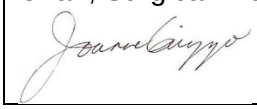
Health Sciences North
Horizon Santé-Nord

SURGICAL PROGRAM
PROCEDURE

CATEGORY: System-Level Clinical **REVISION DATE:**
ISSUE DATE: January 15, 2018
TITLE: **DRESSING – DRY AND MOIST-TO-DRY**

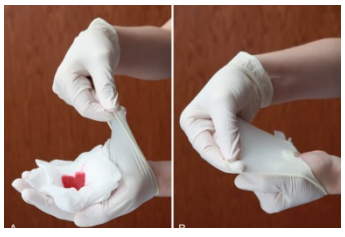
Document Owner: Nurse Clinician, Surgical Inpatient Unit	**Name:** Diane Delvecchio
Update Schedule: Every three years, or sooner if required.	
Stakeholder Consultation and Review: Surgical Patient Care Team	**Date:** October 24, 2017
Approval: Joanne Guizzo Chair, Surgical Program Council Management 	**Date:** November 8, 2017

PURPOSE
To outline the procedure for dry and moist-to-dry dressings.

PROCEDURE
Equipment
- PPE (gloves, gown, mask, and eye protection if splashing from wound is a risk)
- Sterile dressing set (scissors, forceps)
- Sterile dressings (for packing wound and for outer dressing)
- Antiseptic ointment (as prescribed)
- Analgesic, if prescribed
- Wound cleansing spray (as prescribed)
- Sterile normal saline or prescribed solution
- Tape, ties, or bandage as needed (including non-allergenic tape, if necessary)
- Protective waterproof pad
- Waterproof bag
- Adhesive remover wipes (optional)
- Measurement device (optional)
- Additional lighting, if needed

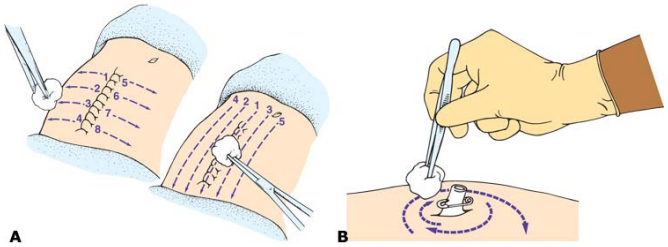
Method
1. Perform hand hygiene before patient contact.
2. Verify the correct patient using two identifiers.
3. Verify the practitioner's orders for the dressing change. **Clarify an order for a wet-to-dry dressing if mechanical debridement is not indicated.**
4. Assess the size, location, and condition of the wound.
5. Determine the patient's level of comfort using an organization-approved pain scale.
6. Assess the patient's and family member's knowledge of the purpose of a dressing change.
7. Determine the patient's and family member's need, readiness, and willingness to participate in dressing the wound.

8. Assess the patient for risk factors for delayed wound healing (i.e. advanced age, prematurity, obesity, diabetes, circulatory compromise, impaired nutritional status, immunosuppression, radiation skin damage, high levels of stress, corticosteroid use).
9. Assess the patient for allergies, including sensitivity to tape and other adhesives.
10. Prepare the supplies on a clean or sterile field per the practitioner's orders or the organization's practice.
11. Provide privacy for the patient.
12. Place a disposable waterproof bag within reach of the work area. Fold the top of the bag to make a cuff.
13. Administer the prescribed analgesic as needed.
14. Reassess the patient's pain status, allowing for sufficient onset of action per medication, route, and the patient's condition.
15. Perform hand hygiene and don gloves. Don gown, mask, and eye protection if a risk of splashing from the wound exists.
16. Explain the procedure to the patient and ensure that he/she agrees to treatment.
17. Position the patient comfortably. Drape the patient to expose only the wound site.
18. Remove tape, gauze wrap bandages, or ties securing the existing secondary dressing.
19. Using your non-dominant hand, gently press down on the intact skin just outside the dressing edges to provide counter pressure and then pull the adhesive edges parallel to the skin toward the dressing. If the dressing is covering areas of the body that have hair, remove the dressing in the direction of hair growth. If needed, obtain the patient's permission to clip hair from the area.
20. Remove excess adhesive from the skin using an adhesive remover wipe.
21. Use fingers or forceps to remove the secondary dressing. Then remove the primary dressing that is in contact with the wound bed. If drains are present, slowly and carefully remove dressings and avoid tension on any drainage device.
    A. If a dry dressing adheres to the wound and mechanical debridement is not indicated, moisten the dressing with saline and remove it.
    B. If a moist-to-dry dressing adheres to the wound, alert the patient to the possibility of discomfort and then gently remove the dressing. **Use a moist-to-dry dressing only when mechanical debridement is appropriate (i.e. when non-viable, necrotic tissue is present and no other debridement options are available).**
    C. If mechanical debridement is not the goal, consult with the practitioner to consider modifying the dressing order to specify saline-moistened gauze for wet-to-moist therapy.
22. Inspect the wound and periwound, noting the colour and size (length, width, and depth) as well as drainage, edema, the condition of drains, any odour, and signs of healing.
23. Gently palpate the wound edges, noting any bogginess, induration, or the patient's report of increased pain. If the wound is healing by secondary intention, gently probe the wound bed and inner edges with a moistened cotton-tipped applicator for the presence of undermining, tunneling, or sinus tracts.
24. Fold the dressing with the drainage contained inside, discard it in a waterproof bag, and remove the gloves inside out. With a small dressing, remove the gloves inside out over the dressing and discard the gloves with the soiled dressing in a waterproof bag.



