SEEK & FIND: WOUND

Cleveland Clinic

Student Name __Shannon McNamara-LaVolpa_____ Date ___6/9/2021_____

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 **Topical therapy: Category and brand name of specific product(s) to be used** **Example: Foam; Restore Foam with adhesive border, 4" x 4"**	**Possible Points**	**Earned Points**	**Column B**	**Possible Points**	**Earned Points**
Wounds with small amounts of drainage. 1. Transparent film i.e., Smith and Nephew, Inc. Opsite™ - as a primary dressing with shallow minimally exudative wound (no secondary dressing needed if using for autolytic debridement of necrotic minimally exudative wound) 2. Hydrogels i.e. Elasto-gel™ by Southwest Technologies, Inc. – comes as 4"x4" sheet that you cut to fit wound,	0.5		Any special cautions when using the chosen products? 1. Transparent films - May tear fragile skin, use adhesive removers and be careful with removal. If wound starts to exude more drainage, add secondary absorptive dressing, such as 4"x4" gauze, as well as watch for periwound maceration 2. Hydrogels –may dehydrate and adhere to wound bed, so must be checked daily in order to assure	0.5	

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

secure with Cover-Roll® Stretch non-woven adhesive bandage.			maintenance of that moist wound healing environment – use non-water soluble skin sealant to protect periwound skin		
Sacral wound covered with intact eschar. 1. Use Transparent film i.e., Smith and Nephew, Inc. Opsite™ -this will help to moisten wound and autolytically debride it in order to remove eschar and visualize wound extent. 2. A LIP would have to sharply cross hatch the wound with a 13" surgical blade and then a daily nickel thick application of Santyl® (collagenase). Then cover the wound with Adaptic™ non-adherent dressing to ensure Santyl's placement and to help moisten wound bed to facilitate the enzymatic removal of eschar, then apply a 4"x4" gauze and paper tape or Cover-Roll® Stretch non-woven adhesive bandage is appropriate secondary dressing with securement.	1		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? Yes, for the wound changed from a non to minimally exudative wound to an exudative wound with indications of infection present (malodorous, thick [purulent],2cm periwound erythema). I would first obtain an order from LIP and obtain a wound culture using the Levine technique (this would be if I were able to locate a section of the wound that had viable tissue to obtain a culture from). I would then chose an antimicrobial absorptive dressing such as Aquacel® Ag^+ as my primary dressing, an abdominal pad as my secondary dressing, and Cover-Roll® Stretch non-woven adhesive bandage to secure. I like to use Cover-Roll® Stretch non-woven adhesive bandage in areas such as the sacrum or perineal areas for it adheres better to the skin in these highly moving areas.	2	
Wounds with 90% yellow adherent slough.	1		Identify two (2) actions used to prevent periwound maceration.	1	

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

1. Using a primary dressing like Aquacel® Ag+ under the hydrocolloid Hydrocolloid such as a 4"x4" Duoderm™ CGF™ for full thickness wounds can help to facilitate further autolytic debridement of adherent slough as well as adequate drainage control. 2. A daily nickel thick application of Santyl® (collagenase) would be appropriate. Then covered Adaptic™ non-adherent impregnated gauze dressing to ensure Santyl's placement. And then an abdominal pad and paper tape or Cover-Roll® Stretch non-woven adhesive bandage is appropriate secondary dressing with securement			1. Use of non-water soluble skin sealant such as No Sting Skin Prep® by Smith and Nephew, Inc. prior to dressing application 2. Use ointment like Coloplast's Triad® to periwound skin to protect it for it is hydrophilic and will protect periwound skin from breakdown under dressing.		
Type 3 skin tear. 1. Primary dressing of Adaptic™ non-adherent impregnated gauze dressing to wound bed so secondary dressing does not stick. Secondary dressing of Aquacel® be applied if there is moderate-heavy drainage. Aquacel® Ag+ can be applied if infection is suspected. Then abdominal pad, conforming rolled gauze, and tape to cover and secure. 2. Dermagran® impregnated gauze dressing applied as primary dressing. Abdominal pad, Curity® stretch rolled gauze, and tape to cover and secure.	1		Identify at least two (2) other nursing actions to be implemented for an individual with fragile skin. 1. Use of Medline Industry's Protective Arm and Leg Sleeves or DermaSaver® arm and leg sleeves that are padded for extra protection. 2. Optimizing nutritional support and hydration to maintain tissue viability. Malnutrition can delay healing and increase infection risk.	1	
Deep tissue injury (DTI)			Identify an additional nursing action for		

