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

Mini Case Scenarios: Wounds

Cleveland Clinic

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Reviewed by: _____ **Date:** _____

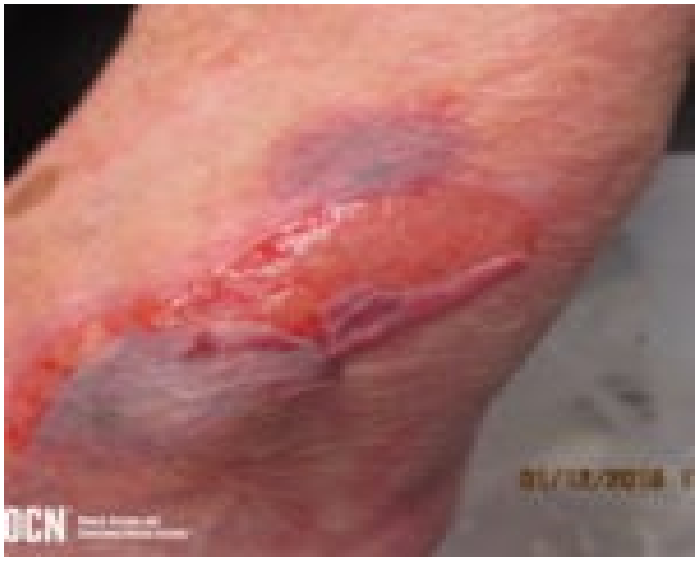
Score: /96

For the following wound case scenarios:

1. Identify the type of wound pictured.
2. Apply wound characteristics provided to identify recommendations/nursing orders for this patient & the wound.
3. Include the following in the recommendations/orders
    a. Dressing
        i. *Type of dressing*
        ii. *Brand name(s)*
        iii. *Secondary dressing if needed*
        iv. *Dressing change schedule*
    b. Other nursing orders pertinent to successful wound healing or prevention
    c. Rationale for choices
4. Provide an alternative to your initial dressing choice. This should be a product substitution, not simply a brand name substitution.
5. Answer any additional questions.

A case study has been completed for you below as an example.

Scenario Example



85-year-old in an extended care facility has 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
(1 point)

Wound Nurse recommendations/orders:

1. Use no rinse, pH balanced bath wipes at bathtime vs. soap, minimize rubbing at bath time, & gently dry fragile skin
2. Apply mesh contact layer (Hollister Adaptic)
3. Moisturize both arms daily with Medline Remedy moisturizing lotion
4. Wrap with roll gauze (Kerlix).
5. Change dressing on every shower day or if wet or soiled
6. Use long sleeve garments or sleeve covers for patient during waking hours

(3 points)

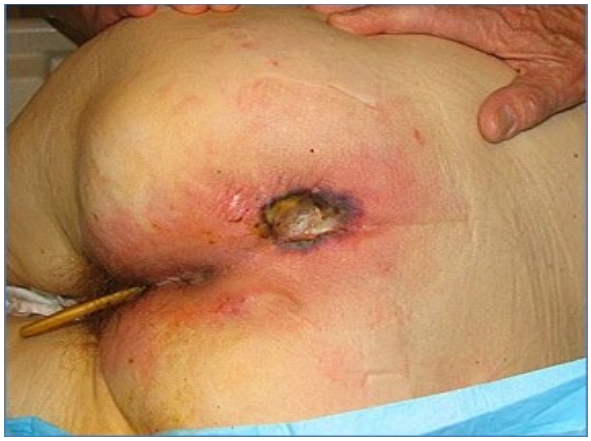
Rationale for choices

1. Bath wipes are pH balanced & soap is usually alkaline & difficult to rinse if person not showering
2. Rubbing creates friction which may cause skin tears
3. Contact layer prevents dressings from sticking to wound
4. Skin moisturizing is a preventive measure for skin tears
5. Roll gauze keeps contact layer in place & patient from touching wound & is non-adhesive
6. Long sleeves protects patient's skin and discourages picking at dressing

(3 points)

