Scottish Wound Assessment and Action Guide (SWAAG)

This guide presumes that Standard Infection Control Precautions (SICPs) are applied at all times when providing healthcare when there is a risk of exposure to blood, other body fluids, secretions or excretions (except sweat), non-intact skin or mucous membranes. (See https://www.hps.scot.nhs.uk/guidance/nipcm/)

October 2025 (Review Oct 2028)

Step 1

Holistic Assessment

Undertake a person-centred assessment, including aetiology (cause of wound) and understand the intrinsic and extrinsic factors which may impact healing along with full medical history, age and cognitive ability.

Consider those who are involved in the wider shared care of the individual and factors which may require further specialist input.

Step 2

Wound Assessment

Perform wound assessment at least every 7 days, when the treatment is being changed or if there is any significant change in the wound or the individual.

Using the NHS Scotland Wound Assessment and Healing Chart (SWAHC accessible here) or a locally approved version, consider the following in your wound assessment:

- Pre-dressing analgesia
- Wound dimensions - It's important not to estimate wound size and use a suitable scale when measuring. Width, length and depth. (See page 2 in the SWAHC further guidance on how to measure). Wounds may appear deeper once non-viable (slough, necrosis) tissue is debrided
- Tracking or undermining (utilise clock face method of documenting as seen in the Adult Wound Healing Plan)
- Photography (ensure appropriate local consent when obtaining)
- Tissue type - See below for full guidance on tissue type
- Wound exudate levels/type. Serous and haemoserous fluid are a normal physiological aspect of wound healing, the components of which support moist wound healing and manage bioburden. Changes in wound exudate (e.g. purulent presentation) with odour may indicate infection, in which case refer to Scottish Ropper Ladder for Infected Wounds / local guidance
- Skin surrounding wound
- Signs of infection. Common signs and symptoms of an infection may include increased pain, spreading erythema or increased heat and change in skin tone from the surrounding skin, increased exudate level, malodour, friable tissue and slough. (Consider using the Scottish Ropper Ladder for Infected Wound or local wound infection guidance)
- Treatment objectives

Step 3

Wound Healing Plan

On initial assessment and whenever the regime is altered, complete/update the wound healing plan (as seen on page 4 of the SWAHC). Detail frequency of dressing changes and document whether the plan has been discussed/agreed with the individual. Within each wound healing plan, consider the following:

Cleansing

If required, gently cleanse the wound to avoid disrupting granulation and/or epithelialisation. Chronic or hard-to-heal wounds with devitalised tissue or suspected biofilm may require mechanical debridement to remove loose devitalised tissue, microorganisms or detritus from the wound bed.

If a biofilm is suspected a surfactant solution should be considered.

Debridement

Always refer to local guidelines/pathways when considering debridement.

Establish if debridement of the wound or wound edges is appropriate. Debridement may not be appropriate where conservative or palliative management of a necrotic wound is required. Do not debride devitalised tissue from wounds which are secondary to Peripheral Arterial Disease (PAD) or diabetic foot ulcers (DFU), without obtaining specialist advice from Vascular/Podiatry. Do not debride devitalised tissue from Malignant wounds.

Consider the types of debridement and suitable techniques which can be used such as:

- Mechanical debridement- using debridement pad/cloth to manually remove loose slough and debris from the wound bed. Selection of product as per local formulary
- Autolytic debridement- using suitable dressing regime to support the body's natural process in removing devitalised tissue. Consider selecting dressings which maintain a therapeutic moisture balance in the wound to support debridement
- Larvae- as per local guidelines
- Sharp- Only to be used by appropriately trained professionals who have achieved competency in performing sharp debridement. Utilising suitable tools to remove devitalised tissue

Other methods of debridement are available for specialist use.

Treatment of the surrounding skin

Consider the wider skin areas. Is a skin barrier required to prevent maceration? Is an emollient required for dry skin and to maintain healthy skin?

Dressings

Following assessment, ensure the chosen dressings align with the treatment objectives.

Be mindful of the action of the dressing and product interactions. Avoid inappropriate multiple layering of dressings.

Consider whether the individual has any allergies, sensitivities or preferences when considering dressing selection.

