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

Mini Case Scenarios: Wounds

Cleveland Clinic

Student Name _____Miranda Prawdzik_____ **Date:** _____11/8/2024_____

Reviewed by: _____ **Date:** _____

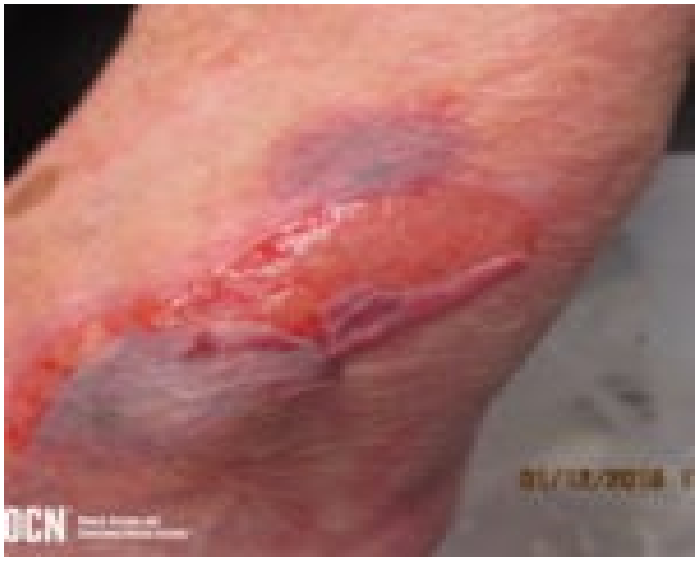
Score: /96

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)

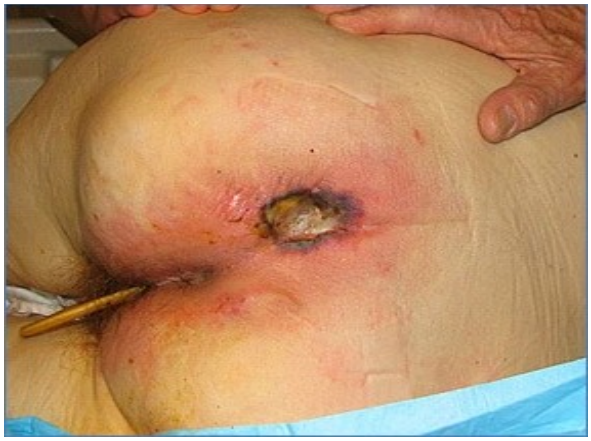
Rationale for choices

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: Pressure Injury, Unstageable

(1 point)

Wound Nurse recommendations/orders:

- Use a non-scented, pH balanced wound cleanser and warm water on the area at least once a day and as needed with continence care, gently pat dry.
- Cut to size and apply sheet hydrogel dressing to the wound bed (AquaDerm Hydrogel Sheet), apply secondary adhesive silicone foam sacral dressing (Mepilex Border, Foam Sacral Adhesive).
- Cleanse the wound and change dressings every 1-2 days or as needed with continence care (wet or soiled).
- Utilize moisture barrier cream or ointments as needed with excess moisture or incontinence episodes.
- Initiate strict Q2 turning and repositioning, ensure sacral off-loading using turning wedges and pillows.

(3 points)

Rationale for choices:

- Wound cleanser and tap water is appropriate to cleanse the wound, and provide light mechanical debridement of the slough present in the wound bed.
- Hydrogel dressings provide a moisture balanced environment for autolytic debridement, appropriate for wounds with depth, and are appropriate for minimal drainage wounds and pressure injuries.
- Autolytic debridement is needed in this situation for management of the yellow slough present in the wound bed.
- Peri wound skin and sacral skin should be further protected with adhesive silicone foam dressing, as well as protection from excess moisture.
- Pressure injury prevention and treatment includes proper off-loading of bony prominences and effected areas, a strict turning schedule will benefit this patient to off-load the sacrum.

