Wound Assessment and Documentation

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Objectives

- Identify the initial steps for assessment
- Identify appropriate terminology
- Become familiar with a few characteristics of some wounds

Steps of Assessment

- Identify the location of the wound
- Determine Cause (etiology) of wound
- Determine stage (if applicable) of the wound
  - Pressure injury staging
- Evaluate and measure depth, length, width of wound
- Measure amount of undermining and tunneling
- Evaluate wound bed
- Assess exudate
- Assess Periwound
- Assess margins
- Assess signs and symptoms of infection
- Assess Pain

Additional Assessment Priorities

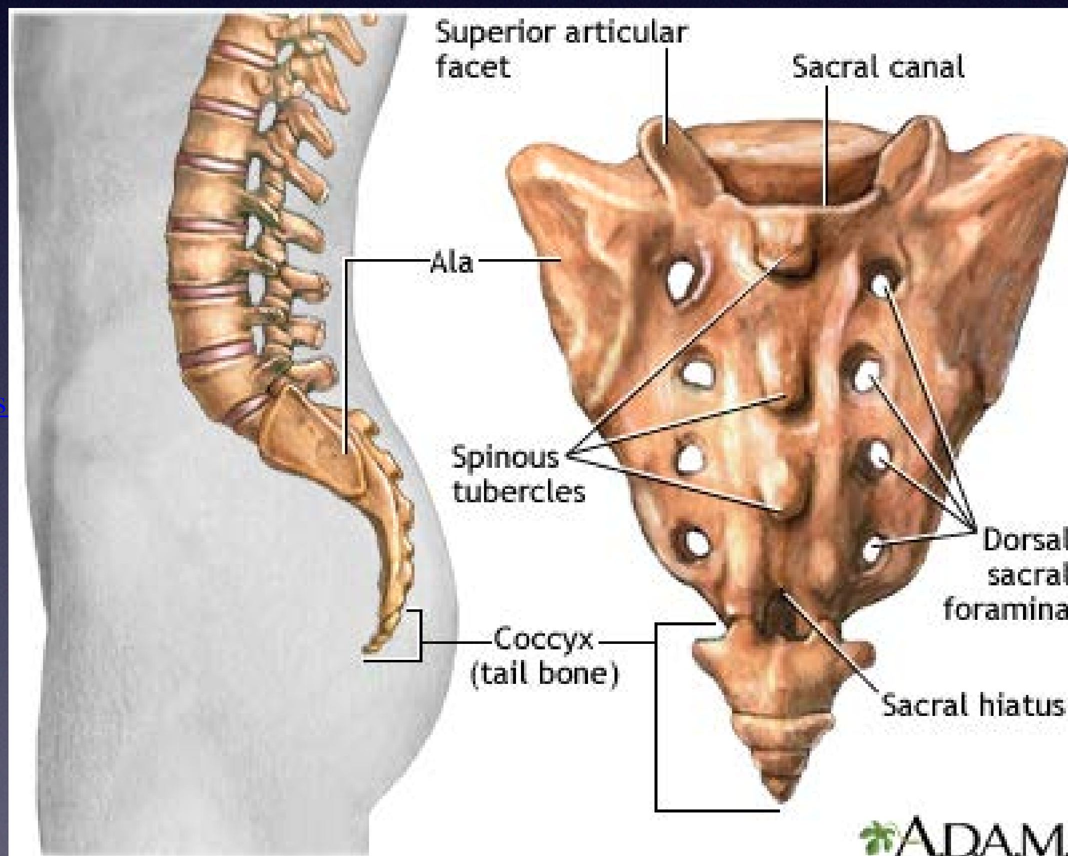
- Nutrition
- Medication
- Immobility

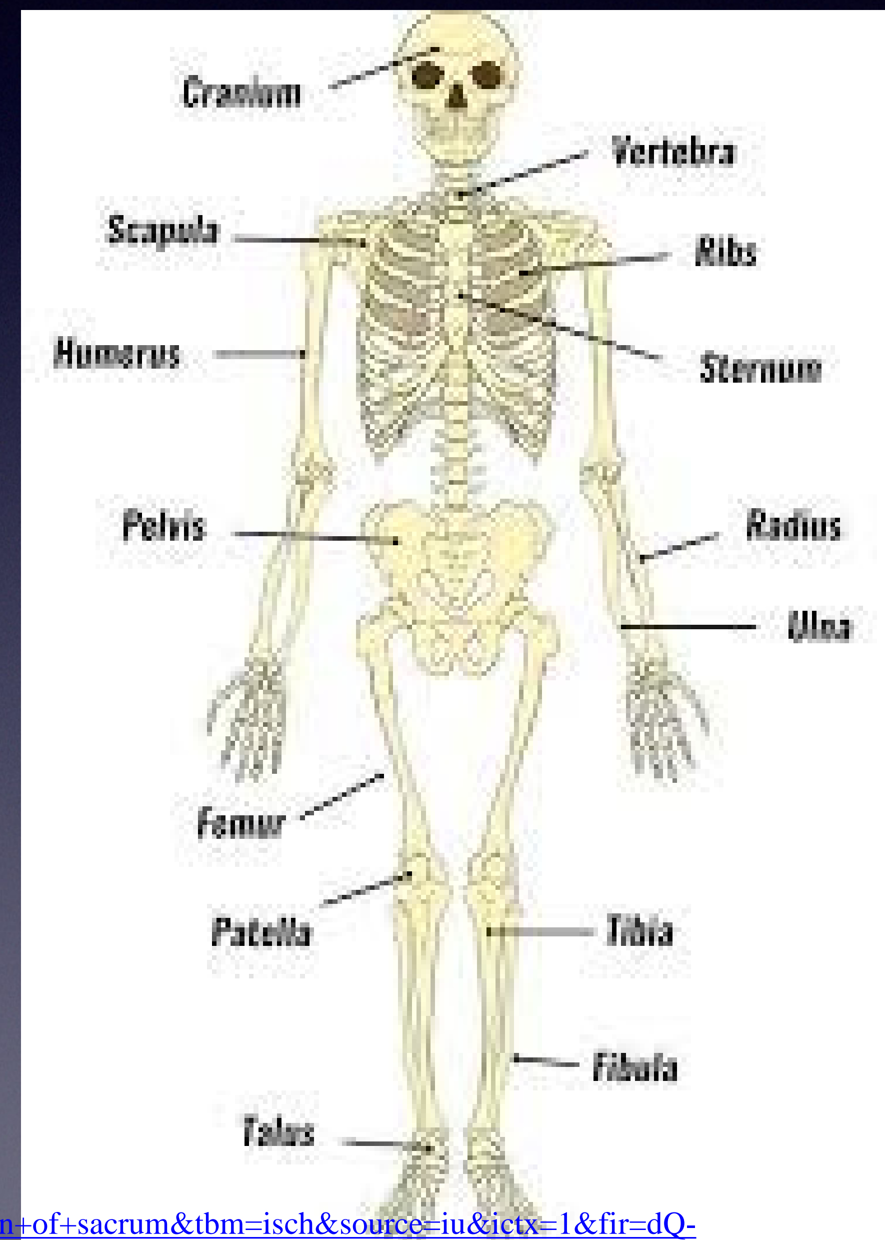
Location Assessment and Documentation

- Direction
  - Superior-Higher
  - Inferior- Lower
  - Anterior - Toward the front
  - Posterior - Toward the rear
  - Dorsal - Toward the back of the torso
  - Palmar - Palm
  - Plantar - bottom of foot
  - Left and right - absolute
  - Medial and lateral
  - Proximal and Distal

Location Assessment and Documentation

https





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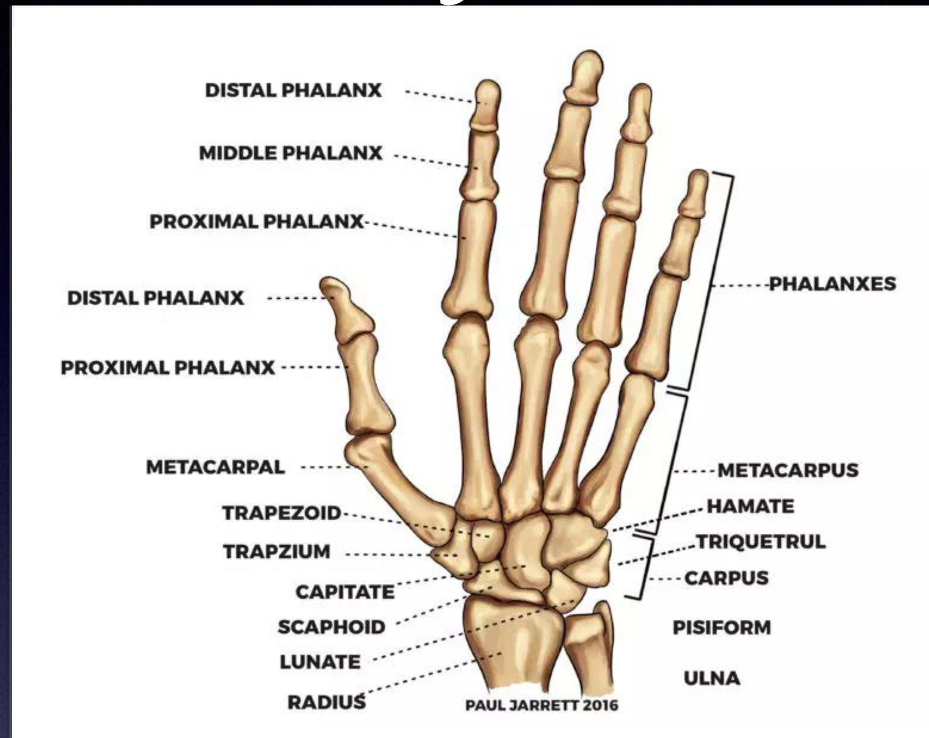
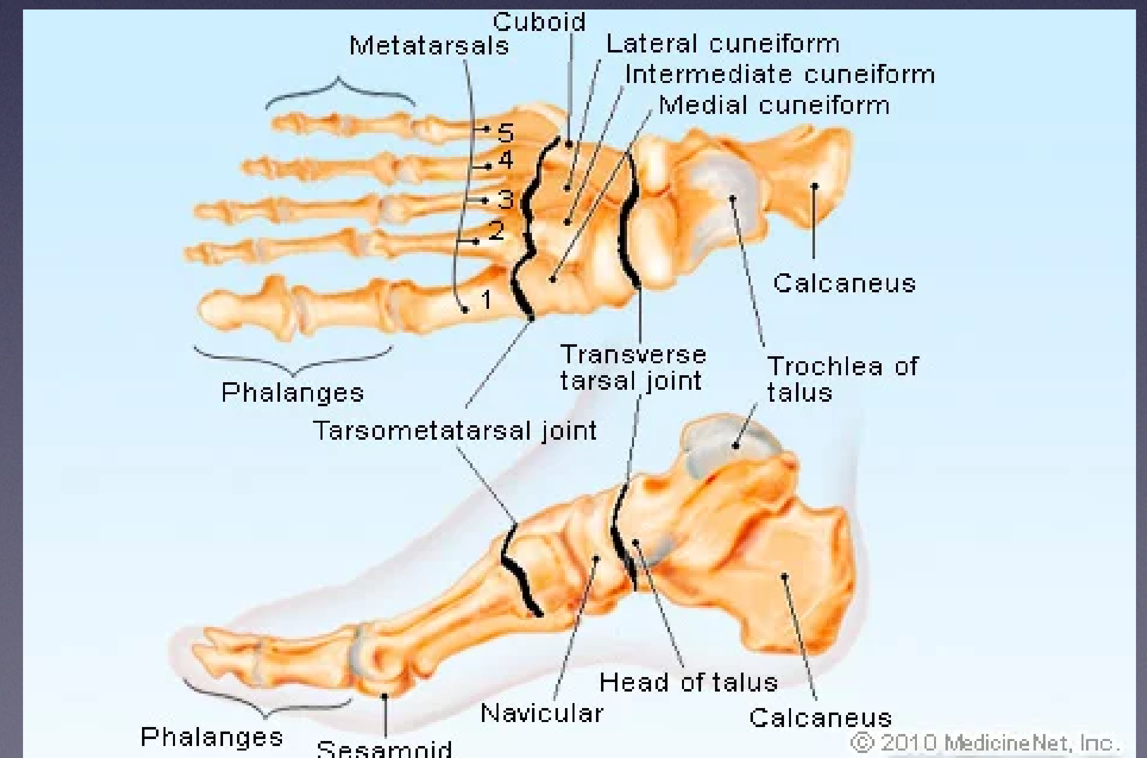
Anatomy of Hands and Feet





