** PURPOSE:**
To remove bacteria and debris with as little chemical and mechanical trauma as possible, while protecting healthy granulation tissue.

**CONSIDERATIONS:**
1. The process of cleansing a wound involves selecting both a wound-cleansing solution and a mechanical means of delivering that solution to the wound.
2. Wound irrigation is an acceptable method of wound cleaning. *(See Integumentary- Wound Irrigation)*
3. The benefits of obtaining a clean wound must be weighed against the potential trauma to the wound bed as a result of such cleansing. Routine wound cleansing should be accomplished with a minimum of chemical and mechanical trauma.
4. Cleanse wounds initially and at each dressing change.
5. Normal saline promotes a moist environment, promotes granulation tissue formation and causes minimal fluid shifts in healthy cells. Skin cleansers or antiseptic solutions, such as acetic acid, hydrogen peroxide, sodium hypochlorite (Dakin’s® solution) or povidone-iodine damage healthy tissue and delay healing. Base the choice of a cleansing solution on the indications, contraindications and benefits to healthy tissue.
6. Consider pulsed irrigation for cleansing wounds that contain thick exudate, slough or necrotic tissue. Trauma can result if the wound or healthy granulating tissue is positioned too closely to high-pressure jets with greater than 15 pounds per square inch (psi) force.

**EQUIPMENT:**
- Gloves
- Gauze
- Clean basin
- Sterile basin (optional)
- Cleansing solution, normal saline or other
- Protective bed pad
- Materials as needed for dressing change
- Impervious trash bag

**PROCEDURE:**
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Review physician’s orders.
4. Establish a clean field with all the supplies and equipment that will be necessary.
5. Remove tape by pushing skin from tape. Remove soiled dressing; discard dressing and soiled gloves in appropriate container. Decontaminate hands and don gloves.
6. Observe for:
   a. Wound size, including length, width and depth.
   b. Wound bed tissue type/color including necrotic, slough, eschar, granulating, clean, non-granulating or epithelial.
   c. Drainage characteristics, including type, amount, color and odor.
   d. Evidence of wound healing or deterioration.
   e. Symptoms of infection, including redness, swelling, pain, discharge or increased temperature.
   f. Development of undermining or tunneling/sinus tract that may require packing.
7. Using a clean gauze moistened with the prescribed cleansing solution, wipe wound areas.
   a. Clean a linear wound from top to bottom, and work outward from the incision in lines running parallel to the incision. Always wipe from the clean area toward the less clean area. Use a new gauze pad for each downward stroke.
   b. For an open wound, moisten a gauze pad with the prescribed cleansing solution; squeeze out excess solution. Clean the wound in full or half circles beginning in the center and working toward the outside. Clean to at least 1 inch (2.5 cm) beyond the end of the new dressing or 2 inches (5 cm) beyond the wound margins, if not applying a dressing. Use a new gauze pad for each circle.
8. Dress wound with appropriate dressings following the manufacturer’s guidelines for use. *(See Integumentary- Application of Wound Dressing)*
9. Discard soiled supplies in appropriate containers.
10. Clean reusable supplies before leaving the home, according to agency policy.

**AFTER CARE:**
1. Document in patient’s record:
   a. Procedure.
   b. Patient’s response to procedure.
   c. Temperature and vital signs per agency policy.
   d. Wound observations noted in No. 6 of procedure.
   e. Response of the wound to the prescribed treatment.
2. Instruct patient/caregiver in care of the wound including:
   a. Reporting any changes in pain, drainage, temperature or other signs and symptoms of infection.
   b. Techniques to change or reinforce dressings.
   c. Diet to promote healing.
   d. Medications/disease processes that may be impeding healing.
   e. Activities permitted.
REFERENCES:


