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

Mini Case Scenarios: Wounds

Cleveland Clinic

Student Name _Blaine McKinney_____ **Date:** __11/10/2025_____

Reviewed by: _____ **Date:** _____

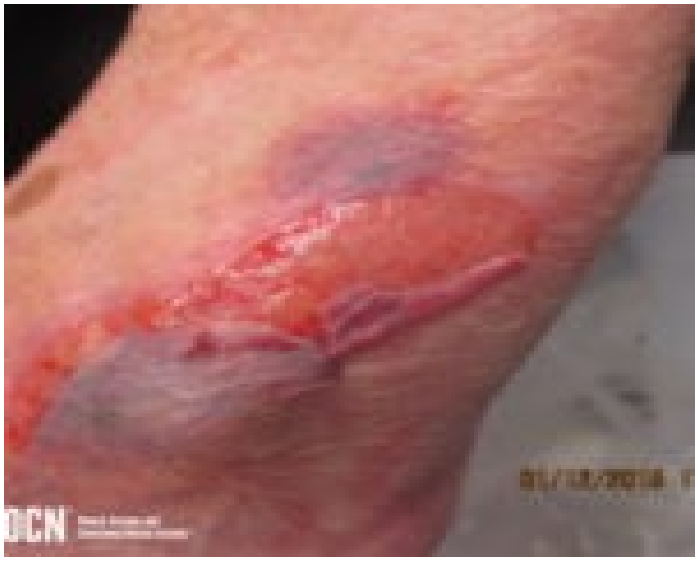
Score: /83

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. To support your actions, include at least three relevant references in addition to the course textbooks. (Use 7th edition APA formatting)

A case study has been completed for you. Below is 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)

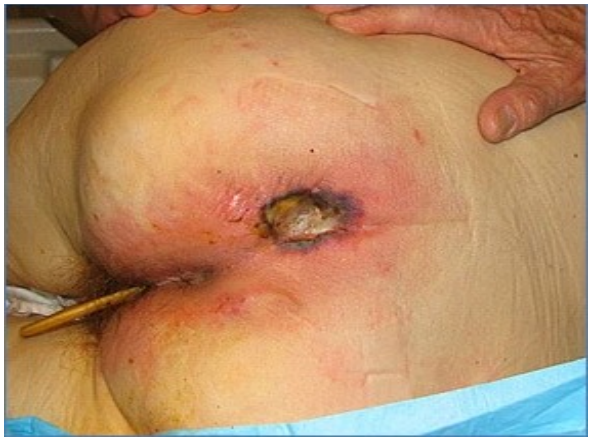
Rationale for choices

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:

Pressure injury, unstageable (POA)

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with non-cytotoxic wound cleanser, such as Anasept Antimicrobial Skin and Wound Cleanser. Cleanse peri wound with pH balanced bath wipes (Stryker Sage Essential Bath Wipes), allow to dry.
2. Apply collagenase (Santyl) enzymatic debrider in a 2mm (nickel thick) layer from the middle of the wound to the edges of the wound, taking care to not extend Santyl beyond wound edges. Cover with saline moistened gauze, then ABD. Secure with tape (Smith & Nephew, n.d.)
3. Change dressing daily and as needed for saturation or soiling
4. Apply Medline PREVENT dimethicone barrier cream to surrounding areas
5. Turn patient every 2 hours using foam wedges and friction reducing underpad and white paper pad (Comfort Glide system), maintain the head of bed at less than 30 degrees when possible.
6. Avoid use of disposable briefs
7. Recommend alternating pressure low air loss mattress or air fluidized mattress
8. Consult nutrition/dietitian for nutrition for wound healing

(3 points)

Rationale for choices:

1. Cleanse wound with non-cytotoxic wound cleanser to avoid damage to healing tissue (Potter et al., 2021). Bath wipes are a preferred alternative to soap and water in a basin, as basins may be linked to transmission of hospital-acquired infections. The cleansing wipes are also pH balanced and gentle on skin, the Stryker Sage bath wipes are infused with aloe and vitamin E to promote skin health (Stryker, n.d.).

