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

Mini Case Scenarios: Wounds

Cleveland Clinic

Student Name Sara Waggoner **Date:** 12/2/25

Reviewed by: _____ **Date:** _____

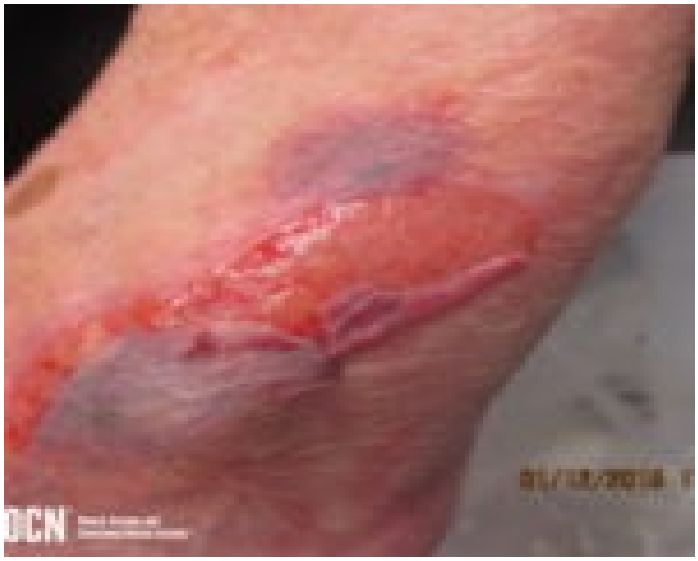
Score: /83

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)

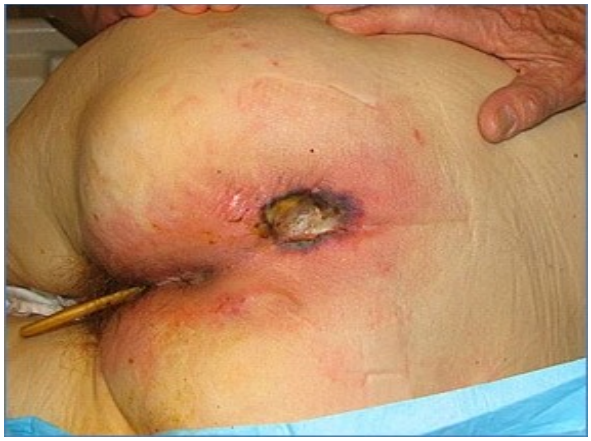
Rationale for choices

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:

Cleanse wound with Vashe wound cleanser, appy skin prep to peri-wound. Apply nickel thick layer of santyl to wound bed. Cover wound with foam dressing and change three times a week.

(3 points)

Rationale for choices:

Vashe wound cleanser is non-cytotoxic and will help to remove bacteria and debis to helps to support the body's natural healing process. Santyl is a great enzymatic debieding agent that will help remove the yellow slough and brown necrotic tissue from the wound. A foam dressing will help wound maintain optimal wound healing environment while providing an extra layer of padding to protect from pressure.

(2 points)

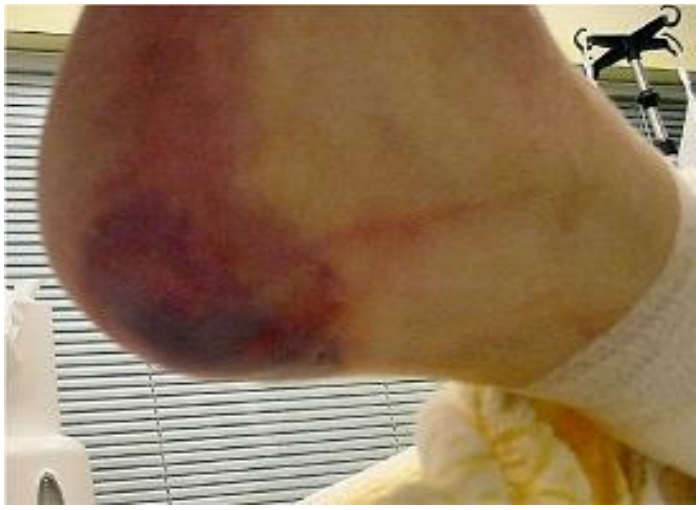
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

Cleanse wound with Vashe wound cleanser, appy skin prep to peri-wound. Apply medi-honey to wound bed. Cover wound with foam dressing and change three times a week.

