Wound Measurement and Proper Wound Examination

November 2021 Monthly Education

Title: Standard Wound Examination	Policy Number: OP.060.0
Date Issued: 04/01/2016	Date Revised: 04/01/2016, 01/01/2018
Source: SerenaGroup™ Inc.	Revisions:
SerenaGroup	Medical Director SerenaGroup, Inc. Thomas E. Serena MD FACS

SCOPE:

All company facilities, including hospitals and any entities operating under the hospital's Medicare Provider Number including, but not limited to, the following:

Nursing Personnel
Staff Physicians/Non-Physician Provider

Purpose:

To insure all necessary information is included in the physician/practitioner History and Physical (H&P)/progress note.

Policy:

All wounds will receive a standardized examination.

Procedure:

In examining any wound, it is necessary to consider not just the lesion, but the entire patient, his or her anatomical make-up, physiological function, and ongoing pathological processes, keeping in mind that the lesions we are treating more often than not are caused by other conditions; which may deserve our attention. The following information will be obtained by the physician and wound care center staff, as well as the patient completing the new patient questionnaire.

1. Identification of the problem(s)

What brought the patient to the Wound Care Center? The problem may be synonymous with the diagnosis.

2. History

The patient's history may include information that can or cannot be verified by the medical record. The source of the information included in the history should be identified, e.g., patient statements should be in quotes.

The following schematic is offered as a guide to questioning relative to the patient's history:

- ✓ History – Age, Sex, Occupation
- ✓ When did the wound, joint problem, foot/ankle deformity, edema or other develop?
- ✓ How did it start?
- ✓ Sudden onset from trauma
- ✓ Gradual onset
- ✓ What happened?
- ✓ Trauma
- ✓ No trauma
- ✓ What happened?
  When first noticed?
- ✓ Symptoms
- ✓ Degree and location
- ✓ Of immediate symptoms
- ✓ Progress since

- Relevant previous history
  - ✓ Is the patient diabetic?
  - ✓ History of peripheral vascular disease, HTN, CHF?
  - ✓ Past treatment for similar problems
  - ✓ Medicines?
  - ✓ Allergies

- Relevant family history (ex. diabetes, cancer, CAD, respiratory disease, etc.)

- Social history
  - ✓ Does patient smoke?
  - ✓ How long? How much?
  - ✓ Current medication?

3. Subjective Examination

This portion of the examination should include the patient's description of his current symptoms. It also includes responses to specific questions, which improve the understanding of the condition (ex. Wound/ulcer, pain, joint problem, edema, other).

- Area of symptoms
  - ✓ Is there pain? If yes, is it just at the ulcer site or are other areas painful?
  - ✓ Paresthesias and/or anesthesia?

- Behavior of Symptoms
  - ✓ In cases of lower extremity ulcerations, are the symptoms relieved or aggravated by elevation, rest, or activity?
  - ✓ Special Questions
  - ✓ Has culture been taken?
  - ✓ Have x-rays been taken to rule out osteomyelitis?

4. Objective Examination

- The physician will plan for the objective examination based on the information obtained from the history and subjective examinations. It is at this point that the therapist or physician/practitioner may decide it is necessary to evaluate other than just the ulcerative lesion.

- Observation and Inspection

- The practitioner should note:
  - ✓ Location, size, and severity of lesion
  - ✓ If lesion is dry or draining
  - ✓ Boundaries of surrounding inflammation
  - ✓ If evidence of poor skin nourishment exists such as skin atrophy and or any loss of hair
  - ✓ Is swelling present?
  - ✓ Is there any discoloration of the skin?

- Motion Examination

  - ✓ The patient should be asked to actively move surrounding joints so the physician or therapist can assess their involvement. If abnormalities exist, a more specific examination is indicated.

- Clinical Measurements:

  - ✓ Determination of size and depth of lesion: The depth of the lesion can be determined by inserting a cotton-tipped applicator into the lesion and measuring the depth to which it penetrates. The length and width will be measured according to a clock face. Photo documentation will be provided using a digital camera.
  - ✓ Girth – If swelling or atrophy are evident, baseline girth measurements should be taken.
  - ✓ Vascular exam – If the ulcerations appear to be caused by a vascular disorder, this problem should be examined more closely. Refer to vascular examination procedure.
  - ✓ Neurological exam – If ulcerations appear to be caused by insensitivity, a complete neurological exam may be indicated.

