

10-step local wound assessment

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 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

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 e.g. stage, grade, system or classification.
- 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.
- 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.

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 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 6

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

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).

* Periwound is defined as 4cm from the wound edges

STEP 4

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.

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 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.

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 WIfI system.

? Consider referring:

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

STEP 10

Infection & biofilm – part 2



! Refer urgently:

- **Systemic infection** (may include loss of appetite, fever/pyrexia, malaise, lethargy or non-specific 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 the wound edge).



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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.



Granudacyn®

Dressings

Exudate level

Very high

High

Low

Superficial wound

Mepilex® Transfer 	or	Exufiber® 	Mepilex Border Flex® 	or	Mepilex Up 	Mepilex Border Flex Lite 	or	Mepilex Lite
+ Mextra® Superabsorbent 			Need of antimicrobial? ^c					
Mepilex Transfer Ag 	or	Exufiber 	Mepilex Border Ag® 	Mepilex Ag 				
+ Mextra Superabsorbent 								

Deep wound

Always combine with Exufiber 	Mextra Superabsorbent 	Mepilex Border Flex® 	or	Mepilex Up 	Mepilex Border Flex Lite 	or	Mepilex Lite
		Need of antimicrobial? ^c					
Always combine with Exufiber Ag+ 	Mextra Superabsorbent 	Mepilex Border Flex® 	or	Mepilex Up 	Mepilex Border Flex Lite 	or	Mepilex Lite

- Cuttable
- Showerproof
- Fixation needed

^aAvailable also in oval, sacrum and heel sizes
^bAvailable also for sacrum

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 week^{2d}.



The dressing can remain in place



Time to change



The Safetac® soft silicone wound contact layer minimises skin damage and pain at dressing changes².



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

^cFollow guidelines for wound infection protocol³. 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.

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