R. B. Turnbull Jr. MD WOC Nursing Education Program

Mini Case Scenarios: Wounds

Cleveland Clinic

Student Name _Lydia Agyekum_ **Date:** 5/7/2025

Reviewed by: Patricia A. Slachta **Date:** 5/27/25

Score: 56.8/83 References are ok but format is not, see comments.

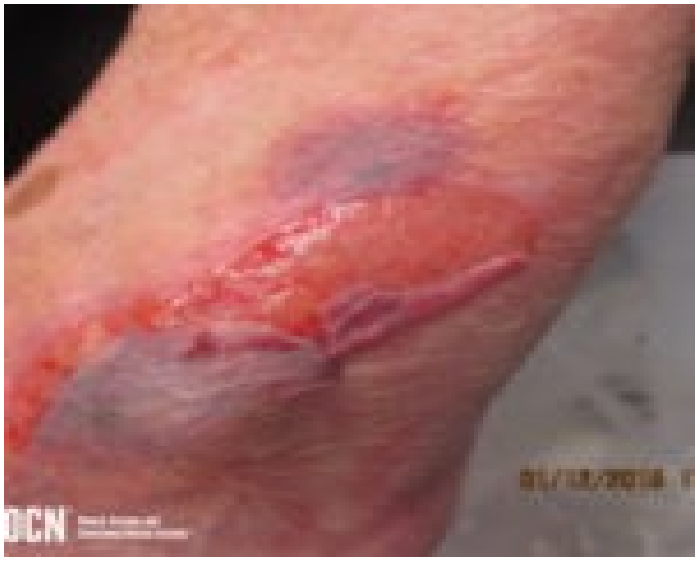
Lydia, Great first attempt at this assignment. I have made some comments throughout so focus on the areas where you can obtain additional points as you need 80% on the assignment. Let me know if you have any questions. **Please write your additional info on this paper in another color & return via dropbox.**

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 *(be specific as to schedule, turning surfaces if applicable, product, etc.)*
    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.
6. *No advanced dressings such as NPWT or CAMPs (formerly called cellular tissue products) unless specifically requested. What would you use if these two dressing types are not available to you?
7. Throughout this assignment you will be applying evidence to treat various wound scenarios. As appropriate, if you use a reference, make sure to cite it correctly.

Include at least 3 references *(other than your text book)* used to back your actions at the end of the assignment that assisted you in this assignment. Make sure to use 7th edition APA formatting. A case study has been completed for you as an example.

Example Scenario



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)

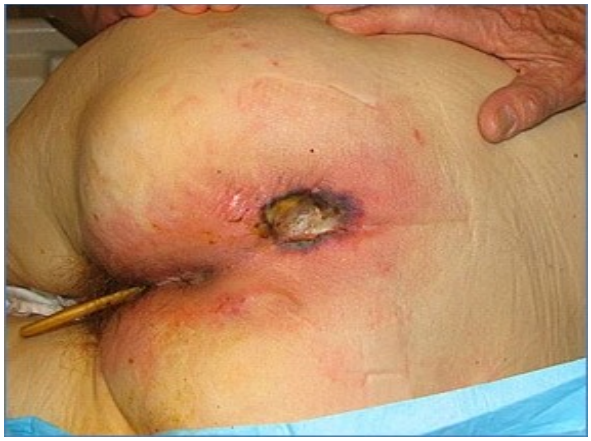
Rationale for choices

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

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order. Non-adhesive foam dressing, 5 layers, (Allevyn) secured with elastic mesh dressing (Medline elastic retention dressing). Change q3d and PRN
(2 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. No exudate noted. 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, stage 3
Pressure injury, unstageable

(1 point) 0 review the description again

Wound Nurse recommendations/orders:

1. Wash sacral wound with wound cleanser with every dressing change
2. Cover wound bed with hydrogel impregnated gauze (Kendall hydrogel wound dressing) in your own practice better to give more explicit instructions-open & fluff gel impregnated gauze & lightly fill wound
3. Cover dressing with RCT foam (Allevyn)
4. Change dressing every 3 days and PRN this may work since it is gel impregnated gauze but consider in your own practice monitoring this wound yourself to make sure Q 3 is frequently enough
5. Turn and reposition patient every two hours left and right side and 30 minutes back time for procedures such as feeding with pillows or wedges excellent order! Definitely need to be specific about positioning
6. Assess bony prominence daily and report any changes. To whom?

