

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

Mini Case Scenarios: Wounds



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Date: 10/3/25

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. To support your actions, include at least three relevant references in addition to the course textbooks. (Use 7th edition APA formatting)

A case study has been completed for you. Below is 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 the wound with normal saline and pat dry.  
Apply 3M Cavilon No Sting skin barrier to the peri wound
2. Apply a nickel-thick layer of Santyl to the wound bed. Fill the remaining space of the wound with Saline moistened gauze. Cover with dry gauze and secure with 3M Medipore tape. Change daily and as needed.
3. Place on low air loss with air fluidized feature.
4. Turn and reposition every two hours
5. Nutrition consult
6. Waffle cushion to the sitting surface when out of bed.
7. Recommend surgical consult for sharp debridement

**(3 points)**

**Rationale for choices:**

1. Cleaning the wound with saline is indicated to remove debris and exudate from the wound bed. I chose the 3M Cavilon skin barrier to protect the wound from any drainage that may be present between dressing changes and to protect from the adhesive in the Medipore tape.
2. I chose Santyl to clean the devitalized/yellow slough tissue from the wound through its enzymatic debriding properties.
3. A low-air-loss surface with an air fluidized feature will provide pressure redistribution and low air loss to manage the microclimate of the skin.
4. To help prevent the formation of further pressure injuries
5. To assist in the assessment of nutritional status and diet modification to promote healing
6. To help alleviate pressure on the sitting surface while out of bed.
7. The wound would benefit from sharp debridement to remove devitalized tissue

**(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. Apply Medihoney calcium alginate dressing to the wound bed. Cover with gauze and secure with 3M Medipore tape. Change every three days, as needed, for soiled or missing dressing.

**(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 pressure injury

**(1 point)**

**Wound Nurse recommendations/orders:**

1. Monitor DTPI on the left heel every shift and document findings in the skin assessment.
2. Offload pressure to heels off the mattress with the use of heel lift boots.
3. Low-air-loss mattress
4. Turn and reposition the patient every two hours and as needed for comfort
5. Notify wound care for worsening of the area or if the area opens
6. Nutrition consult

**(3 points)**

**Rationale for choices:**

1. I want the nurses to look at the wound every shift to determine if it gets worse and to document their findings.
2. The area is caused by pressure; removing the pressure is the main treatment for this area at this time.
3. A low-air-loss mattress will help with pressure redistribution and help to alleviate pressure on bony prominences.
4. The patient is at risk for further pressure injuries; turning will help to alleviate pressure
5. If the wound opens a different treatment option may be indicated.
6. Nutrition consult to help assess nutritional intake and need for diet modification and supplementation

**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.** Apply 3M Cavalon skin barrier to the skin of the left heel every three days and as needed.

**(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:** mixed arterial-venous leg ulcer

**(1 point)**

**Wound Nurse recommendations/orders:**

1. Cleanse the wound and surrounding skin with normal saline and pat dry.
2. Apply Cavalon skin barrier to the periwound
3. Place Aquacel AG+ (hydrofiber with silver) into the wound bed to fill all space.
4. Cover with gauze, wrap with Kerlix, and secure with tape. Change every other day and as needed for strike though drainage.
5. Apply low-level compression of Tubi grip sleeves (measure to fit for light compression), remove at bedtime, and place in the am before getting out of bed.
6. Elevate legs while at home as tolerated to the level of the heart.

**(3 points)**

**Rationale for choices:**

1. Cleaning the wound with saline is indicated to remove debris and exudate from the wound bed.
2. Cavalon to peri wound to protect the skin from excess drainage
3. I chose an Aquacel AG+ due to the wound having a moderate amount of exudate, and I chose one with silver since the wound is described as non-healing and may need an antimicrobial treatment.
4. I chose gauze and kerlix as the secondary dressing as these are inexpensive and may need changed frequently depending on the drainage. They would be gentler on the surrounding skin than tape.
5. I chose a low level of compression (tubi grip) that can deliver 10-15 mmHg compression due to the results of the ABI. They are indicative of arterial disease and do not want to put the patient in full compression due to this.
6. Elevating the legs will help reduce any edema that may be present and may help prevent any dependent edema while sitting.

**(2 points)**

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

Cleanse the wound with normal saline and pat dry. Apply Mepilex Ag foam to the wound. Secure with Kerlix rolled gauze. Change every three days and as needed for strike-through drainage.

