CP
CLINICAL
PATHWAY

South West Regional Wound Care Program:

Wound Care Clinical Pathways

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Overview

The Wound Care Clinical Pathways are interdisciplinary clinical pathways based on clinical practice guidelines at a local, national, and international level to guide practice for patients with wounds. Wound Care Clinical Pathways are for patients with wounds assessed by a Care Coordinator as eligible for South West LHIN services and have been developed to increase the consistent implementation of best practices and delivering on positive patient outcomes. The Wound Care Clinical Pathways are not to a substitute for wound care education or best practice guidelines, rather a tool for the South West LHIN and Service Provider Agencies to have a coordinated approach to the patient journey and reporting expectations to maximize patient healability. The Wound Care Clinical Pathways:

- focus on clinical goals,
- identify clinical tools to measure progress,
- identify key wound care interventions based on wound type,
- emphasize holistic patient and wound assessment,
- focus on team communication and reporting between the South West LHIN and Service Provider Organizations,
- address patient, family and caregivers education towards self-management and organizational support.

Wound Care Clinical Pathways Structure

The Wound Care Clinical Pathways follow a predictable course of assessment, interventions, and outcomes for common wound types. The pathways identify expected outcomes to be achieved by service provider staff within certain periods along the patient journey in home and community care. The Wound Care Clinical Pathways are broken down into three main columns as outlined below.

Column One: Wound Type

The wound care clinical pathways are dependent on the wound etiology which must be established and communicated to the South West LHIN care coordinator. The Wound Type column gives a brief description of the wound type and health care team members beyond the patient/family/caregiver, most responsible primary care providers, and nurse, who may be required to achieve wound healing.

Column Two: Interval Reporting

A guideline of Intervals and block visits are recommended in the pathways. Each interval is 4 weeks (28 days), with APR reporting required at the end of each interval. The exception is Interval 1, which requires an Assessment Report to be submitted within one week of patient assessment. A concise list of interventions and reporting expectations are listed within each interval.

Column Three: Key Interventions/Resources

Column Three includes a non-exhaustive list of key interventions based on wound type. Imbedded within this column are links to best practice guidelines for the wound type, as well as resource links that can be shared with patients.

Wound Care Clinical Pathway Categories

The Wound Care Clinical pathways are categorized as Assessment, Wound, Skin or Non-healing pathways.

Assessment Pathway

The Assessment Pathway is for patients with wounds with an unknown wound type on intake and after Care Coordinator's assessment. The Assessment Pathway is intended to enable the initiation of wound care services to determine the type of the wound and assign the appropriate Wound Care Clinical Pathway. Once the wound type has been established by the SPO, the SPO nurse should initiate best practice treatment of the wound and report to the Care Coordinator in an APR.

Wound Pathways

Wound pathways are for patients with wounds of known wound type. There are ten wound care clinical pathways:

1. Arterial Leg Ulcer
2. Atypical Ulcer
3. Diabetic Foot Ulcer
4. Malignant Wound
5. Pilonidal Sinus
6. Pressure Injury
7. Skin Tear
8. Surgical Open Wound
9. Traumatic Wound (burns, skin tears, other)
10. Venous Leg ulcer

Skin Pathways

Skin pathways are for patients with skin changes that may or may not include wounds:

1. Moisture Associated Skin Damage (MASD)
2. Lymphedema

Non-healing Pathways

Non-healing pathways are for patients with wounds who have failed to close their wound on the wound pathway and have been deemed to have a non-healable wound, or non-healing wound due to patient factors or system barriers:

1. Non-healing Wound
2. Non-healable Wound

Assessment Pathway

Wound Type	Interval Reporting		Key Interventions/Resources
<u>Assessment Pathway</u> Wound assessment pathway is for wounds of unknown type requiring patient detailed assessment to determine wound type and assist with clinical decision-making Once wound type has been identified, the patient should be initiated on the correct wound care pathway by the service provider as well as notify the CC. <u>Referral Considerations</u> Refer to WCS if unable to determine wound type.	Interval 1 Day 1-7 (3 block visits)	<u>Assessment Pathway Report due within 7 days</u> ☐ Wound Location ☐ Holistic patient and wound assessment completed If wound on lower leg complete lower limb assessment: ☐ Loss of protective sensation (Monofilament testing) ☐ ABPI ○ Further vascular assessment required if unable to perform ABPI or if ABPI is abnormal ((<0.9 or >1.3) ☐ Measurement: Length x Width x Depth ☐ Wound therapy initiated and report ○ Primary Dressing ○ Secondary Dressing ☐ ET/NSWOC Consultation requested to determine etiology ☐ Correct Wound Type Pathway identified and CC informed	• Holistic patient and wound assessment • Local wound therapy as ordered OR initiated as per best practice guidelines (dependent on wound type) • Vascular Segmental Pressure Studies is required if unable to perform ABPI/TBPI or due to falsely high ABPI readings, e.g., patients with diabetes, rheumatoid arthritis and/or chronic renal failure • Physician letter sent to MRP • Ordering of appropriate medical supplies and equipment as per IPAC <u>Resources:</u> <u>SWRWCP: Wound Assessment</u>

Arterial Leg Ulcer Pathway

<table>
<tr><th>Wound Type</th><th colspan="2">Interval Reporting</th><th>Key Interventions/Resources</th></tr>
<tr>
<td rowspan="2"><u>Arterial Leg Ulcers</u>

Wound caused by compromised or inadequate arterial blood flow from the heart to the tissues in the leg and foot. Wound fails to heal due to poor blood supply related to the presence of arterial occlusive disease - Peripheral Arterial Disease (PAD).

<u>Referral Considerations</u>

• Consider WCS based on iFUN criteria

• Ensure patient has been referred or is being followed by a vascular surgeon</td>
<td>Initial PED Day 1-7 (3 block visit)</td>
<td><u>Initial PED report due within 7 days</u>
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Wound Location
☐ Holistic patient and wound assessment completed
☐ Lower limb assessment
○ Loss of protective sensation (Monofilament testing)
☐ ABPI completed
○ Further vascular assessment required if unable to perform ABPI or if ABPI is abnormal ((<0.9 or >1.3)
☐ Referral to vascular assessment initiated/completed
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Correct pathway confirmed and initiated
☐ Wound therapy initiated
○ Primary Dressing
○ Secondary Dressing
☐ Patient discharge planning initiated for patient independence and prevention</td>
<td rowspan="2">***Moist wound healing is CONTRA-INDICATED for arterial wounds. Goal is to keep the wound dry and free from infection***

• TREAT THE CAUSE - Holistic patient and wound assessment
• Lower limb assessment
• Local wound therapy as ordered OR initiated as per best practice guidelines
• Physician letter sent to MRP
• Ordering of appropriate medical supplies and equipment as per IPAC

<u>Nursing Resources</u>:

Wounds Canada: <u>Prevention and Management of Peripheral Arterial Ulcers</u>

<u>Patient Resources</u>:

SWRWCP: <u>“My Arterial Ulcer”</u></td>
</tr>
<tr>
<td>Interval 1 Day 8-28 (7 block visit)</td>
<td><u>Interval 1 PED Interim report due before day 28</u>
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement (cm) : Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ % Healing
○ wound may not be smaller due to non-healable arterial wound
☐ Wound therapy reassessed
○ Primary Dressing
○ Secondary Dressing</td>
</tr>
</table>

	Interval 2 Days 29-56 (7 block visit)	<u>Interval 2 PED Interim report due before day 56</u> ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ % Healing o wound may not be smaller due to non-healable arterial wound ☐ Wound therapy reassessed o Primary Dressing o Secondary Dressing ☐ Chronic disease self-management plan initiated ☐ Confirm patient has been referred for vascular assessment	
	Interval 3 Days 57-84 (7 block visit)	<u>Interval 3/Discharge report due before day 84</u> ☐ Wound has closed o If no, move to most appropriate pathway ☐ Measurement : Length x Width x Depth o wound may not be smaller due to non-healable wound ☐ Reinforce chronic disease self-management plan (teach and reduce) ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan	

