

SURGICAL PROGRAM PROCEDURE

CATEGORY: Corporate Clinical
ISSUE DATE: October 2001
SUBJECT: **WOUND PACKING**

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PURPOSE

To ensure the safe packing of an open or tunnelled wound.

PROCEDURE

Equipment

- Dressing tray
- Irrigating/wound packing solution (as ordered by physician/NSWOC)
- Wound packing material (as ordered by physician/NSWOC)
- Sterile scissors (optional)
- Secondary wound dressing
- Sterile cotton swab with measuring guide
- Sterile and non-sterile gloves
- Sterile Normal Saline in 100 mL single-use container
- Disposable blue pad (if irrigation is required)
- Tape or dressing strip

Special Instructions

- After the initial assessment, the nurse (RN or specially trained RPN) may apply medicated dressings and/or wound packing below the dermis to stable wounds.
- Initial post-operative dressings are removed according to service guidelines.
- When a dressing is removed, the temperature of the wound bed decreases which can delay healing.
- Use sterile scissors when adjusting a dressing size. Any leftover sterile dressing pieces, with the exception of packing, can be placed in a sterile specimen container for the patient's subsequent dressing changes.

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- When packing into a tunnel or undermining, the packing material needs to make contact with the entire wound space using a “fluff not stuff” technique. The looser packing enables the wound to fill in from the bottom up and edges inward while the packing serves as a wick for drainage. Over packing a wound (unless specifically directed by the physician/NSWOC) is not best practice.
- Moisten the wound packing. A saturated (“dripping wet”) packing will interfere with mechanical wound debridement, diminish its wicking ability and could macerate the periwound.
- Some specialty packing products are inserted/packed dry into tunnelled areas of the wound bed. This would be indicated in the patient’s chart. Choose the widest packing width that would best fit the tunnel (i.e. if using two packages of ¼” packing, try one package of ½”). Try to use one package of strip gauze that is long enough to permit packing retrieval. If more than one package is required, tie the tails together.
- If frequent dressing changes are needed, consider using Montgomery straps, gauze wraps, tubular mesh dressings and/or protecting the skin under the tape with a skin barrier wipe (3M Cavillon No-Sting).

Method

1. When a physician/NSWOC orders packing to an open or tunnelled wound, the RN will perform an initial wound assessment. The wound assessment will include:
 - A. Measurement in cm
 - **Length** in a head-to-toe (12 to 6 o’clock) direction
 - **Width** in a side-to-side (3 to 9 o’clock direction)
 - **Depth** measured with a sterile cotton applicator in the deepest part of the wound
 - B. Location and extent of tunnelling and undermining
 - C. Colour (red, yellow, black, etc.) and estimate percentage of each colour
 - D. Wound exudate
 - **Amount** – nil, scant, moderate or heavy
 - **Colour** – serous, serosanguinous, sanguineous, purulent (green, yellow, beige other)
 - **Odour** – present or not present
 - E. Periwound tissue (surrounding skin) with respect to erythema (redness) induration (firmness) and/or maceration (moisture)
2. Prepare the dressing tray at the bedside. Add irrigating/wound packing solutions.
3. Apply non-sterile gloves.
4. Remove the soiled wound packing with forceps and dispose. Remove tape in the direction of hair growth by gently rolling back the adhesive from the skin.
5. If irrigation is required:
 - A. Drape the patient with a disposable blue pad.
 - B. Irrigate the wound bed with a Sterile Normal Saline 100 mL single-use container approximately 2 cm from the wound bed at a 45° angle to minimize splash back. This produces approximately 15 PSI of pressure from the tip of the container, which will help to remove surface slough/debris and minimize the growth of bacteria.
6. Remove non-sterile gloves, wash hands and apply sterile gloves.
7. Place a sterile drape below the wound edge.
8. Cleanse wound in a circular motion from the centre of the wound toward the edge. **Do not** return to the centre of the wound, as you will risk re-contaminating what you have just cleansed.
9. Pat the wound dry with sterile gauze using same circular technique.
10. Measure the wound using a sterile measuring guide. Record any tunnelling or undermining.

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11. Apply advanced wound care dressing material/wound packing and fill the wound to the surface.
12. Protect the periwound with a skin barrier (wipe or ointment).
13. Cover the wound packing with a secondary wound dressing (sterile gauze and/or abdominal pad).
14. Secure with tape.
15. Document the wound assessment and observations on the appropriate charting record.

EDUCATION AND TRAINING

Definitions

1. **Tunnelling:** A channel through any part of the wound bed that travels through subcutaneous tissue or muscle. It is measured in cm and the direction is referenced to a clock face.
2. **Undermining:** Tissue damage under the periwound skin around the perimeter of the wound. It is documented noting the location with a sterile swab using the face of a clock as a guide. The top of the wound (12 o'clock) would be in the direction of the patient's head.

Education/Training Related Information

The following tasks cannot be delegated to RPNs unless they are specially trained:

- Eye dressings, burn dressings, skin graft dressings, central line dressings, dialysis catheter dressings, wounds that require mechanical debridement, dressings with drains
- Wound packing to stable wounds with tunnelling
- V.A.C. dressings

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