Policy Title: Wound Dressing, Nursing Responsibility		
Department/Unite: Nursing Unit.	**Policy Number:** UOJ-MSA-NR-P/01	**Replaces No:**
Creation Date: 10/12/2022	**Effective Date:**	**Review Date:**

Revision History

Subject	Changes made	Done by	Revision date

1. **CONDITIONS:** 1.1 All staff of Nursing Unit.

2. **PURPOSE:**

2.1 To clean the wound and protect it with a dressing without contaminating the wound area, without causing trauma to the wound, and without causing the patient to experience pain or discomfort.

2.2 To clean the wound and prevent infection, and other complications.

2.3 To protect the wound from bacterial contamination and from possible soiling, and absorb the exudates.

2.4 To immobilize an injured body part.

2.5 To provide mental and physical comfort for the patient.

3. **DEFINITIONS:**

3.1 **Wound:** it is an injury to the skin as a result of different causes, incision, burn, trauma or other impact leads to broken skin**.**

3.2 **Surgical or Wound dressing definition:** wound is covered by Sterile dressing with using aseptic technique ,accompanied by medication as prescribed by the doctor.

4. **Related Documents:** N/A

5. **POLICY:**

5.1 Nurses should know how to recognize, assess and effectively treat routine wounds, doing wound dressing, promoting fast wound healing as well as improving the condition of patient's wound. Aseptic technique must be adhered. Patient's privacy must be observed during the procedure. It is the responsibility of every nurse to maintain an up to date knowledge regarding wound management. Wound dressings should be checked every day. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.

6. PROCEDURES:

6.1Confirm Physician's written order for wound dressing or change of wound dressing.

6.2 Ensure change of dressing is done at suitable time (e.g. not during mealtime or visiting time) unless necessary.

6.3 Perform hand hygiene.

6.4 Gather all necessary supplies and equipment on a clean dressing trolley.

6.5 Check integrity of each items package and expiration dates.

6.6 Do not use any packages when sterile barrier is not maintained (e.g. peeled opened plastic pouches, torn wrappings).

6.7 Do not use expired supplies or items with opened/torn packages.

6.8 Identify patient correctly.

6.8 Patient's Name – positive identification by asking to state patient's name Provide Privacy, by closing door or curtain.

6.9 Expose the dressing site but respect the patient's modesty and prevent the patient from being chilled.

6.10 When applying a saline-moistened dressing, position the patient so the wound cleanser or irrigation solution will flow from the clean end of the wound toward the dirtier end. Place moisture resistant pad (if necessary) under part of the body where the wound is located.

6.11 Open each dressing set by peeling apart the edges of the package.

6.12 Ensure the sterility of the dressing.

6.13 Remove the old dressing.

6.14 Put on well-fitting gloves (sterile or clean as needed)

6.15 Loosen all tape and gently pull tape ends towards the wound.

6.16 Hold skin taut with one hand while carefully peeling up an edge of the tape with the other hand.

6.17 The tape or adhesive portion of the dressing is removed by pulling it parallel with the skin surface and in the direction of hair growth, rather than at right angles.

6.18 Remove old dressings, one layer at a time, and place them in disposable bag. Do not reach over wound.

6.19 Moisten adherent dressing with small amount of sterile saline solution to facilitate removal.

6.20 Use small amount of sterile saline to help loosen and remove if any part of the dressing sticks to the underlying skin.

6.21 Keep soiled side of dressing away from patient view.

6.22 Assess the color, consistency, amount and odor of the wound drainage

6.23 After removing the dressing, note the size, depth, edges of the wound, presence of undermining, necrotic tissue type and amount, peripheral tissue induration, granulation tissue, epithelialization, exudates type and amount and color.

6.24 Assess if any pain is present.

6.25 Check status of sutures, adhesive closure strips, note any problems to include in the documentation. Dispose soiled dressing as well as moisture resistant pad (when soiled) onto the nearby infectious waste bin.