Atypical Ulcer Pathway

<table>
<tr><th>Wound Type</th><th colspan="2">Interval Reporting</th><th>Key Interventions/Resources</th></tr>
<tr>
<td><u>Atypical Ulcer Pathway</u>

Wounds excluded from the Wound Care Clinical Pathways. Other types of wounds seen in the community include, but are not limited to:
• Pyoderma Gangrenosum
• Bullous Pemphigus
• Cutaneous Vasculitis
• Hidradenitis Suppurativa
• Inflammatory Vasculitis
• Unknown origin/type
• Calciphylaxis
• Necrotising Fasciitis
• Necrobiosis Lipoidica Diabeticorum

Diagnosis excluded from Clinical Pathways:
• Inoperable Arterial Disease
• Gangrene(Tissue Ischemia)
• Acute Charcot Foot
• Osteomyelitis
• Arterial disease awaiting surgical intervention
• Peripheral Neuropathic Ulcer NOT related to Diabetes

<u>Referral Considerations</u>

• WCS based on iFUN criteria</td>
<td>Initial PED Days 1–7 (3 Block Visits)</td>
<td><u>Initial PED report due within 7 days</u>
☐ Etiology
☐ Wound Location
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Holistic patient and wound assessment completed
If wound on lower leg complete lower limb assessment:
☐ Loss of protective sensation (Monofilament testing)
☐ ABPI
○ Further vascular assessment required if unable to perform ABPI or if ABPI is abnormal ((<0.9 or >1.3)
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy initiated
○ Primary Dressing
○ Secondary Dressing
☐ Pressure management and/or compression therapy initiated where appropriate
☐ Patient discharge planning initiated for patient independence and prevention
☐ Referral initiated for WCS</td>
<td rowspan="2">• TREAT THE CAUSE - Holistic patient and wound assess- ment
• Determine wound etiology
• Referral to appropriate physician for underlying disease (i.e. dermatologist, wound specialist, rheumatologist, gastroenterologist)
• Lower limb assessment (as appropriate)
• Wound therapy as ordered OR initiated as per best practice guidelines
• Physician letter sent to MRP
• Ordering of appropriate medical supplies and equipment as per IPAC</td>
</tr>
<tr>
<td>Interval 1 Days 8-28 (7 block visits)</td>
<td><u>Interval 1 PED Interim report due before day 28</u>
☐ Etiology and wound location
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ % Healing
○ 20-30% reduction in wound size from baseline
○ If no, refer to ET/NSWOC
☐ Wound therapy reassessed
○ Primary Dressing:
○ Secondary Dressing:
☐ Patient is adhering to care plan</td>
</tr>
</table>

	Interval 2 Days 29-56 (9 Block Visits)	<u>Interval 2 PED Interim report due before day 56</u> ☐ Etiology and wound location ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound therapy reassessed o Primary Dressing: o Secondary Dressing: ☐ Chronic disease self-management plan initiated	
	Interval 3 Days 57-84 (9 Block Visits)	Interval 3 PED Interim report due before day 84 ☐ Etiology and wound location ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound therapy reassessed o Primary Dressing: o Secondary Dressing: ☐ Chronic disease self-management plan initiated	
	Interval 4 Days 85-112 (7 Block Visits)	Interval 4 PED Interim report due before day 112 ☐ Etiology and wound location ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound therapy reassessed o Primary Dressing: o Secondary Dressing: ☐ Chronic disease self-management plan initiated	
	Interval 5 Days 113-140 (4 Block Visits)	<u>Interval 5 PED Interim report due before day 140</u> ☐ Etiology and wound location ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth	

		☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound therapy reassessed o Primary Dressing: o Secondary Dressing: ☐ Chronic disease self-management plan initiated	
	Interval 6 Days 141–196 (8 Block Visits)	<u>Interval 6 PED Interim report due before day 196</u> ☐ Etiology and wound location ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound therapy reassessed o Primary Dressing: o Secondary Dressing: ☐ Chronic disease self-management plan initiated	
	Interval 7 Days 197 - 280 (12 Block Visits)	<u>Interval 7 PED Interim report due before day 280</u> ☐ Etiology and wound location ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound therapy reassessed o Primary Dressing: o Secondary Dressing: ☐ Chronic disease self-management plan initiated	
	Interval 8 Days 281 - 364 (12 Block Visits)	<u>Interval 8 PED Interim report due before day 364</u> ☐ Wound is closed or ☐ Wound assessment and % of healing reported ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan If wound is not closed, move to Non-Healing (Maintenance) Path-way or Non-Healable Pathway	

Diabetic Foot Ulcer Pathway

Wound Type	Interval Reporting		Key Interventions/Resources

<u>Diabetic Foot Ulcer (DFU)</u>
 	
DFU is a full-thickness wound of the foot in a person with diabetes. Ulceration is a complication of either Type 1 or Type 2 diabetes, which can cause neuropathy resulting in sensory loss of protective sensation, skin changes, foot deformity and limited joint mobility. As a result, pressure from footwear, cuts, bruises or other injury may go unnoticed. Risk for ulceration is exacerbated by peripheral arterial disease, poor glucose control, obesity, self-care deficit and improper footwear.
 	
<u>Referral Considerations</u>
 	
• WCS for DFU offloading assessment
 	
• PT for balance and gait assessment
 	
• RD for glucose management
 	
• Specialty Site – assess for DFU offloading device
	Initial PED Days 1-7 (3 block visit)	<u>Initial PED report due within 7 days</u>
		☐ Wound Location
		☐ Nursing Dressing Frequency
		☐ Self-Dressing Frequency
		☐ Holistic patient and wound assessment completed
		☐ Lower limb assessment
		  ○ Loss of protective sensation (Monofilament testing)
		☐ ABPI completed
		  ○ Further vascular assessment required if unable to perform ABPI or if ABPI is abnormal ((<0.9 or >1.3)
		☐ Measurement : Length x Width x Depth
		☐ BWAT Score
		☐ Pain during dressing change
		☐ Infection (NERDS and STONEES)
		☐ Wound therapy initiated
		  ○ Primary Dressing
		  ○ Secondary Dressing
		☐ Sharp debridement initiated
		☐ WCS referral completed and DFU Offloading measures initiated
		☐ Patient referred to Specialty Site
		☐ Patient discharge planning initiated for patient independence
			• TREAT THE CAUSE - Holistic patient and wound assessment
			• Lower limb assessment
			• DFU offloading
			• Glucose management
			• Local wound therapy as ordered OR initiated as per best practice guidelines
			• Serial sharp debridement
			• Physician letter sent to MRP
			• Ordering of appropriate medical supplies and equipment as per IPAC
			
			IMPORTANT Specialty Site referral required for expert assessment, offloading device/footwear to enhance healing, reduce risk of wound recurrence, and reduce risk of amputation.
			
			<u>Nursing Resources</u>
			
			SWRWCP: DFU Assessment Guidelines
			
			SWRWCP: DFU Treatment Guide- lines
			
			<u>Patient Resources</u>
			
			Wounds Canada: <u>Caring for Your Feet: Safe Foot Care if You Have Diabetes</u>
			
			Wounds Canada: <u>Diabetic Foot Complication: When is it an emergency</u>

	Interval 1 Days 8-28 (7 block visits)	<u>Interval 1 PED Interim report due before day 28</u>
		☐ Nursing Dressing Frequency
		☐ Self-Dressing Frequency
		☐ Measurement : Length x Width x Depth
		☐ BWAT Score
		☐ Pain during dressing change
		☐ Infection (NERDS and STONEES)
		☐ % Healing
		  ○ Goal is 20-30% reduction
		  ○ If no, refer to ET/NSWOC
		☐ Wound therapy reassessed
		  ○ Primary Dressing
		  ○ Secondary Dressing
		☐ Patient has obtained and is adhering to DFU offloading device
		☐ Sharp debridement maintained
		☐ Confirm referral to Specially Site
		☐ Ensure patient has been referred to a Diabetic Education Program	