2. Debridement is a key step in preparing the wound bed, as it removes the necrotic tissue from the wound bed. Necrotic tissue can prevent wound healing, prevents the clinician from evaluating the actual wound bed, and can lead to deeper, tunneling wounds or infection. Enzymatic debridement may be right for patients who need serial debriding or patients in a long-term care facility as qualified staff

may not be present (Sibbald, Niezgoda, & Ayello, 2020). Smith & Nephew (n.d.) recommend maintaining an appropriate moisture balance to activate collagenase enzyme and to promote wound healing, can eliminate saline moistened gauze if wound is already moist. Upon assessment, this wound was noted to not have exudate.

3. Recommended to change dressing daily, as recommended by Smith & Nephew (n.d.).
4. Application of a moisture barrier product, such as dimethicone based barrier cream, helps protect the skin from damaging moisture, such as sweat, wound drainage, or fecal or urinary incontinence (Borchert, 2022). This patient has an indwelling catheter in place, but with a history of dementia it is unclear if she is continent of stool. Over moisturized skin is at risk of developing injury from pressure, shear, or friction (Borchert, 2022).
5. Tissues exposed to pressure over long periods of time have a decrease in arteriolar flow to the tissues, which in turn leads to ischemia and the development of pressure injuries. Repositioning every 2 to 4 hours allows for blood flow to return (Borchert, 2022).
6. Do not recommend the use of disposable briefs in order to support a healthy microclimate and prevention of prolonged moisture exposure on the patient's skin (Borchert, 2022).
7. Alternating pressure mattresses redistribute the patient's body and which areas experience pressure, and low air loss uses airflow to promote a healthy microclimate for the skin. Air fluidized mattresses allows the patient to be enveloped in fluidized beads, however these are not often owned by facilities (Mackey & Watts, 2022).

(2 points)

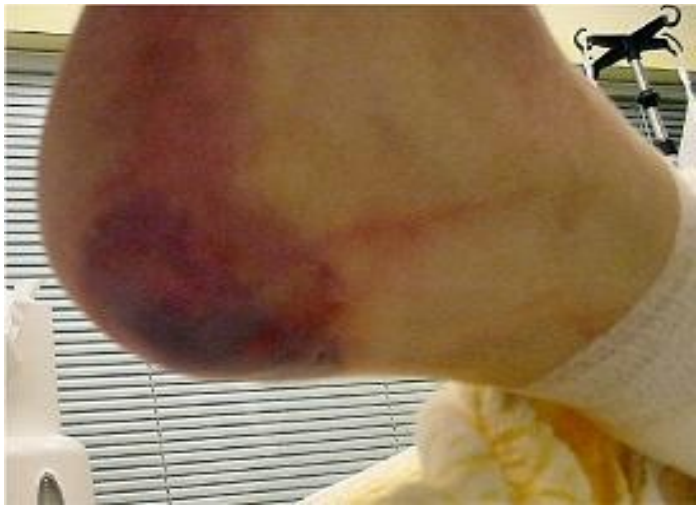
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

For sacral wound, apply Medline Skintegrity Hydrogel to wound bed, taking care to not extend hydrogel beyond wound edges. Cover with DuoDerm Signal hydrocolloid dressing, change when exudate reaches green dotted line or every other day.

(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:

Pressure injury, deep tissue pressure injury
(1 point)

Wound Nurse recommendations/orders:

1. Cleanse foot with soap and water, gently pat dry. Moisturize with Medline Remedy lotion
2. Apply Mepilex bordered foam heel dressing to left heel.
3. Elevate heels off bed with pillows while in bed
4. Check heels every 12 hours and as needed
5. Change dressing every 7 days and as needed

(3 points)

Rationale for choices:

1. Keep skin clean and moisturized to promote skin health
2. Kalowes, Messina, and Li (2016) found "a statistically and clinically significant benefit for the application of the 5-layered Mepilex Border Sacrum foam dressing for the prevention of pressure ulcers when used in combination with thorough risk assessment and evidence-based pressure ulcer prevention via the SKIN bundle."
3. Support heels with a pillow while in bed to prevent high pressure areas on the heel, tendon, or calf.
4. Assess heels frequently to ensure the heel repositioning devices aren't creating areas of high pressure due to patient movement or restlessness
5. Change dressing in accordance with manufacturer recommendations of up to 7-day wear time (Molnlycke, n.d.)

