Wound Assessment Documentation

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Objectives

• Compare facility current wound documentation practices with recommendations that address current wound documentation recommendations from F314, MDS-M-Section and NPUAP guidelines

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F314 - Assessment & Treatment of PrU(s)

- Each existing pressure ulcer be identified
  - Whether present on admission or developed after admission
- Factors that influenced the PrU development
- Potential for development of additional ulcers
- Factors causing deterioration of the pressure ulcer(s) be assessed and addressed (Prevention!!!)
- New pressure ulcer suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers

**Date Wound Identified**

<table>
<thead>
<tr>
<th>Date Wound ID'd</th>
<th>m</th>
<th>m</th>
<th>d</th>
<th>y</th>
<th>□ New Wound</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Recurrence-Same etiology/same location</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Date of Last Recurrence:</td>
</tr>
</tbody>
</table>

**Location**

LOCATION: (Describe anatomically: i.e. L-trochanter)

Describe location anatomically correctly using current medical terminology

<table>
<thead>
<tr>
<th>Specific Terms</th>
<th>Less Specific Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>R-ischium</td>
<td>R-buttock</td>
</tr>
<tr>
<td>R-lateral malleolus</td>
<td>R-ankle</td>
</tr>
<tr>
<td>L-trochanter</td>
<td>L-hip</td>
</tr>
</tbody>
</table>
Location

- Document in reference to head, front or back
- Commonly used terms
  - Proximal, distal
  - Superior, inferior
  - Medial, lateral
  - Anterior, posterior
  - Dorsal, plantar

Etiology

- Plan of care will be specific for etiology identified
- In most instances if etiology incorrect...treatment plan will not be functional and goals not reached
- Outcomes poor

Most Common Wound Etiologies

- Pressure Ulcer
- Peripheral Arterial Disease (PAD)
- Venous Insufficiency
- Diabetic Neuropathic Foot Ulcer
- Lymphedema
Is it an Atypical Wound?

- Basal cell carcinoma
- Malignant Melanoma
- Lupus
- Vasculitis
- Calciphylaxis

Depth of Tissue Injury

<table>
<thead>
<tr>
<th>Depth of Tissue Injury</th>
<th>Non-PtU</th>
<th>PtU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Thickness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstagedible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Heals by regeneration
- No scar tissue
- No slough
- Healing complete 7-14 days.

Classification of Wounds by Tissue Destruction

- Used to classify wounds whose primary cause is something other than pressure
- **Partial thickness**: limited to epidermis & upper portion of dermis
- Heals by regeneration
- No scar tissue
- No slough
- Healing complete 7-14 days.
- **Full-thickness**
- Extends through epidermis & dermis
- May involve subcutaneous tissue, muscle or bone
NPUAP Staging - Pressure Ulcers

- **Classification by Category/Staging**
  - Identify pressure ulcers by tissue layer involved
  - Anatomic description of wound depth
  - NPUAP – Revised Feb 2007
    - Suspected Deep Tissue Injury
    - Category/Stage I
    - Category/Stage II
    - Category/Stage III
    - Category/Stage IV
    - Unstageable
  - *Should only be used on wounds caused by pressure!*
  - NPUAP.org

**Unstageable Pressure Ulcers**

- Three types to differentiate
- Number of these unstageable pressure ulcers present upon admission/ reentry

**E. Unstageable - Non-removable dressing:**

1. Unstageable - Non-removable dressing: Known but not exposed due to non-removable dressing sheet
2. Reason for not removing dressing: (Revised: 02/07)

**F. Unstageable - Slough and/or eschar:**

1. Unstageable - Slough and/or eschar: Known but not exposed due to non-removable dressing sheet
2. Reason for not removing dressing: (Revised: 02/07)

