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: Patricia A. Slachta **Date:** 10/19/23

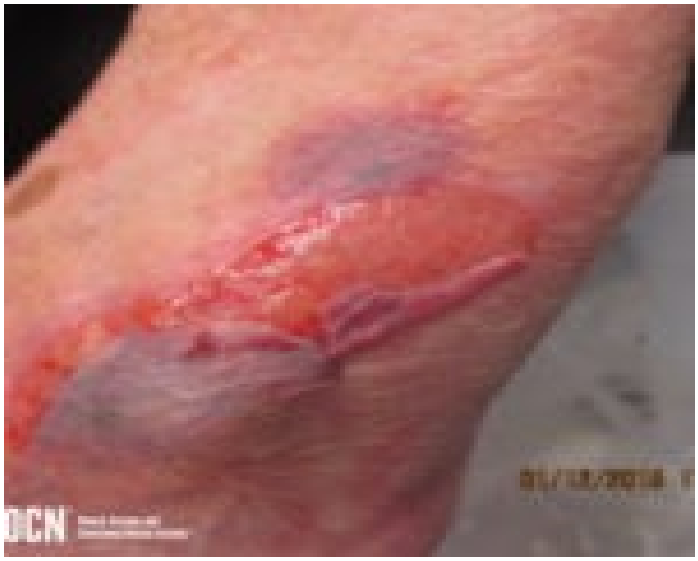
Score: 20.65 /33 You need 6 more points to achieve the 80%. Select another color & just write in the boxes below your current answers, thanks. The points deducted are in the box w a minus sign for most of the questions with the total points awarded at the bottom of each scenario.

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)

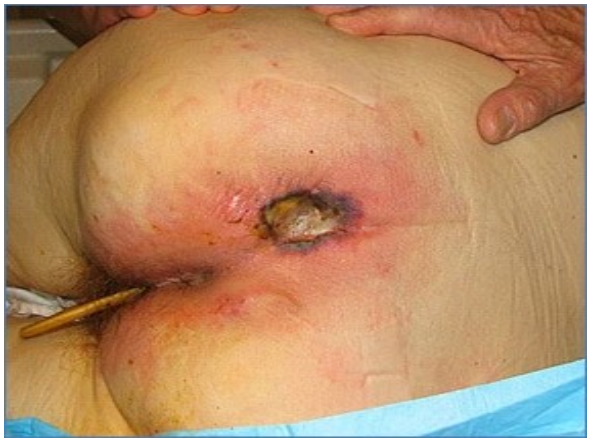
Topical Therapy nursing orders: *Cleanse with normal saline and gently pat dry. Apply mesh contact layer (Hollister Adaptic) and cover with dry gauze and wrap with rolled gauze (Kerlix). Change daily and PRN.*

(2 pts)

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

(0.5 pts)

Scenario 2



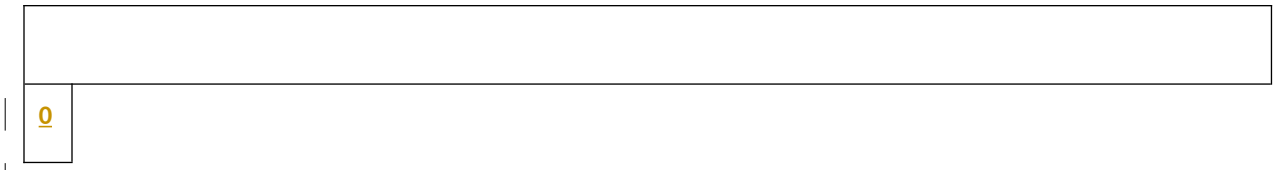
You are asked to assess a new resident admitted with a sacral wound. Patient is 82 year old and admitted with dementia. Wound on sacrum with 100% yellow slough and brown necrotic tissue at wound edges. Wound measures approximately 4 cm x 3 cm x 2 cm. Periwound with blanchable erythema.

