#44 - CHANGING A DRY DRESSING (TEST)

I acknowledge I have physically practiced and successfully learned the following skill(s):

Student: ____________________________**Date:** ________________

Time Limit: 20 Minutes	P2	P3	TEST	Points/ Comments
1. Verified the health care provider's orders.				*
2. Gathered the necessary equipment and supplies.				1
3. Performed hand hygiene, and provided for the patient's privacy.				*
4. Introduced self to the patient and family.				*
5. Identified the patient using two identifiers. Compared the identifiers with the information on the patient's identification bracelet.				*
6. Assessed pain status while explaining the procedure to the patient.				*
7. Applied a gown, goggles, and mask if there was a risk of spray.				*
8. Positioned the patient comfortably, and draped him or her to expose only the wound site. Instructed the patient not to touch the wound or the sterile supplies.				2
9. Placed a disposable biohazard bag within reach of work area. Folded the top of the bag to make a cuff.				2
10. Applied clean disposable gloves.				*
11. Pulled the tape parallel to the skin, toward the dressing, while holding down the uninjured skin. Pulled in the direction of any hair growth. If necessary, secured the patient's permission to clip the area according to agency's policy. Removed any adhesive from the skin.				2
12. With a clean, gloved hand or forceps, removed the old dressing one layer at a time. Observed the appearance of any drainage. Discarded the outside dressing first. Worked slowly and carefully. Kept the soiled underside of the dressings out of the patient's sight.				2
13. Folded the dressing so that the drainage was contained inside it, and removed gloves inside out. If the dressing was small, pulled one glove inside out over the dressing.				2
14. Disposed of the gloves and soiled dressing according to agency's policy. Performed hand hygiene.				*
15. Inspected the color and integrity of the wound. Looked for edema, exudate, and loss of skin integrity. Observed the skin around any drainage devices. Assessed for odor.				2
16. Created a sterile field on the overbed table, used a sterile dressing tray or individually wrapped sterile supplies.				*
17. Applied sterile gloves, and gently palpated the edges of the wound to determine whether the patient's pain had increased and to assess for drainage and bogginess. Measured the length, width, and depth of the wound if indicated. Disposed of gloves and performed hand hygiene.				*
18. Applied sterile gloves				*

Step				
19. Cleansed the wound. Used an antiseptic swab for each cleansing stroke, or sprayed the wound surface with antiseptic.				*
20. Used dry gauze to blot the wound dry. If the patient had a drain, blotted around it.				2
21. Applied an antiseptic ointment, if ordered.				1
22. Removed gloves, performed hand hygiene, applied new sterile gloves if needed. Applied a Dry Dressing: a. Applied loosely woven gauze as the contact layer. b. If a drain was present, applied a pre-cut 4 × 4 gauze to sit flat around the drain. c. Applied additional layers of gauze as needed.				*
23. Secured the dressing with rolled gauze for circumferential dressings; with tape,Montgomery ties, or straps applied perpendicular to the wound; or with a binder				2
23. Initialed the tape with the date and time.				*
24. Removed any personal protective equipment used. Applied clean gloves to dispose of soiled supplies.				*
25. Disposed of used supplies and equipment correctly				*
26. Helped the patient into a comfortable position, and placed toiletries and personal items within reach				1
27. Placed the call light within easy reach, and made sure the patient knew how to use it to summon assistance.				*
28. Raised the appropriate number of side rails and lowered the bed to the lowest position. Locked Bed Wheels				*
29. Removed and disposed of gloves. Performed hand hygiene.				*
30. Documented and reported the patient's response and expected or unexpected outcomes.				*

S = Satisfactory **U** = Unsatisfactory **NP** = Not Performed *=Must Perform to Pass

TOTAL POINTS ________/___**19**_____

% __________

PASS_______

FAIL________

Instructor:___________________________________ Date:____ / ____ / _________

By signing below I acknowledge that I witnessed the skill performed and the student successfully passed the skill.

Practice 1: Evaluator:______________________________ Signature:______________________________

Practice 2: Evaluator:______________________________ Signature:______________________________

FINAL Student Evaluator:_____________________________ Signature:_____________________________

CHARTING CRITERIA: Record appearance of wound, and drainage, client's tolerance, and type of dressing applied, including exactly what was used in nurse's notes. Document also in Graphics. Complete NANDA statement.

