Long-Term Care Wound Assessment and Documentation: Meeting the Regulatory and Clinical Guidelines for Best Practice

FACULTY

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Disclaimer

• “This information is provided for informational purposes only. Patient management decisions should be based on a number of factors, including (but not limited to) professional society guidelines and published clinical literature relevant to a patient’s condition.

• Providers are encouraged to rely on their training and expertise, as well as any and all available information, prior to making management or treatment decisions for any individual patient.”
Objectives

At the end of this program participants will be able to:

- Describe the purpose of the wound assessment and documentation.
- Identify components of wound assessment and documentation that are required by CMS.

Introduction to Presentation

- Documentation: critical component of resident care
- Office of the Inspector General (OIG) of the US Department of Health and Human Services
  - providers carry the burden of proving that care was actually rendered to patients (residents)
  - Health care providers must prove they rendered appropriate care
  - OIG may conclude that claims submitted are false
- Providers also risk liability for negligence or malpractice when they fail to document care provided
- Survey process
- Critical for quality care related to caregiver to caregiver communication
Presentation Content and Forms

- Crossed referenced with current regulatory and clinical best practice guidelines for LTC
  - State Operations Manual - F686/F684
  - MDS 3.0, M-Section
  - NPUAP
  - Current best practice for wound assessment

Documenting Pressure Ulcer/Injury Characteristics According to CMS State Operations Manual

- It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility.

State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Table of Contents
(Rev. 11-22-17)
### Initial Wound Assessment

**Clinically Complicating Factors**

<table>
<thead>
<tr>
<th>Complexity/Effect</th>
<th>Skin</th>
<th>Health History/Injury/Condition</th>
<th>Wound Characteristics</th>
<th>Treatment/Prognosis</th>
<th>Control/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>Cancer, Other Systemic Conditions</td>
<td>Infected, Necrotic</td>
<td>Difficult to treat</td>
<td>None</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Diabetes, Hypertension</td>
<td>Ulcer</td>
<td>Chronic</td>
<td>None</td>
</tr>
<tr>
<td>Obstructive Lung</td>
<td></td>
<td>Obstructive Lung Disease, Other</td>
<td>Serous Effusion</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Skin Lesions</td>
<td></td>
<td>Skin Lesions, Wound Infection</td>
<td>Infection</td>
<td>Difficult to treat</td>
<td>None</td>
</tr>
<tr>
<td>Wound Infections</td>
<td></td>
<td>Wound Infection, Other</td>
<td>Infection</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Weekly Wound Assessment**

**Weekly Wound Assessment Form**

- **Date of Assess:**
- **Wound Site:**
- **Complicating Factors:**
  - **Wound Characteristics:**
    - **Wound Bed:**
      - **Wound Depth:**
      - **Epidermis:**
      - **Dermal:**
      - **Subcutaneous Fat:**
    - **Wound Status:**
      - **Drainage:**
      - **Infection:**
      - **Healing:**
      - **Symptoms:**
      - **Treatment:**
        - **Wound Care:**
        - **Antibiotics:**
        - **Institutional:**
        - **Follow-Up:**

**Notes:**

- **Patient Signature:**
- **Other Observations:**
- **Other Complicating Factors:**

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Date Wound Identified

<table>
<thead>
<tr>
<th>Date Wound ID'd</th>
<th>m m d d y y</th>
<th>□ New Wound</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Recurrence - Same etiology/same location
- Date of Last Recurrence:

Reoccurrence = Recidivism

The presence of a previously healed PU/PI. The history of any healed PU/PI, its origin, treatment, its stages [if known] is important assessment information, since areas of healed Stage 3 or 4 PU/PIs are more likely to have recurrent breakdown.

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Throughout this section, terminology referring to “healed” versus “unhealed” ulcers refers to whether or not the ulcer is “closed” versus “open.”

When considering this, recognize that Stage 1, Deep Tissue Injury (DTI), and unstageable pressure ulcers although “closed” (i.e., may be covered with tissue, eschar, slough, etc.) would not be considered “healed.”

