Wound Ostomy and Continence Nurses Society®

Recommendations for Wound Assessment & Photo Documentation in Isolation

Background:

The Covid-19 Pandemic has affected all aspects of nursing care including wound care. In an effort to minimize unnecessary contact with patients and decrease the spread of the virus, wound providers need to consider alternative strategies to evaluate wounds using telehealth or telemedicine. Wound consults (either in person or remotely) can be managed using principles of basic wound assessment and photography (e.g. may be digital or video based dependent on facility approved methods) as described below:

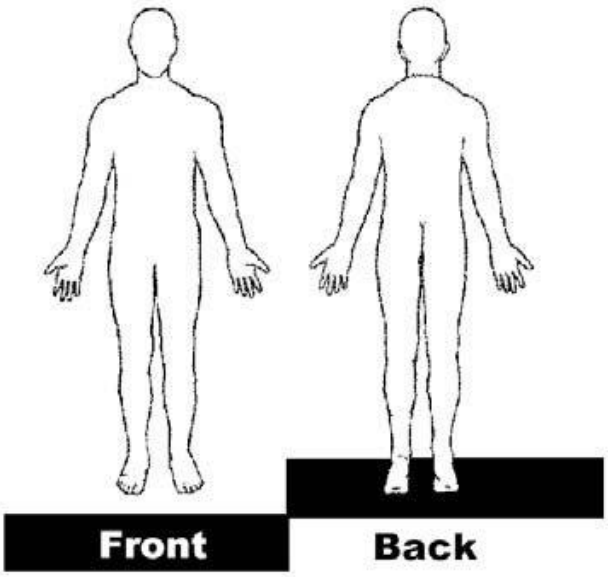
A. Follow facility guidelines for handwashing and donning & doffing personal protective equipment (PPE).
B. Gather all supplies necessary for the wound assessment and treatment before entering isolation room; limit supplies taken in that need to be removed from the room.
C. Wound assessment:
    1. Location: describe the site of each wound specifically (e.g. not just "leg" or "buttocks").
    2. Wound measurements: use a clock face mentally imagined over the surface of the wound bed (12 o'clock is toward the head) measure length and width using a disposable measuring tape or stick noting clock positions (e.g. 10-4 greatest length, perpendicular 7-1 is width). Use measuring stick or sterile cotton tipped applicator to probe depth, measure at greatest depth perpendicular to the wound edge (if able).
    3. Wound drainage amount: none, scant, minimal, moderate, heavy (dripping)
    4. Wound drainage consistency and color: thin or thick, opaque or clear, white/yellow/tan/brown/red/other
    5. Wound edges: flat, elevated, edematous, rolled
    6. Skin around wound: normal & warm, red (less than 5cm) & warm, red (extending more than 5cm) & hot to touch, pale and cool to touch *(may not be able to discern temperature through the PPE, do **NOT** remove PPE to feel for warmth/coolness).*
    7. Photo (e.g. phone, tablet, camera, video; based on facility guidelines & patient consent):
        a. Maximize lighting by turning on all exam lights in the room
        b. Obtain image using approved source of photography at facility (e.g. phone, tablet, camera, video screen shot)
        c. Obtain 1st photo (if possible) of entire body surface where wound is located and 2nd photo of wound within 6 to 12 inches (about 10-15cm) from the wound surface (distance will vary based on device used for photographing)
            i. Transfer images to the medical record (EMR) per facility guidelines; if the facility does not use an EMR, follow facility guidelines for photo storage.
        d. Make sure images are in focus.
        e. Maintain camera lens perpendicular to the body surface, not at an angle.
        f. Place measuring guide in photo for size reference, follow facility guidelines for information to include in the photo/image (e.g. medical record number, wound location, date).
            i. Dispose of measuring tape/guide per facility infection prevention policy.

g. Wipe the device (e.g. phone, tablet, camera) according to facility guidelines, set aside on clean surface away from direct patient care area and let dry as recommended based on solution used prior to removal from patient's room.

The form below can be photocopied on paper to take into the isolation room for bedside wound documentation. The form can be photographed and submitted to an EMR for documentation similar to a photograph (if allowed by facility guidelines), then the paper discarded in the isolation room. Additional documentation can be completed outside the isolation room and photos (wound and/or documentation sheet) can be referenced per facility guidelines.

Assessment	Wound #	Wound #	Wound #	Wound #
Location (be specific, use images below to mark by number)				
Measurements (LxWxD, in cm) Imagine clock face over wound				
Drainage (none, scant, minimal, moderate, heavy)				
Drainage consistency & Color: thin/thick, opaque/clear, white/yellow/tan/brown/red/other				
Wound Edges: flat, elevated, edematous, rolled				
Periwound skin: normal & warm, red (<5cm) & warm, red (>5cm) & hot, pale & cool to touch**				

** Do NOT remove PPE to "touch" the skin. If this parameter isn't assessed, document this deviation from the assessment (on this form or later in the record after exiting patient's room).



Contributors

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