

# RODWELL HOUSE WOUND ASSESSMENT

Resident Name:

Suite No:

Wound Type:

Location:

Grade:

## Photograph

Date Taken:

# Tissue Viability: Wound Assessment

Patient Label or Write Information

RIO No						
NHS No						
Patient Name						
Date of Birth	D	D	M	M	Y	Y
Age						
Ward / Unit						

## Referrals Made (Please tick)

<input type="checkbox"/>	Tissue Viability	Date:
<input type="checkbox"/>	Vascular	Date:
<input type="checkbox"/>	Podiatry	Date:
<input type="checkbox"/>	Plastics	Date:
<input type="checkbox"/>	Dietician	Date:
<input type="checkbox"/>	Other:	Date:

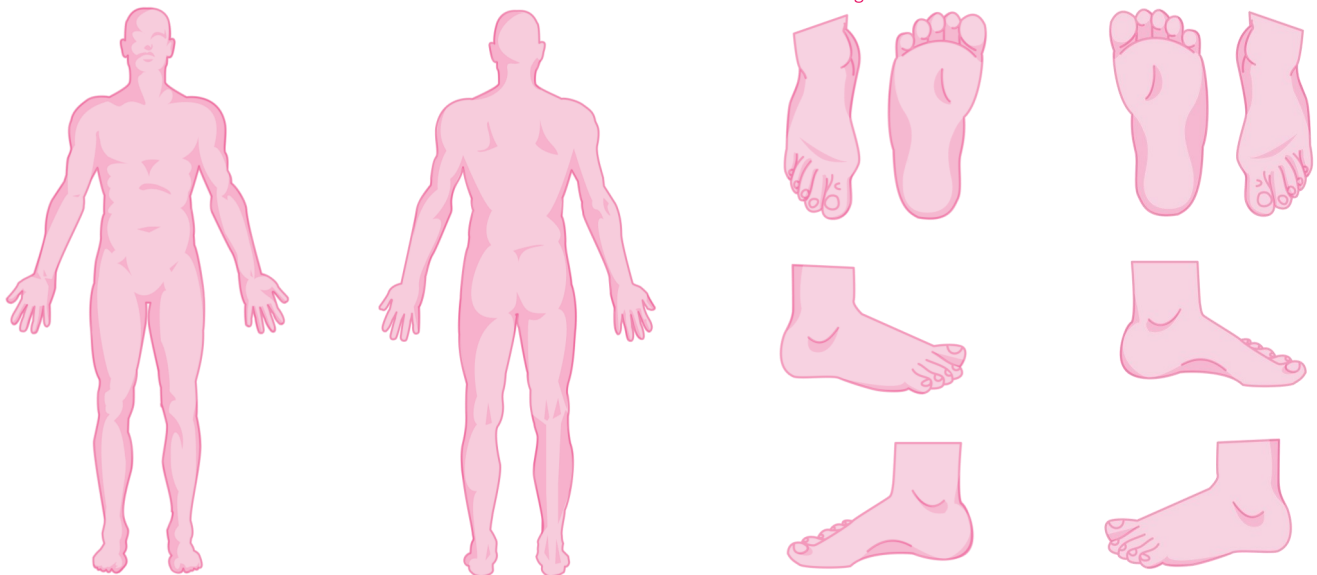
## Primary Wound Type (Please tick)

<input type="checkbox"/>	Pressure Ulcer	Category:	<b>Complete Datix Form</b>
<input type="checkbox"/>	Diabetic Foot Ulcer:		<b>Refer to Diabetic Foot Team and Insert Date Above</b>
<input type="checkbox"/>	Leg Ulcer:		
<input type="checkbox"/>	Surgical Wound		
<input type="checkbox"/>	Skin Tear		
<input type="checkbox"/>	Fungating Tumour		
<input type="checkbox"/>	Burn / Scald		
<input type="checkbox"/>	Moisture Associated Skin Dermatitis (MASD)		
<input type="checkbox"/>	Traumatic Wound		
<input type="checkbox"/>	Other:		

## Factors Which May Delay Healing (Please tick)

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	COPD	<input type="checkbox"/>	Ischemia
<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Chronic Kidney Disease	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Smoking	<input type="checkbox"/>	Radiotherapy / Chemotherapy
<input type="checkbox"/>	Nutrition or obesity problems	<input type="checkbox"/>	Steroids / NSAIDS