**DEFINITION**

**HEALED PRESSURE ULCER**

Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration.

Facilities should be aware that the resident is at higher risk of having the area of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue.

Tensile strength of the skin overlying a closed pressure ulcer is 80% of normal skin tensile strength.

Facilities should put preventative measures in place that will mitigate the opening of a closed ulcer due to the fragility of the overlying tissue.
Ensure Your Braden Done Correctly!!!

Statement in SOM

Regardless of any resident's total risk score on an assessment tool, clinicians are responsible for evaluating each existing and potential risk factor for developing a pressure injury and determining the resident's overall risk.

It is acceptable if the clinician's assessment places the resident at a higher risk level than the overall score of the assessment tool based on assessment factors that are not captured by the tool. Documentation of the clinician's decision should be placed in the medical record.

<table>
<thead>
<tr>
<th>Braden Score</th>
<th>Braden Risk</th>
<th>Advanced to next level of risk due other major risk factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td>See page 2 Complicating Factors</td>
<td></td>
</tr>
</tbody>
</table>

Braden Parameters

<table>
<thead>
<tr>
<th>Sensory Perception</th>
<th>Moisture</th>
<th>Activity</th>
<th>Friction &amp; Shear</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. No Impairment</td>
<td>4. Rarely Moist</td>
<td>Occasionally</td>
<td>Problem</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mobility</th>
<th>Nutrition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Completely Immobile</td>
<td>1. Very Poor</td>
<td>1. Problem</td>
</tr>
<tr>
<td>4. No Limitations</td>
<td>4. Excellent</td>
<td>Problem</td>
</tr>
</tbody>
</table>
**Bradon Scale Scores**

- **Mild Risk** = 15 - 18
- **Moderate Risk** = 13 - 14
- **High Risk** = 10 – 12
- **Very High Risk** = 9 or below

**If other major risk factors are present** e.g.
- Age,
- Fever,
- Poor dietary intake of protein,
- **Diastolic pressure <60**, and/or hemodynamic instability),

**Advance to next level of risk.**

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**Low Blood Pressure**

- **Systolic BP below 100 mmHg** – associated with PrU development

- **Hypotension may shunt blood flow away from the skin to more vital organs**

- Decreasing the skin tolerance for pressure by allowing capillaries to close at lower levels of interface pressure
Each existing pressure ulcer be identified
  • Whether present on admission or developed after admission

Factors that influenced the PU/PI development

Potential for development of additional PU/PIs

Factors causing deterioration of the pressure ulcer(s)

All of these factors should be recognized, assessed and addressed

New pressure ulcer suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers

Residents may develop various types of skin ulceration.

At the time of the assessment and diagnosis of a skin ulcer/wound, the clinician is expected to document the clinical basis (e.g., underlying condition contributing to the ulceration, ulcer edges and wound bed, location, shape, condition of surrounding tissues) which permit differentiating the ulcer type, especially if the ulcer has characteristics consistent with a pressure ulcer, but is determined not to be one.
Etiology

- MDRPU/PI = Medical Device Related Pressure Ulcer/Injury
- MASD = Moisture Associate Skin Damage
- MMPU/PI = Mucosal Membrane Pressure Ulcer/Injury
- MARS = Medical Adhesive-Related Pressure Injury
- DTP = Deep Tissue Pressure Injury
- KTU = Kennedy Terminal Ulcer

Most Common Chronic Wound Etiologies

- Pressure Ulcer/Injuries
- Peripheral Arterial Disease
- Venous Insufficiency
- Diabetic Neuropathic Foot Ulcers
- Lymphedema
Describe location anatomically correctly using current medical terminology

<table>
<thead>
<tr>
<th>Specific Terms</th>
<th>Less Specific Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>R-ischium</td>
<td>R-bottom</td>
</tr>
<tr>
<td>R-lateral malleolus</td>
<td>R-ankle</td>
</tr>
<tr>
<td>L-trochanter</td>
<td>L-hip</td>
</tr>
</tbody>
</table>
Location

