

# Hands-On Wound Assessment: Ready, Set, Let's Go!



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# Objectives

Practice a “hands on” wound assessment which includes the following:

1. Pressure ulcer stage
2. Location
3. Size
4. Drainage, Odor
5. Undermining/Tunneling
6. Character of wound: Tissue type
7. Peri-wound condition
8. Recognize non-pressure related wound types

# Getting Started

- Follow along using your own nursing home's wound care assessment records:
  - Weekly Pressure Ulcer Record
  - Non-Pressure Skin Condition Report
- In this demonstration we will record our “hands on” assessments of our model's wounds.
- The definitions used in this presentation are from MDS 3.0 manual.

# MDS 3.0: What is a Pressure Ulcer?

- CMS has **adapted** the NPUAP 2007 definition of a pressure ulcer as well as categories/staging.
- A pressure ulcer is a localized injury to the skin and/ or underlying tissue *usually* over a bony prominence, as a result of **pressure** or **pressure** in combination with **shear** and/ or **friction**.



CMS, 2010

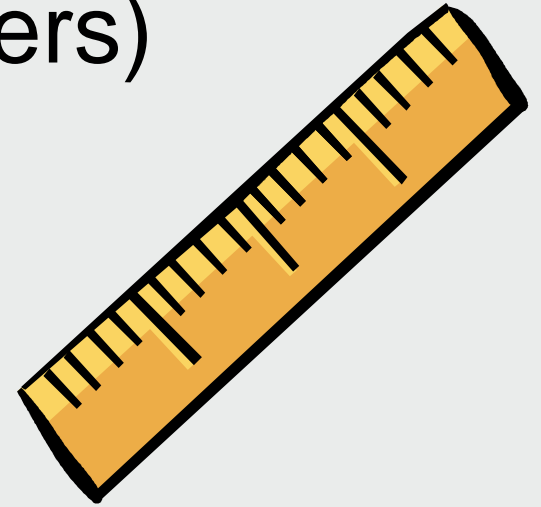
CMS, 2010.

# Pointers in Assessing Skin Condition

- Perform a head-to-toe, full body skin assessment.
- Check any reddened areas for ability to blanch.
- Focus on bony prominences and pressure-bearing areas, such as:
  - Sacrum
  - Heels
  - Buttocks
  - Ankles
- Search for other areas of skin that differ from surrounding tissue.
  - Firm, painful, warmer or cooler, softer, color change.

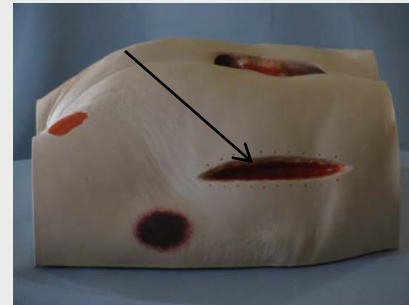
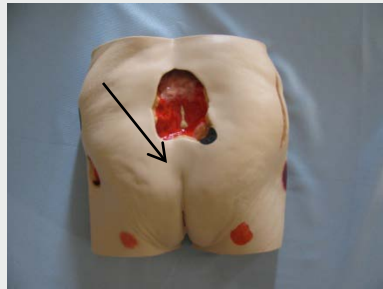
# Wound Assessment

- **Stage** (for pressure ulcers)
- Location/etiology
- Size: Length, width, depth
- Exudate
- Tunneling/Undermining (cm)
- Odor
- Wound bed tissue
- Surrounding skin color
- Surrounding tissue/wound edges
- Pain



# Staging

- If it is a pressure ulcer, choose the applicable stage.
- Non pressure ulcers are not staged.
- Which wound on this model would not be a pressure ulcer?
- Answer: The rectal fissure or the dehisced surgical wound.



# M0300: Pressure Ulcer Staging

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable related to non-removable dressing/device.
- Unstageable related to slough and/or eschar.
- Unstageable related to suspected Deep Tissue Injury.

CMS, 2010.

# Category/ Stage 1 Pressure Ulcer

- Intact skin with ***non-blanchable redness*** of a localized area usually over a bony prominence.
- **Darkly pigmented skin** may not have visible blanching.
- Color may differ from the surrounding area.

