**Skill Checklists for Taylor’s Clinical Nursing Skills:**
*A Nursing Process Approach, 3rd edition*

Name ___________________________ Date ___________________________

Unit ___________________________ Position ___________________________

Instructor/Evaluator: ___________________________ Position ___________________________

**SKILL 8-1**

**Cleaning a Wound and Applying a Dry, Sterile Dressing**

**Goal:** The wound is cleaned and protected with a dressing without contaminating the wound area, without causing trauma to the wound, and without causing the patient to experience pain or discomfort.

**Comments**

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<tr>
<td>1.</td>
<td>Review the medical orders for wound care or the nursing plan of care related to wound care.</td>
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<td>2.</td>
<td>Gather the necessary supplies and bring to the bedside stand or overbed table.</td>
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<td>3.</td>
<td>Perform hand hygiene and put on PPE, if indicated.</td>
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<td>Identify the patient.</td>
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<td>Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.</td>
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<td>6.</td>
<td>Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care dressing change. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness.</td>
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<td>7.</td>
<td>Place a waste receptacle or bag at a convenient location for use during the procedure.</td>
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<td>Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).</td>
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<td>9.</td>
<td>Assist the patient to a comfortable position that provides easy access to the wound area. Use the bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.</td>
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<td>10.</td>
<td>Check the position of drains, tubes, or other adjuncts before removing the dressing. Put on clean, disposable gloves and loosen tape on the old dressings. If necessary, use an adhesive remover to help get the tape off.</td>
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<td>11.</td>
<td>Carefully remove the soiled dressings. If there is resistance, use a silicone-based adhesive remover to help remove the tape. If any part of the dressing sticks to the underlying skin, use small amounts of sterile saline to help loosen and remove.</td>
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</table>
SKILL 8-1

Cleaning a Wound and Applying a Dry, Sterile Dressing (Continued)

12. After removing the dressing, note the presence, amount, type, color, and odor of any drainage on the dressings. Place soiled dressings in the appropriate waste receptacle. Remove your gloves and dispose of them in an appropriate waste receptacle.

13. Inspect the wound site for size, appearance, and drainage. Assess if any pain is present. Check the status of sutures, adhesive closure strips, staples, and drains or tubes, if present. Note any problems to include in your documentation.

14. Using sterile technique, prepare a sterile work area and open the needed supplies.

15. Open the sterile cleaning solution. Depending on the amount of cleaning needed, the solution might be poured directly over gauze sponges over a container for small cleaning jobs, or into a basin for more complex or larger cleaning.


17. Clean the wound. Clean the wound from top to bottom and from the center to the outside. Following this pattern, use new gauze for each wipe, placing the used gauze in the waste receptacle. Alternately, spray the wound from top to bottom with a commercially prepared wound cleanser.

18. Once the wound is cleaned, dry the area using a gauze sponge in the same manner. Apply ointment or perform other treatments, as ordered.

19. If a drain is in use at the wound location, clean around the drain. Refer to Skills 8-7, 8-8, 8-9, and 8-10.

20. Apply a layer of dry, sterile dressing over the wound. Forceps may be used to apply the dressing.

21. Place a second layer of gauze over the wound site.

22. Apply a surgical or abdominal pad (ABD) over the gauze at the site as the outermost layer of the dressing.

23. Remove and discard gloves. Apply tape, Montgomery straps or roller gauze to secure the dressings. Alternately, many commercial wound products are self adhesive and do not require additional tape.
24. After securing the dressing, label dressing with date and time. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.

25. Remove PPE, if used. Perform hand hygiene.

26. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.
**Skill Checklists for Taylor’s Clinical Nursing Skills: A Nursing Process Approach, 3rd edition**

**SKILL 8-2**  
**Applying a Saline-Moistened Dressing**

**Goal:** The procedure is accomplished without contaminating the wound area, without causing trauma to the wound, and without causing the patient to experience pain or discomfort.

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1. Review the medical orders for wound care or the nursing plan of care related to wound care.
2. Gather the necessary supplies and bring to the bedside stand or overbed table.
3. Perform hand hygiene and put on PPE, if indicated.
4. Identify the patient.
5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.
6. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care dressing change. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness.
7. Place a waste receptacle or bag at a convenient location for use during the procedure.
8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).
9. Assist the patient to a comfortable position that provides easy access to the wound area. Position the patient so the wound cleanser or irrigation solution will flow from the clean end of the wound toward the dirtier end, if being used (see Skill 8-1 for wound cleansing and Skill 8-4 for irrigation techniques). Use the bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.
10. Put on clean gloves. Carefully and gently remove the soiled dressings. If there is resistance, use a silicone-based adhesive remover to help remove the tape. If any part of the dressing sticks to the underlying skin, use small amounts of sterile saline to help loosen and remove.
11. After removing the dressing, note the presence, amount, type, color, and odor of any drainage on the dressings. Place soiled dressings in the appropriate waste receptacle.

Comments
SKILL 8-2

Applying a Saline-Moistened Dressing *(Continued)*

### Comments

12. Assess the wound for appearance, stage, the presence of eschar, granulation tissue, epithelialization, undermining, tunneling, necrosis, sinus tract, and drainage. Assess the appearance of the surrounding tissue. Measure the wound. Refer to Fundamentals Review 8-3.

13. Remove your gloves and put them in the receptacle.

14. Using sterile technique, open the supplies and dressings. Place the fine-mesh gauze into the basin and pour the ordered solution over the mesh to saturate it.

