NR33 WOUND MANAGEMENT

Critical Thinking Strategies

Scenario 1

Jane Smith, a 30-year-old obese female had a cholecystectomy (gallbladder removal) 3 days ago. Her gallbladder symptoms began 6 months ago, but the physician wanted her to lose weight before the surgery. She has developed a postoperative infection and now requires wound care and dressing changes. You are assigned to care for Mrs. Smith for your clinical experience.

1. While preparing for your clinical experience, you remember that healing takes place in the following three major phases. Label them in the correct order from 1 to 3.
   a. _____ Proliferative or granulation
   b. _____ Maturation or wound remodeling
   c. _____ Inflammatory

2. If Mrs. Smith’s wound becomes infected, healing takes place by ________ intention healing.
   a. Primary
   b. Secondary
   c. Tertiary

3. In addition to the obvious obesity factor, circle **three** of the following factors that might have affected wound healing in Mrs. Smith’s condition.
   a. Physical health
   b. Nutrition
   c. Pedal pulses: 2+
   d. Past medical history of fracture
   e. Medications she is taking

4. Select **three** of the following signs or symptoms that would indicate that Mrs. Smith has a wound infection.
   a. Vital sign changes
   b. Serosanguineous discharge
   c. Tender and edematous area surrounding incision
   d. Reddened area surrounding incision
   e. Serum albumin: 4.0 g/dL

5. Select **five** goals of wound care from the following.
   a. Moisten the surrounding skin
   b. Remove necrotic tissue
   c. Absorb drainage
d. Protect wound from further injury  
  e. Maintain moist wound environment  
  f. Prevent scar formation  
  g. Prevent or control infection  

6. What are the possible nursing diagnoses when caring for clients with stressors of skin integrity/wounds? Select five of the following.
  a. Impaired skin integrity  
  b. Risk for infection  
  c. Risk for aspiration  
  d. Pain  
  e. Body image disturbance  
  f. Nutrition: More than body requirements  
  g. Knowledge deficit

7. You are preparing to complete a dressing change for Mrs. Smith. Place in sequence from 1 to 10 the activities you perform. (An activity may be performed more than one time.)
   a. ___ Remove old dressing  
   b. ___ Don sterile gloves  
   c. ___ Prepare a sterile field  
   d. ___ Obtain a wound culture specimen  
   e. ___ Don clean gloves  
   f. ___ Wash your hands  
   g. ___ Cleanse the wound  
   h. ___ Apply sterile dressing  
   i. ___ Discard clean gloves  
   j. ___ Discard sterile gloves

8. When putting on sterile gloves, the most important concept to remember is to keep both gloves in ________ of you and above your ________.

9. Which hand is usually placed in a sterile glove first?
   a. Dominant  
   b. Nondominant

10. While setting up a sterile field, guidelines need to be followed to maintain sterility. Circle T if the guideline is true or F if the guideline is false.
    T    F    a. Never turn your back on a sterile field.
    T    F    b. Avoid talking, coughing, sneezing, or reaching across a sterile field.
    T    F    c. When putting on sterile gloves, the second glove may be pulled on by grasping the edge of the folded cuff with the sterile gloved hand.
T F d. Do not spill solutions on the sterile field.
T F e. When opening sterile wrappers, open the first edge toward you.
T F f. When placing medicine cups on a sterile tray, they should be placed near
the center of the field.
T F g. Open all sterile packages away from the sterile field to prevent crossover
and contamination.

11. You are preparing the sterile field. Which of the following methods of transferring
articles onto the sterile field are valid? Select two.
   a. Using sterile gloves
   b. Using clean gloves
   c. Dropping sterile packages onto the field, unpacking and removing contents
   d. Open sterile packages and dropping contents onto the sterile field

12. When cleaning Mrs. Smith’s wound, you start at the __________ area and work toward
the __________ area.

13. When placing the sterile 4x4 gauze pads on Mrs. Smith’s incision, you did not cover the
incision as you intended. You should (choose one):
   a. Remove the gauze pads and replace them with new pads.
   b. Adjust the pads to cover the incision.
   c. Place an additional pad over the exposed area of the incision.
   d. Leave the gauze pads in place and apply an ABD over them.

14. Choose whether the following statements apply to wet-to-damp dressings or wet-to-dry
dressings.
   a. The purpose of the __________ dressing is to debride and clean the wound, via
atraumatic mechanical debridement.
   b. The purpose of the __________ dressing is to debride the wound, via aggressive
mechanical debridement. It can be painful and requires frequent dressing
changes.

15. You are changing Ms. Smith’s wet-to-damp gauze dressing. The dressing adheres to the
wound bed. Choose which one of the following actions should be performed.
   a. The dressing should be moistened with saline to remove the dressing.
   b. The dry dressing should be removed slowly yet deliberately. If the dressing is
extremely dry, a small amount of saline to loosen the dressing is indicated.

16. You are ambulating Mrs. Smith down the hall 7 days after the surgery when she suddenly
coughs and a dehiscence occurs. Your first action is to:
   a. Place her in a supine position
   b. Call the doctor
   c. Obtain the vital signs
   d. Cover the wound with a sterile dressing
Scenario 2

Mrs. Johnson is an 84-year-old retired school teacher who was widowed 10 years ago and now lives alone, excepting monthly visits by her grandchildren. She developed diabetes mellitus at the age of 58. She has been in failing health for the last 3 years and has been at home with the assistance of home health aides and weekly visits by the RN. Her coccyx area has had frequent skin breakdown. The Homecare RN determined she now has a stage III pressure ulcer as a result of her being on bedrest the past week. She is being admitted to the hospital for treatment of the ulcer.