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

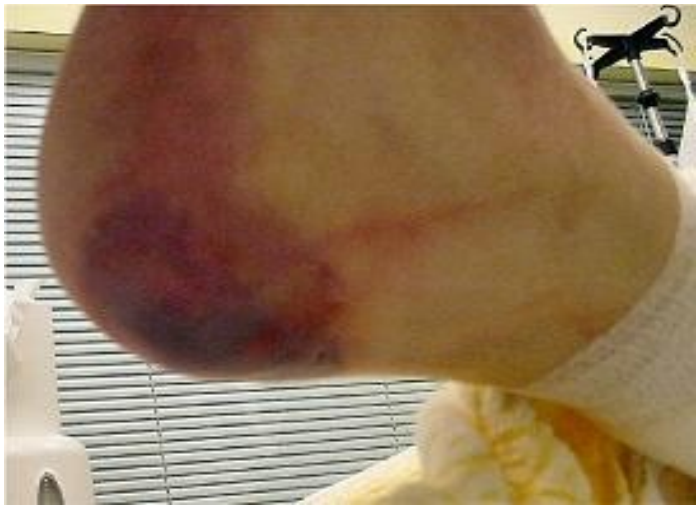
Wound type: ~~Deep tissue pressure injury sacrum~~ Sacral Unstageable Full Thickness Pressure injury with secondary bacterial infection. Injury cannot be staged because of necrotic slough in wound. This slough appears dry to me, but may be moist. The erythema is a sign of infection. Surgical consult for debridement is expected. Labs may reflect elevated WBC. Look for evidence of sepsis. Check to see if infection is being considered and whether antibiotics are ordered or blood cultures pending.

Topical Therapy nursing orders: (OFFLOAD) Wash with Vasche wound cleanser, use wet to damp saline dressings BID pending urgent surgical debridement. Once debridement done, NPWT with KCI Wound Vac, components of wound vac dressing to be determined after debridement

1 alternative product: If surgical debridement not possible, then culture-type as per surgeon, may need aspiration or tissue biopsy for culture. IV antibiotics as per surgeon. Clean wound daily with saline and apply Santyl ointment nickel thick to base of wound, fill with saline moist gauze as needed (fluff don't stuff) and cover an Allevyn life sacrum small or large as appropriate. Change dressing daily



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.

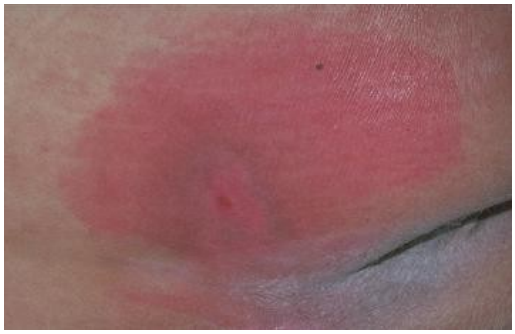
Wound type: Deep tissue injury correct

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 not sure about the research behind gently border & pressure/shear decreases, 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. ✓

3

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 correct

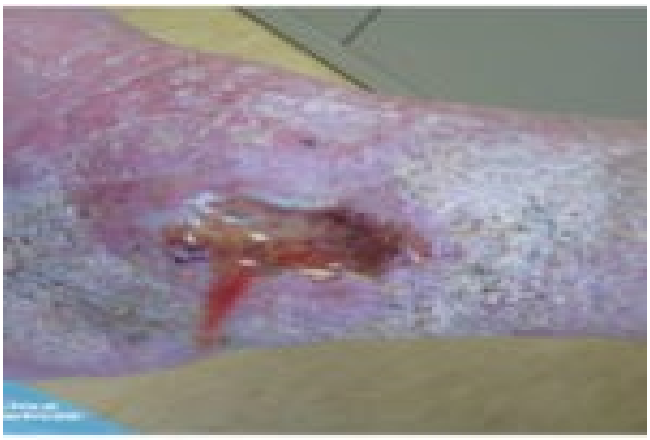
Topical Therapy nursing orders: (OFFLOAD) ✓ Wash with PH balanced skin cleanser Q3D or when dirty soiled?. Protect with Allevyn check daily, replace bandage Q3D or when soiled ~~dirty~~ or saturated ✓

