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

Mini Case Scenarios: Wounds

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Reviewed by: **Patricia A. Slachta** **Date: 6/30/25**

Score: 37.8 /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: Unstageable

(1 point) 1

Wound Nurse recommendations/orders:
Apply skin barrier
Apply collagenase
Apply hydrogel
Place a foam dressing this is expensive
Cleanse the wound with Microcyn Rx spray or saline moistened gauze
Apply santyl out to edges of the wound
Cover with an ABD
Change daily and as needed if soiled

Better orders are needed. See
https://santyl.com/hcp/application

(3 points) 1

Rationale for choices:
Collagenase: topical debridement to remove the slough and necrotic tissue
Hydrogel: maintain and provide moisture to promote the debridement process cheaper to use a saline moistened gauze as this is a daily dressing
Foam Dressing: protection and managed any output
ABD is less expensive
Microcyn Rx Spray: compatible with santyl; cleanses the wound to provide an unobstructed view of the wound, helps prepare the wound bed for topical care, and offers the clinician an accurate picture of the wound condition

ABD: provides protection to the wound and manages any output
(2 points) 1.5

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply alginate to the wound then cover with gauze and paper tape this appears to be a dry wound bed-it could work…do you know why? Gauze is not typically a secondary dressing.
The alginate will work once the debridement method of santyl starts working and produces exudate. Protect with a foam dressing **(R. B. Turnbull Jr. MD WOC Nursing Education Program, 2025)**

(2 points) .5

4/8 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: DTI-DTPI is recommended abbreviation from NPIAP DTPI **(1 point).8**
Wound Nurse recommendations/orders: **Cleansing?** **Change frequency** **Apply abd** **Wrap with gauze** **Offload pressure from heel using green boots. ok (Rivolo et al., 2020)** **Cleanse with normal saline** **Apply a transparent film dressing (Tegaderm)** **Change Q2-3 days unless any assessment changes arise; then reconsult WOCN** **(3 points) 1.5**
Rationale for choices: **Abd and gauze provides protection. Offloading prevents further damage From what? & these dressings just hide the area from the staff** **(Rivolo et al., 2020)** **Normal saline: keeps area clean, prevents infection, provide an unobstructed view of the wound, helps prepare the wound bed for topical care, and offers the clinician an accurate picture of the wound condition** **Tegaderm: allows for frequent assessment without further damaging the wound. Protects from contamination** **Offloading: prevents further damage from friction, shear, and pressure which allows the wound to heal by promoting blood flow** **(2 points)1**

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply hydrocolloid dressing to L heel Hydrocolloids set up autolytic debridement
Apply Opsite Flexifix Transparent Dressing, use pillows to float heels off of bed (R. B. Turnbull Jr. MD WOC Nursing Education Program, 2025)

(2 points) 0

3.3/8 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) 1

Wound Nurse recommendations/orders:
Cleanse wound with normal saline
Apply skin barrier to peri-wound area
Apply aquacel to wound
Apply compression bandage what kind 2-layer bandage system
Elevate leg when resting
Change daily-compression bandages are not changed daily
Change every 2-3 days

(3 points) 2

Rationale for choices:
Clean wound to prevent further damage no, this is not why we clean wounds
Cleanse wound to keep area clean and prevent infection, provide an unobstructed view of the wound, helps

prepare the wound bed for topical care, and offers the clinician an accurate picture of the wound condition

Skin barrier to protect peri wound area from further damage from exudate ok
Aquacel to manage amount of exudate ok
Compression and elevation improves venous return ok

(2 points) 1.5

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply alginate to the wound bed, cover with abd and gauze wrap Alginate & hydrofibers are very similar. What else can you use?
Apply a foam dressing to the wound to absorb exudate and protect the wound **(R. B. Turnbull Jr. MD WOC Nursing Education Program, 2025)**
(2 points) 0

4.5/8 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

(1 point) 1

Wound Nurse recommendations/orders:
Cleanse with normal saline
Apply skin barrier to peri wound skin
Apply alginate to wound bed
Apply hydrocolloid or foam dressing Hydrocolloid does not really manage exudate; foam, perhaps depending on dressing change schedule

Apply a foam dressing
Change dressing every 1-2 and as needed when soiled
Using positioning wedges, turn patient every 2 hours, (R side, L side, supine, continue).
Consult to surgical team for debridement of yellow slough
Change frequency?
What about positioning?

(3 points) 2

Rationale for choices:
Gentile cleanser to prevent further damage not the rationale cleanse wound and prevent infection, provide an unobstructed view of the wound, helps prepare the wound bed for topical care, and offers the clinician an accurate picture of the wound condition
Alginate: creates a moist environment that encourages autolytic debridement; helps to benefit the wound during the proliferation phase of wound healing where new growth of granulation tissue is essential
foam dressing: absorb exudate and protect the wound
to manage exudate and promote healing you keep saying promote healing…how does that work?

