R.B. Turnbull, Jr. MD School of WOC Nursing Education
Mini Case Studies: Wounds

Cleveland Clinic

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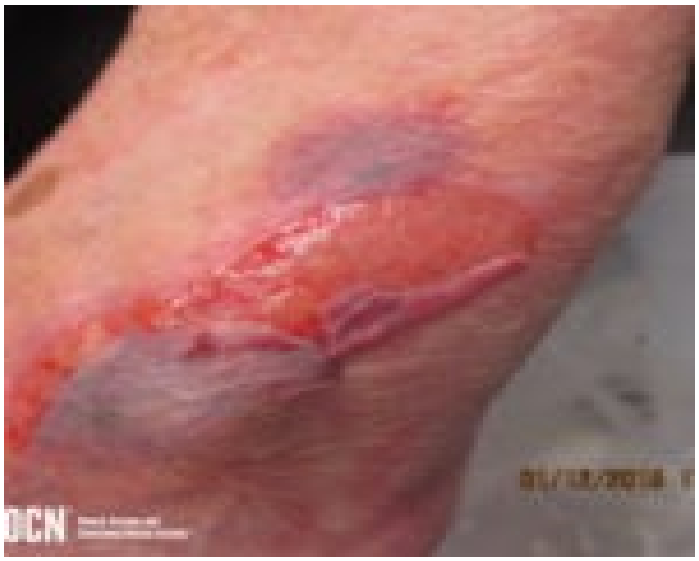
Reviewed by: _____ Date: _____
Score: /33

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 <u>???</u> as described by the International Skin Tear Advisory Panel (ISTAP).

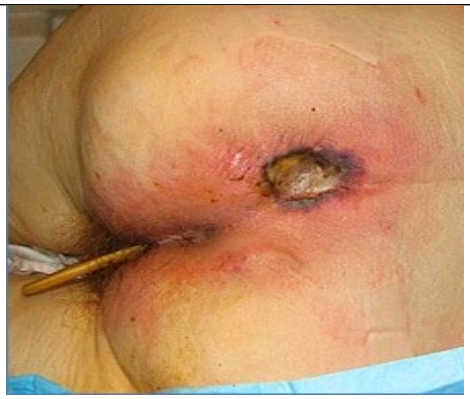
Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

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 PI

Topical Therapy nursing orders:

cut antimicrobial blue foam (hydrofera blue classic) to fit wound bed, apply,

secure with composite dressing (covaderm adhesive)

change every 3 days or prn

1 alternative product: hydrogel sheet dressing (McKensson hydrogel dressing), secured with composite dressing (covaderm adhesive)

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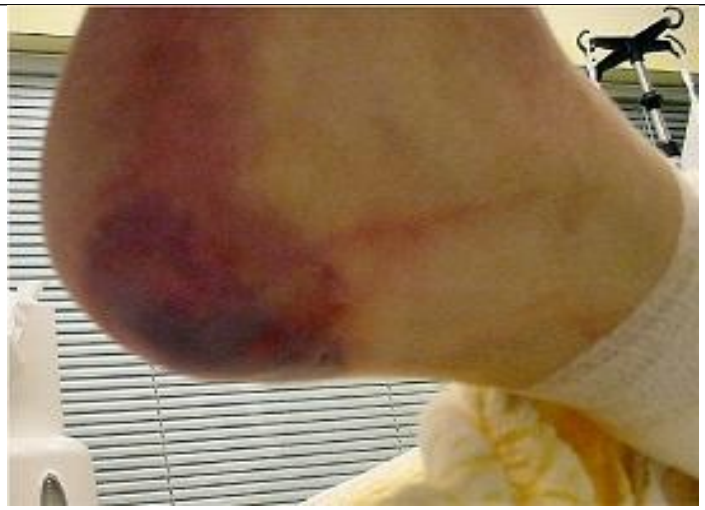
Scenario 2



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 injury

Topical Therapy nursing orders:

offload site with support surfaces such as heel protecting boots

Monitor site daily to track development

Provide appropriate skin care, prevent skin from drying out or from becoming to moist by applying lotion or moisture barrier cream depending on patient needs

