POLICY STATEMENTS

Post operative care of surgical incisions is provided to optimize wound bed healing.

Expected outcomes of post operative incision care include:
- healing occurs (incision is well approximated and wound healing occurs through primary intention)
- incision is free from infection
- child’s pain and anxiety are effectively managed

Dressings should generally remain in place for 48 hours post operatively unless otherwise ordered or as per specific protocol/surgical procedure. Exception: all plastic surgery patients require a physician’s order prior to first dressing change.

- For initial removal of dressing at 48 hours post-operatively, remove dressing and cleanse as per procedure listed below. If incision is free of signs of infection and is healing, leave the incision open to air, examine wound and cleanse daily and prn with gentle soap and water.

PROCEDURE

1. **DETERMINE** if dressing requires changing:
   - per physician’s order, or
   - if saturated/soiled (notify physician for assessment), or
   - per specific protocol/surgical procedure
     - see Sternotomy and Thoracotomy Post Surgical Wound Care

2. **ASSESS** child’s pain and anxiety level; administer pre-medications with analgesics and anxiolytics per physician’s orders if needed.

   **Considerations:** Child Life Specialist may be helpful in working with the child to use non-pharmacological pain and anxiety management techniques.

3. **ASSEMBLE** equipment:
   - sterile dressing tray
   - sterile 0.9% normal saline (NS) solution (warmed to body temperature)
   - non-sterile gloves
   - sterile gloves if procedure cannot be done without touching or contaminating Key Parts. Otherwise use another pair of non-sterile gloves
   - mask
   - personal protective equipment (gown, eye protection) as appropriate if splashing is a risk
   - dressing supplies as required

   **Rationale:** Facilitates completion of tasks in a timely manner. Warmed solution facilitates the healing process.

4. **IDENTIFY** patient and **EXPLAIN** procedure. **ENSURE** patient and family understand procedure and questions are answered.

   **Rationale:** Failure to correctly identify patients prior to procedures may result in errors.
   Reduces child and family’s anxiety. Evaluates and reinforces understanding of previously taught information and confirms consent process.
5. **WASH** hands and **DON** mask and personal protective equipment as indicated for specific procedure.  
   - Standard precautions; reduces transmission of microorganisms.

6. **PREPARE** equipment using aseptic no-touch technique.

7. **REMOVE** old dressing as follows:  
   a. don clean gloves  
   b. loosen tape and gently pull tape ends toward the wound. Use adhesive removal pads as necessary  
   c. remove dressings one layer at a time and dispose appropriately.  
   - Hasty removal of dressing can cause trauma to the newly healing and granulating tissues.

   **NOTE:** adherent dressing removal may be facilitated by moistening with normal saline.

8. **ASSESS** incision for healing and for any signs or symptoms of infection including:  
   - erythema  
   - edema  
   - purulent drainage  
   - odour to drainage  
   - increased pain at surgical site  
   - fever  
   - Wound infection causes an inflammatory response that interferes with wound healing. Regular assessment ensures prompt treatment of wound infection.

9. Gently **CLEANSE** wound with sterile normal saline using aseptic no-touch technique as follows:  
   a. cleanse from top to the base or center to edges  
   b. use a new gauze with each area cleansed  
   c. clean from least to greatest area of contamination  
   - Gentle cleansing prevents damage to newly forming epithelial tissue and reduces bacterial load enhancing wound healing.  
   - Cleansing the wound before collecting a culture swab is done in order to remove surface contaminants. This will not "kill" organisms found in an infected wound.

10. **COLLECT** a swab specimen for culture & sensitivity if signs of infection are present.  
    - Promotes early detection and treatment of wound infection.

11. **DRY** intact skin around incision/wound with sterile gauze.  
    - Prevents healthy skin surrounding incision from remaining moist, which may cause maceration.

12. **APPLY** and **SECURE** new sterile dressing as required.  
    - Bridge of cells over simple approximated surgical wounds exists after 24 hours.

   **NOTE:** a dressing is not required after 48 hours if the incision is healing and free from signs of infection. Some patients may feel sutures/staples catching on their clothes and may prefer to have the site covered. In these cases, re-cover loosely with a sterile dressing after cleansing with mild soap and water (or showering) daily until sutures/staples removed.

13. **REMOVE** equipment and **DISPOSE** appropriately.  
    - Standard precautions; reduces transmission of microorganisms.

14. **DOCUMENT** in appropriate record(s):  
   - Date, time and procedure  
   - Description of incision  
   - Patient’s response to procedure  
   - Communication of wound assessment and management to additional members of the health care team.  
   - Assists with meeting Professional Standards for
If not healing as expected or if any signs of infection noted, communicate to team to identify a plan of action and any other pertinent actions or observations as per documentation and legal requirements.

**REFERENCES**


