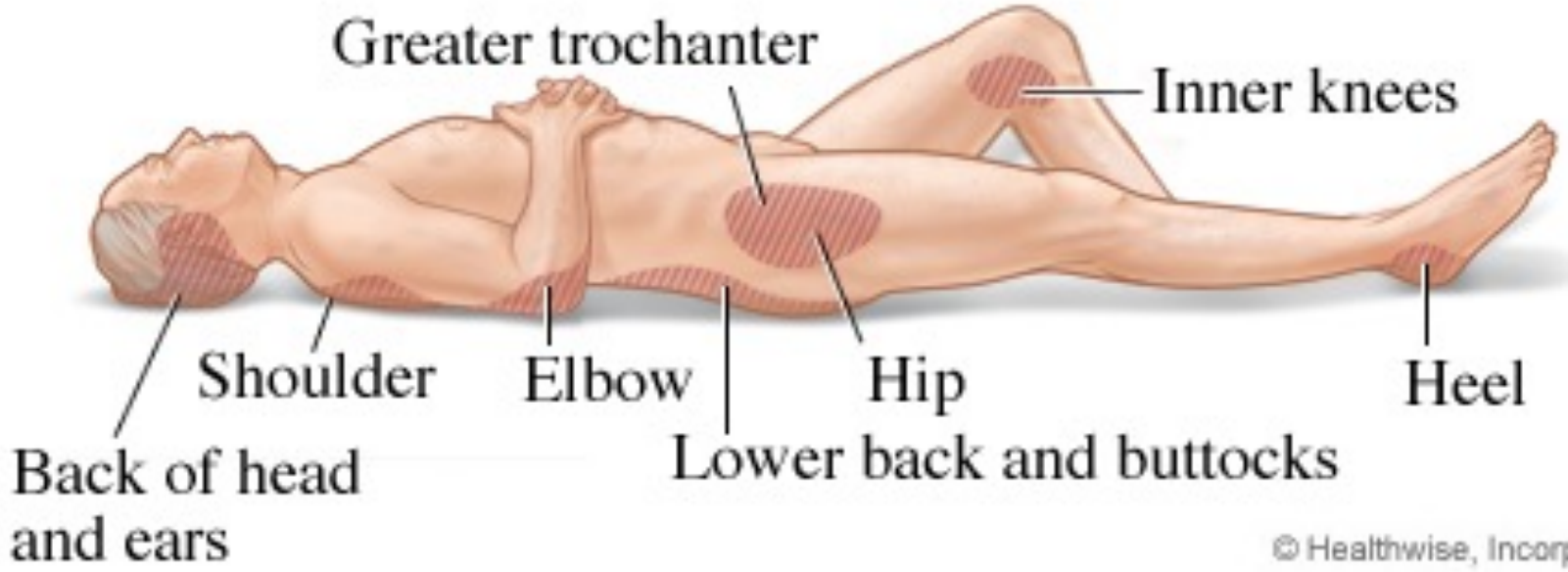
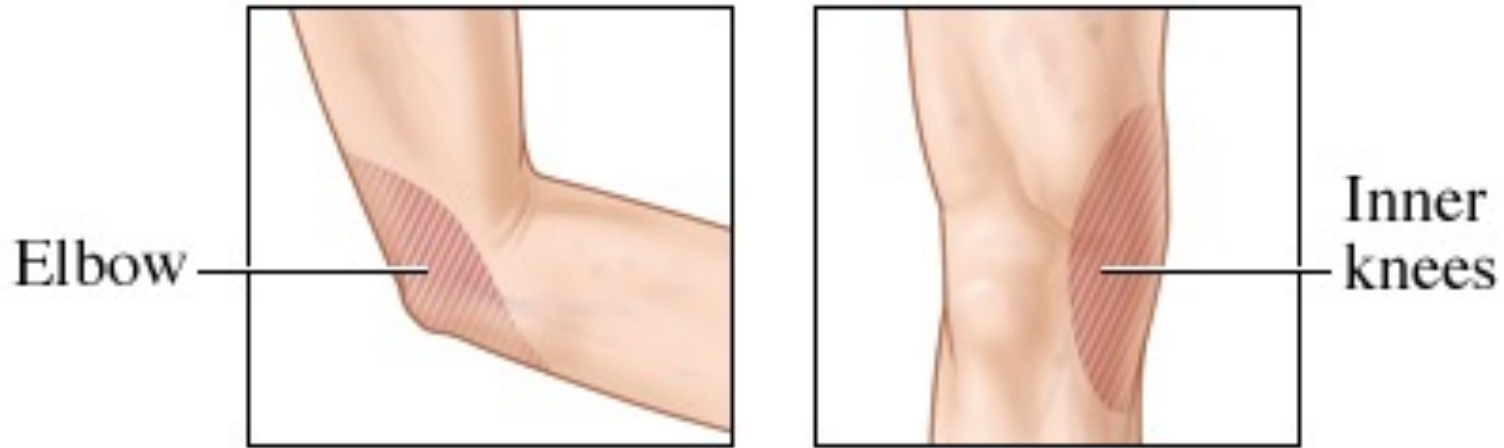






