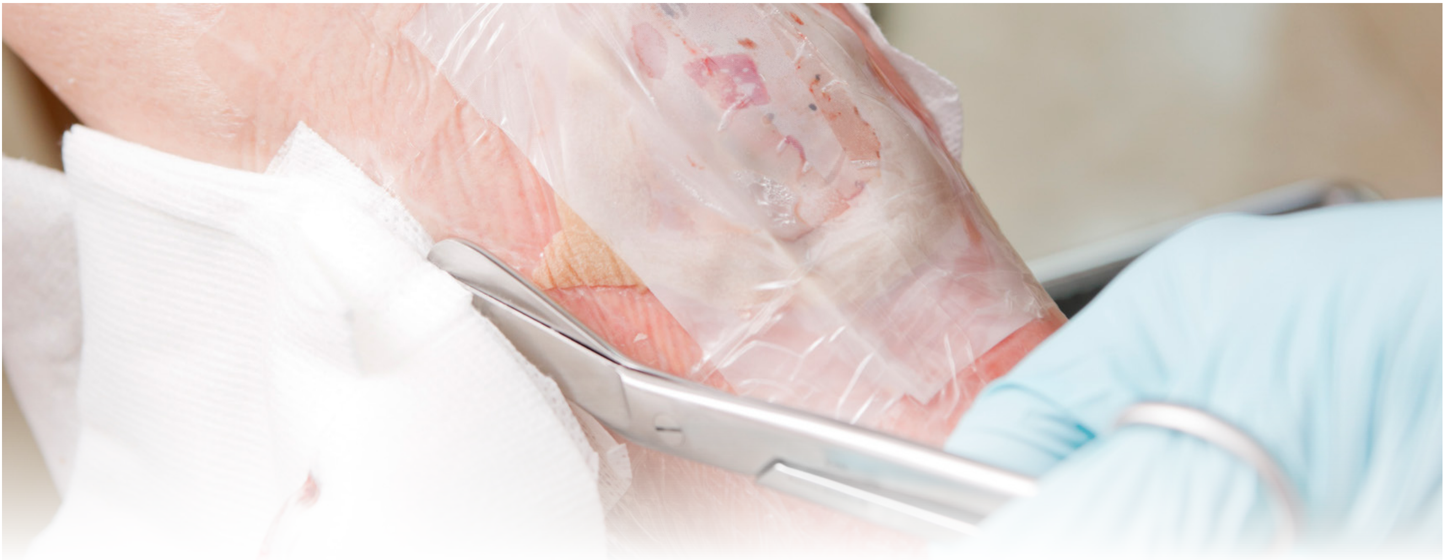

Compliance That Heals: Aligning Outcomes and Costs in Canadian Chronic Wound Care

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Chronic wound care management is complex, and when combined with reporting requirements within interRAI standards (see box), it can seem daunting. Looking at the cost of wound care on our health-care system and the effects of not adhering to appropriate guidelines, we see that practices are not the only things that suffer from audits. Patient care also declines, with wounds consuming billions in public resources despite being considered 'largely preventable' and causing harm we have the power to prevent.

interRAI

interRAI is a collaborative network of researchers in over 30 countries committed to improving services for vulnerable populations including older persons, persons with disabilities and those affected by mental illness. The goal is to promote evidence-informed clinical practice and policy decisions through the collection and interpretation of high-quality data about the characteristics and outcomes of individuals served across the continuum of care. interRAI instruments have been mandated by governments in several countries including Canada, New Zealand, Hong Kong, Singapore, Belgium, Ireland, Switzerland, Finland, as well as many US states.

- The interRAI HC is a comprehensive, standardized instrument for evaluating the needs, strengths and preferences of those who require home care services.
- The interRAI LTCF is a comprehensive, standardized instrument for evaluating the needs, strengths and preferences of those in a Long Term Care facility.

For more information, visit https://interrai.org/

Statistics

Wound care spending estimates: Across Canada, estimates place direct wound spending at about $12.1 billion in 2023, up from approximately $8.28 billion in 2019. These figures are based on a 'standardized costing method' (a framework that accounts for direct health-care costs, indirect and

overhead costs, and adjusts for inflation, ensuring the figures can be compared nationwide) that approximates wounds at about 3.5% of total health-care spending.[1] ***Editor's note:*** *An updated version of Reference 1 is featured in this issue. See pages 37-42.*

Wounds in home care & Long Term Care (LTC): In the most recent national reporting from 2011–2012, CIHI administrative data show that wounds were significantly concerning.

- In home care, out of roughly 4,934 people, 7.3% of clients had a compromised wound, and 4.6% had a chronic wound.
- In Long-term Care (LTC), out of roughly 10,922 people, about 9.6% had a compromised wound and 7.9% had a chronic wound.[2]

More recent national wound data is not available, but a 2025 quality improvement project published in *Wound Care Canada*, titled 'Decreasing Pressure Injuries in Long-Term Care: A Quality Improvement Project', focused on long-term care homes in British Columbia. In that study, pressure injuries accounted for 18.9% of all wounds reported in LTC.

