Patient ID label

Paediatric Wound Assessment and Management Chart

NHS Greater Glasgow and Clyde

Hospital/Healthcentre: _____

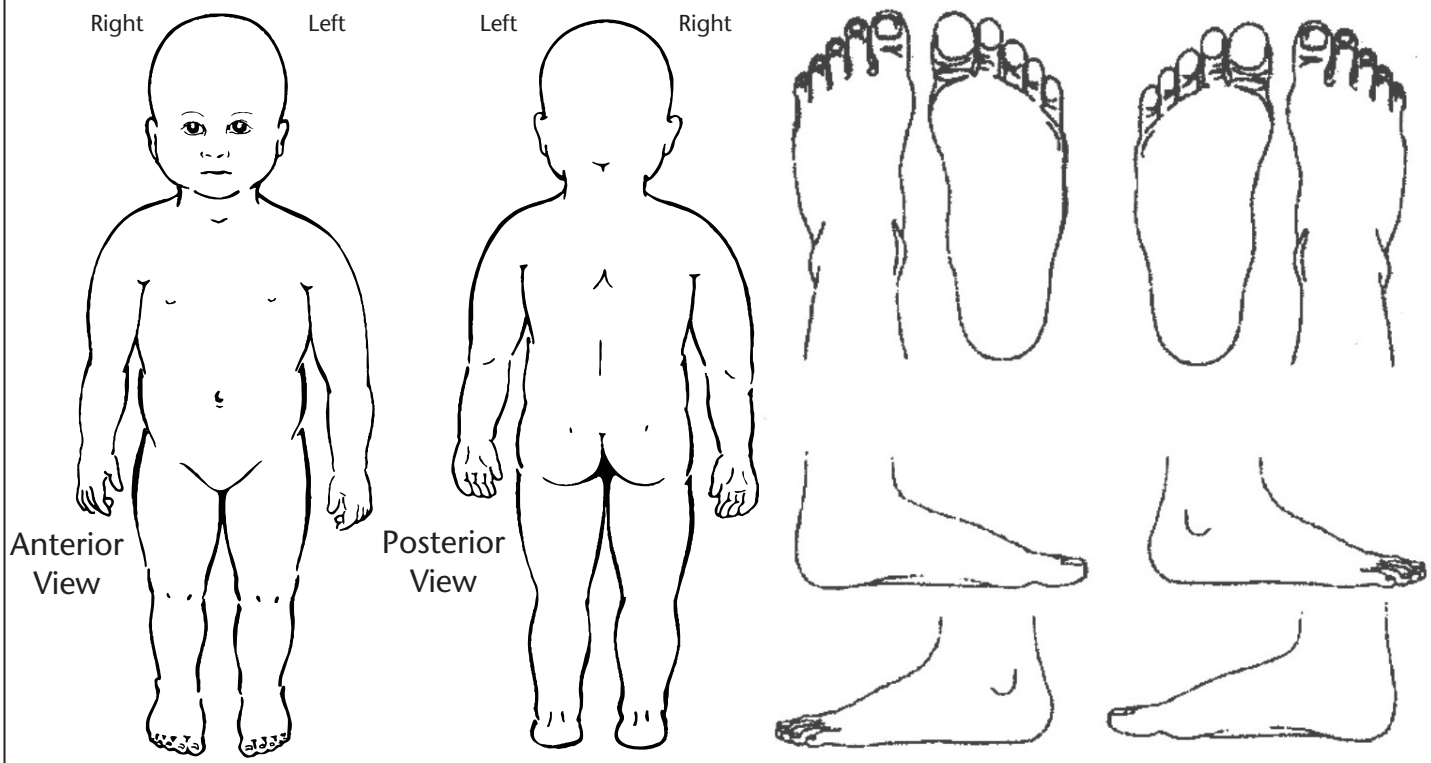
Ward/Department: _____

Factors present that could delay healing: tick all relevant boxes							
Anaemia		Diabetes		Oedema		Steroids	
Anti-coagulants		Incontinence		Poor Nutrition		Wound Infection	
Chemotherapy		Inotropes		Respiratory / Circulatory disease			

Other (please state):

Allergies & Sensitivities (please state):

Body Diagram: No more than 2 wounds per wound chart.