- Document in reference to head, front or back
- Commonly used terms
  - Proximal, distal
  - Superior, inferior
  - Medial, lateral
  - Anterior, posterior
  - Dorsal, plantar

Classification of Wounds by Tissue Destruction

- Used to classify wounds whose primary cause is something other than pressure
  - **Partial thickness** - limited to epidermis & upper portion of dermis
    - Heals by regeneration
    - No scar tissue
    - No slough
    - Healing complete 7-14 days
  - **Full-thickness**
    - Extends through epidermis & dermis
    - May involve subcutaneous tissue, muscle or bone
CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure. Some of these terms include: pressure ulcer, pressure injury, pressure sore, decubitus ulcer and bed sore. Clinicians may use and the medical record may reflect any of these terms, as long as the primary cause of the skin alteration is related to pressure. For example, the medical record could reflect the presence of a Stage 2 pressure injury, while the same area would be coded as a Stage 2 pressure ulcer on the MDS.

Comparisons of Definitions

**F-686/Formerly F314**

- "Pressure Ulcer/Injury (PU/PI)"
- Refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue.

**NPUAP - 2016**

- Pressure Injury:
- A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
Staging- Pressure Ulcers

- Staging of a PU/PI is performed to indicate the characteristics and extent of tissue injury, and should be conducted according to professional standards of practice.
- NPUAP – Revised staging system in 2016
- State Operations Manual – Adapted NPUAP Staging Definitions in 2017
  - Stage 1, Stage 2, Stage 3, Stage 4
  - Unstageable
  - Deep Tissue Pressure Injury (DTPI)
  - Added: Medical Device Related Pressure Injury – must be staged
  - Added: Mucosal Membrane Pressure Ulcer/Injury – NOT able to stage
- Staging system should only be used on wounds caused by pressure!

What is the Purpose of Staging?

- To indicate the depth of tissue damage
- RAI language:
- Pressure ulcer staging is an assessment system that provides a description and classification based on anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer staging also informs expectations for healing times.
- NOTE: More mistakes on Staging than any other section of the MDS!
# Depth of Tissue Injury

**Non-Pressure Injury**
- Partial
- Full-thickness

**Pressure Ulcer/Injury:**
- Stg 1
- Stg 2
- Stg 3
- Stg 4
- DTPI

**Unstageable:** (check reason below)
- Non-removable dressing/device
- Slough/eschar
- Deep tissue pressure injury

## Stage 1 Pressure Injury

![Stage 1 Pressure Injury Image]

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*Images courtesy of Assistive Technologies, Inc.*
Stage 1 Pressure Injury: Slide 1

Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues.

Stage 1 Pressure Injury – Slide 2

- The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes.
- Color changes of intact skin may also indicate a deep tissue PI.
Blanchable vs. Non Blanchable Erythema

**Blanchable Erythema**

Using clear plastic sheet to blanch

**Non-Blanchable**

Stage 1 Pressure Injury: Slide 1

Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues.
The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI.
Stage 2 Pressure Ulcer

- Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer.
- The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister.
- Adipose (fat) is not visible and deeper tissues are not visible.
- Granulation tissue, slough and eschar are not present.
This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions).
### Stage 3 Pressure Ulcer – Slide 1

- Full-thickness loss of skin, in which subcutaneous fat **may be** visible in the ulcer and granulation tissue and epibole (rolled wound edges) are **often** present.
- Slough and/or eschar may be visible but does not obscure the depth of tissue loss.

### Stage 3 Pressure Ulcer – Slide 2

- The **depth of tissue damage varies by anatomical location**; areas of significant adiposity can develop deep wounds.
- Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are **not** exposed.
- If slough or eschar obscures the wound bed, it is an Unstageable PU/PI.
Epibole
Rolled Edges

Shallow Stage 3 on ear

Deep Stage 3 on hip

Stage 3 Examples

Stage 4 Pressure Ulcer
Stage 4 Pressure Ulcer

- Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer.
- Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur.
- Depth varies by anatomical location.
- If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Examples

Attribution: Dot Weir, RN, CWON, CWS
Unstageable Pressure Ulcer – Slide 1

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar.
Unstageable Pressure Ulcer – Slide 2

- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident’s physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.

