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

Mini Case Scenarios: Wounds

Cleveland Clinic

Student Name ___Doris Elliott_____ **Date:** ___10/22/24_____

Reviewed by: _____ **Date:** _____

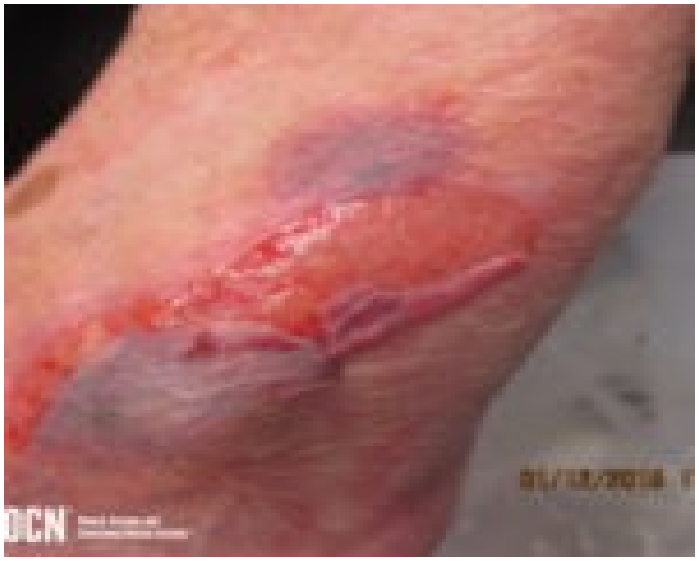
Score: /96

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)

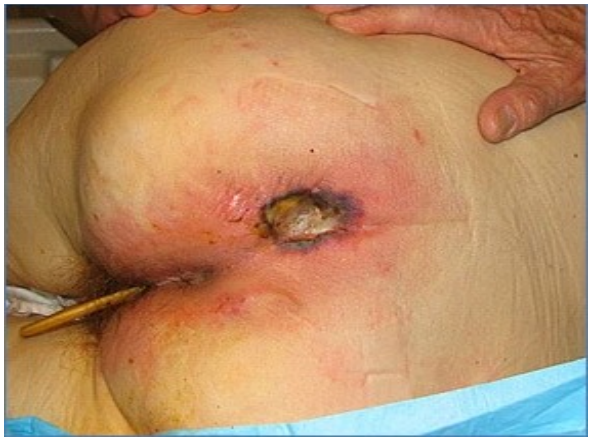
Rationale for choices

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: Unstageable pressure injury

(1 point)

Wound Nurse recommendations/orders:

Every M/W/F

Cleanse wound with vashe soaked gauze, allow vashe to sit on wound bed for five minutes. Pat dry.

Apply Medline skin prep followed by vac drape to the peri-wound and connecting to the hip to protect the intact skin.

Apply MediHoney to the wound bed. Apply negative pressure wound therapy at 125 mmHg, using granufoam black foam that is cut to the size of the wound and tracked to the hip.

Cover all foam with VAC drape, then cut a quarter-size hole into the area of foam located on the hip. Use this opening to connect to the VAC track-head.

Set the machine to 125 mmHg suction and assess for any signs of leaking.

(3 points)

Rationale for choices:

The use of MediHoney will help to break down the slough and necrotic tissue to create and expose a clean wound bed.

The skin prep and drape will help to protect the skin around the wound and prevent further break down.

The negative pressure wound therapy will promote removal of the exudate and non-viable tissue as it breaks down while then promoting granulation of the healthy tissue as it becomes exposed.

