

# Wound Assessment and Documentation

Practical Guidance for  
Health Care Professionals





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# Introduction

Wound healing begins with the assessment of the patient and the wound, and proper documentation by the health care provider. A comprehensive assessment is critical to understanding the factors that may have contributed to the wound's development and/or may impede wound healing. Appropriate and accurate documentation will aid health care providers in the monitoring of a patient's progress toward healing, as well as support payment and help mitigate legal issues from improper or incomplete documentation.

*WoundSource™* editors have compiled this guide containing helpful articles written by leading clinicians in the field of wound management. Wound assessment requires a multifaceted approach; this guide includes topics ranging from patient interview questions to wound bed preparation, and assessment of wounds for signs of infection. Documentation tips are also provided to help health care providers correctly translate their patient wound assessments into complete and accurate patient records.

# 30 Essential Questions to Ask When Assessing a Patient with a Wound

by the WoundSource Editors

A myriad of factors need to be addressed when evaluating a patient with a wound. A thorough patient history, including previous wounds, surgeries, hospitalizations and past and existing conditions will help guide your clinical assessment, in addition to a number of questions specific to the wound(s) being assessed. Following is a list of general questions to ask when evaluating a wound care patient. (Please note that this list is not comprehensive and is intended only to serve as a guide):



*[[* A thorough patient history will help guide your clinical assessment..*]]*

- 1** What type of wound is it?
- 2** Where is the wound located?
- 3** What size is the wound?
- 4** Has the etiology of the wound been determined and addressed?
- 5** Has a biopsy been performed on the wound to rule out infection, inflammatory disease or cancer?
- 6** Is there adequate blood flow to the wound?
- 7** How long has the wound been present?
- 8** Has the patient's pain increased?
- 9** Has the size of the wound increased since last assessed?
- 10** Is the wound tunneling or undermining?
- 11** Is bone exposed?
- 12** Is there an odor present?
- 13** Is there exudate from the wound? If so, how much?
- 14** Is there edema of the wound tissue?

- 15** Is there necrotic tissue present in the wound? If so, how much?
- 16** Is there granulation tissue present in the wound? If so, how much?
- 17** Is there epithelial tissue present in the wound? If so, how much?
- 18** What is the color of the wound tissue?
- 19** What do the wound edges look like?
- 20** Is there induration and erythema of the periwound tissue?
- 21** How is the patient's nutritional intake?
- 22** How is the patient's fluid intake?
- 23** Is the patient taking supplements?
- 24** What are the patient's albumin and pre-albumin levels?
- 25** What is the patient's medical and surgical history?
- 26** What medications is the patient currently taking?
- 27** What is the patient's fasting blood glucose and HgA1C?
- 28** What is the patient's complete blood count?
- 29** Does the patient smoke, consume alcohol or use illegal substances?
- 30** What types of wound dressings have previously been used on the wound?

### Comprehensive Wound Assessment for Improved Outcomes

Always refer to your facility's intake and assessment protocol for thorough assessment and documentation of the patient and the patient's wound. Gathering answers to these questions and taking a holistic approach to assessing the patient—not just the wound—will support treatment options and offer early identification of factors that may become barriers to wound healing.

*Editor's Note: This content has been adapted from the article, "Top 30 Questions to Assess both a Patient and a Wound," by Jackie Brace, PhD, RN-BC, CWOCN, APRN-B, published to WoundSource.com on October 24, 2008. This article has been expanded and updated for comprehension by WoundSource™ staff editors.*



# Wound Assessment Tools: A Basic Introduction to PUSH, NPUAP and Wagner

by Laurie Swezey, RN, BSN, CWOCN, CWS, FACCWS

There are many tools that can be used to assess wounds. It is important to be aware of these tools and what they measure. It is also important to become knowledgeable about the tool(s) used in your facility.



“...The Pressure Ulcer/Injury Scale for Healing (PUSH) tool is a fast and accurate tool used to measure the status of pressure wounds over time.”

