



**Invacare**  
Propad Range

24 hour Community Support  
**The Clinicians Handbook**

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 Thinkpressurecare

**INVACARE**  
Yes, you can.®

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**Invacare UK** is part of Invacare Corporation, a global leader in the manufacture and supply of innovative Healthcare Equipment to the Acute, Primary and Community sectors. With dedicated Research and Development resources and stringent Quality procedures in place, Invacare's products fully conform to NHS and Industry standards.

The Invacare Propad range was introduced to the market over two decades ago and was very quickly an established and successful part of many pressure ulcer prevention strategies. The range consists of both overlays and cushions and is suitable for a 24 hour care plan.

The success of the Propad range came from its unique construction with Invacare using only the highest quality materials from renowned UK suppliers and having been developed alongside key Healthcare Professionals.

The foam has unique geometrically-cut surface cells that were designed specifically to reduce shear, friction and peak pressures with a

high quality polyurethane cover. The Propad range was one of the first to market with this innovative concept which can still be seen in new support surfaces of today.

The 24 hour care range provides a comfortable and cost effective pressure reducing surface with the foam overlays designed to be used on top of an existing mattress, and the cushions placed on either a static chair or a wheelchair.

The Propad range of today still retains the traditional features that it has been recognised for but has had enhancements and improvements to make it suitable for the 21st century healthcare environment.



## REACH Compliant

Invacare has undergone a meticulous inspection and evaluation of the product portfolio to ensure all materials and fabrics used within the Propad range are compliant with the regulation concerning the Registration, Evaluation, Authorization and Restriction of Chemicals (REACH).

### What is REACH?

REACH (Registration Evaluation Authorisation and Restriction of Chemicals) is a European Regulation (No. 1907/2006) concerning chemicals and their safe use.

It addresses the production and use of chemical substances (i.e. everything made of atoms), and their potential impacts on both human health and the environment.

In December 2012, REACH added DecaBDE to its 'Candidate List' which is often used in support surfaces as a flame retardant. The Candidate list is a list of chemicals that could have an impact on both human health and the environment and as a result, all chemicals stated on this list are not to be used in manufacturing. There are 144 chemicals on the 'Candidate list' at present.



**Anyone can get a pressure ulcer but those most at risk are:**

- People who have difficulty moving or repositioning themselves
- Those who cannot feel pain over part or all of their body
- Those who have limited bladder or bowel control
- People who are seriously ill or have had surgery
- Those with a poor diet and low fluid intake
- People who smoke
- Those with previous pressure ulcers/ skin damage
- People with poor circulation



# Invacare Propad Overlay

## High specification pressure redistributing overlay

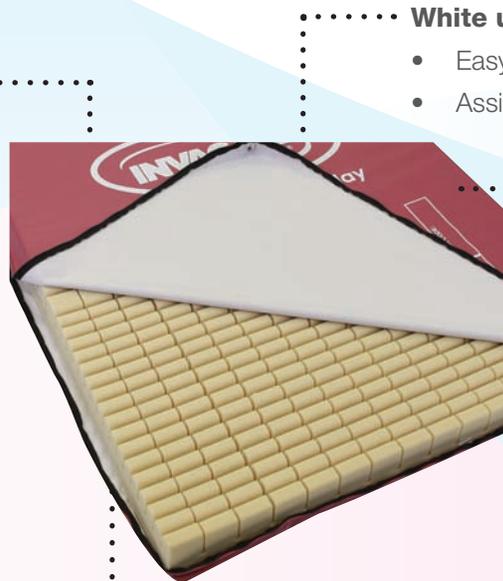
The Propad Overlay is designed to sit on top of an existing conventional mattress, providing a high level of patient comfort with excellent pressure redistribution abilities. The overlay is light weight, available in a range of sizes and suitable for those considered at 'High Risk'\* of developing pressure ulcers, making it ideal for the homecare environment.

