

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

Mini Case Scenarios: Wounds



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Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Score: /83

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.
8. 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 below 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: this appears to be a stage 3 PI present on arrival. Needs to be debrided to be fully staged properly by removing the slough and necrotic tissue.**

**(1 point)**

**Wound Nurse recommendations/orders:**

Clean wound with soft gauze and Vashe, leaving the gauze to soak the wound for 5 minutes. Clean periwound skin lightly with Vashe.

Assess and treat pain with wound care and PRN

Remove slough and necrotic tissue with gauze after soak.

Pat areas dry with soft dry cloth.

Paint the periwound area with skin protectant.

Apply Triad hydrophilic wound dressing gel to the wound bed using a cotton tipped applicator.

Place a silicone bordered foam dressing over the area. (Allevyn Gentle Border Lite)

Repeat above steps every five days or as needed for wound exudate.

Reposition patient every two hours in bed and chair.

Order hospital bed with low air loss alternating mattress (Drive Medical Med-Aire Melody)

PT to evaluate and treat.

Limit sheering and friction with lifting devices and sheets.

Maintain HOB < 30 degrees when resting

Consult Nutrition regarding calorie and protein recommendations.

**(3 points)**

**Rationale for choices:**

Hydrophilic; Hydrogel; and Hydrocolloid dressings are all good choices for autolytic debridement that provide moist wound bed environments. Foam secondary dressings conform, protect and are absorbent, easy to place and remove. (Niezgoda et al., 2020)

Cleaning a wound can be a form of debridement and indicated in wounds that contain non-viable tissue and diets that lack adequate nutrition delay wound healing. Referral to specialist such as nutrition and physical therapy provide holistic approach to wound healing. (Hunt & Azad, 2022)

Progressive mobility by PT helps establish ability and reduce pressure related damage. (Delvecchio & Knarr, 2025)

**(2 points)**

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

3M hydrogel Tegaderm wound filler covered with a 3M T3gaderm Silicone Foam dressing, change every three days or as needed for wound exudate.

(2 points)

/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: HAPI DTI heel**  
**(1 point)**

**Wound Nurse recommendations/orders:**

Place BL EZ assistive cushioned heel protectors to patient while in bed and in chair.  
Inspect area every shift and perform Braden score every shift. Implement Braden Score interventions based on hospital protocol.  
Use sheets and lifting devices to limit shear and friction while moving patient.  
Consult PT to eval and treat, mobilize.  
Medical consultation for underlying medical condition management

**(3 points)**

**Rationale for choices:**

The underlying cause must be addressed for the wound to heal, ie: removing pressure. The Braden scoring and interventions will address risks to patient's skin integrity and healing (Ayello et al., 2020)  
Progressive mobility by PT helps establish ability and reduce pressure related damage. (Delvecchio & Knarr, 2025)

**(2 points)**

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

Allevyn Life Foam Heel protectors every seven days and PRN. Inspect under the dressing daily with total skin inspection.

**(2 points)**

/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:**

- Cleanse wound with Normal saline and Medline soft gauze
- Paint Cavilon no sting skin prep around the peri wound to protect skin from wound drainage
- Apply non-adhesive Med-Pride Calcium Alginate dressing to the wound and wrap with Kerlix roll gauze.
- Change dressing every three days or as needed for increased drainage.
- Hydrate skin with Eucerin Intensive repair lotion BID
- Apply compression stockings with moderate compression nightly
- Elevate legs when seated
- Assess for and treat pain PRN
- Initiate PT referral for activity recommendations
- Routine referral to vascular and or IR for assessment of arterial disease r/t lowered ABI readings.
- Referral to Nutrition for hydration and diet recommendations.
- Biopsy and or culture is there is no improvement in four weeks.

**(3 points)**

**Rationale for choices:**

- Hemosiderin staining is indicative of venous ulcer. (Sieggreen et al., 2020)
- ABI of 0.85 to the right leg is definitive of PAD and the Left 0.90 is on the low normal trend to PAD, referral to IR and vascular would be appropriate. Wound management for arterial and venous wounds utilizes basic wound care healing principles. Refer to nutrition for dietary counseling. (Bonham et al.)
- Consider biopsy and or culture if wound is not showing s/s of healing in four weeks (Sieggreen et al., 2020).

**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.** Apply non adherent hydrocolloid dressing to area every five days and PRN (Dimora foam dressing non-adhesive) and cover with Kerlix rolled gauze.

