



WOUND CARE

Proper wound care is necessary to prevent infection, ensure there are no other associated injuries, and promote healing of the skin.



WOUND TYPES

- **Wound:** Injury to the skin that can range from a minor scrape or blister to a gunshot that damages tissue and organs underneath the skin.
- Each type of wound is treated differently depending on the cause, symptoms, and risks. Some wounds:
 - Heal quickly with minimal care
 - Are chronic and resistant to healing
- All wounds require monitoring and cleaning to prevent infection-causing germs from entering the skin. If improperly managed, even superficial wounds can:
 - Become infected
 - Heal at a slow pace
 - Result in unnecessary scarring

GENERAL WOUND TYPES

- Laceration
- Surgical incision
- Abrasion
- Puncture
- Burn
- Pressure injury
 - Diabetic ulcer
 - Neurovascular ulcer
 - Venous ulcer
 - Arterial wound



ACUTE VS. CHRONIC WOUNDS

- **Acute:** A.k.a. **traumatic wounds** because the skin breaks or puncture occurs suddenly.
 - A new acute wound typically heals within a predicted amount of time.
 - A wound is acute if it occurred in the last 4–6 weeks.
- **Chronic:** Wounds that fail to heal within the expected time frame due to improper care and hygiene or complications including poor blood supply, oxygen, and nutrients.
 - Chronic wounds can persist for months and return after initial healing.
 - Arterial, diabetic, pressure, and venous wounds in the lower extremities are the most common chronic wounds.

ASSESSING THE WOUND

Determine the appropriate management and treatment strategies. Failing to assess a wound correctly can cause delays in healing, patient discomfort, increased infection risk, and inappropriate wound dressings.

WOUND BED PREPARATION

Some health care professionals find it helpful to use the acronym **TIME** for wound assessment, developed by the International Advisory Board on wound bed preparation.

- **Tissue:** Is it viable or nonviable? Is debridement needed to remove necrotic tissue?
- **Infection (or inflammation):** Are antimicrobials or antibiotics necessary?
- **Moisture balance:** What wound fluid/exudate is present?
- **Epithelial edge advancement:** Is the wound area still advancing after treatment?

ASSESSMENT CONSIDERATIONS

- **Is the wound clean or contaminated?** Any dirt, gravel, glass, metal, sand, or other debris need to be cleaned from the wound.
- **Depth:** The skin has three main layers. Care of the wound depends on how many layers of tissue have been damaged by the injury.
 1. **Epidermis:** Surface layer of the skin.
 2. **Dermis:** Much thicker second layer of the skin.
 3. **Subcutaneous fat:** Bottom layer of the skin.
- Wounds may be classified as:
 - **Partial thickness:** Wounds with damage limited to the epidermal and/or dermal layers.
 - **Full thickness:** Wounds with deeper damage evident in the subcutaneous layers and below.
- **Wound size:** A wound is measured by its length times the widest part of the wound.
 - Measure from the deepest point of the wound to the surface using a sterile cotton-tip applicator moistened with saline solution or sterile water.
 - For circular wounds, multiply the longest diameter at right angles.
- **Tissue types:** Wound tissue provides clues about the healing stage. Any nonviable or deficient tissue (slough and eschar) delays healing unless removed. Tissue can be assessed by color.
 - **Epithelial:** New tissue that is light pink and is healing properly.
 - **Granulation:** Healthy tissue that is bright red, firm, and shiny. Dark red tissue or bleeding may indicate infection.
 - **Slough:** Stringy, dead tissue that is usually yellow and separating from the lesion.
 - **Eschar:** Nonviable tissue that is black, brown, or tan in color and often crusty.
- **Moisture:** Both the volume and composition of exudate in chronic wounds can impact healing and determine the best dressing to use to achieve an ideal moisture balance.
- **Infection:** Identify any signs or symptoms of infection, which can include a foul odor, swelling (edema), severe pain, increased redness, and purulent discharge.
 - Taking a wound swab can identify the bacteria type for therapy.
- **Pain:** The presence and intensity of pain may influence treatment recommendations.

- Pain may be classified as neuropathic, isotropic, or anticipatory.
- The degree of pain may not correlate to the seriousness of the injury.

FIRST AID TO STOP SEVERE BLEEDING

Stopping the bleeding is the first step for any serious open wound.

Call 911 or seek emergency care for severe bleeding that you can't control, large wounds that need sutures, serious burns, and animal bites. For immediate care:

1. **Wash hands thoroughly** and wear gloves if available.
 2. **Clear the wound** of clothing or debris, but don't probe or clean the wound while it is bleeding, or try to remove deeply embedded objects.
 3. **Apply pressure** by pressing firmly over the wound with a thick, sterile bandage or clean cloth until the bleeding stops.
 4. **Add a second bandage** on top if bleeding seeps through. Don't remove the gauze or bandage.
 5. **Help the injured person lie down** on a rug or blanket if available.
 6. **Elevate the injury** until the bleeding stops. Raise the injured limb above the level of the heart if possible.
 7. **Keep the injured body part immobile.** Secure the bandage with tape.
- A tetanus shot is needed if the injured person hasn't had one in the last five years.

GENERAL WOUND CARE IF BLEEDING IS CONTROLLED

CLEANING THE WOUND

- Rinse acute wounds with warm tap water and soap.
- Remove any lingering dirt or debris with swabs saturated with alcohol.
 - Disinfect the skin around the wound with antiseptic; avoid getting it inside the wound.
 - Don't use hydrogen peroxide or iodine, which can damage tissue.
- Flush with saline solution only if the wound is open and contaminated.
- If the wound is still not clean, surgical debridement may be needed to remove

debris or dead tissue. See **Debridement under Chronic Wounds**, p. 5, for more information.

APPLYING A TOPICAL ANTIMICROBIAL

- Apply a thin layer of bacitracin or ointment containing it (e.g., Neosporin or Polysporin) or petroleum jelly.
- A moist surface helps prevent infection, reduce pain, and promote healing.

PACKING THE WOUND

- If the wound is deep, the empty space needs packing.

- Use saline and an alginate, hydrofiber, or hydrogel-impregnated dressing.
- Packing material should be easy to remove from the wound base to facilitate dressing changes.

CLOSING OPEN WOUNDS

Primary Closure

Close open wounds within six hours to prevent infection by pulling the edges together to cover any exposed tissue or using:

- Skin adhesive strips for minor wounds if the infection risk is low
- Tissue adhesive glue for small cuts

- Staples for certain wounds to the scalp, neck, arms, legs, torso, and buttocks.
- Sutures (stitches) if the cut is:
 - Wide or deep
 - Longer than ½ in. on the body
 - Longer than ¼ in. on the face
 - In a location prone to flexion, tension, or trauma
- Skin grafting (taking healthy skin from another part of the body) for wounds that are difficult to close using staples or sutures

Note: Sutures and adhesive strips may be removed 10–14 days after a wound is closed.

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