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

Mini Case Studies: Wounds

Cleveland Clinic

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Reviewed by: _____ **Date:** _____

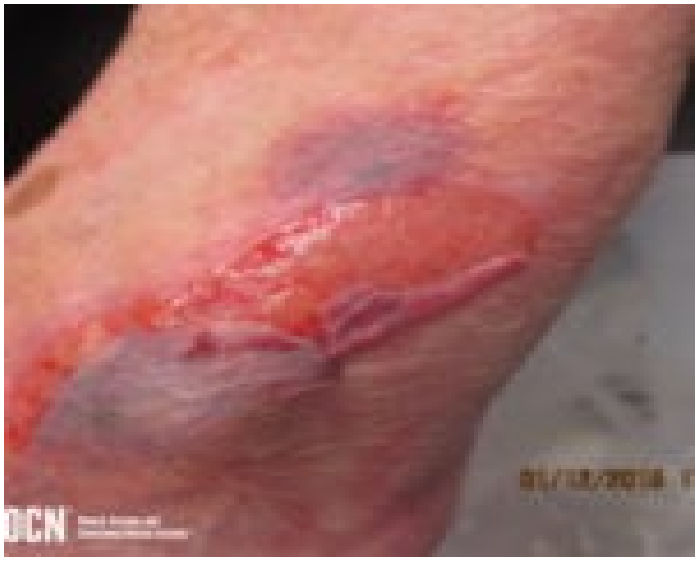
Score: /33

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)

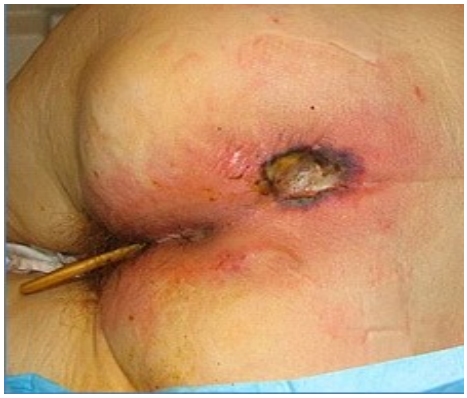
Topical Therapy nursing orders: *Cleanse with normal saline and gently pat dry. Apply mesh contact layer (Hollister Adaptic) and cover with dry gauze and wrap with rolled gauze (Kerlix). Change daily and PRN.*

(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 Pressure Injury

Topical Therapy nursing orders: Cleanse with normal saline and gently pat dry. Gently fill wound with Vashe moistened kerlix and cover with dry sterile dressing. Change BID and PRN.

1 alternative product: Cleanse with normal saline and gently pat dry. Apply Medihoney to the base of the wound and gently fill wound with NS moistened Kerlix and cover with dry sterile dressing. Change daily and PRN.

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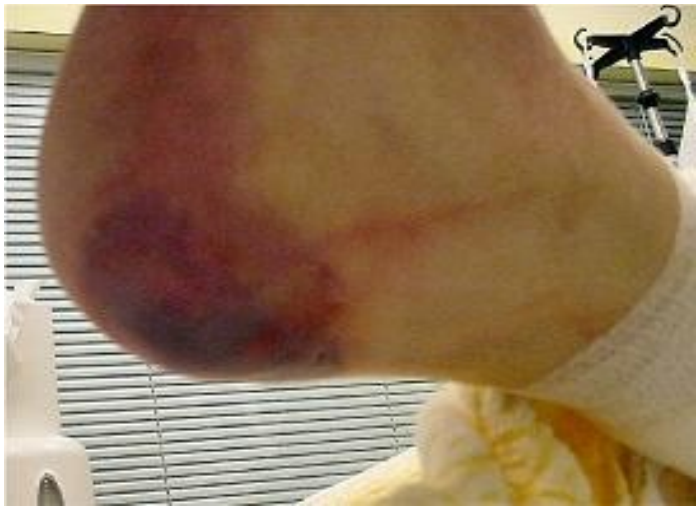
Scenario 2



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: Cleanse with normal saline and gently pat dry. Apply ConvaTec skin barrier foam applicator daily. Leave open to air. Elevate heel at all times while lying in bed.

1 alternative product: Cleanse with normal saline and gently pat dry. Apply Sween cream daily. Leave open to air. Elevate heel at all times while lying in bed.