Causes (etiology) of the Wound

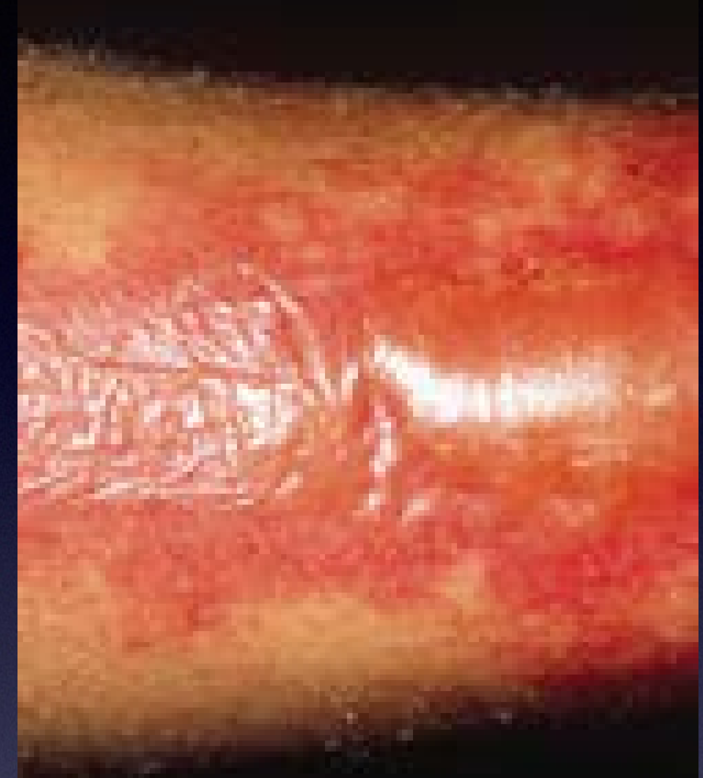
- Each type of wound has a different etiology
- Treatment may or may not be different
- Etiology may not be clear cut
- Some may have multiple etiologies

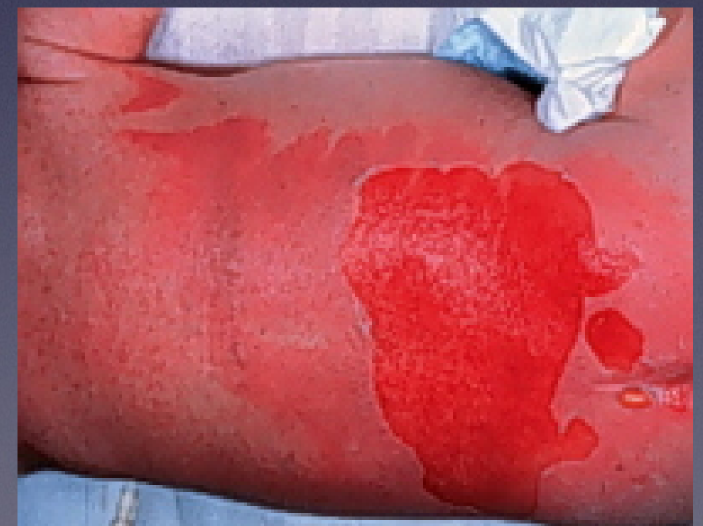
A Few Types of Wounds

- Vascular (arterial, venous, and mixed)
- Neuropathic (diabetic, rheumatic)
- Skin Tear (Friction, Shear)
- Pressure (now labeled as Injury)

Partial Thickness

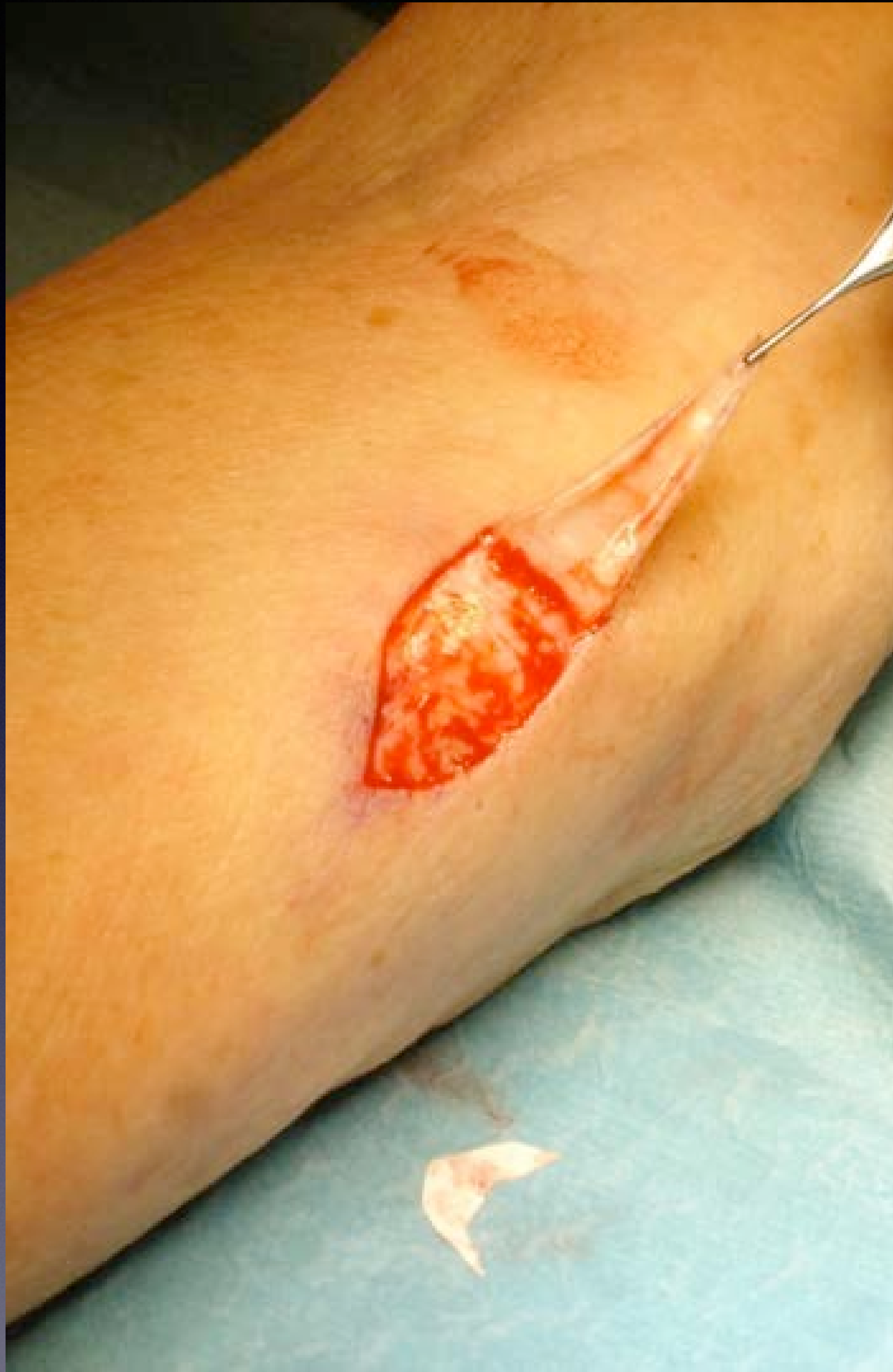
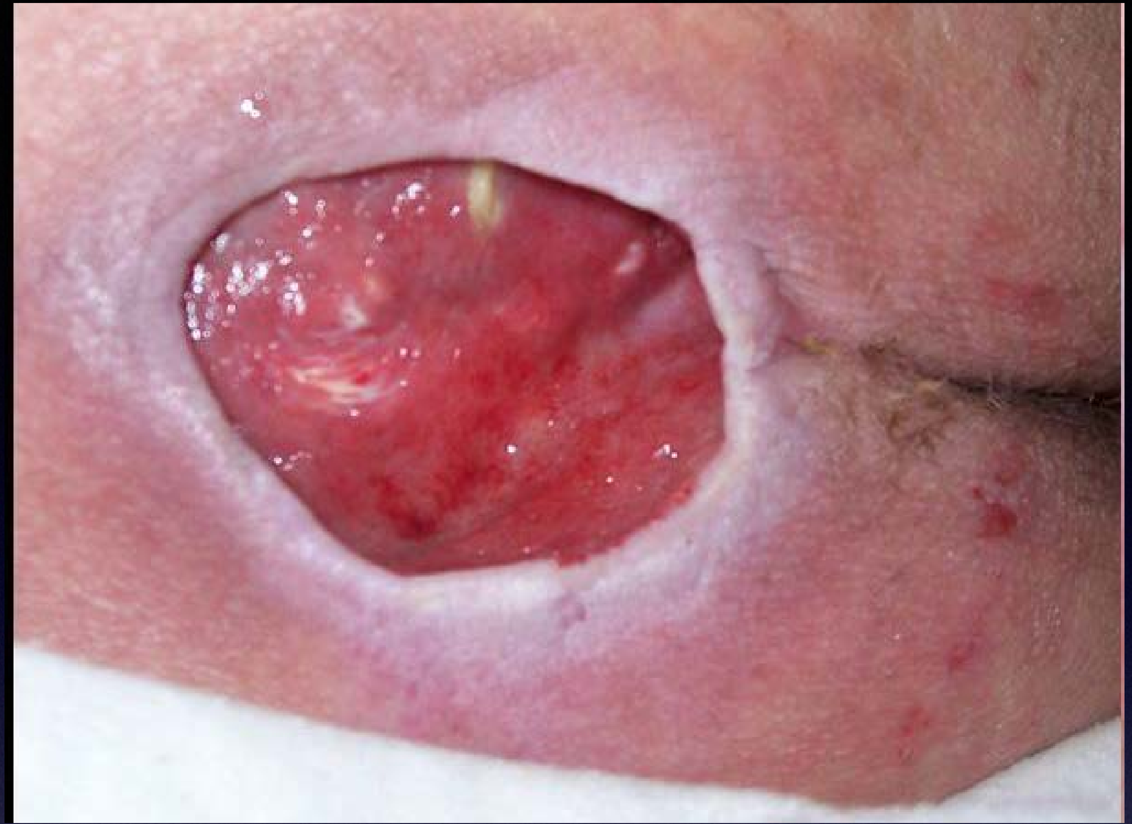
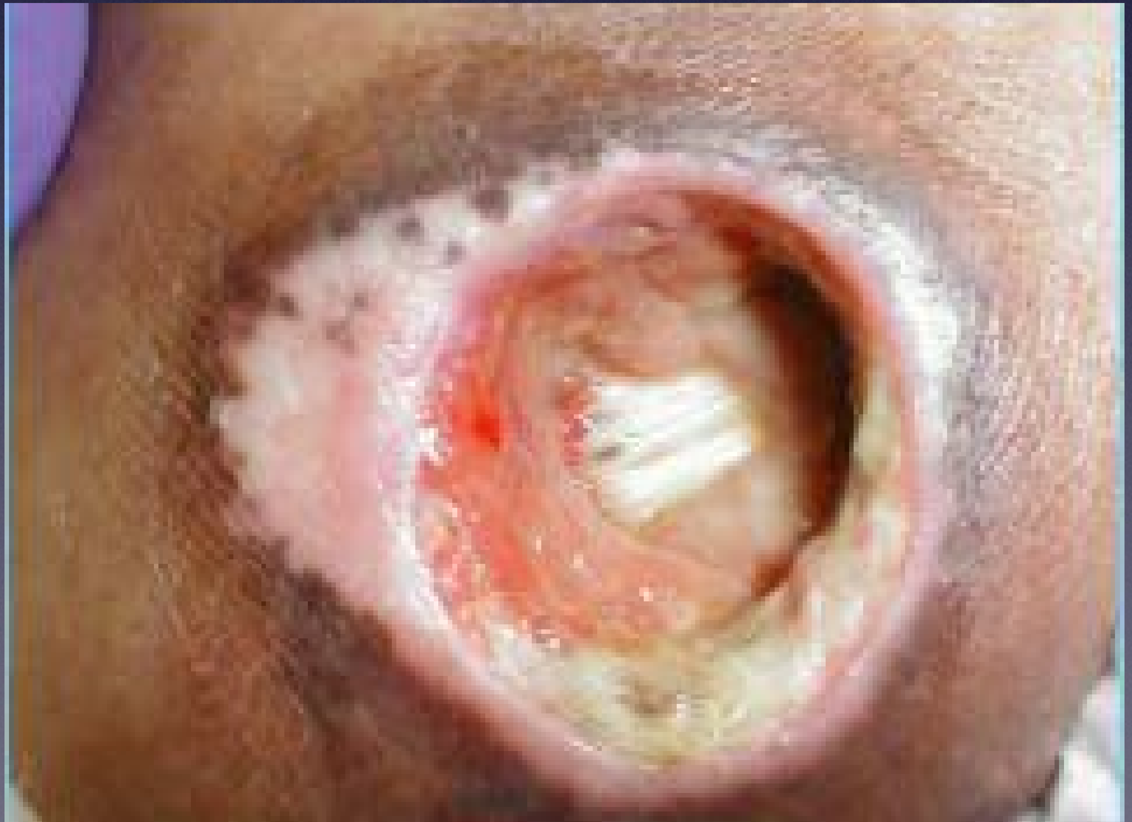
- Loss of epidermis into dermis
  - Abrasions
  - Skin Tears
  - Blisters
  - Skin graft donor sites
    - Split thickness





