Procedure Guideline for Assessing Wounds

1. Before assessing a wound, identify your agency’s approved wound assessment tool. Review the recommended frequency of assessment.
2. Verify the health care provider’s orders.
3. Gather the necessary equipment and supplies.
4. Perform hand hygiene, and provide for the patient’s privacy.
5. Introduce yourself to the patient and family, if present.
6. Identify the patient using two identifiers according to agency policy.
7. Review the patient’s last wound assessment and use it for comparison as you proceed with this one.
8. Ask the patient to rate pain on a scale of 0 to 10.
9. Note whether the patient appears anxious as you explain the wound assessment procedure.
10. Position the patient:
    A. Position the patient comfortably so that the wound is clearly visible.
    B. Expose only the area of the wound.
11. Fold the top of a waterproof biohazard bag to form a cuff, and place the bag within your reach.
12. Apply clean gloves, and remove the soiled dressings.
13. Examine the color and consistency of the drainage on the dressing. Note whether it has any odor. Note whether the dressing is saturated, slightly moist, or dry.
14. After inspecting it, discard the dressings in the waterproof biohazard bag. Discard your gloves. Note your findings.
15. Perform hand hygiene, and apply clean gloves.
16. Inspect the wound and its location of the wound. Determine the type of wound healing, such as primary or secondary intention. Use your agency-approved assessment tool to assess the following:
   A. Wound healing by primary intention (surgical wound):
      (1) When healing occurs by primary intention, the edges of the wound are pulled together and approximated with sutures, staples or stripes of adhesive tape. Gradual formation of scar tissue allows the wound to close slowly.
      (2) Assess the anatomical location of the wound on the body.
      (3) Note if the incisional wound margins are approximated or closed together. Ideally there should be no gap between the edges of the wound.
      (4) Observe for the presence of drainage. Look for evidence of infection, such as the presence of erythema, odor, or wound drainage. A closed incision should have no drainage.
      (5) Lightly palpate along the incision to feel for a healing ridge. The ridge will appear as an accumulation of new tissue presenting as firmness beneath the skin extending to about 1 cm (½ inch) on each side of the wound. It appears 5 to 9 days after surgery. This is an expected positive sign.
   B. Wound healing by secondary intention (pressure ulcer or contaminated surgical or traumatic wound) :
(1) In this process, granulation tissue forms and the wound edges contract healing quickly but leaving behind a more obvious scar.

(2) Assess the anatomic location of the wound.

(3) Assess the wound dimensions. Measure the size of the wound, including length, width and depth, using a centimeter measuring guide:
   a. Measure the length by placing a ruler over the wound at the point of greatest length (or head to foot).
   b. Measure the width from side to side.
   c. Measure the depth by inserting a sterile cotton-tipped applicator into the area of greatest depth and placing a mark on the applicator at skin level. Discard the measuring guide and the applicator in the biohazard bag.

(4) Assess for undermining or tunneling: Use a sterile cotton-tipped applicator to gently probe beneath the edges of the wound. Measure the depth, and note the location using the face of a clock as a guide (with the patient’s head representing the 12 o’clock position and her feet marking 6 o’clock). Document the number of centimeters the undermining extends beneath the intact skin.

(5) Assess the extent of tissue loss. Determine the deepest viable tissue layer in the wound bed of a pressure ulcer. If necrotic tissue does not allow you to visualize the base of the wound, the stage cannot be determined.

(6) Note the tissue type, including the percentage of intact tissue and the presence of granulation, slough, and necrotic tissue.

(7) Indicate the color, consistency, odor and amount of exudate. Indicate the amount of exudate by assessing the part of the dressing that is saturated, such as 1/3, or by describing the quantity in terms such as scant, moderate, or copious.

(8) Note if any of the wound edges are rounded toward the wound bed. This may indicate delayed wound healing. Describe the presence of epithelialization at the wound edges, if present, since this indicates movement toward healing.

(9) Inspect the skin adjacent to the wound, including color, texture, temperature, and a description of its integrity, noting any open, macerated areas. The periwound assessment provides clues as to the effectiveness of the wound treatment, as well as possible wound extension.

17. When your assessment is complete, apply a dressing as prescribed. Write the time, date, and your initials on the new dressing.

18. Using a scale of 0 to 10, reassess the patient’s pain and level of comfort, including pain at the wound site, after the dressing has been applied.

19. Discard the biohazard bag, soiled supplies, and gloves according to agency policy. Perform hand hygiene.

20. Help the patient into a comfortable position, and place toiletries and personal items within reach.

21. Place the call light within easy reach, and make sure the patient knows how to use it to summon assistance.

22. To ensure the patient’s safety, raise the appropriate number of side rails and lower the bed to the lowest position.
23. As part of your follow up care, record your wound assessment findings and compare them with earlier findings to monitor healing. Document and report the patient’s response and expected or unexpected outcomes.