



Performe Basic Nursing Care Procedures and Techniques

NTQF Level III

Learning Guide # 34

Unit of Competence: **Performe Basic Nursing Care Procedures and Techniques**

Module Title: **Performing Basic Nursing Care Procedures and Techniques**

LG Code: HLT NUR3 M06 LO8-19

TTLM Code: HLT NUR3 TTLM 0919v1

LO 8: Performe wound care



This learning guide is developed to provide you the necessary information regarding the following content coverage and topics –

8. Perform wound care

- 8.1. Introduction to wound care
- 8.2. principles of wound care
- 8.3. Types of wound care
- 8.4. procedures of wound care
- 8.5. Aseptic technique
- 8.6. Dressing techniques and materials
- 8.7. Factors and process of Wound healing
- 8.8. infection prevention

This guide will also assist you to attain the learning outcome stated in the cover page. Specifically, upon completion of this Learning Guide, you will be able to –

- describe principles and types of wound care
- apply aseptic techniques during wound care
- use correct procedures of of wound care
- identify factors and process of wound healing
- apply proper infection prevention during wound care

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions describe.
3. Read the information written in the “Information Sheets”. Try to understand what are being discussed.
4. Accomplish the “Self-check.
5. Ask from your trainer the key to correction (key answers) or you can request your trainer to correct your work.
6. Submit your accomplished Self-check. This will form part of your training portfolio.



8. Perform wound care

8.1. Introduction to wound care

The skin acts as a barrier to protect the body from the potentially harmful external environment. When the skin's integrity (intactness) is broken, the body's internal environment is open to microorganisms that cause infection. Any abnormal opening in the skin is a wound.

A wound is any disruption in the skin's intactness. It may be accidental or intentional such as abrasion (rubbing off the skin's surface); a puncture wound (stab wound); or laceration (a wound with torn, ragged edges). A wound may be intentional, such as surgical incision (a wound with clean edges). A wound that occurs accidentally is contaminated; intentional wounds are made under sterile conditions.

8.2. principles of wound care

- Safe method should be used for disposing old dressing. Gauze and cotton used for cleaning wound.
- Take preventive measures to avoid skin irritation and excoriation.
- If drainage tube is attached to the bottle precaution must be taken to secure the tube in place and avoid the risk of cross infection.
- If sterile forceps are not available, use sterile gloves
- Immerse used forceps, scissors and other instrument in strong antiseptic solution before cleansing and discard soiled dressing properly.
- In a big ward it is best to give priorities to clean wounds and then to septic wounds, when changing dressings, as this might lessen the risk of cross infection.
- Consideration should be given to provide privacy for the patient while dressing the wound.
- Wounds should not be too tightly packed in effort to absorb discharge as this may delay healing.

8.3. Types of wound care

- Dressing of a Clean Wound
- Dressing of septic wound



Purpose

- ✓ To keep wound clean
- ✓ To prevent the wound from injury and contamination
- ✓ To keep in position drugs applied locally
- ✓ To keep edges of the wound together by immobilization
- ✓ To apply pressure
- ✓ To promote wound granulation and healing
- ✓ To prevent micro-organisms from entering wound
- ✓ To decrease purulent wound drainage
- ✓ To absorb fluid and provide dry environment
- ✓ .To assist in removal of necrotic tissue
- ✓ To apply medication to wound
- ✓ To provide comfort

8.4. Aseptic technique

- **Surgical Asepsis (sterile technique)**

- ✓ Definition: Practices, which will maintain area free from microorganisms, as by surgical scrub, or sterile technique.
- ✓ Surgical asepsis is used to maintain sterilize. Use of effective sterile technique means that no organisms are carried to the client. Microorganisms are destroyed before they can enter the body.
- ✓ Sterile technique is used when changing dressings, administering parenteral (other than the digestive tract) medications, and performing surgical and other procedures such as urinary catheterization.
- ✓ With surgical asepsis, first articles are sterilized, and then their contact with any unsterile articles is prevented.
- ✓ When a sterile article touches an unsterile article, it becomes contaminated. It is no longer sterile.



8.5. Dressing techniques and materials

- **Equipment for clean wound dressing**

- Pick up forceps in a container
- Sterile bowl or kidney dish
- Sterile cotton balls
- Sterile galipot
- Sterile gauze
- Three sterile forceps
- Rubber sheet with its cover
- Antiseptic solution as ordered
- Adhesive tape or bandages
- Scissors
- Ointment or other types of drugs as needed
- Receiver
- Spatula if needed
- Benzene or ether.

- **Equipment for septic wound dressing**

- Sterile galipot
- Sterile kidney dish
- Sterile gauze
- Sterile forceps 3
- Sterile test tube or slide
- Sterile cotton- tipped application
- Sterile pair of gloves, if needed, in case of gas gangrene rabies etc.
- Rubber sheet and its cover
- Local medication if ordered
- Spatula
- Receiver with strong disinfectant to immerse used instrument
- Probe and director if required
- Scissors
- Benzene or ether
- Bandages or adhesive tape
- Bucket to put in soiled dressing



8.6. Factors and process of Wound healing

Wound healing differs according to how much tissue has been damaged. It occurs by first, second, and third intention.

