SEEK & FIND: WOUND

Cleveland Clinic

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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. Biatain® Foam Dressing 4"x4" 2. DuoDERM® Extra Thin 4"x4".	0.5		Any special cautions when using the chosen products? Foam: Determine whether an adhesive border is needed. If a bordered foam is used, determine whether a gentle adhesive such as silicone or gel-based is needed depending on fragility of periwound skin. Hydrocolloid: At least 2.5 cm of intact periwound skin is needed to safely use a hydrocolloid.	0.5	

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

			Hydrocolloids are not advised for lower extremity wounds unless adequate perfusion has been demonstrated due to infection risk caused by trapped moisture. Hydrocolloids can macerate the periwound due to their occlusive nature. This can be mitigated by using a skin barrier wipe such as Skin-Prep® on the periwound. Hydrocolloids must be used with caution in diabetics or immunocompromised patients due to infection risk caused by trapped moisture. Hydrocolloids are not appropriate for fragile periwound skin (or remove with great caution). They are also not appropriate for infected wounds or wounds with undermining/sinus tracts. They are contraindicated for burns and arterial wounds. The residue can be difficult to remove. It is better to leave the residue in place than risk mechanical skin damage by trying to scrub it off. Hydrocolloids can cause an unpleasant odor due to the reaction of wound exudate with the materials in the dressing. The WOC nurse should educate the patient and caregiver that		

			this odor is normal and not a sign of infection.		
Sacral wound covered with intact eschar. 1. Apply 3M™ Cavilon™ No Sting Barrier Film to periwound. Apply Medihoney® hydrogel colloidal sheet cut to fit wound, cover with DuoDerm® Signal 4”x4”, change every 3 days and prn if dressing becomes loose or soiled. 2. Cross-hatch eschar and apply nickel-thick layer of Santyl to eschar. Cover with gauze moistened with sterile saline and ABD pad. Change daily and prn if dressing becomes loose or soiled.	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, a draining wound with signs of infection needs to be managed differently than a dry wound. It should be managed as follows: 1. Conservative sharp debridement by a qualified individual. 2. Cleanse the wound by irrigating with sterile saline using a 35-mL syringe and 19-gauge angiocath. The WOC nurse should wear appropriate PPE during irrigation. 3. Assess and measure wound bed. 4. Obtain a wound culture using appropriate technique. 5. Apply 3M™ Silvercel™ Antimicrobial Alginate Dressing 4”x4”, cut to fit wound bed. 6. Layer fluffed gauze moistened with sterile saline over the alginate. 7. Cover with Biatain® Super, Adhesive foam 4”x4”. 8. Change every 3 days and prn if loose or soiled.	2	

Wounds with 90% yellow adherent slough. 1. Apply Medihoney® hydrogel colloidal sheet cut to fit wound bed. Cover with 3M™ Tegaderm™ Hydrocolloid Dressing 4”x4”. Change every 3 days. 2. Apply nickel-thick layer of collagenase (Santyl®) to wound bed, cover with moistened and fluffed 4”x4” gauze and ABD, secure with paper tape. Change daily. If the wound is on a lower extremity, a hydrocolloid should not be used. Biatain® Silicone Lite is indicated for low-exuding wounds and would be an appropriate choice. This dressing could also be used with the Santyl, although a daily dressing change would be costly for this product. However, it may be a better choice depending on the size of the wound. Moistened gauze may macerate the periwound, especially if too much is used.	1		Identify two (2) actions used to prevent periwound maceration. 1. Apply a skin barrier product such as 3M™ Cavilon™ No Sting Barrier Film to the periwound. 2. Select an absorbent dressing that appropriately manages exudate to minimize prolonged contact with the wound edges. For example, hydrofiber dressings wick moisture vertically and would direct exudate away from the periwound.	1	
Type 3 skin tear. 1. Apply 3M™ Adaptic™ Touch Non-Adhering Silicone Dressing, cut to appropriate size. Secure with 3M™ Tegaderm™ High Performance Foam Adhesive Dressing, 3”x3”. Change every 3 days.	1		Identify at least two (2) other nursing actions to be implemented for an individual with fragile skin. 1. Use push-pull technique when removing any type of medical adhesive. Do not remove by pulling the dressing back against itself, as this can cause skin	1	

