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

Mini Case Scenarios: Wounds

Student Name _____Nian Wan_____ Date: _02/02/2026_____

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:

(1 point) Pressure injury – unstageable

Wound Nurse recommendations/orders:

(3 points)

Reposition every 2 hours – avoid pressure on sacrum
Use lateral position wedge for reposition
Order low air loss bed
Place Tru Vue heel protectors
Clean periwound with Vashe and dry
Apply 3M Cavilon No Sting skin barrier around periwound
Cut McKesson hydrogel wound dressing pad to size and place around wound
Apply sacral foam dressing over hydrogel wound dressing
Change daily using adhesive remover [3M No Sting adhesive remover] when removing dressing.
In surrounding buttocks, use pH balanced wipes, dry, and apply skin barrier to protect from moisture

Rationale for choices:

(2 points)

Repositioning prevents developing new pressure injuries and worsening existing
Low Air Loss bed helps to provide low-volume airflow and remove heat and water vapor away from skin (Mackey & Watts, 2022)
True Vue heel protectors prevent development of pressure injury on heels
Using lateral position wedges helps to position patient and avoid surface contact of sacrum
Skin barrier helps to protect skin from moisture
Hydrogel helps with autolytic debridement but requires a secondary dressing
Sacral foam dressing acts as secondary dressing and also provide additional protection
Per manufacturer should change dressing 1 to 3 days, changing daily allows for assessment.
Maintain area skin protection around buttocks, using pH balanced wipes and skin barrier help to prevent moisture associated dermatitis that increases risk for skin breakdown

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

Apply collagenase (Santyl) around sacral pressure injury and cover with sacral shaped silicon foam (ALLEVYN) dressing.

Daily dressing change:
Remove dressing using 3M No Sting adhesive remover
Wash area with warm water and dry
Apply skin barrier [3M No Sting skin barrier] around periwound
Apply collagenase (Santyl) directly to wound in thin 2mm layer
Cover with silicon foam dressing [ALLEVYN]
Reposition every 2 hours – avoid pressure on sacrum
Use lateral position wedge for reposition
Order low air loss bed
Place Tru Vue heel protectors
Surrounding buttocks, use pH balanced wipes, dry, and apply skin barrier to protect from moisture

(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:

(1 point) Pressure injury – Stage 1

Wound Nurse recommendations/orders:

(3 points)
Place silicon dressing on heel.
Relieve pressure immediately through using Tru Vue heel protectors (Storm, 2025)
Turn patient every 2 hours
Encourage patient to sit in chair and ambulate as soon as possible
Maintain nutritional intake and hydration to prevent further skin breakdown (Storm, 2025)
Utilize pressure relieving devices such as air cushion when patient sitting
Perform skin checks daily on heel and other bony prominences
Avoid head of bed greater than 30 degrees
Avoid massaging area

Rationale for choices:

(2 points)
Silicon dressing on heel and Tru Vue heel protectors prevent worsening pressure injury
Repositioning patient every 2 hours prevent new pressure injury as allow redistribution of pressure
Encouraging patient to sit and ambulate allows for redistribution of patient's weight
Maintaining nutritional intake and hydration helps to reduce risk for skin breakdown by preventing malnutrition and dehydration (Friedrich et al., 2022)
Avoiding head of bed greater than 30 degrees prevents worsening pressure injury on bony prominences and shear injury
Avoid massaging area to prevent worsening tissue injury (Borchert, 2022)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
ALLEVYN Gentle Border hydrocellular foam dressing and can leave up to 7 days per manufacturer.
Relieve pressure immediately through using Tru Vue heel protectors (Storm, 2025)

Turn patient every 2 hours
Encourage patient to sit in chair and ambulate as soon as possible
Maintain nutritional intake and hydration to prevent further skin breakdown (Storm, 2025)
Utilize pressure relieving devices such as air cushion when patient sitting
Perform skin checks daily on heel and other bony prominences
Avoid head of bed greater than 30 degrees
Avoid massaging area
(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 arterial disease [LEAD] ulcer

