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

Mini Case Scenarios: Wounds

Cleveland Clinic

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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. 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

(1 point)

Wound Nurse recommendations/orders:

1. Clean wound with hypochlorous acid wound solution (Vashe) and gently pat dry
2. Apply hydrogel (Solosite) directly to the wound bed.
3. Pack wound with fluffed gauze to surface level
4. Apply skin barrier cream (Critic-Aid Clear) to the periwound area
5. Cover wound with foam dressing (Mepilex)
6. Change dressing every 3 days or PRN if soiled.
7. Turn and reposition left to right, right to left, q2h.

(3 points)

Rationale for choices:

1. Hypochlorous acid is an antimicrobial pH balanced solution that is gentle on the skin and promotes wound healing.
2. Hydrogel creates a moist wound environment needed for wound healing and it is an autolytic debriding agent and will moisten and soften the slough.
3. The foam dressing helps to protect the wound maintain the moisture
4. Skin barrier protects the skin from maceration.
5. Turn and reposition to reduce risk of pressure injury

(2 points)

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

Apply collagenase (enzymatic debridement) to wound bed, pack with Aquacel Ag and secure with borderless foam.

(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. Clean skin with no rinse pH balanced body wash and gently dry area.
2. Apply a thin layer of protective barrier cream
3. Cover heel with heel foam dressing (Mepilex Border Heel)
4. Offload heel using pillow, turn and reposition q2h

(3 points)

Rationale for choices:

1. Cleaning the skin of microbial agents
2. Barrier creams used to protect the skin from breaking down
3. Foam heel cover protects the hell with cushioning
4. Offloading protects the heel from further injury and breakdown

(2 points)

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

Apply Z-Flow boot to manage the DTPI and prevent further breakdown, examine foot q-shift.

(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:

1. Clean wound with hypochlorous acid wound solution (Vashe) and gently pat dry
2. Apply a thin layer of zinc oxide cream (Triad)) on the periwound area
3. Apply calcium alginate to the wound and cover with foam dressing (Mepilex)
4. Apply moisturizing cream (Sween 24) to dry extremities.
5. Offload foot with pillow

(3 points)

Rationale for choices:

1. Cleaning wound will hypochlorous acid is gentle on the skin. It has antimicrobial properties.
2. Zinc oxide (Triad)will help to promote healing and prevent further maceration
3. Calcium alginate is used to manage exudate and prevent further skin breakdown
4. Foam dressing helps in exudate management and protects the wound with cushioning
5. Offloading helps to prevent pressure injury

(2 points)

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

Apply Aquacel Ag to wound bed, gently pack the wound, cover with foam dressing (Mepilex).

(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 4

(1 point)

Wound Nurse recommendations/orders:

1. Clean wound with hypochlorous wound solution (Vashe) and pat dry wound.
2. Apply hydrogel (Solosite) to wound base and apply Aquacel Ag
3. Apply thin layer of zinc oxide (Triad) to the periwound area
4. Cover with foam dressing (Mepilex)
5. Turn and Reposition left to right, right to left, no back positioning

(3 points)

Rationale for choices:

1. Hypochlorous acid has antimicrobial properties and is gentle on the skin
2. Hydrogel is a debriding agent and will remove the slough.
3. Zinc oxide helps to heal the wound
4. Foam dressing helps to maintain moisture and protect the wound.
5. Turn and repositioning helps to prevent further breakdown and reduce risk of pressure injury.

(2 points)

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

I would recommend a pressure redistribution mattress for this patient. This prevents the development 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: Stage 2

(1 point)

Wound Nurse recommendations/orders:

1. Clean wound with hypochlorous acid wound solution (Vashe) and pat dry
2. Apply barrier ointment (Critic-Aid Clear) to periwound area and perineum
3. Cover sacrum with foam dressing (Mepilex)
4. Turn and reposition left to right, right to left, no back positioning q2h or during window of pain medication administration.
5. Change dressing every 3 days and PRN if soiled.
6. Apply external urinary management system (Purewick).

(3 points)

Rationale for choices:

1. Hypochlorous acid wound solution is pH balanced and is gentle on the skin with antimicrobial properties.
2. Applying barrier ointment to the peri-wound and perineum helps to prevent further skin breakdown
3. Foam dressing helps to maintain moist environment to promote healing, and it helps to protect the wound.
4. Turn and repositioning helps reduce risk of pressure injuries. Repositioning at time of pain administration helps patient to tolerate the activity.
5. Use of Purewick reduces the risk of skin breakdown due to urine contact.

(2 points)

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

Apply small amount of hydrogel (Solosite) to wound bed, apply Aquacel Ag, cover with foam dressing. Change every 3 days or PRN if soiled.