**(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 the wound with normal saline and pat dry.
2. Apply 3M Cavlon skin barrier to the peri-wound. Apply Aquacel AG+ to the wound bed. Cover the Aquacel AG with fluffed gauze to fill any remaining dead space of the wound. Cover with ABD pad and secure with 3M Medipore tape. Change every other day and as needed for strike-through drainage.
3. Turn and reposition every two hours.
4. Place on low air loss with air fluidized feature.
5. Waffle cushion to any sitting surface
6. Limit time sitting to one hour three times a day for meals.
7. Nutrition consult

**(3 points)**

**Rationale for choices:**

1. Cleaning the wound with saline is indicated to remove debris and exudate from the wound bed.
2. I chose the 3M Cavlon skin barrier to protect the peri-wound from any drainage that may be present between dressing changes and to protect from the adhesive in the dressing (Medipore tape). I chose Aquacel AG+ to place in the wound bed due to the wound having a moderate amount of exudate.
3. Turn and reposition every two hours to help prevent the formation of further pressure injuries
4. A low-air-loss surface with an air fluidized feature will provide pressure redistribution and low air loss to manage the microclimate of the skin.
5. A waffle cushion to the sitting surface to help alleviate pressure while sitting
6. Limiting time sitting is going to help reduce pressure to the wound while still allowing for time out of bed.

7. Nutrition consult to assist in the assessment of nutritional status and diet modification to enhance healing

**(2 points)**

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

I recommend a low-air-loss surface with an air-fluidized feature to provide optimal pressure redistribution, reduce shear, and manage the skin's microclimate, supporting both prevention and healing of pressure injuries.

**(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:**

IAD (incontinence-associated dermatitis)

**(1 point)**

**Wound Nurse recommendations/orders:**

1. Cleanse the area with no rinse, pH-balanced wound wash – Remedy no rinse foam cleanser.
2. Pat dry
3. Apply an even layer of Coloplast Triad Hydrophilic wound dressing, the thickness of a dime, daily to open areas. Cleanse areas and reapply as needed after incontinent episodes.
4. Place the patient on an absorbent pad in bed. No briefs
5. Utilize a Medline ComfortGlide glide sheet under the patient for repositioning every two hours
6. Low-air-loss mattress

**(3 points)**

**Rationale for choices:**

1. Cleanse area with Remedy no rinse pH-balanced cleanser to allow cleansing with minimal friction on skin.
2. Pat dry to avoid friction
3. I used Coloplast triad in this instance because it will stick to wet wounds. Triad will provide maintenance of a moist wound surface and protect against urine and stool
4. Absorbent pad to help wick away any urine the patient may be incontinent of
5. The Medline ComfortGlide glide sheet will assist with turning and micro shifts to help alleviate pressure
6. Low air loss mattress for this patient to help reduce pressure on the bony prominences and distribute weight more evenly, and to assist with microclimate control and assist with moisture

**(2 points)**

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

Cleanse area with soap and water and pat dry. Apply DuoDerm (hydrocolloid) over the open areas. Change every three days, as needed, for soiled or missing dressings.

**(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:**  
MDRPI Stage 4  
**(1 point)**

**Wound Nurse recommendations/orders:**

1. Cleanse the wound with normal saline and pat dry
2. Apply 3M Cavalon no-sting skin barrier to the peri-wound. Apply Medline Maxorb II to the wound and cover with gauze and 3M Medipore tape. Change every other day and as needed for strikethrough drainage.
3. Recommend changing pulse oximeter placement every two hours and as needed.
4. Nutrition consult

**(3 points)**

**Rationale for choices:**

1. Cleanse the area for the removal of devitalized tissue and exudate.
2. 3M Cavalon to the macerated peri wound to protect from drainage. Maxorb II to the wound bed to absorb drainage and to maintain a moist, not wet, wound environment. Gauze and tape, as they may need frequent changes, and they will conform around the ear.
3. Changing the pulse oximeter to a different area every two hours to prevent further breakdown.
4. Nutrition consult to evaluate diet and intake and to recommend supplements to assist with wound healing.

**(2 points)**

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

1. Cleanse the area with normal saline and pat dry. Apply DuoDerm Hydrocolloid to the wound. Cut to fit the wound and periwound. Change every 3 days and as needed.

**(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 injury

**(1 point)**

**Wound Nurse recommendations/orders:**

**(3 points)**

1. Paint black eschar with betadine daily and leave open to air.
2. Offload pressure to heels with pillows while in bed
3. Encourage PO intake of protein and adequate fluids
4. Discuss other community resources for the patient and the wife
5. Potential vascular consult with ABI testing, depending on the amount of treatment the patient is agreeable to.

**Rationale for choices:**

1. Stable eschar should not be disturbed if there is no s/s of infection. Painting with Betadine will reduce the bacterial load in the area, helping to prevent infection. Also, there is no information on ABI for the lower extremities. I would also like to know this information.
2. The wound is most likely a result of pressure from being bedridden. Offloading the pressure will help in healing.
3. Intake of protein and fluid is necessary for wounds to heal
4. I would like to explore if the wife is adequately equipped to care for her husband. I don't know if she has any help or resources, or if the husband requires a higher level of care
5. This is an intervention that I would discuss, as a lack of blood flow to the extremity may also cause the wound.

**(2 points)**

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

Another treatment option for this area is to leave it open to the air and leave it dry.

Another option is :

Apply Cavalon skin barrier to the eschar on the left posterior heel every three days and as needed.