While national data remains outdated, findings like these highlight the ongoing burden of chronic wounds in care settings and underscore the importance of consistent prevention and management practices across Canada.[3]

The long-term cost of complications: In Ontario, the modelled lifetime public-payer cost for people hospitalized with wounds can increase drastically. Over their lifetime, treating a diabetic foot ulcer costs an estimated $619,300, a leg ulcer can cost upwards of $548,100, and a pressure injury can total $98,500. These figures highlight the importance of early wound management.[4]

Across Canada, about 7,720 diabetes-associated lower-limb amputations happen yearly. Roughly 23,500 hospital stays are for serious wound-related complications, including ulcers, gangrene or infections. The total strain on the health-care system is close to $750 million. Preventable leg amputations cost around $47,000, and experts estimate that around 85% of these could have been prevented with proper wound care.[5] (Source: CIHI, 2022)

Why Compliance Matters

One thing is clear from these numbers: aligning your care with established laws, following standards and clinical guidelines and following evidence-based pathways for best practices can help reduce clinical errors, improve healing times and minimize legal and financial risks. The result is fewer chronic wounds and far fewer costly long-term complications that strain health-care budgets.

The Backbone Of Compliance

Standardized assessment (interRAI): Across most Canadian provinces, compliance in home care and LTC uses operationalized intake and assessments using the standardized system interRAI Contact Assessment (CA). Assessments ensure that every client is evaluated the same way, consistently and with reliable and comparable information.

In many provinces, home care has a two-step model:

- The first is using interRAI HC when longer-term services are anticipated.
- If ongoing care is needed, a more complete and detailed interRAI HC is completed.

For example, Ontario uses a two-stage approach for client needs at the onset of their care. Home care and long-term care submissions flow to CIHI's interRAI reporting platforms, where timing and content expectations are explicit. Your program's audits will check whether the right instrument was used at the right time and whether the care plan reflects those findings.[5]

Focus is given to:

- Assessment and data standardization
- Clinical guidance and care planning
- Quality monitoring and reporting
- Risk mitigation.

Evidence-Based Pathways

Most home care agencies and health authorities build their clinical pathways using wound care protocols that are built around best-practice recommendations from organizations like the Registered Nurses' Association of Ontario (RNAO) and Wounds Canada; for example, compression therapy assessment and workflow for venous leg ulcers (VLUs), off-loading algorithms for diabetic foot ulcer (DFU) and triggers for conservative sharp debridement and referral. Chart language should mirror your adopted pathway; deviations from the care pathway must be justified and clearly noted.

Scope, Orders And Directives

Each province's regulatory college sets the rules and determines what clinicians can do independently or what should be done, requiring a medical directive or a prescriber's order. Conservative sharp debridement, initiating compression and advanced therapy usage require documented competency validation and, in many programs, medical directives. During inspections and peer reviews, surveyors look for clear evidence that the medical staff is competent and able to perform the procedures recommended and that proper authorization was given.

IPAC As Law In LTC

In Long-Term Care facilities, infection prevention and control (IPAC) is mandatory and is the law. The standards set up in Ontario as outlined in the *Fixing Long-Term Care Act* (Ontario exemplar), are the standards that every LTC facility must follow. Nursing home facilities are obligated to implement the Director-issued IPAC Standard, and inspectors test compliance against that standard during proactive inspections. Home care and community programs are required to follow provincial IPAC guidance, which means they must show evidence of point-of-care risk assessments and demonstrate the proper use of personal protective equipment (PPE), safe cleaning practices and proper equipment transfer and storage.[6]

Information Governance

Privacy statutes (e.g., PHIPA in Ontario and substantially similar regimes elsewhere, with PIPEDA for parts of the private sector) obligate minimum-necessary documentation, secure handling, auditable access, and breach reporting. Compliance reviews increasingly connect clinical quality with privacy compliance.

What Auditors Look For In Home Care

Assessment Fidelity

- Use the InterRAI CA at intake and the interRAI HC assessment for clients with ongoing services, ensuring that both are completed within required timelines. Reassessments must also be completed on schedule, and any "significant change" in a client's condition should trigger a new assessment.[5]
- The cause of the wound should be confirmed (etiology), and it should be noted if the wound is arterial, venous, neuropathic, pressure-related, or atypical with appropriate perfusion and neuropathy screening when needed.

Plan-of-care Alignment

- The care plan should reference the clinical pathway your care team should be following. For example: "Venous leg ulcer pathway, step 3: ankle-brachial pressure index (ABPI) is completed; moderate compression is initiated; wound is reassessed within 48-72 hours", showing that the care team provides consistent best-practice care and the care team is aligned.
- Measurement discipline: L×W×D, undermining/tunneling, tissue types, exudate, peri-wound, pain, infection risk, goals with timelines.
- If the wound is not improving as expected and there is less than a 20–30% reduction in the size of the area after four weeks, or signs of poor circulation (suspected ischemia or infection appear), this should trigger referral to the documented prescriber or a specialist.

