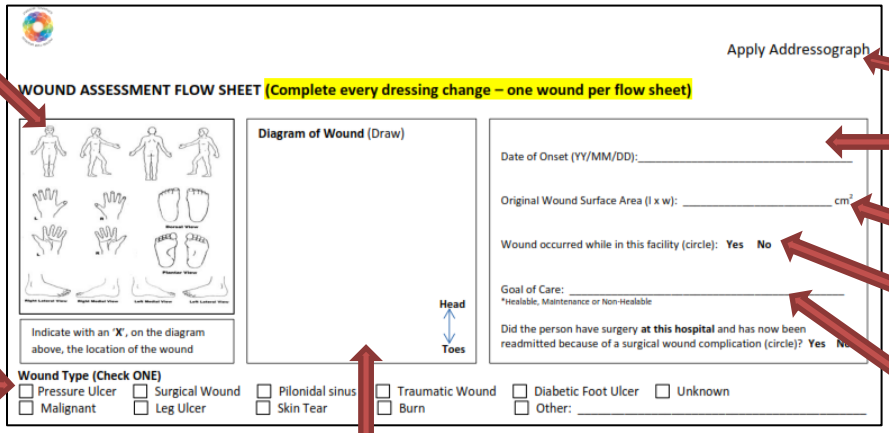
Wound Assessment Flow Sheet Cheat Sheet

Draw an 'X' on the diagram to indicate the location of the wound

Apply the patient's addressograph sticker

Place a check in the box that represents the wound type:

- **Pressure ulcer**: a wound due to pressure +/- friction
- **Surgical wound**: an intentional disruption in the skin
- **Pilonidal sinus**: a wound near the natal cleft that contains hair/skin debris
- **Traumatic wound**: a wound due to trauma
- **Diabetic foot ulcer**: a wound on the foot of a person with diabetes
- **Unknown**: a wound of unknown etiology
- **Malignant**: a wound due to cancer
- **Leg ulcer**: a wound on the leg/foot of a person due to venous +/- arterial disease, lymphedema or some atypical nonatherosclerotic disease
- **Skin tear**: a wound due to friction/shear/trauma that separates the epidermis from the dermis or the dermis from underlying structures
- **Burn**: a skin injury caused by heat, chemicals, electricity, friction, sunlight or radiation
- **Other**: a wound with a known cause other than those listed



Write in the date the wound first occurred, or was first noticed

Write in the original surface area of the wound … surface area = length x width

Indicate whether or not the patient developed the wound while in hospital

Write in the goal of care:

- **Healable**: there is adequate circulation, the person's health can be optimized and the cause of the wound can be addressed
- **Maintenance**: there is healing potential but patient or health system factors are compromising healing
- **Non-healable**: there is no ability to heal due to an untreatable cause or palliative condition

Draw a picture of the wound. You may choose to draw areas of necrosis, granulation tissue, foreign materials, undermining, tunnels, etc.

Input the date of your wound assessment

Date (YY/MM/DD)		
Wound Measurement (cm)	Longest Length (l)	cm
	Widest Width (w)	cm
	Greatest Depth	cm
	Surface Area (l x w)	cm^2
	Tunneling / Undermining	
Tissue Types <25%; 25-<50%; 50-<75%; >75%	Epithelial	%
	Granulation	%
	Slough	%
	Eschar	%
Exudate Type (choose the most predominant): None, Serous, Sero-Sang, Sang, Purulent		
Exudate Amount (choose one): None, Scant, Small, Moderate, Large		
Wound Edge (choose one): Attached, unattached, rolled, approximated		
Periwound Tissue (circle Yes or No)	Intact	Y N
	Reddened	Y N
	Indurated (firm)	Y N
	Macerated	Y N
	Excoriated	Y N
	Callused	Y N

Indicate the following (in centimeters):

- **Length**: Measure the longest length
- **Width**: Measure the widest width perpendicular to the length
- **Depth**: Measure the deepest depth
- **Surface area**: Surface area = length x width
- **Tunneling/Undermining**: Using the cardinal points on a clock, measure the depth or extent of any tunneling or undermining, i.e. 3cm deep at 4 o'clock
  - **Tunnel:** separation of the facial plains leading to a sinus tract
  - **Undermining:** erosion at the edge of a wound involving the subcutaneous tissue

Using 25 percentiles indicate the approximate % of each of the given tissue types:

- **Epithelial**: new pink +/- shiny tissue that migrates from the wound edges and from islands on the wound surface
- **Granulation**: shiny, moist pink or beefy red tissue that is granular/velvety in appearance
- **Slough**: yellow or white non-viable tissue that is mucinous or that adheres to the wound bed in clumps or strings
- **Eschar**: black, brown or tan non-viable tissue that firmly adheres to the wound bed +/- edges

Indicate the type of wound exudate:

- **None**: no visible drainage
- **Serous**: clear, thin, light yellow, watery drainage
- **Sero-sang**: thin, pink → light red, watery drainage
- **Sang**: thin, bright red, watery drainage
- **Purulent**: thin → thick, darker yellow/tan or blue/green, watery → opaque drainage

Indicate the amount of wound exudate:

- **None**: absence of visible drainage on the wound and dressing
- **Scant**: wound tissues are moist but there is no measurable drainage on the dressing
- **Small**: ≤25% of dressing has drainage on it
- **Moderate**: >25% but ≤75% of the dressing has drainage on it
- **Large**: >75% of the dressing has drainage on it

Describe the wound edges:

- **Attached**: Edges are even/flush with the wound base
- **Unattached**: Sides or walls are present; the base of the wound is deeper than the edge
- **Rolled**: Edges are soft to firm and flexible to touch with a rolled appearance
- **Approximated**: No visible wound edges; wound has closed

Circle Y or N to indicate if the following periwound tissue attributes are present:

- **Intact**: Skin that appears 'normal' in tone, texture, temperature, turgor
- **Reddened**: Redness that may or may not be blanchable and may or may not be warm
- Indurated: Abnormal firmness of the periwound tissue
- **Macerated**: Soft, spongy, thin, whitish tissue at the periwound or distal to the wound
- **Excoriated**: Abraded skin
- **Callused**: Firm, rough, yellowish tissue that may be scaling, flaking +/- cracking

Input the date of your wound assessment

Indicate if the wound has 2+ of the following signs of local infection:

- **Stalled healing**: The wound is failing to progress towards closure in a timely manner
- **Friable granulation**: The granulation tissue is red, fragile and bleeds easily
- **Increased exudate**: The amount of drainage has increased
- **Increased/new odor**: There is a new or worsening odor associated with the wound
- **Localized edema**: There is swelling of the immediate periwound
- **Increased/new pain**: There is new or worsening wound pain

Indicate if the wound has 2+ of the signs of local infection PLUS 2+ of the following signs:

- **Increased induration and spreading erythema**: Firmness and redness extending beyond the wound borders
- **Wound breakdown**: Increase in wound area +/- development of satellite lesions
- **Lymphangitis**: Fever, swollen lymph glands, chills, red streaking from wound towards nearest lymph gland
- **Malaise**: Aching muscles, headache, loss of appetite, general ill feeling

Date (YY/MM/DD)		
2 + of these signs? (Yes or No)	Stalled healing, friable granulation, increased exudate, increased/new odor, localized edema, increased/new pain	Y N If 'Yes' you have local infection – treat topically
2+ of the above signs PLUS 1 of these signs? (Yes or No)	Increasing induration and spreading erythema, wound breakdown, lymphangitis, malaise	Y N If 'Yes' you have spreading or systemic infection – treat locally and systemically
Interventions	# of packing pieces in/out (if applicable)	# In / # Out
	Dressing done as per order (Yes or No)	Y N
	Swab taken (Yes/No)	Y N
	New Referrals (check all that apply): Dietician	
	New Referrals (check all that apply): OT	
	New Referrals (check all that apply): PT	
	New Referrals (check all that apply): ET Nurse	
	New Referrals (check all that apply): Other (describe)	
	Care Plan Updated (Yes or No)	Y N
	Progress Note Made (Yes or No)	Y N
	Weekly PUSH Tool done (Yes or No), and score	Y N / Score
Other Notes		
Signature and Designation		

Indicate if you performed any of the following interventions:

- **Wound packing:** Indicate the number of pieces of packing removed and inserted into the wound
- **Dressing as ordered**: Did you change the dressing as ordered? If not, explain in the "Other Notes" section or in a separate progress note
- **Wound swab**: Did you obtain a wound swab?
- **New interdisciplinary referrals**: Did you initiate any referrals to allied health?
- **Care plan update**: Did you update the patient's care plan?
- **Progress notes:** Did you make a progress note related to the wound +/- your treatment?
- **PUSH tool:** Did you assess the wound using the PUSH Tool 3.0? This tool is to be used weekly to determine if the wound is deteriorating or progressing towards closure
- **Other notes:** Insert any other observations or interventions related to the wound and your treatment of it, as necessary. If you do not have anything to insert, strike thru the space or write, "NA" – you cannot leave the space blank
- **Signature and designation:** insert your signature and designation

PLEASE READ:

- The PUSH Tool 3.0 **must be completed weekly** for each wound a patient has to help determine whether the wound is improving or deteriorating. The day of the week this falls on for this patient's wound is:

  _____
  Mon, Tues, Wed, etc.

- Regarding this 'Wound Assessment Flow Sheet', in addition to completing it **every dressing change**, it is to be **initiated upon admission** of a patient with a wound to the hospital (any unit) **or when a newly occurring wound is discovered** on an admitted patient