Wound Care Assessment in the Home Care Setting

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Objectives
- Describe essential elements of a wound assessment
- Understand the importance of “Best Practice Guidelines” in wound care
- Identify how to creatively teach your staff wound assessment
- Identify how to best utilize a WOCN in the home care setting

Why is assessment important?
- Identify etiology and contribution factors
- Aids in accuracy of MOO questions
- Prevent inconsistencies in documentation
- Development of a management plan
Factors to consider
- Skin and wound assessment
- Etiology of skin damage—pressure, poor perfusion, neuropathy
- Comorbid Conditions
- Nutritional/Hydration Status
- Mobility
- Age
- Medications
- Psychosocial Factors

Wound Assessment Essentials
- Location
- Wound dimension—Size & depth
- Characteristics of wound base
- Dead space
- Drainage (exudate) & Odor
- Wound Edges
- Condition of periwound skin
- Infection
- Pain
- Wound Etiology

Location
- Correct identification of anatomic location is critical
- Sacral/coccygeal, and Ischial tuberosity, trochanter, heel, Right and left, etc
Wound dimensions

- Measurement
  - SOC then at least weekly thereafter
  - After wound is cleansed
  - Length x width x depth
  - Length-longest head to toe orientation
  - Width-widest side to side orientation
  - Document the position patient was in when wound measured

Wound Base

- Assess and document type and percentage
- Granulation tissue
- Slough covered
- Muscle
- Other descriptors: pale, friable, pink, green

Wound Base-Granulation tissue

- New tissue
- Beefy red, moist, cobblestone like appearance
- Fills open wound as it is healing
Wound Base-Slough
- Nonviable tissue
- Soft, tan, yellow, brown. Green
- Loose or firm

Wound Base-Eschar
- Necrotic tissue
- Black or brown
- Loose or firm, hard, soft, or boggy
- If wound is covered with eschar, wound size likely to INCREASE when necrotic tissue is debrided

Wound Base-nongranulating
- Granulation tissue not present
- Smooth, red, not granulating
- Can be fragile, friable, bleed easily
- Lacks luster, moist cobblestone appearance
Undermining & Tunneling

- Assess for and document
- Document using depth and location with in the wound bed-use clock as guide

Exudate Assessment

- Amount: none, light, moderate, heavy
- Type
  - Serous-clear,
  - Serosanguineous or blood tinged
  - Sanguineous-bloody
  - Other-yellow, tan, green
- Consistency
  - Purulent
  - Thick
  - Thin
  - Milky
- Odor
  - Absent
  - Faint
  - Strong
  - Foul

Wound Edges

- Open Edges
  - Allow cells to migrate or move freely across the wound, critical to wound healing. (epithelialization)
  - Edges health, pink or pearly in color
- Closed or rolled
  - Healing is halted or slowed down
  - Upper layers of epidermis roll down, epithelial cells can not migrate
Periwound/Surrounding Skin

- **Color**
  - Pink
  - Red, Errythemic

- **Skin temperature**

- **Integrity**
  - Clean and dry
  - Macerated
  - Indurated-hardened
  - Boggy
  - Dermatitis
  - Edematous

Pain

- **Location**
- **Intensity**
  - rate on scale 1-10
- **Pain relief/management**

Tissue Involvement

- **Partial Thickness**
  - Partial tissue loss involving the epidermis and superficial dermis
  - Skin tears, venous, arterial, neuropathic ulcers, stage II pressure ulcers, abrasions

- **Full thickness**
  - Full thickness tissue loss, epidermis, dermis, subcutaneous tissue, muscles, bone
  - Stage III/IV pressure, venous, arterial, neuropathic, surgical wounds, traumatic wounds
Pressure Ulcers

- Localized injury to skin and/or underlying tissue
- Cause: Pressure over bony prominence
- Friction, shear, moisture contributing factors

Suspected Deep Tissue Injury (DTI)

- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. NPUAP 2007

Stage I

- Intact Skin
- Non-blanchable redness
- Reversible
Stage II
- Partial thickness loss of dermis
- Shallow, open ulcer
- Red, pink, no slough
- Open/ruptured serum filled blister
- Is not a skin tear, tape stripping, incontinence associated dermatitis (IAD), maceration or excoriation

Stage III
- Full thickness skin loss
- Bone, tendon and muscle are not exposed
- Slough may be present but can observe depth of tissue loss
- Depth varies by location

Stage IV
- Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling
Unstagable

- Full thickness tissue loss which the base of the ulcer is covered with slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Pressure Ulcer Staging Dilemmas

- Recognizing tissue type!
- Minimal info on condition of wound
  - Viable vs. necrotic base (Stage II only)
  - Clean vs. infected
- Stage I ulcers on dark skinned individuals
- Stage II vs. damage from moisture/friction
- Deep tissue injury (DTI)
- Healing III/IVs
- Documentation “force fit”:

PU Dilemmas con’t

- Oasis does not account for the new NPUAP definitions
- Document a DTI as an pressure ulcer that cannot be observed
Moisture Lesions

- Incontinent Associated Dermatitis
- Superficial moist lesions with irregular borders
- "Moisture lesions" (DeFloor)
- Causative factors
  - Moisture
  - Incontinence
  - Perspiration
  - Friction
  - At risk-immobile, obese

Pressure Ulcer Risk Assessment Tools

- Accurately identifies patients at risk
  - Pressure, shear, friction
  - Sensory perception
  - Immobility
  - Moisture
  - Inadequate nutrition
- More reliable than clinical judgment
- Allocates resources effectively
- But! You have to do something with the number!

