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

**Mini Case Scenarios: Wounds**


**Student Name _Carla Edeh_____ Date: ____11/18/25_____**

**Reviewed by: _____ Date: _____**

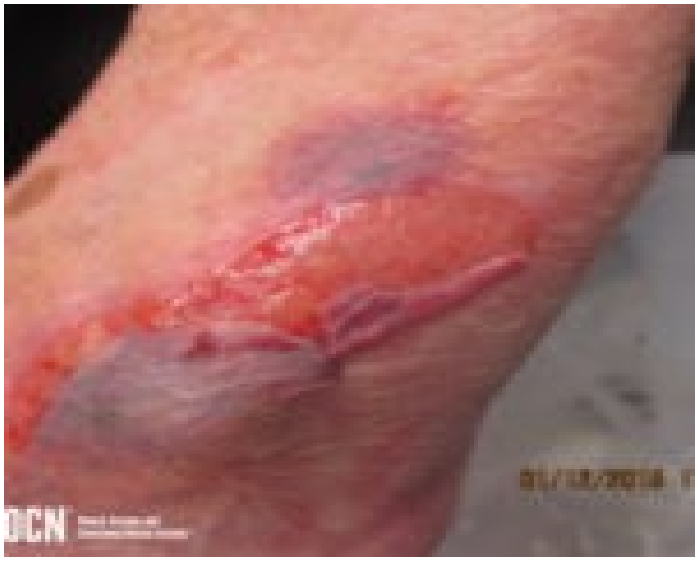
**Score: /83**

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)**

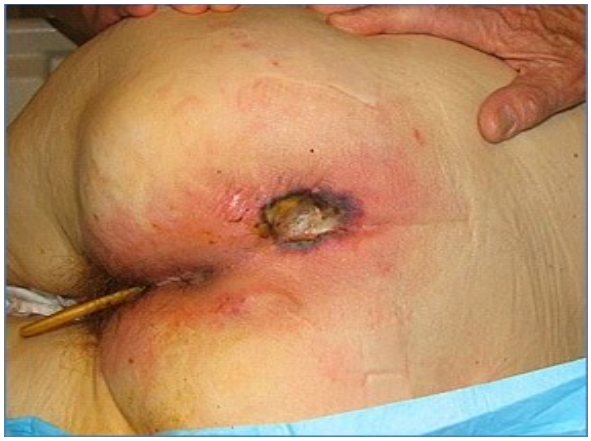
**Rationale for choices**

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:**

Clean wound with normal saline.
Apply Santyl nickel thick to wound bed for debridement.
Cover with a moisten gauze and secure with a border foam eg. Mepilex Border foam.
Reposition patient every 2 hours from side-to-side to offload sacrum pressure.
Keep periwound skin protected with a zinc-oxide moisture barrier to help prevent further breakdown.
Change dressing daily documenting size, changes in odor, drainage, pain, and periwound condition.

**(3 points)**

**Rationale for choices:**

Santyl is an enzymatic debrider this will remove the slough and necrotic tissue.
The moisten gauze and boarder will support debridement and protect the wound.
Repositioning the patient side-to-side will offload pressure and decrease further damage.

**(2 points)**

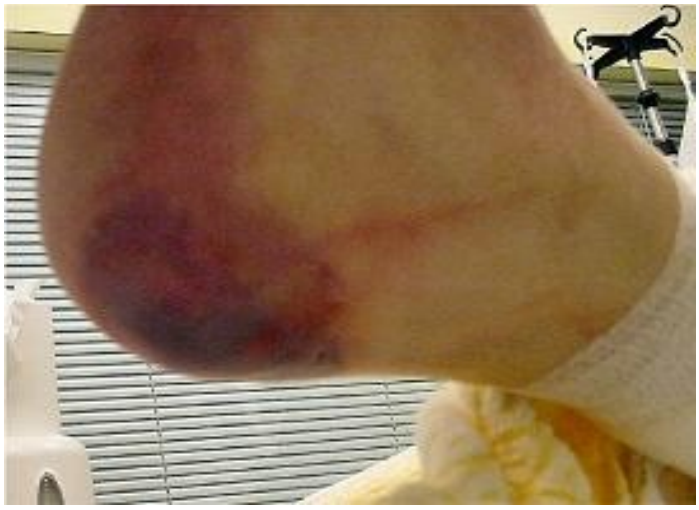
**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.**

Apply duoderm over over the santyl, then secure dressing with a boarder foam for protection.

