SEEK & FIND: WOUND

Cleveland Clinic

Student Name: Meagan Ward Date: January 2, 2023

Instructor Signature _____ Student's earned points _____/20

This assignment is intended to help you become familiar with some of the products used when providing wound care. : It is not uncommon for WOC nurses to be asked for treatment recommendations with little wound information and for unseen wounds. These recommendations are based upon knowledge of wound dressing categories and matching them to wound characteristics. This assignment helps to mimic this situation.

Carefully read the information to help you identify the products that meet the descriptions being provided. The products should be those considered as a topical therapy/wound dressing. Advanced wound therapy options, such as NPWT and collagen, should only be identified when indicated.

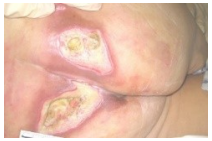
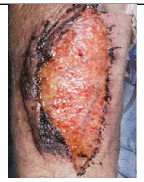
Column A: For each wound type or scenario, identify two different categories/classifications (foam, hydrocolloid, transparent film, etc) of topical therapy. A complete answer identifies the dressing classification, a specific product name and manufacturer, and the secondary dressing if indicated. The inclusion of the primary and secondary dressing is considered a complete answer. For example: Hydrofiber covered by a hydrocolloid: Aquacel (Convatec) covered by a Duoderm (Convatec). Use the product name & NOT the product number when completing this assignment.

Column B: Either identifies additional information related to the wound and mini case scenario in Column A OR asks other wound care related questions Answer the questions.

Column A **Topical therapy**	**Possible Points**	**Earned Points**	**Column B**	**Possible Points**	**Earned Points**
Wounds with scant to small amounts of drainage. 1. Hydrocolloid (DuoDerm: Extra thin 4X4 Hydrocolloid [or other sizes as appropriate] - ConvaTec) secured with gauze (Rolled Gauze – Curad) and/or tape (3M) as a secondary dressing if the hydrocolloid does not have an adhesive border.	0.5		Identify special precautions/considerations for each of the chosen products in Column A? Product 1: Hydrocolloids like DuoDerm should be warmed between the hands before application to allow for easier application (they can be stiff). They are changed every 3-5 days and should not be used on infected wounds.	0.5	

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

2. Hydrogel (Elastogel: Absorbent Wound Dressing – Southwest Technologies) secured with gauze (Curad – Rolled Gauze) or transparent film (Tegaderm) as a secondary/retention dressing if the hydrogel does not have an adhesive border.			Product 2: Hydrogels, when used inappropriately in wounds with heavy exudate can cause maceration, but unlike hydrocolloids can be used in the presence of necrotic tissue and infected wounds.		
Sacral wound covered with 100% intact eschar. 1. If healing is an option/goal: Hydrogel (Elastogel: Absorbent Wound Dressing – Southwest Technologies) secured with transparent film (Tegaderm – 3M) as a secondary dressing if the hydrogel does not have an adhesive border [promote rehydration and autolysis to debride the wound]. 2. If wound is non-healing and one is looking to protect the wound/eschar (i.e., stable, intact eschar): Dry gauze (gauze sponge, sterile - Medline) with a transparent film (Tegaderm – 3M) to secure.	1		The sacral wound (Column A) now presents as boggy and odorous, draining thick exudate and has a 2 cm area of erythema surrounding the wound. 1. **Would this assessment change your topical therapy choice?** This would require reassessment of the wound and a change in dressing selection/topical therapy as the thick exudate could lead to maceration of the periwound tissues. 2. **If yes, what would be your new topical treatment?** An alginate dressing (AlgiSite M 4X4 or other size as appropriate – Smith and Nephew) are useful with moderate to heavy exudate and could be loosely packed into the wound bed and secured with a secondary dressing. Be mindful that the gel formed turns a green/grey color and should be throughly flushed from the wound so as not to be mistaken as exudate upon removal. 3. **Are there any other actions**	2	

			would you perform or initiate as part of the plan of care? A skin sealant/barrier (Sureprep No-Sting Skin protectant - Medline) may be needed around the periwound skin to help prevent any further maceration of the skin.		
Wounds with 90% yellow adherent slough.  1. Alginate (Smith and Nephew: AlgiSite M) covered by a foam dressing (Smith and Nephew: Allevyn Foam Dressing) 2. Hydrogel dressing (Aquaform – Aspen Medical) covered with a secondary dressing like gauze (Gauze sponges – Medline)	1		Identify two (2) <u>different actions</u> used to prevent periwound maceration. 1.To help prevent periwound maceration a skin sealant or skin barrier should be utilized (No Sting Skin Barrier Film – Safe and Simple). 2.Hydrogels can absorb exudate, but heavy exudate could result in leakage causing periwound maceration. It would be important to monitor the dressing and change every 1-3 days so that the dressing can provide rehydration and autolysis without over saturation. If this wound started producing large amounts of exudate it may no longer be an appropriate selection.	1	
 Type 3 skin tear. *Total flab loss entire wound bed exposed* 1. Nonadherent foam dressing (6x6 (or	1		Identify at least two (2) nursing actions, not topical wound treatments, to be implemented for an individual with fragile skin. 1. Short nails, for both patient and caregiver, to help prevent any	1	

