

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

Mini Case Scenarios: Wounds



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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 protect 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 Pressure Injury

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with pH balanced wound cleanser, pat dry.
2. Apply Manuka Honey to wound bed (Medline Therahoney wound dressing sheet), cover with gauze (Dermacea sterile gauze sponges 12 ply 4x4), secure with tape (3M Medipore H soft cloth surgical tape 3in x 10yd.)
3. Offloading- turn/reposition at least every 2 hours with use of support wedge or pillow.
4. Use lift sheets/ transfer devices.
5. Increase dietary protein, dietary consult.

(3 points)

Rationale for choices:

1. Removes bacteria/debris, non-cytotoxic, non-irritating, reduces friction with rubbing.
2. Stimulates tissue growth, enhances epithelialization, minimizes scar formation. Provides autolytic debridement (uses bodies WBCs/enzymes, breaks down necrotic tissue later digested by macrophages). Debridement essential to promote wound contraction and allows full view of wound bed for accurate visual assessment.
3. Help wounds heal and avoids worsening and/or new PIs. Turn no greater than 30 degrees. Make use of redistribution and support surfaces.
4. Allows transfers without shearing skin, reduces friction.
5. Optimizing nutrition by maintaining adequate nutrition/ hydration. Promotes wound healing.

(3 points)

1 alternative primary/secondary dressing: Hydrogels (CarraDres Clear Hydrogel sheet), cover with bordered foam dressing (Optifoam Gentle EX silicone-based foam & border- sacral or 4x4).

(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: Deep Tissue Pressure Injury

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse with mild soap/water with patting motion and pat dry.
2. Heel bordered foam dressing (Medline Optifoam Gentle Heel silicone-based foam & border), change every 3 days unless it loses its integrity or becomes soiled.
3. Elevate heel with pillow or foam cushion, off-loading boot.
4. Limiting putting pressure to heel while walking.
5. Increase protein intake.

(3 points)

Rationale for choices:

1. Rubbing causes friction and may cause further skin damage.
2. For heel protection, prevention of worsening DTPI.
3. Reduces pressure to aid in wound healing, continued pressure can increase pain. Floating heels takes off all pressure to heel.
4. Full pressure to heel while walking can worsen DTPI and increase pain. May cause injury to foot with quick reaction to pain.
5. Additional protein can aid in faster wound healing.

(3 points)

1 alternative primary/secondary dressing: Heel Foam (Optifoam Heel non-adhesive foam wound dressing), rolled gauze (Medline sterile 100% gauze bandage roll), secure with tape (3M Medipore H soft cloth surgical tape 3in x 10 yd).

(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. Peri-wound 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: Lower Extremity Venous Ulcer, class 6/C6 (active venous ulcer).

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse gently with mild non-soap cleanser, pat dry.
2. Apply petroleum emollient (Aquaphor) to peri-wound skin. Place alginate (Medline maxorb II calcium alginate wound dressing) into wound bed, wrap with self-adherent wrap (3M Coban self-adherent wrap NS tan 4in x 5yd. roll). Change every 2-3 days.
3. Position foot off of ulcer while sitting/lying.
4. Increase protein intake, dietary consult.

(3 points)

Rationale for choices:

1. Avoids friction, non-cytotoxic, non-irritating, no rinsing needed.
2. With the peri-wound skin being macerated, applying emollient to surround skin will protect skin and propel moisture, as well as prevent excessive drying of skin.
3. Calcium Alginate absorbs moderate drainage, facilitates autolytic debridement, less frequent dressing changes needed, cost savings.
4. Self-adherent wrap offers compression to foot, increasing healing rate, improves symptoms, decreases edema, and aids in scale/crust/bacteria removal.
5. Avoid pressure to ulcer, preventing worsening wound, helps keeps drainage under control.
6. Adequate nutrition and hydration, with increase in protein aids to wound healing faster.

(3 points)

1 alternative primary/secondary dressing: Abdominal pad (Medline sterile premium abdominal pad 5x9 25ct), rolled gauze (Medline sterile 100% cotton gauze bandage rolls 4.5in x 4.1yd.), tubular dressing (Medline Medigrip elastic tubular bandage size F). To be changed every 1-2 days depending on drainage amount.

(1 point)

/8 points

Scenario 4



An 85-year-old is admitted to the hospital with a stage ??? 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 Pressure Injury

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse with no-rinse skin cleanser, pat dry.
2. Place collagen (Medline Puracol plus collagen wound dressing 2x 2.25) Sinto moist wound bed , cover with foam dressing (Medline optifoam gentle EX silicone-faced foam & border- sacrum)
3. Reposition onto side at a 30-degree tilt with wedge pillow and off back as much as possible, or sit upright.
4. Increase dietary protein, dietitian consult.

