Developed by the BC Provincial Nursing Skin & Wound Committee in collaboration with Wound Clinicians from:

Title	**Wound Assessment &Treatment Flow Sheet: Documentation Guide (WATFS) portrait version**
Practice Level	All NP, RN, RPN, LPN, ESN, SN
Background	• The WATFS is used to document all parameters of a comprehensive wound assessment which provides the basis for the wound treatment plan of care. • The WATFS is a permanent part of the Health Record. • The WATFS is to be initiated for all patients, clients and residents who have a wound where Electronic Health Record systems are not in use.
Indications for Use of Document	• This guide is to be used in conjunction with the Wound Assessment & Treatment Flow Sheet (WATFS) portrait version. • The WATFS is not used to document the assessment for incisions or the insertion sites of tubes, drains or intravenous lines.
Definitions	**N (Note)** - see the notes in the chart for additional documentation on the assessment and treatment done for that day; these notes could be the progress notes, interdisciplinary notes etc.
Related Documents	• Wound Assessment & Treatment Flow Sheet (WATFS) 2 pg landscape version

GENERAL CONSIDERATIONS

a. A wound assessment is done as part of the overall client assessment (cardiorespiratory status, nutritional status, etc)
b. Wound assessments are to be done and documented on the WATFS by an NP/RN/RPN/LPN/ESN/SN. The individual who does the wound assessment must be the person who documents the parameters.
c. All WATFS must be initialled on the front and back of the page.
d. All notations are to be made in black or blue ink using a ballpoint pen.
e. The WATFS must be initiated when a wound is noted to be present and filled in ***each time*** the dressing is scheduled to be changed. Only **ONE** wound is documented per each WATFS. The dressing change frequency will be indicated in the Treatment Plan (last section of the WATFS) and is based on the wound condition and the dressing currently being used, e.g. every 2 days.
f. A full assessment is done every 7 days and whenever a significant change occurs (i.e. odour develops, wound deterioration); this includes measuring the wound size and assessing for all other assessment parameters.
g. A partial assessment is done for dressing changes that occur between the weekly assessments; this includes assessing all the wound parameters but do not measure the wound.
h. When a parameter descriptor is applicable, the corresponding box is marked with a '√'.
i. When a parameter descriptor is not applicable or not assessed, the corresponding box is marked with 'X' or leave blank depending upon the agency's policy.
j. A packing count of all dressings used to fill the wound space is to be done for any wound where the depth or the wound bed, undermining or sinus tract is 1 cm or greater.
k. Documentation in the Notes is required when the WATFS does not adequately describe the assessment or intervention. If additional documentation was made in the Notes, record 'N' in the corresponding box.
l. When a wound splits and becomes two separate wounds, close the initial WATFS and do a WATFS for each of the 'separated' wounds.
m. When two wounds merge together to become one wound, close the two WATFSs and do a WATFS for the 'new' wound.
n. If dressing change not done as per the dressing change frequency, then chart the reason why in the Treatment Done section, e.g. client refused.

o. When the wound heals and no longer requires care, chart the date, write 'Closed' on the assessment form and initial the entry.
p. The WATFS is filed in chronological date order in the flow sheet section of the chart according to the Health Authority's Standardized Record Manual.
q. If there is not noticeable improvement of the wound within three weeks or if there are signs of infection or deterioration, consider appropriate treatment plan changes or consult a Wound Clinician / Physician / NP.

DOCUMENTATION GUIDE

PARAMETER	DIRECTIONS
Facility	Document the facility of admission
Patient Label or Client Name, Date of Birth, PHN	Place a patient label if available or fill in client Name, Date of Birth, and PHN in the upper right-hand corner of the form both sides of form.
Year	Document the year (yyyyy) on the blank line provided, e.g. 2018.
Wound Date of Onset	Document the date (or approximate date) that the wound occurred.
Goal of Care	Choose one of the following: • To Heal (wound healing is anticipated to occur follow a predictable trajectory for the specific wound etiology; some etiolgies are slower to heal than others) • To Maintain (wound is not healing as expected due to client, wound and/or health system barriers; stable situation with little/no deterioration) • To Monitor/Manage (wound healing is not achievable due to untreatable underlying condition, e.g. cancer, un-reversible severe peripheral vascular disease; wound deterioration could be slow or fast)

