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

Mini Case Studies: Wounds

Cleveland Clinic

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Reviewed by: _____ **Date: _____**

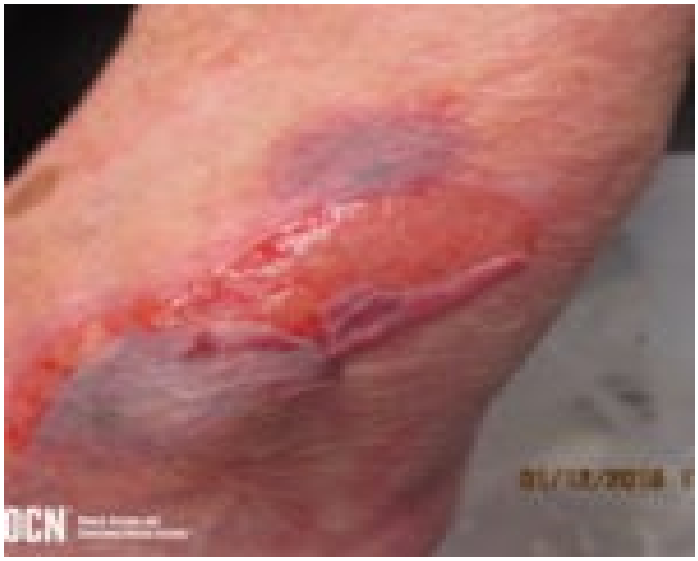
Score: /33

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.

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)

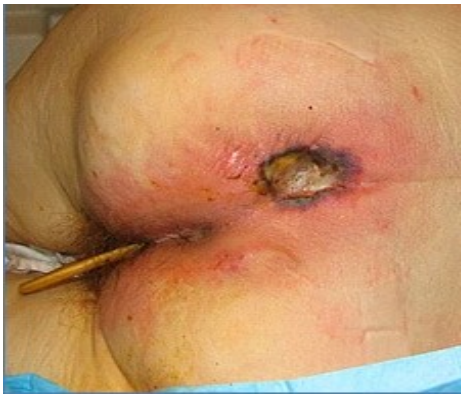
Topical Therapy nursing orders: *Cleanse with normal saline and gently pat dry. Apply mesh contact layer (Hollister Adaptic) and cover with dry gauze and wrap with rolled gauze (Kerlix). Change daily and PRN.*

(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

Topical Therapy nursing orders: Cleanse wound with normal saline. Pat dry, pack wound with silver alginate. Cover with foam dressing 3 times a week. Create a moist environment to promote autolytic debridement

1 alternative product: Foam dressings (moist), hydrogel

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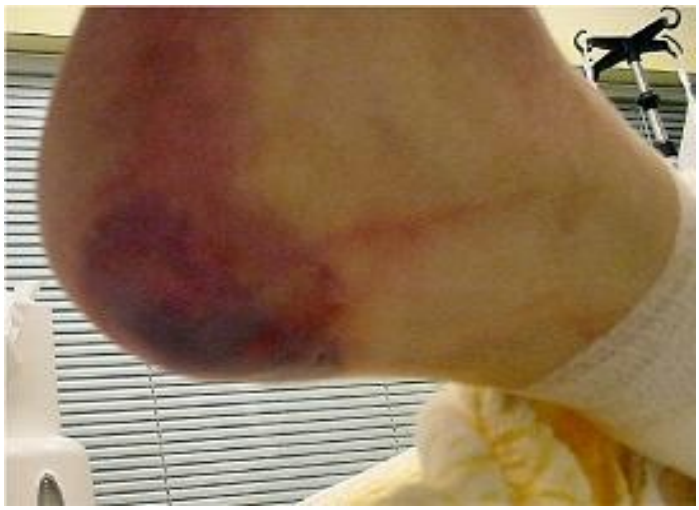
Scenario 2



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 pressure injury

Topical Therapy nursing orders: Silicon foam dressing Allevyn foam (offload pressure) cleanse with normal saline, pat dry, apply foam dressing and offload the pressure with pillows and wedges

