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

Mini Case Studies: Wounds

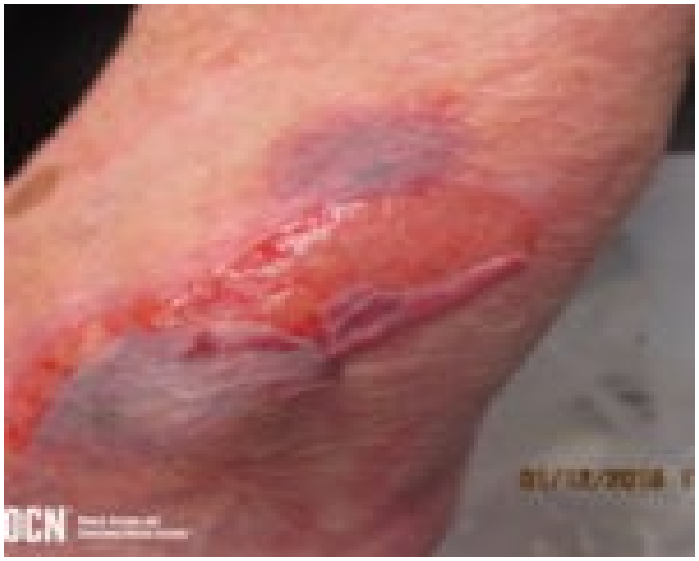
Cleveland Clinic

Student Name & Date: Kelsi Critzer 10/19/23
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).

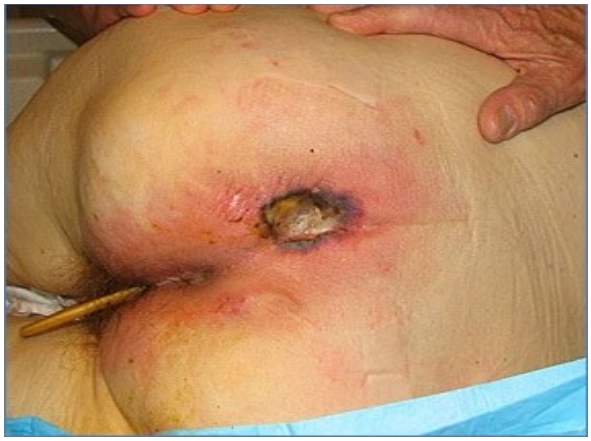
Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

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.

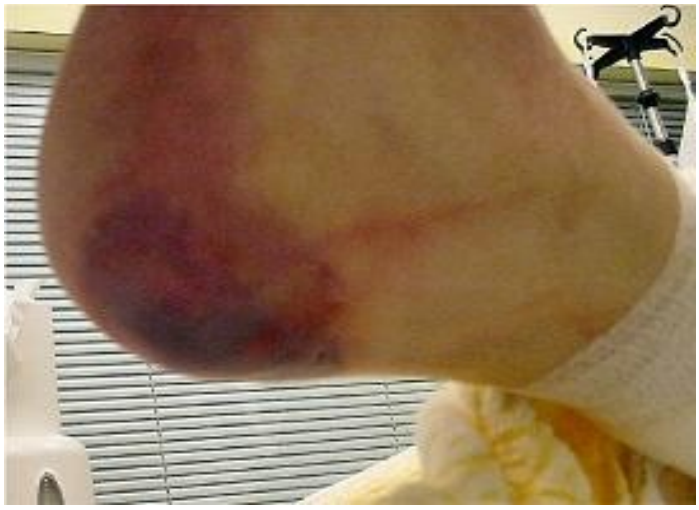
Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

Wound type: unstageable pressure injury

Topical Therapy (Dressing selection): Cleanse wound with normal saline and gently dry the area. Apply a layer of Santyl (about the thickness of a nickle) to the entire wound base including the wound edges. Place a pre-moistened normal saline 4x4 gauze over the wound in contact with the Santyl. Secure the dressing in place with Medline Optifoam gentle absorbent foam dressing with silicone adhesive. Change dressing daily or PRN if soiled.

1 alternative product: Intrasite Hydrogel (Smith-Nephew), cover with Allevyn Adhesive Foam

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.

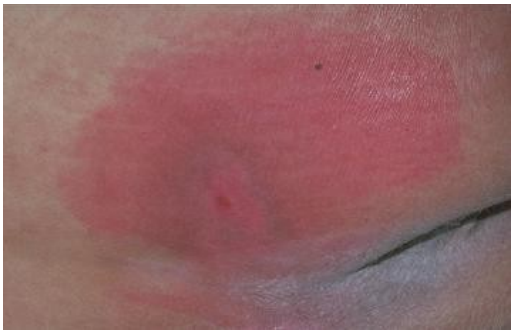
Image courtesy of Judy Mosier, MSN, RN, CWOCN.

Wound type: deep tissue pressure injury

Topical Therapy (Dressing selection): Cleanse area with normal saline and pat dry. Apply Molnlycke mepilex lite border to the heel. Change dressing every other day. Keep heel floated.

