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

Mini Case Scenarios: Wounds

Cleveland Clinic

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Reviewed by: Patricia A. Slachta__ Date: 1/27/25

Score: 72.8/96

Jen Ennyl, Great first attempt at this assignment. I have made some comments throughout so focus on the areas where you can obtain additional points as you need an 80% on the assignment. Let me know if you have any questions. **Please write your additional info on this paper in another color & return via dropbox.**

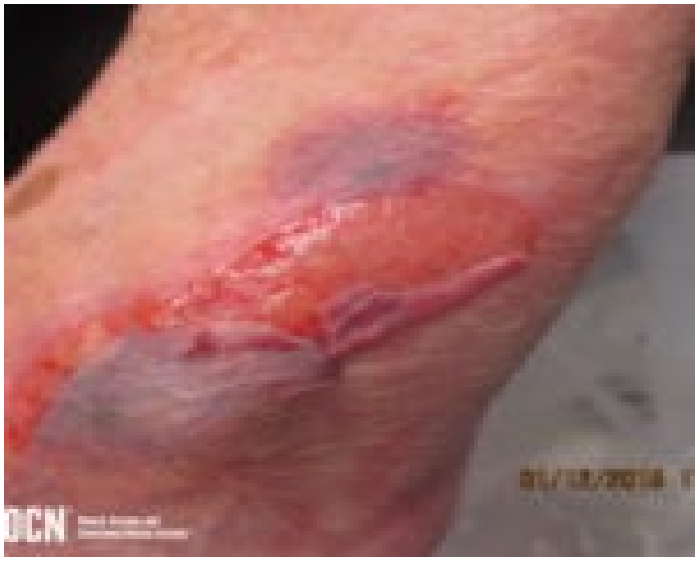
X/96-1 resubmission = Y/96

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)

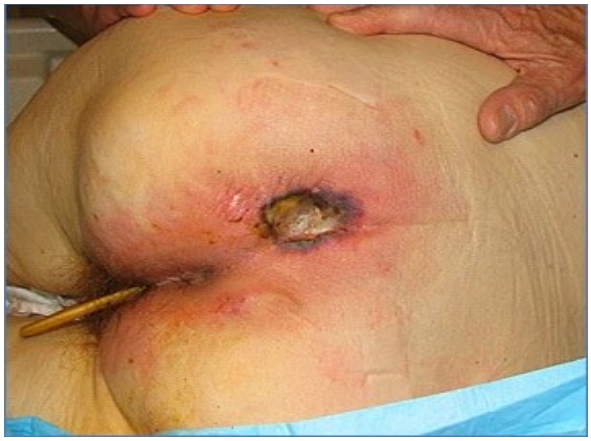
Rationale for choices

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) 1

Wound Nurse recommendations/orders:

1. Cleanse the area with no rinse pH balance wound cleanser (Vashe) and gently pat dry
2. Apply calcium alginate dressing impregnated with manuka honey (Medihoney) to the wound base and covered with dry gauze and secured with ABD pad.
3. Change every other day and as needed.
4. Apply barrier cream to buttocks.

(3 points) 2.5

Rationale for choices:

1. Vashe is a gentle wound cleanser and would not destroy healthy tissue
2. Medihoney will promote autolytic debridement and will help soften and remove slough.
3. Dry dressing can help absorb any drainage and securing with ABD pad helps to keep the dressing dry and in place.
4. Barrier cream to buttocks will help protect the skin for external stimulants.

(3 points) 3

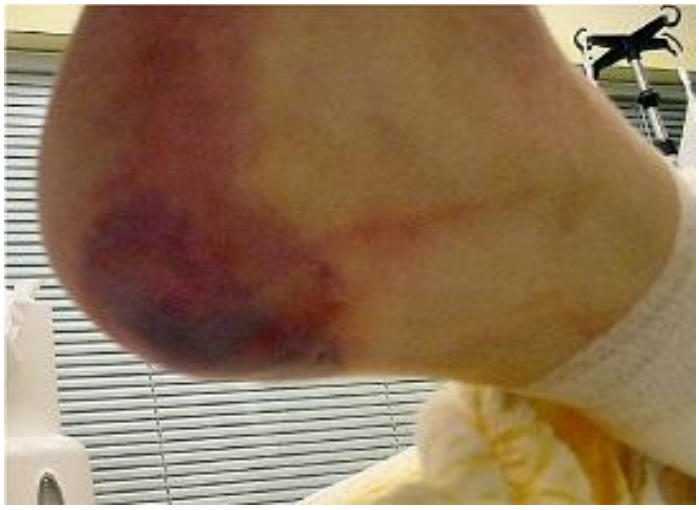
1 alternative primary/secondary dressing

Slightly packed with gauze and with half strength Dakin's in wet to dry dressing covered with ABD pad and secured with paper tape. Change every other day or as needed.

(1 point) 0

6.5/8 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) 1

Wound Nurse recommendations/orders:
1. Cleanse the area with warm water
2. Apply skin prep to bilateral heels
3. Off-load the heels at all times using boots

(3 points) 2

Rationale for choices:
1. Cleaning the area will reduce bacterial count and prevent from building infection.
2. Skin-prep to heels will add skin barrier to prevent shear against the bedsheet.
3. To alleviate discomfort and prevent potential complications, it is important to relieve pressure from both heels. By off-loading the weight from the heels, we can enhance comfort and promote better circulation, ultimately benefiting overall foot health.

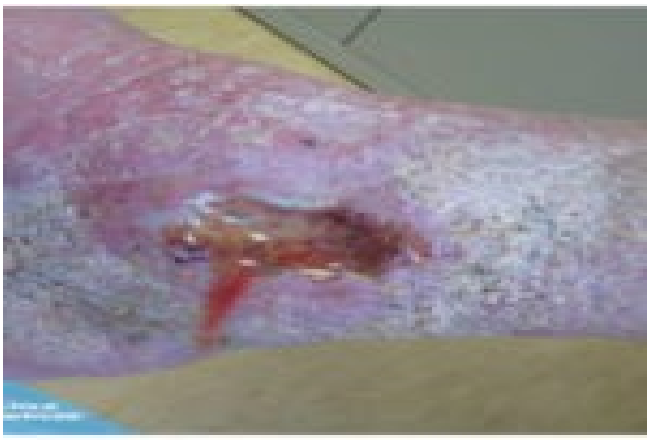
(3 points) 1.5

1 alternative primary/secondary dressing
1. May use Silicone border (PolyMem) on the heel to protects tissue injury and by preventing further tissue damage.

(1 point)

4.5/8 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:

Full thickness venous ulcer

(1 point) 1

Wound Nurse recommendations/orders:

1. Cleanse the area with no rinse pH balance wound cleanser (Vashe) and gently pat dry
2. Apply a non woven fiber (Exufiber Ag) on top of the Adaptic.
3. Cover with ABD pad and roll gauze.
4. Apply daily Sween moisturizer to the dry area.
5. Apply 2-layer compression system and encourage raising the legs with pillow when on bed or chair.
6. Change the dressing daily or as needed.

(3 points) 2.5

Rationale for choices:

1. Cleaning the area will reduce bacterial load and prevent infection.
2. Since the ulcer has moderate exudate, Exufiber silver has antimicrobial properties and when comes in contact with wound exudate it transforms to a gel and promotes moist wound healing environment.
3. ABD pad and roll gauze to keep the dressing intact.
4. Sween moisturizer to dry area helps moisturize and prevent further skin injury. ok
5. 2-layer compression will help promote blood circulation. ok