(1 point)

Wound Nurse recommendations/orders:

(3 points)

Culture wound for appropriate antimicrobial treatment
Apply skin barrier [3M No Sting Skin Barrier] around wound to protect from moisture and maceration
Apply 4x4 Mepilex on wound
Apply HyTape around Mepilex edges
Avoid other adhesives
Change Mepilex foam dressing every 3 days

Rationale for choices:

(2 points)

Ischemic wounds need frequent monitoring and infected wounds can be life and/or limb threatening without appropriate treatment (Bonham, 2022).
Occlusive dressings not recommended for ischemic wounds (Bonham, 2022).
If wounds demonstrate draining, slough, necrotic material, moisture retentive absorbent dressings indicated (Bonham, 2022).
Hy-Tape can be used on patients with LEAD, per manufacturer as will not strip skin and cause medical adhesive-related skin injury [MARSI]
Avoid adhesive dressings to prevent MARSI
Per manufacturer, can change foam dressing every few days up to one week. Want to have somewhat frequent change to monitor wound.

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

Culture wound for appropriate antimicrobial treatment
Apply skin barrier [3M No Sting Skin Barrier] around wound to protect from moisture and maceration

Apply hydrocolloid [DuoDerm] dressing on wound
Do not use adhesives around dressing
Change every 3 days.
Gently peel off dressing using 3M No Sting adhesive remover.
Wash around area with warm water and gently dry.
Apply skin barrier to prevent moisture [3M No Sting Skin Barrier]
Apply DuoDerm on wound. Gently press down with warm hand for 5 minutes
(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:

(1 point) Pressure injury – stage 3

Wound Nurse recommendations/orders:

(3 points)
Clean peri-wound with warm water and dry
Apply skin barrier [3M No Sting Skin barrier]
Apply silicone foam [Optifoam Gentle Ex 5x5] on wound.
Change dressing every 3 days
Reposition every 2 hours
Order wedge [HOVERMATT PROSWedge, 30 degree turning angle]
Order True Vue heel protectors
Order low air loss bed
Head of bed 30 degrees or less
Dietary referral to perform nutritional consult to ensure that patient's nutritional intake remains adequate

Rationale for choices:

(2 points)

Clean around periwound area and maintain dry to prevent maceration.
Apply foam dressings that are appropriate for moderate exudate and promote autolysis that can help remove the small amount of slough (Jaszarowski & Murphree, 2022).
Dressing change ever 3 days per manufacturer.
Heel protector to prevent additional pressure injury
Wedges to prevent additional pressure injury and prevent pressure onto sacral area (Mackey & Watts, 2022)
Low air loss bed helps to assist with microclimate control – remove heat and water vapor from skin and redistributes pressure (Mackey & Watts, 2022)
Head of bed 30 degrees or less to prevent shear or friction skin injury (Edsberg, 2022).
Nutritional management remains essential part of pressure injury prevention and treatment (Borchert, 2022)

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

(2 points)

Low air loss bed. This bed features airflow to assist in managing heat and humidity as well as continuous airflow for even distribution across the skin (Mackey & Watts, 2022). This helps to reduce moisture and prevent skin damage from incontinence-associated dermatitis or maceration (Mackey & Watts, 2022). The patient appears to only have one stage 3 ulcer and thus air fluidized mattress is not an appropriate option at this time (Mackey & Watts, 2022).