25. Perform hand hygiene and don clean gloves.
26. Reassure the patient as needed. Describe or explain the appearance of the wound and any indicators of wound healing or delayed wound healing.
27. Cleanse the wound.
    A. Use a separate saline-moistened gauze for each cleansing stroke or spray the wound surface with an appropriate wound cleanser.
    B. Clean from the least to most contaminated area.
    C. Cleanse around the drain (if present) using aseptic technique. Start near the drain using circular strokes and move outward and away from the insertion site.

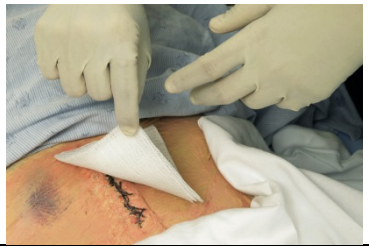
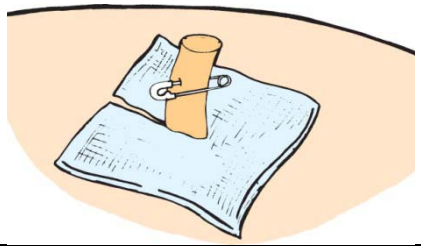
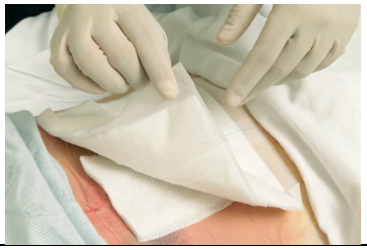
D. Use a separate dry gauze to blot the wound dry from the least to most contaminated area. If a drain is present, use circular strokes starting near the drain and moving outward and away from the insertion site.



28. If ordered, apply antiseptic ointment with a cotton-tipped applicator or gauze over the incision.
29. Remove gloves and perform hand hygiene. Don clean gloves.
30. Apply the dressing.

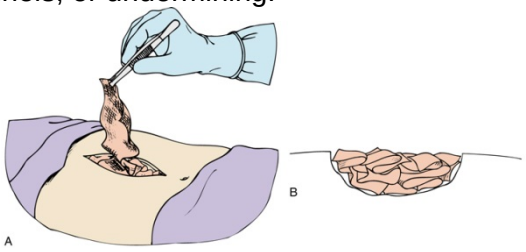
Dry Dressing

A. Apply a layer of gauze over the wound as the contact layer or primary dressing.
B. If a drain is present, apply a precut, split 4x4 gauze around the drain.
C. Apply additional layers of gauze, as needed.
D. Apply a thicker absorbent pad (i.e. abdominal pad).

Moist-to-Dry Dressing

A. Pour the prescribed sterile solution (i.e. saline) on the gauze or gauze wrap or cut the packing strip to be used to fill the wound bed. Wring out excess solution. **If a packing strip is used to fill the wound, use sterile scissors to cut the amount of dressing needed to fill the wound. Do not let the strip touch the side of the bottle to avoid contaminating the packing strip.**
B. Apply moistened gauze or packing material as a single layer directly onto the wound surface.
   i. If the wound is deep, loosely fill it with additional gauze or packing material using sterile forceps until all wound surfaces are in contact with moist gauze, including any sinus tracts, tunnels, or undermining.

