



WOUND ASSESSMENT SIMPLIFIED

This Simplified Guide is intended to provide guidance on effective acute and chronic wound management to ensure the best outcomes for your patient.

This Simplified Guide looks at the purpose of wound assessment and the areas that should be included in the process.

LEARNING OUTCOMES

- ✔ Understanding the significance of a full patient history
- ✔ The importance of identifying the condition and complexity of a wound
- ✔ The need to undertake a full assessment of the surrounding skin
- ✔ Understanding the impact of wound symptoms

The wound healing process is complex, for example it can be affected by several external and internal influences. Accurate wound assessment should include a comprehensive patient history, aetiology of the wound, and condition of the wound bed and periwound area, including the amount, colour, and consistency of exudate as well as signs of infection (Ousey & Atkin, 2013). Management of the individual patient is of the utmost importance, and the patient's journey should be monitored, assessed and reassessed at every stage to maintain high standards (Benbow, 2016).

PATIENT ASSESSMENT

A holistic assessment of the patient is essential to identify the causative or contributory factors and to highlight issues that could delay wound healing. The following factors must be considered when choosing an appropriate plan of care.

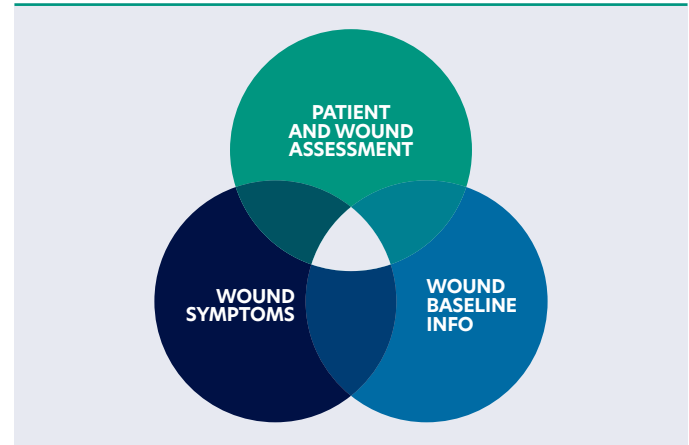
General health information:

- ▶ Medical history
- ▶ Age
- ▶ Medication and allergies
- ▶ Other diseases such as:
 - Diabetes
 - Vascular diseases
 - Immune system compromised
- ▶ Nutritional status and fluid intake
- ▶ Smoking/alcohol
- ▶ Obesity
- ▶ Mobility
- ▶ Continence
- ▶ Pressure ulcer/injury risk

- ▶ Oxygen deficit/anaemia
- ▶ Skin sensitivity and integrity
- ▶ Stress, anxiety, sleep disturbances
- ▶ Psychological aspects - impact the wound has on the social aspects of the patient's quality of life
- ▶ Mental health - feeling good, able to cope
- ▶ Emotional health - ability to express how they are feeling
- ▶ Social health - support network
- ▶ Information provided to patient and/or carers

Recognition of these factors will either delay or promote the wound healing process. Successful wound healing is dependent on the patient's ability to heal, with the choice of dressing being less important by comparison.

WOUND ASSESSMENT



Accurate wound assessment is vital to give a successful resolution and uncomplicated wound healing. It provides valuable information to enable informed decisions about a patient and their wound.

WOUND BASELINE INFORMATION

- ✓ **Number of wounds**
- ✓ **Location** - can identify/determine cause and act as an indicator for potential complications
- ✓ **Cause** - e.g. trauma, pressure, vascular insufficiency, neuropathy, other
- ✓ **Type/classification** - e.g. pressure ulcer, skin tears, burns etc.
- ✓ **Duration** - date of occurrence, length of time, acute/chronic
- ✓ **Treatment aim** - healing, symptom management etc.
- ✓ **Planned reassessment date**

All observations, assessments, planned treatment and interventions of the wound must be documented in the patient's notes. Records must be clear and accurate. It is a helpful and necessary way to track the progress of a wound and ensure patients receive continuity of care.