Unstable Eschar
In Pressure Ulcer

Stable Eschar
On Great Toe

Unstageable Pressure Ulcer – Slide 3

- If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed.
- If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned.
- The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur.

Pre-debridement
Post-debridement

Attribution: Dot Wei, RN, CWON, CWS
Staging Myths

- Wound bed must have at least 50% necrotic tissue to call it unstageable
- Any amount of necrotic tissue (slough, eschar) in wound bed makes it unstageable

• NOTE: Wound base does NOT need to be completely free of necrotic tissue. If you can see the wound base you should be able to stage.
• There are NO percentages of viable vs non viable tissue to guide you (wound staging myth). See or palpate the base...STAGE IT!!!

M0300: Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage (Pg M-8)

- Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable.
- If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
- A pressure injury with intact skin that is a deep tissue injury (DTI) should not be coded as a Stage 1 pressure injury. It should be coded as unstageable.
- Known pressure ulcers/injuries covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. “Known” refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device.
Unstageable Pressure Ulcers – M0300 E, F, G

- Three unstageable types to differentiate
- Number of these unstageable pressure ulcers present upon admission/reentry

E. Unstageable - Non-removable dressing:

1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

F. Unstageable - Slough and/or eschar:

1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable: Deep tissue

G. Unstageable - Deep tissue:

1. Number of unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission

Deep Tissue (Pressure) Injury
Deep Tissue Injury (DTI)

- Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue.
- This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin.

Deep Tissue Injury – Slide 2

- This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.
- The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.
- If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer.
Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage.

- Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

MDS Directions for Coding Blood Filled Blisters

Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), these characteristics suggest a deep tissue injury (DTI) rather than a Stage 2 Pressure Ulcer.
New Definition
Medical Devices Related Pressure Injury

- Medical device related PU/PIs result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. **The injury should be staged using the staging system.**

News Definition in SOM
Mucosal Membrane Pressure Ulcer/Injury

- Mucosal membrane PU/PIs are found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue, these ulcers cannot be staged.

- **RAI Coding Tip:** "**Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item L0200C, Abnormal mouth tissue. Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made.**"

**Shannon Rutledge RNurs, GradCert CritCareNurs, Tissue Viability Unit February 2015**
When classifying injuries caused by pressure and/or shear, the clinician has the following options:

1) If the type of tissue in the wound base can be evaluated, numerically classify as Stage 1 or 2 or 3 or 4, based on the deepest tissue type exposed.

2) If the wound base cannot be evaluated, classify as:
   a) Deep Tissue Pressure Injury (DTPI) when the skin is intact with deep red, purple or maroon discoloration or blood blister(s).
   b) Unstageable when the base is obscured by slough or eschar.

3) If on a mucosal membrane, document, but do not stage.

“KTUs have certain characteristics which differentiate them from pressure ulcers such as the following:

- KTUs appear suddenly and within hours;
- Usually appear on the sacrum and coccyx but can appear on the heels, posterior calf muscles, arms and elbows;
- Edges are usually irregular and are red, yellow, and black as the ulcer progresses, often described as pear, butterfly or horseshoe shaped; and
- Often appear as an abrasion, blister, or darkened area and may develop rapidly to a Stage 2, Stage 3, or Stage 4 injury.”
Kennedy’s Terminal Ulcer: Pressure Ulcer

- Kennedy Terminal Ulcers are considered PRESSURE ULCER/INJURY per CMS.
- Pressure ulcers that generally occur at the end of life.
- For concerns related to Kennedy Terminal Ulcers, refer to F686, 483.25(b) Pressure Ulcers.

**NOTE:** Next statement not CMS approved, but reality.

- These skin changes are not pressure ulcers...they are the result of skin failure due to the dying process or acute or chronic multi-organ failure.
- The resident is in the dying process and the skin...largest organ of the body begins to also fail.
- If you recognize this situation and your MDs/NPs document accordingly, then you can at least document them as unavoidable pressure ulcer/injuries.