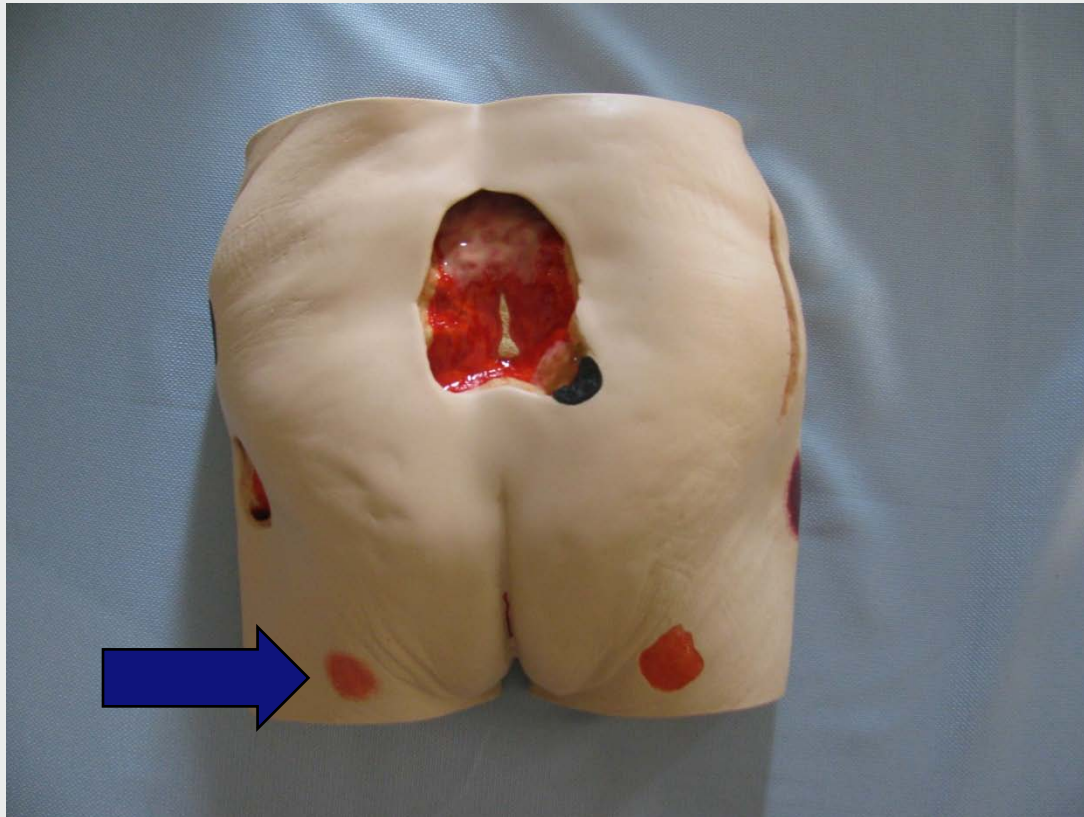


# Is this a Stage 1 Pressure Ulcer?

**Moisture  
associated  
skin damage  
from  
incontinence.**



# Which ulcer is the Stage I pressure ulcer ?



- Left Ischial Pressure Ulcer

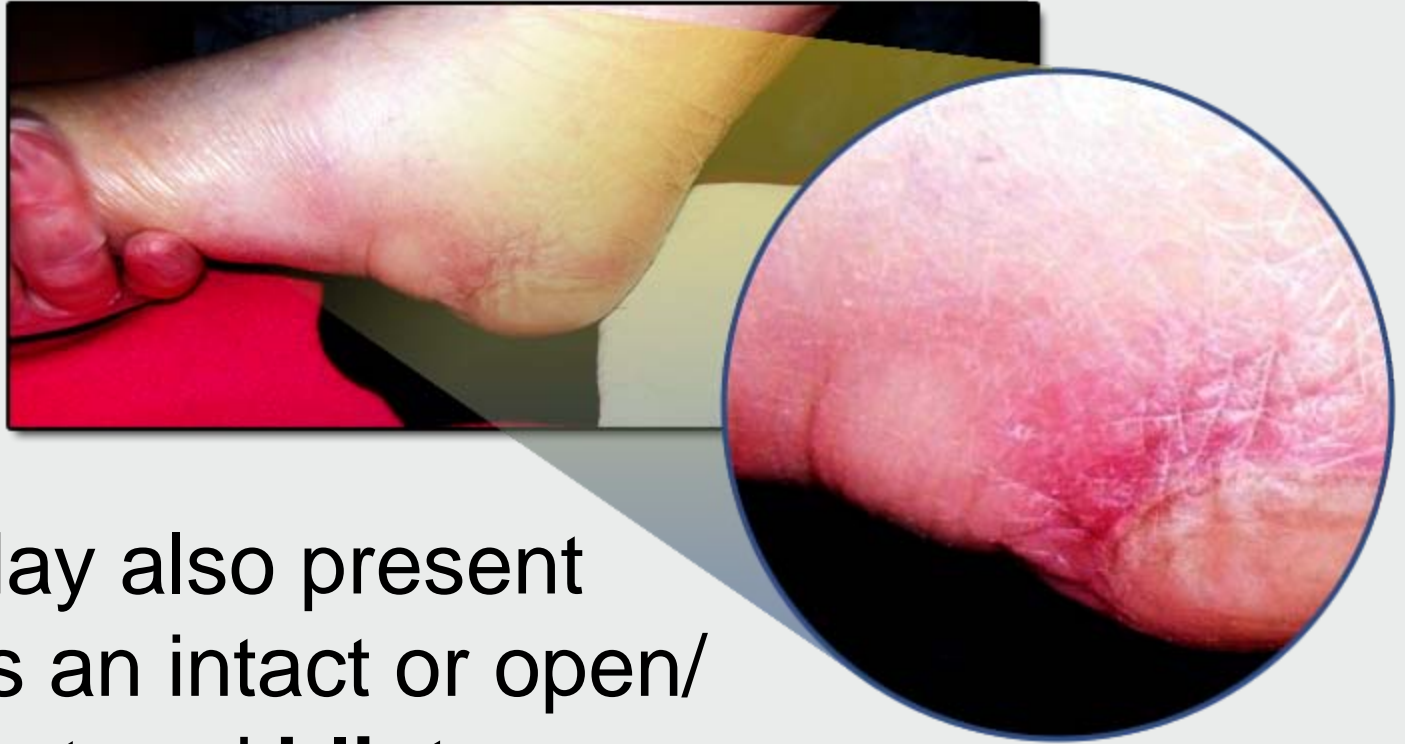
# Category/ Stage 2 Pressure Ulcer<sub>1</sub>

- **Partial thickness** loss of dermis presenting as:
  - **Shallow open** ulcer
  - Red or pink wound bed
  - **Without slough**



CMS, 2010

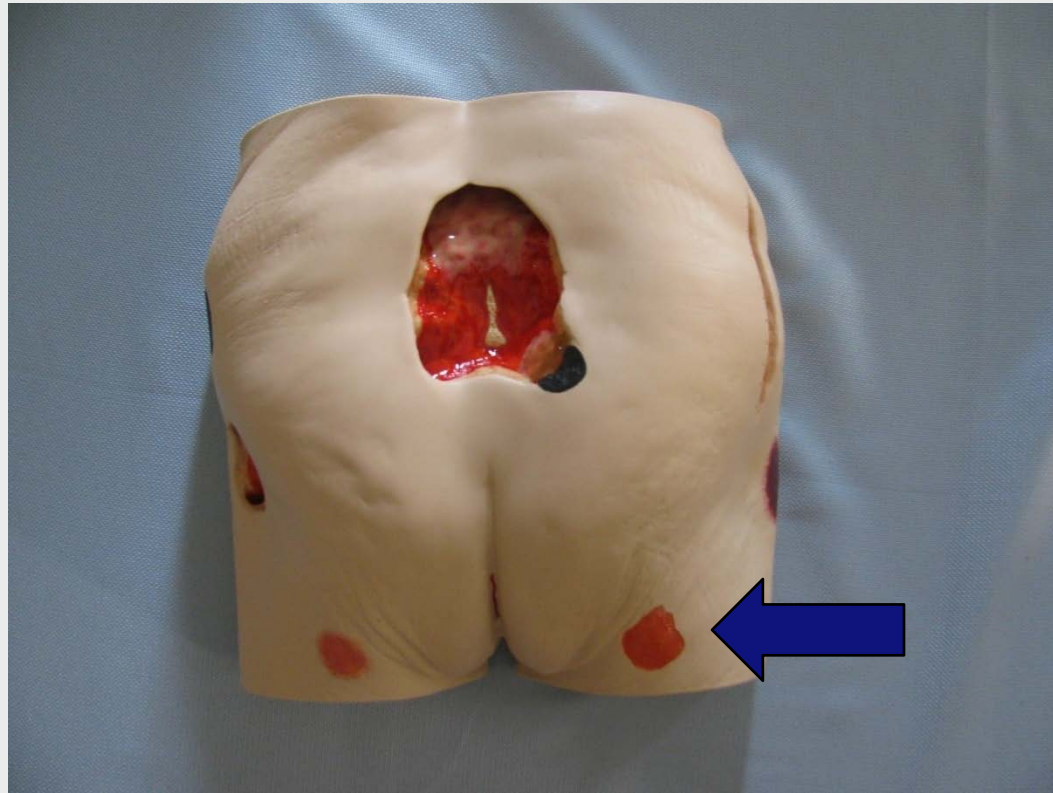
# Category/ Stage 2 Pressure Ulcer<sub>2</sub>



- May also present as an intact or open/ruptured **blister**.