15. Put on the sterile gloves. Alternately, clean gloves (clean technique) may be used to clean a chronic wound.

16. Clean the wound. Refer to Skill 8-1. Alternately, irrigate the wound, as ordered or required (see Skill 8-4).

17. Dry the surrounding skin with sterile gauze dressings.

18. Apply a skin protectant to the surrounding skin if needed.

19. If not already on, put on sterile gloves. Squeeze excess fluid from the gauze dressing. Unfold and fluff the dressing.

20. Gently press to loosely pack the moistened gauze into the wound. If necessary, use the forceps or cotton-tipped applicators to press the gauze into all wound surfaces.

21. Apply several dry, sterile gauze pads over the wet gauze.

22. Place the ABD pad over the gauze.

23. Remove and discard gloves. Apply tape, Montgomery straps or roller gauze to secure the dressings. Alternately, many commercial wound products are self adhesive and do not require additional tape.

24. After securing the dressing, label dressing with date and time. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.

25. Remove PPE, if used. Perform hand hygiene.

26. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.
SKILL 8-3
Applying a Hydrocolloid Dressing

Goal: The procedure is accomplished without contaminating the wound area, without causing trauma to the wound, and without causing the patient to experience pain or discomfort.

Comments

1. Review the medical orders for wound care or the nursing plan of care related to wound care.
2. Gather the necessary supplies and bring to the bedside stand or overbed table.
3. Perform hand hygiene and put on PPE, if indicated.
4. Identify the patient.
5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.
6. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care dressing change. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness before beginning procedure.
7. Place a waste receptacle or bag at a convenient location for use during the procedure.
8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).
9. Assist the patient to a comfortable position that provides easy access to the wound area. Position the patient so the wound cleanser or irrigation solution will flow from the clean end of the wound toward the dirtier end, if being used (See Skill 8-1 for wound cleansing and Skill 8-4 for irrigation techniques). Use the bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.
10. Put on clean gloves. Carefully and gently remove the soiled dressings. If there is resistance, use a silicone-based adhesive remover to help remove the tape. If any part of the dressing sticks to the underlying skin, use small amounts of sterile saline to help loosen and remove.
11. After removing the dressing, note the presence, amount, type, color, and odor of any drainage on the dressings. Place soiled dressings in the appropriate waste receptacle.
SKILL 8-3

Applying a Hydrocolloid Dressing (Continued)

12. Assess the wound for appearance, stage, the presence of eschar, granulation tissue, epithelialization, undermining, tunneling, necrosis, sinus tract, and drainage. Assess the appearance of the surrounding tissue. Measure the wound. Refer to Fundamentals Review 8-3.

13. Remove your gloves and put them in the receptacle.

14. Set up a sterile field, if indicated, and wound cleaning supplies. Put on sterile gloves. Alternately, clean gloves (clean technique) may be used when cleaning a chronic wound.

15. Clean the wound. Refer to Skill 8-1. Alternately, irrigate the wound, as ordered or required (see Skill 8-4).

16. Dry the surrounding skin with gauze dressings.

17. Apply a skin protectant to the surrounding skin.

18. Cut the dressing to size, if indicated, using sterile scissors. Size the dressing generously, allowing at least a 1\textsuperscript{1/2} margin of healthy skin around the wound to be covered with the dressing.

19. Remove the release paper from the adherent side of the dressing. Apply the dressing to the wound without stretching the dressing. Smooth wrinkles as the dressing is applied.

20. If necessary, secure the dressing edges with tape. Apply additional skin barrier to the areas to be covered with tape, if necessary. Dressings that are near the anus need to have the edges taped. Apply additional skin barrier to the areas to be covered with tape, if necessary.

21. After securing the dressing, label dressing with date and time. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.

22. Remove PPE, if used. Perform hand hygiene.

23. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.
### Skill Checklists for Taylor's Clinical Nursing Skills:  
A Nursing Process Approach, 3rd edition

**SKILL 8-4**  
**Performing Irrigation of a Wound**

**Goal:** The wound is cleaned without contamination or trauma and without causing the patient to experience pain or discomfort.

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1. Review the medical orders for wound care or the nursing plan of care related to wound care.

2. Gather the necessary supplies and bring to the bedside stand or overbed table.

3. Perform hand hygiene and put on PPE, if indicated.

4. Identify the patient.

5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.

6. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care and/or dressing change. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness before beginning procedure.

7. Place a waste receptacle or bag at a convenient location for use during the procedure.

8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).

9. Assist the patient to a comfortable position that provides easy access to the wound area. Position the patient so the irrigation solution will flow from the clean end of the wound toward the dirtier end. Use the bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.


11. Put on clean gloves. Carefully and gently remove the soiled dressings. If there is resistance, use a silicone-based adhesive remover to help remove the tape. If any part of the dressing sticks to the underlying skin, use small amounts of sterile saline to help loosen and remove.

12. After removing the dressing, note the presence, amount, type, color, and odor of any drainage on the dressings. Place soiled dressings in the appropriate waste receptacle.
### SKILL 8-4

**Performing Irrigation of a Wound (Continued)**

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13. Assess the wound for appearance, stage, the presence of eschar, granulation tissue, epithelialization, undermining, tunneling, necrosis, sinus tract, and drainage. Assess the appearance of the surrounding tissue. Measure the wound. Refer to Fundamentals Review 8-3.

14. Remove your gloves and put them in the receptacle.

15. Set up a sterile field, if indicated, and wound cleaning supplies. Pour warmed sterile irrigating solution into the sterile container. Put on the sterile gloves. Alternately, clean gloves (clean technique) may be used when irrigating a chronic wound.