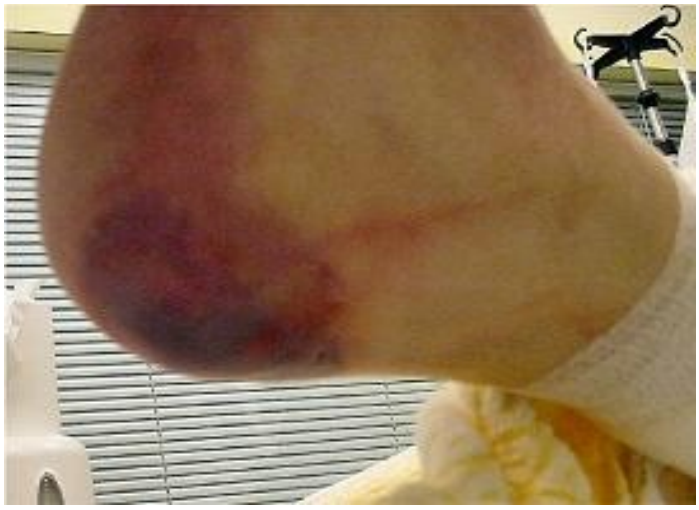
(3 points)

1 alternative primary/secondary dressing: Enzymatic skin ointment (Collagenase/Santyl Ointment), secured with silicone foam dressing with adhesive cloth border (PolyMem). Change daily.

(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: Pressure Injury/Deep Tissue Injury
(1 point)

Wound Nurse recommendations/orders:

- Provide good skin routine. Utilize no rinse, pH balanced bath wipes for skin cleansing. Minimize excessive rubbing or massaging of the area, gently pat dry.
- Apply dry gauze roll dressing to the affected foot.
- Initiate strict heel off-loading of the site utilizing pillows to float heels off bed surface or heel protector boots (Stryker-sage prevalon).
- Strict Q2 turning/repositioning schedule utilizing turning wedges and pillows.
- Avoid excess friction or shearing with movements in bed. Utilize a draw sheet or positioning device. Keep head of bed below 30 degrees as much as possible.
- Maintain activity and range of motion exercises per PT/OT.
- Maintain adequate nutrition and fluid intake, consult nutritional services as needed.

(3 points)

Rationale for choices:

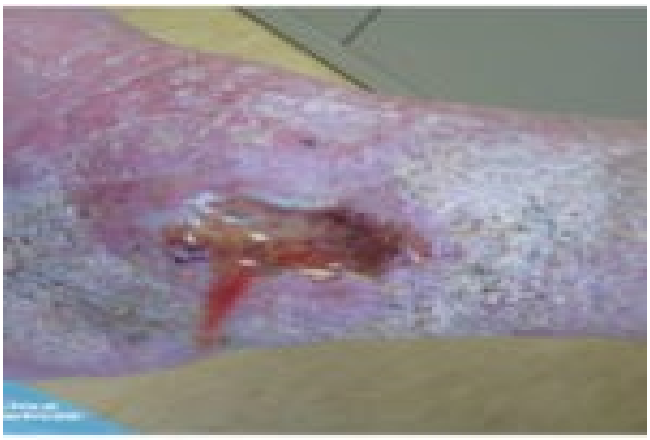
- As the skin is intact, proper skin care and ensuring the skin remains dry and protected is key to further injury prevention.
- Treatment of DTI involves further injury prevention techniques like strict off-loading of the effected site and avoiding excess friction/shear (further injury to the site).
- General pressure injury prevention techniques should be put in place as the patient is at high risk of developing another injury.
- Maintaining normal activity level and adequate nutrition status is important in aiding skin healing process.

(3 points)

1 alternative primary/secondary dressing: Protective silicone foam heel dressing (Mepilex heel foam border dressing OR Allevyn heel silicone foam adhesive border dressing). Apply to bilateral heels, assess skin underneath at each change of shift.
(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: Lower Extremity Venous Ulcer

(1 point)

Wound Nurse recommendations/orders:

- Cleanse the wound with normal saline irrigation, and gently pat skin dry.
- Apply an alginate sheet dressing to the site (Hollister Calcium Alginate sheet), apply a liquid skin sealant to the peri wound skin, then secure in place with dry gauze roll. Change every 1-2 days or as needed when wet/soiled.
- Initiate compression stocking use to bilateral lower extremities. Don stockings in the morning or elevate the extremities for 20-30 minutes prior to applying.
- Moisturize intact skin with non-scented ointments (petrolatum).
- Maintain lower extremity elevation to the level of the heart while at rest, for 30 minute increments.
- Consult PT/OT for exercise and walking therapy planning recommendations.

