

NGN NCLEX CLINICAL JUDGMENT SERIES • FUNDAMENTALS • WOUND CARE & SKIN INTEGRITY

WOUND CARE: CLEANSING, DRESSING & ASSESSMENT

Wound cleansing techniques, dressing change procedure, wound bed color assessment (RYB), dressing type selection, and infection monitoring.

CRITICAL: INFECTION SIGNS

WOUND ASSESSMENT

HEALING INDICATORS

COMPLICATIONS

PATIENT EDUCATION

RYB

WOUND COLOR

CLEAN

→ COVER → HEAL

LEGEND ● Critical / Infection ● Assessment / Mechanism ● Healing / Expected ● Complications ● NCLEX Trap ● Dressing / Procedure ● Patient Education

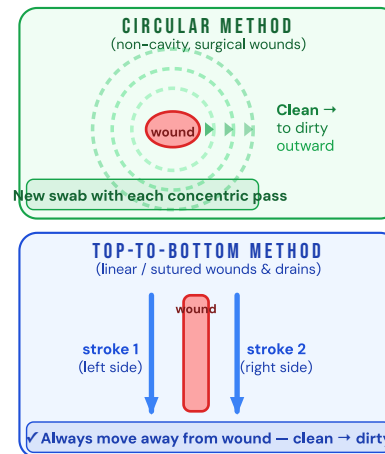
WOUND BED ASSESSMENT & CLEANSING TECHNIQUE

RYB WOUND COLOR ASSESSMENT



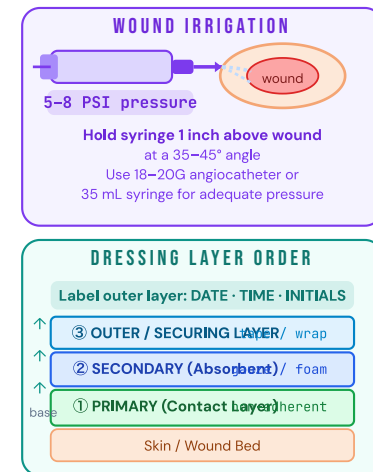
Mixed wounds: treat the most restrictive color present
 Black → Yellow → Red progression = healing

WOUND CLEANSING TECHNIQUE



Golden Rule: Always cleanse from the *least contaminated* area to the *most contaminated* area — center outward / top downward.
 Use normal saline or prescribed solution. Never reuse a swab or gauze on the same pass.

IRRIGATION & DRESSING LAYERS



Irrigation PSI rule: <4 PSI = too gentle (won't remove debris) · 5–8 PSI = optimal · >15 PSI = tissue damage risk

DRESSING CHANGE PROCEDURE & DRESSING TYPE SELECTION

DRESSING CHANGE — STEP-BY-STEP

1 Gather Supplies & Perform Hand Hygiene

Wash hands before and after. Gather: gloves (clean + sterile), dressing supplies, cleansing solution, tape, label. Verify order for dressing type.

CLEAN gloves to **REMOVE** old dressing

2 Remove Old Dressing

Stabilize surrounding skin; remove dressing toward wound (not away). Note the amount, color, odor, and consistency of drainage on the old dressing before discarding.

ASSESS exudate — document in detail

3 Assess the Wound

Assess size (length × width × depth), wound edges, wound bed color (R-Y-B), periwound skin, presence of undermining/tunneling, and drainage characteristics.

4 Change to Sterile Gloves & Cleanse

Apply sterile gloves. Cleanse with prescribed solution (usually NS). Use circular or top-to-bottom technique — always **clean** → **dirty**. New swab with each pass.

5 Apply Primary, Then Secondary Dressing

Apply contact/primary layer first, then absorbent secondary layer. Secure with tape or wrap. Ensure dressing lies flat, covers entire wound, and is not too tight.

6 Label & Document

Label outer dressing with **date, time, and initials**. Document wound assessment, dressing type applied, patient response, and any changes from prior assessment.

