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

Mini Case Scenarios: Wounds

Cleveland Clinic

Student Name _Terryann Simpson_____ **Date: _01/18/26___**

Reviewed by: _____ **Date: _____**

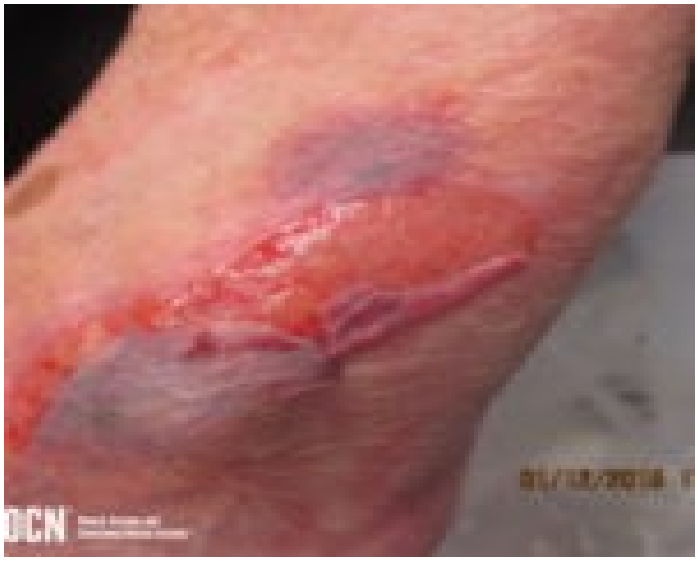
Score: /83

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)

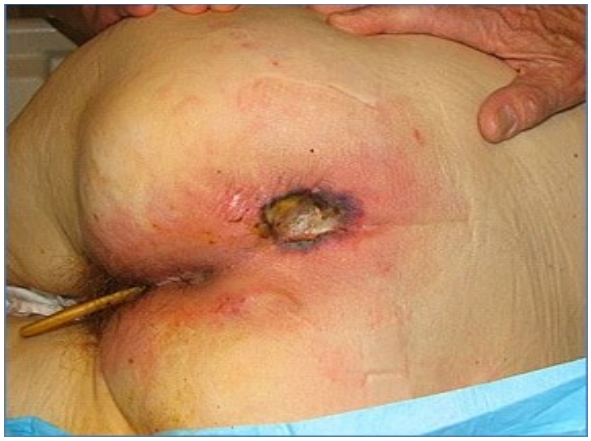
Rationale for choices

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: This is an unstageable wound because the wound bed is 100% covered in slough. (Zaidi & Sharma, 2024), the depth is unknown because slough or eschar obscures the extent of the tissue damage.

(1 point)

Wound Nurse recommendations/orders:
1. Cleanse wound Vashe and pat dry
2. Apply Medline Skintegrity Hydrogel Wound Dressing to gauze, moisten gauze, and gently pack it into the wound bed.
-3. Cover wound with ABD pad and tape
4. Complete dressing change daily and as needed.
-5. Turn and reposition the patient every 2 hours
6. Use an alternating pressure mattress
7. Gel cushion for chairs when out of bed

(3 points)

Rationale for choices:

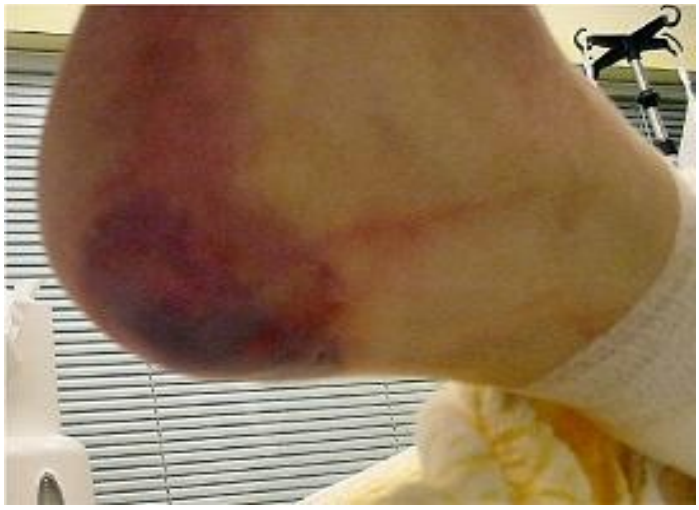
1. Vashe helps to maintain a moist wound, prov PH balance, and kills microorganisms.
2. Hydrogels moisten gauze, which serves as a dressing for healing, moisture, and debridement of the wound bed
3. ABD is used as an inexpensive secondary dressing for daily wound care
4. An alternating pressure mattress and gel cushion evenly distribute pressure across the mattress
5. Repositioning the patient prevents further skin breakdown and relieves pressure on the current wound

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order. Apply Medline TheraHoney Gauze Honey Sheet Dressings to the wound bed and cover with ABD pad and change daily and PRN.
(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: This type of wound is a deep tissue pressure injury. Prolonged pressure results in non-blanchable, deep red, maroon, or purple discoloration, (Zaidi & Sharma, 2024)**.**

(1 point)

Wound Nurse recommendations/orders:

1. Gently cleanse the area of the left heel with 0.9 % NS and pat dry
2. Keep the area clean and dry
3. Leave open to air
4. Offload extremity always (elevating extremity on pillows or offloading boots or wedges)
5. Reposition every 2 hours or per facility policy
6. Leave skin in the area intact
7. Administer pain medication as needed

(3 points)

Rationale for choices:

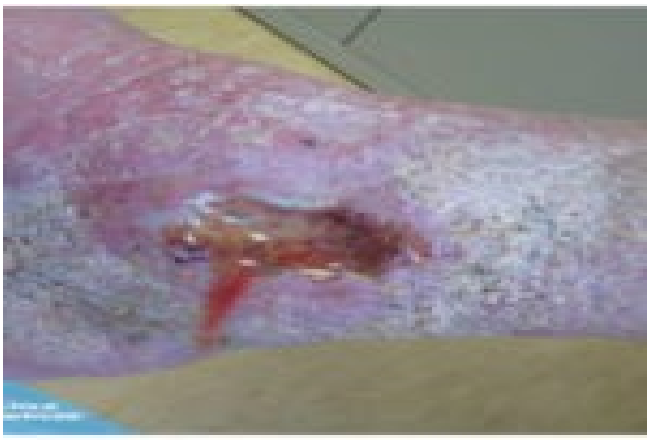
1. Avoid any kind of friction or scrubbing; these wounds must be left intact without debridement or break in the skin
2. Moisture will cause further damage to the area
3. Offloading eliminates pressure to the area and prevents further injury
4. There is damage to the blood supply, so removing intact skin will worsen the condition and slow healing. The wound can evolve quickly or resolve on its own.
5. Management of pain promotes quality of life, reduces anxiety, and the patient is more cooperative with repositioning

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order. Cover with Dermacea Sterile ABD Pad and wrap with gauze for mobility purposes and skin protection.
(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: This wound is a Venous Insufficiency Leg Ulcer of the right lower extremity. Symptoms presented are typical of this type of wound. VLU typically presents with pain in the gaiter area, hyperpigmentation, non-healing wound as well as ABI of less than 1, (Robles-Tenorio & Ocampo-Candiani, 2022).

