

Nursing Level III

Based on January 2022 Curriculum, Version 1



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Prepared by: Ministry of Labor and Skills

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Acronyms

LAP test

Learning activity performance test

PPE

Personal protective equipment

Introduction to wound care

A break in the continuity of the skin surface is the first step in the formation of a wound and provides a potential portal of entry for infection. A wound can be as simple as a surface abrasion, or it can be an extensive, life-threatening destruction of tissue that reaches down to and includes the internal organs of the body. While the healing process is basically the same for all wounds, there are many extenuating factors that will either expedite or impede healing.

Wound care does not belong to any one healthcare profession. Successful outcomes are achieved when an interdisciplinary team approach is used, calling on the expertise of many different clinicians and employing many different treatment modalities—from simple dressings to advanced treatments such as negative-pressure wound therapy and hyperbaric oxygen therapy.

Clinicians encounter wounds in every healthcare setting, from the penetrating gunshot wound that is rushed to the ER, to acute and chronic wounds that need to be treated in the acute care hospital setting, outpatient clinics, nursing homes, hospice care, and in-home care.

Module units

- Wound assessment and identification
- Plan wound care
- Implement wound care
- Evaluate wound care

Learning objectives of the Module

At the end of this session, the students will be able to:

- Assess and identify wound
- Contribute to planning appropriate care for the client with a wound
- Perform wound care
- Implement wound care
- Evaluate the outcomes of nursing actions

Module Learning Instructions:

1. Read the specific objectives of this learning guide.
2. Follow the instructions described below.
3. Read the information written in the information sheets
4. Accomplish the self-checks
5. Perform Operation Sheets
6. Do the “LAP test”

Unit One: Wound assessment and identification

Instruction sheet

This learning unit is developed to provide the trainees the necessary information regarding the following content coverage and topics:

- Basic concept of wound
- Type of wound
- Wound dressing
- Wound assessment
- Wound debridement
- Phase of wound healing process
- Factors affecting wound healing

This unit will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, you will be able to:

- Describe the basic concept of wound
- Identify types of wound
- Identify wound dressing material
- Describe wound debridement
- Describe wound dressing
- Describe wound healing process

- Describe factors affecting wound healing

Unit instructions:

1. Read the specific objectives of this learning guide.
2. Follow the instructions described below.
3. Read the information written in the information sheets
4. Accomplish the self-checks

1.1 Basic concept wound care

A wound is a physical injury to the body consisting of:

- A laceration or breaking of the skin or mucous membrane;
- An opening made in the skin; or
- A membrane of the body incidental to a surgical operation or procedure.

General overview of wound

Acute wound

Acute wounds show the following characteristics:

- Higher risk of infection if there is debris in the wound
- Inflammation

- Healing by primary intention
- May require antiseptic use if wound contaminated

Chronic wound

Chronic wounds show the following characteristics:

- Lower risk of infection with the exception of diabetic wounds
- Symptom of an underlying condition
- Healing by secondary intention
- Not sterile
- Devitalized tissue.

Complex and chronic wounds

A large proportion of wounds seen in clinical practice are chronic in nature. Epidemiological studies indicate one percent of the population has a chronic wound, and of that group some twenty percent have had the wound for more than two years.

Chronic wounds may be classified into the following groups:

- Leg ulcers
- Pressure injury

- Neoplasia (Cancer)
- Chronic infected wounds
- Diabetic wounds

The difficulty in the management of any chronic wound is that there is always an underlying physiological cause of the wound which must be treated, but many patients have multi-factorial issues and co-morbidities. For best results the basic cause of the problem must be addressed, and any negative factors altered. It must be understood that some patients may never heal due to the basic pathophysiology of the disease process and the inability to alter some or all of the major factors influencing the non-healing wound. However, even in the most extreme cases, effective wound care can assist in minimizing the worst effects of such chronic wounds.

1.2 Types of wound

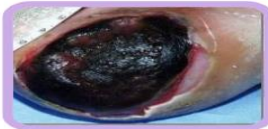
Wound can be classified based on the by depth and by time.

One way of classifying wounds is according to their depth and the amount of tissue destruction involved. The terms partial thickness and full thickness are used to describe wounds of varying depths. A wound that is limited to the epidermis and the dermis is a partial-thickness wound. A wound that extends beyond the dermal layers is considered a full-thickness wound. Another way to classify wounds is according to the length of time they have existed. Wounds may be acute or chronic trauma resulting from an injury where, because of a number of factors, the injury does not heal. Acute wounds may be a planned or unplanned event, and healing typically proceeds in an orderly and timely fashion.

Examples of acute wounds include: A cut, graze or burn.

Examples of chronic wounds include: Leg ulcers, pressure injuries and diabetic wounds.

**NON-DIABETIC BLACK
NECROTIC WOUND**



**EXUDATING WOUND WITH
SLOUGH AND CLINICAL
SIGNS OF INFECTION**



**SUPERFICIAL GRANULATING
WOUND WITH HIGH
EXUDATE**

**YELLOW NECROTIC WOUND
WITH HIGH EXUDATE**

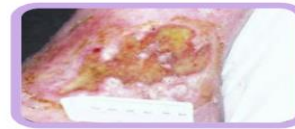


**SUPERFICIAL WOUND
WITH CLINICAL SIGNS
OF INFECTION**

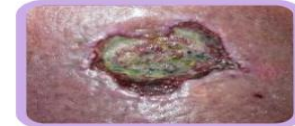


**SUPERFICIAL GRANULATING
WOUND WITH LOW
EXUDATE**

**YELLOW NECROTIC WOUND
WITH LOW EXUDATE**



MALODOROUS WOUNDS

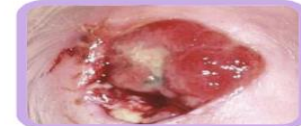


EPITHELIALISING

**CAVITY WOUND
WITH HIGH EXUDATE**



**CAVITY WOUND
WITH LOW EXUDATE**



SKIN TEARS



**NEUROPATHIC
DIABETIC WOUND**



**ISCHAEMIC
DIABETIC WOUND**



**HYPERGRANULATING
WOUND**

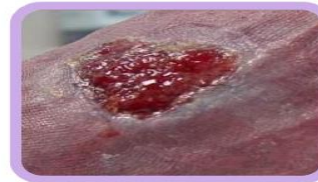


Fig1. Common types of wound

1.3 Wound dressing

A wound dressing is a type of bandage used to cover a wound and stick to the surrounding skin by glue or wound dressing tape. It can either be in the form of a gel (hydrogel), foam, gauze, bandage, and other wound dressing patches.

A dressing at its very basic is a covering applied over an open wound to form a barrier between the wound and the external environment.