/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:

(1 point) Pressure injury – stage 2

Wound Nurse recommendations/orders:

(3 points)
Reposition every 2 hours
Clean peri-wound with warm water and dry
Clean when patient is incontinent of urine and stool
Place urinal close to patient so can urinate when needed.
Place commode close to patient so can defecate when needed
Apply skin barrier [3M No Sting Skin barrier]
Apply sacral hydrocolloid dressing [Tegaderm hydrocolloid sacral dressing]
Can leave up to 7 days per manufacturer.
Reposition every 2 hours
Order wedge [HOVERMATT PROSWedge, 30 degree turning angle]
Order True Vue heel protectors
Head of bed 30 degrees or less
Dietary referral to perform nutritional consult to ensure that patient's nutritional intake remains adequate

Rationale for choices:

(2 points)
Patient is alert and oriented, and may be able to urinate if urinal and commode next to bed to prevent incontinence that contributes to skin injuries (Edsberg, 2022).
Reposition every 2 hours redistributes pressure in tissue and skin.
Per manufacturer, adhesive dressing continue to adhere and protect wound in presence of incontinence.
Long wear time provides undisturbed wound environment to enhance healing, per manufacturer.
Skin barrier helps to reduce moisture-related skin injury and maceration.
Wedge helps to reposition patient to avoid pressure directly on sacrum.
Head of bed less than 30 degrees of less helps prevent shear and friction injuries (Edsberg, 2022).

Nutritional management remains essential part of pressure injury prevention and treatment (Borchert, 2022)
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order. Reposition every 2 hours Clean peri-wound with warm water and dry Clean when patient is incontinent of urine and stool Place urinal close to patient so can urinate when needed. Place commode close to patient so can defecate when needed Apply skin barrier to surrounding periwound [3M No sting skin barrier] ALLEVYN gentle border sacral foam dressing. Can leave for up to 7 days, per manufacturer. Order wedge [HOVERMATT PROSWedge, 30 degree turning angle] Order True Vue heel protectors Head of bed 30 degrees or less Dietary referral to perform nutritional consult to ensure that patient's nutritional intake remains adequate **(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:

(1 point) Medical device-related pressure injury

Wound Nurse recommendations/orders:

(3 points)

Rotate/move the sensor to other ear, finger, or forehead every 2 to 4 hours (Pennsylvania Patient Safety Advisory, 2005).
Check skin integrity every 2 to 4 hours when changing for redness, warmth, or pain.
Use appropriate size monitor and do not tighten clip (Pennsylvania Patient Safety Advisory, 2005).
Use silicone mesh dressing to redistribute pressure without interfering with readings (Pennsylvania Patient Safety Advisory, 2005).
Consider monitors that rest against skin versus clipping on to skin (Pennsylvania Patient Safety Advisory, 2005).
Cut small hydrogel sheet to cover wound located on helix [McKesson hydrogel sheet]
Tape with Mefix tape
Use 3M no sting adhesive remover when removing adhesive.

Rationale for choices:
(2 points)

Rotating sensor helps to prevent tissue ischemia that causes pressure injuries.
Checking skin integrity every 2 to 4 hours when changing sensor helps to monitor and prevent injury, which is an important component to pressure injury prevention (Borchert, 2022)
Hydrogel is highly conformable and can permeable – can help absorb minimal exudate and does not stick to wound (Woundsource Product Guide, n.d.)

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

(2 points)
Rotate/move the sensor to other ear, finger, or forehead every 2 to 4 hours (Pennsylvania Patient Safety Advisory, 2005).
Check skin integrity every 2 to 4 hours when changing for redness, warmth, or pain.
Use appropriate size monitor and do not tighten clip (Pennsylvania Patient Safety Advisory, 2005).
Consider monitors that rest against skin versus clipping on to skin (Pennsylvania Patient Safety Advisory, 2005).
Clean periwound with warm water and dry.
Cut telfa pad to size of wound located on helix.
Tape with Mefix tape
Use 3M no sting adhesive remover when removing adhesive.

/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:

(1 point) Eschar – unstageable

Wound Nurse recommendations/orders:

(3 points)

Keep eschar dry
Do not cleanse with water or normal saline (Triplett, 2024)
Apply povidone to the wound to prevent infection (Triplett, 2024)
Wrap eschar with kerlix to keep dry.
Maintain pressure relief via Tru Vue heel protectors
Consult with dietary that patient has adequate nutrition and hydration status.

