R. B. Turnbull Jr. MD WOC Nursing Education Program
Mini Case Scenarios: Wounds

Cleveland Clinic

Student Name Gabriel Macharia **Date:** July 29, 2025
Reviewed by: _____ **Date:** _____
Score: /83

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: Unstageable Pressure Injury
(1 point)

Wound Nurse recommendations/orders:

1. Gently cleanse wound and periwound with normal saline at each dressing change.
2. Apply amorphous hydrogel (ex: Medline Skintegrity Hydrogel) to the wound bed to promote autolytic debridement.
3. Cover with a hydrocolloid dressing (ex: DuoDERM Extra Thin).
4. Secure with roll gauze (ex: Kerlix), as needed, to keep the dressing in place.
5. Change dressing every 3 days or sooner if soiled.
6. Reposition off the sacrum every 2 hours around the clock. Use pressure redistributing mattress or overlay.
7. Request provider or wound care team evaluation for potential sharp or enzymatic debridement, based on patient goals and if not contraindicated.
8. Monitor for signs of infection (increased redness, warmth, odor, drainage) at least daily.
9. Request dietary consult to assess for adequate protein and calorie intake to support wound healing.

(3 points)

Rationale for choices:

1. Cleansing with normal saline removes debris without cytotoxicity, promoting a clean base for healing.
2. Hydrogel keeps the wound moist, supports autolytic debridement, and softens slough/necrosis for easier removal.
3. Hydrocolloid dressing maintains a moist environment and protects the wound from contamination, supporting autolytic debridement.
4. Roll gauze maintains dressing position without adhesives on fragile skin.
5. Turning and a pressure redistributing surface minimize pressure on the sacrum, preventing further injury.
6. Nutrition is essential for wound healing; older adults with dementia are at especially high risk for malnutrition, which impairs healing.
7. Monitoring for infection is necessary due to necrotic tissue serving as a potential nidus for bacteria.

(2 points)

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

Apply a calcium alginate dressing to wound bed to absorb any mild exudate and help debride slough, cover with a non-adhesive foam dressing, and secure with stretch net or gauze wrap. Change every 2-3 days or sooner if soiled. Continue offloading and frequent turns as above.

(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: Deep Tissue Pressure Injury

(1 point)

Wound Nurse recommendations/orders:

1. Inspect and document wound appearance every shift and with each dressing change, monitoring for progression to open wound.
2. Offload heel at all times using a heel suspension device.
3. Apply non-adhesive silicone foam dressing to protect area and provide cushioning.
4. Change dressing every 3 days or sooner if soiled or dislodged.
5. Do not massage area; avoid any pressure or shear.
6. Continue risk assessment for pressure injuries daily, using Braden Scale or facility protocol.
7. Educate patient and family regarding importance of offloading and early reporting of changes.
8. Monitor for signs of infection.

(3 points)

Rationale for choices:

1. SDTI/DTI is at high risk of rapid deterioration into full-thickness wounds, so close monitoring is critical.
2. Offloading with heel devices fully eliminates pressure and shear, which is essential to prevent progression.
3. Silicone foam protects against external trauma and manages microclimate but is gentle to fragile skin.
4. Frequent monitoring ensures timely intervention if wound status changes.
5. Avoiding adhesives and pressure prevents further damage.
6. Patient/family education fosters adherence to the plan.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category.

Write as a nursing order.
Apply hydrocolloid dressing (ex: DuoDERM Extra Thin) to heel, securing with roll gauze (ex: Kerlix) to avoid adhesives and provide protection. Change every 3 days or sooner if soiled or loses adhesion. Continue strict offloading with a heel suspension device.
(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 Ulcer, Gaiter Area, with Mixed Etiology

(1 point)

Wound Nurse recommendations/orders:

1. Initiate moderate compression therapy (e.g., 20–30 mmHg) using a multi-layer compression bandage system (e.g., Coban 2 Lite, Profore Lite), ensuring careful assessment of distal perfusion (check toe color, temperature, pulses, capillary refill) at each dressing change.
2. Elevate the affected leg above heart level when resting. Encourage ambulation and daily calf muscle pump exercises to improve venous return.
3. Apply calcium alginate (e.g., Algisite M, Sorbsan) or hydrofiber dressing (e.g., AQUACEL® EXTRA™) to wound bed to manage moderate exudate.
4. Cover with absorbent foam dressing (e.g., Allevyn Gentle) or superabsorbent dressing (e.g., Cutimed Sorbion) to enhance fluid management beneath compression.
5. Apply a non-sting barrier film (e.g., Medi Derma-S) or zinc oxide paste to protect macerated periwound skin from further breakdown.
6. Change the entire dressing and compression system every 2–3 days, or sooner if exudate saturates the dressing.
7. Reassess wound size, exudate, and periwound skin at each change. Monitor for signs of infection or declining limb perfusion and refer to a vascular specialist or wound care physician if no improvement in 2–4 weeks.

(3 points)

Rationale for choices:

1. Moderate compression therapy reduces venous hypertension and edema, but must be used cautiously due to mild arterial disease.
2. Leg elevation and calf exercises help improve venous return and decrease swelling.
3. Calcium alginate or hydrofiber dressings absorb moderate exudate and maintain a moist wound environment.
4. Absorbent foam or superabsorbent dressings provide additional absorption to keep exudate from macerating surrounding skin.
5. Barrier film or zinc oxide protects fragile periwound skin from moisture and further breakdown.
6. Changing dressings every 2–3 days or if saturated prevents exudate buildup and reduces infection risk.
7. Ongoing wound and perfusion reassessment ensures timely identification of complications and adjusts the plan if healing does not progress.

(2 points)

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

Apply a superabsorbent dressing (e.g., Cutimed® Sorbion®) as the primary dressing directly over the wound to manage moderate-heavy exudate. Secure with moderate compression bandage (class II, e.g., Coban 2 Lite) and monitor foot perfusion with every dressing change. (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, CWOCN.

Wound type:
Stage 3 Pressure Injury
(1 point)

Wound Nurse recommendations/orders:

1. Implement a strict repositioning schedule (e.g., every 2 hours) to consistently offload the sacrum, a critical intervention for a bedridden patient
2. Maintain the skin in a clean and dry state, utilizing pH-balanced cleansers and barrier creams as indicated.
3. Optimize the patient's nutritional intake, with particular attention to protein and calories, which are essential for wound healing.
4. Apply Hydrofiber (e.g., AQUACEL® EXTRA™ Hydrofiber® Wound Dressing) or Calcium Alginate (e.g., ActivHeal® Alginate) as primary dressing.
5. Apply Silicone foam dressing with border (e.g., Mepilex® Border Sacrum, PolyMem® Silicone Border) as secondary dressing.
6. Change dressing every 2-3 days, or more frequently if exudate saturates the dressing.

(3 points)

Rationale for choices:

1. For a Stage 3 Pressure Injury, the primary goals are to debride the slough, effectively manage exudate, promote granulation tissue formation, and protect the periwound skin.
2. Hydrofiber and alginate dressings are highly absorbent and form a gel upon contact with exudate. This effectively manages the "moderate serosanguineous exudate" and protects the periwound from maceration.
3. They also facilitate autolytic debridement of the "small amount of yellow slough"
4. Silicone foam dressings provide additional absorption, cushioning, and feature a gentle adhesive border for securement without causing trauma to fragile skin.

5. Sacral-shaped foam dressings are specifically designed to conform to the area and effectively redistribute pressure.

(2 points)

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

A Group 2 pressure-reducing support surface, specifically a low-air-loss mattress or an alternating pressure mattress.

Why:

1. Low-air-loss mattresses are effective in managing the microclimate by reducing moisture and heat, both of which are known risk factors for pressure injury development. They achieve pressure reduction by distributing body weight evenly over a larger surface area.
2. Alternating pressure mattresses work by cyclically inflating and deflating air cells, continuously changing pressure points. This mechanism helps to improve circulation and prevent prolonged pressure on any single area
3. Both types of mattresses are considered superior to static foam mattresses for high-risk patients or those with existing Stage 3 injuries.

