

SOP on Wound Dressing in Primary Care Setting

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Standard Operating Procedure (SOP) On Wound Dressing in Primary Care Setting

Issued By

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(1). Purpose

To provide a standardized, safe, and evidence-based approach to wound dressing that promotes optimal wound healing, prevents infection, minimizes complications, and ensures patient comfort and safety.

(2). Scope

This SOP applies to all medical students, medical officers, family physicians, interns, nursing officers, and healthcare professionals involved in wound assessment, wound dressing, and wound care management in primary care clinics, outpatient departments, and family medicine settings.

(3). Responsibilities

(3.1) Medical Officer

- Assess the wound and determine the need for dressing
- Select appropriate wound management strategies
- Identify complications requiring escalation of care
- Prescribe medications when indicated
- Ensure proper documentation

(3.2) Nursing Staff

- Prepare equipment and dressing materials
- Perform wound dressing using aseptic technique
- Monitor wound progress and report abnormalities
- Educate patients regarding wound care

(3.3) Healthcare Assistant

- Prepare the procedure area
- Assist with patient positioning
- Dispose of clinical waste appropriately
- Maintain cleanliness of equipment and surroundings

(4). Indications for Wound Dressing

- Surgical wound
- Traumatic wounds
- Lacerations
- Abrasions
- Burns
- Pressure ulcers
- Diabetic foot ulcers

- Chronic wounds
- Infected wounds requiring regular monitoring
- Post-procedure wound care

(5). Contraindications

- Known allergy to dressing material
- Dressing products contraindicated for specific wound type:

(6). Precautions

- Active bleeding requiring immediate intervention
- Suspected necrotizing soft tissue infection
- Deep wounds requiring surgical assessment
- Signs of systemic infection
- Foreign body within the wound

(7). Required Equipment and Materials

(7.1) Personal Protective Equipment (PPE)

- Disposable gloves



- Sterile gloves



- Surgical mask



- Disposable apron/gown



(7.2) Dressing Equipment

- Sterile dressing pack



- Sterile gauze swabs



- Normal saline (0.9%)



- Sterile forceps



- Adhesive tape or bandage



- Kidney tray



(7.3) Waste Disposal

- Clinical waste bag



- Sharps container



(8). Infection Prevention and Control Measures

- Perform hand hygiene according to WHO guidelines before and after the procedure
- Use appropriate PPE
- Maintain aseptic non-touch technique throughout the procedure
- Use sterile equipment and dressing materials
- Dispose of contaminated materials according to infection control policies
- Avoid cross-contamination between patients

(9) Procedure

(9.1) Patient Preparation

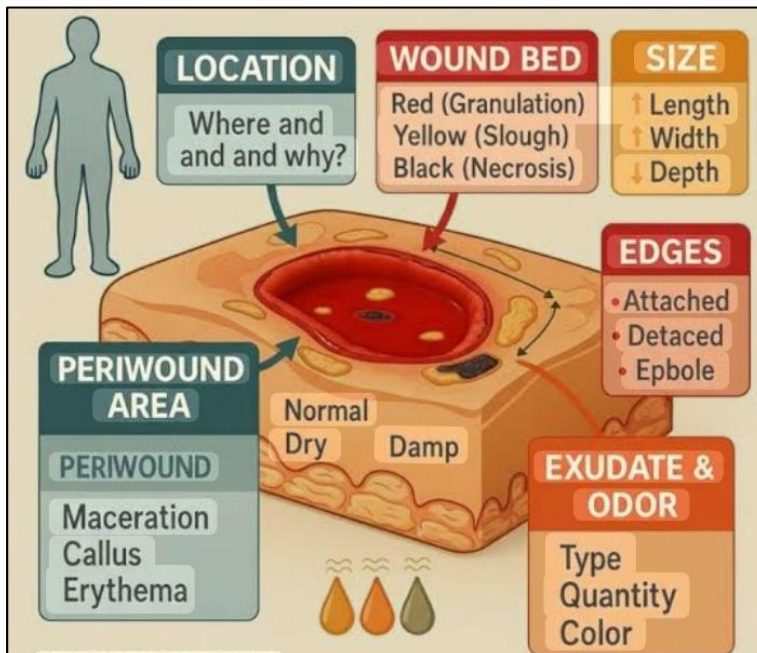
- Verify patient
- Explain the procedure and request informed consent
- Ensure privacy and patient comfort
- Position the patient appropriately.
- Assess pain and provide analgesia if necessary

(9.2) Wound Assessment

Assess and document:

- Location of wound
- Size and depth
- Wound bed appearance
- Presence of granulation tissue
- Exudate type and quantity

- Odour
- Surrounding skin condition
- Signs of infection
- Pain level



(9.3) Preparation of Equipment

- Gather all required equipment
- Check sterility and expiry dates
- Prepare a clean working surface
- Open sterile dressing pack using aseptic technique

(9.4) Removal of Existing Dressing

- Perform hand hygiene
- Wear clean gloves
- Carefully remove the old dressing
- Observe for bleeding, discharge, odour, or infection
- Dispose of contaminated dressing safely
- Remove gloves and perform hand hygiene

(9.5) Wound Cleansing

- Put on sterile gloves



- Irrigate or cleanse the wound with sterile normal saline



- Clean from the least contaminated area to the most contaminated area
- Use one gauze swab for each wipe
- Avoid vigorous scrubbing of healthy tissue
- Dry surrounding skin gently if required

(9.6) Application of New Dressing

- Apply sterile drapes around the wound



- Select the appropriate dressing according to wound characteristics.
- Apply sterile dressing over the wound



- Ensure complete wound coverage
- Maintain aseptic technique throughout the procedure

(9.7) Securing the Dressing

- Secure dressing with tape, bandage, or other suitable fixation method



- Ensure dressing is firm but not excessively tight
- Check circulation if dressing is applied to a limb

(9.8) Post-Procedure Care

- Ensure patient comfort
- Reposition patient if necessary
- Dispose of waste appropriately
- Remove gloves and perform hand hygiene
- Clean and store reusable equipment according to institutional policy

(10). Documentation

- Date and time of dressing
- Wound location
- Wound assessment findings
- Type of dressing used
- Presence of exudate or infection
- Patient's pain score and tolerance
- Advice given to the patient
- Name, designation, signature, and stamp of healthcare provider

(11). Patient Education

Advise the patient regarding:

- Importance of keeping the dressing clean and dry
- Hand hygiene before touching the wound area
- Signs of infection requiring medical attention
- Medication compliance
- Follow-up appointments
- When to return immediately for review

(12). Quality Standards

- Aseptic technique maintained throughout the procedure

- Appropriate dressing selected according to wound type
- Accurate and complete documentation
- Patient comfort and dignity maintained
- Compliance with infection prevention guidelines
- Timely review and follow-up

(13). Monitoring and Audit Indicators

- Wound infection rate
- Compliance with hand hygiene practices
- Compliance with aseptic technique
- Documentation completeness
- Patient satisfaction
- Healing outcomes

(14). References

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