Venous Stasis Ulcers

- Presentation
  - Irregular borders
  - Beefy red base
  - Between mid-calf and medial malleolus
- Assessment findings
  - Warm extremity, palpable pulses
  - LE edema
  - Factor MOST OFTEN impacts healing
  - Compression therapy if ABI (Ankle-Brachial Index) adequate
  - Skin changes
    - Dermatitis
    - Lipodermatosclerosis
    - Hemodermin stains
Lower Extremity Arterial Ulcers

- **Presentation**
  - "Punched out" appearance
  - Usually below malleolus
  - Lack of granulation in the wound
  - Dry, eschar covers wound
  - Gangrenous digits

- **Assessment Findings**
  - Cool to cold
  - Lack of hair
  - Weak or non-palpable pulses
  - Dependent rubor
  - Pain on elevation or walking
  - ABI Values

Neuropathic Ulcers

- **Presentation:**
  - Location: Digits of toes, metatarsal heads, plantar surface of the foot
- **Etiology:** neuropathy + deformity + repetitive pressure
- **Neuropathic ulcers are not considered pressure ulcers**

Wound Deterioration

- **Significant quality indicator**
- **Causes:**
  - Microbial imbalance or infection
  - Poor perfusion
  - Malnutrition
  - Immunocompromised
  - Poor adherence to plan
  - Check equipment regularly
  - Cusions, mattresses/overlays
**Wound Deterioration**

- **Local signs**
  - Pain develops or increases
  - Edema develops
  - Poor quality/ color tissue in base
  - Drainage changes/increases
  - Foul odor
  - Dusky wound edges
  - Surrounding (advancing!) erythema or induration

- **Systemic Symptoms**
  - Fever
  - Malaise
  - Elevated blood glucose in DM
  - Flu-like Symptoms
  - Change in vital signs
  - Change in orientation

**Infection**

- "Classic" signs
  - Erythema*
  - Edema*
  - Heat*
  - Pain*
  - Purulent drainage
  *reflect inflammation

**Infection**

- Consider immune status
- Chronic vs. acute (i.e. surgical) wounds
  - Pain
  - Failure to progress/heal
  - Edema
  - Poor quality tissue
  - Drainage
  - Odor
Culturing the Wound

- Method:
  1. Cleanse the wound
  2. Moisten swab with NS
  3. Obtain spec
     - Z-stroke
     - Levine’s technique
     - Don’t culture necrotic (non-viable) tissue!

Evidence-Based Practice

“The integration of best research evidence with clinical expertise and patient values to facilitate clinical decision making”

Scientific evidence
Guide clinical decisions
Guide clinical interventions
Focus on quality
Help reduce health care costs
Best Practice- Use of evidenced-based practice to guide care interventions, provides for consistency in care
Guidelines for Practice

- www.guidelines.gov
  - National Guideline Clearinghouse
  - Database of evidenced-based clinical practice guidelines and related documents
  - Free on-line access
  - Agency for Health Resource & Quality
  - AHRQ (AHCPR)

- www.wocn.org - Wound Ostomy Continence Nurses Society
- www.whs.org - Wound Healing Society

Clinical Staff Education

- Quarterly presentation by WOCN / Wound Care Specialist
  - Wound classification
  - Assessment parameters
  - Documentation criteria
  - Wound bed preparation
  - Evidenced based treatment protocols
  - Nutrition
  - Support surface criteria
  - Supply management / agency formulary

- Co-visits with case managers/clinical staff

Competency Fair
  - Stations (Pressure Ulcers, Diabetic Ulcers, Venous Stasis Ulcers etc)-identify the wound
  - Identify appropriate wound treatment plan
  - Case studies-scenarios
Utilizing your WOCN

- Promote positive patient outcomes
- Develop patient care policies and treatment plans
- Establish standards of care of patients
  - Chronic wounds
  - Ostomies
  - Incontinence
- Provide education to homecare staff

In light of recent OASIS changes:
- Review of OASIS for accuracy
- Assist with supply utilization
- Assist with the involvement of therapy to improve patient mobility and independence
- Assist with management of long-term wound care patients, cost control and optimal outcomes

What Your Peers are Doing!
The Wound Consultant Model: A New Proactive Position on Wound Care

- CWOCN Consultant – considered expert in the field of wound care
- 1:1 work with clinician
- Goal: Improve patient care outcomes and provide higher standard of care to wound, ostomy, and continence patients
Wound Consultant Model

Consultant Focus:
- Verbal referral on every patient with a wound
- Review of patient history, etiology, wound assessment, comorbidities, resources, and caregiver availability
- Digital photography utilized for patients not needing an in-home visit
- If visit requested, joint visit made
  - CWOCN makes hands on assessment and recommendations for care
  - Educational opportunities for CWOCN and clinician
- Result: Lower utilization of visits and supplies, best treatment initiated during the first visit

Focus on Improved Outcomes
- Review of OASIS documentation for accuracy
- Verification of appropriate treatment plan
- Compliance with documentation
- Determination of appropriate support surface
- Discharge audits-identified potential OASIS errors, this information used for staff education

Education Focus
- Day long seminars to new clinical staff, basis of wound education
  - Anatomy and physiology of skin
  - Pressure ulcers, lower extremity wounds
  - Wound assessment and documentation
  - Support surface criteria
  - Agency product formulary and supply management
Education (con’t)
– Ongoing staff in-services
  ● Focused on chart audit results
  ● Results from consultation visits
  ● Results of documentation compliance
– Wound rounds at beginning of every multidisciplinary team meeting

Wound Consultant Model
Results
– Confident trusting relationship between CWOCN and clinical staff – beneficial to patient
– Improvement in pressure ulcers increased by 16%
– Improvement in status of surgical wounds by 16%
– Improvement in accuracy and compliance of documentation
– Improvement in appropriate wound care choices at SOC
– Decrease in frequency of visits

Questions?
References


National Pressure Ulcer Advisory Panel: www.npuap.org

