

Accurate Wound Assessment and Documentation

Video 2

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BEFORE YOU ACT, ASK!

1. What caused this wound to begin with?
2. What is preventing the wound from healing?

WHAT FACTORS DELAY WOUND HEALING?

Wound healing requires 3 types of resources: Metabolic, Oxygen, and Immunity.

Sometimes we can do everything right, but wounds just refuse to heal. Below are some factors that can delay wound healing. If you identify these factors, make a note in the clinical record and you will look like a real pro! These factors include:

- ◆ Inappropriate local care
- ◆ Illnesses that compete for metabolic resources
- ◆ Illnesses that contribute to tissue hypoxia
- ◆ Inadequate protein, vitamin and mineral intake
- ◆ Steroid use
- ◆ Diabetes
- ◆ Bacterial overload/infection
- ◆ Immunosuppression

WOUND STAGING

Staging gives us a standardized way to describe wounds. Any wound may be staged, not just pressure ulcers. Remember, if a wound base is not visible because of non-viable tissue, you cannot stage it!

Many physicians use the terms “partial thickness” or “full thickness” to describe wounds. Burns are also classified in this way.

The National Pressure Ulcer Advisory Panel sets the standard for staging wounds. They have a very helpful website with links to other organizations related to wounds. They are at NPUAP.org on the web.

PARTIAL THICKNESS: Correlates to Stage I and II

- ◆ Shallow - Involves epidermis and dermis
- ◆ Moist
- ◆ Painful
- ◆ Correlate to Stage II
- ◆ Pink-red color

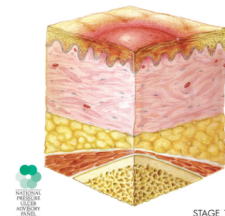
FULL THICKNESS: Correlates to Stages III and IV may present as shallow or deep

- ◆ Extends to subcutaneous layer or deeper
- ◆ Depth may or may not exceed 0.5 cm
- ◆ May include necrotic tissue or infection
- ◆ Correlate to Stage III or IV
- ◆ Often extensive tissue damage

The Four Stage System is the “Universal Language” of Pressure Ulcer classifications:

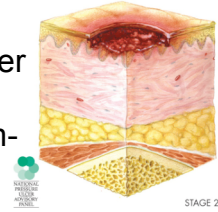
STAGE I:

- Characterized by intact skin with non-blanchable redness of a localized area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching, but its color may differ from the surrounding area.
- To identify a Stage I pressure ulcer, compare the suspected area to an adjacent area or the same region on the other side of the body. Indications of a Stage I include differences in:
 - skin temperature (warmth or coolness)
 - change in tissue consistency or temperature of the skin
 - sensation (pain)



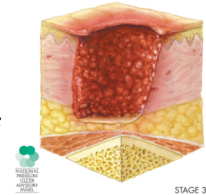
STAGE II:

- Characterized by partial thickness loss of the dermis. This ulcer presents as a shallow, open ulcer with a red-pink wound bed without slough. It can also present as an intact or open serum-filled blister.



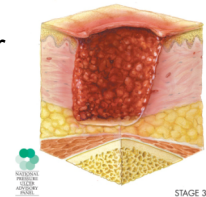
STAGE III:

- Characterized by full-thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, and muscle aren't exposed. Slough may be present but doesn't obscure the depth of tissue loss. Undermining and tunneling may be present. The depth of a Stage III ulcer varies by anatomical location.



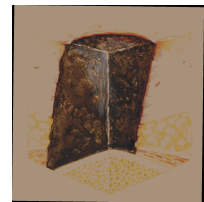
STAGE IV:

- Involves full-thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Undermining and tunneling are common. The depth of a Stage IV ulcer varies by anatomical location.
- Osteomyelitis is a possible complication.



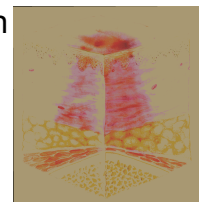
UNSTAGEABLE PRESSURE ULCERS

- Osteomyelitis characterized by full-thickness tissue loss in which the base of the ulcer in the wound bed is covered by slough (yellow, tan, gray, green, or brown), eschar, (tan, brown, or black) or both. Until enough slough or eschar is removed to expose the base of the wound, the true depth and therefore stage can not be determined.



DEEP TISSUE INJURY (DTI):

- Characterized by a purple or maroon localized area of intact skin or blood filled blister caused by damage of underlying soft tissue from pressure or shear. The injury may be preceded by tissue that's painful, firm, mushy, boggy, or warm or cool compared to adjacent tissue. It may be difficult to detect in individuals with dark skin tones.



BACK STAGING WOUNDS:

- As wounds progress, they do not “backstage.” For example, a Stage IV pressure ulcer that progresses from 3 cm depth to 1.5 cm depth is not a “Stage III,” it continues to be a Stage IV.

DOCUMENTING WOUND ASSESSMENT

Wounds should be measured and assessed every 7 days. When documenting your assessment, do your best to “paint a picture” of the wound and surrounding skin. Having the same caregiver perform the assessment will increase its accuracy.

ELEMENTS TO INCLUDE IN WOUND ASSESSMENT:

- ◆ Location

- ◆ Wound type

- ◆ Length

- ◆ Width

- ◆ Depth

- ◆ Stage

- ◆ Base tissue type

- ◆ Presence and location of tunnels and undermining

- ◆ Exudate color, odor and amount

- ◆ Presence of inflammation

- ◆ Condition of surrounding skin
- ◆ Pain
- ◆ Factors that are delaying progress

COMMONLY USED WOUND ASSESSMENT TERMS

- ◆ Clean vs. granulation tissue
- ◆ Non-viable vs. necrotic tissue
- ◆ Inflammation vs. Induration
- ◆ Eschar
- ◆ Slough
- ◆ Maceration

ESCHAR

WHAT IT IS:

ELEMENTS OF ASSESSMENT:

TO DEBRIDE OR NOT TO DEBRIDE:

WHAT HAPPENS TO ESCHAR AND WHAT TO DO ABOUT IT:

1.

2.

3.

REFERENCES

Bryant, Ruth. Acute and Chronic Wounds, 3rd ed. 2007, Mosby.

Sussman, Carrie. Wound Care: A Collaborative Practice Manual for Health Professionals. 3rd ed. 2007, Lippincott Williams & Wilkins.

WOCN. Guideline for Management of Wounds in Patients with Lower Extremity Arterial Disease. 2000, WOCN Society.

WOCN. Guidelines for Prevention and Management of Pressure Ulcers. 2003, WOCN Society.

This reference list is by no means exhaustive. There are numerous other texts and journals devoted to state of the science information related to chronic wounds.