HOME AND COMMUNITY CARE SUPPORT SERVICES

North East

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

CHRONIC MAINTENANCE WOUND CLINICAL GUIDELINES

Chronic Maintenance Wound: Wounds that fail to progress normally through the repair process (present for at least 12 weeks and have not responded to appropriate pathway), frequently caused by vascular compromise, chronic inflammation, repetitive insults to the tissue, or patient lifestyle choices. These wounds either fail to close in a timely manner or fail to result in durable closure.

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			
CHRONIC WOUND ASSESSMENT * IN ADDITION TO ASSESSMENTS PERFORMED IN APPROPRIATE CLINICAL PATHWAY				
Assess for systemic factors impeding wound healing: (i.e. age, co-morbidities, medications, vascular compromise, renal failure, obesity, smoking, vasculopathy, malignant disease).				
Assess for local and extrinsic factors impeding wound healing: (i.e. ischemia, edema, infection, chronic inflammation, necrotic tissue, bacterial load, foreign body) (i.e. adherence to treatment plan, offloading devices).				
Assess for factors affecting quality of life: dressing change frequency, sleep patterns, restricted mobility, pain, odour, polypharmacy, loss of independence, social isolation.				
Complete and document a lower limb assessment (including ABPI) on admission, change of condition and every 3 months.				
GOALS				
Wound will progress through the healing process.				
Prevention of complications and control of symptoms (i.e. odour/exudate/pain).				
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.				
WOUND TREATMENTS				
Topical Therapy for dry, eschar, uninfected ischemic wound ABPI < 0.5 1. Paint with antiseptic solution (e.g. povidone-iodine 10% solution) 2. Apply dry dressing if appropriate 3. Apply protective dressing/padding				
Moist Wound Healing Principles for wounds without vascular compromise 1. Cleanse wound with potable water. For cavity wounds without a visible base, do not irrigate. 2. Clean & pat peri-wound dry and apply a protective barrier to manage peri-wound maceration if indicated. 3. Select dressing to manage moisture and bacterial load, control exudate and meet targeted frequency of dressing changes.				

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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).				
Patient factors contributing to infection will be addressed and mitigated (i.e. nutritional support, glycemic control, restoration of balance between host resistance and microorganisms).				
MEDICATIONS				
Complete medication reconciliation.				
Initiate topical and/or systemic antibiotic therapy as per Primary Care Provider (PCP) order.				
PAIN				
Support use of pre-procedural analgesic to manage pain.				
Review non-pharmacological techniques such as repositioning, relaxation, rest, breaks.				
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.				
Provide patient and family with information that will enhance knowledge and skills necessary to promote quality of life and improve function.				
Involve patient and family in care planning and wound management.				