There are multiple forms of dressings available to the wound clinician, and they all serve the following important functions:

To protect the wound from infection and trauma

To promote a moist wound environment that is conducive to healing

To absorb excess drainage from the wound bed

To protect the intact skin surfaces surrounding the wound

The choice of dressing depends on the anatomical and pathophysiological characteristics of the wound. Contemporary wound dressings provide additional benefits, such as antimicrobial properties and pain relief. In this concise review, we discuss the principles of wound dressing, highlight the features of basic and advanced types of dressings, and offer some practical tips on the choice and application of dressings.

Traditional wound dressing products including gauze, lint, plasters, bandages (natural or synthetic) and cotton wool are dry and used as primary or secondary dressings for protecting the wound from contaminations.

Wound dressings have been used to clean, cover, and protect the wound from the external environment. A wound dressing must provide a moist environment, remove the excess of exudate, avoid maceration, protect the wound from infection and maintain an adequate exchange of gases

Choosing the correct dressing

A wound dressing is only one component of wound healing, but it is an important one. Deciding on the most appropriate dressing for a particular wound is a team effort. The guiding principle is to maintain an environment conducive to moist wound healing. In simple terms, a dry cell is a dead cell and will hinder rather than aid the progression of the wound.

Here are some pointers for clinicians to keep in mind when deciding on a wound dressing:

- Moist does not mean “soupy.” If the wound has too much drainage, then an absorptive dressing will be required
- If the wound is dry, then moisture will need to be added.
- If there is undermining or tunneling, packing will be needed.
- Peri-wound areas will need to be protected from damage.

Types of wound care bandages and medical dressing

- Basic transparent adhesive bandages.
- Medicated bandages.
- Dry gauze dressings.
- Hydrogel dressings.
- Hydrofiber dressings.
- Foam dressings.
- Alginate dressings.
- Gauze sponge -used for all wounds.
- Gauze bandage roll- used for all wounds.

- Non-adherent pads.
- Non-adherent wet dressings

Techniques of wound management

The following dressing techniques are easy to do and require no sophisticated equipment. Clean technique is usually sufficient. Pain medication may be required as dressing changes can be painful. Gently cleanse the wound at the time of dressing change.

When to do which dressing

Remember, the goal is to promote healing. We know that a moist environment facilitates healing. For a clean wound, it is best to use a wet-to-wet or ointment based dressing. For a wound in need of debridement the wet-to-dry technique should be done until the wound is clean and then change to a different dressing regimen. For a wound covered with necrotic tissue, dressings cannot take the place of mechanical debridement. When present, necrotic tissue must be sharply debrided (although there are some preparations than work to dissolve necrotic tissue, they are very expensive and not readily available in rural settings) and then the wound treated with appropriate dressings

A. Dry, sterile dressing

Applying dry, sterile dressing to a wound to protect it from contamination. It is also known as dry-to -dry dressing .This kind of dressing is most often used for wounds healing by primary intention

B. Wet-to-dry dressing Indication:

- To clean a dirty or infected wound.
- They are used most commonly for wounds healing by secondary intention

- Using wet to dry dressing is a common technique for debridement (removal of infected tissue).

Technique:

Moisten a piece of gauze with solution and squeeze out the excess fluid. The gauze should be damp, not soaking wet. Open the gauze and place it over top of the wound to cover it. You do not need many layers of wet gauze. Place a dry dressing over top. The dressing is allowed to dry out and when it is removed it pulls off the debris. It's ok to moisten the dressing if it is too stuck. Ideally, 3-4 times per day. More often on a wound in need of debridement, less often on a cleaner wound. When the wound is clean, change to a wet-to-wet dressing or an antibiotic ointment.

Wet-to-wet dressing Indication

To keep a clean wound clean and prevent build-up of exudates. This dressing provides warmth and moisture, which aid the healing process and make the client more comfortable. Thick exudates also can be removed in this manner. Sterile saline or an antibiotic solution is used to saturate the dressing.

Technique:

Moisten a piece of gauze with solution and just barely squeeze out the excess fluid so it's not soaking wet. Open the gauze and place it over top of the wound to cover it. The gauze should not be allowed to dry or stick to the wound. How often: Ideally, 2-3 times a day. If the dressing gets too dry, pour saline over the gauze to keep it moist.

D. Antibiotic ointment Indication:

Antibiotic ointment is used to keep a clean wound clean and promote healing.

Technique:

Apply ointment to the wound- not a thick layer, just a thin layer is enough. Cover with dry gauze. How often: 1-2 times per day.

1.4 Wound assessment

A thorough physical examination of the wound is vital regardless of the etiology of the wound. Every wound assessment is important, but the initial assessment is particularly so. It is the baseline against which all future assessments will be compared, it provides the basis on which the treatment plan will be devised, and it serves as an important indicator in evaluating the outcomes of care.

A wound assessment can be done by nurse, an advanced practice nurse, a physical therapist, or a physician with the required knowledge and experience in wound care. Each new assessment will be compared to the previous assessment and to the baseline assessment. It is imperative that changes in the wound, especially any subtle signs of deterioration, are caught and addressed immediately.

The classic signs of wound infection include:

- Fever,
- Pus
- Abscess
- Abnormal smell
- Cellulitis
- Persistent inflammation with an exudate

The steps of wound assessment are described below:

Location: The clinician accurately describes the anatomical location of the wound, using identifiers such as proximal, distal, medial, lateral, anterior, posterior, right, left. Depending on facility protocols, diagrams can be useful in precisely identifying wound location.

Shape: The shape of the wound can be useful in identifying the etiology of the wound. For example, chronic wounds on a lower extremity that are round and have what is called a “punched out” appearance are typically caused by problems with arterial circulation to the affected leg, while those that are irregular in shape are associated with venous disease.

Size: Wounds are measured in centimeters using a disposable plastic or paper ruler. An accurate measurement of wound size on the initial assessment is essential.

Depth: Wound depth is gauged by gently placing a sterile cotton-tipped applicator into the wound bed and marking at the point where it is even with the surface of the skin. It is important to keep in mind that many wounds will have areas of varying depth, and measurements may need to be taken at different locations. The deepest area of the wound is used to classify the actual depth.

Undermining: is an area under intact skin where the tissues have separated and there is a “shelf” present. It is not visible from the outside. The “face of the clock” method is typically used to describe the location of undermining. Starting at the top of the wound (toward the head, or the 12 o’clock location), a sterile cotton-tipped applicator is inserted to the full depth of the undermining and slowly moved in a clock-wise direction to determine how far the undermining extends.

Measurements are documented in the following manner: “Undermining to a depth of 5 cm, extending from 12 o’clock to 3 o’clock, deepest at 2 o’clock = 5 cm.” Continue to gently probe along the entire wound edge to determine if there are other areas of undermining. Frequently, undermining will occur at different locations and to different depths and can be interspersed with areas of normal wound edges.