**(2 points)**

/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: Stage 3 PI**

**(1 point)**

**Wound Nurse recommendations/orders:**

- Initiate low air loss mattress with alternating pressure (Drive Medical Med-Aire Melody)
- Assess for and premedicate for pain prior to wound care
- Clean wound with normal saline
- Apply Cavilon no sting skin protectant around the peri wound area
- Apply Convatec Aquacel Foam dressing to wound, change every 5 days and PRN
- Turn and reposition patient every two hours, assess for and provide toileting every two hours
- Keep skin and bed linens dry and avoid shear and friction with the use of lifting sheets and devices
- Consult nutrition for hydration a dietary recommendation
- Consult PT for evaluation and activity recommendations

**(3 points)**

**Rationale for choices:**

- Low air loss mattresses help limit pressure, friction and moisture. Lifting sheets and devices help limit damage to tissue layers. (Brienza et al., 2020)
- Foam dressings are appropriate for stage 3 wounds with moderate drainage (Niezgoda et al, 2020)

**(2 points)**

**What support surface would you recommend (1pt) and why? (1pt) low air loss mattress with alternating pressure to limit friction, pressure and moisture.**

**(2 points)**

/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 painful open area to sacrum. The patient is incontinent of urine and stool and has not been repositioning in bed due to reported pain.**

Image courtesy of Cleveland Clinic.

**Wound type: incontinence moisture wound (IAD)**

**(1 point)**

**Wound Nurse recommendations/orders:**

Keep wound clean with a soft gentle continence care wipe (PDI Hygea continence cloth) and limited friction, keeping skin free of irritants

Keep wound dry and protected with zinc oxide topical paste (Remedy Protect) 2x daily and PRN

Assess for and medicate for pain every four hours and PRN

PT consult for eval and treatment, OOB and ambulation

Turn and reposition patient every two hours, assess for and provide toileting every two hours

Keep skin and bed linens dry and avoid shear and friction with the use of lifting sheets and devices

Consult nutrition for hydration a dietary recommendation

**(3 points)**

**Rationale for choices:**

Pain to poorly defined open areas associated with incontinence is IAD. Protecting the skin from feces and urine will improve skin. Scheduled toileting decreases incidence of IAD. Limit friction clean and protect skin with zinc based paste. (Clinical Excellence Commission, 2021)

**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.** Apply Cavilon no sting skin protectant around peri wound area and apply Nexcare contact layer wound dressing over wound and cover with Nexcare Tegaderm transparent dressing every five days or PRN.

**(2 points)**

/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:** PI stage 4 r/t medical device

**(1 point)**

**Wound Nurse recommendations/orders:**

- Gently clean and debride wound with NS and Nexcare soft gauze cloth, pat dry
- Apply Cavilon no sting skin protectant to the surrounding peri wound area
- Apply Medline Skintegrity Hydrogel wound dressing to the wound with cotton tip applicator
- Cover wound with Nexcare sensitive skin bandage
- Change dressing every three days or PRN with increased drainage
- Rotate site for pulse ox every two hours and discontinue as soon as possible
- Monitor sites for injury with rotation schedule
- Consult nutrition for dietary and hydration recommendations
- Assess for and treat pain PRN

**(3 points)**

**Rationale for choices:**

- Cartilage exposed would be the same as bone exposed and therefore a stage 4 ulcer (Levine et al., 2021)
- Rotating medical devices and discontinuing them as soon as possible helps limit ulcers r/t devices (Borchert, 2022)
- Hydrogels are indicated for PI stages 2-4 with a trauma free removal (Niezgoda et al., 2020)

**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.** Place 2x2 Allevyn foam dressing to wound every five days

**(2 points)**

/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:**

Unstageable PI

**(1 point)**

**Wound Nurse recommendations/orders:**

Initiate Home care for skilled nursing care and HHA, PT to eval and treat, case management and social work  
Hospital bed to home with low loss air flow alternating mattress( Drive Medical Med-Aire Melody)  
Heel protectors BL daily to offload heels from the bed surface  
Keep wound clean and dry  
Reposition every two hours  
Monitor wound for any signs of infection or worsening and notify MD or wound care specialist

**(3 points)**

**Rationale for choices:**

Stable eschar can be left without interventions to debride them. The wound can heal on it's own with offloading and if patient comorbid conditions are controlled (Black, 2023)

**(2 points)**

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

Apply ActivHeal hydrogel to the wound and cover with non-adherent gauze and roll gauze every three days and PRN.

