Ontario Health atHome

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

WOUND CARE PROTOCOL-PRIMARY CARE PROVIDER

☐ Initiate the plan of care for the wound as per Ontario Health atHome Wound Care Protocol & Integrated Clinical Pathways

Patient Address: _____

Patient Phone Number: _____

Note: All wound categories require an appropriate cover dressing; foam is suggested unless stated otherwise. Gauze is also an acceptable cover dressing, where appropriate.

1. Principles of wound bed preparation MUST be adhered to:
   a. Debridement of dead tissue, except in dry diabetic gangrene and ischemia. Proper equipment and training for debridement are **ESSENTIAL** for professionals treating wounds.
   b. Moisture balance.
   c. Bacterial balance: Infected wounds require antimicrobial products for localized infection and antibiotics for systemic infections.
2. All dressing are to be done using aseptic technique.
3. All diabetic wounds require antimicrobial products.
4. Optimize wound health by attention to nutrition, blood supply avoiding smoking, offloading pressure, pain control, etc. (Treat the whole person)
5. Diagnose etiology of wound-May be multifactorial, e.g. traumatic, diabetic and/or ischemic.

Clinical Pathways

Diagnosis:_____

Site:_____

Select Desired Pathway :

☐ Diabetic Foot Ulcer
☐ Surgical Wound
☐ Pressure Injury
☐ Venous Leg Ulcer
☐ Chronic Maintenance Wound
☐ Infected Surgical Wound
☐ Pilonidal Sinus/Incision & Drainage
☐ Trauma Wound
☐ Partial Thickness Burn

*****_Integrated Clinical Pathways (ICPs) can be found on the website._

☐ Atypical wound

Frequency of visits and treatment products may change at the discretion of the nurse or wound care therapist, as per clinical assessment, in accordance with the **ICPs.** Treatment will be taught to the patient/caregiver when appropriate.

The following wound descriptors can be used to select the appropriate dressing protocols. If no selection is made, the nurse will initiate the plan of care as per ICPs and communicate on the status of the wound to the primary care provider:

Superficial Granulating Wound

Minimum exudate:
☐ Hydrocolloid Full Thickness (Every 3-7 days)
☐ Hydrogel + Jelonet/Adaptic (Every 3 days)

Moderate to severe exudate:
☐ Hydrofibre (Every 3-7 days)
☐ Foam Dressing (Every 3-7 days)

Cavity Wound

Minimum exudate:
PHMB (every 3 days) ☐ Ribbon ☐ Gauze ☐ Kerlix Roll
☐ Hydrogel + Jelonet/Adaptic + Appropriate Gauze Packing (every 2-3 days)

Moderate to severe exudate:
☐ Hydrofibre/Calcium Alginate (every 3-7 days)
☐ Foam Cover Dressing (every 3-7 days)

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Burn Wound	☐ Nanocrystalline Silver (every 3 days) ☐ Hydrofibre with Silver - *change cover dressing and non-adhered hydrofibre* (every 3-5 days) ☐ Calcium Alginate with Silver – *change cover dressing and non-adhered alginate* (every 3-5 days) ☐ Flamazine - *requires Physician Rx* (twice a day) ☐ Burns to face – *Polysporin* (patient to apply three times a day)
Chronic Maintenance Wound (Exclude: cancer, foreign bodies, granulomatous diseases, fungi)	☐ Hydrofibre with silver (every 3-7 days) PHMB (every 3 days) ☐ Ribbon ☐ Gauze ☐ Kerlix Roll ☐ Cadexomer Iodine – *e.g. Iodosorb + Gauze* (every 3 days) ☐ Delayed release Iodine dressing (Inadine) (every 3 days) ☐ Silver (every 3-7 days) - *specify type*:_____
Pressure Injury	See *Infected Wound, Cavity Wound, or Superficial Wound.*
Infected Wound	☐ Cadexomer Iodine dressing – *e.g. Iodosorb* (every 3 days) ☐ Delayed release Iodine dressing (Inadine) (every 3 days) ☐ Hydrogel with Silver (every 2-3days) ☐ Hydrofibre with silver (every 3-7 days) ☐ Calcium Alginate with silver (every 3 days) PHMB (every 3 days) ☐ Ribbon ☐ Gauze ☐ Kerlix Roll ☐ Gentian Violet + Methylene Blue (Hydrofera Blue) (every 3-7 days) ☐ Pseudomonas infection: acetic acid (vinegar) 2.5% (*5% diluted 1:1 with saline or water*) soaked gauze BID x5 days*, then revert to appropriate dressing for infected wound.*
Intertrigo	☐ Textile with Silver - Interdry Ag in skin folds - *can be hand-washed, hung to dry and reused, if appropriate, apply as the sole product (ie. no creams or ointments)* PHMB ☐ Ribbon ☐ Gauze ☐ Kerlix Roll (antimicrobial dressing - *apply dry as the sole product* – every 3 days)
Venous Stasis Ulcer	For all patients, ABPI or vascular study required prior to initial treatment. ABPI may not be accurate in diabetic and renal patients, therefore vascular studies are required, and patients must be followed by wound care specialist. Compression is the cornerstone of treatment; life-long compression is necessary once ulcers heal. **ABPI Unknown:** **If the ABPI is not known indicate that compression is required. Within 7 days of initial visit the visiting nurse will complete ABPI and order the appropriate product.** ☐ Compression – ABPI to be completed by visiting nurse

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Venous Stasis Ulcer continued	**ABPI Known:** **If compression is indicated and the ABPI is known, please select the appropriate product from the list below, and provide the ABPI value.** **ABPI Value: ____** ☐ Coban II if APBI is 0.8-1.2 ☐ Coban II Lite if ABPI is <0.8 but >0.5 ☐ Elastic tubular bandage, toes to knee, if ABPI is 0.6-0.8 If exudative: ☐ Calcium Alginate with silver ☐ Hydrofiber with Silver PHMB ☐ Ribbon ☐ Gauze ☐ Kerlix Roll ☐ Cadexomer Iodine ☐ Cover with foam or appropriate cover dressing depending on exudate amount. Change dressing weekly unless strikethrough/slipping of the bandage.	
NPWT - moderate to heavily exudating wounds.	Wound dressing Size: ☐ Small ☐ Medium ☐ Large ☐ X-Large Filler: ☐ White Foam ☐ Black Foam Setting: _____ To be changed every 3 days (cannot be left in place longer than 3 days). If negative pressure unit malfunctions, it must be assessed immediately or changed to conventional dressing if a replacement negative pressure unit is not available. Conventional Dressing Orders: _____	☐ Priority case ☐ High exudate ☐ Necrotizing fasciitis ☐ Orthopedic with hardware
Necrotic Wound If Eschar is loose, remove or trim loose eschar only.	☐ Hydrogel for autolytic debridement ***CONTRAINDICATED IN ISCHEMIC WOUNDS. Vascular assessment necessary. Sharp debridement is CONTRAINDICATED without vascular assessment.*** ☐ Cadexomer Iodine (Iodosorb) at the margins of dry eschar ☐ Dry ischemic wounds: Paint with Betadine solution daily, cover with dry gauze PRN	

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