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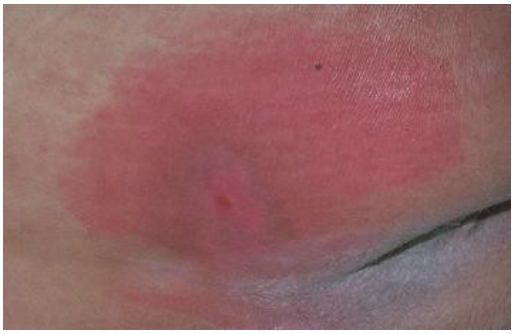
Scenario 3



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 Injury

Topical Therapy nursing orders: Gently cleanse with normal saline and gently pat dry. Apply Critic-Aid Clear Moisture Barrier Ointment BID and PRN. Offload and reposition every 2 hours.

1 alternative product: Gently cleanse with normal saline and gently pat dry. Apply Mepliex dressing, remove every 3 days or PRN. Offload and reposition every 2 hours.

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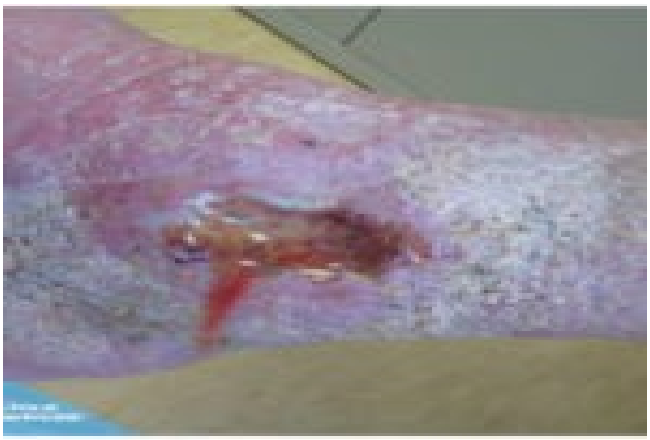
Scenario 4



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: Venous Ulcer

Topical Therapy nursing orders: Gently cleanse with normal saline and gently pat dry. Apply Triad to periwound skin. Apply Aquacel to wound and cover with dry dressing. Change daily or PRN.

1 alternative product: Gently cleanse with normal saline and gently pat dry. Cut Hydrofera Blue Classic to fit wound, moisten with normal saline and ring out excess, apply to wound and cover with dry dressing. Change every other day or PRN.

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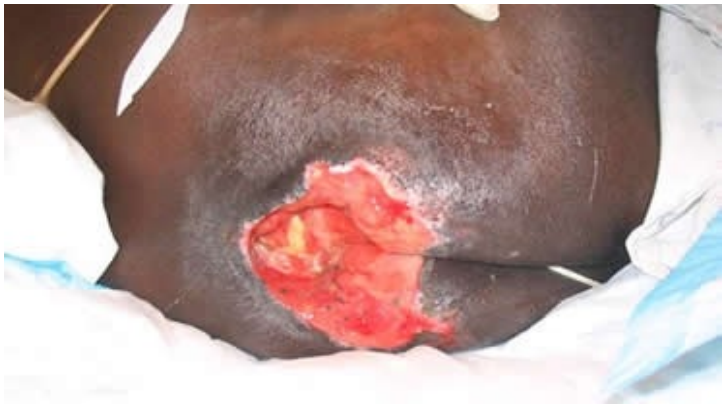
Scenario 5



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: Cleanse with normal saline and gently pat dry. Gently fill wound with Vashe moistened kerlix and cover with dry sterile dressing. Change BID or PRN.

1 alternative product: Cleanse with normal saline and gently pat dry. Apply NPWT device at -125 mm/Hg, change Monday/Wednesday/Friday.

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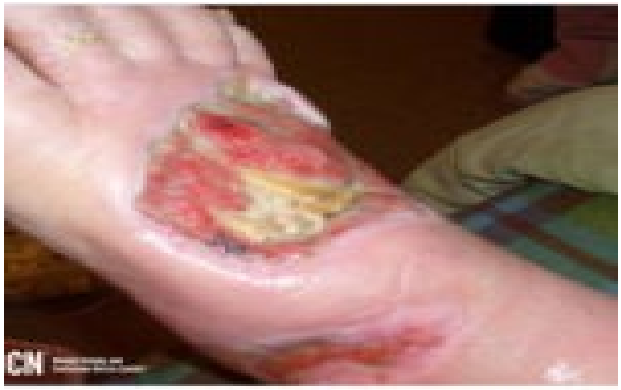
Scenario 6



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: Arterial Ulcer

Topical Therapy nursing orders: Cleanse with normal saline and gently pat dry. Apply hydrogel (Duoderm) to wound, apply UrgoTul directly to wound, apply dry sterile dressing. Change daily or PRN.

1 alternative product: Cleanse with normal saline and gently pat dry. Apply xeroform to wound, cover with dry dressing. Change daily or PRN.

