

Training Module 2

Wound Assessment

PartnerFirst™ 

Upon completion of this Training Module you will be able to:

Describe five wound measurements to include in an assessment

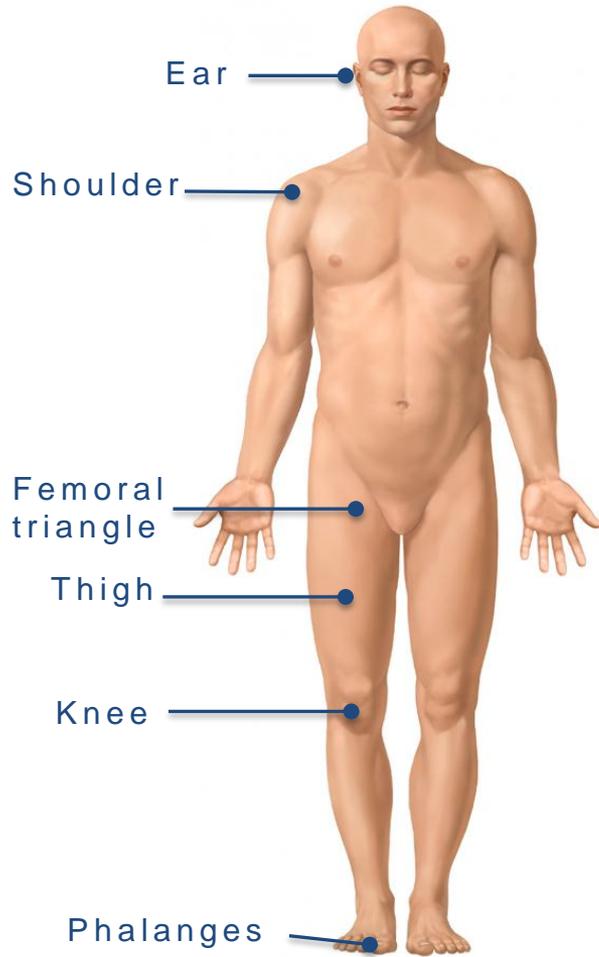
Identify four wound tissue types

Describe the terms used to describe wound drainage

Identify healthy and unhealthy wound edges and peri wound skin

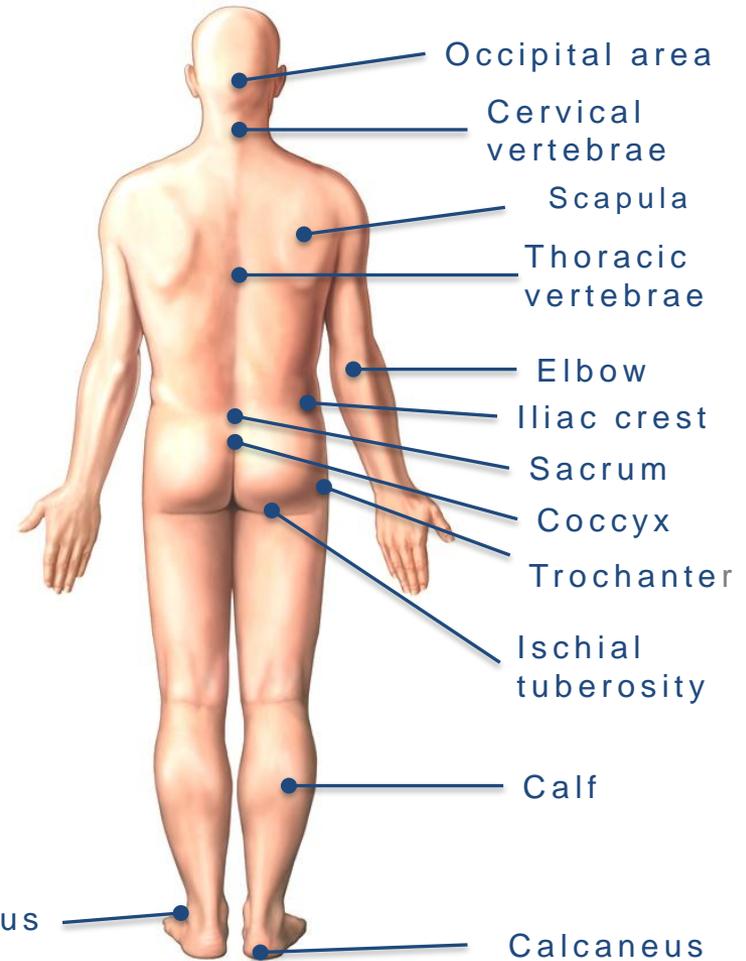
Describe the signs and symptoms of an infected wound