**G. Unstageable - Deep tissue:**

1. Unstageable - Deep tissue: Suspected deep tissue injury

Measurement

<table>
<thead>
<tr>
<th>Measurements (cm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>L ______ cm W ______ cm D ______ cm</td>
</tr>
<tr>
<td>if u.t.d, describe why: __________</td>
</tr>
<tr>
<td>Undermining or Tunneling (cm)</td>
</tr>
<tr>
<td>U/T ______ cm @ _______ o'clock</td>
</tr>
<tr>
<td>U/T ______ cm @ _______ o'clock</td>
</tr>
</tbody>
</table>

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**Skin Management**

**Tool Kit**

**Arkansas Innovative Performance Program (AIPP)**

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**Size = L x W x D**

- Always measure in centimeters
- Clock method
- Measure wound edge to wound edge

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**Wound Measurement:**

- **Depth:** Distance from visible surface to deepest point in wound base **not covered with necrotic tissue**

**NOTE:** Do not record depth if not able to see **TRUE** base of wound. **Use unstageable designation.**

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**Wound Measurement**

- **Tunneling:** A single pathway that may extend in any direction

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Wound Measurement

Undermining
Tissue destruction that occurs to the underlying intact skin adjacent to the wound margins. Formation of a “shelf” of healthy, intact tissue over an area of dead space and/or necrotic tissue.

Shelf under edge of wound

Exudate

Exudate
Amount: None, Scant/Min, Mod, Copious
Consistency: Serous, Serosanguineous, Purulent
Odor: None, Mild, Mod, Strong/Foul

Dressings are saturated with changes at routine intervals; exudate is uncontrolled and freely expressed. More than 75% of the dressing is covered by drainage.

Adapted from the Association for the Advancement of Wound Care Quality of Care Wound Glossary

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PS: Drainage drives dressing decisions.
### Clinical Presentation of Tissue Types: Wound Base

**Granulation tissue**
- Full thickness/Stage III PrUs

**Slough**
- Partial thickness/Stage II PrUs

**Epithelial tissue**
- Caucasian and Non-Caucasian skin

**Foreign object/exposed metal implant visible at base of wound**

**Hypergranulation tissue (exuberant granulation tissue or proud flesh) extends above the wound edge**

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**Wound Bed**

<table>
<thead>
<tr>
<th>Tissue Type/Color &amp; percent</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermal Base (Primary) Partial or Stage II</td>
<td></td>
</tr>
<tr>
<td>Granulation: Healthy</td>
<td></td>
</tr>
<tr>
<td>Poor: Red/healthy</td>
<td></td>
</tr>
<tr>
<td>Pseudomembranous:</td>
<td></td>
</tr>
<tr>
<td>Necrotic</td>
<td></td>
</tr>
<tr>
<td>Dry</td>
<td></td>
</tr>
<tr>
<td>Slough: Necrotic/membranal</td>
<td></td>
</tr>
<tr>
<td>Eschar (black/white)</td>
<td></td>
</tr>
<tr>
<td>Eschar (tan/white/buried/necrotic/boggy)</td>
<td></td>
</tr>
<tr>
<td>Other: eg. tendinous/muscle/bone</td>
<td></td>
</tr>
</tbody>
</table>
Right heel with unstageable pressure ulcer presents with 80% yellow soft slough at central portion of wound base, with 20% pink granulation tissue around wound base periphery. Wound edge smooth and well defined; periwound slightly macerated superiority.

CMS and Wound Related Pain

- **F314**
- Pain, if present: nature and frequency (e.g., whether episodic or continuous);
Wound Related Pain Experiences

- **Chronic Wound Pain**
  - Absence of manipulation
  - May be continuous/intermittent

- **Cyclic Wound Pain**
  - Periodic acute wound pain
  - Regular repetitive treatments (i.e. dressing change)

- **Noncyclic Wound Pain**
  - Provoked by more sporadic procedures (i.e. sharp debridement)

Assessment and Documentation of Pain to Include:

- Location
- Duration
- Character (intensity and radiation)
- Frequency

Wong-Baker FACES™ Pain Rating Scale

- No Symptoms
- Mild Symptoms
- Moderate Symptoms
- Severe Symptoms

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ARKANSAS INNOVATIVE PERFORMANCE PROGRAM (AIPP) Skin Management Toolkit
Infection/Critical Colonization
- None or n/a
- Yes, the following noted:
  - Localized s/s:
    - Systemic s/s:
      - Non-healing
      - Exudate
      - Red/irritable
      - Subcutaneous
    - Culture:
      - Biopsy:
  - New onset of pain
  - Pain > than expected
  - Smell/Odor
*Initiate localized or systemic Rx if > 2 or more criteria noted per NERDS or STONES lists.

