

## QUALITY HEALTH STRATEGIES

**Moderator: Keonia Shaw**  
**June 11, 2013**  
**9:30 am CT**

Operator: Ladies and Gentlemen, thank you for standing by. Welcome to the To Stage or Not to Stage Part 1 Conference Call. During the presentation, all participants will be in a listen only mode. Afterwards, we will conduct a question and answer session. At that time, if you have a question, please press the 1 followed by the 4 on your telephone. If at any time during the conference you need to reach an operator, please press star 0.

As a reminder, this conference is being recorded Tuesday, June 11, 2013. I would now like to turn the conference over to Jacqueline Hairston. Please go ahead.

Jacqueline Hairston: Thanks, (Darryl). And thank you all for joining us today. As (Darryl) says, my name is Jackie Hairston. I'm one of the project managers here at Delmarva Foundation, your QIO for Maryland and the District of Columbia. We are pleased to be able to offer you this series on wound identification and wound documentation. This 2 part series has been created into four 30-minute sessions to minimize the time you and your staff have to be off or away from your units.

What you will be hearing today will be part 1 of the wound identification. And it will be presented by our very own Pamela Cain, wound care certified nurse. This morning session will be repeated this afternoon. The wound identification presentation will be completed on Tuesday, June 18. Actually, that'll be part 2. And both of these recordings and PowerPoint presentations are currently posted on our Delmarva websites, [www.dcqio.org](http://www.dcqio.org) and [www.mdqio.org](http://www.mdqio.org) so you can share with your staff at your convenience.

Phone lines will be muted during the call. We will have a Q&A at the end at which time the operator will instruct on how to pose a question. Well all of you - most of you on the phone know Pamela Cain. She is our very own wound certified nurse. Pam brings 25 years of nursing experience in med surge, intensive care, burn care, chronic and long term care. As a wound care certified nurse, she is an expert in the area of assessment and treatment of chronic wounds.

And also has extensive background in advanced wound care. So I will go ahead and like to turn this over to Pamela Cain. Pam, all yours.

Pamela Cain: Thanks, Jackie. And welcome to the wound ideology webinar part 1. Our objectives today are to really define wound ideology, correctly identify pressure ulcers, and correctly stage pressure ulcers. We're going to start with the basics. What is a wound? All wounds are some type of tissue destruction or tissue breakdown or alteration in the skin. It can be of the skin itself or through the skin. What causes that destruction is the ideology of the wound.

Now there are many types of ideology. There are diseases that can cause wounds, allergic reactions that can cause wounds. Of course there are pressure ulcers. There are traumatic wounds, surgical wounds. But let's start - all wounds - we'll start with the basics that all wounds can be described, open

wounds, as either a partial thickness wound or a full thickness wound. And this has to do with the level of tissue destruction of the skin. So let's look at the anatomy of the skin just as a reminder.

The skin has 2 layers. The epidermis is the top layer and the dermis is the second layer, probably not new information for most of you. Now I think that all of you have seen the epidermis. And if you haven't look at the back of your hand right now and you can put a check, "I know what the epidermis looks like." It is important to know what these structures look like when it comes to identifying wounds and when it comes to staging pressure ulcers.

And I would bet that all of you actually know what human, healthy dermis looks like as well. The dermis layer of the skin as you know carries the blood vessels, the nerve endings and really all the structures of the skin. And if you yourself or maybe your child or maybe a sibling has had a scrapped knee or a scrapped elbow any time in your life and you had an open red bleeding wound, you are looking at human dermis.

And I want you to keep that picture in your mind when it comes to when you're looking at wounds, when you're looking at skin. That red bleeding painful is that dermis layer, important to be able to recognize it. Now underneath the skin or underneath the dermis in most parts of our body is the next layer of tissue which is called the subcutaneous tissue also know as fatty tissue.

And most medical articles or medical books like to draw the skin just like you see on your slide now in that golden yellow color of the subcutaneous tissue. And I don't know why they like to do that. But it's not very representative of fatty tissue in the human body. For those who've had the chance to see human fat, that's great. For those that have not, it is actually not that golden yellow

color but actually white to pale yellow, globular shiny. And it looks very similar to something I'm sure most of you have seen and that's chicken fat.

