REFERENCE FOR WOUND DOCUMENTATION

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1. **Document the wound etiology/cause**
   - Document the cause of the wound: pressure, venous, arterial, neurotrophic, surgical etc.

2. **Describe the anatomic location of wound**
   - Wound location should be documented using the correct anatomical terms (see page 5)

3. **Document the stage** (only if pressure ulcer/injury)
   - Stage 1 – Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.
   - Stage 2 – Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).
   - Stage 3 – Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
   - Stage 4- Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
   - Unstageable- Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
   - Deep tissue injury- Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue,

granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

- Additional pressure injury definitions.

  Medical Device Related Pressure Injury:
  This describes an etiology.
  Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

  Mucosal Membrane Pressure Injury: Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

4. **Describe if the wound is partial or full thickness (non-pressure)**
   - Partial thickness: tissue destruction through the epidermis extending into but not through the dermis.
   - Full thickness: tissue destruction extending through the dermis to involve subcutaneous tissue and possibly bone and muscle.

5. **Measure the size in centimeters – length x width x depth (greatest extent of length & width)**
   - Length = head to toe direction (12 o'clock – 6 o'clock)
   - Width = hip to hip direction (3 o'clock – 9 o'clock)
   - Depth = measure deepest part of visible wound bed

6. **Document the presence, location, and extent of any undermining, tunneling/sinus tract, (refer to location as time on a clock, (ex: wound tunnels 1.9cm at 3 o'clock)**
   - Tunneling – a narrow passageway that may extend in any direction within the wound bed.
   - Undermining – the destruction of tissue extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface. Often develops from shearing forces.
   - Sinus Tract – an elongated cavity that forms allowing purulent material from an abscess to drain to the body surface.

7. **Describe any exudates (drainage)**
   - **Type**
     Serous – thin, watery, clear
     Sanguineous – thin, bright red, fresh bleeding
     Serosanguinous – thin, watery, pale red to pink
     Purulent – thick or thin, opaque tan to yellow
     Foul Purulent – thick opaque yellow to green with offensive odor

- Amount
  None – wound tissue dry
  Scant – wound tissue is moist, no measurable drainage
  Minimal – wound tissue is very moist, drainage <25% on dressing
  Moderate – wound tissue is wet, drainage involves 25 – 75% on dressing
  Large – wound tissue is filled with fluid, involves >75% on dressing

8. **Odor – describe presence or absence of odor, (after cleansing the wound)**
   - Strong, Foul, Pungent, Fecal, Musty, Sweet

9. **Document the method of debridement – removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process.**
   - Autolytic – use of moisture retentive dressings to cover a wound and allow devitalized tissue to self-digest by the action of enzymes present in the wound fluids.
   - Enzymatic – the topical application of substances e.g., enzymes to break down devitalized tissue.
   - Mechanical – the removal of foreign material and devitalized or contaminated tissue from a wound by physical rather than by enzymatic or autolytic means.
   - Sharp or surgical – the removal of foreign material or devitalized tissue by a surgical instruments.

10. **Describe the various types/characteristics of tissue in the wound bed including:**
    - **Adherence of the tissue**
      - Non adherent – easily separated from the wound base
      - Loosely adherent – pulls away from the wound but attached to wound base
      - Firmly adherent – does not pull away from the wound base

    - **Amount** – Describe in % (example: 50% wound bed covered with soft yellow slough, 50% beefy red granulation). May also use the "clock system" in describing location of necrotic tissue in wound bed.

    - **Tissue Types**
      - Granulation – temporary structure composed of vascularized connective tissue that fills the wound void, may be red, pink, pale, or dusky red.
      - Slough – necrotic/avascular tissue that is yellow or tan in color and has a stringy or mucinous consistency.
      - Eschar – is described as thick, leathery, frequently black or brown in color, necrotic or devitalized tissue.
      - Epithelialization – process by which keratinocytes resurface the wound defect, can appear as deep pink, then progress to pearly pink; may form islands in the wound base.

11. **Describe wound edges**
    - **Definition –** Defined or undefined edges (well demarcated)
    - **Attachment-** Attached or unattached edges
    - **Epibole –** Rolled edges
    - **Maceration –** Skin that is white and sometimes wrinkled and soft due to supersaturation
    - **Callused / Fibrotic –** Build up of tissue at wound margin due to hyperkeratosis

12. **Describe surrounding tissue:**
    - Color, Edema, Consistency, Hardness/Induration, Soft/Boggy, Pallor**,** Temperature

13. **Describe any indicators of infection**:
    - Fever, Redness, Increased drainage, Odor, Warmth, Edema, Elevated WBC, Induration, Pain

14. **Document any pain:**
    - Location, Causative factors, Intensity, Quality, Duration, Alleviating factors, Patterns, Variations, Interventions

15. **Document interventions for healing:**
    - Dietary supplements, Vitamins, Lab tests, Turning and Repositioning schedules, Support Surfaces, Padding, Pillows, Elevation, Offloading, Heel protection, Incontinence management, Skin care, Barrier ointments

