Wound Assessment
The Basic’s

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Important Information

- The following presentation represents the opinions, findings and conclusions of the author and *may not necessarily* represent the views of KCI-USA.

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WARNING

GRAPHIC CONTENT AHEAD
THE FOLLOWING IMAGES MAY SHOCK OR DISTURB SOME VIEWERS
Wound Terminology

Partial Thickness

Wound Base

Acute

Slough

Peri-Wound

Full Thickness

Chronic
Classification of Wounds

All wounds classified based upon Depth of tissue destruction
Wound Classification

All wounds are either

- **Partial** Thickness
- **Full** Thickness
Partial Thickness

Destruction of epidermis and dermis
Partial Thickness

- Pink
- Painful
- **NO** yellow tissue
Full Thickness

Destruction of epidermis, dermis, subcutaneous and/or deeper
Full Thickness
Wound Terminology

All wounds are classified based upon healing times.
Acute

- Timely and uncomplicated
- Less than 12 weeks
Chronic

- Failed to proceed orderly
- Greater than 12 weeks
Wound Terminology

Parts of a Wound
Wound

- Open area only
- Diameter from edge to edge
- Size documented in centimeters
  - Length x Width x Depth
Wound Base

The bottom of the wound
Wound Depth

Vertical distance from the visible surface to the deepest area in the wound bed.
Wound Edges/Margin

Inside perimeter of the wound, the rim
Macerated
Epibole

• Rolled edge

• Curled under

• Epithelial cells cannot migrate to close wound
Callused

- Fibrotic
- Hyper-keratotic
Peri-Wound

- Surrounding tissue
  - outside perimeter of wound
  - minimum of 4 cm
Peri-Wound
Color

- Erythema (Red)
  - infection
  - trauma
  - inflammation
Color

- White
  - moisture
Color

- Blue
  - poor blood flow
  - trauma
- Purple
  - trauma
Peri-Wound Temperature

- Warm – Hot
  - possible infection
- Cool
  - poor blood flow
Peri-Wound Texture

- Moist
- Macerated
- Boggy
  - soft
  - mushy
Indurated

- Firm or hard
Edema

- Swelling
- Accumulation of fluid in tissues
Integrity
Denuded

• Loss of epidermis, caused by exposure to urine, feces, body fluids, wound exudate or friction
Excoriated

- Linear erosion - loss of epidermis
- Destruction of skin by mechanical means
Erosion

- Loss of the epidermis
  - Part or all
Lesions

- Rashes
Tunneling

Channel or pathway that extends in any direction from the wound through subcutaneous tissue
Tunneling
Undermining

Tissue destruction underlying intact skin along the wound margins

Caused by shearing
Undermining
Wound Terminology
Types of Tissue
Necrotic Tissue

- Non-viable tissue, dead – NO blood flow
  - Slough
    - yellow, green, grey
    - lighter, thin, wet
    - stringy
  - Eschar
    - black, brown, grey
    - darker, thicker
    - harder
Slough
Slough
Eschar
Epithelial Tissue

- Outer most layer of skin
- Deep pink to pearly pink
- Close the wound
Epithelial Tissue
Granulation Tissue

- New tissue that replaces dead tissue
- Beefy red, puffy, mounded
- Grows from base of wound
Granulation Tissue
Granulation Tissue
Hyper-granulation Tissue

- Forms above surface
- Delays epithelialization
Muscle Tissue

- Pink to dark red
- Highly vascularized (richly supplied with blood)
- Striated (striped, grooved, or ridged)
Tendon

- Attaches muscle to bone
- Shiny when healthy
Tendon
Fascia

- Covering over muscles
- Shiny, white
- Great organizer
Bone

- Shiny
- Smooth
Wound Base Color

Beefy Red - Healthy tissue, good blood flow
Wound Base Color

Pale Pink - Poor blood flow, anemia
Wound Base Color

Purple - Engorged, swelling, high bacteria levels, trauma
Black or Brown - Non-viable necrotic tissue
Wound Base Color

Yellow - Non-viable tissue; slough
Wound Base Color

Green - Infection, non-viable tissue
Wound Base Color

White - macerated; poor blood flow
Exudate (Drainage)

- Documented by:
  - Type
  - Amount
Causes of Drainage

- Bacteria
- Infection
- Necrotic tissue
- Swelling
- Trauma
- Foreign Objects
Types of Exudate

Serous - Thin clear watery plasma
Types of Exudate

Sanguineous – Bloody
Types of Exudate

Serosanguineous - Thin watery pale red to pink, plasma with Red Blood Cells (RBC’s)
Types of Exudate

