Alzheimer's QUEENSLAND

WOUND ASSESSMENT AND MANAGEMENT PLAN

Resident Name:	Date of Birth:
Diagnosis:	
Allergies:	

Reason for assessment:

- ☐ New assessment of acute wound
- ☐ New assessment of chronic wound
- ☐ Reassessment of existing acute wound
- ☐ Reassessment of existing chronic wound
- ☐ New resident with an existing wound
- ☐ New assessment of a pressure injury
- ☐ Reassessment of an existing pressure injury
- ☐ New resident with an existing pressure injury
- ☐ Other

History

Identify any underlying causes or contributing factors that may impact on wound healing: *(this may include age, obesity, poor nutrition, disease, lifestyle, medication, mobility etc.)*

Does the resident have any of the following risk factors:

- ☐ Perfusion and/or oxygenation requirements
- ☐ Poor nutritional status
- ☐ Increased skin moisture
- ☐ Increased body temperature
- ☐ Poor sensory perception
- ☐ Requires haematological measures
- ☐ Poor general health status
- ☐ Existing pressure injury
- ☐ Other

If the resident has any of the above risk factors, please indicate the relevant measures being taken to address these:

History of wounds (Include location and rate of healing):

Local wound assessment				
Date of initial wound assessment:				
Has a completed skin assessment/reassessment been completed as part of the wound review?	☐ Yes			
Which method was used to assess if skin is blanchable or non-blanchable?	☐ Finger pressure method	☐ Transparent disk method		
Please not any relevant indications based on skin temperature, oedema, and changes in tissue consistency:				
Systemic:	☐ Medical *(poor circulation, poor oxygenation, metabolic or auto immune)*	☐ Surgical/latrogenic *(e.g., alteration to lymph system, previous scar tissue or gait changes)*	☐ Nutrition *(e.g., not eating well, malnutrition, obesity)*	☐ Social *(e.g., not mobile, poor environmental controls, smoking)*
	☐ Medications *(e.g., corticosteroids, anti-inflammatories, anticoagulants)*	☐ Allergies	☐ Other	
Regional:	☐ Oedema	☐ Pulses	☐ Atrophy, no hair, thin shiny skin	☐ Hemosiderin staining, varicose veins, ankle flair
	☐ Dry cracked skin	☐ Charcot deformity	☐ Contractures	
	☐ Other			
Location of wound:				

Duration of wound:			
Size of wound (length x width x depth):			
Wound type:	☐ Pressure injury wound ☐ Poor sensory perception ☐ Other	☐ Surgical wound ☐ Requires haematological measures	☐ Vascular/vasculitic wound ☐ Poor general health status
Stage of wound classification:	☐ Stage 1 *(Intact skin with non-blanchable redness of a localised area usually over a bony prominence)*	☐ Stage 2 *(Partial thickness loss of dermis presents as a shallow, open wound with a red-pink wound bed, without slough)*	☐ Stage 3 *(Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.)*
	☐ Stage 4 *(Full thickness tissue loss in which the base of the pressure injury is covered by slough (yellow, tan, grey, green, or brown) and/or eschar (tan, brown or black) in the pressure injury bed)*	☐ Unstageable *(Obscured full-thickness skin and tissue loss in which the extent of loss cannot be confirmed due to obscuring from slough or eschar.)*	☐ Suspected deep tissue injury *(Persistent non-blanchable deep red, maroon, or purple discoloration. Intact or non-intact skin with localised area of discoloration or epidermal separation revealing a dark wound bed or blood filled blister.)*
	☐ STAR skin tear category 1a *(A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is not pale, dusky, or darkened)*	☐ STAR skin tear category 1b *(A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is pale, dusky, or darkened)*	☐ STAR skin tear category 2a *(A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is not pale, dusky, or darkened)*
	☐ STAR skin tear category 2b *(A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is pale, dusky, or darkened)*	☐ STAR skin tera category 3 *(A skin tear where the skin flap is completely absent)*	☐ Other

