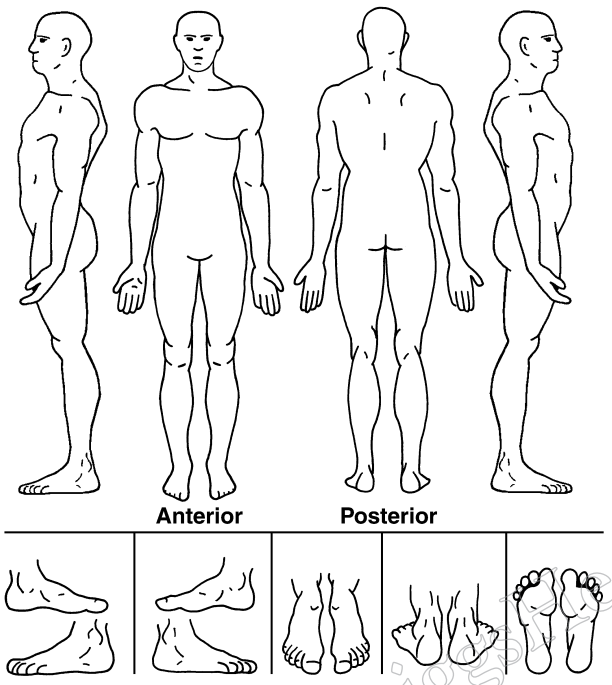
WOUND/SKIN HEALING RECORD

DIRECTIONS: Use a separate form for each site. Select the response that best describes the wound. Record text where indicated (line). Record measurements to the nearest 1/10th centimeter.

❍ Arterial Ulcer ❍ Diabetic Ulcer ❍ DTI ❍ Venous Ulcer ❍ Pressure Injury ❍ Other_____

IDENTIFY SITE ON DIAGRAM BELOW



DATE OF ONSET_____ **DATE HEALED**_____

SITE/LOCATION _____

NOTE: *When documenting the length and width of a pressure injury, use the resident's/patient's body as a road map. The head at north and the feet at south. The width should be measured from side to side.*

DESCRIPTION OF STAGES

Stage 1: Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema, redness or changes in sensation, temperature or firmness may precede visual changes. Color changes of intact skin, such as purple or maroon discoloration, 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 open/ruptured blister. Granulation tissue, slough and eschar are not present.

Stage 3: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.

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.

Unstageable Pressure Injury: 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.

Deep Tissue Pressure Injury: Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue.

Medical Device Related Pressure Injury: Pressure injury resulting from the use of devices designed and applied for diagnostic or therapeutic purposes. The discoloration may appear differently in darkly pigmented skin. The resultant pressure injury generally conforms to the shape of the device. This injury should be staged using the staging system.

Mucosal Membrane Pressure Injury: 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 injuries cannot be staged.

DESCRIPTION OF WOUND BED

Epithelial tissue - new skin growing in superficial wound. It can be light pink and shiny, even in persons with darkly pigmented skin.

Granulation tissue - pink or red tissue with shiny, moist, granular appearance.

Slough - yellow or white tissue that adheres to the wound bed in strings or thick clumps, or is mucinous.

Necrotic tissue (Eschar) - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin.

DATE _____

STAGE ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ Unstageable ❍ Other _____

SIZE IN CM (LENGTH X WIDTH) _____

DEPTH (cm) _____

EXUDATE TYPE ❍ None ❍ Serous ❍ Purulent ❍ Serosanguineous

ODOR ❍ None ❍ Slight ❍ Moderate ❍ Foul

EXUDATE AMOUNT ❍ None ❍ Scant ❍ Small ❍ Moderate ❍ Large ❍ Copious

WOUND BED ❍ Normal ❍ Epithelial Tissue ❍ Granulation Tissue ❍ Slough ❍ Black/Brown (eschar)

SURROUNDING SKIN COLOR ❍ Normal ❍ Pink ❍ Bright Red ❍ White/Gray Pallor ❍ Dark Red/Purple ❍ Black/Brown

SURROUNDING TISSUE/WOUND EDGES ❍ Normal ❍ Peripheral Tissue Edema ❍ Maceration ❍ Hardness/Induration ❍ Rolled Edges

CULTURE SENT ❍ No ❍ Yes, Date _____ Results_____

Tunneling (cm)_____

Undermining (cm)_____

PAIN: Is patient experiencing pain related to wound? ❍ No ❍ Yes ❍ Unable to communicate

Non-verbals demonstrated: ❑ Diaphoresis ❑ Grimacing ❑ Moaning/Crying ❑ Guarding ❑ Irritability ❑ Anger ❑ Tense ❑ Restlessness ❑ Change in vital signs ❑ Other:_____

Pain Location (specify site(s)):

Present level of pain _____

Worst pain gets _____

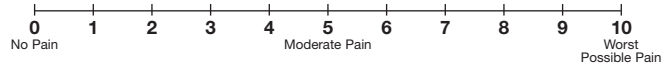
Best pain gets _____

Acceptable level of pain_____

Nature of Pain (specify):_____ **Frequency:** ❍ Episodic ❍ Continuous

Intensity: (using scales at right)

0-10 Numeric Pain Intensity Scale



From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Signature/Title

Date Dietary Notified _____

Date Family/Representative Notified _____

Date Physician Notified _____

Response to Treatment ❍ Improved ❍ Healed ❍ Deteriorated ❍ No Change

Plan of Care Updated ❍ No ❍ Yes

Comments

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed