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

Mini Case Scenarios: Wounds

Cleveland Clinic

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Score: 46.5/83 **Score:** X-1 resubmission = Y/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: Unstageable Pressure Injury, Stage 3 or Stage 4 It is a full thickness wound. Unable to determine the extent of the tissue damage because it is covered by 100% yellow slough and brown necrotic tissue at the edges.

(1 point) 1

Wound Nurse recommendations/orders:

1. Cleanse the area with normal saline.
2. Measure the wound and document any new findings, and take a new photo of the wound.
3. Apply Santyl nickel thick or 2mm to the necrotic tissue area and avoid getting excess ointment on healthy skin. See end of scenario for URL for Santyl application
4. Place a 4x4 gauze over the area. More to this gauze
5. Cover with a Mepilex Sacrum border dressing, change every day.this is a little pricey to change everyday + it is absorptive
6. Turn and reposition the patient every 2 hours from right to left side, trying to avoid pressure to the sacrum. Ok- you could say on back for meals only for 30 min.
7. Order an air loss mattress for the patient because of a pressure injury to the sacrum and help prevent any new injuries. Ok

1. Cleanse the area with normal saline.
2. Measure the wound, document any new findings, and take a photo of the wound.
3. Apply Santyl nickel thick or 2mm to necrotic tissue out to the edges of the wound. Avoid getting excess ointment on healthy skin.
4. Place a 4x4 moist gauze over the area.
5. Cover with an ADB pad and foam tape to secure and change daily.
6. Turn and reposition the patient every 2 hours from right to left, and can be on the back for 30minutes during meals only.
7. Order an air loss mattress for the patient because of the current pressure injury to the sacrum. This mattress helps to shift the weight and pressure off the bony prominences.

(3 points)1.5

Rationale for choices: This is a simple solution to help debride the area. The dressing is not too invasive to the patient and is easy to apply. Since this patient has dementia, he is already receiving care and or has help, it will be easy to continue with this dressing to help improve this wound. Well pt admitted to a LTC facility

1. Use of normal saline might be easier with a dementia patient. I am not sure how easy it is for the

person to shower or clean the area. And why do we clean a wound? Yes, basic but once you write it you have it with a few exceptions depending on agent & wound type

[2.] Santyl is an enzymatic debriding agent that will help to break down and remove the dead ~~skin~~ tissue in the wound base.

2.[3.] The area needs to be covered and stay moist. you do not say how you are doing this

3.[4.] This needs to be done at least once a day to be effective yes but 4 & 5 above are about gauze & foam. In a nursing home, daily Mepilex sacral dressing is most likely too expensive & not needed if pressure not an issue based on positioning

4.[5.] Turning and repositioning in bed is important to take the pressure off the sacrum area. yes

5.[6.] Need to be aware and reduce pressure to the sacrum while making sure no new injuries occur. An air loss mattress can help prevent pressure injuries. Yes

1. Clean wound base with normal saline. The area is cleaned to loosen and remove dirt and debris.
2. Santyl is an enzymatic debriding agent that will help to break down and remove the dead tissue in the wound base.
3. The area is not a moist wound. For Santyl to work best, it needs a moist environment. The area is covered with moist gauze and covered with an ABD pad that stays moist and secured with foam tape. This dressing will be easy and more cost-effective for the facility.
4. This needs to be a daily dressing so the Santyl is effective in breaking down the necrotic tissue.
5. Turning and repositioning in bed is important to take the pressure off the sacrum area.
6. Need to be aware and reduce pressure to the sacrum while making sure no new injuries occur. An air loss mattress can help prevent pressure injuries.

(2 points)1

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

1. Clean the area with normal saline
2. Dry the skin
3. Place an alginate dressing Aquacel AG into the wound, cut to fit the area, but do not overfill. This is a dry wound and alginate is used on wetter wounds. This is not impossible but not with these orders
4. Apply Mepilex sacrum border and change every 3 days.

1. Clean the area with normal saline.
2. Apply Intrasite Gel (hydrogel) to the wound base. This helps maintain a moist wound environment.
3. Cover with a fluffed, damp saline gauze.Cover with gauze and a transparent adhesive dressing (Tegaderm) daily.

(2 points)0 What else can you do for this wound?

3.5/8 points

Someone came up w MEND (the company? or someone else?) but it is a great acronym for application

Moisture, Edge to edge, Nickel thick, Daily & more info can be found at https://santyl.com/hcp/application

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). This cannot be staged at this time. We would have to watch and see what this evolves into to stage the injury. This area could stay closed and resolve or evolve, then open, and we could then stage the injury.

(1 point)1

Wound Nurse recommendations/orders:

1. Protect the area and elevate the heels off the bed with pillows, heel offloading devices, or TruVue Heel protectors.
2. Order a low-air-loss bed. Order a low air loss mattress.
3. Assess the area daily and each shift, and monitor the area for progression or if any area opens.
4. If the area opens, take a new photo and contact the WOC team for new orders

(3 points)3

Rationale for choices: This is a Deep tissue pressure injury that is not open at this time. Patient just had a major surgery and might not be able to ambulate or move easily on their own at this time. By ordering a low air loss mattress, you are using two different words that do not mean the same thing
this will help to lower the risk of another pressure injury. The area that does have a pressure injury, as well as the other heel, needed to be protected and have offloading to this area as well as other pressure point areas, and be monitored for changes.
The low-air-loss mattress helps redistribute weight off of pressure points while the patient is in bed. Even with this mattress, this patient should have the heel protected. You can use true Vue boots to offload, as well as a heel-off foam wedge.

(2 points)1.8

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

1. Cleanse the area with normal saline or pH-balanced cleanser and dry the area.
2. Apply Mepilex heel border foam to both heels. And change every 3 days.
3. Pull back the dressing and assess the area every 8 hours.

4. Elevate the heel off the bed with pillows, heel offloading devices, or TruVue Heel protectors.
(2 points)2

7.8/8 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: Peripheral Artery Disease, Stage 3 Full thickness

Venous Ulcer – full thickness stage 3

(1 point)0

Wound Nurse recommendations/orders:

1. Clean wound with normal saline. ok
2. Measure the wound and document any new findings, and take a new photo of the wound. sure
3. Apply 3m barrier around the periwound to help protect skin.always!
4. Apply Hydrocolloid to the wound base
5. Change dressing every 3 days or PRN if saturated or soiled.

Because you have the wrong wound type your recommendations are not on target or inclusive

1. Clean wound with normal saline.
2. Measure the wound and document measurements, and take a photo.
3. Apply 3m barrier around the peri wound to help protect skin.
4. Apply Aquacel AG cut to fit to base of the wound.
5. Cover with Allevyn foam and change every 3 days or PRN if saturated or soiled.

(3 points)1

Rationale for choices:

1. Need to clean the area. As in #1
2. Skin around the wound has maceration 3m barrier will help to protect the skin and give a layer of protection from the moisture.
3. A hydrocolloid dressing will help with the drainage what does this mean? You need to provide professional explanations as you will be called upon to do this to interns, residents, nursing students, attendings, etc. They need a scientific rationaleand protect the wound base.
4. Dressing can stay on for a longer period, so it does not need to be changed every day unless saturated or soiled. sometimes this is a good thing based on new research & wound temperature and sometimes not

1. Clean the wound base with normal saline to clean the wound base of dirt and debris.
2. A measure and photo of the wound base gives an overview of how the wound is doing and gives evidence of wound progression, and shows if the wound is showing improvement.

3. Since the wound base is draining a large amount of fluid coming from wound the 3m barrier will help protect the good skin and prevent the area from becoming macerated.
4. Cutting the Aquacel AG to the size of the wound. Aquacel will help with the drainage and turn into a gel with the drainage and keeping the wound bed moist.
5. This can be kept in the wound base for 2 to 3 days. Cover with Allevyn foam, which helps to collect the drainage. It should be changed when it becomes saturated or soiled.

(2 points).5

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

1. Clean wound base with normal saline.
2. Apply 3m barrier to the periwound to help protect skin.
3. Apply ~~Allyven~~ Allevyn foam dressing to the wound every 3 days or PRN if saturated or soiled. better choice than hydrocolloid as this does say mod exudate & etiology creates drainage

(2 points)2

3.5/8 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: Pressure injury Stage 3, full thickness

(1 point)1

Wound Nurse recommendations/orders:

1. Cleanse the wound with normal saline.
2. Measure the wound and document any findings, and take a new photo of the wound.
3. Apply a 3m barrier film to the surrounding periwound skin to help protect intact skin from the solution.
4. Pack the wound with moist gauze soaked in Dakin solution and lightly pack the wound base. What is the evidence for using a gauze dressing on a wound that has a pink wound bed? This is still able to be used for this area, which may not be the first choice. Gauze is still able to absorb drainage, protect wounds, and provide a barrier against friction and irritation.
5. Apply ABD pad and secure with paper tape. Good choice for secondary
6. Change wound daily and PRN if soiled. what are sources for daily moist gauze dressing changes? If we are using a gauze dressing, we would want a daily dressing change or BID to the area. The gauze will dry out, and moist wounds do better with a moist environment. We do not want the gauze to stick to the wound base and damage the healthy skin on removal.
7. Turn and reposition the patient every 2 hours from right to left side, trying to avoid pressure to the sacrum. Good idea
8. Order an air loss mattress for the patient because of a pressure injury to the sacrum and help prevent any new injuries. Good plan

1. Cleanse the wound with normal saline.
2. Measure the wound and document any findings, and take a new photo of the wound.
3. Apply a 3m barrier film to the surrounding periwound skin to help protect intact skin from the solution.
4. Apply Aquacel Ag to the wound base
5. Apply Mepeilex border foam dressing
6. Change dressing every 3 days or PRN as needed for drainage or if soiled.
7. Turn and reposition the patient every 2 hours from right to left side, trying to avoid pressure to the sacrum.
8. Order an air loss mattress for the patient because of a pressure injury to the sacrum and help

prevent any new injuries.

(3 points)1

Rationale for choices:

1. The wound base needs to be cleaned.!
2. The area needs to be assessed, and the wound measurement to see if the area is improving. The nurse needs to see if the area is infected, has an odor, tunnels noted, or any other issues. A photo helps to document the changes in the wound base and allows to have documentation and a record of how the wound is responding to the treatment, is helps and improves the wound.
3. 3m barrier film will help to protect intact skin from the solution and reduce the risk of maceration to intact skin. yes
4. To help with yellow slough in the base of the wound, Dakin's will help to break down and clean the area and reduce the risk of infection. It can also help to control odor in a wound. Yes it can do this
5. The area needs to be lightly packed and covered with ABD dressing and secured.this is not a rationale. Why is dead space filled? We fill the space to reduce the risk of infection by minimizing the space bacteria would have to grow. It maintains a moist environment, which helps in tissue regeneration. It can give comfort by reducing pressure points on the injured area.
6. It is important to encourage the patient to be turned and repositioned in bed and to avoid more pressure to this area. A turning schedule as well as an air loss mattress, will help to decrease the risk of damaging the area further and causing a new pressure injury. Ok

1. The wound base needs to be cleaned, and dirt and debris flushed from the area.
2. Photo and documentation show if the wound is improving and if the current orders are helping the area.
3. 3m barrier helps protect the surrounding skin from damage from the drainage.
4. Applying the Aquacel to the area will help with drainage and create a moist environment for the wound. It uses silver, which has bacteriostatic properties.
5. Apply foam dressing to help absorb extra drainage and moisture while protecting the area.
6. This style of dressing can stay in for up to 3 days unless saturated or soiled and needs a change.
7. Turning and repositioning of the patient helps to promote healing to the area if we relieve pressure, and turning the patient hopefully prevents and stops a new pressure injury from forming.
8. The low-air-loss mattress is a good choice to help reduce the risk of a new pressure injury

