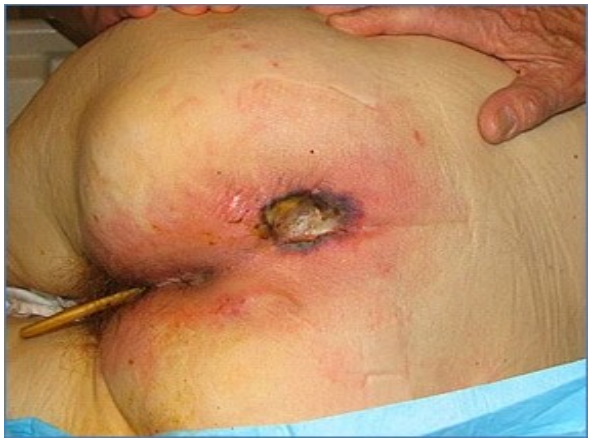
Scenario 1



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 sacral pressure injury, moisture-associated skin damage on peri-wound

(1 point)

Wound Nurse recommendations/orders:

- Gently clean wound with saline or a wound cleanser (vashe) and pat dry.
- Fill wound gently with calcium alignate dressing for moisture management.
- Cover with alleyvn.
- Change dressing every 3 days, and as needed for 50% strike through or when soiled.
- Use Sensicare for the peri-wound area and manage moisture.
- Assess, offload pressure, and manage pressure regularly.
- Consult WOC nurse with questions or concerns

(3 points)

Rationale for choices:

- Saline avoids irritation and maintains a moist environment for healing.
- Alginate dressing is highly absorbent for moderate to heavy exudate and promotes autolytic debridement.
- Foam dressing absorbs exudate and protects from external moisture.
- Barrier ointment prevents further skin breakdown in the peri-wound area.

- Pressure relief minimizes the risk of further tissue damage.
- Regular reassessment ensures optimal healing and timely interventions.

(3 points)

1 alternative primary/secondary dressing
Aquacel, this manages moisture, promotes autolytic debridement, protects against infection, and improves patient comfort—all of which are essential for effective wound healing.

(1 point)

/8 points