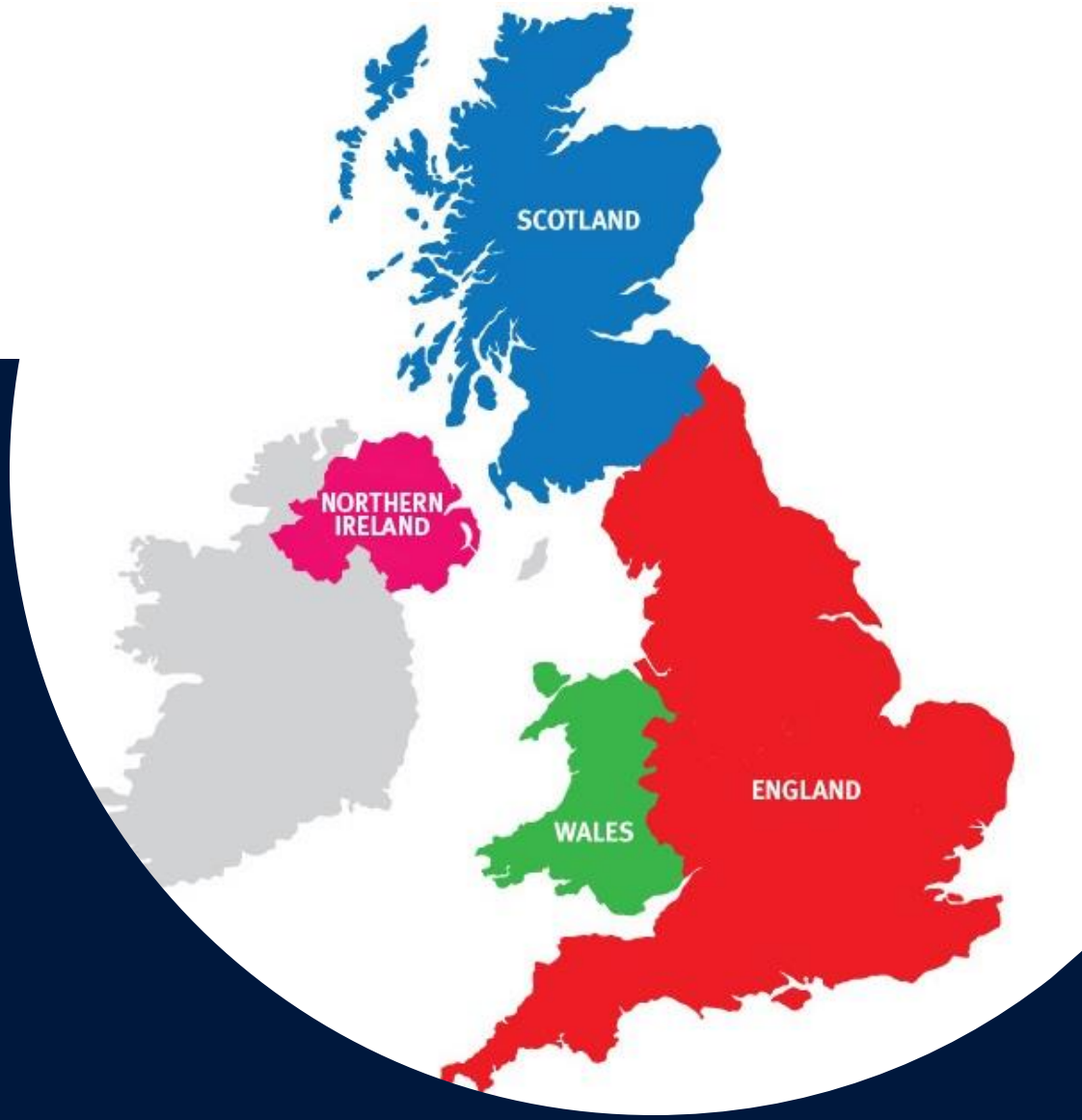
Professional Record Standards Body



WOUND CARE LEG ULCER EXAMPLE

V3.4

Better records for better care

Janice Example

This an example of how the wound care standard would work for a hypothetical person named Janice.

Janice's circumstances

- Janice is a 65-year-old lady who has type 2 diabetes and recently a leg ulcer.
- The leg ulcer was a trauma wound that did not heal and so became a leg ulcer (Clarification note; a leg wound that doesn't heal within two weeks becomes a leg ulcer)
- Janice bandaged it herself for a few weeks, but it got worse rather than healing and started impacting her mobility.
- She booked at appointment at her GP practice and saw the practice nurse who assessed her wound and planned her treatment.
- She had a diabetes care plan (using a personalised care and support plan), and that was updated to cover all her health needs and goals.

