

APPLICATION OF DRY DRESSING

PURPOSE

To aid in the management of a wound with minimal drainage.

To protect the wound from injury, prevent introduction of bacteria, reduce discomfort, and assist with healing.

APPLIES TO

- Registered Nurses
- Licensed Practical/Vocational Nurses
- Therapists
- Other (Identify): _____

EQUIPMENT/SUPPLIES

- One pair of disposable gloves and one pair of sterile gloves or two pair of disposable gloves.*
- Dressing set including scissors and forceps.*
- Sterile gauze dressings.
- Prescribed solution - sterile normal saline or sterile water per physician's orders.
- Tape, ties, or bandage.
- Waterproof bag.
- Measurement device.
- Sterile drape (optional with sterile dressing change).
- Antiseptic ointment (if ordered).
- ABD pads (if ordered).*
- Waste disposal supplies.

**Note: Supplies to be sterile if procedure is ordered to be performed using aseptic technique.*

PROCEDURE

1. Wash hands. Refer to the Hand Washing procedure.
2. Position the client to provide access to the wound.
3. Place waterproof bag next to work area and within reach.
4. Don clean gloves.
5. Remove old dressing. Pull tape toward the dressing.
6. Observe appearance and amount of drainage.
7. Hold soiled dressing in hand and remove glove to wrap inside out around dressing. Repeat with second glove and discard in disposable bag. *If amount of dressing is too great, place dressing directly into waterproof bag, remove gloves, and dispose of in bag.*
8. For sterile procedure, open sterile dressing set.
9. Open supplies.
10. Don second pair of gloves.
11. Assess wound size, characteristics, and drainage. *Use same measurement method throughout service, i.e., inches or centimeters.*
12. Clean the wound with prescribed solution and gauze pad. *Clean from least-contaminated to most-contaminated areas. Use new pad for each stroke.*
13. Apply ointment as ordered.
14. Apply dry sterile dressings:
 - a. Fluff the bottom gauze pad. *This promotes proper absorption of drainage.*
 - b. Apply top gauze pad.
 - c. If wound has a drain, use a precut gauze pad to fit around drain.
 - d. If needed, apply ABD pad to top of dressing.
15. Secure dressing with tape, ties, or binder.
16. Remove gloves and dispose of waste according to the Agency Waste Disposal Policy.
17. Wash hands. Refer to Hand Washing procedure.

DOCUMENTATION GUIDELINES

1. Document in the clinical record:
 - a. Appearance, odor, and size of wound.
 - b. Amount and characteristics of drainage.
 - c. The client's tolerance of the procedure.
 - d. Dressing procedure and time of dressing change.

RELATED PROCEDURES

None.

APPLICATION OF WET-TO-DRY DRESSING

PURPOSE

To mechanically debride a wound.

APPLIES TO

- Registered Nurses
- Licensed Practical/Vocational Nurses
- Therapists
- Other (Identify): _____

EQUIPMENT/SUPPLIES

- Disposable gloves and sterile gloves.*
- Dressing set including scissors and forceps.*
- Sterile gauze pads.
- ABD pads, if ordered.*
- Prescribed solution - sterile normal saline or sterile water.
- Waterproof pad.
- Waterproof bag.
- Tape, ties, or bandage.
- Sterile drape (optional).

**Note: Supplies to be sterile if procedure is ordered to be performed using aseptic technique.*

PROCEDURE

1. Wash hands. Refer to Hand Washing procedure.
2. Position the client to provide access to the wound.
3. Place waterproof bag next to work area and within reach.
4. Don clean gloves.
5. Remove old dressing. Pull tape toward the dressing. Gently free dressing. May use small amount of sterile normal saline or sterile water to assist in loosening dressing.
6. Observe appearance and amount of drainage.
7. Hold soiled dressing in hand and remove glove to wrap inside out around dressing. Repeat with second glove. *If amount of dressing is too great, place dressing directly into waterproof bag, then remove gloves and dispose of in bag.*
8. Prepare sterile dressings. Pour prescribed solution over one to two gauze pads to moisten.
9. Don clean gloves (sterile gloves if procedure is ordered to be aseptic).
10. Assess wound size, characteristics, and drainage. Assess drains if any present. *Use same measurement method throughout service, i.e., inches or centimeters.*
11. Cleanse wound with prescribed solution and gauze pad. *Clean from least-contaminated to-most contaminated areas. Use new pad for each stroke.*
12. Fluff moistened gauze pad(s) and apply over top of wound. For deep wounds, use forceps to ensure all surfaces are in contact with moistened gauze.
13. Apply sterile gauze pads over wet gauze. *Can fluff to ensure wound is loosely packed.*
14. Cover with ABD pad(s).
15. Secure dressing with tape, ties, or binder.
16. Remove gloves and dispose of waste per Agency Waste Disposal Policy.
17. Wash hands. Refer to Hand Washing procedure.