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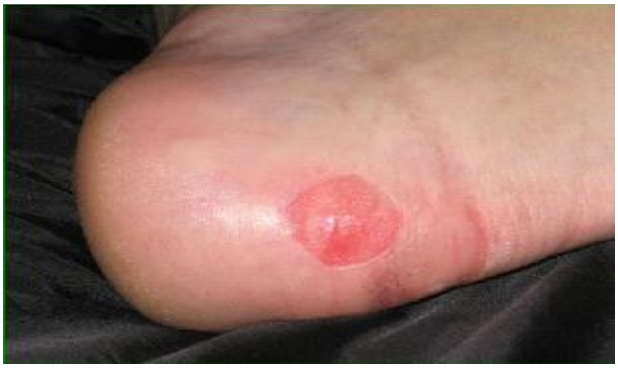
Scenario 7



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: Gently cleanse with normal saline and gently pat dry. Apply hydrogel (Duoderm) to wound and cover with foam dressing. Change dressing every other day or PRN.

1 alternative product: Gently cleanse with normal saline and gently pat dry. Apply UrgoTul and cover with foam dressing. Change every 3 days or PRN.

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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: Stage 4 Pressure Injury

Topical Therapy nursing orders: Cleanse with normal saline and gently pat dry. Gently fill wound with Vashe moistened Kerlix and cover with dry sterile dressing. Change daily or PRN.

1 alternative product: Cleanse with normal saline and gently pat dry. Cut Hydrofera Blue Classic to fit wound, moisten with NS and ring out excess, apply to wound and cover with dry dressing. Change every other day or PRN.

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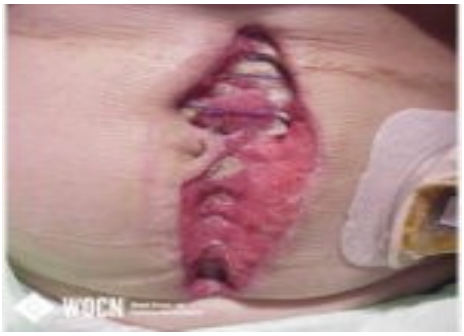
Scenario 9



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: Complete wound dehiscence

Topical Therapy nursing orders: Cleanse with normal saline and gently pat dry. Cut Calcium alginate AG (Biatain Alginaye Ag) to wound size, place to wound bed and cover with Abd pad. Change daily or PRN.

1 <u>Advanced</u> therapy alternative product: Apply NPWT device at -125 mm/Hg, change Monday/Wednesday/Friday.

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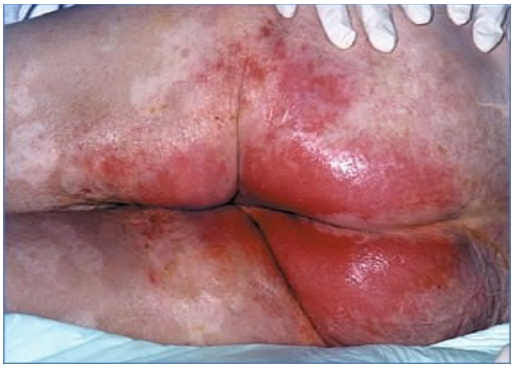
Scenario 10



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: Incontinence Associated Dermatitis (IAD)

Topical Therapy nursing orders: Cleans with normal saline and gently pat dry. Perform crusting technique daily by sprinkling powder over open areas, dust off excess, then applying ConvaTec skin barrier wand over top repeating process 3 times. Apply thick layer of Destin TID and as needed to keep areas covered.

1 alternative product: Cleanse skin thoroughly and gently with Cavilon no-rinse skin cleanser. Apply 3M Cavilon Advanced until the entire area of concern has been covered, allow to dry for 30 seconds. DO NOT APPLY ANY OTHER OINTMENTS TO THE SKIN. Repply the product 2 – 3 times per week.

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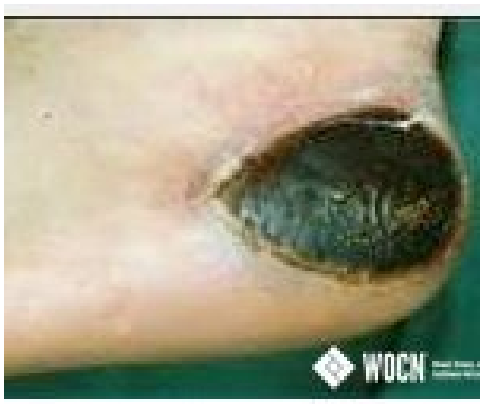
Scenario 11



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: Unstageable

Topical Therapy nursing orders: Cleanse with normal saline and gently pat dry. Paint the wound daily with Betadine. Offload heels.

1 alternative product: ConvaTec skin barrier foam applicator daily. Offload heels.

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