Primary dressing

Dressing choice must accommodate:

- Tissue type
- Exudate level
- Odour
- Bioburden (need for antimicrobial)
- Expected wear time
- Peri-wound skin
- Area to be dressed
- Pain at dressing change and individual's need.

Secondary dressing

Consider need for secondary dressings to secure primary wound dressing and/or manage exudate, reduce risk of contamination or cross infection.

Person-centred goals

Discuss the needs and expectations of the wound management regime with the individual. For example, exudate, odour, pain etc.

Step 4

Documentation

"If you didn't write it down, it didn't happen!"

Documentation of each episode of care ensures that all practitioners undertaking wound management are aware that wound management has been performed and what products have been applied or removed from the wound.

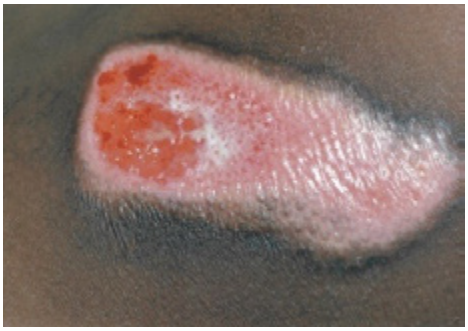
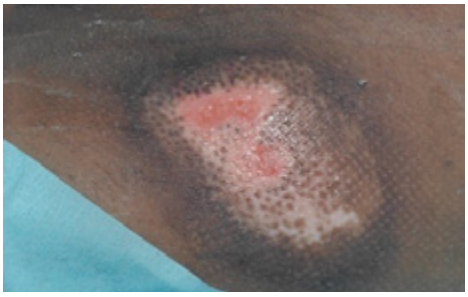
Utilising a document such as the Wound Dressing Change Log (as found on page 6 of the SWAHC) will also highlight additional information for example, wound photography performed, or swab taken.

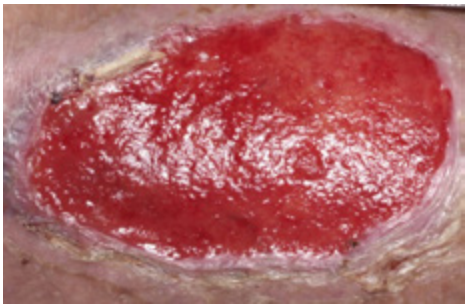
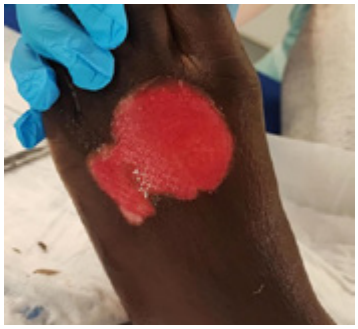
Robust documentation is a professional obligation of any clinician managing an individual with a wound and by communicating clearly it preserves safety and ensures effective practice.

Visual Wound Guide

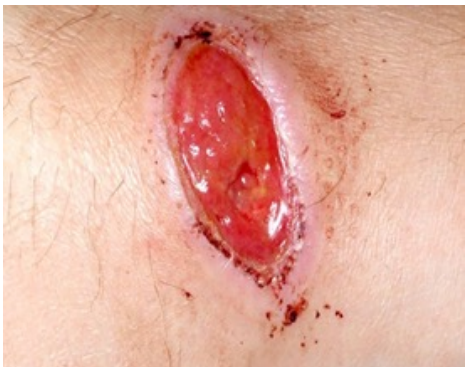
The following pages illustrate wound types and characteristics. This includes a brief description, and treatment aims based on best practice guidance.