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with Vashe and pat dry
2. Apply Remedy Protect Zinc Oxide Paste Skin Protective Barrier Cream, Extra Thick to the peri-wound area with dressing change, making sure not to scrub the area to remove the paste
3. Cleanse legs with Medline Soothe and Cool No Rinse Total Body Cleanser and pat dry with wound care
4. Apply Vaseline to damp legs, avoiding the wound after washing legs with wound care
5. Apply McKesson calcium alginate Ag directly to the wound bed
6. Cover wound with ALLEVYN Life Foam Dressing with Adhesive Border and change every 3 days and as needed
7. Apply compression stockings (30-40mmhg) to lower extremities in the AM and off at HS
8. Elevate extremities

(3 points)

Rationale for choices:

1. Vashe is an antimicrobial cleanser with a pH balance
2. Zinc oxide provides barrier protection from wound drainage
3. Soothe and Cool is a gentle medical-grade cleanser that offers PH balance for the skin
4. Vaseline keeps the skin moist
5. Calcium alginate controls infection and is highly absorbent, non-adherent to the wound bed while providing debridement.
6. Allevyn foam dressing is a secondary dressing that will provide extra absorption of wound drainage
7. Compression and elevation increase the healing rate and reduce edema

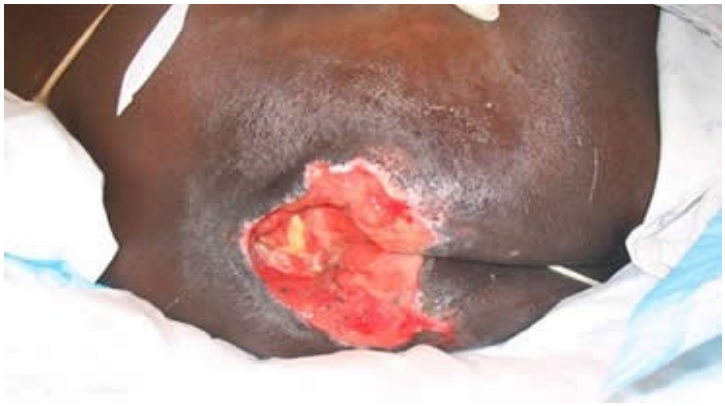
(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order. Apply Aquacel Ag to the wound bed and cover with Mepilex Border Flex Lite Foam Dressing, changing every 3 days and as needed.

(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: This is a stage 4 pressure injury. Stage 4 pressure injury extends through the fascia with considerable tissue loss that might involve muscle, bone, and tendon (Zaidi & Sharma, 2024)
(1 point)

Wound Nurse recommendations/orders: Algicell Ag is used with moderate exudate (Visconti et al, 2023).

1. Cleanse wound Vashe and pat dry
2. Gently pack Algicell Ag Antimicrobial Alginate dressing directly to the moist wound bed (Visconti et al, 2023).
3. Cover wound with McKesson Hydrocellular Foam Dressing with Border Silicone Adhesive, Sacral dressing
4. Change dressing every 3 days and as needed
5. Turn and reposition the patient every 2 hours or per facility policy
6. Use a low-air-loss mattress
7. Medicate for pain before dressing change

(3 points)

Rationale for choices:

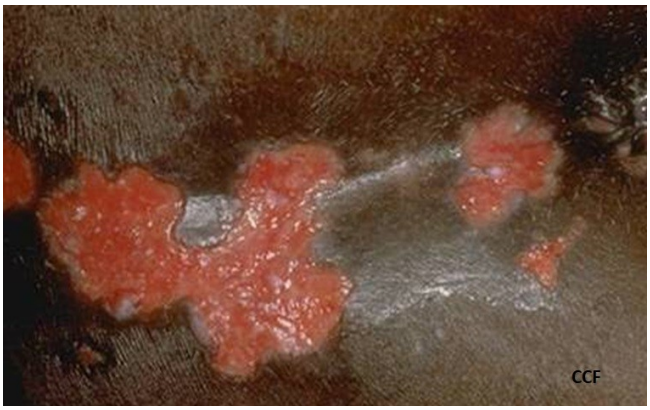
1. Vashe is an antimicrobial cleanser with pH balance.
2. Algicell is highly absorbent and provides microbial properties for bioburden
3. Foam dressing will provide added protection to the sacral area.
4. Positioning and an air loss mattress promote healing and prevent new skin issues.
5. Pain management will prevent stress for the patient while making dressing changes more tolerable.

