CHEAT SHEET
CAVITY WOUND ASSESSMENT

SUMMARY:
There have been several clinical incidents related to cavity wound management, with dressings left undetected resulting in readmission and subsequent unplanned surgery. In order to provide safe and effective wound care, this section is provided to define cavity wounds, provide evidence-based advice for this type of wound, with the aim of improving patient outcomes.
A cavity wound can be defined as any wound that extends beneath the layers of the dermis, which can expose underlying structures such as fascia, tendons, muscles and bone. Therefore, depending on wound presentation, this may include category 3 and 4 pressure ulcers, surgical wounds, pilonidal sinus and abscesses.

KEY POINTS:
As per it is important to consider the following risk factors during wound assessment (Vowden, 2016):

a. Presence of exposed organs
b. Reduced abdominal/chest wall integrity
c. Capacity to assess all wound aspects, particularly the presence of undermining of the wound margins.
d. Wound presentation (Refer to T.I.M.E.R.S).

- Ensure that the number of dressings used, and removed, are count and clearly documented in the patient notes to avoid dressings being left behind.
- Gently probe the sides of the cavity with a gloved finger, if possible, to ensure that no dressings are left behind and check with any documentation about the description and number of dressings previously inserted.
- Document the wound dimensions, including any tunnelling and/or undermining that may be present.
- Lightly fill the cavity with the selected dressing:
- Do not over pack the wound, as this may reduce wound healing capacity and cause trauma on removal.
- Reassess the wound at each dressing change, observing for wound changes and any deterioration/improvement.
- Use clinical judgment to decide on appropriate treatment plan.
- Refer to the Tissue Viability Services if wound is deteriorating despite appropriate treatment plan.

FOR FURTHER INFORMATION, CLICK ON LINK:

Wound Assessment Cheat Sheet