HOME AND COMMUNITY CARE SUPPORT SERVICES
North East

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

WOUND – SURGICAL SITE COMPLICATION CLINICAL PATHWAY

Surgical Site Complication: Any surgical wound that is not healing by primary intention and/or within an expected timeframe due to one or more complications i.e. infection, dehiscence, etc.
Note: Surgical wounds deemed "non-healable" should follow the Chronic Maintenance/Non Healing Wound ICP.

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:	✓ **where applicable; (N/A) where not applicable**			
COMPREHENSIVE ASSESSMENT				
Complete a comprehensive patient history and assessment including surgery type and date, comorbidities, prior scars or surgeries, and medications. Include risk factors for surgical site infection i.e. nutritional status, obesity, smoking, and immune status.				
Perform and document a weekly comprehensive wound assessment including wound dimensions and location, wound bed appearance, exudate type and amount, and peri-wound appearance.				
Identify and document any wound complications i.e. hematoma or seroma formation, edema, tunneling, undermining, fistulas, sinus tracts, incisional hernias, signs of anastomotic leaks, development of wound contractures.				
Identify and document any signs and symptoms of localized or systemic infection i.e. induration, increased exudate, unusual odour, delayed healing, gaps or separations along the incision line, peri-wound erythema greater than 2cm, fever, general malaise, concerns with drain(s). Report concerning findings to Primary Care Provider (PCP).				
Perform and document a complete pain assessment.				
Assess, determine and emphasize importance of patient adherence to individualized treatment plan.				
For lower leg injuries, complete **ABPI** with initial assessment, every 4-6 months and with wound deterioration, forward to Home and Community Care Support Services – North East. Inaccurate ABPIs may occur in patients with diabetes, renal failure or edema.				
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 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.				

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WOUND TREATMENTS				
Cleanse wound with potable water. For cavity wounds without a visible base, do not irrigate.				
Clean & pat peri-wound dry and apply a protective barrier to manage peri-wound maceration if indicated.				
Select dressing to manage moisture and bacterial load, control exudate and meet targeted frequency of dressing changes.				
Wound with bioburden: Manage with antimicrobial dressing, filling dead space, undermining and tunnels loosely Options for exuding wounds include but are not limited to silver calcium alginate, silver hydrofiber, sustained release iodine, PHMB. Apply cover dressing i.e. foam or absorbent. Options for non-exuding 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 without bioburden:** Apply primary dressing i.e. acrylic, hydrocolloid or hydrogel. Apply cover dressing if indicated i.e. foam, absorbent. **Exuding wound without 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 type of dressing used and amount of exudate.				
If chronic inflammation suspected, consider protease inhibitor and/or NSWOC consult.				
Consider NPWT for full thickness wounds with moderate to heavy exudate. Please follow NPWT ICP.				
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 q. 3 days.				

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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.				
SELF-MANAGEMENT & EDUCATION				
Review signs and symptoms of infection and delayed healing.				
Showering is often allowed. **Bathing and/or soaking of wound is discouraged**. Follow PCP protocol.				
Promote safe activity (per PCP) and rest, smoking cessation and appropriate analgesic use.				
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.				
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.				
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.				