# Wound Care / Documentation

# Most Common Pressure Injury Areas



# Full Skin Assessment

Skin Integrity Assessment						
Skin color: <input type="checkbox"/> WNL <input type="checkbox"/> Pale <input type="checkbox"/> Jaundice <input type="checkbox"/> Dusky <input type="checkbox"/> Cyanotic						
Skin is: <input type="checkbox"/> Intact <input type="checkbox"/> No, see below <input type="checkbox"/> No, describe: _____				Braden Scale Score: _____		
Signs/ symptoms of inflammation/ infection: <input type="checkbox"/> Redness <input type="checkbox"/> Tenderness/ pain <input type="checkbox"/> Warmth <input type="checkbox"/> Swelling						
Location(s): _____						
Contusion(s)/ Ecchymosis: <input type="checkbox"/> N/A Size: Length _____ cm Width _____ cm Depth _____ cm						
Location(s): _____ Client's explanation of bruising: _____						
Wounds						
Location	Type	Size	Tunneling	Undermining	Surrounding Tissue	Drainage
  	<input type="checkbox"/> Abrasion <input type="checkbox"/> Avulsion <input type="checkbox"/> Burn <input type="checkbox"/> Laceration <input type="checkbox"/> Puncture <input type="checkbox"/> Pressure ulcer, Stage _____ <input type="checkbox"/> Stasis ulcer <input type="checkbox"/> Surgical incision, closed, edges are approximated <input type="checkbox"/> Surgical, <input type="checkbox"/> open areas <input type="checkbox"/> total wound dehiscence <input type="checkbox"/> _____	Length _____ cm  Width _____ cm  Depth _____ cm  Incision length _____ cm  _____ # of staples/ sutures (circle one)	<input type="checkbox"/> None  <input type="checkbox"/> Present at _____ o'clock, depth _____ cm  <input type="checkbox"/> Present at _____ o'clock, depth _____ cm	<input type="checkbox"/> None  <input type="checkbox"/> Present, surrounding tissue is: <input type="checkbox"/> Dusky <input type="checkbox"/> Soft <input type="checkbox"/> Boggy <input type="checkbox"/> Fluid-full <input type="checkbox"/> Other, describe: _____	<input type="checkbox"/> WNL  <input type="checkbox"/> Redness <input type="checkbox"/> Tenderness <input type="checkbox"/> Pain <input type="checkbox"/> Warmth <input type="checkbox"/> Streaking <input type="checkbox"/> Excoriation <input type="checkbox"/> Bruising <input type="checkbox"/> Discolored <input type="checkbox"/> Dusky  Wound edges <input type="checkbox"/> WNL <input type="checkbox"/> Hyperkeratotic	<b>Color/ Characteristics:</b> <input type="checkbox"/> Serous <input type="checkbox"/> Serosanguinous <input type="checkbox"/> Bloody <input type="checkbox"/> Yellow <input type="checkbox"/> Tan <input type="checkbox"/> Brown <input type="checkbox"/> Green  <b>Purulent?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <b>Odor?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
Is client on a pressure reduction or relief surface: <input type="checkbox"/> No <input type="checkbox"/> Yes, type: _____						