16. Position the sterile basin below the wound to collect the irrigation fluid.

17. Fill the irrigation syringe with solution. **Using your nondominant hand, gently apply pressure to the basin against the skin below the wound to form a seal with the skin.**

18. **Gently direct a stream of solution into the wound. Keep the tip of the syringe at least 1/4 above the upper tip of the wound. When using a catheter tip, insert it gently into the wound until it meets resistance. Gently flush all wound areas.**

19. Watch for the solution to flow smoothly and evenly. When the solution from the wound flows out clear, discontinue irrigation.

20. Dry the surrounding skin with gauze dressings.

21. Apply a skin protectant to the surrounding skin.

22. Apply a new dressing to the wound (see Skills 8-1, 8-2, 8-3).

23. Remove and discard gloves. Apply tape, Montgomery straps, or roller gauze to secure the dressings. Alternately, many commercial wound products are self adhesive and do not require additional tape.

24. After securing the dressing, label dressing with date and time. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.

25. Remove remaining PPE. Perform hand hygiene.

26. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.
## Skill Checklists for Taylor’s Clinical Nursing Skills: A Nursing Process Approach, 3rd edition

### Skill 8-5

**Collecting a Wound Culture**

**Goal:** The culture is obtained without evidence of contamination, without exposing the patient to additional pathogens, and without causing discomfort for the patient.

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1. Review the medical orders for obtaining a wound culture.
2. Gather the necessary supplies and bring to the bedside stand or overbed table.
3. Perform hand hygiene and put on PPE, if indicated.
4. Identify the patient.
5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.
6. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before obtaining the wound culture. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness before beginning procedure.
7. Place an appropriate waste receptacle within easy reach for use during the procedure.
8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).
9. Assist the patient to a comfortable position that provides easy access to the wound. If necessary, drape the patient with the bath blanket to expose only the wound area. Place a waterproof pad under the wound site. Check the culture label against the patient's identification bracelet.
10. If there is a dressing in place on the wound, put on clean gloves. Carefully and gently remove the soiled dressings. If there is resistance, use a silicone-based adhesive remover to help remove the tape. If any part of the dressing sticks to the underlying skin, use small amounts of sterile saline to help loosen and remove.
11. After removing the dressing, note the presence, amount, type, color, and odor of any drainage on the dressings. Place soiled dressings in the appropriate waste receptacle.
**SKILL 8-5**  
**Collecting a Wound Culture (Continued)**

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<td>12. Assess the wound for appearance, stage, the presence of eschar, granulation tissue, epithelialization, undermining, tunneling, necrosis, sinus tract, and drainage. Assess the appearance of the surrounding tissue. Measure the wound. Refer to Fundamentals Review 8-3.</td>
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<td>13. Remove your gloves and put them in the receptacle.</td>
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<td>14. Set up a sterile field, if indicated, and wound cleaning supplies. Put on the sterile gloves. Alternately, clean gloves (clean technique) may be used when cleaning a chronic wound.</td>
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<td>15. Clean the wound. Refer to Skill 8-1. Alternately, irrigate the wound, as ordered or required (see Skill 8-4).</td>
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<td>17. Twist the cap to loosen the swab on the Culturette tube, or open the separate swab and remove the cap from the culture tube. Keep the swab and inside of the culture tube sterile.</td>
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<td>18. If contact with the wound is necessary to separate wound margins to permit insertion of the swab deep into the wound, put a sterile glove on one hand to manipulate the wound margins. Clean gloves may be appropriate for contact with pressure ulcers and chronic wounds.</td>
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<td>19. Carefully insert the swab into the wound. Press and rotate the swab several times over the wound surfaces. Avoid touching the swab to intact skin at the wound edges. Use another swab if collecting a specimen from another site.</td>
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<td>20. Place the swab back in the culture tube. Do not touch the outside of the tube with the swab. Secure the cap. Some swab containers have an ampule of medium at the bottom of the tube. It might be necessary to crush this ampule to activate. Follow the manufacturer’s instructions for use.</td>
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<td>21. Remove gloves and discard them accordingly.</td>
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<td>22. Put on gloves. Place a dressing on the wound, as appropriate, based on medical orders and/or the nursing plan of care. Refer to Skills 8-1 through 8-3. Remove gloves.</td>
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<td>23. After securing the dressing, label dressing with date and time. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.</td>
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<td>24. Label the specimen according to your institution’s guidelines and send it to the laboratory in a biohazard bag.</td>
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<td>25. Remove PPE, if used. Perform hand hygiene.</td>
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**SKILL 8-6**

**Applying Montgomery Straps**

**Goal:** The patient’s skin is free from irritation and injury.

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1. Review the medical orders for wound care or the nursing plan of care related to wound care.
2. Gather the necessary supplies and bring to the bedside stand or overbed table.
3. Perform hand hygiene and put on PPE, if indicated.
4. Identify the patient.
5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.
6. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care dressing change. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness before beginning procedure.
7. Place a waste receptacle at a convenient location for use during the procedure.
8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).
9. Assist the patient to a comfortable position that provides easy access to the wound area. Use a bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.
10. Perform wound care and a dressing change as outlined in Skills 8-1 through 8-4, as ordered.
11. Put on clean gloves. Clean the skin on either side of the wound with the gauze, moistened with normal saline. Dry the skin.
12. **Apply a skin protectant to the skin where the straps will be placed.**
13. Remove gloves.
14. Cut the skin barrier to the size of the tape or strap. Apply the skin barrier to the patient’s skin, near the dressing. Apply the sticky side of each tape or strap to the skin barrier sheet, so the openings for the strings are at the edge of the dressing. Repeat for the other side.
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**SKILL 8-6**

**Applying Montgomery Straps (Continued)**

15. Thread a separate string through each pair of holes in the straps. Tie one end of the string in the hole. Fasten the other end with the opposing tie, like a shoelace. *Do not secure too tightly.* Repeat according to the number of straps needed. If commercially prepared straps are used, tie strings like a shoelace. Note date and time of application on strap.

