

R. B. Turnbull Jr. MD WOC Nursing Education Program

Mini Case Scenarios: Wounds



Student Name Roxanne Britt

Date: 4/28/25

Reviewed by: _____

Date: _____

Score: /83

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 (*be specific as to schedule, turning surfaces if applicable, product, etc.*)
 - 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.
6. *No advanced dressings such as NPWT or CAMPs (formerly called cellular tissue products) unless specifically requested. What would you use if these two dressing types are not available to you?
7. Throughout this assignment you will be applying evidence to treat various wound scenarios. As appropriate, if you use a reference, make sure to cite it correctly.
8. Include at least 3 references (*other than your text book*) used to back your actions at the end of the assignment that assisted you in this assignment. Make sure to use 7th edition APA formatting.

A case study has been completed for you below as an example.

Example Scenario



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

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order. Non-adhesive foam dressing, 5 layers, (Allevyn) secured with elastic mesh dressing (Medline elastic retention dressing). Change q3d and PRN

(2 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. No exudate noted. 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:

PI stage 3

(1 point)

Wound Nurse recommendations/orders:

Cleanse wounds with warmed to body temperature NS or wound wash and gauze.

Apply Medline Hydrogel Skintegrity (tube form) into wound bed to fill and cover with Alleyn foam sacral dressing as secondary dressing.

Dressing Change every 3 days and as needed per soiling or dislodgment.

Notify wound care if any signs of infection develop or any questions.

Wound care will assess after first week to evaluate if appropriate to change frequency of dressing per wear time and patient condition.

Ensure diet intake of 1.25-1.5g/kg/d protein unless contraindicated for hx of CKD along with adequate fluid and multivitamin (Friedrich, Posthauer, & Dorner, 2022, p. 126). Please consult dietary if inadequate dietary intake. Skin inspection daily with ADLs.

Eval of support surfaces and ensure mattress is reactive/constant low-pressure air/foam or similar for pressure redistribution.

Turning schedule q 2 hours and offload sacrum with wedges.

(3 points)

Rationale for choices:

The hydrogel dressing will act as a wound filler, donate moisture since there is no exudate, it is approved for this type of wound and will aid in autolytic debridement of the necrotic slough; The secondary foam dressing will act as a barrier against any soiling and facilitate a moist environment for healing (R. B. Turnbull Jr. MD WOC Nursing Education Program, 2024). The hydrocolloid alternate will promote a moist environment for healing, fill dead space, and act as a barrier as well.

Offloading of sacrum is needed to relieve pressure. WOCN (2025) suggest several options of supportive surfaces for mattresses or mattress overlays to elevate pressure and offer a microclimate conducive to healing; An overlay option could be a reactive/constant low-pressure air by Stryker called the SoftCare or mattress that is reactive/constant low-pressure air/foam by Hill-Rom called Accumax Quantum. Recommendations will probably be based on what the facility has or can be rented.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

May substitute 3M Tegaderm Large Sacral Hydrocolloid dressing to wound. Please hold in place to warm with hand for 30-60 seconds. Dressing to be changed every 3 days and as needed for soiling or dislodgement.
(2 points)

/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:

DTPI

(1 point)

Wound Nurse recommendations/orders:

Skin inspection daily with ADLs.

Offloading of heels please with pillows or heel protection boots.

Cleanse heels with NS and gently pat dry.

Apply Mepilex boarder foam heel dressing to both heels every 3 days or as needed if soiled or dislodged.

May apply foam dressing to other bony prominences as needed for prophylaxis.

Ensure diet intake of 1.25-1.5g/kg/d protein unless contraindicated for hx of CKD along with adequate fluid and multivitamin (Friedrich, Posthauer, & Dorner, 2022, p. 126). Please consult dietary if inadequate dietary intake.

(3 points)

Rationale for choices:

This injury was caused by pressure or shear compressing tissues and vessels. Offloading and heel protection with a foam dressing is needed to stop any further pressure injury, prevent and protect from open wound formation, and aid in healing.

Dietary intake of extra protein aids in healing of pressure injuries.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

DuoDerm Hydrocolloid heel dressing with boarder may be used as substitute if Mepilex heel foam dressings are unavailable but prefer other maker of foam heel dressing like Optifoam Gentle Heel or Allevyn life heel foam dressing.