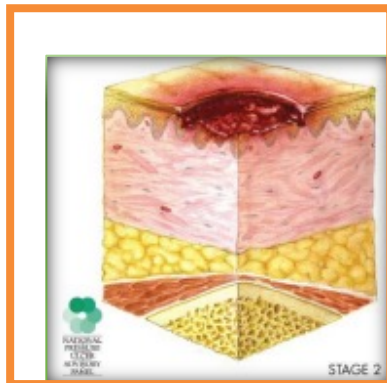
\*Undermining is due to liquefaction of necrotic tissue or mechanical forces that sheared and separated underlying tissues.

# Pressure Ulcer Stage 1 & 2



## Stage 1 Pressure Injury

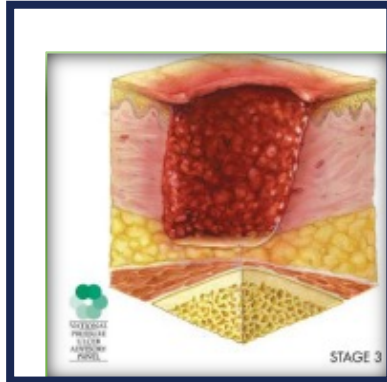
Non-blanchable erythema of **intact skin** with a localized area, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensations, temperature, or firmness may precede visual changes.



## Stage 2 Pressure Injury

**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 ruptured **serum-filled blister**. Adipose (fat) is **NOT** visible and deeper tissues are **NOT** visible. Granulation tissue, slough, and eschar are **NOT** present.

# Pressure Ulcer Stage 3 & 4



## Stage 3 Pressure Injury

**Full-thickness** loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are NOT exposed.



## Stage 4 Pressure Injury

**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.

# Unstageable Pressure Injury



## Unstageable Pressure Injury

**Obscured 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 and eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.

## DTI



## Deep Tissue Pressure Injury

**Persistent non-blanchable deep red, maroon, or purple discoloration intact or non-intact skin** with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a **dark wound bed or blood-filled blister**. Pain and temperature changes often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.

# Other Pressure Injuries



## Medical Device Related Pressure Injury

This describes an etiology. Medical device-related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.



## Mucosal Membrane Pressure Injury

Mucosal membrane pressure injury is 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 ulcers cannot be staged.

# Stages of Non-Pressure Ulcers

Staging non-pressure ulcers:

01

Skin changes are limited to persistent focal edema.

02

An abrasion, blister, and partial thickness skin loss involving the dermis and epidermis.

03

Full-thickness skin loss involving damage and necrosis of subcutaneous tissue.

04

Necrosis of soft tissues through the underlying muscle, tendon, or bone.





