

**SEEK & FIND: WOUND**



Student Name: Sharon Choma \_\_\_\_\_ Date: 9/27/2020 \_\_\_\_\_

Instructor Signature \_\_\_\_\_ Student's earned points \_\_\_\_/20

For each item in column A, select two different and appropriate **topical therapies**. If you choose a primary dressing that also requires a secondary dressing, be sure to identify the secondary dressing type as well in order to receive full points. This pairing (a primary with a secondary dressing) would be considered one answer. Identify each type of dressing used by category and brand name.

Answer questions in column B.

Submit to your dropbox when finished.

**Use the product name & NOT the product number when completing this assignment.**

Column A	Possible Points	Earned Points	Column B	Possible Points	Earned Points
<p><b>Topical therapy: Category and brand name of specific product(s) to be used</b></p> <p><b>Example: Foam; Restore Foam with adhesive border, 4" x 4"</b></p>					
<p>Wounds with small amounts of drainage.</p> <p>1. Hydrogel (skintegrity amorphous hydrogel by Medline). Monitor for peri-wound maceration with hydrogel. May benefit from use of a protective barrier to peri wound such as SurePrep No-Sting Skin Prep Wipe by Medline to prevent.</p> <p>2. Collagen (Promogran by Systagenix). Since there is only a small amount of drainage, it may be necessary to</p>	0.5		<p>Any special cautions when using the chosen products?</p> <p>1. Cover with secondary dressing such as stratasorb composite gauze &amp; change every 72hours or prn. Contraindicated if sensitive to gel components.</p> <p>2. Do not use with any known sensitivity to product (oxidized regenerated cellulose or bovine) cover with secondary dressing based on exudate such as dry sterile gauze.</p>	0.5	

**\*\* This assignment may also be completed via an internet search.**

**SEEK & FIND: WOUND**



moisten the Promogran with 0.9 NS before inserting into the wound.					
<p>Sacral wound covered with intact eschar.</p> <ol style="list-style-type: none"> <li>1. Hydrogel (such as Normigel® Isotonic Saline Gel by Molnlycke). Recommend scoring eschar first. May need to cover gel with vaseline impregnated gauze such as a vaseline petrolatum gauze by Covidien, then cover with dry sterile dressing such as an ABD.</li> <li>2. Hydrocolloid (Duoderm Signal by Convatec). Before applying remove eschar that is particularly thick or fused to wound margins (may need surgical consult). May leave in place up to 7 days. Change when strike through occurs.</li> </ol>	1		<p>Would you change your topical therapy choice if the wound presented as boggy, odorous, draining thick exudate with a 2 cm. area of erythema surrounding the wound? If so, what actions would you initiate?</p> <p>Yes, I would clean the wound with 0.9 NS or wound wash, obtain a culture from an area of the wound that has the actual wound bed exposed (not the eschar), &amp; start an absorbent dressing to prevent maceration &amp; treat the increased bioburden; with a product such as foam with silver (Mepilex AG antimicrobial) by Molnlycke or another antibacterial dressing material such as hydrofera blue bacteriostatic wound dressing by Hollister Wound Care. This is an unstable wound so would also order a surgical consult. But in the meantime would start the above.</p>	2	
<p>Wounds with 90% yellow adherent slough.</p> <ol style="list-style-type: none"> <li>1. Collagenase ointment (Santyl by Smith &amp; Nephew, applied in nickel thickness to wound bed, then cover with 0.9 NS moistened gauze to cover the Santyl, and activate the enzymes, followed with a dry sterile dressing). Apply/change daily, after cleansing wound with 0.9 NS</li> </ol>	1		<p>Identify two (2) actions used to prevent periwound maceration.</p> <ol style="list-style-type: none"> <li>1. Protect peri wound skin with liquid skin prep (non-alcohol) such as Sureprep Skin Protective Wipes by Medline.</li> <li>2. For wounds with large amounts of drainage, use an extra absorbent cover</li> </ol>	1	