(3 points)

Rationale for choices:

1. Has an antimicrobial effect, non-irritating, non-cytotoxic, and reduce/prevent biofilm.
2. Give matrix metalloproteinases an alternative collagen source, allowing body's collagen to aid in wound healing. Absorbent and promote moist wound healing. Foam promotes autolytic debridement of moist tissue/ slough, and absorbs excess exudate.
3. Take pressure off of ulcer, preventing further skin deterioration, helps control pain.
4. Increase in protein aids in faster wound healing.

(3 points)

What support surface would you recommend and why? Low air loss mattress- helps control microclimate by providing low-volume airflow to skin by moving heat/water vapor away from skin. Helps cushion vulnerable parts of the body, redistribute body weight, and manage microclimate.

(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 Pressure Injury

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse with normal saline and pat to dry.
2. Cover with composite dressing, change every other day unless it loses its integrity or becomes soiled.
3. Limit use of shoes, correct fitting shoes, elevate from ankle up.
4. Use lift sheet, pick up foot versus sliding it across bedding.

(3 points)

Rationale for choices:

1. Saline is readily available, inexpensive, easy to use, this is considered a clean wound.
2. Contain 2 or more products manufactured as one. May include contact layer, absorptive layer, cover layer, and adhesive border. Outer layer provides bacterial barrier. Convenient, easy to use, readily available, and low cost.
3. Wearing shoes can cause friction and worsening of ulcer. Correct fitting shoes should be used as big once may slide up and down while walking. Elevation to keep direct pressure off of wound to aid in healing. Elevate ankle up as to not add pressure directly to wound due to location.
4. Use of a lift sheet and lifting foot versus sliding will decrease chance of friction and shear.

(3 points)

1 alternative primary/secondary dressing: Hydrocolloid (McKesson hydrocolloid dressing thin), components of dressing interact with wound exudate to form a gel, thus decreasing trauma to wound bed. It can be worn from 3-7 days and cut to fit wound size.

(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 Pressure Injury, possible fistula in center?

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with sodium hypochlorite solution (Dakin's solution), pat dry with gauze.
2. Pack gauze packing strip (CURAD sterile iodoform gauze packing strips, ½" x 5 yd.) gently into deepest part of wound, leaving ¼" tail above. Wick gauze into rest of wound bed. Cover with sterile gauze and secure with tape.
3. Reposition at least every 2 hours, spend time lying on sides in bed late morning and in afternoon, use pillow behind back and sit on WC cushion.
4. Drinking extra fluids and increase dietary protein; dietitian referral.

(3 points)

Rationale for choices:

1. Bactericidal effectiveness against most bacteria, significantly reduces odor, promotes debridement.
2. Packing strips are ideal for packing or as a drainage conduit for open and/or infected wounds. Tightly woven strips ravel resistant and will not fray. Helps close wound from the inside out. Tail needed for easily removal and use only 1 piece to prevent piece being left inside of wound. Covering for added protection against further skin damage.
3. Use a foam wedge to keep patient off of wound, relieving pressure and aid in wound healing. Using a pillow behind patients back will help protect wound and avoid more trauma from occurring. Sitting on WC cushion will help distribute pressure and for pain relief.
4. Nutritional is of utmost importance to help in speeding up healing time and maintaining homeostasis.

(3 points)

1 alternative primary/secondary dressing: Place sterile nonadherent gauze dressing (CURAD xeroform gauze dressing, sterile 1" x 8"), cover with Abd pad (Medline essential sterile abdominal pads 5x9), secure with tape (3M Medipore H soft cloth surgical tape 4" x 10yd.).

(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 Pressure Injury

(1 point)

Wound Nurse recommendations/orders:

1. Keep buttocks as clean and dry as possible, cleanse with mild soap and water, pat dry.
2. Apply thin layer of zinc oxide to reddened area, twice daily.
3. Limit amount of time sitting, reposition onto hips/ sides at least every 2 hours, early ambulation.
4. Keep bed linens free of wrinkles and ensure patient is not laying on any medical devices (eg: call light, phone, remote, etc.)
5. Use a slip sheet and pick up buttocks' verses sliding it.

(3 points)

Rationale for choices:

1. Keeping skin clean and dry will prevent further skin breakdown, pat verses rub to prevent friction/shearing damage.
2. Zinc oxide used as a skin protector/barrier against further damage.
3. Reduces amount of pressure to right buttocks, helping skin heal.
4. Wrinkles to bed linens can easily lead to worsening PI, laying on medical devices will not take long to cause trauma to skin.
5. Use of a slip sheet will help in reducing amount of friction and shearing. Lift up verses shooting can also prevent further skin damage.

