

# 10 IMPORTANT WOUND ASSESSMENTS

## 1. Location

## 2. Stage (or type)

- Pressure ulcers (Stage I-IV, Unstageable, Suspected Deep Tissue Injury)
- Thermal (burn) injuries (First, second or third degree)
- Other dermal wounds (Partial or full thickness)

## 3. Wound Bed

- Color
- Texture
- Slough

## 4. Size

## 5. Exudate

- Type
- Color
- Odor
- Amount

## 6. Wound Pain

- Pain assessment tool used
- Location
- Length of time pain has been present
- Other symptoms when the pain is present
- Activities associated with pain
- Methods used to control the pain

## 7. Odor

- Distance from which odor is detectable, with and without dressing in place

## 8. Signs of Colonization and Infection

- Critical colonization: new or increased pain at wound site, lack of fever, slight wound odor, increased exudate and possible tunneling or sinus tracking
- Infection: Induration, erythema, edema along with fever, increased pain in the wound and surrounding periwound skin, foul and excessive exudate, foul odor, tunneling or sinus tracking and increased wound size

## 9. Perimeter

- Attached edges
- Undermining
- Tunneling
- Epibole

## 10. Periwound Skin

- Sinus tracts
- Tunneling