(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:
Medical Device Related Pressure Injury Stage 3
(1 point)

Wound Nurse recommendations/orders:

1. Clean wound with hypochlorous acid wound solution (Vashe) and pat dry
2. Apply hydrogel (Solosite) to wound and cover with foam dressing (Mepilex)
3. Do not apply pulse oximeter to that ear
4. Change dressing q3dyas or PRN when soiled

(3 points)

Rationale for choices:

1. Hypochlorous acid wound solution is pH balanced and is gentle on the skin with antimicrobial properties.
2. Hydrogel helps to main moist wound bed
3. Foam dressing keeps moisture in the wound promoting wound healing

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply hydrocolloid dressing to wound, change q3days or PRN if soiled
(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: Eschar – Unstageable wound

(1 point)

Wound Nurse recommendations/orders:

1. Clean wound with hypochlorous acid wound solution (Vashe) and pat dry
2. Apply hydrogel dressing (Solosite) to wound
3. Cover with transparent dressing (Tegaderm)
4. Change dressing q3days or PRN when soiled
5. Offload with pillow

(3 points)

Rationale for choices:

1. Hypochlorous acid wound solution is gentle on the skin
2. Hydrogel will create a moist wound bed and debridement. Only necrotic tissue will be debrided (Manna et al., 2023).
3. Transparent cover will stick to skin and keep the wound moist.
4. Offloading helps to prevent pressure injury and further breakdown

(2 points)

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

Apply collagenase dressing to wound base, cover with gauze and foam dressing. Change q3days or PRN when soiled.

(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. <u>NPWT ordered by physician who has requested WOC nurse input into dressing instructions and pressure settings</u>

Image courtesy of Wound, Ostomy and Continence Nurses Society image library.

Wound type: Dehiscence

(1 point)

Wound Nurse recommendations/orders:

1. Clean wound with hypochlorous acid wound solution and pat dry
2. Apply hydrogel (Solosite) to wound base
3. Place a layer of Petrolatum gauze over the wound
4. Cut black polyurethane foam to size and apply to wound do not extend to intact skin
5. Apply skin barrier prep and apply seal
6. Apply semiocclusive dressing is applied over top of the sponge (Luther et al., 2025)
7. Pressure setting -125 mmHg continuous
8. Change dressing q3days

(3 points)

Rationale for choices:

1. Hypochlorous acid wound solution is gentle on the skin and has antimicrobial properties.
2. Hydrogel will create a moist wound bed and promote healing
3. Petrolatum gauze will protect the wound from trauma when the machine is applied.
4. Application of skin prep to protect the skin when the machine is applied.
5. The semipermeable membrane prevents protein (needed of healing) loss and desiccation, it also protects the wound from environmental contamination, and creates a vacuum seal (Luther et al., 2025).

(2 points)

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

Apply non-adherent contact layer (Adaptic) to wound, cover with black polyurethane foam cut to size, apply skin pre and device set to -125 mmhg.

(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: Moisture Associated Skin Dermatitis. Unstageable wound

(1 point)

Wound Nurse recommendations/orders:

1. Clean wound with hypochlorous acid wound solution (Vashe) and pat dry
2. Apply collagenase to necrotic tissue.
3. Apply layer of zinc oxide (Triad) to wound base (Coccygeal and scrotum)
4. Apply moisture barrier (Critic-Aid Clear) to periwound area
5. Apply Aquacel Ag to coccygeal and cover with foam dressing (Mepilex)
6. Turn and reposition right to left, left to right, q2h

(3 points)

Rationale for choices:

1. Cleaning the wound with hypochlorous acid is gentle on the skin and it has antimicrobial properties.
2. Zinc oxide helps to keep wound moist and it promotes healing
3. Protecting the periwound area with Critic aid helps to reduce skin breakdown
4. Foam dressing helps to keep wound moist for healing and protects the wound
5. Turn and repositioning helps to prevent pressure injury

(2 points)

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

Apply hydrogel to necrotic tissue, cover with foam dressing, change q3days or PRN when soiled

(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: Stage 4

(1 point)

Wound Nurse recommendations/orders:

1. Clean wound with hypochlorous acid wound solution and pat dry
2. Apply hydrogel (Solosite) to yellow, black, brown tissue
3. Apply Aquacel Ag and cover with foam dressing (Mepilexz)
4. Offload feet

(3 points)

Rationale for choices:

1. Cleaning the wound with hypochlorous acid helps to promote healing and it as antimicrobial properties.
2. Hydrogel helps to create a moist wound base needed for healing (Wang et al., 2025)
3. Aquacel Ag used to absorb drainage and foam dressing helps keep wound moist and protects the wound.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply medical grade honey (Medi-Honey) to yellow, black, brown tissue, cover with non adherent foam dressing and secure with gauze wrap (Kerlix)
(2 points)

/8 points

References (3 points):

Luther, L., Maxson, R., & Stinner, D. J. (2025). Negative pressure wound therapy in resource-limited environments: Review and Field Guide. *Journal of Trauma and Acute Care Surgery*, *99*(3S). https://doi.org/10.1097/ta.0000000000004708

Manna, B., Nahirniak, P., & Morrison., C. (2023, April 19). *Wound debridement*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK507882/

Wang, J., Kong, W., & Liu, Y. (2025). Status and future scope of hydrogels in wound healing. *Hydrogels for Wound Healing*, 619–650. https://doi.org/10.1016/b978-0-323-99610-5.00025-1