

Optimum wound healing checklist

Ensure all parts are considered and implemented prior to referral

1

Is the blood supply and blood chemistry supportive to wound healing?

- Review FBC, CRP, U&E, LFTs including Albumin & glucose/HbA1c
- If the wound is to the lower leg/ankle/foot undertake full lower limb assessment and doppler to obtain ABPI—see note 1

2

Is there devitalised tissue or debris present in the wound bed or wound edges?

- Plan removal unless clinically contraindicated - e.g. arterial ulcer, warfarin therapy, tendons visible, diabetic foot ulcer
- Consider debridement - see note 2

3

Is there wound infection or a high risk of infection development?

- Refer to Scottish Ropper Ladder for Infected Wounds - note 3
- Reassess 2 weekly and do not routinely use topical antimicrobial wound care products

4

Is wound environment conducive to healing?

- Too dry - rehydrate wound - moisture donating product
- Too wet - manage cause and review absorbency product
- Refer to the East Region Formulary and step up and down products as needed - note 4

5

Is the cause pressure?

- Complete risk assessment (Waterlow/ Braden)
- Source equipment to offload pressure
- Follow SSKIN Bundle/ Care rounding to implement pressure reduction see note 5

6

Is pain managed, before, during and after treatment?

- Identify cause and review pain medication and strategies
- Assess if required using recognised pain assessment tool

7

Is the person's well being optimised? e.g. nutrition/hydration?

- Refer to note 7

8

Is there any oedema present?

- Yes - discuss results from box 1 with medical staff to review cause
- If lymphoedema - consider a referral to the Lymphoedema service

9

If the wound is not showing signs of improvement, have you considered the presence of a biofilm?

- No— consider the use of the 'Biofilm management pathway'
- Yes— consider onwards referral to the relevant speciality, see note 9

9 Step Holistic Wound Assessment

Notes :

Must be used in conjunction with your clinical judgement. A wound assessment chart must be completed and maintained for all wounds.

1. Check all blood results are within normal limits and work towards correction if they are out of range.
 - FBC – check that Haemoglobin levels are satisfactory to support healing
 - CRP – identifies inflammation and systemic infection
 - U&E – kidney function and dehydration LFT's – Liver Function Tests Glucose – check if raised glucose levels, as may affect healing
 - Glucose/HbA1c to check for diabetes and that blood sugars are stable
 - Albumin—check and optimise if low or high
 - Alk Phos— if rapidly increasing and bone is palpable in wound may indicate osteomyelitis
 - If wound is on a lower leg complete Leg Ulcer Assessment chart and undertake doppler to obtain ABPI.
2. Do not debride devitalised tissue from wounds due to Peripheral Arterial Disease (PAD) or diabetic foot ulcers (DFU), without specialist advice from Vascular/Podiatry. If a dry black heel please refer to the 'Dry Black Heel Guide'
Debridement can be:
 - Autolytic - using dressings, e.g. Honey or gels (**See East Region Formulary-ERF**)
 - Mechanical – debridement pad/lolly to remove slough and debris from wound bed and surrounding skin
 - Enzymatic - using enzymatic dressings e.g. larvae therapy
 - Referral to specialist services for sharp or surgical debridement
3. Infection is part of the wound assessment and should be routinely reassessed. Refer to Scottish Ropper Ladder for Infected Wounds to guide decision on appropriate use of antimicrobials chosen from the East Region Formulary. Antimicrobials should be reassessed at 2 weekly intervals and discontinued where appropriate. Continued use can cause damage to the cells reducing healing rates.
4. Exudate – fluid produced by a wound as part of natural healing, this is assessed in terms of volume and viscosity (thickness of the fluid). This is part of wound assessment, and should be routinely reassessed. If changes occur consider cause including infection, new medications and oedema.
5. SSKIN Bundle—consider **Surface**—instigate and maintain offloading equipment, **Skin Assessment**—to check all other pressure areas, **Keep Moving**—regular repositioning and movement, **Incontinence or Increased moisture**—ensure that continence and moisture are well managed, **Nutrition**—Increase protein, carbohydrates, micronutrients and hydration to improve healing, refer to dietician
6. Ensure pain is assessed and managed, this may include MDT working with your medical staff to obtain the best combination for the person you are looking after.
7. Consider the holistic environment for the person – e.g. Nutrition, hydration, smoking, obesity, polypharmacy, mobility, alcohol intake, co-morbidities and end of life period. Also consider persons tolerance to treatment, advice, and understanding of agreed plan of care. Where possible enable empowerment with self-care and education.
8. Oedema possible causes: cellulitis, infection, lymphoedema, dependant oedema, medication e.g. steroids, cardiac failure etc. Do they/can they elevate their legs? Ask how pain is when in bed. Encourage regular exercises to reduce oedema if in lower limbs.
9. If remains non-healing/static after 4 weeks despite optimum wound care and completion of the 9 steps, consider onwards referral to the appropriate speciality - Vascular, Dermatology, Plastics or Tissue Viability. If referring to Tissue Viability, review referral guidance and ensure all parts are completed before referral to reduce delay.