If you ever pulled back the skin of a chicken and you see those globular white to maybe very pale yellow fatty tissue, it is fat. It looks very similar to human fat. So I want you to keep that picture in your mind for the subcutaneous layer so when we talk about recognizing the stages of pressure ulcers a little bit later, you'll have that visual. So partial thickness wound is any destruction of the skin or inches of skin into the dermis but not through the dermis.

Now remember that visual picture of the dermis is red, bleeding and painful, never any yellow or white structures in the dermis of human skin. Therefore, there will never be any yellow or white tissue in a partial thickness wound. This is a great picture of a partial thickness wound. This happens to be a traumatic ulcer. It's a scrap on a shin on a leg. And you can see it's open to the red dermis. The bleeding eventually stops obviously. But you get the idea, red, open to dermis. This is a partial thickness wound.

Now full thickness wound is really the rest of the wound, wounds that go through the skin. Both layers of skin are destroyed or gone for whatever reason. And a full thickness wound is into the subcutaneous tissue or deeper tissues. Remember, when you've got subcutaneous layer, I want you to keep that chicken fat visual in your mind. This is a great picture of a full thickness wound. It's not a great picture of subcutaneous tissue.

But you can see the open part. And there's some yellow drainage actually covering the exposed subcutaneous tissue. But there's another type of tissue in this wound that's very important when it comes to identifying the full thickness ulcer. This happens to be a surgical wound. But we see all this red, granular tissue. This is granulation tissue. This is the healing tissue. And I

want you to remember how the human body heals. Our bodies can replace skin with skin. So when we lose dermis or we lose epidermis like when you had that scrapped knee as a child, a scab formed.

And underneath new skin was formed. But when it goes through the skin when we've gone into subcutaneous tissue or deeper, the body has to fill that area with sub- with granulation tissue for it to heal. So when you see this red, bumpy granulation tissue, you know that you are dealing with a full thickness wound. So remember, ideology equals type of wound. You always, always, always want to determine the ideology first.

What caused that wound to occur? Was it pressure on the capillaries or pressure in shear creating a pressure ulcer? Was it a doctor or a surgeon actually cut into the skin? Was it some sort of trauma? Or is there a circulation issue going on that can cause arterial or venous wounds. What caused the damage is the ideology. And remember always determine that first.

These are some of the most common ideologies seen in long term care or in nursing homes across the country. This morning we are going to focus on pressure ulcers. The National Pressure Ulcer Advisory Panel or NPUAP for short is considered the authority on pressure ulcers here in the United States. And they define a pressure ulcer as "localized injury to the skin and/or the underlying tissue usually over a bony prominence or as a result of pressure" excuse me "and as a result of pressure or pressure in combination with shear."

So remember, pressure causes pressure ulcers. But also when pressure and shear work together, they can cause pressure ulcers as well. And I'm not talking about friction when I say shear. Friction is when 2 surfaces rub together. If I take a piece of sandpaper to a block of wood and rub it and it would wear away the wood from the top down. Shear happens underneath the

skin at the capillaries that are just in that dermis layer, those teeny, tiny capillaries that are feeding the skin. And shear happens when the skin is going in one direction and the body is going in the other.

For instance, when your resident is sliding down in bed, sliding out of a chair, any sort of dragging situation when we're not fully lifting our residents up when we pull them up in bed can create shear. We're damaging those capillaries. This often happens in the sliding. The two most common locations is the sacrum and the heels. And the two most common locations for pressure ulcers in residents across the country is sacrum and heels.

So remember, pressure and shear often work together to create pressure ulcers. But in the definition, the bony prominence is the key. Almost all pressure ulcers will have a bony prominence that is contributed to that pressure ulcer. So the first thing you need to do when you accessing a wound and you're trying to decide is this a pressure ulcer, obviously look at it. What type of tissue am I looking at? What is the level of tissue? Am I looking a epidermis? Am I looking at dermis? Could it be deeper than that?

