# R.B. Turnbull, Jr. MD School of WOC Nursing Education

**Mini Case Scenarios: Wounds**

Cleveland Clinic

**Student Name** ____Tracy Leal_____ **Date:** _____06/16/2024_____

**Reviewed by:** _____ **Date:** _____

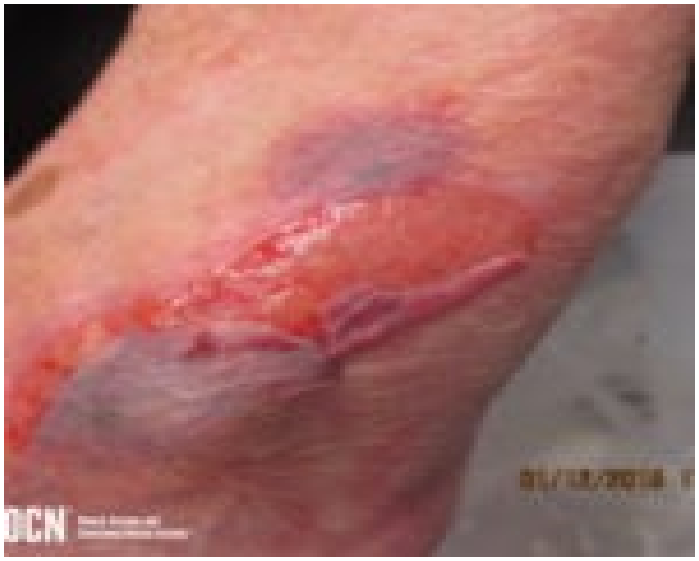
**Score: /96**

For the following wound case scenarios:

1. Identify the type of wound pictured.
2. Apply wound characteristics provided to identify recommendations/nursing orders for this patient & the wound.
3. Include the following in the recommendations/orders
    a. Dressing
        *i. Type of dressing*
        *ii. Brand name(s)*
        *iii. Secondary dressing if needed*
        *iv. Dressing change schedule*
    b. Other nursing orders pertinent to successful wound healing or prevention
    c. Rationale for choices
4. Provide an alternative to your initial dressing choice. This should be a product substitution, not simply a brand name substitution.
5. Answer any additional questions.

A case study has been completed for you below as an example.

Scenario Example



**85-year-old in an extended care facility has a skin tear on her right forearm after a recent fall. The skin tear has been classified as Type ??? as described by the International Skin Tear Advisory Panel (ISTAP).**

Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

**Wound type:** Skin tear, Type 2
**(1 point)**

**Wound Nurse recommendations/orders:**

1. Use no rinse, pH balanced bath wipes at bathtime vs. soap, minimize rubbing at bath time, & gently dry fragile skin
2. Apply mesh contact layer (Hollister Adaptic)
3. Moisturize both arms daily with Medline Remedy moisturizing lotion
4. Wrap with roll gauze (Kerlix).
5. Change dressing on every shower day or if wet or soiled
6. Use long sleeve garments or sleeve covers for patient during waking hours

**(3 points)**

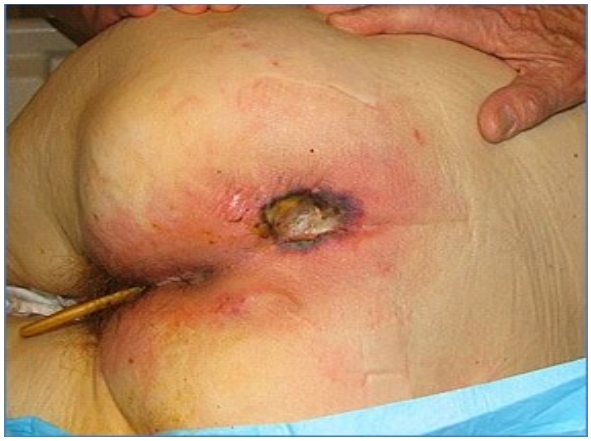
**Rationale for choices**

1. Bath wipes are pH balanced & soap is usually alkaline & difficult to rinse if person not showering
2. Rubbing creates friction which may cause skin tears
3. Contact layer prevents dressings from sticking to wound
4. Skin moisturizing is a preventive measure for skin tears
5. Roll gauze keeps contact layer in place & patient from touching wound & is non-adhesive
6. Long sleeves protects patient's skin and discourages picking at dressing

**(3 points)**

**1 alternative primary/secondary dressing:** Non-adhesive foam dressing, 5 layers, (Allevyn) secured with elastic mesh dressing (Medline elastic retention dressing).
**(1 point)**

Scenario 1



**You are asked to assess a new resident admitted with a sacral wound. Patient is 82-year-old and admitted with dementia. Wound on sacrum with 100% yellow slough and brown necrotic tissue at wound edges. Wound measures approximately 4 cm x 3 cm x 2 cm. Periwound with blanchable erythema.**

Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

**Wound type:** Unstageable community acquired pressure injury

**(1 point)**

**Wound Nurse recommendations/orders:**

1. Wash periwound tissue and perianal area with pH balanced bath wipes ensuring not to contaminate wound with feces.
2. Irrigate wound bed thoroughly with NS and pat dry.
3. Paint or spray no sting barrier film (Cavilon) to periwound tissue and allow to dry.
4. Apply nickle thick layer of collagenase (Santyl) to the wound bed and cover with mesh contact layer (adaptic) cut slightly larger than wound bed.
5. Secure with an ABD pad and paper tape.
6. Change daily and as needed for soiling, disruption, or strikethrough.
7. Turn patient from side to side at a 30-degree angle, ensuring fully offloaded sacrum, every 2 hours (or as tolerated related to patient goals of care). Check for incontinence with every turn. Patient should only be supine for meals and avoid sacral sitting. Encourage out of bed activity if appropriate. Place patient on LAL mattress.

**(3 points)**

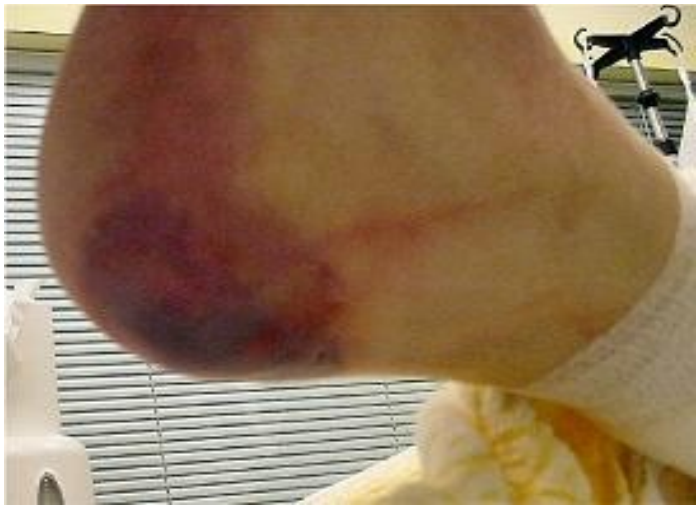
**Rationale for choices:**

1. There appears to be concurrent IAD, so hygiene is important to avoid breakdown.
2. Irrigation of wound will remove any debris or feces
3. Skin prep will protect the surrounding tissue.
4. Collagenase is an enzymatic debrider indicated in this case for treatment of the thick yellow slough obscuring the wound bed.
5. ABD pads have absorptive capacity and are a good option for daily, or possibly more frequent, dressing changes.
6. Collagenase should be changed daily, and the patient should be checked frequently for incontinence. Soiled dressings should never be left in place.
7. Fully off-loading the sacrum is imperative for healing this pressure injury, however, if the patient cannot tolerate full turns or healing is not the goal of care (i.e. comfort care only), off-loading can be based on tolerance. If this is the case, family should be involved in care and informed that wound

| |
|---|
| healing will not be a goal.<br><br>**(3 points)** |
| **1 alternative primary/secondary dressing**<br>Medical grade honey (Medihoney) gel to wound bed, followed by mesh dressing (adaptic) cut slightly larger than wound bed, secure with a sacral foam dressing (Mepilex). Protect periwound tissue with no sting skin prep (Cavilon). Change every three days. OK to use barrier cream to periwound and/or perianal tissue for IAD.<br><br>**(1 point)** |

/8 points

Scenario 2



**The wound care nurse is consulted to see a 54-year-old, post op day 4 after an abdominal surgery. Left heel has non-blanchable purple discoloration.**

Image courtesy of Judy Mosier, MSN, RN, CWOCN.

**Wound type:** Hospital Acquired Deep Tissue Pressure Injury

**(1 point)**

**Wound Nurse recommendations/orders:**

1. Off-load heel at all times using off-weighting boot with heel suspension (Prevalon boots by Medline), ensure proper placement of boot with all patient rounding and turns.
2. Check wound every shift
3. Notify Wound RN or PCP should wound open
4. Dietary consult

**(3 points)**

**Rationale for choices:**

1. The causative factor for this wound was pressure on the OR table. Relief of pressure will allow for return of blood flow allowing for oxygen and nutrients to get to the tissues for healing.
2. Frequent assessment will allow the bedside nurse to note any improvement or worsening of wound status. It will also ensure that the wound is actually off-weighted and positioned properly in the boot.
3. Notifying the wound RN or PCP will allow for changes in the wound care plan as the DTPI evolves
4. Recommendations for caloric and protein intake required for wound healing.

