**Measuring Wounds**

Measure the length “head-to-toe” at the longest point (A). Measure the width side-to-side at the widest point (B) that is perpendicular to the length, forming a “+”. Measure the depth (C) at the deepest point of the wound.

*All measures should be in centimeters.*

![Diagram of wound measurement](image)

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**Tunneling/Sinus Tract**

A narrow channel or passageway extending in any direction from the base of the wound. This results in dead space with a potential risk for abscess formation.

If the wound has many landmarks, you may want to trace it before measuring.

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**Undermining**

Open area extending under intact skin along the edge of the wound.

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*This ruler is intended for use as a reference only. To prevent infection, do not use this ruler to measure an actual wound.*
Wound Measurement & Documentation Guide

Pressure Ulcer Documentation

Wound Location:
- Designate left, right, top, bottom, side, front, middle, etc., as appropriate (for example, inner left knee)
- Describe anatomical location according to your facility practice; abdomen, knee, coccyx, sacrum, trochanter (hip), ischial tuberosity (buttock), calcaneus (heel), malleolus (ankle), etc.

*Be specific! Location description should direct staff to exact area for treatment.*

Stage:
I, II, III, IV, suspected deep tissue injury (sDTI), unstageable

Size:
L x W x D
- Length (head-to-toe)
- Width (hip-to-hip)
- Depth (deepest point)

Exudate/Drainage:

**Amount**
- None, dry, scant, moist, small, medium, large, copious

**Color**
- Serous (thin, watery, clear)
- Sanguineous (thin, bright red)
- Serosanguineous (thin, watery, pale red to pink)
- Purulent (thick or thin, opaque to tan to yellow or green)

**Odor**
- None, foul, pungent, fecal, musty, sweet

Wound Edges:
- Border shape; irregular, round, oblong, etc.
- Edges attached/unattached; undermining
- Rolled under (epibole)
- Callused

Wound Base:
- Granulation (beefy red, bubbly in appearance)
- Epithelialization (light to deep pink, pearly light pink; may form islands in the wound bed)
- Necrotic Tissue
  - Slough - thin stringy consistency; yellow, gray, white, green, brown
  - Eschar - thick hard consistency; brown to black
  - Adherency - Non-adherent, loosely adherent, firmly adherent
- Tunneling/Sinus Tract (use clock to designate location)
- Undermining (use clock to designate location)

Surrounding Tissue:
- Color (red, pink, pallor, purple, normal skin tones)
- Edema; pitting, non-pitting
- Firmness
- Temperature
- Tissue Characteristics: intact, macerated, rash, excoriated, etc.

Pain Assessment:
- Rate on scale of 1-10 before, during and after treatment; episodic or chronic
- Interventions for pain

Wound Progress:
- Improving, deteriorating, no change
- Interventions in place; pillows, low air loss beds, special devices, nutritional supplements, etc.
- Continued treatment or notify MD and responsible party of need for change