**(2 points)**

/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). Periwound 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:** Abdominal Dehisced Surgical Wound, Full thickness

**(1 point)**

**Wound Nurse recommendations/orders:**

Nutrition consult for dietary and hydration recommendations

Assess and treat pain prior to wound care

Irrigate wound with Normal Saline and Medline soft gauze

Clean and dry peri-wound area

Apply Cavilon skin protectant to the peri-wound area

Drape wound with Tegaderm transparent film

Appl 3M Granufoam black foam cut to fit into the wound bed ensuring none is outside the border of the wound

Place 3M Dermatac transparant drape over the foam extending 2 inches around the wound

Cut a 2.5cm hole in the transparent drape and place 3M Sensa T R A C pad over the hole

Attach to the 3M ActiVac unit, apply suction and set to continuous pressure at -125mmHg

For any issues related to NPWT orders and care please contact WOC RN.

Record wound I/O every shift

NPWT change every Monday and Thursday and PRN

Physical therapy consult for activity recommendations

IS pulmonary toileting 15 times every hour while awake

**(3 points)**

**Rationale for choices:**

NPWT is indicated for dehisced surgical wounds assisting in preparing the wound for closure with granulation.

Applying skin protectant around the wound prevents peri-wound excoriation. (Niezgoda et al., 2020)

**(2 points)**

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

Apply Cavilon skin protectant around wound.

Apply Polymem W I C cavity filler to wound, cover with Curity ABD pad and paper tape

Change every four days and PRN

**(2 points)**

/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:** Fournier Gangrene  
**(1 point)**

**Wound Nurse recommendations/orders:**

- Stat Surgical consult for debridement of wound
- ID consult for infection management
- Insert FMS for fecal control and foley for urinary diversion
- Colorectal consultation for possible fecal diversion
- WOC RN consult to continue post op for NPWT and Ostomy care
- Nutrition consult for dietary and hydration recommendations
- Specialty bed mattress low air loss alternating pressure (Drive Medical Med-Aire Melody)
- Lifting devices and draw sheets for ADL assistance with PT recommendations
- Assess and medicate for pain prior to wound care

**(3 points)**

**Rationale for choices:**

Fourniers Gangrene can be precipitated by bacterial infection, usually GI related. It affects the perineal, perianal, genital and surrounding areas. Symptoms include pain, erythema, edema and crepitus in the area. It is life threatening and needs immediate surgical intervention and abx tx after recognition. It affects males more, ages 50-70. (Hong et al, 2024).

**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.** If the dx is not FG, then this is a severe manifestation of incontinence associated dermatitis which will need surgical debridement and ongoing wound care, with fecal and urinary diversion needs. Clean and remove irritants immediately from skin using NS or pH balance incontinence cleaning cloth (PDI Hygea continence cloth), toileting patient every two hours and PRN. After debridement consider Calcium alginate with silver (Convatec Kaltostat Calcium Alginate dressing) covered with Medline ABD and paper tape to maintain MWB environment. Change every three days or PRN.

**(2 points)**

/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:** Full thickness chronic wound with visible structures likely from DM and Reynaud disease  
**(1 point)**

**Wound Nurse recommendations/orders:**

- Surgical Podiatrist consult for surgical wound debridement
- Plastics consult for possible skin reconstruction/flap
- Vascular consult to assess for vascular disease
- ID consult for prophylaxis antibiotic therapy and Pneumonia tx
- Nutrition Consult for dietary and fluid recommendations
- Diabetes education consult
- Clean wound with Vashe and soft cloth
- Lightly pack wound bed with Manuka honey soaked gauze
- Apply Medline ABD over wound and wrap with Kerlix roll gauze
- Change dressing every three days and PRN
- Protect both feet with EZ assistive heel protectors
- NV checks to both feet every four hours
- Assess for and treat pain PRN

**(3 points)**

**Rationale for choices:**

Exposed tendon wounds are treated with TIME principles of wound healing. When edges are assessed to be epibole, they need to be opened. Honey dressings assist in inflammation, proliferation, vascular tissue formation and remodeling. (Deng et al., 2023)

**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.** Place Hydrofera blue classic (hydrate with sterile saline) cut to fit into wound bed

- Apply Kerlix roll gauze
- Change every three days or PRN

**(2 points)**

/8 points

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