(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 Tissure Pressure Injury
(1 point)

Wound Nurse recommendations/orders:
Nurse to assess deep tissue pressure injury to left heel every shift and apply skin prep to bilateral heels. Apply Prevalon boots to bilateral lower extremities to reduce pressure and prevent new pressure injuries from forming. Encourage repositioning every two hours to prevent skin breakdown.
(3 points)

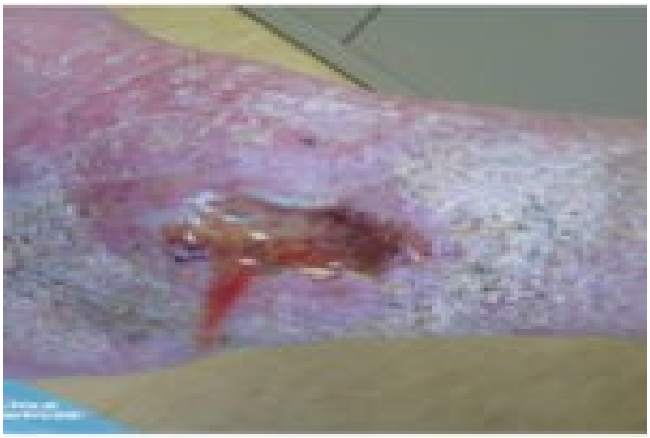
Rationale for choices:
Applying skin prep to the heel will help add a protective layer to the area of fragile skin to help prevent further skin breakdown. This order also encourages the nurses to assess the wound because they have an order to apply a product to the area. Prevalon boots will help support the foot and have a round cut out area for the heel to relieve pressure from the area. Hospitals are very busy and often times patients do not get repositioned as much as they should therefore the boots would be a back up for heel pressure relief if the patient does not get repositioned as much as they should.
(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
If prevalon boots are not available, nurse should off load heels using pillows. Continue to assess heels each shift and gently apply skin prep to bilateral heels.

(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 Ulcer

(1 point)

Wound Nurse recommendations/orders:

Nurse to cleanse would with vashe wound cleanser. Apply skin prep to periwound. Fill wound bed with aquacel AG. Cover wound with ABD pad, wrap with kerlix, and secure with tape. Apply 30-40mmHg compression stockings from toes to just below the knee in the morning and remove at night. Change dressing three times a week and as needed for increased drainage.

(3 points)

Rationale for choices:

This wound is draining a moderate amount so I chose to add aquacel to the wound bed to provide an extra layer for fluid absorption. The abd pad will also help with drainage and to add a protective layer over wound. The lower extremity skin in this photo appears to be very dry and sensitive so any adhesive directly on the skin should be avoided. Compression 30-40mmHg is an appropriate amount of compression for an ABI greater than 0.80 (Ankle brachial index, 2012). Compression therapy will help promopte circulation to improve wound healing.

(2 points)

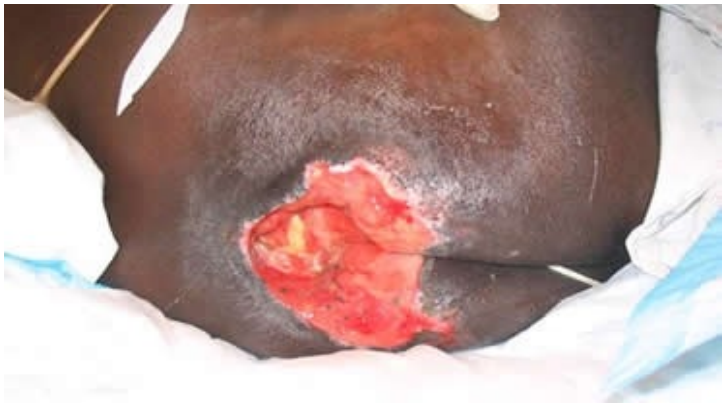
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

Nurse to cleanse would with vashe wound cleanser. Apply skin prep to periwound, if no aquacel available, apply ergotool to wound bed. Cover wound with ABD pad, wrap with kerlix, and secure with tape. Apply 30-40mmHg compression stockings from toes to just below the knee in the morning and remove at night. Change dressing daily.

(2 points)

/8 points

Scenario 4



An 85-year-old is admitted to the hospital with a stage <u>???</u> 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 <u>*not*</u> available at this time.