## PUSH Tool

The Pressure Ulcer/Injury Scale for Healing (PUSH) tool is a fast and accurate tool used to measure the status of pressure wounds over time. The tool was designed by the National Pressure Ulcer Advisory Panel (NPUAP) and has been validated many times over. The NPUAP recommends that the tool be used on a regular basis, at least weekly or whenever the patient or wound status changes. The PUSH tool measures three parameters that are considered most indicative of healing:

- Wound size (greatest length x greatest width = wound surface area)
- Exudate amount (estimate as light, moderate or heavy after removal of the dressing)
- Tissue type (closed/resurfaced, epithelial tissue, granulation tissue, slough, necrotic tissue/eschar)

## National Pressure Ulcer Advisory Panel Pressure Injury Staging System

The NPUAP recently made changes to the Pressure Injury Staging System, by changing the term “Pressure Ulcer” to “Pressure Injury.” The updated System also includes changes in the staging definitions and uses Arabic instead of Roman numerals in the names of the stages.

The staging categories include:

**Stage 1 Pressure Injury (formerly Stage 1 Pressure Ulcer); Nonblanchable erythema or intact skin:** Stage 1 pressure injuries, are characterized by intact tissue with localized, nonblanchable redness (erythema), which may present differently in individuals with darkly pigmented skin. Visual change in the wound may be preceded by blanchable erythema or changes in sensation, temperature or firmness of the tissue area. Color change of the injured area does not include purple or maroon. These color changes may indicate deep tissue pressure injury.

**Stage 2 Pressure Injury (formerly Stage II Pressure Ulcer); Partial-thickness skin loss with exposed dermis:** Stage 2 pressure injuries are characterized by partial-thickness skin loss with dermis exposure with the wound bed presenting as viable, red or moist. Adipose and deeper tissues are not visible, and granulation tissue, slough and eschar are not present. Wounds may also present as an intact or ruptured blister.

**Stage 3 Pressure Injury (formerly Stage III Pressure Ulcer); Full-thickness skin loss:** Stage 3 pressure injuries involve full-thickness skin loss potentially extending into the subcutaneous tissue layer. Wound often presents with granulation tissue and epibole (rolled wound edged) and may have slough and/or eschar.

**Stage 4 Pressure Injury (formerly Stage IV Pressure Ulcer); Full-thickness tissue loss:** Stage 4 pressure injuries are wounds with full-thickness skin and tissue loss, exposing underlying fascia, muscle, tendon, ligament, cartilage or bone. Wounds frequently present with tunneling and/or undermining. If full-thickness skin and/or tissue loss is obscured by slough or eschar, the ulcer is defined as an Unstageable Pressure Injury.

**Unstageable Pressure Injury; Unstageable pressure injury, obscured full-thickness skin and tissue loss:** Unstageable pressure injuries are wounds with full-thickness skin and tissue loss in which slough or eschar obscure the extent of tissue damage. If slough or eschar is removed from the wound, the injury will present as a stage 3 or stage 4 pressure injury.

**Deep Tissue Injury; Deep tissue pressure injuries:** Formerly referred to as suspected deep tissue injuries present with persistent nonblanchable tissue discoloration (deep red, maroon or purple). Injury may present as epidermal separation with a dark wound bed or blood-filled blister. In darkly pigmented skin, discoloration from tissue damage may present differently. The wound may progress quickly and reveal the tissue damage extent, or it may resolve without loss of tissue.

## Wagner Ulcer Classification System

This classification system is widely used and is based on extent of necrosis, presence of gangrene or osteomyelitis and depth of the wound. It is often used to classify diabetic foot ulcers. The Wagner system utilizes six classes, or grades:

0	No open lesions; may have deformity or cellulitis
1	Superficial diabetic ulcer (partial- or full-thickness)
2	Ulcer extension to ligament, tendon, joint capsule or deep fascia without abscess or osteomyelitis
3	Deep ulcer with abscess, osteomyelitis or joint sepsis
4	Gangrene localized to portion of forefoot or heel
5	Extensive gangrenous involvement of the entire foot

As can be seen, there are many wound assessment tools, each with their benefits and drawbacks. It is likely that your workplace will utilize a single tool. What is more important than the tool you use is using the tool regularly to assess wounds, so that the interventions you perform and the extent of healing can be assessed accurately by you and others who may be tasked with caring for the patient's wound.

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# Wound Bed Preparation and Beyond

by Martin D. Vera, LVN, CWS

Wound bed preparation has become the gold standard model for proper wound assessment. It allows us clinicians to identify and breakdown local barriers to wound healing. Throughout our health care careers, we have seen it over and over again: the collective emphasis on standards of care, evidence-based practice and cost-effectiveness in order to achieve positive outcomes for our patients. The wound bed preparation model supports these aspects of care delivery.

