Skin & Wound Assessment

A bedside quick reference for consistent assessment, documentation and escalation

GOAL **Tell the wound story clearly enough that the next clinician can see what changed.**

1 ASSESS THE WOUND

- Record location and wound type / etiology when known.
- Measure length x width x depth in centimeters using the same method each time.
- Note undermining and tunneling when present; assess pain and change from baseline.
- Describe granulation, epithelial tissue, slough and eschar. Note exposed or palpable structures.
- Document drainage amount and type; assess periwound warmth, color change, edema, induration and maceration.
- In darker skin tones, use touch and change from baseline as well as visible color.

DO NOT STAGE NON-PRESSURE WOUNDS

Stage only when the injury is pressure-related.

2 TRACK THE TREND

- Compare findings with the prior assessment.
- State whether the wound is improving, stable or worsening.
- Trend measurements and tissue changes rather than relying on one observation.
- Note new or concerning odor after cleansing.

3 BE SPECIFIC

Avoid: **"Looks worse."**

Instead document measurable change in:

- size / depth / tissue
- drainage / pain
- surrounding-skin findings

4 ASSESS THE WHOLE PATIENT

Healing can be affected by perfusion, pressure, edema, nutrition, infection, mobility, diabetes and other medical conditions.

CLINICAL PEARL

Consistency beats complexity: use the same assessment method every time.

NEW OR WORSENING FINDINGS?
REASSESS / DOCUMENT / NOTIFY / ESCALATE APPROPRIATELY