Student Name ___ **Date: __12/30/2024_____**

Reviewed by: **Date: 1/2/25**

Score: 66.8 /96 Great first attempt at this assignment. I have made some comments throughout so focus on the areas where you can obtain additional points as you need an 80% on the assignment. Let me know if you have any questions. Vishal, read the example & note that the orders are for one therapy and include change orders. You are putting too many things in the orders & they do not make sense.

Please write your additional info on this paper in another color & return via dropbox.

XX/96-1 resubmission = YY/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 Pressure Injury with Epibole based on its rolled edges and subcutaneous fat exposure following progression through the full thickness of the skin (Edsberg, 2022). Roman numerals are no longer used

(1 point) **0 Vishal read the PI stage descriptions**

Wound Nurse recommendations/orders:

1. Remove the old dressing clean the wound with wound cleanser, and pat dry. Apply skin protectant to the periwound skin to prevent possible maceration.
2. Apply a hydrogel dressing (Intrasite Gel) as the primary dressing to maintain moisture and change every 3-4 days or PRN. Apply a secondary foam dressing (Allevyn) to enhance exudate absorption and cushion the area and change every 3-4 days or PRN. You need to be directive in orders not talk about 'consider'. You are also missing some primary dressing info based on the depth of this wound. How often is this dressing to be changed?
3. Obtain midline comfort glide sheet and turning wedges to offload the patient's coccyx/ischium every 2 hours. Encourage the patient to turn and reposition every two hours.
4. Nutrition consult advised for optimized wound healing with dietitians/nutritionists to develop a personalized diet plan.
5. Surgery consult for possible sharp debridement to remove unhealthy tissue.

(3 points)1

Rationale for choices:

1. Hydrogel dressings maintain a moist environment that facilitates autolytic debridement true while foam dressings absorb exudate and protect pressure injuries with epiboles from contamination (Edsberg, 2022).
2. Skin barrier prevents further maceration, shields the wound and periwound from irritants and infections, and minimizes the risk of erythema (Jaszarowski & Murphree, 2022).good
3. Frequent repositioning reduces pressure on the wound area, which promotes healing

and prevents further injury to the wound. ok

4. A personalized diet plan necessitates adequate protein and calorie intake for wound healing (Borchert, 2022).
5. Debridement is essential for the type of wound since it necessitates the removal of necrotic tissue to facilitate healing (Ramundo, 2022).

(3 points) 3

1 alternative primary/secondary dressing

1. Apply alginate dressing (Kaltostat) as an alternative primary dressing to enhance exudate absorption and non-adhesive silicone border dressings (Mepilex Border) as an alternative secondary dressing (Jaszarowski & Murphree, 2022). Collagen is not an appropriate dressing for this wound. Do you understand why after you review staging descriptions?

(1 point) 0

/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 Injury based on the discolored skin and non-blanchable erythema which is suggestive of intact skin tissue (Edsberg, 2022) again, review the stages & no roman numerals

(1 point) 0

Wound Nurse recommendations/orders:

1. Use a heel suspension device (Prevalon Heel Protector) to offload pressure from the heel. Yes!
2. Apply moisture barrier film dressing (Sensi-Care Protective Barrier).
3. Moisturize the surrounding skin to enhance barrier function. ok
4. Assess additional damage to the heel and encourage mobility.

(3 points) 2.5

Rationale for choices:

1. Offloading pressure around the wound area prevents the progression of the injury and necessitates healing.
2. Applying a moisture barrier film dressing can prevent friction and further skin damage
3. Moisturization of the skin around the heel improves resilience against friction and shear.
4. Mobility improves circulation around the affected tissue, enhances pressure redistribution, alleviates edema, and prevents further skin breakdown (Borchert, 2022).

(3 points) 2.5

1 alternative primary/secondary dressing

1. Apply soft silicone foam dressing (Allevyn Gentle Border) to provide gentle cushioning and reduce friction (Jaszarowski & Murphree, 2022).

(1 point) 0

5/8 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: Venous Ulcer

(1 point) 1

Wound Nurse recommendations/orders:

1. Apply compression therapy through a two-layer compression bandage system (Coban 2) to improve venous return.
2. Apply calcium alginate primary dressing (Algisite M) to manage moderate exudate and a non-adhesive foam dressing (Mepilex) as a secondary dressing to absorb exudate and protect the wound.
3. Instruct the patient to elevate the legs when resting.
4. Educate the patient on lifestyle modifications, including encouraging leg exercises and discouraging prolonged sitting or standing.

