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

Mini Case Studies: Wounds

Cleveland Clinic

Student Name _____Jennifer Lemert_____ **Date:** ___10/14/2023_____

Reviewed by: _____ **Date:** _____

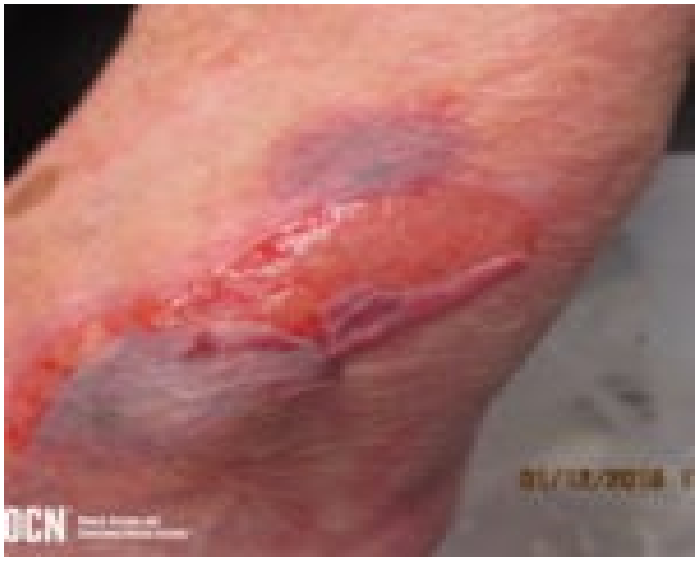
Score: /33

For the following wound case scenarios:

1. Identify the type of wound pictured.
2. Apply wound characteristics provided to identify a topical therapy plan for the patient. Be specific with dressings.
3. Write this like a nursing order & include the following
   a. *Type of dressing*
   b. *Brand name(s)*
   c. *Secondary dressing if needed*
   d. *Dressing change schedule*
4. 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

(0.5 pts)

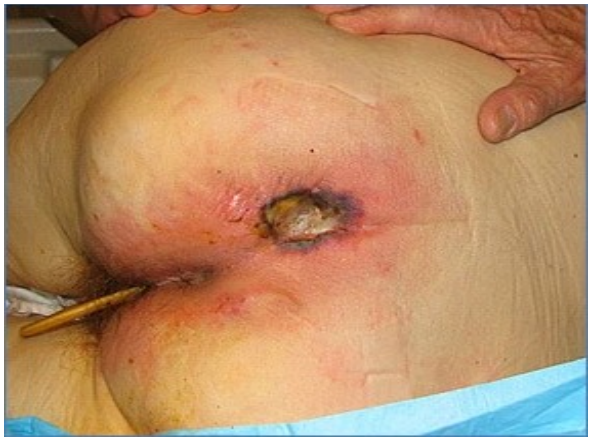
Topical Therapy nursing orders: *Cleanse with normal saline and gently pat dry. Apply mesh contact layer (Hollister Adaptic) and cover with dry gauze and wrap with rolled gauze (Kerlix). Change daily and PRN.*

(2 pts)

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

(0.5 pts)

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: Deep tissue pressure injury-sacrum

Topical Therapy nursing orders: (OFFLOAD) Wash daily gently with saline, apply Santyl ointment-“nickel thick” daily, cover with Allevyn sacral small or large as appropriate, change Allevyn Q3D or PRN dirty or saturated. Avoid any silver products.