(3 points)

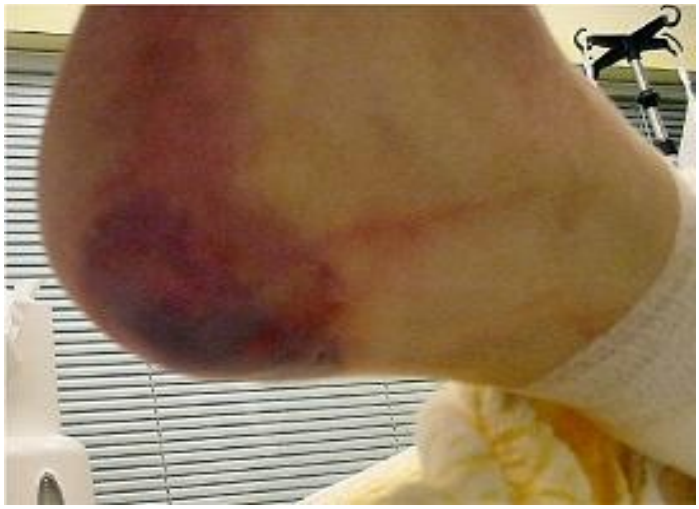
1 alternative primary/secondary dressing

An alternative dressing would be to cleanse the wound every M/W/F with vashe soaked gauze, allowing the vashe to sit for five minutes. Pat dry. Apply skin prep to the peri-wound. Apply Derma Sciences MediHoney alginate squares directly to the wound bed (should be cut to size of wound). Cover with Convatec DuoDerm hydocolloid dressing.

(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 pressure injury

(1 point)

Wound Nurse recommendations/orders:
Cleanse left heel daily with normal saline, pat dry.
Paint heel with iodine and leave open to air
Ensure heel is off-loaded at all times while in bed or chair

(3 points)

Rationale for choices:
The skin should be kept clean and dry
Iodine will help to further keep skin clean and dry
Off-loading will protect the heel from further injury

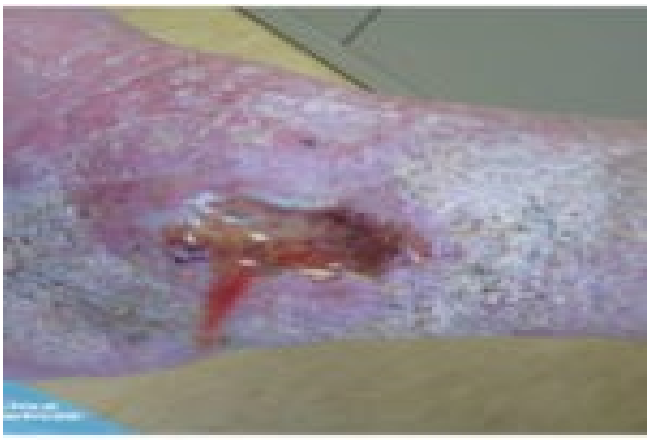
(3 points)

1 alternative primary/secondary dressing
An alternative dressing could be to clean the heel with normal saline and pat dry. Apply Allevyn heel foam dressing every other day and continue with off-loading when ever in bed or in the chair.

(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:
To be done every other day
Cleanse right lower extremity with Molnlycke Hibiclens skin cleanser.
Cleanse wound to RLE with vashe soaked gauze, allow vashe to sit on wound bed for five minutes, pat dry.
Apply skin prep to the peri wound.
Apply smith and nephew iodosorb directly to the wound bed
Cover with Convatec Aquacel dressing to cover the wound, followed by dry gauze.
Wrap and secure dressing using kerlix.
Secure with 3M medipore tape
(3 points)

Rationale for choices:
Cleansing of the entire lower leg should occur with each dressing change because the patient is instructed to avoid shower water to the area.
A vashe soak will cleanse the wound bed
Skin prep will help to protect the peri-wound from the excessive amount of exudate
Iodosorb is a highly absorbent and anti-microbial dressing
The Aquacel will further collect any exudate and protect the peri-wound from excessive exposure to moisture.
Kerlix and medipore tape will secure the dressing in place.