(3 points) 3

Rationale for choices:

1. Compression therapy enables nurses to address patients' underlying venous insufficiency (Kelechi et al., 2022).
2. Calcium alginate dressings help absorb exudate and maintain a moist wound environment for enhanced healing while foam dressings prevent maceration and further damage to the wound and periwound skin (Jaszarowski & Murphree, 2022).
3. Elevating the leg enhances venous return, reduces venous pressure, reduces pain and swelling, and supports healing (Kelechi et al., 2022).

(3 points) 3

1 alternative primary/secondary dressing: Apply a foam dressing (Mepilex) as an alternative primary dressing and to manage exudate, provide cushioning, and protect the wound bed and a compression wrap (Profore) as a secondary dressing to support venous return and prevents further fluid accumulation. alginates & hydrofibers are the same class of dressings

(1 point) .5

7.5/8 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 Roman numerals are no longer used
(1 point) 0 review the stages

Wound Nurse recommendations/orders:

1. Perform enzymatic debridement to remove slough. You need to select what you want & write the appropriate orders
2. Apply collagenase ointment (Santyl) 2mm thick every 24hrs, directly to the sloughy areas. Discontinue application once the wound bed is clear of the slough.
3. Apply moisture retentive dressing (Aquacel) as the primary dressing to control moistture and change every 2-3 days. Apply an absorbent foam dressing (Mepilex Border) as the secondary dressing for moderate drainage and change every 2-3 days (Jaszarowski & Murphree, 2022). Depends on step 1
4. Provide an air-fluidized therapy bed support surface. Pick one & order it
5. Get the patient up and out of bed to chair. When in bed turning wedges to offload the patient's coccyx/ischium every 2 hours. Encourage the patient to turn and reposition every two hours. Do you want this pt on their back?
6. Closely monitor the patient for signs of infection indicated by redness and increased drainage.
7. Introduce a supplement diet with protein and vitamins.

(3 points) 1

Rationale for choices:

1. Surgical and enzymatic debridement helps to clear necrotic tissue and promote healing (Ramundo, 2022).
2. The use of antimicrobial dressing helps manage bioburden and prevents infection while secondary foam dressings control exudate and prevent further periwound breakdown (Jaszarowski & Murphree, 2022).
3. Provision of support surfaces helps redistribute pressure to promote wound healing.
4. Frequent repositioning reduces pressure on the wound area, which promotes healing and prevents further injury to the wound.

5. Close monitoring necessitates early identification and treatment of infections while supplemental proteins and vitamins promote tissue regeneration, enhance immunity, and prevent muscle wasting (Friedrich et al., 2022).

(3 points) **3 rationales are good but you need to be specific on your orders**

What support surface would you recommend and why? air-fluidized therapy bed (Clinitron Bed) might want to consider an envella for optimal pressure relief due to immobility and to reduce the risk of further tissue breakdown.

(1 point) **1**

5/8 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 yes, Arabic numerals are how to stage

(1 point) 1

Wound Nurse recommendations/orders:

1. Use saline or a wound cleanser to gently clean the wound and periwound skin.
2. Apply a hydrocolloid dressing (Duoderm) to protect the wound from further trauma and keep it moist and change it every 3-5 days. You need to include dressing change orders
3. Use a heel offloading device or heel protector (Heel lift Suspension Boot or EHOB Heel Protector Boot) and reposition the patient frequently to relieve pressure from the heel.
4. Regularly assess the wound for redness, increased drainage, warmth, or odor that may indicate infections.
5. Apply a skin protectant spray (Cutimed PROTECT Spray). Unlikely to be best plan as you are trying to use an adhesive based dressing and this is greasy

(3 points) 2

Rationale for choices:

1. Cleaning the wound and periwound skin with saline helps reduce the bacterial load while being gentle on the tissue.
2. Maintaining a moist wound environment reduces pain and enhances the healing process particularly when using hydrocolloid dressings that are excellent for partial-thickness wounds with minimal to moderate exudate (Jaszarowski & Murphree, 2022).
3. Offloading pressure from the heel prevents further deterioration of the wound and enhances healing (Edsberg, 2022).
4. Monitoring for signs of infections necessitates early detection and timely intervention.
5. A skin protectant spray is suitable to protect the periwound skin. What else could you do to protect the skin?