(2 points)1

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

As stated above, I would recommend a low~~n~~ air loss mattress used with this patient. The mattress used at my facility fluctuates and allows the mattress to shift, and pressure is redistributed while the patient is in the bed. The other advantage of the air loss mattress can prevent excessive heat and moisture build-up under the patient, which helps to decrease the possibility of further injuries. For your own practice, do you have the source for this premise?

Working with Hillrom, the new Synergy Air Elite low air loss therapy mattress. The last in-service on this mattress, they were promoting how the new design allows the air to move more freely around the patient, which helps with the heat and moisture buildup. Thought this was a great advantage to this new mattress.

(2 points)2

5/8 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

(1 point)1

Wound Nurse recommendations/orders:
Reduce the amount of moisture the patient is being exposed to. Placement of a condom catheter and a fecal management system, if appropriate for this patient, to decrease the amount of moisture on the skin. Find a pain medication that works to help facilitate the patient's ability to be turned and repositioned in the bed. Order a low-air-loss mattress to help decrease the pressure being applied to the sacrum and other areas.

1. Clean sacrum with a pH-balanced cleanser.
2. Apply Zinc oxide to the sacrum not the best choice as this is denuded moist tissue and zinc ointment does not adhere well to denuded areas
3. Assess skin, turn and reposition, and check for incontinence every 2 hours you need better turning orders similar to those you wrote earlier
4. Keep skin dry this is a very general statement. *What* do you want the nurse to do?
5. Continue education to the patient about the effects of using pain medication, the importance of turning and repositioning to decrease the skin breakdown, and good nutritional intake to help increase healing potential.
   -What else could you suggest for this patient to mobilize him

1. Clean the area with a pH-balance cleanser.
2. Apply Aquaphor to the sacrum and coccyx area TID or after each incontinence episode.
3. Keep the patient's skin dry, check Q2 hours for incontinence episodes, and offer a urinal and bedside commode.
4. Turn and reposition patient Q2 hours right and left, and limit time on sacrum to back during meals for 30 minutes only.
5. Reduce the amount of linen under the patient to 1 fitted sheet and 1 pad for a total of 2 layers.
6. Place the patient on a low-air-loss mattress.
7. Consult physical therapy for the patient to help increase mobility.

(3 points)1

Rationale for choices: The patient is incontinent currently and is having moisture issues. We need to try and find a solution to control and decrease moisture. If possible, we can try to use a condom catheter for urine to reduce moisture this should be in your plan above then. If the stool is liquid, we can try a rectal pouch because collecting the stool vs. allowing it .....you are not providing actual rationales or monitor the patient more closely.ok The patient is having a complaint of pain and refusing to turn. We need to find out why they are having pain and better medication to help with the pain, to allow us to reposition the patient. He would benefit from a low-air-loss mattress not identified above to help with offloading the sacrum and other pressure points.

Patient is incontinent at this time. We need to implement a good plan of care for this patient. Addressing pain, mobility, and moisture issues. Looking into the pain and having the patient better medicated to want to move and participate in normal activities.
The skin needs to stay dry, checking the patient for moisture, checking every two hours, and offering him an opportunity to use a urinal or bedside commode. This will help to keep the patient off wet linens as well as encourage movement and a toileting schedule for the patient.
Limit the amount of linen under the patient to protect the skin and keep him dry. Reaching out to physical therapy to work with the patient to improve mobility while in the hospital.

1. Cleaning with a pH-balanced cleanser will help to get the skin's pH levels in the normal range.
2. Applying a petroleum-based barrier against the moisture.
3. Implement strategies to keep skin dry and start the patient on a toileting schedule.
4. Turning and repositioning the patient to prevent other pressure injuries from developing.
5. Reduce and limit the amount of linen to protect the skin from damage, moisture, and shearing.
6. Replacement to a higher level of mattress to help facilitate turning and reduce pressure to prominent areas on the body.
7. Consulting with therapy for the mobility of the patient.