(2 points)

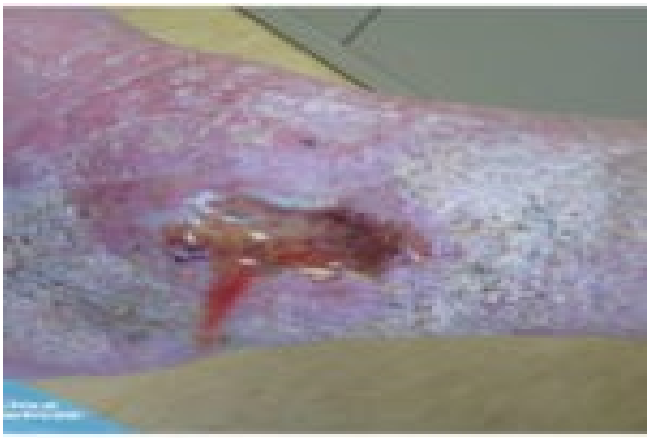
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

Cleanse feet with soap and water daily, gently pat dry. Moisturize with Medline Remedy lotion. Offload heels while patient is in bed with EHOB TruVue boots.

(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:

Lower extremity venous disease, mixed arterial-venous disease

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse lower extremity with mild cleanser such as Dove or Olay, gently massage any dry, crusted areas to loosen and remove crusts.
2. Moisturize area with petrolatum and zinc oxide barrier, such as Medline Remedy PROTECT Clear Zinc Ointment
3. Apply alginate with silver dressing (Silvercel) cut to fit wound bed, secure with rolled gauze (Kerlix)
4. Compress with light multilayer compression (Urgo K2 Lite)
5. Change with home health care or in wound clinic every 3 days

(3 points)

Rationale for choices:

1. Non-soap mild cleanser should be used to prevent dermatitis (Kelechi, Brunette, & Burgess, 2022)
2. Zinc oxide can be used to protect skin from exudate, while petrolatum is an emollient to prevent excessive drying of the skin
3. Alginates are able to absorb a moderate amount of exudate, can be left in place for up to 3 days depending on exudate levels, can conform to irregular wound beds, and form a gel when in contact

with moisture which also promotes autolytic debridement. Alginates need a secondary dressing to hold them in place, which is why kerlix would be used (Jaszarowski & Murphree, 2022).

4. This patient demonstrates mixed arterial-venous disease based on the ABIs above, so light compression should be trialed, Urgo K2 Lite claims a 20mm/Hg compression dosage (Kelechi, Brunette, & Burgess, 2022; Urgo Medical, n.d.).

(2 points)

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

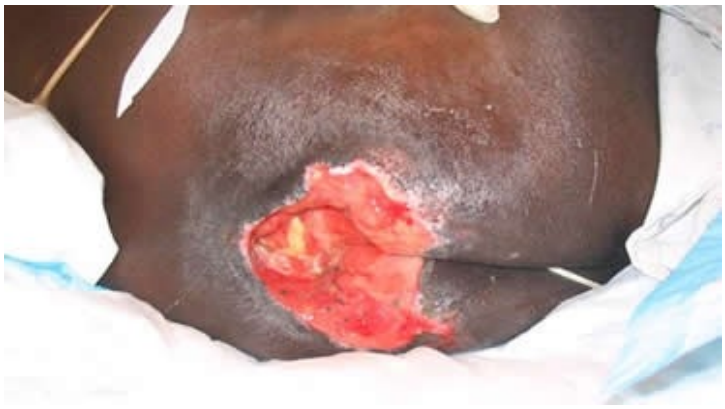
If patient is ambulatory, recommend zinc-based Unna boot applied in wound care clinic by WOC RN, changed weekly

If patient is non-ambulatory, after cleansing and moisturizing, apply Mepilex foam dressing to wound, secure with kerlix gauze roll, and apply multilayer compression (Urgo K2 Lite) to be changed weekly.