Wound Edge/Exposed
- Edge optimal setting
- Edematous
- Exposed
- Hyperemic
- Ulcerated
- Irritated
- Erythema
- Proliferative
- Necrotic
- Other

Wound Healing Status
- Petri Score:
  - Clinically Presenting as:
    - Acute
    - Chronic, one
    - Progressing as expected
    - Stable wound bed maintained, per goal
    - Plateau, stalled but healing expected
  - Size noted s/p debridement activity
  - Exudate noted s/p debridement activity
  - Necrotic tissues as SSI still now declared
  - Declining (See Infection/Critical Colonization box)
Other related factors...
- None
- Yes**, Clinically complicating factors noted
*Continue documentation in agg. 2 of wound assessment form (other considerations for Rx.)
F314 Interpretative Guidelines
483.25(c)

Based upon the assessment and the resident’s clinical condition, choices & identified needs, basic or routine care should include interventions to:

a) Redistribute pressure (such as repositioning, protecting heels, etc)

b) Minimize exposure to moisture and keep skin clean, especially of fecal contamination;

c) Provide appropriate pressure redistributing, support surfaces;

d) Provide non-irritating surfaces;

e) Maintain or improve nutrition and hydration status, where feasible.

Definitions

- Pressure Ulcers (Avoidable/Unavoidable)
- Colonized/Infected Wound
- Cleansing/Irrigation
- Debridement
  - Autolytic
  - Enzymatic
  - Mechanical
  - Sharp
  - MDT (maggot)

M1200 Skin and Ulcer Treatments

M1200. Skin and Ulcer Treatments

Check all that apply

- A. Pressure reducing device for chair
- B. Pressure reducing device for bed
- C. Turning/repositioning program
- D. Nutrition or hydration intervention to manage skin problems
- E. Ulcer care
- F. Surgical wound care
- G. Application of nonsurgical dressings (with or without topical medications), other than to feet
- H. Applications of ointments/medications other than to feet
- I. Application of dressings to feet (with or without topical medications)
- J. None of the above or provided

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Skin Management Toolkit
### Therapeutic Goals Example

<table>
<thead>
<tr>
<th>Therapeutic Goals/Clinical Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Decrease wound size by ______ cm 2/weeks</td>
</tr>
<tr>
<td>2. Decrease necrotic tissue to 50% in 2/weeks</td>
</tr>
<tr>
<td>3. Increase granulation tissue to 50% in 2/weeks</td>
</tr>
<tr>
<td>4. Decrease odor to none</td>
</tr>
<tr>
<td>5. Decrease pain from 7 to 3 during dressing changes</td>
</tr>
</tbody>
</table>

### Short Term Goal Suggestions

- Decrease wound size by ______ cm
- Increase granulation tissue to ______%
- Decrease necrotic tissue to ______%
- Decrease edema ________ grade (pitting)
- Decrease drainage to ________ (small, moderate)
- Decrease odor ________ (min, mod)
- Decrease erythema to ____________
- Decrease undermining or tunneling ______________
- Educate patient/staff/family regarding ____________
- Assess efficacy of pressure redistribution devices, off-loading of heels, positioning, etc

### Long Term Goals Suggestions

- Wound closure in 6 wks
- Functional nutrition/hydration status maintained for wound prevention and healing
- Staff/family/resident safe and competent in protecting and preventing reoccurrence
Skin Management Toolkit

Dressing Change Protocol Example

Dressing Change Protocol:
1. Cleanse wound with normal saline/wound cleanser
2. Fill wound base with calcium alginate
3. Cover alginate with bordered foam
4. Change dressing 3X/wk

F314- DRESSINGS & TREATMENTS
- A facility should be able to show that its document treatment protocols are based upon current standards of practice
- Are in accord with the facility's policies and procedures
- And these policies and procedures are developed with the medical director's review and approval (F501)

Do treatments with these products meet the "current standards of practice"?

