

QUALITY HEALTH STRATEGIES

Moderator: Jackie Hairston
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9:30 am CT

Operator: Ladies and Gentlemen thank you for standing by. Welcome to the Wound Document Assessment of the Wound Part Two conference call. During the presentation all participants will be in a listen only mode. Afterward we'll 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 23, 2013. I'd now like to turn the conference over to Jackie Hairston, Project Manager, please go ahead Ma'am.

Jackie Hairston: Thank you (Mark), and good morning and welcome to all of your today. As (Mark) said 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 have been able to offer you this series on wound identification and wound documentation. And what you'll be hearing today

will be Part Two of Wound Documentation, and it will be presented by our very own Pamela Kane, our Wound Care certified nurse.

For those of you on the phone and on the webinar just to let you know as a reminder this session will be repeated this afternoon at 3:30. So if you have staff that you would like to hear, this call they can catch it again at 3:30.

Part One and Two of the recordings and the PowerPoint presentations will be posted on our Delmarva Web site, www.dcqio.org and www.mdqio.org, so that you can share them with your staff for future trainings.

The 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 we have Pamela Kane with us, most of you probably on the phone know and have worked with Pamela. She is a Wound Care certified nurse who brings many years of nursing practice in Med/Surg, intensive care, burn care, 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. She has extensive background in advanced wound care, working with interdisciplinary teams, providing wound care education and policy and procedure developments in long-term care since the early 90s.

So on that note let's begin our presentation and Pam, it's all yours.

Pamela Kane: Thank you very Jackie, and good morning everyone and welcome to Wound Documentation Assessment of the Wound Part Two.

Wound documentation, as I said last week, "Is a very broad topic," and most people would begin with the wound itself. However, the wound assessment really belongs on the bottom of this list.

Remember it is key to assess your resident first. You really want to know the entire health status of your resident, the history of that wound, the treatment, and consults, and really get a good picture of what was going on before you go in and assess the wound. And although this is at the bottom of the list, specific wound assessment and documenting that assessment is what we will focus on today.

Our objectives are to look at the other wound characteristics that we have yet to look at and how to properly identify them and what is that terminology so that we can document our wound assessment accurately?

This is a list of wound characteristics, and for those of you on the call last week you saw this, that need to be assessed and documented on when you were assessing a wound. It always starts with etiology, it is the first thing you need to identify when you are doing a wound assessment.

And we covered etiology and tissue - level of tissue destruction and staging, and Wound Etiology Part One and Two. And last week in Documentation Part One we covered the location of the wound and measuring wounds correctly.

Today we're going to cover the remaining wound characteristics such as tissue type, drainage and the other characteristics that need to be assessed when you're documenting on a wound.

Let's look at tissue type. Now there are many different tissue types that you will see when you are assessing a wound. You of course will see the normal tissue types that present in an anatomical correct human person.

You will look at a skin or you're looking at a Stage 1 pressure ulcer, the tissue type you would see is epidermis. If you're looking at Stage 2 you will of course will see dermis and all of the other different types that are within the human body, like subcutaneous tissue or muscle or bone. But there are additional tissue types that you will see in a wound as well.

First one we have here is granulation tissues. Granulation tissue is the healing tissue. Remember the human body replaces skin with skin. If you have damage to your skin the body can make new skin that looks exactly like the old skin, and replace it.

However, if the tissue damage is through both layers of skin into the deeper tissues, subcutaneous, muscle, connected tissue, anything, the body doesn't replace those tissues. It actually fills with a new type of tissue, this is granulation tissue. It is red and bumpy or granular in appearance, hence the name. It is not smooth and red.

Remember there's a lot of different red tissues in the body, the dermis is red, muscle is red. Granulation tissue will be that red bumpy tissue, some people think it looks like ground beef.

But here's a great picture of that red bumpy tissue, the little bit of white you see is actually the flash shining off that nice moist tissue. So you can see that it has texture. This is healthy granulation tissue.

Granulation tissue is usually red, but it can be slightly paler if the person happens to be anemic, and we'll see some of that a little bit later.

Another type of tissue is fluff, that you will see in wounds. Slough is a kind of necrotic tissue. Necrotic tissue is the general category for all dead tissue. And slough is necrotic tissue that has begun to separate from the healthy tissue, or begun to slough away. Again, hence the name.

And it can be thin in mucus or very thick and stringy or very adherent. You see a lot of the slough here in this wound.

And here's necrotic tissue, the general category for all dead tissue is necrotic. And here's two wounds that have some very thick, yellow-brown necrotic tissue, it can be almost any color, but yellow, brown, tan, grey, green, anywhere along those line. And again, this is dead tissue, and here you can see how adherent to the wound bed.

