

## General Overview

SKIN ASSESSMENT  
WOUND TYPES  
CARE BASICS  
DRESSINGS  
CARE SETTINGS/RESOURCES FOR SUPPLIES

## When Should I Assess a Patient's Skin?

### Why is this important?

- All patients should receive a comprehensive skin assessment upon initial assessment in any care setting
  - Establishes baseline
  - Drives treatment plan
- Follow up skin assessments based on clinical findings or indications
  - Drives changes and updates to treatment plan
- Quality Care
- Patient Safety
- Liability (Never Events)
- Reimbursement

## Case Scenario

Your neighbor asks for your opinion on a "rash" that has formed on her right side. She mentions that she has been having pain due to kidney stones, and she has been holding her side with her hand. She tells you she has been gardening, and now believes that she has poison ivy.



## How To Perform a Skin Assessment

### Do I have time for this?

- Combine with other patient assessments:
  - Check toes, heels & legs when assessing edema & pedal pulses
  - Check skin folds when listening to bowel sounds
  - Check back, sacrum, & coccyx areas when listening to lung sounds
  - Assess ears and neck when applying oxygen therapy
- Ask patient/family about history of wounds
- Ask patient about pain in specific areas; "tailbone," heels, etc.
- Check areas where tubes or equipment may be in use
- Remove tape, Band-Aids and dressings to assess skin underneath
- Don't forget to use adhesive remover wipes- minimizes skin tears
- Should be completed with each patient assessment/visit

## Wound Categories

### Acute

- Wounds without an underlying defect, usually occurring secondary to trauma or surgery
- Expected to heal quickly and completely



### Chronic

- Wounds that take longer to heal due to underlying conditions such as pressure, poor circulation, diabetes, immuno-insufficiencies or infection

## Case Scenario

You are seeing a new patient with a history of diabetes. He has never had his feet inspected before, and would not know of any reasons for doing so. You suspect that he has little knowledge of neuropathy. You begin to think of teaching points to cover during this visit.

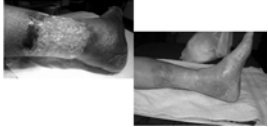


## Different Wound Types

### Lower Extremities


#### Venous Ulcers

- Often seen in presence of edema
- Irregular edges, painless-moderate pain
- Deep or partial thickness; moderate to large amount of drainage
- Usually found on the medial leg & ankle areas



#### Arterial Ulcers

- Punched out appearance, even margins
- Painful
- Minimal drainage
- Found between & on tips of the toes, lateral malleolus, phalangeal heads

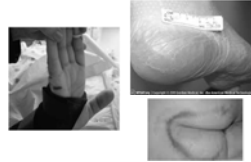


## Different Wound Types

### What is common?


#### Pressure Injury (Ulcers or PU's)

- Usually found over bony prominences
- Caused by pressure; friction, shear and moisture may be contributing factors
- Usually have regular margins or may take shape of an object (if device related)



#### Diabetic Foot Ulcers (DFU's)

- Usually found on plantar surface of foot, over metatarsal heads, or under the heel
- Often seen in patients with peripheral neuropathy
- High risk of infection and amputation



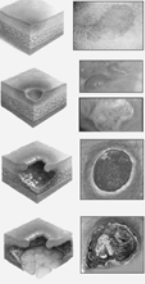
## Pressure Injury Stages

**Stage I:**  
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:**  
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- or serous-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.  
"Cloning" indicates suspected deep tissue injury

**Stage III:**  
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 stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occipital and malleolus do not have subcutaneous tissue and stage III ulcers can be deeper. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly exposed.

**Stage IV:**  
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 stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occipital and malleolus do not have subcutaneous tissue and these ulcers can be deeper. 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.

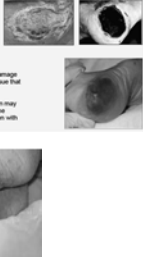


## Pressure Injury Stages

### Continued

**Un-stageable**  
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (dark, 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. Slough, eschar, adherent slough without eschar or fibrinous/eschar on the bases serves as "the body's natural biological cover" and should not be removed.