CMS, 2010

# Which ulcer is the Stage II pressure ulcer ?



- Right Ischial Pressure Ulcer

# M0300B Assessment Guidelines<sub>1</sub>



CMS, 2010

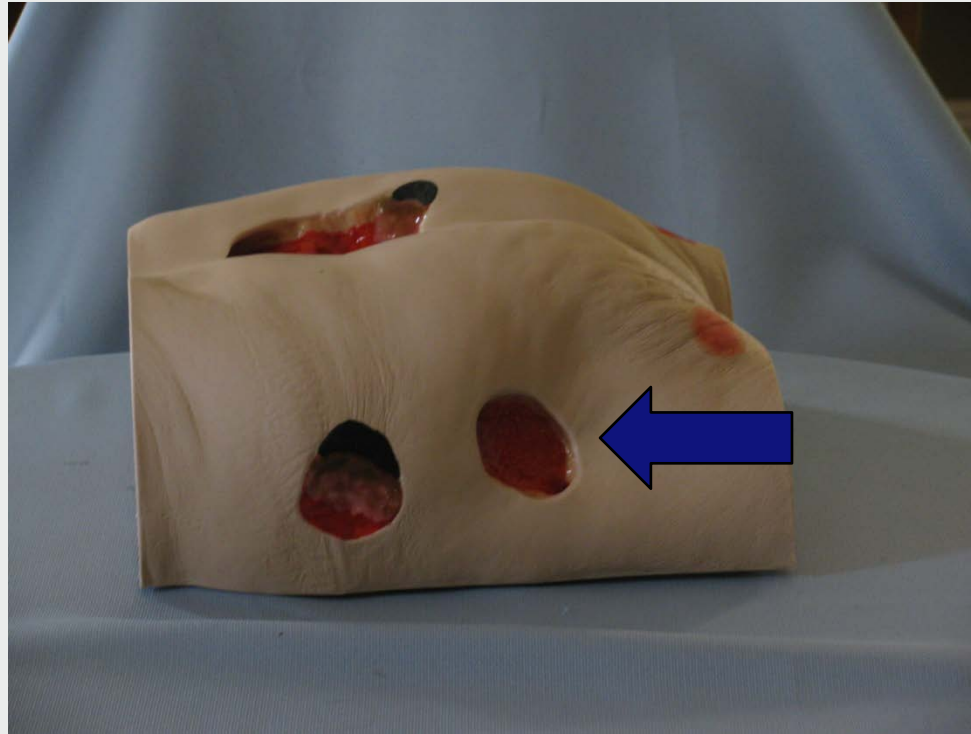
- Do **NOT** code as a Stage 2 when a deep tissue injury is determined. Code in M0300G Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury.

# Category/ Stage 3 Pressure Ulcer

- **Full thickness** tissue loss.
- Subcutaneous **fat may be visible** but bone, tendon or muscle are ***not*** exposed.
- **Slough may be present** but does not obscure the depth of tissue loss.
- **May** include undermining and tunneling.



# Which ulcer is the Stage III pressure ulcer ?



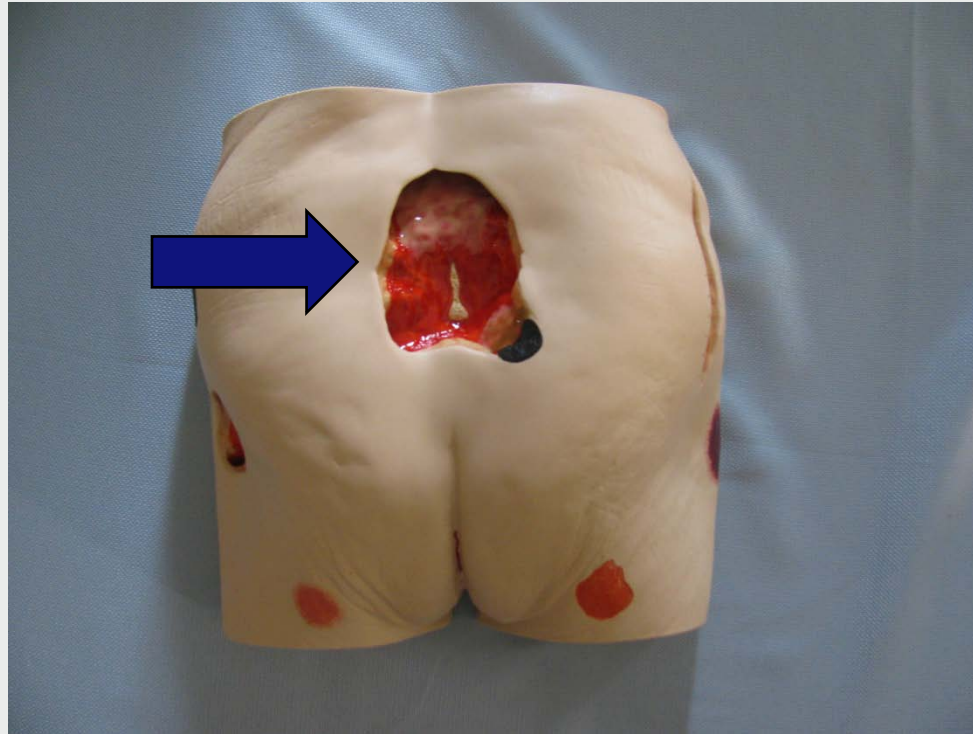
- Left Trochanter Pressure ulcer

# Category/ Stage 4 Pressure Ulcer

- **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.
- Depth varies by anatomical location (bridge of nose, ear, occiput and malleous ulcers can be shallow).



# Which ulcer is the Stage IV pressure ulcer ?



- Sacral pressure ulcer

# M0300E Unstageable Non-Removable Device

- Ulcer covered with eschar under plaster cast.
- **Known** but not stageable because of the non-removable device.



# M0300E Unstageable Non-Removable Dressing

- **Known** but not stageable because of the non-removable dressing.



CMS, 2010

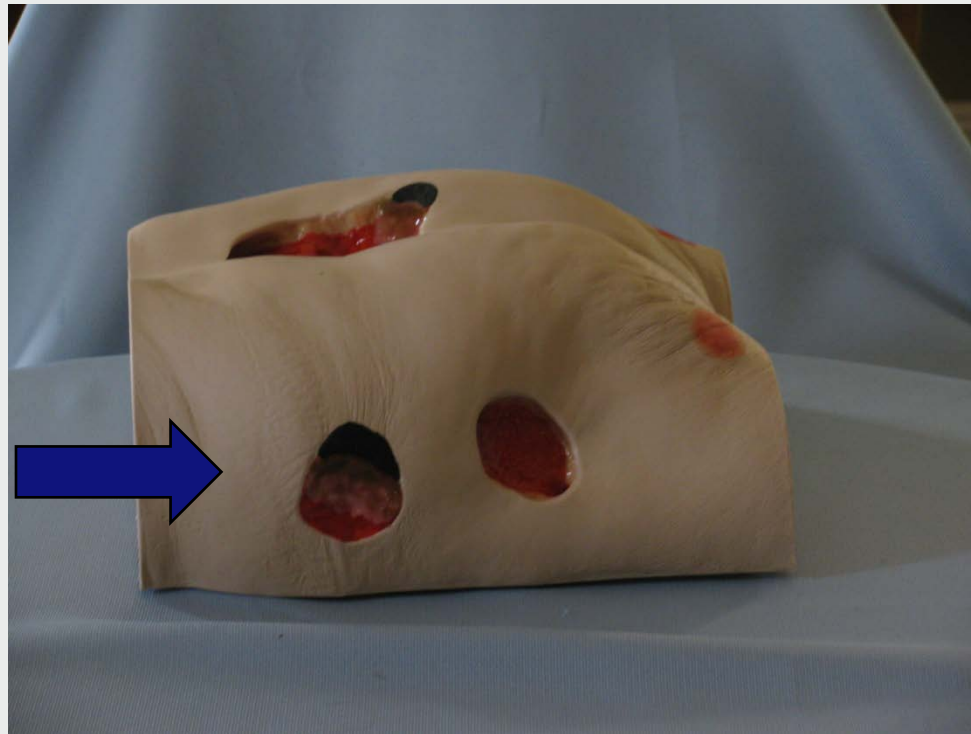
# M0300F Unstageable Slough and/ or Eschar

- **Known** but not stageable related to coverage of wound bed by slough and/ or eschar.
- Full thickness tissue loss.
- Base of ulcer covered by slough (yellow, tan, gray, green or brown) and/ or eschar (tan, brown or black) in the wound bed.



