Ontario
North East Local Health Integration Network
Réseau local d'intégration des services de santé du Nord-Est

Wound - Acute Surgical Clinical Pathway

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

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 **This tool is used only as a guide and does not replace clinical judgment* **ASSESSMENT** Date/Initial →	✓ **where applicable; (N/A) where not applicable**			
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				
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)				
Assess for presence of drains, identify drain type, and assess and record amount and characteristics of drainage or leakage around drain site				
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				
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 >2cm and report to MD				
Notify MD if signs of systemic infection (i.e. fever)				
Perform and document a complete pain assessment				
Assess patient adherence and understanding of treatment plan				
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				

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1. Ensure tubing is in a dependent position and not kinked 2. Stabilize drain to prevent dislodgement **Emptying the Drain:** 3. Wash hands well with soap and water 4. Pull the plug of drain 5. Pour fluid inside bulb into clean measuring cup 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 7. Measure how much fluid you collected and write the amount of drainage, date and time 8. Flush fluid down toilet and wash hands				
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				
Drain removal *per MD (typically 24-48 hours) or (when drainage is <25cc in 24 hours) 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				

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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				

Print Name	Signature	Initials	Date