

Reference for Wound Documentation

Document Wound Etiology/Cause

- + Document the cause of the wound: pressure, venous, arterial, neurotrophic, surgical, etc.

Describe the Anatomic Location of Wound

- + Wound location should be documented using the correct anatomical terms.

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

Fixed anatomical directions
 Superior - Up
 Inferior - Down
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 Posterior - Back
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 Lateral - Away from middle

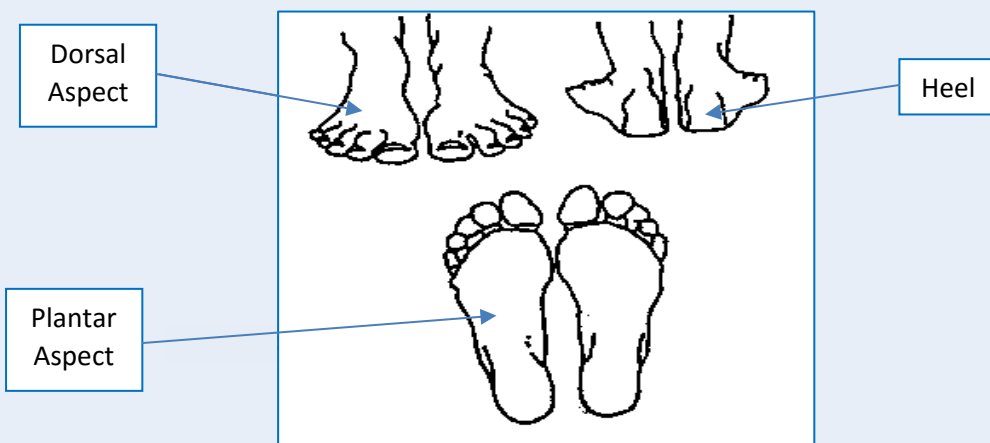
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Document the Stage (Only if Pressure Ulcer/Injury)

+ **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 (MARS), 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.

Document the Stage (Only if Pressure Ulcer/Injury) – 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.

Describe the Wound as Partial- or Full-Thickness (Non-Pressure Wounds)

+ **Partial-Thickness Wounds**

Tissue destruction through the epidermis extending into but not through the dermis.

+ **Full-Thickness Wounds**

Tissue destruction extending through the dermis to involve subcutaneous tissue and possibly bone and muscle.

Measure the Wound Size

- + Measure in centimeters (cm)
- + Measure from the greatest extent: length x width x depth

Length = head to toe direction (12:00 – 6:00)

Width = hip to hip direction (3:00 – 9:00)

Depth = deepest part of visible wound bed

Document Undermining, Tunneling or Sinus Tracts

- + Document the location and extent, referring to the location as time on a clock (e.g., wound tunnels 1.9 cm at 3:00).

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 injury is larger at its base than at the skin surface. Often develops by shearing forces.

Sinus Tract – An elongated cavity that forms, allowing purulent material from an abscess to drain to the body surface.

Document Wound Exudate (Drainage)

- + Document 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

- + Document Drainage *Amount*

None – wound tissue dry

Scant – wound tissue moist, no measurable drainage

Minimal – wound tissue very moist, < 25% of dressing saturated with drainage in a 24 hour period

Moderate – wound tissue is wet, 25% – 75% of dressing saturated with drainage in a 24 hour period

Large – wound tissue is filled with fluid, > 75% of dressing saturated with drainage in a 24 hour period

Document Wound Odor

- + Describe presence or absence of odor *after* cleansing the wound.
- + Descriptors include: strong, foul, pungent, fecal, musty, sweet, etc.

Document Method of Debridement

- + Debridement involves the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process.

- + Document Debridement *Type*

Autolytic – use of moisture retentive dressings to cover a wound and allow devitalized tissue to self-digest by the action of enzymes present in wound fluid

Enzymatic – the topical application of substances (i.e., 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 surgical instruments

Describe Wound Bed Characteristics

Non-Adherent – easily separated from the wound base

Loosely Adherent – pulls away from the wound but is attached to wound base

Firmly Adherent – does not pull away from the wound base

+ Tissue Amount

Describe in percentages (e.g., 50% of wound bed is covered with loosely adherent yellow slough; 50% beefy, red granulation tissue).

May also utilize the “clock system” in describing location of necrotic tissue in the 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

Describe Wound Edges

+ Wound Edge Characteristics

Definition – defined (well-demarcated) or undefined wound edges

Attachment – attached or unattached wound edges

Epibole – rolled wound 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

Describe Surrounding Tissue (Periwound)

- + Describe the color, presence/lack of edema, tissue consistency (e.g., indurated (firm), boggy, etc.), temperature, etc.

Document Indicators of Infection

- + Document fever, erythema (redness), increased drainage, odor, warmth, edema, elevated WBC, induration, pain, etc.

Document Complaints of Pain

- + Document location, causative factors, intensity, quality, duration, alleviating factors, patterns, variations, interventions, etc.

Document Interventions to Promote Healing

- + Examples include: dietary supplements, vitamins, lab tests, turning and repositioning schedules, support surfaces, padding, pillows, elevation, offloading, heel protection, incontinence management, skin care, barrier ointments, etc.

Document Conditions Which May Adversely Affect Healing

- + Examples include: impaired mobility, nutritional status, abnormal labs, infections, deterioration of medical condition, non-compliance, etc.

Document Anticipated Wound Outcome

- + Based on provider evaluation of co-morbid conditions, circulation, medication; and based on discussions and desires of the resident, advanced directors, anticipated life span, goals and wishes
- + Is the wound good for healing, maintenance or palliative?

What & When to Document

- + Examples include: initial intake, daily notes, weekly progress notes, weekly skin reports, change in treatment plan, signs or symptoms of infection, resident and caregiver education, MD notification, current treatment plan, response to treatment, modifications to the treatment plan, implementation of new orders, reason for not changing treatment plan, justifications, referrals, etc.

References

- + The National Pressure Ulcer Advisory Panel: www.npuap.org
- + 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

The documentation presented herein is provided for educational and informational purposes only. Please check with the applicable payer for additional guidance on what may be required in terms of documentation. The amount/type of document required may vary depending upon payer requirements and good clinical practice.