(3 points)

Rationale for choices:

- Venous ulcers are often quite painful, therefore cleansing the area with normal saline irrigation would be appropriate and decrease pain associated with cleansing and dressing changes.
- Alginate dressings are appropriate for wounds with moderate to high exudate amounts, and an additive calcium alginate would have an antimicrobial effect to protect against wound infection risk. Utilizing a gauze roll for securement would help absorb any further drainage.
- Treatment of chronic venous ulcers and venous disease includes extremity compression to aid blood return, elevation of the effected limbs, and exercise plan in place.
- Intact skin the effected limbs should be protected and application of petrolatum would prevent excess drying of the skin surface.

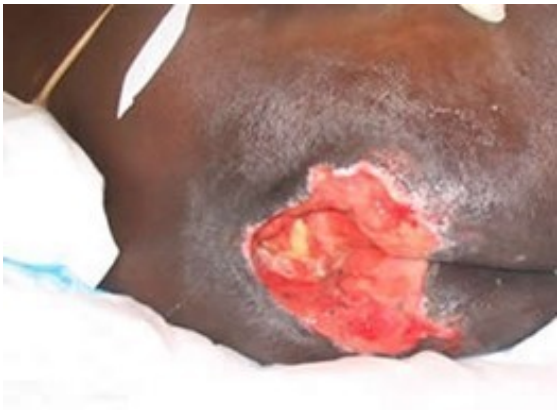
(3 points)

1 alternative primary/secondary dressing: A thin antimicrobial foam dressing (Mepilex AG foam), secured with dry gauze goal. Alternative to compression stocking- compression bandages overtop of lower extremities and wound dressing. Alternative to skin sealant- zinc oxide skin barrier cream to the peri wound skin.

(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: Pressure Injury, Stage 3
(1 point)

Wound Nurse recommendations/orders:

- Use a non-scented, pH balanced wound cleanser and warm water on the area at least once a day and as needed with continence care, gently pat dry.
- Apply wet-to-dry saline moistened gauze dressing to the area (pack lightly as needed to areas of deeper depth) and secure in place with adherent, thin silicone foam dressing (Mepilex foam sacrum dressing). Change dressings daily.
    - Alternative: Hydrofiber sheet (Aquacel) secured with adherent, thin silicone foam dressing.
- Initiate strict Q2 turning and repositioning, ensure sacral off-loading using turning wedges and pillows.
- Monitor peri wound skin for maceration or breakdown. Utilize skin barrier cream in presence of excess moisture and maceration.

(3 points)

Rationale for choices:

- Wound cleanser and tap water is appropriate to cleanse the wound, and provide light mechanical debridement of the slough present in the wound bed.
- A moistened gauze dressing will help to keep the wound bed moist to promote healing while also being useful in absorbing excess exudate (secondary foam dressing will also absorb excess exudate).
- Pressure injury prevention and treatment includes proper off-loading of bony prominences and effected areas, a strict turning schedule will benefit this patient to off-load the sacrum.
- With moderate exudate amount, the peri wound skin is at risk for breakdown related to moisture damage. A skin barrier cream should be utilized as needed to protect intact skin from wound drainage.

(3 points)

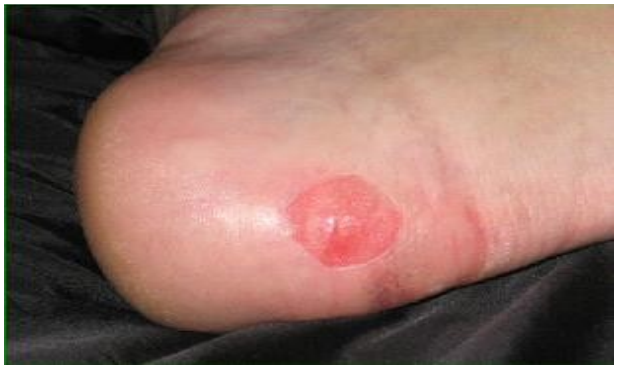
What support surface would you recommend and why?

- Specialty bed/mattress as patient is bedridden- Low air loss mattress (Hillrom Envision) or Air fluidization mattress (Hillrom Envella). Low air loss would assist with patient positioning, decrease pressure on body, and decrease friction with movement. Air fluidized mattress would minimize shear and pressure, as well as maintain microclimate control.

