Simple Sterile Dressing Change - June 2019

Female1: What happens if there isn't an order? What if the physician doesn't write "change dressing"?

Female2: In that case you would use your best practices guidelines which tell you you can change surgical dressings 48 hours after the surgery.

F1: What happens if you start seeing that shadowing come through the dressing?

F2: Well, then you're going to start to think that perhaps the patient is bleeding. Sometimes the nurse will reinforce the dressing. But there may come a point where you become concerned and you actually want to get down to the skin level and see what's going on with the wound.

F1: Do we care if there's shadowing that's coming through?

F2: Of course we do, because it means that the skin edges haven't approximated and there continues to be bleeding.

F1: If the dressing's wet, does that increase the likelihood that there could be infection going in?

F2: Definitely. Moisture acts as a wick for bacteria, so any dressing that is wet to the outside should be covered. There should always be a dry layer between the patient and the environment.

F1: So we should just reinforce that. Like put gauze on top of that to make sure it's healed.

F2: Yes, sterile gauze.

F1: What about, you know, like you go and you work in different types of facilities and they do things different.

F2: Yes. Some surgeons have particular preferences. Sometimes those preferences are written down in policies and sometimes they're not. So whichever agency you're working in, you'll want to become familiar with the policies of the agency. Or even just the practices on the ward.

F1: I know sometimes, you'll get one nurse will do it this way and another nurse does it that way. And there's nothing written. How do you determine [what to do]?

F2: So it always comes back to some best practices guidelines. There is more than one way to do something.

F1: So what's the first thing we do as a student? You know, if we've ascertained that, yes, we need to change that dressing and that there's an order to do that. What's the first step when we come in to see our patient?

F2: Well, I would have assessed the patient and basically done a head-to-toe assessment to see how he or she is doing. If I know I have a dressing that needs changing I would offer some analgesic. Sometimes dressing changes are uncomfortable. Sometimes they're not. But I like to err on the side of caution and always give the patient an option. So I would ask Mr. Jones. I would let him know that I need to change his dressing and [ask if he] would like an analgesic. In this case he has said yes. So I've prepared him an oral analgesic and before I give it to him, I have to identify him [with] two identifiers. So I would ask him his name and his birthdate. I would check his bracelet and compare that to what the MAR says. I would also confirm allergies at that time just in case he has an allergy.

F1: What if it's too soon to give that medication?

F2: Then I'd have to wait. Or perhaps there's an alternate analgesic that I could give him. Bottom line is safety. I have to make sure he stays safe and that he gets the best care possible.

F1: Or maybe if we were close to shift change and somebody had just given it to them and it was effective now could we just go ahead?

F2: Yes, you just have to assess each situation. So because these are oral analgesics I'm going to give them 30 to 40 minutes to work before I come back and do the procedure.

F1: Okay, so the next thing you're going to do is?

F2: I'm going to go gather my supplies. So before I gather my supplies I'm going to clean my hands. As you know hospitals are great places for bacteria to live and breed. So we're going to clean our hands before we collect our supplies. Another thing to think about is the surface that you're going to work on. So cleaning the top of your work surface with an agency approved antiseptic is a smart idea.

F1: Okay, Renee. You've gathered your supplies and you've done your hand hygiene, you've cleaned off the top of your table and you've got all your supplies here. Can you tell me what you've gathered?

F2: Yes, I've gathered clean gloves because you should wear clean gloves when you remove old dressings because there's risk of you touching blood or body fluids. I've brought a sterile dressing kit and I've read what's inside the bag; to see what kinds of supplies are in my kit because I need to use gauzes for cleaning and drying and dressing the wound. So whatever the kit contains I don't need to collect any more.

F1: So that would be very fiscally responsible because you don't want to bring a whole bunch of extra stuff that you don't need, right.

F2: Right, because once supplies come to the bedside I can't take them back to the shelf because of the risk of contamination and spreading infections to other more vulnerable patients. I've brought saline. Saline is the preferred cleaning solution for surgical wounds and I've made sure that I've looked at an expiry date. And best practice is to use single-use vials. I've brought an outer dressing. And I've brought some tape to secure the dressing. I've already looked at the chart to see what the last nurse found when they changed the dressing. I may decide to use some different supplies depending on what I find when I get in there.

