Generic Dressing Change Guidelines for Long Term Care

Treatment Verification & Resident Preparation

1	Confirm the most recent treatment orders. • Review the Treatment Administration Record (TAR) and Orders in the resident's chart (electronic or otherwise). • Review previous wound documentation to obtain information on where/how wound measurements were taken, along with other unique features of the wound. If multiple wounds are present, ensure consistent documentation of each wound.
2	Confirm order for pain medication (if any). • Review Medication Administration Record (MAR) and Orders section in resident's chart (electronic or otherwise).
3	If applicable, prior to dressing change, pre-medicate the resident for pain management per order.
4	Notify a nursing assistant if assistance will be needed during the dressing change for positioning and/or to monitor the resident should you need to leave the room during the procedure.
5	Go to the resident's room and knock. Wait for a response and announce yourself. Confirm the resident's identification and explain that it is time for their dressing change & applicable pain medications. Ask permission to have someone observe and assist with the dressing change (if applicable).
6	**Hand Hygiene**-Clean bedside table/tray and cover w/ barrier (both according to facility policy & procedure). • All items to be used for the dressing change should be gathered from the treatment cart ***before*** the procedure begins to prevent repeated trips to the cart & possible cross-contamination.

Treatment Set Up (Outside Room)

1	Inspect the contents of the treatment cart to be sure it contains everything you need for the dressing change. • Check the expiration dates of dressings and supplies. • Gather refrigerated topical medications (if applicable). • Check for proper labeling of the resident's name and expiration date on tubes and liquid/gel containers (note: all tubes and liquid/gel containers must be dated when opened and may only be used for the time period allotted per relevant facility policies and procedures).
2	Gather all necessary items for the dressing change procedure ***prior*** to entering the resident's room. For infection control reasons, treatment carts should ***not*** be brought into the resident's room. • Topical creams, ointments, or medications should be dispensed into a clean container (e.g., a disposable plastic medicine cup), which will be brought into the resident's room instead of the cream, ointment, or medication container. • If a wound cleanser is used, be sure that it is labeled with the resident's information and date of opening and stored per facility policies and procedures. • Lock the treatment cart since it will be unattended outside of the resident's room. Place the cart in a safe location according to facility policy.

Treatment Procedure (Inside Room)

1	Knock on the resident's door. Wait for response and announce yourself. Remind the resident that you are there to perform a dressing change. • Check orders and premedicate per orders • Call for your nursing aide and introduce anyone who will be observing/assisting with the dressing change procedure. • Don PPE for compliance with CMS Enhanced Barrier Precautions (EBP) • Close the resident's door. Pull the privacy curtain and draw blinds/curtains on window as applicable.
2	Place supplies on designated bedside table/tray. Supplies should be placed on a previously cleansed & prepared area with a barrier) • Clean fields should be arranged per facility protocol and in order of planned use. • Prepare an appropriate trash receptacle for discarded dressings and used supplies. • **Hand Hygiene:** don gloves and open dressing packages, leaving the dressing in the bottom half of the dressing package (if able). • Write the date, time and your initials on the cover dressing or pre-cut tape. The marker/pen used should not bleed into the dressing. • Sharps should be disposed of in a designated container per facility policies and procedures.
3	Position resident.
4	Remove gloves (discarding in appropriate receptacle) and perform **hand hygiene**.
5	Don gloves, remove soiled dressings and note any clinically relevant information from the soiled dressing (e.g., exudate amount and type (i.e. serous, serosanguinous, purulent). Discard dressing in the appropriate receptacle.
6	Remove gloves (discarding in appropriate receptacle) and perform **hand hygiene**.

7	Don gloves and using aseptic (clean) technique, moisten a gauze pad with wound cleanser or normal saline. **Wound Hygiene**.
	• Cleanse the wound using gauze or a monofilament pad using circular motion, starting from the center of the wound and moving outward to approximately. <u>Cleaning the periwound area (10-20 cm from wound edge) helps prevent wound infections.</u>
	• Repeat this process 2-3 times, or as necessary.
	• Change gauze several times to **NOT** spread infectious organisms
	• If the wound requires irrigation:
	    ○ Wear proper personal protective equipment (PPE) if splashing of irrigation fluid is possible. (e.g., pulsatile lavage)
	    ○ <u>Note</u>: a variety of methods and delivery modalities exist for wound hygiene—the key is to provide enough force to dislodge non-viable tissue and debris, but not too much force that would damage newly formed granulation tissue).

8	Assess the resident's tolerance throughout the dressing change procedure. If the resident reports persistent pain related to the dressing change procedure, **stop**. Cover the wound with clean gauze and determine how to improve the resident's comfort: • Reposition resident, provide more pain medication if ordered • Contact the provider if pain cannot be controlled with current pain management interventions.
9	As applicable, measure the resident's wound(s) including length, width, depth, undermining and tunneling if present. Note appearance of wound base, wound edges, periwound, amount and consistency of drainage, and odor (after cleansing).
10	Cleanse all re-usable items per relevant facility policies and procedures (e.g., bandage scissors).

11	Remove gloves (discarding in appropriate receptacle) and **hand hygiene**.

Treatment Procedure (continued)

12	Don gloves for topical/dressing application using aseptic (clean) technique. • If a topical ointment/medication is ordered, apply with a clean, saline-moistened cotton-tipped applicator—using a clean applicator each time it is dipped into the disposable container. • Apply skin protectants and moisture barriers as applicable. • Apply the appropriate primary, secondary, and/or tertiary dressing as appropriate. Secure dressings in place as appropriate.
13	Assess the resident's comfort and reposition/offload as necessary.
14	Remove gloves (discarding in an appropriate receptacle) and perform **hand hygiene**.
15	If multiple wounds are present, repeat the process for each wound, beginning with Step 3 in this section.

Treatment Wrap-Up

1	Ensure that the patient is positioned comfortably with call button in-reach.
2	Clean bedside table/tray after removing/discarding all treatment supplies (per facility policy and procedure).
3	Cleanse all re-usable items per relevant facility policies and procedures (e.g., bandage scissors).
4	Discard trash in the appropriate receptacle/location as dictated by the relevant facility policy and procedure.
5	**Hand hygiene**
6	Complete all appropriate documentation.

Please see the accompanying Dressing Change Checklist. These documents are examples of Dressing Change Guidelines and a Check List that can be customized to facility or organization protocols.

This information is provided for informational purposes only. Patient care decisions should be based on relevant clinical guidelines, including current evidence-based literature, state and federal guidelines (CMS), and facility protocols.

*Decisions for wound management should be based on a holistic review of the patient's clinical condition. The clinical team members are encouraged to rely on their training and expertise, as well as **all** available clinical and other pertinent information, prior to making treatment decisions for any individual patient.*