1 alternative primary/secondary dressing: Non-adhesive foam dressing, 5 layers, (Allevyn) secured with elastic mesh dressing (Medline elastic retention dressing).
(1 point)

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: Pressure injury unstageable

(1 point)

Wound Nurse recommendations/orders:

1. **Cleanse using vashe and gauze, let soak in wound for 5 minutes then remove.**
2. **Using a tongue depressor apply nickel think layer of collagenase to wound.**
3. **Apply topical skin barrier Cavilon to periwound.**
4. **Cover wound with ABD pad (abdominal pad) and secure with medipore tape.**
5. **Assure the patient has foam wedges to offload sacral area and reposition side to side every 2 hours.**
6. **Perform cleansing and dressing changes daily and as needed.**

(3 points)

Rationale for choices:

1. **Vashe has hypochlorous acid that helps decrease bacteria and increase wound healing.**
2. **Collagenase is an easy and painless way of debriding slough and necrotic tissue from wound bed.**
3. **ABD pad is inexpensive, readily available, and effective as an absorptive dressing that will be removed daily and as needed.**
4. **The periwound is red with blisters and Cavilon can help create a barrier to prevent further skin damage.**
5. **Offloading the wound is going to help relieve sacral pressure and thus help promote wound healing.**
6. **Dressing should be changed and assessed daily to determine progress or regress.**

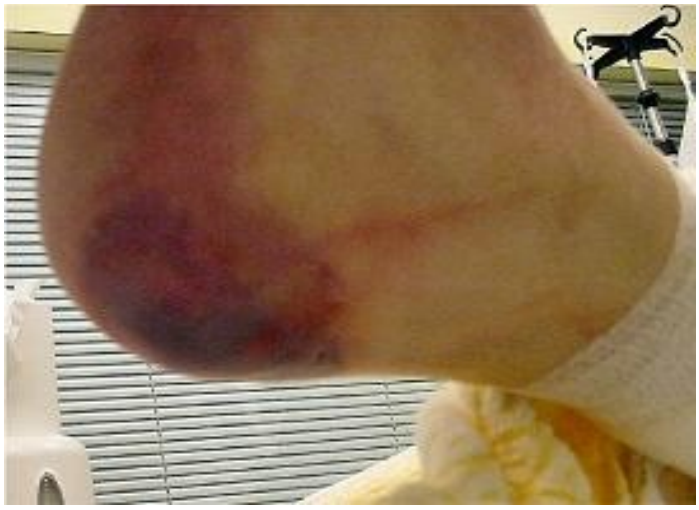
(3 points)

1 alternative primary/secondary dressing – Apply medihoney daily to wound bed and cover with silicone bordered foam dressing such as Allevyn Gentle Border 6x6.

(1 point)

/8 points

Scenario 2



The wound care nurse is consulted to see a 54-year-old, post op day 4 after an abdominal surgery. Left heel has non-blanchable purple discoloration.

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

Wound type: Deep tissue injury

(1 point)

Wound Nurse recommendations/orders:

1. **Cleanse wound/DTI wound area with vashe wound cleanser and gauze.**
2. **Place 3M Tegaderm Silicone Foam dressing.**
3. **Encourage ambulation to reduce pressure.**
4. **Educate patient on offloading and pressure injury causes.**
5. **Wear EHOB heel protector boot while in bed.**
6. **Perform daily assessment and change dressing every 7 days or as needed.**

(3 points)

Rationale for choices:

1. Cleansing the wound area to properly assess and visualize the extent of injury.
2. Tegaderm foam dressing provides protection from further tissue damage, absorbs moisture, and has long wear time.
3. Encouraging ambulation will offload tissue pressure from lying in bed.
4. Educating the patient will help bring understanding, motivation, and compliance to avoid further damage.
5. Wearing EHOB boot will offload DTI and prevent further deterioration.
6. Performing daily assessment will keep track of progress or regress of wound.