Purulent - Thick opaque tan, yellow, green or brown color
Amount of Exudate

None - Wound tissues dry
Amount of Exudate

Scant - Wound tissues moist, NO measurable drainage
Amount of Exudate

Small/ Minimal - Wound tissues very moist
Drainage < 25% of bandage
Amount of Exudate

Moderate - Wound tissues wet
Drainage 25 -75% of bandage
Amount of Exudate

Large/ Copious – Tissues filled with fluid
Drainage > 75% of bandage
Odor

• **Descriptors**
  - strong
  - foul
  - pungent
  - fecal
  - musty
  - sweet

• **Causes**:
  - bacteria
  - dead tissue
  - drainage buildup
Resources

- Standards of Practice
- Pressure Ulcer Staging  www.npuap.org
- Wound Care Products
- Wound Care Resources & Links
  - www.woundconsultant.com
- Wound Care Education Institute
  - www.wcei.net
Documentation
RISK Assessment
Tools

- Recognize and evaluate each patients risk factors
- Identify which risk factors can be removed or modified

- Complete Daily
Tools to Measure Wound Healing

- **PUSH** – Pressure Ulcer Scale for Healing
- Monitor pressure ulcer healing over time
- Monitors
  - Size Length X Width
  - Exudate amount
  - Tissue Type
Include narrative charting if not addressed on checklist forms
Documentation Frequency

• AHCPR (AHRQ) Supported Guidelines: Clinical Practice Guideline #15: Treatment of Pressure Ulcers
  – Assessment and documentation should be carried out at least weekly . . .
  – More often with
    • Wound complications
    • Changes in wound characteristics
Document

Assessment Results

- **Document wound assessment**
  - Size
  - Location
  - Tissue Types
  - Exudate
  - Odor
  - Surrounding Tissue
  - Pain
Interventions

- Turning/repositioning schedule
- Support surfaces
- Heel protection
- Wheelchair cushions
- Wound Consultations
Interventions

- Incontinence management
  - Moisture Control
  - Skin barriers
  - Briefs
  - Catheters
  - Bowel Bladder Training
Treatment

- Current topical treatment
  - Cleansers
  - Dressings
  - Ointments

- Response to treatment
  - Better, no change, decline
  - Changes, modifications
Clinical Account Management Program (C.A.M.P.) is a detailed patient management program to assist with achieving cost effective, positive wound care outcomes. KCI’s highly trained clinical account managers will collaborate with care givers to help them manage V.A.C.® Therapy patients throughout the wound healing process.

* Compared to other NPWT providers. KCI data on file.
C.A.M.P. PROCESS FLOW OVERVIEW

1. **Clinical Provider**
   - Patient Assessment
   - Collaboration - Facilitation

2. **Recommended Changes in Care Plan**

3. **Clinical Review**
   - Help with coverage requirements

4. **Patient**

   - V.A.C.® Therapy
   - Minimal/Lack of Patient Progress
   - Exhaustion of Benefits

- **Physician**

- **Payor**

- **KCI Clinical Account Manager**
KCI Clinical Wound Experts will collaborate with Clinical Provider regarding V.A.C.® Therapy patients, wound progression and required documentation.
KCI Clinical Wound Experts will provide consultation on the development of an evidence based comprehensive care plan to assist with management of V.A.C.® Therapy patients throughout the wound healing process.
KCI Clinical Wound Experts will provide in-depth training and education to Clinical Providers based on wound care standards of care.
Charting Examples
Example - Bad

Dressing change to foot ulcer. Appears to be healing well. No c/o voiced. DSD intact.
Scheduled dressing change to Stage 3 pressure ulcer on Left medial heel. Measurements noted: 3.1 x 3.4 x < 0.1 cm. Wound base 100% dusky pink tissue with epithelial tissue noted around entire inner perimeter measuring approx. 0.5cm. Wound bed moist with scant drainage, no odor, redness, or increased warmth noted. Wound edges contracting inward. Peri-wound tissue is dry and scaly. No c/o pain.
Patient has good pedal pulses and moves legs and feet well.
Dorsalis pedis and posterior tibial pulses in legs 2+/4+ bilaterally. Leg strength 5/5 bilaterally for all major muscle groups. Sensation intact to light touch; pt. denies pain, numbness, or tingling. Skin warm and dry. No edema.
Bad Abbreviations

- A nursing assistant documented “300 ml PWI SOTF.”
  “Plus what I spilled on the floor.”
Bad Abbreviations

• One chart included this order: “Patient may get up AFAWG.”

“As far as the wire goes.”
Bad Abbreviations

- DAAD  Dead as a doornail
- PITA   Pain in the A**
- FTD    Fixin to die
- GLM    Good looking mom
Accurate assessment of a wound and proper documentation is absolutely necessary for medical, legal, and reimbursement reasons.
Thank you for your time and attention!