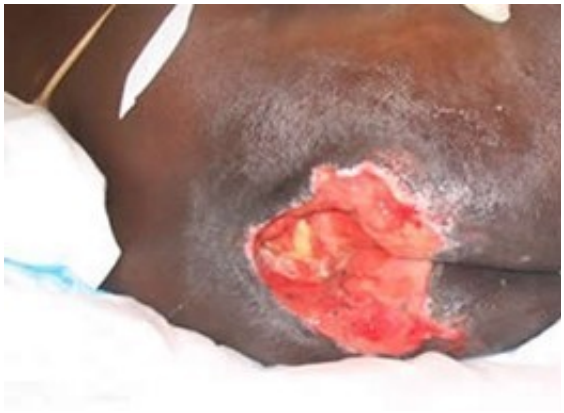
(3 points) 2.5

1 alternative primary/secondary dressing:

1. Alternative dressing is using a Hydrofera blue and change every 3 days or as needed **(1 point)** .8

6.8/8 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: Stage 3- Full thickness pressure injury

(1 point) 1

Wound Nurse recommendations/orders:

1. Cleanse the area with no rinse pH balance wound cleanser (Vashe) and gently pat dry.
2. Apply calcium alginate dressing impregnated with manuka honey (Medihoney) to the wound base and covered with ABD pad and secured with paper tape.
3. Change every other day or as needed.

(3 points) 3 why am I commenting on some wounds that the primary dressing may not be adequate?

Rationale for choices:

1. Cleaning the area with gentle wound cleanser will reduce bacterial load and prevent infection without destructing the healthy tissue.
2. calcium alginate dressing impregnated with manuka honey facilitates autolytic debridement and encourage granulation and epithelization.

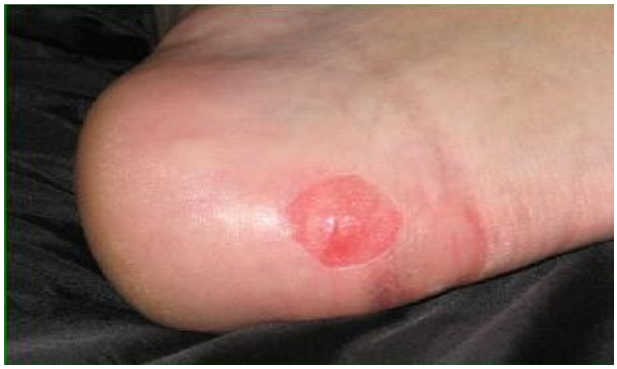
(3 points) 3

What support surface would you recommend and why?

I would suggest using a fluid immersion mattress designed to reduce pressure points, which aids in enhancing blood circulation to tissues for sustaining tissue perfusion throughout the body's surface. **(1 point) .8**

7.8/8 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 2 partial thickness pressure injury

(1 point) 1

Wound Nurse recommendations/orders:

1. Cleanse the area with no rinse pH balance wound cleanser (Vashe) and gently pat dry.
2. Covered with island dressing (Gentac).
3. Change every 3 days or as needed.
4. Off load the heels using pillows from bed at all times.

(3 points) 2.8

Rationale for choices:

1. Cleaning the area with gentle wound cleanser will reduce bacterial load and prevent infection without destructing the healthy tissue.

[2.] Island dressing minimize adhesive stripping ~~ccno~~ and will protect the peri wound area from getting infection.

2.[3.] It also reduce discomfort during dressing change since it has gentle silicon adhesive that helps in easy lifting and repositioning.

(3 points) 2.8

1 alternative primary/secondary dressing

One good alternative is to apply hydrocolloid bandage to prevent getting infected and
Change the dressing every 3 days or as needed.

(1 point) .5

7.1/8 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 full thickness

(1 point) 1

Wound Nurse recommendations/orders:

1. Cleanse the area with no rinse pH balance wound cleanser (Vashe) and gently pat dry.
2. Apply a hydrocolloid with manuka honey (Medihoney square hydrocolloid) over the wound bed.
3. Frequent turning and reposition every 2 hours on bed or 1 hour in chair.
4. Use waffle chair cushion in wheelchair.
5. Encourage the patient to actively participate in all meals by engaging them in the meal selection process, promoting a positive dining experience, and offering support as needed
6. Change daily or as needed.

