**Skill Checklists for Fundamentals of Nursing: The Art and Science of Person-Centered Nursing Care, 8th edition**

Name __________________________________________ Date _______________________
Unit __________________________________________ Position _______________________
Instructor/Evaluator: __________________________________________ Position _______________________

**SKILL 31-7**

**Applying Negative-Pressure Wound Therapy**

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

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Needs Practice</th>
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<tbody>
<tr>
<td>1. Review the medical order for the application of NPWT therapy, including the ordered pressure setting for the device. Gather necessary supplies.</td>
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<td>2. Perform hand hygiene and put on PPE, if indicated.</td>
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<td>3. Identify the patient.</td>
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<td>4. Assemble equipment on the overbed table within reach.</td>
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<td>5. Close curtains around the bed and close the door to the 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 the possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care dressing change. Administer the appropriate prescribed analgesic. Allow enough time for the analgesic to achieve its effectiveness before beginning the procedure.</td>
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<td>7. Adjust the bed to a comfortable working height, usually elbow height of the caregiver.</td>
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<td>8. Assist the patient to a comfortable position that provides easy access to the wound area. Position the patient so that 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.</td>
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<td>9. Have the disposal bag or waste receptacle within easy reach for use during the procedure.</td>
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<td>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.</td>
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<td>11. Put on a gown, mask, and eye protection.</td>
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<td>12. Put on clean gloves. Carefully and gently remove the dressing. If there is resistance, use a silicone-based adhesive remover to help remove the dressing. <strong>Note the number of pieces of foam removed from the wound. Compare with the documented number from the previous dressing change.</strong></td>
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</table>

Comments
SKILL 31-7
Applying Negative-Pressure Wound Therapy (Continued)

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.

15. Clean the area around the wound 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.

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

18. **Using sterile scissors, cut the foam to the shape and meas-
urement 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.**

19. Trim and place the V.A.C. Drape to cover the foam dress-
ing and an additional 3- to 5-cm border of intact peri-
wound tissue. The V.A.C. Drape may be cut into multiple
pieces for easier handling.

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

21. Pinch the drape and cut a 2-cm hole through it. Apply the
T.R.A.C. Pad. Remove V.A.C. Canister from the package
and insert into the V.A.C. Therapy Unit until it locks into
place. Connect the 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 pre-
scribed therapy setting.

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

23. Remove and discard gloves.

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