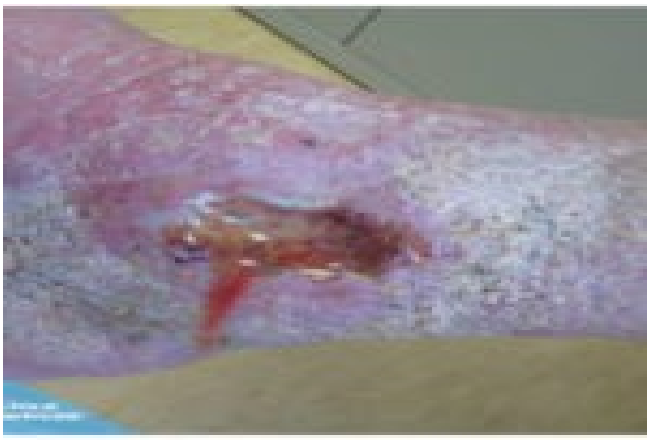
(3 points)

1 alternative primary/secondary dressing – Apply hydrocolloid Duoderm to affected area and can stay in place for up to 7 days.

(1 point)

/8 points

Scenario 3



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. Patient has ABI of 0.85 to RLE and 0.90 to LLE

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

Wound type: Venous ulcer

(1 point)

Wound Nurse recommendations/orders:

1. **Cleanse the wound with Vashe cleanser and gauze.**
2. **Apply 3M Cavilon advanced skin protectant to periwound.**
3. **Apply UrgoClean Ag to wound. (cut to fit size of wound)**
4. **Apply Allevyn non bordered foam dressing over UrgoClean AG.**
5. **Apply Coflex TLC with calamine starting at base of the toes up to two fingers under patient's knee.**
6. **Have patient come back in 3 days to re-assess.**
7. **Advise patient to keep dressing/boot from getting wet.**

(3 points)

Rationale for choices:

1. **Vashe will clean the wound bed from bacteria and prepare the wound bed for treatment.**
2. **Cavilon will provide a barrier that will protect the periwound from further damage from exudate.**
3. **UrgoCleanAg has antibacterial properties that help decrease infection, help with removal of devitalized tissue, promotes granulation tissue.**
4. **Allevyn foam will provide extra absorption and helps keep moist wound bed.**
5. **Coflex TLC with calamine will provide calming calamine to skin along with compression.**
6. **Re-assessment in 3 days is to evaluate wound and patient tolerability.**
7. **Coflex wrap should be kept dry in order to maintain the integrity of compression and the patients skin.**

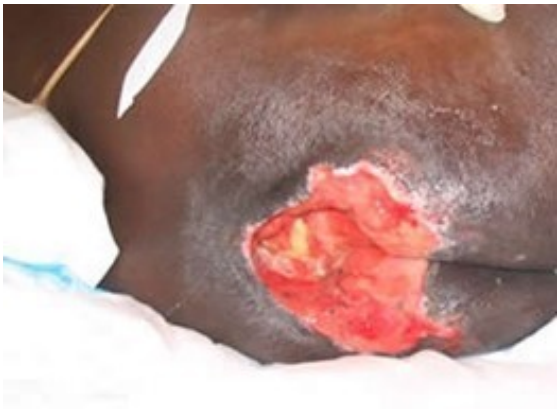
(3 points)

1 alternative primary/secondary dressing: Daily dressing change with silver alginate Durafiber, silicone bordered foam Allevyn 4x4 gentle border, tubigrip Spandagrip compression 2 layer.

(1 point)

/8 points

Scenario 4



An 85-year-old is admitted to the hospital with a stage ??? pressure injury on sacrum and is bedridden. 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 moderate serosanguineous drainage.

