

Developed in collaboration with the Wound Care Champions, Wound Care Specialists, Enterostomal Nurses, and South West Regional Wound Care Program (SWRWCP) members from Long Term Care Homes, Hospitals, and South West Community Care Access Centre contracted Community Nursing Agencies in the South West Local Health Integration Network.



<b>Title</b>	<b>Procedure: Initial Wound Assessment Form</b>
<b>Background</b>	<ul style="list-style-type: none"> <li>• The assessment process includes the gathering of data from a patient history and physical exam, and helps with clinical decision making processes</li> <li>• Assessment is done with/of a person with a wound before implementing special tests/examinations and before implementing interventions to ensure that only medically necessary, reasonable, and appropriate care/treatments/services are provided</li> <li>• “The use of standardized forms is the best method of collecting assessment data quickly and efficiently, thus ensuring that important information is not lost”</li> <li>• The “Initial Wound Assessment Form” was developed by members of the SWRWCP, and is an interdisciplinary assessment tool to be used to assess individuals with wounds. The form is intended:             <ul style="list-style-type: none"> <li>• To be completed at the point of entry to the health care system for individuals with a wound or when a wound is identified on an individual already within the system;</li> <li>• To be completed by a generalist health care provider such as an Registered Nurse, Registered Practical Nurse, Occupational Therapist, Physiotherapist, etc. or by a Wound Care Specialist or Enterostomal Nurse if they are the first person to assess the wound, and;</li> <li>• To follow the individual as they move through the health care system, providing all subsequent health care providers access to the initial assessment information.</li> </ul> </li> </ul>
<b>Indications</b>	This procedure is intended to be used by front line registered health care providers to assist with their assessment and management of individuals admitted with or presenting with a wound.
<b>Procedure</b>	<p><b>NOTE: The use of the “Initial Wound Assessment Form” is but one part of the holistic assessment of an individual admitted with or presenting with a wound.</b></p> <p><b>Assessment</b></p> <ol style="list-style-type: none"> <li>1. Thoroughly review the person’s available medical records and add appropriate information to the “Initial Wound Assessment Form” regarding the following:             <ol style="list-style-type: none"> <li>a. The person’s name, Ontario Health Insurance Plan (OHIP) number or other identifier (ID Number), address and telephone number (unless the person is in an institution, in which case you would add the institutional information)</li> <li>b. The current date</li> </ol> </li> </ol>

NOTE: this is a controlled document. A printed copy may not reflect the current electronic version on the SWRWCP’s website. This document is not a substitute for proper training, experience, and exercising of professional judgment. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the SWRWCP give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omission in the contents of this work.

- c. Demographics and vitals:
  - i. Sex
  - ii. Date of birth
  - iii. Allergies (include allergies to drugs, environment, food, pets, etc.). You may also wish to collect information re the type and severity of allergic reaction
- d. Involved disciplines:
  - i. Name and contact information of the person’s family physician or primary care nurse practitioner, and any other healthcare professionals that are actively involved in the care of the person and/or their wound
- e. Cognition/mental status:
  - i. If available in medical charting, the person’s cognitive level/status
- f. Learning style:
  - i. If available in medical charting, the person’s preferred learning style
- g. Co-morbid factors:
  - i. Current and historical medical conditions/diagnoses
  - ii. Most recent HgbA1c and fasting glucose results, including the date of the blood work. You may also wish to search for previous lab values to use for comparison purposes, i.e. has their diabetes control improved or worsened over time and if interventions have already been instituted, and if so, have they been effective?

Lab Test		Normal Range
Glycosylated Hemoglobin		4-6%
Fasting Glucose		3.9-6.1 mmol/L
Serum Thyroid Stimulating Hormone	Newborn (1-4 days)	1-17 mIU/L
	Infant (2-20 weeks)	1.7-9.1 mIU/L
	Children (21 weeks – 20 years)	0.7-6.4 mIU/L
	Adult	0.4-4.8 mIU/L

- h. Active infections:
  - i. Indicate any active diagnosis of the noted infections and add any other diagnoses of active infections not listed, i.e. cellulitis, urinary tract infection, respiratory infection, etc.
- i. Nutrition:
  - i. Most recent height and weight and any weight gain/loss amounts and the time period over which this weight loss/gain occurred over (days/weeks/months).  
**NOTE: significant unintentional weight loss is equivalent to:**
    - a. **2% in one week**
    - b. **5% in one month**
    - c. **7.5% in three months**

