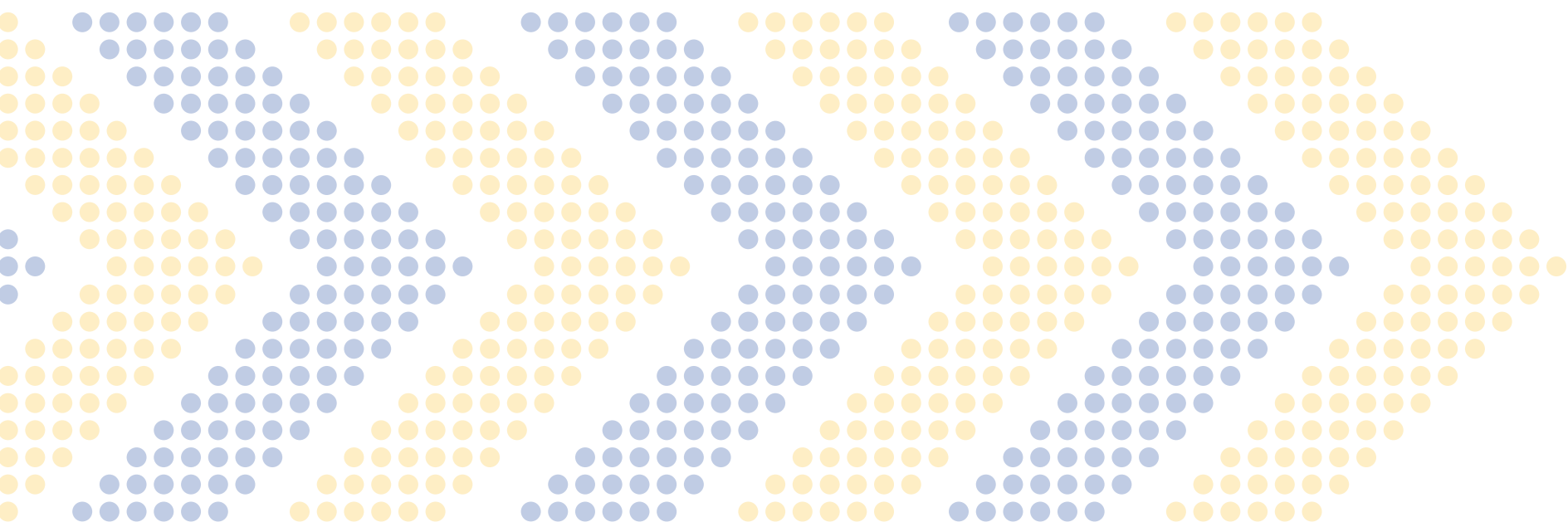


SerenaGroup
Building the Nation's Leading Wound Care Team

EDUCATION SERIES



Grading, Staging, & Measuring

Presented by: SerenaGroup Education Committee

JANUARY 2023

TODAY'S AGENDA

- Measuring Wounds
- Photography Documentation
- Wagner Grading Diabetic Ulcers
- Staging Pressure Ulcers
- Burn Classification
- Quiz

CLINICAL RESOURCES

- **Clinical guidelines** are provided by SerenaGroup to safeguard consistent, high-quality care in every center.
- **SerenaGroup Policies & Procedures**

Measuring Wounds

Wound dimensions are measured in centimeters (cm) using a disposable measuring tape and sterile cotton tip applicator or digital photographic planimetry. (Length x Width x Depth)

- **Length:** The longest distance of the wound from 12 to 6 o'clock.
- **Width:** The widest part of the wound of the wound from 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: Wounds that have a depth of less than 0.1cm but are not fully epithelialized are rounded to 0.1cm. Only wounds that have a full layer of epithelial covering (and therefore are healed) are to be assigned a depth of 0 cm.

Measuring Wounds

- **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 extending from the margins of the wound into the subcutaneous tissue running parallel with the skin. Measure with a sterile cotton tip applicator indicating the location of the tunnel. Utilize the clock face method.
- **Clustering:** When multiple wounds are located within 2cm measure them as one wound.

Photographic Documentation

PROCEDURE:

1. Obtain written consent for medical photography.
 - a. The patient has the right to refuse the photographic request.
2. If refused, document the patient's refusal in progress note.
3. Wounds will be photographed on admission, follow-up, and discharge visits.
4. Photographs will be labeled with patient's identifiers;
 - a. Date and wound number
 - b. Pre and post debridement
5. When a wound changes significantly or a new wound appears.
6. Center the wound in the frame with minimal background or body area exposed.
7. Avoid capturing the patient's face or other identifying marks.
8. Upload photographs in medical record and/or secured location.
9. Store photos in accordance with HIPAA regulations.
10. Appropriate personal protective equipment (PPE) will be worn during wound photography.
11. The device will be cleansed with approved solution upon completion of photography.