Full Thickness

- Through Dermis
- Extends down to
    - Subcutaneous tissue
    - Or muscle
    - Or connective tissue (tendon)
    - Or bone

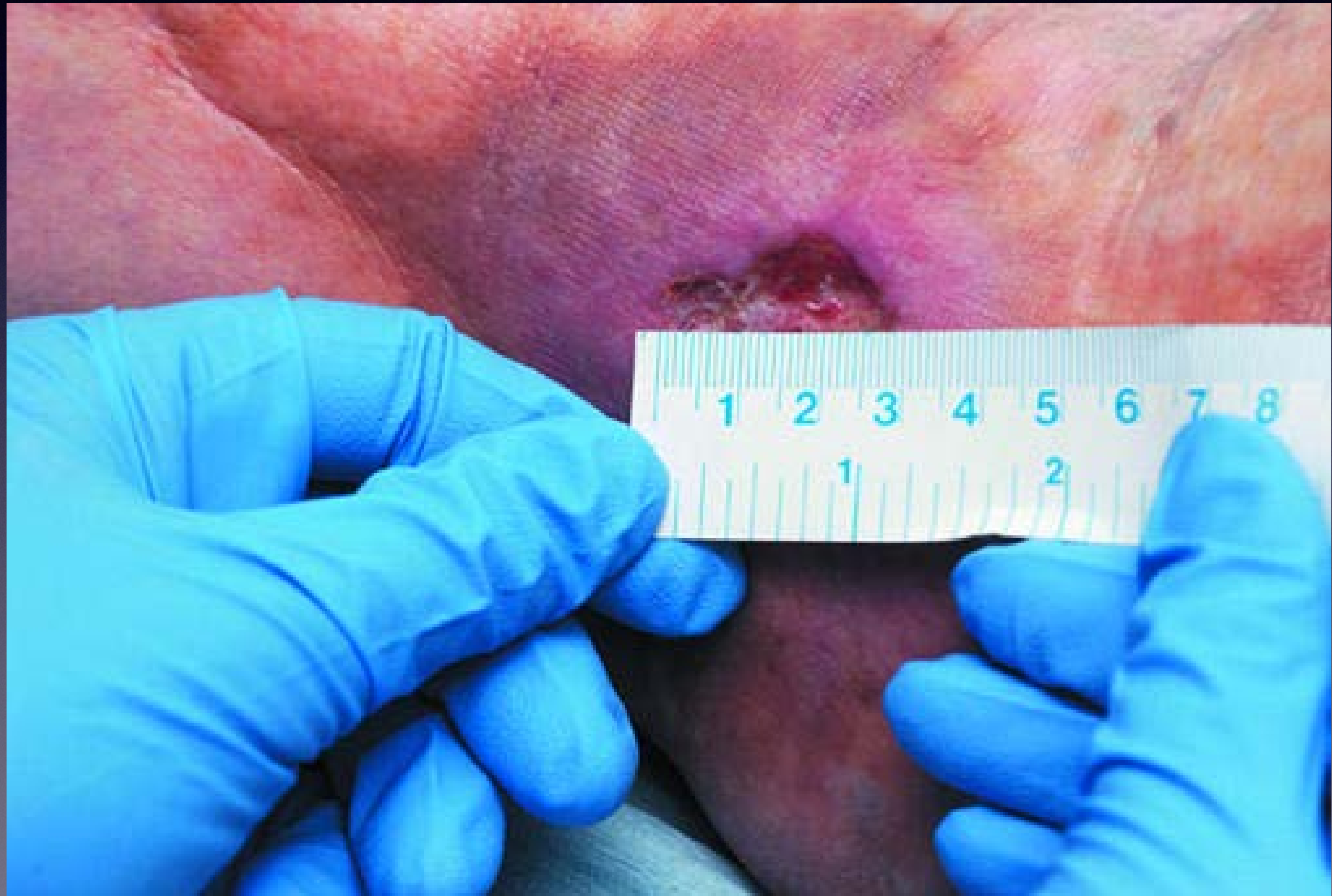
Evaluate and Measure Wound

- Know Assessment Terms
  - Eschar - Cornified or dried out dead tissue
  - Slough - Liquified or wet dead tissue
  - Undermining - extension of the wound bed under the wound edge
  - Tunneling - Tracts extending out from the wound bed

Wound Dimensions

- Length x width x depth
- Measured in centimeters
- In the past
  - Length was measured head to toe
  - Width was measured left to right
- Now
  - Longest is length
  - Shortest is width

Measurement



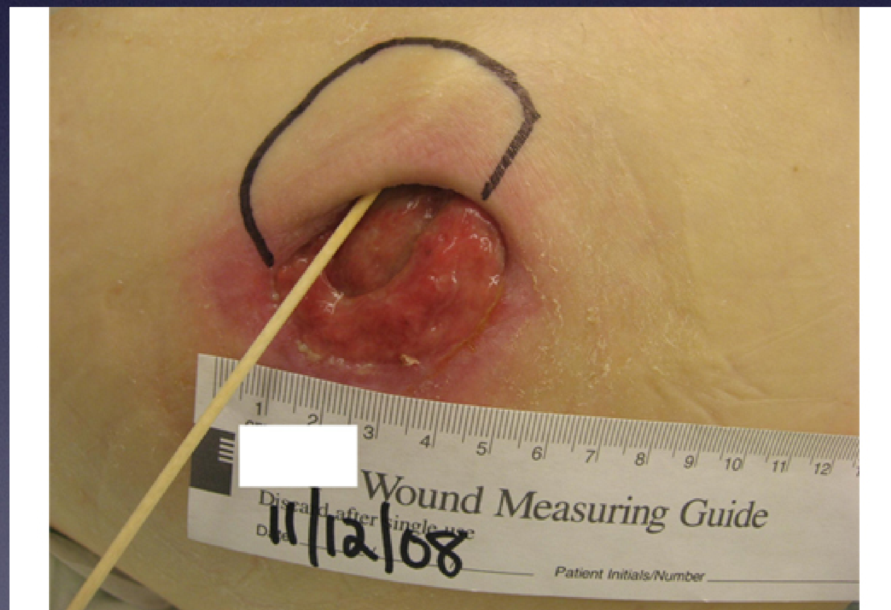
Depth

- Use Cotton Swab
- Tip should be perpendicular to base and measure up to where hour finger touches the edge of the ulcer