**d. 10% in six months**

ii. Most recent nutrition related lab work results (note the date of the lab work):

Lab Test		Normal Range
Serum Albumin		35-50g/L
Pre-Albumin		16-36 mg/dL
Serum Creatinine	Males	53-106umol/L
	Females	44-97 mmol/L
Serum Ferritin		20-200 ug/L
Hemoglobin	Newborns	165-195 g/L
	Children	112-165 g/L
	Males	140-180 g/L
	Females	120-160 g/L
Serum Iron	Males	13-31 umol/L
	Females	5-29 umol/L
Serum Iron Binding Capacity		45-73 umol/L
Serum Potassium	Newborn	3.7-5.9 mmol/L
	Infant	4.1-5.3 mmol/L
	Child	3.4-4.7 mmol/L
	Adult	3.5-5.1 mmol/L
BUN		3.6-7.1 mmol/L

iii. The name of any nutritional supplements the person is taking currently, and the amount and frequency they are consuming them

j. Mini nutritional assessment screen:

i. You may be able to input the following information from the person’s chart, if it is so available and current:

- a. Food intake
- b. Weight loss
- c. Mobility
- d. Acute disease or stress
- e. Body mass index – BMI = weight (kg)/height (m<sup>2</sup>) (below is Health Canada’s BMI reference chart)

Classification	BMI Category
Underweight	<18.5
Normal Weight	18.5-24.9
Overweight	25.0-29.9
Obese Class I	30.0-34.9
Obese Class II	35.0-39.9
Obese Class III	>=40.0

k. Mobility and neurological status:

i. The person’s ability to transfer and ambulate, i.e. are they independent, independent with a mobility device, do they require supervision, stand by assistance, minimal assistance (one or two person), or a mechanical lift?

l. Medication list:

i. List of the person’s current medications (you may be

	<p>able to print/photocopy the person’s Medication Administration Record or Consolidated Orders sheet to save time, if you are in an institution)</p> <ul style="list-style-type: none"> <li>m. Medications that interfere with healing: <ul style="list-style-type: none"> <li>i. Note any medications that may negatively affect the person’s ability to heal, and consider discussions with the person’s prescribing physician re reducing/stopping such medications to allow for wound healing, if appropriate</li> </ul> </li> <li>n. Co-factors affecting wound healing: <ul style="list-style-type: none"> <li>i. Look through the person’s patient records to determine if they have any of the noted intrinsic/extrinsic/iatrogenic factors listed, that may negatively affect wound healing</li> </ul> </li> <li>o. Wound information: <ul style="list-style-type: none"> <li>i. Age of the wound (if available in the person’s chart)</li> <li>ii. Any previous wound treatments, who ordered them, what discipline applied them, and whether or not they were effective</li> </ul> </li> <li>p. Type of wound: <ul style="list-style-type: none"> <li>i. Any noted wound diagnosis by a physician or primary care nurse practitioner or suspected etiology as noted by another registered health care professional</li> </ul> </li> </ul> <p><b>Planning</b></p> <ul style="list-style-type: none"> <li>1. Expected outcomes: <ul style="list-style-type: none"> <li>a. Information from the person’s chart, the person and/or their substitute decision maker (SDM)/power of attorney for personal care (POA C), and your assessment will allow for the thorough completion of the “Initial Wound Assessment Form”, thus providing an accurate initial wound assessment</li> <li>b. The information obtained in the “Initial Wound Assessment Form” will allow for: <ul style="list-style-type: none"> <li>i. The identification of the type of wound and underlying cause(s) of the wound</li> <li>ii. The identification of extrinsic, intrinsic, and iatrogenic factors affecting the person’s ability to heal (if healing is a realistic goal)</li> <li>iii. The determination of the healability of the person’s wound</li> <li>iv. The identification of pertinent person-centered concerns re the wound i.e. pain management and quality of life issues</li> </ul> </li> <li>c. Registered nursing staff, in collaboration with other involved health care disciplines and the person with the wound and/or their SDM/POA C (if applicable), will be able to use the assessment information to initiate/modify and implement an</li> </ul> </li> </ul>
--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