1 alternative product: Coloplast Comfeel plus transparent dressing (thin)

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.

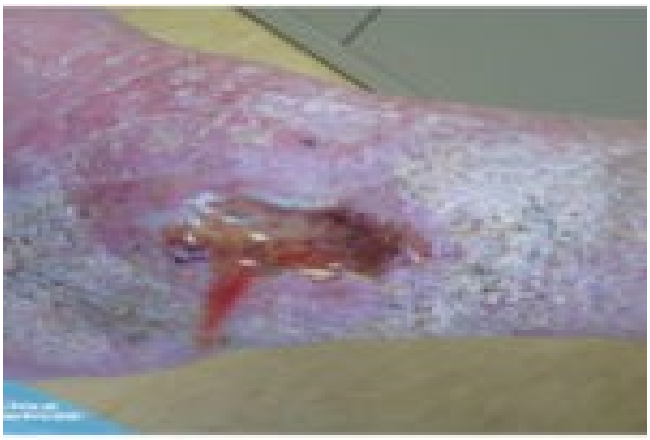
Image courtesy of Judy Mosier, MSN, RN, CWOCN.

Wound type: stage 1 pressure injury

Topical Therapy (Dressing selection): Cleanse area daily with a mild soap and water, pat dry. Pad and protect area with Smith-Nephew Allevyn gentle border lite foam dressing. Assess the right sacrum daily and change the dressing if it becomes soiled. Avoid prolonged pressure to the area.

1 alternative product: Coloplast Comfeel Plus Pressure Relief Hydrocolloid dressing

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

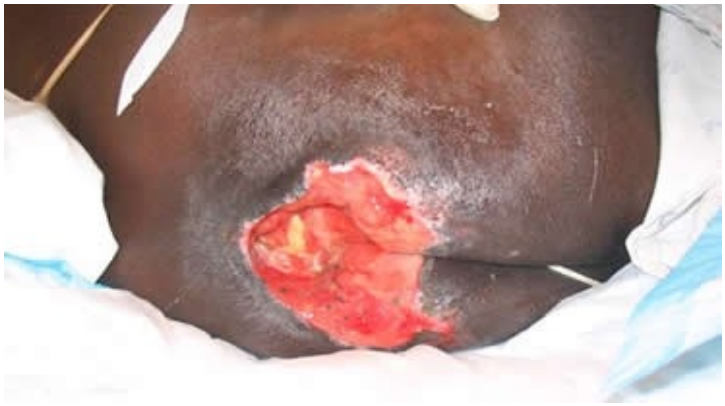
Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

Wound type: venous ulcer

Topical Therapy (Dressing selection): Cleanse area with Vashe wound solution (Urgo medical). Gently pat area dry with clean gauze. Paint the macerated borders of the wound with Cavilon no-sting barrier film (3M). Place a piece of CalCiCare calcium alginate dressing with silver (Hollister) over the wound. Wrap the lower portion of the leg with a rolled gauze such as Kerlix. Change dressing daily and PRN if saturated. Consider obtaining ABI or consulting vascular to assess if patient is a candidate for compression dressings to BLE to assist with venous insufficiency.

1 alternative product: Eclypse adherent dressing with silicone

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 or bone noted. Wound has serosanguinous drainage.

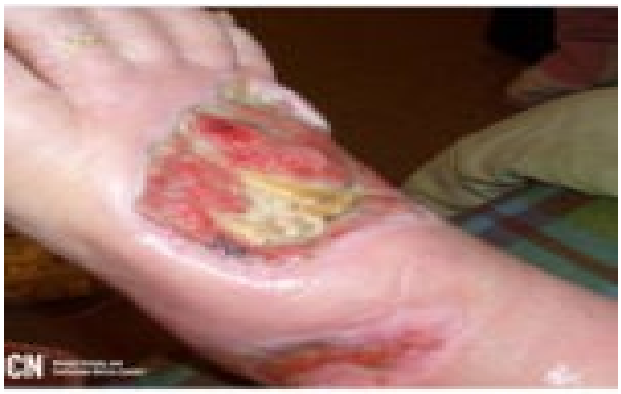
Image courtesy of Judy Mosier, MSN, RN, CWOCN.

Wound type: stage 3 pressure injury

Topical Therapy (Dressing selection): Fill wound with (ConvaTec) Aquacel Ag Advanced Hydrofiber Dressing and cover with Aquacell foam border. Change every other day.

1 alternative product: PolyMem WIC Cavity Filler dressing, covered with Coloplast Comfeel Plus Ulcer Dressing hydrocolloid

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.

