QUALITY HEALTH STRATEGIES

Moderator: Jackie Hairston
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9:30 am CT

Operator: Ladies and gentlemen thank you for standing by and welcome to the Wound Documentation: Assessment of the Wound Part 1. 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, July 16, 2013.

I would now like to turn the conference over to Jackie Hairston. Please go ahead.

Jackie Hairston: Thank you (Tina) and good morning and welcome to all of you today. My name is Jackie Hairston. I'm one of the project managers here at Delmarva Foundation for the QIO for Maryland and the District of Columbia. And I'm here with my Delmarva team this morning.

We are pleased to be able to offer you this series on wound identification and would documentation and we'll be dealing with wound documentation today. You will be hearing Part 1 of wound documentation and it will be presented by our very own (Pamela Kane), our Would Care Certified Nurse.

This session will be repeated this afternoon at 3:30. All of the recordings for Part 1 and Part 2, recordings and PowerPoint presentations will be posted on our Delmarva Web site, www.DCQIO.org and www.MDQIO.org so that you can share them at a later time with your staff.

Phone lines will be muted during the call. We will have a Q&A at the end at which time the operator will instruct you on how to pose a question. So today we have (Pamela Kane). Many of you on the phone are very familiar with her because she's been working with your facility.

She's our very own wound care certified nurse. (Pam) has been doing nursing practice for the past 25 years in med surg, intensive care, burn care and chronic and long term care. As a wound certified - wound care certified nurse she's an expert in the area of assessment and treatment of chronic wounds.

And she has an extensive background in advanced wound care working with interdisciplinary teams, providing wound care education and policy and procedure development in long term care since 1993. So without further ado, we're going to go ahead and pass this onto (Pam).

And (Pam), you can go ahead. It's all yours.

(Pamela Kane): Thank you very much Jackie and good morning everyone and welcome to Wound Documentation: Assessment of the Wound Part 1. Wound

documentation is a very broad topic and most would think that it would start with assessment of the wound itself.

Actually I would put this at the bottom of this list and you really need to start with an assessment of the resident. You need to know what's going on with the resident themselves. What's their diagnosis? What medications are they on? What is their current nutritional status?

What treatment and - is in place currently where dressings have been used? How has that response to that treatment been? You really need to get a good picture of what's going on. Are there any recent consults or referrals that refer to the wound before you go in to assess the wound itself.

And although wound assessment is at the bottom of this list, it is what we are going to focus on today. Our objectives today are to learn how to properly identify the location of the wound and properly measure a wound.

Now here's a list of the wound characteristics that need to be assessed and documented on whenever you go in to see a wound. Ideology is always the first.

You need to decide what type of wound you're looking at and then you need to decide the level of tissue destruction, if it's a pressure ulcer means to stage the wound.

Now we cover these two and wound type and stage ideology of wounds part 1 and that is available on our Web site to listen to that recording. Today we're going to focus on that location and measuring of a wound and the remaining wound characteristics we'll look at in Wound Documentation Part 2.

Location is very important because it becomes the wound's name and you don't want to change that name over the life of the wound. And you want the location to be specific so that you, the next nurse, the next doctor, the next clinician that looks at that resident can find that wound correctly.

Just a quick review - remember ideology is the first thing to determine. This is a list of common wound types found in long term care, the most common being pressure ulcer. And then after determine the ideology you want to document the level of tissue destruction.

If any open wound would be either partial thickness or full thickness. Remember, partial thickness means the damage goes into the epidermis - through the epidermis, excuse me, into the dermis but not through the dermis. Remember the dermis is red. It can be bleeding.

That's painful because that's where the nerve endings are. There's never any yellow or white structures in the dermis so there's never yellow or white in a partial thickness wound.

If the wound goes completely through the skin, through epidermis and dermis into the subcutaneous tissue or lower, it's full thickness. If it's a pressure ulcer then you would stage it using one of these six stages and you only use these six stages to describe pressure ulcers.

After you determine the ideology and the stage or the level of tissue destruction it's time to decide on the location of this wound. In order to properly document the location you really need to know your anatomical body parts.

You need to use those medical terminologies correctly. You need to know the bones of the body. You're going to have to go back to that anatomy and physiology. Every - a lot of these bones have bony prominences.

You can use that bony prominence as a landmark or the actual name for your pressure ulcer. Remember, most pressure ulcers will be located over a bony prominence. This is the standard anatomical position. This is the position that all medical terminology and directional medical terminology is based on.

This is the anterior surface of the body. Notice that the body is facing forward palms up. There is an imaginary line that runs through the body called the midline that separates the right and the left side. Anything closer to that midline is more medial.