### Water-resistant polyurethane cover

- Reduces shear and friction forces
- Vapour-permeable properties
- Easy to wipe down and clean
- Can be laundered to 80° C
- Sewn seams

### Anti-slip base

- Prevents slippage on top of the mattress
- Maintains patient safety



### White underside

- Easy inspection of fluid ingress
- Assists with Infection Control protocols

### High specification foam

- Effective pressure redistributing surface

### Specialised castellated foam surface

- Larger more supportive cells in the sacral area
- Smaller cells for the delicate heel and head area
- Conforms to the body
- Cradles bony areas
- Reduces peak pressures
- Allows air flow

Available in a range of sizes from single to king-size

## Invacare Propad Premier Overlay

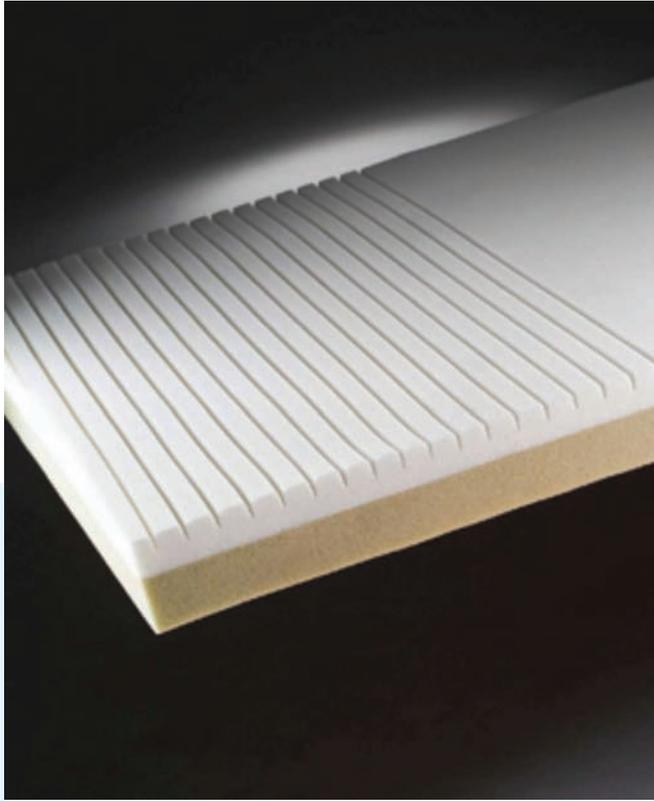
### Easy transport and storage solution



The Propad Premier Overlay offers the same features and benefits as the Propad Overlay, however, its unique foam and cover construction facilitates easy storage and delivery.

The design of the overlay along with the retaining straps enables the overlay to fold to a quarter of its size, ensuring ease of handling and transportation.

Available in L187.5 x W87.6 x H8.5cm - suitable for a standard single bed



## Invacare Propad Visco Overlay

### Dual layered visco elastic overlay

The Propad Visco Overlay is composed of the same polyurethane cover as both the Propad and Propad Premier overlay, but features a high density visco elastic (memory) foam surface with a robust foam base.

This high specification surface is temperature sensitive allowing it to conform to the shape of the body and maximise contact area. This facilitates pressure redistribution and minimises pressure on key areas of the body such as the sacral and heels.

Available in a range of sizes from single to double

### Key technical data:

	Length	Width	Height	Weight	Max User Weight	Warranty
Propad Overlay	1830-1980mm	560-1525mm	85mm	5.5kg	108kg/ 17 stone	3 years
Propad Premier Overlay	1875mm	876mm	85mm	5.5kg	108kg/ 17 stone	3 years
Propad Visco Overlay	1830-1980mm	560-1370mm	85mm	7.1kg	108kg/ 17 stone	3 years

### For more detailed technical information, please go to page 20

\*Essential nursing care is pivotal in pressure ulcer prevention. This product will positively contribute to the outcome of a pressure ulcer prevention care plan. Education, clinical judgement and action based planning based on vulnerability are fundamental factors in the prevention of pressure ulcers. A range of assessment scales can be used as a formal method of assessing risk from pressure ulcer development, and should be used in conjunction with an informal assessment (informed nursing judgement). Informal assessment is considered to be of greater importance and clinical value.



### Did you know...?

- Pressure ulcers/ sores cause patients long term pain and distress, resulting in longer hospital stays
- Treating pressure ulcers costs the NHS more than £3.8 million every day
- In severe cases, pressure ulcers can become life threatening
- Most pressure ulcers can be avoided

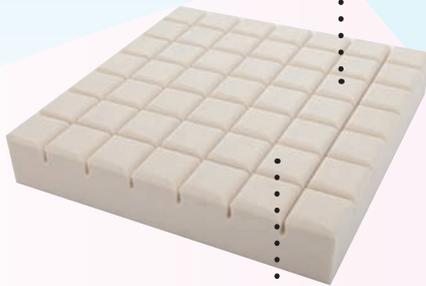
# Invacare Propad Original

## The ultimate comfort cushion

The Propad Original is manufactured using the highest quality pressure redistributing foam, designed to give superior levels of comfort. Specifically engineered to enhance support, the 4” cushion foam maximise’s air flow and provides optimum levels of temperature control to deliver unbeatable levels of comfort. The Propad Original is suitable for those at ‘High Risk’ of developing pressure ulcers.