1 alternative product: Q3D wash with saline, apply Skintegrity (hydrogel), cover with Allevyn

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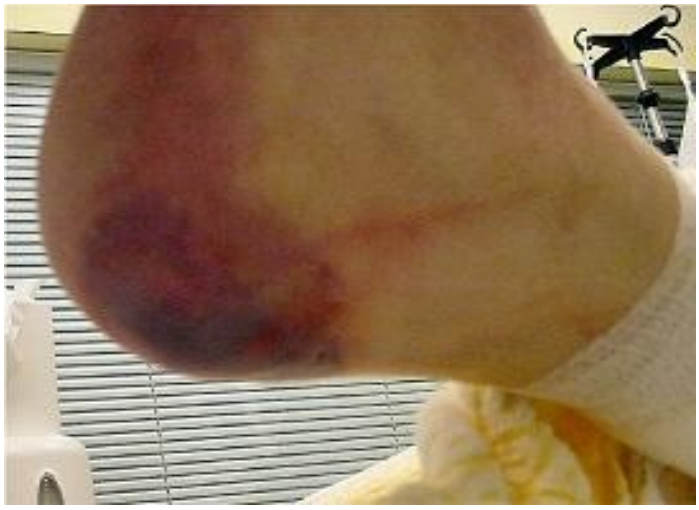
Scenario 3



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 injury

Topical Therapy nursing orders: (OFFLOAD) Wash every three days with saline, PH balanced skin cleanser, or Vasche; cover with Allevyn Life 5x5 or Allevyn gentle border 4x4, recheck daily, drsg change Q3D. Place heel protector boots

1 alternative product: Wash and change dressing daily, cover with Adaptic non-adhering dressing, dry gauze and tape, still boots as above.

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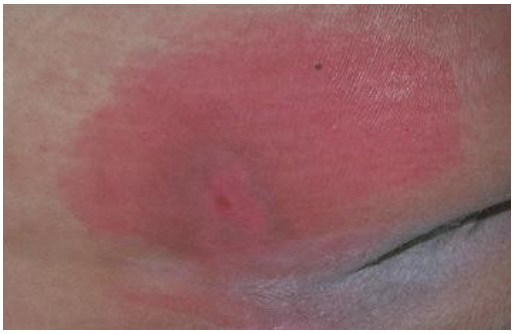
Scenario 4



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 nursing orders: (OFFLOAD) Wash with PH balanced skin cleanser Q3D or when dirty. Protect with Allevyn check daily, replace bandage Q3D or when dirty or saturated

1 alternative product: Mepilex Border Flex (Oval); or Large Hydrocolloid Q3D-disadvantage, not easy to check or see wound.

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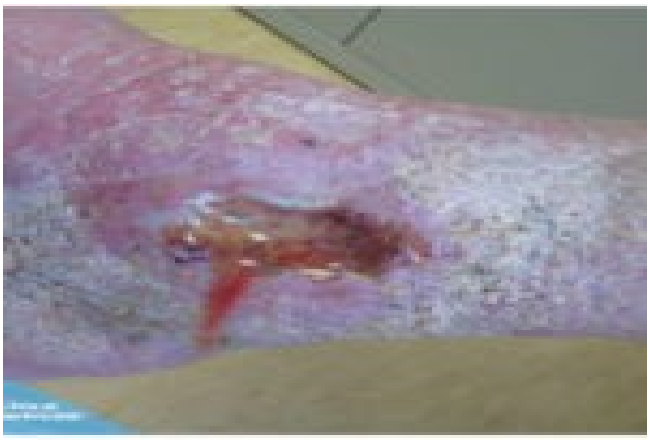
Scenario 5



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: Lower extremity wound, likely venous stasis ulcer with hemosiderin staining, but without edema, cannot rule out lower extremity arterial disease. Assessment to include ABI as well as wound culture after cleaning with saline

Topical Therapy nursing orders: Clean leg and wound Q3D with vasche, pack with Prisma AG, cover with Allevyn, change Q3D or prn saturation or dirty. Emolient to dry periwound skin: A&D ointment.

1 alternative product: Clean with Vasche, cover with Hydrofera blue foam-smallest size to cover wound, roll gauze and an Acewrap (Ace from MTP to above wound. If no arterial disease, elevate feet. No compression needed.

