Wound Treatment Plan

To be completed when treatment or dressing plan altered. NB Print information
When treatment plan altered, score through previous plan, date & sign.

PRINT OR ATTACH LABEL

Surname:..... CHI No:.....

Forenames:..... Sex:.....

DoB:.....

Location:.....

NHS Lothian

Wound No..... Type (e.g. PU)..... Location (e.g. R Hip).....

Date treatment started	Cleansing method & dressing choice	Rationale for dressing choice	Sign and print name	Discontinued: Date, sign and rationale
	Frequency:			
	Frequency:			
	Frequency:			
	Frequency:			

Wound Assessment Chart and Treatment Plan

For multiple wounds complete formal wound assessment for each wound. Add Inserts as needed.

PRINT OR ATTACH LABEL

Surname:..... CHI No:.....

Forenames:..... Sex:.....

DoB:.....

Location:.....

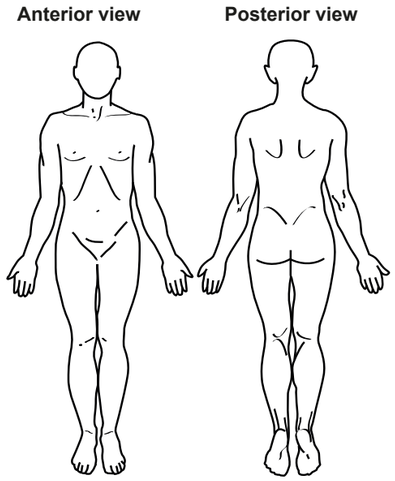
NHS Lothian

Factors which could delay healing (Please tick relevant box)

- ☐ Anaemia
- ☐ Respiratory/Circulatory Disease
- ☐ Nicorandil
- ☐ Steroids
- ☐ Anti-inflammatory
- ☐ Diabetes
- ☐ Poor nutrition
- ☐ Inotropes
- ☐ Chemotherapy
- ☐ Methatrexate
- ☐ Incontinence
- ☐ Oedema
- ☐ Other .....
- ☐ Anti-coagulants
- ☐ Allergies & sensitivities .....

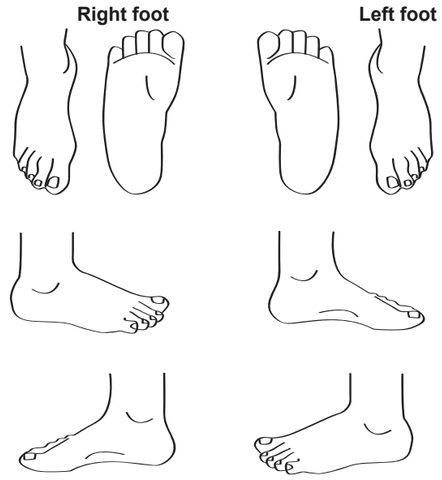
.....

Body Diagram



Mark location with 'X' and number each wound

Feet Diagram



Mark location with 'X' and number each wound

Type of wound (circle)	Time present (wks/mths)	Date referred to:
Burn - Superficial / Partial / Full	.....	TVN.....
Cellulitis + blisters	.....	Physio/OT.....
Diabetic foot ulcer	.....	Diabetic Clinic.....
Fungating	.....	Diabetic Podiatry.....
Haematoma	.....	Podiatrist.....
Ischaemia	.....	Dietitian.....
Laceration / Skin tear	.....	Vascular.....
Leg Ulcer: Venous / Arterial / Mixed	.....	Dermatology.....
Pressure Ulcer: Grade 2 3 4 UG* SDTI**	.....	Plastics .....
Skin Condition - State:.....	.....	Other (speciality).....
Surgical Dehiscence	.....	Signature.....
Other - specifiy:.....	.....	Date.....

*Ungradable **Suspected Deep Tissue Injury

Guide for completing Wound Assessment Chart and Treatment Plan

Front page/page 1 - Only one of these needs be completed for each patient.

- **Factors which could delay healing -** Tick relevant factors
- **Multiple wounds -** mark with X and number. Complete 'wound assessment' and wound treatment plans' for each wound
- **Type of wound -** Circle and enter length of time present
- **Date referred to -** please note the date referred to specialist services
- **Assessor's signature -** Sign and date once completed.