   These orders are suitable for a stage 2 pressure injury due to its partial-thickness loss of skin with exposed dermis and potential for the formation of a ruptured blister.

(3 points) 3

1 alternative primary/secondary dressing

Use hydrogel sheet (Intrasite Gel Sheet) as an alternative primary dressing for additional moisture and a transparent film or silicone foam dressing (Tegaderm Foam) as an alternative secondary dressing to secure and protect the wound.

(1 point) 1

7/8 points

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
(1 point) 1

Wound Nurse recommendations/orders:

1. Use a wound cleanser (Vashe Wound Solution or Saline) to remove debris gently.
2. Use a barrier film (Cavilon No-Sting Barrier Film) or a transparent dressing to protect the surrounding good skin from negative pressure wound therapy (NPWT).
3. Cover the visible bone with non-adhering Adaptic. Cover the entire wound bed with Calcium alginate with silver dressing.
4. Apply a cut-to-fit wound size foam-based negative pressure dressing (V.A.C. Therapy Dressing Kit) and change every 2-3 days.
5. Use an adhesive drape to ensure a tight seal over the wound and maintain negative pressure.
6. Pinch the drape cut a quarter-sized round hole and apply the suction pad / T.R.A.C pad directly over the hole.
7. Connect the suction pad / T.R.A.C pad to the canister tubing and turn on the machine to manage exudate and promote granulation and change every 2-3 days.
8. Reassess the wound weekly for reduction in size and the presence of granulation tissue.
9. Use specialized wheelchair cushions (ROHO Quadtro Select Cushion) and a pressure redistribution mattress (Stryker Isoflex Mattress) to offload pressure on the ischium area and reposition the patient every 2 hours. ok
10. Prepare a high-protein, high-calorie diet plan to support healing. ok

(3 points) .5

Rationale for choices:

1. Cleansing can help reduce bacteria and debris and thus prevent infection and encourage healing.
2. Introducing barrier films protects periwound skin from adhesive-related damage (Thayer et al., 2022).
3. Assessing and controlling local and systemic infection is necessary since bone exposure increases the risk of osteomyelitis.
4. Calcium alginate with silver dressings is necessary since it absorbs drainage and addresses the bioburden, while keeping the wound bed moist and promoting healing (Jaszarowski & Murphree, 2022).
5. NPWT is suitable for the wound since it facilitates wound healing by removing exudate, promoting granulation, and reducing wound size (Netsch, 2022).
6. Frequent monitoring helps track wound healing progress and ensures timely intervention in case of complications.
7. Offloading is necessary since it eliminates pressure that causes and aggravates pressure injury formation and progression.
8. Nutritional support enhances tissue repair and immune function (Friedrich et al., 2022).

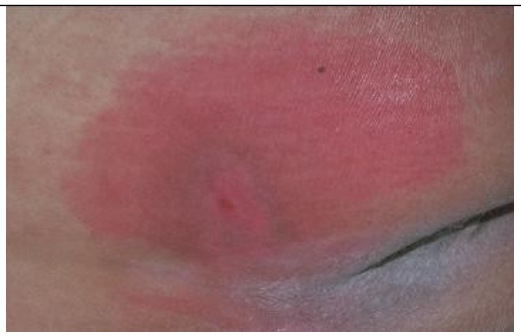
(3 points) 2

1 alternative primary/secondary dressing: Use a non-adherent contact layer dressing (Adaptic Touch) to the visible bone area. Apply antimicrobial dressings (Aquacel Ag+ or Iodoflex) as an alternative primary dressing to absorb exudate and support healing and silicone foam (Allevyn Gentle Border) to support the primary dressing and enhance moisture management. Too similar to alginate + you are using multiple dressings above.
(1 point) 0

Scenario 6

1. 3.5/8 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) 1

Wound Nurse recommendations/orders:

1. Reposition the patient every 2 hours to offload pressure from the sacrum.
2. Use specialized cushions or mattresses (Stryker IsoFlex or ROHO Mosaic Cushion) to relieve pressure.
3. Apply a protective barrier cream or film (Cavilon No-Sting Barrier Film or Sensi-Care Protective Barrier) to reduce friction and protect the skin.
4. Manage any incontinence with pads and undergarments (Tranquility Premium OverNight Pads or Attends Advanced Briefs) to keep the area clean and dry.
5. Frequently assess for progression to blistering or open wounds and educate the patient about prevention strategies.