(2 points)

/8 points

Scenario 4



An 85-year-old is admitted to the hospital with a stage <u>???</u> 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 <u>*not*</u> available at this time.

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

Wound type:

Stage 3 pressure injury, POA

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse peri wound skin and wound with Anasept antimicrobial cleanser
2. Apply Hydrofera Blue Classic, gently pack into wound. Prior to application, Hydrofera Blue Classic should be hydrated with sterile water or sterile saline, then squeeze out excess fluid.

3. Cover with Mepilex bordered foam
4. Change every 3 days and as needed for soiling of dressing or if Hydrofera Blue loses its blue coloration
5. Consider pressure redistribution low air loss mattress and avoiding the use of disposable briefs
6. Reposition every 2 hours to keep pressure off wound as able
7. Recommend consult to dietician for nutrition for wound healing

(3 points)

Rationale for choices:

1. Use a non cytotoxic wound cleanser to prevent damage to granulating tissue (Potter et al., 2021).
2. The wound above appears chronic, which means a biofilm may be present. Hydrofera Blue offers antimicrobial action to decrease bioburden, as well as touts improved granulation (Urgo Medical, 2024).
3. Hydrofera Blue Classic is non-adherent and would need a secondary dressing.
4. Change per the manufacturer's instructions
5. Pressure redistribution and low air loss aid in the changing of surfaces the patient's skin is in contact with and manages the microclimate of the patient's skin. Avoiding disposable briefs also promotes a healthy microclimate (Borchert, 2022).
6. Repositioning of the patient frequently allows for nutrient and oxygen rich blood to return to the affected tissues, preventing ischemia (Borchert, 2022).
7. Nutrition is imperative to wound healing and should be assessed for every wound care patient.

(2 points)

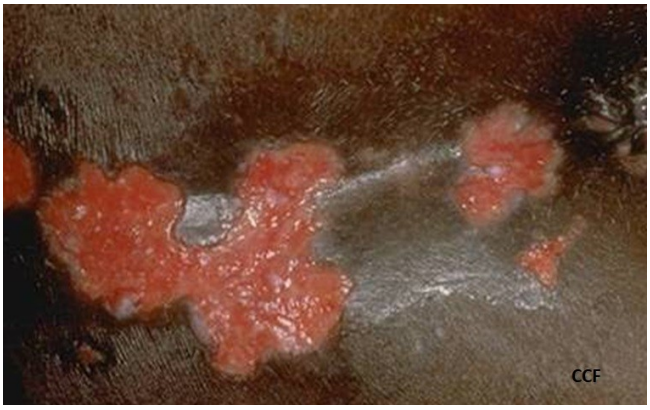
What support surface would you recommend (1pt) and why? (1pt)

I would recommend a pressure redistribution low air loss mattress at a minimum. These support surfaces allow for tighter control of the microclimate to optimize skin health due to their constant flow of air. This support surfaces also allows for redistribution of pressure because the patient is shifted onto different contact surfaces cyclically. When used with corresponding waterproof covers, the friction and shear is lower as well (Brienza, Tescher, & Call, 2020).

(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:

Incontinence associated dermatitis

(1 point)

Wound Nurse recommendations/orders:

1. Assess patient's continence post-operatively, could consider a rectal pouch or fecal management system and condom catheter to prevent urine and stool from sitting on the skin
2. Cleanse wound with non-cytotoxic wound cleanser, such as Anasept Antimicrobial Skin and Wound Cleanser. Cleanse with pH balanced mild soap and water, or with pH balanced bath wipes (Stryker Sage Essential Bath Wipes), allow to dry.
3. Apply zinc-based barrier cream (Medline Remedy PROTECT zinc oxide barrier cream) twice daily and as needed
4. Minimize layers under patient to three or less
5. Reposition patient using foam wedges every 2 hours
6. Place patient on pressure redistribution low air loss mattress

