

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:

Unstageable pressure injury

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse with normal saline
2. Apply no sting skin barrier (Cavilon) to peri wound edges
3. Apply Hydrogel (Aquasite Amorphous Hydrogel) to the wound base
4. Then apply Urgotul over top of the gel
5. Cover with Hydrocolloid dressing (Duoderm)
6. Change daily

(3 points)

Rationale for choices:

Debriding is needed so that the base of the wound will be visible, the hydrogel allows for autolytic debridement and along with the Urgotul encourages moisture from the wound base. Duoderm helps to encourage debridement and helps to lock in moisture. The skin barrier helps to prevent maceration of the wound edges

(2 points)

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

Apply 3cm of Santyl to wound bed (Smith & Nephew, n.d.) once daily for 30 days
Cover wound with Xeroform dressing then apply ABD and use paper tape around edges. Change daily and PRN

(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:

Deep Tissue Injury

(1 point)

Wound Nurse recommendations/orders:

1. Apply Allevyn Life heel protectors to bilateral heels change every 3-4 days and PRN
2. Turn patient every two hours, do not let heels touch the bed
3. Offload patient's heels with pillows

(3 points)

Rationale for choices:

Offloading will help to prevent further breakdown of the skin

-The foam dressing will provide the needed cushion to the heels and the multiple layers of the dressing will also absorb moisture and wick it away from the heel.

(2 points)

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

Apply non stick gauze pads to bilateral heels, wrap with Kerlx roll and secure with tape. Change every 3-5 days and PRN

Apply offloading heels boots

(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 Stasis Ulcer

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse with wound with normal saline and pat dry
2. Use sting free skin barrier prep (Coloplast sting free barrier) and wipe around the peri wound edges
3. Using Hydrofiber dressing (Aquacel extra) Cut out shape of wound and apply to wound surface
4. Cover with ABD and secure with Kerlix roll and Elastic Bandage providing light to moderate compression
5. Elevate leg
6. Change dressing every 2-3 days and PRN

(3 points)

Rationale for choices:

The skin barrier is used to protect skin around the wound from moisture and help prevent further maceration
The Hydrofiber dressing is used to help absorb the moderate drainage from the wound
ABI of both legs is diagnostic for Peripheral arterial disease, the use of compression will help to improve blood flow and help the wound to heal.

(2 points)

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

Cleanse wound with normal saline and pat dry
Cut wound shape from specialty absorbent dressing (Drawtex) and apply to the wound bed
Cover with gauze dressing and paper tape. Change every other day
Then apply compression stocking to secure dressing

(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 pressure injury

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse with normal saline
2. Moisten moisture retentive dressing (Hydrofera Blue Classic) with sterile saline
3. Squeeze out excess
4. Cut Hydrofera blue to fit wound with ½” extra to cover wound edges -change every 3 days or sooner if dressing changes color to white (Hydrofera, 2021)
5. Cover with large ABD change every other day or when soiled
6. Reposition patient every 2 hours
7. Avoid patient lying on their sacrum using pillows or wedges

(3 points)

Rationale for choices:

-Wound should be cleansed to prepare the wound bed prior to dressing application
-Hydrofera Blue Classic provides for autolytic debridement
-Hydrofera blue will not harm the skin and is safe to overlap onto healthy tissue
-Due to the moderate amount of drainage currently coming from the wound a ABD is a good secondary dressing to absorb the fluid and also allows for frequent monitoring of the primary dressing during the changing of the ABD.

(2 points)

What support surface would you recommend (1pt) and why? (1pt)

A mattress that is low air loss and redistributes the pressure around the body. This will keep the pressure off of all of the patient’s bony areas, reduce friction and shearing, and helps decrease moisture from building in certain area from the patient perspiring or having incontinent episodes.

(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:

Stage 2 pressure injury

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse patient with each incontinent episode using a pH balanced no rinse cleanser (3M Cavilon No rinse skin cleanser)
2. Apply barrier cream (Desitin) to perineal area after incontinent episodes and to surrounding skin
3. Cleanse wound with normal saline
4. Apply Moisture Retentive Dressing (Allevyn Gentle Border) to Wound surface
5. Change every 3 days and PRN

(3 points)

Rationale for choices:

-Barrier cream will help to prevent further skin breakdown from patient incontinence

-Allevyn gentle border is good for use on patients with fragile skin, is water proof to prevent urine and fecal matter from infiltrating the dressing, and it is able to easily conform to the changes in the skin's surface (Smith & Nephew, n.d.).

Allevyn's are composed of multiple layers that wick moisture away from the wound allowing for an increased wear time but due to the patient's incontinent status and the moisture of the wound it should be changed at least every 3 days

(2 points)

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

Cleanse wound with normal saline

Cut Alginate dressing (Algicell) to wound shape and place on wound then cover with Bordered gauze adhesive dressing.

Change every 1-2 days and PRN depending on drainage

(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:

Pressure injury stage 3

Medical Device Related Pressure Injury

(1 point)

Wound Nurse recommendations/orders:

1. Use alternative pulseox monitoring option such as an adhesive probe on a toe or finger
2. Swab wound for culture
3. Cleanse ear with Vashe and pat dry
4. Cover with 2x 2 Silicone foam dressing (Allevyn Gentle Border Lite Foam Dressing)
5. Change every 3-5 days and PRN

(3 points)

Rationale for choices:

Vashe is a gentle cleanser that removes organisms from the wound and helps with the healing process.

The wound appears to be moist the Allevyn dressing will absorb any exudate that comes from the wound but will also allow the area to breathe, and the silicone adhesive will be gentle on the patient's skin.

