

Case Report Challenge guide

Ostomy Care / Continence Care / Wound & Skin Care / Urology Care



This is a guide to aid you in filling out the case report template. You can use the PowerPoint document to fill out information for the case.

When you have filled out the case report template in PowerPoint, please email it to slcwadmin@stluke.org.sg by 28 Jan 2022 with your name and contact number.

Please refer to the following for submission guidelines for your case report challenge.

Before starting, please ensure you have all the necessary permission required in your local area.

Choose a patient which you would like to use for the case report and decide on the period of the case report (this may be decided as a specific time period, e.g. 30-45 days, or until an end goal is reached, e.g. reduction in size of a certain amount or until healing)

Challenge guide

Submission Criteria

Submission Criteria	Remarks
Local case that is treated from Sep 2021 to Feb 2022	Wound to be treated in this time period. Does not have to be a new wound, existing chronic wound acceptable
Wound should be chronic and complex	<ol style="list-style-type: none">1. Chronic wound examples: PI, DFU, Venous leg ulcer, Arterial leg ulcer, Infected wounds...2. Complex wound examples: Undermining and/or tunnelling3. No minor wound, i.e scratches, skin tear, abrasions, minor burns
Wound healing dressing to be used	Examples: Primary dressing products: Alginates, hydrofibers, hydrocolloid, foams dressings, hydrogels, contact layers, iodine dressings, collagen based dressing, activated carbon based dressing, Honey based dressing, Silver dressings Secondary dressing products: Foam dressing Exclude: NPWT, NPWTi, Maggot therapy, Biological Skin Substitutes, oxygen delivery devices
Must submit all fields required in the case report template	All sections of case report should be filled up Font size 11, font type Arial
Individual and group submission is allowed	Max 3 pax in a group

Challenge guide

Title:

Ensure you have included the type of wound being treated, and the type of dressing being used, e.g.

Use of a foam dressing with a silicone adhesive contact layer in the treatment of a diabetic foot ulcer

Under the tile, include your name, your job title and your place of employment.

Introduction:

In the introduction include background information about the type of wound being discussed. Also include how full assessment of the wound, including the periwound skin, allows for developing an optimal management plan in these kinds of wounds.

Patient:

Include appropriate information about the patient, such as:

Age, Gender, Medical history, Medications, Nutrition status, Mobility status, Smoking status, Alcohol status.

Include appropriate information about the wound, such as:

Wound type, location of wound, wound duration, previous treatments, pain experienced

