Chapter 22

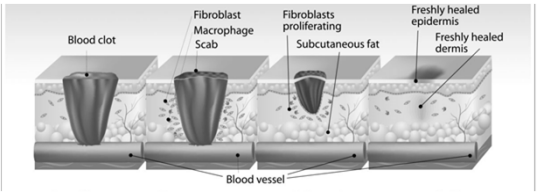
Surgical Wound Care

Lesson 22.1

1. Discuss the body's response during each stage of wound healing.
2. Discuss the role of nutrition in wound healing.
3. Identify common complications of wound healing.
4. Differentiate between healing by primary intention and healing by secondary intention.
5. Discuss the classification of wounds according to the Centers for Disease Control and Prevention.
6. Discuss the factors that impair wound healing and the interventions for each type of wound.
7. Explain procedure for applying dry dressings and wet-to-dry dressings.

Phases of Wound Healing

- Homeostasis
- Inflammatory phase
- Reconstruction phase
- Maturation phase

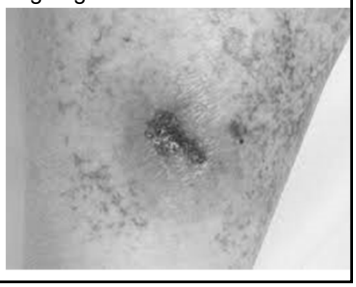


Nutrition

- Nutritional needs
- Fluids
- Rest and activity

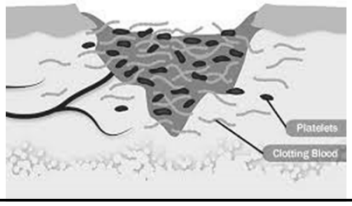
Complications of Wound Healing

- Impaired wound healing requires accurate observation and ongoing interventions
- Wound bleeding
- Wound infection



Process of Wound Healing

- Primary intention
- Secondary intention
- Tertiary intention



Wound Classifications

- Cause
- Severity of injury
- Amount of contamination
- Size
- CDC has classified surgical wounds from class I (clean) to class IV (dirty, infected)

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Surgical Wound Care

- Selection of the site
- Standard steps in care
- Care of incision

Dressings

- Dry dressings
  - May be chosen for management of a wound with little exudate/drainage
- Wet-to-dry dressing
  - Primary purpose is to mechanically débride a wound
  - As the dressing dries, it adheres to the wound and débrides it when the dressing is removed
- Transparent dressings
  - Self-adhesive transparent film is a synthetic permeable membrane that acts as a temporary secondary skin

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Lesson 22.2

8. Discuss dehiscence and evisceration and the nursing care they involve.
9. Identify the procedure for removing sutures and staples.
10. Discuss care of the patient with a wound drainage system: Hemovac or Davol suction or T-tube drainage.
11. Identify the procedure for performing sterile wound irrigation.
12. Identify the nursing interventions for the patient with vacuum-assisted closure of a wound.
13. Describe the purposes of bandages and binders and the precautions taken when applying them.
14. List nursing diagnoses associated with wound care.

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Dehiscence

- Wound layers separate
- Patient may say that something has "given way"
- It may result after periods of sneezing, coughing, or vomiting
- It may be preceded by serosanguineous drainage
- Patient should remain in bed and receive nothing by mouth, be told not to cough, and be reassured
- The nurse should place a warm, moist sterile dressing over the area until the provider evaluates the site

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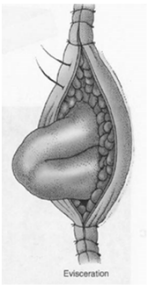
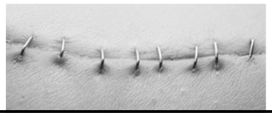
Evisceration

- Abdominal organs protrude through an opened incision
- Patient is to remain in bed, and the wound and contents should be covered with warm, sterile saline dressings
- The surgeon is notified immediately
- This is a medical emergency, and the wound requires surgical repair



Staples and Sutures

- The surgeon's goal is to enter the cavity involved, repair the injured or diseased area, and minimize trauma as quickly as possible
- Many options are available to the surgeon for closing the surgical incision
- Sutures and staples are generally removed within 7 to 10 days after surgery, or sooner if healing is adequate
- The provider determines and orders removal of sutures or staples one at a time or removal of every other suture or staple and replacement with a Steri-Strip as the first phase, with the remainder removed in the second phase



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Exudate and Drainage

- Serous
- Sanguineous
- Serosanguineous
- If the tissue is infected, exudate/drainage may be brown-green purulent
- Exudate/drainage from organs has its own particular color (bile from the liver and gallbladder is green-brown)
- Assess color, amount, consistency, and odor

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Drainage Systems

- They are used in procedures in which organs were removed or repaired
- Requires close monitoring
- Closed drainage
- Open drainage
- Suction drainage

Wound Irrigations

- Wound cleansing and irrigation is accomplished using sterile or clean technique
- Cleansing solution is introduced directly into the wound with a syringe, syringe and catheter, shower, or whirlpool
- Fluid retention is avoided by positioning the patient on his or her side to encourage the flow of the irrigant away from the wound
- Promote wound healing through removing debris from a wound surface, decreasing bacterial counts, and loosening and removing eschar
- Cleanse in a direction from the least contaminated area to the most contaminated area

Wound Vacuum-Assisted Closure

- Uses negative pressure to remove fluid from surrounding the wound

Bandages and Binders

- After a bandage is applied, the nurse should
  - Assess, document, and immediately report changes in circulation, skin integrity, comfort level, and body function such as ventilation or movement
  - Loosen or readjust as necessary
  - Have an order to remove or loosen a dressing applied by a provider
  - Explain to the patient that any bandage or binder feels relatively firm or tight
  - Assess to be sure it is properly applied and is providing therapeutic benefit; soiled bandages should be replaced

Nursing Process

- Nursing diagnoses
  - Impaired skin integrity
  - Imbalanced nutrition: more than body requirements
  - Imbalanced nutrition: less than body requirements
  - Ineffective tissue perfusion (specify type)