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