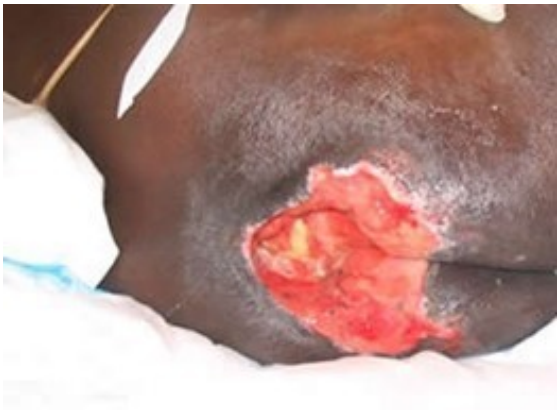
(3 points)

1 alternative primary/secondary dressing:
Every other day and PRN:
An alternative dressing would be to exchange the iodosorb and aquacel for Aquacel AG. The silver in Aquacel AG would provide anti-microbial properties along with being highly absorbent.

(1 point)

/8 points

Scenario 4



An 85-year-old is admitted to the hospital with a stage <u>??? </u>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: Stage 3 pressure injury

(1 point)

Wound Nurse recommendations/orders:
Every M/W/F
Cleanse wound with vashe soaked gauze, allow vashe to sit for 5 minutes, pat dry.
Apply Medline skin prep followed by vac drape to the peri-wound and connecting to the hip to protect the intact skin.
Apply MediHoney to the wound bed where the slough is present.
Apply granufoam black foam to the wound bed that is cut to the size of the wound and tracked to the hip.
Cover all foam with VAC drape, then cut a quarter-size hole into the area of foam located on the hip. Use this opening to connect to the VAC track-head.
Set the machine to 125 mmHg suction and assess for any signs of leaking.

(3 points)

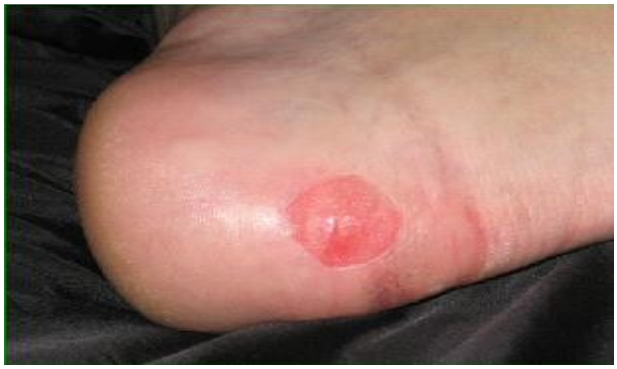
Rationale for choices:
The use of MediHoney will help to break down the slough to create and expose a clean wound bed.
The skin prep and drape will help to protect the skin around the wound and prevent further break down.
The negative pressure wound therapy will promote removal of the exudate and non-viable tissue as it breaks down while then promoting granulation of the healthy tissue as it becomes exposed.

(3 points)

What support surface would you recommend and why?
Daily and PRN:
An alternative dressing would be to cleanse the wound with vashe soaked gauze, allowing the vashe to sit for five minutes. Pat dry. Apply Convatec hydroactive gel to the wound bed. Activate hydrofera blue classic using normal saline and allow dressing to soak for two minutes, squeeze out excess saline and cut to size of wound. Apply to wound bed and cover with Allevyn foam dressing.
(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: Stage two pressure injury

(1 point)

Wound Nurse recommendations/orders:
Every three days and PRN:
Cleanse wound to right heel with normal saline, pat dry.
Apply curad xeroform petroleum dressing to the wound bed.
Cover with dry gauze
Wrap with kling and secure with medipore tape.
Ensure that heel is off-loaded at all times while in bed or the chair.

(3 points)

Rationale for choices:
Cleansing of the wound should occur with each dressing change.
Xeroform petroleum dressing will provide a moist environment and a non-adherent layer to the fragile skin.
Dry gauze will collect any exudate and provide extra padding to the area.
Kling and medipore tape will secure the dressing.
Off-loading will prevent further damage from occurring.
(3 points)

1 alternative primary/secondary dressing
An alternative dressing would be to apply Curad Adaptic contact layer followed by an Allevyn heel foam dressing. This should be done in conjunction with constant off-loading when in the bed or chair.