DATE • TIME • INITIALS required every change

DRESSING TYPE SELECTION GUIDE

DRESSING TYPE	BEST USED FOR	NCLEX NOTE
Normal Saline Gauze (wet-to-damp)	Yellow/necrotic wounds; promotes autolytic debridement; keeps wound moist	DEBRIDE Remove when damp — not dry (wet-to-dry is discouraged; causes trauma)
Transparent Film (Tegaderm)	Superficial, low-exudate wounds; stage I–II pressure injuries; IV sites	MONITOR Allows visual inspection without removal
Hydrocolloid (DuoDerm)	Partial-thickness wounds; low–moderate exudate; promotes autolysis	CHANGE Change when edges lift or fluid accumulates; expect yellow gel under dressing
Foam Dressing	Moderate–heavy exudate; pressure injuries; donor sites	ABSORB High absorbency; change when saturated
Alginate	Heavy exudate; deep wounds; tunneling; hemostatic properties	HEAVY EXU Forms gel on contact with exudate; do NOT use on dry wounds
Hydrogel	Dry wounds; painful wounds; burns; promotes moisture	HYDRATE Adds moisture — contraindicated in heavily exuding wounds
Antimicrobial (Silver/Iodine)	Infected or high-infection-risk wounds; chronic wounds	INFECTION Silver/iodine impregnated; used short-term; biofilm disruption

EXPECTED VS CRITICAL WOUND FINDINGS

✓ EXPECTED / HEALING WOUND FINDINGS

- ▶ Wound edges approximating (closing) with each assessment
- ▶ Granulation tissue: beefy-red, moist, granular texture — healing progressing
- ▶ Clear or straw-colored serous drainage — normal in early healing
- ▶ Serosanguineous drainage (pink-tinged) in first 48–72 hours post-op
- ▶ Mild periwound erythema within 1–2 cm of wound edges — inflammatory phase
- ▶ Wound decreasing in size, depth, and exudate volume over time
- ▶ Epithelialization (new pink skin forming) at wound margins
- ▶ Minimal discomfort during cleansing; wound bed responds to treatment
- ▶ Dressing absorbs expected amount of drainage for wound type

✗ CRITICAL / INFECTION / DETERIORATION FINDINGS

- ▶ Purulent (yellow/green/thick) drainage with or without odor = INFECTION
- ▶ Wound increasing in size, depth, or undermining = deteriorating
- ▶ Fever, ↑WBC, ↑HR, ↑RR = systemic infection/sepsis from wound
- ▶ Periwound erythema spreading beyond 2 cm; warmth; induration = cellulitis
- ▶ Malodorous wound — anaerobic or gram-negative infection
- ▶ Tunneling/undermining not previously documented — notify provider
- ▶ Dehiscence (wound edges separating) — cover with moist NS gauze; call provider
- ▶ Evisceration (organ protrusion) — cover with moist NS towel; Trendelenburg; call 911/STAT
- ▶ Sudden increase in drainage or change in drainage color/character

WOUND DRAINAGE ASSESSMENT TABLE

WOUND DRAINAGE & EXUDATE ASSESSMENT — NCLEX SIGNIFICANCE

DRAINAGE TYPE	APPEARANCE	CLINICAL MEANING	NCLEX SIGNIFICANCE
Serous	Clear, watery, pale yellow	Normal inflammatory response; plasma-like fluid	EXPECTED Normal early wound healing — no intervention needed
Serosanguineous	Pink-tinged, thin, watery	Mix of serum and RBCs; common post-op days 1–3	EXPECTED Normal in early post-op period; reassess if persists
Sanguineous	Bright red, bloody	Active bleeding; RBCs present in drainage	URGENT Significant volume = hemorrhage; apply pressure, notify provider
Seropurulent	Cloudy, thin, yellow-white	Early infection; WBCs entering wound	URGENT Early infection sign — culture wound; increase monitoring
Purulent	Thick, opaque, yellow/green/brown	Established infection; bacterial byproducts and dead WBCs	CRITICAL Collect culture; antibiotics likely needed; notify provider
Malodorous Purulent	Foul-smelling, thick, discolored	Anaerobic or polymicrobial infection; possible necrosis	CRITICAL High sepsis risk — systemic signs may develop