### High specification foam

- High density foam that gives support, comfort and durability and maintains its original shape and density

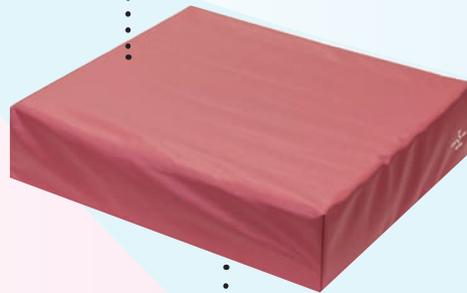


### A wide range of sizes available

- 98 sizes available from paediatric 10x10” to bariatric 24x22”

### Water-resistant polyurethane cover

- Reduces shear and friction forces
- Vapour-permeable properties
- White underside for easy inspection
- Easy to wipe down and clean
- Can be laundered to 80° C

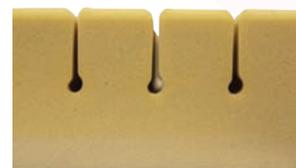


### Anti-slip base

- Prevents cushion slipping
- Maintains patient safety

## Unique castellation design

The foam core has independent, geometrically-cut surface cells that significantly reduce shear and friction, whilst increasing the overall support surface area, thereby reducing peak pressure.



## Invacare Propad Profile

### 3” foam cushion for a lower seat to floor height

The Propad Profile is a 3” cushion designed for those who require a comfortable ‘High Risk’\* cushion benefiting from the same clinical applications as the Propad Original but in a lower height.

Available in 102 sizes ranging from 10x10” to 24x22”

# Invacare Propad Premier

## For comfort and increased stability

The Propad Premier cushion combines comfort and stability with a dual layer construction to ensure improved support as well as prolonged longevity. The cushion has the same water-resistant polyurethane cover as the Propad Original, with a unique foam core suitable for those ‘High Risk’\* of developing a pressure ulcer.

### Castellated foam top layer .....

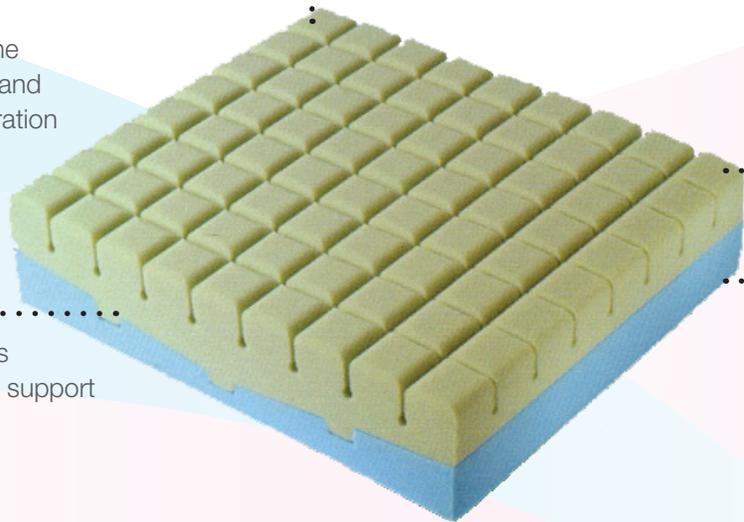
- Each castellation moves independently
- High specification foam provides effective pressure redistribution
- Ensures good air circulation, reducing the potential for sweating and associated skin maceration

### Dual-layered

- High density foam base
- Provides added stability
- Delivers increased support

### Stability .....

- Unique shape provides increased stability and support for the user



## Key technical data:

	Depth	Width	Height	Weight	Max User Weight**	Warranty
Propad Original	10"-22"	10"-24"	4"	1kg	Up to 127kg/ 20 stone	3 years
Propad Profile	10"-22"	10"-24"	3"	1kg	Up to 127kg/ 20 stone	3 years
Propad Premier	13-22"	13-24"	4"	1kg	Up to 197kg/ 31 stone	3 years

**For more detailed technical information, please go to page 20**

### To spot a pressure ulcer, look for the following:

- On lighter skin, look for persistent red patches forming which do not fade after the pressure is removed from the area
- Look for bluish/ purple patches on darker skin

\*Essential nursing care is pivotal in pressure ulcer prevention. This product will positively contribute to the outcome of a pressure ulcer prevention care plan. Education, clinical judgement and action based planning based on vulnerability are fundamental factors in the prevention of pressure ulcers. A range of assessment scales can be used as a formal method of assessing risk from pressure ulcer development, and should be used in conjunction with an informal assessment (informed nursing judgement). Informal assessment is considered to be of greater importance and clinical value.

