



Wounds Research for Patient Benefit

A Survey of Complex Wounds and their Care Data Capture Form

Section 1

DETAILS OF HEALTHCARE WORKER COMPLETING THIS FORM

Job Title	District Nurse <input type="checkbox"/>	Practice Nurse <input type="checkbox"/>	Specialist Nurse <input type="checkbox"/>	Podiatrist <input type="checkbox"/>	Other <input type="checkbox"/>
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If 'Other', please state: _____

Band	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8a	<input type="checkbox"/> Other
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If 'Other', please describe: _____

Service	Community NHS <input type="checkbox"/>	Acute NHS <input type="checkbox"/>	Nursing home <input type="checkbox"/>	Hospice <input type="checkbox"/>	Other <input type="checkbox"/>
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If 'Other', please describe: _____

Date of assessment / / 2 0 1 1
day month year

ID NUMBER
(For office use only)

Section 2

PATIENT DETAILS

Patient's age years

Patient's gender Male Female

Ethnicity

White
British

White
Irish

White
Other

Black
African

Black
Caribbean

Black
Other

Asian
Indian

Asian
Pakistani

Asian
Bangladeshi

Asian
Other

White and
Black
Caribbean

White and
Black
African

White and
Asian

Other mixed
background

Chinese

Other

Type of accommodation individual lives in

Own home

Sheltered accommodation

Residential home

Nursing home

No fixed abode

Other

If 'Other', please describe

RELEVANT CO-MORBIDITIES

Please cross all that apply, if recorded in notes

Cardiovascular disease (CVD)

e.g. Hypertension (high blood pressure, high BP), Myocardial infarction (MI, heart attack, IHD), Angina (IHD), Heart failure (CCF, CHF, HF, LVF)

Peripheral Vascular Disease (PVD)

e.g. Ischaemia (leg/foot), Claudication (intermittent claudication), Rest pain, Arteriopathy/angiopathy, Aneurysm including aortic aneurysm

Diabetes (DM)

e.g. Insulin dependent DM (IDDM, Type I diabetes), Non insulin dependent DM (NIDDM, Type II diabetes)

Arthritis

e.g. Rheumatoid arthritis (RA), Osteoarthritis (OA), Non rheumatoid arthritis

Orthopaedics

e.g. Fractured neck of femur (# NOF, # hip, fractured hip, broken hip), Other fracture/break, Elective orthopaedic

Airways

e.g. Chronic obstructive airways/pulmonary disease (COAD, COPD), Chronic bronchitis, Emphysema, Asthma

Neurological

e.g. Parkinson's disease, Multiple sclerosis (MS), Epilepsy (fits, Grand mal, Petit mal, tonic-clonic, seizure), Spinal Injury

Stroke

e.g. (cerebrovascular accident, CVA, transient ischaemic attack, TIA)

Cancer

e.g. any cancer diagnosis

Other diagnosis

1.

2.

3.

4.

5.

Continence
(please cross all that apply)

No incontinence	Urinary incontinence	Faecal incontinence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is the patient (or has been) an IV drug user?

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nutritional status

Recent weight loss	Recent weight gain	No recent weight change
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mobility
(please cross one box only)

Patient walks freely	Patient walks with difficulty	Patient is immobile
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Braden risk score reported in notes in last month?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If 'Yes', score is

Currently on antibiotics?

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Ankle mobility
(please cross one box only)

Patient has full range of ankle motion

Patient has reduced range of ankle motion

Patient's ankle is fixed

Not reported in notes

Section 3

CURRENT COMPLEX WOUND(S)

Frequency of wound related consultations per week

Duration of most recent consultation hours minutes

Location of wound treatment

Patient's home GP Practice Community Clinic Hospital in-patient Hospital out-patient Other If 'Other', please describe

Does the patient receive wound related treatment anywhere else? Yes No Don't know

Total number of current complex wounds

Please complete the following assessment for the 4 worst wounds.

