

# 9 Step Wound Assessment Tool – 9SWAT

## Chronic Wound Assessment

1

Is the blood supply (**e.g. ABPI/Doppler assessment**) and blood chemistry supportive to wound healing?

- Review FBC, CRP, U&E, LFTs including total protein & glucose
- Wound to lower leg/ankle/foot see - **Lower Leg Ulcers Pathway** - note 1 glossary

2

Is there devitalised tissue present? Plan removal unless clinically contraindicated - e.g. arterial ulcer, warfarin therapy, tendons visible, diabetic foot ulcer

- Consider debridement - note 2 glossary

3

Is there wound infection or inflammation or a high risk of development?

- **Refer to Scottish Ropper Ladder for Infected Wounds** - note 3 glossary
- Do not routinely use topical antimicrobial wound care products

4

Is wound environment conducive to healing?

- Too dry - rehydrate wound - moisture donating product
- Too wet - manage cause and review absorbency product
- Refer to **First Choice Dressing Guide** - note 4 glossary

5

If required, is adequate pressure redistribution equipment in place?

- Complete pressure ulcer risk assessment, and reassess
- Source equipment via local access point

6

Is pain managed, before, during and after treatment?

- Identify cause and review pain medication and strategies
- Assess if required using recognised pain assessment tool

7

Are the host factors optimised, e.g. nutrition/hydration?

- Refer to note 7 in glossary

8

Is there any oedema present?

- Yes - discuss results from box 1 with medical staff to review cause
- If lymphoedema - consider a referral to Chronic Oedema Service

9

Is tissue growth optimised within 7 weeks of initial assessment?

- Yes - Healing well and margins reducing, continue to review and reassess
- No - Refer to note 9 in glossary and consider onward referral for specialist advice

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Glossary / Guidance notes for 9SWAT - 9SWAT must be used in conjunction with your clinical judgement. A wound assessment chart must be completed and maintained for all wounds (excludes healing primary closed wounds). NHSG uses [Applied Wound Management](#).

1. FBC – Full blood count – check that Haemoglobin levels are satisfactory to support healing  
CRP – C Reactive Protein - identifies inflammation and systemic infection  
U&E – kidney function and dehydration  
LFT's – Liver Function Tests  
Glucose – check if raised glucose levels, as may affect healing  
ABPI – Ankle Brachial Pressure Index – assesses arterial blood perfusion to a limb  
[Lower Leg Ulcers Pathway](#)
2. **Do not debride devitalised tissue from wounds due to Peripheral Arterial Disease (PAD) or diabetic foot ulcers (DFU), without specialist advice from Vascular/Podiatry.**  
Debridement can be:
  - autolytic - using dressings, e.g. Honey or ActivHeal range
  - mechanical – debridement pad/lolly to remove slough and debris from wound bed and surrounding skin
  - enzymatic - using enzymatic dressings e.g. Flaminol Forte/ Hydro or larvae therapy
3. Infection – is part of wound assessment and will be routinely reassessed. [Refer to Scottish Ropper Ladder for Infected Wounds](#) to guide decision and [Antimicrobial stewardship](#) website.
4. Exudate – fluid produced by a wound as part of natural healing, this is assessed in terms of volume and viscosity (thickness of the fluid). This is part of wound assessment, and will be routinely reassessed. To aid dressing selection refer to [First Choice Dressing Guide](#).
5. Ensure adequate pressure relief is in place, [NHSG pathway can be looked at for reference](#).
6. Ensure pain is assessed and managed.
7. Consider the holistic environment for the patient – e.g. Nutrition, hydration, smoking, obesity, polypharmacy, mobility, alcohol intake, co-morbidities and end of life period. Also consider patient concordance with treatment, advice, and understanding of agreed plan of care. Where possible enable empowerment with self-care.
8. Oedema possible causes: cellulitis, lymphoedema, dependant oedema, medication e.g. steroids, cardiac failure etc. Do they/can they elevate their legs? Ask how pain is when in bed.
9. Continue to review and assess progress if signs of healing, using the 9 SWAT and maintain AWM. If remains non-healing/static after 7 weeks initiate onward referral to appropriate speciality - consider Vascular, Dermatology, Plastics or Tissue Viability. [Refer to Wound Referral Guide](#).