SELECT AND DELIVER CARE. EVALUATE

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1. Wounds UK. *Best Practice Statement: Improving holistic assessment of chronic wounds*. London: Wounds UK, 2018. Available to download from: www.wounds-uk.com
2. Guest JF et al (2017) *Int Wound J* 14(2):322–30
3. Scott-Thomas J et al (2017) *J Community Nurs* 31(5) 30–4
4. Coleman S et al (2017) *J Tiss Viabil* 26(4): 226–40

Establish Cause of wound, Assess wound bed, Select suitable treatment and dressing regimen, Evaluate and document outcomes

Objectives and related actions should be individualised to the patient and to the wound type/condition, according to local policy (adapted from[1])

Example objectives	Examples of actions
To promote wound progression and prevent deterioration	• Optimise the condition of the patient, treat wound cause, complications and symptoms • Promote a balanced and optimal moist wound healing environment
To avoid pain during dressing changes	• Moisten the dressing before removal to loosen adherence if present • Use a low adherent dressing (e.g.Cuticell® Contact) • Consider use of an adhesive remover • Provide analgesia to cover dressing changes
To prevent or manage wound infection	• Observe hygiene measures • Educate the patient about hygiene • Use antimicrobial dressings/preparations according to local policy (e.g. Cutimed® Sorbact®/ Cutimed® Sorbact® Gel)
To facilitate compression therapy, reducing associated discomfort	• Reassess lower limb for signs and symptoms of deterioration of arterial status, including repeating ankle–brachial pressure index (ABPI) • Consider using a lower level of compression for 1–2 weeks or using an alternative type of compression therapy, e.g. compression wraps • Explain rationale for compression therapy • Review analgesia
To help the patient better understand the cause and treatment of their wound	• Provide and discuss suitable information and education
To prevent recurrence of wounds	• Provide and discuss education on wound prevention (e.g. skin tears, pressure ulcers, diabetic foot ulcers) and who to contact if problems occur
To optimise factors that may prevent wound progression (e.g. malnutrition)	• Identify why the patient is malnourished and correct cause • Refer for nutritional assessment and dietary advice
To improve control of contributory factors or comorbidites (e.g. diabetes mellitus)	• Explain to the patient the importance of controlling contributory factors for healing • Refer to a multidisciplinary team for further assessment of comorbidities
To perform a holistic wound reassessment, to check healing progress, the suitability of the current management regimen and to adjust care plan as needed	• Perform a holistic wound reassessment using the parameters of the generic wound assessment MDS • Review the findings against the objectives and actions, and revise management as necessary • Refer as necessary

Example BSN medical dressings

If there is non-viable tissue (sloughy or necrotic) consider:
» Cutimed® Gel – clear, amorphous hydrogel that can be used to help debride sloughy and necrotic tissue
» Cutimed® Sorbact® Gel – supports infection management and autolytic debridement in one dressing
» Cutimed® Sorbact® Hydroactive – helps stimulate autolytic debridement and reduce baterial load
» Cutimed® HydroControl® – moisture balancing dressings that either absorb excess exudate or donate moisture

If there is fragile peri-wound skin consider:
» Cuticell® Contact – a silicone wound contact layer to help prevent pain and trauma
» Cutimed® PROTECT – spray, foam applicator or cream that provides a long-lasting protective barrier against incontinence, exudate, water loss from the skin and damage to peri-wound margins

If there is risk or presence of infection consider:
» Cutimed® Sorbact®/ Cutimed® Sorbact® Gel – a range of dressings that display hydrophobic properties irreversibly binding bacteria in a moist wound environment. Suitable for the prevention and management of wound infection
» Leukomed® Sorbact – post-operative dressings for closed incision or dehisced wounds for infection prevention and management

If there is moisture imbalance consider:
» Cutimed® Siltec® – foam dressings with a silicone wound contact layer for effective and intelligent exudate management
» Cutimed® Sorbion® – range of super-absorbent dressings that retain high volumes of exudate, even under compression
» Cutimed® HydroControl® – moisture balancing dressings that either absorb excess exudate or donate moisture
» Leukomed® – post-operative film dressings

If patient has leg ulceration and compression treatment is indicated (and if vascular assessment permits) consider:
» JOBST® compression therapy range (JOBST UlcerCARE, JOBST FarrowWrap, JOBST Opaque, JOBST forMen Ambition and Explore)

QUICK GUIDE

Integrating the *Best Practice Statement: Improving holistic assessment of chronic wounds* into clinical care

The *Best Practice Statement*[1] can be used with the CASE tool to complete holistic assessment and facilitate accurate documentation, in order to meet the CQUIN indicator for wound assessment.

Wounds UK

BEST PRACTICE STATEMENT

- The Burden of Wounds Study[2] highlighted inconsistencies in wound assessment, which could negatively impact on wound outcomes and associated healthcare spend[3].
- The importance of wound assessment and improving standards have been recognised through the implementation of a Commissioning for Quality and Innovation (CQUIN) indicator.

The ***Best Practice Statement: Improving holistic assessment of chronic wounds***[1] comprises nine **best practice statements** (examine below) that underpin recommendations for holistic assessment with accompanying **patient expectations**, and useful anatomical diagrams to aid correct recording of wound location.

BPS 1	A patient with one or more wounds should receive a holistic wound assessment at presentation.
BPS 2	All holistic wound assessments and reassessments should be documented. Documentation should include the findings of the assessments, the objectives of care, the care plan, with a clear rationale for the treatment, and the date for holistic wound reassessment.
BPS 4	Holistic wound assessment should include determining the type/cause of the wound(s), identifying factors that may delay healing or increase risk for future wounds, establishing the impact of the wound on the patient's quality of life and determining capacity for self-care.
Patient expectation	Guidance for what the **patient** with chronic wounds should expect from high-quality wound assessment is also provided for each best practice statement.

BUILDING A CASE FOR HOLISTIC WOUND ASSESSMENT

Making a CASE

The **CASE** tool (developed by BSN medical, an Essity Company) appears to be the only established wound assessment tool, apart from the Generic Wound Assessment MDS produced by the NHS[4], that incorporates all the following elements[3]:

» Type/cause of wound
» Assessment of patient concerns, symptoms, quality of life
» Assessment of risk factors for delayed healing
» Assessment of the wound and wound bed
» Assessment of the periwound skin
» Evaluation/reassessment
» Provision of patient information

As part of the Best Practice Statement[1], the **CASE** tool was adapted to incorporate key points at each step.

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