Undermining

- Usually caused by shear forces
  - Often quarter moon shaped, but can totally surround wound edge
  - Use a sterile cotton tip applicator
  - Documentation example “undermining 0.3cm from 12:00 to 4:00”

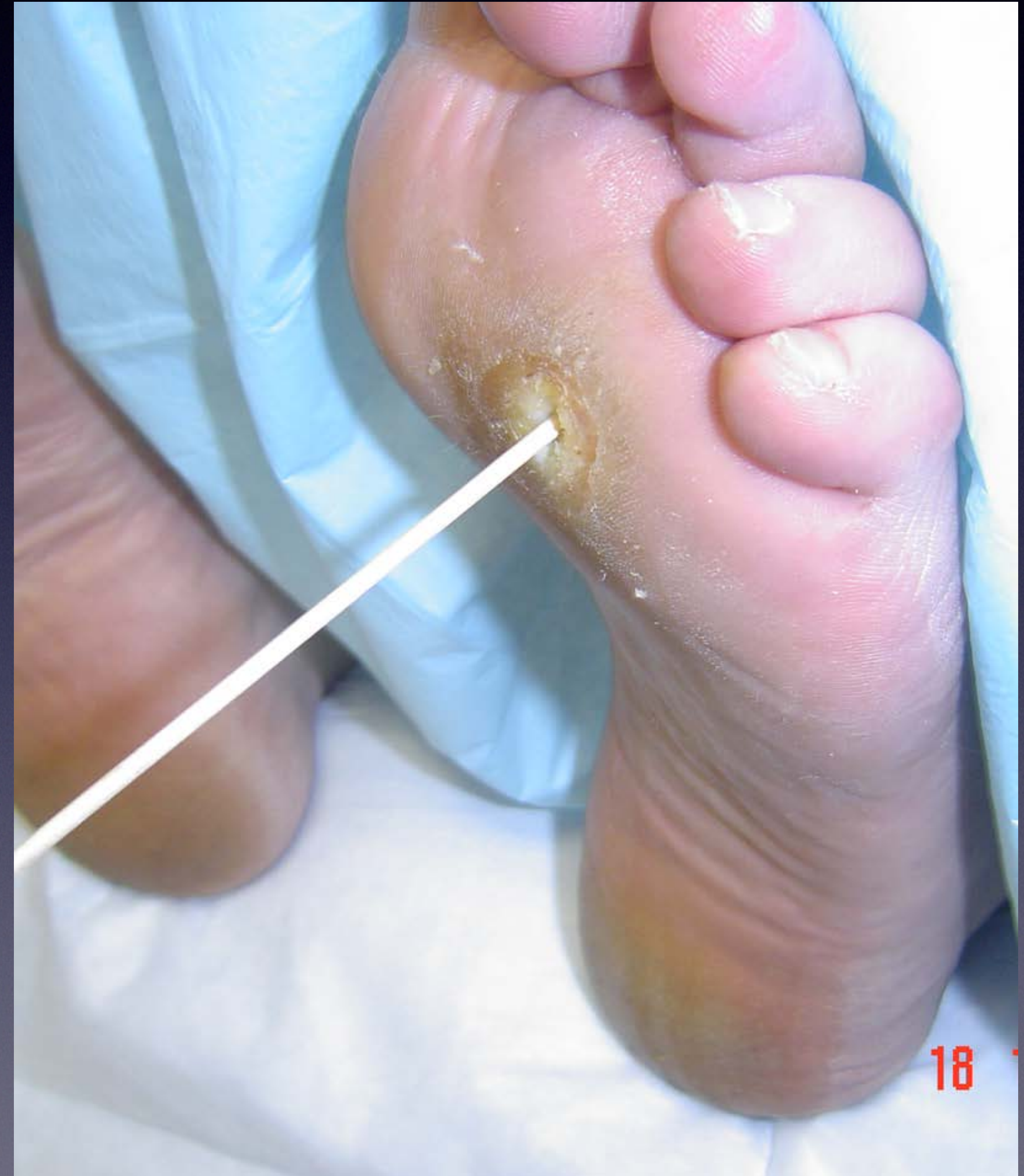
Undermining-tissue loss parallel to skin surface edges



Tunneling

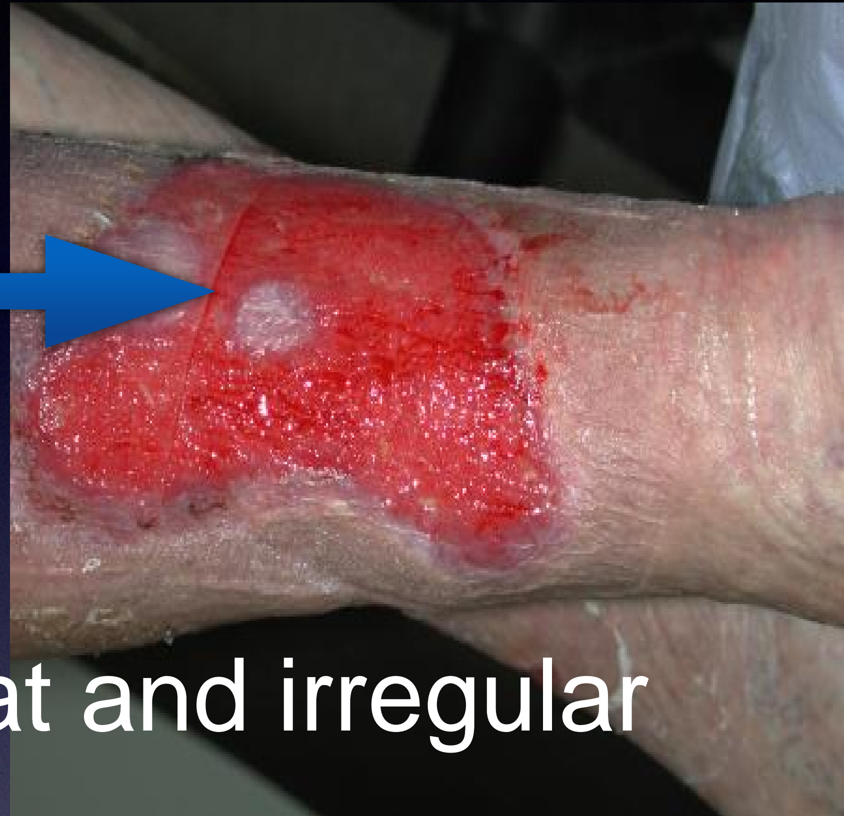
- Can occur in any part of the ulcer bed or edge

- Use cotton-tip applicator
- Note the location using the clock method - “tunneling is present at 4:00, 8 cm depth and 0.2 cm from wound margin



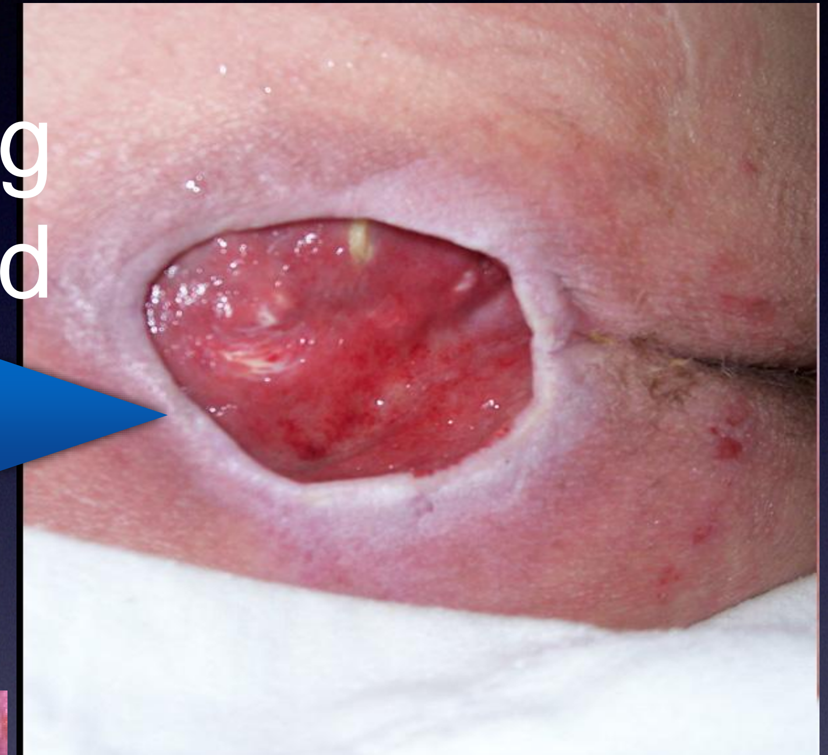
Tunneling

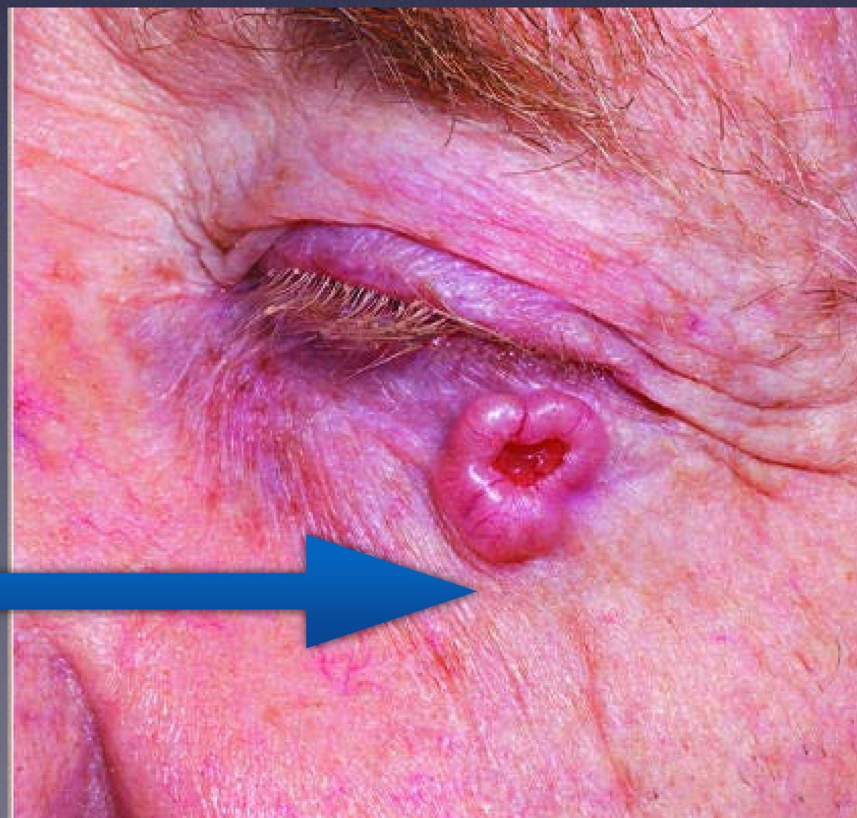
Wound Edges



Flat and irregular

Undermining
& macerated





Suspicious

Wound Edges Characteristics

Edges	Type of wound/ulcer
Sloping	Venous
Punched out	Arterial or vasculitic
Rolled	Basal Cell Carcinoma
Everted	Squamous cell carcinoma
Purple	Vasculitic
Undermining	Tuberculosis, syphilis, pressure

