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

Wound - Trauma Wound Clinical Pathway

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

Trauma Wound: **Superficial:** involves only skin or subcutaneous tissue of the incision
Deep: involves deep soft tissues (such as fascia and muscle layers)

To be completed at least once weekly and/or with change in SDWLHQW condition **This tool is used only as a guide and does not replace clinical judgment*	✓ where applicable; (N/A) where not applicable			
ASSESSMENT Date/Initial →				
Complete a comprehensive SDWLHQW history and assessment including: anatomic location, age of wound, mechanism of injury, comorbidities, medications, and nutritional status				
Perform and document a complete pain assessment				
Perform and document a complete wound assessment identifying wound bed appearance (need for debridement), exudate (type and amount), periwound area and undermining				
Assess wound for signs and symptoms of infection: induration, increased exudate, unusual odour, delayed healing, friable or discoloured granulation tissue, peri wound erythema > 2cm and report to MD/NP				
Notify MD/NP if signs of systemic infection (i.e. fever)				
Assess patient adherence and understanding of treatment plan				
For extremity wounds perform a bilateral vascular assessment including an **ABPI***				
GOALS				
Causative factors will be removed and patient will be protected from further trauma				
Patient will have acceptable pain management, be protected from infection, and supported in a moist wound healing environment				
Patient will demonstrate progression towards healing within a reasonable time frame (i.e. >20% in 3 weeks)				
Prompt identification and management of infection				
WOUND TREATMENTS				
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 exudating 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 Iodine/Gentian Violet** (****) Apply secondary dressing: **Foam/Super Absorbent** (****)				
Manage bioburden in *non-exudating* 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 and as needed				

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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				
CT for unexplored fistulas or sinus tracts (inability to determine wound base)				
Obtain culture and swab as per MD orders				
MEDICATIONS				
Provide analgesics PRN				
Initiate systemic antibiotic/topical therapy as per MD order				
PAIN				
Apply topical analgesics as per MD/NP – State:				
Encourage mobility if appropriate				
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 (using WHO guidelines for analgesic)				
TEACHING AND PSYCHOSOCIAL SUPPORT				
Teach patient: Factors contributing to trauma, delayed healing and signs and symptoms of infection				
Involve patient and family in care planning where appropriate				
Provide patient and family with information that will enhance knowledge and skills necessary to promote recovery and improve function				
Provide patient with information on follow up care and accessing community resources				
REFERRALS				
Request consult for Physiotherapist for proper exercises, mobilization and ambulation techniques, falls prevention assessment, if appropriate *see below for specific interventions*				
PT REFERRAL/INTERVENTION				

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1. **2.**				
Request consult for Occupational Therapist to assess positioning and/or transfers to make appropriate device recommendations. *see below for specific interventions*				
OT REFERRAL/INTERVENTION				
1. **2.**				
Request consult for Dietitian for energy protein assessment if nutritional status implicates delayed wound healing. Complete nutritional assessment screening tool. Based on result – automatic referral (Dietitian to amend) *see below for specific interventions*				
DIETITIAN REFERRAL/INTERVENTION				
1. **2.**				
Request referral for Enterostomal Therapist/Wound Care Specialist/Nurse Practitioner/Physician (i.e. wound deterioration, if < 20% healing following 3 to 4 weeks of appropriate treatment)				
ET/WCS/APN/NP/MD REFERRAL/INTERVENTION				
1. **2.**				
Request consult for ineffective coping, financial issues, etc. State: ______________________ *See below for effective interventions*				
SOCIAL WORK REFERRAL/INTERVENTION				
1. **2.**				
DISCHARGE PLANNING				
Provide educational pamphlet and appropriate education for prevention				
Assess patient/caregivers adherence and understanding to treatment plan				
Discharge patient: Community referrals as required				
Refer to self-management if appropriate				
VARIANCE				

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A variance is any event not noted in the routine clinical pathway i.e. deviation from any clinical pathway (e.g., not wearing compression bandaging, <20% healing, etc.)				

Print Name	Signature	Initials	Date

**Clients with possible false high ABPI's include: diabetics, renal failure, edema and may provide inaccurate Doppler readings*
****G**raduated compression bandages <u>should only be applied</u> by a trained clinician with experience in bandaging