[HEALTH SERVICE LOGO]
SITE: ……

SPINAL CORD INJURY [SAMPLE]
WOUND AND CONTRIBUTING FACTORS ASSESSMENT FORM

FAMILY NAME: …… MRN: ……
GIVEN NAME: …… MALE/FEMALE
DOB: ……/……/……
ADDRESS: ……
……
LOCATION: ……

BACKGROUND AND CONTRIBUTING FACTORS

SCI Level and Extent	**Level:** C__ / T__ / L __ Tetraplegia / Paraplegia	**AIS*:** A / B / C / D Complete / Incomplete	**Date of SCI:**	**Cause of SCI:**

Brief Summary of Current Pressure Injury/Injuries (See each Wound Assessment page for more detail)	Location	Stage	Date developed
	1. R / L		
	2. R / L		
	3. R / L		
	4. R / L		

Red Flags	☐ Persistent Autonomic Dysreflexia (AD) ☐ Sepsis ☐ Severe malnutrition ☐ Multiple pressure injuries ☐ Deep wound infection/ Osteomyelitis	**PLAN:**

CAUSE AND CONTRIBUTING FACTORS

SCI-specific and other medical factors

History of previous pressure injuries	*Location*	*Date*	*Cause*	*Management*	*Time to heal*

Acute illness or injury (e.g. limb fracture)	
Bladder and Bowel (management/ incontinence)	
Cognition	
Heterotopic ossification	
Respiratory function/ complications (e.g. OSA)	
Shoulder pain / injury	
Smoking	
Spasticity and contracture	
Other medical conditions	

*AIS American Spinal Injury Association Impairment Scale (AIS) refers to the International Standards for Neurological Classification of Spinal Cord Injury http://asia-spinalinjury.org/wp-content/uploads/2016/02/International_Stds_Diagram_Worksheet.pdf..

Nutrition	*Screening tool score; signs of inadequate nutrition/ fluid intake, dietary intake; assistance to eat/drink; biochemistry, anthropometry, estimated nutrition requirements*

Mechanical Factors (pressure, friction, shear, microclimate)
Screen for a change in function by reviewing activity and equipment used throughout the 24 hour period.

Mobility	*Mobility*	*Transfers (Consider type, number and quality of lifts b/n varying surfaces)*	*Weight-shift strategies, frequency*	*Recent changes*

Positioning in bed	*Time spent in bed*	*Positions (30^0 side-lying / prone / supine)*	*Bed mobility*	*Assistance to reposition*

Personal care	*Independent/Assisted*	*Care Hours*

Equipment summary	*Equipment*	*Type / Brand*	*Condition*	*Date reviewed, by whom*
	Wheelchair type (include all) ☐ Manual ☐ Power-assist ☐ Powered with tilt ☐ Powered without tilt function ☐ Other _____			
	Cushion			
	Hoist and sling			
	Bed			
	Mattress			
	Commode / Shower/ Bath / Toilet			
	Manual handling equipment			
	Equipment used in car/work/leisure			

Psychosocial Factors			
Psychological and mental health disorders	*Screen for depression, substance use, exacerbation of pre-existing mental illness/disorder.*		
Psychosocial factors	*Social support, personal care hours, domestic assistance, caregiver fatigue, financial concerns, unsustainable work or family commitments, coping and problem solving strategies, quality of life, impact of pain.*		
Lifestyle factors	*Lifestyle priorities; competing interests, roles and responsibilities; change in routine; reduction in preventative behaviours; difficulty obtaining care, services or support; overall increase in risk factors without an increase in prevention factors; other possible barriers to wound healing.*		
Psychosocial impact of pressure injury	*Reaction to PI and management plan, mood, coping strategies, feelings of isolation, able to ask for assistance, able to make decisions.*		
Self management	*Knowledge of pressure risks and management strategies and ability to access assistance/need for support.*		
Additional information regarding likely cause and contributing factors			
Care provider and other organisations involved	*Organisation*	*Contact Person*	*Contact Details*

SUMMARY OF INDIVIDUALISED PRESSURE INJURY MANAGEMENT PLAN				
Wound management summary (See each Wound Management page for more detail)	Location	Stage	Dressing(s) and Frequency	Comments
	1. R / L			
	2. R / L			
	3. R / L			
	4. R / L			
Medical management				
Continence management				
Nutrition plan				
Positioning plan Use *SCI PI Toolkit Positioning Plan*	*Amount of time in bed, positioning, transfer and re-positioning technique, strategies to prevent complications.*			
Personal care plan				
Equipment review / upgrade plan	*Include plan for seating assessment.*			