**\*\* This assignment may also be completed via an internet search.**

**SEEK & FIND: WOUND**



<p>and gently wiping with gauze.</p> <p>2. Manuka honey gel (Medihoney gel by Derma Sciences). Monitor for peri-wound maceration caused by the increased drainage from the Medihoney. Medihoney may be applied directly to the wound bed, or onto an appropriate primary dressing such as alginate or a gauze pad. Apply an appropriate secondary dressing such as foam, or composite dressing, which will be determined by the amount of drainage.</p>			<p>dressing to wick moisture from the surrounding healthy skin such as with a hydroconductive dressing with LevaFiber technology (Drawtex by SteadMed Medical).</p>		
<p>Type 3 skin tear.</p> <p>1. Petrolatum impregnated gauze (such as Vaseline Petrolatum Gauze by Covidien). Will need a secondary dressing such as a dry gauze dressing, held in place with gauze wrap such as kling. Mark dressing with the direction the dressing should be removed in such as with an arrow.</p> <p>2. Silicone contact layer (such as Adaptic Touch by Systagenix). Will need a secondary dressing such as a dry gauze dressing, held in place with gauze wrap such as kling.</p>	<p>1</p>		<p>Identify at least two (2) other nursing actions to be implemented for an individual with fragile skin.</p> <p>1.Prevent injury by covering exposed surfaces of skin such as with arm protectors, or long- sleeved garments or long pants.</p> <p>2.Never apply tape to fragile skin, hold dressings in place with gauze (then apply tape to the gauze, not skin) or even garments. If absolutely necessary use skin protectant barrier first to protect intact surrounding skin, or specialty tape such as 3M medipore soft cloth tape.</p>	<p>1</p>	

**\*\* This assignment may also be completed via an internet search.**

**SEEK & FIND: WOUND**



<p>Deep tissue injury (DTI).</p> <ol style="list-style-type: none"> <li>1. For intact skin apply a protective barrier wipe (non-alcohol) such as a Sureprep No-Sting Skin Prep Wipe by Medline.</li> <li>2. Apply a skin protectant cream (such as Remedy Phytoplex Hydraguard by Medline, to protect fragile skin from excess moisture or incontinence</li> </ol>	<p>1</p>		<p>Identify an additional nursing action for an individual with a DTI.</p> <p>Float heels off of the bed using a pillow (under the calf) and implement use of a pressure re-distributing mattress such as a fluid immersion (an example is the OnCare ® Dolphin Fluid Immersion by Joerns Healthcare).</p>	<p>1</p>	
<p>Red, granulating stage 3 sacral pressure injury with little exudate.</p> <ol style="list-style-type: none"> <li>1. Collagen (such as Puracol Plus which when used in dry wound bed should be moistened with saline to preform/Activate the gel before applying to wound bed.</li> <li>2. Hydrogel (such as Skintegrity Amorphous Hydrogel by Medline), then cover with gauze dressing and change q 72 hours or sooner if needed.</li> </ol>	<p>1</p>		<p>Identify an <u>advanced wound therapy</u> that could be used with this wound type.</p> <p>Negative Pressure Wound therapy such as the Acti V.A. C. therapy unit by KCI.</p>	<p>1</p>	
<p>Heavily draining stage 4 sacral injury.</p> <ol style="list-style-type: none"> <li>1. Negative Pressure Wound Therapy (such as KCI Acti V.A.C. using black sponge-cover any exposed tendon or bone with silicone dressing before applying black sponge, protect peri wound with liquid skin barrier such as with Sureprep No-Sting Skin Prep Wipes by Medline Industries, Inc. and if needed apply protective</li> </ol>	<p>1</p>		<p>Identify an appropriate support surface to use with this patient (category/brand name).</p> <p>Low air loss (such as the Genesis™ III/5, Meridian Ultra Care Alternating Pressure/ Low Air Loss Mattress System by Rosco Medical).</p>	<p>1</p>	

