WOUND CARE PLAN

Action Plan for RN/EN	Action Plan for Support Workers
Get client consent to complete wound care Use Aseptic dressing technique and appropriate infection and waste control procedures. PPE's Refer to Assessment chart for wound management and document – - Factors which could delay healing (immobility, poor nutrition, diabetes, incontinence, respiratory/circulatory disease, anemia, medication, wound infection, inotropes (e.g., digoxin, calcium), anti-coagulants, oedema, steroids, chemotherapy, allergies and sensitivities - Mark/describe location and number of each wound, type of wound, wound dimension, exudate levels and type, and peri-wound skin, signs of possible infection, treatment objectives total number and duration of each type of wound (leg ulcer, surgical wound, diabetic ulcer, pressure ulcer, other) - Note analgesia required, regular or pre-dressing only - Document date referred to tissue viability nurse, (Anne Batchelor, wound clinic CHC), physiotherapist, podiatrist, dietician, other allied health professional. - Document correspondence re handover of dressing needed - Sign wound care plan and date and describe changes to wound treatment plan. - Update Wound Care Plan as per Doctors Wound Care order - Evaluate care – document when dressing renewed, re-assessment date, - Order more wound care products or contact appropriate service provider to order products as per Doctors Wound Care order.	Risk management/Adverse events • Reports adverse conditions in wound e.g., increased swelling, pain, inflammation phone RN or supervisor, document in communication book and progress notes as 'feedback or concern' • Skin Tears Apply first aid if skin tear occurs – e.g., stem the bleeding with a sterile pad. Assist client to dress it with a band aid etc. Document in progress notes as 'issue or concern 'and phone RN or supervisor • Pressure wounds Be aware of the potential of pressure wounds in vulnerable clients. Refer to the Braden Risk Assessment Scale

Braden Risk Assessment Scale

Sensory/ Mental	Moisture	Activity	Mobility	Nutrition	Friction/ Shear
1. Totally limited	1. Constantly moist	1. Bedfast	1. 100% immobile	1. Very poor	1. Frequent sliding
2. Very limited	2. Very moist	2. Chairfast	2. Very limited	2. < ½ daily portion	2. Feeble corrections
3. Slightly limited	3. Occasionally moist	3. Walks w/ assistance	3. Slightly limited	3. Most of portion	3. Independent corrections
4. No impairment	4. Dry	4. Walks w/out assistance	4. Full mobility	4. Eats everything	

Total Braden Score _____

15-16 Mild Risk 12-14 Moderate Risk <12 High Risk
15-18 is considered Mild Risk for those > 75 years