

Surname: _____		First Name: _____	
CHRIS #: _____		Date of Birth (DD/MM/YYYY): _____	
<input type="text"/>		<input type="text"/>	
HCN: <input type="text"/>			Version Code <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Wound - Chronic Maintenance Clinical Pathway

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, or repetitive insults to the tissue. These wounds either fail to close in a timely manner or fail to result in durable closure

<i>To be completed at least once weekly and/or with change in patient condition</i> <i>*This tool is used only as a guide and does not replace clinical judgment</i>		<input checked="" type="checkbox"/> where applicable; (N/A) where not applicable			
ASSESSMENT	Date/Initial →				
Complete a comprehensive patient history and assessment including: wound type and etiology, age of wound, co- morbidities, medications, nutritional status and pain assessment					
Perform and document a complete wound assessment identifying wound bed appearance (need for debridement), exudate (type and amount) Assess for tunnelling / undermining / fistulas / sinus tracts and periwound area					
Assess wound for signs and symptoms of infection: induration, increased exudate, deterioration, unusual odour, friable or discoloured granulation tissue, periwound erythema >2cm and report to MD/NP					
Notify MD/NP if signs of systemic infection (i.e. fever)					
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 Q3 months					
GOALS					
Patient will have acceptable pain management and report a decrease in pain intensity					
Prevention of complications and control of symptoms (ie: odour/exudate)					
Patient will be able to explain and describe self-management interventions and care for wound					
Patient will report improved or sustained quality of life					
Patient will complete self-management education concerning etiology and prevention/infection concerning wound					
WOUND TREATMENTS					
Topical Therapy for dry, eschar, uninfected ischemic wound ABPI < 0.5					
Paint with antiseptic solution (e.g. povidone-iodine 10% solution)					
Apply dry dressing if appropriate					
Apply protective dressing/padding (****)					
Moist Wound Healing Principles for wounds without vascular compromise					
Mechanically irrigate and cleanse wound with PSI pressure between 4-15-unless dry eschar					
If moist wound healing is a goal-Select dressing to keep wound moist, control exudate and avoid maceration of periwound area					

Surname: _____		First Name: _____	
CHRIS #: _____		Date of Birth (DD/MM/YYYY): _____	
<input type="text"/>		<input type="text"/>	
HCN: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			Version Code <input type="text"/> <input type="text"/>

Wound - Chronic Maintenance Clinical Pathway

<i>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</i>		<input checked="" type="checkbox"/> where applicable; (N/A) where not applicable			
ASSESSMENT	Date/Initial →				
<u>Non exudating</u> wound: Apply primary dressing Hydrogel (****) Apply secondary dressing - hydrocolloid or transparent film (****)					
Manage <u>exudate</u> : Calcium alginate/hydrofibre (****) Apply secondary dressing: Foam /Super Absorbent (****)					
Manage <u>bioburden</u> : apply antimicrobial dressing - for <u>exudating wound</u> absorbent silver or Cadexomer Iodine /PHMB/Gentian Violet (****) Apply secondary dressing: Foam/Super Absorbent (****)					
Manage bioburden in <u>non-exudating</u> wound (silver moistened with sterile water or hydrogel (****) Apply secondary dressing: hydrocolloid or transparent film (****)					
Change dressing Q_____ (3-7) days depending on type of dressing used					
Document variance if deviation from Clinical Pathway – Document Tracking Form					
REFERRALS					
Refer to Self Management					
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					
CT for unexplored fistulas or sinus tracts (inability to determine wound base)					
Obtain culture and swab as per MD/NP orders					
MEDICATIONS					
Provide analgesics PRN					
Initiate systemic antibiotic/topical therapy as per MD/NP order					
PAIN					
Encourage mobility if appropriate					
Encourage elevation of legs when resting unless arterial ulcer then dangle legs do not elevate					
Encourage comfortable proper fitting footwear					
Apply topical analgesics as per MD/NP (e.g. EMLA)– State:					
Encourage emollients to help alleviate itching					
Dressing changes are painful (procedural) ensure patient takes analgesic before dressing changes					
Use non-pharmacological techniques such as repositioning, rest – State:					
Cleanse wounds gently using warm water or saline					
Involve patient in pain procedural choices (what helps what doesn't) (e.g. time outs) - State:					
Take analgesics as prescribed (refer to WHO guidelines for analgesic)					

Surname: _____		First Name: _____	
CHRIS #: _____		Date of Birth (DD/MM/YYYY): _____	
<input type="text"/>		<input type="text"/>	
HCN: <input type="text"/>			Version Code <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Wound - Chronic Maintenance Clinical Pathway

<i>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</i>		<input checked="" type="checkbox"/> where applicable; (N/A) where not applicable			
ASSESSMENT	Date/Initial →				
TEACHING AND PSYCHOSOCIAL SUPPORT					
Teach patient: factors contributing to infection and delayed healing and signs and symptoms of infection					
Teach patient/family self-management if appropriate					
Involve patient and family in care planning where appropriate					
Provide patient and family with information that will enhance knowledge and skills necessary to promote quality of life and improve function					
Provide patient with information on follow up care and accessing community resources					
Establish ability for patient/caregiver to perform dressing changes					
REFERRALS					
Request consult for Physiotherapist for proper exercises, mobilization and ambulation techniques, if appropriate see below for specific interventions					
PT REFERRAL/INTERVENTION					
1. Transcutaneous electrical nerve stimulation (Family taught)					
2.					
Request consult for Occupational Therapist for devices as appropriate (i.e. Pressure redistribution surface, heel boots, etc) see below for specific interventions					
OT REFERRAL/INTERVENTION					
1.					
2.					
Request referral for Enterostomal Therapist/Wound Care Specialist/Nurse Practitioner/Physician (i.e. wound deterioration)					
ET/WCS/APN/NP/MD REFERRAL/INTERVENTION					
1.					
2.					
Request consults for ineffective coping, financial issues, etc. State: _____ See below for effective interventions					
SOCIAL WORK REFERRAL/INTERVENTION					
1.					
2.					

Surname: _____		First Name: _____	
CHRIS #: _____		Date of Birth (DD/MM/YYYY): _____	
<input type="text"/>		<input type="text"/>	
HCN: <input type="text"/>			Version Code <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Wound - Chronic Maintenance Clinical Pathway

ASSESSMENT <i>To be completed at least once weekly and/or with change in patient condition</i> <i>*This tool is used only as a guide and does not replace clinical judgment</i>	<input checked="" type="checkbox"/> where applicable; (N/A) where not applicable			
	Date/Initial →	<input type="text"/>	<input type="text"/>	<input type="text"/>
DISCHARGE PLANNING				
Discharge patient: Community referrals as required				
Refer to self-management if appropriate				

Print Name	Signature	Initials	Date