1 alternative product: bordered foam dressing (Mepilex border heel dressing)

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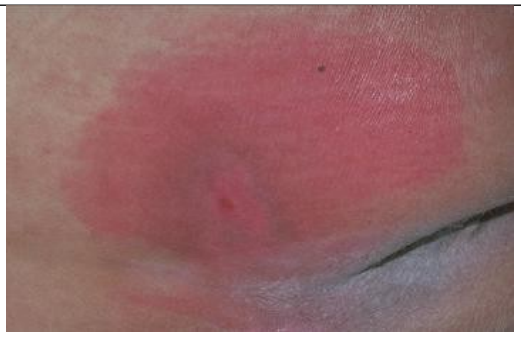
Scenario 3



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 PI

Topical Therapy nursing orders:

if possible, discontinue bed rest orders as soon as safe and begin ambulating patient

Place pt on reactive surface, encourage pt to reposition self if possible, implement turning schedule

Protect site from exposure to moisture, apply zinc oxide paste if site is moist, avoid rubbing skin to prevent further damage

Apply adhesive bordered foam (Mepilex bordered dressing) over site

1 alternative product: Triad hydrophilic paste

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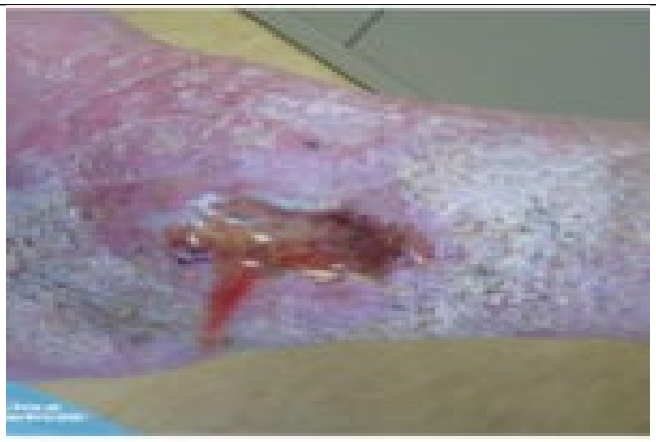
Scenario 4



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 insufficiency ulcer

Topical Therapy nursing orders:
Cleanse with normal saline, dry gently

Apply silicone moisture barrier cream (hydra guard) to macerated Periwound skin

Apply calcium alginate sheet (Algisite M) to wound bed, cover with non-adherent gauze and wrap with roll gauze (Kerlix), secure with cloth (Medipore) tape

Change every 3 days or as needed

1 alternative product: Cadexomer iodine (Iodosorb) to wound bed, cover the same way, change every 2 days or when gel has changed from brown color to yellow or gray

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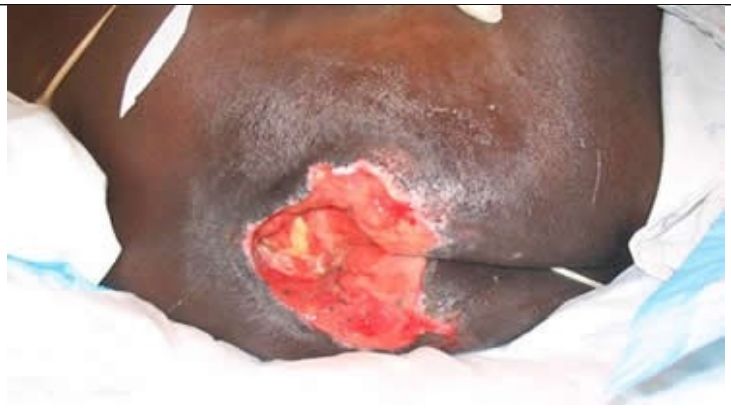
Scenario 5