**(3 points)**

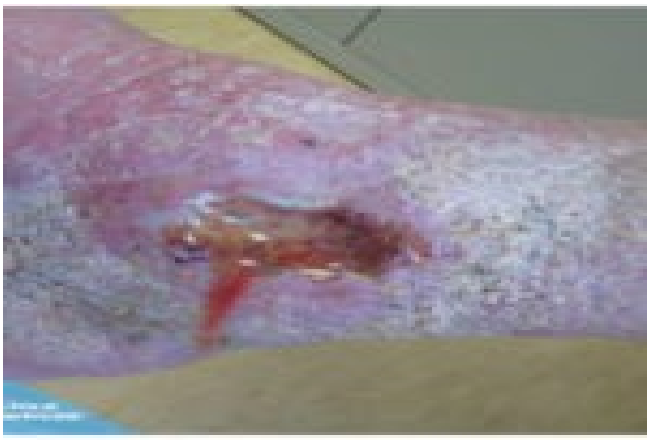
**1 alternative primary/secondary dressing**

1. Foam dressing (Allevyn gentle border heel dressing). Paint or spray wound with no sting barrier film and allow to dry prior to dressing changes for protection from adhesive. Change dressing three times weekly. Peel back every day to inspect wound and replace.
2. Wound RN, or designated trained staff, to provide low frequency ultrasound treatment (Sanuwave) coordinated three times weekly with dressing changes to improve O2 and nutrient delivery through vasodilation and angiogenesis.

**(1 point)**

/8 points

Scenario 3



**A 70-year-old arrives at the outpatient wound clinic with a nonhealing wound located on gaiter area of right lower extremity. The wound measures approximately 5 cm x 2.5 cm x 0.5 cm. The wound is a shallow, irregular shaped ulcer with moderate amount of exudate. Periwound is macerated. Hemosiderin staining is noted to BLE. Patient has ABI of 0.85 to RLE and 0.90 to LLE**

Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

**Wound type:** Vascular wound with mixed etiology related to LEAD

**(1 point)**

**Wound Nurse recommendations/orders:**

1. Cleanse periwound tissue with non-soap gentle cleanser without perfumes or dyes (Cetaphil).
2. Apply Zinc oxide paste (Remedy Protect by Medline) to macerated periwound tissue.
3. Apply an emollient cream to any dry tissue to the lower extremity (Aquaphor) after cleansing and while still damp
4. Apply a hydrofiber (Aquacel Ag) cut to cover wound bed and surrounding maceration.
5. Apply a four-component wrap consisting of a base absorbent layer, a cotton layer, an elastic conformable bandage, and a cohesive self-adherent bandage to both lower extremities after wound care to the right. This should be changed twice weekly in wound clinic, or at home with agency nursing, with continuing frequency to be dictated by exudate.

**(3 points)**

**Rationale for choices:**

1. Cleansing removes, scaling, crusting, and bacteria from periwound tissue.
2. Zinc paste will protect the periwound tissue from further maceration/breakdown.
3. Emollients help to prevent drying and cracking of the skin.
4. The hydrofiber dressing will absorb exudate with the added antimicrobial benefit of impregnated silver as VLU can be heavily colonized.
5. Patient will require compression as gold standard treatment in both lower extremities as they both show signs of LEVD. The ABI of 0.85 to the right lower extremity is indicative of LEAD but remains within the parameters for compression without modification.

**(3 points)**

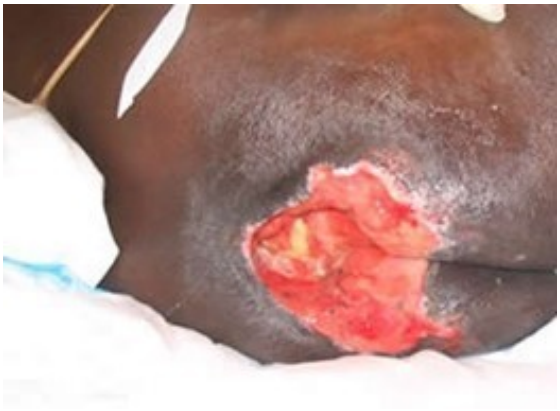
**1 alternative primary/secondary dressing:**

An alternative would be all of the same with a medical grade honey alginate (Medihoney Alginate sheet) replacing the hydrofiber. Medihoney has antimicrobial properties, the alginate portion can help with exudate, and this dressing would be OK to leave for 3-4 days depending on exudate (above states moderate).

**(1 point)**

/8 points

Scenario 4



**An 85-year-old is admitted to the hospital with a stage <u>??? </u>pressure injury on sacrum and is bedridden. Full thickness wound measures approximately 8 cm x 10 cm x 0.4 cm. Wound bed pink with small amount of yellow slough. No structures, no bone noted. Wound has moderate serosanguineous drainage.**

Image courtesy of Judy Mosier, MSN, RN, CWOCN.

