BASIC WOUND CARE

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February 2026

WOC002 2026 Nursing Management of Acute & Chronic Wounds

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INTRODUCTION
WOUND CARE ESSENTIALS

- **Why Basics Matter:** Basics of wound care helps prevent complications, speeds up healing, and yields better outcomes for patients.
- **Core Principles:** The main basics are assessing wounds accurately, keeping them clean, preventing infection, choosing the right dressings, and managing health issues that can slow healing.
- **What You'll Learn:** This presentation will show you how to assess wounds, use proven cleaning and dressing methods, prevent infections, and teach patients—all skills you can use right away in your practice.
- **Real-World Benefits:** By learning these basics, clinicians can help wounds heal faster, avoid complications, and provide good care in any setting, whether in hospitals or at home.

Knowing the basics of wound care helps prevent chronic wounds and improve patient outcomes in any healthcare setting. These principles are the starting point for treating all types of wounds, including surgical incisions, pressure injuries, diabetic foot problems, and wounds from poor circulation. Without this knowledge, wounds can become life-threatening or turn from minor injuries into serious problems that lower the quality of life, increase healthcare costs, and slow down healing.

The main principles of wound care are to assess what caused the wound, keep the wound bed clean, prevent infection with proper cleaning and disinfection, choose the right dressings, and teach patients how to manage any underlying conditions. These steps help create the best environment for the body to heal naturally.

This presentation will help healthcare clinicians learn how to assess wounds correctly, use proven treatments, understand the stages of wound healing, clean and debride wounds properly, choose the right dressings for each wound, spot and prevent infections, and teach patients how to care for their wounds. When nurses learn the basic principles of wound care, they can help to prevent complications, help to keep their patients comfortable, and even set goals to track progress.

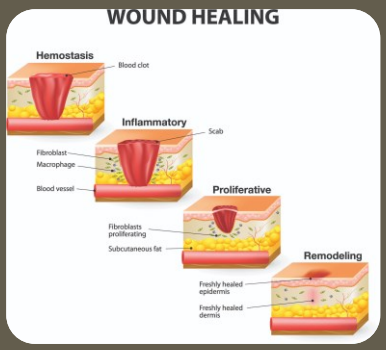
No matter the care setting, knowing these fundamentals is essential for providing consistent,

high-quality wound care that supports healing and avoids problems.

The Wound Bed Preparation 2021 framework recommends that clinicians start by addressing the cause of the wound and any patient concerns. After that, the clinician should assess the wound and create a personalized, evidence-based care plan. This type of technique emphasizes key wound care principles, including pinpointing the cause, cleansing the wound, how to prevent infections, selecting the appropriate dressing, and being sure to educate the patient. These steps help promote healing and reduce complications in all care settings. (Sibbald et al., 2021)

PHASES OF WOUND HEALING

1. **Hemostasis (stop bleeding):** Blood vessels constrict, and a fibrin clot forms. This stops the bleeding and creates a foundation for healing to begin.
2. **Inflammation (clean wound):** Blood vessels widen, allowing white blood cells to enter the area. They remove bacteria and debris and release signals that activate tissue repair. The wound may appear inflamed, warm, and feel tender — all normal signs of this phase.
3. **Proliferation (build new tissue):** Fibroblasts make collagen, new blood vessels grow, and granulation tissue fills the wound. Skin cells move across the surface, and myofibroblasts help pull the wound edges together.
4. **Maturation (Strengthen/remodel):** Over months to even years, collagen is reorganized, and the tissue becomes stronger. The area typically regains only about 80% of its original strength.



Important Considerations Acute vs. chronic wounds: Acute wounds usually heal normally and move through each stage as expected. Chronic wounds often get stuck in the inflammatory stage because of problems like infection, poor blood flow, swelling, diabetes, or pressure. When this happens, new tissue can't grow well, and the wound doesn't close.

Let's start at the beginning, how does wound healing happen?

There are several accompanying stages: hemostasis, inflammation, proliferation, and maturation/remodeling.