Page 2 – Wound Assessment - Complete a separate sheet for each wound, enter wound number, type and location at top of page. Order continuation Wound Assessment sheets **LOT1148**. Complete on initial assessment then make clinical decision and date and sign how often to be reviewed, enter name and sign at top of page.

- **Analgesia required -** note when this is required to aid planning
- **Wound dimensions -** Should be measured weekly unless signed clinical decision states otherwise. If photographed, ensure consent obtained and original digital image is stored securely as per **NHS Lothian policy**
- **Tissue type on wound bed -** estimate percentage on wound bed. For bone/tendon tick if present
- **Wound exudate levels -** tick for level and type of exudate
- **Peri-wound skin -** tick all that apply
- **Signs of infection -** the items in this section and those starred (*) elsewhere may be indicative of infection in the wound. Refer to 'Scottish Ropper Ladder (2018)' guideline for further information. A wound swab should only be sent if there are concerns about a deteriorating wound which may require antibiotic therapy
- **Treatment objectives -** based on assessment and will guide dressing choice
- **Re-assessment date -** note next expected date for reassessing wound
- **Print initials -** ensure this is completed clearly.

Page 3 - Wound Treatment Plan - Complete a separate sheet for each wound, enter wound number, type and location at top of page. Print or write clearly. Do not complete at each dressing change - complete at start of treatment and then whenever there is a change in treatment or dressing regime. Order continuation Wound Treatment Plans **LOT1149.**

- **Date -** this is the date you started treatment
- **Cleansing method and dressing choice -** ensures continuity of wound care
- **Rationale for dressing choice -** aids other staff in understanding your rationale for the dressing choice. Write down reason for using a particular dressing, e.g. hydrogel to rehydrate, adhesive foam to absorb exudate
- **Frequency -** expected days between dressing changes
- **Signature -** Ensure you sign clearly
- **Discontinued -** score through old plan, date and sign when you change treatment plan.

Cavity/Undermined/Tunnelling Wounds (Print Locally) - Use to document insertion and removal of dressings for complex cavity wounds, in conjunction with full wound assessment chart

Developed by the Tissue Viability Service

Wound Assessment

Complete on initial assessment and thereafter complete daily /weekly / 2 weekly (circle)

Name:..... **Signature:**.....

PRINT OR ATTACH LABEL

NHS Lothian

Surname:..... **CHI No:**.....

Forenames:..... **Sex:**.....

DoB:.....

Location:.....

Wound No..... **Type (e.g. PU)**..... **Location (e.g. R Hip)**.....

Date of Assessment								
Analgesia required (refer to local pain assessment tool)	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
• Regular/ongoing analgesia								
• Pre-dressing only								
Wound Dimensions (enter size)- Measure weekly								
• Length (cm)								
• Width (cm)								
• Depth (cm)								
• Or trace wound circumference								
• Is wound tracking/undermining (cm)								
• Photography								
Tissue type on wound bed (enter percentages)								
• Necrotic (Black)	%	%	%	%	%	%	%	%
• Sloughy (Yellow/Green)	%	%	%	%	%	%	%	%
• Granulating (Red)	%	%	%	%	%	%	%	%
• Epithelialising (Pink)	%	%	%	%	%	%	%	%
• Hypergranulating (Red)	%	%	%	%	%	%	%	%
• Haematoma	%	%	%	%	%	%	%	%
• Bone/tendon (Tick if present)								
Wound exudate levels/type (tick all relevant boxes)								
• None								
• Low								
• Moderate								
• **High***								
• Serous (straw)								
• Haemoserous (Red/Straw)								
• **Purulent (Green/Brown/Yellow)***								
Peri-wound skin (tick relevant boxes)								
• Macerated (white)								
• **Oedematous***								
• **Erythema (Red)***								
• Excoriated (Red)								
• Fragile								
• Dry/scaly								
• Healthy/intact								
Signs of Infection* - 2 or more of these signs may indicate possible infection								
• **Heat***								
• **New slough/necrosis (deteriorating wound bed)***								
• **Increasing pain***								
• **Increasing exudate***								
• **Increasing odour***								
• **Friable granulation tissue***								
• Wound swab taken								
Treatment objectives (tick relevant box)								
• Debridement								
• Reduce bacterial load								
• Hydration								
• Absorption								
• Minimise trauma / pain management								
• Healing								
• Palliative / conservative								
Re-assessment Date								
Assessor's Print Initials								