(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:
Pressure Injury (likely Stage 2 or early Stage 3) complicated by Incontinence-Associated Dermatitis (IAD).
(1 point)

Wound Nurse recommendations/orders:

1. Aggressively manage pain to facilitate repositioning. This may involve scheduled analgesics, non-pharmacological interventions (e.g., cold/heat therapy, relaxation techniques), and ensuring comfort during movement.
2. Implement a rigorous repositioning schedule (e.g., every 1-2 hours) with assistance, meticulously avoiding direct pressure on the sacrum.
3. Utilize pressure-reducing support surfaces.
4. Institute a comprehensive incontinence management plan: frequent cleansing with pH-balanced cleansers (avoiding soap), prompt removal of urine and stool, and liberal application of a strong moisture barrier (e.g., zinc oxide paste) to the periwound and surrounding skin.
5. Consideration of a fecal management system is warranted if diarrhea is severe
6. Optimize the patient's nutrition and hydration.
7. Apply Silicone foam dressing (e.g., Mepilex® Border Sacrum, PolyMem® Silicone Border) or Hydrocolloid (e.g., DuoDERM CGF) as primary dressing.
8. Change dressing daily or every 2-3 days, or more frequently if soiled by incontinence or exudate.

(3 points)

Rationale for choices:

1. Effective pain management directly addresses the barrier to repositioning, which is crucial for pressure relief and wound healing.
2. Comprehensive incontinence management prevents further skin breakdown from moisture and irritants (IAD), a significant risk factor for pressure injury development and exacerbation.

3. Barrier creams are essential for skin protection.
4. Silicone foam or hydrocolloid dressings provide cushioning for pressure relief, absorb moderate exudate, maintain a moist wound environment, and protect the periwound.
5. Silicone borders minimize trauma upon removal, which is particularly important for fragile skin.
6. Hydrocolloids are also effective for Stage 2/3 Pressure Injuries

(2 points)

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

Apply calcium alginate dressing (e.g., Kaltostat) to wound bed as the primary dressing, cover with a superabsorbent secondary dressing (e.g., Cutimed Sorbion); secure with gentle fixation and change every 1–3 days or sooner if saturated or soiled by incontinence.

(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 Pressure Injury (MDPRI)
(1 point)

Wound Nurse recommendations/orders:

1. Remove the pulse oximeter from the affected ear/site immediately; rotate the device to a different, intact site, ensuring correct fit and avoiding excess pressure.
2. Institute a schedule for device rotation and site inspection at least every 2–4 hours; document skin assessments and device placement at every shift.
3. Gently cleanse the wound with normal saline and pat dry at each dressing change.
4. Apply a transparent film dressing (e.g., Tegaderm™) or thin hydrocolloid (e.g., DuoDERM Extra Thin) as a primary dressing, and change every 3–5 days or sooner if the dressing is saturated, compromised, or if worsening is noted.
5. Assess all other medical device sites (e.g., endotracheal tube, IV tubing, NG tube, etc.) for early signs of pressure injury each shift, and implement preventive dressings as needed.
6. Educate staff on the importance of frequent skin checks and device repositioning for all non-verbal and critically ill patients.
7. Notify the provider if signs of infection (e.g., increased redness, pain, drainage) or wound deterioration occur.

(3 points)

Rationale for choices:

1. Immediate removal and rotation of the device eliminates ongoing pressure, the primary cause of MDRPI, and enables wound healing to begin.
2. Scheduled skin assessments are crucial for early detection of MDRPIs and prevention of further breakdown, especially as ICU patients cannot self-report discomfort.

3. Normal saline irrigation is gentle and avoids further tissue injury, ensuring a clean wound bed for healing.
4. Transparent film and thin hydrocolloid dressings maintain a moist environment, protect fragile skin, and allow easy inspection of the wound without frequent removal, minimizing trauma.
5. Ongoing assessment and application of prophylactic dressings to all device sites help prevent new MDRPIs.
6. Team education and communication foster a culture of MDRPI prevention in high-risk ICU settings.
7. Prompt provider notification allows timely intervention for infection or wound progression.

(2 points)

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

Apply a silicone foam dressing (e.g., Mepilex® Border Lite) as the primary dressing over the wound; change every 3 days or sooner if soiled. Continue rotating the pulse oximeter site every 2–4 hours, monitor for skin changes, and reassess all other device sites regularly.