(2 points)

/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 Leg Ulceration-LEVD

(1 point)

Wound Nurse recommendations/orders:

Cleanse wounds with warmed to body temperature NS or wound wash and gauze. Apply skin prep to periwound skin. Apply Aquacel hydrofiber sheet dressing to wound and secure with thin silicone border foam Allevyn dressing. Please change dressing every 3 days and per soiling/excessive exudate.

Wound care will evaluate at 1 and 2 week mark if hydrofiber treatment to continue per exudate and maceration. Zippered Compression therapy stockings 30mmHg to be placed on in am and off at bedtime. Recommend 2 pairs for alternate when one is being laundered.

Pt education that compression is gold standard treatment for venous ulcer and prevention of new ulcer formation. Ensure diet intake of 1.25-1.5g/kg/d protein unless contraindicated for hx of CKD along with adequate fluid and multivitamin (Friedrich, Posthauer, & Dorner, 2022, p. 126). Please consult dietary if inadequate dietary intake.

Encourage elevation of legs above heart level for 30 minutes 4 x a day and increase activity of walking, toe lifts, calf pumps/calf muscle exercise, or ankle flexion per patient capabilities and PT consult if needed (Wound, Ostomy and Continence Nurses Society, 2019).

(3 points)

Rationale for choices:

Compression therapy is the gold standard treatment for LEVD; 30-40mmHg is recommended since ABI is greater than 0.80 and will utilize what the patient can tolerate for compliance (WOCN, 2019).

A hydrofiber dressing will not harm periwound skin while containing the exudate for treatment of the maceration in aid of avoiding further skin breakdown. They can also be used in presents of compromised circulation and approved for use with compression therapy.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

A ConvaTec duoderm hydrocolloid dressing may substitute above dressing orders but must establish positive

CSM check with cap refill of 2 seconds for use.

Transparent tegaderm film dressing may also be used as secondary dressing to secure hydrofiber sheet dressing but may warrant more frequent dressing change per exudate.

(2 points)

/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 exudate. NPWT is not available at this time.

Image courtesy of Judy Mosier, MSN, RN, CWCN.

Wound type:

Stage 3 PI

(1 point)

Wound Nurse recommendations/orders:

Cleanse wounds with warmed to body temperature NS or wound wash and gauze.

Apply McKesson 6 x 6 inch Hydrocolloid foam back dressing and hold in place to warm for 30-60 seconds.

Please change dressing every three days or as needed for soiling.

Notify wound care if any signs of infection develop or any questions.

Skin inspection daily with ADLs.

Eval of support surfaces and ensure mattress is reactive/constant low-pressure air/foam or similar for pressure redistribution.

Turning schedule q 2 hours and offload sacrum with wedges.

Ensure diet intake of 1.25-1.5g/kg/d protein unless contraindicated for hx of CKD along with adequate fluid and multivitamin (Friedrich, Posthauer, & Dorner, 2022, p. 126). Please consult dietary if inadequate dietary intake.

(3 points)

Rationale for choices:

The hydrocolloid dressing is appropriate for part or full thickness pressure injuries; They will act as a barrier to UI/FI while also providing a moist wound bed healing environment, act as filler for the 0.4cm dead space and absorptive capabilities for the moderate amount of exudate (R. B. Turnbull Jr. MD WOC Nursing Education Program, 2024).

(2 points)

What support surface would you recommend (1pt) and why? (1pt)

Offloading is imperative for the healing of any pressure injury to allow for adequate cellular circulation of oxygen, nutrients, fibrin, ect for wound healing. This 85 y/o is bedridden so we would be looking at mattress quality. WOCN (2025) suggest several options of supportive surfaces for mattresses or mattress overlays to elevate pressure and offer a microclimate conducive to healing; An overlay option could be a reactive/constant low-pressure air by Stryker called the SoftCare or mattress that is reactive/constant low-pressure air/foam by Hill-Rom called Accumax Quantum. Recommendations will probably be based on what the facility has or can be rented. Wedges could also be used for turning and rotation Q2 hours schedule from side to side to offload sacrum.

(2 points)

/8 points

Scenario 5



56-year-old alert and oriented male hospitalized for cardiac surgery. During the hospital stay, on day 2 post-op they developed painful open area to sacrum. The patient is incontinent of urine and stool and has not been repositioning in bed due to reported pain.

Image courtesy of Cleveland Clinic.

Wound type:

Stage 2 PI

(1 point)

Wound Nurse recommendations/orders:

Please evaluate toileting needs and capability on day 2 post op if bedside commode feasible for safe patient use or implement appropriate UI/FI management plan.