1 alternative product: Aquacel foam

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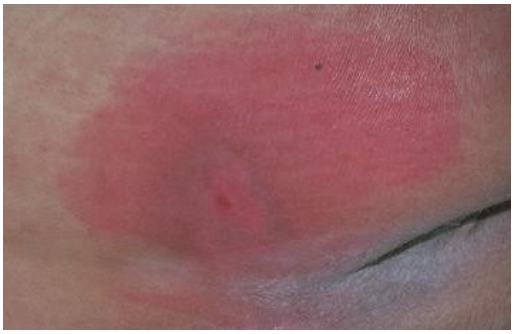
Scenario 3



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

Topical Therapy nursing orders: cleanse with normal saline, pat dry, change positions at intervals

1 alternative product: Skin moisture barrier and lifting the area of the body off the pressure contact

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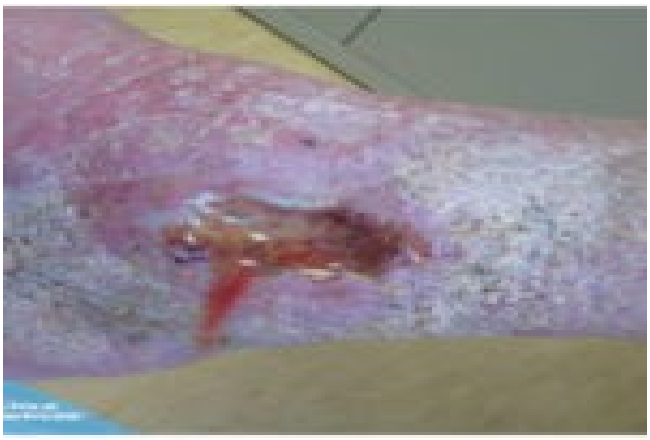
Scenario 4



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: non-healing venous ulcer

Topical Therapy nursing orders: refer to physician for debridement and for recommendations for compression therapy if needed, cleanse with normal saline, Apply Aquacel Hydrofiber silver dressing, cover with a foam dressing. Change every 3 days

1 alternative product: antibiotic treatment

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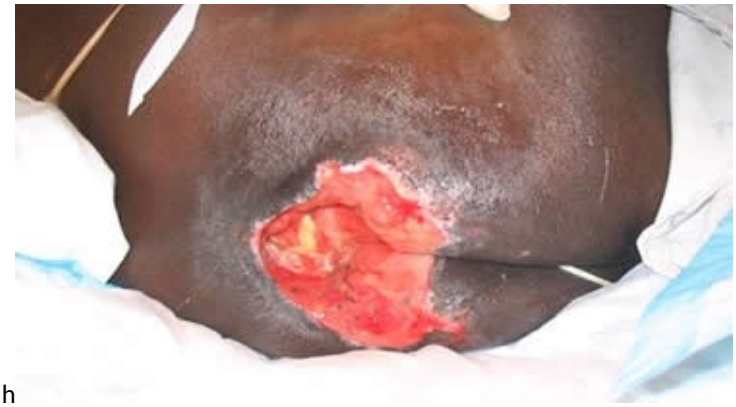
Scenario 5



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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: cleanse with normal saline, pat dry, pack wound with Aquacel extra hydrofiber cover with moist dressing to encourage auto debridement of the slough change dressing 3 times per week

1 alternative product: Aquacel foam dressing with Collagenase for enzymatic debridement of the slough, consult for a negative pressure wound therapy (NPWT)

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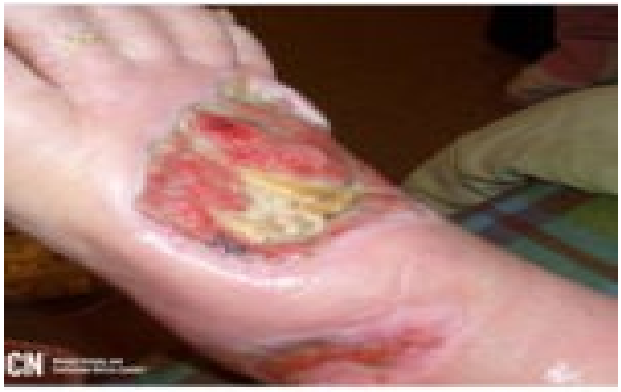
Scenario 6



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: Peripheral Arterial Disease wound

Topical Therapy nursing orders: Cleanse with normal saline, pat dry and apply collagenase Santyl ointment for enzymatic debridement, apply nickel thickness of Santyl once daily, apply moist gauze and cover with foam dressing.