*** Mark each wound site with an X and number it.***

Type of Wound

Wound Number on body chart	Type of Wound	Date wound first identified?	Referred to specialist?
1.			Details: Date:
2.			Details: Date:

Assessor Details

Name: _____ Signature: _____

Designation: _____ Date: _____ Time: _____

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Paediatric Wound Assessment and Management Chart

Patient ID label

Formal Wound Assessment (see guideline notes before completion)

It is mandatory to complete a formal wound assessment for every wound requiring treatment/intervention every time the wound is seen or daily if seen more than once a day.

Wound number								
Date of Assessment								
Time of Assessment								
Pre-dressing analgesia required	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Analgesia effective?	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Wound Dimensions (enter size)								
Length/Width/Depth(cm)	L: W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:
Is wound: Tracking/Undermining	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Photography obtained	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Tissue Type on Wound Bed (percentage total must = 100%)								
Necrotic (black)	%	%	%	%	%	%	%	%
Sloughy (yellow/green)	%	%	%	%	%	%	%	%
Granulating (red)	%	%	%	%	%	%	%	%
Epithelialising (pink)	%	%	%	%	%	%	%	%
Hypergranulating (red)	%	%	%	%	%	%	%	%
Blister	%	%	%	%	%	%	%	%
Haematoma	%	%	%	%	%	%	%	%
Bone/tendon visible	%	%	%	%	%	%	%	%
Other e.g. metal work _____	%	%	%	%	%	%	%	%
Wound Exudate Levels/Type (tick all that apply)								
None								
Low								
Medium								
High								
Serous (straw)								
Haemoserous (red/straw)								
Purulent (green/brown)								
Skin Surrounding Wound (tick relevant boxes)								
Healthy/intact								
Dry/scaly								
Erythema (red)								
Excoriated (red)								
Fragile								
Macerated (white)								
Oedematous								
Signs of Infection - two or more of these signs may indicate possible infection								
Friable granulation tissue								
Heat								
Increasing exudate								
Increasing odour/malodour								
Increasing pain								
Deteriorating wound bed								
Microbiology specimen obtained?								
Treatment Objectives (tick relevant boxes)								
Absorption								
Hydration								
Debridement								
Palliative/Conservative								
Protection/promote healing								
Reduce bacterial load								
ASSESSOR INITIAL/DESIGNATION								

Paediatric Wound Assessment and Management Chart

Patient ID label

Formal Wound Assessment (see guideline notes before completion)

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Date of Assessment								
Time of Assessment								
Pre-dressing analgesia required	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Analgesia effective?	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Wound Dimensions (enter size)								
Length/Width/Depth(cm)	L: W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:
Is wound: Tracking/Undermining	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Photography obtained	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Tissue Type on Wound Bed (percentage total must = 100%)								
Necrotic (black)	%	%	%	%	%	%	%	%
Sloughy (yellow/green)	%	%	%	%	%	%	%	%
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Epithelialising (pink)	%	%	%	%	%	%	%	%
Hypergranulating (red)	%	%	%	%	%	%	%	%
Blister	%	%	%	%	%	%	%	%
Haematoma	%	%	%	%	%	%	%	%
Bone/tendon visible	%	%	%	%	%	%	%	%
Other e.g. metal work _____	%	%	%	%	%	%	%	%
Wound Exudate Levels/Type (tick all that apply)								
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Medium								
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Serous (straw)								
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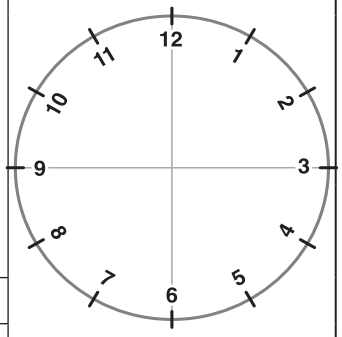
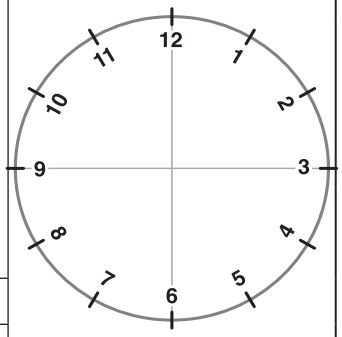
Absorption								
Hydration								
Debridement								
Palliative/Conservative								
Protection/promote healing								
Reduce bacterial load								
ASSESSOR INITIAL/DESIGNATION								