(3 points) 3

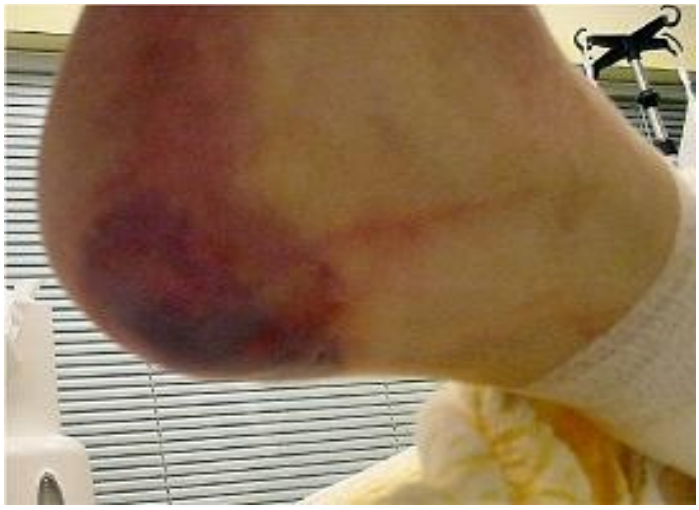
Rationale for choices:
To remove debris, drainage and dressing residue for evaluation.
Hydrogel dressing to provide moist environment and aid in autolytic debridement
RCT foam (allevyn) to reduce pressure at the sacrum
Dressing changed to prevent infection and to promote healing
Turning and reposition to promote blood circulation, relieve pressure and to prevent further tissue damage
Assessing to prevent and manage pressure injury
(2 points) 2

Cover wound with hydrocolloid sacral dressing (Duoderm 0signal), apply ABD pad, change dressing every 5days/ prn 0—A hydrocolloid is not appropriate for this wound. Do you know why? What is one of the keys to this wound & **what else can you use?**

2 0 open and fluff honey impregnated gauze and lightly fill wound, cover wound with ABD pad ,

5/8 points

Scenario 2



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

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

Wound type:
Deep tissue pressure injury
(1 point) 1

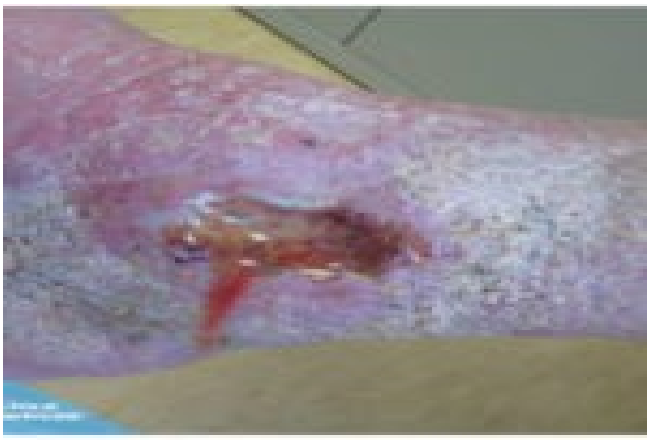
Wound Nurse recommendations/orders:
Clean left heel with wound cleanser and dry
Cover left heel with Allevyn heel foam
Offload heels with offloading boots
Do not rub or massage the left heel, keep it dry
Daily remove offload boots, wash and inspect feet
Turn and reposition every two hours, alternating left and right, allow 30 minutes at back with pillows, or wedges
Monitor left heel for open wound
Administer pain medication as prescribed
(3 points) 3

Rationale for choices:
Cleaning to prevent infection
Offloading heels to relieve pressure and prevent further tissue damage
RCT foam (allevyn) to protect site and reduce pressure at heels
Avoiding massage and rubbing to prevent further tissue damage and promote healing
Monitoring regularly to assess for declaring wound and early management
Pain medication to relieve pain
(2 points) 2

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Cover left heel with Mepilex heel dressing, change every 7 days or prn Mepilex RCT foam is foam. **If you had no foam what could you do?**
Use pillows at the feet to relieve pressure
(2 points) 0

6/8 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:
Lower -extremity venous disease wound