(2 points)1.8

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

1. Clean the area with a ph balance cleanser.
2. Apply Mepilex dressing to the wound.
3. Change dressing every 3 days or PRN if soiled.
4. Assess the area daily and keep the skin dry. Do you have a source for removing the foam & looking at the wound without changing the dressing?

Since this is for treatment, the wound base should stay covered. We can look at the wound base daily, but it should not be done every 8 hours. That was a typo on my part at my facility. If it is a preventive dressing, we should be checking every 8. The treatment dressing is not checked that frequently.

(2 points)1.5

5.3/8 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: Pressure injury, Stage 4 this is also a specific type of PI **Medical device pressure injury**

(1 point).5

Wound Nurse recommendations/orders:

[1.] Clean the ear with normal saline. Change dressing every 3 days, but assess under the foam every 8 hours.- Do you have a source for removing the foam & looking at the wound without changing the dressing?

1.[2.] Apply a foam dressing, Mepitel Lite, to the ear. Do you mean Mepilex lite? This is not the same as Mepitel

2.[3.] Monitor patient and check the position of the head to ensure no additional pressure to the area, and the patient is being turned and repositioned every 2 hours. Yes, monitoring pressure on ear is important

3.[4.] Select a new area for the patient's pulse oximeter. If in an emergency, it is placed on the ear again, assess the area every 2 hours, and reposition the probe. The other ear?

1. Clean with normal saline.
2. Cover with a hydrocollid dressing and change every 3 days.
3. Monitor the patient and check the position of the head to ensure no additional pressure to the area, and maintain that the patient is being repositioned.
4. Select a new area for the patient's pulse oximeter. Use the patient's finger or toes. Assess the medical device every 8 hours.

(3 points)1

Rationale for choices:

1. It needs to be cleaned,? and the area protected with foam dressing. this is a wound that needs to heal too & what is the actual rationale
2. We need to discourage the use of the pulse oximeter being placed on the patients' ears and the importance of shifting and repositioning the probe more frequently to decrease the risk of injury. True

1. Cleaning the wound base of dirt and debris needs to be removed.

2. Hydrocolloid will help with drainage and keep the wound bed moist to help promote good granulation
3. Continue to monitor the area and make sure no more pressure is in the area.
4. Find a new placement of the pulse oximeter and access under the medical device to prevent another pressure injury.

(2 points)1

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

1. Clean the ear with normal saline.
2. Apply Xeroform cut to fit the wound base. xeroform is rarely a good choice for anything as it is petroleum based and does not really allow airflow + the antiseptic in this product is also not very strong and there are many better antimicrobials for wounds available
3. Apply 4x4 gauze and apply paper tape to the area. A 4x4 gauze is an open weave & bacteria can readily move thru this dressing. The petroleum dressing *may* impede this migration but this is a difficult site to treat.

1. Clean the ear with normal saline
2. Apply Mepilex Lite to wound.
3. Change every 3 days.

(2 points)1.8

4.3/8 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, Unable to tell what stage the injury is because of stable eschar, which could be stage 3 or a stage 4

(1 point)1

Wound Nurse recommendations/orders:

1. Leave stable eschar intact.
2. Protect the wound, apply ABD pads, and kerlix. why this? I thought to keep it covered and protected this area could have friction and rub against the sheets and mattress and did not want area to open up. Wanted to kept the eschar intact.
3. Keep the area dry.
4. Elevate the heel off the bed with pillows, heel offloading devices, or TruVue Heel protectors. Best to use an actual device as pillows are unreliable & like the DTPI this may resolve over time on its own if pressure removed
5. Consult the provider to have them assess the area.

1. Leave stable eschar intact.
2. Keep open to air and dry
3. Keep the heels elevated on heels up wedge, making sure the area is not touching or lying directly on the bed when possible, and reduce pressure to this injury.
4. Contact podiatry.