## Wound Location (Please circle)



## Wound Duration (please tick)

<input type="checkbox"/>	<1-2 weeks	<input type="checkbox"/>	2-4 weeks	<input type="checkbox"/>	1-3 months	<input type="checkbox"/>	4-6 months	<input type="checkbox"/>	7-12 months	<input type="checkbox"/>	1-2 years	<input type="checkbox"/>	>2 years
--------------------------	------------	--------------------------	-----------	--------------------------	------------	--------------------------	------------	--------------------------	-------------	--------------------------	-----------	--------------------------	----------

RIO No

Patient Name

## Tissue Viability: Wound Details

Date:									<b>i</b> = May Indicate Infection	
Size (cm/mm)										
Length									Is wound reducing in size? If not Investigate cause.	
Width										
Depth										
Wound Bed Enter the percentage of each tissue type visible									Management Tips:	
Necrotic (Black)	%	%	%	%	%	%	%	%		Do not apply moisture to ischemic areas. Consider vascular referral
Sloughy (Yellow)	%	%	%	%	%	%	%	%		Consider debridement
Granulating (Red)	%	%	%	%	%	%	%	%		Simple atraumatic dressing
Epithialising (pink)	%	%	%	%	%	%	%	%		Softpore
Exudate Levels An increase in exudate can be an indication of infection									Dressing Choice:	
Low										Softpore
Moderate										Absorbent foam dressing
High										Super absorbent
Exudate Type									Could indicate the first sign of infection Swab for culture and antimicrobial dressing	
Serous (Straw)										
Haemoserous (Red/Straw)										
Purulent (Green, Brown, Yellow)										
Surrounding Skin condition of surrounding skin & Maintenance is as important as the wound be									Manage excess moisture & apply barrier cream to surrounding skin - Elevate limb if able - Reverse cause of oedema Determine cause Manage Moisture & apply barrier cream Promote rehydration, apply emollient	
Macerated (White)										
Oedematous										
Erythema (Red)										
Excoriated (Red)										
Dry										
Pain Assessment: (No Pain = 0) —(10 = Worst Pain)									Refer to doctor (if pain not controlled)	
Rate 0—10										
Initials										

RIO No

Patient Name

## Tissue Viability: Treatment Plan & Evaluation of Care

### Starting Plan

Primary Dressing	<input type="text"/>							
Secondary dressing	<input type="text"/>							
Bandage	<input type="text"/>							
Frequency of Dressing change	<input type="text"/>							
Management Aim	Encourage granulation	Deslough	Reduce Bacteria	Reduce odour	Hydrate	Absorb	Protect	Keep Dry
Evaluation & Rationale for dressing type (improving / static /deteriorated)  Consider pain relief	<input type="text"/>							
Nurse Name	<input type="text"/>	Date	<input type="text"/>	Signature	<input type="text"/>			

must be toe to knee or  
wrist to shoulder

### Revised Plan 1

Primary Dressing	<input type="text"/>							
Secondary dressing	<input type="text"/>							
Bandage	<input type="text"/>							
Frequency of Dressing change	<input type="text"/>							
Management Aim	Encourage granulation	Deslough	Reduce Bacteria	Reduce odour	Hydrate	Absorb	Protect	Keep Dry
Evaluation & Rationale for chosen dressing type (improving / static /deteriorated)  Consider pain relief	<input type="text"/>							
Nurse Name	<input type="text"/>	Date	<input type="text"/>	Signature	<input type="text"/>			

must be toe to knee or  
wrist to shoulder

RIO No

Patient Name

## Tissue Viability: Treatment Plan & Evaluation of Care

### Revised Plan 2

Primary Dressing	<input type="text"/>							
Secondary dressing	<input type="text"/>							
Bandage	<input type="text"/>							
Frequency of Dressing change	<input type="text"/>							
Management Aim	Encourage granulation	Deslough	Reduce Bacteria	Reduce odour	Hydrate	Absorb	Protect	Keep Dry
Evaluation & Rationale for chosen dressing type (improving / static /deteriorated)  Consider pain relief	<input type="text"/>							
Nurse Name	<input type="text"/>	Date	<input type="text"/>	Signature	<input type="text"/>			

