HOME AND COMMUNITY CARE SUPPORT SERVICES
North East

Surname:	First Name:
CHRIS #:	Date of Birth (DD/MM/YYYY):
HCN:	Version Code

WOUND - ABSCESS/INCISION & DRAINAGE/PILONIDAL SINUS CLINICAL PATHWAY

Abscess: Collection of pus within inflamed tissue frequently caused by bacterial infection. The infection often damages the surrounding tissue creating a cavity**.**
Incision & Drainage: Common treatment for cysts or abscesses (including pilonidal sinus wounds) may include incision and drainage, where the abscess is incised and the debris is drained.
Pilonidal Sinus Wound: A pilonidal sinus wound is a cyst or abscess located near or at the natal cleft of the buttocks and often contains hair and skin debris.

To be completed at least once weekly and/or with change in patient condition **This tool is used only as a guide and does not replace clinical judgment* Date/Initial:	✓ or N/A			
COMPREHENSIVE ASSESSMENT				
Complete a comprehensive patient history and assessment including procedure type and date, comorbidities, prior scars or surgeries, frequency/recurrence of abscess, and medications. Include risk factors for infection i.e. nutritional status, obesity, smoking, and immune status. Include risk factors for re-abscessing i.e. hygiene practices, hair growth patterns, male gender, obesity, excessive sweating.				
Perform and document a weekly comprehensive wound assessment including wound dimensions and location, wound bed appearance, exudate type and amount, peri-wound appearance, presence of tunneling, undermining, fistulas, or sinus tracts.				
Identify and document any signs and symptoms of localized or systemic infection i.e. induration, increased exudate, unusual odour, delayed healing, peri-wound erythema >2cm, fever, general malaise, concerns with drain(s). Report concerning findings to Primary Care Provider.				
Perform and document a complete pain assessment.				
Assess, determine and emphasize importance of patient adherence to individualized treatment plan.				
Photo image upload at initial visit, monthly and with wound deterioration.				
GOALS				
Wound will progress through the healing process.				
Wound will be protected from further complications.				
Patient factors contributing to infection or recurrence will be addressed and mitigated (i.e. nutritional support, glycemic control, restoration of balance between host resistance and microorganisms).				
Patient will have acceptable pain management.				
Encourage patient/caregiver participation in developing individualized treatment plan and exploring self-management.				
WOUND TREATMENTS				
Encourage/assist patient to assume a position which is comfortable but which allows the nurse to maximize wound access (i.e. pilonidal wounds can be accessed by placing the patient prone and supporting the anterior pelvis with pillows).				
Cleanse wound with potable water. For cavity wounds without a visible base, do not irrigate. Encourage showering prior to dressing change for mechanical debridement.				
Clean & pat peri-wound dry and apply a protective barrier to manage peri-wound maceration if indicated.				

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Select dressing to manage moisture and bacterial load, control exudate and meet targeted frequency of dressing changes. **Ensure that dressings in cavities (i.e. gluteal crease) conform to the body anatomy to reduce friction and trauma.** Consider using a paste or conforming barrier between pilonidal wound and anus to maintain seal.				
Wound <u>with</u> bioburden: Manage with antimicrobial dressing, filling dead space, undermining and tunnels loosely. Options for <u>exuding wounds</u> include but are not limited to silver calcium alginate, silver hydrofibre, sustained release iodine, PHMB. Apply cover dressing i.e. foam or absorbent. Options for <u>non-exuding</u> wounds include but are not limited to nanocrystalline silver mesh moistened with water or hydrogel, cadexomer iodine, silver gel, PHMB. Apply cover dressing i.e. thin foam, hydrocolloid, transparent film. **Non-exuding wound <u>without</u> bioburden:** Apply primary dressing i.e. acrylic, hydrocolloid or hydrogel. Apply cover dressing if indicated i.e. foam, absorbent. **Exuding wound <u>without</u> bioburden***:* Apply primary dressing may include calcium alginate, gelling fiber (hydrofiber)**.** Apply cover dressing i.e. foam, absorbent.				
Always use antimicrobial dressing for patient with diabetes.				
Manage bleeding in an exuding wound i.e. calcium alginate, silver nitrate.				
Change dressing every 3-7 days depending on dressing type used and amount of exudate.				
If chronic inflammation is suspected, consider protease inhibitor and/or NSWOC consult.				
Consider if NPWT is indicated i.e. moderate to heavy exudate, need for accelerated closure. Please consult NPWT Clinical Guidelines.				
CT for unexplored fistulas or sinus tracts (inability to determine wound base).				
Obtain culture and swab as per MD orders.				
Consider if the wound meets the definition of a Chronic Maintenance wound: Wounds that fail to progress normally through the repair process (are present for at least 12 weeks and have not responded to wound specific pathway), frequently caused by vascular compromise, chronic inflammation, repetitive insults to the tissue or patient lifestyle choices. These wounds fail to close in a timely manner or fail to result in durable closure. Please refer to Chronic Maintenance Clinical Guideline.				
Document variance if deviation from Clinical Pathway i.e. frequency greater than 3 days.				
MEDICATIONS				
Complete medication reconciliation.				
Initiate topical and/or systemic antibiotic therapy as per PCP order.				
PAIN				
Support use of pre-procedural analgesic to manage pain.				
Review non-pharmacological techniques such as repositioning, relaxation, rest, time outs.				

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SELF-MANAGEMENT & EDUCATION				
Encourage patient to keep skin clean and dry.				
Review signs and symptoms of infection and delayed healing.				
Teach patient/family proper dressing replacement if soiled or after activities that produce sweating.				
Showering is encouraged. **Bathing and/or soaking of wound is discouraged**. Follow PCP protocol.				
Encourage daily intake to meet recommendations of Canada's Food Guide, focusing on regular balanced meals and adequate fluid intake (1.5-2L/day) unless contraindicated.				
Involve patient and family in care planning and wound management.				
Education specific to pilonidal wounds: Review post bowel movement care/showering – may use a handheld sprayer to gently flush out the inside of the wound and to direct soap, shampoo, and loose hair away, or use moist towelette to cleanse. Review hair removal i.e.: shaving the natal cleft at least weekly in a 5cm-wide strip at least 2.5 cm from wound edges up to and including distal wound to the anus using a pivotal-head razor. Avoid driving and lifting heavy objects for the first week post-surgery. Encourage loose fitting underwear/pants. Encourage frequent repositioning to take pressure off sacral/anal region.				
REFERRALS				
PHYSIOTHERAPY: Request consult for specific intervention PRN i.e**.** proper exercises, mobilization, ambulation techniques, or gait aid assessment.				
DIETETICS: Request consult for Dietitian assessment if nutritional status implicates delayed wound healing and/or energy-protein malnutrition and/or identified need for diabetic diet teaching/monitoring.				
NURSE SPECIALIZED IN WOUND, OSTOMY AND CONTINENCE: Refer according to wound/ostomy escalation process, which includes initial escalation to SPO Wound and Ostomy Care Champion PRIOR to NSWOC referral.				
SOCIAL WORK: Request consult for socioeconomic challenges i.e. coping, financial issues, access to resources.				
DISCHARGE PLANNING				
Provide appropriate patient handbook and Review appropriate teachings to support wound healing. Facilitate community referrals as indicated.				