Wound Edges

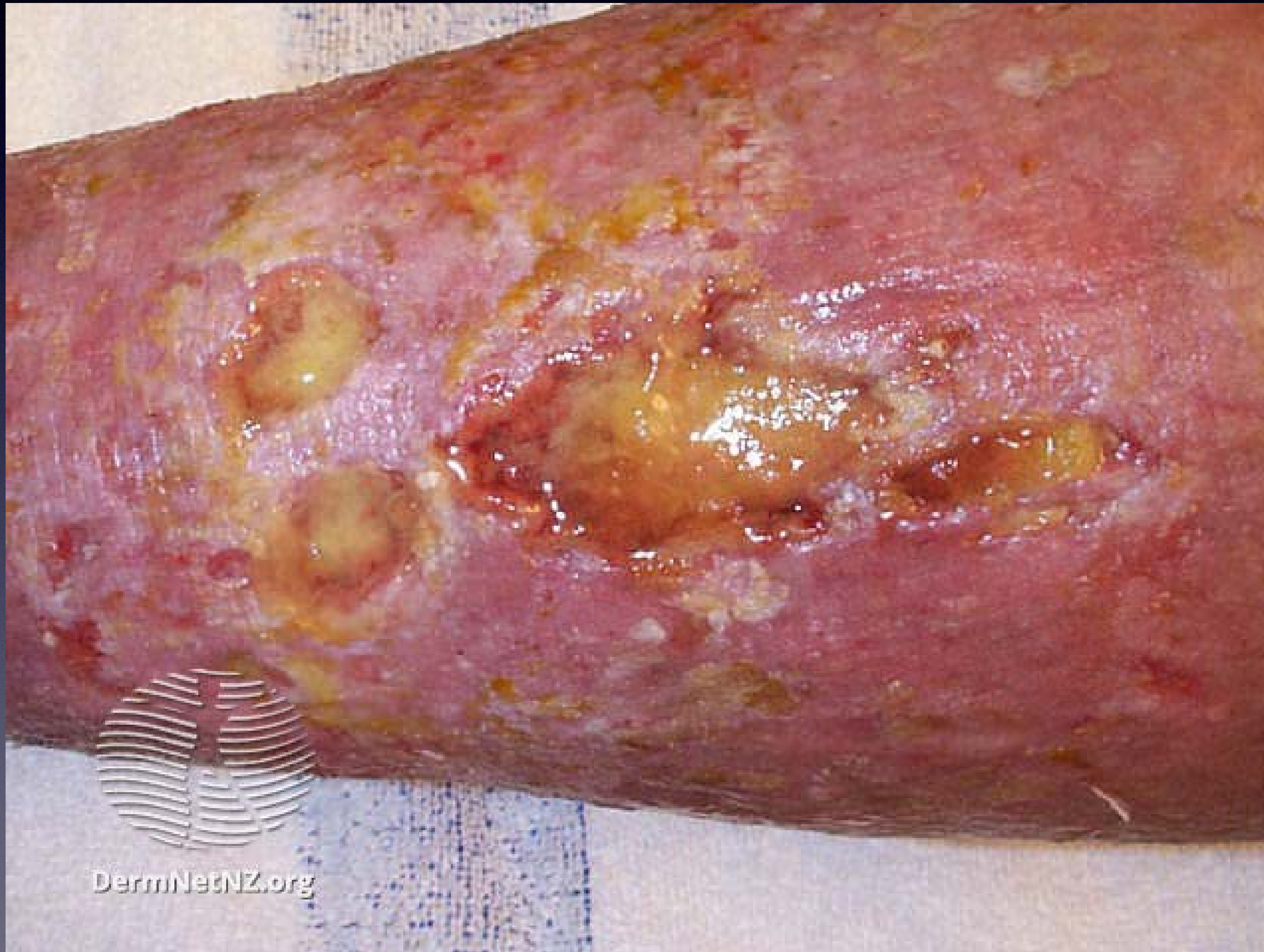
- Is there a potential for healing
- Viable edge for migration of epithelial tissue
- Need for further debridement

Peri-wound

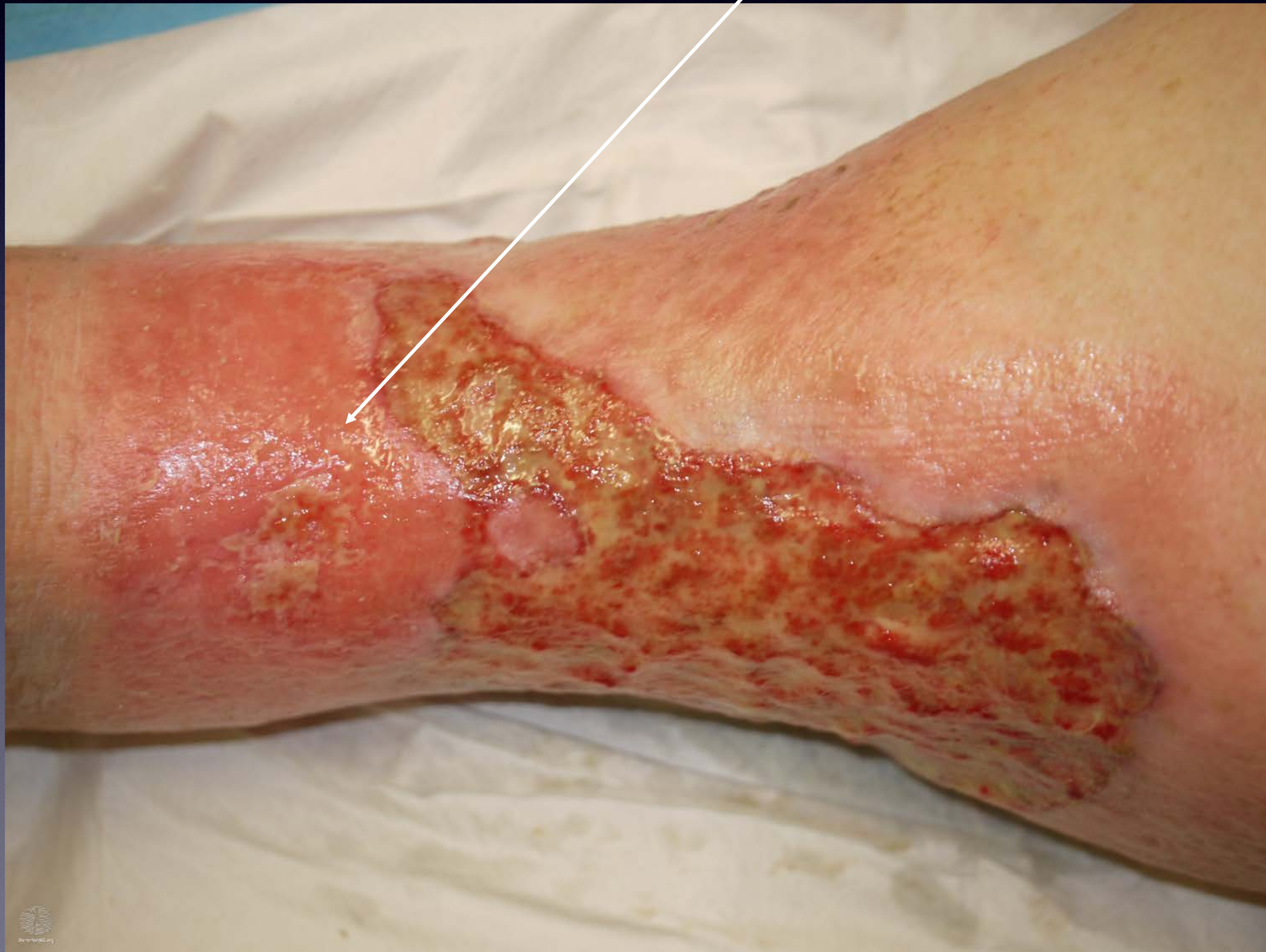
- Normal
- Macerated (as when in the pool for an extended period of time or soaking)
- Temperature
- Callus
- Dry
- Peeling
- Indurated (raised)
- Others

