Developed by the BC Provincial Nursing Skin and Wound Care Committee in collaboration with Wound Clinicians from:

Wound Assessment Parameters and Definitions

Pain: Quantified on the Visual Analogue Scale where 0 = no pain and 10 = excruciating as described by the patient/client/resident

Size: Measurements of the wound

Length	From edge to edge, the longest measurement of the wound
Width	From edge to edge, the widest measurement of the wound at right angles to the length
Depth	The deepest vertical measurement from the base of the wound to the level of the skin
Undermining	A destruction of tissue that occurs underneath the intact skin of the wound perimeter
Sinus/Tunnel	A channel that extends from any part of the wound and tracks into deeper tissue.
Fistula	An abnormal track connecting an organ to the skin surface, wound bed or to another organ.

Wound Bed: The type of tissue or tissue structure(s) observed within the wound

No open wound	Tissue damage noted but the skin is still intact
Epithelialized tissue	Covered completely with new epithelial tissue
Hematoma	Localized collection of blood
Blister	An elevation or separation of the epidermis tissue containing fluid
Weepy skin	Drainage but no obvious open areas noted
Scab	Superficial, dry crust
Superficial pink, red	Clean, open pink/red area with non-measurable depth
Friable	Fragile tissue that may bleed easily
Malignant	Cancerous tissue
Fungating tissue	Cancerous or non cancerous rapidly growing tissue; appears cauliflower-like
New tissue damage	New damage due to pressure or trauma on an open wound bed; presents as dark purple, deep red or grey coloured tissue
Hypergranulation	Red, moist tissue raised above the level of the skin (proud flesh)
Non-granulation tissue	Moist, red (pale to bright) non-pebbled tissue
Granulation tissue	Firm, red, moist, pebbled healthy tissue
Slough	Dry or wet, loose or firmly attached, yellow to brown dead tissue
Eschar – dry, stable	Firm, dry necrotic tissue with an absence of drainage, edema, erythema or fluctuance. It is black or brown in color and is attached to the wound edges and wound base
Eschar – soft, boggy	Soft necrotic tissue which is black, brown, grey, or tan in color. It may be firmly or loosely attached to the wound edges and wound base; fluctuance and drainage may be present.
Adipose	Layer of yellow globular tissue where fat is stored
Fascia	Tough silvery white tissue found covering muscle or within a muscle group
Muscle	Red, firm, striated tissue
Tendon	Shiny white cord of fibrous connective tissue that connects muscle to bone
Bone	Hard, rigid white connective tissue
Underlying tissue structure	Structures such as cartilage, joints or ligaments
Foreign body	Objects such as mesh, hardware, suture(s)
Fully callused	Wound bed that is 100% covered with a callused tissue. Do not use this choice for a open wound with a callused edge.
Epithelial islands	Within an open wound bed, islands (small areas) of epithelial tissue proliferating and migrating from the center to the edge of the wound
Biochemical wound product	Residual/remaining biochemical wound care product in wound bed
Not visible	A portion or all of the open wound bed that cannot be visualized

Exudate Characteristics: appearance of the wound's exudate

Serous	Thin, clear, yellow
Sanguineous	Bloody
Sero-sanguineous	Combination of both serous and sanguineous exudate
Purulent	Thick, cloudy
Other	

Exudate Amount: Wound drainage amount considered in relationship to the size of the wound

Nil	
Small/scant	
Moderate	
Large/copious	

Odour: Unpleasant smell noted from wound ***after*** cleansing

Wound Edge: The perimeter of the wound

Diffuse	Not well defined**,** indistinct, difficult to clearly define wound outline
Demarcated	Well defined, distinct, easy to clearly define wound outline
Epithelializing	New, pink to purple, shiny migrating tissue
Attached	Edge appears flush with wound bed or as a "sloping" edge
Non-attached	Edge appears as a "cliff"
Rolled	Epithelial wound edge of a cavity wound which rolls under
Callused	Hyperkeratosis, thickened layer of epidermis
Scarred	Fibrotic regenerated tissue following wound healing

Periwound Skin: Surrounding area immediately adjacent to the wound edge

Intact	Unbroken skin
Fragile	Skin that is at risk for breakdown
Dry	Flaky skin
Rash	Temporary eruption on the skin-often raised, red, sometimes itchy
Macerated	Wet, white looking skin
Erythema	Redness of the skin; may be intense bright red to dark red
Indurated	Abnormal firmness of the tissues with palpable margins
Increased warmth	Increased warmth when compared to skin in adjacent area
Excoriated/denuded	Superficial loss of tissue
Weepy	Moist, draining areas
Boggy	Soft, spongy tissue
Blister	Elevation or separation of the epidermis containing fluid
Tape tear	Superficial skin loss due to tape
Edema	Interstitial collect of fluid
Bruised	Dark red purplish blue tissue that fades to yellow green grey depending on the skin colour
Callused	Hyperkeratosis, thickened layer of epidermis
Erythema >2cm	Redness of the skin; may be intense bright red to dark red
Indurated >2cm	Abnormal firmness of the tissues with palpable margins
Increased warmth	Increased warmth when compared to skin in adjacent area

References:

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