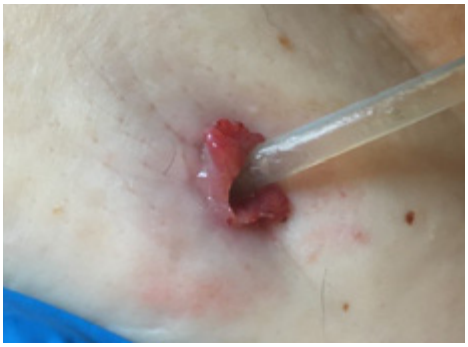
Wound Bed

Epithelialising		
	Definition	**Aims**
 	New skin cells (epithelial cells) migrate across the wound surface creating a new, delicate layer of skin. This usually happens from the edges but can develop from the middle as small islands.	• Promote and protect new tissue growth • Consider exudate levels and apply appropriate dressing to optimise epithelialisation

Granulating		
	Definition	**Aims**
 	The development of new tissue from the wound base, which typically appears bright red in colour, and has a rough or irregular surface.	• Encourage growth of granulation tissue and support moist wound healing **Management considerations** • Presence of biofilm and alternative cleansing methods as discussed in cleansing section • Exudate levels and selection of dressing to optimise moisture balance. (Refer to local guidance/ formulary)

Hypergranulating (Overgranulating)





Definition

An overgrowth of granulating tissue, which appears 'proud' of the wound, preventing epithelialisation.

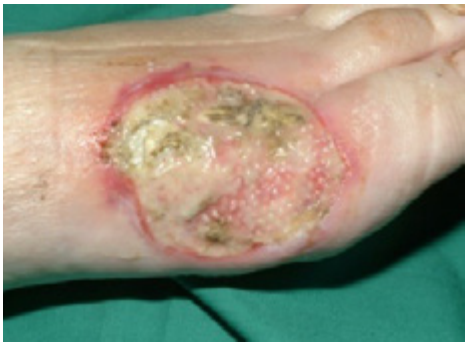
Aims

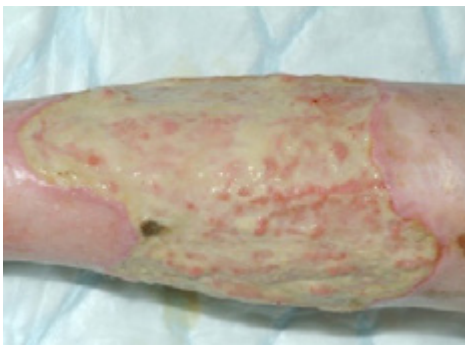
- Reduce the cause for inflammation which is causing the overgrowth of tissue

Management considerations

- Consider any irritants at the wound bed (e.g. friction from tubing) and examine ways to manage cause.
- Consider bacterial load on the wound bed and if there is requirement for antimicrobial product.
- Refer to relevant local guidelines.
- Seek advice from appropriate healthcare professional.

Sloughy





Definition

Slough is a layer of dead tissue, which can be yellow or green in colour, and may be dry or wet on the surface.
It can be of varying depth and may produce an offensive smell.

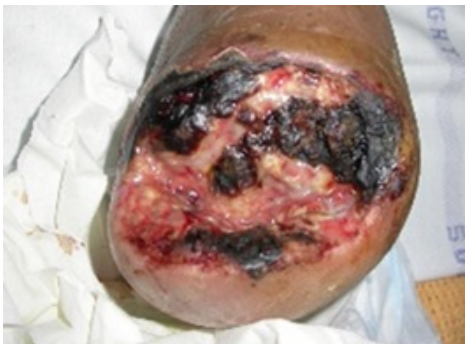
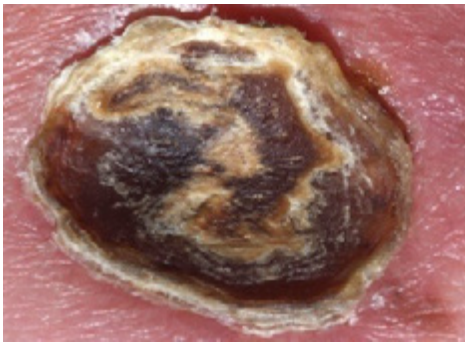
Aims

- Remove all debris from the wound using appropriate wound debridement method e.g. mechanical

