Dressings Non- Sterile (Aseptic)

Purpose

The purpose of this procedure is to provide guidelines for the application of non-sterile dressings.

Preparation

1. Verify that there is a physician's order for this procedure. (Note: This may be generated from a facility protocol.)
2. Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs.
3. Check the treatment record.
4. Assemble the equipment and supplies as needed. Date and initial all bottles upon opening.

Equipment and Supplies

The following equipment and supplies will be necessary when performing this procedure.

1. Non-sterile dressing supplies
2. Plastic bag for soiled dressings
3. Normal saline/wound cleanser
4. Alcohol based hand gel
5. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed)
6. Tape, Scissors as needed

Steps in the Procedure

1. Prepare a clean, dry work area at bedside.
2. Bring supplies into resident's room. Individual resident supplies may be placed on the over bed table after it has been disinfected and a protected barrier placed on the table (clean towel, plastic bag, small chux, foam tray and etc.). Cut strips of tape adequate for securing dressing and add date and initials or if adhesive dressing used, label dressing at this time.

   Treatment cart may ONLY be taken into room and used as a dressing table if disinfected in advance and disinfected after use. May use Virex, facility approved disinfectant solution, or bleach solution (1 part bleach to 5 parts water) to wipe down the top, front and sides of the treatment cart.

   The treatment cart should remain in line of vision of the treatment nurse or be locked when not in view.

3. Explain procedure the resident and/or family and provide privacy.
4. Place plastic trash bag within easy reach of worksite.
5. Wash hands.
6. Prepare/open any necessary supplies and place on top of clean barrier.
7. Apply gloves. In the event that personal contamination is anticipated, personal protective equipment such as gown and mask should be worn.
8. Assist resident to required position and expose area to be dressed. Avoid overexposing the resident unnecessarily. If needed, place waterproof pad under affected area.
9. Remove soiled dressing and place in plastic trash bag.
10. Remove soiled gloves and place in plastic trash bag.
11. Wash hands, of if hands are not visibly soiled, an alcohol based hand gel may be used to decontaminate the hands.

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Steps in the Procedure (continued)

When decontaminating hands with an alcohol based hand gel, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Follow the manufacturer's recommendations regarding the volume of product to use.

12. Apply clean gloves.
13. Clean or irrigate area/wound with solution specified in treatment order (normal saline, wound cleanser, etc.). Pat periwound and wound dry using dry gauze.
14. Observe wound for response to treatment and any signs/symptoms of infection. (If QMA performing dressing change on a skin tear or G-Tube and observes any signs/symptoms of infection, they are to report to nurse immediately and follow further instructions).
15. Apply prescribed ointment and/or dressing per physician treatment order.
16. Secure dressing in place, if needed.
17. Remove gloves and discard in plastic bag.
18. Seal plastic bag. (Plastic bag is not to remain in resident bed side trash. Place plastic bag in bathroom trash container, treatment cart trash or soiled utility room).
19. Wash hands.
20. Sanitize bandage scissors after each use before returning to pocket or treatment cart.
21. Initial treatment Administration Record.

NOTE: In the event more than one wound is present, each wound site is considered a separate treatment. A new pair of non-sterile gloves will be used for the cleansing of each site, as well as disinfecting hands using hand gel between each site.

If at any point during the dressing change hands become visibly soiled, hands must be washed instead of using hand gel to disinfect.

Follow manufacturer's recommendations for application of dressings, ointments, creams, moisturizers, etc.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time the dressing was changed.
2. Wound appearance, including wound bed, edges, presence of drainage.
3. The name and title of the individual changing the sterile dressing.
4. The type of dressing used and wound care given.
5. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound.
6. How the resident tolerated the procedure.
7. Any problems or complaints (e.g., pain or discomfort) made by the resident related to the procedure.
8. Complications related to the wound (e.g., pain, redness, drainage, swelling, bleeding,).
9. If the resident is non-adherent with treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. Document family and physician notification of non-adherence.
10. The signature and title of the person recording the data.

Reporting

1. Report information in accordance with facility policy and professional standards of practice.