Wagner Grading System




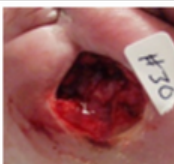

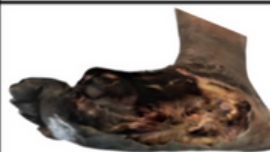
DFU's are graded by severity. The Wagner grading system is the most commonly used acuity scale.

- Wagner I: partial or full thickness not down to any underlying structure.
- Wagner II: The ulcer extends down to deeper structure.
- Wagner III: The ulcer extends into deep tissues such as the joint with abscess, infection and/or osteomyelitis.
- Wagner IV: localized gangrene in the foot
- Wagner V: extensive gangrene in the foot

(This flyer is available on the SerenaGroup Member's Portal)

Wagner Grading Scale

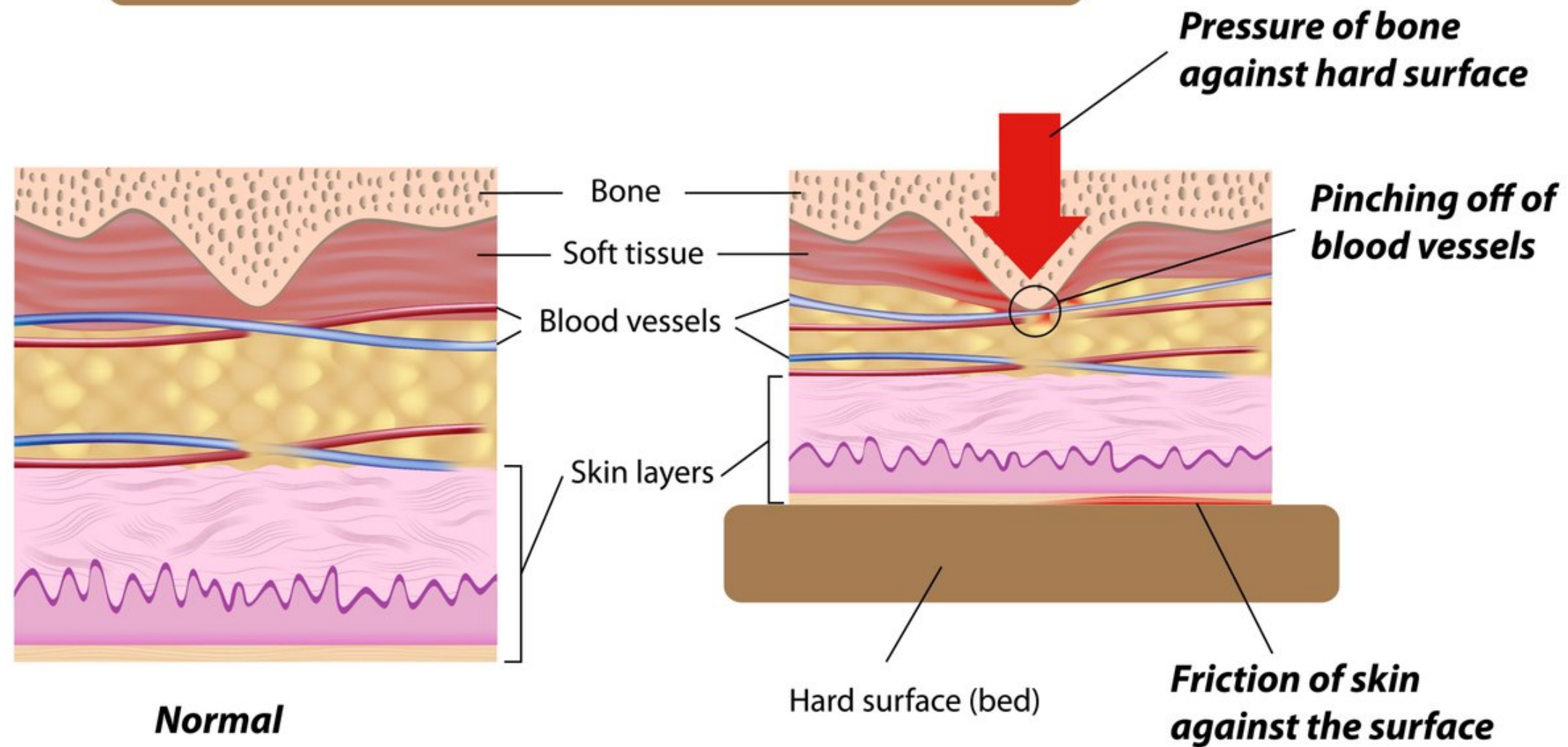
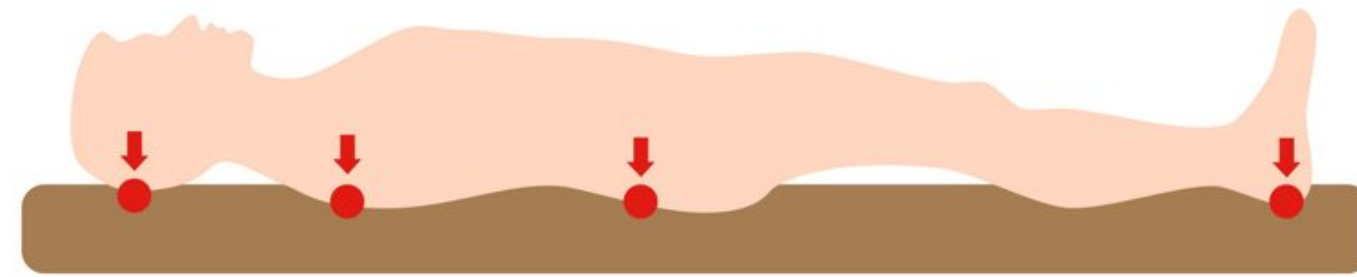
classification system for diabetic foot ulcers

