

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



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Date: _____

9/30/25

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: Unstageable Pressure Injury to the sacrum, midline with blanchable erythema on periwound area

A pressure injury is considered unstageable when the wound base cannot be assessed because it is completely obscured by slough (yellow, tan, gray, green, or brown) or eschar (tan, brown, or black). The inability to stage is due to the wound covering itself, not the clinician's skill or judgment (Edsberg, 2022).

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse the wound with wound cleanser at each dressing change.
2. Apply Hydrogel to wound bed; change every 3 days, and PRN if soiled or displaced.
3. Apply Critic Aid moisture barrier to peri-wound and sacral area after each episode of incontinence or bowel movement.
4. Reposition patient every 2 hours: turn to the left side for 2 hours, then to the right side for 2 hours, followed by the supine (back) position for 2 hours using pillows or positioning wedges (turning schedule: left/right/supine, avoid prolonged supine). Use low-air-loss mattress and pressure-relieving cushion if seated. Offload the heels using heel boots, and assess the skin at least every 8 hours for signs of pressure, redness, or breakdown. During each assessment, remove the boots briefly to allow the skin to rest and put it back all the time, keep head 30-degree angle if not contraindicated.

(3 points)

Rationale for choices:

1. A pH-balanced, non-cytotoxic wound cleanser reduces bioburden, removes debris, and minimizes risk of infection while preserving viable tissue (Wounds International, 2025).
2. Hydrogel dressings are specifically designed to donate moisture to a dry wound bed, which helps rehydrate devitalized tissue and promotes autolytic debridement, a natural process in which the body's own enzymes break down necrotic tissue. By maintaining a moist wound environment, hydrogels support cellular migration and granulation, both of which are essential for wound healing. Some hydrogel products are formulated with antimicrobial agents that help reduce the risk of bioburden and local infection. Hydrogels also provide a cooling effect, which can be soothing to patients and contribute to pain relief during the healing process (Jaszarowski & Murphree, 2022).
3. Barrier ointments protect intact skin from moisture-associated skin damage caused by incontinence, reducing the risk of further breakdown and secondary dermatitis. The overall purpose of moisture management is to protect the skin from both excess moisture and dryness, since overhydrated skin weakens tissue integrity and is more likely to break down when exposed to pressure and shear, thereby increasing the risk of pressure injury development (NPIAP, 2024).
4. Repositioning every 2 hours reduces prolonged pressure, restores tissue perfusion, and decreases risk of ischemia; low-air-loss mattresses and pressure-relieving cushions redistribute weight, minimize interface pressure, and reduce shear and friction forces; offloading the sacral area with pillows or wedges prevents continuous direct pressure on bony prominences and supports neutral alignment; heel protectors or pillows under calves elevate heels completely off the bed, preventing heel pressure injuries by reducing tissue ischemia; and maintaining the head of bed at 30° limits shear forces on the sacrum while still reducing aspiration risk, making it the recommended angle for most immobile patients (Cacior, et al, 2024).

(2 points)

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

Apply Allevyn foam dressing to the sacrum every 3 days and PRN.

Rationale: Foam dressings can be used effectively as either primary or secondary dressings. They maintain a moist wound environment while absorbing excess exudate and also support autolytic debridement by facilitating the breakdown of moist avascular tissue or slough (Jaszarowski & Murphree, 2022).

(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 (DTPI)- Left Heel

An area of intact or non-intact skin with persistent, non-blanchable, deep red, maroon, or purple discoloration, or with epidermal separation that reveals a dark wound bed or blood-filled blister that may indicate that there's damage of underlying soft tissue (Edsberg, 2022).

(1 point)

Wound Nurse recommendations/orders:

1. Gently cleanse the wound with wound cleanser at each dressing change and let it dry.
2. Apply Silicone foam dressing to the left heel and change every 3 days and PRN if soiled and non-adherent. Peel back the dressing gently every shift to assess the skin underneath.
3. Offload the heels using heel boots, and assess the skin at least every 8 hours for signs of skin breakdown. During each assessment, remove the boots briefly to allow the skin to rest and put it back all the time.

(3 points)

Rationale for choices:

1. A pH-balanced, non-cytotoxic wound cleanser reduces bioburden, removes debris, and minimizes risk of infection while preserving viable tissue (Wounds International, 2025).
2. Foam dressings can be used as preventive dressings for patients with fragile skin at risk for friction injuries, and they are also effective in managing pressure injuries, particularly in high-risk areas such as the heels and sacrum. They provide cushioning,

redistribute pressure, and reduce shear forces, thereby lowering the risk of skin breakdown (Jaszarowski & Murphree, 2022).