Paediatric Wound Assessment and Management Chart

Patient ID label

This Treatment Plan MUST be completed when the dressing type and/or regime is altered following changes identified at the wound assessment.

Treatment Plan for Wound No: ____	**Product Choice**	**Rationale for Treatment plan including any new allergies or sensitivities**	**Tracking/ Undermining**
Cleansing Method (if applicable)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)			
Primary Dressing please state: • **Dressing** • **Size** • **Number of dressings used** i.e. fibre dressing, 2.5cmx40cm, x3		**Frequency of dressing change:** **Has care plan been discussed with patient/carer? Yes/No**	
Secondary Dressing (if applicable)		Comments:	
Retention Dressing (e.g. Bandage, Tape)		**Treatment Plan completed by: Sign:** _____ **Date:** _____ **Print:** _____ **Designation:** _____	

Treatment Plan for Wound No: ____	**Product Choice**	**Rationale for Treatment plan including any new allergies or sensitivities**	**Tracking/ Undermining**
Cleansing Method (if applicable)			
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Retention Dressing (e.g. Bandage, Tape)		**Treatment Plan completed by: Sign:** _____ **Date:** _____ **Print:** _____ **Designation:** _____	

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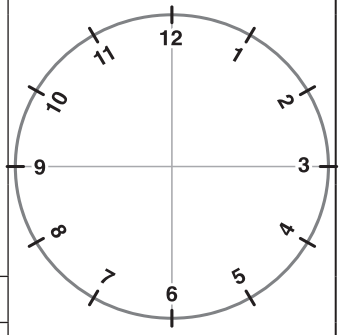
Paediatric Wound Assessment and Management Chart

Patient ID label

This Treatment Plan MUST be completed when the dressing type and/or regime is altered following changes identified at the wound assessment.

Treatment Plan for Wound No: ____	**Product Choice**	**Rationale for Treatment plan including any new allergies or sensitivities**	**Tracking/ Undermining**
Cleansing Method (if applicable)			
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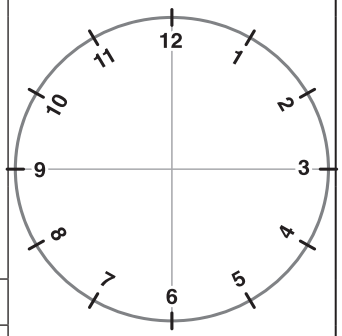
Cleansing Method (if applicable)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)			
Primary Dressing please state: • **Dressing** • **Size** • **Number of dressings used** i.e. fibre dressing, 2.5cmx40cm, x3		**Frequency of dressing change:** **Has care plan been discussed with patient/carer? Yes/No**	
Secondary Dressing (if applicable)		Comments:	
Retention Dressing (e.g. Bandage, Tape)		**Treatment Plan completed by: Sign:** _____ **Date:** _____ **Print:** _____ **Designation:** _____	

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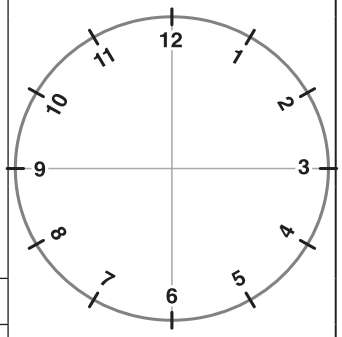
Paediatric Wound Assessment and Management Chart

Patient ID label

This Treatment Plan MUST be completed when the dressing type and/or regime is altered following changes identified at the wound assessment.