WAGNER GRADE	DESCRIPTION	EXAMPLE
0	Intact skin.	
I	Superficial ulcer of skin or subcutaneous tissue.	
II	Ulcer penetrates through subcutaneous tissue and may extend into tendon, bone or joint capsule.	
III	Ulcer extends into tendon, bone or capsule and is complicated by infection of the bone or tissue. Including, but not limited to, abscess, osteomyelitis, pyarthrosis, osteitis or infection of the tendon and tendon sheaths.	
IV	Wet or dry gangrene of toe(s), forefoot, or any area with localized gangrene.	
V	Extensive gangrene involving the whole foot.	

Once an ulcer becomes a Wagner Grade, it can only increase on the scale. It will remain its highest grade until closure.

Pressure Ulcers

Etiology of Pressure Sores



Pressure Ulcer Staging

Staged according to severity:

- Stage I- Intact skin with a localized area of nonblanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration.
- Stage II- Partial thickness loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.

Pressure Ulcers

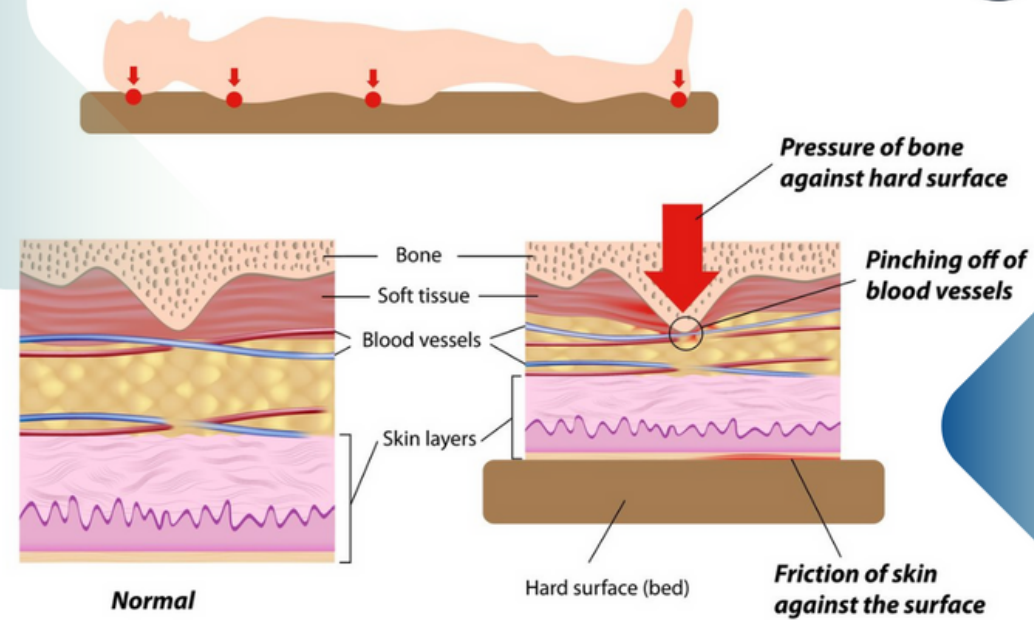
- Stage III- Full thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds.
- Stage IV- 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 tunneling typically occur.

