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.

February 2021
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 https://www.hps.scot.nhs.uk/guidance/nipcm/)

Step 1

Does the wound need cleansing?
Only cleanse if there is visible debris on the wound bed that needs removed. Use warm potable tap water or warmed sterile solutions, such as 0.9% saline. Immunocompromised patients, infected or colonized wounds consider PHMB solution.

Step 2

Consider the aetiology/cause of the wound understanding the intrinsic and extrinsic factors also – past medical history, age, and cognitive ability.
Consider what tissue type and levels of exudate does the wound have?
Consider patient centered care and communication with patient/carer.
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.

Step 3

Document in recognized wound assessment chart the type of wound, location, duration. Measure wound length, width, depth and undermining and tracking as applicable.
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

Document peri-wound skin condition, pain or any clinical signs of infection.
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
• wound photography with appropriate consent.
Step 4

Wound dressing selection

**Primary dressing:** 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.

**Secondary dressing:** Consider need for secondary dressings to secure primary wound dressing and or manage exudates.

**Points to remember:**

- Know the action and possible side effects of any dressing you apply.
- Know how to apply and remove any dressing correctly, e.g. safe and atraumatic removal of all dressings.
- Know how long a dressing can stay in place and indication(s) for dressing change.
- Ensure different primary and secondary types of dressings are compatible together.
- 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.
- Remove old packing from the wound, counting products to ensure all removed and apply any new packing loosely leaving tail(s) at the entrance and record the number of pieces of packing inserted within the wound care plan.
- Use barrier skin preparations as appropriate for any damaged peri-wound skin or if needed as preventative measure.
- For chronic or infected wounds refer to
  - Algorithm for Assessment and Management of Chronic Wounds
  - Scottish Ropper Ladder for Infected Wounds
- If in doubt seek advice from appropriate healthcare professional, ie tissue viability nurse, dermatology nurse, podiatrist.

The following pages illustrate different types of wound, what they look like, including a brief description and treatment options.
| 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 secondary intention 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 hydroactive dressings /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 or colonisation/infection present  
- 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 |
<table>
<thead>
<tr>
<th>Epithelialising</th>
<th>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.</th>
<th>Protect and promote new tissue growth</th>
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<td></td>
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<td>- Non-adherent dressing with pad/foam dressing if exudate moderate to high</td>
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</tbody>
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<tr>
<th>Hypergranulating</th>
<th>Also known as overgranulating. An overgrowth of granulating tissue which appears ‘proud’ of the wound, preventing epithelisation.</th>
<th>Lessen inflammatory response</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>- Refer to local guidelines</td>
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<td>- Seek advice from appropriate healthcare professional</td>
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<tr>
<th>Haematoma</th>
<th>Haematoma is a collection of congealed blood from a leaking blood vessel which appears like a blood filled blister.</th>
<th>Reduce devitalised tissue and blood clot from wound bed if no active bleeding present</th>
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<tr>
<td></td>
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<td>- Hydrogel/Hydroactive dressing</td>
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<td>- Alginate</td>
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<th>Bone</th>
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<th>Maintain a moist environment</th>
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<td></td>
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</table>
| **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  
- Apply super-absorbent dressings for very high exudates |
| **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  
- Consider antimicrobial dressings product  
- 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 absorbent dressing  
- Consider barrier preparation in line with local policy/guidelines |
| **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 with non-adherent dressing |
| **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 and follow manufacturers instructions for correct application.  
- Refer to Skin Excoriation Tool or local guidelines  
- If severe seek advice from appropriate healthcare professional  
- Use of correct foam cleanser or skin wipes (ph 5.5)  
- Gentle drying of area |
| **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 or  
- Iodine based dressing or  
- Silver dressing.  
- Use Algorithm for Assessment and Management of Chronic Wounds  
- Use Scottish Ropper Ladder for Infected Wounds  
- Use of PHMB products for cleansing  
- Use of antimicrobial alginogels for dressing |