CMS, 2010

# Which ulcer is Unstageable Pressure Ulcer with Slough and Eschar?



- Unstageable pressure ulcer with slough and eschar

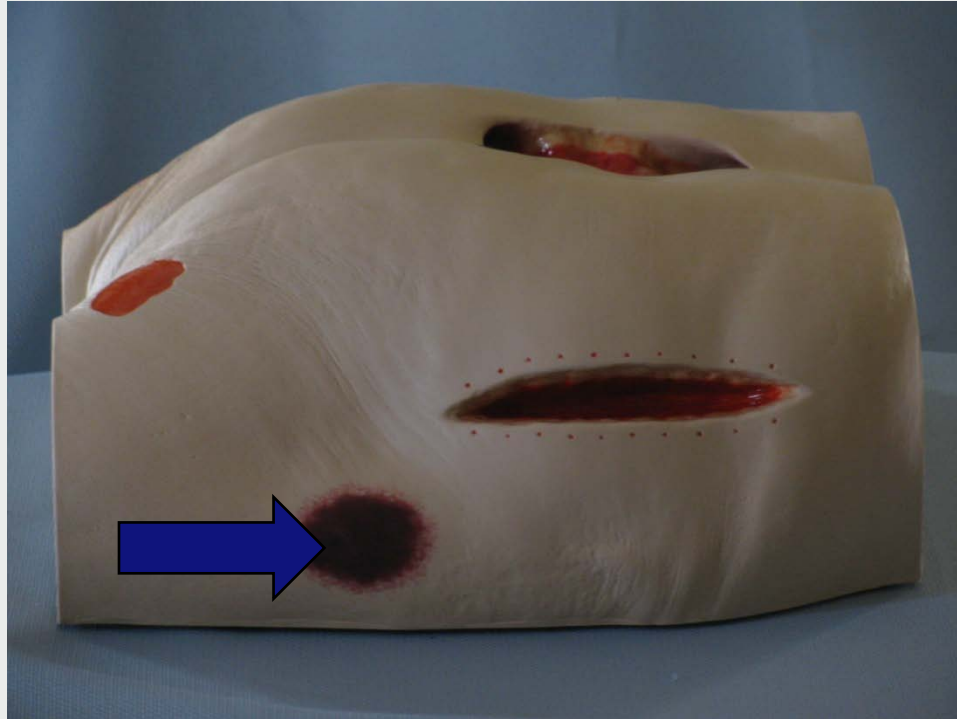
# M0300G Unstageable Suspected Deep Tissue Injury<sub>1</sub>

- Localized area of discolored (darker than surrounding tissue) intact skin.
- Related to damage of underlying soft tissue from pressure and/ or shear.
- Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.



CMS, 2010

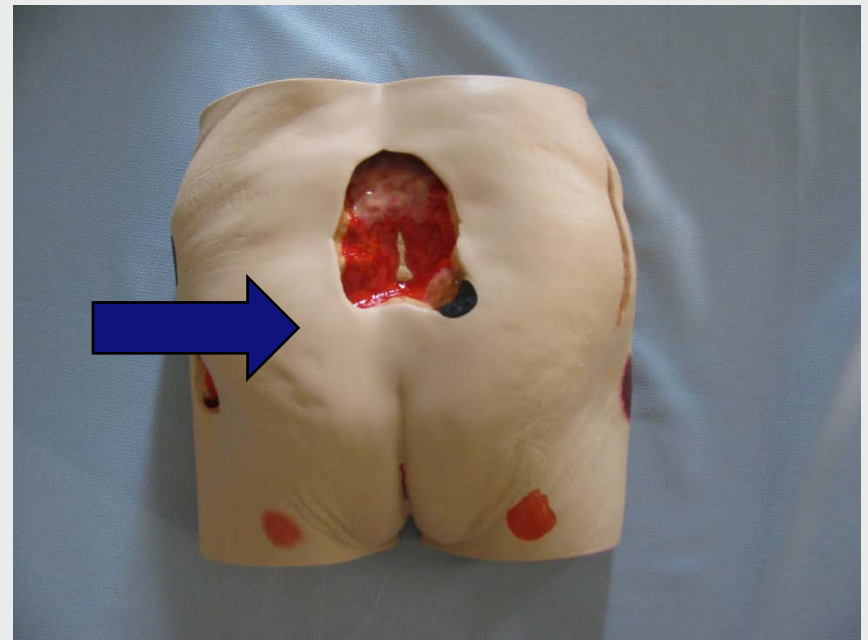
# Which ulcer is Suspected Deep Tissue Injury ?



Suspected Deep Tissue Injury

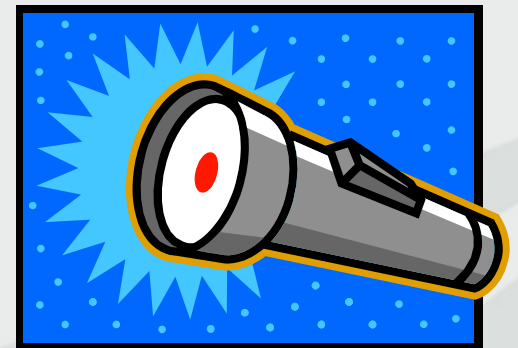
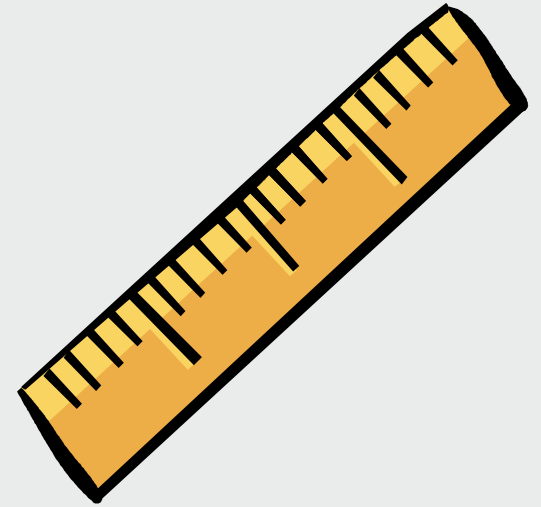
# For Learning Purposes Let's Assess this Pressure Ulcer

- Record your assessment findings on your Weekly Pressure Ulcer Record.
- What stage?
- Stage IV.