(1 point) 1

Wound Nurse recommendations/orders
Clean wound with saline solution.
Clean peri wound with saline and dry
Apply skin barrier cream around peri wound (Medline remedy Z-Guard paste)
Apply non adherent foam on wound bed (silver polymem)
Wrap with multiple layer compression as tolerated
Moisturize dry, scaly area with Medline remedy moisturizing lotion
Educate patients on leg elevation above heart level; 30 minutes, 4times per day
Change dressing every 5 days and prn when saturated. Patient cannot change this so ??????
Reschedule patient to clinic every 5 days for change of dressing
(3 points) 2.5

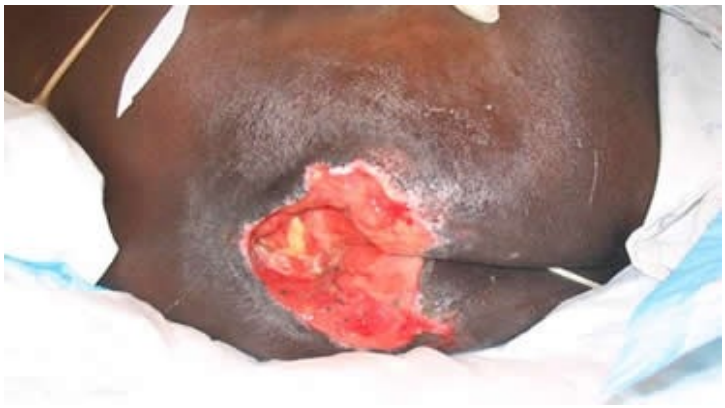
Rationale for choices:
Cleaning wound with saline solution to remove debris, drainage to help in assessment
Skin barrier cream for protecting peri wound from further maceration
Silver polymem to provide moist, absorb drainage and the silver to control infection
Multiple layer compression to reduce edema (Medline multi- layer compression) this needs to be in the orders
Education on leg elevation to promote venous return
Change dressing to prevent infection and for reevaluation
(2 points) 2

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply silver alginate (DermaGinate) to wound bed
Wrap with will most likely strike thru gauze so need a secondary dressing over alginate gauze bandages (Kerlix gauze bandage roll) and put on compression socks change dressing q3days.

(2 points) 1.5

7/8 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 exudate. NPWT is *not* available at this time.

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

Wound type:
Pressure injury, stage 3
(1 point) 1

Wound Nurse recommendations/orders:
Cleanse wound with wound cleanser
Cover wound bed with silver alginate (DermaGinate)
Cover wound dressing with allevyn
Turn and reposition every 2 hours on right to left alternately and 30 minutes on the back for procedures and feeding.
Change dressing every 5 days and prn this is most likely too long in between dressing changes change dressing every 3 days and PRN
Daily assesses bony prominence for signs for pressure injury, record and report abnormalities

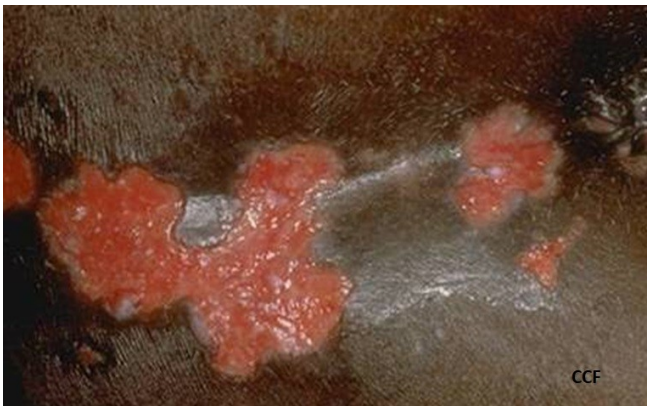
(3 points) 2.8

Rationale for choices:
Wound cleanse to remove debris and exudate for accurate assessment
Silver alginate, for exudate absorption, prevent infection, slough debridement
Allevyn is RCT foam help reduce pressure at sacrum
Turning and repositioning to prevent further tissue damage, reduce pressure and promote blood circulation
Changing dressing to prevent infections and promote healing & inspect wound
Assessment of bony prominence to prevent other areas from pressure injury since the patient is bedridden
(2 points) 2

What support surface would you recommend (1pt) and why? (1pt)
Low- air-loss bed
Helps in redistributing pressure to prevent or treat pressure injury, it also helps to keep the skin dry, cool and reduces heat accumulation due to the continuous airflow design.
(2 points) 2

7.8/8 points

Scenario 5



56-year-old alert and oriented male hospitalized for cardiac surgery. During the hospital stay on day 2 post-op they developed a painful open area to sacrum. The patient is incontinent with urine and stool and has not been repositioning in bed due to reported pain.