Pressure Ulcers

- Unstageable- Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.
- Deep Tissue Injury (DTI)- Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin.

(This flyer is available on the SerenaGroup Member's Portal)

Pressure Ulcer Staging



STAGE	DESCRIPTION	EXAMPLE
I	Intact skin with non-blanchable redness of a localized area, usually over a bony prominence. Affecting the epidermis layer.	
II	A shallow open ulcer. Partial thickness loss to the epidermis and some of the dermis. Wound bed should be pink or red and free of slough.	
III	Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present. Wound may undermine and/or tunnel. Full thickness tissue loss.	
IV	Full thickness tissue loss with exposed bone, tendon, or muscle. Often includes undermining and tunneling. Slough or eschar may be present on part of the wound bed.	
Unstageable	Full thickness tissue loss in which the wound bed is covered by slough, eschar, and/or necrotic tissue in the wound bed, which must be debrided before a true depth can be obtained.	

Offloading is a key component of preventing and treating pressure ulcers!

Burn Stages

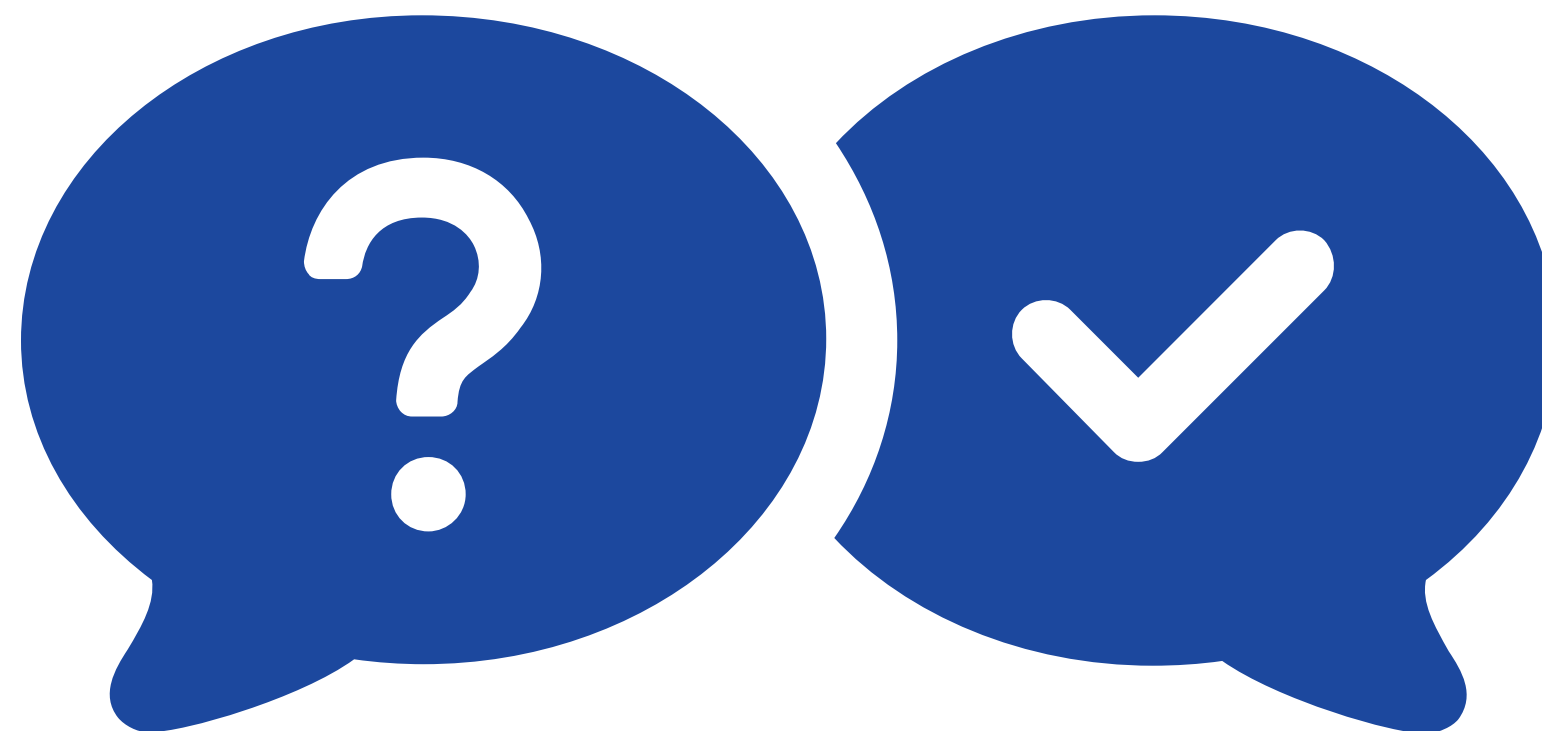
1st degree: Top layer of skin. Painful, does not usually blister or scar.