(2 points) 1

What support surface would you recommend (1pt) and why? (1pt)
Waffle mattress to reduce pressure on the sacrum this may not be adequate for this particular pt
I would recommend a low air loss mattress as it features a "microclimate control" that can help to regulate moisture, helps redistribute pressure (R. B. Turnbull Jr. MD WOC Nursing Education Program, 2024)

(2 points) 1

5/8 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: Stage 2 **(1 point) 1**
Wound Nurse recommendations/orders: **Cleanse with normal saline** **Apply hydrogel** **Apply foam dressing consider a contact layer to keep hydrogel from being absorbed into foam** **Collaboration with team members for pain control, recommend Q2 turns, if refusing place waffle mattress in turning schedules, suggest surfaces such as Q 2 turn right/left w back lying only for meals or orders similar to this** **Change daily and as needed with clean ups** **(3 points) 2.5**
Rationale for choices: **Cleanse to clean the wound and prevent infection to prevent further damage no** **Hydrogel and foam to maintain a moist environment to promote healing the purpose of foam is to absorb** **Repositioning and waffle mattress offload pressure** **(2 points) 1.5**
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order. Apply triad to wound and peri-wound area. Wash triad ok-but what is the actual order for applying & removing? (2 points) 1 Apply triad to wound and peri-wound area Change daily and as needed Wash triad off of peri-wound area down to skin with ph-gentle cleanser every 4 days **(R. B. Turnbull Jr. MD WOC Nursing Education Program, 2024)**

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:
Pressure injury yes but there is more info needed here..type & stage
Stage 4 pressure injury as the cartilage is visible

(1 point) .2

Wound Nurse recommendations/orders:
Rotate to a new pulse ox site, rotate to Q4 ok hours using toe, finger, forehead, nose
Cleanse with normal saline
Apply a hydrogel sheet dressing
Change every 3 days or as needed
Rotate new pulse ox sites daily (R. B. Turnbull Jr. MD WOC Nursing Education Program, 2024)
Cleansing & dressing change orders needed. Positioning orders? Again, foam & hydrogel are not the best combo but no points deducted for this
(3 points) 1.5

Rationale for choices:
NS; cleans the wound and prevents infection
Hydrogel and foam maintains a moist wound environment and protective barrier well, the foam can absorb the hydrogel
Hydrogel sheet dressing: maintains a moist environment, helps to remove dead tissue, sheet form protects the wound from further pressure, irritation, or bacteria from entering
(2 points) 1.8

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply medihoney to wound then cover with a hydrocolloid dressing how are you going to get a hydrocollid to adhere to

the ear? & why two products?
Apply medihoney to the wound
Cover with a Telfa pad and secure with tape **(R. B. Turnbull Jr. MD WOC Nursing Education Program, 2024)**
(2 points) .5

4/8 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

(1 point) 1

Wound Nurse recommendations/orders:
Cleanse with Normal saline and dry
Wrap wth dry gauze
Place pt in green heel offlaoding boots or float heels off bed using pillows
Change daily

Apply heel foam dressing ok but you need cleansing & changing orders & other orders too for offloading
(3 points) 1

Rationale for choices:
Maintain a moist environment to facilitate debridement this is exactly what we do not want to do
Keep wound protected, clean and dry; Stable eschar on the heels serves as “the body’s natural cover” and should not be removed: this is unique to the area of the heel considering the distal natural to the bodies circulatory system and has associated risks with arterial disease

(2 points)0

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply hydrogel to wound cover with a wrap gauze no, this debrides the wound
Clease with ph balanced soap and water, dry, float heels off of bed using a pillow (R. B. Turnbull Jr. MD WOC Nursing Education Program, 2024)
(2 points) 0

2/8 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: dehiscence

(1 point) 1

Wound Nurse recommendations/orders:
Cleanse with normal saline using moderate pressure (35 mL syringe + 19G tip)
Apply no sting barrier film to periwound skin
Apply a fenestrated wound contact layer ok
Cut and apply a black foam dressing appropriate to size to fill the wound ok
Place the foam into the wound, ensuring contact with the entire wound bed. Avoid overpacking or excessive pressure, especially near sutures good
Apply the transparent film dressing, ensuring it extends several centimeters beyond wound edges onto healthy skin, ensuring to smooth out any wrinkles or air bubbles to create an airtight seal ok
Connect the NPWT device tubing to the foam dressing
Turn on NPWT device and set the pressure to -125

mmHG continuous pressure this is an order, be specific
Document time of dressing application, pressure setting, and initial wound appearance
Pressure adjustments made as needed according to physician orders/protocol
Change dressing every 48–72 hours or every 24–48 hours if infection is suspected or wound is highly exudative