3. Offloading eliminates pressure and shear, restoring perfusion and preventing further ischemic damage (NPIAP, 2023).

(2 points)

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

Apply Tegaderm film dressing on the left heel and change every 7 days or as needed if the edges are not fully sealed.

Simple film dressings can help limit the effects of shear by providing a smooth, protective interface between the skin and external surfaces (Greenwood, 2021).

(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 on the right lower extremity, medial gaiter region

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with a pH-balanced, non-cytotoxic wound cleanser at each dressing change.
2. Apply Silver Alginate dressing to wound bed and change every 3 days and PRN if soiled.
3. Apply moisture Barrier cream to periwound skin.
4. Initiate compression bandage and change every time the primary dressing change.

(3 points)

Rationale for choices:

1. Gentle cleansing removes debris and reduces bioburden without harming viable tissue, preparing the wound bed for healing. Using non-cytotoxic, pH-balanced solutions helps maintain cellular integrity (Oropallo et al., 2024).
2. Silver alginate dressings provide broad-spectrum antimicrobial activity while also supporting autolytic debridement. They absorb moderate amounts of exudate, helping to maintain a balanced moist wound environment that promotes healing and reduces the risk of infection (Jaszarowski & Murphree, 2022).
3. Compression is the gold standard treatment for venous leg ulcers as it reduces edema, improves venous return, and accelerates ulcer healing. Bandage should be reapplied

whenever the primary dressing is changed to maintain consistent compression levels (Arundel et al., 2023).

(2 points)

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

Apply Allevyn foam dressing to wound and change every 3 days and PRN.

Absorbent foam dressings are ideal for venous leg ulcers because they manage moderate to heavy exudate, preventing maceration of the periwound skin while maintaining a moist wound environment that promotes healing. They also provide cushioning, reduce shear and friction, and can be used under compression bandaging (Patel et al., 2021).

(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/ Full Thickness on the sacrum, midline

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with a pH-balanced, non-cytotoxic wound cleanser at each dressing change.
2. Apply Calcium Alginate to wound and change every 3 days and PRN
3. Protect periwound skin with moisture barrier cream.
4. Reposition patient every 2 hours, left/right, avoid prolonged supine positioning, use

- pillows/wedges.
5. Place patient on a low-air-loss mattress.

(3 points)

Rationale for choices:

1. The goal of wound cleansing is to remove devitalized tissue, bacteria, and excess exudate while protecting healthy tissue (Jaszarowski & Murphree, 2022).
2. Absorptive dressing manage exudate, protect the wound bed, and facilitate autolytic debridement (Andryukov et al., 2020).
3. Protects surrounding skin from moisture-associated skin damage (Nix & Bryant, 2022).
4. Regular repositioning and the use of support surfaces relieve pressure, enhance tissue perfusion, and help prevent further ulcer progression (Choi et al., 2021).
5. Provides continuous airflow to control moisture, redistributes pressure evenly, and is effective in preventing further tissue damage in bedbound patients with sacral ulcers (Huang et al., 2023).

(2 points)

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

low air low mattress

The characteristics of low-air-loss mattresses—including continuous pressure redistribution, limit on shear and friction, and effective moisture control—make them instrumental in reducing the risk of further tissue breakdown and promoting an optimal healing environment for patients who cannot be repositioned frequently (Huang et al., 2023).

(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 Pressure Injury/ Partial thickness

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with a pH-balanced, non-cytotoxic wound cleanser at each dressing change.
2. Apply a Mepilex foam dressing to the sacral wound; change every 3 days or PRN if soiled by incontinence.
3. Apply zinc oxide barrier cream to periwound skin with each incontinence episode.
4. Reposition patient at least every 2 hours left/right/supine using pillows/wedges; avoid prolonged supine position.

(3 points)

Rationale for choices:

1. Removes debris and reduces bioburden without harming viable tissue, preparing wound bed for healing (Wounds International, 2025).
2. Maintains a moist wound environment, protect the wound from urine and stool, cushions against friction/shear, and is gentle to remove, reducing pain (Jaszarowski & Murphree, 2022).
3. Protects periwound from moisture-associated skin damage caused by urinary and fecal incontinence (Hill & Smith, 2023).
4. Relieves pressure, improves perfusion, and prevents further deterioration of the sacral wound (Choi et al., 2021).

(2 points)

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

Apply hydrocolloid dressing to the wound and change every 5 days and PRN.

It promotes a moist wound environment, promote autolytic debridement, insulates the wound from temperature changes and serve as a barrier to other contaminants (Jaszarowski & Murphree, 2022).

