STEP 1

# **Duration**

### Assess: · How long has the wound been present?

- New or recurring wound?
- · Hard-to-heal or acute wound?
- What dressings are currently being 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

Note location (use patient's R and L and correct

Measure depth and undermining using a depth

Photograph wound with paper ruler in shot.

Assess severity e.g. stage, grade, system or

Probe to bone: may indicate osteomyelitis.

probe stick or cotton tipped applicator.

Measure every 2-4 weeks.

Refer urgently:

Increase in size.

Consider referring:

Fistulae, tunnelling or sinus.

Record wound length and width using clock method.

### Location, size & depth

Assess:

anatomical terms)



### Tissue perfusion



### Assess:

For lower leg/foot ulcers:

- If possible, palpate arteria dorsalis pedis.
- Observe colour, temperature and pain of the

STEP 3

- Wounds with no progression after 2 weeks: check Ankle-Brachial.
- 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; ABPI < 0,5) or TBI (< 30-50 mmHg): vascular referral
- In case of diabetes and/or ABPI >1,4, measure Toe-Brachial Pressure Index TBPI.

### Consider referring:

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

# **Mölnlycke**®

Quick guide

for wound

assessment

### Exudate & odour

### Assess:

- Amount of exudate (none-low-moderatehigh-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 using the Visual Analogue Scale (VAS) to document odour.

### Consider referring:

If you can't control the amount of exudate, (for example frequent dressing changes are required) refer to the multidisciplinary team.

STEP 8

### Wound bed composition



### Assess:

Check for the presence of:

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

### Consider referring:

- If underlying structures such as bone, muscle and tendon are visible.
- If sharp debridement is required to remove non-viable tissue and is outside the scope of practice of the healthcare professional

STEP 9

If there is black necrotic tissue refer to a multidisciplinary team.

### 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).

### Surrounding skin & deformities

### Assess:

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

### 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 a dermatologist for skin concerns.
- If any signs of erysipelas.

### \* Periwound is defined as 4cm from the wound edges

### STEP 10

### 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 a DFU, assess the 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.

### Infection & biofilm part 1

### Assess:

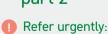
Check for:

- · 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 WIfI system.

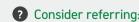
### Consider referring:

If sharp debridement is required to remove non-viable tissue and is outside the scope of the health practitioner.

### Infection & biofilm - part 2







the wound edge).

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





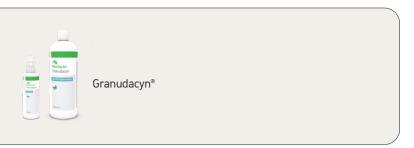
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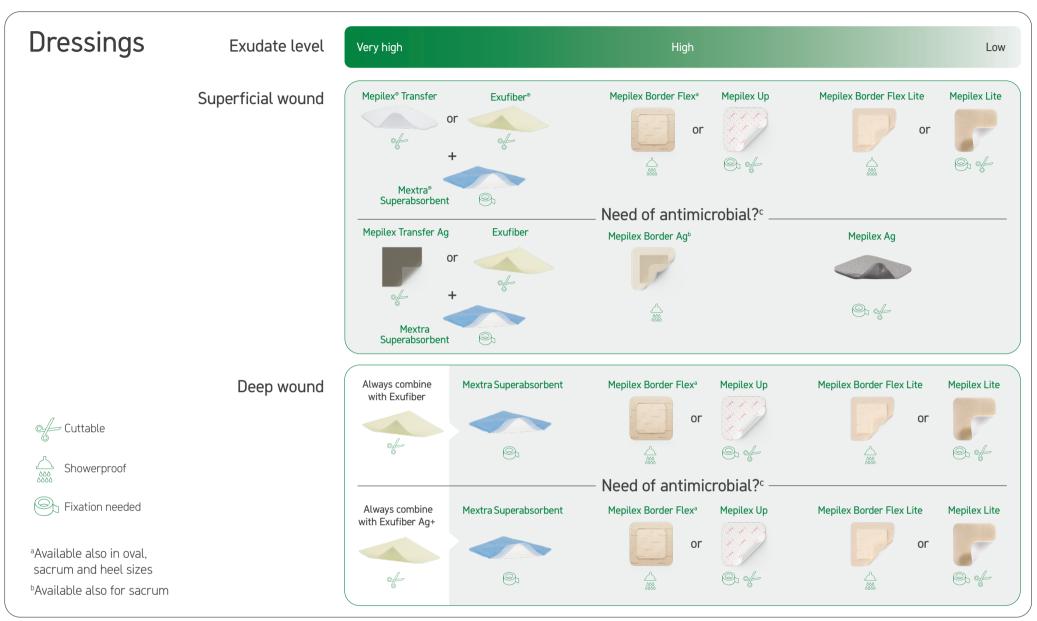


# Product selection guide

## Cleansing and debridement

Cleanse the wound bed and surrounding skin. Debride slough and devitalised tissue within your scope of practice. Follow your local policy.





# Compression

Apply an appropriate compression therapy after examination of the Ankle-Brachial Pressure Index (ABPI) or Toe-Brachial Pressure Index (TBPI) on leg and foot ulcers1.

### Exudate progress monitor

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



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







The Safetac® soft silicone wound contact layer minimises skin damage and pain at dressing changes<sup>2</sup>.



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<sup>c</sup> Follow guidelines for wound infection protocol<sup>3</sup>. Topical antimicrobial agents, e.g. in cleansers or dressings, may be used in combination with systemic antibiotics depending on the severity of the infection. Active spreading infection must be referred as a matter of urgency to a multidisciplinary team or a medical practitioner.

References: 1. Bjork R, Ehmann S. S.T.R.I.D.E. Professional guide to compression garment selection for the lower extremity. Journal of Wound Care. 2019;6(28 suppl 44-1):1. 2. White R. A multinational survey of the assessment of pain when removing dressings. Wounds UK. 2008;4(1):14-22. 3. International Wound Infection Institute (IWII). Wound Infection in Clinical Practice. Wounds International. 2022.