Wound Type/ Etiology	Document the Wound Type/Etiology, if known. If you cannot determine the cause of the wound: • Consider your choices below • Consult with Wound Care Clinician as per agency policy for guidance, or • Chose the Unknown option if etiology is unknown	
	Pressure Injury	Localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open wound.
	Venous Insufficiency	Lower leg wound caused by venous insufficiency
	Arterial Insufficiency	Lower leg wound caused by peripheral vascular disease
	Diabetic Ulcer	Lower leg/foot wound caused by diabetic neuropathy
	Surgical 2^{o} Intention	Surgical wound left open to heal by granulation tissue formation and contraction
	Skin Tear	Loss of epidermis with/without partial loss of dermis due to trauma
	IAD (Incontinence Associated Dermatitis)	Skin/wound related to urinary or fecal incontinence.
	Unknown	Wound type/etiology is unknown.
	Other	

Pressure Injury Stage (How To Stage a Pressure Injury)	Document the stage of a wound determined to be a pressure injury. If you cannot determine what the stage of the pressure injury is: • Consider your choices below • Refer to a Wound Clinician as per agency policy or, • Leave it blank Chart only one stage and enter the date. When an Unstageable or DTI ulcer is fully declared then chart the new pressure injury stage and date. If the pressure injury worsens, then enter new stage and date. Do not back stage pressure injuries.	
	Stage 1	Intact skin, non-blanchable redness, firm to touch (red purple hues in dark skin)
	Stage 2	Partial thickness skin loss, presents as an abrasion or blister
	Stage 3	Full thickness skin loss: involves the subcutaneous tissue down to fascia (the fascia is NOT involved, therefore NO exposed muscle, tendon or bone)
	Stage 4	Full thickness skin loss, involves the subcutaneous tissue and fascia, there is exposed muscle, possible tendon or bone
	Unstageable	Necrotic tissue (slough or eschar) that is covering the wound bed such that the depth of the wound bed cannot be determined
	Deep Tissue Injury (DTI)	Intact skin, dark red purple bruise that indicates DEEP tissue damage, firm to touch
	Medical Device	Related to the use of devices applied for diagnostic or therapeutic purposes. Use the staging system to stage these injuries
	Mucosal	Found on mucous membranes with a history of a medical device in use at the location of the injury, the injuries are not staged

Legend	X or Blank Space	Not Applicable or Not Assessed (as per agency policy)
	√	Assessed or Completed
	PN	See Progress Note/Nurses Note

PARAMETER	DIRECTIONS	
Wound Location	Mark the location of the wound on the diagram provided with an 'X' and record the location on the blank space provided.	
Month/Year	Record the month (MMM) and the year (YYYY), e.g. Dec 2018	
Day/Time	Record the day (dd), and time (24-hour clock) for each entry, e.g. 12th and 11:30	
Wound Measurements (Weekly and PRN)	Record the wound measurement in centimetres.	
	Length	The longest measurement of the wound
	Width	The widest measurement of the wound at right angles to the length
	Depth	The deepest vertical measurement from the base of the wound to the level of the skin
	Sinus Tract	A channel that extends from any part of the wound and tracks into deeper tissue. Document location according to clock face (Head = 12 o'clock, Toes = 6 o'clock)
	Undermining	A destruction of tissue that occurs underneath the intact skin of the wound perimeter. Document location according to clock face (Head = 12 o'clock, Toes = 6 o'clock)
Wound Bed	Record the Wound Bed in increments of 10% (must add up to 100%)	
	Pink/Red	Clean, open area, red/pink tissue
	Granulation	Firm/red, moist, pebbled healthy tissue
	Slough	Dry or wet, loose or firmly attached, yellow to brown dead tissue
	Eschar	Dry, black/brown, dead tissue
	Foreign body	Objects such as sutures, mesh, hardware
	Underlying structures	Structures such as fascia, tendon, bone
	Not visible	The portion of the wound bed that you cannot visualize (deep sinus tracts or cavities with a small opening)
	Other:	Anything that cannot be placed into the above categories
Exudate Amount	Record the Exudate Amount ('√' one) • None • Scant/small • Moderate • Large/copious	
Initials	Record initials for each column entry.	
Wound Location	Mark the location of the wound on the diagram provided with an 'X' and record the location on the blank space provided.	
Month/Year	Record the month (MMM) and the year (YYYY), e.g. Dec 2018	
Day/Time	Record the day (dd), and time (24-hour clock) for each entry, e.g. 12th and 11:30	
Exudate Type	Record the Exudate/Drainage Type ('√' all that apply)	
	Serous	Thin clear yellowish fluid
	Sanguineous	Bloody fluid
	Purulent	Thick cloudy fluid
	Other	Anything you cannot place in the above categories (e.g. green)
Odour	Record the presence of odour after cleansing (Y for yes, N for no)	