(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% 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

(1 point)

Wound Nurse recommendations/orders:
Every M/W/F:
Cleanse wound with vashe soaked gauze, allow vashe to sit for 5 minutes, pat dry.
Apply Medline skin prep followed by vac drape to the peri-wound and connecting to the hip to protect the intact skin.
Apply curad adaptic contact layer to the area of exposed bone.
Apply granufoam black foam to the wound bed that is cut to the size of the wound and tracked to the hip.
Cover all foam with VAC drape, then cut a quarter-size hole into the area of foam located on the hip. Use this opening to connect to the VAC track-head.
Set the machine to 125 mmHg suction and assess for any signs of leaking.

(3 points)

Rationale for choices:
The use of Adaptic over the exposed bone will protect the area and prevent the granufoam from causing damage and adhering to the bone.
The skin prep and drape will help to protect the skin around the wound and prevent further break down.
The negative pressure wound therapy will promote removal of the exudate and non-viable tissue as it breaks down while then promoting granulation of the healthy tissue as it becomes exposed

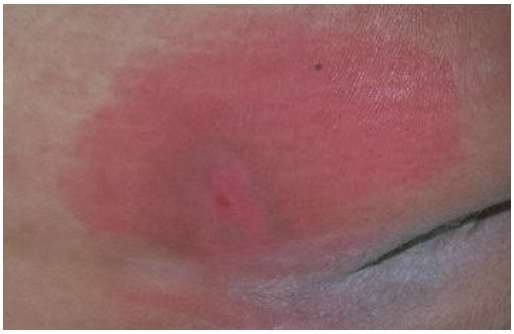
(3 points)

1 alternative primary/secondary dressing:
An alternative would be to use the white foam over the exposed bone followed by application of the granufoam black foam.

(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: Stage one pressure injury
(1 point)

Wound Nurse recommendations/orders:
Daily and PRN:
The area should be cleansed with Stryker shield grey barrier wipes to cleanse the skin. The skin should be gently patted dry.
An Allevyn sacral foam dressing should be applied directly to the area and pressure injury prevention measures implemented such as frequent turning.
(3 points)

Rationale for choices:
Cleansing and drying of the skin will help to moisturize and apply a protective barrier. The skin should always be dried prior to the application of a dressing to prevent prolonged exposure to moisture.
A sacral foam dressing will provide extra cushion and protection against pressure and friction.

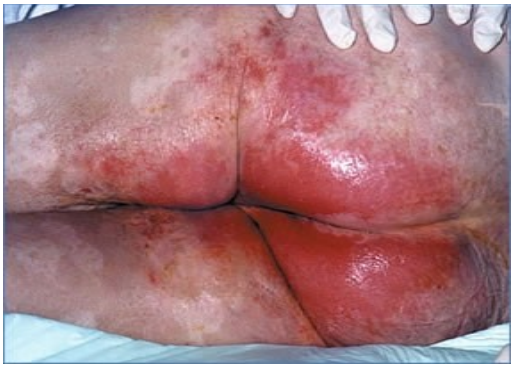
(3 points)

1 alternative primary/secondary dressing
BID and PRN:
If the patient is incontinent foam dressings should be avoided, and coloplast zinc barrier paste can be implemented instead. The zinc should be applied liberally to the area after cleansing and the top layer removed gently and as needed during periods of incontinence.

(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: Incontinence associated dermatitis

(1 point)

Wound Nurse recommendations/orders:
Twice daily and immediately after episodes of incontinence
Gently cleanse perineum and bilateral buttocks with stryker comfort shield barrier cream cloths
Apply coloplast zinc barrier paste liberally to the area

(3 points)

Rationale for choices:
Cleansing should occur immediately after an incontinence episode to remove all corrosive enzymes from the skin and protect from further breakdown
A pH balanced cleanser will be more gentle on the skin and provides a barrier cream to continue protecting
Zinc barrier paste will help the area to heal and protect from further breakdown by creating a thick barrier between the corrosive stool and the perineum.

