Measurement, Assessments of Pressure Ulcers, Wounds and Other Skin Problems

Highlights

Observations and Measurements

Policy Statement

1. At first observation of any skin condition, the charge nurse or treatment nurse is responsible to measure and describe skin condition in the clinical record.

2. All Measurements will be recorded in centimeters. All ulcers (pressure, arterial, diabetic, venous) will be measured weekly and results recorded.

3. Skin conditions other than ulcers, such as bruises, skin tears, abrasion, rashes, excoriations will be described upon initial observation and documented. Weekly measurements of these areas are not required.

Policy Interpretation and Implementation

Observations and Measurement

1. Identify the type of ulcer present such as pressure, arterial, diabetic, venous and etc. Note: The clinical record should clearly support the clinical basis for the determination of the etiology of the ulcer(s) (i.e. diagnosis, signs and/or symptoms characteristics to that type of ulcer, lab or diagnostic tests, etc.)

2. Identify the Stage or extent of tissue destruction involved. Record both the 'Deepest tissue damage' and the 'MDS Stage' on appropriate form in the appropriate box. The deepest tissue damage should describe the deepest level of tissue damage ever present since the onset of the wound. (Example: an ulcer that once had bone or muscle exposed is a Stage IV and will always have 'IV' recorded in the 'Deepest tissue damage' section for the history of the wound. However, for the MDS stage, the wound must be down-staged to accurately code the MDS section M as described in the RAI manual. *See Guidelines Regarding Down Stating for the MDS Coding.*)

PRESSURE ULCERS

Stage I ulcer

Stage I ulcer: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk)

Stage II ulcer

Stage II ulcer: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicated suspected deep tissue injury

Stage III ulcer

Stage III 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. Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

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Stage IV ulcer

Stage IV 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* include undermining and tunneling.Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable ulcer

Unstageable ulcer: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

Deep Tissue Injury (DTI)

DTI ulcer: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Further description: Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

NON-PRESSURE ULCERS

Partial Thickness

Partial Thickness: Tissue destruction through the epidermis extending into but not through the dermis.

Full Thickness

Full Thickness: Tissue destruction extending through the dermis to involve subcutaneous tissue and possible bone and muscle.

Assessment

ULCER ASSESSMENT

1. Using a disposable ruler, obtain length and width as linear distances from wound edge to wound edge. Length will be measured vertically in relation of head to toe (12:00 to 6:00 o'clock). Width will be measured horizontally in relation of hip to hip (3:00 to 9:00 o'clock).

2. A new disposable measuring ruler will be used for each wound/skin condition.

3. To obtain depth, gently insert a clean cotton applicator to the deepest portion of the wound bed that you can see. Grasp the applicator with the gloved thumb and forefinger at the point corresponding to the wound's margin. Carefully withdraw the applicator while maintaining the position of the thumb and forefinger. Measure from the hip to the applicator to position of thumb and forefinger.
   NOTE: * If the wound bed depth is superficial and less than 0.1cm, the depth will be recorded as '<0.1cm'.
   * If the wound bed is covered with eschar or slough making the wound bed non-visible, the true depth of the wounds is unknown and may be recorded as 'UND' for undeterminable.

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Assessment (continued)

4. Assess wound/skin condition for drainage/exudates. Record type and amount.
   - Type: Sanguineous - thin, bright red
     Serosanguineous - thin, watery, pale red to pink
     Serous - thin, watery clear
     Purulent - thick or thin, opaque tan to yellow
     Foul Purulent - thick opaque yellow to green with offensive odor
   - Amount: None - wound tissue dry
     Scant - wound tissues moist, no measurable drainage
     Small - wound tissues very moist, drainage <25% of dressing
     Moderate - wound tissues wet, involves 25-75% of dressing
     Large - wound tissues filled with fluid, involves >75% of dressing

5. Assess for presence of necrotic tissue. Record type and percentage (%)

   Eschar - thick, leathery black crust of dead skin; can be hard or soft

   Slough - String-like dead tissue, may be yellow, gray, green, or white in color, may be firmly attached, loosely adherent or non-adherent.

6. Assess for presence of Granulation tissue. Granulation tissue usually appears as beefy, red, granular, bubbly in appearance. Record in percentage (%). Epithelialization may also be described in the 'comments' section of the appropriate form. Epithelialization can appear as deep pink, then progress to pearly pink/light purple from the edges in full thickness wounds, or may form islands in the wound base with partial thickness wounds. Describe location using percentage (%), clock system, or specific wound edge.

7. Assess the periwound tissue surrounding the wound. Record findings:
   - Healthy - intact, no problems notes
   - Macerated - white wrinkled from excessive moisture
   - Erythema - reddness in color
   - Discolored - blue or purple, frown staining, pallor in color, etc.
   - Other: Document in Comments section. Edema and induration, texture changes, temperature changes, rash, scar tissue, etc.

8. Assess the wound edges. Record findings:
   - Attached - wound edge is attached to the vase of the wound (no undermining or tunneling present).
   - Unattached - wound edge is separated from the base of the wound (undermining or tunneling is present).
   - Rolled Under - rounded or rolled under wound edge.
   - Macerated - white wrinkled from excessive moisture.
   - Callused - a localized build up cells of the stratum corneum due to pressure or friction.
   - Other: describe any additional observations.

9. If undermining and/or tunneling exists, gently insert cotton tip applicator into the sites where undermining/tunneling occurs.
   a. The direction of undermining/tunneling shall be identified in relation to clock. View the direction of the applicator as if it were a hand of a clock (with 12 o'clock pointing to the resident's head, and 6 o'clock point to the feet).

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Assessments (continued)

b. The depth of undermining/tunneling shall be identified using an applicator. Gently insert the cotton applicator into the undermined/tunneling area(s) Grasp the applicator where it meets the wound's edge. Pull the applicator out, place it next to a measuring guide, and document the measurement in centimerets including the direction.

c. Document in centimeters using clock face on form. Example: undermining from 2 to 6 o'clock of 3 cm, tunneling at 9 pm of 3 cm.

10. Assess for odor after cleansing wound bed. Record 'Yes' for wound odor or 'No' for absence or odor.

11. Assess pain in relationship to the ulcer or periwound tissue. If pain is present, describe.

12. Describe any problems with adherence to treatment of wound(s) and/or prevention interventions. Examples: Refusing treatment or to relieve pressure off area or turning/repositioning or nutritional supplement. Care plan should also address these situations and any alternatives that have been offered.

13. Additional wound/skin condition descriptions that may be included may include but not be limited to: bone or muscle exposure, description of pain characteristics, cultures taken, adherence to treatment/prevention measures, physician notification, interventions in place and etc.