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

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

WOUND- PRESSURE INJURY CLINICAL PATHWAY

PRESSURE INJURY CLASSIFICATION/DESCRIPTION:

- **Prevention or Stage 1 –** Patients identified as being at risk for the development of a pressure injury or intact skin with reddened area non- blanchable
- **(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 sheer
- **STAGE II** – partial thickness loss of dermis presenting as shallow open injury 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 injury is covered by slough and/or eschar in the wound bed

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**			
COMPREHENSIVE ASSESSMENT				
Complete a comprehensive patient history and assessment including: age of wound, previous history of wound, comorbidities, medications, immune status, vascular status and nutritional status				
Perform and document a weekly comprehensive wound assessment identifying wound dimensions, wound bed appearance (need for debridement), exudate (type and amount), periwound appearance. Assess for tunneling, undermining, sinus tracts, bone exposure (report immediately to PCP). Record percentage of weekly healing.				
Complete a Braden scale to predict pressure sore risk, at least weekly, more often for high risk patients				
Perform and document a complete pain assessment				
Complete lower leg assessment including **ABPI**, with initial assessment, every 4-6 months and with wound deterioration, forward to NE LHIN. Possible false high ABPI include patients with diabetes, renal failure or edema.				
Inspect client's skin for signs of breakdown. Identify causative factors at each visit, and with any change in wound status				
Assess wound for signs and symptoms of infection: induration, increased exudate, unusual odour, delayed healing, friable or discoloured granulation tissue, periwound erythema greater than 2 cm and report to Primary Care Provider (PCP).				
Assess for and treat incontinence if wound contamination is of concern.				
Complete nutritional assessment screening tool.				
Assess, determine and emphasize importance of patient adherence to individualized treatment plan.				
Photo image upload at initial visit and monthly and with wound deterioration.				

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GOALS				
Encourage patient/caregiver participation in developing individualized treatment plan. Explore self-management.				
Patient will have acceptable pain management and report a decrease in pain intensity.				
Patient will demonstrate healing within a reasonable time frame (greater than 20% healing in 3 weeks).				
Patient will demonstrate adequate nutrition to promote glycemic control and meet energy, protein and fluid requirements.				
Wound is protected from further damage, infection, contamination and periwound skin remains intact.				
WOUND TREATMENT:				
Offload pressure and other contributing factors (offloading mattress, offloading boots, floating heels, repositioning).				
Cleanse wound with potable water. For cavity wounds without a visible base, do not irrigate.				
Clean & pat periwound dry and apply a protective barrier to manage periwound maceration if indicated.				
Select dressing to manage moisture, control exudate and avoid maceration of periwound.				
Non exudating wound: Apply primary dressing i.e. Acrylic, Hydrocolloid or Hydrogel. Apply cover dressing i.e. foam, absorbent **Exudating Wounds***:* Primary dressing calcium alginate, gelling fiber (hydrofiber)**.** Apply cover dressing i.e. foam, absorbent.				
Manage bioburden, fill dead space, undermining and tunnels loosely with antimicrobial dressing (always use antimicrobial for patients with diabetes): **Exudating wound:** including but not limited to silver calcium alginate, silver hydrofiber, sustained release iodine, gentian violet, PHMB. Apply cover dressing i.e. foam or absorbent **Non-exudating wound**: nanocrystalline silver mesh moistened with water or hydrogel, cadexomer iodine, silver gel, PHMB. Apply cover dressing i.e. thin foam, hydrocolloid, transparent film				
Manage bleeding in an exudating wound: Ag Calcium Alginate.				
Change dressing every 3-7 days depending on type of dressing used and amount of exudate.				
If chronic inflammation is suspected, consider protease inhibitor. Consider NSWOC consult.				
Consider NPWT for full thickness with moderate to heavy exudate.				
Document variance if deviation from Clinical Pathway.				
MEDICATIONS				
Complete medication reconciliation.				
Provide analgesics PRN.				
Initiate systemic antibiotic/topical therapy as per PCP order.				

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PAIN				
If dressing changes are painful (procedural) ensure patient takes analgesic before dressing changes.				
Use non-pharmacological techniques such as repositioning, relaxation, rest, time outs.				
Assess carefully for signs of infection; pain is an indicator for infection.				
Encourage proper use of provided offloading devices/supports.				
SELF-MANAGEMENT & EDUCATION				
Teach patient/family: 1. Pathophysiology of pressure ulcerations and the contributing factors of pressure, friction, shearing, moisture. 2. Pressure injury prevention. Turning and repositioning self or with assistance. Reposition at least every 2 hours, avoiding pressure areas. Ensure proper positioning of tubes and medical devices. Keep skin clean and dry. 3. Do not to rub reddened areas or use donut type devices that localize pressure. 4. Use of pillows/wedges between knees and under legs to avoid skin-on-skin and direct contact with bony prominences. 5. Take analgesics as prescribed. 6. Increase activity and mobility as tolerated. 7. Head of bed less than 30 degrees unless eating or if medically indicated. 8. Avoid pulling, friction or shearing forces, using lifting devices/trapeze if available. 9. Encourage daily intake to meet recommendations of Canada's Food Guide with focus regular balanced meals.				
REFERRALS				
PHYSIOTHERAPY: Request consult for Physiotherapist to assess for proper exercises, mobilization, ambulation techniques and for gait aid assessment. Request specific intervention in the physiotherapy referral.				
OCCUPATIONAL THERAPY: Request consult for Occupational Therapist to assess the source and cause of pressure injury, education regarding position strategies, mobility strategies and therapeutic services. Please accompany referrals with wound stage, location, size and duration of the wound.				
DIETETICS: Request consult for Dietitian assessment if nutritional status implicates delayed wound healing and/or energy-protein malnutrition and/or identified need for diabetic diet teaching/monitoring. Consider referral to Complex and Diabetes Education Program.				
ENTEROSTOMAL THERAPY: Refer according to wound/ostomy escalation process. Detailed wound assessment and clinical images must be submitted with referral.				
SOCIAL WORK: Request consult for socioeconomic challenges such as: coping, financial issues, assistance with resources.				
DISCHARGE PLANNING				
Provide 'Pressure Injury Patient Handout' and review appropriate teachings for prevention of further injury.				
Refer to self-management if appropriate.				