Scottish Wound Assessment and Action Guide

This guide is to aid wound assessment and management, and should be used in line with local policy/ guidelines. A holistic person-centred approach to care should be considered at all times. The wound assessment must be completed by a registered nurse or other healthcare professional.

This guide presumes that Standard Infection Control Precautions (SICPs) are applied at ALL times when providing healthcare when there is a risk of exposure to blood, other body fluids, secretions or excretions (except sweat), non-intact skin or mucous membranes. (See http://www.hps.scot.nhs.uk/haiic/index.aspx)

For more information on the key precautions and management principles in tissue viability an educational workbook is available at http://www.nes.scot.nhs.uk/hai/ulcers/

Step 1

Does the wound need cleansing?
Only cleanse if there is debris on the wound bed that needs removed.

Step 2

Measure wound length, width, depth and undermining.
Do not estimate.

Use a scale such as:
- tracing, disposable ruler for length and/or width
- wound swab stick, wound probe for depth and/or undermining

Step 3

a What tissue type and levels of exudate does the wound have?
Dressing choice must accommodate tissue type, exudate level, odour, expected wear time, peri-wound skin, area to be dressed, pain at dressing change and patient/client need.

b Select secondary dressing if required.
See Step 3a above.

Step 4

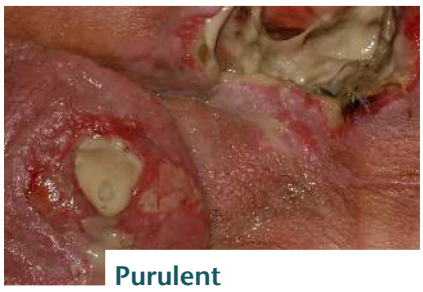
Document in wound chart.
A wound chart must be completed for every patient/client with a wound.

An example of a wound chart can be found at www.tissueviabilityonline.com

Points to remember:

- Know the action and possible side effects of any dressing you apply.
- Know how to apply and remove any dressing correctly, eg safe and atraumatic removal of all dressings.
- Know how long a dressing can stay in place and indication(s) for dressing change.
- Do not mix different primary and secondary types of dressing together, eg hydrogel and hydrofibre.
- Select a dressing that is the correct size for the wound. A dressing that is too big or too small can be detrimental to the wound.
- If in doubt seek advice from appropriate healthcare professional, ie tissue viability nurse, dermatology nurse, podiatrist.

Tissue type description	Objective/action guide
 **Tracking/undermining**	A tunnelling effect or pocket under the edge of the wound. Extension of the wound bed into adjacent tissue, also known as a sinus tract.	Aid healing from inside wound • Loose packing/layering with alginate/ hydrofibre or hydrogel • Seek advice from appropriate healthcare professional
 **Necrotic soft/hard**	Necrotic tissue is a layer of dead tissue which can be brown or black in colour and is caused by inadequate blood supply or infection. It may be soft or hard on the surface, can be of varying depth and may produce an offensive smell.	Rehydrate and remove sloughy/necrotic tissue • Do not apply moisture to ischemic areas • Full assessment of individual should be considered ie vascular assessment • Consider hydrogel/hydrocolloid • Medically prepared honey • Sharp debridement only by competent healthcare professional
 **Sloughy**	Slough is a layer of dead tissue which can be yellow or green in colour, and may be dry or wet on the surface. It can be of varying depth and may produce an offensive smell.	Remove all debris • Hydrogel if exudate low • Medically prepared honey if exudate low • Hydrofibre if exudate moderate to high • Larvae • Sharp debridement only by competent healthcare professional
 **Granulating**	The development of new tissue from the wound base which typically appears bright red in colour, and has a rough or irregular surface.	To encourage granulation tissue • Hydrocolloid if exudate low to moderate • Non-adherent dressing if exudate low to moderate • Hydrofibre if exudate moderate to high • Non-adherent dressing with pad/foam dressing if exudate moderate to high
 **Epithelialising**	Healing of the surface layer of the skin where delicate new skin cells eventually appear at the edges or middle of the wound as tiny pink specks.	Protect and promote new tissue growth • Hydrocolloid if exudate low to moderate • Non-adherent dressing with pad/foam dressing if exudate moderate to high
 **Hypergranulating**	Also known as overgranulating. An overgrowth of granulating tissue which appears 'proud' of the wound, preventing epthelisation.	Lessen inflammatory response • Refer to local guidelines • Seek advice from appropriate healthcare professional

Tissue type description		Objective/action guide
 Haematoma	Haematoma is a collection of congealed blood from a leaking blood vessel which appears like a blood filled blister.	Reduce devitalised tissue and blood clot from wound bed • Hydrogel • Hydrofibre • Alginate • Seek advice from appropriate healthcare professional
 Bone	Bone is a whitish hard mass that is rigid when palpated.	Maintain a moist environment • Hydrogel and non-adherent dressing • Seek advice from appropriate healthcare professional
 Tendon	Tendons are whitish and tough but flex when palpated.	Maintain a moist environment • Hydrogel and non-adherent dressing • Seek advice from appropriate healthcare professional
 Haemoserous	Haemoserous is thin and watery fluid which is blood tinged in appearance. Serous is thin and watery fluid which is pale yellow in appearance.	Manage wound moisture balance • Non-adherent dressing if exudate low • Non-adherent dressing with pad/foam dressing if exudate moderate to high
 Purulent	Thicker fluid containing pus which may vary in colour from yellow to green.	Reduce infection and exudate • Look for other signs of infection (see Infection) • Assess level of exudate • Levels of exudate will determine dressing type ie hydrofibre/foam dressing for high exudate
 Macerated	Maceration of the skin occurs when it is wet for a prolonged period of time. The skin softens and wrinkles and will appear white or grey. The skin can easily become infected with bacteria or fungi.	Reduce excess moisture level • Hydrofibre dressing • Highly absobent dressing • Consider barrier preparation in line with local policy/guidelines

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 **Oedematous** Swollen area of skin due to retention of fluid.	Manage exudate • Non-adherent highly absorbent dressing. • Refer to local policy/guidelines • Seek advice from appropriate healthcare professional
 **Erythema** Abnormal redness of the skin resulting from enlarged blood vessels under the skin.	Protect surrounding skin • Determine underlying cause • If appropriate, protect fragile tissue
 **Excoriation** Excoriated skin can be caused by excessive moisture and can vary in colour from pink to red.	Manage moisture to protect skin • Use a suitable barrier product • Refer to Skin Excoriation Tool (www.tissueviabilityonline.com) • If severe seek advice from appropriate healthcare professional
 **Fragile** Skin which appears 'paper thin' and dry.	Protect surrounding skin • Consider emollient therapy • Consider low adherent atraumatic dressing if appropriate
 **Dry/Scaly** Scaly skin which appears hard and dry.	Promote moisture • Consider emollient therapy • Consider low adherent atraumatic dressing if appropriate
 **Infection** Common signs and symptoms of an infection may include increased pain, spreading erythema, increased exudate level, foul odour, friable tissue and slough.	Reduce bacterial load • It is important to confirm if the wound is infected, identify the cause and determine whether antibiotics are required • Medically prepared honey • Iodine based dressing • Silver dressing