Essential Information to know:

Wound Documentation

As per policy *PC.230—Wound: Prevention & Treatment of—* comprehensive wound documentation must be completed in the patient's EMR for every pressure injury or wound found on admission or discovered after admission.

Initial documentation must include:

1. Assessment/staging of pressure ulcer or wound per Perry and Potter
2. Measurements taken on the wound
   Length—width—depth—undermining—tunneling
3. Description of the wound (including color such as red, pink, purple, gray, etc.), wound bed, exudate, and surrounding tissue
4. Photograph of the wound
   (refer to Policy PC.87—Wound Photography)

Shift documentation must include:

Wound assessment—interventions—and effectiveness of interventions

Weekly documentation must include:

Assessment/staging of pressure ulcer or wound per Perry and Potter
Measurements taken on the wound
Length—width—depth—undermining—tunneling
Description of the wound (including color such as red, pink, purple, gray, etc.), wound bed, exudate, and surrounding tissue

Photographs must be taken:

Upon discovery—monthly thereafter, OR
Upon discharge or when resolved

If the pressure ulcer/wound is noted to be deteriorating on assessment,

All of the components of Initial documentation must be completed regardless of the time frame of previous documentation or photograph date.

*****For all patients with pressure ulcers/wounds—consider:**

Ordering wound nurse consultation earlier rather than later
Ordering nutrition consult when the patient's diet/intake is not supporting the healing process.

Kaweah Delta HEALTH CARE DISTRICT

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