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

Mini Case Scenarios: Wounds

Student Name _Mara Michalski____ **Date: _1/11/26__**

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 wound normal saline and water
2. Apply thin layer of triad to periwound
3. Apply santyl to a saline moistened gauze and apply to wound bed
4. Cover with dry gauze and ABD pad as secondary dressing
5. Secure with tape
6. Change every 24hours
7. Reposition every 2 hours
8. Transfer to p500 pressure reduction bed
9. Nutrition consult

(3 points)

Rationale for choices:

1. Using Vashe deactivates Santyl, they should not be used together
2. Protect periwound skin with zinc oxide skin barrier
3. Santyl will help debride the slough and allow for granulation
4. ABD pad and dry gauze and absorb drainage and is easily accessible on unit
5. Secure to keep dressing in place
6. Santyl needs to be reapplied every 24 hours
7. Reposition every 2 hours for further pressure injury prevention
8. Nutrition consult for optimal nutrition for wound healing

(2 points)

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

Apply Medihoney autolytic debrider to wound bed and cover with dry gauze and a silicone bordered absorbent dressing and change every 3 days or as needed for drainage

(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. Apply Cavilon no skin barrier wipes to heel, allow to dry
2. Offload heel using foam boots or pillows
3. Reposition patient q2 hours
4. Reapply Cavilon every 24 hours and assess wound site for opening of wound or drainage

(3 points)

Rationale for choices:

1. **Cavilon will create a skin barrier and help protect the integrity of the skin to keep it stable**
2. Offload with pillows or foam boots to ensure pressure is not placed on the wound and open the skin or create further damage
3. Reposition patient every 2 hours to avoid any other formations of pressure injuries
4. Cavilon is to be reapplied every 24 hours and also allows nurse to assess wound for any changes or wound openings

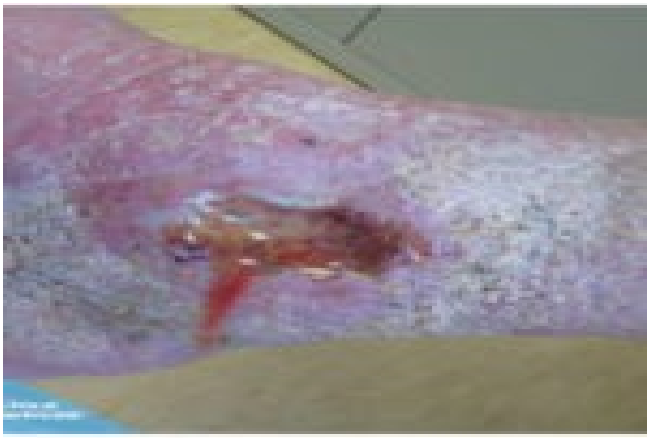
(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Place a Mepilex foam silicone bordered dressing on the heel and change every 3 days or as needed with drainage.

(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. **Cleanse with Vashe moistened gauze, leave on wound bed for 5 minutes before removing.**
2. **Apply triad cream to periwound skin** (Zarrin et al., 2024)
3. Apply Medihoney to wound bed
4. Cover with super absorbent pad
5. Wrap with Coban lite 2 layer compression wrap (25-30 mmHg)
6. Change twice weekly in clinic due to exudate

(3 points)

Rationale for choices:

1. Vashe to help break down slough
2. Triad to protect periwound skin from maceration (Zarrin et al., 2024)
3. Medihoney to debride and promote granulation
4. Super absorbent pad to collect drainage
5. Coban lite 2 layer compression wrap (25-30 mmHg) to help reduce swelling in the area but moving excess fluid of the tissies, improve blood flow, and prevent blood pooling

(2 points)

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

Apply Santyl to wound bed, cover with saline moistened gauze, ABD pad, and wrap in rolled gauze and ACE wrap for 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:

1. Cleanse with Vashe moistened gauze, allow to sit on wound bed for 5 minutes before removing
2. Apply Triad cream to periwound (Zarrin et al., 2024)
3. Apply Aquacel Ag to wound bed
4. Fill wound with lightly packed fluffed gauze
5. Cover with ABD pad
6. Secure with tape to intact skin
7. Change every 24 hours or as needed with drainage
8. Reposition patient every 2 hours with wedges or pillows
9. Transfer patient to p500 pressure reducing mattress
10. Consult dietary

(3 points)

Rationale for choices:

