



## KEY FOR LTC CUSHION COMPARISON CHART

<b>WOUNDS ADDRESSED</b>	<b>Ischial:</b>	Redistribute pressure from ITs to gluteus and femurs. Look for offloading and/or immersion style cushions.
	<b>Trochanter:</b>	Look for an immersion style cushion; stay away from cushions with aggressive tapered adductors that would load the trochanters.
	<b>Sacral/Coccygeal:</b>	Redistribute pressure away from sacrum/coccyx to gluteus and femurs. Look for an immersion style cushion or combination of immersion/offloading cushion for pressure redistribution.
<b>TYPE OF PRESSURE REDISTRIBUTION</b>	<b>Immersion</b>	The principle of conforming to the person's curvature by "sinking the body in", taking its shape and alleviating the bony prominences from unwanted peak pressure to maximize pressure redistribution.
	<b>Offloading</b>	The principle of taking pressure off of a small surface area and loading it onto a greater surface area that can withstand more pressure to prevent unwanted skin breakdown.
<b>CONTOURS FOR MAXIMUM OFFLOADING CAPABILITIES</b>	<b>A Deep Posterior Pelvic Well:</b>	Allows for alleviating the pressure from ITs when combined with tapered adductors. Offloads and suspends the ITs, sacrum and coccyx and loads the femurs instead.
	<b>Lateral Tapered Adductors:</b>	Load the trochanters to alleviate the pressure from the ITs. Align the LEs and prevent abduction and external rotation for optimal femoral loading.
	<b>Medial Abductors:</b>	Align the LEs and prevent adduction and internal rotation for optimal femoral loading.
<b>ADJUSTABILITY</b>		Ability to have separate chambers adjusted through the addition or removal of air cells to customize a cushion to the resident's individual shape and address specific postural abnormalities.
<b>SHAPE</b>	<b>Zero Elevation:</b>	The top surface of the cushion is predominately flat directly out of the box. Allows for freedom of movement of the user. This shape is adjustable in Vicair® cushions.
	<b>Pre-Contoured:</b>	The cushion will have built-in positioning features directly out of the box. This may range from mild to aggressive contouring and is adjustable in Vicair® cushions.

## WOUND ASSESSMENT GUIDELINES

"A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. 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, comorbidities and condition of the soft tissue"  
\*Pressure injury. Prevention & Treatment of Pressure Ulcers: Clinical Practice Guideline. Washington D.C.: National Pressure Ulcer Advisory Panel. April 2016 Update.

**Stage I:** Intact skin with a localized area of non-blanchable superficial reddening of the skin. Presence of blanchable redness or changes in sensation, temperature, or firmness may precede visual changes.

**Stage II:** Partial-thickness skin loss or blister. The wound bed is viable, pink or red, moist. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.

**Stage III:** Full thickness skin loss, in which adipose (fat) is visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough and/or eschar may be visible. Undermining and tunneling may occur.

**Stage IV:** 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. Rolled edges, undermining and/or tunneling often occur.

**Unstageable:** 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 III or IV pressure injury will be revealed.

**Deep Tissue Pressure Injury (DTI):** 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. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.