**Wound type:**
Stage 3 Community Acquired Pressure Injury
**(1 point)**

**Wound Nurse recommendations/orders:**

1. Cleanse periwound tissue, buttocks and perianal area with pH balanced bath wipes ensuring not to contaminate wound with feces.
2. Cleanse wound with surfactant based wound cleanser (Repara)
3. Apply collagenase to slough within wound bed.
4. Followed by fluffed gauze (Kerlix) to loosely pack wound cavity.
5. Protect periwound tissue with no sting skin prep (Cavilon).
6. Secure with ABD pads and medical tape (hypafix). Change daily and as needed for soiling, disruption, or strikethrough.
7. Dietary consult for protein and calorie recommendations.
8. Labs

**(3 points)**

**Rationale for choices:**

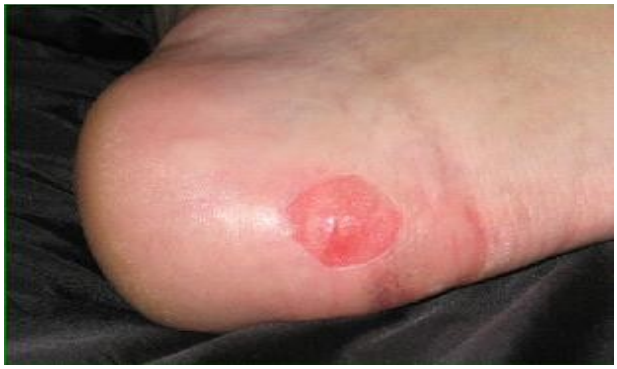
1. This wound is very close to the anus and hygiene will be important to prevent wound contamination.
2. Surfactants help debris and bioburden to lift from the wound bed. This brand is listed as compatible with collagenase on the Santyl website.
3. Collagenase is approved for enzymatic debridement of devitalized tissue.
4. Fluffed gauze to fill negative space and control exudate.
5. Skin prep to protect periwound tissue from moisture.
6. ABD pads for absorption and ease of change if patient is incontinent or exudate increases with use of collagenase. Hypafix tape is gentle on the skin if frequent changes are required.
7. Higher protein and calorie intake is required for wound healing. Patient preferences and restrictions need to be determined.
8. Monitor CBC, crp, esr, albumin, prealbumin for nutrition, inflammation, and infection weekly while inpatient.

**(3 points)**

**What support surface would you recommend and why?**
In my facility I would recommend a LAL/ immersion mattress (Dolphin mattress by Joerns) for microclimate control and immersion properties for pressure redistribution. This mattress is indicated for healing stage 3 and 4 pressure injuries.
**(1 point)**

/8 points

Scenario 5



**56-year-old hospitalized for cardiac surgery. During the hospital stay, developed a blister related to pressure on right heel. The blister has now ruptured.**

Image courtesy of Judy Mosier, MSN, RN, CWOCN.

**Wound type:**

Stage 2 Hospital Acquired Pressure Injury

**(1 point)**

**Wound Nurse recommendations/orders:**

1. Irrigate wound with NS and pat dry.
2. Apply no sting skin prep to periwound tissue and allow to dry.
3. Apply Vaseline gauze (xeroform) cut to fit wound bed and secure with a foam dressing (Allevyn)
4. Change every other day.
5. Apply off-weighting boots with heel suspension (Prevalon by Medline) while in bed. Educate patient to call for assistance with boosting in bed to avoid friction.

**(3 points)**

**Rationale for choices:**

1. Irrigation will help with removal of debris and bacteria from wound bed.
2. Skin prep will protect periwound tissue from moisture from wound and epidermal stripping from foam dressing with changes.
3. Vaseline gauze will help to keep wound bed moist and free from bacterial contaminants.
4. This would not require daily dressing changes. Every other day changes would keep the xeroform moist and reduce wound bed cooling seen with dressing changes.
5. Boots will hopefully protect from ongoing pressure and shear. Assistance with bed mobility should help with shearing in this area as patients often use their heels to help boost up in bed.

**(3 points)**

**1 alternative primary/secondary dressing**

An alternative could be a collagen based dressing (Promogan Prisma) to help with epithelialization, secured with a foam (allevyn) dressing. Change every other day.