Tunneling: Unlike undermining, tunneling is a narrow channel (tunnel) that can be located anywhere along the wound edges or in the base of the

wound. It is measured in the same way as undermining (described above). A newly discovered tunnel in a surgical wound or a trauma wound left open to heal by secondary or tertiary intention needs to be reported to the surgeon and not probed by the clinician until the surgeon has an opportunity to evaluate it.

Wound bed: A gentle cleansing with normal saline and gauze is usually sufficient prior to assessing the wound bed. The type and amount of tissue in the wound needs to be described accurately. If there is more than one type of tissue in the wound, this will be documented in approximate percentages, for example, “the wound base is 50% black necrotic tissue and 50% grayish/green slough.”

Wound edges: Assessment of the wound edges must not be overlooked. Wound edges should be clear and distinct from the wound bed as well as open and proliferative, which means that they are red, moist, and flexible. Wound edges must be open to facilitate the in-growth of new blood vessels and tissue in the wound bed and for the wound to contract and become smaller. Wound edges that are closed are a common finding in chronic wounds. These wound edges are thickened and rolled under and feel hard to the touch.

Drainage: In a dry wound, there is no drainage. A moist wound has sufficient drainage to keep the wound bed moist, which is critical for healing. However, a large volume of malodorous wound drainage is a sign of infection. The following terms are used to describe wound drainage:

Serous: Clear drainage with no blood or pus present

Serosanguineous: Watery drainage that is pink to pale red in color

Sanguineous: Bright red, blood drainage

Purulent: Thick, cloudy drainage that varies in color from tan to dark brown

Wound odor

Odor is present in nearly all wounds. Wound odor can be described as faint, moderate, or strong .Wound odor is usually associated with the amount of drainage in the wound, the presence or absence of necrotic tissue, and infective organisms.

Necrotic wounds have a strong malodor, and wounds infected with *Pseudomonas* have a distinctive sweet, fruity smell.

Peri-wound skin

The skin surfaces around the wound should be carefully assessed. Ideally, these areas should be clean, dry, and intact, indicating that they have not been adversely affected by the wound presence. Peri-wound skin can experience changes that may indicate the current wound treatment is not effective; the absorptive dressing is not preventing leakage of wound drainage onto the intact skin area.

Presence of infection or pressure.

The **color** of the peri-wound area can be described as:

- Increased redness/erythema
- Pale/pallor
- White/gray
- Blue/purple

The **texture** of the area can be:

- Dry/flaky
- Moist
- Indurated/hard
- Excoriated (linear scratch marks)

- Denuded (loss of epidermis)
- Boggy/soft to touch
- Macerated/water logged

Peri-wound skin **temperature** can be assessed as:

- Normal (same temperature as skin surfaces not in the immediate wound area)
- Warm
- Hot
- Cool

Wound cleansing techniques

All debris, foreign bodies, and devitalized tissue must be removed from the wound bed in order for the healing process to begin. It is essential to pick the correct cleaning agent and the correct technique for cleaning depending on the characteristics of the wound. The goal of cleansing is to remove as much devitalized tissue as possible without damaging healthy tissue in the wound. Normal saline or water from a standard treated drinking supply can be used to gently clean the surface of the wound. Studies have shown that when either tap water or normal saline is used for cleaning, there is no difference in infection rates or positive healing outcomes in both acute and chronic wounds. Clean septic wound from more contaminated to less contaminated area.

Commercial wound cleansing products contain chemicals known as surfactants that are capable of breaking down the bonds that attach contaminants to the wound bed, and they provide a higher level of wound cleaning efficiency than saline or tap water. These products should be used at the strength recommended by the manufacturer.

Recommended pressure for wound irrigation is 4 to 15 pounds per square inch as measured using a 19-gauge angiocatheter and a 35-ml syringe. This has been found to adequately clean the wound without harming healthy tissue and embedding debris into the wound base. Pulsatile lavage is another alternative for wound irrigation. It delivers the cleaning agent to the wound bed from a powered device and is usually used in conjunction with suction.

Whirlpool was once a standard method for wound cleansing, and it was the recommended care for chronic wounds with slough and necrotic tissue. Pressurized streams of water were pumped into the whirlpool bath via jets. However, concerns about contamination and cross infection have made whirlpool therapy a less-favored practice in wound care.

Cleansing agents

Cleaning of heavily contaminated wounds will require more than saline or tap water. Antiseptic solutions are usually required to kill bacteria in the wound; however these agents are also capable of destroying healthy wound tissue, so they have to be used judiciously. Antiseptic use should be short term and closely monitored.

Dakin's solution (sodium hypochlorite) half strength 0.25% used for short periods of time (approximately 7 days) has been proven to be effective against most bacteria found in chronic wounds without damaging viable wound tissue; it also decreases wound odor.

Quarter-strength acetic acid can be used as wound irrigation or a soak to clean wounds. It has been shown to eradicate *Pseudomonas aeruginosa* from wounds. Sterile 4" x 4" gauze can be soaked in acetic acid then placed on the wound bed for approximately 15 minutes.

Changing dressings

In general, changing a dressing daily allows for assessing the condition of the wound and progress of the healing process. However, since wounds require being at body temperature for healing to occur, it is important to be aware that any time spent in changing a dressing, or even cleansing the wound, will cool down the wound, which can then take several hours to come back up to body temperature after being re-covered. This may slow the healing process. Therefore, it is important to be organized and prepared prior to beginning the procedure and to choose a dressing that will minimize the need for frequent changes.

The first thing that needs to be decided is when the dressing change is going to be done. Most patients have many activities going on during a hospital stay, and the same is true in nursing homes and assisted living.

Home health nurses collaborate with patients and families when scheduling visits. Changing time depends on the, types of wound, severity of wound and patient status. Once a dressing change time has been decided on, identify the pain and manage accordingly.

Does the patient have pain medication ordered?

1.5 Wound debridement

Debridement is removal of dead tissue from the wound, and it is an important factor in wound bed preparation. When and how to debride is determined based on the type of wound, the patient's overall status, the presence or absence of infection, and the goals of wound care. For example, debridement would not be the treatment of choice for intact, dry eschar covering the wound of a terminally ill patient.

Unless infection is present, debridement should not be done until the patient's ability to heal has been thoroughly assessed. Patients with lower extremity wounds, regardless of the etiology, should have their circulatory status evaluated. The bottom line is that wounds will

not heal without a good blood supply, and before “de-roofing” (removing) eschar and causing an open wound, the clinician needs to have a realistic expectation that the wound will heal.

In hospice patients, however, a wound may be debrided with no expectation the wound will heal. It is debrided to relieve pain and pressure by allowing the wound to drain and to provide improved access to cleanse the wound and decrease odor.