**(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 Wound

**(1 point)**

**Wound Nurse recommendations/orders:**
Position heel completely off bed to prevent pressure.
Clean heel using warm water and a mild soap like liquid dial, rinse, and gently pat dry. No rubbing or massaging.
Apply a boarder foam dressing for protection.
Reposition patient every 2 hours ensuring heel is not in direct contact with any surfaces.
Monitory and palpate pedal pulses, capalliary refill, and temperature every shift and document.
Notify provider for any worsening signs of ischemia.
**(3 points)**

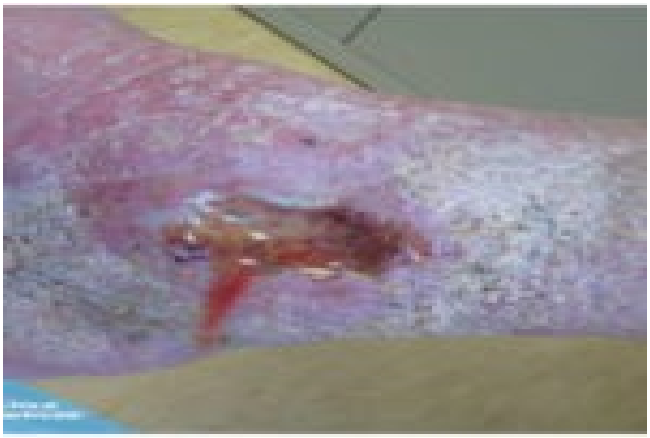
**Rationale for choices:**
Protecting the heel from pressure immediately is key to preventing worsening tissue damage.
Offloading pressure eliminates the cause of pressure injuries and the protective foam barrier reduces friction and maintains cleanliness of the injury.
Monitoring the heel wound every shift helps to identify any changes immediately.

**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.**
Apply duoderm extr thin to the heel this will protect and support/ maintain a clean environment for healing.
**(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 Leg Ulcer

**(1 point)**

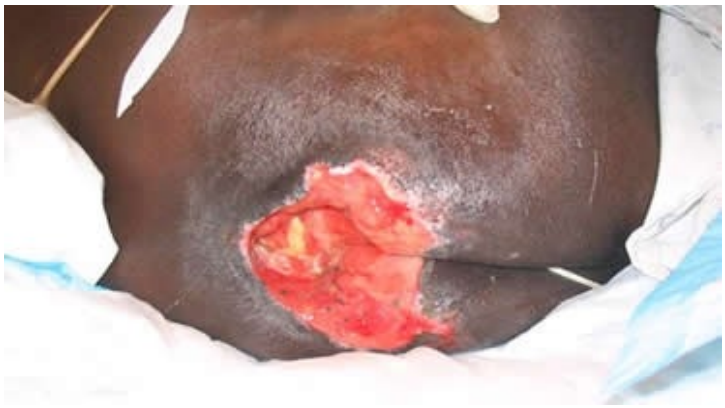
**Wound Nurse recommendations/orders:**
Gently Irrigate wound with normal saline.
Apply calcium alginate. This will support healing and absorb the drainage.
Apply zinc based moisture barrier to periwound to prevent further maceration.
Apply unna boot for compression and help improve circulation.
Educate leg to help decrease edema and improve circulation which will promote healing.
Change dressing twice weekly.
**(3 points)**