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

Wound type: Pressure injury stage III

(1 point)

Wound Nurse recommendations/orders:

1. **Cleanse wound with wound cleanser Vashe and gauze.**
2. **Apply Lidocaine cream 4% topical to area with slough and perform selective debridement.**
3. **Apply 3M Cavilon to periwound.**
4. **Apply silver alginate Durafiber to wound bed.**
5. **Apply 3M Tegaderm silicone foam dressing over wound.**
6. **Cleanse and change dressing daily and as needed.**

(3 points)

Rationale for choices:

1. **Vashe will clean the wound bed from bacteria and prepare the wound bed for treatment.**
2. **Topical lidocaine can help ease discomfort during debridement.**
3. **Cavilon will provide a barrier that will protect the periwound from further damage from exudate.**
4. **Silver alginate will help to decrease bacterial growth, absorb exudate, promote wound healing and granulation tissue formation.**
5. **Tegaderm foam dressing keeps moist wound environment and provides tissue damage protection.**
6. **Daily dressing change is ideal, though due to location if soiled then as needed change of dressing is needed.**

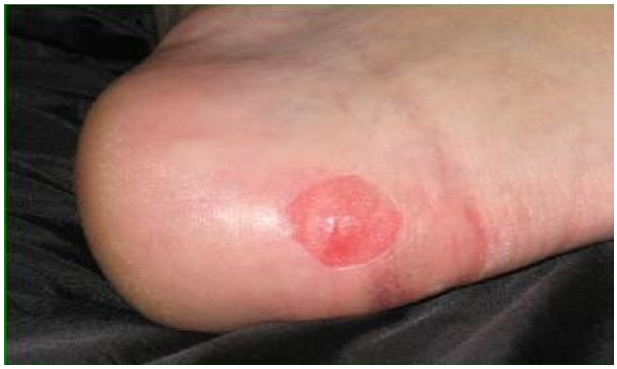
(3 points)

What support surface would you recommend and why? An Envella Fluidized Therapy bed is recommended due to the pressure redistribution via air and tiny beads making pressure areas minimal and faster healing.

(1 point)

/8 points

Scenario 5



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: Pressure injury stage 2

(1 point)

Wound Nurse recommendations/orders:

1. **Cleanse wound with vashe wound cleanser.**
2. **Apply Cutimed Sorbact to wound.**
3. **Apply 3M Tegaderm silicone foam dressing.**
4. **Assess daily but change dressing every other day.**
5. **Educate on offloading.**
6. **Wear EHOB heel protector boot.**

(3 points)

Rationale for choices:

1. **Vashe will clean the wound bed from bacteria and prepare the wound bed for treatment.**
2. **Cutimed will provide moist wound bed and decrease bacterial burden.**
3. **Tegaderm foam dressing provides protection from further tissue damage, absorbs moisture, and has long wear time.**
4. **It is imperative to assess wound daily and assure that treatment is appropriate, and wound is progressing and not regressing.**
5. **Educating the patient will help bring understanding, motivation, and compliance to avoid further damage.**
6. **Wearing EHOB boot will offload wound and prevent further deterioration.**

(3 points)

1 alternative primary/secondary dressing Mupirocin oinment daily covered with telfa non adherent pad and secure with conforming roll gauze and medipore tape.

(1 point)

/8 points

Scenario 6

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% p ink 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: Pressure injury stage IV

(1 point)

Wound Nurse recommendations/orders:

1. **Cleanse wound with vashe and gauze.**
2. **Obtain wound culture using Levine technique.**
3. **Apply silver alginate Durafiber to wound.**
4. **Apply 3M Tegaderm silicone foam dressing.**
5. **Change dressing daily or as needed.**

(3 points)

Rationale for choices:

1. **Due to the tan drainage a wound culture needs to be obtained for culture and sensitivities to prescribe the appropriate antibiotics if needed.**
2. **Cleansing the wound with vashe and gauze will help rid of loose devitalized tissue and bacteria and will prepare the wound for treatment.**
3. **Silver alginate Durafiber will help decrease bacterial burden and absorb exudate.**
4. **3M Tegaderm silicone dressing provides protection from further tissue damage, absorbs moisture, and has long wear time.**
5. **Daily dressing change is ideal, though due to location if soiled then as needed change of dressing.**