During hemostasis, blood vessels narrow, and platelets adhere to the site of injury, forming a clot. A fibrin clot (or a protein plug) stops bleeding and forms a temporary matrix.

This first layer is made mostly of fibrin mesh and other clotting materials, which help stop bleeding and provides cells with a surface to attach to as they begin repairing the wound. As healing develops and new tissue forms, this early matrix is gradually broken down and replaced by stronger, more mature tissue, granulation tissue.

In the inflammatory phase, blood vessels constrict, then dilate and become more porous, allowing WBCs (neutrophils and macrophages) to enter the area. The area may become tender, warm, or swollen, a sign of inflammation. These cells clear away debris and bacteria and release growth factors that help start the repair process. We are initiating the process for new tissue growth.

Next, during the proliferative phase, fibroblasts begin to arrive and produce another protein,

collagen. This protein strengthens the issue. Granular tissue fills the wound, epithelial cells move across the surface, and myofibroblasts help pull the wound closed.

In the final maturation or remodeling phase, collagen is reorganized and strengthens over months or even years, making the new tissue more durable, the healed area usually regains only about 80% of its original strength. This phase is important because it gives the wound stability.

Acute wounds, such as surgical cuts, injuries, or minor burns, usually progress through these healing stages in order and heal on time. Chronic wounds, such as pressure injuries, venous ulcers, arterial ulcers, and diabetic foot ulcers, often get stuck in the inflammatory phase.

This can occur due to infection, biofilm, poor blood flow, swelling, uncontrolled diabetes, or ongoing pressure to the wound area. In these wounds, too many enzymes that like to break down protein, acting like tiny scissors, the ongoing inflammation break down new tissue and growth factors faster than the body can make them. As a result, granulation and epithelialization are slowed or stopped, and the wound does not progress normally into the final healing stage.

The 2024 StatPearls review describes the same four overlapping phases: hemostasis, inflammation, proliferation, and maturation/remodeling. The review also explains that these phases happen in a continuous, connected process rather than as separate events. The review explains that the proliferative phase includes granulation tissue formation, re-epithelialization, and the growth of new blood vessels. It also notes that the maturation or remodeling phase can last for months while collagen is reorganized and strengthened. The review also states that the final scar will never have 100% of the natural strength of the wound and will only have about 80% of the tensile strength. (Wallace et al., 2023).

MODIFIABLE AND NON-MODIFIABLE FACTORS THAT IMPACT WOUND HEALING

MODIFIABLE - Certain factors can slow healing, but they can be improved.

- These include smoking, drinking alcohol, poor nutrition/hydration, uncontrolled diabetes, local wound issues, some medications, and unmanaged pain or stress.

NON_MODIFIABLE - Some factors that slow healing cannot be changed.

- Chronic conditions such as poor circulation, vascular disease, neuropathy, kidney or liver disease, having prior radiation, past soft-tissue infections, advanced age, or frailty can all limit blood flow and weaken tissue quality. These factors can be managed to some extent, but their underlying effects cannot be fully reversed.

Several factors that can be changed affect how wounds heal. These include smoking, drinking alcohol, poor nutrition or hydration, uncontrolled blood sugar in diabetes, local wound problems, some medications, and unmanaged pain or stress. However, some medications may be necessary for other health conditions and cannot always be stopped.

Smoking and heavy alcohol use narrow blood vessels, lower oxygen in tissues, and weaken the immune system and fibroblast function. Quitting or reducing these habits can improve blood flow and help the body make more collagen.

Not getting enough protein, calories, or fluids slows down collagen production, weakens the immune response, and delays new tissue growth. Eating well and staying hydrated helps wounds heal. High blood sugar in diabetes makes it harder for immune cells to work, slows collagen building, and affects skin cell movement, so keeping blood sugar under control is very important.