Anatomical Locations

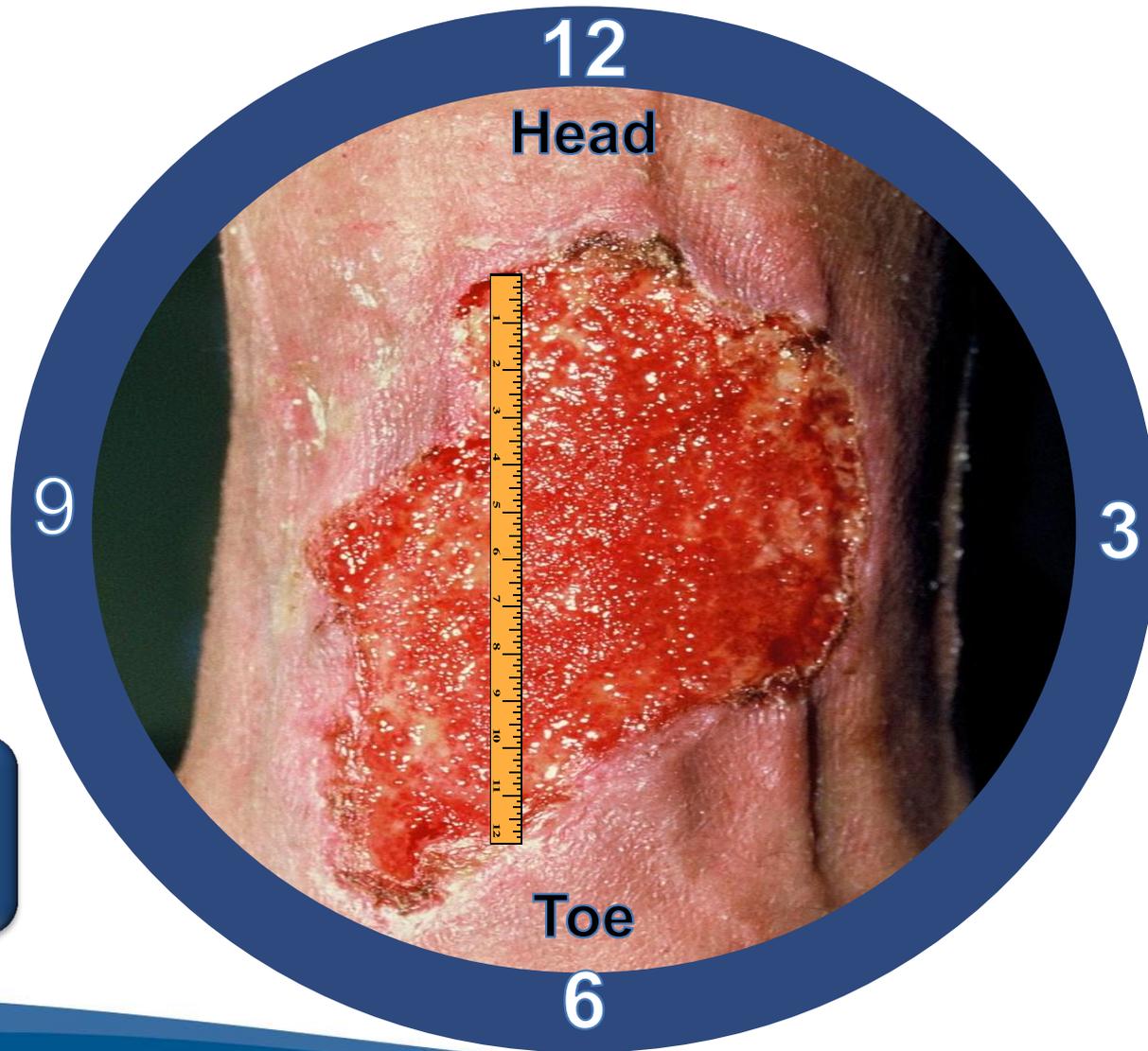


Appropriate anatomical location is important for

- Communication
- Determining the cause of the wound
- Reimbursement

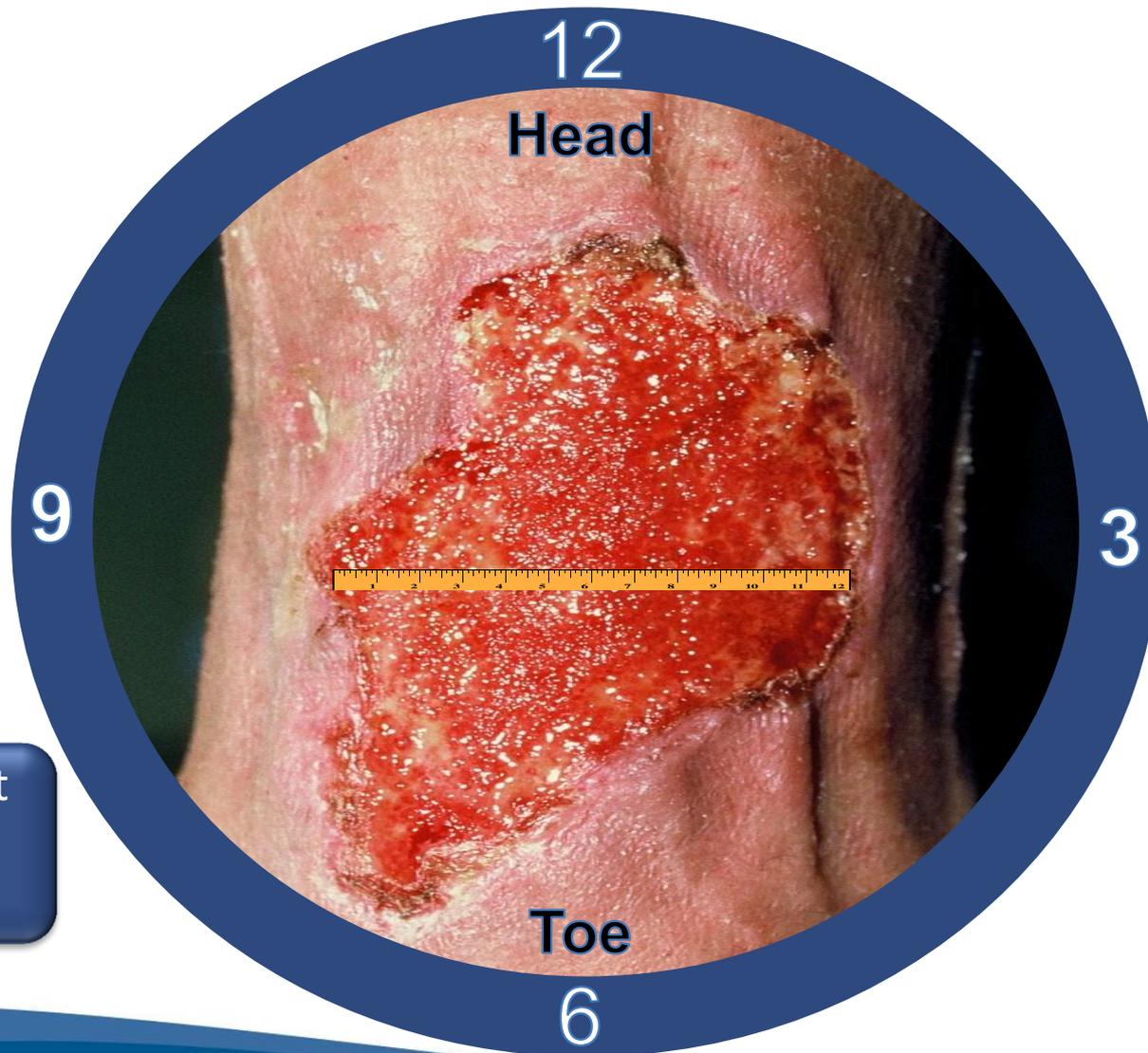


Wound Measurements-Length PartnerFirst™



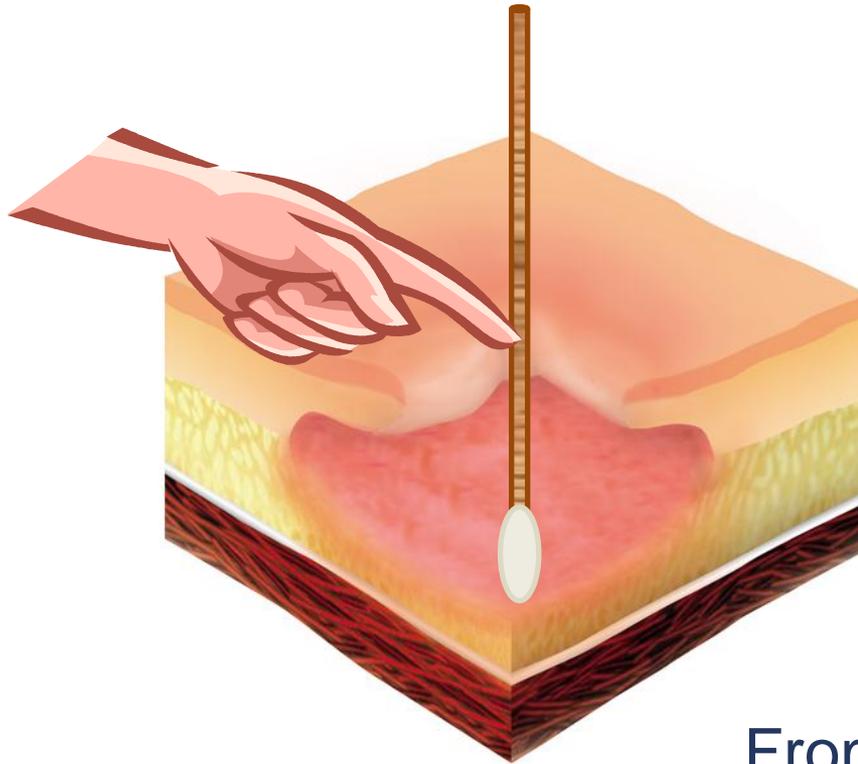
The greatest
length from
head to toe

Wound Measurements-Width PartnerFirst™



