STANDARD GUIDELINE:	**Wound Assessment and Treatment Flow Sheet**
Program Area:	**Across Care Areas**
Section:	**General**
Reference Number:	**CLI.4110.SG.013**
Approved by:	**Regional Lead Acute Care and Chief Nursing Officer**
Date:	Issued 2024/July/03 Revised yyyy/mm/dd

PURPOSE:

The Wound Assessment and Treatment Flow Sheet (WATF) is a tool used by the nurse to record wound progression and care provided.

DEFINITIONS:

Exudate Amount:

- None = no measurable exudate, wound tissues dry
- Scant = wound tissues moist
- Small = wound tissues wet, drainage involves ≤25% of dressing
- Moderate = wound tissues saturated, drainage involves > 25% to <75% of dressing
- Large = wound tissues bathed in fluid, drainage involves >75% of dressing

Exudate Type:

- Sanguinous = bloody, thin, bright red
- Serosanguinous = thin, watery, pale red to pink
- Serous = thin, watery, clear
- Purulent = thin or thick, opaque tan to yellow or green
- Other = describe what is present

Cleansing:

- Circle appropriate method used to cleanse: 18g blunt needle tip/cathalon with a 30 ml syringe or 118 ml bottle
- If cleansing is by 'sponging' the wound, write in space provided (this does not refer to cleansing the periwound skin)
- Document solution utilized to cleanse wound

Odor:

- Yes = present following cleansing
- No = absent following cleansing

Wound Base Status: (describe in percentages)

- Eschar = black, may be soft or firm
- Slough = yellow or white, may be soft or firm
- Granulation tissue = pebbled, beefy, moist, firm
- Pink = salmon colored, firm, moist
- Epithelialization = pink/purple new tissue

Wound Edge:

- Attached = level with wound base
- Unattached = higher than wound base (has depth)
- Punched out = regular, well-defined edges (specific to leg wounds, likely arterial)
- Irregular = poorly-defined (specific to leg wounds, likely venous)

- Callous = hyperkeratotic or callous growth
- Rolled = wound edge has a rolled under appearance (often chronic wound)

Periwound:

- Intact = not damaged or impaired in any way
- Maceration = white hyperkeratosis, indicates excessive moisture
- Erythema = redness
- Induration = abnormal firmness of tissues
- Dryness = epidermis that lacks moisture or sebum
- Scaling = loss of the outer layer of epidermis in large flakes
- Edema = fluid accumulation in surrounding tissues
- Blistered = a collection of fluid underneath the epidermis
- Callous = thick build-up of skin

Wound Size:

- Measure weekly and as indicated (i.e. if changes are noted)
- Indicate if measurements were taken in centimeters (cm) or millimeters (mm)
- Length is the longest measurement
- Width is the widest measurement at right angles to length
- Depth measured straight down at deepest point
- Tunneling = a narrow channel or sinus under or beyond the wound margin, indicate location via 12-hour clock; client's head is 12 o'clock
- Undermining = an area of tissue destruction extending under intact skin along the wound edge, indicate location via 12-hour clock; client's head is 12 o'clock

Dressing Selection:

- List products used
- Wound Care Technique (circle one):
    - Clean No Touch Technique - is a combination of sterile and clean technique. One pair of nonsterile gloves is used to remove the soiled dressing, and a second pair to apply the new dressing. Sterile dressings are picked up by the back corners and the untouched side is placed on the wound bed. Key: technique is no touch, but products are sterile
    - Sterile technique - prevents contamination of a wound with microorganisms and requires utilizing sterile equipment, sterile gloves and sterile technique

PROCEDURE:

1. The nurse ensures the required demographics are completed. An addressograph may be used. If not available, 2 client identifiers are documented CLI.4110.SG.013.FORM.01 Wound Assessment and Treatment Flow Sheet. The nurse indicates the wound location (e.g. right medial malleolus), wound type/cause (e.g. trauma) in the space provided.
2. The nurse identifies the goal of wound care: healing, non healing, non healable.
3. The nurse documents <u>one wound per page</u>. If the client has multiple wounds, the nurse numbers the forms "1 of ___" on the top of the WATF.
4. The WATF is used
    - at every dressing change while the wound is acute (i.e. less than six weeks old);
    - at a minimum of weekly once the wound becomes chronic (i.e. more than six weeks old), or as necessary depending on changes in the wound and at the discretion of the nurse.
5. The nurse indicates date and time of assessment completed and treatment provided.
6. The nurse either places a check mark or document in the box corresponding to his/her findings in each category. A check mark indicates that the information has not changed from that which was previously recorded

7. The nurse measures the wound weekly and prn (i.e. when there is a significant change in wound status).
8. The nurse gently probes any tunnels or areas of undermining, indicating their size in cm or mm and location using the 12-hour clock with the client's head being 12 o'clock and feet 6 o'clock (example: 2.3 cm tunnel at 8 o'clock, undermining 1 cm from 3 to 6 o'clock).
9. The nurse documents the products used/applied in the first dressing section of each WATF. For subsequent dressing changes a check mark indicates that the same products have been continued.
10. Temperature – The nurse feels for increased temperature on the periwound skin, comparing it to the mirror image. If available, an infrared thermometer may be used.
11. The nurse indicates the technique to be used: clean no touch or sterile technique.
12. The nurse approximates the length of any packing inserted into and removed from the wound. If more than one piece of packing is used, the nurse documents the number of packing pieces inserted and removed from the wound.
13. The nurse assesses for pain utilizing the 0-10 pain scale, where '0' is no pain, '5' is equivalent to a bee sting and '10' is equivalent to slamming fingers in a door.
14. If any findings are unusual or not captured in the WATF, the nurse records this in the Integrated Progress Notes (IPN) and indicate this with a 'check'.
15. Photo/Drawing – The nurse documents if a photo of the wound was taken or the nurse may also draw a diagram of the wound on the IPN or on the WATF grid provided on the reverse side of the WATF
    - An "X" is placed on the body image to indicate the location of the wound
    - The corresponding "anterior or posterior" location of the wound is identified
    - This drawing may or may not be to scale
    - Dotted lines are utilized to indicate undermining/tunneling, with accompanying measurements
    - The nurse dates and signs the diagram drawn
16. The nurse initials or signs the documentation completed.

SUPPORTING DOCUMENTS:

CLI.4110.SG.013.FORM.01 Wound Assessment and treatment Flow Sheet

REFERENCES:

Krasner DL, Rodenheaver GT, Sibbald RG, Woo KY. Chronic Wound Care. A Clinical Source Book for Healthcare Professionals. Vol. 1, 5th ed. Malvern, PA: HMP Communications; 2012.

Krasner DL, Rodenheaver GT, Sibbald RG, editors. Chronic Wound Care: A Clinical Source Book for Healthcare Professionals. 4th ed. Malvern, Pa: HMP Communications, 2007.

Registered Nurses Association of Ontario http://rnao.ca/sites/rnaoca/files/Assessment_and_Management_of_Venous_Leg_Ulcers.pdf Vancouver Island Health Authority http://www.viha.ca/NR/rdonlyres/6CE1177D-E463-455E-BD8181666ED3B114/0/Chapter11VIHADocumentation.pdf

VON Canada http://www.von.ca

Winnipeg Regional Health Authority Wound Care Guidelines http://www.wrha.mb.ca/professionals/ebpt/EIPT-013.php