# Wound Documentation

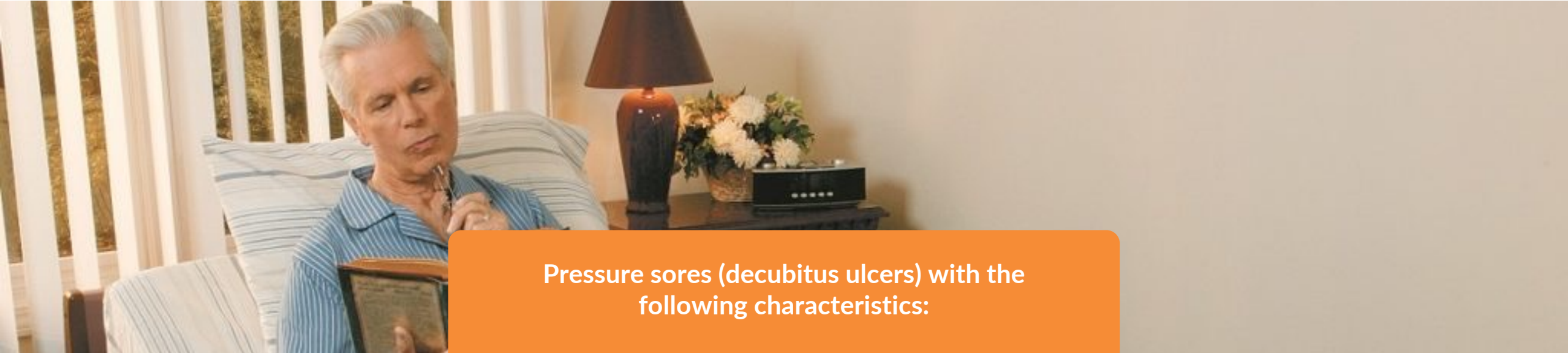
# Wound Care

- Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service.
- For skilled nursing care to be reasonable and necessary to treat a wound, **the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented** in the clinical findings so that an assessment of the need for skilled nursing care can be made.
- Where the physician or allowed practitioner has ordered appropriate active treatment (e.g., sterile or complex dressings, NPWT, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a licensed nurse are usually reasonable and necessary:
  - Infected wounds – receiving antibiotic treatment
  - Wounds with a drain or T-tube that require shortening or movement of such drains
  - Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze
  - Recently debrided ulcers
  - Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed.

# Wound Care Continued

- Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies
- Post-operative wounds where there are complications such as infection or allergic reaction or where there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes)
- Third-degree burns, and second-degree burns where the size of the burn or presence of complications cause skilled nursing care to be needed
- Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present a significant risk to the patient
- Other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.

# Not All Pressure Ulcers are Skilled Wound Care



Pressure sores (decubitus ulcers) with the following characteristics:

There is partial tissue loss with signs of infection such as foul odor or purulent drainage; or  
There is full-thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.

**NOTE:** Wounds and ulcers that show redness, edema, and induration, at times with epidermal blistering or desquamation do not ordinarily require skilled nursing care.



# Medicare Benefit Policy Manual

## Chapter 7 – Home Health Services

### **40.1.2.3 – Teaching and Training Activities (Rev.179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.1.B., HHA-205.1.B.3**

Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services.

**Applies with wound education training.**

### **40.1.2.8 – Wound Care (Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)**

Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service. For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made.

# Daily Skilled Nursing

- If in an exceptional circumstance (e.g., when progress is noted in wound healing and daily visits need to continue for a specific amount of time), daily skilled nursing (SN) care is needed beyond 21 days, then a **finite and predictable endpoint to the daily skilled nursing care is needed**.
- Helpful hints to document an endpoint:
  - Use a finite date, e.g. Daily SN ending May 1
  - Be reasonable and realistic, e.g. if a diabetic wound will take up to three months to heal, use this date
  - Remember, the end-point is for the daily visits, not the care
    - If able to teach another caregiver who is available on weekends, that would be the end-point
    - Collaborate with a physician for alternate wound treatment, if daily visits for wound care
    - Use your best clinical judgment, along with the physician and patient history to project the date when daily SN services can be reduced
  - Avoid using 21 days of the end of certification periods repeatedly.
  - Reassess the need for daily SN by asking:
    - How long has the patient been seen daily?
    - Has his or her condition changed?
    - Would a different treatment that requires less than daily care be as effective?
    - Is there another caregiver who can do care at least one day/week?
    - Is there a realistic end-point or should it be changed?





# Required Wound Documentation

For skilled nursing care to be reasonable and necessary to treat a wound, the **size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented** in the clinical findings so that an assessment of the need for skilled nursing care can be made.