1 alternative product: ~~Mepilex Border Flex (Oval);~~ or Large Hydrocolloid Q3D-disadvantage, not easy to check or see wound. Mepilex is similar to Allevyn & you are correct about hydrocolloid. Aggressive adhesive products are no longer my first choice (hydrocolloids & transparent films) & if I use then can they stay on longer? If you are checking the peri-wound area for edema, erythema, fluctuance, temp, & induration a hydrocolloid may be able to remain in place longer

Just a note about hydrocolloids, if this was a DTPI hydrocolloids foster autolytic debridement so if you hoped DTPI would resolve on its own then a hydrocolloid is not the dressing of choice for that.

3

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.

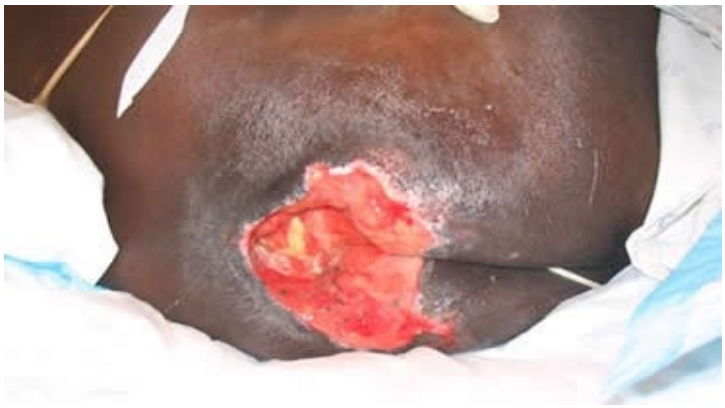
Wound type: Lower extremity wound, likely venous stasis ulcer with hemosiderin staining, but without edema, cannot rule out lower extremity arterial disease. Assessment to include ABI as well as wound culture after cleaning with saline ✓

Topical Therapy nursing orders: Clean leg and wound Q3D with vasєhe, pack (remember, try to not use the word pack with Prisma AG, cover with Allevyn, change Q3D or prn saturation or dirty. Emolient to dry periwound skin: A&D ointment. Just some thoughts here...Vashe is ok as a cleanser but could use water too; A&D is not really a moisturizer but may provide some minimal skin protection; Prisma AG ok & Allevyn but if compression needed, generally adhesive foams not the best as they trap moisture under the dressing -**.25**
(Compression pending ABI-so I used ace wrap, could also use rolled gauze until ABI done.

1 alternative product: Clean with Vasєhe, cover with Hydrofera blue foam-smallest size to cover wound, roll gauze and an Acewrap (Ace from MTP-not sure where you are referring to? But wraps should **always** be from base of toes to back of knee; the majority of the time ACE wraps are ineffective & should not be used as they are long stretch & do not hold the compression to above wound. If no arterial disease, elevate feet. No compression needed. If this is venous, compression is important always if ABI permits. **-.25 (MTP is an abbreviation for metatarsal phalangeal joints-synonym for base of toes.)**

2.5

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 ✓

Because bone is visible, confirm that and evaluation for osteomyelitis has been completed.

Topical Therapy nursing orders: (OFFLOAD) Remove prior alginate dressing, Irrigate with sterile saline using a 35ml syringe and a 19 G needle, to remove all prior alginate dressing. Using Maxorb rope to deepest part of wound and then maxsorb sheet, fill wound (fluff do not stuff). Cover with a secondary dressing Kerrafoam or Allevyn large sacral dressing. Change QD or QOD depending on saturation of dressing.