(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:

Unstageable pressure injury with stable heel eschar

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse periwound skin gently with normal saline at each dressing change.
2. Apply dry, non-adherent primary dressing (Telfa or Adaptic) over the eschar.
3. Cover with dry gauze roll (Kerlix) to secure the primary dressing.
4. Change dressing daily and if wet or soiled.
5. Float heels at all times with a heel suspension device or pillows under calves, not under heels.
6. Reposition patient at least every 2 hours; never position directly on affected heel.
7. Place patient on a pressure redistributing support surface (e.g., low air-loss mattress).
8. Moisturize surrounding intact skin with fragrance-free lotion daily.
9. Notify provider immediately if redness, fluctuance, drainage, odor, or increased pain/swelling develop.
10. Refer to dietitian for nutrition assessment and wound healing support.

(3 points)

Rationale for choices:

1. Normal saline is non-irritating and reduces risk of maceration or chemical injury to wound edges.
2. Dry, non-adherent dressings protect stable eschar and prevent dressing from sticking.
3. Dry gauze secures the primary dressing and absorbs any small drainage.
4. Daily changes promote wound monitoring and prevent moisture build-up.
5. Heel suspension prevents pressure and shear that can worsen the injury.
6. Frequent repositioning redistributes pressure and reduces risk of new breakdown.
7. Pressure-redistributing surface reduces risk of further tissue damage.
8. Moisturizing periwound skin maintains skin integrity and prevents cracking.
9. Early notification of infection signs allows prompt intervention.

10. Nutrition supports tissue repair and healing. **(2 points)**
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order. Apply hydrocolloid dressing (DuoDERM or Tegaderm Hydrocolloid) over entire eschar; change every 3–5 days or if the dressing becomes loose, wet, or soiled. If heel is red or drainage develops, discontinue and notify provider. **(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. <u>NPWT ordered by physician who has requested WOC nurse input into dressing instructions and pressure settings</u>

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

Wound type:

Surgical wound healing by secondary intention

(1 point)

Wound Nurse recommendations/orders:

1. Monitor for infection closely due to increased risk post-ischemic bowel surgery.
2. Optimize nutrition and hydration, collaborate with dietitian for high-protein and calorie-dense diet; encourage oral intake or supplement as needed.
3. Manage pain effectively before and during dressing changes.
4. Cleanse wound gently with normal saline during each dressing change.
5. Prepare wound bed and periwound skin; ensure skin is dry and intact before dressings.
6. Apply NPWT foam dressing (black, open-cell polyurethane) cut to fit the wound bed (including depth); use white foam or ribbon for any tunneling/undermining, leaving a visible tail for removal.
7. Apply NPWT system at -125 mmHg continuous pressure.
8. Secure with transparent adhesive drape extending 3-5 cm beyond wound edges; ensure airtight seal without excess stretching.
9. Change NPWT dressing every 48–72 hours, or more frequently if significant drainage, loss of seal, or signs of infection.
10. Document and count all pieces of foam used in each dressing change.

(3 points)

Rationale for choices:

1. NPWT promotes formation of granulation tissue, manages exudate, and reduces frequency of dressing changes in large, deep, or dehisced surgical wounds.
2. Black polyurethane foam enhances granulation via mechanical microdeformation.
3. Airtight NPWT seal and proper negative pressure are vital for optimal function and wound healing.
4. Pain management ensures patient cooperation and prevents trauma from movement during care.
5. Nutrition and hydration are essential for wound healing and tissue repair.
6. Monitoring for infection is critical in post-abdominal surgery due to risk factors (e.g.,

contamination from bowel).

7. Documentation and counting of foam prevents retained foreign body complications.

(2 points)

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

Apply calcium alginate rope (ActivHeal® Alginate rope or equivalent) to fill wound depth, with an absorbent foam secondary dressing (PolyMem MAX® Non-Adhesive Dressing), secured by adhesive border dressing. Change every 24–48 hours and as needed based on exudate.

