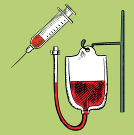
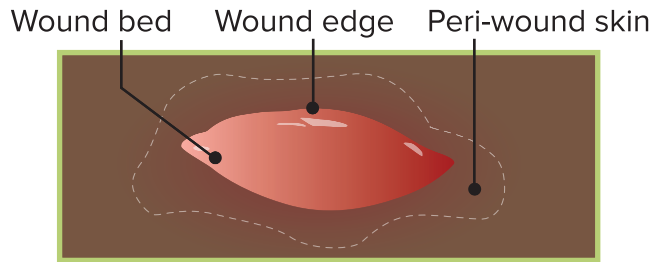
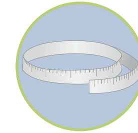
WOUND DOCUMENTATION



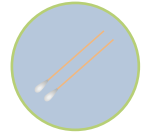
Three areas of wound assessment and documentation ⇒



Supplies needed:



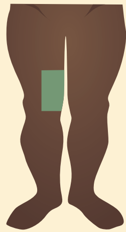
Measuring tape



Sterile cotton tip applicator

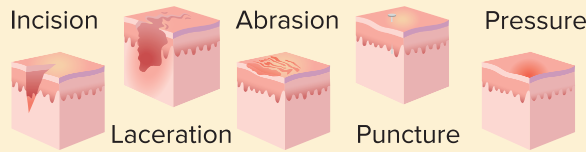
Assessment of wound bed

▶ Location



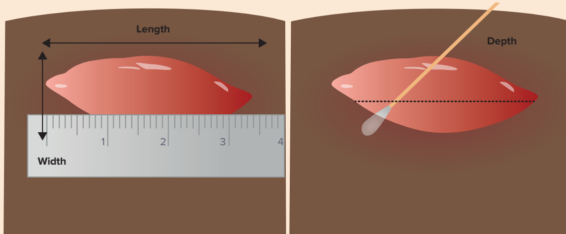
"Client has a wound on **their right distal medial** upper leg."

▶ Type of wound



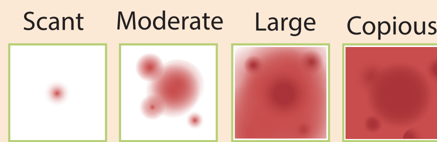
▶ Type of wound tissue

▶ Wound measurements: Include length, width, depth.

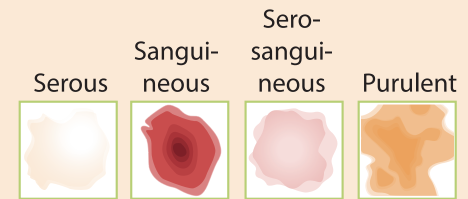


▶ Exudate: Document amount of exudate, color, consistency, and odor.

Amount



Color



Consistency: thin, thick, tenacious

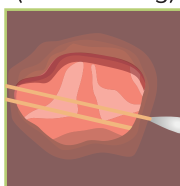
Odor: no odor, foul

Assessment of wound edge

Maceration

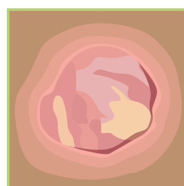
Softening of tissues by soaking in fluids

Tunneling (undermining)



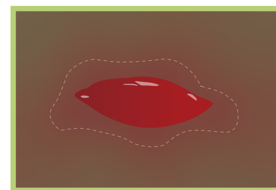
Erosion of tissue under wound edges, causes pocket beneath skin

Rolled edge



Edge rolls over itself, causing body to think wound has healed. Healing ceases prematurely.

Assessment of peri-wound skin



Assess for redness, warmth, edema, pain, skin breakdown.

Note any areas of maceration, excoriation, dry skin, hyperkeratosis, callous, eczema.

Signs of abnormal wound healing

- Increased pain or swelling
- Stiff movement in affected limb
- Pus or odorous exudate
- Tunneling
- Erythema of peri-wound skin
- Wound gaping open or not healing
- Red streaking from, or around, wound

NOTES