- ✓ **First intention healing** occurs in wounds with minimal tissue loss, such as surgical incisions or sutured wounds. Edges are approximated (close to each other); thus they seal together rapidly. Scarring and infection rate with first intention healing are low.
- ✓ **Second intention healing** occurs with tissue loss, such as in deep laceration, burns, and pressure ulcers. Because edges don't approximate, openings fill with granulation tissue that is soft and pinkish. Later, epithelial cells grow over the granulation greater than that for first intention healing.
- ✓ **Third intention healing** occurs when there is a delay in the time between the injury and closure of the wound. For example, a wound may be left open temporarily to allow for drainage or removal of infectious materials.

This type of healing some times occurs after surgery, when the wound closes later. In the mean time, wound surfaces start to granulate. Scarring is common.

8.7. infection prevention

- **Infection Control/Universal Precaution**

Nurses are involved in providing a biologically safe environment and promoting health. Microorganisms exist everywhere in the environment; in water, soil and body surfaces such as skin, intestinal tract, and other areas open to the outside.

- **Conditions Predisposing to Infection**

Certain conditions and invasive techniques predispose clients to infection because the integrity of the skin is broken or the illness itself establishes a climate favorable for the infectious process to occur. Among the most common are surgical wounds, changes in the antibacterial immune system, or alterations to the body.

- **Nosocomial Infection**

Nosocomial infections are infections that are acquired while the client is in the hospital, infections that were not present or incubating at the time of admission.



- **Standard Precautions**

Standard precaution is also called universal precautions. These were instituted as a result of the human immunodeficiency virus (HIV) epidemic. Blood and body fluid precautions were practiced on all clients regardless of their potential infectious state.

In 1987, body substance isolation (BSI) was proposed. The intent of this isolation system was to isolate all moist and potentially infectious body substances (blood, feces, urine, sputum, saliva, wound drainage and other body fluids) from all clients, regardless of their infectious status, primarily through the use of gloves.

Standard precaution blends the major features of universal precautions (blood and body fluids precautions) and body substance isolation into a single set of precautions to be used for the care of all clients in hospitals, regardless of their diagnosis or presumed infection status. The new standard precautions apply to blood, all body fluids, secretions, and excretions, whether or not they contain visible blood; non-intact skin; and mucus membrane.

Fundamental Principles: Certain fundamental principles should be applied to all clients. These include hand washing, use of gloves, proper placement of clients in hospital to prevent spread of microorganisms to others or to the client, and appropriate use of isolation equipment to prevent the spread of microorganisms to health care workers and other clients.



Operation sheet	Clean wound dressing
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procedures

1. Explain procedure to the patient
2. Clean trolley or tray; assemble sterile equipment on one side and clean items on the other side. Make sure it is covered.
3. Drape and put patient in comfortable position.
4. Place rubber sheet and its cover under the affected side.
5. Remove the outer layer of the dressing e.g. adhesive tape bandage.
6. Remove the inner layer of the dressing using the first sterile forceps and discard both the soiled dressing and the forceps.
7. Take the second sterile forceps. Clean wound with cotton balls soaked in antiseptic solution, starting from inside to the outside.
8. Again use the second forceps to clean the skin around and remove adhesive with benzene or ether.
9. Apply medication if any and dress the wound with sterile gauze.

- **Method of Application**

- ✓ Ointment and paste must be smeared with spatula on gauze and then applied on the wound.
- ✓ Solutions or powder can be applied direct on the wound.
- ✓ Make sure that the wound is properly covered.
- ✓ Fix dressing in place using adhesive tape or bandage.
- ✓ Leave patient comfortable and tidy
- ✓ Record state of wound
- ✓ Clean and return equipment to proper place

- **Technique**

- ✓ Aseptic technique to prevent infection



Operation sheet	Septic wound Dressing
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procedures

1. Explain procedure to the patient
2. Clean trolley or tray and assemble sterile equipment on one side and surgically clean items on the other side. Make sure the tray or trolley is covered.
3. Drape patient and position comfortably.
4. Place rubber sheet and its cover under the affected part
5. First remove the outer layer of the dressing
6. Wear gloves if necessary. Use forceps to remove the inner layer of the dressing smoothly and discard them for caps.
7. Observe wound and check if there is drainage rubber or tube.
8. Take specimen for culture or slide if ordered (Do not cleanse wound with antiseptic before you obtain the specimen.)
9. Start cleaning wound from the cleanest part of the wound to the most contaminated part using antiseptic solution.
10. (H₂O₂ 3% is commonly used for septic wound). Discard cotton ball used for cleaning after each stroke over the wound.
11. Cleanse the skin around the wound to remove the plaster gum with benzene or ether
12. Use cotton balls for drying the skin around the wound properly
13. Dress the wound and make sure that the wound is covered completely
14. Fix dressing in place with adhesive tape or bandages
15. Leave patient comfortable and tidy
16. Cleanse and return equipment to its proper places
17. Discard soiled dressings properly to prevent cross infection in the ward.



Self check

Written test

Short Answer question

1. Identify different types of wound care.
2. Mention three types of wound healing intentions.
3. Mention the purposes of wound dressing



Score _____
Rating _____

Answer Sheet

Name: _____ Date: _____

1. _____

2. _____

3. _____



List of Reference Materials

1. Basic Nursing Care, Lecture Note for nursing students, 2005