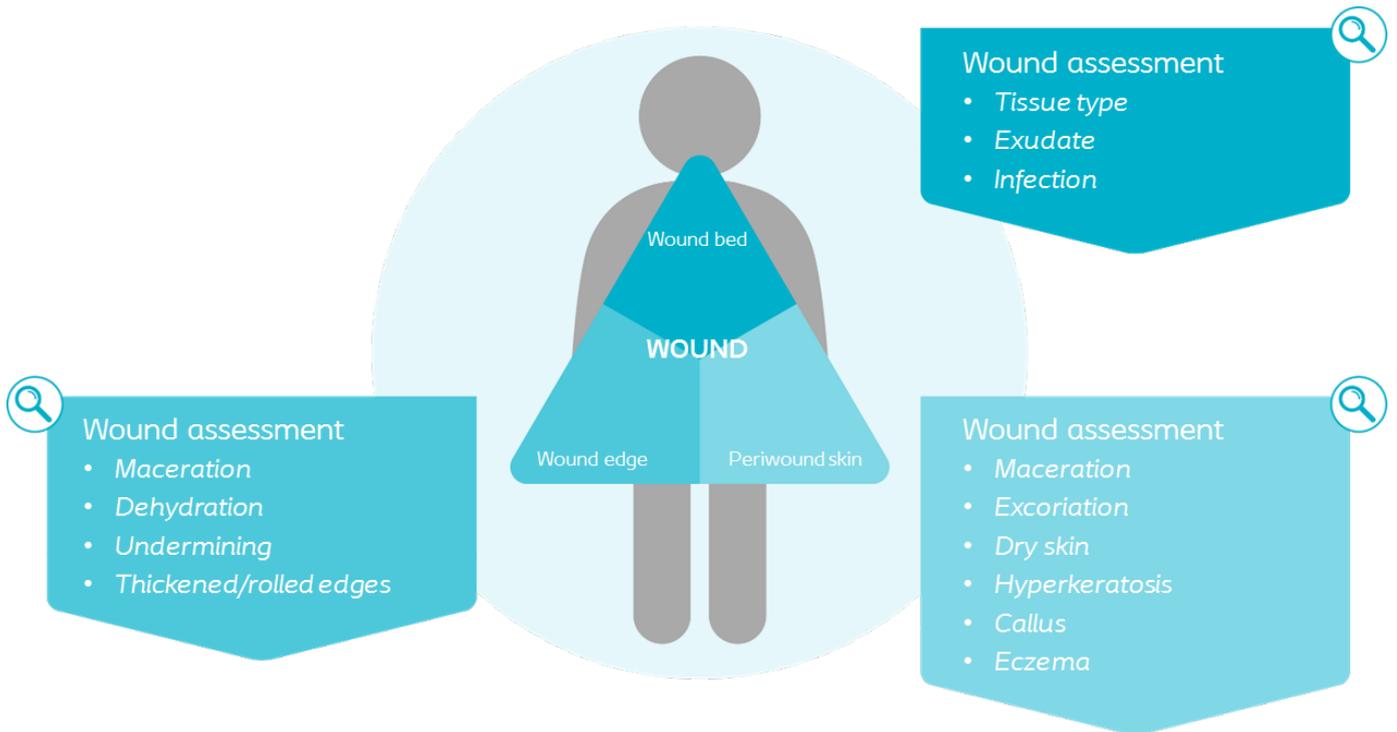
Initial wound assessment:

Include a picture of the wound prior to starting treatment (please follow the photo guidelines to ensure you take a good picture)

Include the size of the wound (length, width and depth) in mm.

Identify what is seen on assessment of the wound bed, wound edge, and periwound skin, using the Triangle of Wound Assessment framework.

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You can use the following pages to record your assessment findings.

Please tick what you see in each of the areas below:

Challenge guide



Wound bed Wound Assessment

Tissue type

Nectrotic



——— %

Granulating



——— %

Sloughy



——— %

Epithelialising



——— %

Exudate

Level

Dry

Low

Medium

High

Type

Thin/watery

Thick

Cloudy

Purulent

Pink/red

Infection

Increased pain

Erythema

Oedema

Local warmth

Local

Increased exudate

Delayed healing

Friable granulation tissue

Malodour

Pocketing

Spreading/
systemic

Increased erythema

Pyrexia

Abscess/pus

Wound breakdown

Cellulitis

General malaise

Raised WBC count

Lymphangitis

Challenge guide



Wound edge Wound Assessment

Maceration		<input type="checkbox"/>
Dehydration		<input type="checkbox"/>
Undermining		<input type="checkbox"/> 
Rolled edges		<input type="checkbox"/>