Debridement can be divided into two broad categories: selective and nonselective.

Selective is the most beneficial to the patient, since it only removes nonviable material from the wound.

Nonselective debridement, as the name suggests, removes healthy granulating tissue as well as devitalized tissue from the wound bed. Saline wet-to-dry dressings are the best-known method of nonselective debridement but are no longer regarded as state-of-the-art care; they are painful for the patient and labor intensive, since dressing changes need to be done 3 to 4 times daily.

1.6 Phases of wound healing

There are three phases of wound healing:

- Inflammatory (destructive)
- Proliferative (regenerative)
- Maturation (reparative)

Inflammatory (destructive)

When a wound is created (through surgical, traumatic or other means), an inflammatory response takes place. This phase is the shortest and involves:

- Bleeding
- Clot formation by platelets
- Haemostasis from the clotting process
- Production of wound exudate

If the inflammatory phase is impaired or prolonged, it can prevent the onset of the proliferative and maturation phases. In turn, this may lead to fibrosed tissue.

Factors that can slow the inflammatory phase are:

- Presence of foreign material
- Necrotic tissue
- Clinical infection
- Excessive antimicrobial use
- Continued disruption of the wound
- Skin dryness
- Poor blood supply

- Thermal shock

The proliferative phase

During the proliferative phase a new vascular bed is formed to provide oxygenated blood to the wound, and the wound fills with granular tissue. The proliferative phase consists of:

Granulation: Granulation tissue, which in part contains fibroblasts, forms in the wound.

Contraction: As the connective tissue fills the wound, contractile cells (myofibroblasts) pull the wound margins together.

Epithelialization: Once the wound has filled with granulation tissue and contracted, epidermal cells grow and cover the surface of the wound.

The maturation phase

The maturation phase is the final stage of healing. During this stage the fibroblasts decrease in number and vascularization decreases. The existing collagen then realigns itself by cross-linking, which importantly increases the tensile strength of the wound. At this stage the wound may have achieved surface closure; however, its tensile strength may take up to 12 months to develop.

1.7 Factors affecting wound healing

Most wounds heal readily whereas others are slow or remain unhealed for a considerable length of time. There are a number of factors which affect the healing of a wound, and these factors are both intrinsic and extrinsic.

Intrinsic factors are internal personal factors that can be further dichotomized into modifiable and non-modifiable risk factors.

Intrinsic factors includes ; Health status, Immune function, Diabetes, Age factors, Body build, Nutritional status, Psychological Status,

Extrinsic factors wield their influence from the outside (i.e., they are environmental, cultural, or related to lifestyle).

Extrinsic factors include: Mechanical stress, Debris, Temperature, Desiccation, Maceration, Infection, Chemical stress, Systemic medications, and Lifestyle factors

Unit summery

A break in the continuity of the skin surface is the first step in the formation of a wound and provides a potential portal of entry for infection. A wound can be as simple as a surface abrasion, or it can be an extensive, life-threatening destruction of tissue that reaches down to and includes the internal organs of the body.

One way of classifying wounds is according to their depth and the amount of tissue destruction involved. The terms partial thickness and full thickness are used to describe wounds of varying depths.

A wound dressing is a type of bandage used to cover a wound and stick to the surrounding skin by glue or wound dressing tape. It can either be in the form of a gel (hydrogel), foam, gauze, bandage, and other wound dressing patches.

A wound dressing is only one component of wound healing, but it is an important one. Deciding on the most appropriate dressing for a particular wound is a team effort. The guiding principle is to maintain an environment conducive to moist wound healing. In simple terms, a dry cell is a dead cell and will hinder rather than aid the progression of the wound.

A thorough physical examination of the wound is vital regardless of the etiology of the wound. Every wound assessment is important, but the initial assessment is particularly so. It is the baseline against which all future assessments will be compared, it provides the basis on which the treatment plan will be devised, and it serves as an important indicator in evaluating the outcomes of care.

Debridement is removal of dead tissue from the wound, and it is an important factor in wound bed preparation. When and how to debride is determined based on the type of wound, the patient's overall status, the presence or absence of infection, and the goals of wound care. For example, debridement would not be the treatment of choice for intact, dry eschar covering the wound of a terminally ill patient. Wound healing phases are Inflammatory (destructive), Proliferative (regenerative) and Maturation (reparative).

Most wounds heal readily whereas others are slow or remain unhealed for a considerable length of time. There are a number of factors which affect the healing of a wound, and these factors are both intrinsic and extrinsic.

Self-Check - 1

Directions: Answer all the questions listed below.

Part I. Say true or false

1. Wound is a laceration or breaking of the skin or mucous membrane
2. A wound dressing is not component of wound healing
3. The shape of the wound can be useful in identifying the etiology of the wound
4. Cleaning of heavily contaminated wounds will require more than saline or tap water

5. Extrinsic factors wield their influence from the outside

Part II: Multiple choice questions

1. Cardinal sign of infection includes
 - A. Fever
 - B. Pus
 - C. Abscess
 - D. All
2. Factors that can slow the inflammatory phase of wound healing includes
 - A. Presence of foreign material
 - B. Necrotic tissue
 - C. Clinical infection
 - D. All

Part III: Matching

Match column A with Column B

| Column A | | Column B |
|--------------------|--|--|
| 1. Drainage | | Bright red, blood drainage |
| 2. Serous | | Thick, cloudy drainage that varies in color from tan to dark brown |
| 3. Serosanguineous | | Watery drainage that is pink to pale red in color |
| 4. Sanguineous | | Clear drainage with no blood or pus present |
| 5. Purulent | | Bright red, blood drainage |

Part IV. Short answer

1. Discuss types of wound
2. Describe dressing materials



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Unit Two: Wound care plan

Instruction Sheet

This learning unit is developed to provide the trainees the necessary information regarding the following content coverage and topics:

- Wound care plan with patient/family
- Holistic approach of wound care plan
- Client comfort needs plan of wound care.
- Potential impact of wound on client and/or family

This unit will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, you will be able to:

- Discuss wound care plan with patient/family
- Holistic approach principles during planning
- Plan client comfort needs before undertaking wound care.
- Create awareness on potential impact of wound on client and/or family

Unit instructions:

- Read the specific objectives of this learning guide.
- Follow the instructions described below.
- Read the information written in the information sheets
- Accomplish the self-checks

2.1 Wound care plan with patient/family

Debriding it of non-viable tissue (for example, necrosis and slough) to reduce risk of infection; managing the moisture balance – rehydrating or reducing exudate levels to create a moist wound environment (for example by using an appropriate dressing);

Patients discharged from hospitals may leave with wounds that require care at home. These wounds may be due to surgery or pressure damage, or the consequence of long-standing chronic conditions, such as venous insufficiency. Some are quite complex and their management requires considerable skill and confidence.