Colour of wound:	☐ The wound is black	☐ The wound is brown	☐ The wound is yellow	☐ The wound is red
	☐ The wound is maroon	☐ The wound is purple	☐ The wound is pink	☐ The wound is green
	☐ Other			
Exudate – type:	☐ The wound exudate is clear	☐ The wound exudate is serous	☐ The wound exudate is haemoserous	
	☐ The wound exudate is sanguineous	☐ The wound exudate is purulent	☐ The wound exudate is seropurulent	
	☐ The wound exudate is malodorous	☐ Other		
Exudate – amount:	☐ The wound has no exudate	☐ The wound has a small amount of exudate	☐ The wound has a medium amount of exudate	
	☐ The wound has a heavy amount of exudate			
Wound odour:				
Wound edge appearance:	☐ The wound edges are level	☐ The wound edges are raised	☐ The wound edges are rolled	
	☐ The wound edges are undermined	☐ The wound edges are calloused	☐ The wound edges are sloping	
	☐ The wound edges are punched out	☐ The wound edges are purple		
	☐ Other			
Peri-wound and surrounding skin characteristics:	☐ The surrounding skin is healthy	☐ The surrounding skin displays signs of induration/inflammation which may be accompanied by localised heat	☐ The surrounding skin is macerated	☐ The surrounding skin is dry (e.g., shows signs of desiccation)
	☐ The surrounding skin is fragile and/or friable	☐ The surrounding skin is oedematous	☐ The surrounding skin displays signs of crusting and/or scabbing	☐ The surrounding skin is intact/damaged, bruised
	☐ The surrounding skin displays signs of dermatitis/eczema	☐ The surrounding skin is calloused	☐ The surrounding skin shows signs of hyperkeratosis	☐ The surrounding skin shows signs of pigmentation
	☐ The surrounding skin displays signs of an allergic reaction (e.g., hives)	☐ The surrounding skin shows signs of erythema	☐ The surrounding skin is excoriated	
	☐ Other:			

Presence of pain:			
Signs and/or symptoms of inflammation/infection:			
Please indicate relevant microbiology tests performed:	☐ Wound swab for semi-quantitative and quantitative organisms ☐ Other	☐ Needle aspiration for quantitative organisms	☐ Wound/bone biopsy for quantitative organisms
Histopathology carried out: ☐ Yes			
Wound microbiology *(e.g., swab date/result/sensitivities):*			
Please select any nutritional screening tools used:	☐ Use of screening and assessment tool that are reliable and valid and appropriate to the individual (e.g., MNA) ☐ Hair and skin changes ☐ Other	☐ Assessment of the quantity, quality and nutritional content of food and fluid intake ☐ Ability to eat, including any assistance or diet requirements (e.g., thickened fluids or pureed food)	☐ Assessment of weight status, including weight history (e.g., weight loss >5% in 30 days or >10% in 180 days) ☐ Additional specific biochemical tests (e.g., albumin, transferrin, zinc, or vitamins)
Are there any behaviours that may impact wound healing?			

Please not any relevant results from the above tests that have been completed

Wound Management	
Moisture content of wound: *(describe ongoing levels of wound moisture and potential dressings)*	
Wound cleansing:	
Wound emollient/barrier: *(wound emollient barrier type to be used and how/why applied)*	
Primary dressing: *(include dressing type/method*	
Secondary dressing:	

Frequency of dressing change:				
Frequency of dressing check:				
Is regular repositioning required? *(if regular repositioning is required, please not frequency and give consideration to tissue tolerances, level of activity and mobility, general medical condition, skin condition, comfort, and overall treatment conditions*				
Pressure relief/reduction device: *(specify device in place e.g., specific fabrics and textiles used to prevent shear and friction, electrical stimulation of muscles)*				
Phase of Wound Healing - Repair Stage:	☐ Haemostasis ☐ Maturation/Remodelling	☐ Inflammation ☐ Destruction	☐ Proliferation ☐ Other	☐ Reconstruction
Wound evaluation:				

Wound Charts:	☐ Refer to wound chart/s for active locations and treatments required			
Additional Considerations				
Is a case conference with family/EPOA required to discuss wound management?	☐ Yes			
Are there referrals required?	☐ GP	☐ Wound Specialist	☐ Dietician	☐ Speech Pathologist
	☐ Occupational Therapist	☐ Physiotherapist	☐ Other	
Does the resident have any preferences or choices around wound care and management?				
Are there any risks associated with the resident meeting their preferences and choices around wound care and management?				
What are the strategies in place to accept, minimize or mitigate the risk with the resident meeting their preferences and choices around wound care and management?				
Goals for wound management				
Name of person completing the form:				
Designation:				
Date and time assessment completed:				
Date uploaded to Clinical Manager:				