And the next thing is you're going to have to put on your gloves and gently palpate the wound. Is it is located over a bony prominence. This will confirm that you do have a pressure ulcer and also help you correctly name the pressure ulcer using that bony prominence as the name. Now the definition did say usually. So of course there are some exceptions. Pressure ulcers can occur over soft tissue where there is no bone inside. And that usually happens when a foreign object is pressing into the skin.

Some common things that can happen in long term care are oxygen tubing on the ears pressing in. That tubing is pressing into the ear. There is no bone in the ear. It's just skin and cartilage and it can create a pressure ulcer. A G2

bumper pressing into the soft tissue of the abdomen can create a pressure ulcer.

Foley's or any kind of drainage tubes pressing into the soft tissue of the thigh can create a pressure ulcer. Clothing or diapers that are too tight especially into the very soft tissue in the groin can create a pressure ulcer. And probably the most common in my experience is in any kinds of casts or splints can often create a pressure ulcer in areas where's there not a bony prominence because it's pressing into an area.

Now pressure ulcers like all wounds are also partial or full thickness. And it's not that it's incorrect to call a pressure ulcer a partial thickness wound or a full thickness wound. It's really just incomplete because pressure ulcers have their own special classification system. It's called staging. And there are 6 different stages. We only use staging to describe pressure ulcers. No other types of wounds should be staged.

Of the 6 different stages, 4 are numbered. Two are not but they are distinct stages. We're going to go through each one. The stage 1 pressure ulcer here is the definition from the NPUAP. And you don't have to memorize the whole thing. But look at that first line and you'll sort of get the gist. It is intact skin. So we're looking at the epidermis. The epidermis is the first layer. This is stage 1, kind of get the connection.

And it's non-blanchable. All of you should know what blanchable means. That's when if it's red it gets lighter or whiter when pressed. And if it doesn't it's non-blanchable. And again, of course this will be over a bony prominence because it is a pressure ulcer. It is very difficult to assess stage 1 pressure ulcers in darker pigmented skin. Make sure you have bright light. If you do

not have exam lights in your rooms anymore because we're making nursing homes much more homelike, make sure you have a bright flashlight with you.

Do not assess dry skin especially on the lower extremities. Moisten it with lotion well. When you're looking through lots of layers of dead cells, you're not going to see the subtle color changes. You also want to assess is the area painful, firmer? Is there any temperature changes? Those can clue you in as well. And remember, if your resident has a stage 1 pressure ulcer, this may be a sign that they're at risk for more pressure ulcers.

This is a great picture of a stage 1. You see the redness. It was non-blanching. It is over the ischium. And if you don't know where your ischium is, you're sitting on it right now. And it is the epidermis is intact. It is a stage 1. In the heel again, the skin or epidermis is intact. Stage 1 pressure ulcer. Stage 2 again has a nice long definition. But I want you to look at the beginning. It is a partial thickness loss.

So stage 2 goes into the second layer or the dermis. And what was the visual I gave you for the dermis? Red, bleeding and painful. Remember there's never any yellow or white in a partial thickness wound. Therefore there's never any yellow or white in a stage 2 pressure ulcer. It's going to be red and open or by definition, it can be a serum-filled blister. Now remember, only if the ideology of the blister is pressure is that blister a stage 2.

Blisters can happen because of burns. Blisters can happen because of allergic - excuse me allergic reactions. Those would not be a stage 2 because those are no pressure ulcers. Only if the blister is a pressure ulcer would it be a stage 2. And of course this needs to be clear or serum-filled. This is one of my favorite pictures of the stage 2 pressure ulcer because it isn't classic. This is the buttocks. And the cheeks are kind of spread apart to get the picture. In the

relaxed natural position, those pressure ulcers are actually touching or almost kissing each other.

And in the buttocks here, the coccyx would be right about here maybe a little bit lower. And I found out that this resident was sitting most of the day. So the first thing I did was I looked at the issue. I see I'm looking at dermis. The next thing I did was palpate the area. And if they sit, so I palpated in the direction that they would be sitting on this wound. And I could feel the coccyx bone right over both of them because remember they're right together when that buttocks is relaxed.

So I knew pressure was playing a part. But the strange shape, I thought maybe moisture was also a factor. However, I found this resident is mostly continent, had just gotten off the bedpan. You can see the lines and only had an accident maybe once a week. So then I asked, "Well what does she do all day?" Well she sits in her chair and she scoots with her feet causing her buttock if you can imagine as you see your scooters if you can visualize them to sort of slide back and forth slightly in her wheelchair.

That pressure sitting on the coccyx bone and then the shear forces of that sliding back and forth has created a pressure ulcer here. I could have put a gallon of moisture barrier on this wound. It would have done no good. Defining the wound ideology as pressure and staging it correctly lead us to the right plan of care which was a decrease in the amount of pressure getting off of that bottom and a better cushion for this resident.

Here's a blister that had popped on a heel. And you can see the skin flap sack over to the right side there a little bit. It is a blister with clear fluid. It's on a bony prominence, stage 2. This is a combination wound. Part of this wound is red, non-blanchable. And part of it is red open to the dermis. This is that

posterior thigh as one of those Foley or drainage tube situations. We would measure it together as one wound. We always stage to the worst. So therefore it would be a stage 2.

And here again just to show you the red dermis flat dermal tissue, no granulation tissue. This was another stage 2. A stage 3 means you've gone to the third layer or the subcutaneous tissue. Remember that fatty tissue looks like chicken fat. There are parts of the body that do not have subcutaneous tissue. So keep in mind, they cannot have a stage 3 pressure ulcer like the bridge of the nose, our ears, our ankle and the back of our head.

This is a stage 3 pressure ulcer. Notice how shallow it is because staging has nothing to do with depth. It's about what tissue type we are seeing. And we see here clearly some very healthy white to pale yellow subcutaneous tissue. This is over the sacrum. It is a pressure ulcer. We're looking at subcutaneous tissue therefore it's a stage 3. Here's another one. I know it's a strange shape.

But it is a pressure ulcer. And you can see the pale yellow tissue as well. Therefore we're looking at subcutaneous tissue. It's healing nicely. But it is still a stage 3. So this one's a little harder to see, this patient was very pale, quite anemic. But in the center you can - the black arrows pointing to a small open area. The edges are pale pink. That's the dermis. But the center is white. It looks almost like intact. - her intact skin because it's so pale.

But actually in person you'd be able to see it was open and weeping. And we clearly were through the epidermis. That white we know there is no white in the dermis is really just a very top layer of the subcutaneous layers. Therefore we're looking at a stage 3 pressure ulcer right over the coccyx bone. Stage 4 is easy. This is the one people rarely get wrong. This is the full thickness. It's

gone through the subcutaneous tissue. It could be into the muscle or tendon or other connective tissue. And it could have bone exposed. It doesn't have too.

But remember we have no subcutaneous tissue on our ears and our bridge of nose, a back of our head and our ankles. So you can have a very small pressure ulcer on the ear caused by one of those oxygen tubing we talked about. And if you're looking at white tissue, you're actually looking at cartilage on the ear. It means it's gone through both layers of skin and that would be a stage 4. It might be small. Size doesn't matter.

It matters what tissue type you're looking at. Here's a nice big stage 4 on an ischium as well. This is also a stage 4. This is large. This is on a sacrum. It's about the size of your hand. But it's fully covered with granulation tissue. It's healing nicely. But at one time, the bone was exposed and they never backstage an ulcer. Therefore it is a stage 4. It will remain a stage 4 until it's completely healed. It's healing nicely and full of granulation tissues. But still, it's stage 4.

Unstageable I think is the easiest of them all. Remember, you have to be able to see the tissue type to be able to stage the ulcer. If the wound is a pressure ulcer and it is covered with necrosis, yellow necrosis, black eschar. It doesn't matter what type of necrosis. And you cannot see the tissue type, it is unstageable. Here's a wound that has a quite a bit of yellow, grey, tannish slimy necrotic tissue, cannot stage this ulcer at this time.

Now if you were wondering, "now how can I tell the difference between that and fatty tissue?" I will bring you back to my analogy of the chicken fat. If you're getting ready to cook chicken and the fat looks like that, do not eat the chicken. That is dead, slimy necrotic tissue. Here's some more necrotic tissue

covering a sacral wound, unstageable. Here's dry black eschar covering a heel pressure ulcer unstageable. And here's a side by side view.

Part 1 is yellow necrotic tissue. The other one is black eschar. Doesn't matter the type of necrotic tissue, I cannot see any structures to know the stage. So this isn't - both of them are unstageable pressure ulcers. The suspected deep tissue injury is the newest member of the pressure ulcer staging family, was added in 2007. And again like all of the rest has a nice long definition. But I want you to remember the first sentence.

It is a purple or maroon area of intact skin or a blood-filled blister. But keep in mind this is one of the 6 stages for pressure ulcers. We do not use this to describe anything but a pressure ulcer. For example, if I get punched in the shoulder right on the bony prominence of my shoulder and I get a purplish, maroon area, I do not have a suspected deep tissue injury because I do not have a pressure ulcer.

I have a traumatic wound. And I have a bruise or hematoma. Now if I'm 85 years old and maybe very frail. And I was laying on my side and you go to turn me and you see a purple or maroon area over the bony prominence on my shoulder, that is pressure. And that would be staged as a suspected deep tissue injury. Let's look at a couple of them. Here's a heel. You can see this is slightly blistered. It's hard to see that it was blistered. But you can definitely see that deep purplish color over the heel.

It is a pressure ulcer. There it's a suspected deep tissue injury. With these types of pressure ulcers, you will often see some redness around the wound indicating some pretty severe tissue damage. If you do see that, you want to document it. It will help your MDS nurses when they're completing section M of MDS 3.0. Now here's another area. And it's quite small, the maroon area.

This is a baby toe, the fifth toe. This is a foot that was sitting a footboard too long. The wound is actually longer. You can see the color changes go all the way down to about there.

However, part of the wound is a purple color, purplish maroon. We always stage to the worst. So this is a suspected deep tissue injury even though the rest of it is a more pale color. Here's another blood-filled blister. This is an unusual shape. This is a very, very old picture back when - I'll show you the age. Back when we use to have side rails in nursing homes. But it was an arm that got pushed into the side rail for too long creating a pressure ulcer.

That's why it's so sort of unusual. But it is a blood-filled blister. And therefore we would stage it as a suspected deep tissue injury. And you can see it also has some redness around the edges that we would want to document. Here's another great picture. This is an admission picture of a sacral coccyx area. And can you see that part of this wound is purple and maroon. Part of this wound is reddish to maybe light purple, not blanching.

Part of it is open to pale yellow tissue, subcutaneous layer. And here - down here is more part that is red and non-blanching. There's nothing from the end - one end to the other that's not involved in some way. So from the bottom to the top, this is one whole wound. Part of it's stage 1. Part of it's stage 3. But part of it is a suspected deep tissue injury so we would definitely stage it to the worst stage which is a suspected deep tissue injury.

Here's another just to show you the color, the maroonish, purple color. This is a side of a foot. And again to show you that sort of purplish color on a little bit darker pigmented skin. So in summary, pressure ulcers are caused by pressure or pressure in combination with shear. They're going to usually be over a bony prominence. Find that bony prominence and name that wound correctly.

If not think about of the foreign object that might have been pressing into the skin and remember we only use staging for pressure ulcers. Stage 1 is that non-blanchable epidermis. Stage 2 is that dermis, red bleeding painful not a lot of color. Stage 3 is that subcutaneous or fatty tissue. Remember that chicken fat. Stage 4 is below the fatty layer into your muscle tendon, could be bone. Unstageable means too much necrosis to be able to stage and that suspected deep tissue injury keep that purple or maroon color in mind.