Image courtesy of Cleveland Clinic.

Wound type:
Pressure injury, stage 2

(1 point) 1

Wound Nurse recommendations/orders:
Clean wound and peri skin with wound cleanser, dry.
~~**Apply xeroform (DermaRite) to wound bed** not necessary~~
Cover with RCT foam (Mepilex border advance foam)
Administer pain medication as prescribed
Gently turn and reposition patient as tolerated every 2 hours, alternating left and right,30 minutes at the back for feeding with pillows.
Change dressing every 7 days
(3 points) 2.8

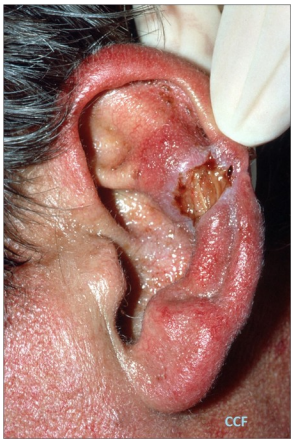
Rationale for choices:
Rationale for choices:
Wound cleanse to remove debris and exudate for accurate assessment
~~**Xeroform is non adherent and provides moist environment**~~ hmmm. Most Xerform I have used dries out readily. Consider the RCT foam by itself as it will not adhere to the wound & requires only one product
Mepilex RCT foam help reduce pressure at sacrum
Turning and repositioning to prevent further tissue damage, reduce pressure and promote blood circulation
Changing dressing to prevent infections and promote healing
(2 points) 1.8

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply Aquaderm hydrogel sheet, cover with foam dressing (foam dressing,3M, Tegaderm) Foam is foam, **what else can you use? Cover with ABD pad and change dressing every 3 days and prn**

(2 points) 1

6.6/8 points

Scenario 6



The wound care nurse is consulted to the intensive care unit to see a non-verbal 57-year-old male respiratory failure patient for a new wound found under the patient's pulse oximeter during routine care. The patient has been admitted to the hospital for 14 days and has no previously documented wounds.

Image courtesy of CCF.

Wound type:
Medical device related pressure injury, stage 3

(1 point) 0

Wound Nurse recommendations/orders:
Wash wound with wound cleanser, dry with every dressing change
Apply foam to wound (silver polymem silicone border adhesive oval)
Change dressing every 5 days and prn
Daily assess skin beneath and around connected devices
Reposition patient and devices, alternating areas every two hours, check for proper position and size of equipment
Pad vulnerable areas with foam (allevyn), keep skin dry and apply barrier cream

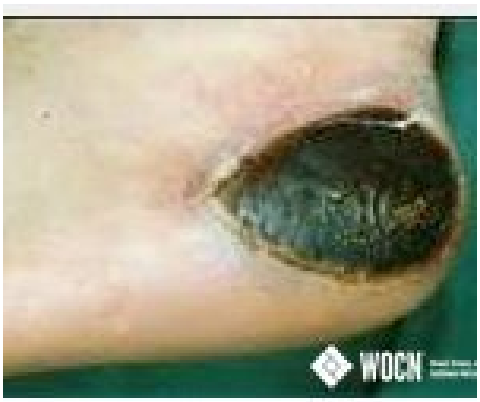
(3 points) 3

Rationale for choices:
Washing wounds to remove exudates, debris to promote healing and for evaluation
Foam provides moist environment, prevent infection
Reposition patient and devices to relieve pressure
Padding vulnerable areas to protect skin from injury
(2 points) 2

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply Silvadene to wound, cover with gauze (mesalt)why mesalt? This is a hypertonic saline dressing & has minimal uses and foam dressing (allevyn), change dressing every 3 days. The rest might work
(2 points) 1