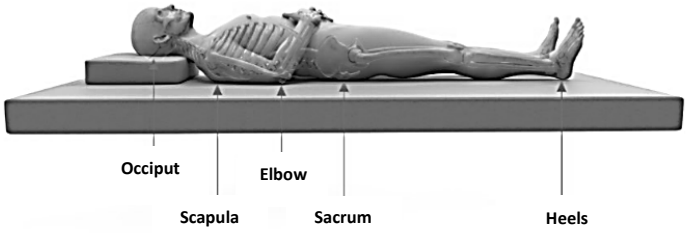
Psychological, social support and emotional wellbeing plan			
Plan for practical support and assistance (e.g. domestic, work, finances)			
Self management support and resources provided		☐ Skin Management Needs Assessment Checklist ☐ Daily Skin Check Guide ☐ Positioning Plan ☐ Bed Rest Information Sheet ☐ Gradual Return To Sitting Plan	
Surgical plan (if required)			
Additional recommendations			
REVIEW DATE		**BY WHOM**	
Referrals	☐ Local multidisciplinary team:_____ ☐ Wound, rehabilitation or SCI clinical nurse consultant/specialist:_____ ☐ SCI or SB-specific service:_____ ☐ Tertiary SCI service:_____ ☐ Case manager or a care coordinator:_____ ☐ Care provider:_____ ☐ Peer support:_____ ☐ Other:_____		

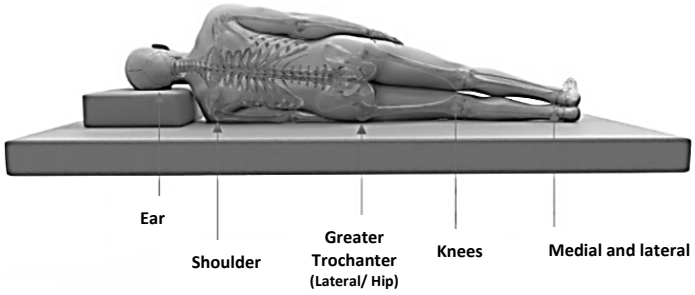
Clinician Name: …… Signature: …… Date:……

WOUND ASSESSMENT - WOUND #1

Location

- ☐ Occiput
- ☐ Ear ☐ Right ☐ Left
- ☐ Shoulder ☐ Right ☐ Left
- ☐ Scapula ☐ Right ☐ Left
- ☐ Elbow ☐ Right ☐ Left
- ☐ Spinous process: _____
- ☐ Sacrum
- ☐ Ischial Tuberosity ☐ Right ☐ Left
- ☐ Greater Trochanter Lateral aspect (Hip) ☐ Right ☐ Left
- ☐ Greater Trochanter Posterior aspect (Underside) ☐ Right ☐ Left
- ☐ Knee ☐ Right ☐ Left
- ☐ Lateral malleolus ☐ Right ☐ Left
- ☐ Medial malleolous ☐ Right ☐ Left
- ☐ Heel ☐ Right ☐ Left
- ☐ Toe: _____ ☐ Right ☐ Left
- ☐ Other: _____ _____ ☐ Right ☐ Left





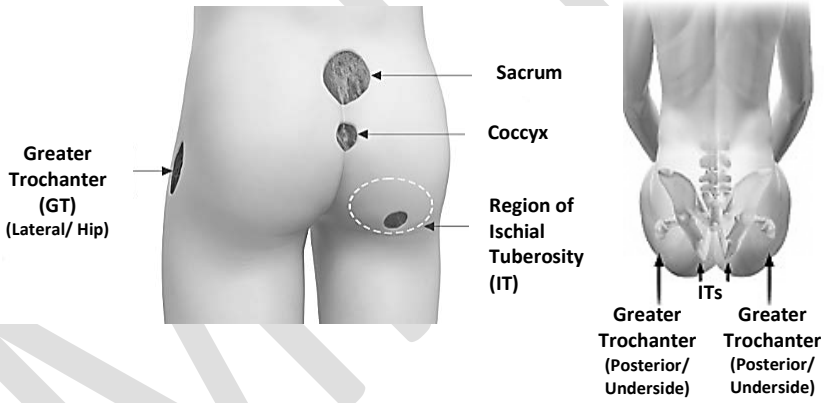


Image credit: Copyright Sunrise Medical Inc., used with permission.

Use hand to check if wound is under pressure when the person is sitting in wheelchair.

Photograph 1: Close Up
[Insert Photo]

Instructions for taking wound photographs:

- *Cover sensitive areas and identifying features*
- *Place a disposable measure ruler approximately 1cm from wound edge to show scale*
- *Take two photos, one close up and one from a distance showing body part for anatomical orientation and identification of left Vs right side. To further assist orientation, an arrow can be used to point in the direction of the person's head*
- *Take the 'close up' photo at 90° to wound surface, about 30-50 centimetres from wound*
- *Review photo to determine whether flash is required*
- *Obtain **consent** from the person and consult the relevant policy in your organisation regarding digital photography*

Photograph 2: Distance (for anatomical orientation)
[Insert Photo]

Instructions for taking wound photographs:

- *Cover sensitive areas and identifying features*
- *Place a disposable measure ruler approximately 1cm from wound edge to show scale*
- *Take two photos, one close up and one from a distance showing body part for anatomical orientation and identification of left Vs right side. To further assist orientation, an arrow can be used to point in the direction of the person's head*
- *Take the 'close up' photo at 90° to wound surface, about 30-50 centimetres from wound*
- *Review photo to determine whether flash is required*
- *Obtain **consent** from the person and consult the relevant policy in your organisation regarding digital photography*

