

R.B. Turnbull, Jr. MD School of WOC Nursing Education

Mini Case Studies: Wounds



Student Name & Date: \_\_

Reviewed by: \_\_\_\_\_

Score: /33

For the following wound case scenarios:

- ❖ Identify type of wound pictured.
- ❖ Apply wound characteristics provided to identify a topical therapy plan for the patient.
  - ❖ Be specific with dressings- Write this like a nursing order. Identify dressings with type and brand name(s). If a secondary dressing is needed, make sure it is included. Include a dressing change schedule.
- ❖ Provide a possible alternative to your initial dressing choice. This should be a product substitution, not simply a brand name substitution.
- ❖ The first case study has been completed for you below as an example

Scenario 1



85 year old arrives to the acute care setting from an extended care facility with 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

**Topical Therapy (Dressing selection):** Cleanse with normal saline and gently pat dry. Apply mesh contact layer (Hollister Adaptic) and cover with dry gauze and wrap with rolled gauze (Kerlix). Change daily and PRN.

**1 alternative product:** Non-adhesive foam dressing (Allevyn) secured with elastic mesh dressing (Medline elastic retention dressing).

Scenario 2



**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. 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

**Topical Therapy (Dressing selection):** Initiate strict turning schedule, nutritional assessment and incontinence management.

Clean wound bed and surrounding periwound area with normal saline and pat dry

Apply 3M no sting skin barrier to periwound approximately the size of the dressing

Apply Duoderm CGF and warm edges for 30-60 seconds to assist with bonding

Change dressing every 3 days, sooner for soiling

Use ph balanced no rinse soap for incontinence between showering, may shower with dressing if edges intact

**1 alternative product:**

Clean wound bed and surrounding periwound area with normal saline and debris soft lolly using medium pressure for 3 minutes, pat dry

Apply 3M no sting skin barrier to periwound approximately the size of the dressing

Apply 3M Tegaderm Hydrogel to wound bed and cover with Mepilex border

Change every 3 days, sooner for soiling

Use ph balanced no rinse soap for incontinence between showering, may shower with dressing if edges intact

Scenario 3



The wound care nurse is consulted to see a 54 year old, post op day 4 of an abdominal surgery. Left heel has non-blanchable purple discoloration.

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

**Wound type: Deep tissue pressure injury**

**Topical Therapy (Dressing selection):**

**Prevalon boots for offloading, no dressing required**

**Strict turning schedule**

**NWB affected extremity**

**Nutritional consult**

**1 alternative product: May apply Mepilex border heel foam dressing and change every 3 days and prn**

**Strict turning schedule**

**NWB affected extremity**

**Nutritional consult**

Scenario 4



The wound care nurse is consulted to see a 66-year-old who developed non-blanchable erythema on right sacrum after being on bedrest for the past 24 hours.

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

**Wound type:** Stage 1 pressure injury

**Topical Therapy (Dressing selection):**

Strict turning schedule

PH Balanced no rinse skin cleanser

Apply Allevyn silicone border dressing and change every 3 days and prn after soiling

Nutritional consult

Assess area every shift

**1 alternative product:**

Strict turning schedule

PH Balanced no rinse skin cleanser

Apply Aloe Vesta twice daily in a thin layer and prn after soiling

Nutritional consult

**Assess area every shift**

Scenario 5



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

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

**Wound type:** Venous stasis ulcer

**Topical Therapy (Dressing selection):**

Cleanse skin with Vashe skin wash

Apply zinc oxide cream to surrounding periskin

Apply Drawtex to the wound bed and cover with gauze and ABD, secure with rolled gauze

Apply edema wear

Change dressing daily

Elevate lower extremities twice daily for 1 hour

**1 alternative product:**

Cleanse skin with Vashe skin wash

Apply zinc oxide cream to surrounding periskin

Apply Aquacel Extra Hydrofiber to the wound bed and cover with gauze and ABD, secure with rolled gauze

Apply edema wear

Change dressing daily

Elevate lower extremities twice daily for 1 hour

Scenario 6



A 85 year old is admitted to the hospital with a stage ??? pressure injury on sacrum.

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, bone noted. Wound has serosanguinous drainage.

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

**Wound type:** Stage 3 (full thickness) pressure injury

**Topical Therapy (Dressing selection):**

**NPWT V.A.C. if patient goals are not palliative, change every M, W, F. Wash wound with Vashe and scrub with medium pressure using Debrisoft lolly for 3 minutes for each dressing change.**

Strict turning schedule

Nutritional consult

Gel overlay for bed

**1 alternative product: Wash wound with Vashe and scrub with moistened gauze for 3 minutes using medium pressure. Apply skin protectant**

**Fill wound bed with Hydrofera Blue and cover with Mepilex Sacral border dressing**

**Change every 3 days and prn for soiling**

Strict turning schedule

Nutritional consult

Gel overlay for bed

Scenario 7



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:** Arterial Ulcer- Referral for immediate Vascular consultation and to determine if adequate blood flow exists to heal this wound. ABI may be falsely elevated r/t DM. NO DEBRIDEMENT. Will need A1C and CBC, rehydrate if increased HCT.

**Topical Therapy (Dressing selection):**

- Wash with Vashe and pat dry.
- Protect periskin with Mastisol
- Apply Adaptic to exposed tendon
- Apply Cadexomer Iodine impregnated dressing to the wound bed
- Cover with dry gauze
- Wrap and secure with dry gauze roll
- NWB status r/t DM, no shoes to avoid pressure

1 alternative product: Wash with Vashe and pat dry.

- Protect periskin with Mastisol
- Apply Adaptic to exposed tendon
- Apply Aquacel to the wound bed
- Cover with dry gauze
- Wrap and secure with dry gauze roll
- NWB status r/t DM, no shoes to avoid pressure

Scenario 8



**56 year old hospitalized for cardiac surgery. During the hospital stay, developed a blister related to pressure on right heel. The blister has now ruptured.**

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

**Wound type:** Partial thickness pressure injury

**Topical Therapy (Dressing selection):**

Clean with NS and pat dry  
Apply clear film dressing and change every 2-3 days.  
Offloading

**1 alternative product:**

Clean with NS and pat dry  
Apply Mepilex border dressing and change every 2-3 days.  
Offloading

Scenario 9



**82 year old arrives to the acute care setting with a pressure injury on the right ischium. Patient has been cared for at home by spouse and spends many hours per day in a wheelchair.**

**The wound measures approximately 6 cm x 8cm x 2 cm Wound bed 80% pink tissue with bone visible. Small amount of tan drainage noted with assessment. Periwound intact.**

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

**Wound type:** Stage 4 pressure injury- Xray for osteomyelitis, wound culture

**Topical Therapy (Dressing selection):**

**Cleanse the wound bed and periskin with wound wash**

**Apply adaptic over exposed bone and any other identified structures**

**Protect periwound with clear film, apply NPWT V.A.C. to intermittent setting, change every M, W, F**

**Nutritional consult**

**Repositioning schedule with bed rest**

**Continence assessment**

**1 alternative product:**

**Cleanse the wound bed and periskin with wound wash**

**Protect periwound with Mastisol**

**Apply Kaltostat rope to loosely fill dead space**

**Cover with ABD and secure with skin safe tape.**

**Change daily.**

**Nutritional consult**

**Repositioning schedule with bed rest**

**Continence assessment**

Scenario 10



**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 pink with small areas of yellow tissue (Less than 10% of wound base). Periwound skin intact without erythema.**

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

**Wound type:** Surgical Dehiscence

**Topical Therapy (Dressing selection):**

- Cleanse with NS
- Protect periwound with Mastisol
- Fill wound bed with Aquacel
- Cover with dry gauze and ABD and secure with skin safe tape
- Change daily and PRN for drainage

**1 Advanced therapy alternative product: (CSWD to remove slough by LIP)**

- Cleanse with NS
- NPWT V.A.C. set to intermittent
- Protect periwound with clear dressing
- Change every M, W, F

Scenario 11



**Wound care nurse consulted to see a 56 year old with a “sore bottom”. Patient has been at your facility for 2 weeks with diagnosis of C-Diff. Today you have been consulted for a treatment plan for damaged skin.**

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

**Wound type:** Moisture Associated Contact Dermatitis (IAD Category I)

**Topical Therapy (Dressing selection):**

**Cleanse area with no rinse ph balanced soap, do not rub hard**

Apply Calmoseptine BID and prn

Do not need to remove completely between applications

Repositioning schedule

**1 alternative product:**

**Cleanse area with no rinse ph balanced soap, do not rub hard**

**Apply 3M No Sting skin barrier to area**

**Reapply every 12-24 hours**

Repositioning schedule

Scenario 12



A 85 year old presents to acute care with dry black eschar on left posterior heel. Cared for at home by elderly spouse and 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- Assess patient goals for wound healing to determine if surgical consult is warranted

**Topical Therapy (Dressing selection): (To be performed by state approved licensed personnel)**

Clean with NS

Crosshatch necrotic wound bed

Apply Santyl ointment to necrotic tissue with a nickel thickness

Cover with Mepilex border dressing

Offloading with Prevalon boots

Change daily

**1 alternative product:**

**Surgical debridement if appropriate followed by NPWT with M, W, F dressing changes**

Nutritional consult

Offloading