Wound Assessment Guidance Notes

It is mandatory to complete a wound chart for all wounds requiring ongoing interventions. Completing a holistic assessment improves continuity of care and can enhance communication with the patient (and / or carers) regarding their wound.

For any non healing wounds, please consider referral to appropriate specialist for further input, e.g. podiatry, tissue viability, Dermatology, Vascular, plastics or burns teams.

Ensure the number of dressing products packed into a wound are documented, it should then be documented how many are removed at each dressing change to avoid the risk of retained products in the wound.

Please ensure the plan of care is discussed with the patient (and/or carer) to improve patient engagement and concordance with treatment plan. Ensure any sensitivities to dressings are documented on front page of chart.

Consider if the patient can self – manage wound care with support from health professionals.

<u>Wound Assessment Guidance</u>

Wound assessment should be recorded for every wound on initial assessment, when changes noted or at least weekly. The dressing change log and evaluation should be completed at **every** dressing change.

Wound dimensions – measure wound in cm/mm.
When documenting tissue type, percentages should total 100% once section completed.
Use a disposable tape measure.
Length is measured from head to toe
Width is measured from right to left
Depth of wound should be measured from deepest area of wound bed to the skin surface.
Record if tracking or undermining is present (and by number of cm/mm's) to help identify full extent of wound and possibility of sinus/fistula

If photographing wound, ensure appropriate consent is obtained and documented.

Only take a wound swab if there are clinical signs of infection.

Determine treatment objectives to guide dressing product choice and plan of care.

If signs of infection or delayed healing, consider use of antimicrobial dressing. Refer to local formulary for appropriate dressings.

WRITE, IMPRINT OR ATTACH LABEL	
Surname	CHI No .....
Forenames	Sex.....
DoB	
Location.....	

Assessment Chart for Wound Management

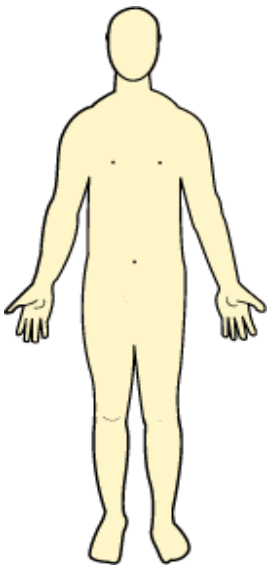
For multiple wounds complete formal wound assessment and treatment plan for each wound.
Add Inserts as needed.

Factors which could delay healing:
(Please tick relevant box)

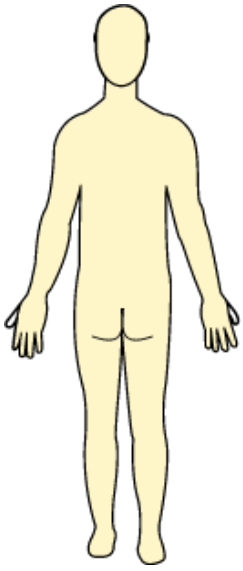
Immobility	☐	Poor Nutrition	☐	Diabetes	☐	Incontinence	☐
Respiratory/Circulatory Disease	☐	Anaemia	☐	Medication	☐	Wound Infection	☐
Inotropes	☐	Anti-Coagulants	☐	Oedema	☐	Steroids	☐
Chemotherapy	☐	Other.....		Allergies & Sensitivities.....			

Body Diagram

Front



Back



Mark location with 'X'

Type of Wound & duration of wound

Leg Ulcer .....

Surgical Wound .....

Diabetic Ulcer .....

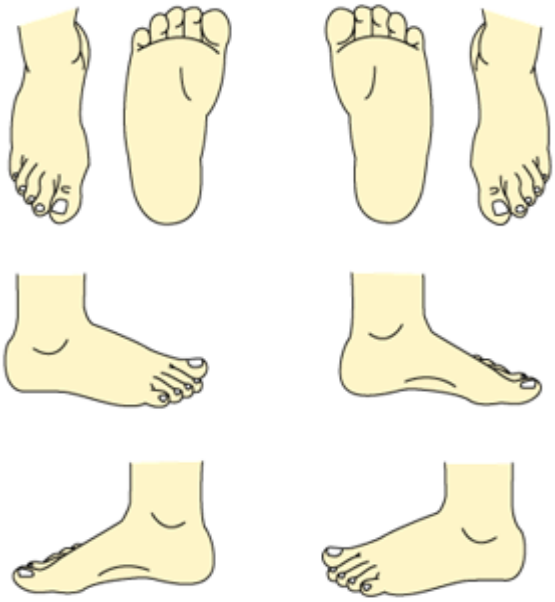
Pressure Ulcer .....

Other, specify .....
Duration of wound .....

Feet Diagram

Right

Left



Mark location with 'X'

Date referred to:

TVN .....Physiotherapist.....

Podiatrist.....Dietician.....

Other (please specify).....

Assessors signature: .....

Date: .....

Formal Wound Assessment

Complete on initial assessment and thereafter complete at every dressing change

Date of Assessment								
Analgesia required *(Refer to local pain assessment tool)*	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**
Regular/ongoing analgesia								
Pre-dressing only								
Wound Dimensions (enter size)								
Length (cm/mm)								
Width (cm/mm)								
Depth (cm/mm)								
Is wound tracking/undermining (cm/mm) Position of tracking in wound?								
Tissue type on wound bed (enter percentages)								
Necrotic (Black)	%	%	%	%	%	%	%	%
Sloughy (Yellow/Green)	%	%	%	%	%	%	%	%
Granulating (Red)	%	%	%	%	%	%	%	%
Epithelialising (Pink)	%	%	%	%	%	%	%	%
Hypergranulating (Red)	%	%	%	%	%	%	%	%
Haematoma	%	%	%	%	%	%	%	%
Bone/tendon	%	%	%	%	%	%	%	%
Wound exudate levels/ type (tick all relevant boxes)								
Dry/Moist								
Wet								
Saturated/Leaking*								
Serous (Straw)								
Haemoserous (Red/Straw)								
Cloudy/Milky/creamy								
Green/Blueish/Yellow/Brown*								
Peri-wound skin (tick relevant boxes)								
Macerated (White, Moist)								
Oedematous *								
Erythema (Red)*								
Excoriated (Red)								
Fragile								
Dry/scaly								
Healthy/intact								
Signs of Infection * 2 or more of these signs may indicate possible infection								
Heat *								
New slough/necrosis(deteriorating wound bed)*								
Increasing pain*								
Increasing exudate*								
Increasing odour*								
Friable granulation tissue*								
Treatment objectives (tick relevant box)								
Debridement								
Absorption								
Hydration								
Protection / promote healing								
Palliative / conservative								
Reduce bacterial load								
Assessors Print Initials								
Re-assessment date								

Wound Treatment Plan

Complete on initial assessment and only update when treatment or dressing product type / regime altered e.g. wound improvmetn/deterioration Does not require completion at each routine dressing change

Date	Wound No.	Cleansing method, Dressing Choice and Rationale for Treatment. Remember to update log on page 5.	Frequency	Care plan discussed with patient / carer? Yes/No/Comment	Sign/Print/ Designation

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Wound Dressing Change Log and Evaluation (complete at EVERY dressing change)

Date & Time	**Wound Number**	**No. of dressing products (sheets / ribbons) removed from wound**	**Reason for dressing change** (include if swab or photography taken) i.e. planned	**Evaluation/ Comment** If applicable	**Sign and Print Name**