HOME AND COMMUNITY CARE SUPPORT SERVICES
North East

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

WOUND – TRAUMATIC WOUND CLINICAL PATHWAY

Traumatic Wound: Includes lacerations, abrasions and penetrating injuries, and usually involves skin/tissue being ripped or torn. These wounds often involve foreign bodies (gravel, glass, etc.) and are prone to infections.

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: age of wound, mechanism of injury, comorbidities, medications, and nutritional 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. Record percentage of weekly healing.				
Identify and document any signs and symptoms of localized or systemic infection i.e. induration or edema, increased exudate, unusual odour, delayed healing, friable or discoloured granulation tissue, peri-wound erythema greater than 2cm, fever, general malaise. 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. Initiate compression if appropriate i.e. pre-existing edema, venous insufficiency.				
Photo image upload at initial visit, monthly and with wound deterioration.				
GOALS				
Causative factors will be mitigated and patient will be protected from further trauma.				
Wound will progress through the healing process.				
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. Encourage showering prior to dressing changes for mechanical debridement.				
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 <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 hydrofiber, 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 type of dressing used and amount of exudate.				
If chronic inflammation suspected, consider protease inhibitor and/or NSWOC consult.				
Consider if NPWT is indicated i.e. moderate to heavy exudate, accelerated closure. Please consult NPWT Clinical Guidelines.				
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.				

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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 encouraged. **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 and wound management.				
REFERRALS				
PHYSIOTHERAPY: Request consult for specific intervention PRN i.e**.** proper exercises, mobilization, ambulation techniques, or gait aid assessment.				
OCCUPATIONAL THERAPY: Request consult for Occupational Therapist to assess the source and cause of injury, education regarding position strategies, mobility strategies and therapeutic services. Please accompany referrals with wound stage, location, size and duration of the wound.				
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.				