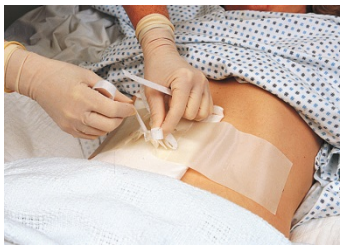


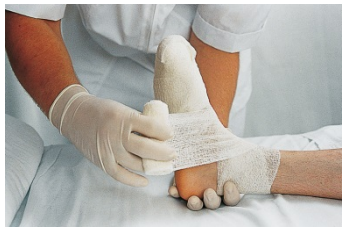
   ii. Ensure that moist gauze does not overlap onto the periwound skin (Box 1). **Do not pack the wound too tightly because tight packing may cause wound trauma.**
C. Apply dry sterile 4x4 gauze over the moist gauze.
D. Cover with an abdominal pad (or similar product) or additional layers of gauze.

Box 1	Principles for Packing a Wound

- Use the wound characteristics to decide which type of packing is appropriate.
- Make sure the packing material can be safely used to pack a wound.
- Moisten the packing material with a noncytotoxic solution, such as normal saline. Never use cytotoxic solutions (e.g., povidone-iodine) to pack a wound.
- If using woven gauze, fluff it before packing it into the wound.
- Loosely pack the wound.
- Do not let the packing material drag or touch the surrounding wound tissue before putting it into the wound.
- Fill all the wound dead space with the packing material.
- Pack the wound until you reach the wound surface; never pack the wound higher than the wound surface.

31. Secure the dressing.
    A. Apply tape to the dressing edges in a window-pane fashion, ensuring sufficient contact with both the intact skin and dressing. Use non-allergenic tape as needed.
    B. Use Montgomery ties or straps.
        i. Ensure that the surrounding skin is clean and intact.
        ii. Apply a skin barrier, such as a hydrocolloid, if needed.
        iii. Expose the adhesive surface of the ties.
        iv. Place the ties on opposite sides of the secondary dressing directly onto the surrounding skin or skin barrier.
        v. Lace the ties securely, avoiding excessive pressure.
    C. Use roll gauze or elastic netting.
        i. Apply roll gauze circumferentially to secure the secondary dressing.
        ii. Cut elastic netting and apply it over the secondary dressing to secure it without using tape or other adhesives.





32. Label the dressing per the organization's practice.
33. Assist the patient to a comfortable position.
34. Observe the appearance of wound for healing: wound size (length, width, depth); amount, colour, and type of drainage; and periwound erythema or swelling.
35. Assess, treat, and reassess pain.
36. Discard supplies, remove PPE, and perform hand hygiene.
37. Document the procedure in the patient's record.

EDUCATION AND TRAINING

References and Related Documents

Ayello, E.A., Baranoski, S. (2014). 2014 survey results: Wound care and prevention. *Advances in Skin & Wound Care, 27*(8), 371-380. doi:10.1097/01.ASW.0000451511.43830.a7.

Bryant, R.A., Nix, D.P. (2016). Chapter 18: Principles of wound healing and topical management. In R.A Bryant, D.P. Nix (Eds.), *Acute& chronic wounds: Current management concepts* (5th ed., pp. 306-324). St. Louis: Elsevier.

Grosso, M.J. and others. (2017). Silver-impregnated occlusive dressing reduces rates of acute periprosthetic joint infection after total joint arthroplasty. *The Journal of Arthroplasty, 32*(3), 929-932. doi:10.1016/j.arth.2016.08.039 (Corrigendum published 2017, *The Journal of Arthroplasty, 32*[12], p. 3862.)

Junker, J.P. and others. (2013). Clinical impact upon wound healing and inflammation in moist, wet, and dry environments. *Advances in Wound Care, 2*(7), 348-356. doi:10.1089/wound.2012.0412.

Perry, A.G., Potter, P.A., Ostendorf, W.R. [Eds.]. [2018]. *Clinical nursing skills & techniques* [9th ed.]. St. Louis: Elsevier.

Sibbald, R.G., Goodman, L., Persaud, R. (2013). Wound bed preparation 2012. *Journal of Cutaneous Medicine and Surgery, 17*(Suppl. 4), S12-S22. doi:10.2310/7750.2013.WOUND5.