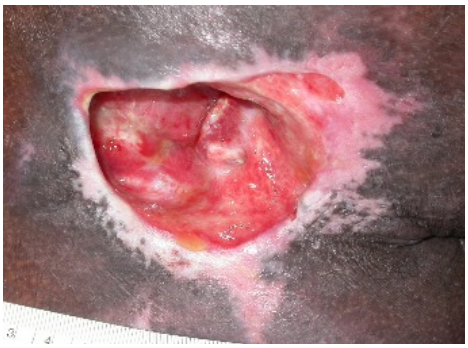
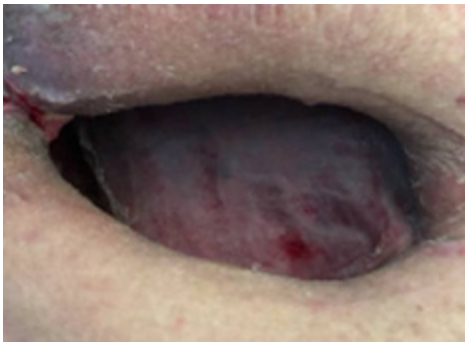
Management considerations

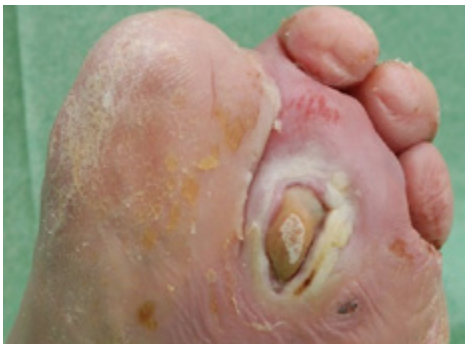
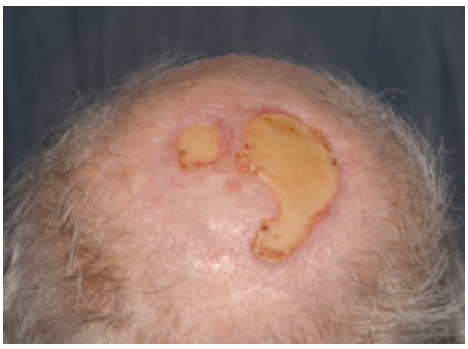
- Consider the presence of a biofilm and the use of a surfactant solution
- Exudate level- hydrate if dry, absorb if wet
- Protection of skin surrounding wound if exudate levels high
- Requirement for antimicrobial as per local guidance

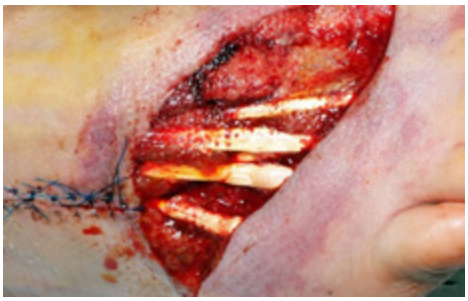
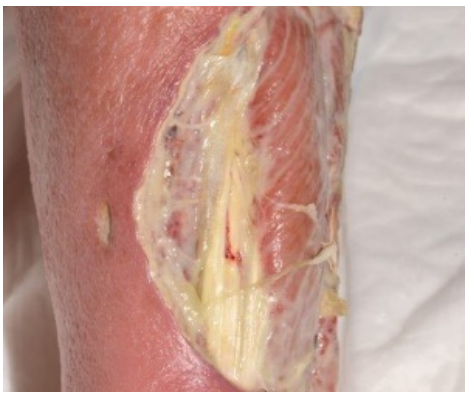
Necrotic

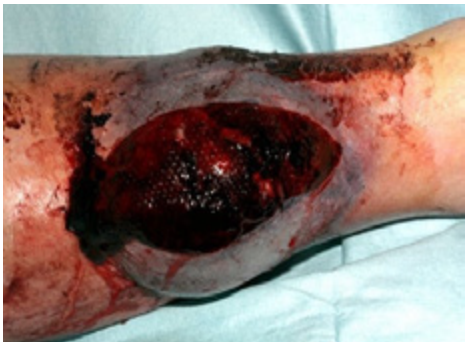
	Definition	Aims
 	Necrotic tissue is a layer of dead tissue which can be brown or black in colour and is caused by inadequate blood supply or infection. It may be soft or hard on the surface, can be of varying depth and may produce an offensive smell	• Establish if the patient is for conservative or progressive management (see debridement section above and refer to local guidance). • **Where debridement is not indicated keep the wound environment dry.** • Where debridement is indicated, consider rehydration and use of appropriate debridement technique (as discussed in debridement section)
		Management considerations
		• Monitor for signs of infection as per local guidance. • Consider malodour and management using appropriate dressings as per local formulary