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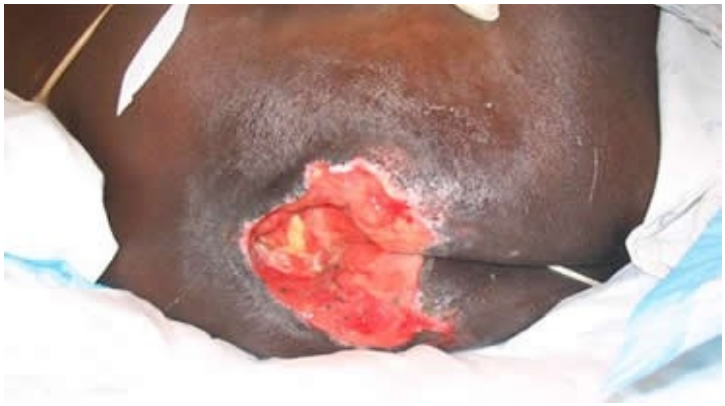
Scenario 6



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 4 pressure injury-bone visible. No obvious infection. ++drainage

Topical Therapy nursing orders: (OFFLOAD) Wash with Vasche, pack Vasche moistened fluffed gauze (fluff, do not stuff), Cover with allevyn large sacral dressing. Change Packing BID and Allevyn Q3D, more frequent as needed.

1 alternative product: For significant drainage that overwhelms Allevyn, pack wound with Aquacel Extra Ribbon (hydrofiber) fluff do not stuff and cover with Allevyn large sacral dressing.

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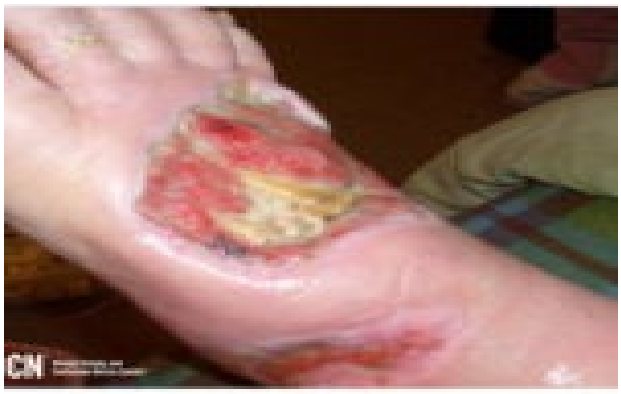
Scenario 7



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: This appears to be a chronic Neuropathic ulcer. Underlying arterial disease is suspected with history of both Reynaud's disease and Diabetes. Foot is swollen, cannot see leg, cannot rule out venous disease as well. Assessment will include review of labs, doppler pulses, Xrays of foot, ABI. I do not appreciate any sign of infection but if heat or red compared to other foot, consider culture.

Topical Therapy nursing orders: Clean wound with sterile saline, cover with allevyn dressing. Re-evaluate after diagnostics (xray, ABI). Likely will get surgical and vascular consults dependent on ABI.

1 alternative product: Clean wound with vasche QD, cover with petroleum gauze or Xeroform if infection is a concern. Then protect with roll gauze.

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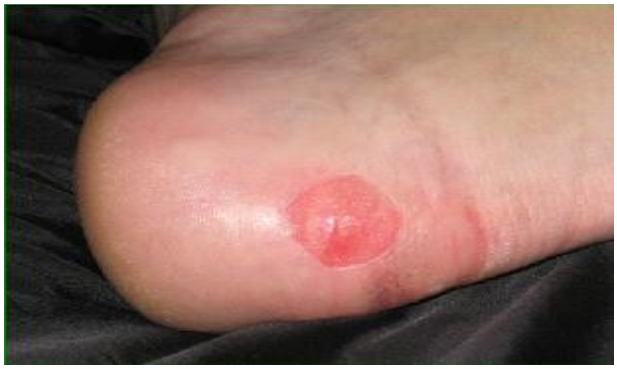
Scenario 8



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: Stage 2 Pressure injury

Topical Therapy nursing orders: (OFFLOAD) Wash with saline or ph balanced wound cleanser, cover with Allevyn Gentle border lite 2x2. Check QD, Clean wound and Change dressing Q3D or prn dirty

1 alternative product: petroleum gauze cut to size of wound with overlying transparent film dressing and heel protector boots. Change Q3D or PRN

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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 Assessment will include Labs and MRI to evaluate for osteomyelitis given bone visible. No debridement needed based on this picture.