F1: Is there a reason why we have paper tape? Are there other tapes that you can use?

F2: Yes, there are lots of different kinds of tapes. You'll always want to choose a tape that's going to secure your dressing. But also be safe for the patient's skin. Some patients have really fragile skin.

F1: Yes, especially the elderly, right.

F2: Yes, sometimes we don't use tape at all. We actually use a netting to hold dressings on depending on which part of their body the wound is.

F1: And what about the new dressings in the hospital? Don't they have ones that have sort of the island in the middle?

F2: Yeah, they're fantastic. They're a special dressing that has a gauze island with a tape border and they stay really nice and secure. They provide a small level of absorbency. Really you need to choose a dressing that serves the purpose of what you [the wound] needs

F1: Okay, so now we're at the bedside, Renee, and you've done your hand hygiene. You've cleaned off the surface. You've gathered all your supplies. You've checked with Julio to make sure that his analgesic is still effective. And I see you've got the bed up really high. Why did you do that?

F2: Well, there are a couple of reasons. The first is for body mechanics. Whenever you're working you should always think about your back. To be bent over even for a couple of minutes is going to cause back strain. So that's the one reason. And then the other reason is I need to set up my sterile field at waist level to maintain sterility. So having these two at the same height makes a lot of sense.

F1: I remember too now back in nursing school them saying earlobes over shoulders to make sure that you're standing straight.

F2: Right, yeah.

F1: Okay, so what are you going to do now?

F2: Next I'm going to prepare my sterile field. I'm going to open it up. Most packages have a perforated edge on the one side, so you can simply open it up that way. And you're going to take out your contents.

F1: Are you righthanded or lefthanded?

F2: I'm righthanded.

F1: So does it make a difference if somebody's lefthanded where they put their table and how they do that?

F2: Oh, that's a really good point. Your table needs to stay within your field of vision. One of the principles of asepsis is if it's left your field of vision you can't guarantee that it's sterile. I've set my table up lengthwise, because I know in

hospitals our space is very small, and I know if I'm positioned here and I know I'm working on the patient here, I could keep my sterile field in field of vision this way.

F1: And I guess, too, you can still see your patient so you always know what's happening here with them. So you never have your back to them.

F2: Yes, it's really important to remember there's a person at the other end of this procedure. It gets easier with time. Brand new students and new nurses sometimes concentrate so much on the skill that they sometimes forget there's a patient here. But that will come with time.

F1: Yes.

F2: Okay, so I have my sterile field. I always open the first fold away from me and the reason for that is one of the principles of surgical asepsis is we don't want to work over top of our field. We want to try to minimize our arms going over top. At this point I think it's a good idea to square up your field to maximize your space. Using the tip-to-tip method…I'm going to put my forceps close to me so that I do not have to reach. Remember there's that 2.5 centimetre border that runs along the edge of the sterile field. I put my ends of my forceps within that border knowing that I'm going to be able to reach and touch them at that point.

F1: Yes, I see you've kind of lined it up there because if it overhangs that means it's not sterile, right?

F2: Yes, this overhang here, what we have to do now is we have to move in 2.5 centimetres this way. Its abstract thinking but you have to think the border is running like this. This is my garbage that I'm going to need for removal of the old

dressing. And I like to arrange things. I like to keep my gauzes that I need for cleaning in one section. And I know I'm going to need three. And then I keep my other gauzes for drying in another section. I don't put my outer dressing into my field. I find it easier to open that when I need it.

F1: What are you going to do with that other drape there?

F2: Sometimes you need it, sometimes you don't. This is a very simple dressing. If I wanted to extend my clean area, I could. Sometimes if I'm doing a procedure like a drain removal extending your clean area is important just so that you don't make a mess of the patient's linens and the patient themselves. Next I'm going to… did you notice how I reached around my field.

F1: Yes... instead of just going right over top like this.