The dressing's indicator allows the provider to see when there is excess fluid buildup and the dressing needs to be changed.

(2 points)

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

Cleanse the ear with saline, then allow it to dry

Apply petroleum jelly to the base of the wound

Cover with 2x2 dry gauze dressing

Change every 2 days and PRN

(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 pressure ulcer

(1 point)

Wound Nurse recommendations/orders:

1. Apply nonadherent gauze pad (Telfa) and wrap with gauze roll (Kerlix roll), change every 4-5 days and PRN
2. Offload heels with heel boots
3. Monitor for any signs of redness, drainage, or softening of the wound

Obtain a Doppler ABI

Podiatry consult

(3 points)

Rationale for choices:

Debridement is not needed since the peri wound shows no signs of infection

Offloading the heels helps to prevent further damage to the feet

The doppler will allow the provider to rule out arterial disease and helps with planning for any potential debridement later

Redness and or drainage can indicate a change in the wound and the need for possible intervention by a specialist

(2 points)

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

Apply Allevyn foam heel protectors to heels and change every 7 days or PRN, Remove daily to assess heels for redness or drainage

(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:

Surgical Wound Dehiscence

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with normal saline
2. Apply no sting skin barrier prep to periwound edges (Cavilon)
3. Apply silicone contact layer (Adaptic touch) to all areas of wound bed extending to edges of wound
4. Cut foam into shape of wound, making sure to fit the entire depth of the wound (if using multiple pieces ensure proper connection between section to allow for proper seal) avoid excess connection with periwound edges
5. Cover foam with NPWT clear adhesive drape
6. Cut hole small hole in drape on foam to allow for suction of trac pad to be placed on foam
7. Connect hose of trac pad to NPWT device and set device to -100mmHg and check for leaks
8. Change dressing every 3-4 days

(3 points)

Rationale for choices:

- Skin barrier prevents skin from maceration from possible foam connection to an area of the periwound
- The contact layer protects the sutures and the wound bed by preventing the foam from adhering
- 100mm Hg is enough pressure to pull moisture but low enough so as to not cause a fistula with a stronger suction, this can be increased later as needed

(2 points)

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

Cleanse wound with normal saline
Cut white NPWT foam to fit wound, moisten with saline and apply to the wound bed
Cut black foam and apply on top of white foam
Cover with clear drape and cut hole for suction of trac pad,
Connect hose and set to 100mmHg and check for leaks
Change every 2 days

(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:

MASD, with Unstageable on coccyx

(1 point)

Wound Nurse recommendations/orders:

Cleanse necrotic coccyx area wound with vashe
Then apply hydrogel (Intrasite) to necrotic area
Cover coccyx with foam dressing (Allevyn life), Change every other day and PRN

Cleanse buttock and scrotal area with pH balanced perineal cleanser and pat dry
Clean off any areas of soiled or overly thick layering of triad from previous incontinent episode
Apply new layer of Triad cream to buttocks and scrotum
Reapply with each episode of incontinence

(3 points)

Rationale for choices:

Vashe is antimicrobial helps remove the biofilm, and is safe for use on damaged skin due to its gentle nature and it also mimics the skin's natural pH.
The hydrogel encourages autolytic debridement softening the necrotic tissue while also keeping the area moist.
The Allevyn helps to keep the hydrogel in place and allow for debridement to occur while also cushioning the area. The weepy lesions are in an area that cannot easily be covered with a normal dressing, the Triad cream will work to cover the area and protect from further breakdown

(2 points)

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

Cleanse necrotic area with saline and pat dry
Apply Medihoney paste to necrotic area
Cover with gauze dressing change every 2 days and PRN

Clenase genital area with pH balanced cleanser
Apply Mositure Barrier cream top buttock and scrotal area and reapply with each episode of incontinence

(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:

Arterial Ulcer
Full thickness

(1 point)

Wound Nurse recommendations/orders:

- Cleanse with vashe soak
- Apply Hydrogel to areas of slough and eschar (avoid tendons) then apply a contact layer (Adaptic)
- Cover with an ABD pad
- Wrap with Kerlix roll to secure in place
- Change dressing every 24 hours
- Silver nitrate to rolled edges-by provider
- Referral to vascular surgeon
- Obtain Doppler ABI

(3 points)

Rationale for choices:

- Vashe irrigates the wound and helps remove from the wound microorganisms, and it is also safe because it mimics the normal pH of human skin (Urgo Medical North America, 2025).
- Hydrogel encourages autolytic debridement of the slough and eschar while not disturbing the healthy tissue, but it needs to be changed often
- The Adaptic will protect the tendon that is exposed while also helping to keep the tissue moist
- Silver nitrate is needed as the picture and case study state epibole which suggest that the wound is stalled

(2 points)

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

- Apply hydrogel sheet (Medihoney) to wound surface and cover with transparent film (Tegaderm) change every 24- 48 hours and PRN

(2 points)

/8 points

References (3 points):

Hydrofera. (2021, June 30). Hydrofera Blue® wound dressing user guide. Hydrofera, LLC. Retrieved from <https://hydrofera.com/app/uploads/2022/03/HFB-Patient-User-Guide-ENG-June-30-2021.pdf>

Smith & Nephew. (n.d.). SANTYL® Ointment for Healthcare Professionals. Retrieved August 10, 2025, from <https://santyl.com/hcp>

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Urgo Medical North America. (2025, July 28). Vashe Wound Solution - A pure hypochlorous acid solution. Urgo Medical. <https://www.urgomedical.us/products/vashe>