Undermining / Tracking

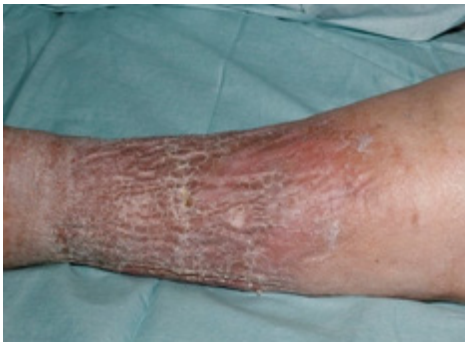
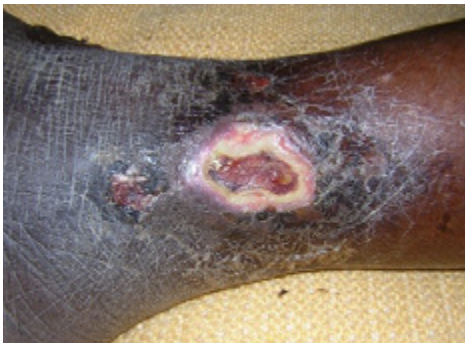
	Definition	Aims
 	A pocket or tunnelling which extends under the edge of the wound. Extension of the wound bed into adjacent tissue (under the skin), also known as a sinus tract	• Aid healing by secondary intention (from the base of the wound upwards)
		Management considerations
		• Consider dressing regime to support healing. • If packing is used, please refer to local guidance and documentation. • Seek advice from appropriate healthcare professional

Bone		
	Definition	**Aims**
 	Bone appears as a pale hard mass that is hard when palpated	• Maintain a moist environment to encourage new granulation tissue. • Reduce the risk of infection. • Seek advice from appropriate healthcare professional

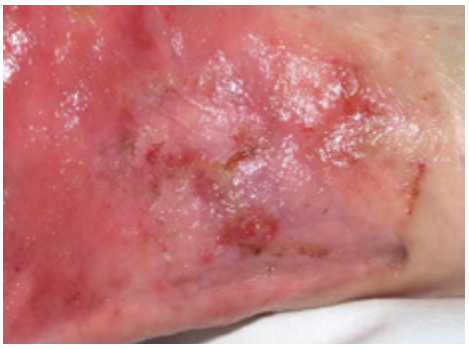
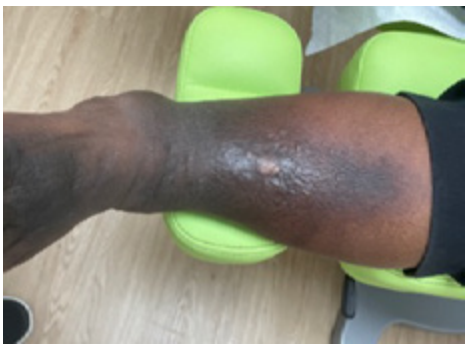
Tendon		
	Definition	**Aims**
 	Tendons are creamy white in colour. They will present as stringy and cord like and can move as the limb or joint flexes. (Can be mis-diagnosed as slough)	• Maintain a moist environment to prevent the tendon drying out. • Seek advice from appropriate healthcare professional

Haematoma		
	Definition	**Aims**
 	Haematoma is a collection of congealed blood from a leaking blood vessel, which appears like a blood-filled blister	• To support appropriate and safe management refer to haematoma pathway (local or NATVNS). • Seek advice from appropriate healthcare professional