Authorizing Mechanisms

- Make sure that appropriate orders and medical directives are on file before performing higher-risk interventions, such as debridement, compression initiation beyond stocking class, negative pressure and advanced cellular/tissue-based products.
- Competency currency recorded.

Education & Continuity

- Document all patient and caregiver education, including evidence that 'teach-back' was used and documented. Record all supplies for your supply management documentation, including the type, product size, frequency, and continuity between visits.

IPAC & Privacy

- Document point-of-care risk assessments, and any steps taken for PPE use and environmental cleaning measures, including hygiene steps recorded when clinically relevant. If wound images are captured, make sure that the images are stored correctly and securely in accordance with your organizational security policies.

Why this matters: When done consistently, this reduces the home care compromised wound burden and the pipeline to avoidable admissions outlined above.

What Good Looks Like In LTC

Programmatic Compliance

- An IPAC program meeting the Director's Standard: surveillance, outbreak management, auditing, feedback, and staff training.
- Skin & wound committee with defined review cadence for non-healing wounds and pressure injuries; integration with mobility, nutrition, and diabetes management.

Assessment & Indicators

- Routine interRAI LTCF assessments informing quality indicators (e.g., worsened stage 2 - 4 pressure injuries), with QI cycles tied to findings.
- Regularly review unit-level trends, including how often wounds occur (incidence and prevalence), and include the length of time it took to heal.

Care Plan Fidelity

- Positioning schedules, off-loading strategies and support surfaces should be adjusted and tailored for each person according to their risk level. Provide compression therapy for venous leg ulcers (VLU) where needed and follow established pathways for diabetic foot ulcers (DFU), including keeping blood sugar well controlled to support healing (glycemic optimization pathways).
- Escalate care promptly if there are signs of infection or poor circulation (ischemia), and connect the patient with appropriate hospital services, vascular, and high-risk foot resources as needed.

Documentation Precision

- Short, standardized wound flowsheets paired with narrative notes that justify clinical decisions (e.g., why compression was deferred today; when it will be re-tried; what was done instead).

Why this matters: This alignment directly addresses the 7.9% chronic wounds in LTC and helps prevent the costs that follow failed management of wounds in home or LTC settings. When wounds are not effectively managed, they can cost upwards of $47,000 with each amputation.[5]

Three Compliance Levers With Outsized ROI

1. **Etiology-first pathways (DFU & VLU)**
   Diabetic foot ulcers (DFU) and leg ulcers are among the most expensive wounds to treat over a patient's lifetime; this is why early prevention is essential. Prioritize blood flow assessments, use off-loading for DFUs and follow ankle-brachial pressure index (ABPI)-guided compression for venous leg ulcers (VLUs). Create order sets and medical directives that allow clinicians to start the interventions during the same visit when criteria are met. Track the time from assessment to the first compression or off-loading as a key performance indicator (KPI) to monitor and improve care.[4]

2. **Rapid escalation for non-healing wounds**
   A documented *4-week Rule*, for example, is when a wound shows less than a 20–30% reduction in size after four weeks. This should automatically trigger a referral to a prescriber or specialist. Link documentation to referral service-level agreements (SLAs) and track any exceptions to this process. Follow this approach to help stop wounds from progressing to more complicated, severe problems like infections, hospitalizations or amputations that can escalate. It has been documented that interruptions in the progression to UGI admissions and amputations have cost the system upwards of $750M annually. [5]
3. **Data that proves it**
   Close the loop by using interRAI anchored data to guide and demonstrate results. Draw on outputs from the Contact Assessment (CA), Home Care (HC) and Long-Term Care Facility (LTCF) assessments to stratify risk and to populate dashboards (healing trajectory, time-to-compression/off-loading, escalation timing). Make sure to create detailed documentation to be proof for an audit and so that practice matches policy.[5]

Avoidable Pitfalls That Trigger Findings

- **Assessment gaps** (wrong instrument usage/timing) or plans that don't echo interRAI findings
- **Pathway drift** (e.g., edema unmanaged; compression omitted without rationale)
- **Unclear authority** (no order/directive on the chart for a controlled act)
- **IPAC blind spots** (poor hand-off of isolation status; reprocessing of reusable tools not documented in policy)
- **Privacy compliance** (no images on unapproved devices; excessive PHI in progress notes).

The Bottom Line

Canada's wound care burden is large, measurable and, in significant part, preventable. The system pays dearly when etiologies aren't established, basic modalities are delayed, or escalation lags.

Annually, there are lifetime costs ranging from billions to five-figures in common ulcer types, and thousands of amputations that policy makers classify as 'largely preventable'.

The compliance playbook is our best lever to put wound care on the right track in both home care and LTC.

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