F2: Right. Again, I'm trying to avoid that. It creates wind currents and there may be skin sloughing and getting onto the field. And you want to try to avoid that. Like I said, single dose or single-use cleaning solutions are best. But sometimes you will use a multiuse solution amongst a lot of people. So what you do in that case, if there were a solution that we were using amongst several people, what I would do is definitely check my expiry date. Most solutions are only good for a month. If you put the solution label in the palm of your hand--

F1: Why is that?

F2: That's because there might be drips and some solutions actually aren't clear and they can interfere with the writing and then you wouldn't know what solution you're using, yeah. So some of the literature says to lip or clean the mouth of the bottle.

F1: I could see that.

F2: But the literature's inconsistent. So the nurse will have to decide for his or herself.

F1: But it makes sense, though, because if somebody had something on there and it was dried on, and then all of a sudden you put it in your sterile field--

F2: Right. And I suppose if you saw crusties or something maybe you would discard the whole thing and start new. It always goes back to patient safety.

F1: For sure.

F2: Okay, so knowing that I have to clean this dressing [wound], I'm just going to put some saline into one section of my kit.

F1: Oh, and I see how again you changed hands there so that you didn't reach over. You came around from the side the shortest distance into your field.

F2: Right. And the other thing I did was I put the lid this way. Again, thinking I need to keep the inside of this sterile if I was using it amongst multiple patients. If I were to have put it down this way I would have contaminated it and then I would have to throw it away. 'So Mr. Jones, I'm going to take your dressing off next'. So again, we use sterile gloves. It's one of those--

F1: Sterile or clean?

F2: Oh, clean gloves. Sterile gloves--

F1: Why didn't you bring sterile gloves?

F2: Oh, good question. Because I'm going to use a no-touch technique. Remember one of the principles of asepsis is I don't want to introduce more bacteria into his wound because that could put him at risk for infection. We have to remember that as nurses we're working amongst a lot of people. There are a lot of bacteria in our

environment. So practicing hand hygiene frequently is really important and not doing anything to introduce bacteria into the wound is really smart too. Okay. All right, so 'Mr. Jones, I'm just going to take the tape off of your belly. It might hurt a little bit'. The last nurse used some nice tape so it should be okay.

F1: I noticed that she's got it tabbed here.

F2: Oh, yeah. That's a really good idea. It just gives the nurse something to grab onto to make the removal of the tape easier. So I'm just going to pull off the old dressing. I'm thinking of a couple of things when I'm doing this. I'm looking at the character of the drainage. What does it look like, how much is there. And in my head I'm thinking is this what I expect so--

F1: How would you describe that? What are the words that we use?

F2: This one I would describe as a moderate amount of serosanguinous. It's not fresh blood. But it's not serous drainage yet. And he's only 48 hours post-op so this is very normal.

F1: Okay, so sanguineous is the word for fresh.

F2: Yes, sanguineous is fresh blood. It's very dark red, and I often think it's like ketchup. It's thickish.

F1: I'm never going to use ketchup again. So sanguineous is dark red, then serosanguinous?

F2: Serosanguinous is blood that has a lot of serum in it. So it's starting to become more dilute and then serous can actually look like water or it can even be a little yellow tinged.

F1: And then what about-- what if I think there's an infection?

F2: If there's an infection I might see some purulent drainage and purulent drainage looks like mucous. It's thick. It can be yellow or green. I've even seen white.

F1: And you can definitely get a mixture of them too. You can have more than one, like, serosanguinous and purulent.

F2: Right. So all the nurse has to do is describe what he or she sees. And of course in your head you're going to think what does that mean. And then follow up if you need to follow up if at all you're concerned. I'm also-- you probably don't realize it, but I'm also smelling. Because if it is odiferous I'm going to start to think hmm, I don't expect that from this patient. I wonder what's going on.

F1: What would that smell like?

F2: It depends. Pseudomonas infection has a distinct smell. If this man had a bowel resection and there maybe is a leak at the anastomosis it might actually smell like stool.

F1: Yeah, little fecal.

F2: Yeah, so it depends. Most wounds should have no odour.