16. After securing the dressing, label dressing with date and time. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.

17. Remove additional PPE, if used. Perform hand hygiene.

18. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.

19. Replace the ties and straps whenever they are soiled, or every 2 to 3 days. Straps can be reapplied onto skin barrier. Skin barrier can remain in place up to 7 days. Use a silicone-based adhesive remover to help remove the skin barrier.
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Name ______________________________ Date __________________
Unit ____________________________ Position ____________________
Instructor/Evaluator: __________ Position ____________________

**SKILL 8-7**

**Caring for a Penrose Drain**

**Goal:** The Penrose drain remains patent and intact; the care is accomplished without contaminating the wound area, or causing trauma to the wound; and without causing the patient to experience pain or discomfort.

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<tr>
<td>1. Review the medical orders for wound care or the nursing plan of care related to wound/drain care.</td>
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<td>2. Gather the necessary supplies and bring to the bedside stand or overbed table.</td>
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<tr>
<td>3. Perform hand hygiene and put on PPE, if indicated.</td>
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<td>5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.</td>
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<td>6. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care dressing change. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness before beginning procedure.</td>
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<td>7. Place a waste receptacle at a convenient location for use during the procedure.</td>
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<td>8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).</td>
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<td>9. Assist the patient to a comfortable position that provides easy access to the drain and/or wound area. Use a bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.</td>
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<td>10. Put on clean gloves. Check the position of the drain or drains before removing the dressing. Carefully and gently remove the soiled dressings. If there is resistance, use a silicone-based adhesive remover to help remove the tape. If any part of the dressing sticks to the underlying skin, use small amounts of sterile saline to help loosen and remove.</td>
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<td>11. After removing the dressing, note the presence, amount, type, color, and odor of any drainage on the dressings. Place soiled dressings in the appropriate waste receptacle.</td>
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<tr>
<td>12. Inspect the drain site for appearance and drainage. Assess if any pain is present.</td>
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### SKILL 8-7

**Caring for a Penrose Drain (Continued)**

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<td>13. Using sterile technique, prepare a sterile work area and open the needed supplies.</td>
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<td>14. Open the sterile cleaning solution. Pour the cleansing solution into the basin. Add the gauze sponges.</td>
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<td>15. Put on sterile gloves.</td>
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<td>16. Cleanse the drain site with the cleaning solution. Use the forceps and the moistened gauze or cotton-tipped applicators. <em>Start at the drain insertion site, moving in a circular motion toward the periphery. Use each gauze sponge or applicator only once. Discard and use new gauze if additional cleansing is needed.</em></td>
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<td>17. Dry the skin with a new gauze pad in the same manner. Apply skin protectant to the skin around the drain; extend out to include the area of skin that will be taped. Place a presplit drain sponge under the drain. Closely observe the safety pin in the drain. If the pin or drain is crusted, replace the pin with a new sterile pin. <em>Take care not to dislodge the drain.</em></td>
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<td>18. Apply gauze pads over the drain. Apply ABD pads over the gauze.</td>
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<td>19. Remove and discard gloves. Apply tape, Montgomery straps, or roller gauze to secure the dressings.</td>
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<td>20. After securing the dressing, label dressing with date and time. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.</td>
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<td>21. Remove additional PPE, if used. Perform hand hygiene.</td>
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<td></td>
<td>22. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.</td>
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**Skill Checklists for Taylor’s Clinical Nursing Skills:**  
* A Nursing Process Approach, 3rd edition

Name __________________________ Date __________________________

Unit __________________________ Position __________________________

Instructor/Evaluator: __________________________ Position __________________________

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**SKILL 8-8**  
**Caring for a T-Tube Drain**

**Goal:** The drain remains patent and intact; drain care is accomplished without contaminating the wound area and/or without causing trauma to the wound; and the patient does not experience pain or discomfort.

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1. Review the medical orders for wound care or the nursing plan of care related to wound/drain care.

2. Gather the necessary supplies and bring to the bedside stand or overbed table.

3. Perform hand hygiene and put on PPE, if indicated.

4. Identify the patient.

5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.

6. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care dressing change. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness before beginning procedure.

7. Place a waste receptacle at a convenient location for use during the procedure.

8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).

9. Assist the patient to a comfortable position that provides easy access to the drain and/or wound area. Use a bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.

**Emptying Drainage**

10. Put on clean gloves; put on mask or face shield if indicated.

11. Using sterile technique, open a gauze pad, making a sterile field with the outer wrapper.

12. Place the graduated collection container under the outlet valve of the drainage bag. *Without touching the outlet, pull the cap off and empty the bag’s contents completely into the container. Use the gauze to wipe the outlet, and replace the cap.*

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13. Carefully measure and note the characteristics of the drainage. Discard the drainage according to facility policy.

14. Remove gloves and perform hand hygiene.

**Cleaning the Drain Site**

15. Put on clean gloves. Check the position of the drain or drains before removing the dressing. Carefully and gently remove the soiled dressings. If there is resistance, use a silicone-based adhesive remover to help remove the tape. If any part of the dressing sticks to the underlying skin, use small amounts of sterile saline to help loosen and remove. Do not reach over the drain site.

16. After removing the dressing, note the presence, amount, type, color, and odor of any drainage on the dressings. Place soiled dressings in the appropriate waste receptacle. Remove gloves and dispose of in appropriate waste receptacle.