Anything further away from that midline is more lateral. Anything closer to the head is superior, closer to the toes inferior. When it comes to the arms and legs anything closer to the fingertips and toes is more distal, closer to the trunk of the body, more proximal.

So I want you to notice that the - some side of the arm is actually the lateral side of the wrist. And the pinky side is the medial side. This is something that I see get mixed up quite often. So let's look at that skeleton, those bones, that's also standing in the standard anatomical position.

Let's start with the skeleton on the left facing forward. The elbow is an area that I see that often just gets documented as right or left elbow. But notice that the actual elbow bone is actually on the posterior side of the body. It's actually a bony prominence at the proximal end of the ulna bone.

And there are other bony prominences. The humerus itself has two, one on the lateral side and one on the medial side. So if you have an elbow area document clearly where it's located. Let's move down to the leg on the right. The knee is another area with multiple bony prominences.

You can have a wound on the top of the knee or over the patella or again the femur bone has several bony prominences, one on the lateral, one on the medial at its distal end that create bony prominences that could be a wound or a pressure ulcer on the lateral knee or the medial knee.

And there's one more bony area that I think it's worth knowing the name of. And that is that ball at the top or at the proximal end of the fibula bone. This creates a pressure area for many of our elderly and long term care who are bed bound. It is the head of the fibula.

And most of you can feel it on your own leg on the lateral side just below your knee. So if you have area - a pressure ulcer there, name it the head of the fibula. Everyone will always be able to find it. Now let's move to the posterior side.

The back is often an area I see where it's documented right back or left back. Look at all of the bones that could contribute to a pressure ulcer on the back. Could it be the scapula right or left? Could it be the posterior rev or the most common area, the spine?

And then of course that is broken into sections as well. The most common would be the thoracic spine because that curves outward but you could have a pressure ulcer on anywhere along the spine. Be specific when you're documenting your pressure ulcers or any type of wound.

We're going to skip the buttocks for now because we're going to look at that in more detail in a moment, and let's move down to the feet. Again, the ankle - I see often right ankle, left ankle. The ankle actually has a lateral side, a medial side, there's even an anterior ankle.

So be specific when you're documenting your wound. And of course the heel can be the same way. It can be lateral, medial and is also known as the calcaneus.

Here's that close-up view of the buttocks I want to talk about because this is the most common - I'll call it a mistake because I think it really is poor practice to document a pressure ulcer on the bottom as right buttock or left buttock. That is a large area.

I would treat a pressure ulcer on the sacrum, may have a completely different treatment plan than a pressure ulcer on the ischium. Find the bony prominence and name your pressure ulcers especially by the bony prominence they're located over.

It is very easy to find the coccyx bone even on a very heavy patient if you follow up the intergluteal and you will be able to palpate it at the top of the intergluteal. You know that the sacrum is above the coccyx and you can see the sacrum has many bony prominent areas.

And a wound could be slightly to the right side of the sacrum or the left and it's okay to document right or left sacrum if it's more to the right or to the left. We have the iliac crest that runs all the way from the anterior surface to the posterior surface of the body.

We of course have the right and left ischium that most of you are probably sitting on right now. And the hip itself or the head of the trochanter, can be more posterior sometimes as well. Find the bony prominence to name your wound.

Let's take a look at the buttock without the bones being there. Again, this top area would be called the sacrum. Underneath the sacrum is the coccyx. Below the coccyx is that intergluteal or can also be called the gluteal cleft. This is not a common area for a pressure ulcer.

But you may have a fungal rash or an incontinence associated dermatitis going on there. There's no bony prominence underneath there as you saw in the picture of the bone. Below coccyx there's no more bones under that area but it is very sensitive and subject to moisture.

Over on the left we have the hip or it could be on the posterior hip. And of course I'm just showing the left ischium but there of course is one on the right side as well. And there's another area where a skin fold that some residents have just underneath the buttock called the gluteal fold.

And you may have a fungal rash or an incontinence associated dermatitis going on there. If you want some help in documenting the location or learning and remembering the location and all the directional terms, go to our Web site, www.MDQIO.org or www.DCQIO.org and look for our spotlight.

The July 2010 and August 2010 spotlights covered directional documentation and location of wounds, August specifically paying attention to the feet which can be a troublesome area sometimes. After you've documented the location it's time to measure your wound.

All wounds should have three measurements - a length, a width and a depth and they should be measured in centimeters. The length is always measured in a head to toe direction. The width would be perpendicular to length or in a hip to hip direction. And don't forget your depth.

So here's a wound - that red area is supposed to symbolize a wound on the back of a person. And the length would be measured from the top of the wound that's closest to the head to the bottom of the wound that's closest to the feet in the head to toe direction.