(3 points)

Rationale for choices:

1. Recommend either an indwelling or external fecal management system to divert stool away from the skin and allow the patient to heal. A condom catheter can divert urine away from the skin. Absorptive products may also be beneficial to prevent the patient's skin from being exposed to urine and stool. Furthermore, assessing further the cause of his incontinence is beneficial, for example a neurogenic bladder and bowel due to quadriplegia.
2. Recommendation of zinc oxide-based barrier cream as zinc oxide creates a barrier over the intact and affected skin, this barrier prevents new breakdown from occurring by blocking moisture and allows the denuded skin to heal (Cleveland Clinic, 2025.
3. Prevent pressure injuries by minimizing layers, this prevents excessive heat and overhydration leading to skin breakdown
4. Reposition to help prevent pressure injuries, repositioning allows for nutrient and oxygen rich blood to return to affected tissues
5. The low air loss mattress can assist in improving the microclimate of the patient's skin, preventing excess moisture and overhydration, leading to skin breakdown

(2 points)

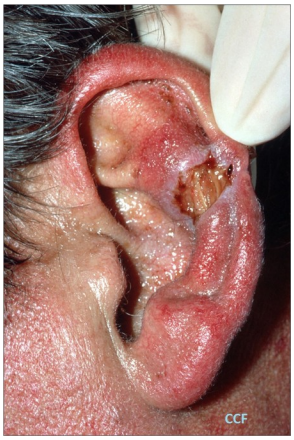
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

Cleanse peri wound skin with foaming no-rinse cleanser and water, allow to dry. Apply Cavilon Advanced Skin Protectant to wound and peri wound, allow to dry for 30 seconds. Apply every 3 days.

(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 3

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with Anasept antimicrobial skin cleanser, allow to dry
2. Apply Triad hydrophilic wound dressing daily
3. Recommend air fluidized pillow, ensure patient's head is turned with repositioning to offload ear

(3 points)

Rationale for choices:

1. It is ideal to cleanse wound with non-cytotoxic cleanser to protect healthy tissue (Potter et al., 2021)
2. This wound is in a hard to dress area, Triad conforms with odd surfaces and acts as a wound dressing to protect the wound and promote autolytic debridement (Coloplast, n.d.).
3. Air fluidize pillow and repositioning patient's head will allow pressure to be redistributed to promote healing.

(2 points)

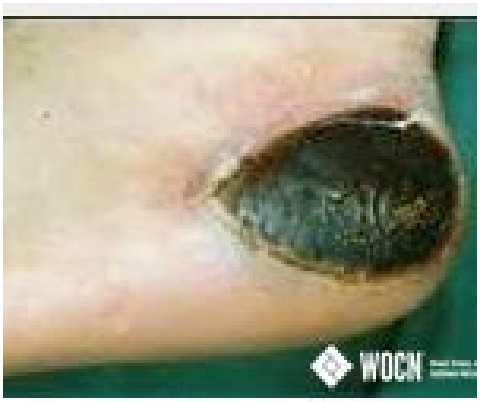
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

Cleanse wound and peri wound with Anasept antimicrobial skin cleanser, allow to dry. Apply Mepilex bordered foam (1.6in x 2in size) to wound, change every 3 days and as needed for soiling or saturation. Recommend use of air fluidized pillow, offloading ear by ensuring patient's head is turned during repositioning

(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

(1 point)

Wound Nurse recommendations/orders:

1. Keep wound dry
2. Offload bilateral heels with EHOB TruVue boots while in bed

(3 points)

Rationale for choices:

1. Wounds with stable eschar that are located in areas with poor perfusion, such as heels, should not be moistened or softened. Opening these wounds places the patient at risk of infection. Edsberg (2022) notes that the redistribution of pressure "is the most important intervention with stable eschar."