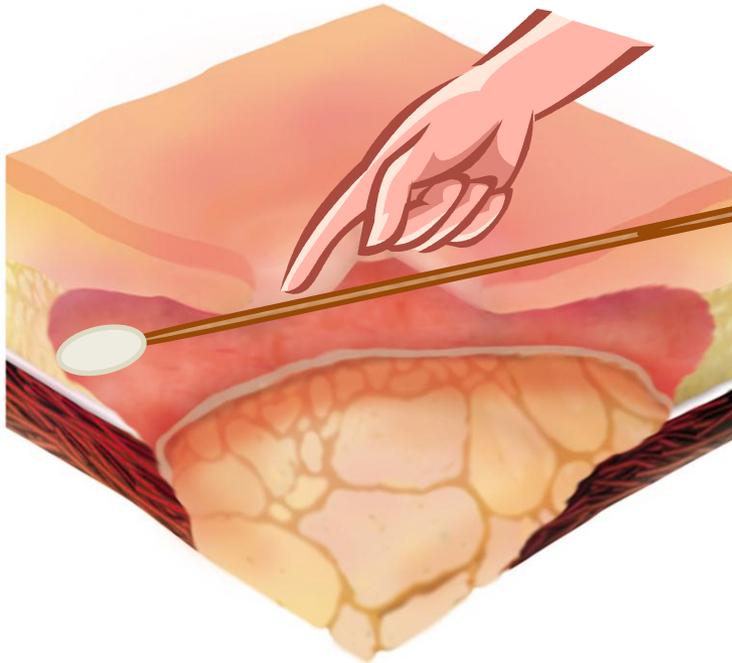
The greatest
width from
side to side

Depth

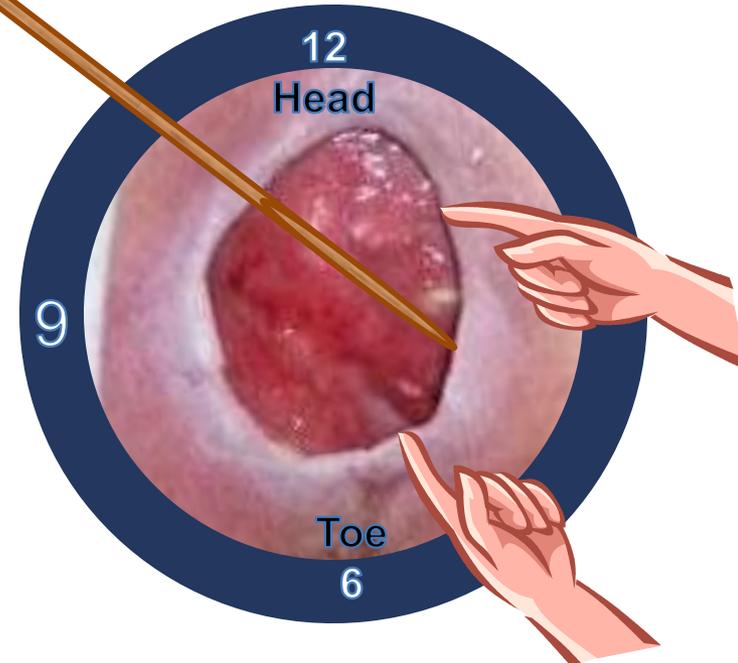


From skin level to the
base of the wound
Depth: 4.2cm

Undermining

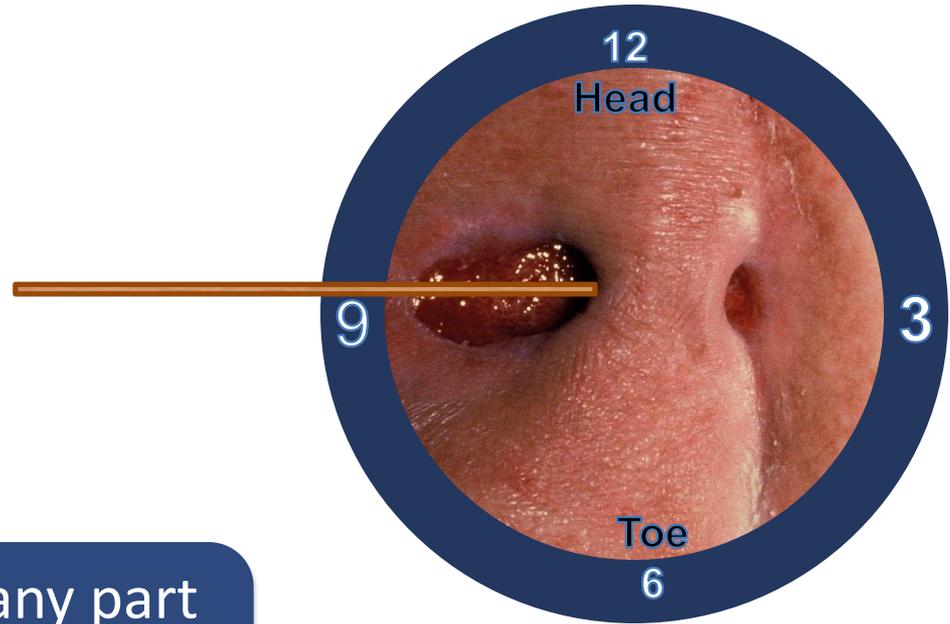
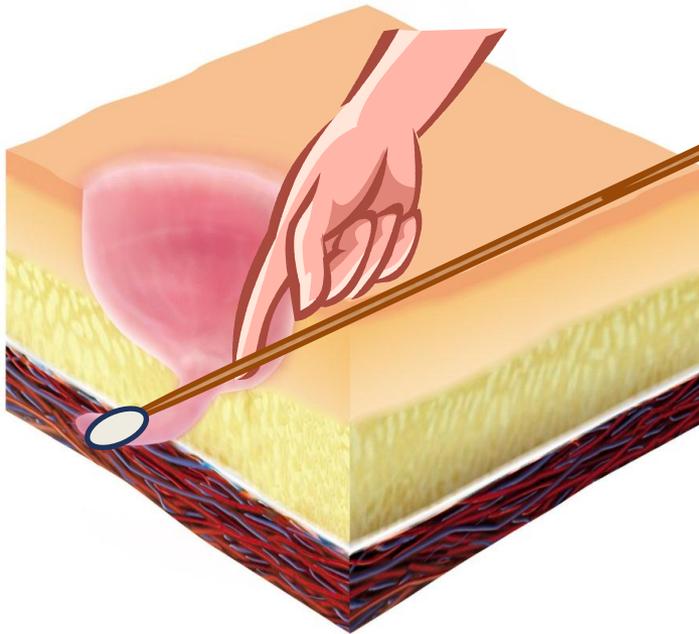


Tissue destruction that occurs under intact skin around the wound perimeter ¹



Documentation:
Undermining
6.2cm from 2 o'clock to 5 o'clock

Tunneling



A channel that extends from any part of the wound through subcutaneous tissue and muscle ¹

Documentation:
Tunneling
5.4cm at 3 o'clock

Wound bed tissue types



=100%

Granulation Tissue



The pink/red moist tissue comprised of new blood vessels, connective tissue, fibroblasts and inflammatory cells, which fills an open wound when it starts to heal; typically appears deep pink or red with an irregular, “berry-like” surface.²

Clean, non-granulating tissue



Absence of granulation tissue: wound surface appears smooth as opposed to granular. For example, in a wound that is clean but non-granulating, the wound surface appears smooth and red as opposed to berry-like.²