	Interval 2 Day 29-56 (7 block visits)	<u>Interval 2 PED Interim report due before day 56</u> ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement : Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ % Healing o Goal is 40-60% reduction ☐ If no, ET/NSWOC referral completed ☐ Wound therapy reassessed o Primary Dressing o Secondary Dressing ☐ Patient has obtained and is adhering to DFU offloading device ☐ Sharp debridement maintained ☐ Confirm referral to Specially Site Chronic disease self-management plan initiated (teach and reduce)	
	Interval 3 Days 57-84 (7 block visits)	<u>Interval 3/Discharge report due before day 84</u> ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Wound is closed by 12 weeks OR ☐ Measurement : Length x Width x Depth ☐ Patient has obtained and is adhering to DFU offloading device ☐ Reinforce health teaching on need for long-term offloading management to prevent wound recurrence (i.e. 2nd tier devices such as custom orthotics) ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan	

Lymphedema Pathway

<table>
<tr><th>Wound Type</th><th colspan="2">Interval Reporting</th><th>Key Interventions/Resources</th></tr>
<tr>
<td rowspan="3"><u>Lymphedema</u>

Lymphedema is caused by a problem with the lymphtic system, a network of vessels and glands spread throughout the body.
There are two types of Lymphedema:
• Primary Lymphedema is a rare, inherited condition caused by problems with the development of lymph vessels in the body
• Secondary Lymphedema is acquired due to damage to the lymphatic system from scarring after trauma or infection, obesity, radiation, prolonged venous stasis, or problems after cancer related surgeries

<u>Referral Considerations</u>

• WCS for compression assessment and skin care health teaching
• PT for exercises
• OT for garment application devices
• RD for nutrition/hydration health teaching
• Therapist for Manual Lymph Drainage</td>
<td>Initial PED Days 1 – 7 (3 Block Visits</td>
<td><u>Initial PED report due within 7 days</u>
☐ Wounds Location
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Holistic patient and wound assessment completed (patient may or may not have wound)
☐ If wound present, wound measurement required for baseline measurement
☐ If lymphedema presenting in lower legs complete a lower leg assessment which includes an ABPI
☐ Obtain initial limb circumference measurements
☐ Confirm history of compression garments
☐ Refer to WCS for compression therapy
☐ Refer to PT for exercise health teaching

NOTE*** when compression therapy is initiated, bandages may need to be changed daily to minimize slippage as edema is reducing</td>
<td rowspan="3">Key Issues for Lymphedema Treatment
• Sustained high compression
• Meticulous skin hygiene
• Prevention of infection
• Manual lymphatic drainage and or self-massage
• Patient support and education on their condition and self-management strategies

Referral initiated for long-term compression system to facilitate wound healing and reduce the risk of wound recurrence.
• Refer to ADP prescriber (physician/NP) for ongoing garment financial support. Contact SWRWCP at swrwcp@lhins.on.ca for resource support.

<u>Nursing Resources</u>

EWMA: Lymphedema bandaging in practice

Lymphedema Association of Ontario: Clinical Guidelines

<u>Patient Resources</u>

SWRWCP: Skin Care Tips for People Living with Lymphedema – a patient self-management video</td>
</tr>
<tr>
<td>Interval 1 Days 8-28 (7 block visits)</td>
<td><u>Interval 1 PED Interim report due before day 28</u>
☐ Nursing Dressing Frequency
☐ Self-dressing Frequency
☐ Wound re-assessment and % of healing reported, if wound present
☐ Limb circumference reported and compared to initial measurement
☐ Refer patient to ADP prescriber for compression garments, SWRWCP can provide resource support if needed
☐ Skin health care teaching reinforced
☐ Patient is adhering to compression care plan</td>
</tr>
<tr>
<td>Interval 2 Day 29–56 (7 Block Visits)</td>
<td><u>Interval 2 PED Interim report due before day 56</u>
☐ Nursing Dressing Frequency
☐ Self-dressing Frequency
☐ Wound re-assessment and % of healing reported, if wound present
☐ Limb circumference reported and compared to initial measurement
☐ Confirm patient is referred to ADP prescriber for compression garments
☐ Patient is adhering to compression care plan</td>
</tr>
</table>

		☐ Chronic disease self-management plan initiated (teach and reduce) ☐ Patients provided with Lymphedema ADP Authorized/Fitter contact information	
	Interval 3 Days 57-84 (7 Block Visits	<u>Interval 3/Discharge report due before day 84</u> ☐ Wound is closed by 12 weeks if wound present or ☐ Wound re-assessment and % of healing reported ☐ Chronic disease self-management plan in place (teach and reduce) ☐ Compression garment maintenance plan in place ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan ☐ If wound is not closed and/or edema is not managed, move to Non-healing (Maintenance) Pathway or Non-Healable Pathway	

Malignant Wound Pathway

<table>
<tr><th>Wound Type</th><th colspan="2">Interval Reporting</th><th>Key Interventions/Resources</th></tr>
<tr>
<td rowspan="2"><u>Malignant Wounds</u>

A wound that is non-healable and is likely to deteriorate. These wounds may be a malignant wound from an invasion of cancer cells into the skin (e.g. malignant melanoma, basal or squamous cell) or may be from the primary cancer itself (e.g. breast, colon or ovary) spreading to other distant sites including the skin (i.e. metastases).

<u>Palliative Wounds</u>
Wounds and associated skin changes that develop in palliative patients are generally considered as non-healable in light of poor health condition and the demands of treatment that may outweigh the potential benefits. These patients often suffer from conditions that are incurable but life-limiting including malignancy, severe malnutrition, advanced diseases associated with major organ failure (renal, hepatic, pulmonary, or cardiac), and, in some cases, profound dementia.

<u>Referral Considerations</u>

• Consider WCS based on iFUN criteria
•
• RD for nutrition support
•
• PCOT for pain and symptom support
•
• Psych/social/spiritual care
•</td>
<td>Initial PED Days 1–7 (5 Block Visits)</td>
<td><u>Initial PED report due within 7 days</u>
☐ Wound Location
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Holistic patient and wound assessment completed
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy initiated
○ Primary Dressing
○ Secondary Dressing
☐ Wound related symptom managed
○ Control Bleeding
○ Control Odour
○ Control Pain
○ Control Exudate
○ Control Superficial Infections
☐ Patient discharge planning initiated for patient independence and prevention</td>
<td rowspan="2">• Holistic patient and wound assessment
• Address Health related Quality of Life issues include physical, fuctional, psychological, emotioal and social components
• Local wound therapy as ordered OR initiated as per best practice guidelines
• Wound related symptoms managed
• Health related Quality of Life issues supported
• Physician letter sent to MRP
• Ordering of appropriate medical supplies and equipment as per IPAC

<u>Nursing Resources</u>

SWRWCP: <u>Malignant Wound Assessment Guideline</u>

SWRWCP: <u>Malignant Wound Treatment Guidelines</u>

<u>Patient/Family/Caregiver Resources</u>

SWRWCP: <u>“My Malignant Wound</u>”</td>
</tr>
<tr>
<td>Interval 1 Days 8-28 (7 Block Visits)</td>
<td><u>Interval 1 PED Interim report due before day 28</u>
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy reassessed
○ Primary Dressing
○ Secondary Dressing
☐ % Healing
○ wound may not be smaller due to non-healable arterial wound
☐ Wound related symptom managed
○ Control Bleeding
○ Control Odour
○ Control Pain
○ Control Exudate
○ Control Superficial Infections</td>
</tr>
</table>

• Palliative Volunteer Support Program		☐ Health related Quality of Life issues addressed ☐ Patient/caregiver health teaching to support self-care if frequent dressing changes are require	
	Interval 2 Days 29-56 (7 block Visits)	<u>Interval 2 PED Interim report due before day 56</u> ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency: ☐ Measurement: Length x Width x Depth *** wound may not be smaller due to non-healable wound ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound related symptom managed ○ Control Bleeding ○ Control Odour ○ Control Pain ○ Control Exudate ○ Control Superficial Infections ☐ Wound therapy reassessed ○ Primary Dressing ○ Secondary Dressing ☐ Chronic disease self-management plan initiated ☐ Health related Quality of Life issues addressed ☐ Chronic disease self-management plan initiated ☐ Add intervals as needed with continued reporting after 28 days and 9 block visits	