\*\* Maximum user weight limits are set provided that the cushion selected is of appropriate width and depth for the intended user/s.

The maximum weight limit applies to a 24"x22" cushions.





## Risk Assessment

When assessing an individual for a pressure reducing cushion or overlay, it is always advisable to carry out some form of risk assessment. This risk assessment can include a formal risk assessment scale such as the Norton scale (1962), the Braden scale (1985) or the Waterlow scale (1985). The Waterlow scale for example provides a guide category of potential risk for that individual, based on the final score.

Category	Waterlow Score
At Risk	10+
High Risk	15+
Very High Risk	20+

It is recommended, however, that the results of a formal risk assessment are always considered alongside more informal clinical judgement before the total care package is decided, of which pressure redistributing equipment is an important part. This ensures that factors that may not be included in the formal risk assessment are given sufficient consideration.

In addition, Invacare recommend that guidance on pressure ulcer risk assessment is sought from relevant institutes, agencies and advisory panels as detailed in the reference section below.

### Waterlow Score

Product	Waterlow Score
Propad Overlay	15+
Propad Premier Overlay	15+
Propad Visco Overlay	15+
Propad Original	15+
Propad Profile	15+
Propad Premier	15+

### References

Bergstrom N., Braden, B., Laguzza A., Holman, V. The Braden Scale for predicting pressure sore risk: reliability studies. *Nurse Res* 1987; 34(6);205-210.

European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers: quick reference guide. Washington DC: National Pressure Ulcer Advisory Panel; 2009.

National Institute for Clinical Excellence. Clinical Guideline 179. The prevention and management of pressure ulcers in primary and secondary care. National Institute for Clinical Excellence, April 2014.

Norton, D., Exton Smith A.N., McLaren R. An investigation of geriatric nursing problems in hospital. London: National Corporation for the Care of Old People. 1962.

Waterlow, J. A risk assessment card. *Nurs Times* 1985; 81 (49);5115

Waterlow, J. The Waterlow pressure ulcer prevention manual. Taunton: Newtons. 2005.



## Knowledge Bank

### What is a pressure ulcer?

A pressure ulcer (also known as a bed sore or pressure sore) is an area of damage to the skin and the underlying tissue, usually over a bony area of the body. Damage to the skin is most commonly caused by pressure, or pressure in combination with shear.

Pressure ulcers range in severity from skin discoloration, to severe open wounds where the muscle and bone are visible.

### What causes pressure ulcers?

The damage to the skin and underlying tissues can be caused by a combination of the following:

#### Pressure

Pressure is a direct (vertical) force which occurs when our skin makes contact with a surface e.g. when sitting on a chair or lying on a mattress. Pressure causes the skin to compress or squash restricting blood flow. Oxygen and nutrients are carried via the blood to our skin, thus when pressure squashes the tissues, which make up our skin, the blood cannot transport the oxygen and nutrients and the tissues become damaged.

### To spot a pressure ulcer, look for the following:

- On lighter skin, look for persistent red patches forming which do not fade after the pressure is removed from the area
- Look for bluish/ purple patches on darker skin
- They are more common over the bony parts of the body like the bottom, heel, elbow and shoulder
- It is not uncommon for them to develop on the back of the ear or other areas of the head and body

## Shear

Shear is also a force but it works in a different direction to pressure. Shear is a (parallel) or horizontal force which causes the skin and underlying tissues to stretch. Shear can occur when someone partially slips down the bed or chair. The skin can stay stuck to the mattress or cushion distorting the underlying tissues.

## Friction

Friction is when the skin is rubbed against another surface and can occur when slipping down a chair or bed. This type of damage is usually quite superficial and should heal without problems. However, for some ill or elderly people, healing may be impaired and a shallow ulcer may progress to something more serious.

## Temperature

Increased body temperature is also thought to increase the risk of pressure ulcer development.





