Skill Checklists for Fundamentals of Nursing:
The Art and Science of Nursing Care, 7th edition

Name _____ Date _____

Unit _____ Position _____

Instructor/Evaluator: _____ Position _____

Skill 32-1

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.

Excellent	Satisfactory	Needs Practice		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.	
____	____	____	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. Use the bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.	
____	____	____	10. 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.	
____	____	____	11. 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.	

Skill 32-1

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

Excellent	Satisfactory	Needs Practice		Comments
____	____	____	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.	
____	____	____	16. Put on sterile gloves.	
____	____	____	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.	
____	____	____	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.	

Skill 32-1

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

Excellent	Satisfactory	Needs Practice		Comments
____	____	____	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.	

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SKILL 32-2

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.

Excellent	Satisfactory	Needs Practice		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.	
____	____	____	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 32-3 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 32-2

Applying a Saline-Moistened Dressing *(Continued)*

Excellent	Satisfactory	Needs Practice		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.	
____	____	____	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 32-1. Alternately, irrigate the wound, as ordered or required (see Skill 32-3).	
____	____	____	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.	

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SKILL 32-3

Performing Irrigation of a Wound

Excellent	Satisfactory	Needs Practice	**Goal:** The wound is cleaned without contamination or trauma 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 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.	
____	____	____	10. Put on a gown, mask, and eye protection.	
____	____	____	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 32-3

Performing Irrigation of a Wound *(Continued)*

Excellent	Satisfactory	Needs Practice		Comments
____	____	____	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.	
____	____	____	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 inch 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 Skill 32-1).	
____	____	____	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.	

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SKILL 32-4

Caring for a Jackson-Pratt Drain

Excellent	Satisfactory	Needs Practice	**Goal:** The drain is patent and intact.	Comments
____	____	____	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 valve, 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 with one hand and replace the cap with your other hand.***	
____	____	____	12. Check the patency of the equipment. Make sure the tubing is free from twists and kinks.	
____	____	____	13. 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.	

SKILL 32-4

Caring for a Jackson-Pratt Drain *(Continued)*

Excellent	Satisfactory	Needs Practice		Comments
____	____	____	14. Carefully measure and record the character, color, and amount of the drainage. Discard the drainage according to facility policy. Remove gloves.	
____	____	____	15. Put on clean gloves. If the drain site has a dressing, redress the site. 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 4 hours. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.	

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SKILL 32-5

Caring for a Hemovac Drain

Excellent	Satisfactory	Needs Practice	**Goal:** The drain is patent and intact.	Comments
____	____	____	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 32-5

Caring for a Hemovac Drain *(Continued)*

Excellent	Satisfactory	Needs Practice		Comments
____	____	____	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, redress the site. 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 4 hours. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly.	

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SKILL 32-6

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.

Excellent	Satisfactory	Needs Practice		Comments
____	____	____	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.	
____	____	____	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.	

SKILL 32-6

Collecting a Wound Culture *(Continued)*

Excellent	Satisfactory	Needs Practice		Comments
____	____	____	13. Remove your gloves and put them in the receptacle.	
____	____	____	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.	
____	____	____	15. Clean the wound. Refer to Skill 32-1. Alternately, irrigate the wound, as ordered or required (see Skill 32-3).	
____	____	____	16. Dry the surrounding skin with gauze dressings. Put on clean gloves.	
____	____	____	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.***	
____	____	____	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.	
____	____	____	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.***	
____	____	____	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.	
____	____	____	21. Remove gloves and discard them accordingly.	
____	____	____	22. Put on gloves. Place a dressing on the wound, as appropriate, based on medical orders and/or the nursing plan of care. Remove gloves.	
____	____	____	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.	
____	____	____	24. Label the specimen according to your institution's guidelines and send it to the laboratory in a biohazard bag.	
____	____	____	25. Remove PPE, if used. Perform hand hygiene.	

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SKILL 32-7

Applying Negative-Pressure Wound Therapy

Excellent	Satisfactory	Needs Practice	**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.	Comments
____	____	____	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 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. 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 dressing. 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.***	

SKILL 32-7

Applying Negative-Pressure Wound Therapy *(Continued)*

Excellent	Satisfactory	Needs Practice		Comments
____	____	____	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 32-3).	
____	____	____	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.	
____	____	____	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.	
____	____	____	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.	

SKILL 32-7

Applying Negative-Pressure Wound Therapy *(Continued)*

Excellent	Satisfactory	Needs Practice		Comments
____	____	____	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.	

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SKILL 32-8

Applying an External Heating Pad

Excellent	Satisfactory	Needs Practice	**Goal:** Desired outcome depends on the patient's nursing diagnosis.	Comments
____	____	____	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.***	
____	____	____	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 Fundamentals of Nursing:
The Art and Science of Nursing Care, 7th edition

Name _____ Date _____

Unit _____ Position _____

Instructor/Evaluator: _____ Position _____

SKILL 32-9

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.

Excellent	Satisfactory	Needs Practice		Comments
____	____	____	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 32-8.)	
____	____	____	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 prewarmed gauze is used, open packaging.	
____	____	____	11. Put on clean gloves. Assess the application site for inflammation, skin color, and ecchymosis.	

SKILL 32-9

Applying a Warm Compress *(Continued)*

Excellent	Satisfactory	Needs Practice		Comments
____	____	____	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.	