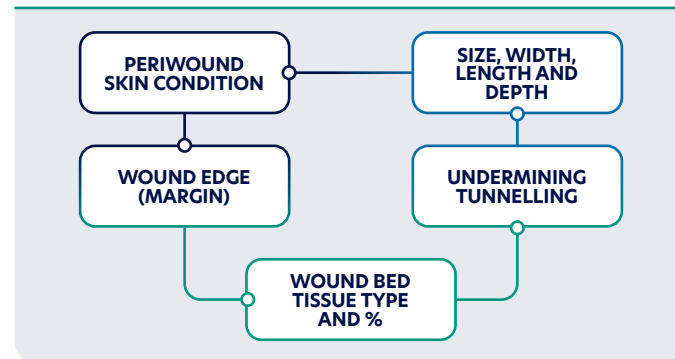
PHOTOGRAPHY

Photography now plays a key role in wound care.

The use of digital photography has enhanced the reliability and accuracy of wound documentation. A good photograph acts as visual confirmation supporting the wound assessment written record (*Wound Care Advisor, 2017*). Please be aware of general data protection regulations (*GDPR, 2018*), the importance of consent and transfer of personal/patient information.

Please refer to your local policy before taking any pictures.

WOUND ASSESSMENT



SIZE, WIDTH, LENGTH AND DEPTH

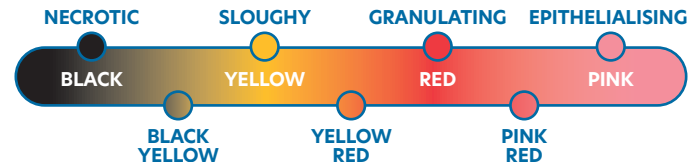
Should be measured and documented so that the progress of the wound can be monitored over time. The use of photography is valuable to provide a visual recording of the wound features.

UNDERMINING AND TUNNELLING

Refers to tissue destruction underlying intact skin and along the margins of the wound. Tunnelling course or pathway can extend in any direction from the wound, resulting in dead space. This should be measured and documented.

WOUND BED TISSUE TYPE

Wound can consist of different tissue types, which can be categorised by name and/or colour. It is useful to be able to record the percentages of the differing tissue types.



WOUND ASSESSMENT

WOUND EDGE (MARGIN)

A healthy wound edge is attached to the wound bed and allows for epithelial migration across healthy granulation tissue, causing the wound to contract and finally close. Examination of the edge of the wound may help to identify its aetiology in the context of the history of the wound and the wound healing stage. The preferable margin type is skin that is smooth and adheres firmly to the wound bed.

Type Of Margin	Effect
Maceration	Resulting from prolonged exposure to moisture may occur from incontinence, sweat accumulation, or excess exudate, which can cause further breakdown and enlargement of the wound.
Desiccation	Indicates removal of physiological fluids that support wound healing. Can increase pain and itching.
Undermining	Tissue destruction underlying intact skin along the margins. Excessive damaging forces being applied to skin.
Rolled edges	May indicate wound stagnation or wound chronicity. Dry and with loose skin may indicate additional shearing injury.
Steep margins	A punched-out appearance. Often associated with arterial ulceration.
Colour	Dusky edges indicate hypoxia; and erythema indicates physiological inflammatory response or cellulitis.

(Adapted from Dowsett et al., 2015)

PERIWOUND SKIN CONDITION

Will provide you with useful information and can alert to problems that may impede healing. The observation of the following should be documented. Is the surrounding skin:

- ✔ Erythematous
- ✔ Macerated
- ✔ Excoriated
- ✔ Hyperkeratosis
- ✔ Desiccated
- ✔ Callused
- ✔ Any skin conditions e.g. eczema

The surrounding skin will also dictate which wound care products will be suitable for use. Erythema and increased heat in the surrounding skin may indicate a wound infection.

Skin that is dry and desiccated with a build-up layer of dead tissue (hyperkeratosis), will need to be removed and the surrounding skin hydrated with emollients (Vuolo, 2009). Signs of macerated skin or

periwound moisture associated skin damage indicate the potentially inadequate management of exudate. Over-hydrated skin can be slow to heal and increase the risk of infection, friction and further skin damage. All of which can lead to wound enlargement. It is important to note that there is a balance and that there is an optimum level of hydration that will enable wound healing (IWII, 2022).

WOUND SYMPTOMS

PAIN	EXUDATE
ODOUR	INFECTION

EXUDATE

Exudate is the fluid produced by the wound during healing. It plays an essential part in the healing process. The levels of exudate, too much or too little, exudate in the wrong place and/or the wrong type of exudate composition can delay healing (IWII, 2022). There is also a difference between acute wound exudate, which is beneficial for healing, compared to chronic wound exudate, which can be damaging

for healing. Effective assessment and management can reduce healing time.

