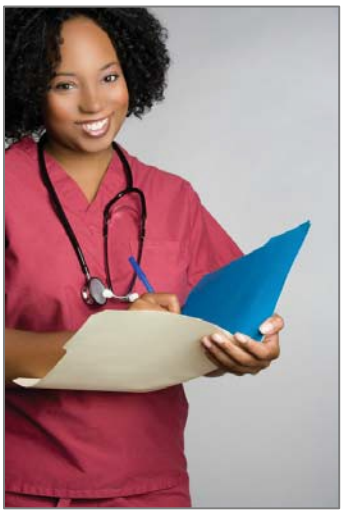
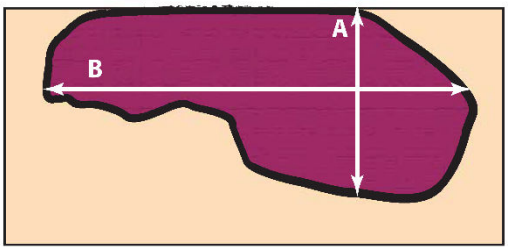
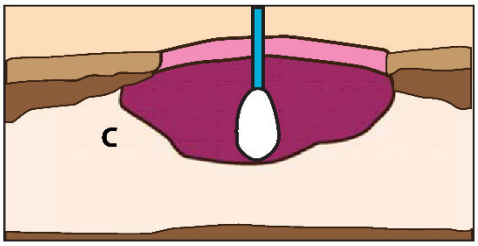
Wound Measurement & Documentation Guide

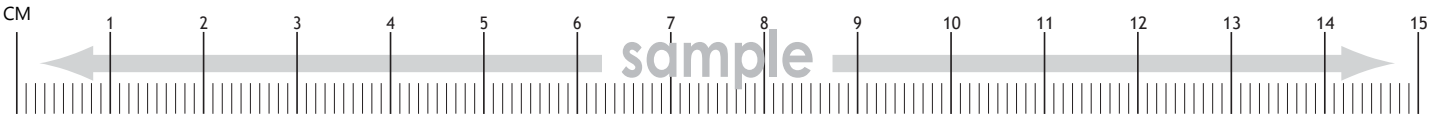


Measuring Wounds

Measure the length "head-to-toe" at the longest point (A). Measure the width side-to-side at the widest point (B) that is perpendicular to the length, forming a "+". Measure the depth (C) at the deepest point of the wound. *All measures should be in centimeters.*





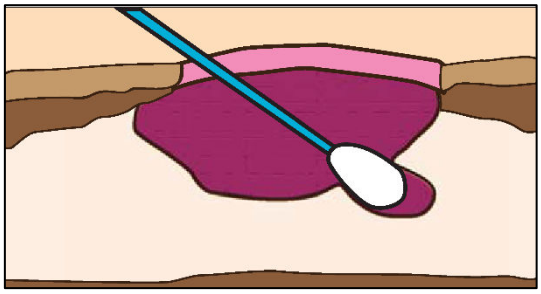


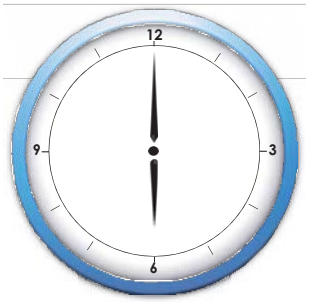
This ruler is intended for use as a reference only. To prevent infection, do not use this ruler to measure an actual wound.

Tunneling/Sinus Tract

Using a clock format, describe the location and extent of tunneling (sinus tract) and/or undermining.

A narrow channel or passage-way extending in any direction from the base of the wound. This results in dead space with a potential risk for abscess formation.

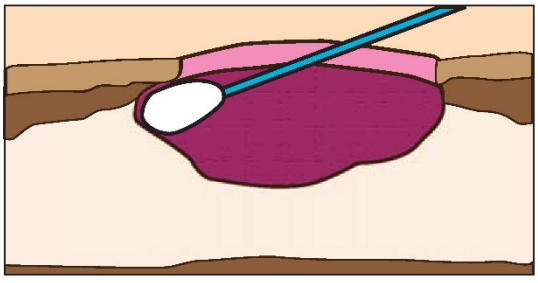




The head of the patient is 12:00, the patient's foot is 6:00.

Undermining

Open area extending under intact skin along the edge of the wound.



If the wound has many landmarks, you may want to trace it before measuring.

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Pressure Ulcer Documentation

Wound Location:

- Designate left, right, top, bottom, side, front, middle, etc., as appropriate(for example, inner left knee)
- Describe anatomical location according to your facility practice; abdomen,knee, coccyx, sacrum, trochanter (hip), ischial tuberosity (buttock), calcaneus (heel), malleolus (ankle), etc.

Be specific! Location description should direct staff to exact area for treatment.

Stage:

1, 2, 3, 4, suspected deep tissue injury (sDTI), unstageable

Size:

L x W x D

- Length (head-to-toe)
- Width (hip-to-hip)
- Depth (deepest point)

Exudate/Drainage:

Amount

- None, dry, scant, moist, small, medium,large, copious

Color

- Serous (thin, watery, clear)
- Sanguineous (bright red)
- Serosanguineous (thin, watery, pale red to pink)
- Purulent (thick or thin, opaque to tan to yellow or green)

Odor

- None, foul, pungent, fecal, musty, sweet

Wound Edges:

- Attached/unattached
- Undermining (use clock to designate location)
- Rolled under (epibole)
- Callused

Wound Base:

- Granulation (beefy red, bumpy in appearance)
- Epithelialization (light to deep pink, pearly light pink; may form islands in the wound bed)
- Necrotic Tissue
  - » Slough - thin stringy consistency; yellow, gray, white, green, brown
  - » Eschar - thick hard consistency; leathery, brown to black
  - » Adherency - Non-adherent, loosely adherent, firmly adherent
- Tunneling/Sinus Tract (use clock to designate location)

Surrounding Skin:

- Color (red, pink, pallor, purple, normal skin tones)
- Edema; pitting, non-pitting
- Firmness (induration)
- Temperature (warmer or cooler than adjacent skin)
- Other Characteristics: intact, macerated,rash, excoriated, etc.

Pain Assessment:

- Rate on scale of 1-10 before, during and after treatment; episodic or chronic
- Interventions for pain

Wound Progress:

- Improving, deteriorating, no change
- Interventions in place: pillows, low airloss beds, special devices, nutritional supplements, etc.
- Continued treatment **or** notify MD and responsible party of need for treatment change

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