

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

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with Dakin's solution and dry using 4x4 gauze
2. Prep periwound skin with skin barrier film (Medline Sureprep)
3. Apply 3 mm thick layer of Plurogel to wound base
4. Fill remainder of wound bed with roll gauze (Kerlix)
5. Cover wound with ABD pad and secure with Medipore tape
6. Consult Wound NP for possible conservative sharp debridement (at our facility the Wound NP is one who would perform this action)
7. Move patient to an air fluidized surface
8. ComfortGlide wedges for turning and repositioning every 2 hours

(3 points)

Rationale for choices:

1. Dakin's is a sodium hypochlorite solution to help reduce biofilm and wound odor.
2. Liquid barrier film is a skin protectant and will help reduce breakdown to periwound.
3. Plurogel donates moisture to the wound bed and loosens wound debris.
4. Wounds with depth should be filled
5. ABD pad will aide in exudate absorption.
6. Wound would benefit from debridement to quicken the wound healing process with quicker removal of devitalized tissue.
7. This surface will provide pressure redistribution
8. Wedges are made to correctly position patient at 30 degree tilt and to effectively offload sacrococcygeal area

(3 points)

1 alternative primary/secondary dressing

Alternative dressing would be Medline TheraHoney gel, cover with Mepilex Border Foam Sacral dressing, change every third day

(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 Injury
(1 point)

Wound Nurse recommendations/orders:

1. Apply liquid barrier film (Medline Sureprep) BID
2. Strict offloading of heels with either pressure reduction boots (Medline HeelMedix) or pillows placed under calves

(3 points)

Rationale for choices:

1. Liquid barrier film is a skin protectant to prevent outer layer of tissue from opening
2. Pressure reduction boots are designed to suspend the heel and reduce pressure, friction, and shear

(3 points)

1 alternative primary/secondary dressing
Urgotul Contact layer and Mepilex Heel Border Foam dressing, change every 2-3 days
(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:

Venous Ulcer

(1 point)

Wound Nurse recommendations/orders: Dressing changes every MWF and as needed for saturation

1. Cleanse wound with normal saline and dry with 4x4 gauze
2. Prep periwound skin with liquid skin barrier (Medline Sureprep)
3. Cut hydrofiber (Medline Opticell) to fit and apply to wound bed
4. Cover with ABD and secure with roll gauze (Kerlix)
5. ACE wrap application daily for light compression from base of toes to base of knees
6. Elevate legs with pillows while in bed
7. Venous duplex US

(3 points)

Rationale for choices:

1. Cleanse wound to reduce bacteria in wound
2. Skin protectant used to protect macerated periwound skin
3. Hydrofiber will absorb moderate to heavy exudating wounds
4. ABD for additional absorption and roll gauze to secure
5. Venous ulcers stem from poor venous return, light compression with ACE wraps will aide in venous return and prevent edema
6. Elevating legs to aide in fluid return
7. US to determine severity

(3 points)

1 alternative primary/secondary dressing:

Hydrofera blue with border foam dressing, change every 3rd day

(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: Change every 3 days

1. Cleanse wound with Coloplast Sea-Cleans wound cleanser and pat dry with 4x4 gauze
2. Cut calcium Alginate (MaxOrb) sheet to fit and use to fill wound bed
3. Secure with Mepilex Sacral Borer foam dressing

(3 points)

Rationale for choices:

1. Wound cleanser to help reduce biofilm, bacteria, and debris
2. Alginate dressings help absorb moderate to heavy exudate and can form gel that can autolytic debride. Also assist with dressing irregular wound shapes.
3. Border foam dressing consists of multiple layers that will aide in additional exudate absorption.

(3 points)

What support surface would you recommend and why?

Would recommend a low air loss surface with redistribution properties to aide in pressure redistribution and management of microclimate - the Stryker PowerPro Elite may work for this patient.

(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, CWOON.

Wound type:

Stage 2 pressure injury

(1 point)

Wound Nurse recommendations/orders: Change every 3-5 days

1. Cleanse wound with saline and dry with 4x4 gauze
2. Liquid barrier film to periwound
3. Urgotul contact layer to wound bed
4. Cover with Mepilex Heel Border Foam dressing

(3 points)

Rationale for choices:

1. Cleanse wound to cleanse of debris and exudate
2. Liquid barrier film used as periwound skin protectant
3. Contact layer used to aide in protecting moist wound healing environment and ease of dressing removal. Will allow exudate to pull through pores in the layer.
4. Border foam dressing to aide with moist wound healing environment while absorbing excess wound exudate

(3 points)

1 alternative primary/secondary dressing

Hydrocolloid (Exuderm)dressing and change every 3-5 days

(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 8 cm 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)

Wound Nurse recommendations/orders:

1. Obtain wound culture
2. Advise that Infectious Disease be involved due to assumed osteomyelitis given unexplored bone exposure
3. Dressing changes every other day and as needed for saturation:
 - a. Cleanse with Dakin's and dry with 4x4 gauze
 - b. Skin barrier film to periwound skin
 - c. Apply contact layer (Urgotul) to area of exposed bone structure
 - d. Use calcium alginate with silver (MaxOrb Ag) to fill wound bed
 - e. Cover with Mepilex Sacral Border Foam Dressing
4. Specialty surface
5. ComfortGlide positioning wedges

(3 points)

Rationale for choices:

1. Given drainage color and exposure of bone recommend a wound culture to determine infective organisms
2. ID consultation to aide in diagnosis of confirmed osteo or rule out and to aide in antibiotic therapy
3. Dressing
 - a. Dakin's to cleanse wound bed and remove debris and odor
 - b. Periwound skin protection
 - c. Cover exposed structure to over damage with dressing changes
 - d. Silver for antimicrobial properties and odor control and alginate to aide in absorption of exudate
 - e. Border foam for absorption properties
4. Stryker Dolphin mattress for pressure redistribution and fluid immersion properties
5. Positioning and offloading when turning and repositioning

(3 points)

1 alternative primary/secondary dressing:

If osteomyelitis was ruled out, would recommend negative pressure wound therapy with contact layer over exposed bone.