Challenge guide



Periwound skin Wound Assessment

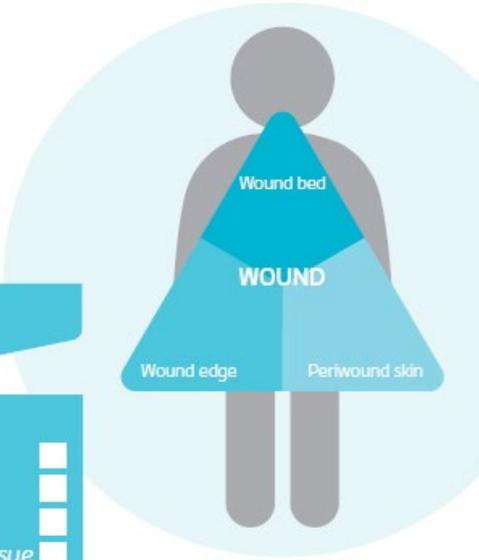
Maceration		<input type="checkbox"/> _____	_____ CM
Excoriation		<input type="checkbox"/> _____	_____ CM
Dry skin		<input type="checkbox"/> _____	_____ CM
Hyperkeratosis		<input type="checkbox"/> _____	_____ CM
Callus		<input type="checkbox"/> _____	_____ CM
Eczerma		<input type="checkbox"/> _____	_____ CM

Challenge guide

Management goals:

Tick the appropriate management goals which relate to the assessment for each area (wound bed, wound edge and periwound skin), using the figure below:

 **Management goals**
Tick all appropriate management goals



Wound Assessment

Management goals

- Remove non-viable tissue
- Manage exudate
- Manage bacterial burden
- Rehydrate wound bed
- Protect granulation/epithelial tissue

Wound Assessment

Management goals

- Manage exudate
- Protect skin
- Rehydrate skin
- Remove non-viable tissue

Wound Assessment

Management goals

- Manage exudate
- Rehydrate wound edge
- Remove non-viable tissue
- Protect granulation/epithelial tissue

Treatment:

Write the treatment of this patient. Remember to include not only dressings used, but also other treatment methods used (e.g. compression therapy, barrier cream etc.)

Also include reason for choosing the dressing (how it works on wound bed, wound edge and periwound skin).

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Results:

Describe what happened to the wound based on the treatment given. This reassessment should be done by using the Triangle of Wound Assessment framework (use appendix 1 for reassessment of the wound).

Please note the changing size of the wound, any changes to assessment parameters (e.g. cessation of infection signs, decreased exudate levels).

Also note significant changes to patient related issues (e.g. pain levels).

Include pictures of the wound at different days, noting number of days after initial treatment started. You can add up to 3 pictures to show progression of the wound. Keep in mind to take photos in accordance with the photo guide, and similar to the other pictures taken.

Use the Triangle of Wound Assessment to reassess the wound at the end of the case report period (you can use appendix 1 to note your findings).

Conclusion:

Include what features and benefits of the product have allowed it to treat the wound, thinking in terms of how it has had an effect on the wound bed, wound edge and periwound skin.