(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:

Incontinence-Associated Dermatitis (IAD) with Possible Superimposed Pressure Injury/Necrotic Tissue (right coccygeal area)

(1 point)

Wound Nurse recommendations/orders:

1. Gently cleanse perineal, buttock, and scrotal skin with pH-balanced, no-rinse cleanser after each incontinence episode; pat dry.
2. Apply zinc oxide barrier cream (e.g., Calmoseptine, Boudreaux's Butt Paste) to all denuded and at-risk skin after each cleansing.
3. For necrotic area at coccyx, apply hydrogel (e.g., Solosite) covered by a non-adherent dressing (Telfa), then secure with mesh or non-adhesive tape.
4. Minimize skin friction and moisture by using a moisture-wicking pad/linen; avoid plastic underpads if possible.
5. Implement a fecal management system if diarrhea is severe and not expected to resolve quickly.
6. Reposition patient every 2 hours and avoid prolonged pressure on affected areas.
7. Consult the provider for possible antifungal or antibacterial treatment if infection is suspected, and for further management of necrotic tissue.

(3 points)

Rationale for choices:

1. Gentle, pH-balanced cleansing prevents further chemical and mechanical trauma to compromised skin.
2. Zinc oxide barrier creates physical protection from moisture and irritants, key in IAD management.
3. Hydrogel maintains moisture and supports autolytic debridement of necrotic tissue, while non-adherent dressings protect fragile skin from sticking.

4. Reducing friction and moisture prevents further tissue breakdown.
5. Fecal management systems limit ongoing exposure to irritants and infection risk.
6. Repositioning reduces pressure-related injury risk and supports skin healing.
7. Provider input is essential for deeper/necrotic wounds and possible superinfection.

(2 points)

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

Apply silver sulfadiazine cream (e.g., Silvadene) to weepy and necrotic areas for potential antimicrobial benefit, cover with silicone foam dressing (e.g., Mepilex or Allevyn Gentle Border). Change daily and as needed after incontinence episodes.

(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:

Diabetic Foot Ulcer (DFU) with exposed tendon, mixed tissue types (granulation, slough, necrosis), complicated by Raynaud's Disease.

(1 point)

Wound Nurse recommendations/orders:

1. Immediately consult with vascular surgeon, podiatrist, and endocrinologist for assessment and surgical/interventional planning.
2. Cleanse wound with normal saline at each dressing change.
3. Apply hydrogel (e.g., Curasol™ or SAF-gel) liberally to all exposed tendon areas, and over necrotic/sloughy tissue to aid autolytic debridement.
4. Cover with a non-adherent dressing (e.g., Melolin, Telfa), topped with foam dressing (e.g., Allevyn™) for absorption and protection.
5. Change dressings daily to every 2–3 days, or more often if needed to maintain moisture over tendon.
6. Institute strict offloading (e.g., total contact cast, removable cast walker, or custom shoe), keep patient non-weight bearing on affected foot.
7. Optimize blood glucose and Raynaud's management in collaboration with primary/medical team; keep limb warm and monitor for ischemia.
8. Ensure adequate dietary protein and calories to promote wound healing.
9. Notify provider for signs of infection, increased necrosis, or clinical deterioration.

(3 points)

Rationale for choices:

1. Moisture and protection are necessary for exposed tendon, which is at high risk of desiccation and necrosis. Hydrogels keep tissue hydrated, and foam dressings protect while absorbing light exudate.
2. Debridement of non-viable tissue is required for wound healing and granulation;

method dictated by provider/specialist.

3. Surgical tissue coverage is often required for exposed tendon to achieve long-term closure.
4. Strict offloading prevents further trauma and is essential for healing in diabetic foot ulcers.
5. Multidisciplinary approach is mandated due to higher limb loss risk from DM+Raynaud's.
6. Systemic optimization (glucose, circulation, nutrition) directly influences wound healing trajectory.
7. Frequent monitoring and dressing change maintain proper wound environment and quickly identify problems.

(2 points)

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

Apply polymeric membrane dressing (e.g., PolyMem® QuadraFoam®) as the primary dressing, with non-adherent contact layer if needed, and secure with roll gauze. Change every 1–3 days as appropriate.

(2 points)

/8 points

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