Wound bed preparation is the basis for clinicians not only to be successful in treatment, but more importantly, to achieve faster and better results for our patients afflicted by wounds. Achieving better wound healing results for our patients is the number one reason why we must continue to educate ourselves and our wound team members in order to be successful in this field. Believe me when I say, it takes a village to a heal a wound.

## What is Wound Bed Preparation?

By definition, wound bed preparation is “the management of a wound in order to accelerate endogenous healing or to facilitate the effectiveness of other therapeutic measures.”<sup>1,2</sup> It allows clinicians to provide wound management by identifying barriers that affect the patient with the wound, and not just the wound itself.



“ The TIME concept was created in 2002 and since then has been providing wound care clinicians with the tools needed to promote wound bed preparation in a simpler way. ”



## The Principles of TIME

To facilitate wound bed preparation, a group of wound care experts developed the mnemonic TIME. The TIME concept was created in 2002 and since then has been providing wound care clinicians with the tools needed to promote wound bed preparation in a simpler way. Following is explanation of the TIME framework:

<b>T</b>	<b>(tissue)</b> Is the tissue nonviable or deficient in the wound? If there is a presence of nonviable tissue, necrosis, slough or eschar, then the next step is to determine the best type of debridement that would be the most appropriate for this patient (enzymatic, autolytic, sharps, surgical, mechanical, etc.). If all tissue is viable, then choose a dressing that maintains optimal moisture conducive for wound healing, and address the presence of dead space, undermining and tunneling of the wound because those areas will need to be loosely packed or filled to prevent further complications or development of new barriers.
<b>I</b>	<b>(infection / inflammation)</b> Are there any visible signs or symptoms of infection? Does the wound appear “angry”? The presence of infection, whether local or systemic, creates a barrier to healing. Presence of edema to the wound bed and/or periwound also creates a barrier. With infection, the host has been overwhelmed by microorganisms that have surpassed their stay. Infection has to go through several stages in order to achieve total control of the host and cause a systemic infection. Microorganisms tend to interact with chronic wounds at different levels. There is wound contamination, colonization, critical colonization and, ultimately, infection. At this point, systemic antibiotics will assist greatly once the organism has been identified, and using local antimicrobials will assist at the local level, as well. With edema at the periwound, how do we manage it? Is compression adequate? Does the patient have enough circulation? Venous or arterial? Answering these questions can help determine the correct amount of compression and type of dressing needed to provide a moist wound environment.
<b>M</b>	<b>(moisture balance)</b> Does the wound appear too dry or too wet? Dr. George Winters’ research in the early 1960s came to the conclusion that moisture balance is essential for positive outcomes in wound healing, resulting in the practice of what we now call moist wound healing. So, if the wound is too dry or desiccated, add moisture. If the wound is too moist or macerated—as evidenced by presence of maceration to wound edges and periwound—then choose dressings that are designed for moderate to heavy drainage.
<b>E</b>	<b>(edge of wound)</b> Are the wound edges non-advancing or undermined? As we evaluate all aspects of local and systemic barriers, identifying the progress, or lack thereof, of wound edges is another critical point in wound management. When healthy, wound edges appear attached, open and migrating or contracting. When wounds are improperly dressed, typically in cases with tunneling and undermining, other barriers such as epibole or undermined or rolled edges will arise. By properly filling in those dead spaces with the use of wound fillers, packing strips or any other appropriate product of choice, the wound edges will then migrate and contract without complications.

## Key Ending Points on Wound Bed Preparation

There is a popular saying that “practice makes perfect.” A martial arts instructor once told me that is not correct, but in fact, “proper practice makes perfect.” I agree with the latter.

Wound bed preparation is the “proper practice” we clinicians should be doing with every dressing change because doing so will allow us to perfect our assessment skills of wounds. Additionally, wound progress should be noted within two weeks of consistently using initial advanced wound care products recommended by the SWAT (skin, wound assessment team, term coined by Dr. Joyce Black, University of Nebraska). The SWAT (if not alone, then in conjunction with wound bed preparation) should be able to modify treatment and meet the current needs of the wound.

So, at the end of the day, we must make sure that the TIME principles are being addressed for wound bed preparation, the patient and facility are in compliance and we are supplying the correct tools for our patients and their families to be successful. Finally, as we are practicing wound management, comorbid conditions should be assessed and addressed, as well as local and systemic factors.