2. Apply Xeroform® Occlusive Dressing patch peelable foil pack, 2”x2”. Secure with Kerlix. Change every 3 days.			stripping. 2. Use adhesives that are silicone or gel-based. 3. Secure dressings with stockinette netting or TubiGrip if feasible. 4. A regular skin care regimen should be followed that consists of cleansing with warm water or with no-rinse pH-balanced skin cleanser and gently patting dry. Apply moisturizer immediately after bathing while skin is still damp. 5. Keep fingernails trimmed and filed to avoid snagging and to reduce risk of injury if the patient scratches. 6. Wear soft, long-sleeved shirts and non-binding knee-high socks to protect extremities from skin tears.		
Deep tissue injury (DTI) 1. Apply 3M™ Tegaderm™ High Performance Foam Adhesive Dressing 5 5/8” x 5 5/8”. Lift foam and inspect skin every shift. Change every 3 days and prn if loose or soiled. 2. Apply 3M™ Cavilon™ No Sting Barrier Film to area of DTI every shift. Reapply	1		Identify an additional nursing action for an individual with a DTI. Turning and repositioning to avoid any pressure on the DTI is essential. If the DTI is on the heels, the heels need to be offloaded at all times using heel protectors or pillows in addition to protective foam. If the DTI is on the	1	

after skin cleansing.			sacrococcygeal area, the patient should rotate from side to side and should not be positioned supine. Foam wedges can be used to ensure that the patient is positioned at a 30-degree tilt.		
Red, granulating stage 3 sacral pressure injury with little exudate. 1. Apply 3M™ Cavilon™ No Sting Barrier Film to periwound. Apply thin layer of 3M™ Tegaderm™ Hydrogel Wound Filler to wound bed and place Adaptic™ Touch Non-Adhering Silicone Dressing over wound. Cover with Comfeel® Plus Ulcer Dressing 6"x6". Change every 3 days and prn if loose or soiled. 2. Apply 3M™ Cavilon™ No Sting Barrier Film to periwound. Apply PrimaCol® Bordered Hydrocolloid, large sacral size. Change every 3 days and prn if loose or soiled.	1		Identify an <u>advanced wound therapy</u> that could be used with this wound type. If the wound has sufficient depth, negative pressure wound therapy will help contract the wound edges and encourage further granulation. If the wound is not deep enough for NPWT, a hydrogel with a collagen product such as CellerateRX® gel or powder or Promogran Prisma® Matrix could be used to stimulate collagen production. Another option is Endoform®, which provides a matrix for the patient's own cells to migrate onto and stimulates angiogenesis.	1	
Heavily draining stage 4 sacral injury. 1. Cleanse wound with sterile saline. Lightly pack with Mesalt® ribbon 3/4'". Cover with Drawtex® 4"x4" and secure with Mepilex® XT Absorbent Foam Dressing 6"x6". Change daily and prn if dressing becomes saturated. 2. Cleanse wound with sterile saline. Apply DermaGinate™ Calcium Alginate Dressing	1		Identify an appropriate support surface to use with this patient (category/brand name). The Therakair® Visio mattress replacement system (MRS) by Arjo provides low air loss therapy together with a pressure redistribution surface. The low air loss feature helps protect the skin's microclimate and provides cushion, while the pressure redistribution	1	

2”x2” to wound bed, fill with fluffed gauze if needed. Do not cut gauze. Cover with Drawtex® 4”x4” and secure with Mepilex® XT Absorbent Foam Dressing 6”x6”. Change daily and prn if dressing becomes saturated.			feature assists the staff with ensuring that pressure points are alternated. Another option would be a reactive support surface such as a RIK® Fluid Overlay. For either of these options, the WOC nurse needs to educate the staff that the support surface is an adjunct to turning and repositioning, and it will still be essential to assist the patient with frequent turning and repositioning.		
Stage 4 ischial pressure injury, 80% granulation tissue, 20% slough with tunneling and undermining. 1. Apply 3M™ Cavilon™ No Sting Barrier Film to periwound. Place 3M™ Fibracol™ Plus Collagen Wound Dressing with Alginate, rope form to tunnel, leaving end of rope in view. Place 3M™ Fibracol™ Plus Collagen Wound Dressing with Alginate 5 cm x 5 cm to wound bed. Cut to fit wound bed, do not layer. If needed, place fluffed gauze that is moistened with 3M™ Tegaderm™ Hydrogel Wound Filler and sterile saline to wound bed to fill dead space. Cover with Biatain® Foam adhesive border 7”x7”. Change daily and as needed. Irrigate wound when changing dressing to ensure that	1		Identify two additional treatments (other than topical) to address with this patient. 1. Keep the ischium offloaded at all times. Avoid lying on affected ischium in bed. Use Isch-Dish® Pressure Relief Cushion when in chair or wheelchair. Limit chair time to 2 hours. 2. Consult Nutrition to determine appropriate protein intake for wound healing and identify any nutritional deficiencies.		

