PURPOSE:
To manage a draining wound by protecting the surrounding skin from maceration; to allow accurate measurement of drainage; to protect the wound from trauma; and to limit the spread of contamination.

CONSIDERATIONS:
1. There are two major methods for managing a draining wound:
   a. Dressing.
   b. Pouching. (See Integumentary - Application of Wound Dressing.)
2. Pouching is the better choice when skin integrity is compromised by caustic or copious drainage. [Note: Rule of thumb - if wound drains more than 50 mL output in 24 hours, a pouching procedure should be considered.]
3. Wound pouching provides accurate measurement of drainage, eliminates the need for frequent dressing changes, limits the spread of contamination and improves the patient’s comfort.
4. Irrigation of the wound and pouch usually accompanies the pouching procedure. Collection pouches are available that are especially designed for wound care management.

EQUIPMENT:
Impervious trash bag
Instruments, e.g., forceps, scissors
Protective bed pad
Gloves
Apron or gown (optional)
Protective eye wear (optional)
Collection pouch (with access port, if irrigation ordered)
Skin protectant
Sterile gauze pads
Waterproof or micropore tape
Graduated, collection container -optional

IF IRRIGATION ORDERED
Clean basin
Prescribed irrigant such as sterile normal saline
Sterile, soft-rubber catheter
50-60 mL piston syringe
Container

PROCEDURE:
1. Adhere to Standard Precautions.
2. Review the physician’s orders.
3. Explain procedure to patient.
4. Prepare materials and equipment for wound care, including opening impervious trash bag and establishing the aseptic field.
5. Empty the collection pouch by inserting the bottom half of the pouch into a graduated, collection container and open the drainage port. Observe the color, consistency, odor and amount of fluid. Wipe the bottom of the pouch and the drainage port with an alcohol wipe or a moistened gauze sponge to remove any spillage that could irritate the patient’s skin or cause an odor. Close the access port.
6. Observe for:
   a. Wound size, including length, width and depth.
   b. Drainage characteristics, including type, amount, color and odor.
   c. Wound bed tissue type/color, including necrotic, slough, eschar, granulating, clean, non-granulating and epithelial.
   d. Evidence of wound healing or deterioration.
   e. Symptoms of infection, including redness, swelling, pain, discharge or increased temperature.
   f. Development of undermining or sinus tract that may require packing.
7. Observe the collection pouch for leakage or nonadhesion of the pouch, including undermining of the seal, or malfunction of pouch. Change pouch every 5 to 7 days or more frequently if seal is broken. Unnecessary change may contribute to skin irritation.
8. Changing the pouch:
   a. Don clean gloves and remove leaking pouch using the push-pull method to avoid trauma to skin. Hold skin taut and gently remove facing from skin by pushing skin away from facing. Discard pouch and save the clip.
   b. Clean periwound with soap and water, rinse and dry thoroughly. Cleanse wound and/or irrigate the wound as ordered. (See Integumentary - Wound Irrigation.)
   c. Remove gloves and discard in appropriate container. Decontaminate hands and don clean gloves. Measure the wound and pattern an opening 1/8 inch (0.3 cm) larger in the collection pouch’s facing or face plate if collection pouch has a skin protectant incorporated in the faceplate.
   d. If pouch does not have wafer barrier/skin protectant, apply wafer barrier skin protectant as needed.
   e. Apply paste around fistula; fill in uneven surfaces with paste or skin barrier strips. Use a damp finger or tongue blade to apply paste.
   f. Make sure the drainage port at the bottom of the pouch is securely closed. Gently press the contoured pouch opening around the wound, beginning at the wound’s lower edge to catch any drainage. Picture frame taping may be advisable to achieve more pouching security. Apply strips of tape to cover each of the four sides of the facing.
9. Wound irrigation of non-visible tract (if ordered):
   a. Wound can be irrigated with the collection pouch in place, if the pouch used has a drainage port or folding drainage system, e.g., Hollister®. Pour the prescribed irrigating solution into a container.
   b. Fill the syringe with the irrigating solution and connect the rubber catheter to the syringe.
   c. Using one hand, open the end of the collection pouch to allow introducing the catheter without contamination. Introduce the catheter through the collection pouch and gently insert the catheter into the wound until you feel resistance. Avoid forcing the catheter into the wound, which could cause tissue damage, bleeding or perforation of underlying structure.
   d. Gently instill a slow, steady stream of irrigating solution making sure the solution reaches all areas of the wound. Plan the solution to flow from the clean areas of the wound to the dirty areas to prevent contamination of clean tissue by wound exudate.
   e. Pinch the catheter closed while withdrawing the syringe. Refill the syringe, reconnect it to the catheter, and repeat the irrigation until prescribed amount of solution has been instilled or the solution returned is clear. Document the amount of solution used.
   f. Remove catheter and syringe. Close drainage port and wipe with gauze pad.

10. Discard soiled supplies in appropriate containers.
11. Position the patient to allow further wound drainage and make sure the patient is comfortable.
12. Evaluate the patient for needed change in medical treatment plan.

AFTER CARE:
1. Document in patient's record:
   a. Procedure.
   b. Patient's response to procedure.
   c. Temperature and vital signs per agency policy.
   d. Wound observations noted in No. 6 of procedure.
   e. Response of the wound to the prescribed treatment.
2. Instruct patient/caregiver in care of the wound, including:
   a. Report any changes in pain, drainage, temperature or other signs and symptoms of infection.
   b. Procedure to utilize if pouch dressing leaks or malfunctions.
   c. Diet to promote healing.
   d. Medications/disease processes that may be impeding healing.
   e. Activities permitted.

REFERENCES: