Healthcare Improvement Scotland

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

NHS SCOTLAND

Published February 2021

www.healthcareimprovementscotland.org

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 if immunocompromised such as saline 0.9%. PHMB if infected, colonised.

Step 2

Document type of wound, location, duration. Measure wound length, width, depth and undermining and tracking as applicable.

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 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.

Consider intrinsic and extrinsic factors also – past medical history, age, and cognitive ability.

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.

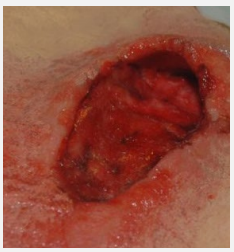
An example of a wound chart can be found at www.tissueviabilityonline.com

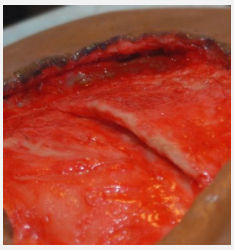
Points to remember:

- 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 dressings 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.
- Remove old packing from the wound, 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





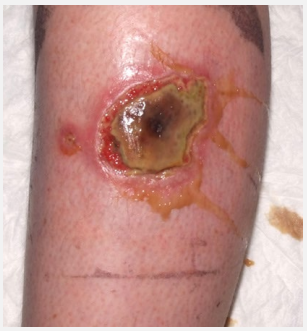
A tunnelling effect or pocket under the edge of the wound.

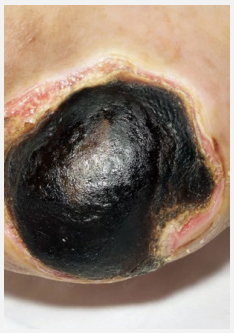
Extension of the wound bed into adjacent tissue, also known as a sinus tract.

Aid healing from inside wound

- Loose packing/layering with alginate/hydrofibre or hydrogel
- Seek advice from appropriate healthcare professional

Necrotic soft/hard



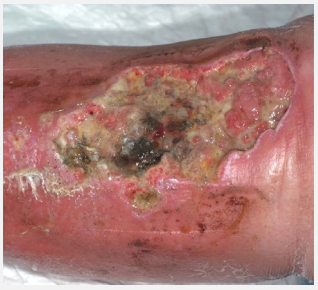


Necrotic tissue is a layer of dead tissue which can be brown or black in colour and is caused by inadequate blood supply or infection. It may be soft or hard on the surface, can be of varying depth and may produce an offensive smell.

Rehydrate and remove sloughy/necrotic tissue

- Do not apply moisture to ischemic areas
- Full assessment of individual should be considered ie vascular assessment
- Consider alginogels /hydrogel/hydrocolloid
- Medically prepared honey
- Sharp debridement only by competent healthcare professional

Sloughy

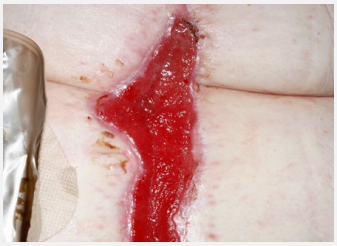


Slough is a layer of dead tissue which can be yellow or green in colour, and may be dry or wet on the surface. It can be of varying depth and may produce an offensive smell.

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

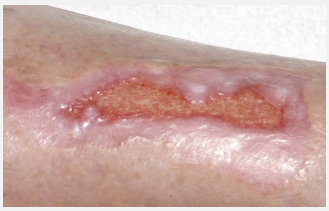


The development of new tissue from the wound base which typically appears bright red in colour, and has a rough or irregular surface.

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

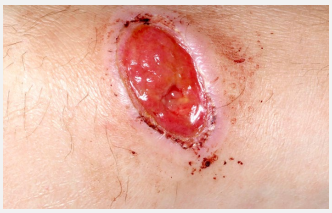


Healing of the surface layer of the skin where delicate new skin cells eventually appear at the edges or middle of the wound as tiny pink specks.

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

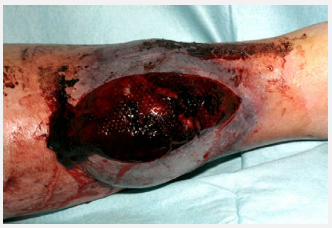


Also known as overgranulating. An overgrowth of granulating tissue which appears 'proud' of the wound, preventing epthelisation.

Lessen inflammatory response

- Refer to local guidelines
- Seek advice from appropriate healthcare professional

Haematoma

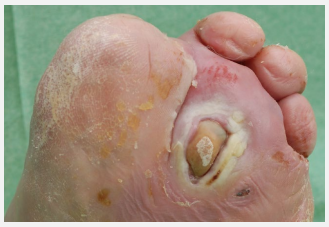


Haematoma is a collection of congealed blood from a leaking blood vessel which appears like a blood filled blister.

Reduce devitalised tissue and blood clot from wound bed

- Hydrogel
- Hydrofibre
- Alginate
- Seek advice from appropriate healthcare professional

Bone

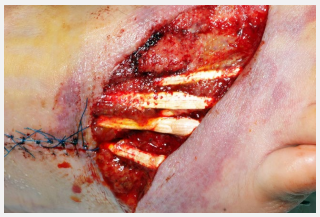


Bone is a whitish hard mass that is rigid when palpated.

Maintain a moist environment

- Hydrogel and non-adherent dressing
- Seek advice from appropriate healthcare professional

Tendon

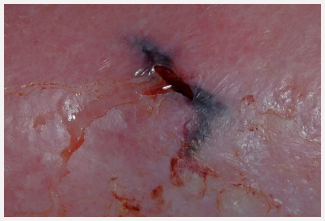


Tendons are whitish and tough but flex when palpated.

Maintain a moist environment

- Hydrogel and non-adherent dressing
- Seek advice from appropriate healthcare professional

Haemoserous



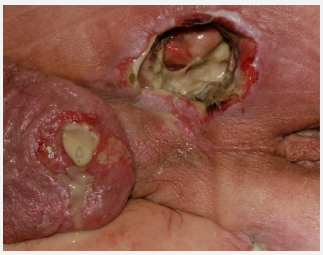
Haemoserous is thin and watery fluid which is blood tinged in appearance.

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

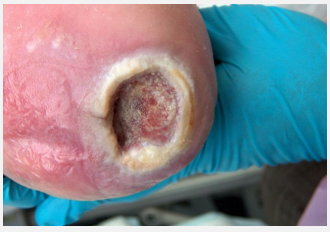


Thicker fluid containing pus which may vary in colour from yellow to green.

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

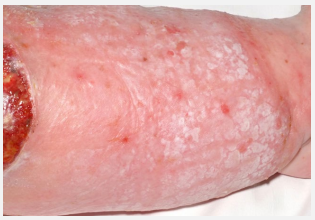
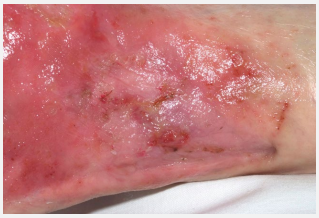
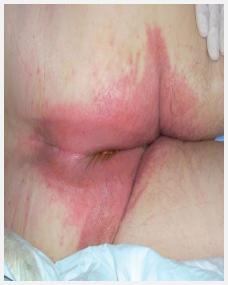
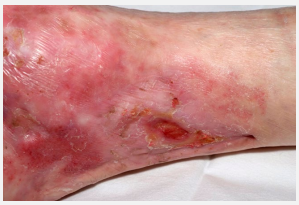
Macerated

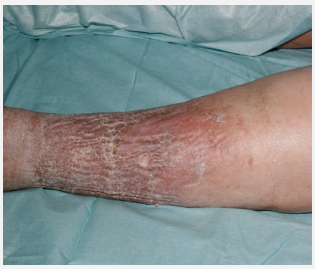
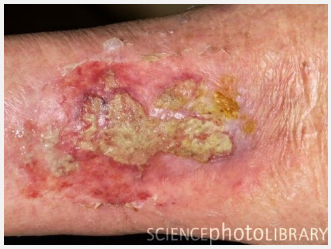


Maceration of the skin occurs when it is wet for a prolonged period of time. The skin softens and wrinkles and will appear white or grey. The skin can easily become infected with bacteria or fungi.

Reduce excess moisture level

- Hydrofibre dressing
- Highly absobent dressing
- Consider barrier preparation in line with local policy/guidelines

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 • (www.tissueviabilityonline.com) 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 • Iodine based dressing • 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

Published February 2021

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