(3 points)1.5

Rationale for choices: why are you leaving this eschar intact? There is science behind this decision

The patient is an 85-year-old bedridden patient being taken care of by an elderly spouse. I do not have all of the information needed to see if we should do debridement in this area.NO based on these characteristics I do not know other comorbidities, diagnostic testing for arterial flow, or the nutritional status of this patient to know if they would have good healing potential. At this time, is area is intact without erythema and/or fluctuance. I feel this area should stay intact. The patient caregiver is also an elderly person so to complicate the care of the spouse and add the stress of a new wound, dressing, and give way to may have an infection from an open wound. I would advise not to open at this time unless the provider feels it is necessary or the area will heal. You do not have a rationale for the ABD & kerlix

Leaving the stable eschar intact acts as a protective barrier to this area. It allows the damaged tissue underneath to stay moist and promote healing. Keeping this area covered in eschar reduces and minimizes pain in this area, and the patient does not have pain while doing dressing changes. This eschar also acts as a shield,

helping protect the areas underneath.

1. We are leaving the area intact because it is showing no signs or symptoms of infection.
2. Leaving the area open to air the eschar is covering the damaged tissues, and it does not need a dressing at this time.
3. Need to keep the area offloaded, not to create any more pressure on this area, and limit the area from friction or injury that could reopen the wound.
4. Contact podiatry for them to access the area and see if any other interventions are needed at this time.

(2 points).2

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

1. Obtain the order and have enzymatic debridement cross-hatching.
2. Cleanse the wound with normal saline and dry it.
3. Apply an enzymatic debridement topical, a collagenase ointment Santyl nickel thick or 2mm to the entire wound surface or eschar area and avoid getting excess ointment on healthy skin.
4. Apply 4x4 gauze, ABD pad, and wrap with kerlix and paper tape to secure.
5. Daily dressing changes.

1. Apply betadine to the eschar and cover with ABD pad daily.
2. Keep the area elevated and offloaded to prevent pressure on the area.

(2 points)0-no this is not warranted at this time. What else could you do?

2.7/8 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: Stage 3/ surgical incision **This is a surgical wound and it is full-thickness**

(1 point) 0 **Is this a pressure injury?**

Wound Nurse recommendations/orders:

1. Clean the area with Vashe and dry well.
2. Apply 3m barrier film to the surrounding periwound skin.
3. Apply a protective contact layer over sutures with an oil emulsion
4. Apply transparent film like a window pane with a 3mm to 5mm border around the wound.
5. Cut black foam to fit into the wound to fit the wound base. You can place more than one piece into the wound but keep count of the pieces being placed in the wound. In your own practice always try to cut foam so you are only using one piece- it is possible more often than not!!
6. Apply a drape with the transparent film over the black foam and make sure that it is completely covered and you have a good seal.
7. Once covered, you need to cut a small opening about a quarter in size to attach the track to the black foam. Think about placement for the patient's movement, and think about the pressure the tube could cause, and avoid this.
8. Attach the drainage tube to the NPWT machine, making sure all tubing is connected, clamps are open, and no kinks in the tubes.
9. Make sure the machine is on and the setting is set to -75mmhg, and no leaks are found. For a wound such as this consider a lower pressure. Know why? A lower pressure to avoid injury to organs.
10. Be sure to fill out the wound packing log and make sure the correct protocols are followed.
11. NPWT dressing should be changed on Monday, Wednesday, and Friday.