Referral Recommendations:
- Vascular consult
- Nutrition consult
- Infectious disease
- Psych/counseling/resident/family
- PT/OT/SLP
- Other:

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Complicating Factors

<table>
<thead>
<tr>
<th>Contributing Cause/Factor</th>
<th>Details</th>
<th>Skin Conditions/Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative Pressure Wound Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Electrical Stimulation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low-frequency Ultrasound</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pulsatile Lavage w/ Suction</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Interventions:**
- Negative Pressure Wound Therapy
- Electrical Stimulation
- Low-frequency Ultrasound
- Pulsatile Lavage w/ Suction

**Complicating Factors**

- **Infection:**
  - Abscess
  - Cellulitis
  - Erysipelas
  - Malignancy
  - Gangrene

- **Pressure Ulcer:**
  - Stage I
  - Stage II
  - Stage III
  - Stage IV

- **Venous Ulcer:**
  - Chronic Venous Insufficiency
  - Varicose Veins

- **Arterial Ulcer:**
  - Atherosclerosis
  - Peripheral Arterial Disease

- **Diabetes:**
  - Diabetic Neuropathy
  - Diabetic Microangiopathy

- **Other:**
  - Hypertension
  - Obesity
  - Smoking
  - Chronic Kidney Disease
  - Chronic Liver Disease

**Other DIAGNOSISES:**

- **Cancer:**
  - Breast
  - Lung
  - Colon

- **Heart Disease:**
  - Coronary Artery Disease
  - Congestive Heart Failure

- **Chronic Obstructive Pulmonary Disease (COPD):**

- **Liver Disease:**
  - Chronic Hepatitis
  - Cirrhosis

- **Renal Disease:**
  - Chronic Kidney Disease
  - Renal Failure

**Other DIAGNOSISES:**

- **Endocrine:**
  - Diabetes Mellitus
  - Hyperparathyroidism

- **Infectious:**
  - Methicillin-resistant Staphylococcus aureus (MRSA)
  - Other gram-negative bacteria

- **Immunosuppressed:**
  - HIV/AIDS
  - Transplant Recipient

- **Other:**
  - HIV/AIDS
  - Transplant Recipient

**Other DIAGNOSISES:**

- **Trauma/Injury:**
  - Burn
  - Laceration
  - Fracture

- **Neurologic:**
  - Spinal Cord Injury
  - Multiple Sclerosis

- **Psychologic:**
  - Depression
  - Anxiety

- **Hematologic:**
  - Thrombocytopenia
  - Anemia

- **Renal Disease:**
  - Chronic Kidney Disease
  - Renal Failure

- **Endocrine:**
  - Diabetes Mellitus
  - Hyperparathyroidism

- **Immunosuppressed:**
  - HIV/AIDS
  - Transplant Recipient

- **Other:**
  - HIV/AIDS
  - Transplant Recipient

**Other DIAGNOSISES:**

- **Chronic Obstructive Pulmonary Disease (COPD):**
  - Bronchiectasis
  - Chronic bronchitis

- **Cardiac:**
  - Congestive Heart Failure
  - Arrhythmias

- **Cancer:**
  - Breast
  - Lung
  - Colon

- **Renal:**
  - Chronic Kidney Disease
  - Renal Failure

- **Other:**
  - HIV/AIDS
  - Transplant Recipient

**Other DIAGNOSISES:**

- **Endocrine:**
  - Diabetes Mellitus
  - Hyperparathyroidism

- **Immunosuppressed:**
  - HIV/AIDS
  - Transplant Recipient

- **Other:**
  - HIV/AIDS
  - Transplant Recipient
Other Clinically Complicating Factors / Other Comments