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 PI

Topical Therapy nursing orders:

cleanse wound bed and Periwound skin with normal saline and gauze, pat dry

Apply skin prep (Cavilon, 3M skin barrier wipes) to peri wound skin

Fill wound with alginate (Algisite M), cover with abd pad, cloth (Medipore) tape

Change every other day or as needed

If pt is incontinent, consider external catheter, fecal management system

1 alternative product: Fill wound with Medline non-woven gauze pads, soaked with normal saline, secure same way, change every other day or as needed

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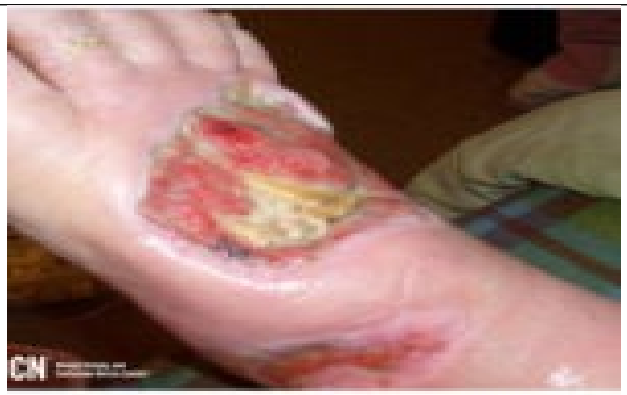
Scenario 6



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 wound bed and Periwound skin gently with normal saline, gauze

Apply saline moistened silver alginate dressing, secure with roll gauze (Kerlix), cloth (Medipore) tape

Apply double layer compression wrap (Coban 2) over dressing

Change every 3 days or prn

If adequate blood supply can be attained, consider debridement of epibole

1 alternative product: antimicrobial hydrofiber sheet (Aquacel Ag), secure same way, change every 3 days or prn

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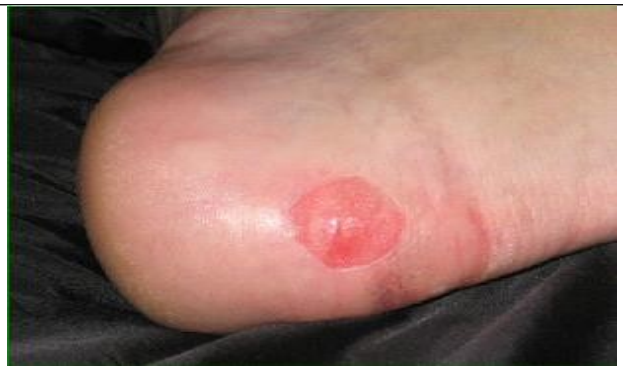
Scenario 7



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 PI

Topical Therapy nursing orders:
cleanse gently with normal saline, gauze

Apply silicone bordered foam dressing (Mepilex bordered heel dressing) over wound bed

Change every 3 days or prn

Offload heels

1 alternative product: absorbent transparent dressing (absorbent tegaderm), change eery 7 days or prn

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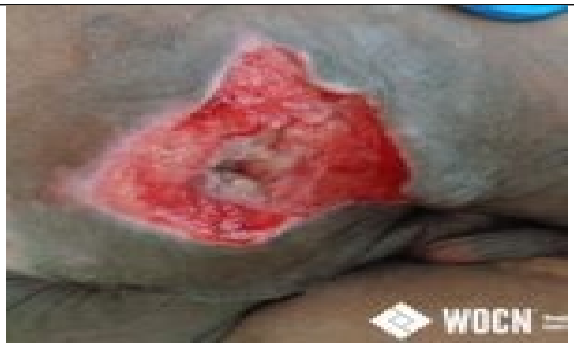
Scenario 8



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 PI

Topical Therapy nursing orders:

gently cleanse wound bed and Periwound skin with normal saline, gauze

Apply skin barrier (Cavilon, 3M skin barrier wipes) to Periwound skin

Cut silicone contact layer (Medline Versatel One) to fit exposed bone

Fill wound bed with black NPWT foam (3M V.A.C. Ganufoam), track foam away from wound and bony prominence, cover with transparent dressing

Cut small hole in transparent dressing over foam tracked away from wound, apply track pad over foam

