20.7: Checklist for Wound Assessment

Use the checklist below to review the steps for completion of "Wound Assessment."

**Steps**

**Disclaimer:** Always review and follow agency policy regarding this specific skill.

2. Perform safety steps:
   - Perform hand hygiene.
   - Check the room for transmission-based precautions.
   - Introduce yourself, your role, the purpose of your visit, and an estimate of the time it will take.
   - Confirm patient ID using two patient identifiers (e.g., name and date of birth).
   - Explain the process to the patient and ask if they have any questions.
   - Be organized and systematic.
   - Use appropriate listening and questioning skills.
   - Listen and attend to patient cues.
   - Ensure the patient’s privacy and dignity.
   - Assess ABCs.
3. Identify wound location. Document the anatomical position of the wound on the body using accurate anatomical terminology.
4. Identify the type and cause of the wound (e.g., surgical incision, pressure injury, venous ulcer, arterial ulcer, diabetic ulcers, or traumatic wound).
5. Note tissue damage:
   ◦ If the wound is a pressure injury, identify the stage and use the Braden Scale to assess risk factors.
6. Observe wound base. Describe the type of tissue in the wound base (i.e., granulation, slough, eschar).
7. Follow agency policy to measure wound dimensions, including width, depth, and length. Assess for tunneling, undermining, or induration.
8. Describe the amount and color of wound exudate:
   ◦ Serous drainage (plasma): clear or light yellowish
   ◦ Sanguineous drainage (fresh bleeding): bright red
   ◦ Serosanguineous drainage (a mix of blood and serous fluid): pink
   ◦ Purulent drainage (infected): thick, opaque, and yellow, green, or other color
9. Note the presence or absence of odor, noting the presence of odor may indicate infection.
10. Assess the temperature, color, and integrity of the skin surrounding the wound. Assess for tenderness of periwound area.
11. Assess wound pain using PQRSTU. Note the need to premedicate before dressing changes if the wound is painful. (Read more about PQRSTU assessment in the “Health History” chapter.)
12. Assess for signs of infection, such as fever, change in level of consciousness, type of drainage, presence of odor, dark red granulation tissue, or redness, warmth, and tenderness of the periwound area.
13. Assist the patient back to a comfortable position, ask if they have any questions, and thank them for their time.
14. Ensure safety measures when leaving the room:
   ◦ CALL LIGHT: Within reach
   ◦ BED: Low and locked (in lowest position and brakes on)
   ◦ SIDE RAILS: Secured
   ◦ TABLE: Within reach
   ◦ ROOM: Risk-free for falls (scan room and clear any obstacles)
15. Perform hand hygiene.
16. Document the assessment findings and report any concerns according to agency policy.

Note

View a supplementary video of a nurse performing a wound assessment in [Wound Care: Assessing Wounds](https://www.youtube.com/watch?v=s76P1DdtBAA).