PRIORITY INTERVENTIONS & IF → THEN RULES

PRIORITY NURSING ACTION LADDER

- Assess for Infection / Systemic Compromise**
Fever + purulent drainage + ↑WBC = infection/sepsis risk — highest priority. Airway/circulation assessments precede wound care.
- Manage Dehiscence or Evisceration**
Dehiscence: moist NS cover, notify. Evisceration: moist NS towel, Trendelenburg, call provider STAT — life-threatening.
- Perform Wound Cleansing with Correct Technique**
Clean to dirty, appropriate pressure (5–8 PSI), new swab each pass. Prevents cross-contamination and further infection.
- Select & Apply Appropriate Dressing**
Match dressing to wound characteristics (exudate level, wound bed color, depth). Label every dressing change.
- Document Complete Wound Assessment**
L × W × D, wound bed color, drainage type/amount, periwound skin, pain, and any changes from previous assessment.

IF → THEN CLINICAL DECISION RULES

- IF** Evisceration occurs (organ protruding from wound) → **THEN** cover with sterile moist NS towel/saline-soaked gauze; position Trendelenburg with knees flexed; call provider STAT; NPO — surgical emergency.
- IF** Dehiscence noted (wound edges separating) → **THEN** cover with sterile moist NS gauze; keep patient still; notify provider; reassess vital signs.
- IF** Purulent, malodorous, or worsening drainage → **THEN** collect wound culture before starting antibiotics; notify provider; increase frequency of dressing changes.
- IF** Wound shows tunneling or undermining not previously documented → **THEN** measure depth/direction; pack lightly; notify provider — wound is enlarging.
- IF** Yellow gel appears under hydrocolloid dressing → **THEN** do NOT mistake for infection — this is normal dressing breakdown. Assess wound bed directly before concluding infection.

6 Educate Patient & Support Healing

Nutrition (protein, vitamin C, zinc), hydration, glucose control, smoking cessation, and signs of infection to report.

IF Wound is dry with no exudate → **THEN** use hydrating dressing (hydrogel) — do NOT use alginate or foam which will further dry the wound.

IF Wound has heavy exudate → **THEN** use alginate or foam dressing — do NOT use hydrogel or film which cannot absorb excess moisture.

NCLEX PITFALLS & PATTERNS

⚠ 8-TRAP NCLEX PITFALL GRID — WOUND CARE

01

Wet-to-Dry = Outdated

Wet-to-dry dressings cause traumatic debridement and damage healing tissue. Modern practice uses moist wound healing — remove dressings damp, never dry.

02

Yellow Gel ≠ Infection

Yellow gel found under a hydrocolloid dressing (DuoDerm) is a normal byproduct of dressing breakdown — not purulence. Always assess the wound bed directly.

03

Culture BEFORE Antibiotics

Always collect wound culture BEFORE initiating antibiotics. Post-antibiotic cultures may be falsely negative and miss the causative organism.

04

Evisceration ≠ Same as Dehiscence

Dehiscence = wound edges separated (cover with moist gauze, notify). Evisceration = organ protruding = SURGICAL EMERGENCY — these require different urgency levels.

05

Too Much Irrigation Pressure

PSI >15 causes tissue trauma and drives bacteria deeper into the wound. Stay at 5–8 PSI with a 35 mL syringe and 18–20G angiocatheter for optimal cleansing.

06

Reusing Swabs on Same Pass

Each stroke or pass over the wound requires a NEW, clean swab. Reusing a swab spreads contamination from the outer area back toward the wound center.

07

Clean Gloves for New Dressing

STERILE gloves are required when applying a new dressing to an open wound. Clean gloves are used only to remove the old dressing (changing gloves between steps).

08

Hydrogen Peroxide on Wounds

Hydrogen peroxide and povidone-iodine damage new granulation tissue and fibroblasts. Unless ordered, use only normal saline or wound-approved cleansing solutions.

📊 NCLEX CLINICAL JUDGMENT PATTERNS

RECOGNIZE CUES

Post-op day 3 client has new onset fever 38.8°C, wound with thick green drainage and foul odor, WBC 16,000. → Recognize as surgical site infection with potential systemic spread.

ANALYZE CUES

Purulent drainage + fever + elevated WBC = infection cluster. Distinguish from normal post-op serosanguineous drainage (days 1–3, pink/thin, no odor, no fever) — key NCLEX comparison.