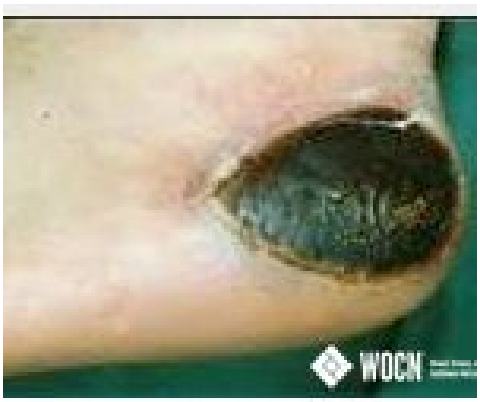
(3 points)

1 alternative primary/secondary dressing:
Coloplast Triad Hydrophilic wound dressing can be used alternatively instead of zinc barrier paste if 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: Unstageable pressure injury
(1 point)

Wound Nurse recommendations/orders:
Daily:
Cleanse left heel with normal saline, pat dry.
Paint heel with iodine and leave open to air
Ensure heel is off-loaded at all times while in bed or chair

(3 points)

Rationale for choices:
The eschar and surrounding skin should be kept clean and dry
Iodine will help to further keep skin clean and dry, and prevent the opening of stable eschar on the heel.
Off-loading will protect the heel from further injury

(3 points)

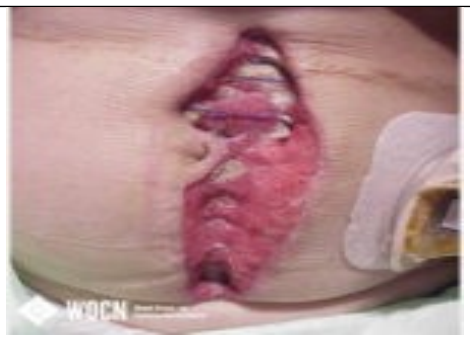
1 alternative primary/secondary dressing:
If iodine cannot be used the eschar and surrounding skin can have skin prep applied to the area after cleansing to promote dryness and prevent the opening of stable eschar.

(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: Surgical incision

(1 point)

Wound Nurse recommendations/orders:
Every M/W/F
Cleanse wound with vashe soaked gauze, allow vashe to sit for 5 minutes, pat dry.
Apply Medline skin prep followed by vac drape to the intact skin of the peri-wound.
Apply Curad adaptic contact layer to the sutures.
Apply granufoam black foam to the wound bed that is cut to the size of the wound and gently pack into the wound.
Cover all foam with VAC drape, then cut a quarter-size hole into the drape and foam. Use this opening to connect to the VAC track-head.
Set the machine to 125 mmHg suction and assess for any signs of leaking.

(3 points)

Rationale for choices:
Negative pressure wound therapy will promote granulation of the tissue and angiogenesis.
A vashe soak will clean the wound bed.
Skin prep and VAC drape to the peri-wound will prevent damage to the intact skin.
Adaptic should be applied to the sutures to prevent damage and adherence of the foam to the sutures.

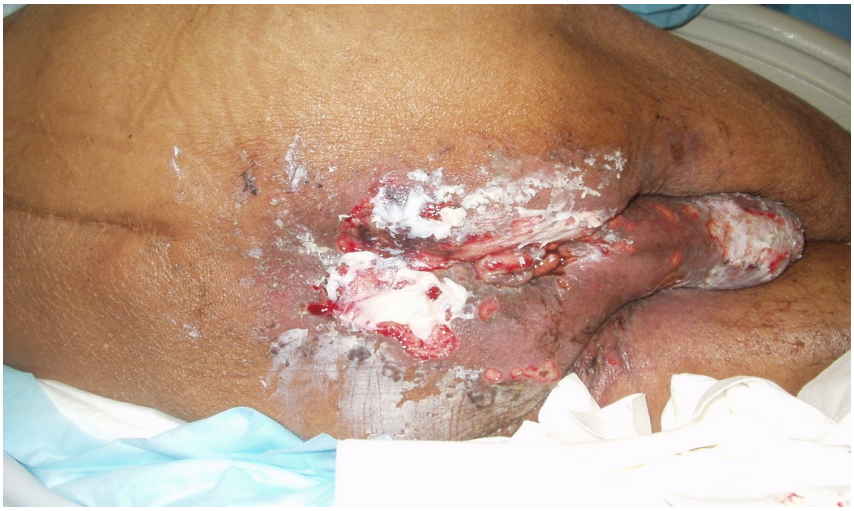
(3 points)