NOTE: this is a controlled document. A printed copy may not reflect the current electronic version on the SWRWCP’s website. This document is not a substitute for proper training, experience, and exercising of professional judgment. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the SWRWCP give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omission in the contents of this work.

appropriate, person-centered, interdisciplinary plan of care which contains:

- i. Clear directions to staff and others who are providing the person with direct care, and;
  - ii. Interventions to reduce or relieve pain, enhance wound related quality of life, promote wound closure (if healing is the goal), manage exudates/odor, and prevent infection, as required.
2. Explain the procedure and purpose behind the “Initial Wound Assessment Form” to the person (and/or their SDM/POA C) and obtain verbal or implied consent to proceed with the assessment

**Implementation**

1. Provide for privacy and ensure the person is in a comfortable position to facilitate the assessment
2. Ensure the person’s SDM/POA C is present or available if the person does not have a reliable memory or is unable to accurately answer any questions on the “Initial Wound Assessment Form”
3. Following the order of the “Initial Wound Assessment Form”, ask the person and/or their SDM/POA C questions to elicit responses to the identified “Initial Wound Assessment Form” items. Specific instructions:

a. Demographics and vitals:

- i. Before beginning the “Initial Wound Assessment Form”, ensure that the person’s name, OHIP or other identifying number, and current date are added to the top of every page (in the header space where indicated)
- ii. Take the person’s blood pressure, pulse, temperature, and assess their respiration rate, and record. Normal adult ranges:

Vital Sign	Normal Values
Blood pressure	<135/85 mmHg
Pulse	60-100 beats per minute
Temperature	36.5-37.5 *C
Respiration rate	12-18 breaths per minute

b. Allergies:

- i. Confirm/determine any drug, environmental, food and pet allergies and the type and severity of any allergic reactions

c. Involved disciplines:

- ii. Confirm the name of the person’s family physician or primary care nurse practitioner, and any other healthcare professionals that are actively involved in the care of the person and/or their wound

d. Cognition/mental status:

- i. Confirm/determine the person’s cognitive/mental

NOTE: this is a controlled document. A printed copy may not reflect the current electronic version on the SWRWCP’s website. This document is not a substitute for proper training, experience, and exercising of professional judgment. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the SWRWCP give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omission in the contents of this work.

	<p>status. If concerned, consider requesting a formal cognitive assessment from a Social Worker, trained Registered Nurse, or the person’s family physician/primary care nurse practitioner</p> <ul style="list-style-type: none"> <li>e. Learning style: <ul style="list-style-type: none"> <li>i. Confirm/determine the person’s learning style or the learning style of their SDM/POA C if they will be receiving verbal/written education re skin and wound care prevention and management strategies</li> </ul> </li> <li>f. Co-morbid factors: <ul style="list-style-type: none"> <li>i. Confirm/determine the person’s medical diagnoses. Write in any diagnoses that are not listed but that may be applicable to wound healability</li> </ul> </li> <li>g. Active infections: <ul style="list-style-type: none"> <li>i. Confirm/determine any active infections. Ensure that the entire health care team is notified of any previously unidentified infection(s) and that the appropriate infection control measures are initiated</li> </ul> </li> <li>h. Nutrition: <ul style="list-style-type: none"> <li>i. If not available in the person’s chart, or if values found are not relatively current, obtain the person’s weight (Kg) and height (cm)</li> <li>ii. If not available in the person’s medical chart, ask the person about any weight loss/gain over the past six months</li> <li>iii. Complete the “Nestle Mini-Nutritional Assessment (MNA®) Tool” as per the document “Procedure: Nestle Mini Nutritional (MNA®) Assessment Tool”, and calculate the person’s score</li> <li>iv. Consider a referral to a Registered Dietician for those who score <math>\leq 11</math> and who have a wound (see “Criteria for Interdisciplinary Referrals”)</li> </ul> </li> <li>i. Mobility and neurological status: <ul style="list-style-type: none"> <li>i. If not noted in the persons medical record, determine the person’s transfer/ambulation statuses by asking them and/or observing them</li> <li>ii. Consider a referral to a physiotherapist for people who present with an unsteady gait, mobility issues, or who have been identified as a fall risk (see “Criteria for Interdisciplinary Referrals”)</li> <li>iii. Consider a referral to an occupational therapist for immobile people who require a surface assessment (see “Criteria for Interdisciplinary Referrals”)</li> </ul> </li> <li>j. Medications: <ul style="list-style-type: none"> <li>i. Review the person’s medications with them, ensuring accuracy and ensuring that they understand the</li> </ul> </li> </ul>
--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