Topical Therapy nursing orders: (OFFLOAD) Clean with saline or Vasche, initially pack with saline moistened gauze (fluff, do not stuff), cover with ABD and low adherent silicone dressing. Once Assessment is complete, dress according to infection risk, see alternative product.

1 alternative product: PolyMem cavity filler covered with Silicone film, minimally adherent to keep PolyMem in place.

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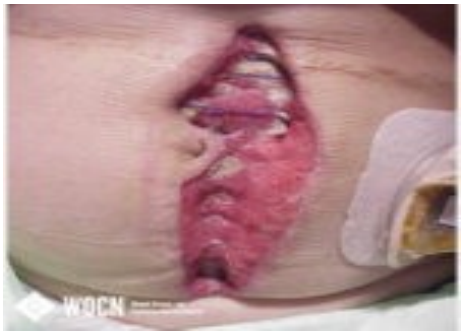
Scenario 10



Wound care nurse is consulted to see a 74 year old fo 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 wound, non-infected, facia closed

Topical Therapy nursing orders: wet to damp saline soaked gauze (fluff, do not stuff) but fill wound, abd pad, paper tape, Change BID

1 <u>Advanced</u> therapy alternative product: NPWT KCI/3M wound vac is the product used in my facility. Black foam, change MWF.

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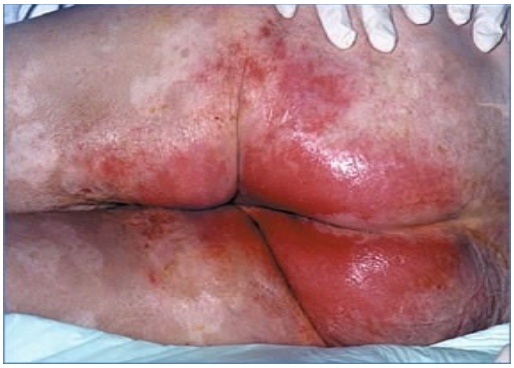
Scenario 11



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: Incontinence associated dermatitis

Topical Therapy nursing orders: (OFFLOAD TO PREVENT PI), Consider internal fecal management system to divert any diarrhea and contain c diff. Clean skin with PH balanced, no rinse skin cleanser that is alcohol and sting free. Generously apply zinc-based skin barrier ointment. (Desitin). Clean PRN, no need to totally remove skin barrier, just remove stool.

1 alternative product: Clean skin with PH balanced, no rinse skin cleanser after every stool or episode of incontinence, Apply cavilon skin barrier film and let dry QD, consider Cavilon Advantage Q3D. There may be satellite lesions, if yeast suspected, consider crusting with Mycostatin powder and Cavilon.

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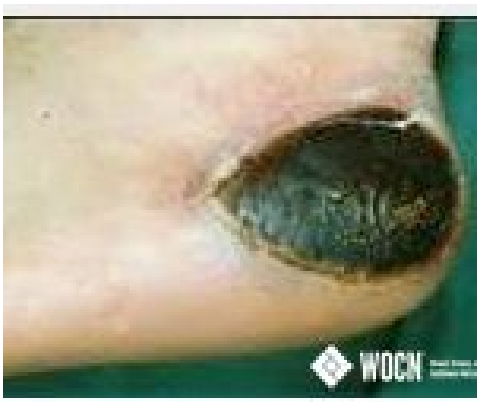
Scenario 12



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: Depp tissue pressure injury with dry eschar

Topical Therapy nursing orders: (Off load and protect) Keep clean and dry and use heel protection boots

1 alternative product: Allevyn or Mepilex border dressing Q3d. Watch for softening or sign of infection at which point debridement may be necessary