**\*\* This assignment may also be completed via an internet search.**

**SEEK & FIND: WOUND**



<p>hydrocolloid around the wound perimeter such as with DuoDERM Extra Thin Dressing by ConvaTec).</p> <p>2. Alginate (such as Aquacel hydrofiber wound dressing by Convatec, then cover with secondary dressing such as a secondary gauze dressing and ABD.</p>					
<p>Stage 4 ischial pressure injury, 80% granulation tissue, 20% slough with tunneling and undermining.</p> <p>1. Alginate (such as Aquacel hydrofiber wound dressing by Convatec) ribbon to tunneling and a flat alginate dressing to the wound bed with a secondary moisture retentive dressing over such as foam or a gentle border dressing (such as Allevyn Gentle Border by Smith &amp; Nephew).</p> <p>2. The tunneling may be able to be reduced through application of a Negative Pressure Wound Therapy system such (such as an Acti VAC by KCI-with white foam inserted into the tunnels and black foam into the wound bed. Any bone, tendon or muscle would need to be protected from the black foam however with use of protective contact layer such as silicone (such as Mepitel contact layer by Molnlycke Health Care) or Adaptic (such as Adaptic Touch by Systagenix).</p>	1		<p>Identify two additional treatments (other than topical) to address with this patient.</p> <ol style="list-style-type: none"> <li>1. May benefit from a plastic surgery consult to evaluate for the possibility of performing a flap/graft to assist in the healing process.</li> <li>2. This patient would also benefit from an in- depth nutritional analysis starting with biochemical data such as albumin, pre-albumin, transferrin and a CBC. Then a dietary consult is indicated to determine what support this patient needs nutritionally such as with protein or amino acid supplementation.</li> </ol>	1	
<p>Patient with incontinence-associated dermatitis as a result of diarrhea and urinary incontinence. Address topical skin care (cleansing and protection).</p>	1		<p>Identify two methods of containment of diarrhea.</p> <ol style="list-style-type: none"> <li>1. Fecal incontinence system (such as</li> </ol>	1	

**\*\* This assignment may also be completed via an internet search.**

**SEEK & FIND: WOUND**



<p>1. Cleanse with skin cleanser (such as Soothe and Cool no-rinse perineal wash by Medline) then protect with barrier cream (such as Remedy Calazime skin protectant paste by Medline).</p> <p>2. Cleanse with incontinent barrier cream impregnated cloths, wiping after each incontinent episode (Such as with Shield Barrier Cream Cloths by Sage) prior to applying a topical barrier cream such as zinc oxide in either paste or cream.</p>			<p>Flexiseal Signal by Convatec).</p> <p>2. Rectal pouching system (such as the Hollister drainable fecal collection system).</p>		
<p>Venous insufficiency ulcer with large volume of drainage.</p> <p>1. For weeping/edematous lower extremity venous insufficiency ulcers, apply a product to manage exudate such as a foam dressing (for example Allevyn gentle border foam dressings by Smith &amp; Nephew, over the ulcer- than an appropriate level of compression (usually moderate consisting of 30-40 mm Hg. distally, with 12-17 mm Hg. at the infrapatellar notch). The ankle-brachial index (ABI) should be obtained prior to any use of compression and needs to be &gt;0.8 for moderate compression. Compression may be removed at bedtime and re-applied in the morning. Dressings/foam should be changed 3 x week or as needed. Elevate legs throughout the day (and at least 30 minutes prior to re-applying the compression) and reduce dietary sources of sodium.</p>	<p>1</p>		<p>Identify two (2) other areas to be addressed for the patient with a venous insufficiency ulcer.</p> <ol style="list-style-type: none"> <li>1. You should obtain an ankle brachial index (ABI) prior to applying compression. If &lt;0.5 to 0.8 consider low compression only- if needed. Anything less than 0.5 requires a vascular consult.</li> <li>2. Dietary management of sodium is also an important component in edema management in venous insufficiency, as is elevation.</li> </ol>	<p>1</p>	

**\*\* This assignment may also be completed via an internet search.**

**SEEK & FIND: WOUND**



<p>2. In an ambulatory patient you can also consider unna boot application (such as with the Unna-Z by Medline Industries). You also need to know the ABI prior to application and address the large volume of drainage before applying. A foam suitable for heavily exuding wounds/ulcers is Optifoam non-adhesive foam island dressing by Medline Industries, then apply the unna boot. If the foam is handling the drainage it can be left in place for 7 days, if strike through occurs, it needs to be changed more often (usually every 2-3 days-with the unna boot then changed as well).</p>					
--	--	--	--	--	--

\*\*Submit completed project to your dropbox

**\*\* This assignment may also be completed via an internet search.**

**2018**