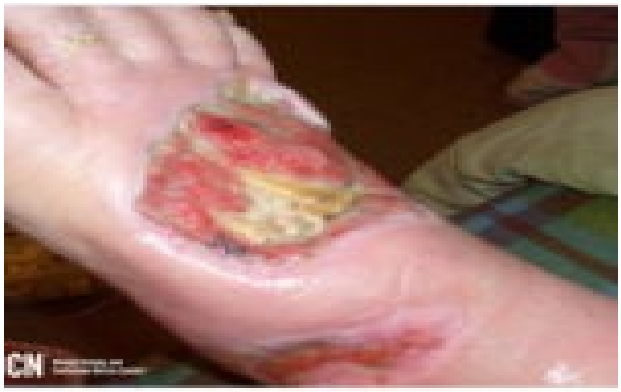
Wash with Vashe, ~~pack~~ lightly fill dead space w Vashe moistened fluffed gauze (fluff, do not stuff), Cover with allevyn large sacral dressing. Change ~~Packing~~ dressing BID Consider changing on a more spaced schedule such as Q 12 hours vs BID and Allevyn Q3D, more frequent as needed. Secondary dressing not a good choice as once it is removed from a *wound* it needs to be tossed; you cannot change the primary dressing BID & foam Q3D. **This is a wound w serosanquineous drainage-is Vashe required?** You have a good alternative below. What other type of dressing & instruction can go in this cell? And you are using adhesive dressings so what other order would you do for the skin? **-2**

1 alternative product: For significant drainage not really saying this is a lot of drainage that overwhelms Allevyn, ~~pack wound with~~ use Aquacel Extra Ribbon (hydrofiber) fluff do not stuff and cover with Allevyn large sacral dressing.

1

I love the fluff do not stuff (may I use that in my things?) but it would be great to also not use the word pack…

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 Arterial/Neuropathic ulcer. Underlying arterial disease is suspected with history of both Raeynaud's disease and Diabetes as well as shiny skin, and distinct borders. Foot is swollen, cannot see leg. 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.

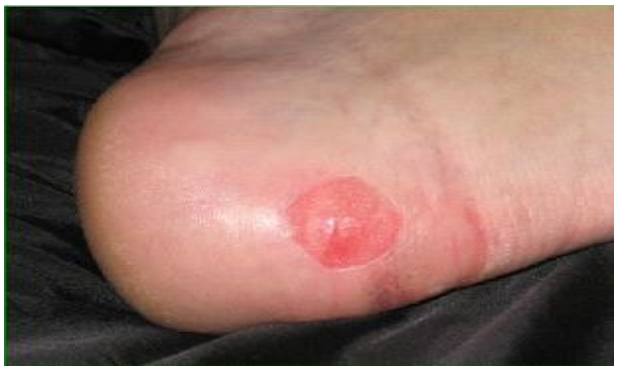
Topical Therapy nursing orders: Clean wound with sterile saline by irrigating using a 35ml syringe and a 19G needle, this should clean the wound in a way that gently washes away debris and bacteria. Protect peristomal skin with skin barrier film (Cavilon). Cover with Allevyn AG gentle border.

Re-evaluate after diagnostics (xray, ABI). (Likely will get surgical and vascular consults dependent on ABI. Yes but this is more info than requested) **-.5**

1 alternative product: Clean wound with vashe QD, cover with petroleum gauze or Xeroform if infection is a concern. Then protect with roll gauze. Ok but there are better options than petroleum & xeroform if antimicrobial is required.

2.5

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) **yes very true!** 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 I would do something additional to the wound

1 alternative product: petroleum gauze cut to size of wound with overlying transparent film dressing and heel protector boots. Change Q3D or PRN tough to get this to stay on if there is grease under the film. What else could you do?

3

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. Center of wound is different color- indicating deeper injury or necrotic tissue, tan drainage consider infection. (MRI for Osteomyelitis already stated)

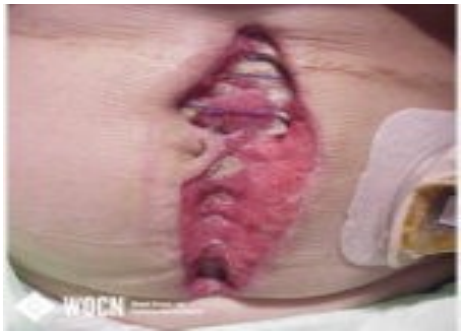
~~No debridement needed based on this picture.~~ What about the area in the center?

