WOUND CARE PROTOCOL:

STEP-ONE:

1. Initial Assessment Patient Identification Verify patient identity using two identifiers (e.g., name and date of birth). Medical History Review Review patient's medical history, including allergies, medications, and past medical conditions that may affect wound healing (e.g., diabetes, vascular diseases). Wound Assessment Location: Document the anatomical location of the wound. Size: Measure the length, width, and depth of the wound. Type: Identify the type of wound (e.g., surgical, pressure ulcer, laceration). Appearance: Note the color, presence of necrotic tissue, granulation tissue, and exudate. Odor: Assess for any unusual odor that may indicate infection. Surrounding Skin: Inspect the skin around the wound for redness, swelling, or other signs of infection.

STEP2:

2. Cleaning the Wound Hand Hygiene Perform hand hygiene before and after wound care using soap and water or an alcohol-based hand sanitizer. Personal Protective Equipment (PPE) Wear appropriate PPE (e.g., gloves, gown, mask) to protect against exposure to blood and body fluids. Remove Old Dressing Carefully remove the old dressing and dispose of it in a biohazard container. Inspect the dressing for any signs of infection (e.g., increased exudate, odor). Clean the Wound Use sterile saline or an appropriate wound cleanser to irrigate the wound gently. Avoid using harsh antiseptics unless specifically ordered by a healthcare provider.

STEP3:

3. Debridement (if necessary) Types of Debridement Autolytic: Using dressings that maintain a moist environment. Enzymatic: Applying topical agents that break down necrotic tissue. Mechanical: Using tools (e.g., gauze) to remove dead tissue. Surgical: Performed by a healthcare provider. Procedure Follow the specific method of debridement as ordered by the healthcare provider. Ensure pain management is provided if necessary.

STEP4:

4. Dressing the Wound Select Dressing Type Choose the appropriate dressing based on the wound type, exudate level, and healthcare provider's orders (e.g., hydrocolloid, foam, alginate). Application Apply a sterile dressing to cover the wound. Secure the dressing with tape or a secondary dressing as needed. Ensure the dressing provides a moist wound environment but does not macerate the surrounding skin.

STEP5:

5. Documentation Record Keeping Document the date and time of wound care. Note the wound assessment findings, including size, appearance, and any changes. Record the type of dressing applied and any patient responses or complaints.

STEP6:

6. Patient Education Instructions Educate the patient on wound care at home if applicable. Provide instructions on signs of infection and when to seek medical attention. Advise on the importance of nutrition and hydration for wound healing. Follow-up Schedule follow-up appointments as needed for ongoing wound assessment and care.

STEP7:

7. Infection Control Signs of Infection Monitor for increased redness, swelling, warmth, pain, or purulent discharge. Report any signs of systemic infection (e.g., fever, malaise) to the healthcare provider immediately. Antibiotic Therapy Administer antibiotics as prescribed and monitor for effectiveness and adverse reactions.

STEP8:

8. Pain Management Assessment Assess the patient’s pain level before, during, and after wound care. Interventions Administer pain medication as prescribed. Utilize non-pharmacological pain relief methods (e.g., relaxation techniques).