CHRONIC PD CATHETER EXIT SITE CARE
POSTOPERATIVE DRESSING TECHNIQUE

PURPOSE:

1. To ensure standardization of technique between all of the Toronto Home Peritoneal Dialysis (PD) Units and Home Care Agencies.

2. To minimize the risk of infection and promote healing of the peritoneal catheter exit site.

POLICY:

1. To be performed by a registered nurse (or registered practical nurse) trained in PD for the patient recovering from PD catheter implantation. The early postoperative or healing period is generally considered to be two-three weeks from the date of the implantation procedure. The complete healing process generally takes six weeks.

2. In order to minimize bacterial colonization of the exit and tunnel during the early healing period, the dressing procedure is carried out as a sterile procedure (with a dressing tray).

3. For trauma prevention to the exit site and traction on the cuffs, an occlusive dressing is used to ensure catheter immobilization.

4. In order to promote epithelialization over the granulation tissue beneath the scab, a sterile and undisturbed condition at the exit site during the initial healing period is important. The frequency of the dressing procedure is limited in the early postoperative period. Refer to the table in the Nursing Guidelines (#4). Once healing has occurred (generally at the time the clips/sutures are removed), the procedure referred to as Shower Technique is usually recommended.

5. The condition of the exit site and incision line must be documented on the Patient Care Record.

6. Reporting of serious complications including leak, trauma, infection and bleeding must be reported to the home PD Unit.

7. The standard cleaning solution for catheter care is chlorhexidine gluconate 2% aqueous solution with a 4% isopropyl alcohol as a stabilizer.

If the patient is sensitive to chlorhexidine gluconate 2%, check his/her records or ask the Home PD Unit for a substitute antiseptic solution order.
For removal of gauze attached to a scab, alternate solutions may be prescribed (i.e. Shur-Clens, normal saline). Cytotoxic agents should be avoided in early wound management.

8. Tub baths are not recommended for patients with peritoneal catheters.

9. Dressing should be air permeable. Depending on each unit's preference, materials used include mepore, mefix, hypafix or gauze with abdominal pad and paper tape. Burnnet or Flexnet may be used instead of tape based on the patient's allergies or preference.

10. If mupirocin ointment is ordered, ensure that the PD catheter is the silastic type and the mupirocin is applied sparingly. Mupirocin cream may be used with polyurethane catheters.

PROCEDURE:

1. Assist the patient as required to a lying or sitting position. Assess the condition of the patient's current dressing. Assessment of the external condition of the dressing will influence the supplies assembled to carry out the procedure. Instruct the patient regarding the procedure. (see Guidelines #1, 3, 6, 10)

2. Gather the equipment: (see Policies #7, 9, 10 and Guidelines #2, 3, 7, 8)
   - sterile dressing tray
   - masks for nurse and patient
   - sterile gloves + procedural gloves
   - EZE scrub brush, chlorhexidine hand wash
   - 3-4 packages of sterile 10x10 cm gauze
   - abdominal pads as required
   - chlorhexidine gluconate 2% aqueous solution
   - mepore, mefix, hypofix or paper tape and/or Burnnet/Flexnet

3. Close window/door/fan to room. Ensure environment and work area is clean. (see Guideline #2)

4. Mask and have patient mask. (see Policy #2 and Guideline #3)

5. Complete 2 minute handwash with chlorhexidine skin cleanser or EZE scrub brush.

6. Open the dressing tray. Add cleaning solutions and supplies required.

7. Remove the old dressing, taking care not to forcibly remove any scab. (see Policy #7 and Guideline #8)
Avoid pulling or twisting the PD catheter. (see Guideline #6)

8. Assess the site.
9. Wash hands.
10. Don sterile gloves.
11. Drape the patient.
12. Cleanse the exit site in a circular fashion with gauze saturated with chlorhexidine gluconate 2%
    starting from the exit site and moving outwards. (see Policy #7)
13. Gently pat dry or allow to air dry for 30-60 seconds. (see Guideline #6)
14. Cleanse the incision line.
15. Apply mupirocin sparingly around the exit site as ordered by the physician, using a gauze. (see Policy #10)
16. Gently lay the cleansed PD catheter onto a gauze. Completely cover the exit site and incision with several layers of gauze. (see Guideline #6)
   Cover with an abdominal pad. Use a large piece of mefix tape to secure the dressing. Alternate dressings may be mepore or hypafix (without an abdominal pad) in the later postop period when there is little or no drainage. (see Guideline #7)
17. As required, date and initial the dressing.
18. Document the procedure and condition of the exit site in the Patient Care Record. Notify the unit if there is anything unusual (eg. leakage, discharge). (see Policy #5+6)

NURSING GUIDELINES:

1. Inform the patient that dressing changes may be associated with some discomfort due to local response at the incision related to the use of cleansing solutions containing alcohol.
2. Ensure the procedure is done in a clean environment (no pets). If indicated, clean the counter or surface area being used to set up the dressing tray.
3. The postoperative dressing technique is a sterile procedure. Ensure the patient understands why he/she needs to mask during this procedure.
4. Frequency for PD catheter dressing will be ordered by the physician, including:
<table>
<thead>
<tr>
<th>Dressing Option</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Initial postop dressing</td>
<td>Remains in place first 10-14 days postop. Then do shower technique.</td>
</tr>
<tr>
<td>2-3 dressings per week</td>
<td>During the 3\textsuperscript{rd}-6\textsuperscript{th} weeks postop.</td>
</tr>
<tr>
<td>PRN change</td>
<td>Dressing is not intact + needs to be changed. Wound requires assessment secondary to pain, wet dressing. Suspected infection. When patient is being dialysed.</td>
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5. If the patient has multiple dressings on the abdomen, clean and dress each one separately, beginning with the PD catheter.

6. Immobilization of the catheter AT ALL TIMES is critical in preventing trauma by mechanical action during handling and normal body movements. Minimal and gentle movements of the catheter should be used when carrying out the dressing procedure. Explain the importance of these concepts to the patient.

7. The amount of gauze used will gradually lessen as drainage stops.

8. Do not forcibly remove crusts. Hydrogen peroxide or Shur-Clens may be recommended according to the physician's order.

9. Mupirocin cream is more expensive than mupirocin ointment.

10. Teach the patient that tub baths should not be taken with a peritoneal catheter in place. Showers must be avoided until the exit site is well-healed (usually 2-3 weeks postop). Sponge baths should be used during this period.

11. Instruct the patient not to lift anything heavier than a small bag of groceries for the six week postoperative period.

References