17. Inspect the drain site for appearance and drainage. Assess if any pain is present.

18. Using sterile technique, prepare a sterile work area and open the needed supplies.

19. Open the sterile cleaning solution. Pour the cleansing solution into the basin. Add the gauze sponges.

20. Put on sterile gloves.

21. Cleanse the drain site with the cleaning solution. Use the forceps and the moistened gauze or cotton-tipped applicators. *Start at the drain insertion site, moving in a circular motion toward the periphery. Use each gauze sponge only once. Discard and use new gauze if additional cleansing is needed.*

22. Dry with new sterile gauze in the same manner. Apply skin protectant to the skin around the drain; extend out to include the area of skin that will be taped.

23. Place a presplit drain sponge under the drain. Apply gauze pads over the drain. Remove and discard gloves.

24. Secure the dressings with tape as needed. Alternatively, before removing gloves, place a transparent dressing over the tube and insertion site. *Be careful not to kink the tubing.*
SKILL 8-8  
**Caring for a T-Tube Drain (Continued)**

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<td>25.</td>
<td>After securing the dressing, label dressing with date and time. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.</td>
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<td>26.</td>
<td>Remove additional PPE, if used. Perform hand hygiene.</td>
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<td>27.</td>
<td>Check drain status at least every four hours. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.</td>
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**Comments**
**SKILL 8-9**

**Caring for a Jackson-Pratt Drain**

**Goal:** The drain is patent and intact.

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<td>1. Review the medical orders for wound care or the nursing plan of care related to wound/drain care.</td>
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<td>2. Gather the necessary supplies and bring to the bedside stand or overbed table.</td>
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<td>3. Perform hand hygiene and put on PPE, if indicated.</td>
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<td>4. Identify the patient.</td>
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<td>5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.</td>
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<td>6. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care dressing change. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness before beginning procedure.</td>
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<td>7. Place a waste receptacle at a convenient location for use during the procedure.</td>
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<td>8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).</td>
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<td>9. Assist the patient to a comfortable position that provides easy access to the drain and/or wound area. Use a bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.</td>
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<td>10. Put on clean gloves; put on mask or face shield if indicated.</td>
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<td>11. Place the graduated collection container under the outlet of the drain. Without contaminating the outlet valve, pull the cap off. The chamber will expand completely as it draws in air. <em>Empty the chamber’s contents completely into the container. Use the gauze pad to clean the outlet. Fully compress the chamber with one hand and replace the cap with your other hand.</em></td>
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<td>12. Check the patency of the equipment. Make sure the tubing is free from twists and kinks.</td>
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SKILL 8-9  
Caring for a Jackson-Pratt Drain (Continued)

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<td>13.</td>
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<td>Secure the Jackson-Pratt drain to the patient’s gown below the wound with a safety pin, making sure that there is no tension on the tubing.</td>
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<td>14.</td>
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<td></td>
<td>Carefully measure and record the character, color, and amount of the drainage. Discard the drainage according to facility policy. Remove gloves.</td>
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<td>15.</td>
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<td>Put on clean gloves. If the drain site has a dressing, re-dress the site as outlined in Skill 8-8. Include cleaning of the sutures with the gauze pad moistened with normal saline. Dry sutures with gauze before applying new dressing.</td>
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<td>16.</td>
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<td>If the drain site is open to air, observe the sutures that secure the drain to the skin. Look for signs of pulling, tearing, swelling, or infection of the surrounding skin. Gently clean the sutures with the gauze pad moistened with normal saline. Dry with a new gauze pad. Apply skin protectant to the surrounding skin if needed.</td>
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<td>17.</td>
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<td>Remove and discard gloves. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.</td>
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<td>18.</td>
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<td>Remove additional PPE, if used. Perform hand hygiene.</td>
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<td>19.</td>
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<td>Check drain status at least every four hours. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.</td>
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**SKILL 8-10**

**Caring for a Hemovac Drain**

**Goal:** The drain is patent and intact.

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1. Review the medical orders for wound care or the nursing plan of care related to wound/drain care.
2. Gather the necessary supplies and bring to the bedside stand or overbed table.
3. Perform hand hygiene and put on PPE, if indicated.
4. Identify the patient.
5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.
6. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care dressing change. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness before beginning procedure.
7. Place a waste receptacle at a convenient location for use during the procedure.
8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).
9. Assist the patient to a comfortable position that provides easy access to the drain and/or wound area. Use a bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.
10. Put on clean gloves; put on mask or face shield if indicated.
11. Place the graduated collection container under the outlet of the drain. Without contaminating the outlet, pull the cap off. The chamber will expand completely as it draws in air. *Empty the chamber's contents completely into the container. Use the gauze pad to clean the outlet. Fully compress the chamber by pushing the top and bottom together with your hands. Keep the device tightly compressed while you apply the cap.*
12. Check the patency of the equipment. Make sure the tubing is free from twists and kinks.
SKILL 8-10

Caring for a Hemovac Drain (Continued)

13. Secure the Hemovac drain to the patient’s gown below the wound with a safety pin, making sure that there is no tension on the tubing.

14. Carefully measure and record the character, color, and amount of the drainage. Discard the drainage according to facility policy.

15. Put on clean gloves. If the drain site has a dressing, re-dress the site as outlined in Skill 8-8. Include cleaning of the sutures with the gauze pad moistened with normal saline. Dry sutures with gauze before applying new dressing.