Nurses play an important role in preparing these caregivers to perform wound care, which includes basic assessment and treatment of acute postoperative or chronic wounds. Providing wound care at home can be a stressful experience for nonprofessional caregivers. They need to learn skills that will enable them to assess and clean the wound, as well as apply treatment. Because every wound and patient is different, nurses should provide caregivers with individualized instructions. Demonstrations of wound care should be available to family caregivers in multiple forms (both written and spoken instructions, for example). This helps to ensure the caregiver has easy access to his information at home. Patients and caregivers will need to learn how to identify normal wound healing as well as the signs and symptoms of infections or complications, which should be reported to the patient's health care professional as soon as possible.

The ideal time to engage family caregivers, if they are available, is while the nurse is performing wound care in the hospital. This enables the nurse to determine the family caregiver understands of the patient's condition and the care that will be required at home. It also provides an opportunity to demonstrate how to perform necessary procedures. Discussions about wound care after hospitalization should start as early as possible to give the family caregiver time to process this information and identify questions and concerns. It's important to recognize that this task can evoke a variety of emotions, including fear and concerns about safety, among caregivers.

Nurses should provide information in a clear manner, including instructions and details about how to obtain supplies, and strive to promote a discussion in which questions and mutual problem-solving are encouraged.

2.2. Holistic approach of wound care

A holistic wound assessment is an approach that takes into account the combination of factors inside and outside the wound that affect the healing process.

A holistic wound assessment involves:

The patient's medical history: including current and past medical conditions; their psychological, social and spiritual history; their wound care environment and access to specialized health services.

A physical assessment of the patient: including factors such as respiration, blood pressure, heart sounds, skin assessment, etc.

A comprehensive wound assessment: including assessment of the wound bed, the wound edges, the periwound skin and patient pain levels.

The holistic approach to wound assessment is a structured and comprehensive approach to wound management. It helps you to consider all the factors that affect wound healing and gives you a baseline for tracking the healing process so you can adjust the goals you set for management along the way. With this approach, you are considering the 'whole patient' and not just the 'hole in the patient'.

2.3 Client comfort needs plan

Comfort is a concept that is inherently linked to the practice of nursing care and in a health context. It is characterized by the satisfaction of one's needs, by the person feeling strong, safe, supported and cared for. The nurse promotes physical health and wellness by providing care and comfort, reducing client risk potential and managing health alterations.

Seven themes describing caregivers' comfort needs were identified, including the need to understand, need for self-efficacy, need to derive meaning, need for informal support, need for formal support, need for resources, and need for self-care.

Many factors affect comfort, including a patient's needs and the level at which they are met, environmental factors, the disease, and patient's perceptions of the disease

Patient with wound faces pain and consider that pain management. This includes positioning, back massage, relaxation, guided imagery, and distraction. Remember to report and document the information about the pain before and after the intervention and which method was used to alleviate the client's pain.

2.4 Potential impact of wound on client and/or family

A person with a chronic wound is also at risk of mental health issues including anxiety and depression resulting from social isolation, changes to body image. Chronic wound can be a stressor (life event) that affects the family and may produce a change in the family social system. A chronic wound may alter a family member's mobility, self-esteem, and role in the family, altering the family structure and role functions.

The psychological consequences of having a wound may include stress, sleep disturbances, negative mood and social isolation. These outcomes may be a result of the physical effects of the wound, such as pain or high levels of exudate

The psychological impact for patients with wounds can be significant, and adverse psychological effects frequently occur when there are permanent changes in the body's structure or function. Evidence suggests that anxiety, depression and stress can adversely affect the wound healing process.

Summary

Patients discharged from hospitals may leave with wounds that require care at home. These wounds may be due to surgery or pressure damage, or the consequence of long-standing chronic conditions, such as venous insufficiency. Some are quite complex and their management requires considerable skill and confidence.

A holistic wound assessment is an approach that takes into account the combination of factors inside and outside the wound that affect the healing process

Comfort is a concept that is inherently linked to the practice of nursing care and in a health context. It is characterized by the satisfaction of one's needs, by the person feeling strong, safe, supported and cared for.

A person with a chronic wound is also at risk of mental health issues including anxiety and depression resulting from social isolation, changes to body image

Self-Check – 2

Directions: Answer all the questions listed below.

Part I. Say true or false

1. Patients discharged from hospitals may leave with wounds that require care at home
2. Comfort is a concept that is inherently linked to the practice of nursing care and in a health context.
3. A person with a chronic wound is also at risk of mental health issues

4. The psychological impact for patients with wounds can be significant

Part II. Short answer

1. Describe wound care plan
2. Describe holistic approach principle in wound care
3. Discuss potential impact of wound on family

Unit Three: Implement wound care

Instruction Sheet

This learning unit is developed to provide the trainees the necessary information regarding the following content coverage and topics:

- Information to the patient or relatives.
- Client cooperation
- Wound care procedure requirement
- Patient comfort
- Privacy and dignity
- Aseptic techniques
- Wound management
- Waste disposal techniques
- Documentation

This unit will also assist you to attain the learning outcomes stated in the cover page.

Specifically, upon completion of this learning guide, you will be able to:

- Deliver necessary information to the patient or relatives.
- Ensure client cooperation
- Collect all requirements for the procedure
- Make patient comfortable
- Maintain client privacy and dignity
- Use clean and sterilized tools
- Follow aseptic techniques
- Perform wound care
- Follow appropriate waste disposal techniques
- Document the procedure and findings

Unit instructions:

1. Read the specific objectives of this learning guide.
2. Follow the instructions described below.
3. Read the information written in the information sheets
4. Accomplish the self-checks
5. Perform Operation Sheets
6. Do the “LAP test

3.1 Information to the patient or relatives

Patient education should be a priority to empower patients to care for themselves and improve patient outcomes. Involving patients in their own care can help them to understand about their wound and be more adherent to the overall treatment plan. Remember to involve the caregiver or family if applicable. Ask your patient questions about who will be changing the dressing so the appropriate parties can be involved.

Educating and explaining wound bed preparation to your patient is vital in impacting their healing outcome. Demonstrating the appropriate technique for wound cleansing and explaining the signs and symptoms of infection to watch for, when to call their doctor, and how to change the dressing are all examples of topics that are essential in education.

As clinicians we tend to forget how the patient with an open wound must feel. Most patients have feelings of fear and uncertainty, and they may also experience feelings of depression and reduced self-image. Providing ongoing education from admission to discharge, while keeping your patient or caregiver involved in their care, will support all aspects in their plan of care.