Date__________________

MULTIDISCIPLINARY NOTES

Time	Prob. #	

NANDA STATEMENT:

Use this scenario for ICP - RISK FOR INFECTION

John Smith is a 45 year old male who was involved in a MVA 3 days ago. He has a wound to his right arm with a dressing in place. The dressing has an area of bloody drainage measuring 5cm by 5 cm. The previous shift documented drainage of 2cm by 2 cm. The skin around the dressing is red and warm to touch. John states, " It hurts a lot more today," and "I feel very hot." His vital signs are BP 120/60, Temp 101.1, Pulse 100, and RR 20.

<table>
<tr><td colspan="3">NURSING DIAGNOSIS: RISK FOR INFECTION</td><td>Patient's Medical Diagnosis:</td></tr>
<tr><td colspan="2">DEFINITION:</td><td colspan="2">The state in which an individual is at increased risk of being invaded by pathogenic organisms.</td></tr>
<tr><td colspan="2">DEFINING CHARACTERISTICS:</td><td colspan="2">Inadequate primary defenses (broken skin, traumatized tissue, decrease in cilliary action, stasis of body fluids, change in pH, secretions, altered peristalsis); inadequate secondary defenses (decreased hemoglobin, leukopenia, suppressed inflammatory response) and immunosuppression: inadequate acquired immunity; tissue destruction and increased environmental exposure; chronic disease; invasive procedures; malnutrition; pharmaceutical agents; trauma; rupture of amniotic membranes; insufficient knowledge to avoid exposure to pathogens.</td></tr>
<tr><td colspan="2">RELATED FACTORS:</td><td colspan="2">Included in risk factors.</td></tr>
<tr><td colspan="2">STUDENT INSTRUCTIONS:</td><td colspan="2">In the space below enter the subjective and objective data gathered during your patient assessment.</td></tr>
<tr><td rowspan="2">ASSESSMENT</td><td colspan="2">Subjective Data Entry</td><td>Objective Data Entry</td></tr>
<tr><td>TIME OUT!</td><td colspan="2">Student Instructions: To be sure your patient diagnostic statement written below is accurate, you need to review the defining characteristics and related factors associated with the nursing diagnosis and see how your patient data matches. Do you have an accurate match or is additional data required or does another nursing diagnosis need to be investigated?</td></tr>
<tr><td>DIAGNOSIS</td><td>PATIENT DIAGNOSTIC STATEMENT:</td><td colspan="2">Nursing Diagnosis: ____________________
Related to: ____________________
AEB: ____________________</td></tr>
</table>

<table>
<tr><td rowspan="3">PLANNING</td><td colspan="2">Desired Outcome And Patient Criteria: The Patient Will:</td></tr>
<tr><td>TIME OUT!</td><td>The desired outcome must meet criteria to be accurate. The outcome must be specific, realistic, measurable, and include a time frame for completion. Does the action verb describe the patient's behavior to be evaluated? Can the outcome be used in the evaluation step of the nursing process to measure the patient's response to the nursing interventions listed below?</td></tr>
<tr><td>Interventions</td><td>Rationale For Selected Intervention and References</td></tr>
<tr><td rowspan="3">EVALUATION</td><td>TIME OUT!</td><td>Do your interventions assist in achieving the desired outcome? Do your interventions address further monitoring of the patient's response to your interventions and to the achievement of the desired outcome? Are qualifiers: when, how, amount, time, and frequency used? Is the focus of the action's verb on the nurse's actions and not on the patient? Do your rationales provide sufficient reason and directions?</td></tr>
<tr><td colspan="2">What was your patient's response to the interventions?</td></tr>
<tr><td colspan="2">Was the desired outcome achieved? If no, what revisions to either the desired outcome or interventions would you make?

Yes No</td></tr>
<tr><td rowspan="2">DOCUMENTATION</td><td colspan="2">Documentation Focus: Now that you have completed the evaluation, the next step is to document your care and the patient's response. Use the areas below to enter your progress note information.</td></tr>
<tr><td colspan="2"></td></tr>
</table>