F1: Okay, so I guess observation is a big key here to looking at what you're seeing and smelling and--

F2: Right. So I'm also-- at the same time I'm assessing the wound I'm hoping to see a wound that's well approximated so the edges are together. And that the staples are intact. And in which case his looks really good. This little bit of redness that we see, that's just normal inflammatory response that happens post-op.

F1: Is it important to know how many staples are in there?

F2: Well, some of the literature does say to count them. In my practice I have other

things to do that I think are more important. So now I'm going to take off my clean gloves because I don't need them anymore. And now 'Mr. Jones, I'm going to go ahead and clean your wound'. So there's a couple of ways I can do this. I can take each gauze, create a ball, dip it in saline, and then come and clean the wound. What some students have actually taught me, and it works really great, is to take the whole works, dip them into the saline, and them move them to a different section of your field. The saline makes them a little bit heavier and so it's much easier to create little balls for cleaning. So the first clean is always down the center of the wound and it's always one wipe, one way and then get rid of your guaze ball.

F1: So what about-- I've seen some nurses, they go up and down like this or some they actually do a circular motion when they're cleaning. Is that good practice?

F2: That's good practice as long as you're not introducing bacteria from the-- furthest away from the incision towards the incision.

F1: So depending on if they did big circles like this they would be grabbing stuff out here and bringing it back.

F2: Right.

F1: So that's probably not a good--

F2: And I probably wouldn't have my fingers that close to the wound either.

F1: Okay.

F2: Thank you. And then I'm going to clean down the next edge. So you'll notice that I got my saline balls moist, but not so dripping wet that I'm going to drip all over my field as I'm coming over. Because that would contaminate the wound [she

meant field]. So now I've finished cleaning. In general you do three swipes. One down the center and one down each side. And then we're going to dry in the same fashion. So one down the center.

F1: Does it matter if you're using four by four's or two by two's?

F2: No, it does the same thing. Then I just have a little bit [of saline] still there. And now I'm going to discard my forcep. Now this wound was draining a moderate amount of serosanguinous drainage. I've selected an abdominal pad to put on there. Depending on the agency that I'm working in I might have other choices. But for what I have available to me at this point, I've decided to use this kind of dressing. I've checked the package to make sure that there's no signs of it having been contaminated with water. And then--

F1: Or punctured or anything like that.

F2: Exactly. So we have to think about packaged sterile objects as being within their own sterile field. So if I were to open it like this you can see that there's a little border around the edge. So this dressing's actually in its own sterile field. If I were adding it to my sterile field itself, I could do that a few ways. I could simply open it like this, making sure that it stays within its own little island and then put it into the sterile field. Another way would be to open my package and fold the top edges over and pull it out like this and then put it into the field.

F1: So I see. Just as long as you remember what the principles are you can do it different ways.

F2: Exactly.

F1: You can adjust it, yeah.

F2: Right. So knowing how the manufacturer packages abdominal pads, which is what I've just used, I didn't even have to do either of those procedures. Because they have folded it in a way that the inside of the dressing which will come in contact with my patient, is already protected. So I can touch the outside of the dressing and then apply it that way.

F1: So the outside-- what's with this blue line?

F2: Oh, the blue line is a radiopaque line. If for some reason we've lost this dressing and we think it's inside the patient they could do an x-ray.

F1: But it's always on the outside because if we look on the inside there's no blue line.

F2: There's no blue line, exactly. And now I'm going to tape my dressing to my patient. And taping is a little bit of an art as well. You'll get to know how to apply tape in a way that keeps the dressing secure when the patient gets up and is mobilizing around. 'Thank you, Mr. Jones'.

F1: So now that we have the dressing done, what are the final things that we have to do to finish up this procedure?

F2: I need to put his bed down. Put his side rail up if that's what he had before. Make sure that he's comfortable. I'll ask him does he need anything more before I leave. And then I'll go and I'll chart.

F1: Okay, and so what would you chart?

F2: I would chart what came off the old dressing; What the wound looked like; The procedure that I did; I cleansed with normal saline and then what I dressed the wound with; And how the patient tolerated it.

F1: So easy way is just doing-- just charting how you did it like in the order of which you did it.