

Mini Case Studies: Wounds



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Reviewed by: _____

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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: Cleanse with Dermal Wound Cleanser, pat dry with gauze, apply thin layer of Solosite Wound gel to wound base with fluffed gauze filling in wound base, apply thin layer of moisture barrier cream to wound border and cover with Mepilex foam border in large size sacral shape. Change dressing daily, when soiled, and as needed.

1 alternative product: Cleanse with Dermal Wound Cleanser, pat dry with gauze, apply thin layer of Medihoney Wound paste to wound base with fluffed gauze filling in wound base, apply thin layer of moisture barrier cream to wound border and cover with Mepilex foam border in large size sacral shape. Change dressing daily, when soiled, and as needed.

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: Offloading with Z-flex boots, ensuring boots are in proper placement q shift

1 alternative product: Apply Medline Marathon skin protectant to DTI area and surrounding wound border and continue to offload heels. Reapplying Marathon skin protectant every 3 days.

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: Cleanse with soap and water, pat dry. Apply Coloplast Moisture Barrier Cream, on bony prominence apply Mepilex foam border dressing for cushion and prevention. Roll down dressing border and reapply moisture barrier cream daily. Change dressing every 3 days or if dressing is soiled, PRN. Continue turning and positioning q2 hours for offloading.

1 alternative product: Replace the Moisture Barrier cream with a zinc based cream, Coloplast Triad

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: Cleanse with wound cleanser and pat dry, gently pack Maxorb extra calcium alginate rope to wound bed filling in dead space. Apply moisturizing cream Colorplast Sween 24 Moisturizing Skin Protectant daily and PRN. Cover wound with Abdominal pad and wrap with Kerlix, loose enough that two fingers can fit under the dressing. Change dressing daily and PRN if soiled.

1 alternative product: Replace Abdominal pad and Kerlix dressing with Medline Optifoam Gentle SA, silicone faced foam and border and apply moisturizing cream after Optifoam.

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 wound cleanser, pat dry and remove any excess slough that comes off naturally. Apply a thin layer of Silvasorb Hydrogel to wound bed and to fluffed gauze, then gently fill in dead space of wound bed with fluffed gauze. Cover with layered ABD pads and secure with transparent Opsite Flexifix (10x4cm) to cover the entire space.

1 alternative product: Cover the dressing with Allevyn Life Dressing, size measuring 15.4cm x15.4cm to cover entire space.

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: Diabetic Foot Ulcer

Topical Therapy nursing orders: Cleanse with wound cleanser, gently pat dry. Cover with Xeroform gauze Dressing and cover with ABD pad and wrap with Spandage Tubular Retainer Net. Change daily and PRN. Limit the amount of pressure placed on this area, spandage should be fitted but not tight around the foot. When removing dressing be sure to moisten area and gently remove xeroform dressing as it can adhere to wound bed if it dries out.

1 alternative product: Instead of xeroform occlusive dressing another great product would be Polymem non-adhesive pad which will donate moisture and absorb drainage. Then continue the same Abd pad and spandage cover to limit tape use on fragile skin.

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 open blister

Topical Therapy nursing orders: Cleanse with normal saline and pat dry, apply Smith & Nephew Skin Prep Protective Wipes. Keep offloading the heel. Reapply skin prep q2 days

1 alternative product: Instead of Skin prep wipes apply Medline skin protectant cream, Nutrashield. Maintain offloading, reapply skin q shift.

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 gently with wound cleanser, gently pack wound with Aquacel Ag Advantage rope dressing and then cover the wound bed with Aquacel Ag Advantage Sheet dressing, cutting to fit wound bed size. Then cover with Mepilex border foam dressing. Mepilex border foam dressing can be gently peeled back and inside dressing changed daily, unless soiled then replace Mepilex border foam dressing. Mepilex border foam dressing should be replaced q3 days if not soiled.

1 alternative product: Replace Aquacel Ag Advantage rope and sheet dressing with Medihoney rope and sheet dressing, same application of loosely packing. Medihoney has more conformity characteristics so it may need to be cut or molded to shape of wound bed.

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). Peri wound skin intact without erythema.

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

Wound type: Wound dehiscence

Topical Therapy nursing orders: Cleanse the wound with normal saline moistened gauze, Apply non adhesive contact layer to wound bed, Curad Oil Emulsion Gauze Dressing. Apply Solosite hydrogel wound gel to fluffed gauze and loosely pack into wound bed. Apply Skin prep to wound border. Cover with ABD pad and tape border with hypafix tape once skin prep has dried onto skin. Change daily and as needed if soiled. When removing ensure any gauze that has dried out is moistened upon removal, this tissue is very fragile.

1 Advanced therapy alternative product: Negative Pressure wound therapy applied to wound bed.

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 skin dermatitis

Topical Therapy nursing orders: Cleanse skin with soap and water, patting dry, minimal rubbing, ensuring no fecal residue is left on the skin. Apply a thin layer of Triad Wound paste to entire area of affected skin and healthy skin at the border. Cleansing and reapplying daily and as needed. Removal with warm water and Coloplast Clear Moisture barrier ointment will help remove excess dried on Triad.

1 alternative product: Instead of Triad Wound paste, is Medline Sooth and Cool barrier ointment, the aloe will provide a cooling effect for the patient’s skin.

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: Cleanse area with soap and water, pat dry. Apply betadine to wound bed and wound border. Offload heels on Z-flex boots, education provided to caregiver on offloading and repositioning.

1 alternative product: Instead of betadine, apply Skin prep to wound bed and surrounding skin, maintain offloading of heels.