Rationale for choices:

(2 points)

Maintain dry eschar that that helps protect the wound from infection.
Avoid water or normal saline to maintain dryness and povidone helps to disinfect while dry the eschar.
Avoid pressure on the heel.
Nutrition and hydration essential for wound healing Nutritional management remains essential part of pressure injury prevention and treatment (Borchert, 2022)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
The eschar does not actually require dressing but to be kept clean and dry.
After povidone application, ensure eschar dry.
Place foot in True Vue heel protector
(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:

(1 point) Dehisced abdominal wound

Wound Nurse recommendations/orders:

(3 points)

Prepare by premedicating patient approximately 30 minutes prior to initiating wound vac change.
Perform the following (3M V.A.C. Therapy, n.d.):

- Obtain 3M V.A.C. dressing kit [SensaT.R.A.C. Pad, V.A.C. Drape, V.A.C. Granufoam Dressing]
- Cut foam dressing [VAC Granufoam Dressing] to the wound size where the foam pieces fill inside the wound – avoid going outside the wound.
- Place foam dressing into wound.
- Cut drape [VAC Drape] to cover the foam dressing. Peel back layer 1 and place down on foam dressing and wound, peel back layer 2, and separate perforated layer 3.
- Identiy the site for the SensaTRAC Pad and cut a 2.5 cm [size of quarter] hole in layer.
- Remove backing layer 1 and layer 2 from the pad and place the center over the 2.5 cm hole.
- Pull blue tab to remove stabilization layer.
- Connect SensaTRAC Pad tubing to the cannister tubing
- Turn on power to 3M V.A.C. Therapy Unit

Initiate -125 mmHg to begin setting.
Wound V.A.C dressing change every 48 to 72 hours per manufacturer.
If wound therapy alarm more than 2 hours, remove the dressing, and apply a new sterile dressing: hydrogel sheet [3M Kerralite Cool Moisture Balancing Hydrogel Dressing], cut to fit over wound, apply skin barrier [3M No Sting Skin Barrier] over periwound, cover with 5x9 ABD pad and tape with Mefix tape.
Inform ostomy and wound service that dressing V.A.C. had been turned off and dressing changed.
Consult with dietary for caloric and hydration needs
Ensure Tru Vue heel protectors on.
Reposition every 2 hours.

Rationale for choices:
(2 points)

Provided step-by-step on how to set up wound V.A.C. for nursing
Studies show pressure between -75 mmHg and -150 mmHg promote healing more quickly than other pressures, and so start at -125 mmHg
If unit off for more than 2 hours, per manufacturer, remove the dressing and place new one. Place hydrogel and secondary dressing that keeps wound bed moist.

Nutrition important for wound healing and ensure that nutrition is adequately addressed (Bonham, 2022). Reposition and heel protection to prevent pressure injury.
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order. If wound vac turned off more than 2 hours, remove dressing. Apply skin barrier [3M No Sting skin barrier around periwound] Cut hydrogel sheet 3M Kerralite Cool Moisture Balancing Hydrogel Dressing] to size of wound, cover with 5x9" ABD pad, and tape with Mefix tape. Per manufacturer, dressing change every 24 to 72 hours. Another alternative: Apply silicone foam dressing along the length of patient's wound Secure with Mefix tape. Can leave up to 7 days, per manufacturer. **(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:

(1 point) Pressure injury and incontinence-associated dermatitis

Wound Nurse recommendations/orders:

(3 points)
Initiate contact precautions
Gently wash coccyx area with pH balanced cleanser.
Dry with soft cloth.
Apply stomahesive powder and dust off
Then apply skin barrier [3M No Sting Skin Barrier]
Apply silicone sacral foam dressing [Dimora silicone foam dressing].
Change every 3 days per manufacturer.
Clean buttocks and perineal area daily and after incontinence episodes.
Place superabsorbent under pads beneath patient
Tru Vue heel protectors
Place bed wedges under patient when reposition patient every 2 hours
Consult nutrition to ensure patient caloric intake and hydration satisfactory.