Eschar is another type of necrotic tissue, it is necrotic tissue that has become completely devitalized, or basically completely dried out and very leathery. It is usually black or a very dark brown in color, and here you see a great picture of eschar on a heal.

Epithelial tissue is another type of healing tissue, and basically it's the new epidermis or the new skin that begins to form over a healing wound. It usually starts at the edges of the wound, and it usually appears almost a pearly pink. Some people describe it as a very light lavender in color, but this is new skin that is beginning to grow, or the epithelialization that is happening of a healing wound. So this is another tissue type that you may see in a wound.

Once you've decided what type of tissue, you may want to describe how adherent that necrotic tissue is. Now some skin assessment tools do not have this category, and that's okay, but if they do or if you want to be very specific, you will describe your necrotic tissue or your slough as you see in the right hand picture. The tissue has not started to pull away from the healthy tissue, from the healing wound, at all.

Or on the left, it could be very non-adherent. This is that mucousy, slimy slough that usually can be wiped away when you clean the wound gently with gauze.

And I don't have a picture of the loosely adherent, but I am you all have seen it. That's the stingy slough that has been pulling away from the wound, but the base is still attached to the wound.

Once you look at the different tissue types you'll want to document how much you have of each type. You want your percentage to add up to 100%, you should never document that the wound is 50% necrotic and then that's the end. Well, what's the other 50% of the wound.

Now if you're 100% of one type of tissue that's fine, it may be 100% clean dermis, or red clean tissue, or it may be 100% eschar. Regardless of what the percentages are you want it to add up to 100% and you want to describe the different tissue types that are present in the wound you're looking at. It can be a bit tricky though, so let's look at a wound.

Here's a picture of a wound, it has some pink clean tissue and quite a bit of necrotic tissue. So before I show you a little trick that might make the - assessing the amount of tissue types easier for you.

I want you, just in your mind, jot down what you think and what you write for this wound. How much necrotic tissue and how much pink clean tissue would you document?

And it is a judgment call, so you do have to use your best judgment. But I'm going to give you a little trick that might make it easier. Our eyes sometimes can play tricks on us when we see something we think is mostly necrotic or more than what it really is. But when you create a barrier, when you split something in half or into thirds, you can actually see sections a little bit better.

So what I recommend you do is to place imaginary lines across the wound, or you can actually make them physical lines and use your measuring tapes to do this. But if I place imaginary lines around the area that's usually either mostly necrotic or I pick the area that's mostly clean.

So the middle of this wound tends to be a little bit cleaner than the edges, but immediately by placing those lines we can see that we split this wound into thirds, and we can see that at a minimum two-thirds of the wound is quite necrotic and one-third is cleaner. However, we also see quite a bit of necrosis around the edge and there is still some scattered necrosis in the cleaner section.

So I would, after doing these lines, estimate this wound to be about 70% necrotic and 30% clean, or even as much as 75% necrotic and 25% clean. So compare that to what you thought it was before and see if those imaginary lines don't help a little bit in your eyes being able to break the percentages up. Let's take a look at another wound.

Okay here's a wound that has some pink healthy granulation tissue in the center, you can see that bumpy texture again. This person might be slightly

anemic, that's the only reason the granulation tissue isn't a bright red. And then it has some thick necrosis at both ends of this wound.

And again, I'm going to ask you just jot down how would you document the amount of necrosis and the amount of clean, pink granulation tissue in this wound if you were just glancing at it? I'll give you a sec.

Now I'm using my - sort of a tricky technique, but I think it really does help. If I put imaginary line and sort of the block off the necrotic - most necrotic areas and then proceed to split the wound up into even sections, you can see that I have five even sections on this wound. And I can clearly now see that two of the sections, or 40% of the wound is necrotic and about 60% of the wound is granulation.

Now if you got that same answer just by looking at it, then great, I think you have some good experience in wound assessment. But if you didn't, take the time to visually put something to break that wound up and you'll eyes will be able to get those percentages a little bit more accurate. Five sections would be the most I would do. And usually you can break the wound up into halves, thirds or even quarters and be able to get a more accurate percentage of tissue types. I hope that helps you all.

After you've done your tissue types and amount you look at your drainage. Now all of you should know this, this is Nursing 101. The types of drainage are serous, which is that clear thin, sanguineous which is bloody, serosanguineous which is a combination, and purulent.

Now some people like to also document foul purulent, but when you talk about odor later I think it's kind of redundant. And you all know that purulent drainage is that tan, opaque or yellow type of drainage.