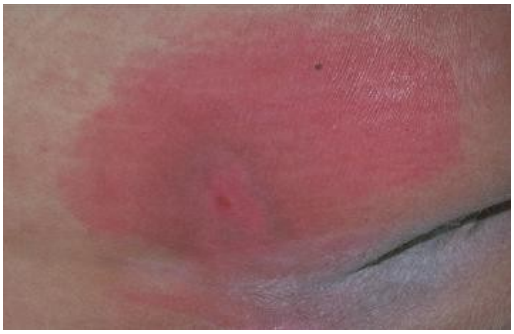
(3 points)

1 alternative primary/secondary dressing: Cleanse wound with vashe and gauze, apply UrgoClean AG to wound, cover with ABD pad, conforming roll gauze and secure with medipore tape.

(1 point)

/8 points

Scenario 7



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: Pressure injury stage I

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with vashe and gauze.
2. Measure injury area.
3. Place 3M silicone foam dressing.
4. Provide foam wedges and educate on offloading.
5. Inspect and assess injury daily.
6. Dressing can stay in place for 7 days or change as needed.

(3 points)

Rationale for choices:

1. **Cleansing to be able to clearly visualize extent of wound.**
2. **Measure to keep track of progress or regress.**
3. **Silicone dressing has long wear time, stays in place, and provides barrier from tissue strain.**
4. **Foam wedges are recommended for offloading then long periods of time spent on bedrest.**
5. **Assess to keep track of progress or regress.**
6. **Dressing has long wear time if intact.**

(3 points)

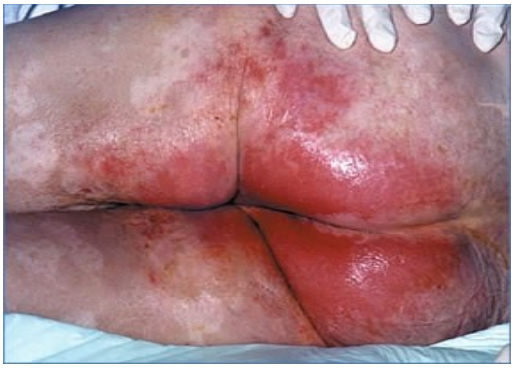
1 alternative primary/secondary dressing

Apply hydrocolloid Duoderm to injury, assess daily, dressing can be changed after 7 days or as needed.

(1 point)

/8 points

Scenario 8



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: MASD - IAD

(1 point)

Wound Nurse recommendations/orders:

1. **Clean with sensitive skin soap and water.**
2. **Apply 3M cavilon advanced skin protectant.**
3. **Apply fecal pouch to anal area and connect to drainage bag.**
4. **Cavilon can be reapplied up to 3x a week.**
5. **Assessment should be performed daily and as needed.**

(3 points)

Rationale for choices:

1. **Cleansing with soap and water has proven to be tolerable than wipes.**
2. **Cavilon creates barrier that protects from incontinence, reapplication 1 to 3x a week, lessens pain for the patient during cleanings.**
3. **Fecal pouch will contain liquid stool away from already damaged skin.**
4. **Cavilon remains in place for up to 7 days but can be reapplied 1 to 3 times weekly.**
5. **Assessment should always be daily priority to assure IAD is healing.**

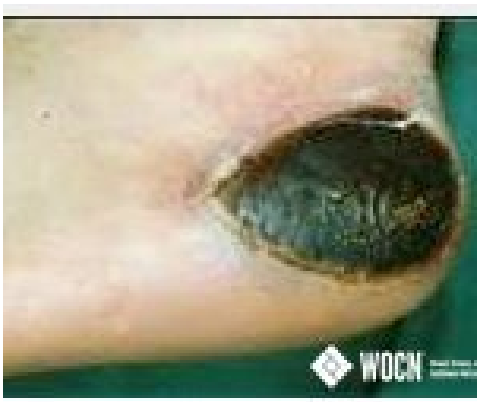
(3 points)

1 alternative primary/secondary dressing: cleanse wound with water, apply Coloplast Triad twice a day and as needed.