Rationale for choices:

(2 points)

Both pressure injury and IAD may be present at the same time – patient has necrotic area on bony prominence [sacrum] as well as weepy sores indicative of IAD (Clinical Excellence Commission, New South Wales, Australia, 2021)
Patient has *Clostridium difficile* and contact precautions for infection prevention.
Washing coccyx with pH balanced cleanser, dry with soft cloth, and crusting helps to cleanse skin and apply skin barrier to protect skin from exposure to urine/feces (Clinical Excellence Commission, New South Wales, Australia, 2021)

Skin barrier application superior to zinc oxide in randomized study (Baatenburg de John & Admiraal, 2004)
Placing superabsorbent under pads helps to keep moisture from skin
Cleaning skin daily and after incontinence episodes help to keep skin clean and urine/feces from disrupting skin microclimate that can cause IAD and increase skin injury (Clinical Excellence Commission, New South Wales, Australia, 2021)
Silicone sacral foam dressing helps to prevent urine/feces contaminating wound and maintain moist environment for healing as well as protect area from developing pressure injury as IAD leaves skin vulnerable to breakdown from friction and shear (Clinical Excellence Commission, New South Wales, Australia, 2021)
Prevention of pressure injuries around bony prominences using heel protectors, wedges, and repositioning every 2 hours.
Nutrition important for wound healing and ensure that nutrition is adequately addressed (Bonham, 2022).

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Initiate contact precautions
Gently wash coccyx area with pH balanced cleanser.
Dry with soft cloth.
Apply stomahesive powder and dust off
Then apply skin barrier [3M No Sting Skin Barrier]
Apply hydrocolloid dressing [3M Tegaderm hydrocolloid dressing] on sacral pressure injury.
Change every 3 days per manufacturer.
Clean buttocks and perineal area daily and after incontinence episodes.
Place superabsorbent under pads beneath patient
Tru Vue heel protectors
Place bed wedges under patient when reposition patient every 2 hours
Consult nutrition to ensure patient caloric intake and hydration satisfactory.

(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)
Hypoxia and poor perfusion leading to ischemic necrosis and epibole leading to stalled wound.

Wound Nurse recommendations/orders:

(3 points)
Clean periwound with warm water and dry.
Apply skin barrier [3M No Sting Skin Barrier] on periwound
Scrub closed wound edges with monofilament [Debrisoft]
Apply hydrogel over wound [SOLOSITE] over wound.
Cover with foam dressing [ALLEVYN gentle foam]
Change dressing every 2 days per hydrogel manufacturer and remove using sterile saline or wound cleanser to remove old gel.
Maintain appropriate blood sugar levels.
Consult with nutrition for adequate nutrition and hydration.

Rationale for choices:

(2 points)

Maintaining clean periwound and barrier helps to treat current eliminate future epibole (Pearls for Practice, 2009).
Scrubbing with monofilament contributes to help body remove epibole and this debridement essential for continued wound healing (Deng et al., 2023)
Hydrogel helps keep tendons moist and foam dressing covered to reduce injury to tendon and begin tissue granulation (Triplett, 2025).
Tight blood sugar control important in wound healing process (Bonham, 2022).
Nutrition and hydration important in wound healing

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Clean periwound with warm water.

Apply skin barrier [3M No Sting Skin Barrier] around periwound
Scrub closed wound edges with monofilament [Debrisoft]
Cut PolyMem Max Foam wound dressing to shape of wound and place in wound bed (Triplett, 2025).
Wrap foam and foot in Kerlix.
Per manufacturer, dressing change every 3 days.

(2 points)

/8 points

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