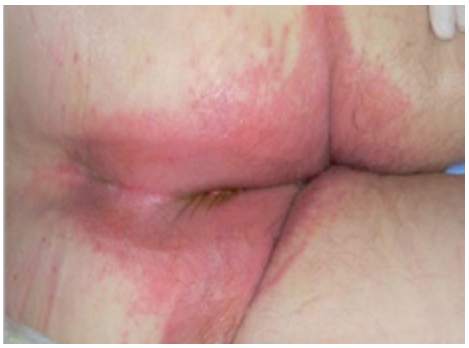
Skin Surrounding Wound

Dry / Scaly		
	Definition	**Aims**
 	Scaly skin which appears hard and dry	• Promote healthy skin **Management considerations** • Consider emollient therapy. • Encourage hydration through good fluid intake. • Consider mechanical debridement of skin plaques

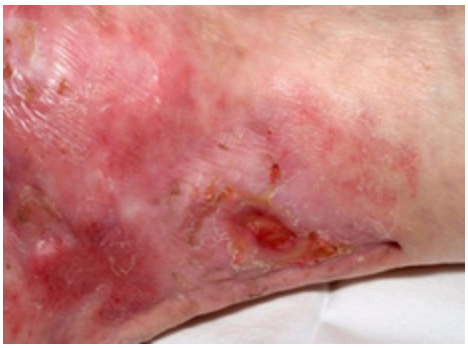
Erythema

	Definition	Aims
 	Abnormal redness or change in skin tone from the surrounding area, resulting from enlarged blood vessels under the skin	• Understand the underlying cause and treat appropriately. • Prevent deterioration of the surrounding tissues **Management considerations** • Refer to local wound infection pathways/guidance. • Seek advice from appropriate healthcare professional

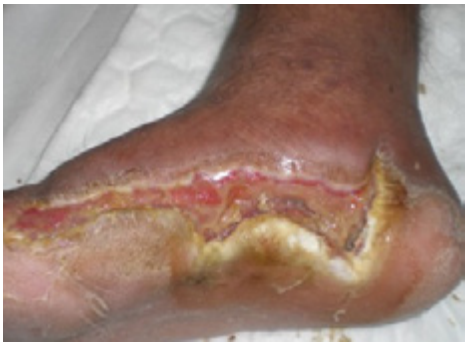
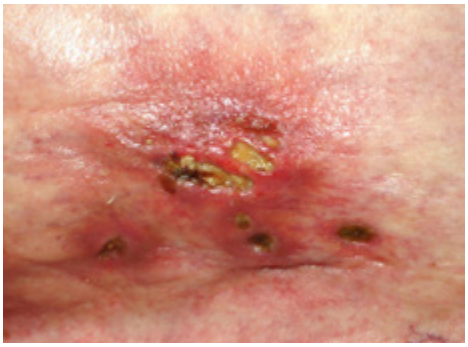
Excoriation

	Definition	Aims
	Trauma to the skin surface layer caused by excessive moisture with or without abrasion. It can vary in colour depending on the individuals normal skin tone	• Identify and manage underlying cause **Management considerations** • Manage moisture levels and protect the skin. • Refer to Skin Excoriation Tool (local or NATVNS). • Seek advice from appropriate healthcare professional

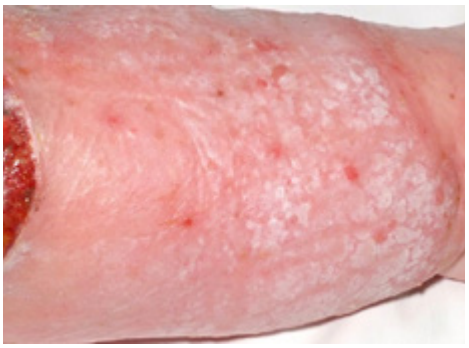
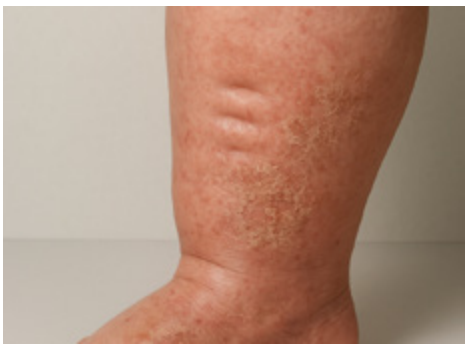
Fragile

