# Wound Assessment

Corinne Ward

# Learning outcomes

- Objectives of Wound Assessment
- Patient Assessment: General assessment
  - Wound bed
  - Other factors to be included in assessment
- Wound Assessment Charts

# Why do we need a wound assessment chart ?

- Decision making:forms the basis for clinical decisions in the selection of a suitable wound care regime.
- Continuity of care: all members will be using the same system of care and the same treatment
- Collection of important information:monitoring of progress of wound - data collection

# Other reasons..

- Identifies wider problems that might have adverse effect on wound healing
- Monitors effectiveness of dressings
- Improves the ability of the nurses to do assessments
- May improve communication between multi-disciplinary team
- Teaching tool for students

# Patient Assessment

- General patient factors that could delay healing
- Immediate causes of the wound and any underlying pathophysiology
- Local conditions at the wound site
- Potential consequences of the wound for the individual

# General Assessment

- General physical condition & conscious state
- Self-care abilities & continence
- Mobility+ sensory functioning
- Nutritional status
- Cardiovascular status & respiratory function
- Presence or absence of pain
- Emotional state & and social circumstances
- Current medications & allergies

# Wound Bed

- Necrotic: BLACK or brownish in colour- dehydrated dead tissue (eschar)
- Slough- YELLOW in appearance. It is a collection of dead cellular debris accumulating at the base of the wound
- Granulating- RED. Tissue repair phase. Health granulating tissue looks bright red and moist
- Epithilialisation-PINK- tissue starts migrating

# Other important factors that should be included in Wound Assessment

- Exudate-The amount and type of the exudate
- Pain-McCafferey's (1983) definition 'Pain is what the patient says it is and exists when he says it does' ***Pain location, frequency and severity***
- General surrounding condition of skin
- Infection- indicate if wound swab sent

# Wound Assessment Charts

- Various types of charts- for open or closed wounds, acute or chronic
- Specific Charts - pressure sore, leg ulcer, or closed surgical wounds
- Should be adapted to ward/hospital needs
- Should accompany other charts including: Nursing assessment on admission, at risk assessments to pressure sores, etc.