Cleansing, periwound protection, change frequency
(3 points) 1.5

Rationale for choices:
Contact layer: protect the skin under the foam the contact layer is not on skin, Protects sutures and wound base from foam adherence or trauma during dressing changes
Black Foam: because wound is 3 cm deep so foam can fill the wound and conform to the shape. Black foam is suitable for wounds with minimal drainage and the foam provides good protection for the sutures also good for lots of drainage; promotes tissue granulation
Transparent film: creates airtight seal, transparency allows for visualization
Continuous pressure setting: promotes granulation tissue formation that avoids excessive pressure
Instructions when not working

(2 points) .5

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply a hydofiber dressing to the wound bed then apply a foam dressing again, change orders
Apply hydrogel-impregnated gauze to wound bed to maintain moisture balance in dry wound.
Cover with bordered foam dressing to provide absorption and protection.
Change every 48–72 hours, or sooner if saturated or loose (R. B. Turnbull Jr. MD WOC Nursing Education Program, 2024)
(2 points) 1.5

4.5/8 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:
IAD +? IAD: MASD with possible infection and pressure injury
(1 point) .5

Wound Nurse recommendations/orders:
Using soap and water, gently remove excess barrier cream, rinse thoroughly may or may not work. What else removes adherent ointment?
Cleanse with normal saline
Apply an enzymatic debridement method
Apply a hydrofiber dressing to the wound areas
(3 points) 0 Hannah, this is off target for MASD +?

We have added a lecture on MASD to the curriculum & it was uploaded into practicum… 2025 Moisture Associated Skin Damage Assessment & Management— Please review this lecture & hopefully you will find it valuable

Gently remove all excess barrier cream a silicone based adhesive remover, no scrubbing (Fildalgo de Faria et al., 2020)
Using a pH balanced skin cleanser, cleanse area, pat dry
Apply no sting barrier film to intact peri wound skin, allow to dry
Apply triad to wound and peri-wound skin to dime size thickness
Contain drainage with rectal pouch, condom cath, breathable wicking underpads, consider indwelling urinary/fecal catheters

Clean down to skin every 5 days
Apply low air loss mattress

Rationale for choices:
Cleanse area thoroughly to visualize wound completely and allow debridement method to work
Debridement: to remove non-viable tissue that can harbor bacteria and impede healing
Hydrocolloid dressing: absorbent to manage drainage you said hydrofiber above + it is highly unlikely a hydrocolloid can adhere to this area. Also, is debridement the key here?
Remove excess cream previously applied: Gain full visualization of the wound to properly and completely assess the wound
Cleanse: provides an unobstructed view of the wound, helps prepare the wound bed for topical care, and offers the clinician an accurate picture of the wound condition

No sting: protect peri-wound skin from moisture so further damage does not occur

Triad: Protects Denuded Skin, Adheres to Moist/Wet Skin, No Secondary Dressing Needed, has mild anti-inflammatory and antimicrobial properties and supports a moist wound environment conducive to healing, Low-Trauma Removal

Containment: prevents from further incontinence associated damage, allow for healing

(2 points) 0

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Cleanse with vashe, Apply a hydrocolloid dressing to the wound area
Cleanse affected areas with normal saline, Pat dry gently.
Apply a thin layer of impregnated non-adherent contact layer
Cover with a soft silicone foam dressing (R. B. Turnbull Jr. MD WOC Nursing Education Program, 2025)

(2 points) 0

.5/8 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: Arterial wound there may be an arterial component here but it is classified as? Chronic arterial insufficiency ulcer
(1 point) .5

Wound Nurse recommendations/orders:
Cleanse with normal saline
Apply a hydrogel dressing to the wound
Cover with a sterile, non-adherent secondary dressing- yes, good plan
~~**Secure with a compression wrap**~~
Change dressing daily
Elevate foot with pillow
Cleansing & change frequency

(3 points) 1.5

Rationale for choices:
Cleanser: clean the wound, provides an unobstructed view of the wound, helps prepare the wound bed for topical care, and offers the clinician an accurate picture of the wound condition

Hydrogel: facilitates autolytic debridement & most importantly keeps the tendons moist
Non-adherent dressing: protects the wound bed yes but it also does minimal absorption of the gel you used.
~~**Compression wrap: supports arterial circulation-NO**~~
Elevate: reduces swelling ok
(2 points) 1

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply a calcium alginate dressing to the wound then place a foam dressing there is scant drainage, what else

can you do?
Apply collagen dressing
Cover with an ABD (R. B. Turnbull Jr. MD WOC Nursing Education Program, 2024)
(2 points) 0

3/8 points

References (3 points):1.0 **In Word docs reference lists are not bolded, double-spaced & have a hanging indent**

Faria, M. F. de, Ferreira, M. B. G., Felix, M. M. dos S., Bessa, R. M. V., & Barbosa, M. H. (2022). Prevention of medical adhesive-related skin injury during patient care: A scoping review. *International Journal of Nursing Studies Advances, 4*, Article e100078. https://doi.org/10.1016/j.ijnsa.2022.100078

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