**Rationale for choices:**
Hemosiderin staining can indicate venous insufficiency.
Alginate dressings manages moderate exudate while maintaining a moist environment.
Compression is a therapy used to management venous ulcers.
Protecting the periwound prevents further breakdown and promotes healing.
**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.**
Apply a hydrofiber dressing like Aquacel to manage the drainage.
Cover with an absorbent foam dressing then compression.
**(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:**
Clean wound with normal saline.
Apply a hydrofiber like Aquacel Ag.
Apply a liquid barrier film, like no sting skin prep, to the periwound
Apply boarder foam dressing for protection.
Reposition every one to two hours from side-to-side.
Change dressing daily and/ or as needed.
**(3 points)**

Rationale for choices:
Stage 3 wounds are full thickness tissue loss with granulation tissue and slough but without exposed bone.
Hydrofiber manage moderate exudate, helps with moisture balance, and helps with formation of granulation tissue.
Frequent repositioning helps with pressure that are directly responsible for pressure injuries.

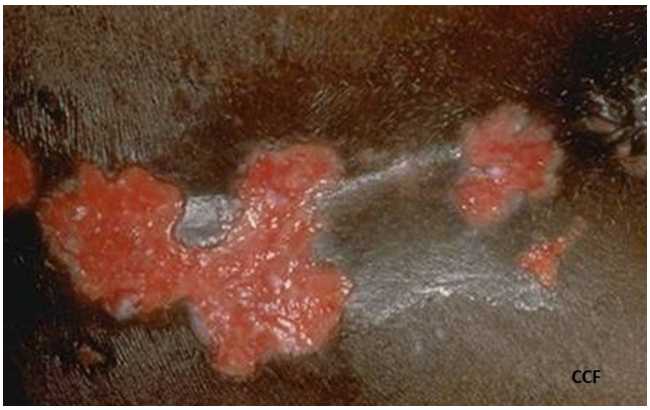
(2 points)

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

Apply an air mattress to help redistribute pressure.
**(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:**
Clean wound with normal saline and a mild soap like liquid dial, rinse, and pat dry.
Apply Aquacel to wound which will provide a moist healing environment, help with exudate and protect wound during healing.
Apply Cavilon no sting barrier to periwound and cover wound with a protective boarder.
Reposition patient every 2 hours.
Apply a silicone border foam to protect the wound.
Change dressing daily noting size, exudate, pain, and notify provider with worsening changes.
**(3 points)**

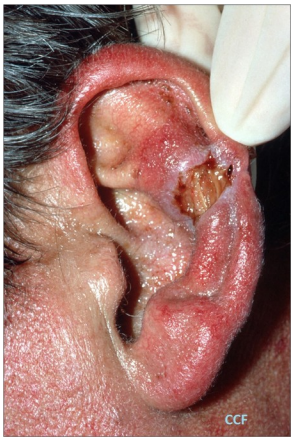
**Rationale for choices:**
Stage 2 ulcers are shallow without slough or exposed structures.
Aquacel will provide a moist healing environment, protect the wound and help with exudate absorption.
No sting barrier helps to reduce moisture associated skin damage.
Repositioning will help with pain and reducing pressure

**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.**
Apply duoderm extra thin to wound.
**(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:**
Stage 2 pressure injury

**(1 point)**

**Wound Nurse recommendations/orders:**
Remove the pulse oximeter and place on finger or toe.
Clean wound with normal saline and pat dry
Apply a silicone border foam dressing.
Apply no sting barrier to periwound.
Educate nursing staff on the importance of routine checks under medical devices every shift.
Document healing every shift.
**(3 points)**