- If not noted previously, the following may be noted and recorded for appropriate patients:
  - ✓ Sensory disturbances
  - ✓ Presence of deep tendon reflexes
  - ✓ Presence of bracing, type, location and hours worn
  - ✓ Contractures and/or laxity of joint ligaments
  - ✓ Activities of daily living: lifting, feeding, transfers, bathing, personal toileting, dressing, incontinence, ambulation, communication

5. Assessment

At this point, the physician or therapist should assimilate all of the information obtained from the history, subjective and objective examinations and come to a determination as to whether physician, nursing, and/or physical therapy treatment might be beneficial for this patient. This is determined by the physician/practitioner.

6. Plan

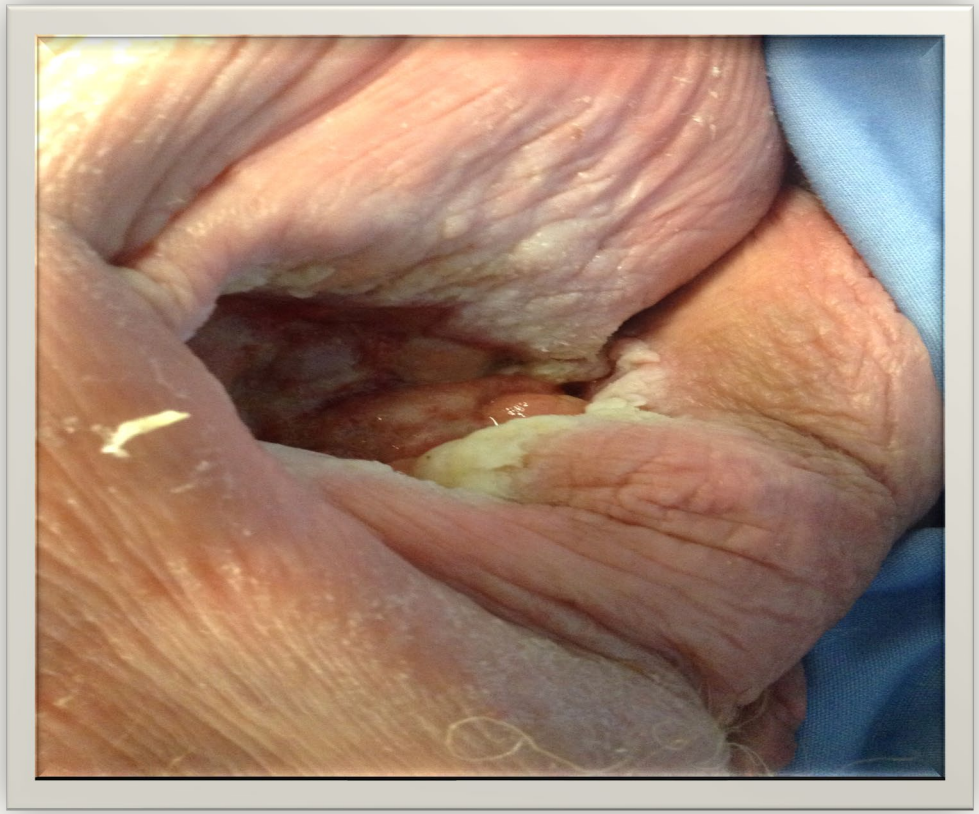
Treatment goals and the methods to be used to accomplish these goals or a plan should be outlined and documented in the medical record.

Wound Assessment

Examining any wound, it is necessary to consider not just the lesion, but the entire patient. Anatomical make-up, physiological function, and ongoing pathological processes, keeping in mind that the wounds we are treating more often than not are caused by other conditions; which may deserve our attention.