(3 points) 3

Rationale for choices:

1. Repositioning and pressure offloading allows the tissue around the wound to recover and prevent deterioration.
2. Using barrier creams and films creates a protective layer that minimizes friction, shear, and moisture damage (Thayer et al., 2022).
3. Proper moisture management prevents maceration of the skin that could otherwise worsen the wound.
4. Monitoring for wound progression and signs of blistering necessitates early intervention and ensures timely escalation of care if the wound worsens.

(3 points) 3

1 alternative primary/secondary dressing

Use transparent dressings like Tegaderm Film (3M Tegaderm Transparent Film Dressing) or Opsite Flexigrid (Smith+Nephew Opsite Flexigrid Transparent Film) as alternative dressings to protect the area and allow visualization of the skin.

(1 point) 1

8/8 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: Erythematous incontinence-associated dermatitis (IAD)

(1 point) yes but there is more .5

Wound Nurse recommendations/orders:

1. Use a pH-balanced cleanser (Peri-Wash or Hibiclens) to gently clean the affected area while avoiding harsh soaps that may cause irritation or further injuries.
2. Apply a liquid acrylate skin protectant (Cavalon No Sting Barrier Film [NSBF]) to protect the skin.
3. Use breathable, moisture-wicking incontinence pads (Tranquility Premium OverNight Pads) as absorbents. ok
4. Address diarrhea if present with medications (loperamide) and prepare a low-residue diet to enhance outcomes. ok
5. Inspect the skin regularly for signs of irritation and address them promptly. ok

(3 points) 1

Rationale for choices:

1. Using a pH-balanced cleanser minimizes irritation and prevents further breakdown of wounds and periwound skin (Thayer & Nix, 2022).
2. Applying a liquid acrylate skin protectant (Cavalon No Sting Barrier Film [NSBF]) barrier helps protect the skin, and studies have shown it leads to significantly greater wound size reduction and cost effectiveness (Thayer et al., 2022).
3. Using absorbent products like breathable pads reduces moisture buildup and maintains dryness to enhance healing.
4. Since diarrhea exacerbates IAD, controlling stool consistency is vital for recovery (Thayer & Nix, 2022).
5. Regular monitoring of the affected area ensures timely intervention if the condition worsens.

(3 points) 3

1 alternative primary/secondary dressing:

1. Apply zinc oxide-based moister barrier cream or ointment (Coloplast Baza Protect).
2. Use a superabsorbent pad (Tranquility Super Absorbent Liners) to manage moisture effectively and change every 6-8 hours.
3. Get the patient up out of bed to the bedside commode.

(1 point) 0 these will not remain in place

4.5/8 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 (due to eschar obscuring the wound bed)

(1 point) 1

Wound Nurse recommendations/orders:

1. Do not debride the wound since the eschar appears dry, stable, and intact and thus serves as the body's natural barrier. Only debride if the wound develops signs of infection or drainage appear. ok
2. Apply a barrier cream (Cavilon No-Sting Barrier Film) to protect the periwound area.ok
3. Use heel protectors (Heel lift Suspension Boot or EHOB Heel Protector Boot) to offload pressure and promote healing.ok
4. Monitor the wound regularly for signs of infection like redness, warmth, and drainage.ok
5. Provide guidance on pressure offloading and maintaining skin integrity.ok

(3 points) 3

Rationale for choices:

1. Debridement should be avoided for this wound since removing the stable eschar on the heel could expose the wound to infection unnecessarily (Ramundo, 2022). In its current form, the eschar could serve as a natural barrier.
2. Using barrier creams protects the periwound area from drying and breakdown.
3. Pressure offloading eliminates pressure on the affected area and allows the body to heal while preventing further tissue damage.
4. Regular monitoring ensures early detection and response to complications.
5. Educating the patient enhances accountability and increases their involvement in wound management.