## Knowledge Bank

If you are looking for an overlay or cushion and not sure where to start, here are a few key features you should look for:

### Pressure Care

**Castellated foam** surfaces allow the patient to be immersed into the foam to maximise body contact area, therefore optimising pressure redistribution. The individual movement of each castellation can significantly reduce shear and friction forces.

**High quality foams** ensure a good life span and reduce the possibility of them bottoming out. Avoid cheap foam overlays and cushions – they are a false economy. Cheap foam will collapse after a short period of use and will need to be replaced. They may also put clients at risk of developing pressure ulcers.

A good overlay or cushion will feature a **multi-stretch polyurethane (PU)** cover, which is designed to contribute to the reduction of shear and friction forces. Avoid non-stretch materials and materials that have poor vapour-permeability. Also, avoid cover materials that include Latex; Latex has poor allergenic properties; and some patients can be particularly vulnerable, leading to adverse skin reactions. Some overlays and cushions use glue as an essential part of their construction but this is primarily to save cost.

**Glue should be avoided where possible**, but if used, should be deployed sparingly. An overlay or cushion which uses a lot of glue to hold the foam core together will become rigid and inflexible overtime, thereby significantly reducing its ability to conform to a client's body. This will reduce any pressure redistributing properties within the overlay and cushion, and may significantly increase the potential of skin tissue damage.

### Infection Control

The overlay and cushion cover should be water resistant and vapour permeable but should not allow bacteria through. These features will also help to prolong the longevity of the product and reduce the risk of strikethrough, hydrolysis and de-lamination.

A quality overlay and cushion will also feature a toughened PU coated base to help prolong the longevity and reduce the risk of strikethrough, hydrolysis and delamination.

The overlay and cushion should be able to satisfy all laundering requirements laid down by the Infection control department. Full laundering instructions should be clearly printed on the mattress cover.

Easily removable covers are key to avoid the need to replace the entire overlay or cushion if the cover is damaged, prolonging its life and saving money.

### Prolonged chair nursing may result in:

- An increase in shear damage to skin and tissue
- Can contribute to ankle or leg oedema due to impaired venous return
- Increase in pressure at skin and/or muscle layer due to a reduction in support surface area

#### Remember:

Complications of bedrest do not exist. The complications occur as a result of immobility. Chairfast patients are generally more vulnerable to pressure ulcer development than patients on bedrest



# Knowledge bank

## Seating and posture guide

Good posture is dependent on the balance of the skeleton and symmetrical alignment of body segments. Posture is not static, but is an active and dynamic process which underpins movement and function. This means we change our posture continuously to enable our bodies to move and allow us to do what we want to do. On average we change our posture every 8 seconds.

### The following influences a persons posture:

- Muscle tone (high or low)
- Contracture
- Body shape and size (height and weight)
- Decreased balance & equilibrium reactions
- Proprioception
- Fatigue
- Level of health; well being/emotional state of individual
- Existing pressure ulcer

### A persons posture can then influence:

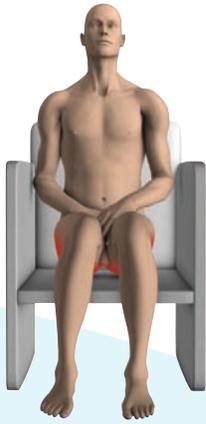
- Pressure ulcer development
- Function
- Pain & discomfort
- Postural deformity
- Breathing
- Swallowing
- Communication
- Vision

### What is a good posture?

- Historically 90/90/90 (Hips, knees and ankles) was the benchmark for seating but we have come to realise that this position is really tiring and cannot be maintained for any length of time. However, it is a starting point and you may need to adjust these angles to meet the needs of your client
- The pelvis should be level with the ASIS and the PSIS
- There should be equal weight bearing
- The trunk should be upright with a slight lumbar curve
- Stability is key



# The most common seating and postural problems are as follows:



## Seat too low

### Difficult To Get Out

Body weight is supported on a small area. This leads to high pressure under the buttocks.



## Arm rest too high

### Uncomfortable – Poor Posture

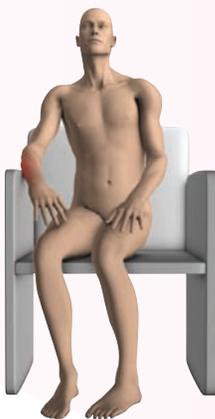
High pressure under elbows.  
May be difficult to eat and drink.



