

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

Mini Case Studies: Wounds



Student Name Kelsey Rogers Corrigan
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Date: _____

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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.

Example Scenario



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 1



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 nursing orders: Consult for surgical debridement. Cleanse with wound cleanser and pat dry. Apply Aquacell Ag fill wound bed. Apply 3M Cavilon No Sting Barrier Film to periwound skin. Cover with an adhesive Allevyn foam dressing as secondary dressing. Change daily and PRN.

1 alternative product: Collagenase ointment (Santyl) to promote slough removal. If needed, fill dead space with fluffed gauze, apply skin protectant to peri wound area, and apply Tegaderm to cover. Change daily.

Scenario 2



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: Apply adhesive Allevyn foam heel cup dressing. Peel back every shift to assess for skin breakdown. Institute pressure offloading measures. Change every three days and PRN

1 alternative product: Consider a hydrocolloid dressing here as added protection of the skin. However, pressure offloading measures and frequent reassessment is still crucial.

Scenario 3



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: institute pressure offloading measures. Apply adhesive foam dressing (Allevyn). Peel back every shift to assess for skin breakdown. Institute pressure offloading measures. Change every three days and PRN

1 alternative product: Triad dressing

Scenario 4



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 nursing orders: Gently cleanse wound with wound cleanser and pat dry. Place alginate dressing to along wound bed. Over alginate, ABD dressing, and Kerlix gauze. Apply skin protectant to periwound skin. Change daily and as needed. Ensure removal of all alginate when cleansing for each dressing change.

1 alternative product: Aquacell

Scenario 5



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, no bone noted. Wound has serosanguinous drainage.

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

Wound type: Stage 3 pressure injury

Topical Therapy nursing orders: Place an Allevyn life sacrum dressing, change daily. If needed for depth, would add a thin layer of non-bordered foam dressing to fill dead space.

1 alternative product: Aquacell

Scenario 6



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: Neuropathic foot ulcer

Topical Therapy nursing orders: gently cleanse wound with saline. Hydrate Hydrofera blue dressing with 5-10 ml of sterile saline. Squeeze out excess fluid. Place Hydrofera blue foam dressing in wound bed. Cover with Tegaderm clear dressing. Change every 3 days, and PRN if turns white or light in color.

1 alternative product: Honey alginate dressing

Scenario 7



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: cleanse gently with wound cleanser. Place silicone contact layer in wound bed, avoiding overlap to peri wound skin. Apply skin protectant to periwound skin. Cover silicone contact layer with foam adhesive bordered dressing like an Allevyn heel dressing.

1 alternative product: composite dressing contact layer, foam and adhesive all in one

Scenario 8



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

Topical Therapy nursing orders: Gently cleanse wound with sterile saline. Coat wound bed with hydrogel in wound bed and wound edges. Fill dead space with fluffed gauze impregnated with hydrogel (or alternatively saline). Apply skin protectant to periwound skin. Cover with Tegaderm. Also, institute pressure offloading measures, including pressure relieving cushion on wheelchair. Change daily and PRN

1 alternative product: Allevyn life for depth, would add layer of non-bordered foam dressing to fill dead space.

Scenario 9



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: Open abdominal surgical wound without fascial dehiscence.

Topical Therapy nursing orders: Apply Silver alginate dressing (Coloplast Biatain Alginate Ag) along wound bed. Fill any dead space with open and fluffed gauze. Protect periwound skin by applying skin protectant to periwound. Cover with ABD and secure with tape. Gently irrigate with normal saline to remove all alginate residue with each dressing change. Change daily and PRN.

1 Advanced therapy alternative product: Negative pressure wound therapy

Scenario 10



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 Dermatitis with candida infection

Topical Therapy nursing orders: Gently cleanse with wipes and pat dry. Consult for order for antifungal cream. Apply antifungal cream, and then apply Sensi-Care Zinc skin protectant. Promptly cleanse peri-area, and apply barrier ointment liberally with each episode of incontinence.

1 alternative product: Triad dressing instead of Zinc barrier ointment

Scenario 11



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

Topical Therapy nursing orders: Keep heel clean and dry, leaving eschar intact. Institute pressure offloading measures. Cover area with dry gauze, keeping area clean and dry, change daily and PRN. Peel back and assess every shift. Notify provider immediately if drainage or erythema develops.

1 alternative product: Apply povidone iodine daily and allow to dry