The volume of exudate should reduce as healing progresses. The IWII (2022) suggests clinicians should assess and record the following in regard to exudate: colour, consistency, odour and amount. Changes in the volume and type of exudate can provide information on the state of wound healing.

WOUND SYMPTOMS

INFECTION

The wound should be assessed for signs and symptoms of infection. This may include erythema, swelling, local warmth, heat, pain and possibly, discharge and pyrexia. The presence of infection will influence the treatment plan and choice of dressing. Systemic infection relating to the wound should be noted. This could include raised temperature, chills, rapid pulse/breathing and general deterioration. (For more information see our *Infection Simplified Guide*)

ODOUR

Wound odour (also referred to as malodour) is usually caused by the breakdown of tissue and is typically a sign of necrosis or infection. A malodorous wound is not directly harmful to a patient but can have a significant psychological and social impact. Controlling malodorous wounds will have a positive effect on the patient's mental wellbeing and quality of life.

PAIN

Wound related pain can change over time; and dressing changes can be a painful part of wound care. The type, time of onset, frequency and severity of pain should be noted and monitored. Careful and ongoing assessment of the levels, and type

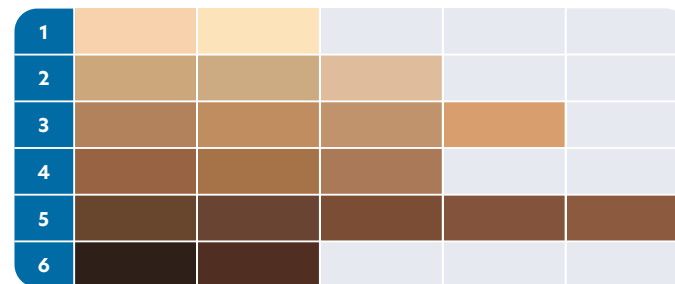
of pain will help to distinguish between pain that is background, provoked by procedures and/or due to dressing changes. This allows the relevant pain management plan to be implemented. High levels of pain can psychophysically and detrimentally impact the patient and delay healing.

SKIN TONES

A full assessment should involve a thorough inspection of the skin, and should include finding about the patient's baseline skin tone. This is a necessity so that any changes to the patient's skin can be monitored and identified early. Lack of early identification of skin changes can lead to vital signs being missed, which could lead to skin and tissue breakdown and damage. (Wounds UK, 2021) The 2021 Best Practice Statement addressing skin tone bias in wound care, shows a validated skin tool showing a range a skin tones. It is also key to note that skin tone may differ across different areas of the body. (Wounds UK, 2021)

The chart was designed to enable selection of the tone that most closely matches the individual's inside upper arm. It is a simple way of assessing skin tone across care settings.

The tool encompasses more gradients than just 'light' and 'dark' is helpful for use in practice. (Dhoonmoon et al., 2023)



Adapted from Wounds UK 2021

PATIENT INVOLVEMENT

The patient is at the centre of wound care, and it is essential to remember that it is not just looking at the wound in isolation, but the person as a whole and the wound (WUWHS, 2017). Following assessment, treatment should be tailored to the individual and involve, where possible, a collaborative relationship between patients/carers and health care professionals. Where it is practical, involving patients and carers in the assessment and subsequent treatment plan can have positive results (International Best Practice Statement, 2016). Moore (2016) acknowledged that the importance of recognising the degree to which a patient and/or carer may wish to be involved will be influenced by age, the duration of their wound and underlying disease, in addition to their level of education and literacy.

SPECIALISTS

Any referrals to specialists such as Tissue Viability, Vascular, Podiatry, Dermatology, Plastics or for any other medical opinion, should be included in the assessment along with the referral date.

Always refer to local policy.

DOCUMENTATION

Record keeping is a fundamental part of nursing practice. High-quality record keeping will assist health care professionals to give skilled and safe care. It is essential to document all patient and wound assessments to ensure continuity of care and act as communication between the multi-disciplinary team.

CONCLUSION

Wound assessment is a fundamental aspect of wound management. It is also important to reassess the wound at regular intervals and to change treatment as required. Assessment leads to appropriate treatment aims and to the correct use of a wound care product, which will improve patient outcomes and quality of care.

Accurate patient and wound assessment documentation is central to establishing a serial record of healing or deterioration (Benbow, 2016).

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NOTES



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Complexities of
Wound Care



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