(3 points) 3

1 alternative primary/secondary dressing:

Apply soft silicone foam dressing (Allevyn Gentle Border) to provide gentle cushioning and reduce friction. Transparent film sets up autolytic debridement

(1 points) 0

7/8 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 healing by secondary intention, with delayed closure due to wound size and partial devitalized tissue

(1 point) yes, but .5

Wound Nurse recommendations/orders:

1. Use a wound cleanser (Vashe Wound Solution or Saline) to remove debris gently.
2. Use a barrier film (Cavilon No-Sting Barrier Film) or a transparent dressing to protect the surrounding good skin from negative pressure wound therapy (NPWT).
3. Apply a cut-to-fit wound size foam-based negative pressure dressing (V.A.C. Therapy Dressing Kit) and change every 2-3 days.
4. Use an adhesive drape to ensure a tight seal over the wound and maintain negative pressure.
5. Pinch the drape and cut a quarter-sized round hole and apply the suction pad / T.R.A.C pad directly over the hole.
6. Connect the suction pad / T.R.A.C pad to the canister tubing and turn on the machine to manage exudate and promote granulation and change every 2-3 days.
7. Reassess the wound weekly for reduction in size and the presence of granulation tissue.

(3 points) 1 again you are without change orders

Rationale for choices:

1. Cleansing can help reduce bacteria and debris and thus prevent infection and encourage healing.
2. Introducing barrier films protects periwound skin from adhesive-related damage (Thayer et al., 2022).
3. NPWT is suitable for the wound since it facilitates wound healing by removing exudate, promoting granulation, and reducing wound size (Netsch, 2022).
4. Frequent monitoring helps track wound healing progress and ensures timely intervention in case of complications.

(3 points) 3

1 alternative primary/secondary dressing:

Use collagen dressing (Promogran Prisma or Biostep) as an alternative for primary dressings to support wound healing by providing a scaffold for tissue regeneration. Apply non-adherent foam secondary dressing (Mepilex Border) to secure the primary dressing and enhance moisture management.

(1 point) .5 well, ok, but a collagen in this wound is not enough

5/8 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 (IAD)

(1 point) 1

Wound Nurse recommendations/orders:

1. Use a gentle, pH-balanced cleanser (Hibiclens or Peri-Wash) to clean the affected area and alleviate further irritation.
2. Apply Polymer-cyanoacrylate skin protectant (3M Cavilon Advanced skin protectant)
3. Use breathable polymer-based absorbative pads (Tranquility Premium OverNight Pads) to keep the area dry and reduce friction.
4. Address the cause of diarrhea and rule out impaction, and infection.
5. Get the patient up out of bed to the bedside commode.
6. Inspect the area frequently for signs of infection or worsening damage.

(3 points) too many contradictory orders 1

Rationale for choices:

1. Cleansing using a pH-balanced cleanser helps maintain skin integrity and minimizes irritation (Thayer & Nix, 2022).
2. Applying a liquid acrylate skin protectant (Cavalon No Sting Barrier Film [NSBF]) barrier helps protect the skin, and studies have shown it leads to significantly greater wound size reduction and cost-effectiveness (Thayer et al., 2022).
3. Absorbent products wick away moisture, reduce maceration, and enhance skin recovery
4. Addressing the cause of diarrhea will address the removal of the irritants and protection of the area promoting healing cases (Thayer & Nix, 2022).
5. Routine monitoring ensures timely detection of skin breakdown and intervention.

(3 points) 3

1 alternative primary/secondary dressing:

-Apply zinc oxide-based moister barrier cream or ointment (Coloplast Baza Protect).
-Apply a superabsorbent pad (Tranquility Super Absorbent Liners) for moisture management and change every 6-8 hours.

(1 point) 0 this will not provide protection

5/8 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: Wagner Grade 2 diabetic foot ulcer (DFU) not sure this is a 3
(1 point) .5

Wound Nurse recommendations/orders:

2. Apply antimicrobial dressings (Aquacel Ag+ or Iodoflex) and change every 2-3 days.
3. Use a total contact cast (TCC) to reduce pressure on the wound.
4. Perform ankle-brachial index (ABI) to evaluate peripheral artery disease (PAD).
5. Consult Podiatrist

(3 points) **too many conflicting orders 1**

Rationale for choices:

1. Dressing is absorbent and it has antimicrobial properties that manage exudate, reduce the bacterial load, and prevent infection in a high-risk wound.
2. Offloading reduces pressure on the ulcer and is standard in DFU management (Bonham, 2022).
3. Blood flow assessment by addressing PAD ensures sufficient perfusion for healing and identifies the need for vascular intervention (Bonham, 2022).

(3 points) 3

1 alternative primary/secondary dressing:

-Apply hydrofiber primary dressing (Aquacel Extra) for exudate management and foam secondary dressing (Mepilex Border) for protection and change every 3-5 days. Are you aware of the RCTs for Mepilex & Allevyn & what they are able to do?
(1 point) **.8**

5.3/8 points

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