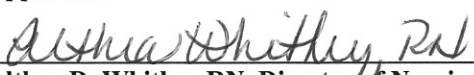
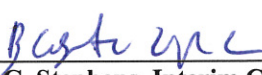




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Policy # 9022	Wound Care
Origination Date: February 1998	
Revision Date: June 2004; March 27, 2006; January 28, 2009, July 28, 2016	
Reviewed Date: February 2005; July 20, 2007; May 18, 2010, October 3, 2012, May 8, 2013	
Approved:	
 Althea D. Whitley, RN, Director of Nursing	 Bryan G. Stephens, Interim CEO

PURPOSE:

To ensure that sutured, stapled and sealed wounds are treated in such a manner to prevent infection or from spreading infection to other clients or staff.

PROCEDURE:

1. Assess wound/dressing and status of surrounding skin. Ensure that there are current orders from the attending medical physician for wound care orders/directions. If orders/directions are unclear, contact program nurse and do not proceed. The nurse is responsible for contacting the physician. Explain procedure to client and wash hands before and after taking care of any wound.
2. Gather equipment:
 - a. gloves
 - b. dressings
 - c. tape
 - d. bandages as indicated
 - e. ointments if ordered.
3. Remove the dressing currently in place and dispose of it in a covered waste receptacle.
4. When the dressing is removed, inspect wound and area surrounding the wound for signs of infection: redness, drainage, odor, swelling, fever or reports of pain. If there is any evidence of infection, report to nurse immediately.
5. Reapply clean dressing and/or dress wound according to physicians order.
6. Document dressing changes in the client's clinical record. Notify nurse if signs and symptoms of infection or complications are observed. If redness or drainage is present, take client's temperature and also record in clinical record.
7. If sutures/staples present, notify nurse to schedule removal of staples/sutures.