Maceration

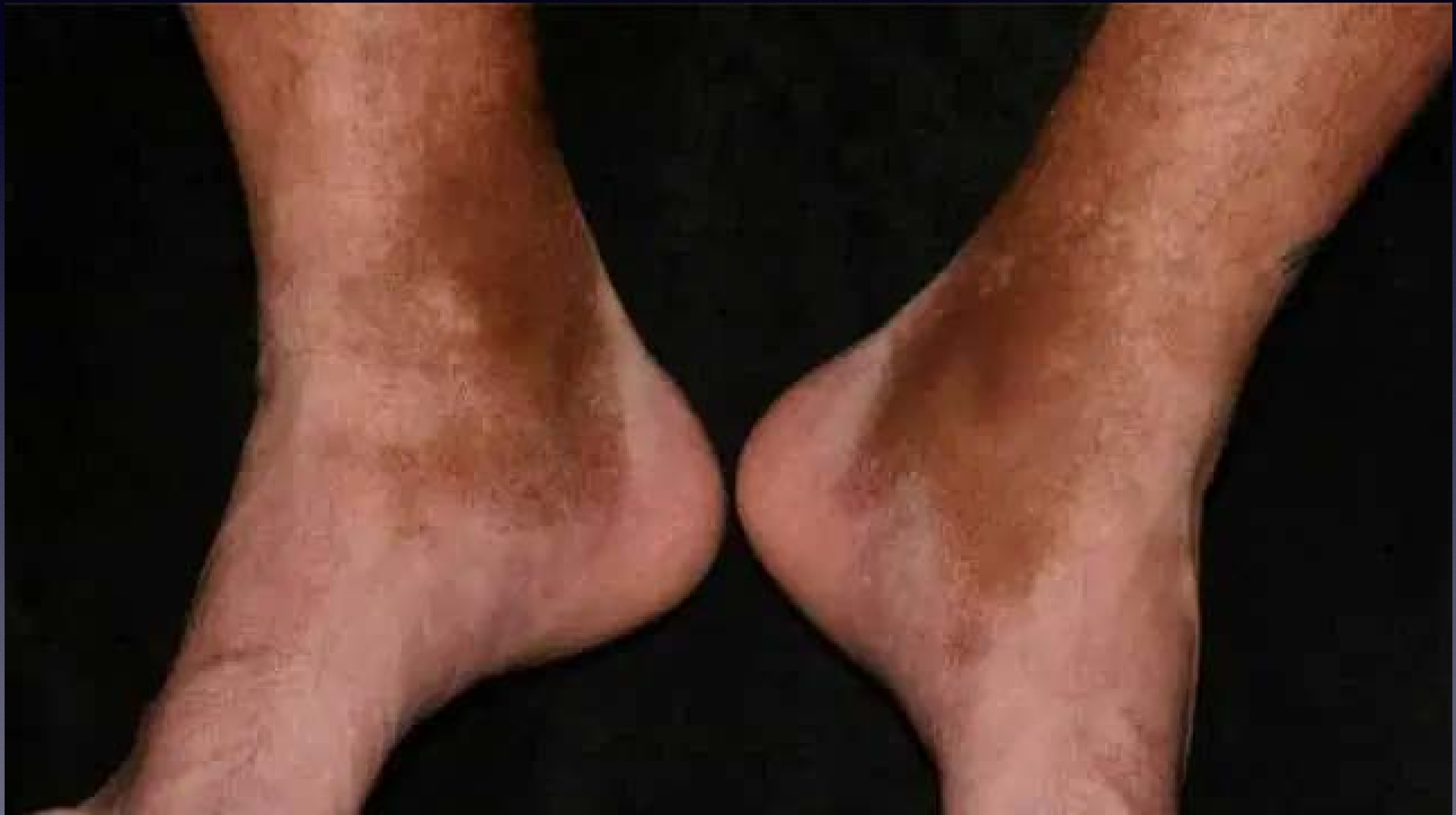
Erythema/Inflammation

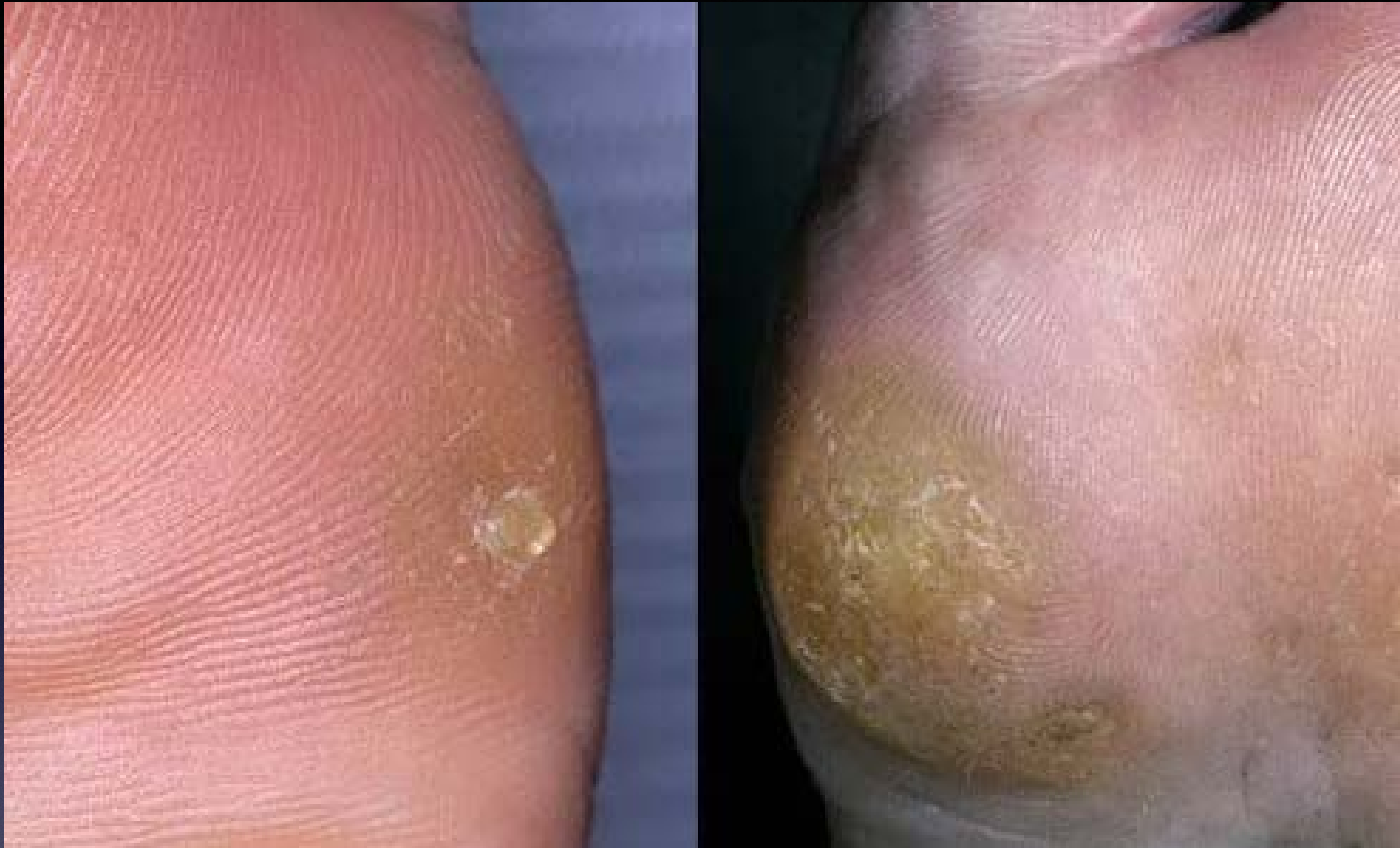


Weeping



Hemosiderin





Callus

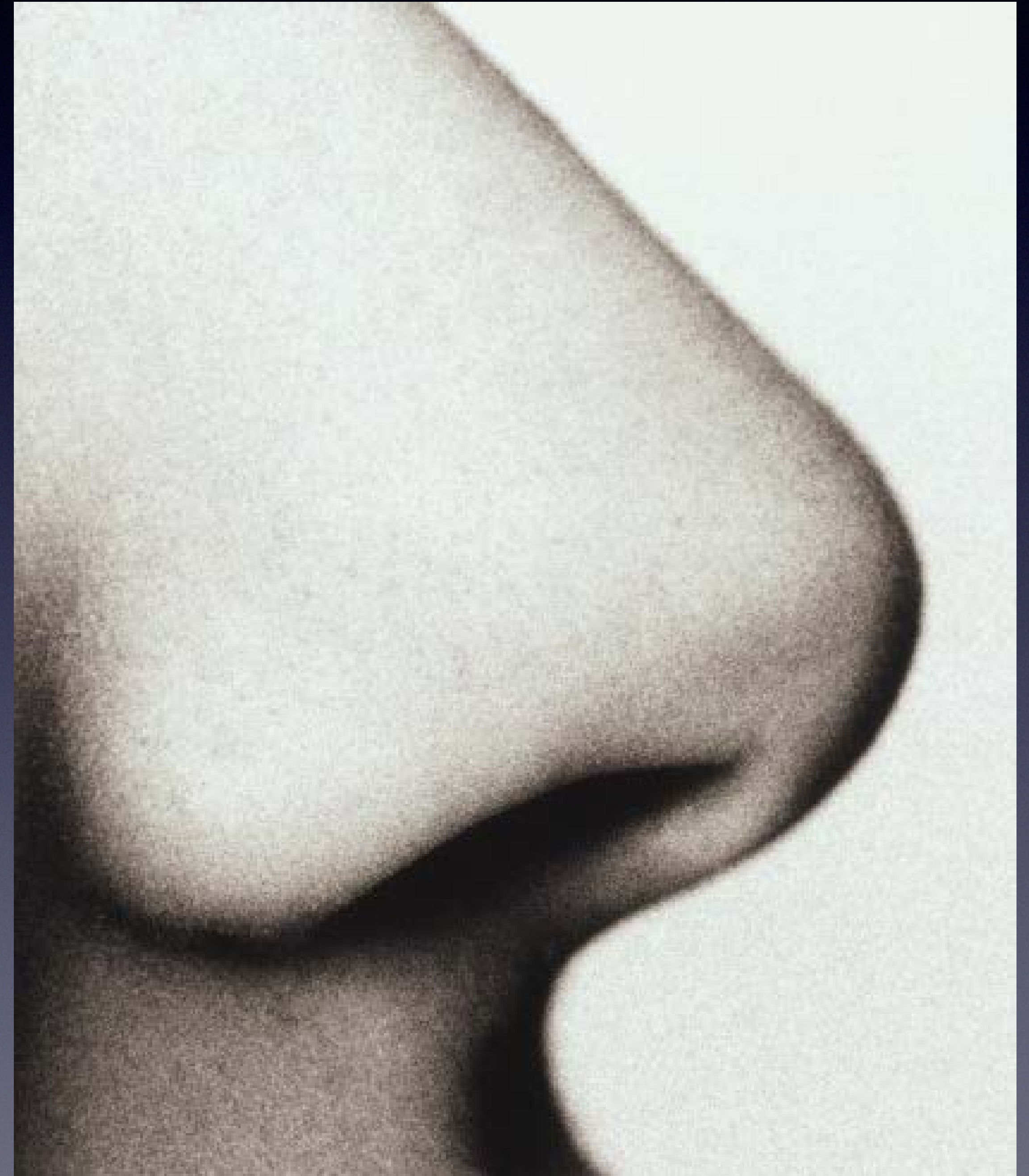
Exudate

- None
- Scant/minimal
- Moderate
- Large
- Copious
- When was the last dressing change?