Local issues like pressure, not moving enough, too much or too little moisture, changes in skin pH, dead tissue, foreign objects, infection, swelling, and skin damage from moisture can all slow healing. These problems can be managed by reducing pressure, keeping the right moisture balance, removing dead tissue, using compression, and treating infections. Certain drugs, such as steroids, some chemotherapy medicines, and NSAIDs, as well as ongoing pain

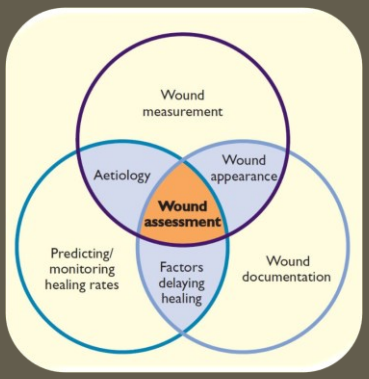
and stress, can weaken the body's inflammatory response and lower blood flow. Adjusting medications and managing pain can help improve healing.

Some factors cannot be changed or can only be changed a little. These include age, frailty, and many long-term health problems. The older adult population tends to heal more slowly because they have less skin protein, slower cell growth, and more health issues. Conditions like vascular disease, nerve damage, kidney or liver failure, past radiation, and old soft-tissue infections can permanently reduce blood flow and tissue quality. While their effects can be managed, they cannot be reversed.

The 2022 EWMA document, *The Impact of Patient Health and Lifestyle Factors on Wound Healing, highlights several lifestyle risks that can be changed, such as smoking, drinking alcohol*, poor nutrition, lack of physical activity, and obesity. These factors are major reasons for delayed or poor wound healing. Smoking and alcohol misuse lower tissue perfusion and oxygen levels, weaken the immune system, and slow down repair. It also points out the clear benefits of quitting smoking. In addition, the document discusses how some commonly used medications, while often necessary, can still disrupt normal healing. (European Wound Management Association, 2022).

WHAT IS A HOLISTIC WOUND ASSESSMENT

1. Considers both the patient as a whole and the wound itself, rather than focusing only on the skin opening.
2. Reviews important factors such as other health conditions, current medications, nutrition, mobility, psychosocial concerns, caregiver support, and any financial or insurance limitations.
3. Performs a full skin and general health assessment from head to toe to identify other risks or signs of illness affecting the whole body.
4. Describes the wound thoroughly, including its cause, location, size, depth, types of tissue, amount of drainage, wound edges, surrounding skin, pain level, and any signs of infection or inflammation. Uses standardized tools when available.
5. Asks important questions about the cause of the wound, its ability to heal, possible barriers, and the overall goal. Continues to reassess and adjust the care plan as needed for each patient.



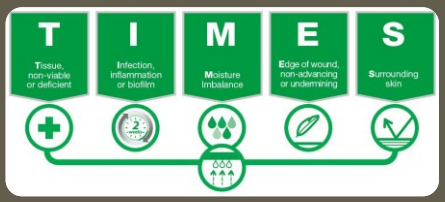
A holistic wound assessment takes into account both the patient and the wound. Rather than solely addressing the wound. You must see the patient and their lifestyle as a whole person. Start by gathering information about the patient, which includes other health conditions such as diabetes or vascular disease, medications, nutrition, mobility, mental health, support from caregivers, and any financial or insurance limitations. The assessment also involves a full-body skin and health check to spot other risks or signs of illness.

On the wound side, a holistic assessment describes the wound itself, including its etiology. The exact location, size, depth, tissue types, exudate, wound edges, periwound skin, pain, and signs of infection or inflammation, adopting standardized tools when possible. The clinician then asks key questions—what is causing the wound, whether it is healable, what the barriers are, and whether the goal is healing, maintenance, limb salvage, symptom control, or lifesaving—and uses serial reassessment to guide an individualized plan of care.

Wound bed preparation is a holistic approach that starts by treating the cause and focusing on patient-centered concerns. Next, they recommend deciding if the wound is healable, needs maintenance, or is non-healable (palliative), and then matching care strategies to that category. They also stress that figuring out healability and setting realistic goals, like healing, maintenance, palliation, limb salvage, or comfort, is essential for creating a personalized, evidence-based care plan. (Sibbald et al., 2021).