# Wound Assessment

- Stage
- Location**
- Size: Length, width, depth
- Exudate
- Tunneling/Undermining (cm)
- Odor
- Wound bed tissue
- Surrounding skin color
- Surrounding tissue/wound edges
- Pain



# Pressure Ulcer Location

Educational Workshop for RNs and RPNs: Assessment and Management of Pressure Ulcers

## Assessing Risk Factors for Developing Pressure Ulcers

### Common Pressure Ulcer Sites

#### Supine Position

- ▶ heels, sacrum, elbows, scapulae, back of head

#### Lateral Position

- ▶ malleous, medial and lateral condyles, greater trochanter, ribs, acromion process, ear

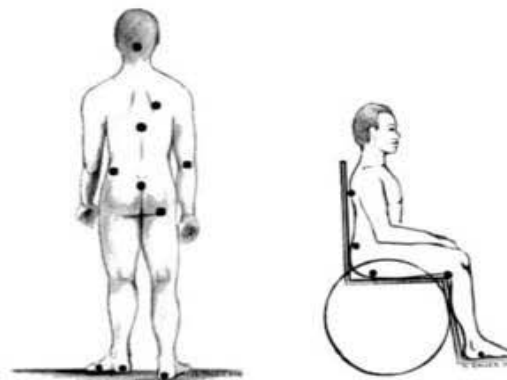
#### Prone Position

- ▶ toes, knees, genitalia (men), breasts (women), acromion process, cheek and ear

#### Sitting Position

- ▶ elbow, sacrum, ischium

*Be consistent!*



Illustrated by Nancy A. Bauer, BA, Bus Admin, RN, ET

Educational Workshop for RNs and RPNs: Assessment and Management of Pressure Ulcers:  
Part 1: Assessment and Management of Pressure Ulcers. Registered Nurses of Ontario, 2007.  
<http://www.rnao.org/Page.asp?PageID=924&ContentID=1275>

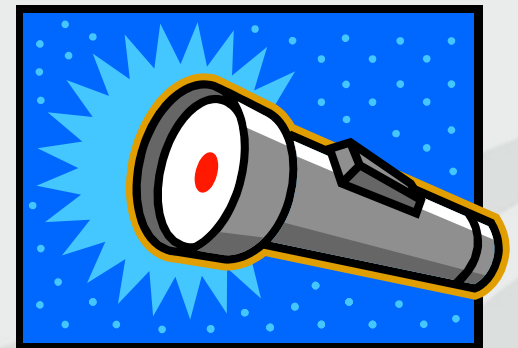
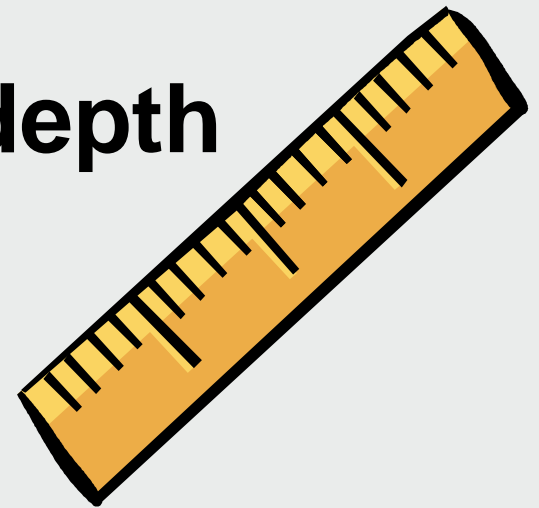
Nursing Best Practice Guidelines Program

Registered Nurses' Association of Ontario

# Wound Assessment

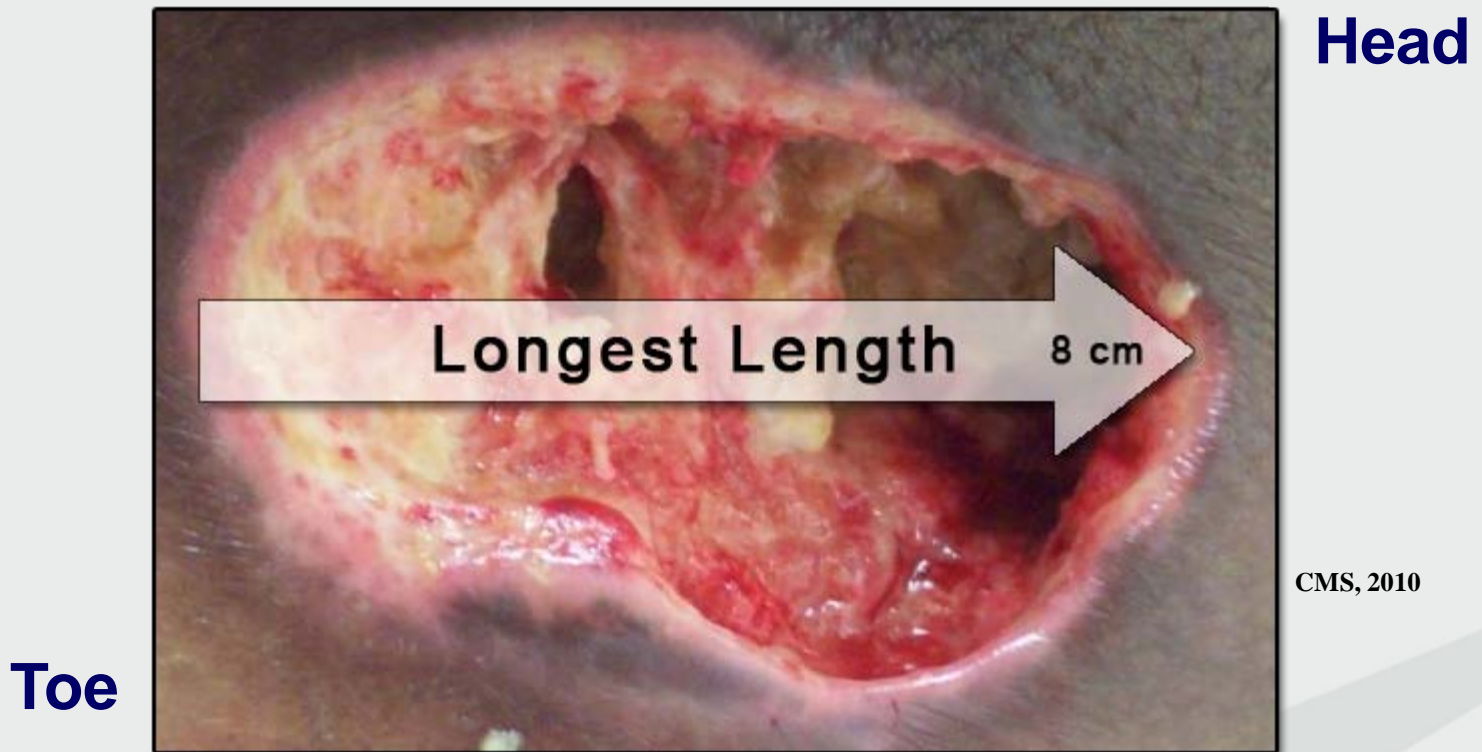
## Sacral Stage IV

- Stage
- Location
- Size: Length, width, depth**
- Exudate
- Tunneling/Undermining (cm)
- Odor
- Wound bed tissue
- Surrounding skin color
- Surrounding tissue/wound edges
- Pain