Slough



Soft moist avascular (devitalized) tissue; may be white, yellow, tan or green; may be loose or firmly adherent.²

Eschar



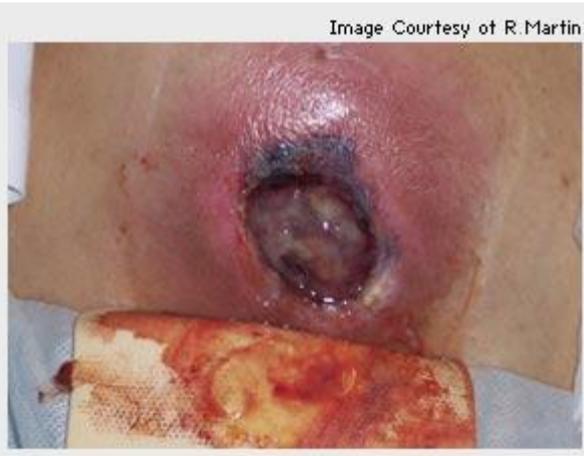
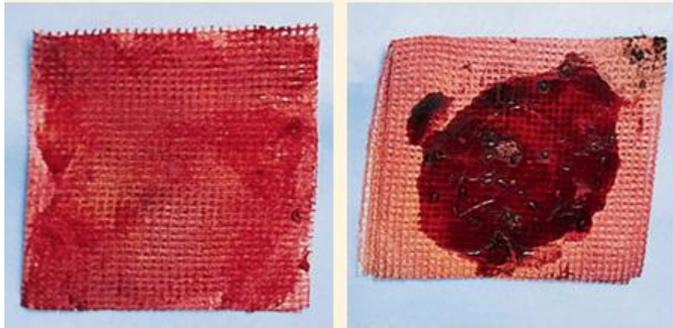
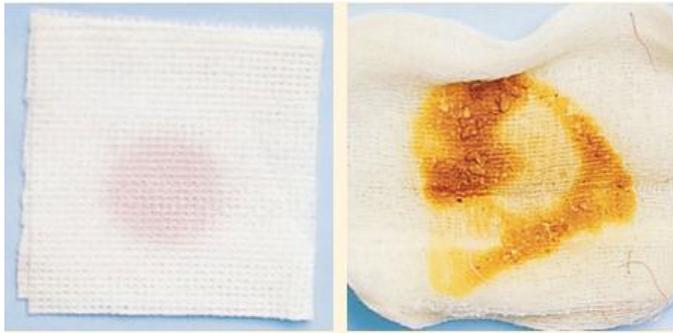
Black or brown necrotic, devitalized tissue; tissue can be loose or firmly adherent, hard, soft, dry or wet.²

