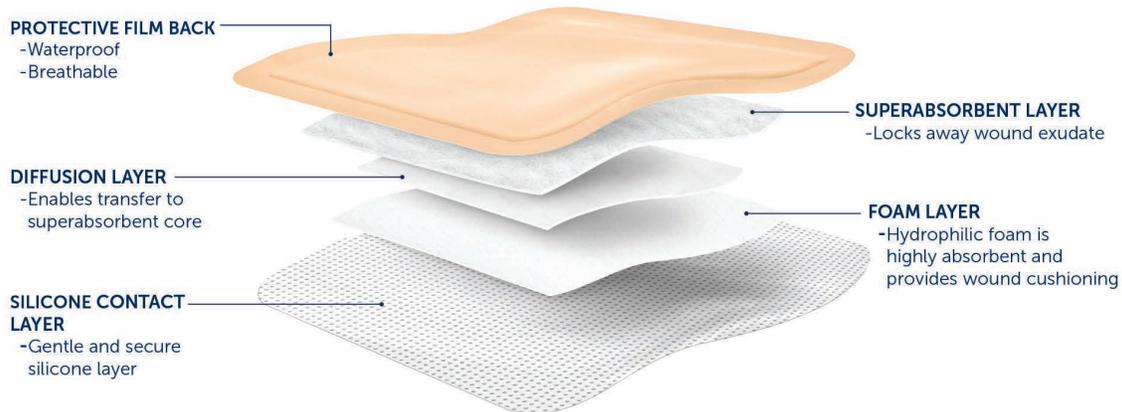
HALYARD\* Advanced Wound Care dressings target the range of wound types, from diabetic foot ulcers through pressure injury management and prevention. All dressings are backed by HALYARD\* quality, reliability and affordability in the management of partial-and full-thickness wounds with minimal-to-heavy drainage.



# SILICONE FOAM DRESSINGS

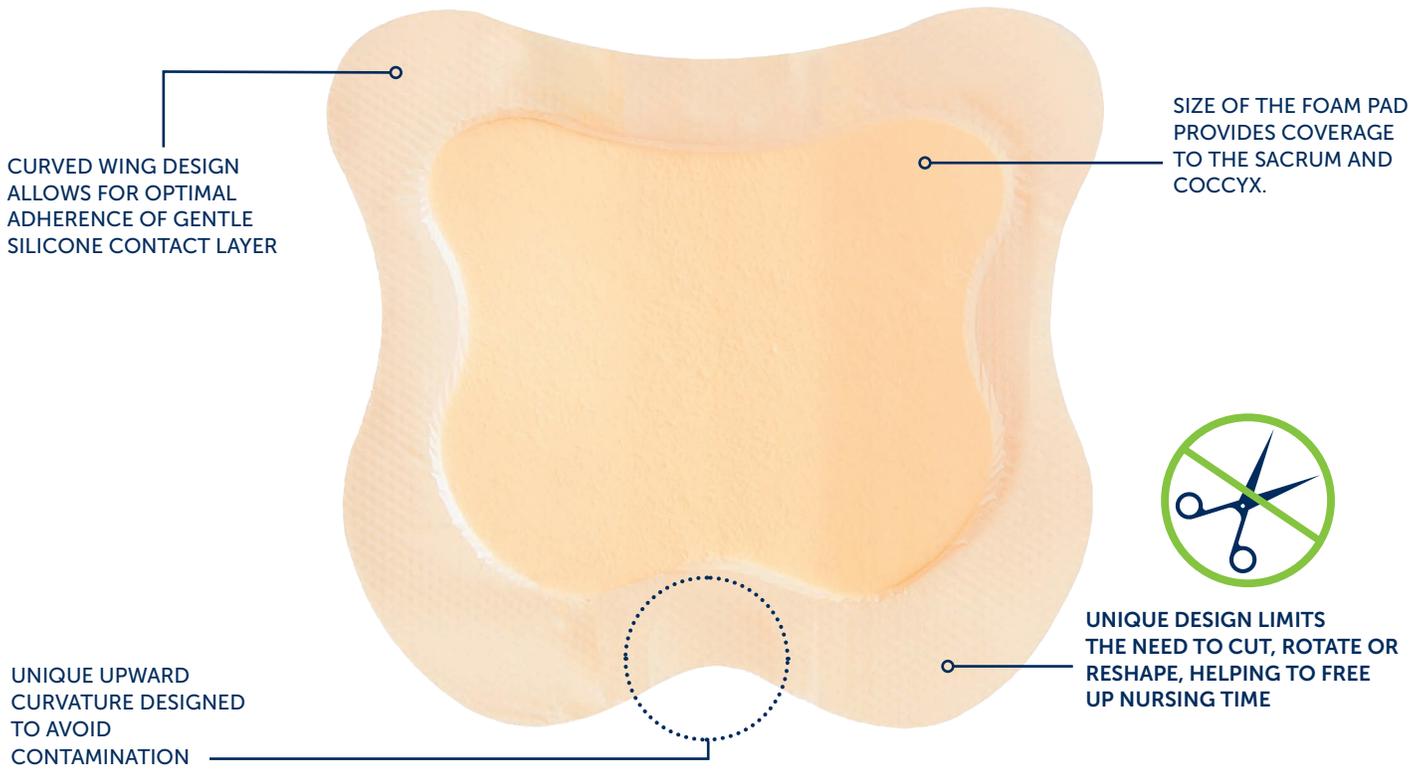
## HALYARD\* MULTI-LAYERED SILICONE FOAM DRESSING

Made with a superabsorbent foam layer, protective film backing and gentle silicone adhesive.



