

4. Assessment

Wounds will heal themselves given the right conditions. It is crucial to combine a thorough assessment of the patient with the wound assessment. Identification, improvement and minimisation of any factors known to impede healing will benefit the patients progress. It may not be possible to alleviate all factors that are detrimental to wound healing, however these should be considered in the management and expected outcomes.

Assessment should include information from different sources. It should bring together general and specific information on the patient, the skin and the wound itself, only in this way can an accurate diagnosis be made, risk factors evaluated and effective treatment commenced.

Patient assessment can be thought of on four levels (World Union of Wound Healing Societies, 2008)

- 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

Assessment should identify the following:

Chronic diseases, which prolong or delay healing		
<ul style="list-style-type: none"> • Circulatory disorders, e.g. Anaemia, peripheral vascular disease and arteriosclerosis. • Respiratory disorders e.g. Chronic pulmonary disease, bronchitis and pneumonia • Malabsorption disorders e.g. Crohn's disease, ulcerative colitis • Metabolic disorders e.g. Diabetes, renal & hepatic failure. • Disorders of mobility & sensation e.g. Hemiplegia, paraplegia and neuropathy. • Immune deficiency disorders e.g. Rheumatoid arthritis, HIV/AIDS, malignancy 		
Local factors which prolong or delay healing		
<ul style="list-style-type: none"> • Impaired blood supply • Oxygen deficit • Temperature fluctuations • Dehydration • Wound location 	<ul style="list-style-type: none"> • Age of wound • Mechanical stress (pressure, shear and friction) • Extent of tissue loss • Local infection 	<ul style="list-style-type: none"> • Type of tissue involvement • Foreign bodies • Necrotic tissue • Skin maceration
Other factors that affect healing		
<ul style="list-style-type: none"> • Nutritional state • Dehydration • Body build • Systemic infection 	<ul style="list-style-type: none"> • Stress • Immuno-suppressive agents • Drug therapy • Lack of sleep/rest 	<ul style="list-style-type: none"> • Aging • Inappropriate wound care • Factitious injury • Pain
Psychological factors which affect healing		
<ul style="list-style-type: none"> • Motivation • Concordance 	<ul style="list-style-type: none"> • Attitudes of patients & carer • Knowledge & understanding 	<ul style="list-style-type: none"> • Body image
Lifestyle factors that may affect healing		
<ul style="list-style-type: none"> • Lifestyle e.g. patterns of working • Care environment 	<ul style="list-style-type: none"> • Financial status • Major life stress 	<ul style="list-style-type: none"> • Cultural or religious belief • Substance misuse

4.1 Wound assessment

The aim of any wound assessment is, to describe the wound appearance and allow accurate classification of pressure ulcers. Measurement of wounds forms an important part of documentation and can be achieved by using tracing maps, disposable rulers or photography. (Refer to local guidelines for photography.)

Assessment of the wound should include a detailed evaluation of:

- Wound classification
- Wound appearance
- Wound exudate, levels and type
- Any signs of clinical infection
- Condition of wound margin
- Condition of surrounding skin

Although wound exudate should not be assessed alone it must be recognised as an important aspect of the healing process and gives distinct clues as to the condition of the wound. Wound exudate is not just an inert fluid – understanding its components will help to improve patient care. An unexpected change in exudate characteristics may indicate a change in wound status or associated disease process and should prompt re evaluation. All the above information should be recorded on a wound assessment chart.

It is essential that a date be set for reassessment of the wound and that any changes in treatment following reassessment should be recorded.

The information gathered from the assessment should form the initial plan of care which should include:

- 1) Factors such as the general appearance of the skin, wound pain or allergies.
- 2) Factors that will delay healing such as general health, nutritional status, underlying disease, medication or incontinence.
- 3) The cause of the wound so that further problems can be prevented, such as immobility resulting in pressure ulcers or diabetes giving rise to a neuropathic ulcer.
- 4) Functional and psychological factors that will result from the wound or its treatment that may delay healing.
- 5) The requirements needed on discharge for the patient and/or carer.
- 6) All factors that could influence wound healing should be addressed. This may include referral to other members of the multi disciplinary team such as Tissue Viability Nurses, Dieticians, Physiotherapists, Podiatrists, General Practitioners, Vascular Consultant or Dermatologist.

4.2 Skin assessment

When selecting wound management products, assessment of the surrounding skin must be undertaken to determine the potential impact the specific product may have on managing the wound characteristics, in addition consideration of allergies must be given. Caring for the surrounding skin may include use of topical treatments.

Definitions of topical skin applications

Emollients: also known as moisturisers. These are grease-based substances which when applied to the skin either trap water in or allow water to be pulled from the dermis to the epidermis. Emollients can be used as wash products in the form of soap substitutes and bath oils. Once washing is complete, emollients can be applied to the skin in the form of lotions, creams or ointments to seal water into the skin (Penzer and Burr, 2005).

For example; Diprobase, Zerobase, Doublebase, Oilatum emollient.

Lotions: these are the lightest and least greasy emollients. They are less effective as they contain less oil.

For example; Dermol lotion

Creams: these have a higher oil content than lotions, allowing the oil to sink into the skin. They are good for daytime use.

For example; Diprobase, Zerobase, Doublebase

Ointments: these have the highest oil content and are very greasy. They can leave the skin looking shiny and clothes greasy. However if the skin is very dry, ointments should be used and may be best applied at night.

For example; Emulsifying ointment, Diprobase ointment.

NB:

Some cream based products may contain preservatives that patients can become sensitive to. Please refer to latest edition of BNF for more information on individual products.

NB:

**Please refer to National Patient Safety Agency (NPSA) website regarding use of flammable products
i.e. Yellow soft paraffin.**