(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: Pressure Injury, Stage 2

(1 point)

Wound Nurse recommendations/orders:

- Use a non-scented, pH balanced wound cleanser and warm water on the area once a day, gently pat dry.
- Apply petroleum impregnated gauze (Xeroform) to the area and secure in place with a transparent film dressing (Tegaderm) or a protective silicone foam dressing (Mepilex adhesive border foam heel dressing). Change dressings daily.
- Maintain good skin care hygiene and moisture level, utilize skin moisturizing lotions.
- Initiate strict heel off-loading of the site utilizing pillows to float heels off bed surface or heel protector boots (Stryker-sage prevalon).
- Follow a Q2 turning and repositioning schedule to prevent further pressure injury damage.
- Consult PT/OT for resuming activity and mobility assessment.

(3 points)

Rationale for choices:

- An impregnated gauze dressing will be gentle on the wound bed and can apply moisture to the site. They are indicated for partial thickness wounds like above.
- Pressure injury treatment and prevention starts with proper off-loading of the affected site as well as all bony prominences/high risk areas. This can be done by floating the heels off the bed surface with pillows or with heel protection boots.
- Protecting intact and healthy skin is important for injury reduction and can be done through a proper skin care regimen and moisturizing intact skin.
- Early mobilization and ambulation can aid in skin healing and get pressure off of the at risk areas of skin.

(3 points)

1 alternative primary/secondary dressing

- Hydrocolloid sheet dressing (DuoDerm).

(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: Pressure Injury, Stage 4
(1 point)

Wound Nurse recommendations/orders:

- Cleanse the wound with normal saline irrigation daily, gently pat area dry.
- Apply a mesh contact layer to the wound bed (Urgotel Polyester Mesh), Hydrogel (Coloplast collagen hydrogel), and secure with dry gauze and transparent dressing or tape. Change dressings daily, contact layer does not need to be changed daily.
- Initiate pressure redistribution chair cushion while up in wheelchair (Gel or air cushions).
- Avoid sitting for extended periods of time while injury is healing, promote ambulation or reclining in bed.
- Initiate strict Q2 turning and repositioning, off-load affected area as possible with turning wedges, chair cushions, and pillows.
- Consult PT/OT for mobility assessment.

(3 points)

Rationale for choices:

- Excess mechanical debridement with washing is not needed in this situation, no slough is present and tissue in the wound bed is pink and granulated. Normal saline irrigation is appropriate.
- A contact layer is important for this patient for the wound bed as there is exposed bone present. A contact layer will also help to promote moisture in the wound bed for optimal healing, as well as the hydrogel. The contact layer can be left intact with dressing changes to avoid trauma to the wound bed.
- Off-loading the ischium is the most important action for wound healing for this patient. This should include limiting time spent sitting up in the wheelchair, utilizing turning wedges and chair cushions for positioning, and promoting activity and ambulation.
-

(3 points)

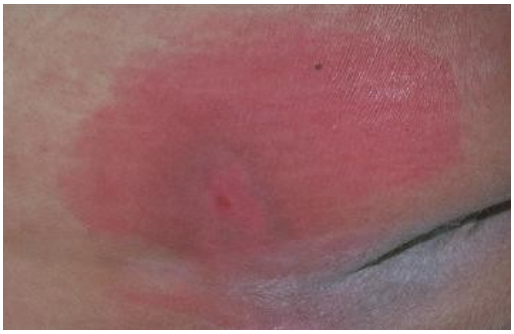
1 alternative primary/secondary dressing:

- Hydrogel (AquaDerm hydrogel sheet) or petroleum (Xeroform) impregnated gauze fluffed into wound bed and secured in place with a thin adhesive silicone foam dressing (Allevyn).

(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: Pressure Injury, Stage 1
(1 point)

Wound Nurse recommendations/orders:

- Provide good skin routine. Utilize no rinse, pH balanced bath wipes for skin cleansing. Minimize excessive rubbing or massaging of the area, gently pat dry.
- Apply protective thin silicone foam sacral dressing (Mepilex sacrum adhesive foam dressing).
- Initiate strict Q2 repositioning and off-loading of the site. Utilize turning wedges and pillows.
- Avoid excess friction or shearing with movements in bed. Utilize a draw sheet or positioning device. Keep head of bed below 30 degrees as much as possible.
- Consider use of specialty bed surface while patient remains on bedrest (Hillrom Envision).
- Consult PT/OT for range of motion exercise recommendation for bedrest. Ambulate the patient and resume normal activity as soon as medically cleared.
- Maintain adequate nutrition and fluid intake, consult nutritional services as needed.

