Government of **Western Australia**
North Metropolitan Health Service

Residential Care Line

Six steps to wound assessment and referral

Scan the QR code to visit our webpage.

Step 1: Provide essential details

- Referrer name and position
- Facility
- Resident name and DOB
- GP details/aware of referral?

Step 2: Provide the wound history

- Location and how long wound has been present
- Cause of wound
- Classification if skin tear or pressure injury
- Current dressing plan, including frequency

Step 3: Describe the wound

- Measurements: length (head to toe), width, depth, circumference, any undermining or tracking?
- Wound bed e.g. percentage of granulating / slough / necrotic / epithelial tissue
- Wound edges e.g. rolled, flat, macerated (wet/white), dehydrated (dry)

Step 4: Describe the exudate

- Level: none, low, moderate, high
- Type: serous (clear), haemoserous (pink/clear), sanguineous (bright red blood), purulent (pus)

Step 5: Describe the surrounding skin

- Is it: healthy / red / macerated (wet/white) / dry / eroded / is there skin loss?

Step 6: Check for infection

- Local: erythema (redness), local warmth, malodour, healing delay, increased pain, increased exudate, oedema (swelling)
- Systemic: febrile, confusion, delirium, increased drowsiness, cellulitis, malaise, decreased appetite, increased leukocytes

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