Image courtesy of Judy Mosier, MSN, RN, CWOCN.

Wound type:
Stage 3 Pressure Inury
(1 point)

Wound Nurse recommendations/orders:
Cleanse stage 3 pressure injury to sacrum with normal saline. Gently fill wound bed with aquacel AG. Cover wound with ABD pad and secure with paper tape. Change dressing daily and as needed. Assess wound for new tunneling or undermining with each dressing change. Reposition patient every two hours with wedges and offload from wound with each position. Order wave bed. Consult nutrition for optimal diet for wound healing.
(3 points)

Rationale for choices:
Aquacel Ag is a good option for this wound since it is noted to have a moderate amount of drainage and a small amount of yellow slough. Aquacel will help to soak up the drainage and promote autolytic debridement of the wound. Since this patient is in the hospital, this wound will need changed daily for close monitoring, therefore an ABD pad is a good option because it will hold a lot of drainage and they are cheap. Paper tape is the most gentle tape on skin which is why it should be used in this scenario.

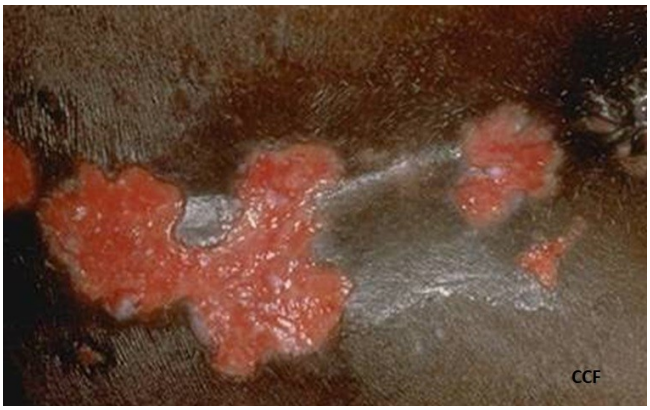
(2 points)

What support surface would you recommend (1pt) and why? (1pt)
I would recommed ordering a wave bed for this patient because they are bedbound and high risk for deterioriation of the wound as well as continued skin breakdown over other bony prominances. A wave bed is a type of low airloss mattress that promotes pressure redistribution and an optimal climate for wound healing. A recent meta-analysis concluded that alternating pressure air surfaces “reduce pressure ulcer risk” and “increase complete ulcer healing” (Shi, et al., 2020).

(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 ulcer.
(1 point)

Wound Nurse recommendations/orders:
Cleanse perineum with no rinse bath wipes. Cleanse wound with Skintegrity wound cleanser. Apply promogran to wound bed. Cover with foam dressing. Change dressing every other day and PRN. Encourage repositioning every two hours with foam wedges. Apply male external cathether to reduce moisture.

(3 points)

Rationale for choices:
Urine and stool needs to be cleaned off the skin immediately to prevent skin breakdown. This wound appears to have healthy pink tissue with minimal exudate which makes collagen a good option since it does not have highly absorbative properties. A foam dressing is semi waterproof so should help protect the wound from some incontinence. A male external catheter will reduce urinary incontinence to promote skin healing and reduce breakdown.

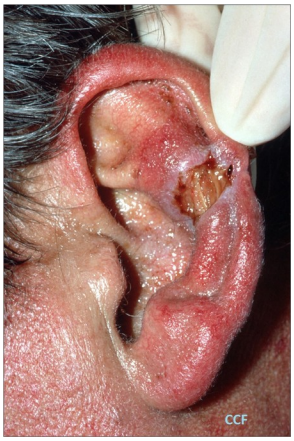
(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Cleanse perineum with no rinse bath wipes. Cleanse wound with Skintegrity wound cleanser. Apply triad paste to wound bed. Cover with foam dressing. Change dressing every other day and PRN. Encourage repositioning every two hours with foam wedges. Apply male external cathether to reduce moisture.

(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 Stg 4
(1 point)

Wound Nurse recommendations/orders:
Avoid applying pulse oximeter to ear with wound. Rotate pulse oximeter area each shift. Recommend switching to a finger pulse ox or forehead pulse ox. Cleanse Stage 4 medical device related pressure injury to ear with normal saline, apply hydrogel to wound bed, cover with 2x2 island dressing. Change dressing daily and as needed.
(3 points)

Rationale for choices:

Since this wound is secondary to pulse ox being placed on the ear, it is impairitive to change the location of the pulse ox to prevent further skin breakdown. The wound bed in this picture looks mostly dry and hydrogel would help to moisten the wound bed and promote an optimal temperate and pH for wound healing. An island dressing would be easy to gently fold around ear to cover wound. The ear is a delicate surface so it is important to pick a secondary dressing that does not apply to much pressure to the area and prevent circulation that could stall wound healing.

