DOCUMENTATION OF PRESSURE ULCERS

1. Document the type of wound and location
2. Describe the stage (if wound is pressure ulcer) or if the wound is a partial or full thickness wound (if non-pressure ulcer):
   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.
   Stage
   A. *Stage I* . An observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.
   B. *Stage II* . Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.
   C. *Stage III* . Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to but not through, underlying fascia. The ulcer presents as a deep crater with or without undermining.
   D. *Stage IV* - Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures. Undermining and sinus tracts also may be associate with Stage IV ulcers.
3. 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
4. Document any undermining/tunneling/sinus tracts.
   - Tunneling/Undermining . tissue destruction underlying intact skin along wound margins
   - Sinus Tract . course or pathway extending in any direction from wound surface results in dead space with potential for abscess formation.
   - Document using the .Clock System. with head = 12:00 (example: 2cm undermining at 3 o.clock)
5. Describe any exudates . 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
   Odor - Describe presence or absence of odor
6. Describe the wound bed of various types of tissue in wound.
   Necrotic Tissue
   Slough . usually lighter in color, thinner and stringy in consistency
   Eschar . usually darker in color, thicker and hard consistency
   - **Adherence -**
     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
   - **Color .** Can be yellow, gray, white, green, black or brown in color.
   - **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.

   Granulation Tissue **-** it is usually beefy red, granular, bubbly in appearance
   - Should be differentiated from a smooth red wound bed
   - Describe color of tissue . 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, describe using % or .clock system.
7. Describe wound edges:
   Definition . *Defined or undefined edges*
   Attachment . *Attached or unattached edges .*
   Epibole (Rolled Under) . Macerated . Fibrotic . Callused
8. Describe surrounding tissue: Color, edema, firmness, intact.
9. Describe any warmth or pain, rashes and border shape.
10. Document any conditions which would affect healing: Mobility/Turning Surface and Positioning Limitations, Nutritional Status, continence**, *type of support surface***, interventions being implemented for healing, abnormal labs, infections, pain on dressing change, deterioration of medical condition, and response to treatments.