1 alternative primary/secondary dressing:
Daily
If the wound VAC cannot be used the wound may be cleansed with a vashe soak, then apply Convatec hydroactive gel to the wound bed. Followed by loosely packing the wound with kerlix soaked in normal saline with the excess amount squeezed out. An ABD pad can be placed over the packing and secured with Medipore tape.

(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: Severe incontinence associated dermatitis
(1 point)

Wound Nurse recommendations/orders:
Gently cleanse with Medline AloeTouch Protect Barrier Cream Cloths, and pat dry.
Mon/Thur Apply 3M Cavilon Advanced Skin protectant in a sweeping motion starting at the rectum and gradually applying in an outwards motion. Allow 30 seconds for the cavilon to dry before letting skin-on-skin contact occur.
Skin protectant does not need to be removed and gentle cleansing will not penetrate the barrier.
Clean the patient immediately after any episodes of incontinence.

(3 points)

Rationale for choices:
Barrier cream cloths are pH balanced and allow for gentle cleansing.
The cavilon will attach to the wet and weepy skin seen here while providing an effective barrier against future exposure to stool. The product only needs to be applied 2-3 times weekly and will allow for easier cleaning which will promote comfort for the patient.

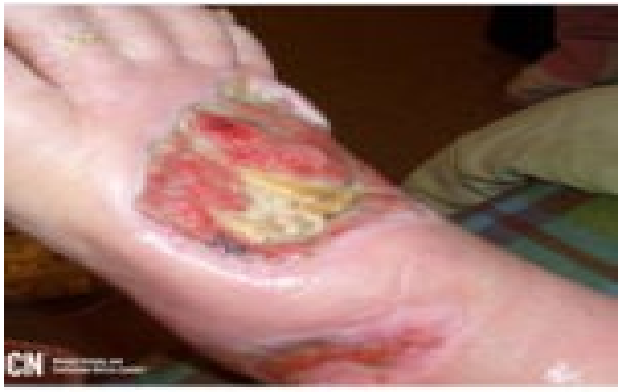
(3 points)

1 alternative primary/secondary dressing:
Triad barrier wound dressing can be used instead of Cavilon advanced skin protectant, but will need to be applied twice daily to the affected areas.

(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 ulcer

(1 point)

Wound Nurse recommendations/orders: Podiatry consult and wound culture recommended
Every other day and PRN:
Cleanse wound with vashe soaked gauze, allow vashe to sit for five minutes. Pat dry.
Apply derma sciences medihoney to the areas of slough/non-viable tissue.
Cover the exposed tendon with Curan adaptic cut to appropriate size.
Activate hydrofera blue classic with normal saline, allowing saline to soak for two minutes, squeeze out excess and cut to size of wound.
Cover with dry gauze.
Loosely wrap with kerlix and secure with medipore tape.

(3 points)

Rationale for choices:
A vashe soak will cleanse the wound
Medihoney will help to remove slough and other non-viable tissue
Adaptic will help to protect the fragile tendon and ease in removal of the hydrofera blue dressing
The hydrofera blue classic will help to clean the wound bed, promote granulation, and may help to eliminate epibole at the wound edge.
Dry gauze will absorb any exudate that is not collected by the hydrofera.
Kerlix and primapore will secure the dressing in place.

(3 points)

1 alternative primary/secondary dressing:
An alternative dressing would be to use smith and nephew santyl ointment as a replacement, this dressing is expensive but would replace the medihoney, adaptic, and hydrofera blue classic.

(1 point)

/8 points