(3 points) .5

Rationale for choices:

1. Cleaning the area with gentle wound cleanser will reduce bacterial load and prevent infection without destructing the healthy tissue.
2. Hydrocolloid with manuka honey facilitates autolytic debridement and encourage granulation and epithelization and does not require secobndary dressing.
3. Regularly turning every 2 hours on bed and every 1 hour in chair helps prevent prolonged pressure and lowers the risk of skin injury. Waffle cushions in chairs or wheelchairs can be use since patient spends many hours on the wheelchair.

(3 points) 2.5

1 alternative primary/secondary dressing:

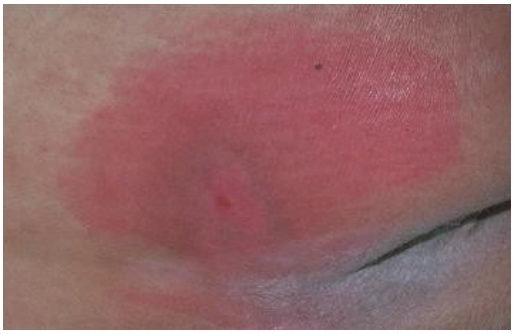
Apply Alginate wound dressings (ALGICELL) over the wound bed and cover with ABD pad.

Change dressing every other day or as needed.

(1 point) 0

4/8 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 1 Pressure Injury

(1 point) 1

Wound Nurse recommendations/orders:

1. Wash the area with warm water.
2. Relieve the pressure by frequent turning on bed every 2 hours.
3. Use off-loading device like to prevent further pressure on sacrum.

(3 points) 2.5

Rationale for choices:

1. Keeping the skin clean will reduce bacterial load and prevent infection.
2. Off-loading is instrumental in redistributing pressure, thereby facilitating the healing process of the affected tissue.

(3 points) 2

1 alternative primary/secondary dressing

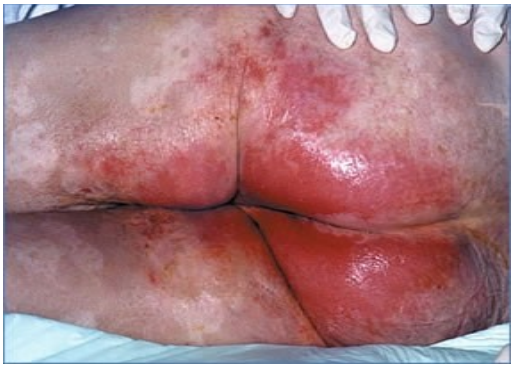
May apply Non-Adhesive Dressings (PolyMem) which contains glycerol to soothe traumatized tissues.

Change every 3 days or as needed.

(1 point) 1

6.5/8 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: Moisture Associated Skin Damage and intertriginous dermatitis

(1 point) .5

Wound Nurse recommendations/orders:

1. Cleanse the area with no rinse pH balance wound cleanser (Vashe) and gently pat dry.
2. Dust antifungal powder (Nystatin) and seal with 3m no sting barrier spray.
3. Leave open to air.
4. Apply rectal collection pouch.
5. Check for leakage every 2 hours or as needed.

(3 points) 1

Rationale for choices:

1. Cleaning the area with gentle wound cleanser will reduce bacterial load and prevent infection without destructing the healthy tissue.
2. Nystatin helps treat fungal or yeast infection on the skin.

