Clinical Protocol: Acute Surgical Wound –  heals by primary intention, the acute surgical wound is defined as “a disruption in the integrity of the skin an underlying tissues that progresses through the healing process in a timely and uncomplicated manner.” This tool is only a guide and does not replace clinical judgement

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

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<table>
<thead>
<tr>
<th><strong>ASSESSMENT</strong></th>
<th><strong>Date/Initial</strong></th>
<th>✓ where applicable; (N/A) where not applicable</th>
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<tbody>
<tr>
<td>Complete a comprehensive patient history and assessment including risk factors for surgical site infection: date of surgery, comorbidities, medications, and nutritional status, obesity, smoking, prior scar at incision site</td>
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<tr>
<td>Perform and document a complete wound assessment identifying location and size of incision, approximation/epithelialization of wound edges, presence of healing ridge, and presence and condition of wound closure devices (tapes, sutures, staples)</td>
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<tr>
<td>Assess for presence of drains, identify drain type, and assess and record amount and characteristics of drainage or leakage around drain site</td>
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<tr>
<td>Assess for acute wound complications: hematoma or seroma formation, edema, formation of fistulae, incisional hernias, signs of anastomotic leaks, development of wound contractures, hypertrophic scarring or keloid formation</td>
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<tr>
<td>Assess for signs and symptoms of surgical site infection: induration, increased exudate, unusual odour, delayed healing, gaps or separations along the incision line, peri wound erythema &gt;2cm and report to MD</td>
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<td>Notify MD if signs of systemic infection (i.e. fever)</td>
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<td>Perform and document a complete pain assessment</td>
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<td>Assess patient adherence and understanding of treatment plan</td>
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**GOALS**

Wound will progress through the healing process in a timely uncomplicated manner

Patient will have acceptable pain management and report a decrease in pain intensity

Wound will be protected from infection and supported in an optimal acute surgical wound healing environment

Incision will be re-epithelialized with no gaps by 3rd day post op

Healing ridge will be present / palpable by 5th day post op

Wound will be exposed to minimal tension or pressure

Patient factors contributing to infection will be corrected (i.e., nutritional support, glycemic control, restoration of balance between host resistance and microorganisms)

**WOUND TREATMENTS**

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

*Avoid use of antiseptic cleansers as they inhibit the normal healing process*

Pat peri-wound dry and apply **dry dressing** for 24-48 hours post op

*A cover dressing is unnecessary once the incision is re-epithelialized, (usually 2-3 days post op)*

Patients may elect to wear a light dry dressing to protect the incision and prevent staples/sutures from rubbing on clothes

**Closed suction drain care (e.g. JP drains)** Patient teaching
## ASSESSMENT

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<tr>
<td>1. Ensure tubing is in a dependent position and not kinked</td>
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<td>2. Stabilize drain to prevent dislodgement</td>
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<tr>
<td><strong>Emptying the Drain:</strong></td>
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<td>3. Wash hands well with soap and water</td>
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<td>4. Pull the plug of drain</td>
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<td>5. Pour fluid inside bulb into clean measuring cup</td>
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<td>6. Clean the plug with alcohol then squeeze bulb flat. While bulb is flat, put the plug back into the bulb. Bulb should stay flat after it plugged so that vacuum suction can restart</td>
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<td>7. Measure how much fluid you collected and write the amount of drainage, date and time</td>
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<td>8. Flush fluid down toilet and wash hands</td>
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### Care for skin around drainage site

1. Wash hands with soap and water
2. Remove dressing from around the drain; use soap and water (on gauze) clean around drain site Q day
3. Place old dressing in trash, if it bloody wrap in plastic sandwich bag

### Complications: if either of these occur notify MD immediately

1. Large amounts of fluid that leak from around drain site (soaking dressing) - clean with soap and water and verify bulb drain is secured and flat to provide suction
2. Clot in drain (appears as a dark, stringy lining - it could prevent drainage from flowing
3. Drainage is cloudy or foul smelling (signs of infection)
4. Fever, increased redness, pain or swelling

### MD protocol for removal of staples / sutures

1. Assess patient for pain (pain medication) and explain that drainage removal can be uncomfortable (drains that are kept in for long periods of time can be painful to remove because of tissue growth)
2. Document drain removal, any complications during procedure, ensure entire drain has been removed, record amount of fluid in the drain and any samples obtained. Apply appropriate dressing based on assessment and exudate management

## REFERRALS

Refer to MD if surgical site infection suspected
Consult Physiotherapist for proper exercises and techniques if appropriate
If nutritional deficit is suspected consult dietician
Consult Advanced Practice Nurse/MD/Wound Care Specialist if wound is not progressing through normal healing process and conversion to a chronic wound (*initiate chronic wound protocol*)

## NUTRITION
## Wound - Acute Surgical Clinical Pathway

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### ASSESSMENT

- Encourage a diet high in protein and calories unless contraindicated
- Encourage adequate fluid intake (2L/day) unless contraindicated

### DIAGNOSTIC TESTS

- Obtain culture and swab as per MD orders
- Drain samples as per MD orders

### MEDICATIONS

- Provide analgesics PRN
- Initiate systemic antibiotic therapy as per MD order

### TEACHING AND PSYCHOSOCIAL SUPPORT

- Teach patient: Factors contributing to surgical site infection, delayed healing and signs and symptoms of infection
- Instruct patient regarding showering and bathing. Showering 48 hours post op is commonly allowed once incision is re-epithelialized (2-3 days post op) **Bathing or soaking of incisions is discouraged** (*follow MD protocol*)
- Teach patient: purpose of drains, signs and symptoms of blocked drains, and what to expect during drain removal
- Teach patient: to avoid use of over the counter lotions, solution or preparations on incision
- Counsel patient regarding activity and rest, avoidance of heavy lifting, smoking and appropriate use of pain medication
- Involve patient and family in care planning where appropriate

### DISCHARGE PLANNING

- Discharge report sent to Care Coordinator within 3 days of last visit

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