Wound Assessment

1. Identification of the problem
2. History
3. Subjective Examination
4. Objective Examination
5. Assessment
6. Plan



Notes

The following schematic is offered as a guide to questioning relative to the patient's history:

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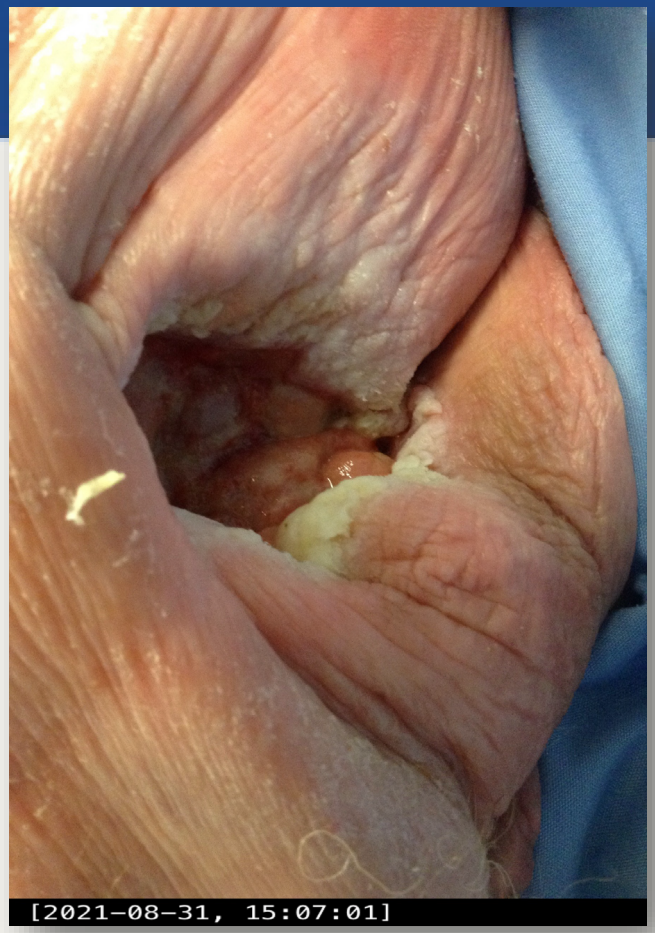

Title: Wound Measurements	**Policy Number:** OP.066.0
Date Issued: 04/01/2016	**Date Revised:** 04/01/2016, 01/01/2018
Source: SerenaGroup™ Inc.	**Revisions:**
SerenaGroup	**Medical Director SerenaGroup, Inc.** Thomas E. Serena MD FACS

SCOPE:

All company facilities, including hospitals and any entities operating under the hospital's Medicare Provider Number including, but not limited to, the following:

Nursing Personnel
Staff Physicians/Non-Physician Provider

PURPOSE:

Information about the dimensions of the wounds will be collected and recorded on a patient's initial assessment visit and all subsequent visits. If more than one wound is being treated, measurements for all wounds will be collected and clearly recorded for each wound number. If a debridement is performed during a visit, pre and post debridement measurements will be collected and recorded.

PROCEDURE:

Dimensions of the wound are measured in centimeters (cm) using a disposable measuring tape and sterile cotton tip applicator, when appropriate.

Wounds are measured:

1. At initial assessment
2. At all subsequent visits, no less than weekly.
3. Prior to and after any debridement is performed

DEFINITIONS:

Length: The longest distance of the wound referencing head-to-toe direction.

Width: The widest girth of the wound from left to right, 3 to 9 o'clock.

Depth: Using a sterile cotton tip applicator, locate the deepest point of the wound, measuring it at a 90 degree angle with the skin, to the level of the skin.

Note: All wounds which have a depth of less than 0.1cm, but are not fully epithelialized are rounded to 0 .1cm. Only wounds which have a full layer of epithelial covering (and therefore are healed) are to be assigned a depth of 0 cm.

Sinus Track/Tunneling: The longest or deepest area which extends through a small opening or channel from the base of the wound to be measured using gentle probing with sterile cotton tip applicator, and recorded indicating the general location through the reference of a clock - the patient's head representing 12 o' clock.

Undermining: The longest area which extended from the margins of the wound into the subcutaneous tissue which runs parallel with the skin. To be measured using gentle probing with a sterile cotton tip applicator, and recorded indicating the general location through the reference of a clock- the patient's head representing 12 o'clock.

PROCEDURE:

Dimensions of the wound are measured in centimeters (cm) using a disposable measuring tape and sterile cotton tip applicator, when appropriate.