ITEM NUMBERS	DESCRIPTION- FOAM BORDERED	BOX UOM	HCPCS CODE
50084	HALYARD* Multi-Layer Bordered Silicone Foam Dressing, 3"x 3"	10	A6212
50085	HALYARD* Multi-Layer Bordered Silicone Foam Dressing, 4"x 4"	10	A6212
55571	HALYARD* Multi-Layer Bordered Silicone Foam Dressing, 5.75" x 5.75"	10	A6212
50086	HALYARD* Multi-Layer Bordered Silicone Foam Dressing, 6"x 6"	10	A6213
55572	HALYARD* Multi-Layer Bordered Silicone Foam Dressing, 6"x 8"	10	A6213
50087	HALYARD* Multi-Layer Bordered Silicone Foam Dressing, Sacral, Sm, 7"x 6.5"	5	A6213
50088	HALYARD* Multi-Layer Bordered Silicone Foam Dressing, Sacral, Lg, 9"x 8"	5	A6213
55570	HALYARD* Multi-Layer Bordered Silicone Foam Dressing, Heel, 9" x 9"	5	A6213
<b>DESCRIPTION- FOAM NON-BORDERED</b>			
55573	HALYARD* Non-bordered Silicone Foam Dressing, 3"x3"	10	A6209
50089	HALYARD* Non-Bordered Silicone Foam Dressing, 4"x 4"	10	A6209
50091	HALYARD* Non-bordered Silicone Foam Dressing, 4"x 5"	5	A6210
55574	HALYARD* Non-bordered Silicone Foam Dressing, 4"x 8"	10	A6210
50090	HALYARD* Non-bordered Silicone Foam Dressing, 6"x 6"	10	A6210
55575	HALYARD* Non-bordered Silicone Foam Dressing, 6"x 8"	10	A6210
55576	HALYARD* Non-bordered Silicone Foam Dressing, 8"x 8"	5	A6211

## SACRAL AND BORDERED FOAM DRESSINGS



The **HALYARD\* Silicone Foam Sacral Dressing** incorporates years of research and clinical feedback into a unique design that mimics natural anatomy and protects high risk areas.

When added to standard pressure injury prevention protocols, the HALYARD\* Sacral Dressing is designed to give clinicians and caregivers peace of mind and confidence that a preventative measure is in place to help protect against pressure injuries.

ITEM NUMBERS	DESCRIPTION	BOX UOM	HCPCS CODE
50087	HALYARD* Multi-Layer Bordered Silicone Foam Dressing, Sacral, Sm, 7"x 6.5"	5	A6213
50088	HALYARD* Multi-Layer Bordered Silicone Foam Dressing, Sacral, Lg, 9"x 8"	5	A6213

# LITE FOAM DRESSINGS

## HALYARD\* LITE FOAM DRESSINGS

Offer a low profile design, available in bordered and non-bordered silicone, providing a high contour option for hard to dress wounds.

- Gentle and secure silicone contact layer
- Low profile design
- Flexible foam
- Suitable for low drainage/exudate wounds
- May be used as part of a pressure injury prevention protocol



ITEM NUMBERS	DESCRIPTION	BOX UOM	HCPCS CODE
55691	HALYARD* Bordered Lite Foam Dressing, 1.6"x 2"	10	A6212
55692	HALYARD* Bordered Lite Foam Dressing, 4"x 4"	10	A6212
55693	HALYARD* Bordered Lite Foam Dressing, 6"x 6"	10	A6213
55694	HALYARD* Non-bordered Lite Foam Dressing, 2.4" x 3.4"	10	A6209
55695	HALYARD* Non-bordered Lite Foam Dressing, 4"x 4"	10	A6209
55696	HALYARD* Non-bordered Lite Foam Dressing, 6"x 6"	10	A6210

# GELLING FIBER DRESSINGS

## HALYARD\* GELLING FIBER WOUND DRESSING

A sterile, non-woven wound dressing. Available in both Silver and standard options.

