

### Generic Wound Assessment for Trial 3

<b>Patient</b>	
Name: _____	NHS Number: _____
Address: _____	Date of Birth: _____
_____	
_____	
Telephone: _____	Mobile Tel: _____
<b>Clinician</b>	
Name: _____	Date: _____

### Generic Wound Assessment for Trial 3

This Questionnaire has been published for Trial within Tissue Viability potentially ahead of wider use across LCH.  
Proposed Updates from May / June 2011

All questions marked with a \* should be answered.

#### 1. General

This questionnaire has been through a clinical consultation process within Leeds Tissue Viability Service and has been approved for use.

It is primarily intended for use within a community care setting within Leeds Community Healthcare Services.

1. Gender of patient

- Male  
 Female

2. Brief Description of Wound: (to include no more than Area of Body and Left or Right and/or Front or Back)

3. Re-Assessment No.

4. Date

It is essential that each wound is captured on a separate form. Do not include more than one wound on each assessment.

#### 2. A. Type of Wound

A measurement should be taken as a Baseline and on an on-going basis at least monthly or if wound has improved / deteriorated.

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5. Type of Wound

- Leg Ulcer - arterial
- Leg Ulcer - venous
- Leg Ulcer - mixed
- Pressure Ulcer
- Diabetic Foot Ulcer
- Non-diabetic Foot Ulcer
- Dehisced Surgical Wound
- Pilonidal Sinus
- Abscess
- Fungating Wound
- Traumatic Wound
- Bum
- Other (Please give details in Notes Box)

Please complete a specific assessment form as appropriate e.g. leg ulcer / pressure ulcer.

6. Position of wound / wound site

- Left
- Right
- Front
- Back

7. Area of Body

- Sacrum
- Buttock
- Ischial Tuberosity
- Hip
- Heel
- Ankle
- Foot
- Above Knee
- Below Knee
- Upper Arm
- Lower Arm
- Back
- Chest
- Abdomen
- Head
- Other (Please give details in Notes Box)

8. ABPI

- Below 0.4
- 0.4 - 0.6
- 0.61 - 0.8
- 0.81 - 1.0
- 1.01 - 1.2
- 1.21 and above
- Not Applicable

3. B. Risk Factors

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Consider appropriate referrals for those with \*  
Select all those appropriate below:-

9. Chemotherapy / Radiotherapy

Yes

10. Continence / Moisture Issues

Yes

11. Diabetes\*

Yes

12. Elderly

Yes

13. Immunosuppression

Yes

14. Infection

Yes

15. Mobility

Yes

16. Nutrition\*

Yes

17. Peripheral Neuropathy

Yes

18. Poor Blood Supply

Yes

19. Poor Oxygen supply to wound

Yes

20. Recent Acute Illness / Surgery

Yes

21. Smoking

Yes

22. Steroids or NSAIDS

Yes

23. Other - please specify in Notes Box

Yes

24. Method of Measurement

Wound Map

Ruler

25. Has Photograph been taken?

Yes

No

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26. Maximum Length (mms)

27. Maximum Width (mms) measure perpendicular to the Maximum Length

28. Wound Category

- 1 - Non-blanching erythema
- 2 - Partial thickness, skin loss no slough
- 3 - Full thickness skin loss with/without slough
- 4 - Full loss as above with exposed tendon / bone
- Unstageable Slough/Necrosis obscuring depth

29. Are Dimensions...

- Increasing
- Decreasing
- Static
- Unknown

#### 4. C. Wound Bed Condition

Specify percentages (Digits ONLY, that MUST add up to 100)

30. Necrotic (black)

31. Slough (yellow)

32. Granulating (red)

33. Overgranulating (red)

34. Epithelialising (pink)

35. Bone / Tendon / underlying structure

#### 5. D. Infection Indicators

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In the section below, items may indicate \* chronic or + acute infection.  
If any of the following are present tick Yes, if not tick No

36. Granulation, tissue bleeds easily \*

- Yes  
 No

37. Fragile bridging of Epithelium occurs \*

- Yes  
 No

38. Odour increasing \*

- Yes  
 No

39. Healing is slower than anticipated \*

- Yes  
 No

40. Wound breakdown \*

- Yes  
 No

41. Dehiscence +

- Yes  
 No

42. Exudate Levels (Must tick ONE)

- High \*  
 Moderate  
 Low  
 None

43. Exudate Viscosity (Must tick ONE)

- Viscosity Thin  
 Viscosity Thick\*  
 Pus / Abscess+

44. Exudate Amount (Must tick ONE)

- Amount increasing \*  
 Amount decreasing  
 Amount static  
 Unknown

Wound Margin / Surrounding Skin

If any of the following are present tick YES otherwise tick NO

45. Macerated \*

- Yes  
 No

46. Localised Oedema \*

- Yes  
 No

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47. Localised Erythema \*
- Yes  
 No
48. Cellulitis / extending 2cms from wound edge +
- Yes  
 No
49. Eczema / Contact Dermatitis
- Yes  
 No
50. Fragile \*
- Yes  
 No
51. Dry / Scaling
- Yes  
 No
52. Healthy / Intact
- Yes  
 No
53. Pain (if present complete a full pain assessment) (PLEASE TICK ONE)
- Continuous / Constant  
 At specific times  
 At dressing change  
 None  
 Change in character of pain +
54. Odour (PLEASE TICK ONE)
- No odour  
 On dressing removal  
 When dressing intact  
 On entry to the room  
 Abnormal smell +

If the above set of questions have identified chronic / acute infection, please swab and refer to the wound infection algorithm.

55. Swab taken?
- Yes  
 No

#### 6. E. Treatment Objectives

Select all those applicable

56. Debridement
- Yes

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- 57. Absorption  
 Yes
- 58. Hydration  
 Yes
- 59. Bacterial Load Management  
 Yes
- 60. Odour Management  
 Yes
- 61. Reduction of Overgranulation  
 Yes
- 62. Protection  
 Yes
- 63. Pain Management  
 Yes
- 64. Other (outline in Notes Box)  
 Yes
- 65. Promote granulation tissue growth - TNP  
 Yes

### 7. F. Wound Treatment

- 66. Was wound treatment carried out?  
 Yes  
 No

If Yes above, select all those applied from the list below whilst adding the appropriate dressing code in the Notes Box

- 67. Primary Dressing - add dressing code below  
 Yes  
 No

68\*. Primary Dressing code

- 69. Secondary Dressing - add dressing code below  
 Yes  
 No

70\*. Secondary Dressing code

- 71. Bandage - add dressing code below  
 Yes  
 No

05 Jul 2011  
Andrew W Page

NHS Confidential: Personal Data about a Patient

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72\*. Bandage code

- 73. Hosiery - add code below  
 Yes  
 No

74\*. Hosiery code

- 75. Wound Healed?  
 Yes  
 No