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Wound dressing and healing Initial assessment

Nursing Foundation | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

47-year-old woman with a healing surgical wound. Care stage: At the first supervised assessment.

Medical history: A surgical wound is being followed during recovery. The patient was previously independent and is learning the prescribed dressing plan. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: The current episode includes a surgical wound requiring follow-up. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Local tenderness and uncertainty about changing the dressing.

Objective findings and required checks: Wound edges and exudate require documented assessment; no systemic instability in this scenario.

Physical examination and investigations: Assess wound dimensions, tissue, drainage, pain and infection signs; review glucose or cultures when indicated.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Wound dressing and healing: Healing depends on tissue perfusion, protection from contamination and adequate nutrition.

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Medical / surgical management

Use the prescribed dressing and aseptic technique, protect surrounding skin and address healing barriers.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed analgesic	Support comfortable wound care	Assess timing and effect
prescribed antimicrobial	Treat clinically diagnosed infection when indicated	Check allergy and response rather than routine use.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Local tenderness and uncertainty about changing the dressing. Wound edges and exudate require documented assessment; no systemic instability in this scenario. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize skin damage or vulnerability to pressure-related injury; pain interfering with rest or activity; vulnerability to infection or worsening infection; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Use the prescribed dressing and aseptic technique, protect surrounding skin and address healing barriers. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about discomfort, usual mobility and ability to reposition. Assess: Inspect skin, pressure points, wound characteristics and moisture exposure.	Skin damage or vulnerability to pressure-related injury. Possible factors: pressure, moisture, impaired sensation or tissue injury. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Skin is protected and existing damage shows no avoidable deterioration. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates the individualized skin-protection plan.	1. Assess skin and pressure risk using the local tool and clinical judgment. Rationale: Risk identification guides targeted prevention. 2. Individualize repositioning, heel offloading and pressure redistribution. Rationale: Reducing sustained pressure and shear protects tissue perfusion. 3. Use appropriate wound care and moisture management; refer for nutrition or specialist advice when needed. Rationale: Healing requires local protection and support for underlying contributors. 4. Use the prescribed dressing and aseptic technique, protect surrounding skin and address healing barriers. Rationale: Healing depends on tissue perfusion, protection from contamination and adequate nutrition. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about pain site, onset, severity, quality and the patient's acceptable pain level. Assess: Observe guarding, expression and effect on movement; use an appropriate pain scale.	Pain interfering with rest or activity. Possible factors: tissue irritation, injury or the underlying condition. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Pain decreases toward the patient-agreed target after reassessment. Longer-term: Before the clinically approved transition or agreed follow-up: Uses agreed comfort strategies and explains when new or worsening pain needs review.	1. Assess pain and associated red flags before and after treatment. Rationale: Changing pain may signal a complication and helps evaluate relief. 2. Provide comfortable positioning, reassurance and appropriate non-drug measures. Rationale: Comfort measures can reduce distress and complement prescribed treatment. 3. Give prescribed analgesia and monitor sedation, breathing and other adverse effects. Rationale: Relief should improve function without creating medication-related harm.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about exposure, wound symptoms and recent invasive devices. Assess: Inspect relevant sites and monitor systemic findings and investigation trends.	Vulnerability to infection or worsening infection. Possible factors: disrupted barriers, exposure or reduced host defence. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Aseptic care is maintained and any new signs of infection are escalated promptly. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates relevant hygiene and explains the infection-prevention plan.	1. Use hand hygiene and risk-based standard or transmission precautions. Rationale: Interrupting transmission protects the patient, staff and other patients. 2. Review invasive device need with the team and maintain indicated aseptic care. Rationale: Unnecessary devices and barrier breaks increase infection exposure. 3. Monitor for systemic deterioration and administer prescribed antimicrobials on schedule. Rationale: Early escalation and timely indicated treatment reduce avoidable harm.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach dressing protection, hand hygiene, nutrition and the wound review schedule. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach dressing protection, hand hygiene, nutrition and the wound review schedule.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Spreading redness, increasing pain, wound separation, heavy bleeding or systemic illness needs urgent review.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Healing depends on tissue perfusion, protection from contamination and adequate nutrition.

- Priority concerns: Skin damage or vulnerability to pressure-related injury; Pain interfering with rest or activity; Vulnerability to infection or worsening infection; Learning needs about the condition and care plan.

- Spreading redness, increasing pain, wound separation, heavy bleeding or systemic illness needs urgent review.

- Teach dressing protection, hand hygiene, nutrition and the wound review schedule.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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