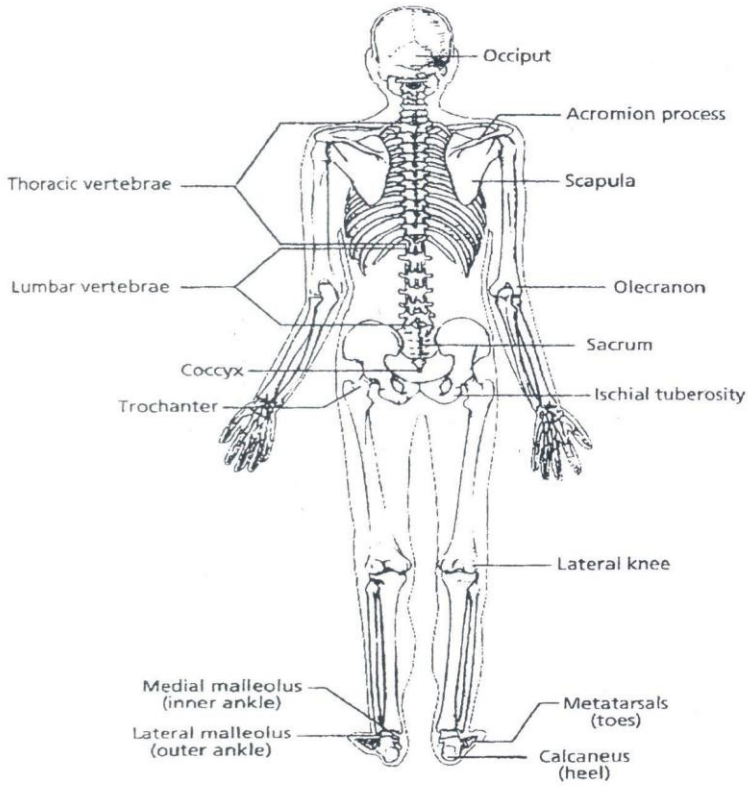
16. **Document any conditions which would affect healing**:
    - Impaired mobility, Nutritional Status, Abnormal labs, Infections, Deterioration of medical condition, Non-compliance

17. **Document current treatment plan, response to treatment, modifications to the plan, implementation of new orders, reason for not changing treatment plan, justifications, referrals.**

18. **What and When to Document**

    - Initial intake, Daily notes, Weekly progress notes, Weekly skin reports, Any change in treatment plan, Any signs or symptoms of infection, Patient and caregiver education, MD notification.

Pressure points of bony prominences



Fixed anatomical directions
Superior - Up
Inferior - Down
Anterior - Front
Posterior - Back
Medial - Towards middle
Lateral - Away from middle

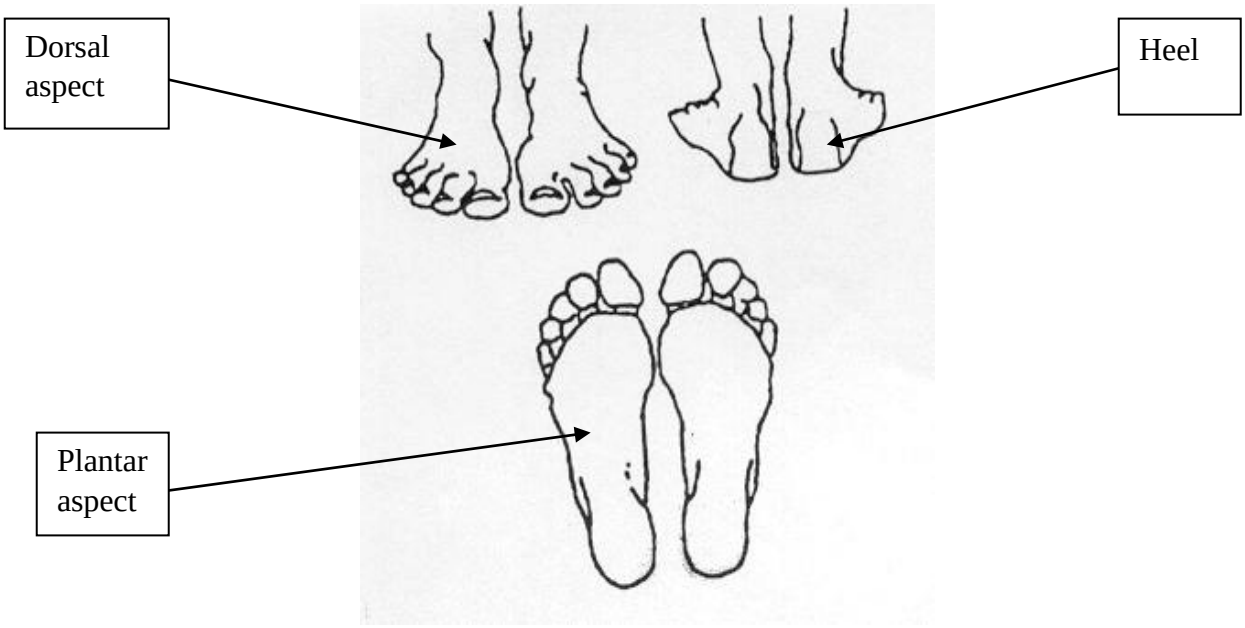
Directions attached to specimen:
Cephal - Towards head
Caudal - Towards tail
Ventral - Towards belly
Dorsal - Towards back

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

Specialized directions for forearm
Ulnar - towards ulna, medial
Radial - towards radius, lateral



References:

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Wound Care Essentials, Second Edition: Sharon Baranoski MSN, RN, CWOCN, APN, DAPWCA, FAAN, Elizabeth A. Ayello PhD, RN, APRN, BC, CWOCN, FAPWCA, FAAN

The Clinical Practice Guidelines from the Agency for Healthcare Research and Quality: www.ahrq.gov