(2 points)

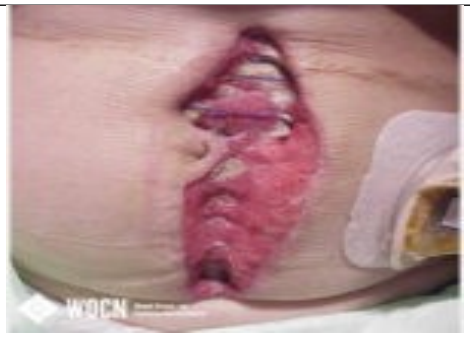
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

1. Keep wound dry, paint dry eschar and immediate peri wound skin with betadine.
2. Allow betadine to dry, cover with dry gauze, secure with kerlix.
3. Change daily

(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, appears left open to heal by secondary intention.

(1 point)

Wound Nurse recommendations/orders:

1. Assess wound for visible structures, tunneling, and undermining
2. Administer pain medication as needed and as ordered prior to dressing change
3. Cleanse wound and periwound skin with Anasept antimicrobial wound cleanser, allow to dry
4. Prep skin with Cavilon no sting barrier film
5. Apply 3M VAC Whitefoam dressing to explored tunneled areas. Apply VAC Granufoam black foam to wound bed over Whitefoam, taking care to keep black Granufoam off periwound skin. Foams must be in contact with each other to function appropriately. While placing foam, count the number of dressing pieces in the wound.
6. Secure with VAC drape, ensuring area is occlusive. Cut quarter sized hole in drape, apply track pad
7. Set VAC to VAC therapy mode, suction to -125mmHg and medium intensity.
8. Change Monday/Wednesday/Friday

(3 points)

Rationale for choices:

1. Wound VACs should not be placed in unexplored or blind tunnels, or exposed vessels, tendons, or organs (Solventum Medical, 2025).
2. Wounds and dressing changes can be quite painful for patients, and pain is what the patient expresses it is. Pain should be minimized as able, utilizing analgesic medications and other methods, such as calming music if they prefer, distractions, closing windows or curtains, and comfortable positioning as able (Woo & Sibbald, 2020).
3. -125mmHg is the recommended setting for Whitefoam due to its higher density, and Whitefoam should be changed every 48 to 72 hours, per the manufacturer's instructions (Solventum Medical, 2025).

(2 points)

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

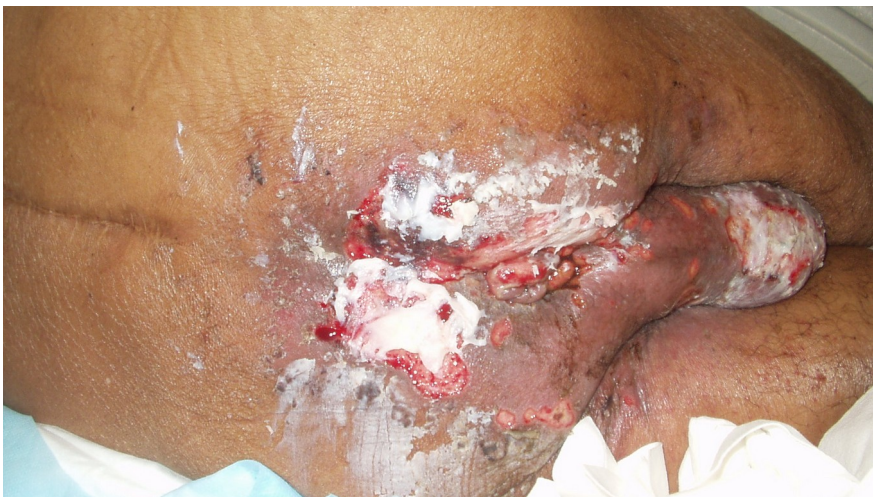
If wound VAC loses suction or is non-operative for 2 hours, remove VAC dressing with adhesive remover wipes. Cleanse wound and periwound skin with Anasept antimicrobial wound cleanser. Apply saline moistened Hydrofera Blue Classic to wound bed, cover with Mepilex bordered foam dressing and change every 3 days and

as needed if dressing loses color.