WOUND BED PREPARATION

1. Examine the wound tissue and depth, and identify what you see. Granulation tissue, slough, or eschar?
2. Check the wound edges and the surrounding skin. Are the edges healing? Are they rolled, is there undermining? Is the skin around the wound soft, red, firm, or inflamed?
3. After cleansing, assess drainage. Take note of how much fluid there is, what type (clear, pus, or blood-tinged). This helps pick a dressing.
4. Watch for signs of infection, which commonly include redness, a foul odor, fever, pain, and slow healing.
5. Use the T.I.M.E framework:
   - **Tissue** (healthy vs. unhealthy)
   - **Infection/Inflammation**
   - **Moisture** (too much or too little)
   - **Edge** (how the wound is progressing)



Wound bed assessment means describing what you see at the base of the wound to figure out its cause, stage, and the best dressing to use. A thorough assessment covers the wound's location and likely cause, such as pressure, venous or arterial disease, diabetic neuropathy, moisture-related skin damage, trauma, surgery, or less common reasons. Next, you check the type and depth of the tissue to determine whether the wound is partial- or full-thickness and which structures are visible.

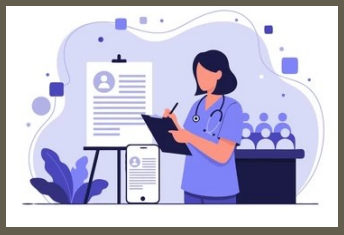
You should also record the percentage of each tissue type, such as healthy granulation tissue, nonviable slough, or eschar. The state of the wound edges and the skin around the wound gives important information. Edges that are attached and even show healing, while signs like rolled edges, undermining, softening, redness, rash, or firmness can indicate delayed healing or problems. After cleaning the wound, check how much exudate is present, what type it is, and if there is any odor. These details help you choose the right dressing and may point to an infection.

It is important to watch closely for signs of local or systemic infection, such as redness, warmth, swelling, increased drainage, pain, or fever. You can organize all your findings with tools like PUSH or BWAT to track healing over time. The T.I.M.E. framework also helps by focusing on Tissue, Infection or Inflammation, Moisture balance, and Edge advancement to guide wound care and treatment planning.

Wound assessment guides clinicians to check the wound's location, cause, stage or depth, and any exposed structures. It also suggests looking closely at the wound bed for visible bone, vessels, hardware, or fat. Clinicians should note the amount and type of exudate, check the skin around the wound for damage or changes, and examine the wound edges for tunneling, rolled edges, undermining, or fibrosis. The chapter points out that signs of infection such as warmth, pain, odor, pus, and slow healing should be included in a thorough assessment. (Nagle et al., 2023).

WOUND CARE DOCUMENTATION

1. Patient and wound history (cause, how long it's been there, comorbidities, meds, nutrition, mobility).
2. Exact wound description (location, size, depth, tissue in the bed, edges, and surrounding skin).
3. Exudate, odor, pain, and any signs of local or systemic infection.
4. All treatments and supports used (cleansing, dressings, debridement, offloading, compression, systemic meds/therapies).
5. Patient response, goals of care, trends over time, and teaching provided to patient/caregiver



When documenting wound care, begin by sharing basic information about the patient and how the wound started. Explain what probably caused it, such as pressure, poor circulation, diabetes, surgery, injury, or skin irritation. Note when the wound first appeared, how long it has lasted, if the patient has had a wound in the same spot before, and what treatments have already been tried. Include any special considerations, health problems that could down the slow healing process, such as diabetes, circulation issues, a weak immune system, kidney disease, or nerve damage. List any medications that might affect or delay healing, such as steroids, blood thinners, or chemotherapy. Also, mention simple details about the patient's nutrition, whether they smoke, how well they move, if they can relieve pressure from the wound, their ability to do daily activities, and whether they have support at home or face financial barriers to care.

