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

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| **COMPLETE WOUND CARE CHART**  Photograph of the wound with resident’s consent. If no capacity, to have best interest form completed.  Body map completed.  What grade or is it unclassified?  Measurement taken.  Description of wound.  Complete Waterlow and MUST scores.  Complete wound chart. |

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| **WOUND CARE PLAN/RISK ASSESSMENT**  Ensure that this is up to date with information of where the wound is.  What dressing is required.  Has there been a referral to TVN?  How often is dressing required?  Contact made with GP if wound showing signs of infection.  Care plan updated.  Is any 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 is 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.  Information documented on continuation chart and care plan updated if necessary. |

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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? |