# Elements to Document:

**Location:** Use the correct anatomical terms to clearly document the wound's location.

**Type of Wound:** Many types of wounds can be assessed and documented, including surgical wounds, burns, and pressure injuries. Wounds can also be acute or chronic.

**Measurement:** The size of the wound should be measured in centimeters and listed in the wound care treatment chart as length times width times depth. Nurses must also document the location and depth of any tunneling or undermining.

**Wound Bed:** It's important to document tissue type (slough, eschar, epithelial, granulation, etc.), coloring, and level of adherence using percentages. For example, "40% of the wound is covered in non-adherent tan slough while 60% is covered with red granulation tissue."

**Wound Edges:** Indicate whether a wound's edges are defined or undefined, attached or unattached, rolled under, macerated, fibrotic, or callused.

**Drainage:** The amount and type of drainage must be documented in a wound care assessment. Common types of draining include serous, sanguineous, serosanguineous, and purulent. Words like "none," "scant," "small," "moderate," and "large/copious" are often used to describe the amount of drainage assessed.

**Odor:** Wounds can have different odors, including those that are strong, foul, pungent, fecal, musty, or sweet. Some have no odor at all.

**Surrounding Tissue:** Describe the color, firmness, and pallor of the surrounding skin. Note any signs of edema or induration, as well as any lesions, scarring, rashes, staining, moisture, or variations in texture.

**Infection:** Wounds are often prone to infection, which can significantly disrupt the healing process. A wound assessment should cite any indicators of infection, including redness or localized pain.

**Pain:** A comprehensive wound assessment describes a patient's pain in detail, noting its location and intensity as well as any patterns and variations in pain type. Common pain descriptors include throbbing, stabbing, burning, pulsing, pounding, pricking, hot, tingling, stinging, cramping, beating, gnawing, dull, tight, squeezing, piercing, and electrical. The assessment should also address possible causative and alleviating factors, including any interventions that were taken.

**Response to Care/Treatment Plan:** It's important to document whether the wound has improved and to list any evidence of healing. Nurses will also need to document any pain the patient experiences when the wound dressing is changed as well as any examples of an adverse reaction. If the patient has not been adhering to treatment plans, that should be noted in the assessment.



# All Wound Care – Needs an Order

Example of wound care orders:

- SN to do dressing changes on stage 3 pressure ulcer of left buttocks. SN to cleanse with NS or wound cleanser, dry with gauze, apply medi-honey, apply self-adhesive optifoam dressing. SN is to change dressing 2 times a week and PRN for saturation or loosening of dressing.

Document: Location and type of wound, dressing change steps (clean with, dry with, apply dressing & secure with), and how often to be performed.



## Example of Wound Documentation

SN removed old dressing and packing to left lower leg diabetic ulcer. Wound bed beefy red with granulation tissue noted on 50%, surrounding skin is intact with no redness, large amount of serosanguineous drainage with no order. Wound measurements are 7 cm (L) x 5 cm (W) x 0.3 cm (D). No tunneling or undermining present. No s/s of infection present. Patient is diabetic and has PVD complicating wound healing. Wound care provided per MD order as follows using aseptic technique: Cleansed with NS, pat dry with gauze, applied medi-honey, lightly packed with strip gauze to wound surface area, covered with duoderm dressing. Patient reported minimal pain (1-2) during dressing change. SN taught on s/s of infection to report, taking pain medications 30-60 minutes prior to dressing change visits. Picture of wound taken and uploaded to patient's chart.

# Document Drainage Type

**Serous** – thin, watery, clear

**Sanguineous** – thin, bright red, fresh bleeding

**Serosanguinous** – thin, watery, pale-red to pink

**Purulent** – thick or thin, opaque-tan to yellow

**Foul Purulent** – thick opaque-yellow to green with offensive odor

# Document Drainage Amount

**None** – wound tissue dry

**Scant** – wound tissue moist, no measurable drainage

**Minimal** – wound tissue very moist, <25% of dressing saturated with drainage in a 24-hour period

**Moderate** – wound tissue is wet, 25%-75% of dressing saturated with drainage in a 24-hour period

**Large** – wound tissue is filled with fluid, >75% of dressing saturated with drainage in a 24-hour period

# Document Wound Odor

Describe presence or absence of odor after cleansing the wound

Descriptors include: strong, foul, pungent, fecal, musty, sweet, etc.