16. If the drain site is open to air, observe the sutures that secure the drain to the skin. Look for signs of pulling, tearing, swelling, or infection of the surrounding skin. Gently clean the sutures with the gauze pad moistened with normal saline. Dry with a new gauze pad. Apply skin protectant to the surrounding skin if needed.

17. Remove and discard gloves. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.

18. Remove additional PPE, if used. Perform hand hygiene.

19. Check drain status at least every four hours. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.
Skill Checklists for Taylor's Clinical Nursing Skills:
A Nursing Process Approach, 3rd edition

Name ___________________________ Date ___________________________

Unit ___________________________ Position ___________________________

Instructor/Evaluator: ___________________________ Position ___________________________

SKILL 8-11
Applying Negative Pressure Wound Therapy

Goal: The therapy is accomplished without contaminating the
wound area, without causing trauma to the wound, and without
caus[ing the patient to experience pain or discomfort.

Excellent | Satisfactory | Needs Practice
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1. Review the medical order for the application of NPWT
   therapy, including the ordered pressure setting for the
device.

2. Gather the necessary supplies and bring to the bedside
   stand or overbed table.

3. Perform hand hygiene and put on PPE, if indicated.

4. Identify the patient.

5. Close curtains around bed and close door to room if possi-
   ble. Explain what you are going to do and why you are
   going to do it to the patient.

6. Assess the patient for possible need for nonpharmacologic
   pain-reducing interventions or analgesic medication before
   wound care dressing change. Administer appropriate pre-
  scribed analgesic. Allow enough time for analgesic to
   achieve its effectiveness before beginning procedure.

7. Adjust bed to comfortable working height, usually elbow
   height of the caregiver (VISN 8, 2009).

8. Assist the patient to a comfortable position that provides
   easy access to the wound area. Position the patient so the
   irrigation solution will flow from the clean end of the
   wound toward the dirty end. Expose the area and drape
   the patient with a bath blanket if needed. Put a waterproof
   pad under the wound area.

9. Have the disposal bag or waste receptacle within easy
   reach for use during the procedure.

10. Using sterile technique, prepare a sterile field and add all
    the sterile supplies needed for the procedure to the field.
    Pour warmed, sterile irrigating solution into the sterile
    container.

11. Put on a gown, mask, and eye protection.

12. Put on clean gloves. Carefully and gently remove the dress-
    ing. If there is resistance, use a silicone-based adhesive
    remover to help remove the drape. Note the number of
    pieces of foam removed from the wound. Compare with the
documented number from the previous dressing change.

Comments

Excellent | Satisfactory | Needs Practice
SKILL 8-11

Applying Negative Pressure Wound Therapy *(Continued)*

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13. Discard the dressings in the receptacle. Remove your gloves and put them in the receptacle.

14. Put on sterile gloves. Using sterile technique, irrigate the wound (see Skill 8-4).

15. Clean the area around the skin with normal saline. Dry the surrounding skin with a sterile gauze sponge.

16. Assess the wound for appearance, stage, the presence of eschar, granulation tissue, epithelialization, undermining, tunneling, necrosis, sinus tract, and drainage. Assess the appearance of the surrounding tissue. Measure the wound. Refer to Fundamentals Review 8-3.

17. **Wipe intact skin around the wound with a skin-protectant wipe and allow it to dry well.**

18. Remove gloves if they become contaminated and discard them into the receptacle.

19. Put on a new pair of sterile gloves, if necessary. **Using sterile scissors, cut the foam to the shape and measurement of the wound. Do not cut foam over the wound.** More than one piece of foam may be necessary if the first piece is cut too small. Carefully place the foam in the wound. **Ensure foam-to-foam contact if more than one piece is required. Note the number of pieces of foam placed in the wound.**

20. Trim and place the V.A.C. Drape to cover the foam dressing and an additional 3 to 5 cm border of intact periwound tissue. V.A.C. Drape may be cut into multiple pieces for easier handling.

21. Choose an appropriate site to apply the T.R.A.C. Pad.

22. Pinch the Drape and cut a 2-cm hole through the Drape. Apply the T.R.A.C. Pad. Remove V.A.C. Canister from package and insert into the V.A.C. Therapy Unit until it locks into place. Connect T.R.A.C. Pad tubing to canister tubing and check that the clamps on each tube are open. Turn on the power to the V.A.C. Therapy Unit and select the prescribed therapy setting.

23. Assess the dressing to ensure seal integrity. The dressing should be collapsed, shrinking to the foam and skin.

24. Remove and discard gloves. Apply tape, Montgomery straps or roller gauze to secure the dressings. Alternately, many commercial wound products are self adhesive and do not require additional tape.
SKILL 8-11

Applying Negative Pressure Wound Therapy (Continued)

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25. Label dressing with date and time. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.

26. Remove PPE, if used. Perform hand hygiene.

27. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.
**Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach, 3rd edition**

Name _______________________________ Date _______________________________

Unit _______________________________ Position _______________________________

Instructor/Evaluator: _______________________________ Position _______________________________

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**SKILL 8-12**

**Removing Sutures**

**Goal:** The sutures are removed without contaminating the incisional area, without causing trauma to the wound, and without causing the patient to experience pain or discomfort.