(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: Change every 3-5 days

1. Apply Mepilex Sacral Border Foam dressing
2. Use Medline Comfort Glide Foam wedges for every 2 hours turn and reposition

(3 points)

Rationale for choices:

1. Border Foam dressing to protect intact skin and decrease friction and shear
2. Positioning wedges to offload with every 2-hour turning and repositioning

(3 points)

1 alternative primary/secondary dressing

Medline Remedy PREVENT silicone cream application BID and prn with incontinence care

(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 (IAD)

(1 point)

Wound Nurse recommendations/orders: BID and prn with incontinent care

1. Cleanse with Medline Remedy CLEANSE no-rinse foam cleanser and pat dry
2. Medline Remedy PROTECT zinc oxide paste
3. Insertion of FMS
4. KOH scraping to rule out candidiasis

(3 points)

Rationale for choices:

1. Cleanse area of irritants of stool and urine and pat dry to prevent rubbing skin and causing damage
2. Zinc barrier paste will provide a barrier between the irritant and the damaged skin and will hold against moist skin
3. FMS insertion will divert caustic liquid stool to allow for healing of skin and decrease exposure to irritants
4. The patchy rash along the edges of the wound and possible antibiotic therapy that patient may be receiving for C.Diff make me question whether it is candidiasis.

(3 points)

1 alternative primary/secondary dressing:

Triad Hydrophilic Topical Dressing

(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: Change daily

1. Apply betadine to dry eschar and cover with dry dressing
2. Strict offloading of heels at all times with Medline HeelMedix boots or pillows under calves
3. Monitor for signs of infection

(3 points)

Rationale for choices:

1. Betadine will cleanse as well as keep the eschar dry. Eschar on heels is the body's natural band-aide and should be kept dry as the heel should heal under the eschar and once it is fully healed the eschar will naturally come off.
2. Heels should be offloaded and suspended off bed to prevent any additional damage from pressure
3. Once signs of infection are identified - the eschar may need to be removed due to it enabling bacteria to continue to grow

(3 points)

1 alternative primary/secondary dressing:

Liquid barrier film application BID

(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

(1 point)

Wound Nurse recommendations/orders: Change every MWF and change cannister weekly

1. Cleanse with saline
2. Apply oil emulsion dressing (Curad) over exposed sutures and areas with yellow tissue
3. Prep periwound with barrier film (Medline Sureprep)
4. Picture frame wound with clear transparent film
5. Apply black foam to gently film wound bed
6. Secure with clear transparent film and cut quarter sized hole into film over foam
7. Attach tubing and set to -125mmHg suction and ensure no seal leaks

(3 points)

Rationale for choices:

1. Cleanse to reduce bacterial burden and remove debris
2. Contact layer to protect exposed yellow tissue and exposed sutures
3. Prep periwound with skin protectant to avoid skin shearing with removal of draping
4. Draping to cover healthy skin
5. Fill wound bed with black foam for promotion of granulation tissue
6. Allows tubing application to dressing
7. Standard negative pressure settings of -125mmHg

(3 points)

1 alternative primary/secondary dressing:

Hydrofera Blue wound dressing, cover with gauze, and cover with ABD, secure with 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 (IAD)

(1 point)

Wound Nurse recommendations/orders: BID and as needed with incontinence care

1. Gentle cleansing with every incontinent episode with Medline Remedy No-rinse cleanser, pat dry
2. Coloplast Triad Hydrophilic Wound Dressing
3. Low Air Loss surface
4. Discontinue disposable chux and use absorbent cloth pad under patients
5. FMS if continuing to have frequent liquid stool

(3 points)

Rationale for choices:

1. Gentle cleansing to prevent additional damage to fragile skin
2. Triad wound dressing acts as barrier cream and has cellulose gum to aide in adherence to moist wound beds
3. Assist with managing microclimate
4. Disposable pads hold moisture so we want to use a pad that absorbs and pulls excess moisture away from area
5. FMS to contain stool and decrease contact of skin with irritants

(3 points)

1 alternative primary/secondary dressing:

Medline PROTECT Remedy Zinc Oxide Paste

(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:

Diabetic Ulcer

(1 point)

Wound Nurse recommendations/orders: Daily dressing change

1. Wound culture
2. Podiatry consult
3. Cleanse wound bed with saline and dry
4. Apply nickel thick layer of Santyl to wound bed
5. Cover with saline moistened gauze, ABD, and Kerlix

(3 points)

Rationale for choices:

1. Culture due to drainage properties and devitalized tissue in wound bed to assess for infective organisms
2. Consult to podiatry for evaluation for surgical intervention for epibole
3. Cleanse wound to decrease bacterial burden and remove debris
4. Collagenase ointment for enzymatic debridement
5. Moist saline as moisture is needed to active enzymes for debridement

(3 points)

1 alternative primary/secondary dressing:

Medline MediHoney sheet to fill wound bed and cover with dry dressing

(1 point)

/8 points