	Definition	Aims
	Skin which is friable and may appear 'paper thin'. More vulnerable to damage. N.B. Fragile skin is more common at the extremes of age e.g. neonates and older adults	• Protect the skin and reduce the risk of harm. • Maintain good skin hydration **Management considerations** • Consider use of full-length, soft clothing and bedding to protect skin. • Keep nails short. • Use approved manual handling techniques and equipment. • Consider low adherent atraumatic dressing if appropriate • Consider use of adhesive removers when removing adhesive dressings and tapes

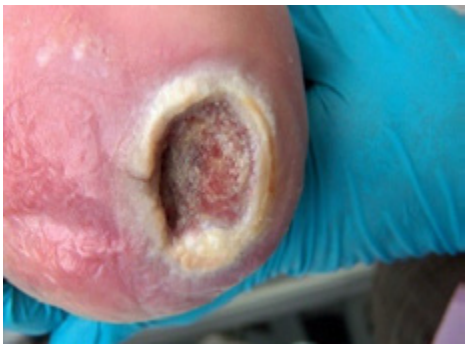
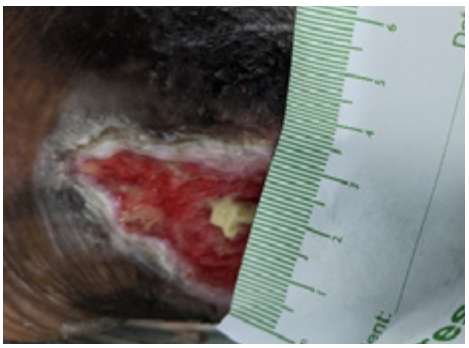
Infection

	Definition	Aims
 	When the quantity of microorganisms in a wound becomes imbalanced and the individual's response becomes overwhelmed, resulting in impairment of the normal wound healing process	• Confirm that the wound is infected prior to commencing treatment regime. • Reduce bacterial load and consider the presence of a biofilm **Management considerations** • Consider the use of an appropriate topical anti-microbial wound product in line with local formulary/ guidance. • Consider if systemic treatment is required in conjunction with topical products (e.g. antibiotics or antifungals). • Use Scottish Ropper Ladder for Infected Wounds or local infection guideline/pathway for full guidance

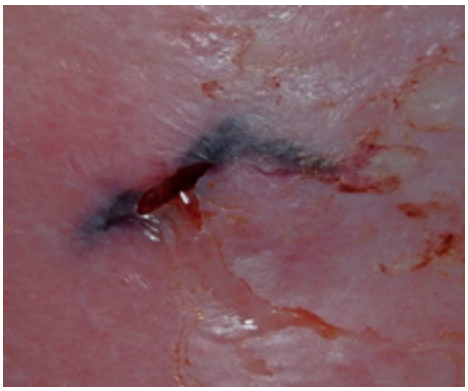
Oedematous

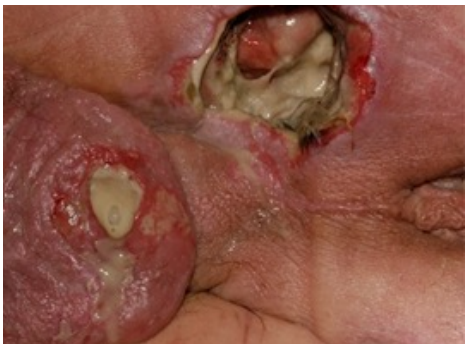
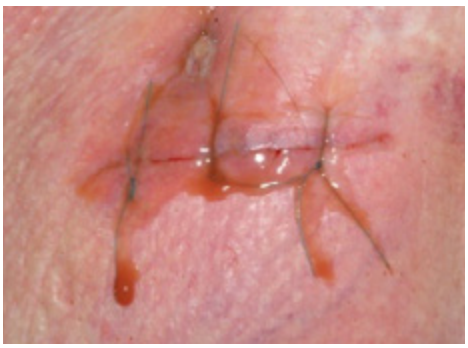
	Definition	Aims
 	Acute or chronic, soft tissue swelling	• Consider and manage the underlying cause for the oedema. • Protect skin surrounding the wounds using barrier products **Management considerations** • Manage exudate using appropriately non-adherent, absorbent products. • Consider elevating the limb when at rest. • Assess suitability for compression therapy (where appropriate). • Refer to local policy/ guidelines. • Seek advice from appropriate healthcare professional. • Consider referral to chronic oedema/ lymphoedema service if available

Macerated

	Definition	Aims
 	Softening and breakdown of the skin as a result of prolonged exposure to moisture (urine, sweat, wound exudate, faeces etc.)	• Establish the underlying cause and manage excess moisture level **Management considerations** • Consider barrier products in line with local formulary/ guidelines • Where appropriate, ensure correct continence products are in use. • Refer to local pathway/guidance on moisture associated skin damage (MASD) and • Refer to local pathway/guidance on suitably absorbent wound management products N.B. Macerated skin is at higher risk of infection or further breakdown

Exudate

Haemoserous / Serous (serosanguineous)		
	Definition	**Aims**
	Haemoserous is thin and watery fluid which is blood tinged in appearance. Serous is thin and watery fluid which is pale yellow in appearance	• Manage wound moisture balance utilising appropriately absorbent dressings as per local formulary/ guidelines. • Protect surrounding skin from moisture associated skin damage using appropriate barrier products in line with local formulary/ guidelines

Haemopurulent / Purulent / Fibrinous		
	Definition	**Aims**
 	An opaque, cloudy or milky exudate which can be yellow, brown, green or red in colour and can be thick viscosity	• Manage wound moisture balance utilising appropriately absorbent dressings as per local formulary / guidelines. • Protect surrounding skin from moisture associated skin damage using appropriate barrier products in line with local formulary / guidelines
		Management considerations
		• Consider investigations for signs of systemic infection. Ensure appropriate treatment plan is embedded to manage infection in line with local policy/guidelines

References:

Anderson, K. N. (1998) Mosby's Medical Nursing and Allied Health Dictionary. St Louis: Mosby- Year Book Inc.

Beldon, P. (2012) The causes, presentation and management of chronic oedema. Wound Essentials, 2, pp: 41-45. Available at: https://wounds-uk.com/wound-essentials/wound-essentials-72-the-causes-presentation-and-management-of-chronic-oedema/ [Accessed 25 Jun 25].

Iwasaki, M., Shimomura, M. and Li, T. (2021) Negative-pressure wound therapy in combination with bronchial occlusion to treat bronchopleural fistula: a case report. Surgical Case Reports. 7(1), pp. 61. https://doi.org/10.1186/s40792-021-01144-4.

Keast, D., Angel, D., Weir, D., Haesier, E., Ousey, K., Carville, K., Waters, N., Idensohn, P., Swanson, T. and Bjarnsholt, B. (2022) International Wound Infection Institute. Wound Infection In Clinical Practice: Principles of best practice. London: Wounds International. Available at: https://woundsinternational.com/wp-content/uploads/2023/05/IWII-CD-2022-web.pdf [Accessed 25 Jun 2025].

Mayer, D. O., Tettelbach, W. H., Ciprandi, G., Downie, F., Hampton, J., Hodgson, H., Lazaro-Martinez, J. L., Probst, A., Schultz, G., Sturmer, E. K., et al. (2024) Best practice for wound debridement. Journal of Wound Care, 33 (Sup 6b), pp. S1-S32.

NHS National Services Scotland (2012) National Infection Prevention and Control Manual. Available at: https://www.nipcm.scot.nhs.uk/ [Accessed 25 Jun 2025].

Nichols, E. (2015) Describing a wound: from presentation to healing. Wound Essentials, 10 (1), pp. 56-61. Accessible at: https://wounds-uk.com/wp-content/uploads/2023/02/content_11582.pdf [Accessed 25 Jun 2025].

Schultz, G., Tariq, G., Harding, K., Carville, K., Romanelli, M., Chadwick, P., Percival, S. and Moore, Z. (2019) World Union of Wound Healing Societies (WUWHS) Consensus Document. Wound exudate: effective assessment and management. London: Wounds International. Available at: https://woundsinternational.com/world-union-resources/wuwhs-consensus-document-wound-exudate-effective-assessment-and-management/. [Accessed 25 Jun 2025].