This example shows:

- The information recorded at the 1st appointment with the practice nurse
- Only the elements and information which are recorded in this example. Elements of the standard which are not relevant and would not be used for this example and the 1st appointment are not shown.

The standard will also enable all other contacts about wound care to be recorded along with observations, assessments, treatments, and updates/changes to her personalised care and support plan.

Wound assessment and treatment (Page 1)

Professional Record Standards Body

Contacts with Professionals

Seen by: <Name> Role: Practice Nurse Date: 7 Feb 2022 Where: C01 (General Medical Practitioner Practice)

Baseline information

Problem: Complex venous leg ulcer

Onset date: 22 Jan 2023 Body site: Mid calf medial aspect Laterality Left Status: Active

Anatomical site: Left mid calf medial aspect

Wound description: Trauma wound which hasn't healed and become a leg ulcer. Overt signs of infection.

Date wound occurred: 8 Jan 2023

First (initial) assessment of Janice's wound

- Length 4cm, Width 5cm, depth 0.2-0.3 cm, Point of ref: Mid calf medial aspect
- Wound and surrounding skin description
  - Margin & Edge description: macerated
  - Tissue type: 50% granulation, 50% slough
  - Surrounding skin condition: Dry
  - Skin colour: Erythema
- Image: <url for image>
- Wound complications: Local infection of wound
  - Vascular assessment:
    - ABPI: 0.9

Wound observations

Clinical observations

- Pain score: VAS 6/10. Severity worst on dressing change
- Wound pain frequency: Intermittent, usually more at night or after activity
- Signs & symptoms of infection: Overt signs of infection
- Exudate: High exudate, serous fluid, low viscosity, yellow
- Performance of dressing: Moderate strike through
- Odour: Offensive pre-dressing change
- Pulse sounds:
  - Doppler: biphasic pedal pulse sound
  - Foot pulse is palpable
- Oedema: Mild oedema, ankle circumference 26cm
- Temperature: Normal
- Other observations: Signs and symptoms of venous disease

Person observations

- Person observations: -

Wound assessment and treatment (Page 2)

Professional Record Standards Body

Wound and skin care treatment

- Wound care products
  - Medication/Product name: Topical antimicrobial primary dressing, Super absorbent, 4 layer compression bandaging, odour absorbing dressing (carbon based)
  - Medication trade family : <manufacturer name>
  - Form: dressing
- Procedures: Debridement and cleaning
- Consent: Consent given
- Information and advice given: Follow personalised care and support plan including exercise and leg elevation
- Plan and requested actions
  - Professional: -
  - Person: Follow personalised care and support plan
- Future appointments:
  - Date: 10 Feb 2023
  - To see: <Name>, Practice nurse
  - Location: <name> GP practice
  - Reason for appt: dressing change

Risks (for delayed healing)

- Risk (repeated for each risk)
  - Start date: 7 Feb 2022
  - End date: -
  - Risk: Local infection of the ulcer
  - Comment: -

Wound treatment plan (Page 1)

Professional Record Standards Body

Janice's Treatment Plan – created with a Personalised Care and Support Plan (PCSP)

Janice already has a Personalised Care and Support Plan (PCSP) created to help manage her diabetes. The practice nurse discusses Janice's existing PCSP including its About Me and establishes Janice's preferences.

Person preferences and treatment objectives

- What matters to the person: to heal the leg ulcer and recover her mobility so she can go back to doing the activities she enjoys.
- Previous treatment experience: -
- Previous equipment experience: -

Care & support plan

Using Janice's preferences and About Me they agree new needs, goals and actions for the PCSP. Below is just a summary of the key parts which would be added to Janice's PCSP.

- Strengths: a confident and outgoing person
- Needs: Recover her mobility [this is a new need added to the existing PCSP]
  - Goal: Heal the ulcer
  - Actions: Wound treatment plan, pain management, leg elevation, physical activity-walking, balanced diet with extra protein.

Wound treatment plan (Page 2)

Addition support plan

This is created to hold the wound care medical treatment plan and is added to Janice's PCSP.

Schedule of assessments: Monthly comprehensive assessments (ref Lower Limb Recommendations - Improving Wound Care: Building on The National Wound Care Programme - FutureNHS Collaboration Platform)

Dressing changes: 2 times a week. To be continuously reviewed with an aim for once weekly changes once infection is under control.

