WOUND CARE

REMOVAL OF SUTURES

**NOTE:** SPECIFIC INSTRUCTIONS FROM THE MEDICAL OFFICER MUST BE RECEIVED BEFORE REMOVING SUTURES.

**CONSIDERATION**

Factors which may delay wound healing, and should therefore be considered prior to the removal of sutures include:

- Diseases, disorders and syndromes, e.g. anaemia, autoimmune disorders, diabetes, previous surgery in same areas using same suture line
- Drugs: e.g. alcohol, nicotine, steroids, anti-inflammatory, cytotoxic medication
- Poor nutritional state: anaemia, malnutrition, mineral, protein and/or vitamin deficiency
- Microenvironment of wound: e.g. blood supply, humidity, infections
- Other factors: obesity, site of wound, dehydration, age

**EQUIPMENT**

- Trolley
- Sterile dressing pack
- Stitch cutter or sterile scissors
- Sterile Gloves
- Optional equipment e.g. normal saline, steri-strips, gauze
- Disposable bag

**PROCEDURE**

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<thead>
<tr>
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<th>Prior to the procedure</th>
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| 1.1 | Explain the procedure and obtain verbal consent from the patient. 
Check the post-op instructions for time of suture removal (MR 310 caesarean section or MR 315 operation record) |
| 1.2 | Ensure patient privacy and comfort. 
Assess the comfort level of the patient. Address if necessary 
Assist the patient into a position which is comfortable and allows easy access to the suture line 
Adjust the height of the bed to promote safe manual handling for the attending staff member |
| 1.3 | Perform hand hygiene. |
| 1.4 | Ensure the trolley is cleaned prior to use. |
| 1.5 | Don gloves and protective equipment as |

**ADDITIONAL INFORMATION**

- Advise the patient that the procedure may cause slight discomfort e.g. pulling or stinging sensations.
- MR 810 analgesia charted
- Hand hygiene reduces transmission of microorganisms.
<table>
<thead>
<tr>
<th>PROCEEDURE</th>
<th>ADDITIONAL INFORMATION</th>
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<tbody>
<tr>
<td>1.6</td>
<td>Prepare equipment</td>
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<td>1.7</td>
<td>If a dressing is in place, remove, and perform hand hygiene and replace gloves. To minimise the risk of cross infection.</td>
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<tr>
<td>2</td>
<td>Assessing the suture line</td>
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<tr>
<td>2.1</td>
<td>Observations should include: Determination of healing and approximation of wound edges; Signs of infection. Advise the patient to assess and report signs of wound infection e.g. redness, pain, increased warmth and discharge, and to notify staff of any signs of wound dehiscence after suture removal.</td>
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<td>3</td>
<td>Cleansing of the wound</td>
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<tr>
<td>3.1</td>
<td>Consider cleaning the wound with normal saline only to remove debris or dry exudate which may cause skin trauma and patient discomfort during suture removal. Avoids solutions seeping into suture holes.</td>
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<tr>
<td>4</td>
<td>Removal of interrupted sutures</td>
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<tr>
<td>4.1</td>
<td>Place the drape from the dressing pack between the wound and the operator.</td>
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<tr>
<td>4.2</td>
<td>Remove alternative sutures first even if all sutures are ordered to be removed. Note: do not remove remaining sutures if dehiscence occurs. Contact the team doctor to assess the wound and implement a management plan.</td>
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<tr>
<td>4.3</td>
<td>Hold the forceps in the non-dominant hand and grasp the knot to raise it slightly. Pulls the suture away from the patient's skin.</td>
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<td>4.4</td>
<td>Place the stitch cutter or scissors directly under the knot close to the skin. Prevents contaminated suture material being pulled through the tissue.</td>
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<tr>
<td>4.5</td>
<td>Cut the suture close to the skin where the suture emerges from the skin.</td>
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<tr>
<td>4.6</td>
<td>Pull the long end of the suture to remove it from the skin. Detects early dehiscence of the skin.</td>
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<tr>
<td>4.7</td>
<td>After suture removal assess the approximation and healing of the skin.</td>
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<tr>
<td>4.8</td>
<td>Apply steri-strips across the suture line if required and there is no obvious infection or exudate present. Steri-strips assist securing the wound edges to aid healing.</td>
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<tr>
<td>4.9</td>
<td>Dispose of soiled and disposable equipment. Ensure the trolley is cleaned after use.</td>
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<td>4.10</td>
<td>Remove gloves and perform hand hygiene.</td>
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<tr>
<td>5</td>
<td>Post procedure</td>
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</table>
PROCEDURE

Lower the bed if it was raised for the procedure.

6 Care in the Home (Visiting Midwifery Service)

- Check the VMS summary (referral) for post-operative instructions for time of suture removal or contact the ward of discharge.
- Ensure patient and staff safety in terms of correct manual handling and posture within the home environment.
- Follow the procedure as documented.
- Document care given and wound healing / status in the patients Caesarean Birth clinical pathway (MR249.61) or VMS progress notes (MR255).

If concerned regarding the wound:

- Discuss with the VMS Coordinator or a core staff member
- Discuss with Obstetric or Gynaecology registrar (via KEMH switchboard)
- Arrange review in the Emergency Centre at KEMH (if applicable)
- Complete the VMS to EC referral form (MR026) and notify the department
- Alternatively, the patient may choose to see her local general practitioner or present at an Emergency Centre closer to home.
REFERENCES / STANDARDS


National Standards –
1- Care provided by the clinical workforce is guided by current best practice
3- Preventing Healthcare Associated Infections

Legislation - Nil
Related Policies - Nil
Other related documents – Nil

RESPONSIBILITY
OGCCU

Policy Sponsor
Director of Nursing and midwifery

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April 2001

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September 2014

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September 2017

Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website.