Wound - Pressure Ulcer Clinical Pathway

- **Prevention or Stage 1** – Clients identified as being at risk for the development of a pressure ulcer or intact skin with reddened area-nonblanchable
- **(Suspected) DEEP TISSUE INJURY (DTI)** - purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear
- **STAGE II** – partial thickness loss of dermis presenting as shallow open ulcer with a pink red wound bed without slough, may also present as an intact or open/ruptured serum filled blister
- **STAGE III** – full thickness skin loss, subcutaneous fat may be visible; but bone, tendon, or muscle are not; slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling
- **STAGE IV** – full thickness skin loss, with exposed muscle, tendon, or bone. Slough or eschar may be present, often includes undermining or tunneling.
- **UNSTAGEABLE** – Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed

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### ASSESSMENT

To be completed at least once weekly and/or with change in client condition

*This tool is used only as a guide and does not replace clinical judgment*

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<tr>
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<tr>
<td>Complete a comprehensive client history and assessment including: age of wound, comorbidities, medications, and nutritional status</td>
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<tr>
<td>Perform and document a complete wound assessment identifying wound bed appearance (need for debridement), exudate (type and amount) Assess for tunnelling / undermining / sinus tracts and periwound area</td>
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<td>Measure baseline assessment; then record percentage of healing weekly</td>
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<tr>
<td>Assess healability of wound. Consider co-morbid conditions, immune status, overall general condition of patient, vascular status, etc</td>
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<td>Perform and document a complete pain assessment</td>
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<td>For extremity wounds: Assess for healability; perform a bilateral vascular assessment including an ABPI*</td>
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<td>Inspect client’s skin for signs of breakdown. Identify causative or contributing factors at each visit, and with any change in client’s condition</td>
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<tr>
<td>Assess wound for signs and symptoms of infection: induration, increased exudate, unusual odour, delayed healing, friable or discoloured granulation tissue, peri wound erythema &gt;2cm and report to MD</td>
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### GOALS

- Pressure and causative factors will be removed
- Client will have acceptable pain management and report a decrease in pain intensity
- Client will demonstrate healing within a reasonable time frame (>20% in 3 weeks)
- Wound is protected from infection, insulated and supported in a moist wound healing environment
- Prompt identification and management of infection
- Client will have acceptable pain management and report a decrease in pain intensity

### ACTIVITY AND HYGIENE

- Encourage client/caregiver to keep skin clean and dry
- Assess for and treat bowel and bladder incontinence
- Increase activity and mobility as tolerated: Facilitate independent and dependent movement
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| Date/Initial | ✔️
|--------------|--------------
| Encourage client and family to reposition at least every 2 hours, avoiding pressure areas. Ensure proper positioning of tubes | where applicable; (N/A) where not applicable
| Encourage use of pillows/wedges between knees and under legs to avoid skin-on-skin and direct contact with bony prominences |  
| Head of bed less than 30 degrees unless eating or if medically indicated (i.e. respiratory needs) |  
| Avoid pulling, friction or shearing forces, using lifting devices/trapeze if available. |  

**WOUND TREATMENT:**

Mechanically irrigate and cleanse wound with PSI pressure between 4-15

Pat periwound dry and apply barrier for protection

Select dressing to keep wound moist, control exudate and avoid maceration of peri-wound area

**Non exuding** wound: Apply primary dressing **Hydrogel (****)**

Apply secondary dressing – thin foam, hydrocolloid or transparent film (***)

Manage **exudate**: **Calcium alginate/hydrofibre (****)** Apply secondary dressing: **Foam/Super Absorbent (****)**

Manage **bioburden**: apply antimicrobial dressing- for **exudating wound** absorbent silver or **Cadexomer/Gentian Violet (****)**

Apply secondary dressing: **Foam/Super Absorbent (****)**

Manage bioburden in **non-exudating** wound (silver moistened with sterile water or **hydrogel (****)**)

Apply secondary dressing: thin foam, hydrocolloid or transparent film (***)

Change dressing **Q_____** (3-7) days depending on type of dressing used and as needed

If chronic inflammation is suspected, consider protease inhibitor (****)

Consider NPWT for full thickness with moderate to heavy exudate

Document variance if deviation from Clinical Pathway – Document Tracking Form

**NUTRITION**

Encourage regular meals throughout the day. Encourage meal plan to meet recommendations of Canada Food Guide

Encourage adequate fluid intake (1.5-2L/day) unless contraindicated

**DIAGNOSTIC TESTS**

Obtain culture and swab as per MD/NP orders

Ultrasound to assess for abscess

Diagnostics to assess for osteomyelitis

**MEDICATIONS**

Provide analgesics PRN

Initiate systemic antibiotic/topical therapy as per MD order

**PAIN**

Encourage proper use of provided offloading devices/supports
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<td>Apply topical analgesics (as per MD/NP) – State:</td>
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<td>Encourage mobility if appropriate</td>
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<td>Dressing changes are painful (procedural) ensure client takes analgesic before dressing changes</td>
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<td>Use non-pharmacological techniques such as repositioning, rest – State:</td>
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<td>Cleanse wounds gently using warm water or saline</td>
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<td>Involve client in pain procedural choices (what helps what doesn’t) (e.g. time outs) – State:</td>
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<td>Take analgesics as prescribed (using WHO guidelines for analgesic)</td>
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**TEACHING AND PSYCHOSOCIAL SUPPORT**

Teach client pressure ulcer prevention. Turning and repositioning self or with assistance

Provide family with information that will enhance knowledge and skills necessary to promote quality of life and improve function

Teach client and family not to rub reddened areas or use donut type devices that localize pressure

**REFERRALS**

Request consult for Physiotherapist for proper exercises, mobilization and ambulation techniques, if appropriate *see below for specific interventions*

**PT REFERRAL/INTERVENTION**

1.

2.

Request consult for Occupational Therapist for offloading, equipment needs (i.e. Pressure redistribution surface, heel boots, if appropriate) *see below for specific interventions*

**OT REFERRAL/INTERVENTION**

1. Assess pressure offloading cushion/mattress for reassessment or repair due to wear and tear.
2. Reinforce teaching with client/caregiver to minimize layers between client and offloading surface

Requests consult for Dietitian for energy protein assessment if nutritional status implicates delayed wound healing. If a client scores less than 3 on a BRADEN Scale an automatic referral to the dietician.

**DIETITIAN REFERRAL/INTERVENTION**

1.

2.

Request referral for Enterostomal Therapist/Wound Care Specialist/Nurse Practitioner/Physician (i.e. wound deterioration, <20% healing in 3 weeks etc.)

**ET/WCS/APN/NP/MD REFERRAL/INTERVENTION**

1.
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**ASSESSMENT**

2. Requests consult for ineffective coping, financial issues, etc. State: ___________________ See below for effective interventions

**SOCIAL WORK REFERRAL/INTERVENTION**

1. 
2. 

**DISCHARGE PLANNING**

Assess client/caregiver adherence and understanding of treatment plan

Provide education fact sheet and appropriate education for prevention of further pressure ulcers

Discharge client – Community referrals as required

Refer to self-management if appropriate

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