(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/ Stage 2

(1 point)

Wound Nurse recommendations/orders:

1. Remove or reposition the pulse oximeter probe; avoid placing it on the affected ear.
2. Cleanse wound with a pH-balanced, non-cytotoxic wound cleanser.
3. Apply a thin silicone foam dressing to protect the wound and cushion against shear/friction.
4. Reposition pulse oximeter to an alternative site (e.g., finger, toe) with frequent skin checks.
5. Assess wound daily and monitor for healing or signs of infection.

(3 points)

Rationale for choices:

1. **Device removal/repositioning:** Eliminates ongoing pressure and shear from the pulse oximeter, the root cause of the injury.
2. **Gentle cleansing:** Reduces bioburden and removes debris while protecting fragile tissue (Wounds International, 2025).
3. **Silicone foam dressing:** Provides a moist wound environment, absorbs light exudate, and cushions fragile ear tissue against friction (Jaszarowski & Murphree, 2022).

4. Conducting daily assessments of the wound is vital for the early detection of worsening conditions, including signs of infection or delayed healing

(2 points)

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

Apply hydrocolloid dressing to the wound and change every 3 days and PRN.

Hydrocolloids maintain a moist wound environment and support autolytic debridement (Jaszarowski & Murphree, 2022).

(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 dry black eschar on the Left Heel

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse surrounding skin with pH-balanced, non-cytotoxic cleanser as needed.
2. Apply Allevyn foam dressing every 3 days and PRN if soiled or non-adherent. Peel back the dressing each shift to assess the skin.
3. Offload the heel with heel boots or pillows to completely relieve pressure.

(3 points)

Rationale for choices:

1. The surrounding skin should be cleansed with a pH-balanced solution to reduce the risk of irritation and enhance healing. Cleansing with non-cytotoxic agents minimizes the risk of cellular damage, which has been shown to facilitate a conducive healing environment by maintaining skin integrity and supporting optimal pH levels for repair (Beeckman et al., 2023).
2. Allevyn foam dressings are beneficial for managing exudates while maintaining a moist wound environment, which is essential for facilitating healing in pressure injuries (Patel et al., 2021).
3. Offloading is a cornerstone principle in pressure injury management, aimed at relieving pressure from the affected area to promote healing. The utilization of heel boots or pillows effectively redistributes pressure, thus reducing the risk of further tissue ischemia and damage (O'Brien et al., 2024).

(2 points)

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

Apply Hydrogel to the left heel, change dressing every 3 days.

Hydrogel dressings maintain moisture and are particularly effective in autolytic debridement, providing comfort to the patient while keeping the wound hydrated, which is crucial for healing dry wounds (Floyd et al., 2021).

(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 ordered by physician who has requested WOC nurse input into dressing instructions and pressure settings

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

Wound type: Post-surgical wound dehiscence, Abdomen/midline'

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with pH-balanced, non-cytotoxic wound cleanser prior to dressing.
2. Place non-adherent contact layer such as Adaptic to cover exposed sutures before NPWT foam application.
3. Protect periwound with no-sting barrier film to reduce risk of skin stripping.
4. Initiate NPWT to the abdominal wound with settings at -125 mmHg continuous pressure.
5. Change NPWT dressing every 72 hours, or sooner if system fails or dressing is soiled.

(3 points)

Rationale for choices

1. The use of non-cytotoxic wound cleansers prevents damage to the surrounding healthy tissue and promotes cellular viability, which is paramount for effective healing and helps to remove debris, bacteria, and necrotic tissue (Oropallo et al., 2024).
2. A non-adherent dressing, such as Adaptic, prevents the NPWT foam from adhering directly to the sutures. When NPWT is applied directly over sutured areas, there is a significant risk that the foam will bond with the sutures and the surrounding tissues, it can cause trauma to the skin and sutures, resulting in pain, tearing of healing tissue, or even disruption of the wound repairs initiated by the sutures, increasing the likelihood of complications like dehiscence or infection (Cannata et al., 2021).
3. NPWT has been shown to promote healing in postoperative abdominal wounds by enhancing local blood flow, reducing edema, and facilitating the removal of exudate and debris from the wound bed. Studies highlight that NPWT can lead to a decrease in surgical site infections and improved wound healing rates (Jimale et al., 2023).
4. Protects skin from adhesive trauma and maceration (Simões et al., 2024).

5. Maintains negative pressure seal, prevents infection, and ensures system functionality.

(2 points)

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

Apply a hydrocolloid dressing over the abdominal wound, change every 7 days or PRN.