# Describe Wound Edges

**Definition** – defined (well-demarcated) or undefined wound edges

**Attachment** – attached or unattached wound edges

**Epibole** – rolled wound edges

**Maceration** – skin that is white and sometimes wrinkled and soft due to supersaturation

**Callused/Fibrotic** – build-up of tissue at wound margin due to hyperkeratosis

# Describe Surrounding Tissue (Periwound)

Describe the color, presence/lack of edema, tissue consistency (e.g., indurated (firm), boggy, etc.), temperature, etc.

# Describe Wound Bed Characteristics

**Non-Adherent** – easily separated from the wound base

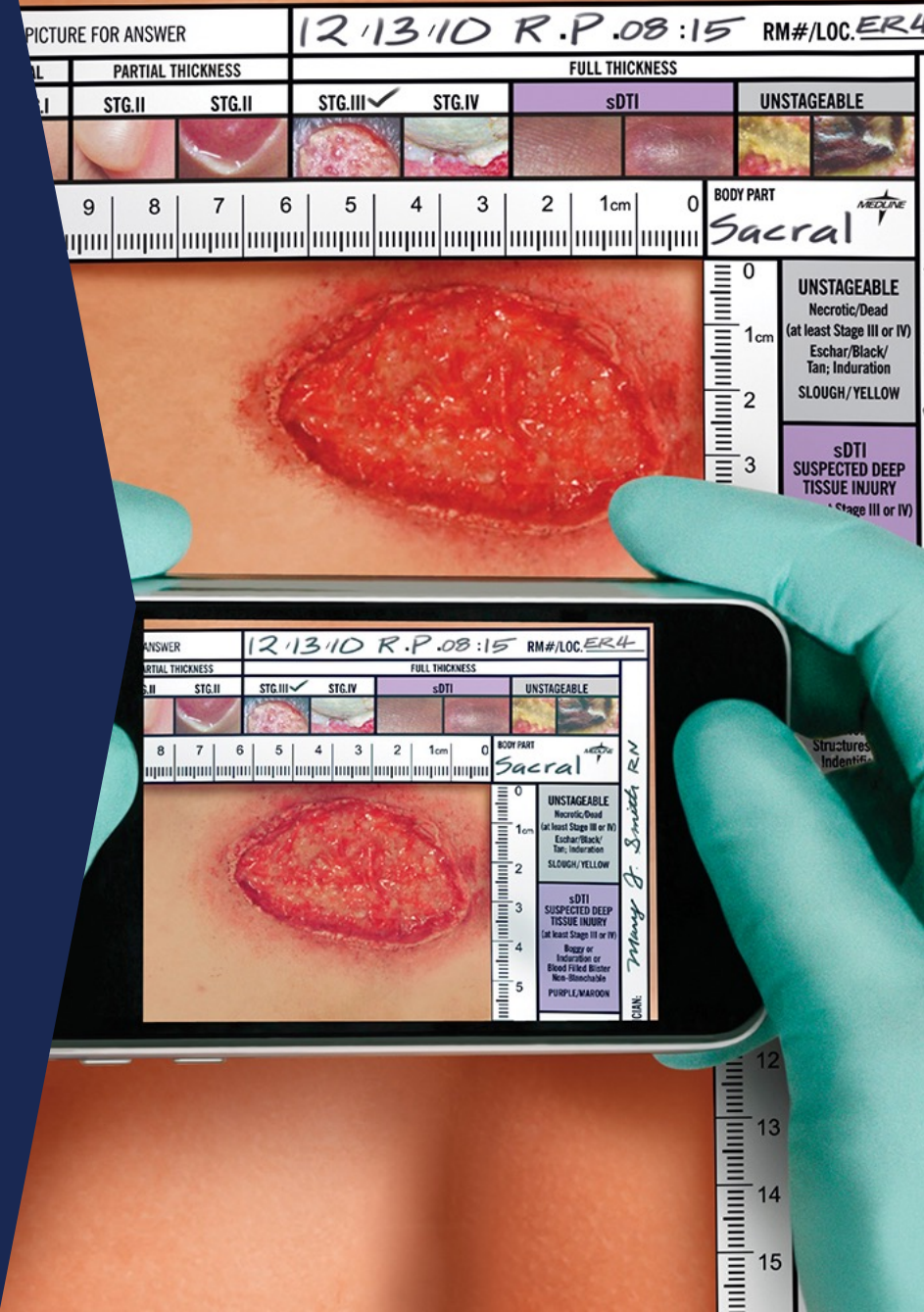
**Loosely Adherent** – pulls away from the wound but is attached to the wound base