Position of person during assessment	☐ Supine	☐ Prone	☐ Lying on R-side	☐ Lying on L-side
	Degree of hip flexion: 0^0 / 30^0 / 45^0 / 60^0 / 90^0 / Other _____			
Pain assessed with wound/ dressing changes	**Description:** **Pain score: ____/10**			
Stage of Wound	☐ **Stage 1** Non-blanching erythema ☐ **Stage 2** Partial thickness skin loss ☐ **Stage 3** Full thickness skin loss ☐ **Stage 4** Full thickness skin loss with exposed tendon/ muscle ☐ **Unstageable** Full thickness tissue loss, slough/eschar covering wound bed		☐ **Suspected Deep Tissue Injury** Purple/maroon skin discolouration/blood filled blister Tissue is: ☐ painful ☐ boggy ☐ firm ☐ warmer ☐ mushy ☐ cooler compared to adjacent skin	
Wound Dimensions Use clock face system	**Length:** **Width:**	**Depth:** **Undermining**:	**Tracking:** **Other:**	
Wound Bed	☐ **Healthy granulation:** Dark pink / red, clean ☐ **Epithelialisation:** pink, clean	☐ **Slough:** white, yellow, stringy ☐ **Necrotic / Eschar:** Black	☐ **Over granulation:** dark pink, red, bumpy ☐ **Other** (e.g. mixed tissue): _____ _____	
Wound Edges	☐ **Epithelialisation** (clearly defined attached edges) ☐ **Indistinct/ Diffuse** ☐ **Fibrotic** (hard rigid tissue)	☐ **Hyperkeratosis** (hard, rigid) ☐ **Macerated** (moist, wet) ☐ **Rolled edge** ☐ **Raised edge**	☐ **Tracking, sinus tract** ☐ **Undermined** (unattached edges) ☐ **Other:** _____	
Condition/ Appearance of surrounding skin	☐ **Healthy and intact** ☐ **Fragile/ skin tearing** ☐ **Bruised** ☐ **Dry/ cracking/ desiccated** ☐ **Dermatitis**	☐ **Macerated or soggy** ☐ **Erythema/ inflammation/ cellulitis** ☐ **Oedematous/ swelling** ☐ **Excoriated**	☐ **Induration** ☐ **Fibrotic / scarred** ☐ **Hyperkeratotic** ☐ **Callus** ☐ **Other:** _____	
Temperature	Normal / Warm / Hot / Cool	**Odour**	Strong / Moderate / Slight / Nil	
Exudate	**Exudate amount:** Nil / Low or Small / Moderate / High or Large / Copious **Exudate type:** ☐ Serous / clear (amber coloured) ☐ Serosanguinous (pink) ☐ Sanguineous (containing blood) ☐ Purulent (thick, opaque, creamy) ☐ Other: _____			
Signs and symptoms of infection	Superficial wound compartment (NERDS): ☐ **N**on-healing ☐ **E**xudate increased ☐ **R**ed, friable granulation tissue ☐ **D**ebris or dead cells on the wound surface ☐ **S**mell The presence of <u>at least 3</u> of the above indicates increased bacterial burden.		Deep and surrounding wound compartment (STONEES): ☐ **S**ize increasing ☐ **T**emperature increasing ☐ **O**'s: probing to exposed bone ☐ **N**ew or satellite wounds ☐ **E**rythema/edema ☐ **E**xudate increasing ☐ **S**mell The presence of <u>at least 3</u> of the above indicates increased bacterial burden.	
Results of investigations				
Validated tool to monitor progress	☐ Pressure Ulcer Scale for Healing (PUSH) ☐ Bates-Jensen Wound Assessment Tool (BWAT) ☐ Other _____			

References: National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance (2014). *Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline*. Emily Haesler (Ed.) Cambridge Media: Perth, Australia; Houghton PE, Campbell KE & CPG Panel (2013). *Canadian Best Practice Guidelines for the Prevention and Management of Pressure Ulcers in People with Spinal Cord Injury. A resource handbook for clinicians.*

WOUND MANAGEMENT/RECOMENDATIONS – WOUND #1		
Goal of treatment		
Cleansing routine		
Wound dressing NB: Product and size and any allergies to dressing products.	**Primary dressing:**	**Secondary dressing:**
Fixation NB: Skin allergies		
Dressing frequency		
Surrounding skin care		
Pain management plan		
Additional wound information, management recommendations and wound response to previous management strategies.		

Information from the Australian Wound Management Association Telehealth Framework Document used with permission http://www.awma.com.au/publications/2013_awma_telehealth.pdf
With thanks to the specialist spinal cord injury wound care teams at Royal North Shore Hospital and Prince of Wales Hospital, Sydney Australia, for their assistance in the development of this document.

Clinician Name: …… Signature: …… Date:……