	<p>purpose of the medications. Remind the person to consider any drops, puffers, patches, creams, over the counter, vitamins/minerals, and any herbal supplements they may be taking. Note any medications that may delay wound healing</p> <ul style="list-style-type: none"> <li>ii. Consider discussions with the person’s family physician, primary care nurse practitioner, prescribing physician, pharmacist or pharmacy consultant re medications that delay healing and potential adjustments</li> </ul> <p>k. Co-factors affecting wound healing:</p> <ul style="list-style-type: none"> <li>i. If the information is not available in the person’s chart, ask about any intrinsic, extrinsic, and iatrogenic factors are present that may affecting wound healing and document them accordingly</li> <li>ii. Ensure that these factors are addressed (if possible) and that such interventions are noted in the person’s plan of care</li> </ul> <p>l. Quality of life:</p> <ul style="list-style-type: none"> <li>i. Ask the person how they are feeling about their quality of life related to the presence of their wound, and have the person rate their responses to the noted questions</li> <li>ii. Consider a Social Work referral if the person’s quality of life is seriously affected by the presence of the wound and/or its effects</li> </ul> <p>m. Wound pain:</p> <ul style="list-style-type: none"> <li>i. Ask the person with the wound (or their SDM/POA C) questions to elicit responses to the noted pain questions. Please note that the pain history is based on the highest level of wound pain present in the last seven days. If the person cannot respond to your questions, consider utilizing other valid pain tools as per the document “Generic Pain Assessment Tools” found on the SWRWCP website (<a href="http://www.swrwoundcareprogram.ca">www.swrwoundcareprogram.ca</a>)</li> <li>ii. Consider notifying the person’s family physician or primary care nurse practitioner re the person’s wound pain should they rate it as four or greater out of 10 on a 0-10 point Likert scale (0 being no pain and 10 being the worst possible pain), or equivalent if you are using a different pain scale. You may consider using the SWRWCP’s “Comprehensive Assessment of Chronic Pain in Wounds” tool, found on the Program’s website, to facilitate such communication (<a href="http://www.swrwoundcareprogram.ca">www.swrwoundcareprogram.ca</a>)</li> <li>iii. You may wish to suggest to the primary care</li> </ul>
--	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

NOTE: this is a controlled document. A printed copy may not reflect the current electronic version on the SWRWCP’s website. This document is not a substitute for proper training, experience, and exercising of professional judgment. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the SWRWCP give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omission in the contents of this work.

	<p>practitioner, a referral to a pain specialist, if attempts at managing the wound pain have been unsuccessful, and/or a referral to physiotherapy for a trial of electrical stimulation for pain management (see “Criteria for Interdisciplinary Referrals”)</p> <ul style="list-style-type: none"> <li>n. Wound history: <ul style="list-style-type: none"> <li>i. If such information is not available in the person’s medical chart, as them when they developed their wound (have them approximate to the best of their ability) and Indicate by checking the appropriate box if the wound is new, chronic, or recurrent</li> <li>ii. Confirm with/ask the person what wound treatments have been used in the past to treat their wound, and their effectiveness</li> </ul> </li> <li>o. Type of wound: <ul style="list-style-type: none"> <li>i. Assess the wound using the “NPUAP PUSH Tool 3.0” (see “Procedure: NPUAP PUSH Tool 3.0”)</li> <li>ii. If the wound is a pressure ulcer, indicate it stage using the “NPUAP Staging System for Pressure Ulcers” (see “Procedure: NPUAP Staging System for Pressure Ulcers”)</li> <li>iii. If the wound is a diabetic foot ulcer, indicate the grade and stage using the “University of Texas Staging System for Diabetic Foot Ulcers” (see “Procedure: University of Texas Staging System for Diabetic Foot Ulcers”)</li> <li>iv. If the wound is a skin tear, indicate its category using the “Payne Martin Classification for Skin Tears” (see “Procedure: Payne Martin Classification for Skin Tears”)</li> <li>v. Indicate the exact location of the wound(s) on the body diagram in the “Initial Wound Assessment Form” by placing an “x” in the corresponding area</li> </ul> </li> </ul> <ol style="list-style-type: none"> <li>4. Upon completion of the form, sign the bottom of every page. Include your professional designation</li> <li>5. Discuss your findings and their implications with the person and/or their SDM/POA C</li> <li>6. Share the results of your assessment with the interdisciplinary members of the person’s wound care team</li> <li>7. Complete documentation as required, i.e. complete/update interdisciplinary, person-centered care plans as per your organization’s policies, based on your holistic assessment</li> <li>8. Utilize the contents of the form to help develop a person-centered, interdisciplinary care plan for the person and their wound</li> <li>9. Store the completed “Initial Wound Assessment Form” in the person’s medical record for future reference. Should the person be transferred to another facility/service, a copy of this document should accompany</li> </ol>
--	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