When it comes to amount of drainage you need to look at the dressing you're removing, and these categories were established based on a dressing that was present on a wound for 24 hours. So many wound dressing today are left much longer, three, four, five, even seven days.

So if you had a long wearing dressing you need to adjust your drainage amounts based on that fact. But if you have a two day dressing and it has no drainage and the wound bed is dry, you would document, None.

If you have a two day dressing and there's just a, not a measurable amount of drainage on the dressing, but the wound that is nice and moist, this would be scant. Now some skin sheets combine these two and just say, "None," if there's no measurable drainage, and that's fine.

And the next three categories are pretty standard, small or light is 25% or less, moderate is that 25% to 75% and large is more than 75% of the dressing is covered with drainage.

And there is one more category listed here if you want to be very specific, and that's copious drainage. And that's if there's more drainage than the dressing could handle, the dressing is completely saturated and maybe even drainage is leaking out of the dressing. I would call that copious if I wanted to be very specific.

After you look at your drainage you want to look at the wound and document if there's anything in the wound that really is not usually there, or should be there. Or if there's bone present.

So if you have any sutures in the wound you definitely want to document their presence, or retention sutures as you see in some abdominal wounds.

If you have bone present and regardless of type of wound, you want to document it. And this does make your resident at higher risk for osteomyelitis, so it's critical that you document if bone is exposed. Some physicians actually believe that if the bone is exposed you should automatically assume that they are osteomyelitis. It depends on the physician you're talking to.

If there's any staples at the edge, and just as an aside, these staples really should be removed. They're not holding anything together right, or if you happen to see any maggots. And, no I didn't put that in there to gross any of you out, just to make sure you're awake and listening with me this morning.

Man, hopefully you would not see any maggots that you didn't purposely put there, and this is where this picture came from. We're actually using maggot therapy for debridement, and this is the maggot.

However, whether they're sterile maggots that you're specifically using for debridement, or ones that you don't want to - that you didn't put there, they look the same. So just so you know what they look like.

It's now time to look at the wound edge, and this is pretty straight forward, it's regular or irregular. Often they won't document if it's a regular shaped wound, that's sort of considered normal, but if it is irregular you'll want to note that.

Remember it might help you determine your etiology because venous stasis ulcers are often very irregular. And irregular means like a puzzle piece, it's not a shape that you learned in kindergarten. It's not oval or round or tear-dropped, it's just irregular.

You want to look at your edges, are they defined or undefined? Defined means you can clearly see where the wound ends and good tissue begins. And while again, you won't often see defined document - documented, that sort of considers the norm, you do want document if you have very undefined wound edges.

Look at the picture on the right, it's very difficult to tell where the edges of this wound start and stop. There's red open areas, there's dark almost black areas, there's purple areas, where are the starting and stopping points of this wound? This makes this wound very difficult to measure.

That means from week-to-week the measurements may change dramatically. And these are - you usually see these undefined edges in wounds that are deteriorating, or in suspected deep tissue injuries that are evolving. The damage has been done and the tissue is dying. So you want to document that for sure.

You also can have wound edges that attached or unattached. And again, sometimes you don't get this specific, but if they're unattached you definitely want to measure that undermining document, the direction and the amount. And we talked about that in Wound Documentation Part One.

If you have an epiboly you definitely want to document this. At the very top of this wound you can see that edge of the wound has curled under or rolled under and attached itself to itself. On the rest of the wound you can see where the wound edge is and skin begins.

When you have an epiboly this can actually halt or stop healing altogether. And sometimes the need to be actually cut away or a surgeon needs to cut a

new wound edge. So you want to document if you have one. A small one like this in one small area may not be as much of a problem as an epiboly all around the edge.

You want to document if your wound edges are macerated. This is the white, wet tissue you see here. This means that the wound drainage is too much for the dressing you chose, you need a more absorptive dressing, or you need to change that dressing more frequently or it means that the dressing you applied was much too moist.

We do not want to see macerated edges because they can turn into fibrotic tissue or scar tissue. And again, that also needs to be debrided. And if you have it you want to document that as well.

You want to document odor. Here's a few options you can list for odor, I will be honest with you, for me it's either there is an odor or it's foul or it's not. My nose is not sensitive enough anymore after smelling wounds for many, many, many years to distinguish between sweet or musty. But you can get specific if you want. But certainly just foul or an odor or no odor is perfectly fine.

