Sullivan County Department of Public Health

Title: Unna Boot Dressing **Number**: CP-40 **Page Number:** 1 of 2	Original Approval: 1989 Reviewed/ revised: 10/05, 5/24

Statement/ Purpose:
To provide guidelines for the application of Unna boot dressings.

Authority:
n/a

Application:
SCDPH CHHA RNs and LPNs

Terminology:

Responsible Party:
Training and Quality Improvement Coordinator

Cross-Reference:
Hand Hygiene, Wound Documentation

Procedure:
1. Confirm provider's order for Unna boot application
2. Instruct the patient and/or caregiver regarding the purpose of the dressing:
    a. To contain wound secretions.
    b. To decrease the need for dressing changes.
    c. To prevent further skin irritation.
    d. To encourage tissue healing.
    e. To increase circulation to affected area.
    f. To promote skin comfort.
3. Perform hand hygiene
4. Gather supplies.
5. Position the patient in a position of comfort that allows for ease of Unna boot application by the nurse.
6. Explain the procedure to the patient.
7. Don non-sterile gloves.
8. Cleanse affected area with warm water and prescribed cleaning solution.
9. Rinse well.
10. Gently pat dry.
11. Ass wound for size, depth, color, drainage, and condition of surrounding tissue.
12. Keep the patient's foot perpendicular to the leg.
13. Begin to wrap bandage in circular fashion around the foot and entire heel. Proceed up to one to two inches

below the knee.

   a. Cut the bandage frequently to ensure smoothness and prevent drying too tight- restricting circulation.

14. Apply two to three layers of Unna boot, beginning at the foot and continuing to one to two inches below the knee.
15. Secure dressing.
16. Discard used dressings appropriately.
17. Remove gloves and discard.
18. Position patient for comfort.
19. Perform hand hygiene.
20. Instruct the patient to do the following:
    a. Keep the limb in a pressure-free position for 20 to 30 minutes post dressing application.
    b. Remove the dressing should the exposed toes become discolored, or if pain or swelling develops.
21. Document the procedure, including the following, in the patient's clinical record:
    a. Condition of the limb
    b. Circulation to extremities
    c. Drainage, if any
    d. Odor, if any
    e. Condition of surrounding tissue.
    f. Patient's tolerance of the procedure.
    g. Instructions provided
    h. Any communication with patient's provider, if necessary
22. Plan to redress the wound every three to seven days, or when dressing becomes wet with drainage, or per provider's order.