(1 point)

/8 points

Scenario 9



An 85-year-old presents to acute care with dry black eschar on left posterior heel. Cared for at home by elderly spouse, he 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: Pressure injury unstageable 100% eschar

(1 point)

Wound Nurse recommendations/orders:

1. **Refer to vascular specialist.**
2. **Leave wound open to air and dry.**
3. **Educate on offloading .**
4. **Wear EHOB offloading boot when in bed.**
5. **Follow back up with patient after vascular testing is completed.**

(3 points)

Rationale for choices:

1. **Vascular specialist can carry out vascular testing of veins and arteries or procedures before any debridement treatment.**
2. **Leaving wound open to air and dry will assure that the wound will not become moist and become open to bacteria.**
3. **Offloading the heels will prevent further damage.**
4. **EHOB boot cushion will prevent further tissue damage.**
5. **Once testing has been completed wound can possibly be treated if results are all clear.**

(3 points)

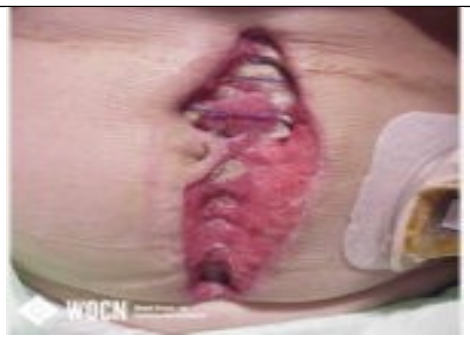
1 alternative primary/secondary dressing: Apply betadine on wound daily and leave open to air.

(1 points)

/8 points

Scenario 10

/8 points



The wound care nurse is consulted to see a 74-year-old patient transferred from a community hospital with 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 dry, pink with small areas of yellow tissue (less than 10% of wound base). Periwound skin intact. WOC team consult for NPWT orders.

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

Wound type: Open abdominal surgical wound

(1 point)

Wound Nurse recommendations/orders:

1. **Cleanse wound with vashe and gauze.**
2. **Apply 3M adaptic dressing over wound base.**
3. **Use hydrocolloid Duoderm to window drape periwound.**
4. **Cut black foam to fit size of wound and apply.**
5. **Apply Dermatac dressing over black foam and make hole for connector site.**
6. **Apply connector and turn on negative pressure wound therapy device at 125mmhg.**
7. **Change dressing 3x a week.**

(3 points)

Rationale for choices:

1. **Cleaning the wound will clean the wound of bacteria and prepare the wound for treatment.**
2. **3M adapti dressing will protect sutures and underlying structures in abdomen.**
3. **Hydrocolloid around periwound will protect periwound from exudate and suction of wound vac.**
4. **Black foam has good porous texture that helps conform to wound bed and promotes granulation tissue formation.**
5. **Dermatac dressing can be moved within 20 mins of applying and is gentle on removal.**
6. **Pressure setting of 125mmhg is ideal for exudate management and granulation tissue growth.**
7. **3x a week dressing change will help with prevention of infection and keep foam from sticking to granulation tissue.**

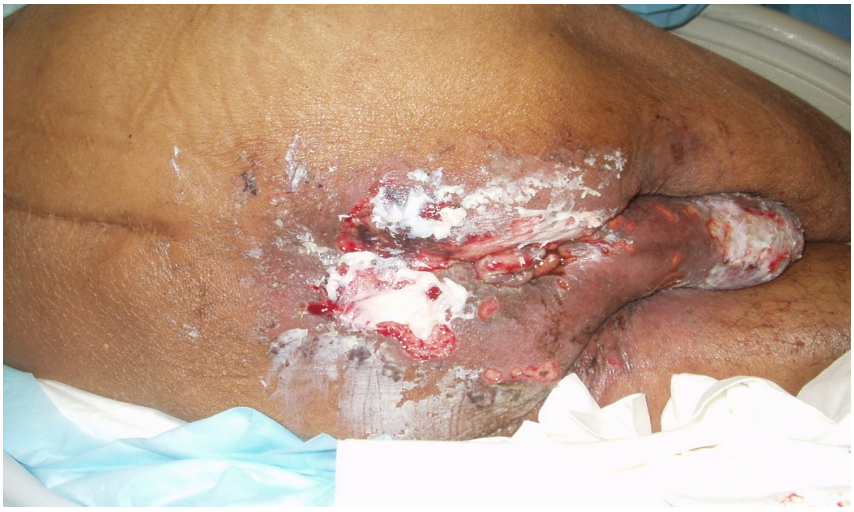
(3 points)

1 alternative primary/secondary dressing: CutiMed Sorbact, saline gauze, abd pad, medipore tape daily or as needed.