- Green
- Yellow
- Blue-green
- Gray
- Red
- Tan
- Serous
- Serosanquinous
- Purulent
- Opaque
- Clear
- Cloudy
- Liquefying necrotic tissue

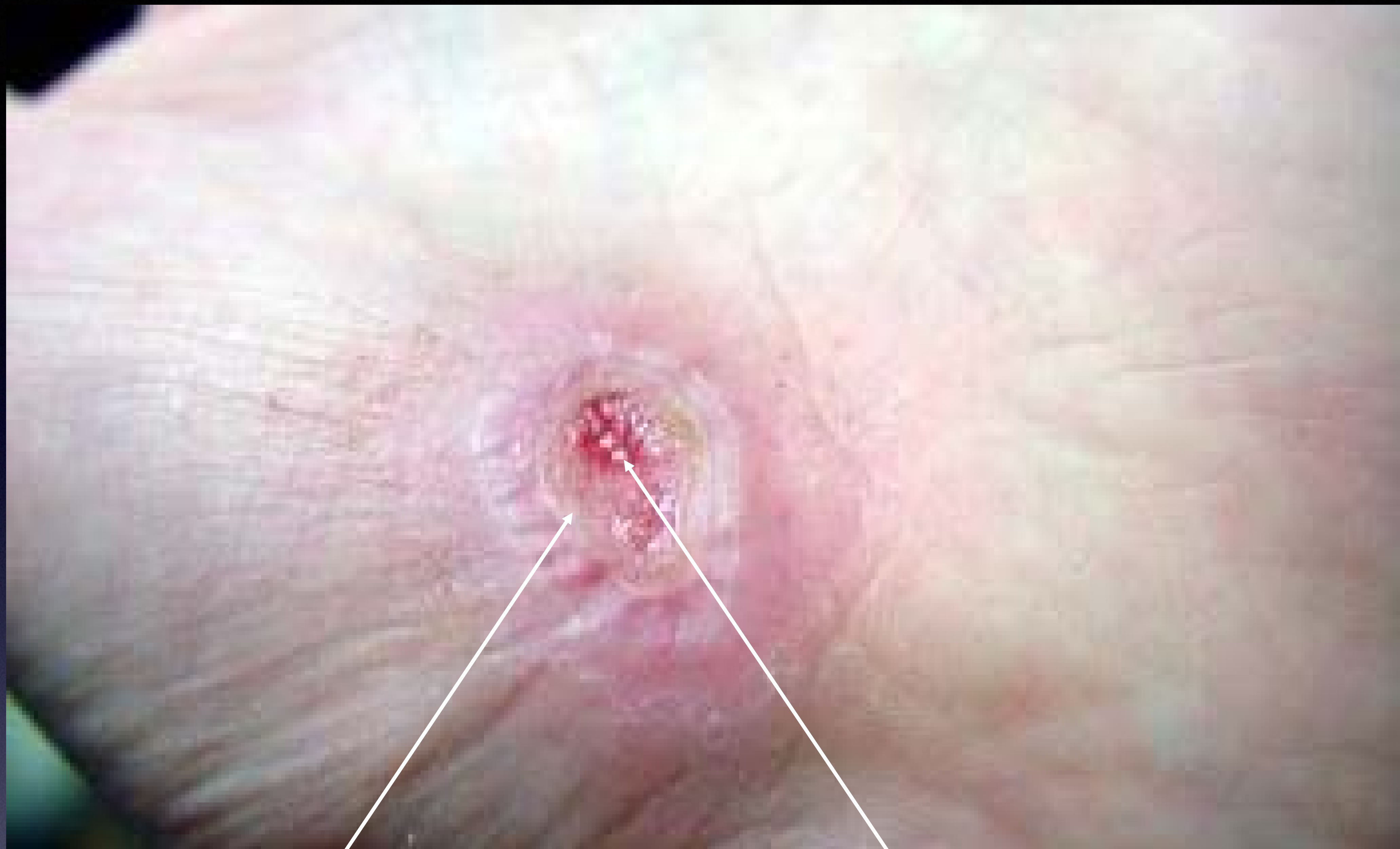
Odor

- Present
- Absent
- Increasing growth of bacteria
- Increase frequency of dressing changes
- Affects quality of life
- Fruity (suggest Staph)
- Foul (possible gram negative)



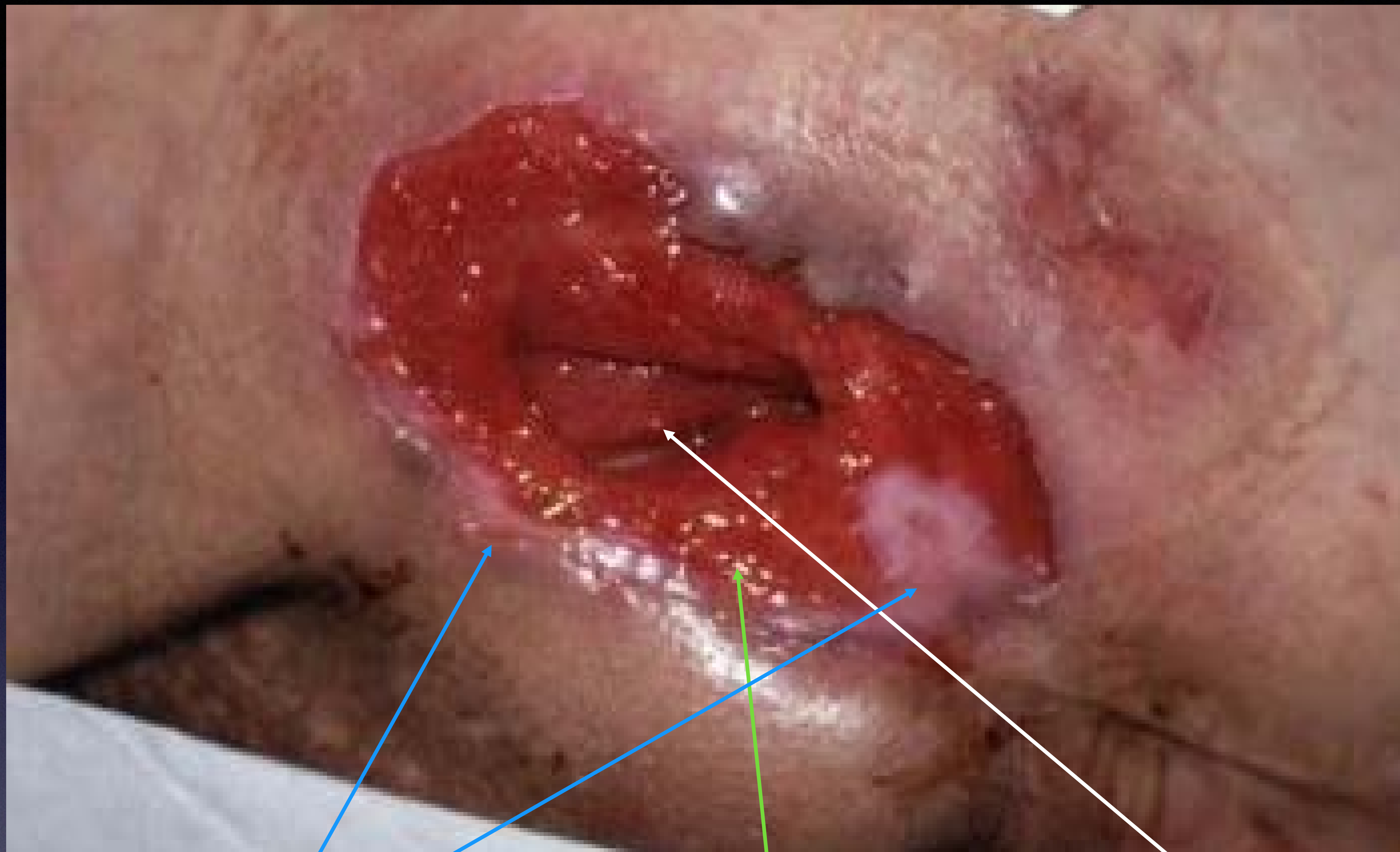
Wound Bed

- Granulating
- Red tissue
- Dusky tissue
- Epithelial
- Hypergranulation
- Dry



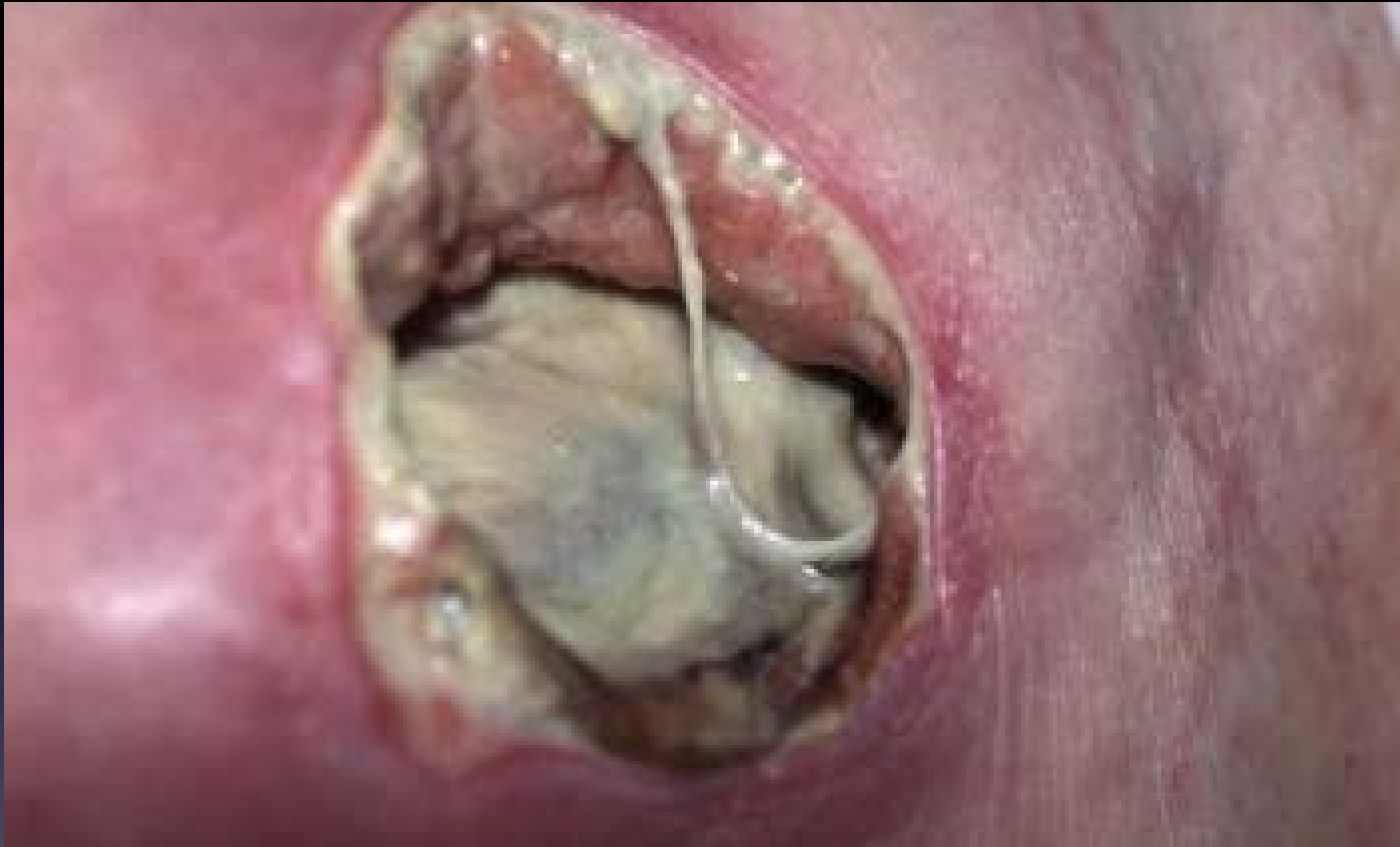
Epithelial and granulation

Document % of each (example; 30% granulation and 70% epithelial tissue)