But remember, only for pressure ulcers. And I'd now like to turn this back to (Darryl) and open the line for questions.

Operator: Thank you. Ladies and gentlemen, if you would like to register a question, please press the 1 followed by the 4 on your telephone. You will hear a 3-tone prompt to acknowledge your request. If your question has been answered and you would like to withdraw your registration, please press the 1 followed by the 3. If you're using a speaker phone, please lift your handset before entering your request.

That once again, ladies and gentlemen if you'd like to register for a question, please press the 1, 4 on your telephone. We do not seem to have any questions at this time.

Jacqueline Hairston: Well I had one question for you, Pam. You know as you're going out visiting with your teams, what do you see as the most common error when folks are staging their wounds?

Pamela Cain: Well I'll give you the 2 top things. One, I see other types of wounds being staged. For instance, skin tears, moisture associated skin damage or incontinence associated dermatitis being listed as a stage 2 which is incorrect

because the ideology of those wounds is not pressure. And the other is understaging. People think because there's not a lot of depth, that you can't have a stage 3 or a 4.

You have to remember it's about the tissue type. So stage 3 is just underneath the skin. As soon as you hit subcutaneous tissue, it's a stage 3. And in some parts of the body where there are no - is no subcutaneous tissue, you can have a very shallow wound that is a stage 4. Great question, Jackie. Thank you.

Jacqueline Hairston: (Darryl), do we have any other question?

Operator: Actually we do have a question that popped up. And our first question comes from the line of Anita Morrissey with Carroll Manor Nursing Home and Rehab. Please go ahead.

Anita Morrissey: Hello, Pam. Good morning.

Pamela Cain: Good morning.

Anita Morrissey: I have a question - good morning. I have a different - I just wanted to know the difference between fibrin and slough because sometimes when I tell the doctors that's slough, they say, "no, that's not slough. It's just fibrin - fibrin". So is there a clear difference between that.

Pamela Cain: Slough is dead tissue. And...

Anita Morrissey: Yes.

Pamela Cain: Fibrin is the way that they're describing fibrous tissue or scar tissue that's formed. And it will sometimes appear white.

Anita Morrissey: Okay.

Pamela Cain: And - and especially at the edges of wounds, it is scar tissue although it can impede healing. So while it is not slough, it is not dead tissue. Think of it as scar tissue.

Anita Morrissey: Okay. Okay. Thank you.

Pamela Cain: Does that help you, Anita?

Anita Morrissey: Yes. Thank you.

Pamela Cain: Okay. Sure. You do sometimes need to remove it for a wound to heal. So keep that in mind especially if there's a lot of it.

Operator: And we do not have -

Pamela Cain: Go ahead (Darryl).

Operator: I'm sorry. Pardon me, no. We do not have any further questions at this time.

Pamela Cain: Okay, well we're right about at 11 O'clock. I want to thank everyone for joining us. Remember this exact session will be repeated this afternoon. And then next week we will do part 2 which we will focus on other types of wounds - the ideology of wounds other than pressure ulcers that you see in long term care. And how to recognize them and how they differ from pressure ulcers.

So I hope you guys can join us then. And always keep in mind if you have any questions, you can always contact one of your Quality Approver consultants here at Delmarva. So I thank you very much. Jackie, do you have anything else you wanted to add.

Jacqueline Hairston: Yes, I just want to add, Pam thank you so much for the presentation.

That's been a lot of valuable information that I know everyone on the phone can go back and put into action right away and share with your staff. As closing, those of you that are on the WebEx portion of the call, we do ask you to complete a brief evaluation that will be popping up shortly before you do get off the call.

And just some quick reminders for the month of June, your May data was due on June 10. And so those of you that are still working on your QAPI, your QAPI assessments, you need to get with your quality improvement consultant and get those submitted as soon as possible. And teams that are working on their goals and need some assistance please again contact your quality improvement consultant so she can help you finish that.

And I just want to end by saying, thank everyone for joining us today. And (Darryl), I'll turn the call over to you.

Operator: Ladies and gentlemen, that does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your line.

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