Drain Management Policy

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Policy/Purpose

To drain the patient's post-operative wound site of serosanguineous fluid in order to reduce pain, wound ooze and haematoma formation to best practice standards.

Scope/Audience

Nursing/Midwifery staff

Medical staff

Nursing/Midwifery Students under direct supervision

Associated documents

CDHB Infection Control Manual

Standard Precautions & Disposal of Body Fluids/Hazard

Fluid Balance Chart/Fluid Balance summary chart

Clinical Notes QMR0003

PACU/SCU Location Manual Stryker Blood Conservation System

PACU/SCU Stryker Drainage System- Reinfusion using Stryker Blood Conservation System

Medinorm Manufacturers Resource folder (In reference section)

Handover

PACU will handover drain details to receiving nurse.

Procedural considerations

Monitoring

At least twice each shift nurse to check or as per service guidelines

- Ensure dressing is intact to prevent accidental removal
- Ensure patency of drain (clamp is off)
- insertion site (if visible)
- all connections
- vacuum is maintained
- drainage level
- mark container with date and time on bottle at end of each shift
- document findings on fluid balance and variances in bvbclinical notes
- Inform medical staff of excessive losses/dramatic changes in output

Removing Drains

Clamp off the tubing 30 minutes prior to change to allow suction to dissipate

Check drain site ½ hour after removal and document any variances

Lippincott procedure

Medinorm drainage system, changing dressings, bottle and removal procedure

References

Manufacturer's resource folder

Policy Owner	Burwood and Medical Surgical Cluster review group - CNS and CNEs
Policy Authoriser	Executive Director of Nursing
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