**Firmly Adherent** – does not pull away from the wound base

**Tissue Amount**

Describe in percentages (e.g., 50% of the wound bed is covered with loosely adherent yellow slough; 50% beefy, red granulation tissue).

May also utilize the “clock system” in describing the location of necrotic tissue in the wound bed.





# Describe Wound Bed Characteristics

## Tissue Types

**Granulation** – a temporary structure composed of vascularized connective tissue that fills the wound void; it may be red, pink, pale, or dusky red.

**Slough** – necrotic/avascular tissue that is yellow or tan in color and has a stringy or mucinous consistency

**Eschar** – is described as thick, leathery, frequently black or brown in color, necrotic or devitalized tissue

**Epithelialization** – process by which keratinocytes resurface the wound defect – can appear as deep pink, then progress to pearly pink; may form islands in the wound

## Document Indicators of Infection

Document fever, erythema (redness), increased drainage, odor, warmth, edema, elevated WBC, induration, pain, etc.

## Document Complaints of Pain

Document location, causative factors, intensity, quality, duration, alleviating factors, patterns, variations, interventions, etc.

## Document Interventions to Promote Healing

Examples include: dietary supplements, vitamins, lab tests, turning and repositioning schedules, support surfaces, padding, pillows, elevation, offloading, heel protection, incontinence management, skin care, barrier ointments, etc.

## Document Conditions Which May Adversely Affect Healing

Examples include: impaired mobility, nutritional status, abnormal labs, infections, deterioration of medical condition, non-compliance, etc.

## Document Anticipated Wound Outcome

Based on provider evaluation of co-morbid conditions, circulation, and medication; and based on discussions and desires of the resident, advanced directives, anticipated life span, goals, and wishes

Is the wound good for healing, maintenance or palliative?





# Potential Documentation Errors

- **Partial vs. Full Thickness: The Presence of Granulation Tissue**  
Granulation tissue is present in full-thickness wounds. You would not see granulation tissue in a stage 2 pressure injury – you could see pink or red non-granular tissue, a shallow wound bed, partial-thickness tissue loss, or epidermis.
- **Slough vs. Purulence**  
Slough is stringy, moist, and yellow, and as it is debrided, it can liquefy or dissolve. Purulence is the presence of pus, and it usually is associated with erythema, odor, redness that does not improve with elevation of a limb, pain, increase in drainage, fever, chills, nausea, or vomiting.
- **Moisture-Associated Skin Damage vs. Pressure**  
Moisture-associated skin damage (MASD) is irregularly shaped, not round or punched out, and usually is not isolated over a bony prominence. MASD is usually superficial (partial-thickness) and is present in patients who are incontinent, diaphoretic, or frequently moist as a result of a leaking drain, tube, or wound. MASD certainly has the potential to evolve into a pressure injury. However, our goal is to catch it early, identify and correct the cause, and topically treat the skin damage.
- **Dependent Rubor vs. Erythema**  
Dependent rubor is when the limb is red when in a dependent position. Normal coloring returns when the limb is elevated. Erythema is the presence of redness in any limb position.