NOTE: this is a controlled document. A printed copy may not reflect the current electronic version on the SWRWCP’s website. This document is not a substitute for proper training, experience, and exercising of professional judgment. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the SWRWCP give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omission in the contents of this work.



	<p>them to prevent duplication of assessment and to promote the continuity of care</p> <p><b>Evaluation</b></p> <ol style="list-style-type: none"> <li>1. Unexpected outcomes:       <ol style="list-style-type: none"> <li>a. Information from the person’s medical records, the person and/or- their SCM/POA C, and your assessment do not allow for the thorough completion of the “Initial Wound Assessment Form”</li> <li>b. The information obtained does not allow you to:           <ol style="list-style-type: none"> <li>i. Accurately identify the most likely wound etiology and underlying cause(s) of the wound</li> <li>ii. Accurately identify extrinsic, intrinsic, and iatrogenic factors affecting the person’s ability to heal</li> <li>iii. Determine the healability of the person’s wound</li> <li>iv. Identify pertinent person-centered concerns re the wound i.e. pain management and quality of life issues</li> </ol> </li> <li>c. Registered nursing staff, in collaboration with other involved health care disciplines and the person with the wound or their SDM/POA C, are unable to use the assessment information to initiate/update and implement an appropriate person-centered, interdisciplinary plan of care</li> <li>d. The “Initial Wound Assessment Form” is not completed according to this procedure</li> </ol> </li> </ol>
<b>References</b>	<ol style="list-style-type: none"> <li>1. Sussman C, Bates-Jensen B. The diagnostic process. In: Sussman C, Bates-Jensen B., eds. Wound Care: A collaborative practice manual for health professionals. Third Ed. Baltimore: Lippincott Williams &amp; Wilkins, 1997:2-3.</li> </ol>
<b>Related Tools</b> <b>(NOTE: these tools and their instructions can be found on the SWRWCP’s website: <a href="http://swrwoundcareprogram.ca">swrwoundcareprogram.ca</a>)</b>	<ul style="list-style-type: none"> <li>• Initial Wound Assessment Form</li> <li>• Nestle Mini Nutritional Assessment (MNA®) Tool</li> <li>• Procedure: Nestle Mini Nutritional Assessment (MNA) Tool</li> <li>• Criteria for Interdisciplinary Referrals</li> <li>• Generic Pain Assessment Tools</li> <li>• Comprehensive Assessment of Chronic Pain in Wounds</li> <li>• Procedure: Comprehensive Assessment of Chronic Pain in Wounds</li> <li>• NPUAP PUSH Tool 3.0</li> <li>• Procedure: NPUAP PUSH Tool 3.0</li> <li>• NPUAP Staging System for Pressure Ulcers</li> <li>• Procedure: NPUAP Staging System for Pressure Ulcers</li> <li>• University of Texas Staging System for Diabetic Foot Ulcers</li> <li>• Procedure: University of Texas Staging System for Diabetic Foot Ulcers</li> <li>• Payne Martin Classification for Skin Tears</li> <li>• Procedure: Payne Martin Classification for Skin Tears</li> </ul>