(2 points)

What support surface would you recommend (1pt) and why? (1pt).
This patient can use a low-air-loss mattress. This type of mattress will keep him cool, preventing excess moisture that can affect wound healing while also alternating pressure to prevent further skin issues.
(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: This is moisture-associated skin damage. (Pittman, 2022), occurs in the perineal area, inner thighs, and buttocks in a patient with incontinence, usually partial thickness, with irregular edges.
(1 point)

Wound Nurse recommendations/orders:

1. Cleanse skin and the surrounding area with 0.9% NS and Pat dry
2. Apply a thin layer of Medline Remedy Clinical Zinc Oxide Skin Protectant Paste to the wound with each incontinence episode
3. Medicate the patient for pain before dressing change
4. Repositing every 2 hours or per facility policy
5. Provide incontinence checks and care to improve skin condition.

(3 points)

Rationale for choices:

1. NS is non-toxic, safe on wound tissue, does not cause any damage to new tissue, and reduces infection.
2. Zinc Oxide protects from fluids that cause further skin damage, while healing the current wound.
3. Pain management will promote mobility for the patient and allow his wound to heal
4. Repositioning and incontinence care will resolve current skin issues and promote healing as well.

(2 points)

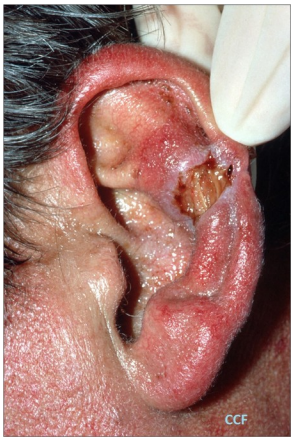
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

1. McKesson Hydrocellular Foam Dressing with Border Silicone Adhesive, Sacral, and change every 3 days and as needed.

(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: This is a medical device pressure wound, stage 2, related to the pulse oximeter.
(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with 0.9% NS, pat dry
2. Cover with Mepilex border flex lite and change twice weekly and as needed

(3 points)

Rationale for choices:

1. NS is non-toxic, safe on wound tissue, does not cause any damage to new tissue, and is antimicrobial
2. Mepilex border dressing is gentle on the skin, does not stick to the wound bed, and provides a moist wound environment

(2 points)

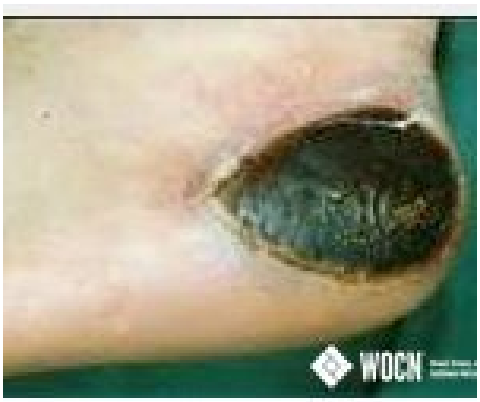
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

1. Apply Vaseline Petrolatum Gauze Dressing to the wound and cover with a gauze pad, tape, and change daily.

(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: This wound is a stable Eschar unstageable wound.
(1 point)

Wound Nurse recommendations/orders:

1. Keep the area clean and dry, and do not remove stable eschar
2. Leave the area open to air
3. Monitor for instability (swelling, pain, redness) around the area
4. Elevate extremity (pillow or heel protector boots)
5. Apply Medline Povidone Iodine Prep Solution to the wound twice daily

(3 points)

Rationale for choices:

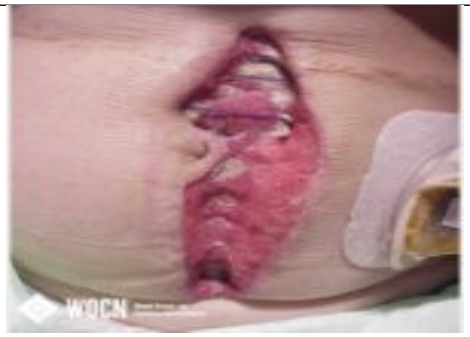
1. Keeping the area clean and dry will keep the Eschar in place
2. Leaving it open to air will prevent moisture build-up and reduce the risk of eschar becoming unstable and infected.
3. If the eschar becomes unstable, it needs to be surgically debrided to prevent further damage.
4. Elevation and protection will prevent further damage
5. Povidone Iodine will serve as an antiseptic and keep the area dry.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
The gold standard of treatment for stable eschar is to keep it in place, clean and dry; no dressing is recommended for this type of wound.
(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: This type of wound is a full dehiscence wound. Full dehiscence is dehiscence down to fascia, stemming from incisional failure following primary closure,(Brindle & Creehan, 2022).

(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with 0.9% NS solution and pat dry
2. Apply Mepitel Non-Adherent Transparent Wound Contact Layer to the wound bed.
3. Use a 3M black granulation dressing kit, applying over Mepitel transparent contact layer dressing and set at 125mmhg.
4. Leave Mepitel contact layer in place for 7 days
5. Change wound Vac system twice weekly and as needed

(3 points)

Rationale for choices:

5. NS is non-toxic, safe on wound tissue, does not cause any damage to new tissue, and reduces infection.
6. The contact layer prevents foam from sticking to the wound bed, and can last up to 14 days in the wound
7. NPWT promotes wound granulation, removes any exudate, and reduces healing time for the wound. NPWT also reduces the frequency of dressing changes

(2 points)

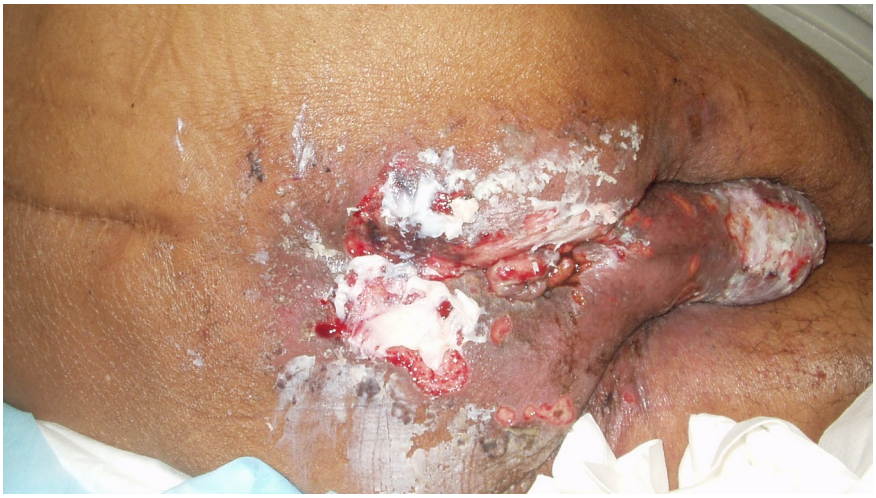
Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.

Apply McKesson Hydrogel Amorphous Dressing to the wound bed for primary dressing, fluff 0.9% NS, moisten gauze as secondary dressing, and cover with ABD pad and change daily.

(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: This is a combination of moisture-related partial thickness incontinence-associated dermatitis wound related to c-diff as well as pressure, as evidenced by the necrotic area.
(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wounds with 0.9% NS and pat dry, avoiding rubbing the area
2. Apply Triad Hydrophilic Wound Dressing to other open areas.
3. Reapply Triad to open areas twice daily.
4. Fecal diversion to manage diarrhea and eliminate the source
5. Reposition the patient

(3 points)

Rationale for choices:

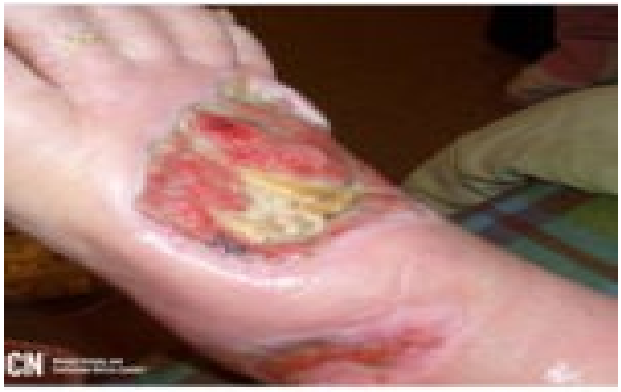
1. NS is antimicrobial, cost-effective, and gentle on the skin.
2. Triad dressing will adhere to already moist areas and maintain moisture during healing.
3. Fecal diversion, such as a rectal tube, will divert feces to eliminate contact with the skin and allow the skin to heal until c-diff is managed/resolved.
4. Repositioning facilitates wound healing while preventing further damage.

(2 points)

Identify 1 alternative primary/secondary dressing from a different dressing category. Write as a nursing order.
Apply ConvaTec Duoderm hydrocolloid dressing to the sacral area and change every 3 days, and as needed
(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: This type of wound is a diabetic foot ulcer
(1 point)

Wound Nurse recommendations/orders:

1. Cleanse wound with Vashe and pat dry
2. Apply McKesson Sterile Hydrogel Sheet Dressing to the wound bed.
3. Cover wound with ALLEVYN Life Foam Dressing with Adhesive Border and change every 3 days and as needed
4. Elevate the extremity
5. Refer to a podiatrist

(3 points)

Rationale for choices:

1. Vashe is safe for wounds and peri-wound; it is an antimicrobial and pH-balanced wound cleanser
2. Hydrogel will provide moisture and debridement to the wound bed. Hydrogel dressings have been a critical aid in the treatment of non-healing diabetic wounds; they provide hydration and autolytic debridement (Hartmeier, et al., 2020).
3. Foam dressing will help to maintain a moist wound barrier while protecting the wound
4. Elevation to reduce edema
5. Podiatrist referral for diabetic foot care and diabetic orthotic shoes for offloading.

(2 points)

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

1. Apply 3M Fibracol Plus Collagen Wound Dressing with Alginate to the wound bed and cover with Allevyn foam dressing, and change every 3 days and as needed.

(2 points)

/8 points

References (3 points):

Brindle, T., & Creehan, S. (2022). Management of surgical wounds. In L. L. McNichol, C. R. Ratliff, & S. S. Yates, *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (pp. 738-775). Wolters Kluwer.

Hartmeier, P. R., Pham, N. B., Velankar, K. Y., Issa, F., Giannoukakis, N., & Meng, W. S. (2020, December 21). *Hydrogel dressings for chronic wound healing in diabetes: Beyond hydration*. National Library of Medicine National Center for Biotechnology Information: https://pmc.ncbi.nlm.nih.gov/articles/PMC9473423/

Pittman, J. (2022). General concepts related to skin and soft tissue injury caused by mechanical factors. In L. L. McNichol, R. C. Ratliff, & S. S. Yates, *Wound, Ostomy, and Continence Nurses Society core Curriculum: Wound management* (2nd ed., pp. 314-322). Wolters Kluwer.

Robles-Tenorio, A., & Ocampo-Candiani, J. (2022, September 18). *Venus leg ulcer*. National Library of Medicine National Center for Biotechnology Information: https://www.ncbi.nlm.nih.gov/books/NBK567802/

Visconti, A. J., Sola, O. I., & Raghavan, P. V. (2023). Pressure Injuries: Prevention, evaluation, and management. *American Family Physician, 108*(2), 166-174. American Family Physician: https://www.aafp.org/pubs/afp/issues/2023/0800/pressure-injuries.html

Zaidi, S. R., & Sharma, S. (2024, January 3). *Pressure Ulcer*. National Library of Medicine National Center for Biotechnology Information: https://www.ncbi.nlm.nih.gov/books/NBK553107/