Moisture Associated Skin Damage (MASD) Pathway

Wound Type	Interval Reporting		Key Interventions/Resources
<u>Moisture Associated Skin Damage</u> (MASD) Moisture that stays on the skin too long can put the skin at risk for break-down in the form of burning, rashes and open sores. Sources of moisture include: • Urine and/or stool: Called incontinence-associated dermatitis (IAD) or more commonly, diaper rash • Sweat, saliva or mucous: Called Intertrigo or intertriginous dermatitis (IDT) • Fluid (drainage) from wounds: Called periwound MASD • Moisture on a foot: Called immersion foot (IF) or trench foot The result of skin being in contact with too much moisture for too long is generally the same regardless of the type: red, shiny, tight or swollen skin that may or may not have broken skin. Patients with MASD often complain of burning or pain in the affected area. <u>Referral Considerations</u> • WCS for skin assessment and health teaching based on IFUN criteria • Nurse Continence Advisor for toileting assessment • OT/PT for equipment and mobility assessment • RD for impaired nutritional assessment	Initial PED Days 1–7 (3 Block Visits)	<u>Initial PED report due within 7 days</u> ☐ . Holistic patient and skin assessment that includes ○ Patients continence status ○ Mobility ○ Nutrition ○ Allergies ○ Previous skin problems ○ Risk assessment for pressure ulcer using BRADEN ☐ Treat the cause – consider key referrals ☐ Skin care program initiated as ordered or as per evidence informed practice ☐ Patient/caregiver health teaching initiated to promote preventative MASD interventions ☐ Provide resource/link “Nutrition in Wound Healing” available at: https://swrwoundcareprogram.ca/Uploads/Content-Documents/SWRWCP_NUTRITIONinWOUND.pdf	TREAT THE CAUSE - Holistic patient assessment including: • Patient’s continence status • Mobility • Nutrition • Allergies • Previous skin problems/wounds • Bathing routine and skin care regimen including ability for self-care and involvement of caregivers • Pressure ulcer risk assessment • Exclude pressure damage as the cause of skin injury <u>Nursing Resources</u> BCPN Skin & Wound Committee: <u>Assessment. Prevention and Treatment of MASD</u> <u>Patient Resources</u> Wounds Canada: <u>Caring for Easily Damaged Skin: Preventing and Managing Moisture-associated Skin Damage</u>
	Interval 1 Days 8-28 (7 block visits)	<u>Interval 1 PED Interim report due before day 28</u> ☐ Skin reassessment complete ☐ Continue preventative skin care interventions ☐ Reinforce patient/caregiver health teaching to promote preventative MASD interventions ☐ Patient/caregiver adhering to treatment plan ☐ Consider Key referrals	
	Interval 2 Day 29–56 (7 Block Visits)	<u>Interval 2/discharge report due before day 56</u> ☐ Patient skin remains intact ☐ Interventions are in place to prevent or limit MASD ☐ Chronic disease self-management plan initiated (teach and reduce) ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan ☐ If wound is not closed, move to Non-healable Pathway or Non-Healing Pathway	

Non-Healable Wound Pathway

<table>
<tr><th>Wound Type</th><th colspan="2">Interval Reporting</th><th>Key Interventions/Resources</th></tr>
<tr>
<td rowspan="3"><u>Non-Healable Wound</u>

A wound in which the patient does not have the physical capacity to heal.

<u>Referral Considerations</u>

• WCS for wound assessment based on iFUN criteria
• OT for safety equipment assessment
• PT for gait/exercise assessment
• RD to optimize nutrition
• SW to address psych/social issues that may be barrier to care</td>
<td>Interval 1
Days 1-28
(4 Block Visits)</td>
<td><u>Interval 1 PED Interim report due before day 28</u>
☐ Wound Location
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Holistic patient and wound assessment completed
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy initiated/reassessed
○ Primary Dressing
○ Secondary Dressing
☐ % Healing
***wound may not be smaller due to non-healing wound
☐ Consider Interdisciplinary Case Conference for non-healing pathway care plan
☐ Patient discharge planning initiated for patient independence and Prevention
☐ Chronic disease self-management plan initiated</td>
<td rowspan="3">***Non-healing wound goal of care is to manage exudate and wound symptoms using cost effective dressings (not advanced wound dressings)***

• Holistic patient and wound assessment
• Lower limb assessment (as appropriate)
• Local wound therapy as ordered OR initiated as per best practice guidelines
• Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan
• Physician letter sent to MRP
• Ordering of appropriate medical supplies and equipment as per IPAC

<u>Nursing Resources</u>

SWRWCP: Dressing Selection and Cleansing Enabler

<u>Patient Resources</u>

Wounds Canada: Care at Home Series</td>
</tr>
<tr>
<td>Interval 2
Days 29-84
(8 Block Visits)</td>
<td><u>Interval 2 PED Interim report due before day 84</u>
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy reassessed
○ Primary Dressing
○ Secondary Dressing
☐ % Healing
***wound may not be smaller due to non-healing wound
☐ Assessment and identification of resource/system barriers – intervention initiated</td>
</tr>
<tr>
<td>Interval 3
Day 85-168
(12 Block Visits)</td>
<td><u>Interval 3 PED Interim report due before day 168</u>
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement: Length x Width x Depth
☐ BWAT Score</td>
</tr>
</table>

		☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound therapy reassessed ○ Primary Dressing ○ Secondary Dressing ☐ % Healing ***wound may not be smaller due to non-healing wound ☐ Resource/system barriers addressed	
	Interval 4 Day 169-252 (12 Block Visits)	<u>Interval 4 PED Interim report due before day 252</u> ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound therapy reassessed ○ Primary Dressing ○ Secondary Dressing ☐ % Healing ***wound may not be smaller due to non-healing wound ☐ Resource/system barriers addressed	
	Interval 5 Day 253-336 (12 Block Visits)	<u>Interval 5 PED Interim report due before day 336</u> ☐ Wound has closed or ☐ Wound assessment and % of healing reported ☐ Chronic disease self-management plan confirmed (teach and reduce) ☐ Consider 3rd party funding (ODSP, private insurance) to support wound care and products ongoing)	

Non-Healing (Maintenance) Wound Pathway

<table>
<tr><th>Wound Type</th><th colspan="2">Interval Reporting</th><th>Key Interventions/Resources</th></tr>
<tr>
<td rowspan="3"><u>Non-Healing (Maintenance) Wound</u>

Wound is healable but either the patient is making choices not consistent with optimal wound healing or the system is unable to support the optimal treatment for the patient at this time.
• Patient factors, refusing a treatment/condition resistant to treatment that addresses the cause (i.e. not wear compression therapy or not using a specialty-seating cushion).
• A health system error or barrier (i.e. no provision of plantar pressure redistribution, specialty footwear or the individual cannot afford the device).

<u>Referral Considerations</u>

• WCS for wound assessment based on iFUN criteria

• OT for safety equipment assessment

• PT for gait/exercise assessment

• RD to optimize nutrition

• SW to address psych/social issues that may be barrier to care</td>
<td>Interval 1
Days 1-28
(4 Block Visits)</td>
<td><u>Interval 1 PED Interim report due before day 28</u>
☐ Wound Location
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Holistic patient and wound assessment completed
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy initiated/reassessed
○ Primary Dressing
○ Secondary Dressing
☐ % Healing
***wound may not be smaller due to non-healing wound
☐ Consider Interdisciplinary Case Conference for non-healing pathway care plan
☐ Patient discharge planning initiated for patient independence and Prevention
☐ Chronic disease self-management plan initiated</td>
<td rowspan="3">***Non-healing wound goal of care is to manage exudate and wound symptoms using cost effective dressings (not advanced wound dressings)***
• Holistic patient and wound assessment
• Lower limb assessment (as appropriate)
• Local wound therapy as ordered OR initiated as per best practice guidelines
• Assessment and identification of resource/system barriers – intervention initiated (consult with SWRWCP)
• Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan
• Physician letter sent to MRP
• Ordering of appropriate medical supplies and equipment as per IPAC