Please medicate for pain if needed and 30 minutes prior to dressing change.

Cleanse wound gently with a no-rinse pH balanced cleanser with surfactant at each dressing change. Please use this product as well to cleanse skin with ADL's and each episode of FI or as needed (Thayer & Nix, 2022).

Apply Allevyn large sacral foam dressing to wound.

Please change dressing every three days or as needed for soiling.

Notify wound care if any signs of infection develop or any questions.

Skin inspection daily with ADLs.

Eval of support surfaces and ensure mattress is reactive/constant low-pressure air/foam or similar for pressure redistribution.

Turning schedule q 2 hours and offload sacrum with wedges.

Ensure diet intake of 1.25-1.5g/kg/d protein unless contraindicated for hx of CKD along with adequate fluid and multivitamin (Friedrich, Posthauer, & Dorner, 2022, p. 126). Please consult dietary if inadequate dietary intake.

(3 points)

Rationale for choices:

The foam dressing is appropriate for partial thickness pressure injuries; They will act as a barrier to UI/FI while also providing a moist wound bed healing environment rate amount of exudate (R. B. Turnbull Jr. MD WOC Nursing Education Program, 2024).

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

Large DuoDerm sacral hydrocolloid may be used as substitute if Allevyn large sacral foam dressing not available. Please change dressing every three days or as needed for soiling.

(2 points)

/8 points

Scenario 6



The wound care nurse is consulted to the intensive care unit to see a non-verbal 57-year old male respiratory failure patient for a new wound found under the patient's pulse oximeter during routine care. The patient has been admitted to the hospital for 14 days and has no previously documented wounds.

Image courtesy of CCF.

Wound type:

Medical Device related PI (appears to be full thickness if that is cartilage exposure).

(1 point)

Wound Nurse recommendations/orders:

Cleanse wounds with warmed to body temperature NS or wound wash and gauze.

Apply Triad paste with sterile CTA to wound bed and surrounding affected periwound skin every 3 days or as needed for reapplication.

Notify wound care if any signs of infection develop or any questions.

Skin inspection daily with ADLs.

Please encourage no side lying to affected ear to relieve pressure and facilitate healing.

Ensure diet intake of 1.25-1.5g/kg/d protein unless contraindicated for hx of CKD along with adequate fluid and multivitamin (Friedrich, Posthauer, & Dorner, 2022, p. 126). Please consult dietary if inadequate dietary intake.

(3 points)

Rationale for choices:

Coloplast Triad paste is a dressing that will be easily applied to hard to conform areas that a foam or other dressing may be difficult to stay in place. It allows for avoiding the need to wrap gauze around a patient head which could be a strangulation hazard with a non-verbal patient. It also facilitates a moist healing environment, aides in autolytic debridement, will not harm periwound skin, and acts as a primary dressing without the need for a secondary dressing (Coloplast US, 2025). It's wear time may be extended to 5 days as well, so it is also a cost-effective dressing.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

If patient is touching ear and compromising Triad paste dressing may cover with telfa cut to ear shape and secure with paper tape to intact skin. Please apply skin prep or Calvion to periwound skin prior to tape application.

Mepilex foam dressing may be substituted if Triad paste is unavailable. May cut dressing match to shape ear.
Change dressing every 3 days and as needed for soiling or dislodged.

(2 points)

/8 points

Scenario 7



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:

Arterial- LEAD

(1 point)

Wound Nurse recommendations/orders:

Social Services consult and if patient and care giver capabilities appropriate to return home please set up VNA services for homecare assistance.

Obtain ABIs and consult vascular if appropriate.

CSM and cap refill check daily.

Maintain stable eschar- leave it intact and monitor daily for signs of infection or lifting off (Wound, Ostomy, and Continence Nurses Society, 2019).

Apply iodine daily to dry stable eschar.

Apply Optifoam Gentile foam heel dressing every 7days or as needed if soiled or dislodged.

Offloading with heel boots or pillows to float heels.

Reposition every two hours.

Skin inspection with ADLs.

Ensure diet intake of 1.25-1.5g/kg/d protein unless contraindicated for hx of CKD along with adequate fluid and multivitamin (Friedrich, Posthauer, & Dorner, 2022, p. 126). Please consult dietary if inadequate dietary intake.

(3 points)

Rationale for choices:

The Optifoam Gentile foam heel dressing offers a wear time of 7 days but the manufacture states the silicone boarder peels back easily for skin checks. The dressing will offer extra protection to keep the stable eschar intact as it is acting as a physiological barrier.