other appropriate size) nonadherent foam dressing – MedVance Foam) with a protective sleeve (Tubular Elastic Retention Dressing – Curad) 2. Hydrogel dressing (Aquaform – Aspen Medical) covered with a secondary dressing like gauze (Gauze sponges – Medline)			accidental mechanical trauma to a patient's skin. 2. Routine (twice daily) use of moisturizers (creams over lotions) to aid in maintain skin moisture has shown to help decrease the incidence of skin tears.		
Deep tissue pressure injury (DTPI) 1. Foam Dressing (Allevyn Dressing – Smith and Nephew). 2. Barrier cream containing zinc (Remedy Phytoplex Z-guard Skin Protectant Paste – Medline); this would allow for moisture barrier in high moisture areas. Additionally turning and repositioning Q2 and offloading the area of injury to reduce/prevent further exposure to pressure (i.e., utilizing heal boots – Heal Protector with integrated wedge – Prevalon).	1		Both of these pictured dressings are from the same classification. Identify the classification/category and the implication for use.   **Classification**: Foams **Use**: Foam dressings help provide a warm, moist environment for healing as well as provide some cushioning. They can come impregnated with different properties (Methylene blue – antimicrobial, charcoal – odor control) to assist with wound healing/management. They should be used for wounds like skin tears, some pressure injuries, partial or full thickness wounds, or those wounds which have moderate to heavy drainage.	1	
Red, granulating stage 3 sacral pressure injury with little exudate.	1		Identify an appropriate support surface (category/brand name) to use when pressure injuries are present.	1	

1. Hydrocolloid Dressing (DuoDerm Hydrocolloid Dressing - ConvaTec) – monitor for the development of hypergranualtion tissue as this is possible with this type of dressing. 2. Hydrogel Dressing (Elastogel: Absorbent Wound Dressing – Southwest Technologies) secured with gauze (Curad – Rolled Gauze) or transparent film (Tegaderm) as a secondary/retention dressing if the hydrogel does not have its own adhesive border. Hydrogels can have a cooling/soothing affect which could assist with pain control.			Patient positioning wedges – Sandel		
Partial thickness wound with moderate amounts of drainage 1. Hydrofiber dressing (Hydrofiber wound dressing – Aquacel Extra – ConvaTec) secured with a secondary dressing like gauze (gauze sponges – Medline). 2. Alginate dressing (Smith and Nephew: AlgiSite M) covered by a gauze cover dressing (Rolled gauze dressing – Conforming Stretch Gauze Bandages – Medpride).	1		Identify the classification/category for each pictured dressing. 1.   Hydrofiber dressing 2.  Alginate dressing	1	
Stage 4 ischial pressure injury, 80% granulation tissue, 20% slough with tunneling and undermining. 1. Foam dressing that can also be utilized	1		Identify two additional treatments (other than topical) to address with this patient. 1. Prompt and complete incontinence care with each episode. This would	1	

to pack a wound as they can conform and support autolytic debridement (small individual pieces should not be used to pack as they will be difficult to ensure removal) (Allevyn Life Foam Dressing – Smith and Nephew). 2. Hydrogel Dressing can provide a warm, moist environment and promote autolysis of the slough (Elastogel: Absorbent Wound Dressing – Southwest Technologies) with gauze/film as a secondary dressing (gauze sponges – Medline, Tegaderm – 3M).			include gentle cleaning of the area, removal of any solid dressing materials, and proper replacement of appropriate dressing. If incontinence is preventing healing from occurring this patient may meet necessary qualifications for temporary use of an indwelling urinary catheter to allow for healing and prevent further degradation of the wound. 2. Implementation of a turning regimen (i.e., turning/repositioning Q2) with appropriate support surfaces to offload pressure (i.e., wedges, heal boots, low air loss mattress).		
Patient with incontinence-associated dermatitis as a result of diarrhea and urinary incontinence. Address topical skin care. **Cleansing**: Cleaning with a pH balanced cleanser that contains surfactant (reduce surface tension/friction) or with warm water. Cleansing should be gentle so as not to damage the skin further. **Protection**: Moisture barrier creams (Protective Barrier Cream with Zinc Oxide – Sensi Care) can be utilized to reduce the skins contact with the urinary/fecal matter when incontinence is present. Of note, it should be applied in thin layers, and it is not necessary to remove every last bit of previously applied cream when performing	1		In addition to BWAPs, there are additional methods of diarrhea containment. Identify two other methods. 1. Internal fecal management system (aka: fecal containment system/rectal tube) like FlexiSeal from ConvaTec in the acute care setting. 2. Rectal Trumpet (RT) which uses a nasopharyngeal airway for the containment of stool in the acute care setting typically in the critically ill.	1	

incontinence care as that friction could potentially damage the healing skin.					
Identify topical dressings for lower extremity venous ulcers with large amounts of wound drainage. 1. Multi component wrapping for compression therapy. Gauze/absorbent padding as a base layer to absorb exudate (ABDs – Dermacea – Covidien), followed by cast padding (Cast padding – Hopsora) that can smooth out the padding layer in preparation for the elastic layer, finished with an elastic bandage (Elastic Bandages – Mighty X). 2. Alginate dressing (Smith and Nephew: AlgiSite M) could be used as they are highly absorptive but would require daily dressing changes. It could be secured with previously mentioned layers to provide compression therapy as well.	1		Identify two (2) other areas to be addressed in the plan of care for the patient with a lower extremity venous ulcer. 1. Compression therapy is the standard of care for patients with LE ulcers for both prevention and treatment. A patient would need to be properly measure by a trained individual for a compression garment. With the additional education of how wash/care for the compression garment. 2. Elevation is also important in this patient population. Elevation of the feet to at least the level of the heart for thirty minutes three to four times a day is the current recommendation.	1	

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