Negative Pressure Wound Therapy (NPWT)

Screening Tool

For Home Care

Name: ____________________

AHC#: ____________________

SCREENING	YES	NO	DETAILS
1. Wound meets NPWT criteria, which has been ordered			❑ ET consultation completed
2. Client is willing to have NPWT in situ 24 hours a day for the time that the therapy is in place			
3. Education and understanding:			❑ Client ❑ Support Person ❑ See Comments Below
a. Willing to attend an educational in-service			
b. Able to demonstrate understanding of operation, troubleshooting, and emergency measures			
c. Speaks and understands English			
d. Competent to troubleshoot and describe exudate (i.e. hearing and vision not notably impaired, mentally competent, etc.)			
4. Ability to manage NPWT equipment:			❑ Client ❑ Support Person ❑ See Comments Below
a. Can change canister			
b. Can manage the equipment in the home setting			
c. Would be able to discontinue therapy and replace with appropriate dressing in extenuating circumstances			
5. Client has agreed to adhere to a comprehensive care plan to optimize healing that considers:			
a. Wound area can be offloaded			
b. Nutrition and hydration status promote wound healing (b/w: albumin and transferrin levels; if diabetic, A1C)			
c. Substance use			
d. The need for pressure relieving equipment (i.e. with skin grafts)			
e. Ability to sit and lie without tubing causing further skin damage			
6. Home environment has the following:			
a. Permanent address			
b. Electricity			
c. Running water			
d. Working telephone			
e. Heating			
f. Cleanliness			
g. Safety			
7. Client has reliable access to transportation			❑ Client ❑ Support Person ❑ See Comments Below
8. Cost is covered (i.e. AADL, WCB, private health insurance, etc.)			

COMMENTS (additional space on reverse)

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SCORING

✕ If a "**NO**" or "**UNKNOWN**" response is given for #1 or #2, client is not suitable for NPWT at this time.

✕ If a "**NO**" or "**UNKNOWN**" response is given for any of the screening items, further assessment and interventions may be required prior to the initiation of the therapy.

RECOMMENDATION	INTERPROFESSIONAL REFERRAL		COMMUNITY REFERRAL
❑ **NPWT APPROVED**	❑ WOCN/ET Nurse	❑ Plastics	❑ Handi-Bus
❑ **NPWT Approved With SUPPORTS (see interdisciplinary referral)**	❑ Clinical Educator	❑ Specialist ________	❑ Housekeeping/Laundry
	❑ OT	❑ Dietician	❑ Meals-On-Wheels
❑ **CONTINUE NPWT**	❑ PT	❑ Social Work	❑ Other ____________
❑ **NPWT NOT Approved At This Time**	❑ MD	❑ Counseling	❑ Band Health Authority

Initiation Date:	Reassessment Date:	Form Completed By:	Case Manager:

Developed by Mackenzie Garrett, Christina Huff, and Carmen Meyer, University of Lethbridge. © 2008; **Version: April 10, 2008**

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Additional Notes/Comments

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