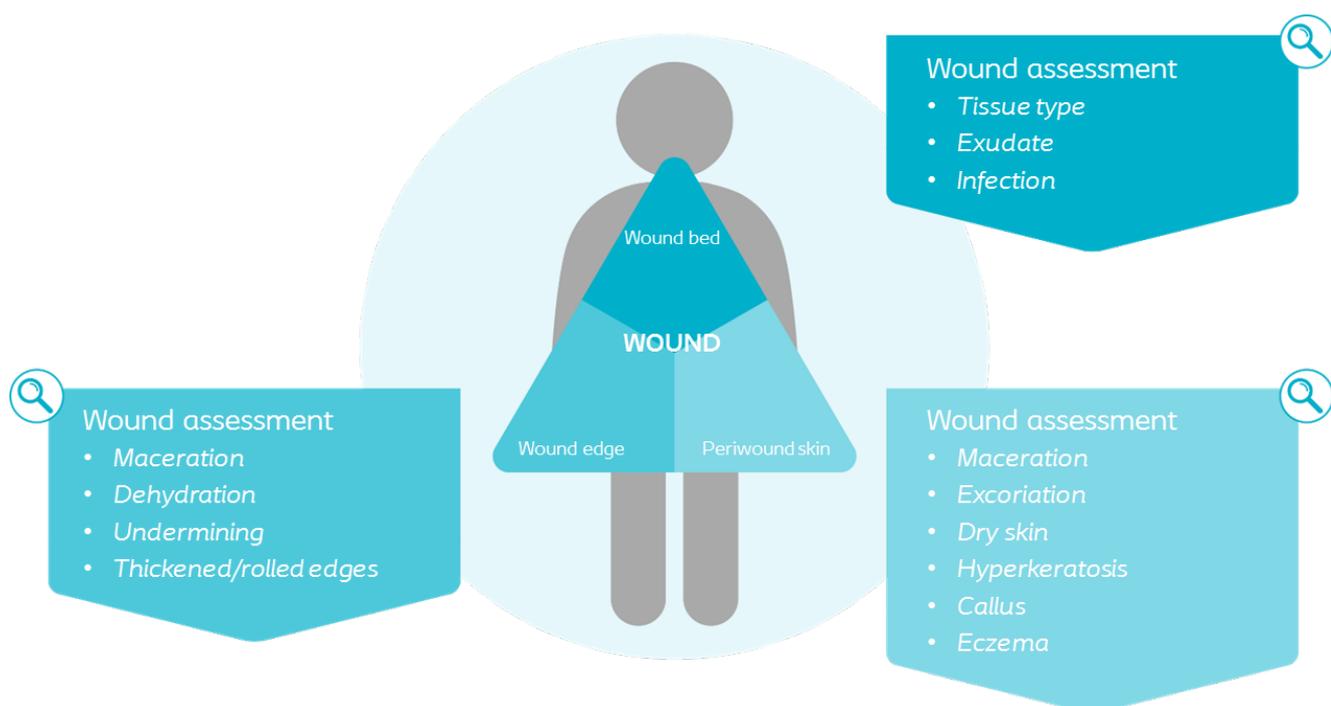
Also explain how assessing all 3 areas of the wound (wound bed, wound edge and periwound skin) have allowed for better management and treatment of the wound.

If you have any questions, please email to sgadmin@coloplast.com who will be able to help you with filling out the template.

Challenge guide

Appendix 1

You can use the forms below to record findings on subsequent visits after the initial assessment. For these reassessments, use the Triangle of Wound Assessment.



Challenge guide

Second visit

Size of wound:	Length _____ cm
	Width _____ cm
	Depth _____ cm



Wound bed Wound Assessment

Tissue type

Nectrotic		<input type="checkbox"/>	_____ %	Granulating		<input type="checkbox"/>	_____ %
Sloughy		<input type="checkbox"/>	_____ %	Epithelialising		<input type="checkbox"/>	_____ %

Exudate

Level Dry Low Medium High

Type Thin/watery Thick Cloudy Purulent Pink/red

Infection

<input type="checkbox"/> Increased pain	<input type="checkbox"/> Increased erythema
<input type="checkbox"/> Erythema	<input type="checkbox"/> Pyrexia
<input type="checkbox"/> Oedema	<input type="checkbox"/> Abscess/pus
<input type="checkbox"/> Local warmth	<input type="checkbox"/> Wound breakdown
Local <input type="checkbox"/> Increased exudate	Spreading/ systemic <input type="checkbox"/> Cellulitis
<input type="checkbox"/> Delayed healing	<input type="checkbox"/> General malaise
<input type="checkbox"/> Friable granulation tissue	<input type="checkbox"/> Raised WBC count
<input type="checkbox"/> Malodour	<input type="checkbox"/> Lymphangitis
<input type="checkbox"/> Pocketing	

Challenge guide



Wound edge Wound Assessment

Maceration



Dehydration



Undermining



Rolled edges



Challenge guide



Periwound skin Wound Assessment

Maceration		<input type="checkbox"/> _____	_____ CM
Excoriation		<input type="checkbox"/> _____	_____ CM
Dry skin		<input type="checkbox"/> _____	_____ CM
Hyperkeratosis		<input type="checkbox"/> _____	_____ CM
Callus		<input type="checkbox"/> _____	_____ CM
Eczema		<input type="checkbox"/> _____	_____ CM

