NURSING QUICK REFERENCE: WOUND CARE BASICS

Provided by Singh Wound Care | Dr. Singh, MD *Mobile Physician Services • (833) WOUNDOC*

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1. THE "T.I.M.E." ASSESSMENT

Assess these 4 factors every time you change a dressing.

- **T = Tissue:** What does the wound bed look like?
    - *Pink/Red:* Healthy granulating tissue (Good).
    - *Yellow/Tan:* Slough (Needs cleaning/debridement).
    - *Black/Brown:* Eschar (Dead tissue).
- **I = Infection:** Check for redness (cellulitis), heat, swelling, or foul odor.
- **M = Moisture:**
    - *Dry:* Needs hydration (Hydrogel).
    - *Moist:* Ideal healing environment.
    - *Wet:* Heavily draining/Macerated (Needs absorption/Foam).
- **E = Edge:** Are edges closing (migrating) or rolled/stalled?

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2. MEASURING WOUNDS (The Clock Method)

Always measure in Centimeters (cm). Length x Width x Depth.

- **Head = 12:00** | **Feet = 06:00**
- **Length:** Measure from 12:00 to 06:00.
- **Width:** Measure from 09:00 to 03:00.
- **Depth:** Insert sterile applicator into the deepest part of the bed.

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3. PRESSURE INJURY STAGING

- **Stage 1:** Redness that does *not* turn white when pressed (Non-blanchable). Skin intact.
- **Stage 2:** Partial skin loss. Looks like a blister or shallow abrasion. Pink bed.

- **Stage 3:** Full thickness loss. Fat is visible.
- **Stage 4: Bone, tendon, or muscle is visible.**
- **Unstageable:** Covered in yellow slough or black eschar (cannot see the bottom).
- **Deep Tissue Injury (DTI):** Purple/Maroon discolored area of intact skin (looks like a deep bruise).

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4. THE GOLDEN RULES OF DRESSING

1. **If it's WET -> DRY it.** (Use Alginates, Foams, or ABD pads).
2. **If it's DRY -> WET it.** (Use Hydrogels or Hydrocolloids).
3. **Protect the Skin:** Always apply barrier film/cream to the skin *around* the wound to prevent maceration.
4. **Do Not Scrub:** Granulation tissue (red/bumpy) is fragile. Cleanse gently.

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Do not wait for weekly rounds if you see:

- **Sudden Infection:** Fever, spreading redness, or new foul odor.
- **Decline:** Wound significantly increases in size overnight.
- **Bone Exposure:** If you can probe bone (Risk of Osteomyelitis).
- **No Progress:** Wound has not improved in 2 weeks.