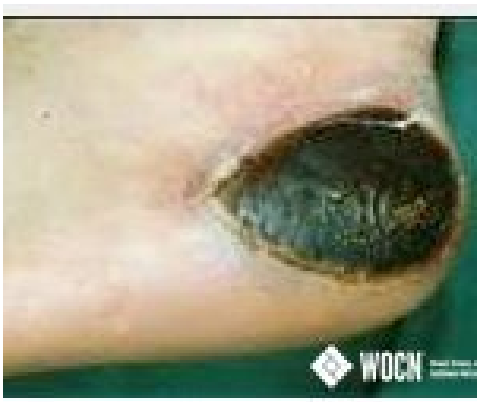
**Rationale for choices:**
**Stage 2 pressure injury can occure over a bony prominence from a medical device.**
Removing the medical device will take away the pressure that caused the injury.
Silicone dressing will provide cushion and maintain a healing environment.
Skin checks under devices every shift is a preventive measure.

**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.**
Apply duoderm, which is a hydrocolloid, every other day.
**(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:**
**Keep eschar intact. Do NOT debride.**
Clean wound with normal saline and pat dry.
Wrap heel with gauze to protect.
Elevate heel off all surfaces.
Reposition patient every 2 hours with heels off all surfaces.
Assess heel daily and document, pain, odor, drainage.

**(3 points)**

**Rationale for choices:**
Unstageable because tissue under the eschar cannot be assessed.
Stable eschar should not be debrided which can increase risk for infection
Offloading pressure prevents tissue injuries.

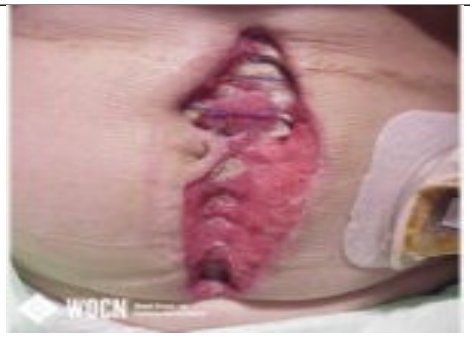
**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.**
Apply duoderm extra thin for protection.

**(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 that is healing by secondary intention that has some granulation tissue with small amounts of slough

**(1 point)**

**Wound Nurse recommendations/orders:**

Clean wound with normal saline.
Apply mepitel to wound this is a non adherent contact layer
Place no sting prep to outer edges
Apply foam dressing to the wound -make sure wound is completely covered with the foam
Apply the clear thin plastic layer over the foam and onto the intact skin
Make a small slit on the plastic layer and place the tubing over securing it with another layer of the clear plastic.
Connect the tubing to the pump and set the negative pressure as ordered by the provider.
Unclamp all clamps and turn on.
Change every 2-3 days.

**(3 points)**

**Rationale for choices:**

**NPWT promotes granulation tissue and manages drainage.**

Regular dressing changes help prevent skin damage.

**(2 points)**

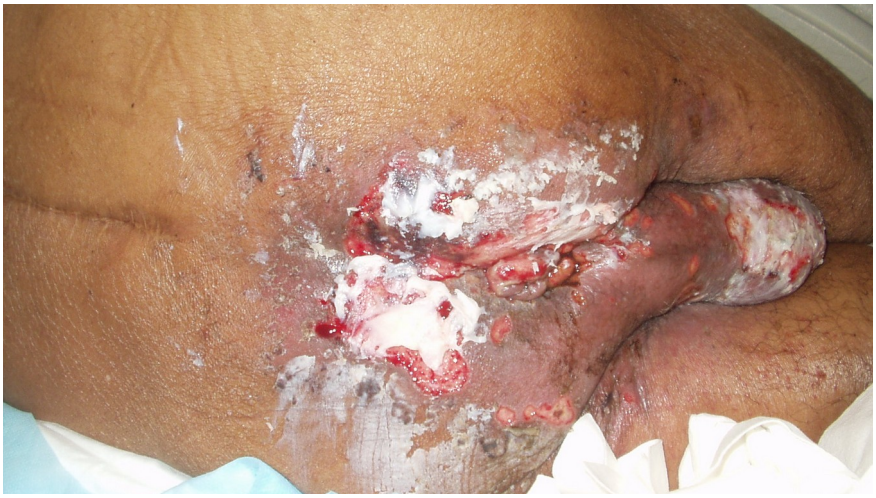
**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.**

Apply Aquacel to wound and cover with silicone border.