# Slough vs. Purulence

It is important to look at the entire picture here. The peri-wound skin can provide some important information here as well – is there erythema, fluctuance, or any other sign of infection? Or, is there a more stringy, yellow, liquefying slough related to the debriding agent being used? Is there an odor? Remember always to use your senses when completing a thorough wound assessment. More information on this topic is available in an earlier blog: [Assessing Wound Tissue and Drainage Types: Slough Versus Purulence](#)

## Dependent Rubor vs. Erythema

- This is an important concept to understand to best treat the cause of the skin condition. Dependent rubor and erythema have different causes and therefore should be managed differently.
- Dependent rubor, as the name suggests, is seen when the legs are in a dependent position. The legs appear red but return to a normal color when they are elevated.
- True erythema typically does not resolve when the legs are elevated. Additionally, some indicators of a vascular process could be hemosiderin staining and changes consistent with venous stasis or venous dermatitis. Understanding the differences between cellulitis and vascular issues is important when formulating a treatment plan for leg ulcers. It is always best to take an interprofessional approach and formulate an interdisciplinary plan of care. Again, if you're not sure, just describe what you see in your charting, and consult with your wound care specialist.





# Partial vs. Full Thickness

- Partial-thickness wounds consist of damage to the first two layers of the skin: the epidermis and the dermis. These wounds are superficial. They manifest with a pink-red wound base without slough. Partial-thickness wounds do not have granulation tissue because they heal by epithelialization and regeneration of the epidermis across the wound bed. Some examples of common partial-thickness wounds are abrasions, skin tears, medical adhesive-related skin injuries (MARSIs), MASD, and stage 2 pressure injuries.
- Full-thickness wounds extend beyond the first two layers of the skin damaged by partial-thickness wounds (the epidermis and the dermis). These wounds penetrate subcutaneous tissue and may involve bone, muscle, or tendon. Necrotic tissue such as eschar or slough may also be present in these wounds. Full-thickness wounds contain granulation tissue and heal by granulating inward from the bottom up, contraction, and finally epithelialization. A deeper wound requires a more in-depth healing process.
- Sometimes unstageable pressure injuries or deep tissue injuries present a challenge when determining partial vs. full thickness. These two wound stages typically evolve to full-thickness tissue damage. When determining the level of tissue damage within a wound, it is always important to look at the depth of tissue involved (epidermis, dermis, or extending beyond the dermis). If you're not sure, simply describe what you see, and consult with your wound care specialist.

# Medication List and Wound Supplies

Wound care supplies that should be listed on the medication list includes:

- Ointments
  - Creams
  - Wound was (NS, Wound Cleanser, etc.)
- 
- All supplies used for wound care should be listed under supplies on the plan of care (excluding those on the medication list).
  - Wound care supplies used for each visit should be listed in the nurse's visit notes.
  - Example: SN changed dressing to left ankle DM ulcer – cleansed with NS, patted dry with 4x4 gauze (2), applied medi-honey to wound bed, applied foam dressing, and secured with Coban.



# References

[Medicare Benefit Policy Manual \(cms.gov\)](#)

[Amt-wound-documentation-reference - updated per 6.21.18 meeting.pdf \(amtwoundcare.com\)](#)

[Tips for Wound Care Documentation | Relias](#)

[Outcome and Assessment Information Set OASIS-E Manual \(cms.gov\)](#)

NPUAP Pressure Ulcer Stages



**ORACLE**  
CODING | BILLING | CONSULTING

# Thank You

**Celeste Miller RN, BS, HCS-D, COS-C**

Administrator

[Celeste@OracleBCC.com](mailto:Celeste@OracleBCC.com)

435-575-8416

OracleBCC.com