### Gelling Fiber AG

- Broad spectrum antibacterial effects
- Inhibits 99.99% of bacterial growth for up to 7 days
- Enhanced fibers with Ionic silver
- Highly absorbent and conformable

### Gelling Fiber

- Composed of 100% Carboxymethyl Cellulose (CMC) fibers
- Highly absorbent and conformable
- Fibers absorb and transform exudate into soft gel that facilitates healing



ITEM NUMBERS	DESCRIPTION	BOX UOM	HCPCS CODE
50092	HALYARD* Gelling Fiber (CMC) Dressing, 2"x 2"	10	A6196
50093	HALYARD* Gelling Fiber (CMC) Dressing, 4"x 5"	10	A6197
50094	HALYARD* Gelling Fiber (CMC) Dressing, 6"x 6"	5	A6197
50095	HALYARD* Gelling Fiber (CMC) Dressing, 1" x 18", Reinforced	5	A6199

ITEM NUMBERS	DESCRIPTION	BOX UOM	HCPCS CODE
56344	HALYARD* Gelling Fiber AG, 2"x 2"	10	A6196
56345	HALYARD* Gelling Fiber AG, 4"x 5"	10	A6197
56346	HALYARD* Gelling Fiber AG, 4"x 8"	10	A6197
56347	HALYARD* Gelling Fiber AG, 6"x 6"	10	A6197
56348	HALYARD* Gelling Fiber AG, 1" x 12", Reinforced	10	A6199

# ALGINATE DRESSINGS

## HALYARD\* ALIGINATE WOUND DRESSING

A sterile, non-woven calcium-sodium alginate dressing consisting of high strength gel alginate.

- Highly absorbent
- Conformable
- Management of partial and full thickness wounds
- Moderate to heavy drainage
- Reinforced ribbon



ITEM NUMBERS	DESCRIPTION	BOX UOM	HCPCS CODE
50096	HALYARD* Alginate Dressing, 2"x 2"	10	A6196
50097	HALYARD* Alginate Dressing, 4"x 4"	10	A6196
50098	HALYARD* Alginate Dressing, 4"x 8"	5	A6197
50099	HALYARD* Alginate Dressing, 1"x 12"	5	A6199
50100	HALYARD* Alginate Dressing, 4.25"x 4.25"	10	A6197

# COLLAGEN DRESSINGS

## HALYARD\* COLLAGEN WOUND DRESSING

A porous matrix of cross-linked bovine collagen makes up HALYARD\* Collagen Wound Dressing. The HALYARD\* Collagen Wound Dressing is a sterile, single-use wound dressing that is white or off-white, malleable, absorbent, and biodegradable.

- 100% native bovine collagen
- Bio-compatible
- Supports natural wound healing
- Gentle PH



ITEM NUMBERS	DESCRIPTION	BOX UOM	HCPCS CODE
56350	HALYARD* Collagen Dressing, 2"x 2"	10	A6021
56351	HALYARD* Collagen Dressing, 4"x 4"	10	A6021
56353	HALYARD* Collagen Dressing, 7"x 7"	10	A6023
56352	HALYARD* Collagen Particles, 1G	10	A6010

# XEROFORM DRESSINGS

## HALYARD\* XEROFORM WOUND DRESSING

A sterile, non-adherent protective dressing consisting of fine mesh absorbent gauze impregnated with USP White Petrolatum and 3% Bismuth Tribromophenate.

- May be used on open wounds
- Absorbent impregnated gauze
- Mildly deodorizing
- May be used as a primary dressing



ITEM NUMBERS	DESCRIPTION	BOX UOM	HCPCS CODE
50197	HALYARD* Xeroform Dressing, 5" x 9"	50	A6223
50198	HALYARD* Xeroform Dressing, 2" x 2"	25	A6222
50199	HALYARD* Xeroform Dressing, 4" x 4"	25	A6222
50200	HALYARD* Xeroform Dressing, 1" x 8"	50	A6222

# HALYARD\* STERILE BORDERED GAUZE ISLAND DRESSING

## HALYARD\* STERILE BORDERED GAUZE ISLAND DRESSING

A sterile, non-impregnated gauze with a non-adherent pad.

- Covers and protects
- Non-adherent pad



ITEM NUMBERS	DESCRIPTION	BOX UOM	HCPCS CODE
50194	HALYARD* Sterile Bordered Gauze Island Dressing, 2"x 2"	50	A6219
50195	HALYARD* Sterile Bordered Gauze Island Dressing, 4"x 4"	25	A6219
50196	HALYARD* Sterile Bordered Gauze Island Dressing, 6"x 6"	25	A6219

# HALYARD\* ADVANCED WOUND CARE: A PARTNERSHIP OF PEOPLE AND PRODUCTS



O&M Halyard advances our legacy of healthcare innovation with a portfolio of highly effective, advanced wound care solutions.



## CLINICAL CONSULT

Reach out anytime to a HALYARD\* Advanced Wound Care clinical support specialist.

[www.halyardhealth.com](http://www.halyardhealth.com)

**1-844-HALYARD** (1-844-425-9273)

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

2 Schultz, G.S., Barillo, D.J., Mazingo, D.W. and Chin, G.A. (2004), Wound bed preparation and a brief history of TIME. International Wound Journal, 1: 19-32. <https://doi.org/10.1111/j.1742-481x.2004.00008.x>

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4 Braden, B. J., & Bergstrom, N. (1987). The Braden Scale for Predicting Pressure Sore Risk. Nursing Research, 36(4), 205-210.

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