1. Offloading of area is essential. Podiatry felt (McKesson Orthopedic Felt Roll) can be cut to expose DTI and built up around periwound so pressure is adequately offloaded on wound base. 2. Skin Prep by Smith and Nephew, liquid film forming protective barrier wipe can be applied to wound to help form a protective film on wounds surface to help reduce friction. You can also apply a foam dressing (Allevyn® by Smith and Nephew) for protective covering with padding, but it will not be covered by insurance for there is no open wound.	1		an individual with a DTI. The area needs to be further offloaded. So EHOB™ Waffle® cushion can be implemented, gelled seat cushion like a Roho®, an air fluidized pressure redistributive mattress, heel lift boots, and turning every two hours while in bed and shifting weight while sitting every hour will reduce pressure to the area.	1	
Red, granulating stage 3 sacral pressure injury with little exudate. 1. Hydrocolloid such as a 4"x4" Duoderm™ CGF™ can be applied as primary dressing 2. Hydrogels i.e. Elasto-gel™ by Southwest Technologies, Inc. – comes as 4"x4" sheet that you cut to fit wound, use Cover-Roll® Stretch non-woven adhesive bandage to cover and secure.	1		Identify an <u>advanced wound therapy</u> that could be used with this wound type. Oasis® by Smith and Nephew can be applied to this type of wound. It will have to have Adaptic™ non-adherent impregnated gauze dressing to cover and secure that with steri-strips. Then Hydrofera Blue® READY can be applied over it for a protective foam barrier and to maintain moisture of wound bed. Lastly, secure with Cover-Roll® Stretch non-woven adhesive bandage.	1	
Heavily draining stage 4 sacral injury. 1. Pack wound with Aquacel® Ag+ ribbon, cover with Softsorb® absorbent wound	1		Identify an appropriate support surface to use with this patient (category/brand name).	1	

dressing and secure with Cover-Roll® Stretch non-woven adhesive bandage 2. Pack wound with Hydrofera Blue® HEAVY drainage, cover with Softsorb® absorbent wound dressing, secure with Cover-Roll® Stretch non-woven adhesive bandage.			Airisana™ Therapeutic Support Surface – which is an air fluidized mattress that performs pressure redistribution as well as controls moisture. This will be good with a heavily draining wound.		
Stage 4 ischial pressure injury, 80% granulation tissue, 20% slough with tunneling and undermining. 1. Pack wound with Aquacel® Ag+ ribbon, with light induction of the hydrofiber into tunnels and tucked into undermining. Cover with abdominal pad. Secure with Cover-Roll® Stretch non-woven adhesive bandage. 2. Pack wound with Mesalt® ribbon and lightly pack tunnels and tuck into undermining. Cover with abdominal pad. Secure with Cover-Roll® Stretch non-woven adhesive bandage.	1		Identify two additional treatments (other than topical) to address with this patient. 1. Pressure relief - EHOB™ Waffle® cushion to be implemented and or gelled seat cushion like a Roho®. A low air loss pressure redistributive mattress, and turning every two hours while in bed and shifting weight while sitting every hour will reduce pressure to the area. 2. Keep skin clean and clear of bodily fluids, i.e., urine, stool, moisture from sweat, etc. Bathe perineal area daily using pH balanced cleanser. Dry areas thoroughly with soft washcloth or using the cool function on a hair dryer.	1	
Patient with incontinence-associated dermatitis as a result of diarrhea and urinary incontinence. Address topical skin care (cleansing and protection).	1		Identify two methods of containment of diarrhea. 1. External fecal collection device – such as ConvaTec Flexi-seal™ Fecal	1	

1. Cleanse skin daily and after episodes of fecal or urinary incontinence with pH balanced cleanser such as 3M™ Cavilon™ Continence Care Wipes. Allow to completely dry, can pat dry with gentle cloth if needed. Use 3M™ Cavilon™ No Sting Barrier Film after every incontinent episode for patients with reddened intact or non-intact skin for protection. 3M™ Cavilon™ Durable Barrier Cream for dry skin and protection for IAD at risk skin. 2. Cleanse skin daily and after episodes of fecal or urinary incontinence with Ca-Rezz® Norisc® antibacterial pH balanced incontinence wash. Wipe with warm gentle wash cloth and pat dry. Can use cold function on hair dryer to ensure area is completely dry. Apply Ca-Rezz® Norisc® antibacterial cream to affected areas. Can apply Nystop® antifungal powder if fungal infection suspected twice daily or as directed.			Collection Pouch 2. Internal collection device such as ConvaTec Flexi-seal™ Signal™ Fecal Management System (FMS).		
Venous insufficiency ulcer with large volume of drainage 1. Aquacel® Ag^+ to wound bed, cover with Softsorb® absorbent wound dressing, wrap with Curity® stretch rolled gauze, and tape to secure. 2. Hydrofera Blue® CLASSIC moistened with saline or water, Softsorb® absorbent wound dressing, wrap with Curity® stretch rolled gauze, and tape to secure.	1		Identify two (2) other areas to be addressed for the patient with a venous insufficiency ulcer. 1. Compression – use of multilayer compression wraps pressure ranging from 20-50mmHg. Coban™ 2 lite or Coban™ 2 two layer wraps. Dewrap™ three layer wrap or Profore four layer wrap. Or dual layer compression stockings, Velcro compression stockings with	1	

			liners, or single layer compression stockings. 2. Elevation. Legs lifted above the level of heart 3 times daily for 1 hour each session.		

**Submit completed project to your dropbox

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