

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

Mini Case Scenarios: Wounds



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Reviewed by: Patricia A. Slachta

Date: 12/17/25

Score: 53.8/83 Taylor, you did not achieve the required 80%. Review my notes & look for the areas where you did not achieve the total points & revise on this paper in another color & resubmit through Dropbox.

XX/83-1 for resubmission = YY/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) 1

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 lightly fill wound with fluffed NSS moistened gauze to surface level
- 3.4. Apply skin barrier cream (Critic-Aid Clear) to the periwound area
- 4.5. Cover wound with foam dressing (Mepilex)
- 5.6. Change dressing every 3 days or PRN if soiled. probably needs to be changed daily
- 6.7. Turn and reposition left to right, right to left, q2h.

(3 points) 2

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) 2

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 if there is no border on the foam how does it stay in place? Also, foam daily is expensive.. See the info on correct use of collagenase at end of document

(2 points) 1

6/8 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) 1

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 may not be necessary, consider a liquid skin protector
3. Cover heel with heel foam dressing (Mepilex Border Heel)
4. Offload heel using pillow, turn and reposition q2h

(3 points) 3

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 heel with cushioning
- 3.[4.] Offloading protects the heel from further injury and breakdown

(2 points) 2

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) 2

8/8 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) 1

Wound Nurse recommendations/orders: how often will the dressings be changed?

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
6. What else needs to happen here?

(3 points) 2

Rationale for choices:

1. Cleaning wound with hypochlorous acid is gentle on the skin. It has antimicrobial properties.
2. Zinc oxide (Triad) will help to promote healing and prevent further maceration read a little about Triad as it is more than zinc oxide!
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 think about the physiological aspects of foam dressings. Cushioning is not the most accurate terminology
5. Offloading helps to prevent pressure injury

(2 points) 1.8

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). Aquacel AG & alginate are in the same dressing category. What else could you use?

(2 points) 0

5.8/8 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 [review the description again](#)

(1 point) 0

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 [Aquacel & hydrogel do opposite things so are not used together. Use Solosite if wound dry or Aquacel or alginate if wound is wet](#)
3. Apply thin layer of zinc oxide (Triad) to the periwound area [a less messy option is liquid skin preps such as Marathon or 3 M Cavilon](#)
4. Cover with foam dressing (Mepilex)
5. Turn and Reposition left to right, right to left, no back positioning [ok](#)
6. [How often is the dressing changed?](#)

(3 points) 1.5

Rationale for choices:

1. Hypochlorous acid has antimicrobial properties and is gentle on the skin
2. Hydrogel is a debriding agent [hydrogel keeps the wound moist & therefore promotes autolytic debridement but is not really classified as a debriding agent](#) and will remove the slough. [So why the Aquacel AG?](#)
3. Zinc oxide helps to heal the wound [no this is not accurate - zinc protects skin](#)
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) 1

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

I would recommend a pressure redistribution mattress for this patient. This [helps](#) prevents the development of pressure injuries.

(2 points) 2

4.5/8 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:

1. Clean wound with hypochlorous acid wound solution (Vashe) and pat dry
2. Apply barrier ointment (Critic-Aid Clear) to periwound area and perineum It will be difficult for the foam to adhere so again, consider a liquid skin prep that dries
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) 3

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. Read more about Mepilex & Allevyn as they have RCTs re pressure & shear distribution
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) 2

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. If you use Solosite consider a dressing such as Alldress or another non adherent, bordered gauze dressing that will not absorb the gel

(2 points) 5

6.5/8 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) .5

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) in your own practice consider not using a foam over a hydrogel if the gel is mostly water based as it may be absorbed into the foam
 3. Do not apply pulse oximeter to that ear
- [4.] Change dressing q3d ayyas or PRN when soiled

(3 points) 3

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 the better foams wick moisture into the dressing although companies do say the dressing does not dry out wound

(2 points) 2

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 this will be challenging

(2 points) 2

7.5/8 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 yes, what was the cause?

(1 point) .5

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
- 2.[5.] Offload with pillow

(3 points) 0 read about wounds like this at this location....