DOCUMENTATION GUIDELINES

1. Document in the clinical record:
 - a. Appearance, odor, and size of wound.
 - b. Amount and characteristics of drainage.
 - c. The client's tolerance of the procedure.
 - d. Dressing procedure and time of dressing change.

RELATED PROCEDURES

None.

APPLICATION OF TRANSPARENT DRESSING

PURPOSE

To manage superficial wounds.

APPLIES TO

- Registered Nurses
- Licensed Practical/Vocational Nurses
- Therapists
- Other (Identify): _____

EQUIPMENT/SUPPLIES

- One pair of disposable gloves and one pair of sterile gloves or two pair of disposable gloves.*
- Sterile normal saline or prescribed wound cleanser.
- Sterile gauze pads.
- Proper size transparent dressing.
- Waterproof bag.
- Dressing set (optional).*
- Skin preparation materials (optional).

**Note: Supplies to be sterile if procedure is ordered to be performed using aseptic technique.*

PROCEDURE

1. Wash hands. Refer to Hand Washing procedure.
2. Position the client to provide access to the wound.
3. Place waterproof bag next to work area and within reach.
4. Don clean gloves.
5. Remove old dressing. Gently free dressing and pull back slowly across dressing in the direction of hair growth.
6. Observe appearance of wound and any drainage.
7. Hold soiled dressing in hand and remove glove to wrap inside out around dressing.
8. Don clean gloves (sterile gloves if procedure is ordered to be aseptic).
9. Gently cleanse area with gauze pads or spray with cleanser. Swab exudate away from wound.
10. Thoroughly dry skin around wound with gauze pads.
11. If the client perspires a great deal or the dressings tend to come off, use skin preparation materials around periphery of wound and allow drying thoroughly.
12. Apply transparent dressing. *Do not stretch or wrinkle dressing.*
13. Remove gloves and dispose of waste according to the Agency Waste Disposal Policy.
14. Wash hands. Refer to Hand Washing procedure.
15. Change dressing every seven days or as needed.

DOCUMENTATION GUIDELINES

1. Document in the clinical record:
 - a. Appearance, odor, and size of wound.
 - b. Amount and characteristics of drainage.
 - c. The client's tolerance of the procedure.
 - d. Dressing procedure and time of dressing change.

RELATED PROCEDURES

None.

APPLICATION OF HYDROCOLLOID DRESSING

PURPOSE

To manage wounds stages 1, 2, and 3.

APPLIES TO

- Registered Nurses
- Licensed Practical/Vocational Nurses
- Therapists
- Other (Identify): _____

EQUIPMENT/SUPPLIES

- One pair of disposable gloves and one pair of sterile gloves or two pair of disposable gloves.*
- Sterile normal saline or prescribed wound cleanser.
- Sterile gauze pads.
- Proper size hydrocolloid dressing.
- Waterproof bag.
- Dressing set (optional).*
- Water-soluble lubricant (optional).