Challenge guide

Third visit

Size of wound:	Length _____ cm
	Width _____ cm
	Depth _____ cm



Wound bed Wound Assessment

Tissue type

Nectrotic		<input type="checkbox"/> _____ %	Granulating		<input type="checkbox"/> _____ %
Sloughy		<input type="checkbox"/> _____ %	Epithelialising		<input type="checkbox"/> _____ %

Exudate

Level Dry Low Medium High

Type Thin/watery Thick Cloudy Purulent Pink/red

Infection

<input type="checkbox"/> Increased pain	<input type="checkbox"/> Increased erythema
<input type="checkbox"/> Erythema	<input type="checkbox"/> Pyrexia
<input type="checkbox"/> Oedema	<input type="checkbox"/> Abscess/pus
<input type="checkbox"/> Local warmth	<input type="checkbox"/> Wound breakdown
Local <input type="checkbox"/> Increased exudate	Spreading/ systemic <input type="checkbox"/> Cellulitis
<input type="checkbox"/> Delayed healing	<input type="checkbox"/> General malaise
<input type="checkbox"/> Friable granulation tissue	<input type="checkbox"/> Raised WBC count
<input type="checkbox"/> Malodour	<input type="checkbox"/> Lymphangitis
<input type="checkbox"/> Pocketing	

Challenge guide



Wound edge Wound Assessment

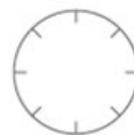
Maceration



Dehydration



Undermining



Rolled edges



Challenge guide



Periwound skin Wound Assessment

Maceration		<input type="checkbox"/> _____	_____ CM
Excoriation		<input type="checkbox"/> _____	_____ CM
Dry skin		<input type="checkbox"/> _____	_____ CM
Hyperkeratosis		<input type="checkbox"/> _____	_____ CM
Callus		<input type="checkbox"/> _____	_____ CM
Eczerma		<input type="checkbox"/> _____	_____ CM

Challenge guide

Fourth visit

Size of wound:	Length _____ cm
	Width _____ cm
	Depth _____ cm



Wound bed Wound Assessment

Tissue type

Nectrotic		<input type="checkbox"/> _____ %	Granulating		<input type="checkbox"/> _____ %
Sloughy		<input type="checkbox"/> _____ %	Epithelialising		<input type="checkbox"/> _____ %

Exudate

Level Dry Low Medium High

Type Thin/watery Thick Cloudy Purulent Pink/red

Infection

<input type="checkbox"/> Increased pain	<input type="checkbox"/> Increased erythema
<input type="checkbox"/> Erythema	<input type="checkbox"/> Pyrexia
<input type="checkbox"/> Oedema	<input type="checkbox"/> Abscess/pus
<input type="checkbox"/> Local warmth	<input type="checkbox"/> Wound breakdown
Local <input type="checkbox"/> Increased exudate	Spreading/ systemic <input type="checkbox"/> Cellulitis
<input type="checkbox"/> Delayed healing	<input type="checkbox"/> General malaise
<input type="checkbox"/> Friable granulation tissue	<input type="checkbox"/> Raised WBC count
<input type="checkbox"/> Malodour	<input type="checkbox"/> Lymphangitis
<input type="checkbox"/> Pocketing	

Challenge guide



Wound edge Wound Assessment

Maceration



Dehydration



Undermining



Rolled edges



Challenge guide



Periwound skin Wound Assessment

Maceration		<input type="checkbox"/> _____	_____ CM
Excoriation		<input type="checkbox"/> _____	_____ CM
Dry skin		<input type="checkbox"/> _____	_____ CM
Hyperkeratosis		<input type="checkbox"/> _____	_____ CM
Callus		<input type="checkbox"/> _____	_____ CM
Eczema		<input type="checkbox"/> _____	_____ CM