

CHEAT SHEET WOUND ASSESSMENT

SUMMARY:

Wound assessment is a crucial component of effective wound management and healing. It involves a systematic evaluation of various aspects of a wound to determine its severity, underlying causes, and appropriate treatment strategies.

An accurate and complete wound assessment and subsequent documentation on healthcare records improve care planning and clinical decision making, promote continuity of care, aid communication among the multidisciplinary team, contribute to patient safety, improve patient's outcomes, support legal documentation, and serve as a resource for audit and research to evaluate care/outcomes or service delivery

KEY POINTS:

- A full skin assessment must be undertaken within 6 hours of admission to identify pre-existing skin damage.
- It is the responsibility of medical/surgical and nursing teams to carry out a wound assessment within 24 hours of admission. If admission is related to the wound, a full assessment should be completed earlier.
- Patient assessment should be comprehensive and include patient's present and past medical history (including a review of blood tests and relevant diagnostic imaging), drug therapies and any other factors that may affect wound healing.
- These may include malnutrition, certain co-morbidities such as diabetes, immobility, frailty, smoking, lifestyle factors, concordance with treatment, pain and impact of wound on patient's life and wellbeing.
- Community services (such as community or district nurses, nursing homes) should be contacted to obtain a wound history and should include any relevant current treatment plans. This must be documented in the patient EPR or clinical notes.
- Wound assessment should include:
 - Type of wound and aetiology of wound
 - Location and duration of wound
 - Size of wound, including width, length, and depth. As well as undermining and tunnelling, if applicable. This should be measured with a probe and documented using clock face method.
 - Surrounding skin
 - Wound photography – further information regarding clinical photography can be found from OMI.
- The acronym TIMERS (Tissue; Infection; Moisture; Edge; Surrounding skin; Repair; Social Situation) can be used to support clinicians in structuring their approach to assessing wounds.

- Reassessment should be undertaken and recorded weekly as a minimum by a registered nurse.
- Following assessment, redress wound as per current plan of care or revise care plan according to assessment findings. EPR wound assessment must be completed.
- Any rapidly deteriorating wound must be referred to the patient's medical/surgical team the day it is diagnosed as a priority.
- All wounds must be assessed and with a plan of care implemented prior to any referral being made to the Tissue Viability Services.
- The patient and/or their carer will be informed of the outcomes of the assessment and will be supported in the decision making for potential management options.

Wound bed preparation based on TIMERS framework	
T issue – percentage of:	- Necrosis - Slough - Granulation - Epithelialisation - Hyper-granulation.
I nfection	- Local (wound bed only – treat the wound topically). - Systemic (Swab to be taken if patient presenting with systemic infection or a deterioration condition. In these cases, antibiotics may be advised – Wound Swab At A Glance). - Odour.
M oisture (exudate)	- Volume (Low, Moderate, High) - Type and consistency (serous, haemoserous, purulent).
E dge	- Rolled, fragile, Hyper-granulated.
S urrounding Skin	- Excoriated, macerated, oedematous, erythema.
R epair	- Observe for wound stalling and failure to respond to conservative therapies (Consider referral to Tissue Viability Service for support).
S ocial Situation	- Support patient engagement in care plan by: ▪ Patient education; ▪ Understanding patient belief system; ▪ Providing active listening and understand patient's own goals; ▪ Patient family/care giver education.

FOR FURTHER INFORMATION, CLICK ON LINK:

[Oxford Medical Illustration \(OMI\)](#)

[Tissue Viability Referral Criteria](#)