## Seat too narrow

### Difficult To Get In and About

Allows no movement in the seat.



## Seat too wide

### No Support – Poor Posture

No stability may lead to fixed spinal deformities with time



## Correct arm rest height & seat width

### Good Posture and Support

A correctly sized seat provides good pressure care, good sitting posture and allows the individual to move in the seat.

# Training resources

**Preventing Pressure Ulcers – A Clinical Guide**

**Flo-tech Propad Softform** Yes, you can.

**INVACARE**

Preventing Pressure Ulcers – A Clinical Guide  
Part no. 1517305

**QUICK GUIDE PREVENTING PRESSURE ULCERS FOR PATIENTS AND CARERS**

Thinkpressurecare  
www.thinkpressurecare.co.uk

**INVACARE**  
Yes, you can.

Quick guide: Preventing pressure ulcers for patients and carers  
Part no. 1573897

**Simple... safe... effective... the 30° tilt**

**Semi-recumbent Position**

- Supports the lumbar spine. Pump or lift the lower pillow if necessary.
- An additional pillow is positioned under the buttock to 'lift' the body, giving the ischial tuberosities and sacrum clearance.
- Ensure that the heels are clear of the mattress.
- The full semi-recumbent 30° tilt position.

**Recumbent Position**

- Use one or two pillows to support the head and neck.
- Added pillows 'lift' the patient onto one buttock and lifts the sacrum clear of the mattress.
- Support the full leg on another pillow. Ensure that the heel overhangs the edge of the pillow.
- Additional pillows may provide comfort for the legs.
- The full recumbent 30° tilt position.
- This demonstrates the necessity to use an additional pillow to prevent 'drop floor'.
- Variant position. Alternative position for patients who cannot achieve or maintain normal posture.

**Points to remember**

- Encourage patients to re-position themselves if possible.
- Remember to ask the patient if they are comfortable and check their position and skin\* at regular intervals.
- The 30° tilt is used to enhance patient comfort and reduce pressure over high risk areas. It should be used with prevention protocols.
- Use your hand to check clearance.

\* Consult Tissue Viability for guidance on skin condition if concerned

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**INVACARE**  
Yes, you can.

Simple... safe... effective... the 30° tilt  
Part no. 1492224

**Areas at risk from pressure damage**

Patients may be at risk/elevated risk from pressure damage within a very short period of time if repositioning and pressure relief does not take place

**The added effect of shearing and friction forces**

Semi-recumbent Position	Seated Position

**Supine Position**

**Lateral Position**

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Yes, you can.

Areas at risk from pressure damage  
Part no. 1492636

## Concepts of chair nursing

### PROLONGED CHAIR NURSING

**May result in**

- Increase in shear damage to skin and tissue.
- Can contribute to ankle or leg oedema due to impaired venous return.
- Increase in pressure at skin and/or muscle layer due to a reduction in support surface area.
- 19% of body weight should be transferred through the feet. If the chair is too high and prevents this, the extra weight will result in an increase of pressure occurring over the ischial tuberosities (IT).
- Studies have indicated that limiting chair nursing effectively reduces the risk of pressure ulcer development (The RCN\* recommends two-hourly sessions, which can be repeated throughout the day)
- The RCN recommends the introduction of a repositioning schedule to assist regular position changes.

**Remember**

Complications of bedrest do not exist. The complications occur as a result of immobility! Chairfast patients are generally more vulnerable to pressure ulcer development than patients on bedrest.

### COMMON PROBLEMS

- Seat too high or too low.
- Seat too wide or too narrow.

Seat too low	Arm rest too high	Seat too narrow	Seat too wide	Correct arm rest height & seat width
<p><b>Difficult To Get Out</b></p> <p>Body weight is distributed on a small area. The back is high pressure under the buttocks. May be difficult to sit and stand.</p> <p><b>RCN: Royal College of Nursing</b></p>	<p><b>Uncomfortable - Poor Posture</b></p> <p>High pressure under the elbows. May be difficult to sit and stand.</p>	<p><b>Difficult To Get In and Out</b></p> <p>Allows no movement in the seat.</p>	<p><b>No Support - Poor Posture</b></p> <p>No stability may lead to fixed spinal deformities with time.</p>	<p><b>Good Posture and Support</b></p> <p>A correctly used seat provides good posture, good sitting posture and allows the individual to move in the seat.</p>

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**matrix** **INVACARE**  
Yes, you can.