Wounds are measured:

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2. At all subsequent visits, no less than weekly.
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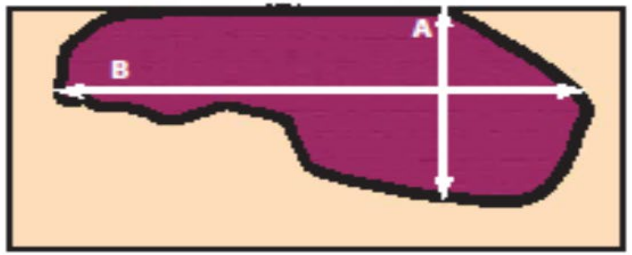
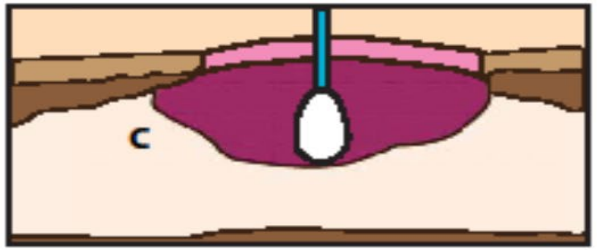
Measuring Wounds

Measure the length "head-to-toe" at the longest point (A). Measure the width side-to-side at the widest point (B) that is perpendicular to the length, forming a "+". Measure the depth (C) at the deepest point of the wound.
All measures should be in centimeters.





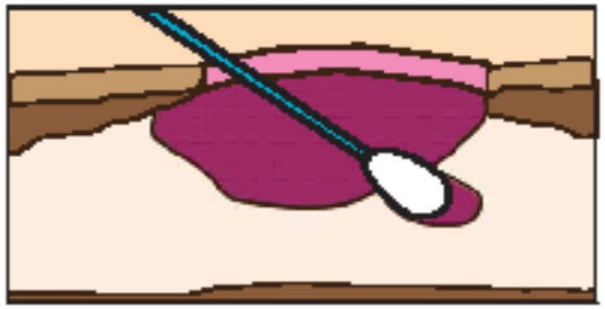
Measure Tunneling & Undermining

Using a clock format, describe the location and extent of tunneling (sinus tract) and/or undermining.

The head of the patient is 12:00, the patient's foot is 6:00.

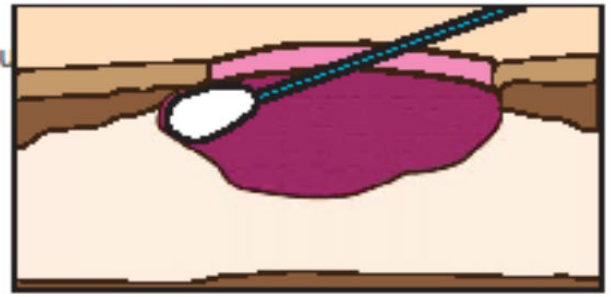
Tunneling/Sinus Tract

A narrow channel or passageway extending in any direction from the base of the wound. This results in dead space with a potential risk for abscess formation.



Undermining

Open area extending under intact skin along the edge of the wou



If the wound has many landmarks, you may want to trace it before measuring.


QUIZ TIME

QUESTION 1:

All wounds will receive a standardized exam.

ANSWER 1:

All wounds will receive a standardized exam.

QUESTION 2:

Measurement are only taken on Initial visit.

ANSWER 2:

Measurement are only taken on Initial visit.

***Answer*: False. Measurements should be performed at least weekly**

QUESTION 3:

The head of the patient is 12:00 o’clock and the foot of the patient is 6:00 o’clock.

ANSWER 3:

The head of the patient is 12:00 o’clock and the foot of the patient is 6:00 o’clock.

***Answer*: True. The clock format is used for measuring.**

QUESTION 4:

Measurement are as follows: L x W x D

ANSWER 4:

Measurement are as follows: L x W x D

QUESTION 5:

The physician will plan for the objective examination based on the information obtained from the history and subjective examinations.

ANSWER 5:

The physician will plan for the objective examination based on the information obtained from the history and subjective examinations.

QUESTION 6:

Wound measurements are to be done before and after debridement.

ANSWER 6:

Wound measurements are to be done before and after debridement.

Thank you for taking the time to complete SerenaGroup Education for November 2021. SerenaGroup continues to focus on providing education to all clinical staff. If you have ideas, questions, comments around education – please reach out to the Education Committee Members.

SerenaGroup Education Committee Members,
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