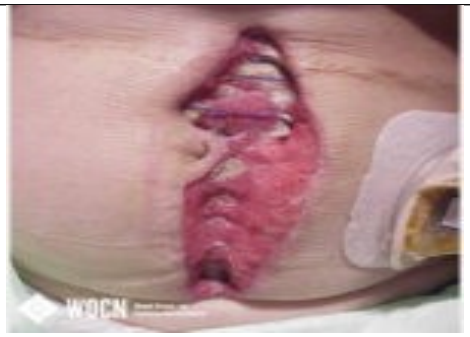
Connect to NPWT device (3M V.A.C.) and preform a seal check, initiate therapy at 125 mmHg

Change every two days, or prn

May moisten foam with saline to facilitate removal

1 alternative product: lightly fill wound with saline moistened gauze (Medline non-woven), cover with silicone bordered foam dressing (Mepilex), change daily

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: Full thickness surgical wound

Topical Therapy nursing orders:

clean wound bed, Periwound skin with normal saline, gauze

Soak roll gauze (Kerlix) in hypochlorous acid (Vashe) solution and lightly fill wound bed, trim any remaining gauze, not allowing moistened gauze to contact Periwound skin

Cover with bordered gauze dressing (covaderm adhesive)

Change once a day or prn

1 <u>Advanced</u> therapy alternative product:
NPWT

Cleanse wound bed, Periwound skin, apply skin prep (Cavilon, 3M skin barrier wipes) to Periwound skin

Cut premoistened white foam (3M V.A.C. Whitefoam) to fit base of wound, place to base of wound bed, covering underlying structures

Fill remaining wound bed with black foam (3M V.A.C. Ganufoam)

Cover foam with transparent wound vac dressing (3M V.A.C. drape)

Cut small hole in transparent dressing over foam, apply track pad over hole, connect to wound vac (3M V.A.C.) and initiate therapy at 125 mmHg

Change dressing every 48 hours or prn

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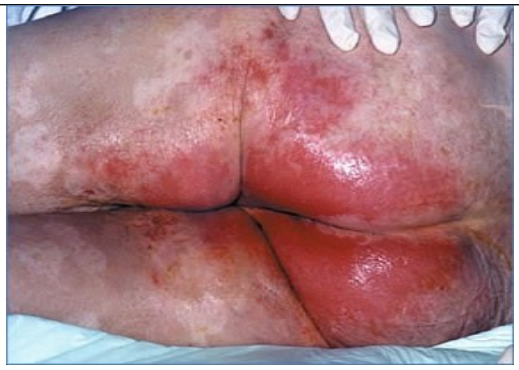
Scenario 10



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: IAD

Topical Therapy nursing orders:

cleanse buttocks with ph balanced no rinse foam cleanser (Medline Remedy Cleanse), pat dry

Apply hydrophilic paste (Triad) to reddened areas

Repeat after episodes of incontinence

If pt is significantly incontinent with liquid stools, place internal fecal management system

1 alternative product:
moisture barrier cream (Hydroguard)

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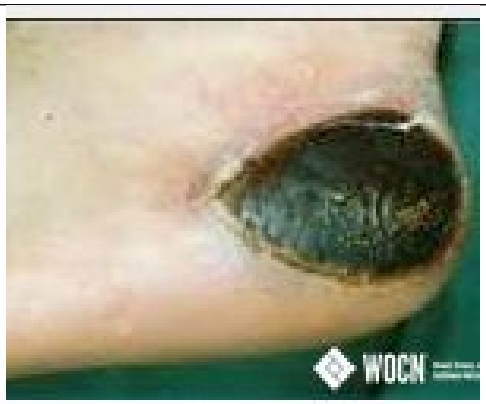
Scenario 11



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 PI

Topical Therapy nursing orders:
Apply antimicrobial blue bordered gauze (hydrofera blue ready border dressing)

Change every 7 days per manufacturer guidelines or prn

Offload heel

1 alternative product: paint heel daily with iodine swabs (Medline providone-iodine), leave open to air and offload

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