

Margaret H. Rollins School of Nursing
Nursing 101 - Foundations of Nursing
Dry Sterile Dressing Procedure – 2021

1. Verify the dressing change order on the electronic medical record (EMR).
2. Perform hand hygiene, enter patient room, identify patient, and explain procedure. Also verify any patient allergies to tape, skin cleansers, or medications.
3. Note the size and condition of current dressing and location of surgical drains, if applicable.
4. Perform a pain assessment and medicate, as needed and as ordered, before beginning dressing change procedure.
5. Perform hand hygiene when leaving room to gather all necessary equipment/supplies (red biohazard bag, clean gloves, sterile gloves, dressing materials, topical medication, tape, etc.).
6. Perform hand hygiene again upon entry into patient room.
7. Identify patient and briefly explain procedure again. Ask to use bedside table. Clear bedside table and clean with disinfectant wipes.
8. Prepare the biohazard (red) trash bag. Open to form a cuff by turning down the top; place near the patient's bed but away from the sterile field. (Options: Tape to edge of bedside table or place bag inside patient's trash can).
9. Provide privacy and position patient to expose only the wound/incision site.
10. Perform hand hygiene and apply clean gloves. Using foot pedals, raise bed to comfortable working height.
11. Loosen the old dressing by holding the patient's skin and pulling the tape away from the skin and towards the wound.
12. Gently remove old dressing. If gauze adheres to the wound, loosen by moistening it with sterile normal saline (NS) solution. Assess the old dressing for amount, type, color, and odor of drainage.
13. Discard old dressing and gloves in the biohazard (red) trash bag.
14. Perform hand hygiene.
15. Establish a sterile field with all equipment and supplies needed for the dressing change. Open all packaging and prepare any medications/solutions needed. Maintain sterility. (*Do not touch anything that is sterile or let anything sterile touch something non-sterile.*)
16. Carefully apply sterile gloves.
17. Implement any ordered interventions: wound culture, wound irrigation, wound cleansing, etc. (*Keep in mind that some items must be opened before donning sterile gloves – stop and think before you react!*)
18. Cleanse a linear wound from top to bottom. Clean the incision line first (top to bottom), then one side of the incision, then the other side of the incision. *Remember to wipe only once with each applicator.* Clean

to at least 1 inch beyond end of wound in all directions.

19. For an open wound, clean in a full or half circle, beginning in center and working outward. *Use a new swab for each circle.* Clean to at least 1 inch beyond end of wound in all directions.
20. If the wound has a drain, clean the drain area last by wiping in half or full circles from the drain site outward. *Again, use a new swab for each circle.*
21. Carefully assess the wound/incision for size, edge approximation, color, drainage, erythema, edema, and odor.
22. If ordered, apply topical medication using sterile applicators.
23. Apply new dressing: Gently place sterile 4x4 gauze dressings at the *center* of the wound/incision and work progressively outward to the edges. Extend gauze 1” beyond the wound/incision in all directions and cover the area evenly with enough sterile dressings to absorb all drainage until the next dressing change. Apply a large absorbent dressing (ABD pad) on top of gauze pads, if needed, to provide greater absorbency.
24. Secure the dressing edges using tape, elastic “spandage”, Montgomery straps, or whatever is ordered. If using tape, apply the first strip down the center of the dressing. Continue taping in parallel strips, ensuring that all of the dressing edges are secure.
Note: Once the initial piece of tape is applied and you are confident that the dressing will not move, you may choose to remove your gloves, perform hand hygiene, and finish taping without gloves.
25. If a drain is present, use pre-cut sterile drain sponges. Gently place one drain sponge close to the skin around the drain so that the tubing fits into the slit. Place the second sponge dressing around the drain in the opposite direction to ensure that the drain is completely encircled. Layer dressings as needed to absorb expected drainage and secure with tape.
26. On a separate, small piece of tape, note your initials, date, and time of the dressing change. Affix the tape to an easily visible area of the patient’s new dressing.
27. Remove sterile gloves and perform hand hygiene, if not already done.
28. Position patient for comfort.
29. Properly discard all equipment and biohazard trash bag in appropriate receptacles.
30. Document the wound assessment, old dressing assessment, cleaning supplies used, type of dressing re-applied, and patient response in the EMR.

Surgical Wound Dressing Application. (2021). Lippincott Procedures.
<https://procedures.lww.com/lnp/view.do?pld=2263264&hits=dressing.dressings.sterile.dry&a=true&ad=false>

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