HOME AND COMMUNITY CARE SUPPORT SERVICES
North East

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

WOUND - ACUTE SURGICAL CLINICAL PATHWAY

Acute Surgical Wound: Acute surgical wounds heal within an expected timeframe and without complications.

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:	✓ or N/A			
COMPREHENSIVE ASSESSMENT				
Complete a comprehensive patient history and assessment including surgery type and date, comorbidities, prior scars or surgeries, and medications. Include risk factors for surgical site infection i.e. nutritional status, obesity, smoking, and immune status.				
Perform and document a weekly comprehensive wound assessment including dimensions and location, exudate, peri-wound appearance, approximation of edges, presence of healing ridge, and description and condition of wound closure devices (e.g. tapes, sutures, staples, etc.).				
If drains present, identify drain type, note amount and type of exudate and/or leakage around drain site.				
Identify any wound complications i.e. hematoma or seroma formation, edema, formation of fistulae, incisional hernias, signs of anastomotic leaks, development of wound contractures, hypertrophic scarring or keloid formation.				
Identify any signs and symptoms of localized or systemic infection i.e. induration, increased exudate, unusual odour, delayed healing, gaps or separations along the incision line, peri-wound erythema greater than 2cm, fever, general malaise, concerns with drain(s). Report concerning findings to Primary Care Provider (PCP).				
Perform and document a complete pain assessment.				
Assess, determine and emphasize importance of patient adherence to individualized treatment plan.				
Photo image upload at initial visit, monthly and with wound deterioration.				
GOALS				
Wound will progress through the healing process in a timely uncomplicated manner, i.e. wound closure by 3rd day postop with a palpable healing ridge by 5th day postop.				
Patient will have acceptable pain management.				
Wound will be protected from further damage, infection and contamination and peri-wound skin remains intact.				
WOUND TREATMENTS				
Cleanse wound with potable water.				
Pat peri-wound dry and apply dry dressing if needed to manage exudate. A cover dressing is not required once re-epithelialized. A dry dressing may be applied PRN to protect staples/sutures - nursing to teach self-management.				

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

WOUND - ACUTE SURGICAL 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:	✓ or N/A			
WOUND TREATMENTS				
Remove staples/sutures/drain as per PCP order. Document removal and any complications.				
Drain care (e.g. JP drains/Hemovac/Penrose) 1. Perform hand hygiene. 2. Ensure tubing is not kinked or occluded. If closed suction occlusion occurs, milk drain PRN. 3. Stabilize drain to maintain position. 4. Cleanse skin around drain with potable water. 5. Apply dry dressing PRN. 6. For closed suction drains, remove plug and empty drainage into clean measuring cup. Clean plug with alcohol then squeeze drain flat and re-insert plug. Drain should remain compressed indicating vacuum suction is intact. 7. Measure and record amount and type of drainage collected including date and time.				
SELF-MANAGEMENT & EDUCATION				
Review signs and symptoms of infection and delayed healing.				
Showering is encouraged once incision is re-epithelialized. **Bathing and/or soaking of incisions is discouraged**. Follow PCP protocol.				
Review purpose of drains, signs and symptoms of drain occlusion, and what to expect during drain removal.				
Over the counter lotions, solutions and preparations are often contraindicated while sutures/staples are in situ.				
Promote safe activity and rest, smoking cessation and appropriate analgesic use.				
Involve patient and family in care planning and wound management.				
REFERRALS				
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.				
NURSE SPECIALIZED IN WOUND, OSTOMY AND 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 i.e. coping, financial issues, access to resources.				
DISCHARGE PLANNING				
If greater than 3 visits required, complications arise, or patient unable to self-manage, assess for transition to alternate ICP.				
Provide appropriate patient handbook and review appropriate teachings to support wound healing.				