Your measuring device should be in that direction head to toe, pointing to the head and pointing to the toes. Even if the person is lying down you still measure length in a head to toe direction. Width again is perpendicular or at a 90 degree angle to length and measured in the hip to hip direction.

Even if the length of your wound is much smaller in number than the width of your wound, it is still the length in the head to toe direction. So as you see in this picture, this wound's length is much smaller than its width but it is still considered the length because of the direction head to toe.

The wounds that become difficult are those odd shaped wounds. The best way to handle them is to put them in an imaginary box or rectangle and then measure the length and the width of that rectangle.

You can see that wound fits inside that box and we get the correct length and width measurement using the correct directions. Here's a picture of a real wound.

You can see the head is at the top and we would put - this is again a sort of a strange shaped wound so the best way to measure it is to use our imaginary

box or rectangle. And then we could measure the length in the head to toe direction and the width in the hip to hip direction.

Now this person is obviously laying down because you see the head is over to the right here. And again we have another strange shaped wound here so we would put our imaginary box in place.

Now when you're in a resident's room trying to measure, a good way to create this box is to use your paper measuring tapes and actually lay them around the wound to create the box until you get used to measuring these odd shaped wounds.

But because this person is laying down and length is always head to toe, the length would be measured in the head to toe direction and the width in the hip to hip. After you do your length and the width it's time to measure the depth.

The depth of the wound is from the skin's surface to the deepest part of the wound. So in this picture the red area is supposed to symbolize the open wound. The tan area, the remaining tissue. And think of this as a cross section or a slice right through the middle of a wound.

You would use a Q-tip. You want to be gentle. You don't want to create any trauma to the wound. And you would measure how deep the wound is from the skin's surface. Even if the person is lying down you want to keep the Q-tip perpendicular to the skin and measure your depth.

You do not want to lean your Q-tip over to the edge of the skin to get your depth measurement. So sometimes it can be difficult when you have a large wound and you place your Q-tip in what appears to be the deepest part, often at the center. So pretend that's the Q-tip, that dot in the middle.

And how can I sort of see where the skin's surface is? Here's a little hint. Take your second Q-tip and lay it across the skin's surface and then your Q-tip you're using to measure the depth.

And where they intersect will give you that skin's surface and then you can measure correctly from skin's surface to the deepest part of the wound. What you don't want to do is never forget your depth even if it is 0 as it would be in a stage 1 pressure ulcer. You want to document that 0.

Now if your wound is open but the depth is quite shallow like with many stage 2 pressure ulcers, as a matter of fact it may be too shallow to visually measure with the naked eye, best practice dictates that you would document that depth as less than .1 centimeter or a tenth of a centimeter.

You know that it's open. You know that there is some depth so you - but you can't measure it with the naked eye. However, I do want to caution, I want you to follow your facility's policy.

If your facility's policy calls for, if it cannot be measured with the naked eye to document it as 0, follow your policy. If you don't have a policy or you're not sure, check with your administrator or your director of nursing.

Now sometimes the depth could be above the level of skin as it could be a wound that has over granulated tissue or in a cancer or fungating wound.

In that case you still document the depth but you would put a plus sign in front of your measurement and indicate how far above the level of skin the wound has grown, as in this example of plus .8 or plus 2.4.

After you've measured your wound you need to determine if your wound has any undermining, tunneling or sinus track. Undermining is destruction of the tissue just underneath the skin. This is usually found at the wound edges and it can actually be around the whole edge of the wound.

Tunneling is actually destruction of the skin deeper. It's not just underneath the skin but it's underneath the skin plus other tissue - subcutaneous tissue, muscle. Think of a tunnel going through a mountain. It's much deeper. And a sinus track is sort of a tunnel.

This is where you have an abscess activity going on somewhere inside and that purulent fluid has found a way out. Think of a volcano. That would be a sinus track. Now sometimes in documentation and even in articles, you will see sinus track and tunneling used interchangeably.

Sinus track should be reserved though for infectious situations or think of that volcano where a tunnel is just a deeper pathway that's underneath underlying tissue. This is a picture of undermining. You can see the little lip just underneath the skin around the edge of this wound.

Here's another undermining. It's a little bit more significant amount because the Q-tip you can't even see the tip. But you can see it just goes underneath the skin. Here's a picture of tunneling. Although it's hard to see in a two dimensional picture, the surface of this wound is way up here.

There's about 2 centimeters of healed tissue before you even begin to get to the open part of the wound. So you can see this Q-tip is not going just underneath the skin but it's going underneath skin, subcutaneous tissue and actually muscle so this is a tunnel.