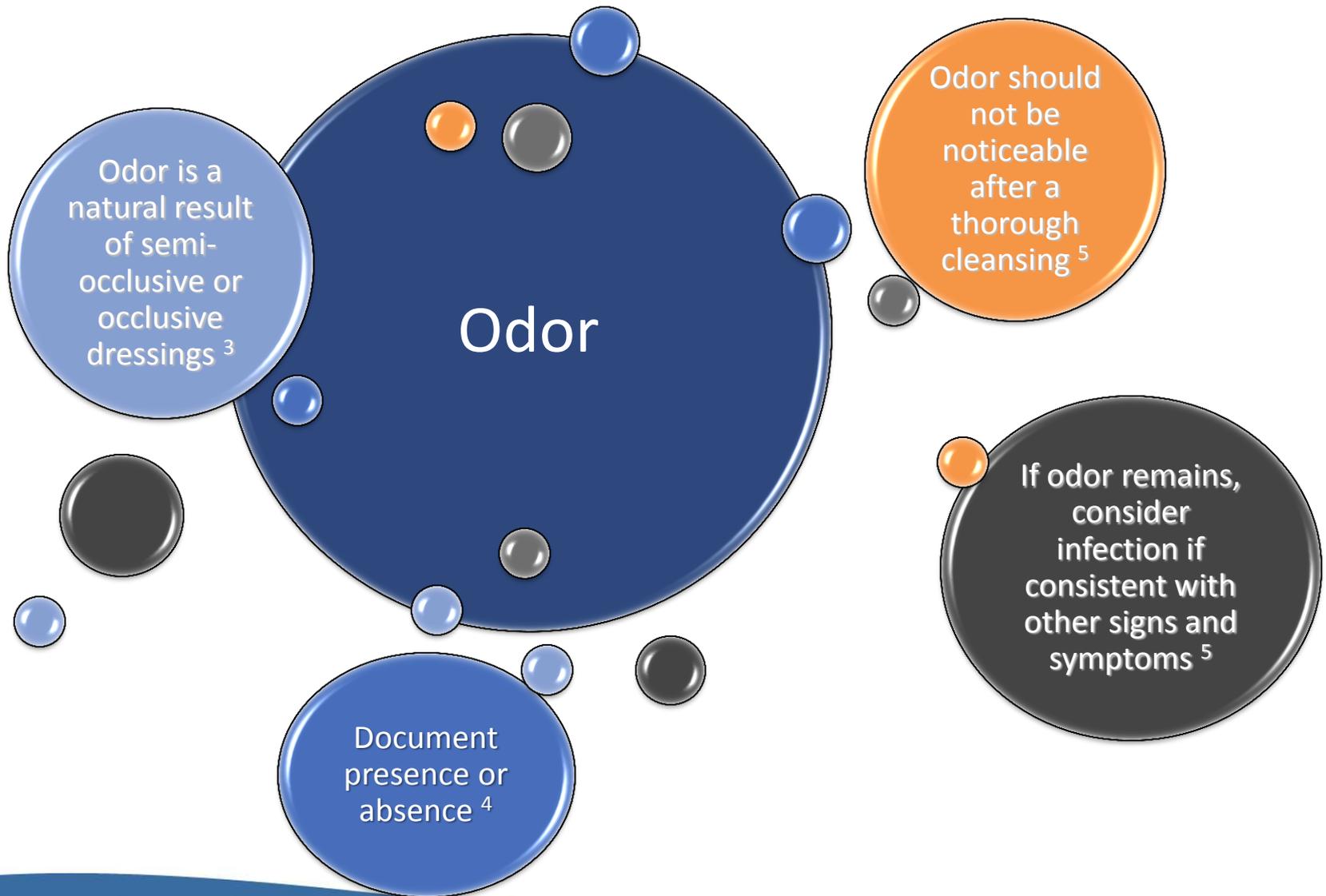
Drainage

Type
Serous
Sanguineous
Serosanguineous
Purulent

Amount
Minimal or none
Light
Moderate
Heavy

Wound drainage





Wound Edges

Healthy



- Flat open epidermis

Epibole



- Rolled under “thickened—soft to firm and flexible to touch”⁴

Hyperkeratotic

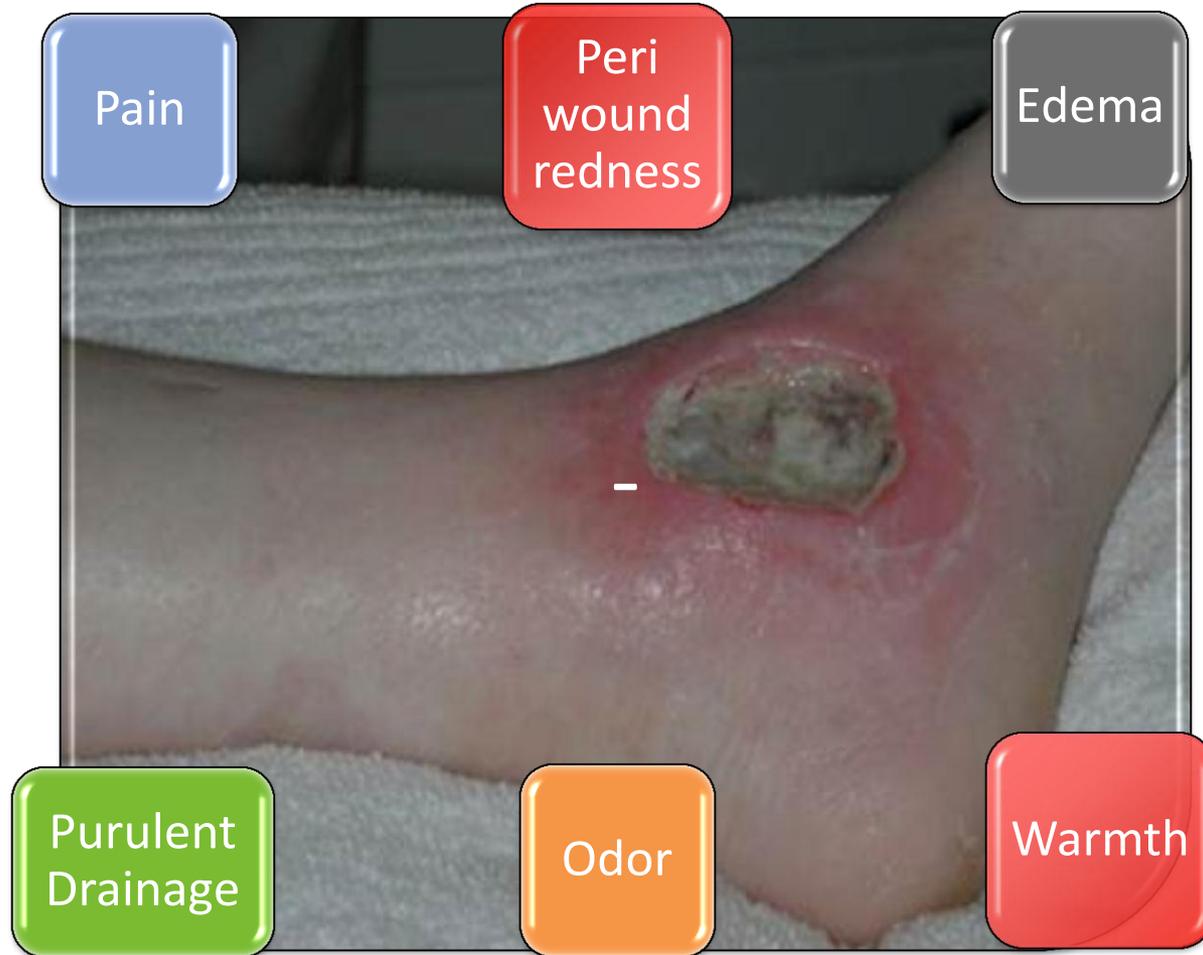


- Well defined, fibrotic, scarred, or – “callus-like tissue formation around wound and at edges”⁴

Surrounding Skin



Signs and Symptoms of Infection



Clinical Signs of Infection

Chronic Wounds – *often subtle*

- New breakdown or slough⁷
- Drainage – change in color and consistency, increase⁷
- Poor granulation tissue – friable,^{7,8} dark red, exuberant, dull, bright red⁷
- Pocketing at base of the wound⁸
- Elevated blood sugar in diabetic patients⁸
- Delayed healing,⁸ non-healing⁷
- Increased size or satellite areas⁷
- Probing to bone⁷
- Undermining⁷



Documentation

Clear

Concise

Accurate

		Weekly Wound Assessment			
Patient Name		Type	Open Surgical		
Room Number			Closed Surgical		
			Arterial		
			Venous		
			Diabetic		
			Pressure Ulcer (PU)		
			Trauma		
			Fistula		
			Skin Tear		
			Rash		
			Other		
			Classification	Partial Thickness	
		Full Thickness			
	Pressure Ulcer Stage (I, II, III, IV)				
		Suspected Deep Tissue Injury			
		Unable to Stage-Eschar			
	Dimensions (cm)	Length			
		Width			
		Depth			
		Tract /Tunneling (cm@_o'clock)			
Week					
