<u>Title</u> : Dry Sterile Dressing	Original Approval: 1989
Number: CP-37	Reviewed/ revised: 9/99,
<u>Page Number:</u> 1 of 2	9/05, 4/24

Statement/ Purpose:

To provide guidelines for the application of sterile, dry dressings.

Authority:

Application: RNs, LPNs, PTs, OTs

Terminology:

Responsible Party:

Training and Quality Improvement Coordinator

Cross-Reference:

Hand Hygiene, Photography/ Videography of Patients

Procedure:

- 1. Confirm provider's order for the dressing change.
- 2. Instruct the patient and/or caregiver regarding the purpose of the dressing:
 - a. To absorb wound secretions, if any
 - b. To prevent further skin irritation
 - c. To enhance healing
 - d. To prevent infection
 - e. To promote skin comfort
- 3. Perform hand hygiene
- 4. Gather necessary dressing supplies
- 5. Position patient comfortably and in a position that the dressing can be easily changed
- 6. Don non-sterile, disposable gloves
- 7. Remove old dressing and place in trash receptacle
- 8. Assess wound size, color, depth, drainage, odor, and condition of surrounding tissue.
- 9. Don sterile gloves
- 10. Using prescribed cleaning solution, clean from the clean to dirty area of the wound, utilizing gentle but firm strokes.
- 11. Apply dressing as ordered.
- 12. Secure dressing
- 13. Discard trash/ original dressing in patient's household trash.
- 14. Remove gloves and discard appropriately

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- 15. Assist patient with comfort measures.
- 16. Complete hand hygiene.
- 17. Document procedure, including the following, in the patient's clinical record:
 - a. Wound size/ measurements
 - b. Drainage, if any
 - c. Odor, if any
 - d. Patient's tolerance of procedure
 - e. Condition of surrounding tissue
 - f. Instructions provided to patient and/or caregiver.