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| **IDENTIFY WOUND**  Where is the wound  How it occurred if known  Person aware and PoA/NoK informed |

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| **COMPLETE WOUND CARE CHART**  Photograph of the wound with residents’ consent. If no capacity to have best interest form completed  Body map completed  Inform D/N  What grade or is it unclassified (information gained from D/N)  Complete Waterlow and MUST score |

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| **WOUND CARE PLAN/RISK ASSESSMENT**  Ensure that this is up to date with information of where the wound is  How dressing is being managed  How often is dressing required by D/N  Contact made with GP – is pain relief needed?  Is there a clear pressure relieving plan in place? |

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| **REFERRAL TO CQC**  This should be completed if wound Grade 3 or above  Adult concern form sent if any element of neglect (also check local policy guidance) |

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| **WOUND CARE CHART**  To complete on review date by D/N.  Information documented on D/N notes.  D/N to pass on information to person in charge |

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| **WEIGHT**  Check for good nutritional intake for wound healing.  Check care plan |

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| **REFERRAL TO DIETICIAN IF REQUIRED**  Look on contacts and has the information been shared with staff and kitchen |

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**Contact numbers for GP / D/N:**