Epithelial/granulation/red

Example 20% epithelial, 60% granulation; 20% red tissue



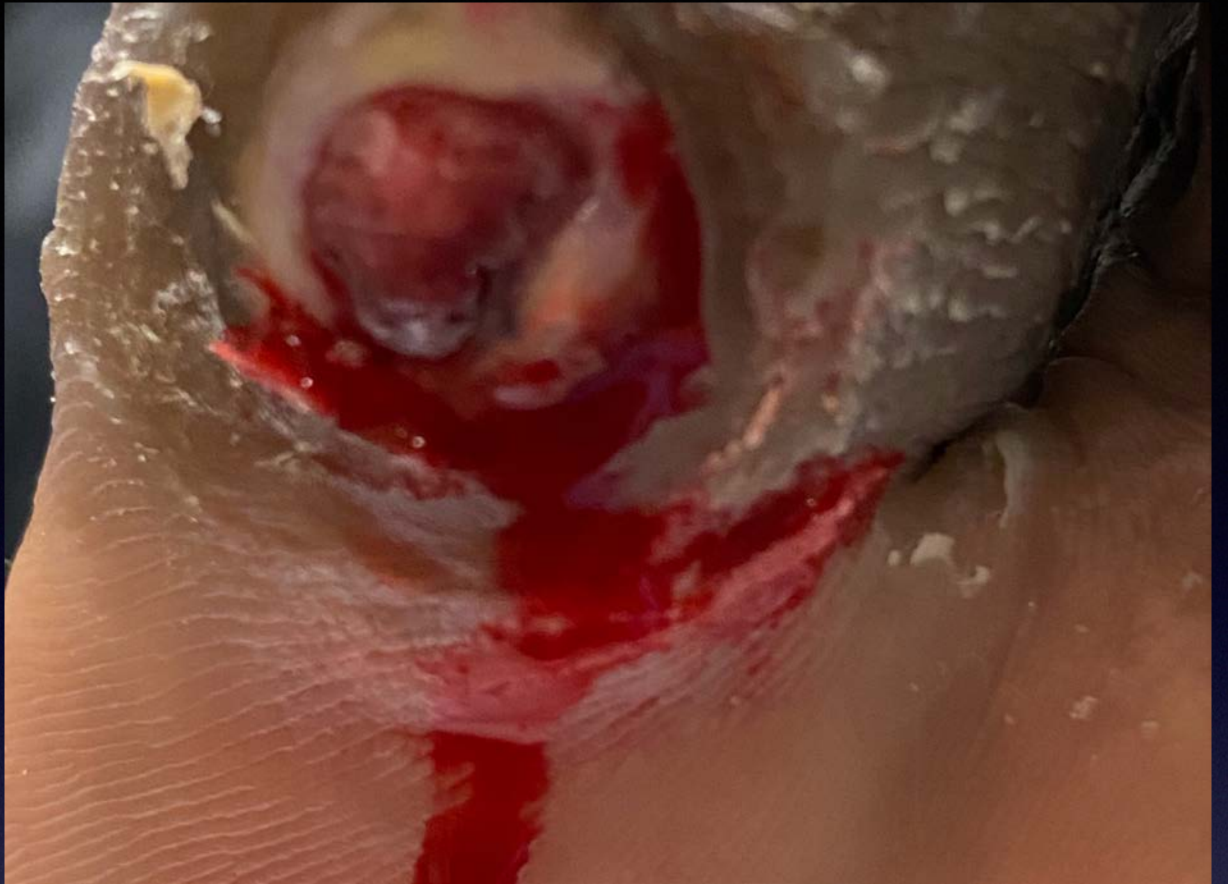
Eschar/unstable

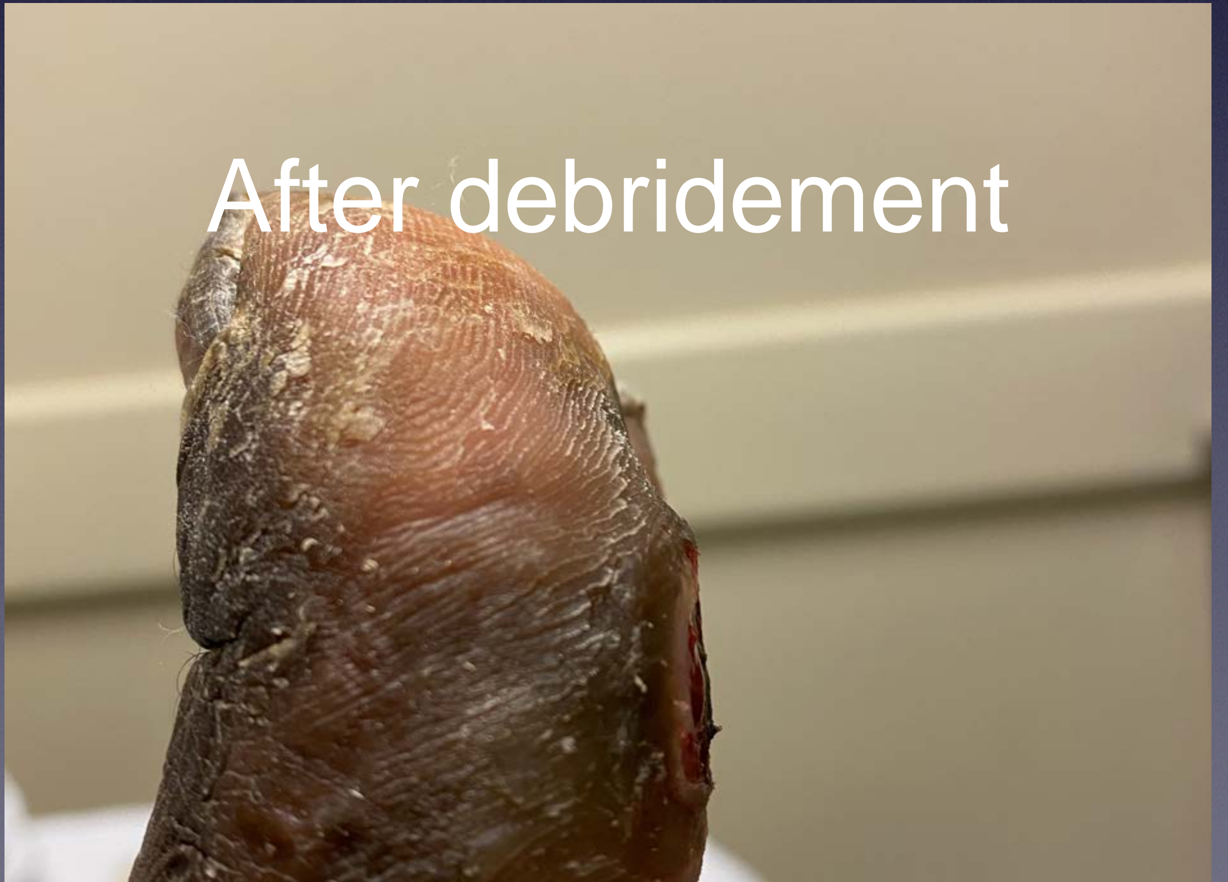
Eschar/stable

Slough

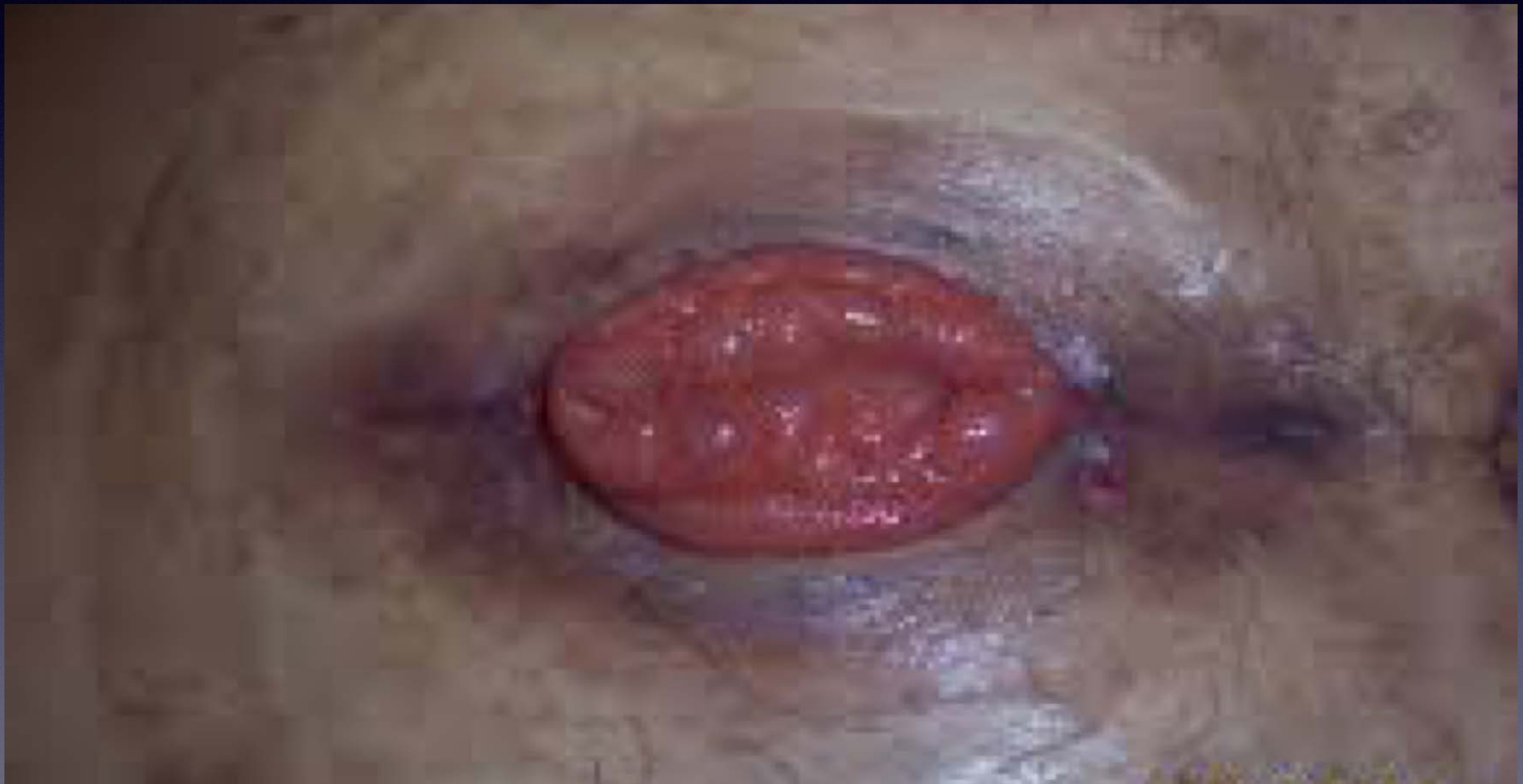
Fibrin

Hypergranulation





Hypergranulation



Write a documentation for this ulcer; #1 image