6/8 points

Scenario 7



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
(1 point) 1

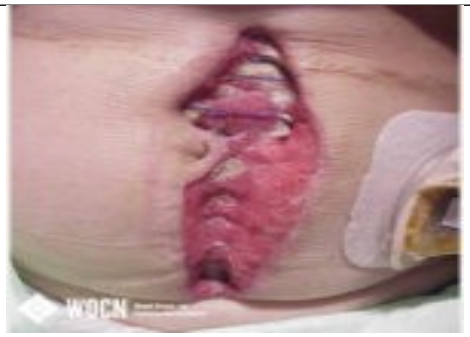
Wound Nurse recommendations/orders:
Cleanse wound and peri wound with wound cleanser
Apply hydrogel impregnated gauze (McKesson hydrogel dressing)
Cover with foam dressing (Allevyn heel foam dressing)
Change dressing every 3 days
Offload heels with boots or pillows as tolerated by patient
Daily remove boots, inspect and wash
Turn and reposition patient to both sides and back for every 2 hours, supporting with pillows or cushions
(3 points) 0 **you need to review the lesson on PIs & peripheral PIs**

Rationale for choices:
To remove debris, drainage and dressing residue for evaluation.
Hydrogel dressing to provide moist environment and aid in autolytic debridement
RCT foam (allevyn) to reduce pressure at the heel ok
Dressing changed to prevent infection and to promote healing
Turning and reposition to promote blood circulation, relieve pressure and to prevent further tissue damage ok
To prevent and manage pressure injury
(2 points) .5 **After you review what to do make sure the rest of your rationales match your actions**

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply collagenase cream (Santyl ointment), cover with gauze ABD pad (Medline ABD pad) change dressing every 3 days
(2 points) 0 **What else can you do?**

1.5/8 points

Scenario 8



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 dry, pink with small areas of yellow tissue (less than 10% of wound base). Peri wound skin intact. NPWT ordered by physician who has requested WOC nurse input into dressing instructions and pressure settings

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

Wound type:

Surgical wound Dehiscence

(1 point) 1

Wound Nurse recommendations/orders:

cleanse wound with sterile saline solution, clean peri wound and dry

assess for visible organs, infections and bleeding

Apply a non-adherent contact layer (Hollister Adaptic) over wound base yes

~~**Drape peri wound with draping tape**~~ this is not really necessary if you keep foam in wound & you skin prep

Avoid placing foam directly over sutures if they are superficial or under tension.

Cut foam to fit the wound dimensions without overlapping intact skin.

Gently insert the foam into the wound cavity without force.

Do not pack tightly—foam should fill the wound without compression.

Cover the foam with adhesive drape, ensuring an airtight seal.

Cut a small hole (1–2 cm) over the foam and place the suction port (track pad), connect tubing to therapy unit

Set pressure at -125 mmHg, intermittent. Set pressure at -75 continous. Consider a lower pressure & continuous since this is a dehisced abdominal wound

Change dressing 3 times within the week or PRN

3 points) 2.5

Rationale for choices:

Cleaning to remove debris and exudate

Assessing to prevent trauma to expose organs

Contact layer to prevent foam sticking to wound bed and to protect sutures but mostly to protect sutures

Draping to seal the wound and dressing to maintain an airtight environment and create a vacuum

Change dressing to prevent infections

(2 points) 1.8

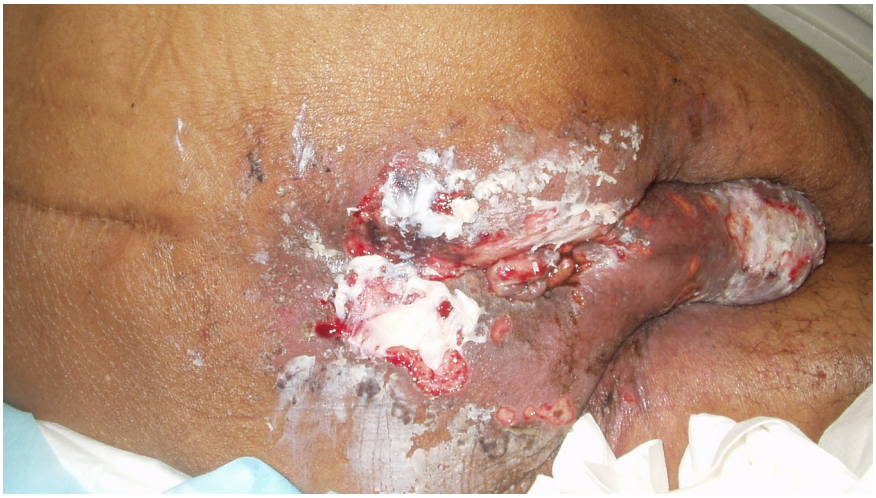
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

apply petroleum impregnated gauze (xeroform) to wound bed, cover with ABD pad (McKesson ABD pad), change dressing every three days Xerform is not petroleum gauze but is impregnated w bismuth tribromophenate & petroleum, therefore, Xeroform is not our best choice for a contact layer + the wound needs an actual dressing so **what can you use here as a dressing?**

(2 points) 0

5.3/8 points

Scenario 9



Wound care nurse consulted to see a 45-year-old male with damaged skin. Patient has been at your facility for 2 weeks with diagnosis of C-Diff. You note some necrotic tissue in the right coccygeal area as well as painful weepy lesions across both buttocks and scrotum.