Wound bed preparation: Cleaning and debridement

Wound care products; Topical antimicrobial primary dressing, Super absorbent, 4 layer compression bandaging, odour absorbing dressing (carbon based)

Pain management: 1st phase; Paracetamol 1g four times per day

Agreed with: Janice Date: 07/02/2023

Review date: 1 month Responsible for review: Practice nurse

Contingency or Escalation Plan

This is created to show what to do should things get worse.

Triggers factors:

a) Pain management not working
b) wound not improving
c) odour remaining very offensive
d) Infection spreading

What should happen:

a) Switch to Codeine in line with pain ladder, escalated to prescriber
b) Refer to tissue viability nurse
c) Review infection status
d) Escalate antimicrobial – change to systemic antibiotics

Who should be contacted: <Name>, Practice nurse, <phone no.>

Early warning signs: Spreading infection, increasing signs of SEPSIS

Agreed with: Janice Date: 07/02/2023

Review date: 1 month Responsible for review: Practice nurse

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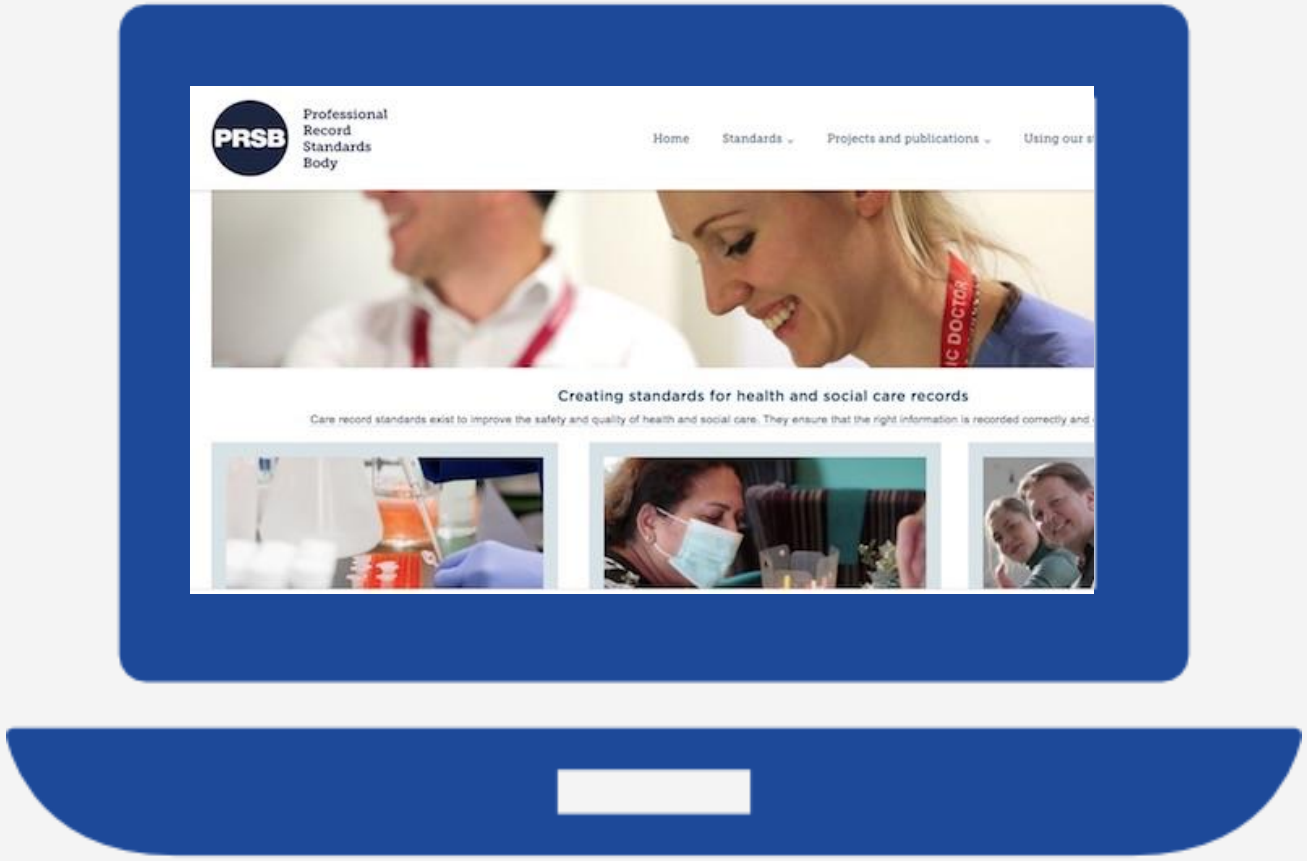

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