

Wound Assessment Tool

MEASURE – A guideline for wound assessment.

M	Measurement of the wound	Provides baseline data even if the incision line is well approximated. Measure the length of the incision and width of the approximated edge. Length is always the longest dimension, width is determined at the widest point 90° from length and if the wound is open, depth is the deepest part to the edge of the skin. <i>Always chart. Length x width x depth in cm.</i>
E	Exudate quality and amount Describe volume as a percentage of saturation on the dressing. (this makes it measurable.)	Colour, amount, consistency and odour (if present). Drainage from surgical wound should diminish within three to four days. Signs of increasing bio burden may include increased serous exudate; purulent drainage; colour change from clear serous to opaque yellow; odour.
A	Appearance of wound bed Again, describe in terms of percentage of visible tissue. (E.g. 70% granular and 30% slough.)	Tissue in the wound bed: quality, type and amount; epithelial tissue; granulation tissue; and presence of slough or necrotic tissue. Make note if tendon, muscle, or bone is visible.
S	Suffering	Complete a pain assessment; note type, quality and degree of pain. Use a pain assessment tool (PQRSTU). Offer analgesic prior to dressing change.
U	Undermining	Identify whether there is tunneling or Undermining, and measure the amount. Describe the location of the undermining as you would a clock. (E.g. 4 cm tunnel at 4 o'clock) (The patient's head is 12 o'clock)
R	Re-evaluate	Too-frequent assessment may lead to inappropriate changes in the treatment plan, while infrequent assessment may miss significant deterioration. Always recheck your dressing after applying. It may be as simple as it was not secured and is falling off, or if there is any breakthrough on the cover dressing. With optimum wound healing You can expect 30% reduction in size in 3 weeks.
E	Exudate	Edge of the wound • Asses the edge (gaps in the suture line). if dehiscence occurs. Description of the peri-wound tissues should include colour, temperature and presence/location of edema or induration. Induration along both sides of the suture line may be expected, and may be a healing ridge.



This is an open abdominal post-surgical wound. Measuring 18 cm x 4.0 cm x 4.5 cm deep. Wound bed is 98% clean and pale pink, no visible granulation tissue present. Muscle is visible in the deepest part of wound.

Remember these best practice principles...

- Fluff don't stuff the wound
- Use one piece of packing where possible
- Don't forget the "whole person, not the hole in the person"
- Optimize nutrition
- If the factors that contributed to the wound are not resolved , healing will not take place.

Nursing Wound Care Guidelines

**James L. Harris, Linda A.
Roussel, Catherine Dearman, Patricia L.
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