**Deep Tissue Injury**  
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 surrounded 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. Evaluation may include the use of a blunder over a dark wound bed. The wound may further evolve and become covered by the eschar. Evaluation may be rapid exposing additional layers of tissue even with optimal treatment.




## What Is It?

Pressure Ulcer or Incontinence Associated Dermatitis (IAD)


#### Pressure Ulcer

- Caused by pressure; moisture may be contributing factor
- May be partial or full thickness
- Redness does not blanch
- Tissue may be boggy or hard
- Usually regular wound margins



#### IAD

- Caused by exposure to urine or stool
- Usually full thickness; **no** slough or "bumpy" granulation tissue
- Redness may blanch (area turns white/lighter or "purple" for darker skin tones when pressed and then color returns)
- Irregular margins



## Treatment Goals of Care


### Multifactorial

#### Manage Wound Symptoms

- Short-term goal**
  - Prevent further tissue destruction
    - Identify causative factors and remove
  - Moist wound healing
    - Increases healing rate
    - Decreases pain
- Ability for patient or patient/family to manage the dressings
- Dressing change frequency appropriate to the wound needs and CG ability/availability
- Use of advanced wound dressings to accomplish all this

#### Heal the Wound

- Long-term goal**
  - May require stages of treatment
    - Treat/manage underlying or contributing factors such as disease process and infection



## Various Dressing Uses

### Debridement

- If its dirty - Clean it

### Absorbent Dressing

- If its wet - Dry it

### Gels

- If its dry - Add moisture

### Packing

- If its deep - Fill it

### Antimicrobial Dressings & Antibiotics

- If its infected - Treat it

### Occlusive Dressing

- If its clean and moist - Maintain it



## How to Choose Dressings

BASED ON WOUND CHARACTERISTICS  
NOT USUALLY BASED ON WOUND TYPE

## Dressings

### What should I use?

#### Wet or Weeping Wounds

Use absorbent dressings

- o Foam: with or without border



- o Alginate or hydrofiber:



- o Super absorbent:



#### Dry Wounds

Add moisture

- o Gel:



## Dressings

### What should I use?

#### Deep Wounds

Use packing

- o Roll gauze:



- o Packing strip:



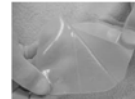
- o Negative Pressure Wound Therapy:



#### Shallow Wounds

Use occlusive dressings

- o Hydrocolloid:



- o Transparent film:



## Dressings

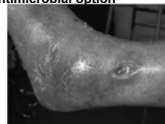
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#### Necrotic/Dirty Wounds

- Presence of slough or eschar
- Slough may be adherent, translucent, stringy and vary in color
- Eschar may be hard and black, may be soft
- "Stable" eschar on foot/heel in patient with poor circulation: do *not* debride. Considered body's natural band aid
- Products that help debride: honey gel is long acting, Collagenase requires daily dressing care, occlusive dressings
- Sharp debridement - bedside or surgical

#### Infected Wounds

- Usually highly exudating
- May be painful
- May have foul odor
- May be necrotic
- Foams, alginates, gels, and contact layers come as antimicrobial option



## Outpatient Services

### What resources can patients utilize?

#### Home Health Care

- Covered 100% by CMS & some insurance policies
- Homebound requirements & Skilled need
- Intermittent skilled care; nursing, therapy services, MSW for support and long range planning
- Diagnosis, long term care management education
- Wound care & supplies provided
- Some have certified wound specialists on staff

#### Wound Care Center

- CMS & insurance coverage
- Physician referral not required\*
- Wound care specialists
- Vascular, podiatry, infectious disease specialists
- Monday – Friday services
- Product oversight & prescriptions
- Collaborate with primary care physicians
- Advanced care; grafts, debridement
- Hyperbaric oxygen therapy