At each visit, clearly describe what you see. Where is the wound located, and what type is it? Measure the wound size (length, width, and depth), if needed. Is the wound tunneled or hidden in areas under the skin? Use the clock-face directions to indicate their location, such as "undermining at 3 o'clock." Describe what you see inside the wound, like healthy red tissue, yellow tissue, dead tissue, or deeper layers such as fat, muscle or even bone. Check the skin around the wound and note if it is

red, soft, firm, wet, irritated, bruised, or fragile.

After cleaning, describe the drainage by noting how much there is, its color, thickness, and if it has an odor. Watch for any signs of infection. Also, include a simple pain assessment: how much it hurts, where the pain is, what it feels like, and what makes it better or worse. Include tests you used to check the wound or the patient's overall risk, such as scoring tools for wound healing or skin breakdown, or tests that check blood flow or nerve function. Include any important lab results, imaging, or specialist recommendations that affect the care plan. Then describe everything you did during the visit: how you cleaned the wound, whether you removed any dead tissue (and how much), what ointments or dressings you used, how often they need to be changed, and any devices or strategies used to take pressure off the wound. Also include any medications, supplements, or advanced treatments the patient is receiving.

It is encouraged to document the progression of the injury, obtain a thorough medical and social history, and document the precise wound location and size. An assessment should include wound bed characteristics such as color, drainage, odor, slough, and any undermining or tunneling, as well as the condition of the surrounding skin and the patient's pain level. Tools like PUSH and BWAT should be used to track healing, along with reassessment, offloading, nutritious support, debridement techniques, proper dressing selection, attention to patients' needs, and patient education. (Edmonds & Sprowls, 2023)

CLINICAL OVERVIEW OF THREE WOUND DRESSING CLASSIFICATIONS

Hydrocolloid dressings
- Classification: Semi-occlusive dressing that absorbs exudate, forms a gel, and supports autolytic debridement

Foam dressings
- Classification: Absorptive polyurethane foam that manages exudate and provides cushioning.

Alginate dressings
- Classification: Seaweed-derived .fibers that absorb up to 20× their weight, form a gel, and require secondary dressing.

Foam dressings

Foam dressings are plush and absorbent. These dressings help to remove extra fluid from wounds while providing gentle cushioning. They can be used as primary or secondary dressings and work well with compression therapy. Some types need a skin sealant for better sticking. It is not recommended to cut foam dressings, as this can leave fibers in the wound. Foam dressings are best for partial-thickness wounds with moderate to heavy drainage, like stage 2 or 3 pressure injuries, venous ulcers, and donor sites. Foam dressings also work well as a cover over wound fillers or antimicrobial dressings and can be used safely under compression wraps, even on fragile skin with integrity issues. Of note, sacral foam dressings have been shown to significantly reduce sacral pressure injuries, including stage II or higher, and decrease blanchable erythema compared to standard care without a sacral foam dressing (Xia et al., 2024). Do not use foam dressings on dry wounds, wounds with little drainage, or third-degree burns. If drainage is so heavy that the surrounding skin cannot be protected, choose a different dressing. Be careful when using foam dressings near fragile skin, and consider a barrier product to protect the skin around the wound.

Hydrocolloid dressings

Hydrocolloid dressings are semi-occlusive or occlusive, which means they keep wounds moist. They absorb fluid and form a gel that helps wounds heal and gently removes dead tissue from clean or slightly necrotic wounds. These dressings are good for shallow wounds

with low to moderate drainage, such as clean stage 2 or shallow stage 3 pressure injuries, superficial venous ulcers, or donor sites. They can also protect intact or recently healed skin. Sometimes, these dressings help with mild autolytic debridement in necrotic wounds, as long as there is no infections and there is good blood flow to the area. Hydrocolloid dressings create a barrier that keeps the wound moist, absorbs drainage, and helps the body's immune cells (granulocytes and monocytes) work well (Nguyen et al., 2025). Do not use them on wounds with heavy drainage, since too much moisture can harm the skin around the wound. Avoid using them on infected wounds, wounds with tunneling or undermining, legs with poor blood flow, or in immunocompromised patients when the dressing is fully occlusive. They are also not suitable for third-degree burns, very dry stable eschar, or extremely fragile skin around the wound. The adhesive needs clean, intact skin to stick properly.