**(1 point)**

/8 points

Scenario 6


**82-year-old arrives to the acute care setting with a pressure injury on the right ischium. Patient has been cared for at home by spouse and spends many hours per day in a wheelchair.**
**The wound measures approximately 6 cm x 8cm x 2 cm. Wound bed 80% pink tissue with bone visible. Small amount of tan drainage noted with assessment. Periwound intact.**

Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

**Wound type:**
Stage 4 Community Acquired Pressure Injury
**(1 point)**

**Wound Nurse recommendations/orders:**

1. Plastics consult for I+D with bone biopsy for culture driven antibiotics if indicated.
2. Physical Therapy consult for evaluation of current seating surface, pressure mapping, and patient education regarding weight shifts.
3. NPWT with irrigation (Veraflo V.A.C.) set at 125 mm Hg using smart instill feature with NS until cultures come back. (Could consider Sulfamylon or Vashe pending sensitivities and after review of patient allergies). Use a bridge method to avoid pressure from tubing on the ischium.
4. Nutrition consult for protein intake, fluid intake, and caloric recommendations.
5. Labs

**(3 points)**

**Rationale for choices:**

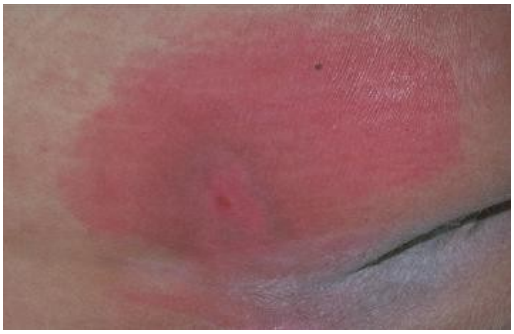
1. According to our text, the most accurate diagnosis of OM underlying a pressure injury is intraoperative bone cultures.
2. Pressure injuries over the ischium are indicative of a “sit wound” so a seating eval with pressure mapping is indicated. The patient might also need a different WC (power WC?) that can allow for tilt in space weight shifts if the patient cannot perform manual weight shifts.
3. The benefit of NPWT is faster healing rates, better control of exudate, and 2-3 times weekly dressing changes instead of daily or more often. Irrigation V.A.C. therapy has the added benefit of better removal of debris and topical antimicrobial therapy if indicated.
4. Higher protein/calorie intake is required for wound healing. Adequate water intake will help distribute nutritents. Patient preferences and restrictions need to be determined.
5. Monitor CBC, crp, esr, albumin, prealbumin for nutrition, inflammation, and infection weekly while inpatient.

**(3 points)**

**1 alternative primary/secondary dressing:**
A hydrofiber tucked into depth and overlying wound bed surface (Aquacel Ag) for a moist wound environment, exudate control, and antimicrobial benefits of impregnated silver, followed by fluffed gauze (kerlix), and held in place with a foam dressing (Mepilex) for protection and pressure redistribution. Change every other day and as needed for soiling, disruption, or strikethrough. Protect periwound tissue with no sting skin prep (Cavilon).
**(1 point)**

/8 points

Scenario 7



**The wound care nurse is consulted to see a 66-year-old who developed non-blanchable erythema on right sacrum after being on bedrest for the past 24 hours.**

Image courtesy of Judy Mosier, MSN, RN, CWOCN.

**Wound type:**
Stage 1 Hospital Acquired Pressure Injury
**(1 point)**

**Wound Nurse recommendations/orders:**

1. LAL mattress (TxCair by Joerns)
2. Help patient to turn every 2 hours, check for incontinence with all turns.
3. Assist patient with toileting.
4. Apply sacral foam dressing (Sacral Mepilex). Peel back daily to inspect skin beneath. Change dressing every three days and as needed for soiling or wrinkling that could cause pressure.
5. Nutrition consult

**(3 points)**

**Rationale for choices:**

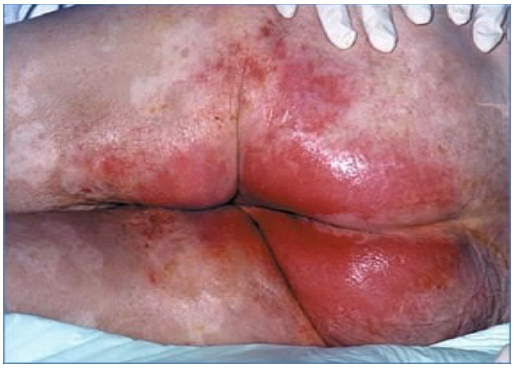
1. Microclimate control and pressure redistribution
2. Pressure relief, hygiene when needed (also pulmonary toilet)
3. To avoid IAD which will put patient at even greater risk of further breakdown
4. Approved by NPIAP for pressure injury prevention related to pressure redistribution and protection from shearing
5. Adequate nutrition (protein, calories, and fluids) is needed for wound healing

**(3 points)**

**1 alternative primary/secondary dressing**
All interventions above, but a silicone based moisturizer (Remedy Prevent) instead of a foam dressing.
**(1 point)**