(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 across buttocks and scrotum, stage 3 pressure injury to sacrum

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse entire area with pH balanced bath wipes (Stryker Sage Essential Bath Wipes), allow to dry.
2. Apply dime thick layer of Triad Hydrophilic Wound Dressing to entire affected area
3. Recommend Abena San Special Fecal Incontinence Pad, replace when soiled
4. Place patient on pressure redistribution low air loss mattress, turn every 2 hours with foam wedges

(3 points)

Rationale for choices:

1. Cleansing with pH balanced bath wipes helps to protect skin and may contribute to the prevention of hospital acquired infections, as use of basins may be linked to hospital acquired infections.
2. The area appears moist and is irregular in shape. The patient also has an active *C. diff* infection, which implies the patient has been experiencing diarrhea. If patient is incontinent, keeping a dressing in place will be difficult. The Triad is easy to apply and is designed to stick to wet areas.
3. Assuming the patient is incontinent in this scenario, neither a rectal pouch nor internal fecal management system would be appropriate. Patient's perianal area has significant skin loss so a rectal pouch would not be effective, and the patient appears to have significant hemorrhoids, which is a contraindication to the Flexi-Seal Fecal Management System (Convatec, 2020). The Abena San Special Fecal Incontinence Pad is designed to accommodate diarrhea and loose stools.

4. A pressure redistribution low air loss mattress will help promote a healthy microclimate for the patient's skin, turning will allow blood flow to the affected area and keep pressure off the wound as able.

(2 points)

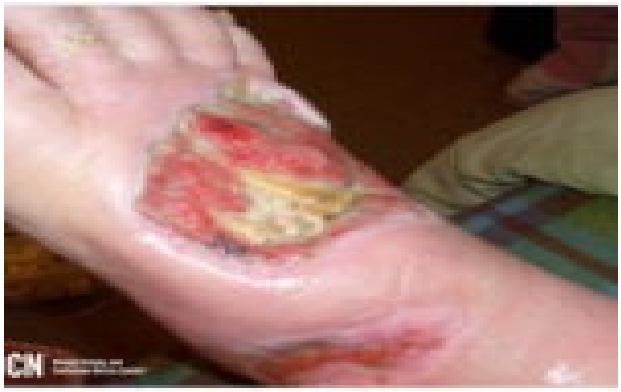
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

Cleanse patient's skin with Stryker Sage Essential Bath Wipes daily and as needed for incontinence episodes. Apply zinc oxide-based barrier cream to buttocks and perianal area twice daily and as needed.

(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:

(1 point)

Wound Nurse recommendations/orders:

1. Recommend podiatry/critical limb consult
2. Cleanse wound and peri wound with Anasept wound cleanser, pat dry
3. Apply MediHoney Alginate dressing to wound bed, cover with ABD
4. Secure with kerlix
5. Change every other day
6. Offload feet and heels using a pillow to "float" feet off the bed

(3 points)

Rationale for choices:

1. Exposed tendon in a wound may require more significant intervention to treat and is at risk of the tendon drying out and infection (Deng, Long, & Chen, 2023). A licensed independent practitioner will

have more resources for invasive wound treatment, such as skin grafts or flaps. Debridement and addressing the wound edges may also be necessary due to the presence of non-viable tissue and epibole (Holloway et al., 2020).
2. Until the podiatrist is able to evaluate the patient, the wound should be kept clean to prevent infection, which can be achieved by cleansing with an antimicrobial wound cleanser.
3. The MediHoney Alginate will keep the wound moist, as well as promote debridement in the meantime. As it can get sticky and runny, a secondary dressing should be considered.
4. Securing with kerlix will hold all pieces of the dressing in place.
5. Preventing more wounds is important, as the patient has multiple risk factors for impaired blood flow to their feet. EHOB boots have a strap across the dorsum of the foot which may place undue pressure on the wound.

(2 points)

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

Cleanse wound and peri wound with Medline no rinse foaming cleanser, pat dry. Apply Adaptic Non-Adherent Gauze cut to fit over wound bed. Cover with Mepilex Bordered Foam, change every other day.
(2 points)

/8 points

References (3 points):

Borchert, K. (2022). Pressure injury prevention: Implementing and maintaining a successful plan and program. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 672 - 721). Wolters Kluwer.

