

# Wound Care Insider

An educational resource from Gentell

June 2026

## Admission Assessments

Skin, wound, and risk assessments need to be completed when a new resident is admitted to a long-term care (LTC) facility in order to identify and document pre-existing conditions and to generate an effective care plan for the resident. These assessments have a positive impact on resident health and also help facilities prevent legal issues related to delays in treatment and failure to properly identify and document signs of infection and other pre-existing wound conditions.

## Wound Assessment

**Wound assessment is required within 24 hours of admission or in accordance with your facility's policy.**

It is imperative to assess a resident's skin for current compromised skin integrity upon arrival in accordance with your facility's policy. Pressure injuries can be hidden just under the skin surface, and the resident could suffer if these injuries go unnoticed. Moreover, you and your facility could be held accountable if an assessment is not completed and documented. Essential documentation includes:

- Wound location
  - Left, Right, Upper/Lower Extremity, Medial, Lateral, Anterior/Posterior
- Wound type
  - Refer to admission documentation for etiology
  - Describe, but do not diagnose/stage unless within your scope of practice
- Size
  - Length: measured head to toe
  - Width: measured side to side
  - Depth: measures tissue loss from the skin surface to the deepest area of the wound bed and must be documented
- Undermining/tunneling
  - Undermining is documented according to hours on a clock with a starting and stopping point, going clockwise
  - Tunneling is documented as one point on a clock with depth extending beneath the perimeter of the wound
- Exudate
  - None, Light, Moderate, or Heavy
- Periwound description (descriptions not limited to the following)
  - Intact, Macerated, Erythema, Induration
- Pain
  - Baseline pain level is to be assessed with the initial skin assessment/dressing application.
  - Repeat pain assessment with each assessment/dressing change and report any increases in pain or discomfort to the physician immediately
- Risk Assessment Tool
  - Indicates the resident's level of risk for developing wounds
  - The risk assessment tool to be utilized is determined by your facility's policy

## Risk Assessment

The approved risk assessment tool utilized by a facility provides documentation of your observations, and it will score the resident's risk in relation to:

- Physical condition
- Mental status
- Activity
- Mobility
- Incontinence
- Nutrition
- Sensory perception
- Moisture
- Friction and shear

Categories assessed are dependent upon the tool used. Always be sure to include documentation of scars noted on bony prominences. These scars are indicative of resolved full-thickness wounds or deep tissue injuries and are areas of high risk for reoccurring pressure injuries. It is important to review records sent with a resident to determine the wounds they have had in the past including wound type and stage associated with pressure injuries.



Scar over a healed scapular ridge wound.

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## Treatment Implementation

Review documentation to determine wound treatment orders upon admission. Be sure to consult with the attending physician to obtain treatment orders if none can be found within admission documentation. The Gentell Wound Management Algorithm is a great resource for best practices in wound treatments. Use this tool to discuss treatment options with the attending physician. Always refer to your facility's wound management policy and Gentell Wound Protocols for implementation of best treatment practices.

Wound Management Algorithm for Advanced Wound Care Products				Gentell We make it better							
Notify Resident, Physician & Family/POA		Review Clinical Test Results		Determine Nutritional Status		Consider Support Surfaces & Pressure Relief		Assess Wound & Drainage		Identify Underlying Cause	
Light Exudate			Moderate Exudate			Heavy Exudate			Additional Wound Info		
Cleanse with Gentell Wound Cleanser <b>Full-Thickness Wounds</b> <u>Hydrate wound bed with:</u> Gentell Hydrogel Tube or Gentell Hydrogel Saturated Gauze or Gentell Honey Hydrogel Sheet or Gentell Collagen Dressing or Gentell Collagen Particles  <u>Cover with:</u> Gentell Bordered Gauze Dressing or Gentell Roll Gauze or Stretch Gauze  <u>Stage 2 &amp; Partial-Thickness Wounds:</u> Hydrocolloid, Xeroform or Hydrogel Sheet			Cleanse with Gentell Wound Cleanser <b>Full-Thickness Wounds</b> <u>Control exudate with:</u> Gentell Calcium Alginate Dressing or Gentell Collagen Dressing or Gentell Collagen Particles or Gentell Gelling Fiber Dressing  <u>Cover with:</u> Gentell Super Absorbent Dressing or Gentell Comfortell Dressing			Cleanse with Gentell Wound Cleanser <b>Full-Thickness Wounds</b> <u>Control exudate with:</u> Gentell Calcium Alginate Dressing or Gentell Gelling Fiber Dressing  <u>Cover with:</u> Gentell Super Absorbent Dressing or Gentell Bordered Foam Dressing or Gentell Silicone Foam Dressing or Gentell Non-Bordered Foam Dressing or Gentell Comfortell Dressing			<ol style="list-style-type: none"> <li>Select Appropriate Debridement Method:               <ul style="list-style-type: none"> <li>Autolytic</li> <li>Enzymatic</li> <li>Sharp</li> <li>Surgical</li> <li>Mechanical</li> </ul> </li> <li>Assess Surrounding Skin:               <ul style="list-style-type: none"> <li>Moisturize as needed</li> <li>Protect from excess moisture</li> <li>Control edema</li> </ul> </li> <li>Wound Bed Environment:               <ul style="list-style-type: none"> <li>Contain exudate</li> <li>Fill bed space</li> <li>Protect and insulate</li> <li>Maintain optimal moisture balance in wound bed</li> </ul> </li> </ol>		
<b>Infected/Colonized Wounds:</b> Apply - Hydrogel Ag, Honey Hydrogel Sheet, Collagen Ag, Calcium Alginate Ag, Gelling Fiber Ag, Honey Fiber, Bordered Foam Ag or Gentell Blue Foam <small>*If wound is infected, do not use occlusive dressings such as Hydrocolloids or Hydrogel Sheet Dressings</small>											

### References:

Wound Source - Long Term Care: Skin Assessment Observation - Susan Cleveland, BSN, RN, WCC, CDP 10/29/2020  
 Gentell Wave - Photo Library  
 Legal Aspects in Wound Care - Elaine Horibe Song MD, PhD, MBA, Kim Simonson RN-BC, ACHRN, CWS, FACCWS,  
<https://woundreference.com/p/topic?id=legal-aspects-inwound-care> 2/27/2026