<u>Nursing Resources</u>

SWRWCP: <u>Dressing Selection and Cleansing Enabler</u>

<u>Patient Resources</u>

Wounds Canada: <u>Care at Home Series</u></td>
</tr>
<tr>
<td>Interval 2
Days 29-84
(8 Block Visits)</td>
<td><u>Interval 2 PED Interim report due before day 84</u>
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy reassessed
○ Primary Dressing
○ Secondary Dressing
☐ % Healing
***wound may not be smaller due to non-healing wound
☐ Assessment and identification of resource/system barriers – intervention initiated</td>
</tr>
<tr>
<td>Interval 3
Day 85-168
(12 Block Visits)</td>
<td><u>Interval 3 PED Interim report due before day 168</u>
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change</td>
</tr>
</table>

		☐ Infection (NERDS and STONEES) ☐ Wound therapy reassessed ○ Primary Dressing ○ Secondary Dressing ☐ % Healing ***wound may not be smaller due to non-healing wound ☐ Resource/system barriers addressed	
	Interval 4 Day 169-252 (12 Block Visits)	<u>Interval 4 PED Interim report due before day 252</u> ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound therapy reassessed ○ Primary Dressing ○ Secondary Dressing ☐ % Healing ***wound may not be smaller due to non-healing wound ☐ Resource/system barriers addressed	
	Interval 5 Day 253-336 (12 Block Visits)	<u>Interval 5 PED Interim report due before day 336</u> ☐ Wound has closed or ☐ Wound assessment and % of healing reported ☐ Chronic disease self-management plan confirmed (teach and reduce) ☐ Consider 3rd party funding (ODSP, private insurance) to support wound care and products ongoing)	

Pilonidal Sinus Pathway

<table>
<tr><th>Wound Type</th><th colspan="2">Interval Reporting</th><th>Key Interventions/Resources</th></tr>
<tr>
<td rowspan="2"><u>Pilonidal Sinus</u>

Wound or abscess near or at the natal cleft of the buttocks in the midline of the sacrococcygeal area of the back. This acquired condition is caused by one or more factors: body hairs entering the natal cleft or previous incision site causing a foreign-body reaction or keratin plugs in hair follicles causing folliculitis/abscess.

A pilonidal sinus is sinus tract, which commonly contains hairs. It occurs under the skin between the buttocks (the natal cleft), a short distance above the anus. The sinus tract goes in a vertical direction between the buttocks. Rarely does, a pilonidal sinus occur in other sites of the body.

<u>Referral Considerations</u>

• WCS based on iFUN criteria
• PT/OT to mitigate lifestyle factors that may be impeding healing</td>
<td>Initial PED Days 1–7 (5 Block Visits)</td>
<td><u>Initial PED report due within 7 days</u>
☐ Wound Location
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Holistic patient and wound assessment completed
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy initiated
○ Primary Dressing
○ Secondary Dressing
☐ Education and patient management of periwound environment Initiated
○ Hygiene
○ Periwound Decontamination
○ Hair removal
○ Avoid activities with excessive friction
○ Avoid constipation
☐ Patient discharge planning initiated for patient independence and prevention</td>
<td rowspan="2">• TREAT THE CAUSE -Holistic patient and wound assess- ment
• Education and patient management of peri-wound environment initiated and maintained
○ Hygiene
○ Periwound decontamination
○ Hair removal
○ Avoid friction
○ Avoid constipation
• Wound therapy as ordered OR initiated as per best practice guidelines
• Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan
• Physician letter sent to MRP
• Ordering of appropriate medical supplies and equipment as per IPAC

<u>Nursing Resources</u>

SWRWCP: <u>Pilonidal Sinus Assessment Guideline</u>

SWRWCP: <u>Pilonidal Sinus Management Guideline</u>

<u>Patient Resources</u>

SWRWCP: “<u>My Pilonidal Sinus”</u></td>
</tr>
<tr>
<td>Interval 1 Days 8-28 (8 block visits)</td>
<td><u>Interval 1 PED Interim report due before Day 28</u>
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ % Healing
○ 20-30% reduction from baseline
○ If no, refer to ET/NSWOC
☐ Wound therapy reassessed
○ Primary Dressing
○ Secondary Dressing
☐ Reinforce education and patient management of peri-wound environment</td>
</tr>
</table>

	Interval 2 Days 29-60 (8 Block Visits)	Interval 2/Discharge report due before day 60 ☐ Wound is closed by 8 weeks or ☐ Wound assessment and % of healing reported ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan ☐ If wound is not closed, move to Maintenance Pathway or Non-Healing Pathway	

Pressure Injury Pathway

<table>
<tr><th>Wound Type</th><th colspan="2">Interval Reporting</th><th>Key Interventions/Resources</th></tr>
<tr>
<td rowspan="2"><u>Pressure Injury</u>

A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

NPUAP Pressure Injury Stages:
• Stage 1
• Stage 2
• Stage 3
• Stage 4
• Unstageable
• Deep Tissue Pressure Injury

<u>Referral Considerations</u>

• OT/PT for pressure management assessment
• RD for nutrition assessment
• WCS/PT for E-Stim treatment</td>
<td>Initial PED Days 1–7 (3 Block Visits)</td>
<td><u>Interval 1 report due within 7 days</u>
☐ Wound Location
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Holistic patient and wound assessment completed
If wound on lower leg complete lower limb assessment:
☐ Loss of protective sensation (Monofilament testing)
☐ ABPI
○ Further vascular assessment required if unable to perform ABPI or if ABPI is abnormal ((<0.9 or >1.3)
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy initiated
○ Primary Dressing
○ Secondary Dressing
☐ Turning/repositioning schedule initiated
☐ Pressure redistribution measures initiated
☐ Patient discharge planning initiated for patient independence and prevention
☐ Referral to RD for nutrition assessment (as needed)
☐ OT/PT referral for pressure management and equipment (as needed)
☐ Referral for E-Stim treatment</td>
<td rowspan="2">• TREAT THE CAUSE - Holistic patient and wound assessment
• Lower limb assessment (as appropriate)
• Wound therapy as ordered OR initiated as per best practice guidelines
• Treat the cause using pressure management and offloading of pressure injury
• Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan
• Physician letter sent to MRP
• Ordering of appropriate medical supplies and equipment as per IPAC

Nursing Resources

SWRWCP: Pressure Injury Assessment Guideline

SWRWCP: Pressure Injury Management Guideline

NPUIP: Heel Pressure Injury Guidelines

<u>Patient Resources</u>

SWRWCP: “My Pressure Injury”</td>
</tr>
<tr>
<td>Interval 1 Days 8-28 (7 Block Visits)</td>
<td><u>Interval 1 PED Interim report due before Day 28</u>
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ % Healing:
○ Goal is 20-30% reduction from baseline
○ If no, refer to ET/NSWOC
☐ Wound therapy reassessed
○ Primary Dressing:
○ Secondary Dressing:
☐ Referral initiated for long-term pressure redistribution system
☐ Turning/repositioning schedule maintained</td>
</tr>
</table>

		☐ E-Stim therapy initiated	
	Interval 2 Days 29-56 (7 Block Visits)	<u>Interval 2 PED Interim report due before day 56</u> ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ % Healing o 40-60% reduction from baseline o If no, refer to ET/NSWOC ☐ Wound therapy reassessed o Primary Dressing o Secondary Dressing ☐ Turning/Resposition schedule maintained ☐ Patient has obtained and is adhering to pressure redistribution system ☐ Ongoing E-Stim therapy ☐ Chronic disease self-management plan initiated	
	Interval 3 Days 57-84 (7 Block Visits)	<u>Interval 3 PED Interim report due before day 84 days.</u> ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ % Healing o 70-80% reduction from baseline o If no, refer to ET/NSWOC ☐ Wound therapy reassessed o Primary Dressing o Secondary Dressing ☐ Turning/Reposition schedule maintained ☐ Patient has obtained and is adhering to pressure redistribution system ☐ Ongoing E-Stim therapy ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan	

	Interval 4 Days 85-126 (10 Block Visits)	<u>Interval 4/Discharge report due before day 126</u> ☐ Wound is closed by 18 weeks OR ☐ Wound assessment and % of healing reported ☐ Reinforce health teaching on need for long-term pressure management to prevent wound recurrence if closed ☐ If wound is not closed, move to Non-Healing (Maintenance) Pathway or Non-Healable Pathway	

Skin Tear Pathway

<table>
<tr><th>Wound Type</th><th colspan="2">Interval Reporting</th><th>Key Interventions/Resources</th></tr>
<tr>
<td rowspan="2"><u>Skin Tear</u>
A skin tear is a traumatic wound caused by mechanical forces, including removal of adhesives that result in separation of skin layers. Skin tears are the most common wound among elderly people.