**Note: Supplies to be sterile if procedure is ordered to be performed using aseptic technique.*

PROCEDURE

1. Wash hands. Refer to Hand Washing procedure.
2. Position the client to provide access to wound.
3. Place waterproof bag next to work area and within reach.
4. Don clean gloves.
5. Remove old dressing. Gently free dressing and pull back slowly across dressing in the direction of hair growth. May use water-soluble lubricant for easier removal.
6. Observe appearance of wound and any drainage.
7. Hold soiled dressing in hand and remove glove to wrap inside out around dressing. Repeat with second glove. *If amount of dressing is too great, place dressing directly into waterproof bag, then remove gloves and dispose of in bag.*
8. Prepare sterile dressings. Pour sterile normal saline or prescribed solution over one to two gauze pads.
9. Don clean gloves (sterile gloves if procedure is ordered to be aseptic).
10. Assess wound size, characteristics, and drainage. *Use same measurement method throughout service, i.e., inches or centimeters.*
11. Gently cleanse area with gauze pads or spray with cleanser. Swab exudate away from wound.
12. Thoroughly dry area around wound with gauze pads.
13. Apply hydrocolloid dressing.
 - a. Hold slight pressure with palm of hand covering dressing for one to two minutes to assist in adhering.
 - b. For deeper wounds, apply hydrocolloid granules or paste before applying wafer dressing as prescribed by the physician. *Do not stretch or wrinkle dressing.*
14. Remove gloves and dispose of waste according to the Agency Waste Disposal Policy.
15. Wash hands. Refer to Hand Washing procedure.
16. Change dressing minimally every seven days.

DOCUMENTATION GUIDELINES

1. Document in the clinical record:
 - a. Appearance, odor, and size of wound.
 - b. Amount and characteristics of drainage.
 - c. The client's tolerance of the procedure.
 - d. Dressing procedure and time of dressing change.

RELATED PROCEDURES

None.

APPLICATION OF HYDROGEL DRESSING

PURPOSE

To facilitate wound debridement by rehydration.

APPLIES TO

- Registered Nurses
- Licensed Practical/Vocational Nurses
- Therapists
- Other (Identify): _____

EQUIPMENT/SUPPLIES

- One pair of disposable gloves and one pair of sterile gloves or two pair of disposable gloves.*
- Sterile normal saline or prescribed wound cleanser.
- Sterile gauze pads.
- Hydrogel dressing.
- Waterproof bag.
- Dressing set (optional).*

**Note: Supplies to be sterile if procedure is ordered to be performed using aseptic technique.*

PROCEDURE

1. Wash hands. Refer to Hand Washing procedure.
 2. Position the client to provide access to wound.
 3. Place waterproof bag next to work area and within reach.
 4. Don clean gloves.
 5. Remove old dressing. Lift hydrogel dressing off wound.
 6. Dispose of soiled dressings in waterproof bag.
 7. Remove soiled gloves by wrapping them inside out.
 8. Prepare sterile dressings. Pour sterile normal saline or prescribed solution over one to two gauze pads.
 9. Open new hydrogel dressing or hydrogel container.
 10. Don clean gloves (sterile gloves if procedure is ordered to be aseptic).
 11. Assess wound size, characteristics, and drainage. *Use same measurement method throughout service, i.e., inches or centimeters.*
 12. Gently cleanse area with gauze pads or spray with cleanser. Swab exudate away from wound.
 13. Apply new hydrogel dressing or hydrogel. The gel should be approximately 1/4 to 1/2-inch thick across the wound.
 14. Cover with secondary dressing:
 - a. Gauze.
 - b. Hydrocolloid.
- Note:** Refer to *Application of Wet-to-Dry Dressing or Application of Hydrocolloid dressing procedures.*
15. Remove gloves and dispose of waste according to the Agency Waste Disposal Policy.
 16. Wash hands. Refer to Hand Washing procedure.

PROCEDURE

1. Document in the clinical record:
 - a. Appearance, odor, and size of wound.
 - b. Amount and characteristics of drainage.
 - c. The client's tolerance of the procedure.
 - d. Dressing procedure and time of dressing change.

RELATED PROCEDURES

Application of Wet-to-Dry Dressing, Application of Hydrocolloid Dressing

ASSESSMENT/STAGING OF PRESSURE ULCERS

Pressure ulcers result from pressure applied with great force for short periods of time or less force over a longer period. Circulation is impaired depriving tissues of oxygen and other life sustaining nutrients. This process damages skin and underlying structures.

Common sites for pressure ulcers are over bony prominences where friction and force combine to break down skin.

Home care should use a risk assessment tool to determine risk and plan accordingly.

