NURSING LEVEL III

NTQF III

LEARNING GUIDE#38

Unit of Competence	:	Undertake basic wound care
Module Title	:	Undertaking basic wound care
LG Code	:	**HLT NUR3 M07 LO4- LG36**
TTLM Code	:	HLT NUA3 TTLM 0919v2

LO4. Assist in evaluating the outcomes of nursing action

Instruction sheet #4	learning guide #4

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

- Involvement of client in evaluation
- Documentation and reporting

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:

- Involve Client in the evaluation process.
- Ensure Documentation records of the on-going progress .
- Discus Progress of report with a registered nurse.

Learning Instructions:

1, Read the specific objectives of this Learning Guide.

2, Follow the instructions described in number 3 to 7.

3, Read the information written in the “Information Sheets 1 and 2”. Try to understand what are being discussed. Ask you teacher for assistance if you have hard time understanding them.

Accomplish the “Self-check on page 5 .

4,Ask from your teacher the key to correction (key answers) or you can request your teacher to correct your work. (You are to get the key answer only after you finished answering the Self-check).

5, If you earned a satisfactory evaluation proceed to “Information Sheet ”. However, if your rating is unsatisfactory, see your teacher for further instructions or go back to Learning Activity.

Submit your accomplished Self-check. This will form part of your training portfolio.

6,If you earned a satisfactory evaluation proceed

- Referance on page 7

Information Sheet-1	Involvement of client in evaluation

4.1, Involvement of client in evaluation

Expected patient outcomes may include:

1. Maintains optimal respiratory function
   - **a. Performs deep-breathing exercises**
   - b. Displays clear breath sounds
   - c. Uses incentive spirometer as prescribed
   - d. Splints incision site when coughing to reduce pain
2. Indicates that pain is decreased in intensity
3. Exercises and ambulates as prescribed
   - a. Alternates periods of rest and activity
   - b. Progressively increases ambulation
   - c. Resumes normal activities within prescribed time frame
   - d. Performs activities related to self-care
4. Wound heals without complication
5. Maintains body temperature within normal limits
6. Resumes oral intake
   - a. Reports absence of nausea and vomiting
   - b. Takes at least 75% of usual diet
   - c. Is free of abdominal distress and gas pains
   - d. Exhibits normal bowel sounds
7. Reports resumption of usual bowel elimination pattern
8. Resumes usual voiding pattern
9. Is free of injury
10. Exhibits decreased anxiety
11. Acquires knowledge and skills necessary to manage therapeutic regimen
12. Experiences no complications

4.2. Ensure documentation process

Information Sheet-2	Assessment ,Documentation and reporting

Assessment , Documentation and reporting

Location

Stage and Size

Periwound

Undermining

Tunneling

Exudate

Color of wound bed

Necrotic Tissue

Granulation Tissue

Effectiveness of Treatment

Wound and Risk Assessment every visit

-Documentation on Wound Assessment Form every 7 days when 1 or more pressure ulcer exists

-Physician assessment and documentation on Physician Wounds Care Assessment tool

4.3. Report and discuss progress with registered nurse.

Nursing Responsibility

As a wound undergoes the phases of healing, many elements should be considered.

The Nurse should be assess the clients health status and address all factors which affect or help wound healing.

The Nurse should be handling all tissue care fully and evenly.

Follow guide lines for proper suturing and dressing technique.

Monitor vital signs and observe incision site for evidence of bleeding

Provide maximum protection to prevent infection

Administer proscribed treatment.

Self-Check -2	Multiple choice

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page

1, All of the following are expected patient out come except

A. Wound heals without complication

B. Maintains body temperature within normal limits

a. Resumes usual voiding pattern

D, Non of the above

2, Assessment of the wound includes

A, Location Stage and Size

B, Color of wound bed

C, Necrotic Tissue or Effectiveness of Treatment

D, All of the above

3, Which one of the following is/are nursing responsibility

3, Documentation on Wound Assessment

A. Report and discuss progress with registered nurse

B. Monitor vital signs and observe incision site for evidence of bleeding

C. All of the above

Note: **Satisfactory rating - 3 points** **Unsatisfactory - below 3 points**

Answer Sheet

Score = _____
Rating: _____

Name: _____ Date: _____

Answer

1,_____

2_____

3_____

Reference and Manuals

.

1, Maklebust, J. (1999). Wound care: **Treating pressure ulcers in the home. Home Healthcare Nurse**,17(5), 307–316.

2, World Wide Wounds:www.worldwidewounds.com

3, European Wound Management Association: www.ewma.org

4, Wound Ostomy and Continence Nurses Society: www.wocn.org

5, Federal Democratic Republic of Ethiopia Ministry of Health Ethiopian Hospital Reform Implementation Guidelines Volume 1 Ethiopian Hospital Management Initiative March 2010,Version 1.0

6, Suzanne C. O'Connell Smeltzer, & Brenda G. Bare. (2004). Brunner and Suddarth's Text Book of Medical-Surgical Nursing. 10th Edition: Lippincott Williams and Wilkins. Pp 249-282.

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