(3 points)

Rationale for choices:

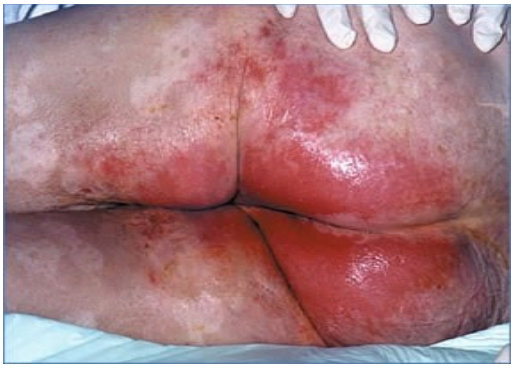
- As the skin is intact, proper skin care and ensuring the skin remains dry and protected is key to further injury prevention.
- Treatment of a stage 1 pressure injury involves strict off-loading of the area and prevention of further injury.
- Thin silicone foam dressings are appropriate for stage 1 pressure injuries, they protect fragile skin against friction and pressure related injury.
- Adequate nutritional status should be maintained to support skin healing, as well as maintain activity and range of motion exercises.
- Specialty bed surfaces can further protect against skin breakdown/pressure injuries, as well as minimize friction and shear.

(3 points)

1 alternative primary/secondary dressing: Protective, thin hydrocolloid dressing (DuoDerm signal). Apply to effected area and assess skin underneath at each change of shift.
(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:

- Provide prompt skin care and cleansing with each bowel movement/incontinence episode. Cleanse the perineal area with a non-scented, pH balanced, no rinse liquid cleanser. Gently pat dry.
- Avoid any excess friction, rubbing, or massaging of the affected area.
- After bowel movement/incontinence episode and cleansing of the skin, apply a zinc-oxide skin barrier cream/wound cream (Desitin barrier cream) to the perineal skin and buttocks. No need to wash off cream completely between applications.
- Utilize absorbent padding in bed and in the chair.
- Assess patient's continence level, ability to void independently.
- Consider using an external collection device (external urinary catheter or a rectal pouch).
- Consult PT/OT to assess patient mobility and for recommendation of toileting accommodations.
    - Bedside commode, raised toilet seat, bedpan, etc.

(3 points)

Rationale for choices:

- No rinse perineal cleansers are usually pH balanced and gentle on the skin and avoids excess drying out of the skin or excess rubbing seen when washing with normal soap.
- Prompt skin care is crucial with incontinence associated dermatitis to rid the skin of the irritant (fecal enzymes).
- IAD is treated by eliminating the source of moisture, so access to toileting facilities or external collection devices is crucial. Absorbent padding should be used to wick away excess moisture in bed and when sitting in the chair.
- The wound/denuded skin above would benefit from a moisture-repellent barrier cream like Desitin as it will repel excess moisture from incontinence episodes, without drying out skin underneath the cream.

(3 points)

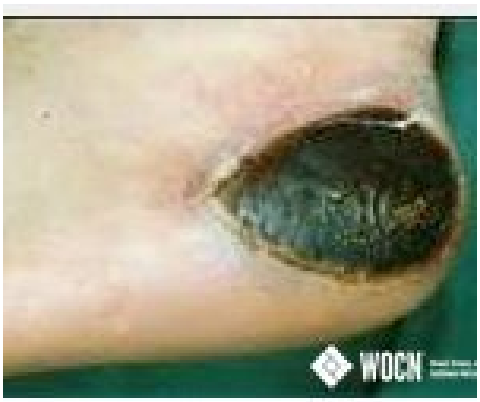
1 alternative primary/secondary dressing:

- Skin barrier powder if there is weapy skin. OR topical antifungal medication if there is suspected fungal infection/Candidiasis to the IAD affected skin (Nystatin).