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**Pressure Ulcer/Injuries at End of Life**

*F686 Page 267 – Guidance to Surveyors*

- “It is important for surveyors to understand that when a facility has implemented individualized approaches for end-of-life care in accordance with the resident’s wishes, the development, continuation, or worsening of a PU/PI may be considered **unavoidable**.

- If the facility has implemented appropriate efforts to stabilize the resident’s condition (or indicated **why the condition cannot or should not be stabilized**) and has **provided care to prevent or treat existing PU/PIs** (including pertinent, routine, lesser aggressive approaches, such as, cleaning, turning, repositioning), the PU/PI may be considered **unavoidable and consistent with regulatory requirements.**
With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the PU/PI should be documented. At a minimum, documentation should include the date observed and:

- Location and staging;
- Size (perpendicular measurements of the greatest extent of length and width of the PU/PI), depth; and the presence, location and extent of any undermining or tunneling/sinus tract;
- Exudate, if present: type (such as purulent/serous), color, odor and approximate amount;
- Pain, if present: nature and frequency (e.g., whether episodic or continuous);
- Wound bed: Color and type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); and
- Description of wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate.

Wound Measurements

<table>
<thead>
<tr>
<th>Measurements (cm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>L ______ cm</td>
</tr>
<tr>
<td>If u/d, describe why: ____________________________</td>
</tr>
<tr>
<td>Undermining or Tunneling (cm)</td>
</tr>
<tr>
<td>U / T ______ cm @ ______ o'clock</td>
</tr>
<tr>
<td>U / T ______ cm @ ______ o'clock</td>
</tr>
</tbody>
</table>

Size (perpendicular measurements of the greatest extent of length and width of the PU/PI), depth; and the presence, location and extent of any undermining or tunneling/sinus tract;
Wound Measurement:

Depth: Distance from visible surface to deepest point in wound base not covered with necrotic tissue

**NOTE:** Do not record depth if not able to see TRUE base of wound. Use unstageable designation.

Wound Measurement

Tunneling

A single pathway that may extend in any direction
Wound Measurement

Undermining

- Tissue destruction that occurs to the underlying intact skin adjacent to the wound margins.
- Formation of a “shelf” of healthy, intact tissue over an area of dead space and/or necrotic tissue.

Shelf under edge of wound

Exudate

<table>
<thead>
<tr>
<th>Exudate</th>
<th>Serous</th>
<th>Sanguineous</th>
<th>Serosanguineous</th>
<th>Purulent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount</td>
<td>None</td>
<td>Scant/Min;</td>
<td>Mod;</td>
<td>Hvy/Copious</td>
</tr>
<tr>
<td>Consistency</td>
<td>Serous</td>
<td>Sanguineous/bleeding</td>
<td>Serosanguineous</td>
<td>Purulent</td>
</tr>
<tr>
<td>Odor*</td>
<td>None; Min.; Mod.; Strong/foul</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Assess after dressing removal & cleansing

Reasons drainage may increase:
- Infected
- After sharp or surgical debridement
- When using collagenase

Drainage drives dressing decisions.
### QUANTIFYING WOUND EXUDATE

<table>
<thead>
<tr>
<th>Status</th>
<th>Indicators: Based on a 24-hour observation period</th>
</tr>
</thead>
<tbody>
<tr>
<td>None/Dry</td>
<td>Wound bed is dry; there is no visible moisture and the primary dressing is unmarked; dressing may be adherent to wound.</td>
</tr>
<tr>
<td>Scant/Small/Minimal</td>
<td>Small amounts of fluid are visible when the dressing is removed; the primary dressing may be marked up to 25%, but strikethrough (or saturation through the dressing) is not occurring; in many cases, this is the goal of exudate management. Wound bed glistens. Routine dressing changes fully control the exudate.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Routine and appropriate dressing changes show that the drainage has met the dressing’s absorptive ability without saturating or leakage; may cover 25%-75% of the dressing.</td>
</tr>
<tr>
<td>Large/Heavy Copious/Very Heavy</td>
<td>Dressings are saturated with changes at routine intervals; exudate is uncontrolled and freely expressed. More than 75% of the dressing is covered by drainage.</td>
</tr>
</tbody>
</table>