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1. Review the medical orders for suture removal.
2. Gather the necessary supplies and bring to the bedside stand or overbed table.
3. Perform hand hygiene and put on PPE, if indicated.
4. Identify the patient.
5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient. Describe the sensation of suture removal as a pulling or slightly uncomfortable experience.
6. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before beginning the procedure. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness before beginning procedure.
7. Place a waste receptacle at a convenient location for use during the procedure.
8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).
9. Assist the patient to a comfortable position that provides easy access to the incision area. Use a bath blanket to cover any exposed area other than the incision. Place a waterproof pad under the incision site.
10. Put on clean gloves. Carefully and gently remove the soiled dressings. If there is resistance, use a silicone-based adhesive remover to help remove the tape. If any part of the dressing sticks to the underlying skin, use small amounts of sterile saline to help loosen and remove. Inspect the incision area.
11. Clean the incision using the wound cleanser and gauze, according to facility policies and procedures.
12. Using the forceps, grasp the knot of the first suture and gently lift the knot up off the skin.
SKILL 8-12

Removing Sutures (Continued)

13. Using the scissors, cut one side of the suture below the knot, close to the skin. Grasp the knot with the forceps and pull the cut suture through the skin. *Avoid pulling the visible portion of the suture through the underlying tissue.*

14. Remove every other suture to be sure the wound edges are healed. If they are, remove the remaining sutures as ordered. Dispose of sutures according to facility policy.

15. If wound closure strips are to be applied, apply skin protectant to skin around incision. *Do not apply to incision.* Apply adhesive closure strips. Take care to handle the strips by the paper backing.

16. Reapply the dressing, depending on the medical orders and facility policy.

17. Remove gloves and discard. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.

18. Remove additional PPE, if used. Perform hand hygiene.

19. Assess all wounds every shift. More frequent checks may be needed if the wound is more complex.
Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach, 3rd edition

Name ___________________________ Date ___________________________

Unit ___________________________ Position ___________________________

Instructor/Evaluator: ___________________________ Position ___________________________

SKILL 8-13
Removing Surgical Staples

**Goal:** The staples are removed without contaminating the incisional area, without causing trauma to the wound, and without causing the patient to experience pain or discomfort.

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1. Review the medical orders for staple removal.
2. Gather the necessary supplies and bring to the bedside stand or overbed table.
3. Perform hand hygiene and put on PPE, if indicated.
4. Identify the patient.
5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient. Describe the sensation of staple removal as a pulling experience.
6. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before beginning the procedure. Administer appropriate prescribed analgesic. Allow enough time for analgesic to achieve its effectiveness before beginning procedure.
7. Place a waste receptacle at a convenient location for use during the procedure.
8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8).
9. Assist the patient to a comfortable position that provides easy access to the incision area. Use a bath blanket to cover any exposed area other than the incision. Place a waterproof pad under the incision site.
10. Put on clean gloves. Carefully and gently remove the soiled dressings. If there is resistance, use a silicone-based adhesive remover to help remove the tape. If any part of the dressing sticks to the underlying skin, use small amounts of sterile saline to help loosen and remove. Inspect the incision area.
11. Clean the incision using the wound cleanser and gauze, according to facility policies and procedures.
12. Grasp the staple remover. **Position the staple remover under the staple to be removed. Firmly close the staple remover. The staple will bend in the middle and the edges will pull up out of the skin.**

Comments
SKILL 8-13

Removing Surgical Staples (Continued)

13. Remove every other staple to be sure the wound edges are healed. If they are, remove the remaining staples as ordered. Dispose of staples in the sharps container.

14. If wound closure strips are to be applied, apply skin protectant to skin around incision. Do not apply to incision. Apply adhesive closure strips. Take care to handle the strips by the paper backing.

15. Reapply the dressing, depending on the medical orders and facility policy.

16. Remove gloves and discard. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.

17. Remove additional PPE, if used. Perform hand hygiene.

18. Assess all wounds every shift. More frequent checks may be needed if the wound is more complex.
**Skill Checklists for Taylor’s Clinical Nursing Skills: A Nursing Process Approach, 3rd edition**

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**SKILL 8-14**  
**Applying an External Heating Pad**

**Goal:** Desired outcome depends on the patient’s nursing diagnosis.

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1. Review the medical order for the application of heat therapy, including frequency, type of therapy, body area to be treated, and length of time for the application.
2. Gather the necessary supplies and bring to the bedside stand or overbed table.
3. Perform hand hygiene and put on PPE, if indicated.
4. Identify the patient.
5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.
6. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).
7. Assist the patient to a comfortable position that provides easy access to the area where the heat will be applied; use a bath blanket to cover any other exposed area.
8. Assess the condition of the skin where the heat is to be applied.
9. Check that the water in the electronic unit is at the appropriate level. Fill the unit two-thirds full or to the fill mark, with distilled water, if necessary. Check the temperature setting on the unit to ensure it is within the safe range.
10. Attach pad tubing to electronic unit tubing.
11. Plug in the unit and warm the pad before use. Apply the heating pad to the prescribed area. Secure with gauze bandage or tape.
12. **Assess the condition of the skin and the patient’s response to the heat at frequent intervals, according to facility policy. Do not exceed the prescribed length of time for the application of heat.**

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13. Remove gloves and discard. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.
14. Remove additional PPE, if used. Perform hand hygiene.
15. Remove after the prescribed amount of time. Reassess the patient and area of application, noting the effect and presence of adverse effects.
**Skill Checklists for Taylor's Clinical Nursing Skills:**
*A Nursing Process Approach, 3rd edition*

Name ___________________________ Date ___________________________
Unit ___________________________ Position ___________________________
Instructor/Evaluator: ___________________________ Position ___________________________

**SKILL 8-15**

**Applying a Warm Compress**

**Goal:** The patient displays signs of improvement, such as decreased inflammation, decreased muscle spasms, or decreased pain that indicate problems have been relieved.

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1. Review the medical order for the application of a moist warm compress, including frequency, and length of time for the application.

