

## COMPLEX WOUND CARE SUPPORT PLAN

Identified need for support	Goals	Interventions
<p><b>Complex Wound Care Secondary to:</b></p> <p><input type="checkbox"/> Burns</p> <p><input type="checkbox"/> PVD (Peripheral Vascular Disease)</p> <p><input type="checkbox"/> Metabolic disease e.g. diabetes</p> <p><input type="checkbox"/> Osteomyelitis</p> <p><input type="checkbox"/> Pressure ulcers</p> <p><input type="checkbox"/> Traumatic tissue injury</p> <p><input type="checkbox"/> Other: _____</p> <p><b>Evidenced by:</b></p> <p><input type="checkbox"/> Clinical wound consultant notes</p> <p><input type="checkbox"/> Medical notes</p> <p><input type="checkbox"/> Complex Wound Care Support Plan</p> <p>Wound Consultant</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Contact Details: _____</p> <p>Date: _____</p>	<p><input type="checkbox"/> Multi-disciplinary team approach</p> <p><input type="checkbox"/> Identification of risk factors</p> <p><input type="checkbox"/> Multifactorial treatment plan</p> <p><input type="checkbox"/> Maintain skin integrity</p> <p><input type="checkbox"/> Adequate Nutrition</p> <p><input type="checkbox"/> Other: _____</p> <p>Who to contact with questions or concerns:</p> <p>_____.</p>	<p><b>Complex Wound Care Support</b></p> <p><input type="checkbox"/> Inspect wound, undertake assessment (type, size, location, tissue type)</p> <p><input type="checkbox"/> Replace dressings (follow instruction on wound chart) under Health Practitioner supervision</p> <p><input type="checkbox"/> Monitor, report and manage pain before, during and after wound dressing change</p> <p><input type="checkbox"/> Provide prescribed pain medication before/after dressing requirement</p> <p><input type="checkbox"/> Monitor and report on signs of infection - redness, purulent exudate, malodour, localised heat/pain, oedema</p> <p><input type="checkbox"/> Schedule daily support activities e.g. showering, toileting, mealtime activities around wound care support</p> <p><input type="checkbox"/> Provide training and direction for support workers for daily support care, work required for</p> <p><b>Other participant specific intervention:</b></p> <p>_____.</p> <p><b>Pressure Care</b></p> <p><input type="checkbox"/> Identify any symptoms of pressure and associated risk e.g. Pressure ulcers</p> <p><input type="checkbox"/> Position and turning to manage pressure</p>

**Other participants specific interventions:**

**Risk/Response:**

- Autonomic dysreflexia
- Faecal blockages
- Constipation/faecal impaction
- Diarrhoea/faecal incontinence
- Signs of infection
- Rectal bleeding
- Perforation

Refer to General Practitioner if any of the above risks occur to ensure participants well-being.

<b>Prepared by:</b>		
Position Title:		
Signature:		Date:
<b>Reviewed and Approved by:</b>		
General Practitioner Name:		
General Practitioner Signature:		Date:
Health Professional Name:		
Health Professional Signature:		Date:

## Agreement

By signing this Support Plan, I agree that I have been involved in the development of my plan. I agree and consent to the care and interventions of this Complex Wound Care Support Plan.

Participant/Representative Name:		
Participant/Representative Signature:		Date:
Company Representative Name:		
Company Representative Signature:		Date:

### Communication / Copy of Support Plan

Copy of Support Plan given to:	<input type="checkbox"/> Participant <input type="checkbox"/> Health Professional <input type="checkbox"/> Health Practitioner <input type="checkbox"/> Other:
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## Complex Wound Care Directive

### General Practitioner, Health Practitioner, Registered Nurse (RN) or Other Health Professional

<b>Date:</b>	
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<b>Diagnosis/Medical History</b>
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<b>Specific Problem: Complex Wound Care Support</b>
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<b>Specific Care Orders/Treatment Plan (state type/frequency)</b>
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<b>Plan Review Frequency</b>	
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<b>Informed Consent Obtained</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>If NO, state details:</b>
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### Authorisations

<b>Medical Practitioner Name</b>			
<b>Medical Practitioner Signature</b>		<b>Date</b>	
<b>Client Name</b>			
<b>Client Signature</b>		<b>Date</b>	

## Document Control

Version No.	Issue Date	Document Owner
1	19/12/2024	Elizabeth Bradshaw
Version History		
Version No.	Review Date	Revision Description