<u>Key Interventions/Referrals</u>

Treat the Cause; consider the underlying cause affecting healability of a wound

• OT for home safety assessment
• RD for nutrition assessment to optimize healing
• meticulous skin care

<u>ISTAP Skin Tear Classification System</u>

Type 1: No skin loss: linear or flap. Tear can be repositioned to cover the wound bed

Type 2: partial flap loss that cannot be repositioned to cover the wound bed

Type 3: total flap loss that exposes the entire wound bed</td>
<td>Initial PED Days 1–7 (3 Block Visits)</td>
<td><u>Initial PED report due within 7 days</u>
☐ Wound Location
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Holistic patient and wound assessment completed
If wound on lower leg complete lower limb assessment:
☐ Loss of protective sensation (Monofilament testing)
☐ ABPI
○ Further vascular assessment required if unable to perform ABPI or if ABPI is abnormal ((<0.9 or >1.3)
☐ For traumatic wounds involving the foot of a person with diabetes, refer to the DFU clinical pathway
☐ Root cause of trauma identified and addressed
☐ Skin Tear
○ Type I – No Skin Loss
○ Type 2 – Partial Skin Loss
○ Type 3 – Total Flap Loss
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy initiated
○ Primary Dressing:
○ Secondary Dressing:
☐ Patient discharge planning initiated for patient independence and prevention</td>
<td rowspan="2">• TREAT THE CAUSE - Holistic patient and wound assess- ment completed
• Wound skin tear classification reported
• If partial or full thickness skin tear, wound measurement required for baseline measurement
• Wound dressings as ordered OR initiated as per evidence informed practice
• If skin tear is on the lower leg; complete a lower leg assessment which includes an ABPI and consider compression therapy to enhance healability
• Optimal skin care health teaching initiated for patient/caregiver
• Determine if patients Tetanus is up-to-date
<u>Nursing Resources</u>
SWRWCP: <u>The Assessment of People with Skin Tears Guideline</u>

SWRWCP: <u>The Management of People with Skin Tears Guideline</u>

<u>Patient Resources</u>
SWRWCP: <u>“My Skin Tear”</u>

Wounds Canada: <u>Preventing and Managing Skin Injuries</u>

Wounds Canada: <u>Keeping Your Home Safe</u></td>
</tr>
<tr>
<td>Interval 1 Days 8-28 (7 Block Visits)</td>
<td>Interval 1 PED Interim report due before Day 28
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ % Healing:
○ 20-30% reduction in wound size from baseline
○ If no, refer to ET/NSWOC
☐ Wound therapy reassessed</td>
</tr>
</table>

		○ Primary Dressing ○ Secondary Dressing	
	Interval 2 Days 29-56 (7 Block Visits	<u>Interval 2 PED Interim report due before day 56</u> ☐ Wound is closed by 8 weeks or ☐ Wound assessment and % of healing reported ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan If wound is not closed, move to Non-Healing (Maintenance) Pathway or Non-Healable Pathway7	
	Interval 3 Days 57-84 (7 Block Visits)	<u>Interval 3/Discharge report due before day 84</u> ☐ Wound is closed by 8 weeks or ☐ Wound assessment and % of healing reported ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan If wound is not closed, move to Non-Healing (Maintenance) Pathway or Non-Healable Pathway	

Surgical Open Wound Pathway

<table>
<tr><th>Wound Type</th><th colspan="2">Interval Reporting</th><th>Key Interventions/Resources</th></tr>
<tr>
<td rowspan="2"><u>Surgical Open Wounds</u>
A wound caused by a surgical incision that is intentionally left to heal by secondary intention, or when primary wound closure with staples or stitches is unsuccessful with subsequent dehiscence.

Surgical wounds are made in optimal conditions but failure to heal may be a result of infection. These wounds may be referred to as surgical site infections (SSI).

Common contributing factors include surgical site infection, obesity and poor nutrition.

Negative Pressure Wound Therapy (NPWT or VAC) is often utilized for surgical open wounds.

<u>Referral Considerations</u>

• WCS based on iFUN criteria</td>
<td>Initial PED Days 1–7 (3 Block Visits)</td>
<td><u>Initial PED report due within 7 days</u>
☐ Wound Location
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Holistic patient and wound assessment completed
☐ For surgical wound on the lower leg, complete a lower leg assessment which includes an ABPI (surgeon orders required)
☐ For surgical wounds involving the foot of a person with diabetes, refer to the DFU clinical pathway
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy initiated as per surgeon orders
○ Primary Dressing
○ Secondary Dressing
☐ Patient discharge planning initiated for patient independence and prevention
☐ Provide resources/links to reinforce health teaching</td>
<td rowspan="2">• Holistic patient and wound assessment
• Education and patient management of surgical wound
• Wound therapy as ordered OR initiated as per best practice guidelines
• Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan
• Physician letter sent to MRP
• Ordering of appropriate medical supplies and equipment as per IPAC

<u>Nursing Resources</u>

SWRWCP: <u>The Assessment of People with Open or Closed Surgical Wounds Guideline</u>

SWRWCP: <u>The Management of People with Open or Closed Surgical Wounds Guideline</u>

<u>Patient Resources</u>

Wounds Canada: <u>Caring for Yourself After Surgery</u>

SWRWCP: <u>“My Surgical Wound”</u>

SWRWCP: <u>“My Hemovac Drain”</u></td>
</tr>
<tr>
<td>Interval 1 Days 8-28 (7 block visits)</td>
<td><u>Interval 1 PED Interim report due before Day 28</u>
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ % Healing:
○ 20-30% reduction in wound size from baseline
○ If no, refer to ET/NSOWC
☐ Wound therapy reassessed
○ Primary Dressing
○ Secondary Dressing</td>
</tr>
</table>

	Interval 2 Days 29-56 (8 Block Visits)	Interval 2 report due before day 56 ☐ Wound is closed by 8 weeks or ☐ Wound assessment and % of healing reported ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan ☐ If wound is not closed, move to Maintenance Pathway or Non-Healing Pathway	SWRWCP: "My Jackson-Pratt (JP) Drain" FD SWRWCP: "My Skin Graft"

Traumatic Wound Pathway

<table>
<tr><th>Wound Type</th><th colspan="2">Reporting Intervals</th><th>Key Interventions/Resources</th></tr>
<tr>
<td rowspan="2"><u>Traumatic Wound</u>

A traumatic wound is an acute wound caused by external injury such as friction, shear or blunt trauma (i.e. skin tear, burn). The layers of the skin are separated with a variable degree of tissue damage. They may be referred to as partial or full thickness wounds and may occur anywhere.