/8 points

Scenario 8



**Wound care nurse consulted to see a 56-year-old with a "sore bottom". Patient has been at your facility for 2 weeks with diagnosis of C-Diff. Today you have been consulted for a treatment plan for damaged skin.**

Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

**Wound type:**
Incontinence Associated Skin Damage
**(1 point)**

**Wound Nurse recommendations/orders:**

1. Rectal tube (Dignishield) if not contraindicated and diarrhea is ongoing
2. Hygiene with pH balanced bath wipes as needed (Ready Cleanse by Medline)
3. Dust an antifungal powder (Nystatin) over affected area twice daily
4. Apply barrier cream (Remedy Protect) over antifungal powder. If fungal infection is persistent can consider oral antifungal (fluconazole). Cleanse skin after any contact with stool but you do not have to remove completely. Remove any stool seen and apply more barrier cream after.
5. If diarrhea is ongoing despite 2 weeks of treatment reconsult infectious disease for recommendations.
6. Frequent turns and checks for needed hygiene. LAL mattress (Tx Cair by Joerns) for microclimate control.

**(3 points)**

**Rationale for choices:**

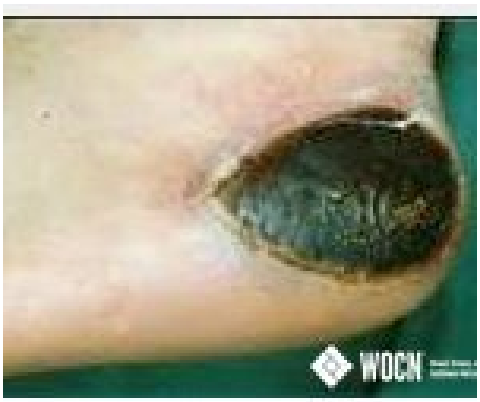
1. First line treatment is to remove or divert the chemical irritant, in this case stool.
2. Hygiene will also remove the stool causing the breakdown. Using pH balanced soft wipes should help with pain and preventing further mechanical damage with cleansing.
3. There looks like satellite lesions which are indicative of a fungal infection, which is common in MASD (IAD is a type of this). Dusting an antifungal prior to use of a barrier cream is an accepted "off-label" practice.
4. Barrier creams can be used for severe IAD to serve as a barrier between the skin and stool. Not scrubbing off the barrier cream with every episode of incontinence is important staff education. This can cause further skin breakdown related to mechanical trauma.
5. Oral vancomycin is a common treatment for C-diff infection, but if the infection is recurrent or persistent ID can offer other treatment options.
6. Pressure injury prevention strategies as patient is at greater risk related to overly moist skin and risk for shear.

**(3 points)**

**1 alternative primary/secondary dressing:**
Hygiene needs remain the same. Dusting with an antifungal is still indicated (Miconozole) and then you could spray with a skin barrier film (cavilon) twice daily.
**(1 point)**

/8 points

Scenario 9




**An 85-year-old presents to acute care with dry black eschar on left posterior heel. Cared for at home by elderly spouse, he has been bedridden for the past 6 months. The wound measures approximately 6 cm x 10cm x 0 cm. Wound edges are dry and periwound has no erythema.**

Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

**Wound type:**
Unstageable Community Acquired Pressure Injury
**(1 point)**

**Wound Nurse recommendations/orders:**

1. Apply off-weighting boots with heel suspension (Prevalon boots by Medline)
2. ABIs to determine presence of arterial disease
3. Vascular consult if indicated
4. Podiatry consult if indicated
5. Labs
6. Dietary consult

**(3 points)**

**Rationale for choices:**

1. This appears to be dry stable eschar likely related to pressure from being bed bound. There are no immediate signs of infection, though this can be subtle if there is arterial disease present.
2. While necrotic tissue can be a source of infection, debridement is not indicated until perfusion status can be determined. ABIs can help determine presence of arterial disease.
3. Vascular consult to determine if any surgical interventions might be warranted.
4. Podiatry consult if debridement is determined necessary.
5. Labs to monitor for systemic infection and nutritional status.
6. Determine caloric, protein, and fluid needs for wound healing and dietary preferences.