Adapted from the Association for the Advancement of Wound Care Quality of Care Wound Glossary

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### Wound Bed Tissue Types

<table>
<thead>
<tr>
<th>Wound Bed</th>
<th>Tissue Type/Color &amp; Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Epithelial Tissue</td>
</tr>
<tr>
<td></td>
<td>□ Dermal Tissue (Pink/Red)</td>
</tr>
<tr>
<td></td>
<td>*Partial or Stage 2 PU/PI</td>
</tr>
<tr>
<td></td>
<td>□ Granulation: _____ %</td>
</tr>
<tr>
<td></td>
<td>□ Pink, Red; Healthy</td>
</tr>
<tr>
<td></td>
<td>□ Pale Pink/Red; hypogranular tissue</td>
</tr>
<tr>
<td></td>
<td>□ Hypergranulation tissue</td>
</tr>
<tr>
<td></td>
<td>□ Red, Friable (fragile/bleeds) and/or Dusky</td>
</tr>
<tr>
<td></td>
<td>□ Necrotic: _____ %</td>
</tr>
<tr>
<td></td>
<td>□ Slough (white/yellow/gray)</td>
</tr>
<tr>
<td></td>
<td>□ Eschar (intact/stable)</td>
</tr>
<tr>
<td></td>
<td>□ Eschar (unstable/fluxuant/mushy/boggy)</td>
</tr>
<tr>
<td></td>
<td>□ Other: (e.g. tendon/muscle/bone)</td>
</tr>
</tbody>
</table>
Tissue Types

Epithelial Tissue
Epithelium is white. Formation, growth and migration of new skin cells to cover the wound surface.

Granulation Tissue
Granulation tissue is red/pink, soft and granular.

Slough
Yellow stringy or thick devitalized tissue, that can be adherent on the tissue bed.

Eschar
Dead or devitalized tissue; hard or soft in texture; usually black, brown, or tan in color; usually firmly adherent to the base of the wound.

CMS and Wound Related Pain

- F686
  - When assessing the PU/PI itself, it is important that documentation addresses the presence of pain, what was done to address it, and the effectiveness of the intervention;

  - Pain, if present: nature and frequency (e.g., whether episodic or continuous);
Wound Related Pain Experiences

Chronic Wound Pain
- Absence of manipulation
- May be continuous or intermittent

Cyclic Wound Pain
- Periodic acute wound pain
- Regular repetitive treatments (i.e. dressing change)

Noncyclic Wound Pain
- Provoked by more sporadic procedures (i.e. sharp debridement)

Pain – F686, F684

Pain
- None ☐ Yes: Intensity Rating (0-10)_____
  Location: _______________________
  Nature/Type Radiate/local_________________
- Chronic wound pain
- Cyclic acute wound pain (e.g. dressing change)
- Noncyclic wound pain (e.g. debridement)
  Frequency: _______________________
  Local/systemic Rx? ☐ None
- Yes (Describe Rx)_________________

F697 for more guidance on pain management

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The physician diagnosis of infections present in a PU/PI are based on resident history and clinical findings, such as a **wound culture**.

- Pus, slough or necrotic tissue should not be cultured.
- Findings such as an elevated white blood cell count, bacteremia, sepsis, or fever may signal an infection related to a PU/PI area or a co-existing infection from a different source.
- The treatment of an infection will depend on the type of infection present.