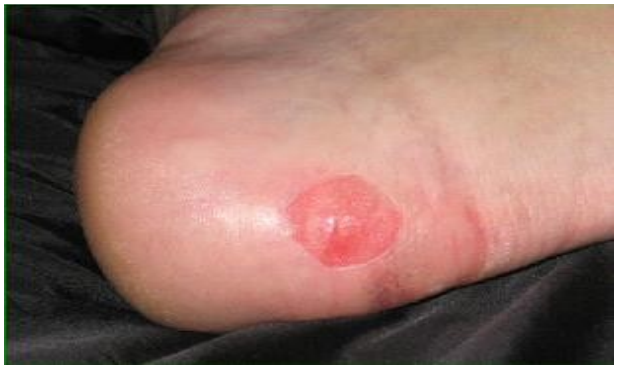
Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

Wound type: diabetic neuropathic foot ulcer

Topical Therapy (Dressing selection): Cleanse area with Vashe wound solution (Urgo medical). Gently pat area dry with clean gauze. Apply Hydrofera Blue Ready-Border dressing over the affected area. May trim border to accommodate proximal wound. Change dressing every 3 days or PRN if saturated.

1 alternative product: Woun'Dres hydrogel (Coloplast), covered with Biatain foam dressing

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 (Dressing selection): Cleanse area with normal saline and gently pat dry. Cover area with PolyMem oval film adhesive. Change dressing every 2 days to avoid periwound maceration or PRN if saturated.

1 alternative product: Duoderm Hydrocolloid dressing

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.

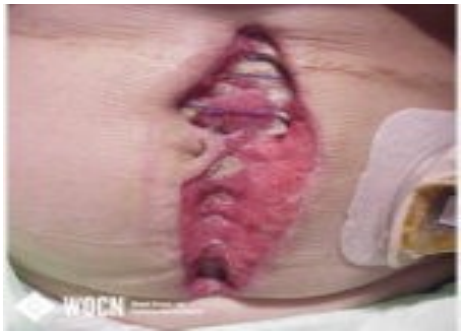
Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

Wound type: stage 4 pressure injury

1. **Topical Therapy (Dressing selection):** Aquacel Ag Advanced Hydrofiber Dressing (ConvaTec), covered with DuoDerm Hydrocolloid. Change daily or PRN if soiled._

1 alternative product: Woun'Dres hydrogel (Coloplast), covered with Biatain foam dressing

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.

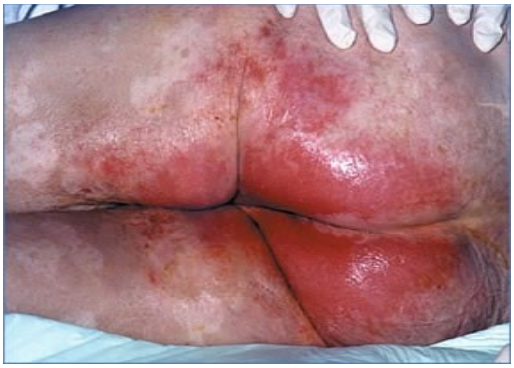
Wound type: post-surgical wound dehiscence

Topical Therapy (Dressing selection): Cleanse area with Vashe wound solution (Urgo medical). Gently pat area dry with clean gauze. Paint borders of the wound with Cavilon no-sting barrier film (3M) if wound has drainage. Place Aquacel Ag Advanced Hydrofiber Dressing (ConvaTec) into the wound. Be sure to gently pack dressing into all areas including into deeper pockets and undermining if present. ABD pad may be used to cover Aquacell dressing and medipore tape (3M) to secure dressing in place. Dressing should be changed daily or PRN if saturated.

1 <u>Advanced</u> therapy alternative product:

Consider NPWT to help granulate tissue and promote wound closure. Pay close attention to any signs of possible fistula formation in the wound prior to placing the wound VAC (KCI now 3M).

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 skin damage

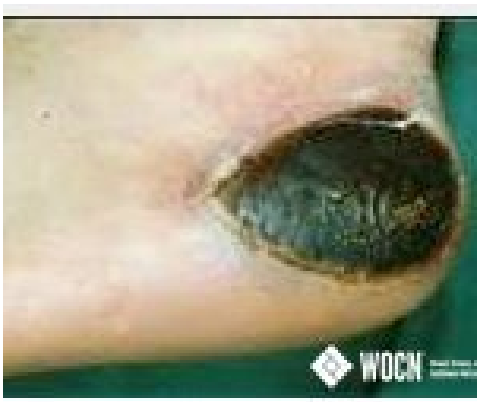
Topical Therapy (Dressing selection): Apply Triad hydrophilic wound dressing (Coloplast) to affected area with each incontinent episode. Cleanse area with comfort shield barrier cream clothes (Sage Products). Remove only the soiled layer of cream and reapply. Do not scrub off all previous layers before reapplying.

1 alternative product: Cleanse with mild soap and water, gently pat dry. Apply Remedy with Z-Guard Skin Protectant Paste.

or

ConvaTec FlexiSeal fecal management system

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: dry stable eschar/ unstageable pressure injury

Topical Therapy (Dressing selection): Leave eschar in place, do not attempt to remove. Gently paint affected area including periwound with ChloraPrep swabstick (Becton Dickinson) daily. Allow area to for 30 seconds.

1 alternative product: protect heal with Biatain adhesive foam dressing (Coloplast)