(3 points) 1

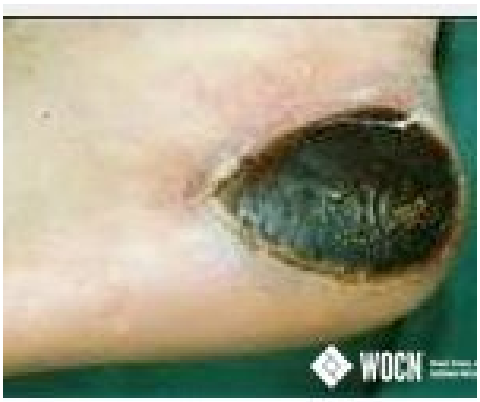
1 alternative primary/secondary dressing:

May use zinc oxide cream as alternative

(1 point) 0

2.5/8 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) 1

Wound Nurse recommendations/orders:

1. Cleanse the area with no rinse pH balance wound cleanser (Vashe) and gently pat dry.
2. Paint iodine over the dry eschar daily and leave open to air.
3. Keep the area dry and monitor for lifting of eschar.
4. Pressure relief with frequent repositioning.
5. Off-load heels using boots on bed at all times.
6. Maintain adequate nutrition.

(3 points) 3

Rationale for choices:

1. Cleaning the area with gentle wound cleanser will reduce bacterial load and prevent infection without destructing the healthy tissue
2. Iodine is a broad spectrum and has anti-microbial help prevent infection.
3. Keeping the area dry will prevent inducing infection.
4. To alleviate pressure on the heels, it is beneficial to use heel protector cushions while resting in bed. These cushions are designed to provide support and distribute weight evenly, minimizing the risk of developing pressure sores or discomfort.

(3 points) 2.8

1 alternative primary/secondary dressing:

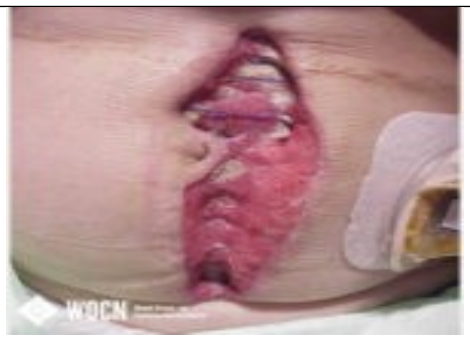
Apply skin prep of bilateral heels daily to protect heels from irritation due to friction damage caused by external surfaces.

(1 points)

6.8/8 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: Wound dehiscence

(1 point) 1

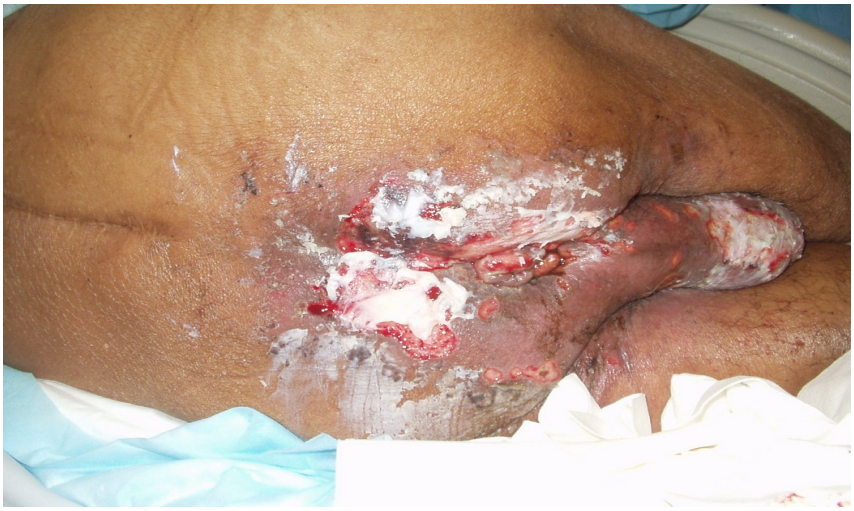
Wound Nurse recommendations/orders:
Clean the area with vashe and dry.
Apply Adaptic on top of the sutures
Trim the Granufoam black to the size in wound bed only.
Apply the adhesive sheet to the foam dressing.
Cut a hole to adhesive sheet and apply the suction port tubing with tubing of the canister.
Setting on continuous suction to 75mmhg.
Verify the suction machine for a good seal.
Change every 3x/week and document amount and color of drainage.
(3 points) 2.8