The hydrocolloid dressings create a moist wound environment, which is essential for promoting granulation tissue formation and reducing healing time. Studies have shown that hydrocolloids maintain optimal moisture levels in the wound bed, preventing the formation of a dry scab that can delay the re-epithelialization process (Jafari et al.,2023).

(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: Stage 2 Pressure Injury, Moisture Associated Skin Damage (MASD) / Incontinence- Associated Dermatitis involving bilateral buttocks, scrotum and right coccygeal area.

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound gently with pH-balanced, non-cytotoxic wound cleanser.
2. Apply a no-sting liquid barrier film to the affected areas.
3. Once the barrier film has dried, cover the area with a hydrocolloid dressing, change the dressing every 7 days or sooner if it becomes soiled or saturated.
4. Apply a zinc oxide ointment to further protect the skin from moisture damage and provide a barrier effect.
5. Reposition patient at least every 2 hours left/right/supine using pillows/wedges; avoid prolonged supine position.

(3 points)

Rationale for choices:

1. Using a pH-balanced cleanser is vital for removing irritants without further damaging sensitive skin affected by MASD (Gray et al., 2022).
2. The no-sting liquid barrier film protects the damaged skin from further exposure to irritants and moisture, which is critical for maintaining skin integrity (Bodkhe et al., 2021).

3. Hydrocolloids maintain a moist environment conducive to healing while providing protective cushioning that minimizes friction, which is crucial for painful areas (Wang et al., 2023).
4. By applying this ointment, the skin receives additional moisture protection and relief from irritation due to incontinence-associated dermatitis (Hill & Smith, 2023).
5. Repositioning the patient at least every two hours serves to relieve pressure and shear. Studies indicate that regular repositioning can significantly reduce the incidence of pressure injuries in various care settings by redistributing weight and minimizing tissue ischemia (Choi et al., 2021).
- 6.

(2 points)

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

Apply Mepilex foam dressing to wound, change every 3 days and PRN.

Foam dressings are highly absorbent and provide cushioning to the skin while also maintaining a moist environment conducive to healing. They are particularly beneficial in the management of wounds with moderate exudate while offering protection against friction and shear forces (Babino & Argenziano, 2022).

(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 on the right dorsum of the foot

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with pH-balanced, non-cytotoxic wound cleanser at each dressing change.
2. Apply Adaptic non-adherent contact layer directly over tendon to prevent desiccation and trauma.
3. Cover with Allevyn foam dressing to maintain moist healing and manage exudate; change every 3 days or PRN.
4. Apply barrier film/ointment to periwound to protect intact skin.
5. Offload affected foot using heel boots or specialized footwear to minimize pressure and shear.

(3 points)

Rationale for choices:

1. A pH-balanced, non-cytotoxic wound cleanser reduces bioburden, removes debris, and minimizes risk of infection while preserving viable tissue (Wounds International, 2025).
2. The primary function of non-adherent contact layers like Adaptic is to retain moisture around the exposed tendon. Maintaining a moist wound environment is crucial as it promotes cellular activities essential for healing and prevents the tendon from drying out, which can impede recovery. Keeping the wound hydrated also facilitates faster re-epithelialization and minimizes scarring (Ho et al., 2025).

3. Foam dressings provide a moist environment conducive to healing while managing exudate effectively. The foam's absorbent properties prevent maceration of surrounding skin and provide cushioning, which is imperative in reducing shear and friction forces that could disrupt healing processes. Dressing changes every 3 days or PRN ensure that hydration levels and exudate management are optimized, promoting better healing outcomes (Sun et al., 2022).
4. The no-sting liquid barrier film protects the damaged skin from further exposure to irritants and moisture, which is critical for maintaining skin integrity (Bodkhe et al., 2021).
5. Offloading is a cornerstone principle in pressure injury management, aimed at relieving pressure from the affected area to promote healing. The utilization of heel boots or pillows effectively redistributes pressure, thus reducing the risk of further tissue ischemia and damage (O'Brien et al., 2024).

(2 points)

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

Apply silver alginate dressing to wound bed with exposed tendon, covered with secondary Allevyn foam; change every 3 days or PRN.

It was found that alginates included in wound dressings, in addition to the high hemostatic activity, provide the optimum moist environment in the wound and good absorption of wound exudate, stimulate the growth of granulation tissue, reduce the concentration of pro-inflammatory cytokines, inhibit the formation of free radicals, and have a pronounced antimicrobial activity (Andryukov et al., 2020).

(2 points)

/8 points

References (3 points):