Treatment Plan for Wound No: ____	**Product Choice**	**Rationale for Treatment plan including any new allergies or sensitivities**	**Tracking/ Undermining**
Cleansing Method (if applicable)			
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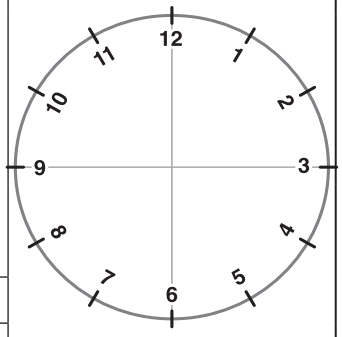
Cleansing Method (if applicable)			
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Paediatric Wound Assessment and Management Chart

Patient ID label

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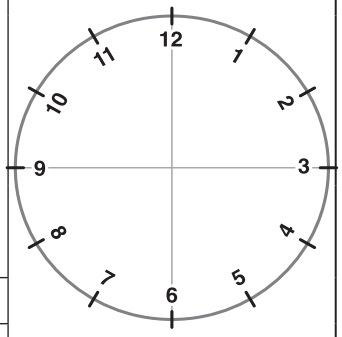
Cleansing Method (if applicable)			
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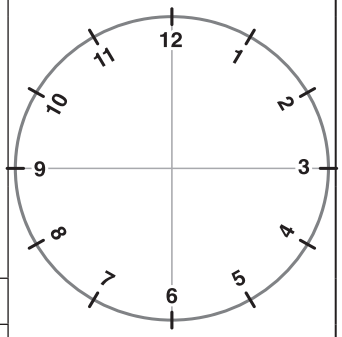
Cleansing Method (if applicable)			
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Paediatric Wound Assessment and Management Chart

Wound dressing change log

To be completed at EVERY dressing change

Patient ID label

Date	Time	Wound Number	Number of sheets/ribbons removed from wound	If dressing change is unplanned please state the reason e.g. swab taken, dressing adhering or dressing saturated	Additional Comments e.g. swab obtained, reason or investigation requested, wound photographed,	Sign, Print , Designation

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Paediatric Wound Assessment and Management Chart

Wound dressing change log

To be completed at EVERY dressing change

Patient ID label

Date	Time	Wound Number	Number of sheets/ribbons removed from wound	If dressing change is unplanned please state the reason e.g. swab taken, dressing adhering or dressing saturated	Additional Comments e.g. swab obtained, reason or investigation requested, wound photographed,	Sign, Print , Designation

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Patient ID label

Paediatric Wound Assessment and Management Chart

NHS Greater Glasgow and Clyde

Wound Assessment Chart Guidelines

PLEASE READ GUIDELINE PRIOR TO COMPLETING FORM

Completion of the wound assessment chart assists in the holistic assessment and management of patients requiring ongoing treatment of their wound(s), enhances communication and helps improve continuity of care. It is <u>mandatory</u> to complete wound chart for all wounds requiring ongoing intervention.

Page 1 - to be completed on initial assessment

- Attach patient label
- Record ward/department and the site (hospital or health centre)
- Identify all factors present which could delay wound healing by ticking relevant box/boxes
- Use the Other box to add any additional factors that could delay wound healing. i.e. obesity, concordance issues
- Record any known allergies or sensitivities including those to dressing products
- Identify the location of each wound on body or foot diagram. Number each wound (maximum of 2 per wound chart)
- Record wound type and duration of wound to corresponding number - these factors will influence wound management plan
- Record any specialist service details that the child may have been referred to, i.e. Tissue Viability, Physiotherapy, Dietitian, and date when referred
- record designation as well as date a time assignment completed"

Page 2 & 3 - wound assessment information must be completed for every wound on the initial assessment, every time the wound is reviewed or daily if seen more than once a day.