must be toe to knee or wrist to shoulder

### Revised Plan 3

Primary Dressing	<input type="text"/>							
Secondary dressing	<input type="text"/>							
Bandage	<input type="text"/>							
Frequency of Dressing change	<input type="text"/>							
Management Aim	Encourage granulation	Deslough	Reduce Bacteria	Reduce odour	Hydrate	Absorb	Protect	Keep Dry
Evaluation & Rationale for chosen dressing type (improving / static /deteriorated)  Consider pain relief	<input type="text"/>							
Nurse Name	<input type="text"/>	Date	<input type="text"/>	Signature	<input type="text"/>			

must be toe to knee or wrist to shoulder



## Tissue Viability: Guide to Common Dressings on ONPOS

Dressing	Indications	Contraindications
<b>Softpore</b> Absorbent Pads/Low Adherent Dressing	<ul style="list-style-type: none"> <li>• Dry or sutured wounds</li> <li>• Superficial cuts or abrasions</li> <li>• Minimal exudate</li> </ul>	<ul style="list-style-type: none"> <li>• Highly exuding wounds</li> <li>• Necrotic or sloughy wounds</li> </ul>
<b>Adaptic touch/N-A Ultra</b> Non-Adherent Dressing (requires secondary dressing)	<ul style="list-style-type: none"> <li>• Granulating wounds</li> <li>• Requires secondary dressing</li> </ul>	<ul style="list-style-type: none"> <li>• Allergy to silicone</li> </ul>
<b>Duoderm/Granuflex</b> Hydrocolloid	<ul style="list-style-type: none"> <li>• Partial and full thickness wounds</li> <li>• Supports autolytic debridement</li> <li>• Maintains a moist environment</li> <li>• Protection to intact skin around negative pressure wound therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Highly exuding wounds</li> <li>• Presence of infection</li> <li>• Diabetic foot ulcers</li> </ul> <p>*Contains gelatine derived from Pork. Consider patients with religious or ethical objections*</p>
<b>Aquacel Extra</b> Hydrofibre (requires secondary dressing)	<ul style="list-style-type: none"> <li>• Moderate to heavily exuding wounds</li> <li>• Ribbon to pack cavities</li> <li>• Supports autolytic debridement</li> </ul>	<ul style="list-style-type: none"> <li>• Dry wounds with minimal exudate</li> </ul>
<b>Biatain adhesive/non adhesive</b> Absorbent silicone foam	<ul style="list-style-type: none"> <li>• To maintain moist environment</li> <li>• Moderate to heavily exuding wounds</li> </ul>	<ul style="list-style-type: none"> <li>• Dry wounds with minimal exudate</li> <li>• Do not cover with film dressing as this restricts water vapour loss</li> </ul>
<b>Iodoflex</b> Antimicrobial	<ul style="list-style-type: none"> <li>• Infected wounds</li> <li>• Sloughy wounds</li> </ul>	<ul style="list-style-type: none"> <li>• Children</li> <li>• Pregnant or lactating women</li> <li>• Renal Impairment</li> <li>• Thyroid disorders</li> <li>• Patients prescribed Lithium</li> <li>• Maximum single application 50g, 150g weekly.</li> </ul> <p>*Successive treatment should not exceed 2 weeks*</p>
<b>Acticoat, Acticoat flex, Aquacel Ag</b> Antimicrobial Silver	<ul style="list-style-type: none"> <li>• To reduce bioburden</li> <li>• Localised infection</li> <li>• Spreading infection</li> <li>• Systemic infection</li> </ul>	<ul style="list-style-type: none"> <li>• Patients with sensitivity to silver</li> <li>• Patients undergoing and MRI scan</li> <li>• Prior to radiotherapy treatment (can be reapplied after treatment)</li> <li>• Where bioburden is not an issue</li> </ul>
<b>Activon/Algivon Honey</b>	<ul style="list-style-type: none"> <li>• Malodourous wounds</li> <li>• Sloughy wounds</li> <li>• Acts as an anti-inflammatory</li> <li>• Can stimulate healing</li> </ul>	<ul style="list-style-type: none"> <li>• Patients with an allergy to bee stings or extreme sensitivity to honey</li> </ul>

### References

National best practice and evidence based guidelines for wound management. Available from: <http://www.hse.ie/eng/services/publications/Primary/woundguidelines.pdf>

2013. Wound assessment tools and nurses' needs: an evaluation study, Sheila Greatrex-White & Helen Moxey. International Wound Journal ISSN 1742-4801

Author: **Pauline Robinson**, Tissue Viability Nurse Specialist. Design, Graphics and Editing: **Simon Pawlin**