Rationale for choices:
Mesh contact layer (Adaptic) would help prevent sticking the wound bed from foam.
Negative pressure wound therapy facilitates wound healing by employing sub-atmospheric pressure to diminish inflammatory exudate and promote the formation of granulation tissue.
(3 points) 2

1 alternative primary/secondary dressing:
Apply salinized gauze and cover with abd pad. Change daily or as needed.
(1 point)

5.8/8 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 & Stage 2 Pressure injury
(1 point) 1

Wound Nurse recommendations/orders:
Cleanse the area with Vashe and gently pat dry
Apply Zinc oxide thick barrier cream over the wound bed and periwound area.
Leave open to air and use breathable pad under the patient.

Use wedges to reposition every 2 hours, relieving pressure on the sacrum and buttocks area.

Apply a rectal collection bag.

Check for incontinence ever 2 hours

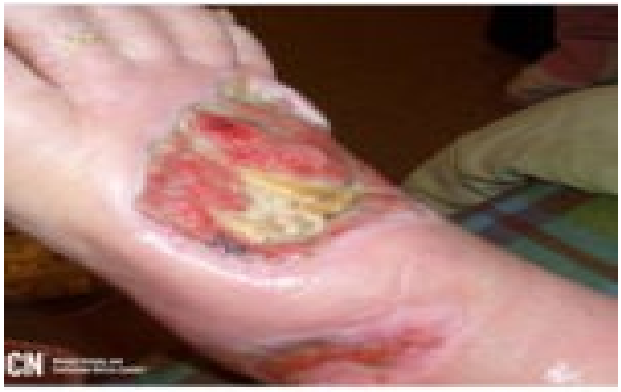
(3 points) 2.5

Rationale for choices:
Zinc oxide will help prevent further moisture and serve as a protective barrier.
Rectal drainage bag will help collect output and prevent from getting in contact with skin
Off loading will prevent putting pressure and allows for wound to heal.
(3 points) 3

1 alternative primary/secondary dressing:
Triad cream can be recommended every incontinence episode.
(1 point) 1

7.5/8 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: Arterial ulcer or diabetic neuropathic ulcer
(1 point) 1

Wound Nurse recommendations/orders:
Cleanse the area with gentle cleanser like Vashe
Place Mesh contact layer (Adaptic) to the wound bed
Apply Exufiber Ag and cover with ABD pad and roll kerlix.
Secure with paper tape and change every 3 days or as needed.
Encourage exercising the legs and encourage for glycemic control.
M
(3 points) 3

Rationale for choices:
Cleaning the area with gentle cleanser will prevent damaging the healthy tissue.
Adaptic will help to prevent getting the dry dressing on the wound bed.
Exufiber will transform to gel that facilitates moist wound healing environment and has silver which is antimicrobial.
Exercise will promote better blood circulation.
Glycemic control will help in wound healing.
(3 points) 3

1 alternative primary/secondary dressing:
May use Adaptic then medihoney on the wound bed, cover with dry gauze and roll with kerlix gauze. Change daily or as needed.

7/8 points

Foam dressings can be expensive, and foam is not foam is not foam. There are two foams with randomized controlled trials regarding their efficacy in reducing pressure & shear forces, Allevyn & Mepilex

Black, J. M. (2019). Prophylactic dressings for pressure injury prevention: How do they work? *Advances in Skin & Wound Care, 32*(7S, Suppl.), S2-S3. https://doi.org/10.1097/01.ASW.0000558696.45433.30

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