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# Knowing the Difference Between Scabs and Eschar

by Cheryl Carver, LPN, WCC, CWCA, FACCWS, DAPWCA, CLTC

Knowing the difference between a scab and eschar may not seem like a big deal. However, if you are being audited, or your facility is in survey, you might think otherwise. Here are a couple of scenarios for you to think about.

## 1 SCENARIO ONE

You have an acquired, unstageable pressure injury in a long-term care facility. The treatment nurse documented a deep tissue injury (DTI) dry scabbed area, measuring 4 x 4 x UTD (unable to determine). First, an sDTI is intact skin with no depth. The tissue level of destruction may be full-thickness, but intact skin. Second, a scab is found on a superficial or partial-thickness wound. This is considered a discrepancy in documentation.

## 2 SCENARIO TWO

A physician has documented, "sharp debridement removing eschar," when it was actually a scab. This is now considered a full-thickness wound, leading to an incorrect billing code. Documentation is critical to ensure accurate reimbursement for the procedures performed.

## Scab vs. Eschar



**Eschar on heel pressure injury.**

The term "eschar" is NOT interchangeable with "scab." Eschar is dead tissue found in a full-thickness wound. You may see eschar after a burn injury, gangrenous ulcer, fungal infection, necrotizing fasciitis, spotted fevers and exposure to cutaneous anthrax. Current standard of care guidelines recommend that stable intact (dry, adherent, intact without erythema or fluctuance) eschar on the heels should not be removed. Blood flow in the tissue under the eschar is poor, and the wound is susceptible to infection. The eschar acts as a natural barrier to infection by keeping the bacteria from entering the wound. If the eschar becomes unstable (wet, draining, loose, boggy, edematous, red), it should be debrided according to the clinic or facility protocol.

The term "scab" is used when a crust has formed by coagulation of blood or exudate. Scabs are found on superficial or partial-thickness wounds. Scab is the rusty brown, dry crust that forms over any injured surface on skin, within 24 hours of injury. Whenever our skin is injured as a result of any cut or abrasion, it starts bleeding because of blood flowing from the severed vessels. This blood, containing platelets, fibrin and blood cells, soon clots to prevent further blood loss. The outer surface of this blood clot dries up (dehydrates) to form a rusty brown crust, called a scab, which covers the underlying healing tissues like a cap. The purpose of a scab is to prevent further dehydration of the healing skin underneath, to protect it from infections and to prevent any entry of contaminants from the external environment. Scabs generally remain firmly in place until the skin underneath has been repaired and new skin cells have appeared, after which it naturally falls off.

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# Identifying Infection in Wounds: Overview and Assessment

by Laurie Swezey, RN, BSN, CWOCN, CWS, FACCWS

As health care providers, we are all familiar with the signs of wound inflammation. However, it can sometimes be difficult to determine whether a wound is inflamed, undergoing the normal and expected inflammatory response to tissue injury or infected. In this section we will review the definition of infection and assessment of the potentially infected wound.



It is important to remember that it is normal to have bacteria on the skin.

## What is Infection?

In order to identify infection, we first have to define it. It is important to remember that it is normal to have bacteria on the skin. These resident bacteria, or microflora, protect against pathogenic bacteria. Resident bacteria do not cause infection (except under special circumstances).

### CONSIDER THE FOLLOWING DEFINITIONS:

**Contamination:** The presence of nonreplicating microbes, as in the resident microflora present on our skin

**Colonization:** Occurs when the resident microflora adhere to the surface of the body and begin to replicate but do not affect the host's condition or cause a response

**Critical colonization:** The turning point at which the increasing number of resident bacteria becomes a wound bioburden and begins to affect the host negatively

**Infection:** Occurs when bacteria multiply and invade healthy tissues

Infection was once strictly defined as there being 10<sup>5</sup> microbes per gram of tissue; however, it is now known that the number of bacteria present is only one factor that must be considered. Certain types of bacteria are highly detrimental to the host and should be eradicated at any number, such as beta-hemolytic *Streptococcus*, which can cause infection at low numbers. Finally, the host's immune function and ability to fight infection should also be considered. Individuals with diabetes are at greater risk of infection.

## Identifying and Assessing Infection

Now that we understand how infection is defined, how do we recognize it? Infection can be thought of as a classic fight between good and evil, between the host's immune system and the bacteria that are trying to invade the host. This battle results in signs and symptoms that are generally fairly recognizable if one is looking for them.