Patients should be told what to expect during and after wound healing. Some helpful information to give a patient is described below:

- The wound area may tingle, feel strange, or itch. By pressing on the skin or by lightly rubbing it, the feelings can usually be lessened. These feelings may show up for many months, but they should be gone within a year.
- Deeper wounds may have injured some sensory nerves, so there may be numbness or lessened sensation distal to the wound. This problem usually improves on its own within a year.
- All full-thickness wounds, no matter how artfully repaired, leave a scar. Typical scars get darker and redder before they eventually fade. It can be a year or more before they reach their final appearance. Scar mobilization techniques taught by a physical therapist may be helpful.
- Currently, there is limited evidence that creams or lotions can limit scar formation, however Mederma cream can help to improve the overall appearance of the skin.
- If the patient is worried about something seen or felt in the wound or if the patient develops any of the signs and symptoms of an infection, it is important to contact the appropriate healthcare professional.
- If tissue glue has been used, it may cause a mild local inflammatory reaction.

3.2 Client cooperation

As patient-centered approaches to health care gain favor, financial pressures in the healthcare sector mount, and competition for patients increase, health care organizations are continually looking for ways to improve their health care delivery, practices and outcomes. Involving patients more deeply in their own care and recovery is one such area of innovation.

The term ‘patient engagement’ refers to the collaboration between patients and providers, which aims to have patients willingly take some ownership for their own health, and as a consequence behave in a manner that improves their health outcomes. The theory of patient engagement is that those who are engaged, and can contribute to their own care plans, tend to have better health outcomes. Patients engaged in their health care and healing progress will often seek information from external sources to supplement that provided by their healthcare providers.

Patient engagement can span all aspects of the health care process—from prevention to diagnosis, to care plans, to compliance with these care plans and through to their satisfaction levels. Patient engagement contributes to improved health care outcomes for both patients and their care providers through

3.3 Wound care procedure requirement

The current standard of care for chronic wounds consists of swabbing for infection, cleaning, dressing, and in some cases debridement of the wound. For diabetic ulcers, systemic glucose control, debridement of nonviable tissue, and maintenance of adequate extremity perfusion is paramount.

Cleanse and irrigate the wound per its assessment, without causing irritation. Create the most optimum environment for healing. Swab the wound with gauze or a similar product and irrigate to remove deeper debris. Wound assessment is the first and foundation step of proper wound management.

Five important requirements that you need to follow in wound dressing

- Decrease the pain.
- Apply compression for hemostasis.
- Protect the wound from the environment.
- Protect the wound from soiling with body fluids or waste.
- Immobilize the injured body part.
- Promote wound healing.

3.4 Patient comfort

For a physician or nurse in wound care, the primary thing to remember is this: you are not just seeing a wound; you are seeing a person who has a wound. Do not lose sight of this human and their humanity. Always look at the whole picture of your patient, not just their wound. Find out what is important to them and for them. Your patient might tell you, “Doc, I don’t care about the wound, I just can’t stand the smell,” or “Doc, just cut my leg off because I can’t stand the pain.”

For the first case, the response is, “sure, we can help the odor, and maybe this will help the wound too.” For the second, the response is, “I have more pain meds than you have pain,” then “let’s see what we can do to eliminate the pain.” If your patient can’t talk to you, find a family member or close friend who can.

Also, consider where your patient is in their life span. Are they near the end of their life? How long will they live? If your patient with the wound is near the end of their life, they may not live long enough to heal a wound. Your goal for this patient will not be to heal the wound, but to provide comfort reduce pain, control odor, and relieve the symptoms that cause the patient discomfort.

All patients deserve to be free of pain and to not suffer the humiliation of odor. Providing comfort for the patient is in keeping with treating the patient, not just the wound. So please, please remember you are not just seeing a wound to be treated, you are seeing a person who needs your help.

3.5 Privacy and dignity

Privacy is defined as giving someone space where and when they need it, and dignity is defined as focusing on the value of every individual, including: Respecting their views, choices and decisions, Not making assumptions about how they want to be treated,

Dignity in care means providing care that supports the self-respect of the person, recognizing their capacities and ambitions, and does nothing to undermine it.

The principles of treating others with dignity, honesty and fairness, and of respecting the diversity and rights of individuals, are the cornerstones of modern societies. These principles enable individuals to have successful personal and professional relationships and the adoption of these principles is fundamental to the role of all healthcare professionals .Within wound care, there are multiple professional relationships that must be fostered in an environment of trust and openness and keep the privacy and dignity of the patient.

Aseptic techniques

Asepsis is defined as the absence of pathogenic (harmful) organisms. An aseptic technique is used to carry out a procedure in a way that minimizes the risk of contaminating an invasive device, e.g. urinary catheter, or a susceptible body site such as the bladder or a wound.

.The principles of asepsis/aseptic technique are:

- Reducing activity in the immediate vicinity of the area in which the procedure is to be performed
- Keeping the exposure of a susceptible site to a minimum
- Checking all sterile packs to be used are in date and there is no evidence of damaged packaging or moisture penetration
- Ensuring all fluids and materials to be used are in date
- Not re-using single use items
- Ensuring contaminated/non-sterile items are not placed in the sterile field
- Ensuring appropriate hand decontamination prior to and after the procedure
- Protecting uniform/clothing with a disposable apron
- Using sterile gloves

3.7 Wound management

Wound management involves a comprehensive care plan with consideration of all factors contributing to and affecting the wound and the patient. No single discipline can meet all the needs of a patient with a wound.

Wound care means and refer to therapies and products utilizing placental tissue to enhance the healing of skin abrasions, blisters, cracks, craters, infections, lacerations, necrosis, and/or ulcers.

Wound care is usually ordered for any immobilized or bedridden individual with compromised skin integrity in order to prevent pressure sores from developing or to keep red, tender areas from deepening into serious wounds. Wound care nurses use several techniques to assess, treat, and care for patients with wounds.

Proper wound care is necessary to prevent infection, assure there are no other associated injuries, and to promote healing of the skin. An additional goal, if possible, is to have a good cosmetic result after the wound has completely healed.

.The basic principles for the management of a wound or laceration are:

- Haemostasis.
- Wound debridement/some case
- Cleaning the wound.
- Analgesia.
- Skin closure.
- Dressing and follow-up advice.

3.8 Waste disposal techniques

Medical waste is healthcare waste that that may be contaminated by blood, body fluids or other potentially infectious materials and is often referred to as regulated medical waste.

Biomedical waste management is of great significance because biomedical waste can adversely affect health inviting serious implications to the people who get in touch with it. Segregation, storage and safe disposal of the waste is the key to the effective management of biomedical waste in a workplace. After performing wound care for the patient you should dispose the waste according to your facility guide line.