Brienza, D. M., Tescher, A. N., & Call, E. (2020). Pressure redistribution: Seating, positioning, and support surfaces. In S. Baranoski & E.A. Ayello (Eds.), *Wound care essentials: Practice principles* (5th ed., pp. 270 - 305). Wolters Kluwer.

Cleveland Clinic. (2025). Zinc oxide cream, lotion, paste, or ointment. Retrieved on November 8, 2025, from https://my.clevelandclinic.org/health/drugs/18700-zinc-oxide-cream-ointment-paste

Convatec. (2020). FlexiSeal Protect Plus directions for use. Retrieved on November 10, 2025, from https://flexi-seal.convatec.com/media/kamnwofw/flexi-seal-protect-plus-luer_directions-for-use-poster.pdf

Coloplast. (n.d.). Triad hydrophilic wound dressing. Retrieved on November 8, 2025, from https://products.coloplast.us/coloplast/wound-care/triad-hydrophilic-wound-dressing/?srsltid=AfmBOorDiOuAmLIuKcOdUbluT3V3M0HwWTDGUQ8huJJSHmF2piRsDnpw

Deng, Z., Long, Z., & Chen, G. (2023). Mini-review: Tendon-exposed wound treatments. *Journal of Investigative Surgery*, *36*(1), 2266758. https://doi.org/10.1080/08941939.2023.2266758

Edsberg, L. (2022). Pressure and shear injuries. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 836 - 874). Wolters Kluwer.

Holloway, S., Tate., Stechmiller, J. K., & Schultz, G. (2020). Acute and chronic wound healing. In S. Baranoski & E.A. Ayello (Eds.), *Wound care essentials: Practice principles* (5th ed., pp. 79 - 101). Wolters Kluwer.

Jaszarowski, K., & Murphree, R. W. (2022). Wound cleansing and dressing selection. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 346 - 378). Wolters Kluwer.

Kelechi, T. J., Brunette, G., & Burgess, J. J.. (2022). Lower extremity venous disease, venous leg ulcers, and lymphedema. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 997 - 1078). Wolters Kluwer.

Mackey, D., & Watts, C. (2022). Therapeutic surfaces for bed and chair. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 722 - 750). Wolters Kluwer.

Potter, P. A., Perry, A. G., Stockert, P. A., & Hall, A. M. (2021). Fundamentals of Nursing, 10th ed. Elsevier.

Sibbald, R. G., Niezgoda, J. A., & Ayello, E. A. (2020). Wound debridement. In S. Baranoski & E.A. Ayello (Eds.), *Wound care essentials: Practice principles* (5th ed., pp. 163 - 184). Wolters Kluwer.

Smith & Nephew. (n.d.). How to apply Santyl ointment. Retrieved November 2, 2025, from https://santyl.com/hcp/application

Solventum Medical. (2025). Solventum V.A.C. therapy clinical guidelines. Retrieved November 8, 2025, from https://www.solventum.com/content/dam/public/language-masters/en/msb/document/2025/vac-therapy-clinical-guidelines-ms-npwt-en-us.pdf

Stryker. (n.d.). Sage Essential bath washcloths. Retrieved November 1, 2025, from https://homecare.stryker.com/sage-essential-bath-cloths-7800-7803?sku=7803-E&gad_source=1&gad_campaignid=10578352314&gbraid=0AAAADmJCyH0w7jytdl0De50qNJtHNsgQ&gclid=Cj0KCQjw35bIBhDqARIsAGjd-cZ3VO-UCKsqPWvySNmBhyZhO1orYj_97ekkJ3KzEPIKjKrF12TsY2MaAlfnEALw_wcB

Urgo Medical. (n.d.). Urgo K2. Retrieved on November 2, 2025, from https://www.urgomedical.us/products/urgok2

Wood, K. Y., & Sibbald, R.G. (2020). Pain management and wounds. In S. Baranoski & E.A. Ayello (Eds.), *Wound care essentials: Practice principles* (5th ed., pp. 306 - 332). Wolters Kluwer.