(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: Pressure Injury, Unstageable
(1 point)

Wound Nurse recommendations/orders:

- Cleanse the wound with a non-scented, pH balanced wound cleanser and warm water. Gently pat dry.
- Apply dry gauze dressing to the area.
- Monitor area for signs of edema, erythema, increasing size, or drainage.
- Consult podiatry and vascular services.
- Initiate strict heel off-loading using pillows or heel protection boots (Stryker).
- Initiate other pressure injury prevention techniques, Q2 turning and repositioning using turning edges.
- Consult PT/OT for mobility assessment.

(3 points)

Rationale for choices:

- An area of stable, black, dry eschar should be left as is, no debridement should be done, and vascular and podiatry services should be consulted.
    - Unless wound becomes infected (edema, erythema, drainage, odor, etc.) in which case surgical debridement should be considered.
- Pressure injury prevention should be the focus of care to prevent further injury and to aid healing of current heel injury.
- Off-loading the effected area is crucial, through floating the heels on pillows or with heel protecting boots.

(3 points)

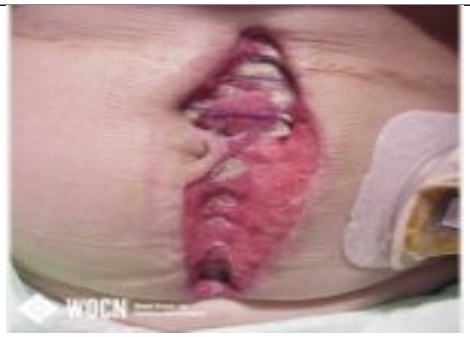
1 alternative primary/secondary dressing:

- Paint the affected area with Povidone-iodine solution and cover with dry gauze dressing. OR apply protective thin, adhesive silicone foam heel dressing (Mepilex foam heel border dressing).

(1 points)

/8 points

Scenario 10



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 Site/Wound Dehiscence

(1 point)

Wound Nurse recommendations/orders:

- Cleanse wound with normal saline irrigation and gently pat dry.
- Apply NPWT system and change dressing every 3-5 days.
    - Apply adhesive transparent film barrier to peri wound skin.
    - Apply a petroleum impregnated gauze to the wound bed.
    - Lightly pack black foam into the wound bed, covering completely.
    - Apply transparent film barrier drape overtop of black foam and onto peri wound skin.
    - Cut small opening in top transparent drape to fit the suction device appropriately. Connect to tubing and canister. Ensure good seal by turning on device to ordered settings.
- Notify provider if unable to achieve proper NPWT seal for 2 hours. Remove NPWT and place a wet gauze dressing (normal saline) over the wound until system can be replaced.
- Notify provider if large increase in vac output or if output takes on the characteristics of gastric contents (green, brown).
- Consult nutritional services for adequate nutrition and fluid management, possible need for enteral feeds, TPN.

(3 points)

Rationale for choices:

- One must cleanse the wound bed before applying a NPWT system.
- If unable to obtain a seal on a NPWT for greater than 2 hours, the dressing should be removed and a new gauze dressing applied to decrease infection risk.
- The provider should be notified of changes to the vac output as there could be excess bleeding that needs to be managed, or a fistula may have formed in the wound bed from the abdominal surgery.
- Nutrition is very important for wound healing, especially protein. Nutritional services should be consulted to determine adequate diet and route of feeds.

(3 points)

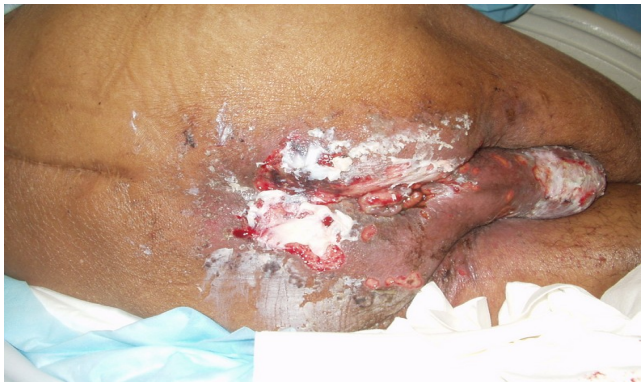
1 alternative primary/secondary dressing:

- If NPWT not indicated or not an option: Moistened gauze packing dressing (normal saline) secured with a gauze pad and tape or transparent film. OR petroleum impregnated gauze dressing (Xeroform) secured with gauze pad overtop and tape.