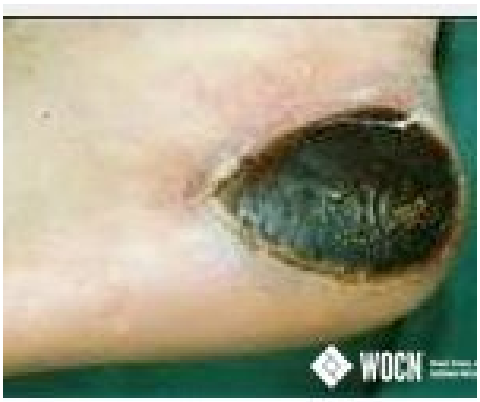
(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Cleanse wound with normal saline, apply medihoney to woundbed, cover with 2x2 gauze, and secure with paper tape. Change dressing daily 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:
Keep area of black eschar clean, dry, and intact. Paint wound with betadine swabs daily. Float heels on pillow.
(3 points)

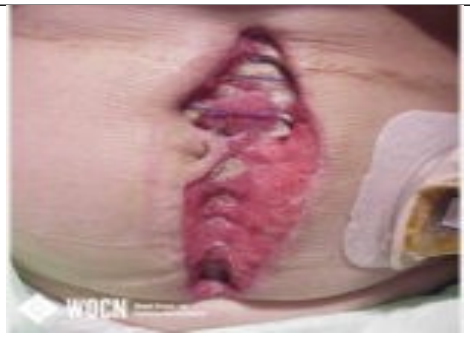
Rationale for choices:
The patient in this scenario is cared for by his elderly wife therefore she needs a dressing change that is easy to complete. The wound in this picture is dry, hard, black eschar which is basically the bodys own bandaid. Providone iodine has bee shown to have a “broad antimicrobial spectrum” which will help keep this wound clean, free of infection, and dry (Bigliardi, et al., 2017). Floating the heels on pillows will help off load pressure to pevent deterioration and formation of new wounds.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Wash foot with soap and water. Do not soak foot. Cover wound with ABD pad, loosely wrap with kerlix, and secure with tape. Float heels to offload pressure.
(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 dehissance

(1 point)

Wound Nurse recommendations/orders:

Cleanse wound with normal saline. Apply skin prep to periwound. Apply clear transparent drape to periwound to windowpane wound. Apply urgotool to wound bed to protect visible sutures. Fill wound cavity with black foam, do not over stuff. Cover with transparent drape, cut quarter size hole in top drape to apply suction device at 125mmHg intermittent suction. Change wound vac Monday, Wednesday, and Friday. May change as needed for vac malfunction.

(3 points)

Rationale for choices:

The decision to set the negative pressure wound therapy (NPWT) device at 125 mmHg with intermittent suction using black foam was informed by both clinical experience and evidence-based practice. Prior studies have demonstrated that a negative pressure setting of 125 mmHg optimizes granulation tissue formation. Agarwal et al. (2019) reported that intermittent NPWT can nearly double the rate of granulation tissue formation compared to continuous modes.

(2 points)

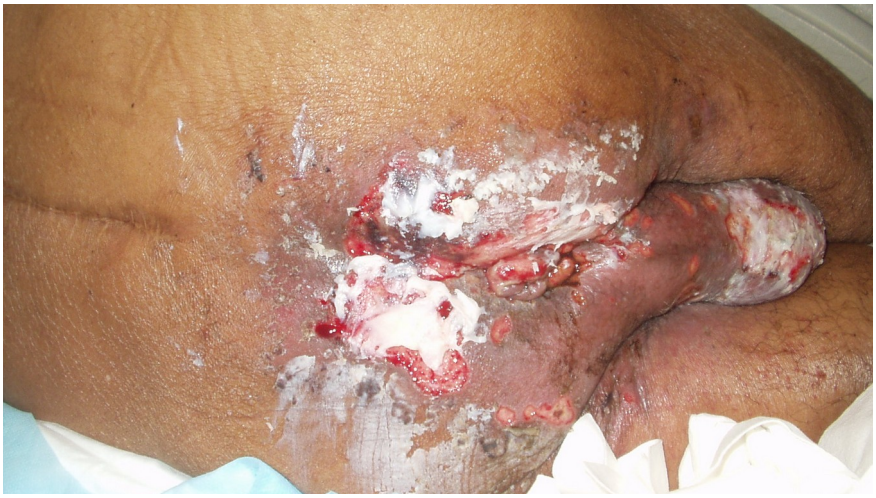
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