Traumatic Injuries:
• Skin tears
• Burns
• Dog bites
• Stab and gunshot wounds
• Thermal Injury
• Hematomas
• Pre-tibial lacerations

<u>Referral Considerations</u>
• WCS based on iFUN criteria
• OT for home safety and equipment assessment
• RD for nutrition assessment to optimize healing
• PT for mobility, falls risk assessment, and exercise</td>
<td>Initial PED Days 1 – 7 (3 Block Visits)</td>
<td><u>Initial PED report due within 7 days</u>
☐ Wound Location
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Holistic patient and wound assessment completed
If wound on lower leg complete lower limb assessment:
☐ Loss of protective sensation (Monofilament testing)
☐ ABPI
○ Further vascular assessment required if unable to perform ABPI or if ABPI is abnormal ((<0.9 or >1.3)
☐ For traumatic wounds involving the foot of a person with diabetes, refer to the DFU clinical pathway
☐ Root cause of trauma identified and addressed
☐ Burn
○ 1st degree
○ 2nd degree
○ 3rd degree
☐ Skin Tear
○ Type I – No Skin Loss
○ Type 2 – Partial Skin Loss
○ Type 3 – Total Flap Loss
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ Wound therapy initiated
○ Primary Dressing:
○ Secondary Dressing:
☐ Patient discharge planning initiated for patient independence and prevention</td>
<td rowspan="2">• Holistic patient and wound assessment with root cause of trauma identified
• Wound therapy as ordered OR initiated as per best practice guidelines
• Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan
• Physician letter sent to MRP
• Ordering of appropriate medical supplies and equipment as per IPAC

<u>Nursing Resources</u>
SWRWCP: The Assessment of People with Skin Tears and/or
Pre-Tibial Injuries Guideline

SWRWCP: The Management of People with Skin Tears and/or Pre-Tibial Injuries Guideline

Wounds Canada: The Prevention and Management of Burns Guideline

<u>Patient Resources</u>
SWRWCP: “My Burn Wound”
SWRWCP: “My Skin Tear”</td>
</tr>
<tr>
<td>Interval 1 Days 8-28 (7 block visits)</td>
<td><u>Interval 1 PED Interim report due before Day 28</u>
☐ Nursing Dressing Frequency
☐ Self-Dressing Frequency
☐ Measurement: Length x Width x Depth
☐ BWAT Score
☐ Pain during dressing change
☐ Infection (NERDS and STONEES)
☐ % Healing:
○ 20-30% reduction in wound size from baseline</td>
</tr>
</table>

		○ If no, refer to ET/NSWOC ☐ Wound therapy reassessed ○ Primary Dressing ○ Secondary Dressing	
	Interval 2 Days 29-56 (8 Block Visits)	<u>Interval 2/Discharge report due before day 60</u> ☐ Wound is closed by 8 weeks or ☐ Wound assessment and % of healing reported ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan ☐ If wound is not closed, move to Non-Healing (Maintenance) Pathway or Non-Healable Pathway	

Venous Leg Ulcer Pathway

Wound Type	Reporting Intervals		Key Interventions/Resources
Venous Leg Ulcers (VLU) Wound caused by the impairment in the flow of venous blood from the legs to the heart *(venous stasis ulcer, venous insufficiency ulcers).* This impairment is associated with venous stasis hyperten- sion as a result of one or a combination of the following: • Valve dysfunction (reflux) • Blockage of the veins (i.e. clots) • Impaired calf muscle pump Venous stasis hypertension causes chronic edema in the lower extremities resulting in damage to the skin. The damaged skin may eventually break down to form an ulcer, or minor trauma can result in a wound that will not heal. Referral Considerations • WCS for compression therapy • PT for calf muscle pump exercises and gait assessment • OT for assistive devices for com- pression application and self-man- agement • Compression fitter may be required to assess for long term compres- sion garments	Initial PED Days 1 – 7 (3 Block Visits)	Initial PED report due within 7 days ☐ Wound Location ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency: ☐ Holistic patient and wound assessment completed ☐ Lower limb assessment ○ Loss of protective sensation (Monofilament testing) ☐ ABPI completed ○ Further vascular assessment required if unable to perform ABPI or if ABPI is abnormal (<0.9 or >1.3) ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound therapy initiated ○ Primary Dressing ○ Secondary Dressing: ☐ WCS/NSWOC referral sent for high compression therapy ☐ PT referral sent and calf muscle pump exercises initiated ☐ Patient discharge planning initiated for patient independence and prevention ☐ Consider RD referral for nutrition assessment	• TREAT THE CAUSE - Holistic patient and wound assess- ment • Lower limb assessment • Compression therapy (decrease edema) • Calf muscle pump exercises • Local wound therapy as ordered OR initiated as per best practice guidelines • Long term compression therapy (maintenance) • Physician letter sent to MRP • Ordering of appropriate medical supplies and equipment as per IPAC Nursing Resources SWRWCP: The Assessment of People with Leg Ulcers SWRWCP: The Management of Peo- ple with Leg Ulcers Patient Resources SWRWCP: Preventing and Managing a Venous Leg Ulcer Wounds Canada: Caring for Your Swollen Legs at Home
	Interval 1 Days 8-28 (7 block visits)	Interval 1 PED Interim report due before day 28 ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Referral initiated for long-term compression system ☐ % Healing ○ 20-30% reduction in wound size from baseline ○ If no, refer to ET/NSWOC ☐ Enquire with MRP for appropriateness of Pentoxifylline treat- ment, in combination with compression therapy ☐ Wound therapy reassessed ○ Primary Dressing: ○ Secondary Dressing: ☐ Patient is adhering to compression therapy	

		○ If No, (specify reason): ☐ Patient is adhering to calf muscle pump exercises	
	Interval 2 Day 29–56 (7 Block Visits)	<u>Interval 2 PED Interim report due before day 56</u> ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Measurement: Length x Width x Depth ☐ BWAT Score ☐ Pain during dressing change ☐ Infection (NERDS and STONEES) ☐ Wound therapy reassessed ○ Primary Dressing ○ Secondary Dressing ☐ Patient adhering to compression therapy and calf muscle pump exercise ☐ Chronic disease self-management plan initiated ☐ % Healing ○ 40-60% reduction in wound size from baseline ☐ Refer patient to community fitter for long- term compression system	
	Interval 3 Days 57-84 (7 Block Visits)	<u>Interval 3 PED Interim report due before day 84</u> ☐ Nursing Dressing Frequency ☐ Self-Dressing Frequency ☐ Wound has closed or ☐ Wound assessment and % of healing reported ☐ Patient has obtained long-term compression system and adhering to compression therapy ☐ Consider Interdisciplinary Case Conference to identify and mitigate barriers/gaps in care plan ☐ If wound is closed, move to Interval 4 to support patient's independence with long-term compression. ☐ If wound is not closed, move to Maintenance Pathway or Non-healing Pathway	
	Interval 4 Days 84-98 (7 Block Visits)	<u>Interval 4 PED Interim report due before day 98</u> ☐ Patient is independent with long-term compression system ☐ Patient is independent with compressions garments by week 14 ☐ Reinforce health teaching on need for long-term compression to prevent wound recurrence	

Glossary

Assessment Terminology		
	Holistic Patient Assessment	Patient assessment which includes history and current health status (physical, emotional and lifestyle); skin status (and wound if applicable); environmental factors such as socio-economic status, culture, care setting, access to services and system factors such as government policies, support and programs.
	Infection Prevention and Control (IPAC)	IPAC practices are required during all wound care interventions to ensure patient and health care provider safety during assessment and treatment interventions. This includes using aseptic techniques for local wound care and appropriate use and discarding of sterile instruments and dressings.
	Lower Leg Assessment	Holistic patient assessment with the additional bilateral lower limb assessment which includes: • Observation (Missing limbs/digits, leg shape, skin assessment/changes, nail assessment) • Toes, ankle, knee and hip range of motion • Venous and arterial circulation which includes Doppler sounds and ABPI • Edema measurement • Sensation assessment which includes monofilament testing • Pain assessment
	Wound Assessment	Detailed wound assessment which includes the following outcomes as a minimum reporting standard: • Wound location: area of body where the wound is located • Wound measurement: length x width x depth, undermining, tunneling • BWAT: Bates Jensen Wound Assessment Tool score • Pain with dressing change: Numeric Pain Scale /10 • Infection using NERDS and STONEES N-Non healing E-Erythema R-Red & Friable D-Debris S-Smell S-Size increased T-Temperature O-Os (probes to bone) N-New areas of breakdown E-Erythema, edema E-Exudate S-Smell ○ If 3 or more NERDS, patient may have spreading infection

