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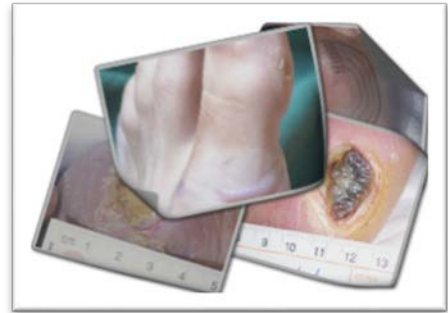
# Assessing Chronic Wounds





# Wound Assessments Should Always Include

- Wound Type/Etiology
- Anatomic Location
- Stage/Thickness
- Size/Measurements
- Type of Tissue to the Wound Bed
- Wound Edges
- Exudate
- Peri Wound
- S/S of Infection (if applicable)





## Type Of Wound/Etiology

Determining the type of wound you are treating is of utmost importance, as the treatment plan that is put in place is entirely based off of the wound's etiology. Typical wounds seen in skilled facilities:

Pressure Ulcer



Arterial Ulcer

Skin Tear



Diabetic Foot/  
Neuropathic Ulcer

Venous Ulcer



Surgical Wound

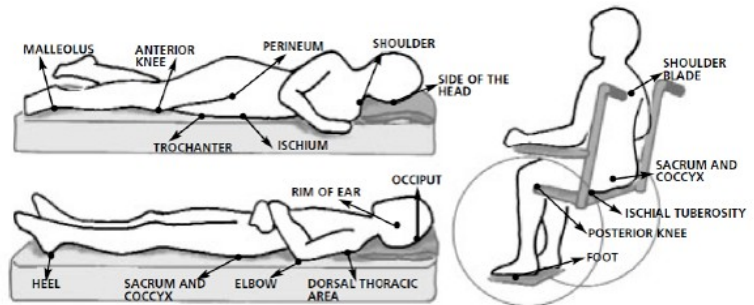


## Anatomic location

- Be specific as to body part (arm, leg, abdomen, etc.) and then where on the body part (elbow, medial malleolus, LLQ, etc.)

- Use words such as:

- distal/proximal
- inferior/superior
- medial/lateral
- posterior/anterior



# Stage/Thickness (cont'd)

The Wound Stage/Thickness tells the extent of tissue damage that is visible

- Only pressure injuries are staged
- All other wounds are considered Full Thickness or Partial Thickness

A **Partial Thickness** wound is *similar* to a Stage 2 Pressure Injury; a **Full Thickness** wound is *similar* to a Stage 3 or 4 Pressure Injury

Partial Thickness  
Skin Tear



Partial Thickness  
Burn Injury



Full Thickness  
Arterial Wound



Healing of a Stage 4 Pressure Injury. NEVER backstage a Pressure Injury as it heals





## Stage/Thickness (cont'd)

- The Stages of Pressure Injuries

Stage 1



Stage 2



Stage 3



Stage 4



sDTI  
*Suspected Deep  
Tissue Injury*



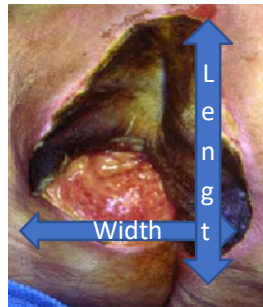
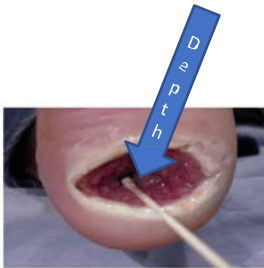
Unstageable





# Measuring Wounds

- Measure in centimeters only
- Length (head to toe) X Width (side to side) X Depth (straight down perpendicular to skin)



Only measure where the wound is actually open. Any peri wound maceration, discoloration, etc should be documented under the appropriate category



# Measuring Wounds

## Undermining and Tunneling...Know the Difference

### What is Tunneling

A narrow opening or passageway that can extend in any direction through soft tissue and result in dead space with potential of abscess formation. Also known as a sinus tract.



### To Measure:

- Insert a sterile cotton tipped applicator into the tunnel
- Grasp the applicator at the wound margin
- Hold to ruler and measure using the Clock Method

### What is Undermining?

The destruction of the underlying tissue surround some or all of the wound margins. May extend in one or many directions underneath the wound edge(s).



### To Measure:

- Check for undermining at each "hour" of the clock
- Insert a sterile cotton tipped applicator into the undermining depth
- Grasp at the wound edge and measure against a ruler
- Use ranges for undermining areas using the face of the clock (ie. Undermining 1.5cm from 12:00 to 3:00)





## Type Of Tissue To The Wound Bed

- **Viable, healthy tissue** is called **Granulation Tissue** and is seen in Stages 3 & 4 Pressure Injuries and Full Thickness wounds only
- **Non-Viable**, or unhealthy tissue can be either:
  - **Eschar** - Hard or soft, thick or thin, black/brown/tan tissue
  - **Slough** - White, yellow or grey; loose, stringy or adherent
- Non-Viable tissue is only seen in Stages 3 & 4 Pressure Injuries and Full Thickness wounds only



Granulation  
Tissue

Eschar, Slough and  
Granulation



# Wound Edges

- **Epithelial** (Healthy tissue growing from edge of wound towards center, or may be islands growing within wound bed)
- **Rolled** (edges not connected to base of wound, or unattached; aka “epiboly”)
- **Shape** (distinct, irregular, diffuse, defined, etc.)
- **Hyperkeratotic** or **Calloused** (common to diabetic wounds)
- **Macerated** (white/boggy from too much moisture)



Hyperkeratotic/  
Calloused



Rolled/Epiboly



Epithelial Tissue



# Exudate/Drainage

The amount of exudate you document will dictate the type and quantity of dressings you can order

## "Light" Exudate

Less than 5cc of wound fluid *within a 24 hr period*  
Front and back of **Gentell's** Waterproof 4x4 foam dressing



5cc = 1tsp

## "Moderate" Exudate

5cc - 10cc of wound fluid *within a 24 hr period*  
Front and back of **Gentell's** Waterproof 4x4 foam dressing



## "Heavy" Exudate

Greater than 10cc of wound fluid *within a 24 hr period*  
Front and back of **Gentell's** Waterproof 4x4 foam dressing





# Exudate/Drainage

Document the color and consistency of exudate you see on the dressing:

- **Serous** (clear fluid)
- **Sanguinous** (bloody)
- **Sero-sanguinous** (pink)
- **Purulent** (thick, yellow/green, can indicate an infection)
- **Other** (bright green/yellow may indicate pseudomonas infection)
- **Odor** (mild, strong, sweet, none, etc.)



Pseudomonas Infection



## Peri Wound (Surrounding) Skin

- Maceration (usually white from too much moisture)
- Erythema (redness)
- Induration (firmness felt around the wound)
- Edema (swelling around the wound)
- Temperature (warm, hot, cool, etc.)





# Signs of Infection

- Heat/warm to touch
- Pain or tenderness
- Fever
- Odor
- Exudate (appearance and/or amount)
- Swelling/edema
- Alteration in mental status
- Tachycardia
- Hypotension
- Erythema
- Induration





# Describe These Wounds





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## References

- CMS-Guidance to Surveyors for Long Term Care Facilities, F309,F314
- Evidence Based Management Strategies for Treatment of Chronic Wounds: 2009, Frank Werdin MD
- Acute and Chronic Wounds-Ruth A Bryant, 4th edition
- 2014 Prevention and Treatment of Pressure Ulcers: Clinical Practice Guidelines