Cleansed with					
Coated with					
Loosely filled with					
Covered with					
Secured with					
Debridement type					
Compression via					
Support Surface					
Address Risk Factors for Delayed Healing		Wound Base	%Granular/Red		
			% Clean non Granular		
			% Slough/Yellow		
			% Eschar/Black/Brown		
			Other		
		Exudate	Dry, minimal		
			Moist, lightly		
			Moist, moderately		
			Wet, heavily		
		Type of Exudate	Serous		
			Serosanguinous		
			Sanguinous		
			Purulent		
			Odor absent		
			Odor present		
		Surrounding Skin	Healthy		
			Epithelialization		
			Reddened/flushed		
			Erythema		
			Hypopigmentation		
			Maceration		
			Nonblanchable erythema		
			Dermatitis		
			Incrustation		
			Edema		
			Heat/warmth		
			Other		
		Wound edges	Healthy/Indistinct		
			Healthy/Attached		
			Unhealthy/Not attached		
			Rolled under		
			Hyperperforative		
		Pain	No pain reported		
			Pain reported (1-10-point scale)		
		Infection	No signs & symptoms		
			Signs & symptoms present		
RN	Date	RN	Date	RN	Date

Wound Assessment Documentation



Evaluate
Healing



Documentation is
important



Evaluate Plan
of Care



Communication



Reimbursement

ASSESSING THE WHOLE PATIENT

Conditions which may affect healing

Health and
wound
history

Environment

Nutrition/
Hydration

Oxygenation

Medication

Psychosocial
concerns

Financial

Caregiver
support

(Cooper, 2000)

References

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