(3 points)

1 alternative primary/secondary dressing: Bordered foam dressing (Medline Optifoam gentle EX silicone-faced foam dressing 4x4)- wound is not open and will provide extra protection with foam built into 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 Dermatitis

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse with no-rinse, pH balanced liquid cleanser, pat dry.
2. Apply thin layer of skin protectant/ barrier cream (Dimethicone Cream).
3. Start fecal management system (ConvaTec Flexi-Seal Protect FMS).
4. Urgent clean-up after each loose stool with mild soap and water.
5. Referral to Infectious Disease.

(3 points)

Rationale for choices:

1. These cleansers are water based with surfactants to reduce surface tension and allow cleansing without friction.
2. Protection of skin to repel moisture and remain in-place over affected area. Additional barrier function achieved by adding zinc, petroleum, or dimethicone. Creams are an emulsion of oil and water, for added moisturizing, barrier, or combination products.
3. For frequent, loose stools in non-ambulatory patients. Offers stool diversion and containment for both skin health and infection control. Sitting in loose stool increases severity of skin irritation. The acids in stool are very toxic to skin. Wet wipes may cause burning and further skin irritation.
4. Pastes are not indicated due to being applied in a thick layer to provide physical barrier, adheres to skin making it difficult to remove and worsens skin damage.

(3 points)

1 alternative primary/secondary dressing: Ointment (Medline Remedy Essentials barrier skin protectant ointment) – moderately thick, semi-solid, formed from a base, occlusive, altering TEWL of skin. External Fecal Management system (Medline external fecal collection system)- fecal pouch is applied to perianal area, provides alternative to indwelling fecal management system, difficult to keep on skin.

(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 Pressure Injury

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with a pH balanced wound cleanser.
2. Paint with betadine (Medline Povidone-Iodine swab sticks), 4x4 gauze, heel foam (Allevyn non-adhesive foam heel dressing 4.5" x 5.5"), rolled gauze (Medline Bulkee Lite cotton conforming bandages), and secure with tape (Medipore H soft cloth surgical tape 2" x 10yd.), every 3 days.
3. Heel elevation, keep weight off of heel as much as possible, float heels.
4. Increase dietary protein & fluids.
5. Referral to vascular surgeon, PT.

(3 points)

Rationale for choices:

1. This type of cleanser is non-cytotoxic, non-irritating, for clean wounds.
2. Iodine is an antimicrobial, effective against many organisms, inexpensive, and readily available.
3. Gauze and heel help to protect wound and avoid inadvertent removal, may need to be trimmed due to eschar will start to loosen.
4. Stable eschar in poorly perfused areas should not be removed, as it can result in an open wound that may expose limb to infection.
5. Pressure redistribution important with stable eschar. Floating heels will prevent further deterioration.
6. Protein plays a huge role in wound healing.
7. Vascular surgeon to check blood flow and perfusion to foot. PT to help patient get stronger and be more ambulatory.

(3 points)

1 alternative primary/secondary dressing: Heel bordered foam dressing (Medline Optifoam gentle heel silicone-faced foam dressing 9x9) every 3 day unless it becomes soiled or loses its integrity.

(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: Surgical Wound Dehiscence- wound closed to fascial level.

(1 point)

Wound Nurse recommendations/orders:

1. Remove visible sutures with suture removal kit.
2. Cleanse wound with normal saline, soak up excess saline with gauze.
3. Use no-sting barrier wipe (SurePrep No-Sting Protective Barrier Wipe, 1 mL) to peri-wound skin, allow to dry.
4. Window frame peri-wound skin with hydrocolloid dressing (Medline Exoderm satin hydrocolloid wound dressing 4x4), apply drape to surround skin, place black foam into wound bed, cover with drape, cut quarter-sized hole in middle of drape, use additional foam to bridge onto right side of wound, apply tract pad, secure with drape, set pump to 125mmHg.
5. Do not leave off for more than 2 hours, if so, remove dressing and apply damp to dry gauze dressing.
6. Do not immerse pump in water, do not shower with pump attached.
7. Increase dietary protein.

(3 points)

Rationale for choices:

1. Removing visible sutures helps prevent infection and delayed wound healing.
2. Saline readily available, easy to work with, inexpensive, helps to remove biofilm and debris.
3. Protects skin, prevents itching/skin irritation, helps with dressing adherence.
4. Hydrocolloid and drape will protect peri-wound skin, foam placed directly on healthy skin may cause skin damage.
5. Bridging tract pad to skin on right side of wound prevents pressure directly over wound and skin breakdown.
6. If NPWT is left off for more than 2 hours and pump is restarted, it can cause infection and further skin deterioration.
7. NPWT promotes healing through effects of microcirculation, endothelial cell activation, removes wound exudate/ debris, stimulates angiogenesis/ collagen synthesis, reduces levels of proinflammatory cytokines and bacterial colony counts.
8. Pump does not go well mix water, it may quit working and damage the pump.
9. Protein aids in wound healing.

