Documentation should provide enough information to:

- monitor progress in wound healing
- evaluate the effectiveness of management
- guide management and prevention plans

This is a guide only and does not replace clinical judgment

References:

WUWHS. Principles of best practice: Minimising pain at wound dressing-related procedures. London: MEP Ltd 2004

Wounds Australia. Standards for Wound Prevention and Management. 3rd ed. Cambridge Media: Osborne Park, WA; 2016

The Wound Healing and Management Node Group. Chronic wound management. (JBI) Best Practice: evidence-based information sheets for health professionals 2016.

International Wound Infection Institute (IWII) Wound infection in clinical practice. Wounds International 2016

promoting healthy skin
Champions for Skin Integrity

QUT ihbi Institute of Health and Biomedical Innovation

60 Musk Ave
Kelvin Grove Qld 4059
Brisbane, Australia

Phone: + 61 7 3138 6000
Email: ihbi@qut.edu.au
Email (Wound Healing): woundresearch@qut.edu.au

CRICOS No. 00213J

www.qut.edu.au/ihbi

This project was funded by the Australian Government Department of Health and Ageing under the Encouraging Better Practice in Aged Care (EBPAC) program.

Wound Assessment

Information for **health professionals**

promoting healthy skin
Champions for Skin Integrity

QUT ihbi Institute of Health and Biomedical Innovation

Wound Assessment

What is a wound?

A wound is an injury to the skin or underlying tissue that may or may not involve a loss of skin integrity. Physiological function of the tissue is impaired. Common types include leg ulcers, traumatic wounds, pressure injuries, surgical, and burns.

Phases of wound healing

1. Haemostasis (bleeding stops): 10 minutes
2. Inflammation (redness, swelling): three days
3. Proliferation (new tissue growth): 28 days
4. Maturation (regaining normal function): a year or more

Factors promoting wound healing

- A moist healing environment
- Adequate blood supply and oxygenation
- Stable temperature
- Good nutrition and hydration
- Treatment of underlying medical conditions
- Avoiding pressure, shear, friction, maceration
- Avoiding smoking

Wound Assessment

- Undertake a comprehensive assessment of physical, medical, psychosocial and wound history, nutrition and pain (include a pain scale)

  Evaluate and document the following:

  - **Cause**, site, type and classification of wound
  - **Depth:** superficial, partial or full thickness
  - **Dimensions, shape, area:** on first presentation, then once/month
  - **Wound edge:** sloping, punched out, raised, rolled, undermining, purple, calloused
  - **Wound bed:** necrotic, sloughy, infected, granulating, epithelialisation
  - **Exudate:** serous, haemoserous, purulent
  - **Surrounding skin:** oedema, cellulitis, colour, eczema, maceration, capillary refill time
  - **Any signs of infection:** heat, redness, swelling, pain, odour, delayed healing, purulent exudate
  - **Pain:** associated with disease, trauma, infection, wound care practices, products
  - **Progress in healing:** assess regularly

Is the wound healing?

✔ **Yes, signs of a healing wound:**

- pink or ruddy red in colour
- small to moderate amounts of clear or serous exudate
- wound is decreasing in size
- surrounding skin is warm, pink and healthy

✘ **No, signs of an unhealthy wound:**

- malodour
- green, yellow slough or necrotic tissue
- large amounts of exudate
- increased size or no decrease in size
- surrounding skin is red, hot, swollen
- increased pain
- systemic symptoms of infection

An acute wound that has not healed after 28 days needs investigation