Regardless of whether you have undermining, tunneling or sinus track you measure them all the same using the clock system. The clock tells you the direction and then you measure the amount in centimeters using your Q-tip.

The clock is just like a regular clock and you set the 12:00 is always at the head, 6:00 is always at the feet and three and nine fall in their correct places. For instance, there's someone standing and someone lying down.

Regardless of the position of the resident 12:00 is always the head, 6:00 is always the feet. And you are looking at the clock correctly so the nine and the three fall in their correct position. So here we have a wound. It's a drawing. So the bright red in the center is - think of that as the open part of the wound.

And the thick red line, think of that as the undermining or tunneling that we can't see, underneath. We would measure the amount of tunneling or undermining at the four landmarks - at 12:00, at 6:00 and at 9:00 and 3:00.

You do not need to measure every hour of the clock all the way around the wound. But you also want to document the longest amount of undermining and in this case this is right about 5:00. And that's if the longest is not at one of the landmarks.

And you can see, even if this resident is lying down the documentation does not change, 12:00 and 6:00 are still at the head and feet, 9:00 and 3:00 fall in their correct places and the longest is still at 5:00.

If you have undermining or tunneling only on part of the wound you still want to do your landmarks - 3:00 is here. You want to do your longest which here is about 4:00. And then you want to document about where the undermining starts which here would be 2:00 or arguably 1:00.

I had trouble getting the arrow in that little spot. You get the idea. Here's a picture of a real wound with a clock sort of laid over top of it. You can see where the head is. You can see this has some undermining or tunneling right about 4:00.

Jus to review - remember the first thing is always ideology. Here we have a pressure ulcer and then we would decide the stage in this case, which is obviously a stage 4. The location - this is sacrum or sacrum/coccyx. You might want to combine. It's such a large wound in our picture.

You would measure the length would be the head to toe direction, the hip to hip would be your width measurement and then you would look for your undermining and measure the direction.

And here it looks like it has some tunneling or undermining from about 11:00, maybe 10:00, it's hard to say in the picture. Definitely measure the 12:00. That's one of our landmarks and then all the way over to around 2:00. Ideology is always first.

Determine what type of wound you're dealing with first and then you want to stage your ulcer or document the level of tissue destruction. Use your bones to identify your location. When you're measuring always three measurements - length, width and depth. Don't forget your depth even if it's zero.

And then you want to assess for and measure your undermining and tunneling. Remember, that medical record is a legal documentation. You want to use your proper medical terminology. So I'm going to wrap it up here. I want to thank you all for joining. And I want to open the line for questions.

So (Tina) if you could please do that, thank you.

Operator: My pleasure. Ladies and gentlemen if you would like to register a question or a comment please press the 1 followed by the 4 on your telephone. You will hear a three toned 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 speakerphone please lift your handset before entering your request. One moment please for our first question.

Ladies and gentlemen, as a reminder, if you would like to register a question via the phone lines please press the 1 followed by the 4 on your telephone keypad.

Jackie Hairston: Well (Pam), while folks are thinking of their questions, I had one. You talked about always measuring from your length, head to toe or your width, hip to hip. Is that always the way measurement is done?

(Pamela Kane): That is considered the best practice in wound care across the country and is the way that it must be done in long term care because of MDS rules. However, that's a great question Jackie, because some of you may send some of your residents out to wound clinics.

They do not have to follow the same rules. Sometimes wound clinics measure in millimeters instead of centimeters and sometimes their policies indicate to measure the wound - the longest part of the wound is the length and then the width is perpendicular to that.

So sometimes you'll get a resident back and the measurements quite don't match yours and that's why and that's okay. But best practice does dictate that it should be length, head to toe, width, hip to hip. Thanks again Jackie. That was a great question.

Jackie Hairston: Do we have any questions in the queue (Tina)?

Operator: We do not at this time.

Jackie Hairston: Okay. Well we won't hold you any longer. I just want to thank all of you for getting on the call and (Pam) thank you for sharing that information with us today. As we close we do want to remind you that this portion or this webinar will be repeated this afternoon at 3:30.

So if you have staff that weren't able to get on this morning they can certainly hear the presentation at 3:30. Just some quick reminders - you know that everlasting monthly data is due now.

And for those of you working on your QAPI assessments we ask that you get those into your consultants as soon as you finish those. Again, we want to thank you for getting on the phone and there will be a quick evaluation that should be popping up soon, for you to complete. And we do ask that you complete that because we do value your feedback so that we can make these events better for you. And we should be seeing that polling soon.

(Pamela Kane): Thank you everyone.

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