(3 points)

1 alternative primary/secondary dressing: Hydrogel gauze (Simpurity Hydrogel impregnated gauze wound dressing 4" x 5"), covered with dry gauze, and secure with tape (Medipore H cloth surgical tape, 4" x 10 yd.). Dressing to be changed daily or twice daily depending on amount of exudate coming from wound. This promotes autolytic debridement and is an antimicrobial agent.

(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

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse with mild soap and water, pat dry.
2. Apply thin layer of barrier cream (Dimethicone).
3. Initiate Fecal Management System (ConvaTec Flexi-Seal Protect FMS).
4. Referral to Infectious Disease
5. Quick clean-up after each loose stool.
6. Reposition at least every 2 hours, ensure bed linens are as flat as possible, keep skin clean and dry.

(3 points)

Rationale for choices:

1. Less irritating to skin, non-cytotoxic, patting verses rubbing prevent friction/shearing damage, wipes can cause more irritation to skin breakdown.
2. Creams form a barrier with use of petroleum and zinc. May vanish into epidermis, provides benefit of visualization of underlying surfaces.
3. Cream moisture barrier that is breathable. Vanishing cream or polymer-based barriers attach to skin and typically do not transfer to other surfaces. Helps maintain functionality of body worn absorbent product, low irritant potential.
4. Diversion of liquid stool in non/ minimally ambulatory patients. Containment provides benefit of both skin health and infection control.
5. ID can ensure this patient is taking the best antibiotic for this type of infection.
6. Stool sitting on patients’ skin for any length of time can quickly lead to skin irritation due to acid in stool

content.

7. Keep bed linens/ disposable bed pads free of wrinkles decreases chance of causing worsening skin damage.
8. Reposition off of sore buttocks as much as possible to improve heat transfer and air out to decrease moisture.

(3 points)

1 alternative primary/secondary dressing: Barrier Ointment (Coloplast Baza clear barrier ointment) and incontinence briefs (FitRight extra protection underwear). Ointment helps prevent and temporarily protects chafed, chapped, or cracked skin and seals out wetness. Briefs' have 4-layers: cover stock layer contacts skin, acquisition layer sequesters fluid, outer barrier layer prevents flow of fluid from product into environment.

(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: Lower Extremity Arterial Disease

(1 point)

Wound Nurse recommendations/orders:

1. Foot Xray, possible MRI, ABIs, blood work- CBC, CMP, Hgb A1C, thyroid panel, vitamin B12.
2. Vascular Surgeon and Infectious Disease Referrals.
3. Cleanse with pH balanced wound cleanser, apply silver nitrate ((Medline Grafco Silver Nitrate applicators) to epibole with use of sterile cotton-tipped applicator. Apply burn/ wound dressing (PluroGel Burn and Wound Dressing, 0.7 oz. tube) to wound bed, cover with rolled gauze (Medline Lite sterile cotton conforming bandages), secure with tape (3M Medipore H soft cloth surgical tape).
4. Low cholesterol or Mediterranean diet, increase dietary protein.
5. Strict blood glucose control.

(3 points)

Rationale for choices:

1. Checking for osteomyelitis, tissue perfusion, electrolyte/ blood levels, vitamin levels, thyroid function, and check blood glucose control over past 3 months.
2. Vascular surgeon to help with tissue and blood perfusion, Infectious Disease for infection control and antibiotic therapy.
3. Wound cleanser will prevent irritation, non-cytotoxic, easy to use.
4. Plurogel helps maintain moist wound environment, protects healthy skin, soften wound debris- rinses off more easily. Water soluble dressing that provides moisture to wound to prevent desiccation. Non-cytotoxic surfactant to soften/ loosen wound debris, breaks up/ prevents biofilm formation to aid in wound healing.
5. Silver Nitrate cauterizes to remove granulated tissue, soluble in all secretions, rigid wooden applicator for precision placement. Bactericidal effect against numerous pathogens.
6. Keeping cholesterol down can improve blood flow, prevent MI, protein increases wound healing time. Keeping blood glucose controlled can improve arterial perfusion and decrease healing times.

(3 points)

7. 1 alternative primary/secondary dressing: Nonadherent gauze dressing (CURAD Xeroform sterile nonadherent gauze dressings 1" x 8"), lightly wrap with rolled gauze (Medline Lite sterile cotton conforming bandages), secure with tape (3M Medipore H soft cloth surgical tape). Non-adherent solution, provides moist wound environment, bacteriostatic properties, decrease infection risk, deodorizes wound, and provides autolytic debridement.

(1 point)

/8 points