2. Gather the necessary supplies and bring to the bedside stand or overbed table.

3. Perform hand hygiene and put on PPE, if indicated.

4. Identify the patient.

5. Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before beginning the procedure. Administer appropriate analgesic, consulting physician’s orders, and allow enough time for analgesic to achieve its effectiveness before beginning procedure.

6. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.

7. If using an electronic heating device, check that the water in the unit is at the appropriate level. Fill the unit two-thirds full with distilled water, or to the fill mark, if necessary. Check the temperature setting on the unit to ensure it is within the safe range (Refer to Skill 8-14).

8. Assist the patient to a comfortable position that provides easy access to the area. Use a bath blanket to cover any exposed area other than the intended site. Place a waterproof pad under the site.

9. Place a waste receptacle at a convenient location for use during the procedure.

10. Pour the warmed solution into the container and drop the gauze for the compress into the solution. Alternately, if commercially packaged pre-warmed gauze is used, open packaging.

11. Put on clean gloves. Assess the application site for inflammation, skin color, and ecchymosis.

Comments
### SKILL 8-15

**Applying a Warm Compress (Continued)**

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12. *Retrieve the compress from the warmed solution, squeezing out any excess moisture. Alternately, remove pre-warmed gauze from open package. Apply the compress by gently and carefully molding it to the intended area. Ask patient if the application feels too hot.*

13. Cover the site with a single layer of gauze and with a clean dry bath towel; secure in place if necessary.

14. Place the Aquathermia or heating device, if used, over the towel.

15. Remove gloves and discard them appropriately. Perform hand hygiene and remove additional PPE, if used.

16. *Monitor the time the compress is in place to prevent burns and skin/tissue damage. Monitor the condition of the patient's skin and the patient's response at frequent intervals.*

17. After the prescribed time for the treatment (up to 30 minutes), remove the external heating device (if used) and put on gloves.

18. Carefully remove the compress while assessing the skin condition around the site and observing the patient’s response to the heat application. Note any changes in the application area.

19. Remove gloves. Place the patient in a comfortable position. Lower the bed. Dispose of any other supplies appropriately.

20. Remove additional PPE, if used. Perform hand hygiene.
### Skill Checklists for Taylor’s Clinical Nursing Skills: A Nursing Process Approach, 3rd edition

**Goal:** The patient states an increase in comfort.

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1. Review the medical order for the application of a Sitz bath, including frequency, and length of time for the application.
2. Gather the necessary supplies and bring to the bedside stand or overbed table.
3. Perform hand hygiene and put on PPE, if indicated.
4. Identify the patient.
5. Close curtains around bed and close door to room if possible.
6. Put on gloves. Assemble equipment; at the bedside if using a bedside commode or in bathroom.
7. Raise lid of toilet or commode. Place bowl of sitz bath, with drainage ports to rear and infusion port in front, in the toilet. Fill bowl of sitz bath about halfway full with tepid to warm water (37°C–46°C [98°F–115°F]).
8. Clamp tubing on bag. Fill bag with same temperature water as mentioned above. Hang bag above patient’s shoulder height on the IV pole.
9. Assist patient to sit on toilet or commode and provide any extra draping if needed. Insert tubing into infusion port of sitz bath. Slowly unclamp tubing and allow sitz bath to fill.
10. Clamp tubing once sitz bath is full. Instruct patient to open clamp when water in bowl becomes cool. *Ensure that call bell is within reach. Instruct patient to call if she feels light-headed or dizzy or has any problems. Instruct patient not to try standing without assistance.*
11. Remove gloves and perform hand hygiene.
12. When patient is finished (in about 15–20 minutes, or prescribed time), put on clean gloves. Assist the patient to stand and gently pat perineal area dry. Remove gloves. Assist patient to bed or chair. Ensure that call bell is within reach.
13. Put on gloves. Empty and disinfect Sitz bath bowl according to agency policy.
14. Remove gloves and any additional PPE, if used. Perform hand hygiene.
**Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach, 3rd edition**

**SKILL 8-17**

**Applying Cold Therapy**

**Goal:** The patient reports a relief of pain and increased comfort.

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1. Review the medical order or nursing plan of care for the application of cold therapy, including frequency, type of therapy, body area to be treated, and length of time for the application.

2. Gather the necessary supplies and bring to the bedside stand or overbed table.

3. Perform hand hygiene and put on PPE, if indicated.

4. Identify the patient. Determine if the patient has had any previous adverse reaction to hypothermia therapy.

5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.

6. Assess the condition of the skin where the ice is to be applied.

7. Assist the patient to a comfortable position that provides easy access to the area to be treated. Expose the area and drape the patient with a bath blanket if needed. Put the waterproof pad under the wound area, if necessary.

8. Prepare device:
   - Fill the bag, collar, or glove about three-fourths full with ice. **Remove any excess air from the device.** Securely fasten the end of the bag or collar; tie the glove closed, checking for holes and leakage of water.
   - Prepare commercially prepared ice pack if appropriate.

9. **Cover the device with a towel or washcloth.** (If the device has a cloth exterior, this is not necessary.)

10. Position cooling device on top of designated area and lightly secure in place as needed.

11. **Remove the ice and assess the site for redness after 30 seconds. Ask the patient about the presence of burning sensations.**

12. Replace the device snugly against the site if no problems are evident. Secure it in place with gauze wrap, ties, or tape.

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SKILL 8-17
Applying Cold Therapy *(Continued)*

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<td>13. Reassess the treatment area every 5 minutes or according to facility policy.</td>
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<td>14. <em>After 20 minutes or the prescribed amount of time, remove the ice and dry the skin.</em></td>
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<td>15. Remove PPE, if used. Perform hand hygiene.</td>
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