3.9 Documentation

Documentation is any communicable material that is used to describe, explain or instruct regarding some attributes of an object, system or procedure. Clear, concise, and accurate documentation is an essential part of wound care in all settings. It needs to be done with each wound contact. Documentation allows all those involved in the patient care to know the wound status and provides for good communication among all clinicians. It is also of paramount importance for reimbursement and in the case of litigation.

Documentation of the care given includes the following components:

- Date and time
- Interventions performed
- Wound characteristics, including the amount and type of drainage
- Wound odor
- Patient's pain level during and after the treatment
- Interventions to relieve pain and the effectiveness of the interventions
- Patient's level of anxiety before, during, and after treatment
- Patient's reported level of comfort with applied dressings
- Supplies used
- Name and credentials of the clinician providing the care

Summary

Patient education should be a priority to empower patients to care for themselves and improve patient outcomes. As patient-centered approaches to health care gain favor, financial pressures in the healthcare sector mount, and competition for patients increase, health care organizations are continually looking for ways to improve their health care delivery, practices and outcomes.

The current standard of care for chronic wounds consists of swabbing for infection, cleaning, dressing, and in some cases debridement of the wound. For diabetic ulcers, systemic glucose control, debridement of nonviable tissue, and maintenance of adequate extremity perfusion is paramount.

Privacy is defined as giving someone space where and when they need it, and dignity is defined as focusing on the value of every individual, including: Respecting their views, choices and decisions, Not making assumptions about how they want to be treated,

Wound care means and refer to therapies and products utilizing placental tissue to enhance the healing of skin abrasions, blisters, cracks, craters, infections, lacerations, necrosis, and/or ulcers.

Medical waste is healthcare waste that that may be contaminated by blood, body fluids or other potentially infectious materials and is often referred to as regulated medical waste.

Documentation is any communicable material that is used to describe, explain or instruct regarding some attributes of an object, system or procedure

Self-Check - 3

Directions: Answer all the questions listed below.

Part I. Say true or false

1. The term 'patient engagement' refers to the collaboration between patients and providers
2. Keeping Privacy and respecting dignity does not need during wound care

Part II: Short answer

1. Describe the necessary information to be given for patient and family
2. Discuss the wound management principles
3. Describe the component of wound care documentation

Operation sheet -1

Operation Title: Wound care

Instruction: Perform all steps/tasks according to standard procedures /guideline

Purpose:

To Keep the wound moist and therefore enhance epithelialization

To Keep the wound clean

To keep locally applied drugs in position

To keep edges of the wound together by immobilization

To relief pain and comfort the patient

Provide physical, psychological, and aesthetic comfort

Remove necrotic tissue

Prevent, eliminate, or control infection

Maintain a moist wound environment

Protect wound from further injury

Protect skin surrounding wound

To protect the wound from mechanical injury.

To protect the wound from microbial contamination.

To absorb drainage

To prevent hemorrhage

To splint or immobilize the wound site and there by facilitate healing

General Precautions in wound dressing

- Wash hands thoroughly before, after and between several dressings.
- Dressing should be done after the wards have been cleaned
- Clean wounds should be dressed before wounds with drainage.

- Never do a dressing when the air is dusty from sweeping, bed making or in dust.
- Wear gloves when touching blood, body fluids, mucous membrane and handling soiled items with blood or body fluids.
- Do talk , cough and sneeze over wound
- Wear mask and protective eye wear as necessary
- Practice strict aseptic techniques to reduce transmission of micro organism
- Soaked wound with frequent drainage should be changed frequently.
- Clean wound from the cleanest area to the less clean area
- Separate instruments should be used for each dressing.
- Keep forceps lower than the handles at all times
- Saline should be used to remove adherent dressings.
- Medicines are given and applied if necessary.
- 15. Be economical on using gauze , sponges' applicators, adhesive or medication.
- Adhesive marks on skin can be removed with solvent such as ether alcohol or benzene
- **Equipment:-**

Sterile dressing set

- One kidney dish

- Sterile gloves
- Cotton balls in a galipot
- Sterile gauze (4×4 inch) or squares
- Sterile Dressing forceps (3)
- Sterile Scissor
- Sterile galipot
- Sterile fenestrated towel (drape)
- Spatula if ointment

Clean try

- Clean glove
- Cleaning solution (Normal Saline, Sterile 0.9% sodium chloride), chlorhexidine, povidone-iodine, and hydrogen peroxide
- Adhesive tape (Plaster)
- Bath Blanket: (if needed)
- Rubber and draw sheet
- Bandage scissors or surgical blade
- Antimicrobial Ointment: if prescribed

- Bath Blanket: (if needed)
- Screen
- Adhesive remover
- Protective apron: as the condition of the wound
- Waste Receiver (disposable plastic container)
- Chart

Procedure

| S.N | Task/Steps | Perfo rmed (2) | Partially Performed (1) | Not Performed (0) | Remark |
|-----|--|----------------------|-------------------------------|-------------------------|--------|
| 1 | Explain the procedure to the client. | | | | |
| 2 | Assemble equipment's | | | | |
| 3 | Perform hand hygiene | | | | |
| 4 | Check order for dressing change. Note whether drain is present. | | | | |
| 5 | Close door and put screen or pull curtains. To provide privacy | | | | |
| 6 | Position waterproof pad or mackintosh under the client if desired To prevent bed sheets from wetting body substances and disinfectant | | | | |
| 7 | Assist client to comfortable position that provides easy access to wound area. • Proper positioning provides for comfort. | | | | |
| 8 | Place opened, cuffed plastic bag near working | | | | |

| | | | | | |
|----|---|--|--|--|--|
| | Area. | | | | |
| 9 | Loosen tape on dressing. Use adhesive remover if necessary. If tape is soiled, put on gloves. | | | | |
| 10 | <p>1) Put on disposable gloves</p> <p>2) Removed soiled dressings carefully in a clean to less clean direction.</p> <p>3) Do not reach over wound.</p> <p>4) If dressing is adhering to skin surface, it may be moistened by pouring a small amount of sterile saline or NS onto it.</p> <p>5) Keep soiled side of dressing away from client's view</p> | | | | |
| 11 | <p>Assess amount, type, and odor of drainage.</p> <p>Wound healing process or</p> <p>Presence of infection should be documented.</p> | | | | |
| 12 | <p>1) Discard dressings in plastic disposable bag.</p> <p>2) Pull off gloves inside out and drop it in the bag when your gloves were contaminated extremely by drainage.</p> | | | | |