(3 points)3

Rationale for choices:

The NPWT was ordered by the doctor. This is a good way to help promote wound closure and encourage wound healing. The area needs to be cleaned. Placing a contact layer over the sutures helps protect them as well when removing the foam for a change yes and limiting the risk of sutures being pulled on. Surrounding periwound skin needs protection and to be covered with a border to protect the healthy skin. Actually, this is not really necessary if 1. Skin prep is used 2. The foam is not out of the wound edges, 3. The seal is good so that leakage is not occurring. If we are really concerned about peri-wound skin, we could use a hydrocolloid or a stoma wafer around the wound which are a little more sturdy & may actually remain in place at the first dressing change. We need to limit the amount of black foam pieces and know the amount placed to be sure when it is changed again, we remove all objects in the wound base. The drape has to cover all of the black foam and have a good seal for the machine to work. The machine will alarm is there is not a good seal and you have a small leak. When applying a track on a patient, we must think of how they are moving and how we can place this to limit a

negative effect on a patient's mobility. It is also important to remember that this is now a tube that a patient could possibly get a pressure injury from, and we need to be vigilant on the placement and repositioning so no harm comes to the patient. The -125mmhg is the standard setting mostly used. We should be monitoring the area and make sure that this pressure is not causing harm or pain to the patient.

(2 points)2

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

1. Clean wound base with Vashe cleanser.
2. Apply a wet-to-dry dressing to the wound.
3. Gauze should be soaked in Vashe cleanser and lightly packed into the wound base.
4. Apply ABD pads and apply paper tape dressing should be changed every day or PRN when soiled.

Lisa, wet dressings are not EBP in today's wound world. Do they work? Yes, they may work especially when someone is healthy. But they are time consuming and difficult to work w in terms of keeping the wound moist. There are so many better options today and as specialists we should be moving our colleagues away from these dressings with a few exceptions.

1. Clean the wound base with Vashe cleanser.
2. Place Aquacel in the wound.
3. Cover with ABD pads.
4. Secure with paper tape.
5. Change dressing every other day or when it becomes soiled.

(2 points)0

5/8 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: Unstageable wound necrotic tissue **and some stage ? and .....**
Incontinence Associated Dermatitis
Unstageable wounds
Stage 2

(1 point).4 there are a at least 3 things going on here

Wound Nurse recommendations/orders:
Monitor patient's urine and bowel movements and decrease moisture in this area. If the patient is able to use alternative ways to keep patient dry. Are they a candidate for a condom catheter or a fecal pouching system? Would this patient benefit from a toileting schedule to try and decrease the moisture on the sacrum?

1. Clean area with pH-balanced cleanser.
2. Apply Santyl nickel thick or 2mm to the necrotic tissue area and avoid getting excess ointment on healthy skin.
3. Place a 4x4 gauze over the area.
4. Cover with a Mepilex Sacrum border dressing, change every day. Where are you going to adhere this dressing?
5. Apply zinc oxide to other areas of the sacrum. Not the best option
6. Turn and reposition the patient every 2 hours from right to left side, trying to avoid pressure to the sacrum and check moisture in that area. Yes
7. Order an air loss mattress for the patient because of a pressure injury to the sacrum and help prevent any new injuries. Yes

And there is a slightly bigger picture here based on his dx...

1. Clean area with pH-balanced cleanser
2. Insert Flexiseal and a condom catheter.
3. Apply A&D ointment to the sacrum.

4. Turn and reposition the patient every 2 hours from right to left side, trying to avoid pressure to the sacrum and limit time on this area.
5. Order an air loss mattress for the patient because of a pressure injury to the sacrum, and help prevent any new injuries

(3 points)1

Rationale for choices:

We need to treat the wounds to the sacrum, but we have to look at this patient and how we can limit the amount of moisture they have against the skin. Need to investigate why we have so much skin damage and how we can prevent more moisture and protect the area. Does this patient need more assistance to make it to the bathroom or need a toilet schedule to help keep the patient on track and dry. this is the rationale for your actions above

1. Clean the area and try to get back to a healthy pH value.
2. Insert Flexiseal and a condom catheter. This patient is having skin breakdown from all the moisture. Placing both of these products will help to prevent the skin from sitting in moisture.
3. Applying A&D ointment will allow a barrier to help protect the skin, and because it goes on clear, you can better monitor the open areas.
4. We need to continue to monitor the necrotic area, and we can watch to see how they evolve and place recommendations when areas open/ when the area is treatable.
5. When needed, turning and repositioning the patient to reduce the risk of any more injuries or pressure injuries to the sacrum, and this will also allow us to make sure the patient is staying dry and not sitting in wet linens.
6. The air loss mattress will allow the patient's weight to be shifted and pressure taken off of the bony prominence areas.