Concepts of chair nursing  
Part no. 1492635

## MATTRESS CARE

### Why do you need to test your mattresses?

It has been established that foam, like body tissue, does not respond well when exposed to long term compression and moisture. The connection between damaged, contaminated mattresses and outbreak of bacteria infections has been documented in several reports.

To ensure mattresses remain fit for purpose and clinically effective, it is recommended that their condition should be checked on a regular basis - ideally every six months, or at the very least every 12 months. The results of these regular audits should be recorded on mattress audit forms (available from Invacare).

The audit should focus on the quality of the surface on which the patient is placed, ensuring it's free from infection and that it retains its pressure reducing properties. Ideally, a Tissue Viability Nurse (TVN) or Infection Control Nurse (ICN) should be involved in the test.

The following information is meant as a guide only to mattress auditors and while it's hoped that this information will prove useful in helping mattress auditors decide whether or not to condemn a mattress, the auditors cannot accept responsibility for such decisions.

### How to check your mattresses

- 1. Mattress Type**  
Identify the mattress type and check if the mattress has specific or peculiar features that could affect the outcome of the audit.
- 2. Mattress Depth**  
Measure the mattress depth using a ruler. The mattress thickness (not including any covering) should be around 175mm in depth.
- 3. Cover Condition**  
The auditor should evaluate the mattress cover both internally and externally, looking for visible evidence of wear and tear. This might include:
  - Damage e.g. splits, tears, punctures
  - Stain/water
  - Staining along zip lines
  - Staining of the inner cover or foam
  - Staining of the exterior cover\*
  - Loss of the cover's appearance for the type of mattress

\*Remember to take note when looking for stains on the placement covers.
- 4. Foam Condition**  
**a) Bottoming Out**  
It's important to check the foam has bottomed out. This is where the bulk of the bed can be felt through the mattress during testing. The recommended method of determining whether bottoming out is taking place is the 'Pat Test':  
**To undertake the Pat Test:**
  - 1) Kneel on the top of the mattress to level with the auditor's greater trochanter (hip bone)
  - 2) Ensure the mattress cover is in place
  - 3) Stand on the side of the bed
  - 4) A hand to form a fist, keep elbows straight
  - 5) Lean forward with body weight and push the fist into the mattress along the seven points indicated below.

If the foam is compressed, the mattress should be withdrawn from service immediately and the cover replaced. If the foam and cover are compromised, the whole mattress would be replaced. Failure to do so poses a significant risk of infection to both the patient and the healthcare team.

In the event the cover fails the audit, only the cover needs to be replaced. To avoid significant loss of pressure storage or friction to the patient, it is imperative that the new mattress cover be the same. If there is any doubt about the size of the cover, contact Invacare.
- b) Inner foam core**  
Unroll the mattress cover and examine the inner foam core for evidence of the following:
  - Compression with staining at the interior of the cover
  - Staining
  - Mould\*

\*If any of these problems are found, it is recommended the mattress is withdrawn from service immediately. It may pose a significant risk of infection to both patient's and staff.

### Points to remember

Every new mattress should be allocated a number and a note made of the day it was put into service.

### PROVIDING CARE AND PROTECTION

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**Softform** **INVACARE**  
Yes, you can.

Part number: 1492637

Mattress care  
Part no. 1576928

## PRESSURE ULCER CLASSIFICATION

		<b>Category Stage I:</b> Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones <sup>1</sup> .
	<b>Category Stage II:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguinous filled blister <sup>1</sup> .	
	<b>Category Stage III:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss <sup>1</sup> .	
	<b>Category Stage IV:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunnelling. Category Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) <sup>1</sup> .	

1. The extract has been taken from the Pressure Ulcer Prevention and Treatment EPLAP Review Guideline written by the European Pressure Ulcer Advisory Panel (EPUAP). This poster is designed as a guide only and Invacare is strongly recommended the full EPLAP guidelines are studied. Invacare accepts no responsibility for medical intervention as a result of misinterpretation of the content of this poster.

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**Softform** **INVACARE**  
Yes, you can.

Part number: 1522584

Pressure Ulcer Classification  
Part no. 1522584

If you would like to download a copy of the Invacare brochures and posters, please visit [www.thinkpressurecare.co.uk](http://www.thinkpressurecare.co.uk). Alternatively, if you would like free hard copies, please call Customer Services on 01656 776222 quoting the part numbers.