- Record wound number, date and time of assessment
- Ensure effective pain management/sedation is provided; identify if analgesia/sedation is required prior to/during dressing change. Circle No, Yes, or NA (Not Applicable) to describe if analgesia effective, or not required.
- Wound dimensions – measure wound in cm/mm. Use disposable tape measure provided in dressing packs.
- Length is from head to toe
- Width is from right to left
- Depth of wound should be measured

DO NOT PROBE WOUNDS IF UNSURE WHAT STRUCTURES ARE EXPOSED/YOU CANNOT VISULAISE THE BASE OF THE WOUND.

- Record if tracking or undermining is present to help identify full extent of wound and possibility of sinus/fistula
- Record direction of undermining/ tracking on clock face diagram in treatment plan (page 4-7)
- Record if photographic record is obtained-N.B. written consent is required and photographs can only be taken by Medical Illustration/authorised camera users and stored within a secure system as per policy link belowhttp://www.staffnet.ggc.scot.nhs.uk/Acute/Diagnostics/Medical%20Illustration%20Services/Pages/OtherLinks.aspx
- The type of tissues present will help identify stage of healing and treatment objectives
- Identify tissue types on wound bed and record percentages of each tissue type to obtain 100%. This will identify if treatment objectives are being achieved.
- Record percentage of each tissue type to obtain 100%, will identify if treatment objectives being achieved.
- Wound Exudate - identify exudate levels and record type of exudates

Descriptor	Description
None	Wound tissues dry
Low	Wound tissues wet, moisture evenly distributed in wound <25% of dressing soiled
Medium	Wound tissues saturated, drainage may or may not be evenly distributed in wound, 25%-75% of dressing soiled
High	Wound tissues bathed in fluid, drainage freely expressed, may or not be evenly distributed in the wound, >75% of dressing soiled
Serous	Clear, light colour, Thin, watery
Haemoserous	Light red to pink, Thin, watery
Purulent / Pus	Yellow, tan to green, Thick, opaque

- Record the skin condition around the wound
- Monitor for signs of infection and obtain wound swab if infection suspected
- Treatment objectives - determine treatment objectives to guide dressing choice and plan care
- Record assessors details in line with requirement for record keeping

Pages 4-7 - treatment plan

ONLY to be completed when the dressing type and/or regime is initiated/altered following changes identified at wound assessment. For advice speak to relevant specially.

Complete information in dressing choice section as indicated for:

- Method of cleansing if required (refer to wound cleansing guidelines)
- Record if any product is to be applied to surrounding skin e.g. for protection
- Primary dressing including size and number of dressing pieces used

When inserting dressing product into a cavity wound, ensure end of every dressing piece is left above skin surface and size/number of pieces of dressing used is recorded on application/removal to ensure there is no risk of dressing products being retained in the wound.

- Secondary dressing used if applicable
- Any retention dressing required such as bandages
- Rationale for treatment plan – record objective of treatment to allow effectiveness and appropriateness of treatment to be evaluated
- Record frequency for each dressing change
- Comments - Record whether wound care has been discussed with the patient/parents/carers to ensure care is patient centred
- Draw line to indicate direction of Tracking/Undermining on clock face diagram with 12 o'clock referring to head, 3 o'clock to patient's left side, 6 o'clock referring to feet, and 9 o'clock to patient's right side
- Record assessors details
- Use continuation sheet as required
- If there is a change in care plan then discontinue previous care plan by one score through, initial and date

Page 5 - wound dressing change log

- Complete at EVERY dressing change
- Record date and time
- Record number for corresponding wound as noted on the wound assessment chart
- Record the number of dressing pieces removed from the wound, refer to number of pieces applied from previous dressing application (as per treatment plan) to ensure no dressing products are retained within the wound
- Record reason for any unplanned wound dressing changes
- Provide additional comments as required such as when wound photographed, wound swab obtained for culture and sensitivity, investigations requested or feedback from patient
- Sign your record of care, print name and designation
- Use continuation sheet as required