Wound Assessment

Nursing

A structured description of a wound bed, so the next nurse can see what you saw.

TIME describes the bed; the rest describes the wound and the person.

The wound bed · TIME

- Tissue — granulation, slough, eschar, epithelium
- Infection or inflammation — local and systemic
- Moisture — exudate amount, type and odour
- Edge — advancing, rolled, undermined, macerated

Also record

- Site, and measurements in millimetres
- Depth, tunnelling and undermining
- Surrounding skin condition
- Pain at rest and at dressing change
- Cause, and whether the cause is now removed
- A photograph if local policy allows it

Educational reference. Dressing choice follows local wound formulary and tissue viability advice. Report spreading redness promptly.