(2 points)0

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

1. Clean area with a pH-balanced skin cleanser.
2. Apply Medi honey to the necrotic area.
3. Apply gauze and Mepilex border sacrum.
4. Apply zinc oxide to the surrounding area.

1. Clean area with a pH-balanced skin cleanser.
2. Apply Medi honey to the necrotic area daily.
3. Apply gauze and foam tape to secure.
4. Apply A&D to the surrounding area.

(2 points)1 honey might work but do not put gauze & Mepilex over the honey---too many dressings. How can you adapt the above?

2.4/8 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: Stage 4 this is not classified as a pressure injury given the diagnosis of DM. What kind of ulcer is this?
Neuropathic Ulcer
(1 point)0

Wound Nurse recommendations/orders:

1. Clean wound with normal saline being gentle to the exposed tendon in the wound.yes
2. Apply oil emulsion to the exposed tendon and be sure to cover completely.
3. Apply Santyl to the slough in the wound avoiding healthy tissue and apply gauze. Actually you do not have to avoid healthy tissue w Santyl as it does not harm that tissue. Read the Santyl dressing info on the URL as there is a specific way to do this dressing
4. Place ABD pad and wrap foot with Kerlix and secure with an Ace bandage.
5. Change dressing daily.
6. Notify provider of any signs of infection.

1. Clean wound with normal saline, being gentle to the exposed tendon in the wound.
2. Apply oil emulsion to the exposed tendon and be sure to cover completely.
3. Apply Santyl the wound bed edges and apply a nickel-thick layer or 2mm.
4. Place the ABD pad and wrap the foot with Kerlix and secure with an Ace bandage.
5. Change dressing daily.
6. Notify the provider of any signs of infection.

(3 points)2

Rationale for choices:
The exposed tendon needs to be protected and kept moist. yes This is why we place a layer to cover the tendon. On the slough and necrotic areas we can apply Santyl to help with debridement this area. I chose to place an~~d~~ Abd pad over top to help not only pad and protect this area but because this area was noted to have drainage. All wounds need to be monitor for chance of infections and provider should be told straight away. Daily dressing will allow use to assess the area help with debridement and make sure the area is staying moist and has not

become infected. + Santyl is a daily dressing

(2 points)2

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

1. Clean wound with normal saline being gentle to the exposed tendon in the wound.
2. Apply oil emulsion to the exposed tendon and be sure to cover completely. You could also consider a silver hydrogel, or honey, with a non-oily contact layer & nonadherent dressing with a daily dressing initially
3. Cut to fit Aquacel Ag to cover area to help with debridement and moisture to the wound base. Aquacel or other alginates or hydrofibers are a little risky as you do not want the tendons to dry out.
4. Place ABD pad and wrap foot with Kerlix and secure with an Ace bandage.
5. Change dressing daily.
6. Notify provider of any signs of infection.

1. Clean the area with normal saline.
2. Apply a medihoney sheet cut to fit the wound base.
3. Apply Mepilex to cover and secure, and change every 3 days.

(2 points)1

5/8 points

References (3 points): 2 Lisa, just as we unbold things, the reference section should not be italicized except for the appropriate sections. Also, a Word document requires hanging indent and double spacing which does not mean double spacing between each entry but double spacing between each line. See my example below in purple.

Good references & great that you found the guideline for heel injuries!

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Lisa, highlight the two references below & then click on the arrow on the Home tab for the Paragraph section to see how you can set this automatically.

Nix, D., & Bryant, R. A. (2022). Fistula management. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 283-303). Wolters Kluwer.

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