Wound Care

Evidence-based recommendations for wound assessment, treatment & documentation

1. Initial Assessment

Before treating any wound, evaluate:

- Type of wound: surgical, traumatic, pressure injury, diabetic ulcer, venous ulcer, burn, etc.
- Size and depth: length × width × depth
- Wound bed: percentage of granulation tissue, slough, or necrotic tissue
- Drainage: amount, color, and odor
- Surrounding skin: redness, swelling, maceration, or breakdown
- Pain level
- Signs of infection: increasing redness, warmth, swelling, pain, purulent drainage, fever, or other systemic symptoms

2. Wound Cleansing

Recommended

- Clean wounds with normal saline or potable water
- Irrigate gently to remove debris and reduce bacterial burden
- Clean from the least contaminated area toward the most contaminated area

Avoid Routine Use Of

- Hydrogen peroxide
- Full-strength povidone-iodine (Betadine)
- Alcohol

These agents may damage healthy tissue and delay wound healing.

3. Debridement

Debridement may be indicated when necrotic tissue or slough is present. Methods include:

- **Autolytic**: moisture-retentive dressings
- **Mechanical**: irrigation or specialized techniques
- **Enzymatic**: prescribed topical agents

- **Sharp/Surgical**: performed by qualified clinicians

> **Important:** Do not debride stable, dry eschar on an ischemic heel unless directed by a wound care specialist or qualified provider.

4. Maintain a Moist Healing Environment

Modern wound care supports **moist — not wet —** healing. Benefits include:

- Faster healing
- Reduced pain
- Improved cellular activity
- Decreased scarring
- Enhanced tissue regeneration

5. Dressing Selection

Dry wound	Hydrogel
Minimal drainage	Hydrocolloid
Moderate drainage	Foam dressing
Heavy drainage	Alginate or Hydrofiber
Infected wound	Antimicrobial dressing (per protocol)
Deep cavity	Appropriate packing material

Dressings should be selected based on wound characteristics and changed according to manufacturer recommendations, facility protocols, and clinical judgment.

6. Infection Prevention and Monitoring

Monitor for:

- Increasing redness, swelling, and warmth
- Purulent drainage and malodor
- Delayed healing
- Fever or systemic symptoms

Use systemic antibiotics only when clinically indicated and prescribed by an authorized healthcare provider.

7. Protect Periwound Skin

Prevent moisture-associated skin damage by:

- Using skin barrier products
- Managing wound drainage effectively
- Minimizing adhesive-related skin injury
- Keeping surrounding skin clean and dry

8. Support Healing

Optimize factors that promote wound healing:

- Adequate nutrition and hydration
- Sufficient protein and caloric intake
- Blood glucose management for diabetic patients
- Smoking cessation
- Adequate circulation and oxygenation
- Pressure redistribution and offloading when indicated

9. Documentation

Document the following at each assessment:

- Date and time
- Wound measurements
- Tissue type and wound bed appearance
- Drainage amount and characteristics
- Dressing and treatment provided
- Pain assessment
- Signs of infection
- Patient response to treatment

Photographs may be utilized in accordance with facility policies and patient consent requirements.

10. When to Escalate Care

Seek advanced wound care evaluation for:

- Wounds not improving within 2–4 weeks
- Exposed tendon, muscle, or bone
- Suspected osteomyelitis
- Diabetic foot ulcers
- Arterial ulcers
- Significant infection
- Rapidly deteriorating wounds
- Complex or non-healing wounds

Key Principle: Cleanse → Debride when appropriate → Maintain moisture balance → Prevent infection → Protect surrounding skin → Address underlying causes of delayed healing.