APPLIES TO

- Registered Nurses
- Licensed Practical/Vocational Nurses
- Therapists
- Other (Identify): _____

PRESSURE ULCER ASSESSMENT GUIDE

In assessing the pressure ulcer, the following parameters should be addressed consistently.

- Site, Stage of ulcer, and size of ulcer (include length, width, and depth).
- Presence of tunneling or undermining.
- Presence of necrotic tissue (slough or eschar).
- Drainage amount, color, and odor.
- Granulation.
- Pain.
- Condition of surrounding tissue.

STAGING A PRESSURE ULCER

- Stage 1: non-blanchable redness of intact skin. in individuals with darker skin where redness is not visible, note discoloration, warmth, swelling and/or in duration. (*use adhesive film dressing--healing can occur within 24 hours*)
- Stage 2: Partial thickness skin loss - dermis, epidermis, or both superficial epithelial damage has occurred. Area is reddened and edematous; may have excoriation or blisters. Redness does not disappear when pressure is relieved. Surrounding area is red and scaly with irregular borders. (*Transparent dressings if non draining, hydrocolloid if draining*).
- Stage 3: Full thickness skin loss--damage to subcutaneous tissue--may extend down to but not through underlying fascia. Deep crater with or without tunneling. Necrotic tissue; destruction of capillary bed, producing serosanguineous drainage. Surface of ulcer will likely be smaller than internal diameters (*hydrocolloid dressings, if large amounts of drainage, absorptive product in wound and cover with hydrocolloid*).
- Stage 4: Full thickness skin loss - extensive destruction and tissue necrosis, Destruction of deeper tissue, extending through subcutaneous layers into muscle mass and bone. Ulcer edge appears to “roll over” into the defect and is a tough, fibrinous ring. (*Often require surgical intervention.*)
- Eschar: A tough, membranous layer covering ulcer. Layer may be rigidly adherent to the base of the wound. This stage is difficult to determine until eschar has sloughed off or has been removed surgically.

RELATED PROCEDURES

None.

PRESSURE ULCER DRESSING CHANGE

PURPOSE

To remove secretions and dead tissue from the wound.

To decrease infection in wound.

To promote healing.

APPLIES TO

- Registered Nurses
- Licensed Practical/Vocational Nurses
- Therapists
- Other (Identify): _____

EQUIPMENT/SUPPLIES

- Irrigation set or irrigating syringe.
- Gloves. (sterile and non sterile).
- Sterile saline and basin.
- 4 x 4 gauze sponges.
- Cotton swabs.
- Wound measuring device.
- Topical dressing per order.
- Hypoallergenic tape or netting.
- Betadine solution.
- Betadine swabs.
- Plastic bag for waste.

PROCEDURE

1. Gather equipment.
2. Wash hands. Refer to the Hand Washing procedure.
3. Explain procedure to client.
4. Put on gloves and remove old dressing and discard.
5. Note color amount and odor of drainage and presence of necrotic debris.
6. Apply new pair of gloves.
7. Measure wound perimeter with disposable device.
8. Using syringe, irrigate with force to remove necrotic tissue and decrease the presence of bacteria in the wound.
9. Assess for undermining or wound tunneling by inserting sterile swab into the wound. (*tunneling indicates wound extension*) Measure length of undermining (*tunneling*).
10. Cleanse the wound bed.
11. Note condition of wound bed and surrounding skin. (If necrotic tissue adheres to wound, notify physician or wound care specialist for debridement).
12. Apply topical dressing (as appropriate for wound and as ordered by physician).

DOCUMENTATION GUIDELINES

1. Document in the clinical record:
 - a. Date and time of procedure.
 - b. Specific treatment.
 - c. Location, size of ulcer.
 - d. Color and appearance of wound bed.
 - e. Amount color and consistency of drainage.
 - f. Condition of surrounding tissue.
 - g. Changes in general condition - complaints of pain, elevated temperature.
 - h. Physician notification.
 - i. Preventive measures taken.
 - j. Teaching done.
 - k. Client response.

RELATED PROCEDURES

None.

MANAGEMENT/PREVENTION OF PRESSURE ULCERS

Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible.

APPLIES TO

- Registered Nurses
- Licensed Practical/Vocational Nurses
- Therapists
- Other (Identify): _____

THE BRADEN SCALE

Commonly used tool in predicting ulcer risk. Six areas are evaluated to determine risk using a numeric scale. The lower the score the higher the risk. The areas are:

- Sensory perception: the ability to respond to pressure related discomfort - high risk paraplegics or quadriplegics with no sensation.
- Moisture: the degree to which the skin area is exposed to moisture. (incontinent clients).
- Activity: degree of physical activity - the less active the higher the risk.
- Mobility: ability to change and control body position.
- Nutrition: note usual food and intake pattern.
- Friction and shear: ability to assist with management or be moved in a way that prevents contact with bedding or other surfaces.

IDENTIFYING RISK FACTORS AND IMPLEMENTING PREVENTION MEASURES

- Turn and position every one to two hours.
- Use pressure reducing devices such as cushions, mattresses etc.

- Range of motion exercises to relieve pressure and improve circulation.
- Lift rather than slide (body or body part).
- Avoid positions with direct weight on bony prominences.
- Adjust or pad appliances, casts, splints, etc.
- Avoid increased pressure.
- Avoid heat lamps and harsh soaps.
- Individualize bathing routines - dry skin is more susceptible.
Use lotions keep skin moist.
- Nutrition is important to prevention and to healing - evaluate and use other disciplines as necessary.
- Manage the incontinent client - keep dry and use protective moisture barriers.
- Avoid heel and elbow protectors that fasten with single strap as they can affect movement and circulation.
- Avoid artificial sheepskin as it does not decrease pressure.

RELATED PROCEDURES

None.

SURGICAL STAPLE REMOVAL

PURPOSE

To remove staples from an incision or wound.

APPLIES TO

- Registered Nurses
- Licensed Practical/Vocational Nurses
- Therapists
- Other (Identify): _____

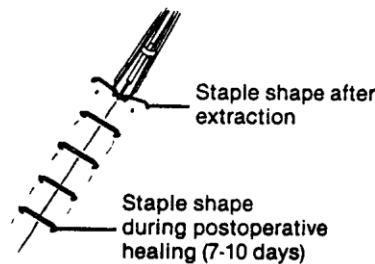
EQUIPMENT/SUPPLIES

- Antiseptic swabs.
- Butterfly adhesive strips.
- Disposable gloves.
- Sterile gloves.
- Disposable, waterproof bag.
- Dressing supplies, as needed.
- Staple extractor.

PROCEDURE

1. Wash hands. Refer to the Hand Washing procedure.
2. Position the client for easy access to incision.
3. Place disposable, waterproof bag next to the client and within reach.
4. Prepare sterile field and open supplies, maintaining sterility.
5. Don clean gloves.
6. Remove old dressing.

7. Hold soiled dressing in hand and remove glove to wrap inside out around dressing. Repeat with second glove. *If amount of dressing is too great, place dressing directly into waterproof bag, then remove gloves and dispose of in bag.*
8. Assess wound characteristics, size, and appearance. *Use same measurement method throughout, i.e., inches or centimeters.*
9. Don sterile gloves.
10. Cleanse staples and incision with antiseptic swabs.
11. Place lower tips of staple extractor under first staple.



12. Close handle. The upper tip of the staple extractor depresses the center of the staple. This causes both ends of the staple to bend upward and exit their insertion sites at the same time.
13. Securely hold staple extractor and move the staple away from the incision site.
14. Holding the staple extractor over the disposable bag, release handles. The staple should drop into the bag.
15. Repeat until all staples are removed.
16. Assess incision site.
17. If any separation is present, place butterfly adhesive strips across the incision line. *This maintains contact between wound edges for healing.*
18. Apply dry dressing, if needed. Expose to air if incision will not come in contact with clothing.
19. Remove gloves and dispose of waste as outlined in the Agency Waste Disposal Policy.
20. Wash hands. Refer to Hand Washing procedure.

DOCUMENTATION GUIDELINES

1. Document in the clinical record:
 - a. Incision characteristics and any bleeding, drainage, or wound separation.
 - b. Number of staples removed.
 - c. The client's tolerance of the procedure.

RELATED PROCEDURES

Application of Dry Dressing