6.26 Dispose used gloves to the infectious waste bin.

6.27 Replace the soiled moisture resistant pads.

6.28 Clean the wound.

6.29 Wound cleansing aims to remove gross contamination with minimal pain to the patient and minimal trauma to the tissues.

6.30 Wound cleansing is advocated before obtaining swabs in order for the culture to isolate wound tissue microorganisms, not microorganisms associated with wound exudates, topical therapies, or non-viable tissue.

6.31 Open the package of sterile gloves.

6.32 Open the sterile cleaning supplies (sterile gauze, sterile dressing set, sterile solution cap, sterile saline solution.

6.33 Depending on the amount of cleaning needed, the solution might be poured directly over gauze sponges over a container for small cleaning jobs, or into a basin for more complex or larger cleaning. Put on sterile gloves.

6.34 Clean along the wound edges using a small circular motion from one end of the incision to the other.

6.35 Clean the wound from top to bottom and from the center to the outside.

Following this pattern, use new gauze for each wipe, placing the used gauze in the waste receptacle. Alternately, spray the wound from top to bottom with a commercially prepared wound cleanser.

6.36 Clean the wound using a pair of artery or tissue forceps (Keep the forceps tips lower than the handles at all times).

6.37 Be sure to clean each side of the wound separately.

6.38 Use a separate gauze for each stroke, cleaning the top of incision downward.

6.39 Clean with strokes from top to bottom starting at the center and continuing to the outside.

6.40 Repeat the process using another moistened gauze until the entire incision is clean.

6.41 Do not scrub back and forth.

6.42 Discard gauze after each downward stroke

6.43 Discard all materials used into the infectious waste bin.

6.44 Dry the area using a gauze sponge once the wound is cleaned.

6.45 Perform hand hygiene.

6.46 Open the sterile package of gloves.

6.47 Open the package containing the sterile syringe and needle.

6.48 Keep all products within their sterile open package until use.

6.49 Put on sterile gloves.

6.50 Dress the wound:

6.50.1 Maintain asepsis with the use of sterile gloves.

6.50.2 Apply appropriate dressing but take into consideration the nature of the wound.

6.51 Observe the following when applying a saline-moistened dressing:

6.51.1 Open the supplies and dressings.

6.51.2 Place the fine-mesh gauze into the basin and pour the ordered solution over the mesh to saturate it.

6.51.3 Apply first a skin protectant or barrier to the peri wound.

6.51.4 Squeeze excess fluid from the gauze dressing.

6.51.5 Unfold and fluff the dressing.

6.51.6 Gently press to loosely pack the moistened gauze into the wound.

6.51.7 Use the forceps or cotton-tipped applicators to press the gauze into all wound surfaces, if necessary.

6.51.8 Apply several dry, sterile gauze pads over the wet gauze.

6.51.9 Follow up referral to and coordinate with the Wound Management and

6.51.10 Hyperbaric Unit when choosing appropriate wound management products.

6.51.11 Adhere to the Wound Care Management Policies and Procedures.

6.51.12 Remove sterile gloves after use.

6.51.13 Secure the dressing using only the amount of plaster required for secure attachment.

6.51.14 Apply "Skin Prep" on the site to be taped to facilitate fixation and reduce irritation. Label dressing with date and time.

6.51.15 Remove all remaining equipment.

6.51.16 Place the patient in a comfortable position, with side rails up and bed in the lowest position.

6.51.17 Perform hand hygiene.

6.51.18 Assess the patient's tolerance to the procedure.

6.51.19 Make patient more comfortable (e.g. repositioning).

6.52 Document in the Nurse's Notes the following:

6.52.1 Date and time the procedure was done.

6.52.2 Condition of the wound. Color odor and amount of discharge.

6.52.3 Patient's response to the procedure.

6.52.4 Record in the Nursing Kardex.

7. RESPONSIBILITIES 7.1 All staff of Nursing Unit.

8. Appendix: 8.1 Nurse's Notes.

9. REFERRANCES: 9.1 Ministry of Health Manual for Nursing Unit.

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