

# 10-step local wound assessment



Quick Guide for wound assessment

This quick guide for wound assessment can be used as a support when deciding the treatment plan for your patient.  
10 steps to help you assess hard to heal wounds and to know when to refer.  
An easy-to-use tool for everyday work.

## Your notes

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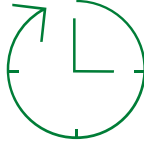
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## STEP 1



### 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 with pressure ulcer/injury stage system.
- Assess baseline skin tone.
- Measure and record at every dressing change.

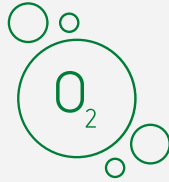
#### ! Refer urgently:

- 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: in the absence of red flags (NWCSP)

- 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).
- If ABPI > 0.8, and venous signs are present, consider strong compression.
- For foot ulcers: assess using WifI (Wound Ischemia and foot infection system).
- Consider oxygen assessment e.g. with transcutaneous oximetry (TcPO<sub>2</sub>).

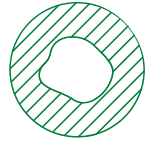
## ! Refer urgently:

- If ABPI < 0.5, urgent referral to vascular services (possible severe arterial disease).
- In case of diabetes and/or ABPI >1.4, measure. Toe Brachial Index (TBI).

## ? Consider referring:

- Venous or arterial signs may need vascular review. If ABPI >0.5, refer for assessment

## STEP 4



# Surrounding skin & deformities

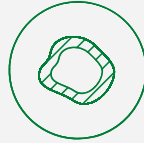
## Assess:

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

## ? Consider referring:

- If signs of venous or peripheral arterial disease are present consider a vascular referral.
- Venous disease signs e.g. oedema, varicose veins, discoloured skin: reddish-brown, lipodermatosclerosis, eczema, atrophie blanche.
- Peripheral arterial disease signs eg. hair loss on legs and feet, brittle slow-growing toenails, non-healing ulcers or skin changes on feet or legs (which may be harder to see on brown and black skin), shiny skin, and muscle wasting in the legs.
- Refer to a podiatrist for foot concerns.
- Refer to dermatologist for skin concerns.
- If any signs of erysipelas.

## STEP 5



# Wound edges and periwound\*

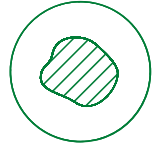
### Assess:

- 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 (eg, 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.

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

## 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) scale to document odour.

### ? Consider referring:

- If you can not control the amount of exudate (for example at frequent dressing changes) refer to multidisciplinary team.

## STEP 8



# Pain & loss of peripheral sensation

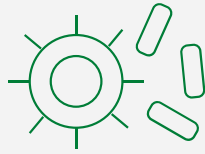
### Assess:

- 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:

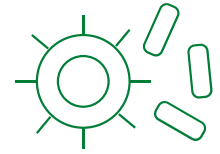
Check for:

- **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:

- 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 nonspecific general deterioration, severe sepsis, septic shock, organ failure, may lead to death but not include 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

## Cleansing and debridement

Cleanse the wound bed and surrounding skin. Debride slough and devitalized tissue when appropriate and use a gel when needed. Follow your local policy.



Granudacyn®



Mepi™ Debripad

## Oxygenation

Consider topical oxygen for wounds affected by hypoxia.



Granulox®

Granulox is suitable for patients at high risk of delayed wound healing<sup>1</sup>.

## Dressings

Exudate level

Very high

Superficial wound

Mepilex® Transfer

Mextra® Superabsorbent



Deep wound

Always combine with Exufiber®

Mextra® Superabsorbent



Always combine with Exufiber® Ag+

Mextra® Superabsorbent



Cuttable



Showerproof



Fixation needed

<sup>a</sup>Available also in oval, sacrum and heel sizes

<sup>b</sup>Available also for sacrum

High

Low

Mepilex® Border Comfort

Mepilex® Up

Mepilex® Border Comfort Lite

Mepilex® Lite



or



or



Need of antimicrobial?<sup>c</sup>

Mepilex® Border Ag

Mepilex® Ag



Mepilex® Border Comfort

Mepilex® Up

Mepilex® Border Comfort Lite

Mepilex® Lite



or



or



Need of antimicrobial?<sup>c</sup>

Mepilex® Border Comfort

Mepilex® Up

Mepilex® Border Comfort Lite

Mepilex® Lite



or



or



## Compression

Apply appropriate compression therapy after examination of the Ankle/Brachial Pressure Index (ABPI) or TBI (Toe Brachial index) at leg and foot ulcers.<sup>2</sup>

Follow local guidance on compression type:

- Multi-Layer
- Short Stretch
- Four Layer
- Compression wrap
- Leg Ulcer Hosiery Kit
- Reduced Compression

Consider preventative hosiery upon healing to maintain compression and reduce recurrence risk

## 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.<sup>d</sup>



The dressing can remain in place



Time to change

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

<sup>c</sup> Follow guidelines for wound infection protocols<sup>4</sup>. 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.

**Safetac**  
TECHNOLOGY

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







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#### References:

1. Chadwick, P, et al. Expert panel report: the role of topical oxygen in the management of diabetic foot ulcers. *The Diabetic Foot Journal*. 2019; 8-9:019. 2. Bjork, R, Ehmann S. S.T.R.I.D.E. Professional guide to compression garment selection for the lower extremity. *Journal of Wound Care* 6(28):2019 suppl 44-1:1. Consensus recommendations. *Wounds International* 2015. 3. White, R. A multinational survey of the assessment of pain when removing dressings. *Wounds UK* 2008;4(1):14-22. 4. International Wound Infection Institute (IWII) *Wound Infection in Clinical Practice*. *Wounds International* 2022.

Find out more at [www.molnlycke.co.uk](http://www.molnlycke.co.uk)

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