		○ If 3 or more STONEES, patient may have systematic infection and requires physician intervention • Wound Re-assessment: % healing $\frac{\text{SA (Initial)} - \text{SA (Current)}}{\text{SA (Initial)}} \times 100 = \%$ reduction in SA (SA = surface area of wound calculated as Longest Length (head to toe) x Perpendicular Widest Width)
Healing Trajectory		Wound healing is a complex process that is impacted by many factors. Healability is a key determinate of the treatment plan. Involving patients in discussions about the healability of their wound empowers them to make more informed treatment choices and helps establish common expectations between patients and team members. Once the healability has been determined, patients and healthcare teams can work together to establish realistic treatment plans that are more easily adhered to by everyone.
	Healable Wounds	Have the potential to heal; causative and/or valid cofactors can be mitigated or treated. • The goal of the service plan is for closure of the wound with ongoing functional integrity • These patients follow a Wound Care Clinical Pathway based on wound type
	Non-Healing (Maintenance) Wounds	A non-healing (maintenance) wound is a wound that is healable, but either the patient lifestyle factors are not consistent with optimal wound healing or the health system is unable to support the optimal treatment for this patient at this time. • Patient factors may include refusing a treatment/condition resistant to treatment that addresses the cause (i.e. not wearing compression therapy, not wearing offloading devices or not using a specialty seating cushion) • A health system error or barrier may include waitlists for service, lack of required medical care or lack of affordable supplies/equipment which are not covered by OHIP • The goal is to maintain the current wound condition and prevent further deterioration and infection, if possible, to promote patient independence in the wound care regime through self-managed care techniques or with caregivers' assistance
	Non-Healable Wounds	A Non- Healable wound is a wound in which the patient does not have the physical capacity to heal. For example, in the case of end-of-life patients, lack of circulation, or systemic disease. The goals is to promote comfort and maximum function of the patient, prevent infection and, if possible, prevent further wound deterioration.

Interdisciplinary Team		All wound care best practice guidelines, regardless of wound type, emphasize the importance of wound care teams. This is especially challenging in the home and community care setting. It is important to know who your team members are, their roles, and communication strategies to improve patient outcomes.
	ADP Prescriber/Authorizer/ Fitter	Team members who can sign, recommend, and fit compression devices for patents. These team members are part of the process for patients with lymphedema to receive ADP funding for their compression garments.
	DFU Specialty Site	Teams across the South West region who specialize in diabetic foot ulcer management and can prescribe total contact casting and 2nd tier offloading devices.
	Care Coordinator (CC)	Provides patient system navigation and assists with implementation of wound pathway key interventions.
	Occupational Therapist (OT)	The occupational therapist's expertise can be used to identify causative factor to skin breakdown, and to make recommendations that protect the skin or promote wound healing while promoting participation in meaningful occupation including equipment needs for activities of daily living.
	Physiotherapy (PT)	Physiotherapists benefit the team with their advanced knowledge of biomechanics and anatomy to assist with positioning, mobility, exercise, and equipment issues. Physiotherapists also have the skills to utilize biophysical agents as adjunctive therapies in chronic wound care.
	Registered Dietitian (RD)	Nutrition plays a key role in comprehensive wound care plans for the prevention and treatment of wounds. Registered dietitians are an essential team member for wound healing.
	Registered Nurse/Registered Practical Nurse (RN/RPN)	Nurses assess and treat wounds, develop care plans, and often lead the wound care team in the implementation of wound care pathways.
	South West Regional Wound Care Program	SWRWCP advocates for the integrated delivery of evidence-informed skin and wound care that spans the continuum of care. A plethora of resources for wound care can be found at www.swrwoundcareprogram.ca

	Wound Care Specialist (WCS)	WCS have advanced knowledge, skills and judgement for the management of complex wounds (i.e. NSWOC). Referral to a WCS is based the iFUN criteria: i- intervention required that requires the knowledge, skills and judgement of a WCS (i.e. CSWD) F-frequency of visits for wound management is > 3/week after 1 month of intervention U-unknown etiology of a wound; require further assessment by a WCS to develop care plan N-number of % healing has not decreased by 20-30% after 1 month of intervention
Preparing the Wound Bed		Wound bed preparation involves the assessment and treatment of the cause of the wound, the investigation and management of systemic and local factors that may delay healing, and the assessment and management of person-centered concerns prior to choosing an appropriate treatment regimen.
	Identify/Treat the Cause	Identify and determine the wound type in order to treat the underlying cause of the wound (i.e. manage pressure for a pressure injury). Review the cofactors and comorbidities to create an individualized plan of care that address causes and co-factors affecting healing by correction of underlying disease or contributing factors.
	Treat the Patient	The patient/family/caregiver is the centre of the wound care team. Engaging the patient is crucial to promote adherence to care plans, foster patient self-care, maximize quality of life (pain management and preventing infection) and provide ongoing support.
	Wound Therapy (Local wound care)	Wound therapy, or local wound care, refers to the care plan and interventions for the open wound. Local wound care follows the DIME framework: D-debridement I-Irrigation/cleansing I-Infection and inflammation (NERDS and STONEES – bacterial balance an manage infection) M-Moisture balance (exudate control and protect periwound skin) E-Edge of wound
	Organizational Supports	• Education to the patient, caregiver, and family on the treatment plan Evidence-informed practice with holistic interprofessional approach to individualized care plan to improve patient outcomes

	Chronic Disease Self-Management	Self-management support is defined as the systematic provision of education, coaching and supportive interventions by health care staff to increase patients' skills, knowledge, confidence and motivation to manage the physical, social and emotional impacts of their disease.
Treatment Interventions		There is a multitude of treatment interventions for acute and chronic wounds. Key interventions in the Wound Care Clinical Pathways are outlined below.
	Compression Therapy	Compression therapy is used for the treatment of venous stasis hypertension and chronic edema for a variety of lower leg wounds. Compression therapy is initiated after completion of the appropriate assessments (i.e. lower limb assessment, ABPI) in accordance with Best Practice Guidelines.
	DFU Offloading	DFU offloading devices are specialized products, such as Total Contact Cast (TCC), removable casts or specialized shoes that relieve pressure on foot ulcers to help patient to heal and reduce the risk of amputation. The choice of offloading device should be based on a comprehensive assessment and an individualized care plan to optimize quality care for the person with the DFU.
	Electrical Stimulation (E-Stim)	Estim is used to speed healing and promote closure of open wounds such as pressure injuries, leg ulcers, and diabetic foot wounds. Estim is applied to the wound and surrounding area using a specialized electrical stimulation device and surface electrodes.
	Pressure Management	Pressure management is the ability of a support surface to redistribute load over the contact areas of the human body. Pressure management devices are provided based on the body location of the wound and can be purchased or customized for patients with wounds (i.e. air mattress, wheelchair cushion).
	Conservative Sharp Wound Debridement	Conservative sharp wound debridement (CSWD) is the removal of non-viable wound tissue using a scalpel, scissors or a curette to create a clean wound bed. It is important to note that Conservative Sharp Wound Debridement (CSWD) may only be performed by providers where it is included in the scope of practice as regulated by each province and allowable only where organizational policy and procedures explicitly permit it. Health care providers must also demonstrate the knowledge, judgement and skill to perform CSWD.
Reporting Terminology		
	Interval/Frequency	Refers to key time intervals/frequencies according to wound type in the overall care trajectory of patients admitted with a wound or multiple wounds. Intervals/frequencies may be defined using different parameters depending upon the patient's condition/presenting problem and the criteria required to complete each care plan.

	Reporting (Initial, Interim, Discharge)	An Electronic Automated Provider Report (APR) to report status of patient and any variances identified. Interval Reporting must occur in accordance to intervals identified on the relevant Wound Care Clinical Pathways.
	Block Visits	The allotted interval Block Visits numbers are based on Best Practice Guidelines. Each interval reporting timeline are pre-populated for the period of 4 weeks (28 days) or more according to wound etiology with wound closure as final outcome at the end of the Provider End Date (PED).
	Frequency End Date (FED)	Frequency End Date is the last date of each interval pre-populated in the Service Pathway Referral that guides the SPO to submit an Interim APR report for that interval.
	Provider End Date (PED)	PED is the Frequency End Date of the last Interval/Frequency in the Service Pathway Referral that guides the SPO to submit a Discharge APR report to indicate wound closure or transition to another wound pathway

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