HOME AND COMMUNITY CARE SUPPORT SERVICES
North East

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

WOUND - PRESSURE INJURY CLINICAL PATHWAY

Pressure Injury: Localized damage to the skin and underlying tissue occurring as a result of intense and/or prolonged pressure with or without shear.

PRESSURE INJURY CLASSIFICATION:

- **STAGE I –** Patients identified as being at risk for the development of a pressure injury or intact skin with reddened area non-blanchable
- **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
- **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

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: location of wound, age of wound, previous history of wound, comorbidities, medications, immune status, vascular status, nutritional status and use of offloading surfaces.				
Perform and document a weekly comprehensive wound assessment identifying wound dimensions, wound bed appearance (need for debridement), exudate (type and amount), peri-wound appearance.				
Assess for tunneling, undermining, sinus tracts, bone exposure (report immediately to PCP). Record percentage of weekly healing.				
Assess wound for signs and symptoms of infection: induration, increased exudate, unusual odour, delayed healing, friable or discoloured granulation tissue, peri-wound erythema greater than 2 cm and report to Primary Care Provider (PCP).				
Perform and document a complete pain assessment.				
For lower leg injuries, complete **ABPI** with initial assessment, every 4-6 months and with wound deterioration, forward to Home and Community Care Support Services – North East.				
Complete a Braden scale to predict pressure sore risk, at least weekly, more often for high risk patients.				
Inspect client's skin for signs of breakdown. Identify causative factors at each visit, and with any change in wound status.				
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, monthly and with wound deterioration.				

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

WOUND - PRESSURE INJURY CLINICAL PATHWAY

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**			
GOALS				
Wound will progress through the healing process.				
Wound will be protected from further complications through use of offloading strategies/surfaces.				
Patient factors contributing to infection will be addressed and mitigated (i.e. nutritional support, glycemic control, restoration of fluid balance) between host resistance and microorganisms).				
Patient will have acceptable pain management.				
Encourage patient/caregiver participation in developing individualized treatment plan and exploring self-management.				
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 peri-wound dry and apply a protective barrier to manage peri-wound maceration if indicated.				
Select dressing to manage moisture, control exudate and meet targeted frequency of dressing.				
Wound with bioburden: Manage with antimicrobial dressing, filling dead space, undermining and tunnels loosely Options for exuding wounds include but are not limited to silver calcium alginate, silver hydrofiber, sustained release iodine, PHMB. Apply cover dressing i.e. foam or absorbent. Options for non-exuding wounds include but are not limited to nanocrystalline silver mesh moistened with water or hydrogel, cadexomer iodine, silver gel, PHMB. Apply cover dressing i.e. thin foam, hydrocolloid, transparent film. **Non-exuding wound without bioburden:** Apply primary dressing i.e. acrylic, hydrocolloid or hydrogel. Apply cover dressing if indicated i.e. foam, absorbent. **Exuding wound without bioburden***:* Apply primary dressing may include calcium alginate, gelling fiber (hydrofiber)**.** Apply cover dressing i.e. foam, absorbent.				
Manage bleeding in an exudating wound i.e. calcium alginate, silver nitrate.				
Change dressing every 3-7 days depending on type of dressing used and amount of exudate.				
If chronic inflammation is suspected, consider protease inhibitor and/or NSWOC consult.				
Consider NPWT for full thickness with moderate to heavy exudate. Please consult NPWT Clinical Guidelines.				
Consider if the wound meets the definition of a Chronic Maintenance wound: Wounds that fail to progress normally through the repair process (are present for at least 12 weeks and have not responded to wound specific pathway), frequently caused by vascular compromise, chronic inflammation, repetitive insults to the tissue or patient lifestyle choices. These wounds fail to close in a timely manner or fail to result in durable closure. Please refer to Chronic Maintenance Clinical Guideline.				
Document variance if deviation from Clinical Pathway i.e. frequency greater than 3 days.				

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

WOUND - PRESSURE INJURY CLINICAL PATHWAY

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**			
MEDICATIONS				
Complete medication reconciliation.				
Initiate systemic antibiotic/topical therapy as per PCP order.				
PAIN				
Support use of pre-procedural analgesic to manage pain.				
Review non-pharmacological techniques such as repositioning, relaxation, rest, time outs.				
SELF-MANAGEMENT & EDUCATION				
Review with patient/family the pathophysiology of pressure injuries and their contributing factor, and promote practices that support healing and decrease recurrence, including: • Reposition at least every two hours, avoiding pressure areas and paying attention to positioning of tubes and devices • Keep skin clean and dry • Do not rub reddened areas, or use devices that localize pressure (like donut cushions) • Use pillows and wedges between legs and to avoid skin on skin contact especially around bony prominences • Avoid pulling, friction and shearing forces; use lifting devices if available				
For bed-bound patients, keep head of bed less than 30 degrees unless eating or medically indicated.				
Encourage daily intake to meet recommendations of Canada's Food Guide with focus on regular balanced meals and adequate fluid intake (1.5-2L/day) unless otherwise indicated.				
Involve patient and family in care planning.				
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.				

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

WOUND - PRESSURE INJURY CLINICAL PATHWAY

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**			
NURSES SPECIALIZED IN WOUND, OSTOMY & CONTINENCE: Refer according to wound/ostomy escalation process, which includes initial escalation to SPO Wound and Ostomy Care Champion PRIOR to NSWOC referral.				
SOCIAL WORK: Request consult for socioeconomic challenges such as: coping, financial issues, assistance with resources.				
DISCHARGE PLANNING				
Provide appropriate patient handbook and review appropriate teachings to support wound healing. Facilitate community referrals as indicated and provide teachings for prevention of further injury including offloading strategies.				