In the case of wound vac malfunction and unable to reapply wound vac, remove entire wound vac dressing. Cleanse wound with normal saline, gently pack saline soaked gauze into wound bed, cover with ABD pad, and secure with paper tape. Change dressing daily and as needed until able to reapply wound vac.

(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 dermatitis
(1 point)

Wound Nurse recommendations/orders:
Cleanse perineum with no rinse bath wipes. Apply triad paste to open areas and peri-wound. Encourage repositioning every two hours with foam wedges. Apply fecal management system to contain stool and promote healing of skin.

(3 points)

Rationale for choices:
Urine and stool needs to be cleaned off the skin immediately to prevent skind breakdown. Bath wipes tend to be more gentle than wash clothes therefore they are a better option in this scenario since the skin is fragile. Triad paste will promote optimal pH for wound healing, encourage autolytic debridemnt of slough, and provide a barrier from incontinence episodes which could worsen current skin breakdown or cause new areas of skin breakdown to form. A fecal management system will help contain liquid stool incontinence to promote skin healing and reduce excoriation.

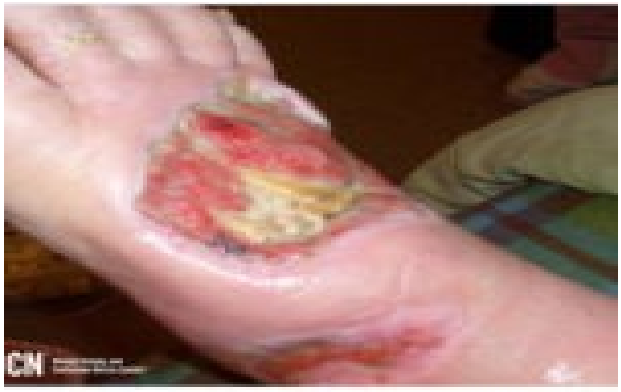
(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
If no-rinse bath wipes are not available, may gently clean peri-area with soap and water. Do not scrub. If triad paste is not available, may use desitin on open area and peri-wound.

(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:
Non-pressure arterial ulcer.
(1 point)

Wound Nurse recommendations/orders:
Cleanse wound with Vashe wound cleanser. Apply hydroferra blue to wound bed and cover with ABD pad. Secure with kerlix and tape. Do not wrap to tight. Change dressing daily and as needed.

(3 points)

Rationale for choices:

In this scenario, I chose hydroferra blue as my primary dressing because it is a moist foam that will help to moisten the would bed for healing and it is safe to apply over exposed tendon. In my recent clinical rotaion, I learned that hydroferra blue is beneficial for wounds with epibole as it can flatten wound borders.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Cleanse wound with vashe wound cleanser, apply urgotol to wound bed, then apply hydrogel to wound, and cover with ABD pad. Secure with kerlix and tape. Do not wrap to tight. Change dressing daily and as needed.

(2 points)

/8 points

References (3 points):

References

Agarwal, P., Kukrele, R., & Sharma, D. (2019). Vacuum assisted closure (VAC)/negative pressure wound therapy (NPWT) for difficult wounds: A review. *Journal of clinical orthopaedics and trauma*, *10*(5), 845–848. https://doi.org/10.1016/j.jcot.2019.06.015

Ankle brachial index. (2012). *Journal of Wound, Ostomy &Continence Nursing*, *39*(2S). https://doi.org/10.1097/won.0b013e3182478dde

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Shi, C., Dumville, J. C., Cullum, N., Rhodes, S., McInnes, E., Goh, E. L., & Norman, G. (2021). Beds, overlays and mattresses for preventing and treating pressure ulcers: an overview of Cochrane Reviews and network meta-analysis. *The Cochrane database of systematic reviews*, *8*(8), CD013761. https://doi.org/10.1002/14651858.CD01376