(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:

- Provide prompt skin care and cleansing with each bowel movement/incontinence episode. Cleanse the perineal area with a non-scented, pH balanced, no rinse liquid cleanser. Gently pat dry.
- Avoid any excess friction, rubbing, or massaging of the affected area.
- After bowel movement/incontinence episodes and cleansing, apply zinc-oxide based barrier cream (Triad Wound dressing) to areas of skin breakdown, and apply a liquid skin barrier film (Cavilon-no sting skin barrier) to all intact areas surrounding areas of breakdown.
- Assess patient incontinence level, presence of fecal and/or urinary incontinence.
- Utilize absorbent pads in bed and in the chair.
- Consider use of external collection devices (external catheter).
    - Consider use of internal fecal management system if all other less invasive measures are unsuccessful in decreasing contact with irritant.

(3 points)

Rationale for choices:

- No rinse perineal cleansers are pH balanced and gentle on the skin and avoids excess drying out of the skin or excess rubbing seen when washing with normal soap.
- Prompt skin care is crucial with incontinence associated dermatitis to rid the skin of the irritant (fecal enzymes).
- Triad wound dressing cream is indicated for moist perineal wounds and helps promote autolytic debridement and healing while also repelling excess moisture on the surface from incontinence episodes.
- Skin barrier film should be utilized to help protect the intact peri wound skin from excess moisture contact.
- Treatment of IAD begins with minimizing moisture and contact with the irritant, this would include using absorbent pads and collection devices. An internal fecal management system may need to be considered if less invasive measures are unsuccessful, in order to aid wound healing in the case of total fecal incontinence.

(3 points)

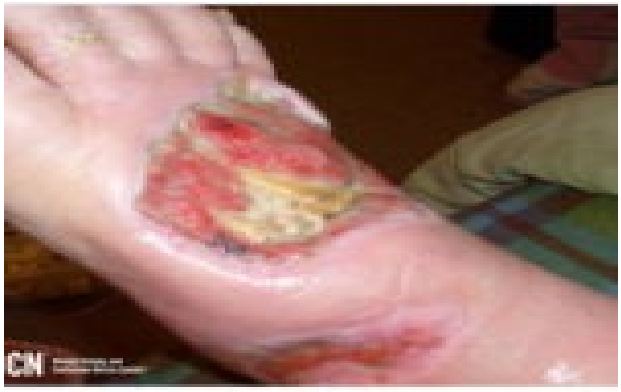
1 alternative primary/secondary dressing:

- MediHoney gel or paste to the open areas/full-thickness wounds, apply skin barrier film to intact peri wound skin.

(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 Neuropathic Foot Ulcer
(1 point)

Wound Nurse recommendations/orders:

- Cleanse wound daily with normal saline irrigation, gently pat the area dry.
- Apply a mesh contact layer dressing (Adaptic silicone non-adherent dressing) to the wound bed and exposed tendon. Secure in place with dry gauze roll dressing. Change dressings daily and as needed (wet/soiled).
- Assess degree of neuropathy present, perform monofilament testing.
- Assess for adequate lower extremity circulation, consult vascular team for concerns of poor arterial perfusion.
- Consult endocrinology for diabetes management plan.
- Ensure proper fitting socks and shoes are worn.

(3 points)

Rationale for choices:

- Protection should be provided for the exposed tendons in the wound bed. A contact layer would be non-adherent and gentle to remove. Contact layer also allows for moisture promotion in the wound bed but autolytic debridement and wound healing.
- Gauze roll dressing helps to keep contact layer in place on wound. Keeps wound covered and clean.
- With present neuropathy, ulcer healing can be complicated by poor arterial perfusion in the lower extremities. Pulses, appearance, and ABI should be assessed to determine poor circulation risk.
- Adequate blood glucose control is crucial for wound healing.
- Ill-fitting shoes and garments can lead to further injury in those with diabetic neuropathy.

(3 points)

1 alternative primary/secondary dressing:

- A petroleum impregnated gauze dressing (Xeroform) in the wound bed, secured with a dry gauze dressing OR a hydrogel sheet dressing (AquaDerm) secured with dry gauze dressing.

(1 point)

/8 points