

Wound Identification and Follow-up Checklist

This checklist is designed to assist the nurses with assessment, documentation and follow-up. It is to be used with the identification of any single wound, or when a 100% audit is completed, to ensure that the wound is identified and has appropriate follow-up.

- _____ 1. When a wound is initially identified, it is the responsibility of the nurse first observes the wound to assess the area, location, size, depth, exudate, etc.
- _____ 2. Document the findings in the nurse's notes, and 24-Hour Report
- _____ 3. Notify the Physician of the assessment findings, obtain appropriate treatment orders based on facility treatment protocols.
- _____ 4. Document the notification of the Physician, and any new orders in the Nurses Notes.
- _____ 5. Notify the family of the wound, Document the notification in the Nurses Notes.
- _____ 6. Follow-up with the Physician's Orders; Properly route the orders, to the Physician's Order Sheet, the Treatment Record, the Pharmacy.
- _____ 7. Initiate the treatment order and document.
- _____ 8. Communicate the new area and treatment orders to the WCL.
- _____ 9. WCL/ADON will document on wound weekly on the individual wound documentation sheets.
- _____ 10. If the wound is a Pressure Ulcer, a Pressure Ulcer Intervention Worksheet will be completed by the Wound Care Liaison.
- _____ 11. The WCL will generate all weekly reports for Pressure Ulcers and Other Skin Conditions, and distribute to the appropriate people; Dietary Manager, Care Plan Coordinator, Administrator, DON, Regional Nurse, and Wound Care Specialist.
- _____ 12. The Care Plan Coordinator will update the plan of care with the Current Stage and Location of the wound.
- _____ 13. The Dietary Manager will ensure that the resident is reviewed by the Registered Dietitian for recommendations.