Offloading the pressure and proper nutrition are needed for optimal wound healing conditions as well.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

A gauze dressing with nonadherent telfa to heel may be secured with paper tape to dressing- do not apply tape to skin.

This would not be a low cost substitute in the end since we need to be able to do daily skin checks but a dressing is needed to protect heel as well as not collect moisture so a hydrocolloid or hydrogel would be less desired. A different foam dressing with up to 7 day wear time would be more appropriate substitute ie. Allevyn

foam boarder heel dressing.
(2 points)

/8 points

Scenario 8



Wound care nurse is consulted to see a 74-year-old for 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. NPWT has been ordered by the physician.

Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

Wound type:

Dehiscence of abdominal post-surgical site

(1 point)

Wound Nurse recommendations/orders:

Cleanse wound and periwound skin with NS and gauze.
Apply skin prep to periwound skin.
Apply transparent dressing to periwound skin around wound bed.
Apply Cardinal Health Contact layer to wound bed.
Black foam to be measured and cut away from wound to fit wound bed.
Place black foam in wound bed and secure foam with transparent film.
Cut hole in film to accommodate wound vac pad suction appliance and put in place.
Cover with transparent dressing strips to ensure seal.
Trace edges of film dressing with skin prep if needed to ensure adherence and seal.
Apply NPWT continuous setting per facility policy and patient tolerance (125mmHg typical setting).
Discontinue NPWT for bleeding and alert MD and WOC team.
Call WOC team for any changes or wound dressing concerns.
Monitor NPWT twice a shift to ensure patience of suction and functioning.
Canister exudate to be measured and discarded every shift.
Monitor exudate and alert WOC if any increase or change in exudate quality.
Monitor for fevers or changes in wound that denote infection or deterioration.
Dressing to be changed every 72 hours or sooner if needed.
Pre-medicate for pain 30 minutes prior to dressing change. Shut off wound vac at this time when medicating patient.
Ensure diet intake of 1.25-1.5g/kg/d protein unless contraindicated for hx of CKD along with adequate fluid and multivitamin (Friedrich, Posthauer, & Dorner, 2022, p. 126). Please consult dietary if inadequate dietary intake.
Skin inspection daily with ADLs.

(3 points)

Rationale for choices:

NWPT has been shown to promote healing, stimulate angiogenesis, remove wound exudate and debris including bacterium, reduce proinflammatory cytokine activity while stimulating collagen synthesis (Brindle & Creehan, 2022).
Proper nutrition needed to aid in wound closure.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

May substitute brand of contact layer with Medline Versatel per availability.

If NPWT off more than 2 hours please change wound dressing to NS wet to moist gauze dressing using fluffed 4x4s and cover with ABD pads secured with paper tape in windowpane fashion maintaining contact layer in place. Must apply skin prep to periwound skin prior to application of paper tape or continue to use transparent film strips at peri wound edges for securement of ABD pads. Please consult surgery or WOC team for further instruction.

(2 points)

/8 points

Scenario 9



Wound care nurse consulted to see a 45-year-old male with damaged skin. Patient has been at your facility for 2 weeks with diagnosis of C-Diff. You note some necrotic tissue in the right coccygeal area as well as painful weepy lesions across both buttocks and scrotum.

Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

Wound type:

MASD- IAD specifically from the alkaline stool exposure

(1 point)

Wound Nurse recommendations/orders:

Assess toileting needs and toileting schedule or fecal management system to assist in reducing or eliminating FI for skin integrity per patient ability.

Ensure treatment of C-diff has been completed at this 2-week mark or consider recurrent infection and seek medical orders.

Medicate for pain with medical orders provided 30 minutes prior to dressing wounds.

Dressing change every 3 days or as needed for soiling.

Cleanse wound gently with a no-rinse pH balanced cleanser with surfactant at each dressing change. Please use this product as well to cleanse skin with ADL's and each episode of FI or as needed (Thayer & Nix, 2022).

Apply 3M Tegaderm hydrocolloid dressing sacral design 6.75 inch and ensure to cover necrotic area at R coccygeal area.

Apply Coloplast Brava Barrier Cream to remaining affected skin as a leave on moisturizer and skin barrier.

Notify wound care if any signs of infection develop or any questions.

Wound care will assess after first week to evaluate if appropriate to change frequency of dressing per wear time and patient condition.