When wounds are infected, the classic signs of inflammation are disproportionate to the size and extent of tissue damage. It can be difficult to tell when a wound has crossed the line between normal inflammation and abnormal infection. You should suspect infection when the cardinal signs of inflammation are exaggerated:



**RUBOR (REDNESS):** An infected wound will have a poorly defined erythematous border, and redness will be obvious and disproportionate to the size and extent of the wound; there may also be proximal “streaking.”

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**CALOR (TEMPERATURE):** In infected wounds, the normal localized increase in skin temperature will be increased, and the warmth will extend farther from the wound borders; there may also be a systemic increase in temperature (fever).

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**DOLOR (PAIN):** Wound infection often causes a very noticeable increase in the level of pain associated with the wound; in immunocompromised patients, an increase in pain may be the only sign that a wound has become infected, as the body's ability to mount an immune response will be dampened.

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**FUNCTIO LAESA (FUNCTIONAL DECLINE):** An individual with an infected wound will often feel unwell, in addition to being unable to use the affected body part as usual; there may be fatigue or malaise, hypotension, tachycardia or other symptoms that contribute to functional decline.

Drainage from infected wounds is often higher in amount, thicker in consistency and malodorous, with drainage color that may be green, blue, yellow or white, as opposed to the normal serous or sanguineous drainage associated with uninfected wounds.

A decline in wound status can also be a sign of wound infection. For example, a wound that was previously healing in the expected fashion and suddenly plateaus, or even declines, should be closely assessed for signs and symptoms of infection.

Identifying infection in wounds is important because infection can lead to a prolonged hospital stay, sepsis, amputation or even death for individuals with comorbidities. Assessing wounds for the signs above, and reassessing wounds frequently, can help to identify infection, thus preventing further complications in wound healing.

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# Wound Exudate: Assessment and Management Strategies

by Lindsay D. Andronaco, MSN, RN, AGACNP-BC, CWCN, WOC, DAPWCA, FACCWS



When a patient is changing gauze four times a day because of exudate, it would be more beneficial for the patient and financial bottom line to use a foam dressing.

Wound exudate and how to assess and manage it properly has been a long-standing clinical challenge in wound care. Assessing the exudate color, odor, volume, and viscosity and if it is causing maceration of the periwound skin are all important to note when creating a care plan for the patient. If there is not proper management of the exudate, then the high protease levels and low growth factor levels will negatively impact wound healing time.

## Types of Wound Exudate

There are four types of wound drainage: serous, sanguineous, serosanguinous and purulent. Serous drainage is clear, thin and watery. The production of serous drainage is a typical response from the body during the normal inflammatory healing stage. Yet, if there is a large amount of serous drainage, it can be the result of a high bioburden count. Sanguineous drainage is normal in occurrence only during the inflammatory stage of healing, where a small amount of this blood may leak from a full- or partial-thickness wound. If it is seen outside of the inflammatory phase, sanguineous drainage can be a result of trauma to the wound.



Serosanguinous drainage is the most common type of exudate that is seen in wounds. It is thin, pink and watery in presentation. Purulent drainage is milky, typically thicker in consistency and can be gray, green or yellow in appearance. If the fluid becomes very thick, this can be a sign of infection.

## Considerations in Managing Exudate



[[ dressing selection should be based on the individual patient and wound characteristics. ]]

Exudate is a byproduct of vasodilation during the inflammatory stage, and in chronic wounds the drainage changes and contains proteolytic enzymes. Effective management of the exudate depends on the characteristics of the wound such as amount of exudate, location and exudate composition. Chronic wounds often have bacteria, like *Pseudomonas* or *staphylococci*, which inhibit new cell growth. In this case, cultures to combat the bacteria can be beneficial so that an accurate care plan can be initiated. This may include topical antimicrobials, topical antibiotics, antifungals or oral/IV medications.

Other considerations are the cost and frequency of dressing changes. When a patient is changing gauze four times a day because of exudate, it would be more beneficial for the patient and financial bottom line to use a foam dressing. Changing the dressing less allows the wound bed to be left undisturbed, which allows for the migration of new cells. When wound beds are left undisturbed in an optimal moist environment, they are able to heal at a faster rate. Changing dressings only when needed also causes less trauma to the periwound that can result from adhesives or maceration damage. Negative pressure wound therapy, compression and foam dressings can be helpful in managing exudate.

