Weekly Wound Tracking Form

*For QA Purposes Only NOT A CHART DOCUMENT

Facility: _____ Unit: _____ Date: _____

Resident	Room No.	Present on Admit or In-House	Location of Wound	Type of Wound	Stage/ Pressure Previous Week	Stage/ Pressure Current Week	Treatments	Treatment Changed	Improved (I) Worsening (W) Comments

A. Number Residents with Facility Acquired Pressure Injuries: _____ % Residents with Facility Acquired Pressure Injury (A÷B) _____

B. Total Number of All Residents in Census: _____

Wound Type Key:	1 Pressure Injury	2 Surgical	3 Venous Stasis	4 Arterial Ulcer	5 Skin Tear	6 Abrasion	7 Laceration	8 Diabetic Ulcer	9 Burn	10 Other

Pressure Injury Stages: **Suspected Deep Tissue Injury:** Purple or maroon localized area of discolored intact skin or blood-filled blister.
Stage 1: Intact skin. Redness that DOES NOT BLANCH. Skin tones may appear red, maroon, blue, purple. Affected area may be warm, boggy or firm.
Stage 2: Skin is cracked, blistered, sheared or torn. Partial thickness wound. Does not heal with granulation.
Stage 3: Broken skin, deep tissue involvement. Full thickness wound. Muscle, tendon, or bone is NOT visible.
Stage 4: Broken through all layers of tissue. Full thickness wound. Muscle, tendon, or bone may be visible.
Unstageable: Base of ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown, or black) in the wound bed.

Harmony Healthcare International (HHI)
430 Boston Street, Suite 104, Topsfield, MA 01983 ♦ Tel: 1.800.530.4413