1 alternative product: Hydrocolloid dressing (Tegaderm)

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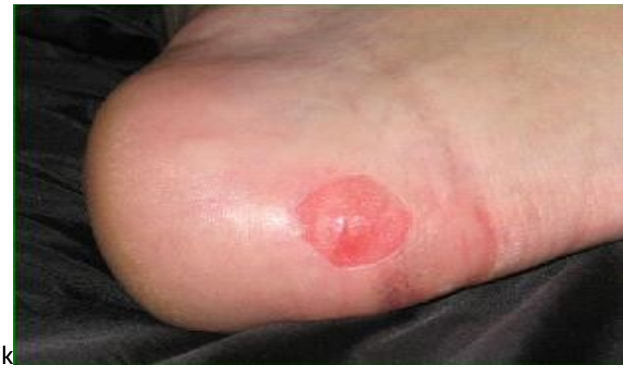
Scenario 7

hhjk 

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 with normal saline, pat dry, apply a hydrocolloid and foam dressing, change dressing 3 times a week.

1 alternative product: non-adherent synthetic foam dressing (Allevyn).

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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: Stege 4 pressure wound

Topical Therapy nursing orders: Cleanse the wound with normal saline, pat dry apply alginates dressing, cover with foam dressing, change every 3 days.

1 alternative product: Hydrocolloid dressing

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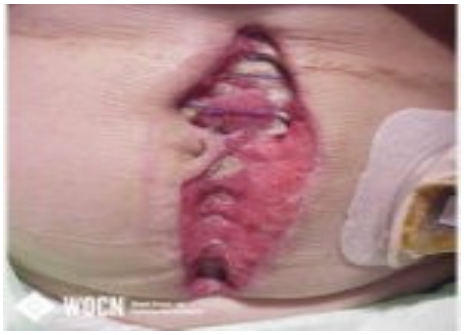
Scenario 9



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: Dehisced wound

Topical Therapy nursing orders: Cleanse with normal saline, pack with moist gauze and a gentle silicon foam (Allevyn) change every 2 to 3 days

1 <u>Advanced</u> therapy alternative product: Negative Pressure Wound Therapy (NPWT)

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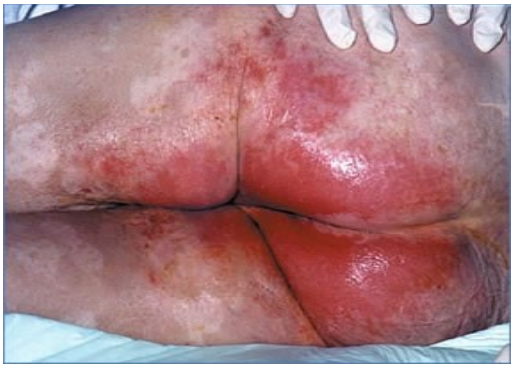
Scenario 10



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 skin damage, (MASD): Incontinent-associated Dermatitis (IAD)

Topical Therapy nursing orders: Cleanse with normal saline, pat dry, place Interdry Moisture Wicking fabric with silver (Antimicrobial) in the area. Change once a week.

1 alternative product: Wash the area with a cleanser with pH compatible with the skin, apply hydrogel or petroleum-based products, cover with zinc oxide and wear soft clothing material over the area

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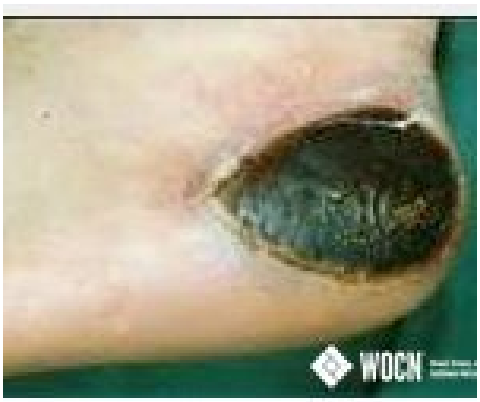
Scenario 11



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: Dry eschar on heel

Topical Therapy nursing orders: Put some gauze soaked with Betadine on the heel, wrap the heel with gauze, relief pressure on the heel. Dressing change daily.

1 alternative product: Vashe (Hypochlorous acid)

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