Complex Wound 1

Duration of wound years months weeks

Type of wound (refer to guidelines for wound definitions)
(please cross one box only)

Diabetic foot ulcer <input type="checkbox"/>	Non-diabetic foot ulcer <input type="checkbox"/>	Venous leg ulcer <input type="checkbox"/>	Arterial leg ulcer <input type="checkbox"/>	Arterial/Venous leg ulcer <input type="checkbox"/>
Pressure ulcer <input type="checkbox"/>	Dehisced surgical wound <input type="checkbox"/>	Pilonidal sinus <input type="checkbox"/>	Abscess <input type="checkbox"/>	Traumatic wound e.g. road traffic accident <input type="checkbox"/>
Other surgical wound <input type="checkbox"/>	Fungating carcinoma <input type="checkbox"/>	Bum <input type="checkbox"/>	Other <input type="checkbox"/>	If 'Other', please describe <input type="text"/>

What do you believe the underlying cause of the wound to be?
(please cross all that apply)

Venous Arterial Mixed Arterial/Venous Pressure/
Friction/Sheer Infection Post Surgical

Is a Doppler ABPI recorded in the notes? Yes No

If 'Yes', what is it? .

Location of wound (anatomical description)

Category of wound (1 to 4) Unstageable

Exudate High Moderate Low None

Wound margin/ surrounding skin (please cross all that apply) Macerated Oedematous Erythema

Malodour? Yes No

Treatment objectives
(please cross all that apply)

Debridement Absorption Hydration Bacterial load management Odour management
Reduce overgranulation Encourage granulation Protection Other

If 'Other', please describe:

Wound dressing being used (refer to the list of dressings in the guidelines and insert the corresponding code in the boxes)

Primary dressing

Secondary dressing

OTHER WOUND TREATMENTS

(please cross all that apply)

Drugs / medicines	Antibiotics for wound infection <input type="checkbox"/>	Pentoxifylline <input type="checkbox"/>	Topical steroids <input type="checkbox"/>	Analgesics <input type="checkbox"/>
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Bandaging

Multi layer compression <input type="checkbox"/>	3 layer reduced compression <input type="checkbox"/>
Short stretch e.g. Actico/Comptan <input type="checkbox"/>	2 layer e.g. K2 <input type="checkbox"/>
Non compression bandage plus wadding e.g. K Lite <input type="checkbox"/>	Dressing retention bandage e.g. K-Band <input type="checkbox"/>

Hosiery e.g. Mediven, Jobst

Class 1 over the counter <input type="checkbox"/>	Class 2 over the counter <input type="checkbox"/>
Class 3 over the counter <input type="checkbox"/>	Class 2 made to measure <input type="checkbox"/>
Class 3 made to measure <input type="checkbox"/>	40 mm hg treatment hosiery - over the counter <input type="checkbox"/>
40 mm hg treatment hosiery - made to measure <input type="checkbox"/>	

Equipment

Pressure relieving mattresses	
High specification foam replacement e.g. MSS glide <input type="checkbox"/>	Crutches <input type="checkbox"/>
Air alternating replacement e.g. Quattro deep cell prime <input type="checkbox"/>	Wheelchair <input type="checkbox"/>
Air alternating overlay e.g. Alpha excel <input type="checkbox"/>	Other <input type="checkbox"/>
Repose (overlay system) <input type="checkbox"/>	If 'Other', please describe: <input type="text"/>
Foam overlay <input type="checkbox"/>	

**Footwear/Orthotics/
Foot pressure
relieving equipment**

Prescribed footwear <input type="checkbox"/>	Footwear adaptation <input type="checkbox"/>	Insoles <input type="checkbox"/>	Heel pressure relief e.g. Repose Heel Trough, PROFO boot <input type="checkbox"/>	Other <input type="checkbox"/>
If 'Other', please describe: <input type="text"/>				

Other

Hyperbaric oxygen therapy <input type="checkbox"/>	Physiotherapy <input type="checkbox"/>	Occupational therapy <input type="checkbox"/>
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Section 3 completed up to four times where the patient had multiple wounds