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.
   - **Length** = head to toe direction
   - **Width** = hip to hip direction
   - **Depth** = measure deepest part of visible wound bed
   - 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** –
     - **Epible (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.