



Wound Documentation Tips

1. Document the type of wound and location.
2. Describe if the wound is a partial or full thickness wound
 - Partial Thickness - tissue destruction through the epidermis extending into but not thru the dermis.
 - Full Thickness- tissue destruction extending thru the dermis to involve subcutaneous tissue and possibly bone and muscle.
3. Describe the stage (if wound is pressure ulcer) **National Pressure Ulcer Advisory Panel Staging Guidelines 2/2007**
 - Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Further description: Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.
 - Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding areas. Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk)
 - Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicated suspected deep tissue injury
 - Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.
 - Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.
 - Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.
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4. Document Size. Measure in centimeters – ALWAYS Document Length x Width X Depth
 - Length = head to toe direction
 - Width = hip to hip direction
 - Depth = measure deepest part of visible wound bed
5. Document any undermining/tunneling/sinus tracts. Document using the "Clock System" with head = 12:00 (example: 2cm undermining at 3 o'clock)
 - Tunneling- course or pathway that can extend in any direction from the wound, results in dead space
 - Undermining – tissue destruction underlying intact skin along wound margins
 - Sinus Tract – A drainage pathway from a deep focus of acute infection through tissue and/or bone to an opening on the surface
6. Describe any drainage (exudate) – type, amount, or odor using descriptions below:
 - Type
 - Sanguineous – thin, bright red
 - Serosanguineous – thin, watery, pale red to pink
 - Serous – thin, watery, clear
 - Purulent – thick or thin, opaque tan to yellow
 - Foul Purulent – thick opaque yellow to green with offensive odor
 - Amount –
 - None – wound tissues dry
 - Scant – wound tissues moist, no measurable drainage

- Small – wound tissues very moist, drainage <25% dressing
 - Moderate – wound tissues wet, drainage involves 25 – 75% dressing
 - Large – wound tissues filled with fluid – involves > 75% dressing
7. Odor – Describe presence or absence of odor- strong, foul, pungent, fecal, musty, sweet
 8. Describe the various types/characteristics of tissue in wound bed including:
 - Adherence of the tissue
 - Nonadherent – easily separated from wound base
 - Loosely adherent – pulls away from wound, but attached to wound base
 - Firmly adherent – Does not pull away from wound
 - Amount – Describe in % (example: 50% wound bed covered with soft yellow slough, 50% beefy red granulation tissue) May also use “clock system” in describing location of necrotic tissue in wound bed.
 - Tissue Types
 - Slough – usually lighter in color, thinner and stringy in consistency; Color – Can be yellow, gray, white, green, brown
 - Eschar – usually darker in color, thicker and hard consistency black or brown in color.
 - Granulation Tissue – it is usually beefy red, granular, bubbly in appearance; should be differentiated from a smooth red wound bed; color of tissue – red, pink, pale pink or full dusky red
 - Epithelialization – can appear as deep pink, then progress to pearly pink/ light purple from the edges in full thickness wound or may form islands in the wound base with superficial wounds
 - Foreign Bodies
 9. Describe wound edges:
 - Definition – Defined or undefined edges
 - Attachment – Attached or unattached edges –
 - Rolled Under (Epibole) – Macerated – Fibrotic – Callused
 - Border shape
 10. Describe surrounding tissue: Color, edema, firmness, intact, induration, pallor, lesions, texture, scar, rash, staining, moisture
 11. Describe any indicators of infection: fever, streaking, redness, increased drainage, odor, warmth, elevated WBC, induration, malaise, edema, weeping, increased pain, discolorations
 12. Document any pain – location, causative factors, intensity, quality, duration, alleviating factors, patterns, variations, interventions
 13. Document interventions for healing: dietary supplements, vitamins, lab tests, turning repositioning schedules, support surface, cushion, padding, pillows, elevation, heel protection, incontinence management, skin protection(barrier ointments)
 14. Document any conditions which would affect healing: Mobility/Turning Surface and Positioning Limitations, Nutritional Status, continence, abnormal labs, infections, deterioration of medical condition, non-compliance.
 15. Document current topical treatment plan, response to treatment , modifications to plan, implementation of new orders, reason for not changing treatment plan, referrals.
 16. Patient and caregiver education.

Anatomical Directions

Lateral – toward side

Distal – away from center

Medial – toward middle

Dorsal – located near

Posterior – back, underside

Superior – Top, up

Anterior – Front, top

Inferior – below, down

Proximal – toward center, nearest

Specialized directions for limbs

Proximal - Towards body

Distal - Away from body

Specialized directions for Hand

Palmar - towards palm, also volar

Dorsal - opposite of palmar

Specialized directions for Foot

Plantar - towards bottom of foot, also volar

Dorsal - opposite of plantar