1. Which of the following are risk factors for Mrs. Johnson developing pressure ulcers? Select five.
   a. Age: 84 years
   b. Occasional contact with children
   c. Bed rest for past week
   d. Former school teacher
   e. History of diabetes mellitus
   f. Lives alone: nutrition and hygiene concerns
   g. Inability to care for self when health aide/RN is not present

2. Select five other risk factors for pressure ulcers that are important during hospitalization.
   a. Respiratory condition
   b. Impaired sensory perception
   c. Decreased mental status
   d. Friction & shearing forces on skin
   e. Albumin < 3.5
   f. Lymphocyte count > 1800
   g. Moisture on skin

3. Pick from the following areas of the body the four that are most vulnerable to the formation of pressure ulcers.
   a. Calves
   b. Trochanter
   c. Sacrum
   d. Heels
   e. Toes
   f. Outer ankles
   g. Lips
4. Pick three valid reasons for elderly clients’ higher susceptibility to pressure ulcers.
   a. They have chronic illnesses
   b. Diets may be deficient in protein, minerals, and vitamins
   c. Weaker joints
   d. Vascular insufficiency
   e. Impaired tissue regenerative ability

5. Which of the following interventions is most beneficial in preventing formation of a pressure ulcer (choose one)?
   a. Keep skin dry by applying benzoin or alcohol around reddened areas.
   b. Ensure fluid intake of at least 2000 mL each day.
   c. Elevate head of bed to prevent pressure on coccyx and heels.
   d. Change chux under client each shift.

6. Label each definition with the corresponding pressure ulcer stage: I, II, III, or IV.
   a. Stage ____ : Tissue damage involves the epidermis (or both), usually caused by friction or moisture plus pressure
   b. Stage ____ : Defined area of persistent redness in lightly pigmented areas
   c. Stage ____ : Damage or necrosis of subcutaneous layer
   d. Stage ____ : Tissue damage involves muscle, bone, or tendon

7. Identify the three most effective treatments for the stage III pressure ulcer.
   a. Transparent adhesive film
   b. Hydrocolloid dressing
   c. Hydrogel
   d. Hydrophilic foam dressings
   e. Irrigation with a 10cc syringe

8. In addition to dressing changes, identify two preventative therapies that should be used for clients at high risk for pressure ulcers.
   a. Use of specialized beds such as low air-loss or air-fluidized
   b. Maintain head of bed >30°
   c. Warm-up® Therapy system
   d. Use of plastic chuxs
   e. Elevate heels by placing pillow underneath heel

9. True or false: Massaging bony prominences should be avoided for clients at risk for pressure ulcer formation.
   a. True: It can lead to deep tissue trauma.
   b. False: It can beneficially increase circulation.
Scenario 3

A young client was in a motor vehicle accident and has numerous wounds on his buttocks, back, and both legs. He is in extreme pain and is on a PCA pump with Morphine Sulfate for pain control. He is able to respond to questions. His vital signs are: BP 140/88, P. 110, R. 26, O₂ Sat 96% on room air.

1. When assessing the client’s wounds, what **three** topics are most important to discuss with the client to determine his history and physical findings that contribute to his treatment?
   a. History and physical findings associated with his usual health and any current medical diagnosis
   b. Living condition
   c. Current and recent medications
   d. Nutritional assessment and hydration status

2. The assessment and evaluation of wounds and their management is the role of the (pick one):
   a. Physician
   b. RN
   c. LVN/LPN and RN
   d. RN and physician

3. Which observations are important when determining the extent of the wounds? Select all that apply.
   a. Assess location.
   b. Observe the color of the wound: black, yellow, or red.
   c. Assess level of moisture.
   d. Type and odor of the wound exudates.
   e. Current type of dressing.
   f. Tissue viability and absence/presence of necrotic tissue.
   g. Periwound conditions and extent of pain.
   h. The length, width, and depth of the wound.

4. The physician has determined that the Negative Pressure Wound Therapy protocol would be the most beneficial treatment for the leg wounds. What would be **two incorrect or insufficient** criteria for such a decision?
   a. Client is nutritionally stable
   b. Client is able to use the device 22 hours each day
   c. Client is ambulatory
   d. Surrounding area is at least 2 cm of periwound tissue
   e. Wound is open enough to insert foam dressing that touches all edges
   f. Wound produces a large amount of odorous discharge
g. Sufficient circulation is available to assist in the healing process
h. The wound is debrided

5. Negative pressure wound therapy will **not** be used for which of the following clients? Clients with (select **one**):
   a. Traumatic wounds
   b. Necrotic tissue and eschar
   c. Pressure ulcers
   d. Dehisced wounds.

6. The patient’s wound has been dressed and is in the process of healing. You are assigned to perform a dressing change. Choose **eight** items that **must** be documented during a dressing change.
   a. Observation of wound site, including amount, color and odor of drainage, as well as appearance of suture site.
   b. Current patient diet
   c. Observation of granulating tissue and redness.
   d. Patient’s tolerance of procedure
   e. Observation of surrounding skin, document any undermining and size of wound
   f. Changes in VS that may indicate infection
   g. Patient’s ROM and muscle strength
   h. Type of dressing applied
   i. Material used in wound packing
   j. Observations on wound irrigation, type of solution used