PRIORITIZE HYPOTHESES

Wound infection with systemic signs outprioritizes routine dressing change. Systemic compromise (sepsis risk) must be assessed before any local wound treatment is initiated.

GENERATE SOLUTIONS

Infected wound → culture first → antibiotics. Dry wound → hydrogel. Heavy exudate → alginate or foam. Dehiscence → moist NS cover. Evisceration → NS towel + Trendelenburg + STAT.

TAKE ACTION

Wound cleansing sequence: (1) Hand hygiene + clean gloves → (2) Remove old dressing + assess → (3) Change to sterile gloves → (4) Cleanse clean-to-dirty → (5) Apply correct dressing → (6) Label + document.

EVALUATE OUTCOMES

Expected post-dressing change: wound clean, dressing secured and labeled, patient comfortable, granulation visible, periwound skin intact, patient verbalizes infection signs to report, drainage decreasing in volume.

NGN BOW-TIE — WOUND CARE: INFECTION RISK & HEALING PROMOTION

CONDITIONS / RISK FACTORS

CONDITION

Open wound requiring cleansing, dressing, and ongoing assessment

RISK FACTOR

Improper cleansing technique (dirty-to-clean) → cross-contamination → infection

RISK FACTOR

Wrong dressing type → impaired healing (too dry or too wet wound bed)

RISK FACTOR

Delayed identification of dehiscence or evisceration → serious complication

RISK FACTOR

Poor nutrition (↓ protein, ↓ vitamin C, ↓ zinc) → impaired collagen synthesis → delayed healing

PRIORITY ACTIONS

Correct technique + appropriate dressing + thorough assessment every change

EXPECTED OUTCOMES

OUTCOME

Wound progressing through healing phases: inflammation → proliferation → remodeling

OUTCOME

No signs of infection: afebrile, clear/serous drainage, no odor, no spreading erythema

OUTCOME

Wound edges approximating; granulation tissue visible; epithelialization occurring

OUTCOME

Appropriate dressing applied and labeled; patient comfortable

OUTCOME

Patient verbalizes infection signs, dietary needs, and dressing care instructions

PATIENT & FAMILY EDUCATION CHECKLIST

WOUND CARE TEACHING — DISCHARGE & HOME

✓ Promoting Wound Healing at Home

- ✓ Wash hands thoroughly with soap and water before and after touching your wound or dressing
- ✓ Keep the wound **moist but not wet** — follow instructions for your specific dressing type
- ✓ Change dressing exactly as prescribed — do not skip changes even if wound "looks fine"
- ✓ Eat a **high-protein diet** (eggs, meat, beans) + **vitamin C** (citrus) + **zinc** — essential for collagen and skin repair
- ✓ Stay well-hydrated — tissue perfusion and healing depend on adequate fluid intake
- ✓ Keep blood sugar controlled (if diabetic) — hyperglycemia significantly impairs wound healing
- ✓ Avoid smoking — nicotine causes vasoconstriction and dramatically impairs wound healing
- ✓ Protect wound from pressure, friction, and trauma — use positioning aids as instructed

🚨 Report to Provider Immediately If:

- ! Wound drainage becomes **thick, yellow, green, or foul-smelling** — signs of infection
- ! Increasing redness, warmth, or swelling spreading **away from the wound** — cellulitis
- ! **Fever above 38°C (100.4°F)** — may indicate wound infection or systemic spread
- ! Wound edges begin to **separate or open** — cover with moist gauze and go to emergency room
- ! Anything protrudes from the wound — **call 911** ; cover with moist towel; do not push it back
- ! Sudden increase in drainage amount or significant bleeding through dressing
- ! Wound shows **no signs of healing** after 2–4 weeks — may need further evaluation
- ! Pain at wound site **worsening** rather than improving over time

PDF Export: Chrome or Edge → Print (Ctrl+P / Cmd+P) → Save as PDF · Scale: **65–70%** · Enable **"Background graphics"**
NGN NCLEX Clinical Judgment Series · Fundamentals: Wound Care — Cleansing Technique, Dressing Change & Assessment