**(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

**(1 point)**

**Wound Nurse recommendations/orders:**

1. Cleanse the wound with normal saline and pat dry.
2. Apply a Cavalon skin barrier to the periwound.
3. Cover sutures with a single layer of adaptic dressing.
4. Windowpane the peri wound with a single layer of Vac-Drape.
5. Apply black (GranuFoam) foam to the wound bed. Cut black foam to fit into the wound bed. Avoid overlapping onto intact skin. Do not cut foam over the top of the wound. Secure with a single layer of vac drape.
6. Cut a one-inch hole in the drape and apply the trac pad. Attach the trac pad to the KCI wound vac.
7. Set at -125mmhg continuous suction.
8. Change dressing every Monday, Wednesday, Friday, and as needed.
9. Notify the provider if the VAC alarm persists for more than two hours without resolution of the issue.

**(3 points)**

**Rationale for choices:**

1. Cleanse the wound to remove exudate and debris.
2. Applying a skin barrier will protect the periwound skin and also help prevent shearing with VAC drape removal.
3. Applying Adaptic to cover the sutures will help protect them from sticking to the black foam, which can be painful.
4. This will help to add protection to the peri-wound skin. Protection from drainage or any black foam that may get overlapped.
5. The black foam is what will fill the wound cavity and assist in the negative pressure. Overlapping the foam onto good skin will damage the good skin. Cutting the foam over the wound has a risk of small bits of foam getting into the wound that may not be seen.
6. Cutting a hole large enough is essential for the suction to fully work
7. This setting is the recommended starting point from the manufacturer.
8. These dressings are changed every 48-72 hours on average, as recommended by the manufacturer.
9. Leaving a dressing in place for greater than two hours without the suction may cause damage to the wound

**(2 points)**

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

1. Cleanse the wound with normal saline and pat dry. Apply hydrogel (RestorGel) to the wound bed and fill the remaining wound space with fluffed gauze. Cover with a non-sterile pad and secure with 3M Medipore tape. Change daily and as needed for strike through drainage.

**(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:**

Unstageable pressure to right coccygeal area with IAD

**(1 point)**

**Wound Nurse recommendations/orders:**

1. Cleanse area with pH balanced no rinse cleanser and pat dry. Apply even layer of coloplast Triad Hydrophillic wound dressing the thickness of a dime daily to right coccygeal wound and IAD areas to bilateral buttocks and scrotum. Cleanse areas and reapply as needed after incontinent episodes.
2. Turn and reposition patient every two hours
3. Low air loss surface
4. Nutrition consult

**(3 points)**

**Rationale for choices:**

1. Cleansing an area will remove exudate and debris from the wound and IAD areas. Pat areas dry as rubbing will cause more friction and damage. I used Coloplast triad in this instance because it will stick to wet wounds and will also assist in autolytic debridement of the coccegeal wound.
2. This will prevent more pressure from developing
3. A low-air-loss surface will help with the microclimate of the skin with the added moisture related to incontinence.
4. Nutrition consult to assist with intake and assess for supplements that may be needed/aid in healing

**(2 points)**

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

Another type of protective barrier would be a hydrocolloid. For this product, I would encourage the use of a rectal pouching system. The pouching system will collect the stool and keep it out of the wounds, and the hydrocolloid will cover the IAD areas and will provide a warm, moist healing environment. It will aid in autolytic debridement for the unstageable wound.

Cleanse buttocks, scrotum, and right coccygeal areas with soap and water and pat dry. Apply Hollister Premier

Fecal Collector to the anal area. Cover areas of IAD and the right coccygeal area with DuoDerm thin hydrocolloid dressings. Change every 5 days and as needed.

**(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 wound

**(1 point)**

**Wound Nurse recommendations/orders:**

1. Cleanse the wound with normal saline and pat dry. Apply Hydrofera Classic to the wound. Rehydrate with normal saline and gently remove excess fluid. Cut so that the dressing will overlap onto the periwound edges. Cover with gauze and 3M Medipore tape. Change every three days and as needed.
2. Nutrition consult
3. Recommend vascular studies (ABI)
4. Recommend podiatry consult

**(3 points)**

**Rationale for choices:**

1. I chose Hydrofera Blue Classic as it will maintain a moist wound environment, assist in autolytic debridement, and, by overlapping onto the wound edges, it will assist with epibole by providing natural negative pressure. It can stay in place up to seven days but I would want to check it after three to assess the dressing.
2. Nutrition consult to assist with diet recommendations and supplement recommendations for healing.
3. ABI studies to assess blood flow to the area.
4. Podiatry consult to evaluate for any surgical intervention that may be necessary.

**(2 points)**

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

Cleanse with normal saline and pat dry. Apply (RestorGel) hydrogel to the wound bed. Cover with gauze and secure with Kerlix rolled gauze. Change every other day, as needed, for soiled dressings.

A (RestorGel) hydrogel will help provide a moist wound environment while assisting in autolytic debridement.

For this patient, I would avoid applying silver nitrate to the rolled edges until I had more information available about the blood flow to the wound.

(2 points)

/8 points

**References (3 points):**

**References**

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