PURPOSE:
To maintain physiologic integrity of the wound by keeping the wound bed moist and normothermic, and the surrounding skin dry.

CONSIDERATIONS:
1. Use of a dressing that will keep the wound surface continuously moist. Wet-to-moist dressings should be used only for a short duration as this type of dressing requires frequent changes (3 or more per day) to maintain a moist wound bed.
2. Wet-to-Dry-Dressings are typically intended for the debridement of necrotic tissue from the wound bed. This type of dressing is no longer routinely recommended as it is non-selective and dressing removal can be painful and injure the wound bed.
3. The following criteria should be considered when selecting a dressing:
   a. Wound-related factors, such as etiology, severity, environment and depth, anatomic location, volume of exudate and the risk or presence of infection.
   b. Patient-related factors, such as vascular, nutritional, and medical status; odor-control requirements; comfort and preferences; and cost-versus-benefit ratio.
   c. Dressing-related factors, such as availability, durability, adaptability and uses.
4. Dressing changes may be painful. Pain medication may be necessary 30 minutes before each dressing change.
5. A dressing is not indicated when skin integrity is compromised by caustic or excessive drainage. Pouching may be indicated to protect the skin when the draining is copious or excoriating.
6. Follow manufacturer's guidelines regarding length of time dressing may be left on wound. Always reapply if leaking exudate or loosening of dressing occurs.
7. Certain wounds may require sterile technique. Use appropriate sterile supplies.

EQUIPMENT:
Sterilized instrument pack (optional)
Dressings (as needed)
Hypoallergenic tape
Gloves
Skin protectant
Basin (optional)
Cleansing solution, normal saline or other
Protective bed pad
Scissors
Personal protective equipment (as needed): apron/gown, eyewear
Impervious trash bag

Montgomery straps (optional)
Sterile Cotton tipped applicator

PROCEDURE:
1. Adhere to Standard Precautions.
2. Review physician's orders.
3. Explain procedure to patient/caregiver.
4. Establish a clean field (sterile, if necessary) with all the supplies and equipment that will be necessary.
5. Remove tape by pushing skin from tape. Remove soiled dressing. Discard dressing and gloves in appropriate containers. Decontaminate hands and don clean gloves.
6. Observe for:
   a. Wound size including length, width and depth. Document weekly and when needed.
   b. Wound bed tissue type/color including necrotic, slough, eschar, granulating, clean, non-granulating and epithelial.
   c. Evidence of wound healing or deterioration.
   d. Drainage characteristics including type, amount, color and odor.
   e. Symptoms of infection including redness, swelling, pain, discharge or increased temperature.
   f. Development of undermining or sinus tract that may require packing.
8. Cleanse wound with normal saline or wound cleanser per wound care orders. (See Integumentary- Wound Cleansing.)
9. Dress wound with appropriate dressings following manufacturer’s guidelines and physician orders.
10. If the dressing’s edges need to be secured with tape, apply a skin sealant to the intact skin around the wound. After area dries, secure the dressing to the skin with hypoallergenic tape.
11. For frequent dressing changes, Montgomery straps or a hydrocolloid dressing may be used to prevent trauma to the periwound skin.
12. Write date of application and initials of applier directly on the dressing (optional).
13. To apply wet-to-moist dressings follow these steps:
   a. Moisten the gauze with solution, such as normal saline, and wring it out until it is slightly moist.
   b. Fluff the gauze completely and place it over the wound bed.
   c. Cover the wound with gauze and a semi-occlusive dressing. Allow enough layers of gauze to absorb drainage until the next dressing change. Secure dressing with tape.
   d. Moisten dressing for removal.
14. To apply a wet-to-dry dressing follow these steps:
   a. Moisten the gauze with solution, such as normal saline, and wring it out until it is slightly moist.
   b. Fluff the gauze completely and place it over the wound bed.
c. Cover the wound with dry gauze, allowing enough layers to absorb drainage until the next dressing change. Secure dressing with tape.

d. Remove the dressing when it is almost dry.

15. Discard soiled supplies in appropriate containers.
16. Clean reusable supplies before leaving the home, according to agency policy.

AFTER CARE:
1. Document in patient’s record:
   a. Procedure and type of dressing used.
   b. Patient’s response to procedure.
   c. Temperature and vital signs.
   d. Wound observations noted in No. 6, under procedure.
   e. Response of the wound to the prescribed treatment.

2. Instruct patient/caregiver in care of the wound including:
   a. Reporting any changes in pain, drainage, temperature or other signs and symptoms of infection.
   b. Techniques to change or reinforce dressings. It is not routine to teach lay people to pack wounds.
   c. Diet to promote healing.
   d. Medications/disease processes that may be impeding healing.
   e. Activities permitted.

REFERENCES:


Ovington, L. (2002). Hanging wet – to - dry dressings out to dry. Advances in Skin and Wound Care. 15:2 P. 79-84