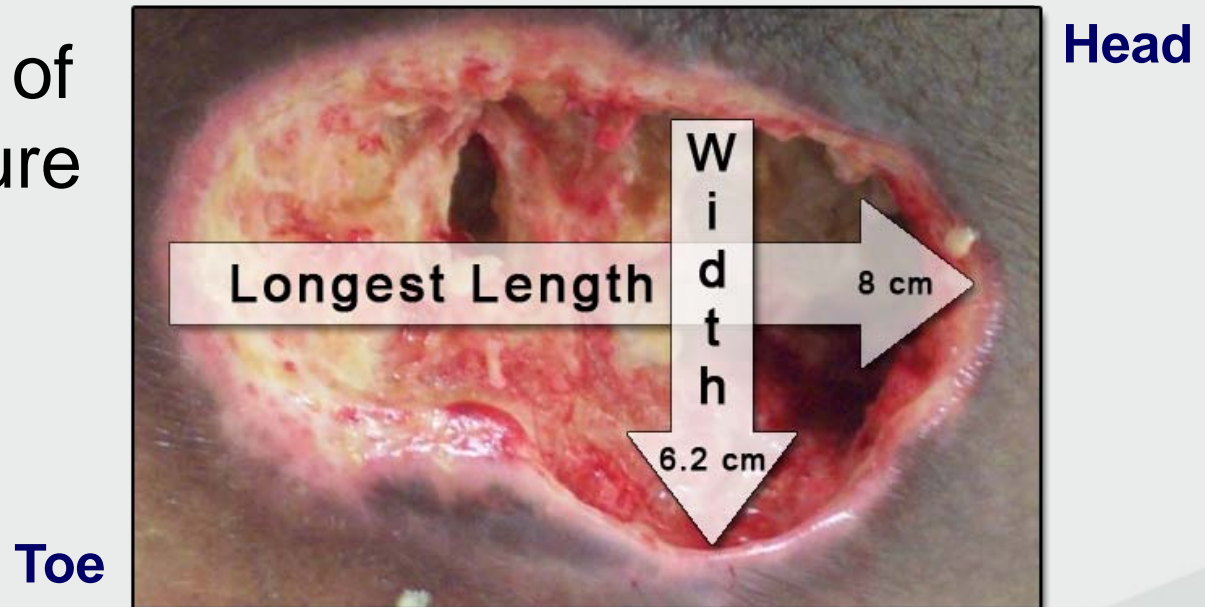
# M0610A Length

- Measure the longest length from head to toe using a disposable device.



# M0610B Width

- Measure widest width of the pressure ulcer side to side perpendicular (90° angle) to length.
- The depth of this pressure ulcer is 3.7 cm.



CMS, 2010

# M0610C Depth

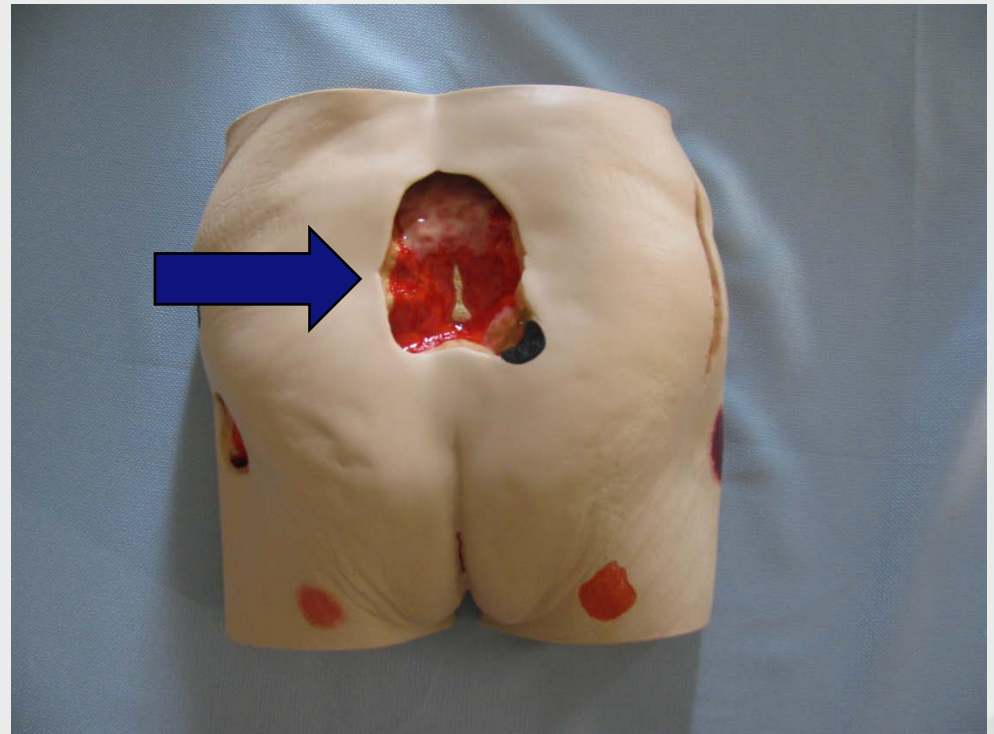
- Moisten a cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water.
- Place applicator tip in deepest aspect of the wound and measure distance to the skin level.



CMS, 2010

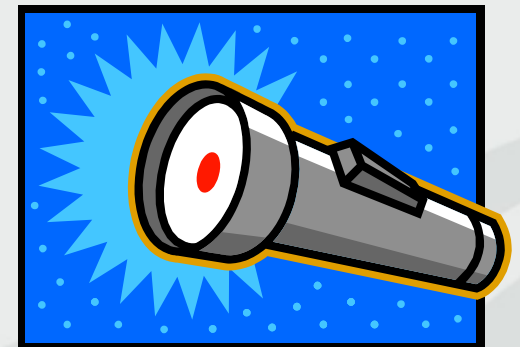
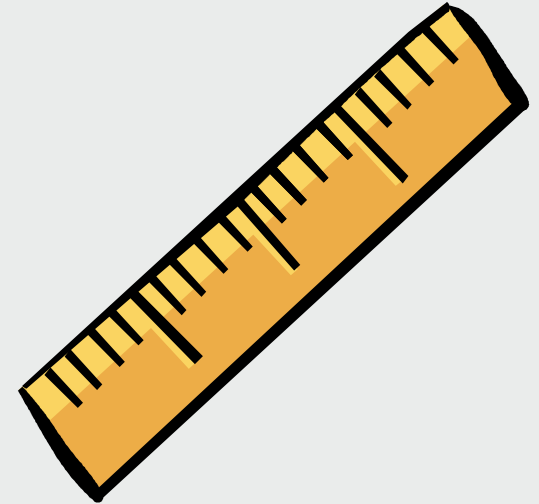
# Identify the Sacral Stage IV Pressure Ulcer's Measurements?

- Length: 9.6 cm
- Width 7.7 cm
- Depth 3.2 cm



# Wound Assessment

- Stage
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# Wound/Skin Healing Record Form

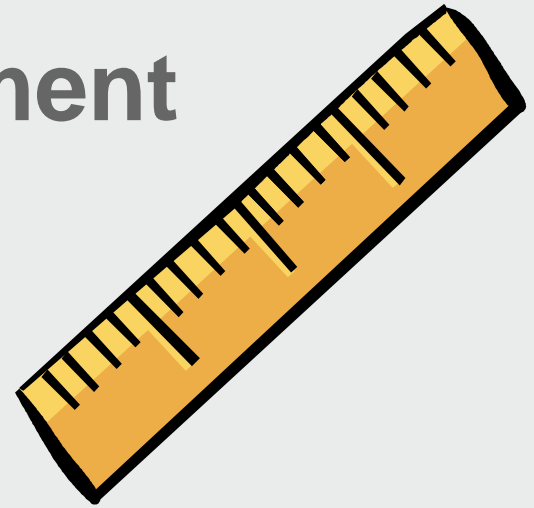
## Exudate

- **Exudate type:**
  - None, serous, serosanguineous, purulent
- **Exudate amount:**
  - None, scant, small, moderate, large, copious
- **Odor:**
  - None, slight, moderate, foul

Briggs, Form 3169HH, 9/10

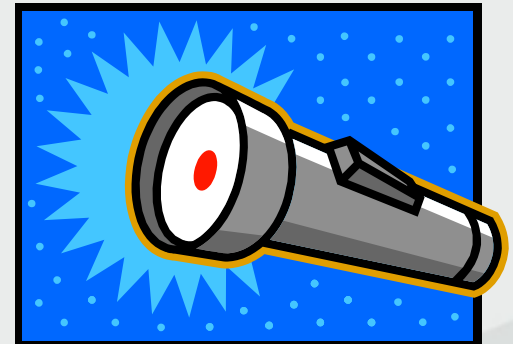
# Wound Assessment

- Stage
- Location
- Size: Length, width, depth
- Exudate



## •Tunneling/Undermining (cm)

- Odor
- Wound bed tissue
- Surrounding skin color
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- Pain



# Undermining/Tunneling

## Tunneling

A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.



CMS, 2010

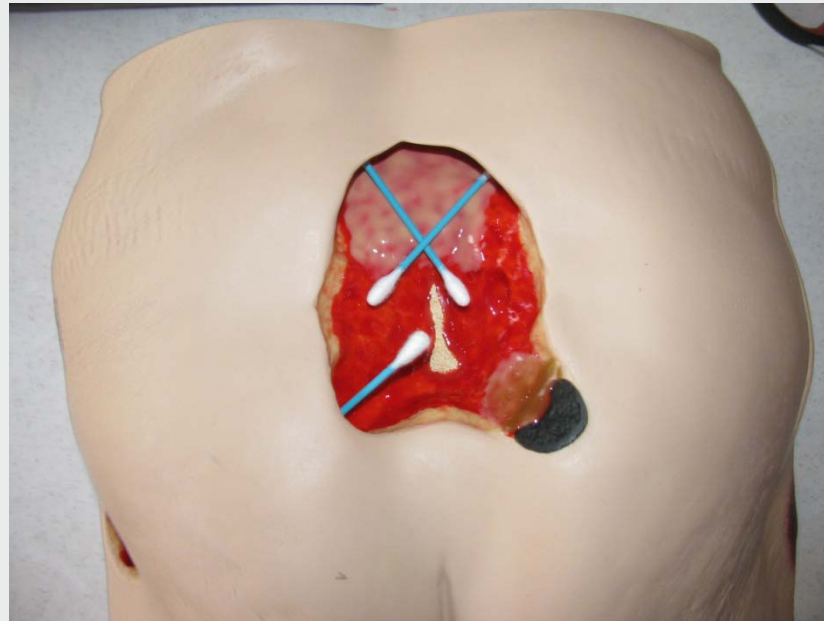
## Undermining

The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.

## Practice Point

Describe undermining or tunneling in relation to a clock. Head is 12 o'clock, feet 6 o'clock.

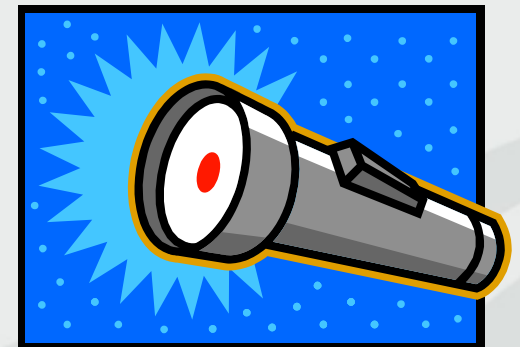
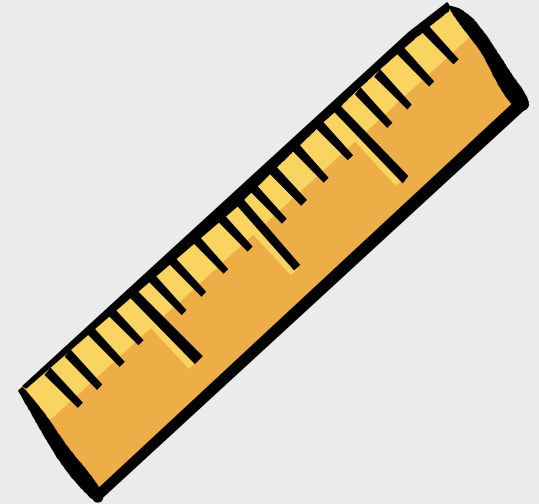
# Assess the Tunneling and Undermining of the model



- Tunneling 7 to 8 o'clock; 4cm
- Undermining: 11 to 1 o'clock, 2.4 cm

# Wound Assessment

- Stage
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# Wound Bed Tissue

Describe the wound bed appearance.

If the wound has a mixture of these, mark the percentage of each.



**Epithelial tissue**



**Granulation tissue**



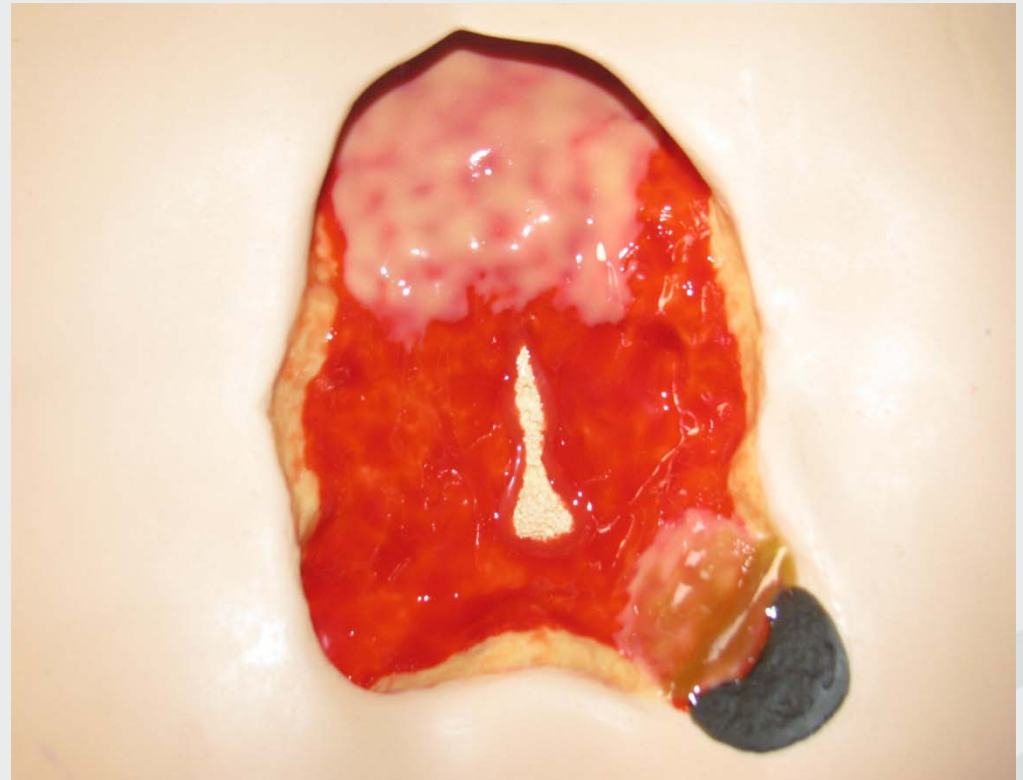
**Slough**



**Eschar**

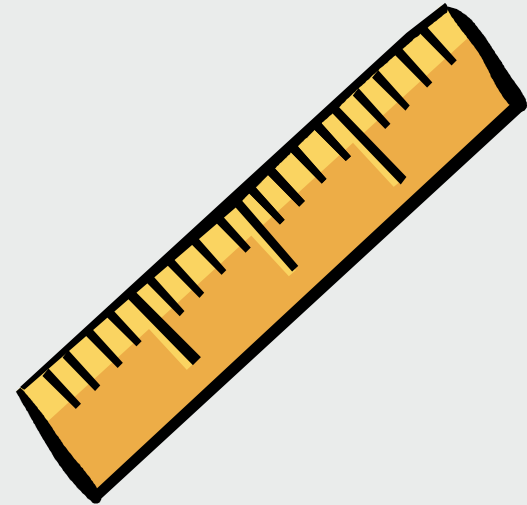
# What's the tissue type of the model's Sacral Stage IV pressure ulcer?

- Eschar: 10%
- Slough: 40%
- Granulation: 50%



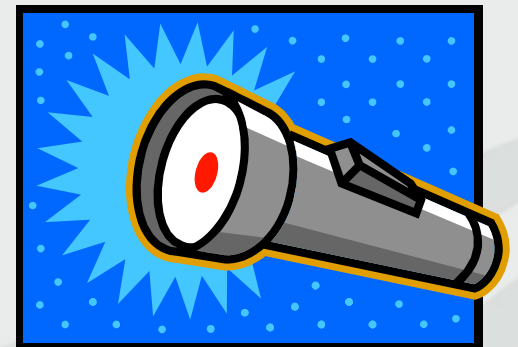
# Wound Assessment

- Stage
- Location
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- Wound bed tissue



- Surrounding skin color**

- Surrounding tissue/wound edges
- Pain



# Wound/Skin Healing Record Form

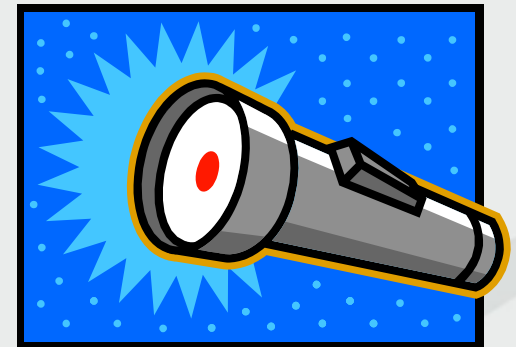
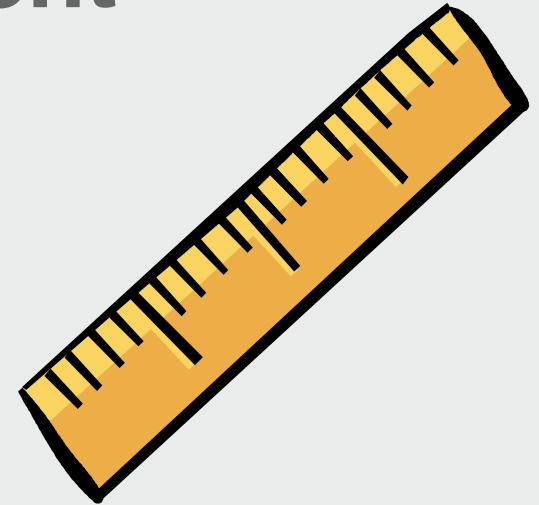
## Surrounding Skin Color

- Assess tissues within 4 cm of the wound edge.
- Normal
- Pink
- Bright Red
- White/Gray Pallor
- Dk Red/Purple
- Black/Brown

Briggs, Form 3169HH, 9/10

# Wound Assessment

- Stage
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# Wound/Skin Healing Record Form

## Surrounding Tissue/Wound Edges

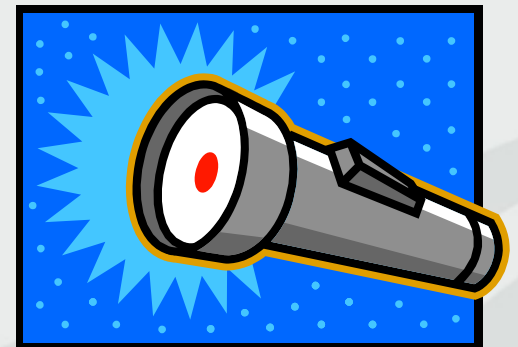
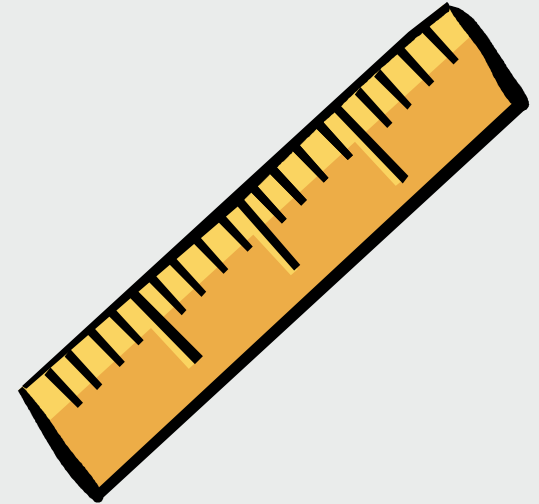
### Choices:

- Normal for skin
- Peripheral tissue edema
- Maceration
- Hardness/induration
- Rolled edges

Briggs, Form 3169HH, 9/10

# Wound Assessment

- Stage
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# Wound/Skin Healing Record Form

## PAIN

- Pain location
- Nature of Pain
- Intensity: Wong's Face Scale or Numeric Pain Scale
- Nonverbal clues: Diaphoresis, grimacing, moaning/crying, guarding, irritability, anger, tense, restlessness, change in vital signs, other.

Briggs, Form 3169HH, 9/10

# Lab Data

## Practice Point

**Assess laboratory parameters for nutrition status. No single measurement has been shown to predict the risk of developing pressure ulcers. WOCN, 2010.**

	Normal	Moderate Depletion	Severe Depletion
<b>Albumin</b> <small>Can be affected by infection, acute stress, surgery, cortisone excess, dehydration.</small>	3.5 G/dl or greater	2.8-3.5 G/dl	2.8 G/dl or less
<b>Prealbumin</b> <small>Low levels may indicate metabolic stress and inflammation</small>	14 mg/dl or greater	11-14 mg/dl	11mg/dl or less

# References

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[http://www.rnao.org/Storage/18/1221\\_LearningPackage\\_VenousLegUlcers.pdf](http://www.rnao.org/Storage/18/1221_LearningPackage_VenousLegUlcers.pdf)
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