Overall, it should be noted that the dressing selection should be based on the individual patient and wound characteristics. If the wound is not in the normal inflammatory phase of healing, the clinician must investigate what is the root cause and how to manage the drainage.

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# Wound Documentation: How to Tell If a Wound Is Healing

by Aletha Tippet MD



There is an ever-growing number of software-based wound documentation tools available to clinicians.

We are supposed to check a wound every week and measure length, width and depth. These measurements should be getting smaller if the wound is healing, and we need to see improvement within two weeks or have to consider that we need a different dressing on the wound. Of course, we also look at the type of tissue in the wound—granulation, slough or necrosis—and the amount of drainage and odor. Those things can change our opinion about the wound. Maybe the wound measurements are not smaller but the wound has good granulation and shows signs of contraction; that wound is healing despite the measurements. Wound measurements can be very inaccurate. Often it depends on how the patient is positioned and who is doing the measurement. Even the same person taking measurements will not be the same every time.

## Using Computerized Wound Documentation to Track Wound Healing Progress

Using a computerized imaging system where you mark length and width on the computer picture and then draw around the wound can help tremendously. This will give you good information on the size of the wound and will give you percentage change. You can track it over time, even drawing a graph of wound change.

Another new way to monitor wound progress is with the use of an infrared camera. We recently trialed one in our office by using a camera with associated software (WoundVision, Indianapolis, IN), and the results are wonderfully helpful. You still have your measurements, and a photograph, but you also get an infrared picture either in black and white or color that really tells you at a glance how the wound is doing. In the black and white picture, dark is cool—necrosis or lack of blood flow or, surprisingly, pyoderma gangrenosum—and white can mean inflammation or infection. More than once I have been convinced of infection based on the infrared picture of white, treated the patient with antibiotics and been very gratified by the outcome. The software with the camera can be used to compare the wound with the normal tissue and show you how close the wound is to becoming normal. There is an ever-growing number of software-based wound documentation tools available to clinicians. Visit [WoundSource.com](http://WoundSource.com) for more information on the systems currently available.

Being able to use newer wound assessment technology with cameras and computers can be very helpful in wound care, ensuring that you are progressing and meeting goals. With the infrared you are able to detect a problem before you can see it, such as a developing infection or osteomyelitis. It can also identify deep tissue injury for you. The key for us in wound care is to be aware of innovations in the field that can help us, be open to considering them and look for ways to use them.

# 5 Tips for Proper Wound Care Documentation

by Rick Hall, BA, RN, CWON

Wound care documentation is a hot topic with overseeing agencies dealing with the medical industry. Good documentation is imperative to protect all those giving care to patients. Documentation should be **L**egible, **A**ccurate, **W**hole, **S**ubstantiated, **U**naltered, **I**ntelligible and **T**imely. If these components are not incorporated into your wound care documentation, you could end up in a **LAWSUIT**.

With some patients, families and attorneys looking for a way to attain capital gain, we health care providers must protect ourselves and the facilities we work for.

## Essential Wound Care Documentation Practices

- 1 Upon admission, a full body inspection of the patient must be performed and any pressure ulcers (injuries) photographed, measured and documented including any red areas that are nonblanchable. Documentation of existing pressure ulcers and skin areas showing signs of damage is important because if in three to five days it worsens and you didn't document it, you have caused your facility a deficiency.
- 2 If you have a patient who leaves the floor or facility temporarily and develops a pressure ulcer within 72 hours after returning, you can look back and determine where they acquired that pressure ulcer. So document where they were 72 hours ago. The deficiency belongs there.
- 3 Lawyers and their hired medical personnel are also looking for key words in the charting like "packed the wound." Remove the terms "pack" or "packed" a wound from your documentation language. If the wound gets worse, you could find yourself defending the wording used in your wound documentation. If you packed a wound and it got worse, then that could be interpreted as you "packed" it too tight and caused the damage. Choose language such as "filled the wound loosely," or "laid the dressing in the wound bed" to document your wound treatment.
- 4 When measuring a wound, measure from head to toe for length (0600 and 1200) and 0300 to 0900 for width. This is the way most wounds are measured, and you will have more consistent measurements using this method. Make sure all those in your facility who measure and document wounds are consistent with whatever wound measurement method your facility protocol dictates.
- 5 Use measurement numbers instead of approximate sizes such as that of a dime, nickel, quarter or half dollar size. Lawsuits have been lost using this type of description of a wound.

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# WOUND SOURCE™

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