

## Moisture, Edges and Surrounding Skin

Management of moisture is required to create a balanced, moist wound environment for healing.

Exudate is a normal part of wound healing. However excessive or too little exudate leads to disrupted healing and potential damage to the surrounding skin. Wound exudate contains elements which can be highly corrosive. Both to the wound bed and intact skin surrounding the wound. Moisture characteristics must be assessed, including:

- Amount: L Heavy, Moderate, Minimal, None
- Traditionally, nurses have documented exudate levels using the symbols +, ++ and +++, however this is highly subjective (Kerr, 2014; Lloyd Jones, 2014). A better gauge of volume is to assess the dressing type and its wear time against descriptors
- Type: Serous, Haemoserous, Purulent, Haemopurulent
- Colour.

Amount of exudate	Description
<b>Dry/None</b>	No visible moisture. Not an ideal wound healing environment (except for ischaemic wounds). Surrounding skin may be dry, flaky or hyperkeratotic.
<b>Minimal/Low</b>	An ideal wound environment. Dressing may be lightly marked. Wound bed could appear glossy. Surrounding skin may be intact and hydrated.
<b>Moderate</b>	Primary dressing may be extensively marked. Potential for peri - wound maceration.
<b>High</b>	Free fluid is visible. Primary dressing is wet and leakage is visible on the secondary dressing. Strike through may occur. Risk of macerated peri - wound skin.

### Understanding different types and colours of moisture/exudate:

- Serous exudate is thin and watery, coloured clear, amber or straw, similar to plasma. It is often considered as normal.
- Haemoserous exudate is thin and slightly thicker than watery, coloured pink or red. It has the presence of red blood cells, indicating capillary damage.
- Purulent exudate is viscous and sticky, coloured yellow, brown or green. It has the presence of white blood cells, bacteria and/or slough.
- Haemopurulent exudate is viscous, coloured red and milky. It is the sign of an established infection containing neutrophils, dry dying bacteria. Inflammatory cells, blood and active bacteria.

### Edges

- The edges of the wound should be assessed to monitor the epithelial resurfacing taking place. The epithelial progression of the resurfacing will guide the management.
- Measure the wound bed width, length, depth and any tracking or undermining areas (cm). (Undermining is suggestive of a chronic wound with prolonged inflammation).
- Lack of new, healthy tissue at the wound edges, or the presence of rolled edges, indicate wound healing is not progressing normally.
- Maceration is the softening and breaking down of peri wound skin due to prolonged exposure to moisture. It present as white wet tissue.

### Surrounding Skin

The peri- wound is the area around a wound that may be affected by wound-related factors and/ or underlying pathology'. Types of peri-wound damage include maceration, denouement, excoriation, erosion, skin stripping and allergic reactions affecting the skin. Skin irritation can also lead to excoriation, pruritis (itch) can also occur.

Promoting peri-wound health can:

- Improve healing
- Decrease infection risk
- Reduce dressing frequency and associated cost
- Reduce pain and discomfort, and improve quality of life.