1. Vashe to help break down slough
2. Traid cream to protect periwound skin from exudate and maceration (Zarrin et al., 2024)
3. Aquacel Ag to absorb drainage which also includes antimicrobial properties due to silver
4. Lightly pack wound to fill open space which ensures premature surface closure, absorbs drainage, encourages tissue growth from the base upward
5. ABD to absorb drainage
6. Aquacel can be changed every 24 hrs or as needed with drainage
7. The most effective wound treatment is pressure relief
8. Consult dietary to ensure adequate protein

(2 points)

What support surface would you recommend (1pt) and why? (1pt) P500 pressure reducing mattress, so that on top of Q2HR turns, it provides advanced pressure redistribution, aid in wound healing and prevention of further pressure wounds **(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: incontinence associated dermatitis

(1 point)

Wound Nurse recommendations/orders:
(3 points)

1. Cleanse with pH balanced skin cleanser
2. Apply zinc oxide cream over wounds and to periwound (Zarrin et al., 2024)
3. Apply external urinary incontinence device such as Primafit to wall suction, change every 12 hours or as needed if soiled
4. Apply rectal pouch to rectum, change every 3 days or as needed for leakage
5. Consult pain management for pain control
6. Reposition patient every 2 hours for pressure redistribution and to assess for incontinence

Rationale for choices:

1. pH balanced cleanser will not irritate skin
2. zinc oxide cream to create moisture barrier and protect skin from further damage (Zarrin et al., 2024)
3. Primafit to collect urine and draw it away from skin to prevent further breakdown
4. Rectal pouch will collect loose stool to prevent further breakdown
5. The patients pain needs to be managed better since that is why he is refusing Q2turns
6. Continue to offer patient q2 hour repositioning

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
After cleansing, apply duoderm to wound bed and extend the border 1 ½ inches past wound bed. Change at least every 7 days or as needed for drainage and examine dressing during each q2 hr repositioning to check if soiled. (Nguyen et al., 2025).

(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

(1 point)

Wound Nurse recommendations/orders:

1. Remove and relocate pulse ox to finger and rotate every 2 hours
2. Cleanse with pH balanced cleanser
3. Apply Duoderm and change every 7 days or as needed with drainage (Xu et al. 2024)

(3 points)

Rationale for choices:

1. Remove device that caused pressure injury, continue to rotate site every 2 hours to avoid pressure injury in another site
2. Use non irritating cleanser
3. A hydrocolloid dressing will provide protection from friction from devices, a moist wound environment, and absorb drainage (Xu et al. 2024)

(2 points)

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

Apply Mepilex silicone bordered dressing to absorb drainage and provide a foam cushion to pressure and prevent friction.

(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: dry eschar

(1 point)

Wound Nurse recommendations/orders:

1. **leave stable eschar intact**
2. Apply Betadine to a gauze and place on wound bed (Harun et al., 2024)
3. Cover with dry gauze and ABD pad and rolled gauze to secure in place
4. Change daily
5. Offload pressure from heel with pillows or moon boots
6. Consult social work to inquire about home health care for the patient before being discharge for wound care
7. Follow up with podiatrist regularly to monitor for signs of infection

(3 points)

Rationale for choices:

1. **Dry, stable eschar without signs of infection can be continued to be monitored**
2. **Betadine will keep area dry and prevent infection (Harun et al., 2024)**
3. **Dry gauze and abd pad will absorb any drainage and keep area dry and covered**
4. **Change daily to monitor for changes**
5. **Offload pressure to prevent opening of wound and prevent further pressure damage**
6. **Patient does not seem to have adequate care at home and social work should help set up home health or other resources before discharge**
7. **Routine appointments with a podiatrist will help monitor for infection or changes to the wound**

(2 points)

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

Apply Cavilon no sting barrier to wound and periwound and let dry. Then apply Mepilex foam bandage to heel and continue to offload.

(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 surgical incision

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse with Vashe moistened gauze, leave in place for 5 minutes before removal
2. Apply Cavilon advanced skin barrier to periowound skin
3. Window frame with the acrylic drape
4. Cut black foam to size of wound and pack into wound
5. Cover with a layer of drape and ensure a seal
6. Cut a quarter size hole in drape for the port and attach pad
7. Connect to cannister tubing
8. Turn on machine and set to 125mmHg for black foam
9. Ensure there is a seal and no issues
10. Change every 48-72 hours

(3 points)

Rationale for choices:

1. Vashe to help break down slough
2. Cavilon to protect skin against irritation from acrylic drape
3. Window frame ensures protection against black foam touching intact skin
4. Black foam used because there is not tunneling present
5. A good seal will optimize correct function of machine
6. Pad needs a quarter size hole touching black foam
7. Needed for negative pressure
8. 125mmHg for black foam
9. Ensure proper seal before leaving patient
10. Change every 48-72 hours