Ensure diet intake of 1.25-1.5g/kg/d protein unless contraindicated for hx of CKD along with adequate fluid and multivitamin (Friedrich, Posthauer, & Dorner, 2022, p. 126). Please consult dietary if inadequate dietary intake.

Skin inspection daily with ADLs.

(3 points)

Rationale for choices:

The hydrocolloid dressing will provide a barrier to the affected skin from liquid stool exposure but also aid in autolytic debridement of the necrotic area, provide barrier from friction/sheer forces, and provide moisture balanced healing environment (R. B. Turnbull Jr. MD WOC Nursing Education Program, 2024).

Thayer & Nix (2022) state a no-rinse pH balanced cleanser with surfactant is the choice cleanser per studies.

The Coloplast Brava product acts as a moisturizer and barrier with its two ingredients for IAD treatment.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

Dimora 7x7 Hydrogel Sacrum foam wound dressing may be used as a substitute if hydrocolloid sacral dressing unavailable and will afford same benefits including aid in autolytic debridement of necrotic tissue.

Plain water may be used if needed to wash but please do not use soap to open and affected skin.

Zinc oxide may be substituted as a leave on skin barrier but a moisturizer (house supplied pH balanced without fragrance) will also need to be applied before zinc oxide.

(2 points)

/8 points

Scenario 10



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: Mixed etiology of neuropathic and arterial most likely. Ulcer is deep with a punched-out appearance and well-defined borders with scant drainage all indicative of arterial nature and diagnosis dependent on studies which will verify and dictate need for re-vascularization and glucose control.

Wound Nurse recommendations/orders:

Cleanse wounds with warmed to body temperature NS. Medial smaller wound may be cleansed with NS and gauze. Cleanse dorsal larger foot wound with Braun Prontosan Monofilament pad for the treatment of slough and epibole.

Gently pat dry.

Apply skin prep to periwound skin.

Moisten Hydrofera Blue Ready foam dressing with NS and squeeze out excess NS. Apply to wound beds and secure with secondary liner provided. Smaller foam dressing may be cut to fit smaller wound but ensure foam extends past ½ inch from wound edges.

Please change dressing every 3 days and per exudate/soiling prn.

Notify wound care if any signs of infection develop or any questions.

Wound care will assess after first week to evaluate if appropriate to change frequency of dressing per wear time and patient condition.

Consult Podiatry for diabetic footwear/surgical post-op shoe if not done so already to avoid pressure at wound sites and offloading as needed.

Monitor glucose per medical orders and consult nutrition to ensure adequate protein and micronutrient intake appropriate for wound healing and fluid balance along with ADA diet for glycemic control.

Please contact PCP for hx of ABI and recent A1C. Question if hx of vascular consult for vascular studies.

Obtain ABI if outpt wound clinic records not obtainable.

Obtain A1C if recent report not available with PCP.

Skin inspection daily with ADLs.

Rationale for choices:

Some topicals and microfilament pads can treat epibole. Effort should be made to treat the slough to remove the necrotic tissue for optimal wound bed conditions for healing as well as the wound edges that will never close if they are rolled.

The Hydrofera blue foam dressing will aid in autolytic debridement of the slough and is expected to treat the

epibole within two weeks per the manufacture's claim. The new Hydrofera Blue Ready provides a secondary transparent film that should aid in cost containment.

This product will also afford a moisture balance to promote wound healing and is antimicrobial if the non-healing wound with tan drainage is infected. The foam will also provide some protection as a barrier and offer padding and protection.

If these efforts fail, a surgical consult can be placed for treatment of epibole and debridement of the slough. Scope of care per state and licensure may allow for silver nitrate cautery to the wound edges may also be a more convenient bed side treatment rather than needing our infirmed patient to wait for and travel to an outpt surgical appointment.

If ABI is in consult range (less than 0.5) for vascular it is needed to reestablish circulation because no wound will heal if the circulation is not adequate.

Glucose control upon the same note. Wounds will be stalled if glucose levels are not controlled.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

Debrisoft may be used substituted as monofilament pad alternate if Braun Prontosan Monofilament pad not available.

Covidien Kendall AMD antimicrobial foam boarder dressing impregnated with 0.5% PHMB may be used as dressing substitute if Hydrofera blue ready is not available.

Surgical consult for treatment of Epibole and slough will be ordered if no improvement with mechanical debridement and topical treatment after 2-4 weeks.

(2 points)

/8 points

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