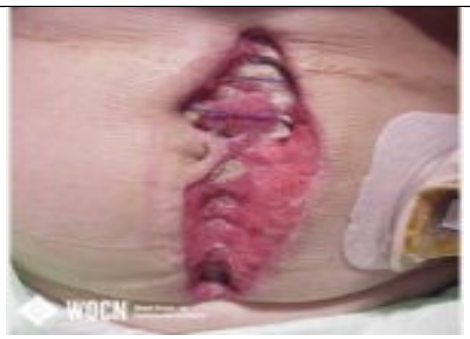
**(3 points)**

**1 alternative primary/secondary dressing:**
If the patient cannot tolerate the off-loading boots, his heels can be off-loaded using pillows placed longitudinally behind the lower leg, ensuring floating of the heel. Dressings are not indicated until ischemia and infection can be ruled out.
**(1 points)**

/8 points

Scenario 10

/8 points




**The wound care nurse is consulted to see a 74-year-old patient transferred from a community hospital with an abdominal wound several days post-surgery for ischemic bowel. Wound measures approximately 10 cm x 4 cm x 3 cm with visible sutures. Wound bed dry, pink with small areas of yellow tissue (less than 10% of wound base). Periwound skin intact. WOC team consult for NPWT orders.**

Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

**Wound type:**

Open abdominal Wound to level of fascial sutures

**(1 point)**

**Wound Nurse recommendations/orders:**

1. Bedside consult with surgeon
2. Nutrition consult
3. Patient education regarding intraabdominal pressure
4. NPWT (V.A.C.) using mesh contact layer (Adaptic) and black granufoam sponge at setting determined with information from surgeon. Change three times weekly by WOC team.

**(3 points)**

**Rationale for choices:**

1. Communication with the surgeon is needed to determine any exposed structures in the wound, discuss the location of any anastomosis or enterotomies created and risk of ECF and need for possible low-pressure settings, and the patients plan of care.
2. Determine protein and calorie needs for healing
3. Encourage pt to brace the abdomen while coughing, performing pulmonary toilet, or repositioning, determine if stool softeners are needed.
4. Use of mesh contact layer for pain control and atraumatic removal, NPWT for edema and exudate control. Would discuss NPWT settings with the surgeon based on risk of dehiscence and ECF risk. Standard is 125 mm Hg, but this wound could require lower pressures. This wound seems complicated enough that changes should be performed by a wound certified nurse whenever possible.

**(3 points)**

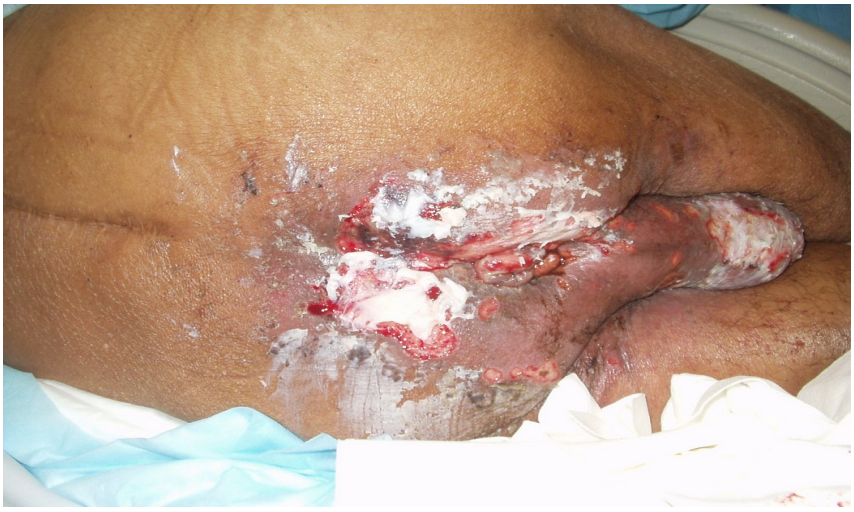
**1 alternative primary/secondary dressing:**

If VAC therapy is contraindicated, NS moistened antimicrobial gauze (AMD kelrix) with ABD pads to be changed daily and as needed for strike through. Periwound tissue can be protected with no sting skin prep (Cavalon) and/or a thin hydrocolloid (duoderm extrathin).

**(1 point)**

/8 points

**Scenario 11**



**Wound care nurse consulted to see a 45-year-old with a "sore bottom". Patient has been at your facility for 2 weeks with diagnosis of C-Diff. Today you have been consulted for a treatment plan for damaged skin.**

Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

**Wound type:**
Incontinence Associated Dermatitis category 2

**(1 point)**

**Wound Nurse recommendations/orders:**

1. LAL mattress for microclimate control. Pressure injury prevention measures including hygiene, Q 2 hour turning schedules, and adequate turning for offloading. If the patient can tolerate proning or Sims position to off-load this is also an option. Do not use multiple layers of absorbent pads beneath patient. Use pull sheets or lift mats (HoverMatt) for bed mobility.
2. Mineral oil to gently cleanse off barrier cream so wounds can be fully visualized. Rinse with warm water and pat dry.
3. Insert rectal tube (Dignishield) if not contraindicated.
4. Medical grade honey (MediHoney gel) to any devitalized tissue.
5. Apply barrier paste (Remedy protect) to periwound tissues.
6. Apply ABD pads and secure with medical tape (Hypafix) change every other day and as needed for soiling or strikethrough.
7. If diarrhea is ongoing despite treatment reconsult infectious disease
8. Dietary consult

**(3 points)**

**Rationale for choices:**

1. This patient is at great risk for pressure injury, if not already present. Multiple layers of absorbent pads can bunch up beneath as patient causing pressure and will eliminate the microclimate benefits of the LAL mattress. Use of appropriate safe patient handling tools can help to reduce friction and shearing forces with bed mobility.