Topical Therapy nursing orders: (OFFLOAD) Irrigate with saline using a 35ml syringe and 19G needle, apply 3m Tegaderm Hydrogel to wound base, fill wound lightly with non woven hydrogel coated gauze and cover with #mTegaderm Silicone Foam Dressing, change Q2-3 days when saturated.

~~e~~initially ~~pack~~ lightly fill with saline moistened gauze (fluff, do not stuff), cover with ABD and low adherent silicone dressing.this appears to be two secondary dressings Once Assessment is complete, dress according to infection risk, see alternative product. Saline dressings are not evidence based & should rarely be used as the primary dressing **-2**
1 alternative product: PolyMem cavity filler covered with Silicone film what is the brand name for this silicone film?, minimally adherent to keep PolyMem in place. **-.2**

.8

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. Sutures failed, no apparent infection.

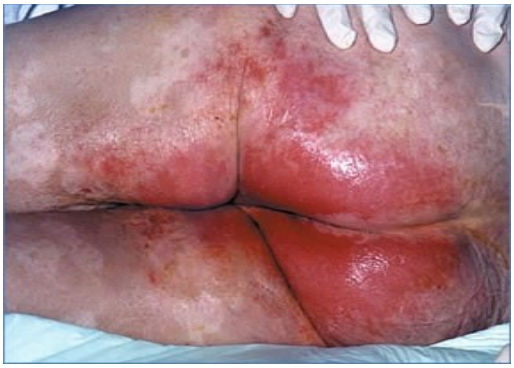
Topical Therapy nursing orders: **Irrigate wound with sterile saline using 35ml syringe and 19G needle. Fluff but do note stuff wound with saline moistened Aquacel AG ribbon filling approximately 80% of wound, cover with Kerramax cover dressing 4x9. Change every 3-7 days when saturated.**

wet to damp saline soaked gauze (fluff, do not stuff) but fill wound, abd pad, paper tape, Change BID NSS moist dressings not evidence-based **-2**

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

.5

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.

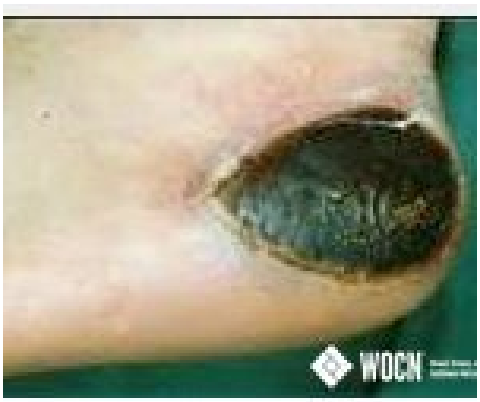
Wound type: Incontinence associated dermatitis and secondary candida infection (satellite lesions) **-.25**

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. Apply nystatin cream and then protect with zinc-based skin barrier ointment. (Desitin). Clean PRN, no need to totally remove skin barrier, just remove stool✓. **Absolutely no need to remove to bare skin, but because wound type is not on target neither is this!** **-.75**

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. OK yes this is most likely candida.so what else can you do in the middle row & what is your 'wound type'

2

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 You are calling this a pressure injury but what stage is it? (unstageable) **-.25**

Topical Therapy nursing orders: (Off load and protect) Keep clean and dry and use heel protection boots OK, I would definitely do more here but this is ok

1 alternative product: Allevyn or Mepilex border dressing Q3d. **Watch for softening** or sign of infection at which point debridement may be necessary you are potentially setting up autolytic debridement which is not usually what we want to do. What else can you do here? Enxymatic debridement (Crosshatch and apply Santyl QD) **-.5**

2.25