Then when you look at the periwound, that's the area around the wound. And of course you're looking for color and temperature. Is there any warmth, is there any induration, that's firmness. That could be an indication of infection. You would want to note if there was any scars indicating that this is a wound over a previous wound, or rashes or lesions of any kind in the periwound area. Of course you're documenting for signs and symptoms of infection.

For a wound this could be an increase in drainage, a change in the drainage, if it becomes purulent, increase in pain, of course that odor we talked about, any discolorations in the wound bed. Of course that induration just talked about.

And of course any redness periwound or any streaking could certainly be an indication of infection.

You'll of course want to also document your wound pain. And it's the same as any other type of pain assessment, it's location, intensity, quality and duration. You want to document what works, and if your resident has a premedication order be sure to document the effectiveness of that post-dressing.

And although resident or family education isn't really part of wound assessment, it should definitely be part of your wound documentation. You want to document that you explained the dressing, the procedure, what you were doing to the resident during, what the plan of care is for that wound, if the resident is alert enough to hear that, or that the family is completely aware of that plan of care.

So remember, tissue is type and amount. Drainage is also type and amount. Any foreign objects or any bone present, you want to document that. Look at your wound edge, your periwound, always look for signs and symptoms of infection, and always assess for pain and document.

So let's do a quick review of this wound. This wound is a pressure ulcer, and I'll give you the etiology. It is a Stage 4, and I'll show you in a minute while we're sure that that is. And it's located over the sacral coccyx area, and you can kind of see where the head of the person would be.

So and then the next step would be to look at tissue type and amount. Well it is obviously quiet, almost all, necrotic tissue. Maybe about 10% somewhere around those edges that are fairly clean.

It has what I would call, probably a larger copious amount of drainage. And even though we can't see the dressing, we actually see some drainage pooling on the left side of that wound. So that tells us that it's probably at least a large amount.

And there is bone present. If you look at that slightly brighter white spot just above that copious drainage, slightly to the right, that is actually bone, that's the coccyx bone. So we know that this a Stage 4, we have bone exposed even though there's a lot of necrotic tissue.

The edges are very undefined, irregular, and there is some undermining so they're unattached. And of course we don't have smell-o-vision so we can't tell the odor. And the periwound is a little bit cut off but those are the other things we wouldn't want to forget. Of course signs of infection and pain would be assessed as well.

Keep in mind the medical record is a legal record and you want to use correct terminology when you're assessing and documenting on your wounds.

I'd like to thank you all for your participation this morning and turn it over from (Mark) and ask any - if there are any questions.

Operator: Thank you. Ladies and Gentlemen if you'd like register a question please press the 1 followed by the 4 on your telephone. You will hear a three tone prompt to acknowledge your request. If your question has been answered and you'd like to withdraw your registration, please press the 1 followed by the 3. If you are using a speaker phone please lift your handset before entering your request. One moment please for the first question.

Ladies and Gentlemen as a reminder to register for a question press the 1 4.

Jackie Hairston: Well Pam while folks are kind of thinking of questions, I found that little trick that you shared about measuring the wound to be really handy. And I'm sure I've heard you say that before, but it really kind of rung in my head today. Is that a trick that they teach Wound certified nurses or is that kind of - because I don't remember that from nursing school.

Pamela Kane: No they don't teach it at nursing school, it's actually - a Wound certified doctor taught me that even before I was Wound Care certified, and how the eye really does play a trick.

But when you visually have division that you're looking at, you can divide something in half or in thirds visually much easier just by putting that line there. So that was more than twenty-some years ago. I have to thank the doctor for that.

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

Operator: There are no questions at this time.

Jackie Hairston: Okay. Well (Buck Anear) I know you're on the line if you would go ahead and post the polling questions for us as we bring this call to a conclusion. And I just want to thank you Pam for providing us with this critical and pertinent information. And I know our participants that are out there listening will be going back to their facilities and putting these lessons into practice.

As we close, those of you on the WebEx portion, we do ask that you would complete this brief evaluation. We do value your feedback. As I said earlier, "Part Two of Wound Documentation will be repeated at 3:30," so if you have

staff that are struggling with documentation, I would recommend that you have them get on the phone and listen in to this call.

Just to let you know, you will be receiving information shortly on the next National Learning session. That will be happening on August 21, so you will be getting information on how to register for that national call.

And, you know, this is a great time or an opportunity for you to be able to hear what your peers are doing across the nation. And also mark your calendars for our Learning Session Number 2, which will be happening in October, October 24, which is a Thursday. And it will be an all-day session so do mark your calendars. I know you received an initial Save the Date, and we will be sending additional information as it gets a little bit closer.

So again, thanks for joining us today. And this officially ends the call. Thank you everyone.

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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