

Quick guide for wound assessment



STEP 1

Duration

Assess:

- How long has the wound been present?
- New or recurring wound?
- Hard-to heal or acute wound?
- What dressings are used?

Consider referring:

Diabetes-related foot ulcer (DFU) or any wound that has healed <40% in 4 weeks: needs multidisciplinary team (MDT) approach.

STEP 2

Location, size & depth

Assess:

- Note location (use patient's R and L and correct anatomical terms).
- Record wound length and width using clock method.
- Measure depth and undermining using a depth probe stick or cotton tipped applicator.
- Photograph wound with paper ruler in shot.
- Assess severity for example, with pressure ulcer/injury stage system.
- Measure every 2–4 weeks.

Refer urgently:

- Probe to bone: may indicate osteomyelitis

Consider referring:

- Fistulae, tunnelling or sinus.
- Increase in size.

STEP 3

Tissue perfusion

Assess:

For lower leg/foot ulcers:

- If possible, palpate arteria dorsalis pedis.
- Observe colour, temperature and pain of the limb and foot.
- Wounds with no progression after 2 weeks: check Ankle/Brachial Pressure Index (ABPI).
- For foot ulcers: assess using WIfI (Wound Ischemia and foot Infection) system.
- Consider oxygen assessment e.g. with transcutaneous oximetry (TcPO₂).

Refer urgently:

- ABPI (< 50–70 mmHg; ABI < 0,5) or TBI (< 30–50 mmHg): vascular referral.
- In case of diabetes and/or ABPI >1,4, measure Toe-Brachial Index (TBI).

Consider referring:

- Signs of venous disease (see step 4) or peripheral arterial disease may require intervention from a vascular specialist.

STEP 4

Surrounding skin & deformities

Assess:

- Is the skin dry, thin, fragile or cracked?
- Any discolouration present?
- Oedema or eczema?

Consider referring:

- Signs of venous disease e.g. oedema, varicose veins, discoloured skin: reddish-brown, lipodermatosclerosis, eczema, atrophie blanche.
- Refer to a podiatrist for foot concerns.
- Refer to dermatologist for skin concerns.
- If any signs of erysipelas.

STEP 5

Wound edges and periwound*

Assess:

- Are the wound edges healthy?
- Do the wound edges show signs of concern such as raised, rolled, undermined or callused?
- Is the periwound macerated?
- Is swelling present?

Consider referring:

- Epibole (rolled), undermining or non-advancing wound edges.
- Discolouration (e.g., redness, violet or blue).

STEP 6

Wound bed composition

Assess:

Check for presence of:

- Epithelialized tissue.
- Red granulated tissue.
- Yellow fibrin (slough).
- Yellow, non-viable tissue (slough).
- Black necrotic tissue.
- Visible bone, tendons, blood vessels.
- Hypergranulation.
- Flap (at skin tears).

Consider referring:

- If underlying structures such as bone, muscle, tendon are visible.
- If sharp debridement is required to remove non-viable tissue and is outside the scope of the health practitioner.
- If black necrotic tissue refer to multidisciplinary team.

STEP 7

Exudate & odour

Assess:

- Amount of exudate (none–low–moderate–high–very high).
- Colour and type: serous (clear), serosanguineous (pale, red), purulent (yellow, green, tan, brown), sanguineous (red, bloody).
- Exudate consistency.
- How well the dressing has handled the exudate.
- When does the wound smell (before dressing change and after cleansing)?
- At what distance to patient does it smell?
- Consider referring: Visual Analogue Scale (VAS) scale to document odour. If you can control the amount of exudate, (for example at frequent dressing changes) refer to multidisciplinary team.

* Periwound is defined as 4cm from the wound edges

STEP 8

Pain & loss of peripheral sensation

Assess:

- Intensity (use the VAS to document).
- When it is painful (before, during or/and after dressing change).
- Duration of pain.
- Location of pain.
- For DFU, assess for loss of peripheral sensation with monofilament and tuning fork or using the Ipswich touch test.

? Consider referring:

- Where the cause of pain cannot be determined.
- Where pain management strategies are not effective.
- Patient with LOPS (loss of protective sensation), for example patient with diabetes need a multidisciplinary team.

STEP 9

Infection & biofilm – part 1

Assess:

Check for:

- Classic signs of local infection (erythema, warmth, swelling, purulent discharge, delayed wound healing, new or increasing pain, increasing malodour.)
- Subtle signs of local wound infection (hypergranulation, bleeding, friable granulation, epithelial bridging and pocketing in granulation tissue, increasing exudate.)
- For foot ulcers, assess using Wifl system.

? Consider referring:

- Where the cause of pain cannot be determined.
- Where pain management strategies are not effective.
- Patient with LO

STEP 10

Infection & biofilm – part 2

! Clinical emergency

- Systemic infection (may include loss of appetite, fever/pyrexia, malaise, lethargy or nonspecific general deterioration, severe sepsis, septic shock, organ failure, death.)

? Consider referring:

- Spreading infection (may include: extending induration, swelling of lymph glands, crepitus, wound breakdown/dehiscence with or without satellite lesions, spreading inflammation or erythema >2cm from wound edge.)

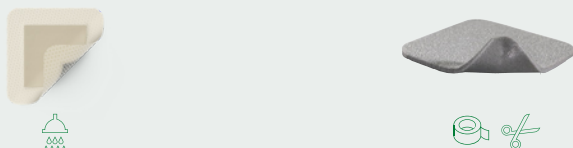
Product selection guide

Dressings



Available also in oval, sacrum and heel sizes
Available also for sacrum

Follow guidelines for wound infection protocols⁴. Topical antimicrobial agents, e.g. in cleansers or dressings, may be used in combination with systemic antibiotics depending on the severity of infection. Active spreading infection must be referred as a matter of urgency to a multidisciplinary team or a medical practitioner.

Exudate level	Very high	Exudate level	High	Low
Superficial wound	Mepilex® Transfer + Mextra® Superabsorbent  — Need of antimicrobial?e Mepilex® Transfer Ag+ Mextra® Superabsorbent 	Superficial wound	Mepilex® Border Flex+ Mepilex® Up Mepilex® Border Flex Lite+ Mepilex® Lite  — Need of antimicrobial?e Mepilex® Border Ag+ Mepilex® Ag 	
	Deep wound		Always combine with Exufiber® + Mextra® Superabsorbent  — Need of antimicrobial?e Always combine with Exufiber® Ag+ Mextra® Superabsorbent 	Deep wound

Exudate progress monitor

Leave the dressing in place for as long as possible. Normally a dressing is changed between 1 and 3 times a week.^d



The dressing can remain in place



Time to change

^dWound inspection and dressing change frequencies are driven by clinical decision and should be at the discretion of the clinician.

Safetac
TECHNOLOGY

The Safetac® soft silicone wound contact layer minimises skin damage and pain at dressing changes.³



Find out more at www.molnlycke.com

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