| | | | | | |
|----|---|--|--|--|--|
| 13 | <p>Cleaning wound:</p> <p>a. When you clean wearing sterile gloves:</p> <p>1) Open sterile dressings and supplies on work area using aseptic technique.</p> <p>2)Open sterile cleaning solution</p> <p>3) Pour over gauze sponges in place container or over sponges placed in sterile basin.</p> <p>4) Put on gloves.</p> <p>5) Clean wound or surgical incision. Clean from top to bottom or from center outward</p> <p>5) Use one gauze square for each wipe, discarding each square by dropping into plastic bag. Do not touch bag with gloves.</p> <p>Clean around drain if present, moving from center outward in a circular motion. Use one gauze square for each circular motion. When you clean using sterile forceps:</p> <p>1. Open sterile dressings and supplies on work area using aseptic technique.</p> <p>2)Open sterile cleaning solution</p> | | | | |
|----|---|--|--|--|--|

| | | | | | |
|----|--|--|--|--|--|
| | 3) Pour over gauze sponges or cottons in place container or over sponges or cottons placed in sterile basin. 4) Clean wound or surgical incision: | | | | |
| 14 | Dry wound or surgical incision using gauze sponge and same motion. Moisture provides medium for growth of microorganisms. | | | | |
| 15 | Apply antiseptic ointment by forceps if ordered. Growth of microorganisms may be retarded and healing process improved. | | | | |
| 16 | Apply a layer of dry, sterile dressing over wound using sterile forceps. | | | | |
| 17 | If drainage is present: Use sterile scissors to cut sterile 4 X 4 gauze square to place under and around drain. | | | | |
| 18 | Apply second gauze layer to wound site. Additional layers provide for increased absorption of drainage. | | | | |
| 19 | Place surgical pad over wound as outer most layer if available. Wound is protected from microorganisms in environment. | | | | |

| | | | | | |
|----|--|--|--|--|--|
| 20 | Remove gloves from inside out and discard the min plastic bag if you worn. To prevent cross-infection | | | | |
| 21 | Apply tape or existing tape to secure dressings Tape is easier to apply after gloves have been removed. | | | | |
| 22 | 1) Perform hand hygiene. 2) Remove all equipment's and disinfect them as needed. Make him. /her comfortable. | | | | |
| 23 | Document the following: 1) Record the dressing change 2) Note appearance of wound or surgical incision including drainage, odor, redness, and presence of pus and any complication. 3) Sign the chart | | | | |
| 24 | Check dressing and wound site every shift. Close observation can find any complication as soon as possible. | | | | |

Quality criteria:

Performed: performed the step or task according to the standard procedure or guidelines=2

Partially Performed: unable to perform the step or task according to the standard procedure or guidelines=1

Not Performed: step or task not performed by participant =0

| LAP Test | Practical Demonstration |
|----------|-------------------------|
|----------|-------------------------|

Name: _____

Date: _____

Time started: _____

Time finished: _____

Instruction I: Given necessary templates, tools and materials you are required to perform the following tasks within 2 hours.

Task: Perform wound care

Unit Four: Evaluate Wound Care

Instruction Sheet

This learning unit is developed to provide the trainees the necessary information regarding the following content coverage and topics:

- Client involvement
- On-going progress report
- Client progress

This unit will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, you will be able to:

- Ensure client involvement
- Report on going progress
- Discuss client progress

Unit instructions:

1. Read the specific objectives of this learning guide.
1. Follow the instructions described below.
2. Read the information written in the information sheets
3. Accomplish the self-checks

4.1 Client involvement

Patient involvement in wound care evaluation requires the right patient having access to the right services and the right information, which will give them the knowledge and confidence to make informed decisions about their own care. The level of patient involvement may affect wound healing process.

On-going progress report

The definition of ongoing is something that is still going on at the present time and that is going to continue. A progress report is a report in which you are updating information about a status of wound healing. Progress reports make it possible for nurses and clients to stay informed about a progress of wound healing and to change or adjust intervention.

When you report the progress of wound healing of the patient you have to describe of wound healing level considering characteristics of the wound bed, such as necrotic tissue, granulation tissue and infection. odor and exudate (none, low, moderate, high) condition of the surrounding skin (normal, edematous, white, shiny, warm, red, dry, scaling, thin).

Client progress/wound healing progress

For wounds healing by primary intention, key assessment factors include the approximation of wound margins (the edges of the wound fit together snugly), drainage (a closed incision should not have any drainage), evidence of infection and the presence of a palpable healing ridge along the incision by the fifth day. If the wound is discharging small amounts of pus, it is a positive sign of healing. However, if there is continuous drainage and you start noticing bad odor or have discoloration, the wound is likely infected. Pain is a normal condition after sustaining an injury. Sign of good wound healing indicates that the wound becomes slightly swollen, red or pink, and tender. You also may see some clear fluid oozing from the wound. This fluid helps clean the area. Blood vessels open in the area, so blood can bring oxygen and nutrients to the wound.

Summary

Patient involvement in wound care evaluation requires the right patient having access to the right services and the right information, which will give them the knowledge and confidence to make informed decisions about their own care.

The definition of ongoing is something that is still going on at the present time and that is going to continue. A progress report is a report in which you are updating information about a status of wound healing.

For wounds healing by primary intention, key assessment factors include the approximation of wound margins (the edges of the wound fit together snugly), drainage (a closed incision should not have any drainage), evidence of infection and the presence of a palpable healing ridge along the incision by the fifth day.

Self-Check - 4

Directions: Answer all the questions listed below.

- 4.1 Describe the client involvement process in wound care evaluation
- 4.2 Describe on ongoing progress report writing components
- 4.3 Describe progress of patient wound healing

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Developer Profile

| S.No | Name | Educational back ground | Qualification(Level) | Field of Study | Organization/ Institution | Mobile number | E-mail |
|------|--------------------|-------------------------|---|---------------------------|---------------------------|---------------|--|
| 1 | Fikre Bojola | BSc Nursing | Master in public health | Public Health | ACHS | 0924744202 | fikrebojola94@gmail.com |
| 2 | S/ r Dinkie Tadele | BSc Nursing | MSC in nursing | Clinical nurse in medical | DHSC | 0914736645 | dinkiebereded@gmail.com |
| 3 | Tesgera Begize | BSc Nursing | MSC (A) | Medical Nursing | PHSC | 0945747265 | tesgera125@gmail.com |
| 4 | Habtam Teshome | Bsc nursing | Master of Public health | MPH epidemiology | MACOHS | 0921897815 | habtamutes97@gmail.com |
| 5 | Kitesa Biresa | Health Officer | MPH | MPH in Epidemiology | ShHSC | 0902774004 | tarkitessa14@gmail.com |
| 6 | Admasu Belay | Nursing | Assistant Professor of Adult Health Nursing | Adult Health Nursing | ENA & JU | 0925270512 | admasu2004@gmail.com |



የሥራ እና ክህሎት ሚኒስቴር
MINISTRY OF LABOR
AND SKILLS



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የዜጎች ጤና ለማረጋገጥ ብልፅግና!
HEALTH FOR EVERY ETHIOPIAN NATION!