2. Oil based products are noted to atraumatically remove zinc-based barrier paste. It needs to be rinsed free prior to determining treatment.
3. Diversion or containment of chemical irritant (stool) will help these wounds to heal as it is at least part of the etiology.
4. Medical grade honey has some antimicrobial properties related to desiccation of bacterial cells and aids in autolytic debridement.
5. Zinc based barrier creams will aid in protection of periwound tissue from stool and exudate
6. ABD pads can absorb any excess wound exudate and keep the barrier paste from wiping off. Medical tape should reduce the risk of epidermal stripping due to adhesives.
7. Oral vancomycin is frequently used for treatment, but if C diff is persistent or recurrent ID might have other suggestions for treatment (including fecal transplant).
8. To meet protein, caloric, and fluid requirements for wound healing

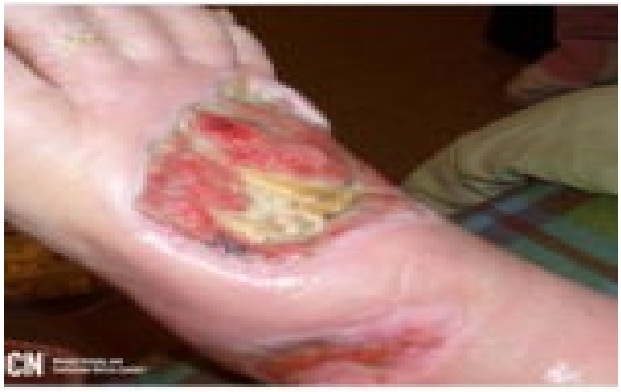
**(3 points)**

**1 alternative primary/secondary dressing:**
After hygiene and fecal containment, crust the area with stoma powder (Stomahesive) and skin barrier film (Cavilon). Follow this with a barrier cream. Reassess in 24 hours.

**(1 point)**

/8 points

**Scenario 12**



**A 75-year-old is admitted to acute care setting from home with pneumonia. They have a history of Raynaud Disease and Diabetes Mellitus. Has been seen at an outpatient wound clinic but is uncertain what the treatment plan is and you have no access to those medical records.**
**Open wound on dorsum of foot with exposed tendon. Measures approximately 8 cm x 12 cm x 0.2 cm. Wound bed 60% pink tissue and 40% yellow/black, brown tissue. Scant amount of tan drainage. Periwound intact with epibole.**
Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

**Wound type:**
Arterial Wound
**(1 point)**

**Wound Nurse recommendations/orders:**

1. Labs
2. Referral to endocrine if indicated
3. Vascular studies and referral if indicated
4. MRI to r/o osteomyelitis (OM)
5. Surgery/podiatry consult for debridement and possible biopsy
6. Irrigate wound bed with NS and pat dry. Apply collagenase to necrotic tissue followed by a hydrofiber (aquacel) and secure with a gauze wrap (kerlix). Change daily.
7. Apply Vascular boots (Rooke)
8. Monofilament and/or vibratory testing for neuropathy/LOPS

**(3 points)**

**Rationale for choices:**

1. HbA1c, crp, esr, CBC, albumin, prealbumin
2. Tight glycemic control for wound healing
3. Vascular studies to determine if LEAD is present and the extent
4. OM needs to be treated with antibiotics that should be culture driven
5. Tissue or bone cultures could be necessary, surgical debridement of necrotic tissue, excision of epibole to aid in wound closure
6. Irrigate wound to remove debris and bioburden, enzymatic debridement of devitalized tissue with collagenase, a hydrofiber will provide a moisture balanced wound environment, and gauze will secure the wrap while avoiding adhesives to possibly fragile skin, as well as providing some warmth related to the patients Raynaud disease.
7. Vascular boots will provide protection, pressure injury prevention, and warmth and improved circulation to help with wound healing and Raynaud disease.
8. Testing for neuropathy can guide treatment for prevention of repetitive trauma, education regarding daily foot inspection, and foot/nail care from a professional.

| **(3 points)** |
| --- |
| **1 alternative primary/secondary dressing:**<br>Medical grade honey sheet with alginate (Medihoney alginate), followed by nonadherent gauze (Telfa) and secured with a gauze wrap (kerlix). Change every 3 days and as needed for strikethrough or disruption.<br>**(1 point)** |

/8 points