**WRITE, IMPRINT OR ATTACH LABEL**

Surname ……………….... CHI No ….…………..

Forenames ………………… Sex…………………..

DoB ………………..

Location……………………………………………………

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**Assessment Chart for Wound Management**

**For multiple wounds complete formal wound assessment for each wound**.

Add Inserts as needed.

|  |
| --- |
| **Factors which could delay healing:***(Please tick relevant box)*Immobility □ Poor Nutrition □ Diabetes □ Incontinence □Respiratory/Circulatory Anaemia □ Medication □ Wound Infection □ Disease □Inotropes □ Anti-Coagulants □ Oedema □ Steroids □Chemotherapy □ Other………………… Allergies & Sensitivities……………………… |
| **Body Diagram** **Front Back** personfron personbackMark 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. Does not require completion at each routine dressing change**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date | Wound No. | Cleansing method, Dressing Choice and Rationale for Treatment | Frequency | Care plan discussed with patient / carer?Yes/No/Comment | Sign/Print/Designation |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date | Wound No. | Cleansing method. Dressing Choice and Rationale for Treatment | Frequency | Care plan discussed with patient / carer?Yes /No/Comment | Sign/Print/Designation |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date | Wound No. | Cleansing method. Dressing Choice and Rationale for Treatment | Frequency | Care plan discussed with patient / carer?Yes /No/Comment | Sign/Print/Designation |
|  |  |  |  |  |  |

**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) | **Evaluation/****Comment** | **Sign and Print Name** |
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**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.

Wound Assessment Guidance

Wound assessment should be recorded for every wound on initial assessment, when changes noted or at least weekly. The dressing 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.