<u>Title</u> : Wound Documentation	Original Approval: 3/02
<u>Number</u> : CP-32	Reviewed/ revised: 9/05,
Page Number: 1 of 2	3/06, 7/12, 5/24

Statement/ Purpose:

To provide guidelines for accurate wound status documentation to include surgical wounds, pressure injuries, and stasis ulcers.

Authority:

Application: SCDPH CHHA RNs

Terminology:

Responsible Party:

Cross-Reference:

Hand Hygiene, Wound Measurement, Photography/ Videography of Patients

Procedure:

1. At each home visit, the RN will document the following in the patient's electronic health record:

- a. Wound characteristics including:
 - i. Size (measurements at least once weekly)
 - ii. Depth (measurements at least once weekly)
 - iii. Color
 - iv. Drainage
- b. Treatments applied
- c. Patient response to treatment
- d. Any follow up instructions for patient and/or caregiver.
- e. Any communication with the patient's provider.