alginate is completely removed. 2. Cut Hydrofera Blue® Classic into wick shape to fit tunnel, moisten with sterile saline, and place in tunnel leaving end in view. Apply Hydrofera Blue® Classic moistened with sterile saline to wound bed. If needed, place fluffed gauze that is moistened with 3M™ Tegaderm™ Hydrogel Wound Filler and sterile saline to wound bed to fill dead space. Cover with DuoDERM® CGF® Border Dressing 8"x8". Change every 3 days and as needed.					
Patient with incontinence-associated dermatitis as a result of diarrhea and urinary incontinence. Address topical skin care (cleansing and protection). 1. Cleanse skin daily and with each episode of incontinence using Aloe Vesta® Perineal/Skin Cleanser. Wipe the perineum from front to back. If the patient cannot tolerate wiping, use a peri-bottle with warm water to cleanse. Gently wipe dry with Dry Wash Cloths (Dukal Corporation) or allow to air dry. Apply Aloe Vesta® Daily Moisturizer. Apply Remedy® with Phytoplex™ Z-Guard Skin Protectant Paste.	1		Identify two methods of containment of diarrhea. Methods of containing stool include absorbent pads or reusable continence products, stool containment pouches, and fecal containment systems. Disposable absorbent pads require that the patient be checked frequently to prevent the skin from being in prolonged contact with irritating fecal enzymes that will rapidly erode the skin. Stool containment pouches are designed to adhere to a pectin-based skin barrier that is applied to the perianal skin and inner buttocks. The skin must be intact to use these products; if the skin is	1	

Remove only soiled portion of skin paste when performing incontinence care, do not remove entire layer and expose skin. 2. Cleanse skin daily and with each episode of incontinence using EasiCleanse® Bath wipes. If the patient cannot tolerate wiping, saturate the wipe and squeeze excess over the skin to rinse it. Gently wipe dry or allow to air dry. Apply Sween® 24 Cream. Apply Critic-Aid® Skin Paste. Remove only soiled portion of skin paste when performing incontinence care, do not remove entire layer and expose skin. If the patient is unable to tolerate application of moisturizer or paste, use 3M™ Touchless Care™ Zinc Oxide Protectant Spray to protect denuded/eroded skin.			constantly moist or already eroded, the skin barrier will not adhere. Fecal containment systems consist of a rectal catheter held in place by a water-inflated balloon, similar to an indwelling urinary catheter. Small amounts of leakage can occur with these systems, and staff must be properly trained in their insertion and maintenance. They are best suited for bedbound patients with high volumes of liquid stool.		
Venous insufficiency ulcer with large volume of drainage 1. Clean wound with sterile saline and pat dry with gauze. Apply Aquacel® EXTRA™ Hydrofiber® Wound Dressing			Identify two (2) other areas to be addressed for the patient with a venous insufficiency ulcer. 1. It is important to reduce edema as	1	

with Strengthening Fiber 4”x5” to ulcer. Cover with ABD pad and secure with kerlix. Secure entire dressing with TubiGrip size G, cut to fit from base of toes to 1 inch below bend of knee. Change every 3 days and prn if dressing becomes saturated. 2. Moisten Hydrofera Blue® Classic with sterile saline. Apply to ulcer. Cover with Exu-dry and secure with kerlix. Secure entire dressing with 3M Coban 2-layer compression. Change every 3 days and prn if dressing becomes loose or rolls down leg. Option 2 assumes that the patient’s ABI is greater than 0.8 and less than 1.3, per manufacturer specifications.			much as possible. Compression is an important part of the treatment plan. Compression can be done with tubular knit stockings such as Tubigrip or compression bandage systems such as 3M’s Coban. A walking program can also help to reduce edema by strengthening the lower leg muscles, thereby improving venous return. Legs should be elevated frequently throughout the day. 2. If the patient smokes, smoking cessation should be highly encouraged. The patient should be educated that smoking causes vasoconstriction and blood pooling in the the narrowed leg veins in the legs will increase the risk of further ulcers. In addition, oxygen delivery to the tissues is reduced, delaying wound healing.		

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