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Wound Care and Dressing

Nursing Foundation

Types of wounds, wound healing, wound assessment, dressing techniques, wound irrigation, drainage systems, suture care and prevention of wound infection.

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CHAPTER 18

CHAPTER 18 Wound Care and Dressing

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Wounds and classifications

A wound is disruption of skin, mucosa or deeper tissue integrity. Types: incision (clean cut), laceration (tear), abrasion (superficial scraping), puncture (penetration), contusion (closed bruising), avulsion (tissue torn away), ulcer and pressure injury. Classify acute/chronic, open/closed, and surgical contamination (clean, clean-contaminated, contaminated, dirty/infected).

Healing

Four overlapping stages: haemostasis (clotting), inflammation (immune response), proliferation (granulation, angiogenesis, epithelialization and contraction), maturation/remodelling (collagen reorganization). Primary intention: approximated edges; secondary: open wound heals by granulation/contraction; tertiary: delayed primary closure. Factors: circulation, infection, glucose control, nutrition, smoking, pressure, trauma, immune status and medication.

Assessment and dressing types

Assess location, dimensions/depth, wound bed, edge, surrounding skin, exudate, pain, odour, tunnelling when indicated and infection signs. Use consistent measurement and approved documentation.

Dressing	Typical application
Gauze/non-adherent	Selected coverage, absorption or fragile tissue protection.
Foam	Moderate to higher exudate.
Hydrocolloid	Selected low-to-moderate exudate wounds.
Hydrogel	Selected dry wounds.
Alginate	More heavily exuding wounds.
Transparent film	Selected superficial wounds and protection.
Antimicrobial	Specific indications following care plan.

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Dressing procedure and irrigation

Verify order/care plan, identify patient and assess pain, explain and provide privacy, prepare articles and hand hygiene. Remove old dressing with appropriate PPE, assess wound, create clean or sterile field according to wound/procedure, cleanse with prescribed solution and technique (sterile saline commonly used), protect healthy tissue, apply selected dressing and secure without impairing circulation. Dispose of waste, reassess comfort and document. Irrigation removes loose debris with appropriate solution and controlled pressure; avoid routine cytotoxic cleansers unless indicated.

Drains, sutures and complications

Drains include Penrose and closed-suction systems (e.g. Jackson-Pratt). Assess insertion site, output, colour, patency and prescribed suction; secure and maintain system; do not routinely strip. Observe sutures/staples and wound edges; remove only with authorization and appropriate training. Complications: infection (increasing pain, spreading erythema, purulent discharge or systemic signs), haematoma, seroma, dehiscence, evisceration and delayed healing. Evisceration: activate urgent response, protect exposed tissue with sterile saline-moistened dressing if available and do not push organs back.

Nursing responsibilities and exam revision

Prevent infection with aseptic technique, promote nutrition and pressure relief, educate on wound care and warning signs; track healing and escalate deterioration.

1. 1. Explain wound types, healing phases and influencing factors.
2. 2. Describe dressing and irrigation principles.
3. 3. Discuss wound drainage, sutures, infection and complications.

Educational notes. Clinical skills require supervision, authorized orders and current facility protocols.

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Quick Revision

- Wounds may be classified by tissue injury, duration, openness and surgical contamination.

- Healing phases overlap: haemostasis, inflammation, proliferation and maturation/remodelling.

- Primary intention uses approximated edges, secondary uses granulation and contraction and tertiary is delayed primary closure.

- Assess wound dimensions, depth, bed, edges, surrounding skin, exudate, pain and infection signs.

- Choose dressings according to wound needs: foam for moderate/higher exudate, hydrogel for selected dry wounds and alginate for heavier exudate.

- Use the prescribed cleansing technique and dressing, assess drains and escalate infection, dehiscence or evisceration.

Practice questions

Choose one best answer. The answer key and explanations follow the questions.

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1. Which healing phase includes granulation, angiogenesis and epithelialization?

A. Haemostasis

B. Proliferation

C. Maturation

D. Inflammation

2. A wound with approximated edges heals by which intention?

A. Secondary

B. Tertiary

C. Primary

D. Delayed primary only

3. Which dressing is listed for selected dry wounds?

A. Alginate

B. Foam

C. Transparent film

D. Hydrogel

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Answer key and explanations

1. B - Proliferation

These processes occur in the proliferative phase.

2. C - Primary

Primary intention involves approximated wound edges.

3. D - Hydrogel

Hydrogels are listed for selected dry wounds.

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