**(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:**
**Stage 3 pressure injury with necrotic tissue noted**

**(1 point)**

**Wound Nurse recommendations/orders:**
Clean the area with water and a mild soap, rinse and pat dry thoroughly.
Apply a thin layer of an enzymatic debrider like collagenase daily to the necrotic area.
Apply zinc oxide moisture barrier to the denuded area twice daily and after each incontinence episode.
Cover with an absorbent retentive foam dressing.
Apply stoma powder to the weepy area and dust away the excess then seal with no sting barrier film.
Contain stool, with a provider's order, of a fecal management system for liquid stool.
Reposition patient every 2 hours from side to side.
**(3 points)**

**Rationale for choices:**
**The pressure injury and the MASD both require intervention.**
The enzymatic debridement is needed for the necrotic tissue only.
Zinc oxide restores the epidermis tissue and protects the skin.
Repositioning off loads pressure that causes pressure injury.
The fecal management system will prevent the skin being exposed stool which is an irritant.

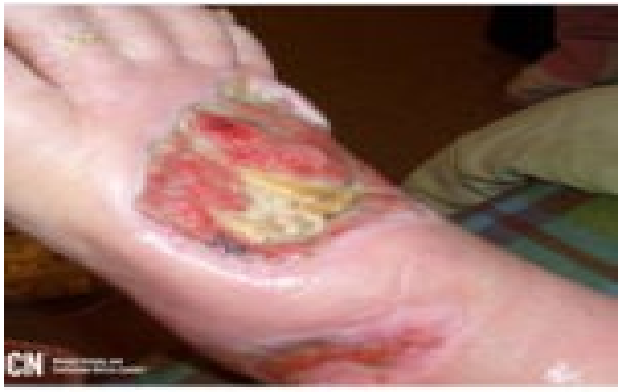
**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.**
Apply a hydrocolloid dressing to the necrotic tissue and change every 3 days.

**(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 diabetic foot ulcer with necrotic tissure**

**(1 point)**

**Wound Nurse recommendations/orders:**
Clean wound with normal saline.
Apply an enzymatic debriding agent like, collagenase, daily to the necrotic area
Apply a non adherent contact layer like Mepitel directly to the tendon area.
Apply a moisture retentive foam dressing and change every 2-3 dats,

**(3 points)**

**Rationale for choices:**
Covering the tendon with a non adherent layer decreases more injury when dressing is being removed.
Enzymatic debridment is safer than sharp debridement.

**(2 points)**

**Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.**
Apply a hydrogel impregnated sheet dressing over the exposed tendon and secure with a gauze wrap every 24-48 hrs.

**(2 points)**

/8 points

***References (3 points):***

***Acton, C., Ivins, N., Bainbridge, P., & Browning, P. (2020). Management of incontinence-associated dermatitis patients using a skin protectant in acute care: A case series. Journal of Wound Care, 29(1), 18–26.***

*Alshahrani, B., Sim, J., et al. (2021). Nursing interventions for pressure injury prevention among critically ill patients: A systematic review. Journal of Clinical Nursing, 30(15–16), 2151–2168.*

*De Decker, I., De Graeve, L., Hoeksema, H., Monstrey, S., Verbelen, J., & De Coninck, P. (2022). Enzymatic debridement: Past, present, and future. Acta Chirurgica Belgica, 122(4), 279–295.*

*Paranhos, T., Paiva, C. S. B., Cardoso, F. C. I., Apolinário, P. P., Rodrigues, R. C. M., et al. (2021). Systematic review and meta-analysis of the efficacy of Unna boot in the treatment of venous leg ulcers. Wound Repair and Regeneration, 29(3), 443–451.*