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

Wound type:
Incontinence- Associated Dermatitis (Moisture-Associated Skin Damage) &?
(1 point) .8

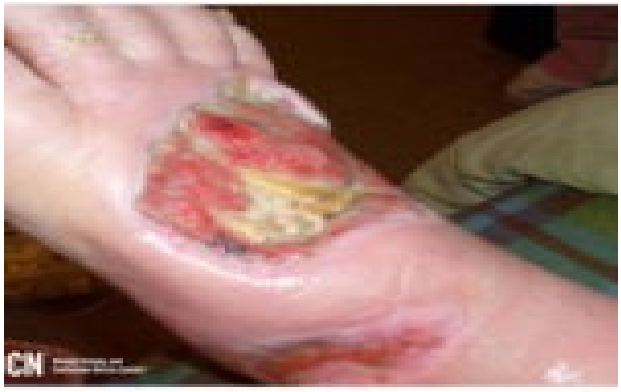
Use no rinse, pH balanced cleanser to clean affected area, pat dry
Gently Clean after every incontinence episode
Apply hydrophilic wound dressing (Triad hydrophilic wound dressing) to wound
Use moisture-wicking incontinence pads or air-permeable air under pads change frequently when soiled
Place foam or cotton cloth between scrotum and thigh you need a wicking product here
Keep bed and clothing dry and breathable what does this mean?
Turn and reposition patient on left/ right sides every 2 hours good
Change dressing bid and prn this is not the instructions for use for Triad
(3 points) 1.5

Rationale for choices:
No rinse cleanser because they are gentle, effective, and protect the skin barrier better than soap and water. yes & they also remove these types of ointment more easily than soap and water
Using absorbent under pads (non-plastic-backed) to wick moisture away
Hydrophilic wound dressing is skin protectant, helps maintain a moist wound healing environment to facilitate autolytic debridement. & healing
foam or ~~cotton cloth~~ between scrotum and thigh to reduce skin-to-skin friction what other product can you use
(2 points) 1.8

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply silver alginate to wound, cover with foam (Allevyn), change dressing every 3 days I am not sure you can adhere a dressing to all of these wounds but perhaps to some. **What else can you do?**
(2 points) 1

5.1/8 points

Scenario 10



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, grade 2 more accurate to say neuropathic ulcer
(1 point) 1

Wound Nurse recommendations/orders:
Wash wound with normal saline and dry
lightly fill wound bed w opened, honey impregnated gauze (Medihoney) if there is any chance the gauze can adhere to the wound then use a nonadherent contact layer
cover with ABD pad and wrap roll quaze to hold in place (McKesson gauze)
Keep in between toes dry.
Change dressing daily.
Elevate foot above heart level for 30 minutes, several times daily definitely check circulation first

(3 points) 2.5

Rationale for choices:
Cleaning to remove debris, drainage and dressing residue for evaluation.
Hydrogel dressing to provide moist environment and aid in autolytic debridement medihoney to provide moist environment and aid in autolytic debridement medihoney is not hydrogel
Roll gauze wrapped to hold dressing in place
Changing dressing to prevent infection and to inspect wound **why else do you change a dressing?**
Elevate foot to reduce edema circ check first though, why?
(2 points) 1

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply hydrocolloid(douderm) to wound bed, cover with foam (Allevyn) , change dressing every 7 days
(2 points) **0 hydrocolloids are primary dressings alone or secondary dressings**

4.5/8 points

References (3 points): **2 points** Lydia, in Word documents the format for references is double spaced w hanging indent. Highlight my example to see under the paragraph tap on the Home tab how that can easily be done

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Krapfl, L. A. & Peirce, B. F. (2022). General principles of wound management: Goal setting and systemic support. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.). *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 93-103). Wolter Kluwer.

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