# How to clean and care for your overlays and cushions

## Cleaning the covers

It is recommended that a solution of neutral detergent and warm water with a single use non-abrasive cloth is used to clean the overlay and cushion covers. Ensure the cover is rinsed with clean water, using a single use non-abrasive cloth and make sure the surface is thoroughly dried.

All covers are removable for laundering. The recommended washing temperature is between 60° C - 80° C using a diluted detergent solution (please see instructions on label).

The covers should then be hung from a line or bar and drip dried in a clean indoor environment.

Tumble dry on a low heat setting. Covers must be thoroughly dried before re-fitting to the mattress.



Tumble dry setting must not exceed 40° C



Do not tumble dry for longer than 10 minutes



Washing at higher temperatures may cause shrinkage

## Disinfecting the covers

**Light soilage:** Ensure that any residual detergent has been removed prior to disinfection. The cover can be wiped down with a 0.1% Chlorine Solution (1,000ppm). Ensure that the cover is rinsed with clean water using a single use nonabrasive cloth, and thoroughly dried.

**Heavy soilage:** For spillages of bodily fluids i.e blood, urine, faeces, sputum, wound exudate and all other bodily secretions. All spillages should be cleared up as soon as possible. A 1% Chlorine Solution (10,000ppm) can be used to disinfect the mattress. Rinse well with clean water and a damp single use non-abrasive cloth. Large spillages of blood should be absorbed and removed



Contaminated foams should be removed from use.



Do not use phenols, alcohols, bleaches, or abrasive materials.



Keep Clear of Open Heat Sources.

with paper towels followed by as above. Do not use granules. The surface should then be rinsed using clean water with a clean non-abrasive cloth.

Polyurethane coated fabrics can absorb liquids for short periods causing a temporary change to the polyurethane characteristics. The mattress cover swells temporarily and is more vulnerable to physical damage for a period after it is surface dried, by which time it will revert to its previous state.

The foam when either contaminated or when it reaches its end of life should be disposed of in accordance with Environmental Legislation.

1% Chlorine Solution used on a regular basis can diminish the life of the cover if not rinsed and dried properly.

**N.B; Always ensure you read the user instructions prior to use and inspect the interior and exterior of the overlays and cushions on a regular basis.**

For further information on mattress cleaning and care, please refer to the BHTA 'Protect, Rinse and Dry' document that can be downloaded from [www.bhta.net](http://www.bhta.net)



## Postural complications of the seated patient:

### Pelvic Obliquity

- Results in one ischial tuberosity supporting extra weight which over time will effect the trochanter

### Posterior Pelvic Tilt

- Results in greater weight and pressure being transferred through the coccyx and sacrum. May contribute to the development of sacral and heel ulcers

### Such complications can arise for two reasons:

- Patient's condition
- Poor seating



## Technical Information

Product	Warranty	Fire Testing	Grade Ref & Colour	Nominal Density Range (kg/m)	Nominal Hardness Range (N)	Fatigue Class	Weight of Product (kg)
Propad Premier Overlay	3 years	BS 5852: Crib 5 BS 7175: Crib 5	Gr. RX36/125 Beige	35-37	110-140	Very Severe	5.5
Propad Overlay	3 years	BS 5852: Crib 5 BS 7175: Crib 5	Gr. RX36/125 Beige	35-37	110-140	Very Severe	5.5
Propad Visco Overlay	3 years	BS 7177: Crib 5	Gr. VC5580 White Gr. RX36/125 Beige	55 35-37	80 110-140	N/A Very Severe	7.1
Propad Original Cushion	3 years	BS 7176: Crib 5	Gr. RX36-125 Beige	36-37	110-140	Very Severe	1
Propad Profile Cushion	3 years	BS 7176: Crib 5	Gr. RX36-125 Beige	35-37	110-140	Very Severe	1
Propad Premier Cushion	3 years	BS 7176: Crib 5	Gr. RX36/125 Beige Gr. RX39-/200 Blue	35-37 38-40	110-140 180-200	Very Severe Very Severe	1



**The following will assist with reducing pressure ulcers:**

- Check the skin for damage at least once a day if lying or sitting for long periods
- Make sure the client is turned and changes position regularly to transfer weight off bony areas
- Reposition in a chair every 15-30 minutes
- Ensure suitable support surfaces are in place
- Eat a well-balanced diet and drink plenty of fluids
- Keep the skin clean and dry



**Yes, you can.®**

**Part no. 1578275**

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