Alginate (calcium alginate) dressings

Alginate dressings are made from seaweed derivatives and come as sheets or ropes, sometimes with added silver. They can absorb up to 20 times their weight and form a gel when they come into contact with wound fluid. These dressings are good for wounds with moderate to heavy drainage or minor bleeding, and they always need a secondary dressing. Use them for deeper stage 3 or 4 pressure injuries, venous ulcers, donor sites, and wounds with cavities or undermining. Apply them with care. They may also be used on infected wounds when combined with the right systemic therapy. One study found that alginate dressings help reduce discomfort or pain and need fewer dressing changes. (Lou et al., 2025). It is not recommended to use alginate dressings on dry wounds, wounds with little drainage, wounds covered with dry eschar, third-degree burns, or in narrow tunnels where fibers could be left behind. Do not use too many layers. Use silver alginates only when needed, and do not mix iodine or silver with enzymatic debriders, following guidelines.

CLINICAL GUIDELINES FOR WOUND DRESSING SELECTION AND CARE - FOAM

Foam dressing
- For example, you can use a 4 by 4-inch silicone adhesive foam dressing.

Nursing order:
- Cleanse the right trochanter stage 3 pressure injury with normal saline, pat dry.
- Apply liquid barrier to peri-wound skin; allow to dry.
- If there is any shallow undermining, loosely pack it with a non-adherent contact layer. Then cover the area with a 4 by 4-inch silicone foam, and do not cut the foam.
- Secure the dressing according to the manufacturer's instructions. Change it every 48 to 72 hours, or sooner if it becomes more than 75% saturated or starts to lift.

Foam Dressings
When you document the use of foam dressings, be sure to include the following details:

Wound Assessment
- Describe the wound bed, noting if there is granulation tissue, slough, or necrosis.
- Record how much exudate is present.
- Note any changes in the size or depth of the wound.
- Signs of infection

Dressing Details
- Whether foam is the primary or secondary dressing
- Indicate if the foam is placed under compression or over a filler.
- Specify the type of foam used, such as silicone, adhesive border, or non-adhesive.
- Include the size of the dressing and how it is secured.
- Mention if a barrier film was used to protect the skin around the wound.

Note if the dressing had to be changed early because it was saturated or there was a risk of maceration.
- Record the patient's pain score and their tolerance to the dressing.
- Document any findings that may warrant a different dressing or a referral.

Sacral foam dressing significantly reduced the incidence of sacral pressure injuries, including those of stage II or higher, and blanching erythema when compared to standard care without sacral foam dressing.
(Xia et al., 2024).

CLINICAL GUIDELINES FOR WOUND DRESSING SELECTION AND CARE - HYDROCOLLOID

Hydrocolloid dressing

- For example, you can use a 4 X 4-inch hydrocolloid dressing.

Nursing order:

- Cleanse sacral stage 2 pressure injury with normal saline, pat dry.
- Apply skin barrier film to peri-wound skin and allow to dry.
- Place the 4 by 4 hydrocolloid dressing so there is at least a 2 cm border of healthy skin around the wound. Gently warm the dressing with your gloved hand for 30 to 60 seconds to help it stick better.
- Change the dressing every 3 to 5 days, or sooner if it starts to leak, becomes loose, or is saturated.

Hydrocolloid Dressings

When you document the use of a hydrocolloid dressing, make sure to include the following details:

Wound Assessment

- Note where the patient is and exactly where the wound is located.
- Record the size and depth of the wound.
- Describe the type of tissue you see in the wound.
- Include how much exudate is present and what it looks like.
- Check and note the condition of the skin around the wound, such as whether it is intact, fragile, macerated, or red.
- State if you applied a skin barrier.