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) 2 but the orders are not what should be done with this wound

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) 0

2.5/8 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 ok, abdominal surgical wound dehiscence

(1 point) 1

Wound Nurse recommendations/orders:

1. Clean wound with hypochlorous acid wound solution and pat dry
 2. Apply hydrogel (Solosite) to wound base what is the evidence for this?
 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 what is a seal?
- [6.]** Apply semioclusive dressing ~~is applied~~ over top of the sponge (Luther et al., 2025)
- 6.[7.]** Pressure setting -125 mmHg continuous consider this pressure setting
- 7.[8.]** Change dressing q3days see end of doc for IFU for NPWT, VAC in particular

(3 points) 1

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 evidence?
3. Petrolatum gauze will protect the wound from trauma when the machine is applied. Not all wounds need a contact layer - why does this one?
4. Application of skin prep to protect the skin when the machine is applied. Taylor, the machine is not applied, a dressing 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).ok

(2 points) 1

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) 0-read the instructions

3/8 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) 1

Wound Nurse recommendations/orders:

1. Clean wound with hypochlorous acid wound solution (Vashe) and pat dry
2. Apply collagenase to necrotic tissue.ok
3. Apply layer of zinc oxide (Triad) to wound base (Coccygeal and scrotum) ok but again, read about Triad!
4. Apply moisture barrier (Critic-Aid Clear) to periwound area too many products in use
5. Apply Aquacel Ag to coccygeal and cover with foam dressing (Mepilex) I do not understand how this is going to adhere with all of the ointments in place
6. Turn and reposition right to left, left to right, q2h yes no back lying
7. Support surface?

(3 points) 1

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 Triad will do the same
4. Foam dressing helps to keep wound moist for healing and protects the wound yes but...
5. Turn and repositioning helps to prevent pressure injury

(2 points) 1.5

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 OK & what are you going to do w the rest of the skin breakdown?

(2 points) 1

| 4.5/8 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: Stage 4 this is not a pressure injury per se

(1 point) 0

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 (Mepilex) you are mixing dressings which is not appropriate
- 3.[4.] Offload feet

(3 points) 1

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) 1 all true but you are putting two different dressings w different actions in the same wound

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) 2

4/8 points

References (3 points): Interesting references but formats not correct 1.5

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> [there is more info for this reference](#)

Manna, B., Nahirniak, P., & Morrison., C. (2023, April 19). *Wound debridement*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK507882/> [see slide #23 for StatPearls](#)

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> [this is actually a chapter in an edited book](#)

Santyl

[Someone came up w MEND \(the company? or someone else?\) but it is a great acronym for application](#)

[Moisture, Edge to edge, Nickel thick, Daily & more info can be found at <https://santyl.com/hcp/application>](#)

[Santyl compatibility info at <https://santyl.com/hcp/compatibility>](#)

NPWT

[“Wounds being treated with the Solventum™ V.A.C.® Therapy System should be monitored on a regular basis. In a monitored, non-infected wound, Solventum™ V.A.C.® Granufoam™ Dressings, Solventum™ V.A.C.® Granufoam™ Silver Dressings, and Solventum™ V.A.C.® White Foam Dressings should be changed every 48–72 hours but not less than three times per week, with frequency adjusted by the treating clinician as appropriate” \(Solventum, 2025, p. 17\). Frequency adjustment most likely referring to changing more frequently not less frequently since the booklet is specific about that.](#)

[Solventum. \(2025\). *Solventum™ V.A.C.® therapy clinical guidelines: A reference for clinicians* \[Brochure\]. <https://www.solventum.com/content/dam/public/language-masters/en/msb/document/2025/vac-therapy-clinical-guidelines-ms-npwt-en-us.pdf>](#)

[Consequently, a planned twice a week dressing change does not follow the instructions for use. This would be a great research project though & 3M might be interested in it \(although it does mean using less of their supplies\)!](#)

The reference list is hanging indent double spaced for the entire list. If you highlight what I wrote below & look at the Home tab, paragraph section you will see the settings that are pretty simple to use

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>