PARAMETER	DIRECTIONS	
Wound Edge	Record the status of the wound edges ('√' all that apply)	
	Attached	Edge appears flush with wound bed or as a 'sloping edge'.
	Non-Attached	Edge appears as a 'cliff'
	Demarcated	Edges are clearly seen
	Diffuse	Edges are not clear
	Rolled Edge	Edge appears curled under
	Epithelialization	New, pink to purple, shiny skin tissue
Peri-wound Skin	Record the status of the peri-wound skin ('√' all that apply)	
	Intact	Unbroken skin
	Erythema	Redness of the skin – may be intense bright red to dark red or purple (if possible, measure in cm from wound edge out)
	Indurated	Abnormal firmness of the tissues with palpable margins (if possible, measure in cm from wound edge out)
	Macerated	Wet, white, waterlogged tissue
	Excoriated	Superficial loss of tissue
	Calloused	Hyperkeratosis, thickened layer of epidermis (mostly in lower leg/foot areas)
	Fragile	Skin that is at risk for breakdown
	Other	Anything you cannot place in the above categories (e.g. weepy, dry, rash, blister, tape tear, edema, bruised, boggy)
Wound Pain	Record the wound pain as quantified on the Numeric Rating Scale where 0 = no pain and 10 = excruciating pain as described by the patient/client. For more details please refer to the Pain Assessment Flow Sheet (where available).	
Packing Count	Any depth (wound bed, undermining or sinus tract) of 1 cm or greater, count the number of packing pieces removed (Out) and inserted (In). This is to ensure that ALL packing pieces are accounted for and that the next shift will know how many pieces to account for at the next dressing change.	
Treatment	Record treatment done as per Treatment Plan by charting a '√'.	
Initials	Record initials for each column entry.	
Treatment Plan	• The Wound Treatment Plan is to be documented in either the WATFS's Treatment Plan section or Clinical Treatment/Care Plan as per HA/agency standard/policy. • When using the WATFS Treatment Plan, ○ State the date treatment was started, the treatment plan and your initials; for example: *Skin prep peri-wound skin, Mesalt 4 x 4, to wound bed, cover with abd pad, change daily Aug 21/2018 LN* ○ If the wound changes or the treatment plan is not effective, discontinue (D/C) the previous treatment plan by noting the D/C date and your initials; then indicate the new treatment plan on the next available line. • The rationale for changing the treatment plan is to be documented either in the WATFS Rational for Change section or in the Notes.	

REFERENCES

- BC Provincial Nursing Skin and Wound Committee Wound Assessment Parameters and Definitions (2009)
- Vancouver Coastal Health Authority (2009). Wound Care Assessment and Treatment Flow Sheet.

Document Creation/Review

Created By	British Columbia Provincial Nursing Skin & Wound Committee in collaboration with the Wound Care Clinicians from across all Health Authorities
Publication Date	June 2011
Revision Date(s)	July 2014, August 2018
Review Date (s)	