(1 point)

/8 points

Scenario 11



Wound care nurse consulted to see a 45-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: MASD/ IAD

(1 point)

Wound Nurse recommendations/orders:

1. **Cleanse wound with soap and water.**
2. **Apply Coloplast Triad Hydrophilic Wound Dressing directly on wound and periwound.**
3. **If incontinence occurs daily then reapply after each episode. Otherwise, dressing can stay in place for 7 days.**
4. **Leave wound/peri-area open to air. (no brief).**

(3 points)

Rationale for choices:

1. **PH balanced soap and water is gentle and effective at removing acids from urine and stool.**
2. **Triad adheres to moist skin, has petrolatum and zinc oxide to assist with wound healing.**
3. **A constant thick layer of Triad is needed to be effective and may need reapplication before the 7 days.**
4. **Covering peri-anal area that is affected with brief will only accumulate moisture which will contribute to deterioration of wouds. May use absorbent pad over bedding.**

(3 points)

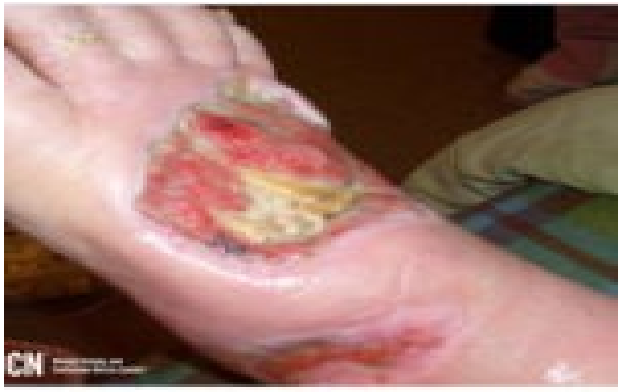
1 alternative primary/secondary dressing:

1. Cleanse wound with ph balanced soap and water, apply 3M cavilon advanced skin protectant, reapply 2x per week.

(1 point)

/8 points

Scenario 12



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 wound

(1 point)

Wound Nurse recommendations/orders:

1. **Control blood sugars. (Check hgb A1c, make sure pt has diabetic diet, glucose checks and treatment AC and HS)**
2. **Perform ABI to determine if pt needs vascular consult.**
3. **Cleanse wound with vashe and gauze. Let soak for 5 minutes.**
4. **Collect culture using Levine technique.**
5. **Apply Cutimed Sorbact with hydrogel.**
6. **Apply ABD pad.**
7. **Secure with conforming roll gauze and medipore tape.**
8. **Change dressing daily.**

(3 points)

Rationale for choices:

1. **Wound will have significant delayed wound healing if blood sugars are not well controlled.**
2. **ABI and/or vascular consult are essential to guide what direction for treatment plan. (etc. dressing type, debridment).**
3. **Thoroughly cleans and prepares wound for treatment.**
4. **Culture to be collected to determine infectious process and need for antibiotics.**
5. **Cutimed Sorbact will keep wound in moist environment and help with bacteria bioburden.**
6. **Abd pad is readily available in the acute care setting and provides absorption of wound exudate.**
7. **Conforming gauze roll and medipore tape are also readily available and inexpensive.**
8. **Dressing should be changed and assessed daily to determine progress or regress.**

(3 points)

1 alternative primary/secondary dressing: Apply negative pressure wound therapy using contact layer and black foam. Apply at 125 mmhg and change dressing 3x a week.
(1 point)

/8 points