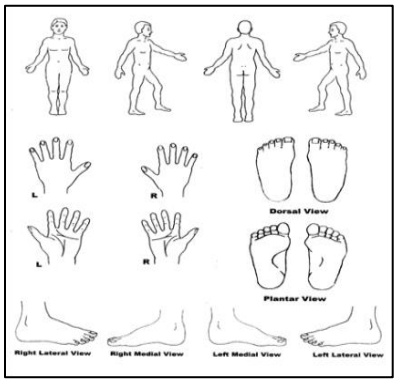
Apply Addressograph

Wound Assessment Flow Sheet *(Complete every dressing change – one wound per flow sheet)*



Indicate with an '**X**' the location of the wound

Diagram of Wound (D*raw)*

Head

Date of Onset

(YY/MM/DD):_____

Original Wound Surface Area:

_____ cm^2

(Original Length x Original Width)

Wound occurred while in this facility *(circle one)*: **Yes** **No**

Goal of Care:

_____

(Input either healable, maintenance, non-healable or unknown)

Wound Type *(check one)*

☐ Pressure Injury ☐ Diabetic Foot Ulcer ☐ Malignant ☐ Leg Ulcer ☐ Skin Tear

☐ Moisture Associated Skin Damage

☐ Unknown ☐ Other:

_____

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Date *(YY/MM/DD)*						
Wound Measurement (cm) *(take and record measurements **weekly**)*		Length - (*measure head to toe*)	cm	cm	cm	cm
		Width – (*perpendicular to length*)	cm	cm	cm	cm
		Greatest Depth	cm	cm	cm	cm
		Surface Area (*length x width*)	cm^2	cm^2	cm^2	cm^2
		Tunneling/Undermining (D*escribe using cardinal clock points, i.e. Tunnel 2cm deep at 2 o'clock)*				
Tissue Types	*Describe in quarters* 0-25% 25-50% 50-75% 75-100%	Epithelial	%	%	%	%
		Granulation (*red or pink*)	%	%	%	%
		Slough (*yellow or tan*)	%	%	%	%
		Eschar (*black, grey or brown*)	%	%	%	%
Exudate Type *(indicate one)***:** None, serous, serosanguinous, sanguineous, purulent						
Exudate Amount *(indicate one):* None, scant, small, moderate, large						
Wound Edge *(describe):* Approximated, attached, unattached, rolled						
Periwound Tissue *(circle Y or N)*		Intact	Y N	Y N	Y N	Y N
		Reddened	Y N	Y N	Y N	Y N
		Indurated (firm)	Y N	Y N	Y N	Y N
		Macerated	Y N	Y N	Y N	Y N
		Excoriated	Y N	Y N	Y N	Y N
		Callused	Y N	Y N	Y N	Y N
Date *(YY/MM/DD)*						
Localized Infection Suspected ? *(circle Y or N)*		Signs of ***localized infection*** include: stalled healing, friable granulation tissue, increased exudate, increased/new odor, localized edema, and increased/new pain	Y N	Y N	Y N	Y N
			If YES, notify physician/NP. Topical antimicrobials may be indicated.			
Spreading or Systemic Infection Suspected ? *(circle Y or N)*		Signs of ***spreading or systemic infection*** include the above PLUS: spreading erythema/induration, wound breakdown, general malaise, fever, rigors, chills, lymphangitis,etc.	Y N	Y N	Y N	Y N
			If YES, notify physician or NP. Topical and systemic antimicrobials may be indicated.			
Interventions		**Swab Taken** *(circle Y or N)* *If **Yes**, insert date swab taken*	Y N Date:	Y N Date:	Y N Date:	Y N Date:

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	# of Packing Pieces In/Out *(indicate # if applicable)*		# In:		# In:		# In:		# In:	
			# Out:		# Out:		# Out:		# Out:	
	New Referrals *(circle Y or N)* *If* **Yes,** *insert date of referral*	Dietician	Y N Date:		Y N Date:		Y N Date:		Y N Date:	
		OT	Y N Date:		Y N Date:		Y N Date:		Y N Date:	
		PT	Y N Date:		Y N Date:		Y N Date:		Y N Date:	
		ET Nurse	Y N Date:		Y N Date:		Y N Date:		Y N Date:	
	Weekly PUSH Tool Done *(circle Y or N and input score)*		Y N Score:		Y N Score:		Y N Score:		Y N Score:	
	Dressing Done as Per TAR *(circle Y or N)*		Y N		Y N		Y N		Y N	
	Care Plan Reviewed/Updated *(circle Y or N)*		Y N		Y N		Y N		Y N	
	Care Plan Interventions Being Followed (i.e. pressure relief) *(circle Y or N)*		Y N		Y N		Y N		Y N	
	Resident +/- POA C Consent to Plan of Care *(circle Y or N)*		Y N		Y N		Y N		Y N	
	Progress Note Made *(circle Y or N)*		Y N		Y N		Y N		Y N	
Other Notes or Diagrams *(insert **NA** if you have nothing further to document)*										
Signature and Designation										

Please Read:

- The PUSH Tool 3.0 **must be completed weekly** for each wound a resident has to reliably determine whether the wound is improving or deteriorating. The PUSH Tool has been validated for us in all chronic wounds (not just pressure ulcers).
- Regarding the 'Wound Assessment Flow Sheet', in addition to completing it **every dressing change**, it is to be **initiated upon admission** of a resident with a wound to your unit and/**or when a newly occurring wound (of any type) is discovered** on an admitted resident.