Dressing Details

- Write down the specific hydrocolloid product used and its size.
- Describe how you applied the dressing, such as if you warmed it first, checked the border, or confirmed there was no undermining.
- Record the date and time you applied the dressing.
- Include how long the dressing is planned to stay in place.

Response and Outcomes

- Note if there was any leakage, odor when removing the dressing, or signs of maceration, as these may mean you need to adjust care.
- Record the patient's pain level and how well they tolerated the procedure.

Hydrocolloid dressings are commonly used in the treatment of chronic wounds by forming a gel-like protective layer upon the dispersion of water, absorbing exudate, and creating a moist environment that promotes healing. (Nguyen et al., 2025).

CLINICAL DOCUMENTATION STANDARDS FOR WOUND ASSESSMENT AND CARE – ALGINATE

Alginate dressing

- For example, you can use a calcium alginate rope along with a secondary foam dressing.

Nursing order:

- Cleanse left heel stage 3 pressure injury with normal saline, pat dry.
- Gently fill the wound cavity and any undermined areas with calcium alginate rope, but do not pack it too tightly. Make sure to leave a small piece visible so it can be removed easily.
- Place a 4 by 4 foam dressing over the wound, then secure it with soft roll gauze or tape on healthy skin.
- Change the dressing every 24 to 48 hours, or sooner if you see drainage coming through the outer layer. Before re-packing, gently rinse the wound with saline to remove any leftover alginate.

Alginate Dressings

When you document the use of alginate dressings, make sure to include the following details:

Wound Assessment

- Describe how deep the wound cavity is.
- Note if there is any undermining or tunneling present.
- Record the amount of exudate, as this helps explain the need for a highly absorbent filler.

Dressing Details

- Confirm that you packed the alginate loosely and did not overfill the wound.
- State which product type you used, such as plain or silver.
- Mention if there was any minor bleeding when you removed the dressing.
- Include what type of secondary dressing you applied.

Response and Outcomes

- Describe how much exudate was absorbed when you changed the dressing.
- Note the condition of the wound and the surrounding skin, such as any maceration, dryness, or irritation.
- If you suspect a biofilm or infection, mention this, as it can affect how often you use antimicrobials or perform debridement.

Alginate dressings have the ability to shorten recovery time and offer meaningful benefits to treatment —such as reduced pain and fewer dressing changes—making them a valuable option in burn wound management (Lou et al., 2025).

SUMMARY

- The four phases of wound healing—hemostasis, inflammation, proliferation, and maturation—guide how acute and chronic wounds progress.
- Healing is influenced by modifiable factors (nutrition, glycemic control, smoking, moisture balance) and non-modifiable factors (age, vascular disease, comorbidities).
- Holistic wound assessment includes evaluating the patient as a whole and the wound itself using tools like the T.I.M.E. framework.
- Wound bed preparation focuses on optimizing tissue quality, managing infection/inflammation, maintaining moisture balance, and supporting edge advancement.
- Hydrocolloid, foam, and alginate dressings each have specific indications, contraindications, and nursing application guidelines to support optimal healing.
- Accurate documentation includes wound characteristics, drainage, tissue type, periwound skin, pain, dressing type, application method, and patient response.

The Basic Wound Care presentation covers the four phases of healing: hemostasis, inflammation, proliferation, and maturation. It also talks about how to manage things that can slow healing, like smoking, poor nutrition, diabetes, age, and vascular disease. The hope is that this presentation highlights the importance of looking at the whole patient, including their health, medications, mobility, and any social or monetary difficulties. It also points out the need to assess the wound itself, including its cause, size, depth, tissue type, drainage, edges, surrounding skin, pain, and signs of infection. Frameworks such as T.I.M.E. help guide wound bed preparation. The presentation goes over the main types of dressings, such as hydrocolloid, foam, and alginate, and explains when to use or avoid each one and how they help keep wounds moist and clean. Additionally, this presentation gives examples of nursing orders and documentation. It focuses on making clear assessments, picking the right product, applying and changing dressings, and tracking how patients respond to improve care in any setting.

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