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**Levine’s Technique**

- Surface swab of a one cm² area of **healthy tissue** in the wound
- Press into wound to obtain fluid

---
Describe Wound Edges

- **Wound Edges/Periwound**
  - **Wound Edges/Margins**
    - Edge epithelializing flush w/wound base
    - Edge attached to base
    - Edge not attached to base
    - Well defined wound edges
    - Irregular wound edges
    - Epibole/Rolled
    - Hyperkeratotic (callus)
    - Fibrotic, scarred
    - Other

- **Callus**
  - Irregular wound edges
  - Edge not attached • Epibole

Periwound Tissues

- **Periwound Tissues**
  - Intact/Uninvolved tissues
  - Macerated
  - Inflamed/Erythematic
  - Indurated/Firm
  - Fluctuance/Boggy tissue
  - Excoriated/Denuded
  - Deep red/purple hue (DTPI)
  - Sclerotic tissue
  - Other-ex weeping, dry, rash, blister

- **Macerated**
- **Inflamed, Erythematic, Indurated**
- **Denuded**
- **DTPI-Periwound**
Watch for Changes in These Wound Parameters to Give You Clues as to Progression or Regression of the Wound

Wound Assessment - Evidence of wound improvement or deterioration includes measurable changes in the following:

- Drainage
- Inflammation
- Swelling/Edema
- Pain/tenderness
- Wound size
- Undermining/Tunneling size
- Granulation tissue %
- Necrotic tissue %

- No improvement noted s/p 30 days; (NOTE: Consider new approach including MD reassessment of underlying infection, metabolic, nutritional, or vascular problems that may be inhibiting wound healing, or a new treatment approach including selection of dressing(s), dressing combination and/or frequency of change.

### Treatment Plan

<table>
<thead>
<tr>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debridement Type:</td>
</tr>
<tr>
<td>- n/a</td>
</tr>
<tr>
<td>- Autolytic</td>
</tr>
<tr>
<td>- Enzymatic</td>
</tr>
<tr>
<td>- Mechanical (ex): wet-to-dry</td>
</tr>
<tr>
<td>- Surgical: Sharp</td>
</tr>
<tr>
<td>- Other</td>
</tr>
</tbody>
</table>

| Topical Rx:             |
| - None                  |
| - Yes                   |

| Systemic Rx:            |
| - None                  |
| - Yes                   |

| Incontinence POC:       |
| - n/a                   |
| - Yes                   |

| Pressure redistribution device: |
| - n/a                        |
| - Yes                        |

| Frequency:               |
| - Daily                   |
| - 3X/wk                   |
| - 2X/day                  |
| - Other                   |

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Dressings and Treatment Per F686

Determination of the need for treatment for a PU/PI is based upon the individual practitioner’s clinical judgment, facility protocols, and **current professional standards of practice**.

A facility should be able to show that its **treatment protocols are based upon current professional standards of practice and are in accord with the facility’s policies and procedures as developed with the medical director’s review and approval**.

Below current professional standards of practice

- Wet to dry
- Damages new tissue
- Cytotoxic to new cells & tissues

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### M1200 Skin and Ulcer/Injury Treatments

<table>
<thead>
<tr>
<th>M1200. Skin and Ulcer/Injury Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that apply</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>A. Pressure reducing device for chair</td>
</tr>
<tr>
<td>B. Pressure reducing device for bed</td>
</tr>
<tr>
<td>C. Turning/repositioning program</td>
</tr>
<tr>
<td>D. Nutrition or hydration intervention to manage skin problems</td>
</tr>
<tr>
<td>E. Pressure ulcer/injury care</td>
</tr>
<tr>
<td>F. Surgical wound care</td>
</tr>
<tr>
<td>G. Application of nonsurgical dressings (with or without topical medications) other than to feet</td>
</tr>
<tr>
<td>H. Applications of ointments/medications other than to feet</td>
</tr>
<tr>
<td>I. Application of dressings to feet (with or without topical medications)</td>
</tr>
<tr>
<td>Z. None of the above were provided</td>
</tr>
</tbody>
</table>
**Referral Recommendations:**
- Vascular consult
- Nutrition consult
- Infectious disease
- Psych/counseling-resident/family
- PT
- OT
- SLP
- Other ____________________________

**Other Interventions:**
- NPWT
- E-stim
- Other modalities/interventions: ____________________
THANK YOU!!!

References