(2 points)

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

If NPWT unavailable then pack wound with normal saline moistened rolled gauze and cover with ABD pads and secure with tape until able to place NPWT and change every 12 hours

(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:
Incontinence associated dermatitis and unstageable pressure injury
(1 point)

Wound Nurse recommendations/orders:

1. Cleanse with pH balanced cleanser
2. Apply zinc oxide barrier cream to open lesions (Zarrin et al., 2024)
3. Apply santyl to necrotic tissue, cover with a saline moistened gauze and cover with silicone bordered absorbative dressing
4. Change daily or as needed if soiled
5. Assess rectum for rectal tone and assess for ability to have a fecal management system placed
6. Turn patient every 2 hours

(3 points)

Rationale for choices:

1. Ph balanced to prevent skin breakdown
2. Zinc oxide to create a moisture barrier and prevent skin from further breakdown (Zarrin et al., 2024)
3. Santyl on necrotic tissue to debride dead tissue and promote granulation
4. Santyl is needed to be reapplied every 24 hours and wound should be reassessed frequently for sings of infection or change
5. If patient is appropriate for fecal management system this would help keep loose stool off of skin and prevent further breakdown
6. Patient should be offloaded from sores and repositioned every 2 hours to prevent pressure injury

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order. After cleansing, apply medihoney to necrotic tissue and covered with a dry gauze, use antifungal powder such as miconazole on affected lesions.

(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:
Arterial insufficiency ulcer with exposed tendon
(1 point)

Wound Nurse recommendations/orders:

1. Consult vascular surgery
2. Optimize glucose control by consulting endocrinology to manage insulin and dietary to place patient on diabetic diet
3. Cleanse with Vashe moistened gauze, let sit for 5 minutes before removing
4. Apply thin layer of Triad cream to periwound (Zarrin et al., 2024)
5. Adaptic gauze should be applied to wound bed
6. Cover with dry gauze and ABD pad and secure with tape
7. Change every 24 hours and assess for signs of infection
8. Avoid extreme changes to temperature such as a cold pack to body

(3 points)

Rationale for choices:

1. **Vascular surgery should be consulted to obtain the appropriate studies to ensure there is adequate blood supply to the area to promote wound healing**
2. **Diabetes needs to be managed for effective wound healing so insulin control and proper diet will help aid in wound healing**
3. **Vashe will help break down slough and promote granulation**
4. **Triad to periowound to protect skin and prevent maceration** (Zarrin et al., 2024)
5. **Adaptic gauze used since tendon is exposed to prevent dressings from adhering and promote moisture that is essential for granulation**
6. **Dry gauze and ABD pad to absorb drainage**
7. **Monitor every 24 hours to assess for infection, or wound progression**
8. **Raynauds can be triggered by extreme temperature changes and cause ischemia so avoid changes in temperature**

(2 points)

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

order.
Apply polymem with silver cut to size with wound bed, to prevent adherence to the tendon, is antimicrobial, and will absorb some drainage from the wound. Polymem can stay in place for up to 7 days. Cover with silicone bordered foam bandage and change every 3 days or as needed if drainage is noted on the polymem or dressing. **(2 points)**

/8 points

References (3 points):

Harun, H., Haroen, H., Mirwanti, R., Apriani, N., & Akuoko, C. P. (2024). Uncovering the benefits of povidone iodine compared to other therapeutic agents in wound infection prevention and healing outcomes: A scoping review. Journal of Multidisciplinary Healthcare, 17, 3605–3616. https://doi.org/10.2147/JMDH.S469037

Nguyen, N., Dulai, A. S., Adnan, S., Khan, Z. E., & Sivamani, R. K. (2025). Narrative review of the use of hydrocolloids in dermatology: Applications and benefits. Journal of Clinical Medicine, 14(4), 1345. https://doi.org/10.3390/jcm14041345

Zarrin, N., Rafiei, H., Safari Alamuti, F., Sohrabi, L., & Rashvand, F. (2024). Comparing the efficacy of Zinc Oxide versus Vaseline prophylactic dressings in preventing sacral pressure injuries in patients admitted to the intensive care unit. International wound journal, 21(11), e70139. https://doi.org/10.1111/iwj.70139

Xu, H., Chen, R., Li, Y., Xu, L., Pan, Y., & Huang, X. (2024). Role of hydrocolloid dressing in preventing face pressure ulcers in patients with noninvasive ventilation: A systematic review and meta-analysis. International Wound Journal, 21(2), e14780. https://doi.org/10.1111/iwj.14780