2nd degree: Damage beyond the epidermis. The presence of blisters indicates a longer healing time.

3rd degree: Penetrate every layer of skin.



QUIZ TIME!



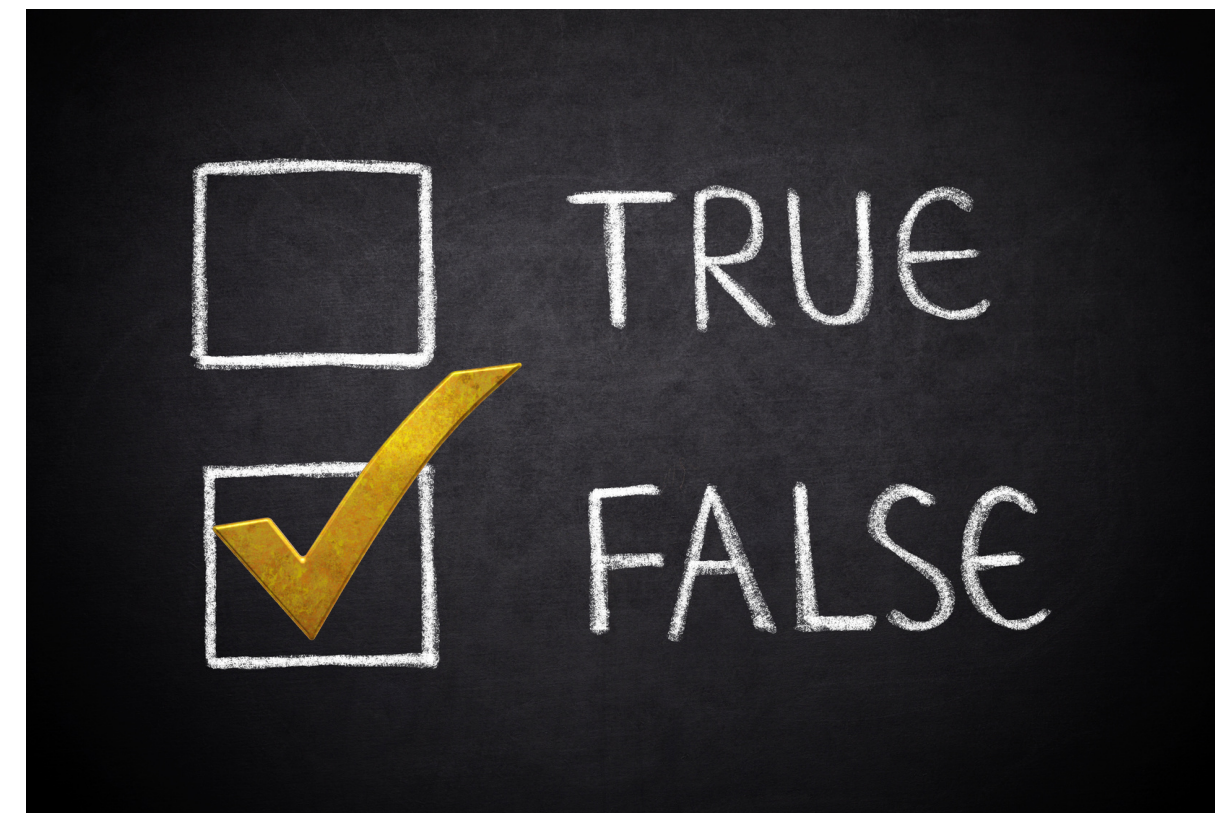
QUESTION ONE

Pictures are not required post-debridement, if pictures were taken pre-debridement.

- TRUE
- FALSE

ANSWER ONE

False. Pre and Post-debridement pictures are required.



QUESTION TWO

A diabetic patient with a foot ulcer had a deep abscess. The abscess was drained. What Wagner Grade is the ulcer?

ANSWER TWO

Wagner Grade 3. With the abscess it immediately becomes a Grade 3 and it will never deescalate until it is healed.

REFERENCES

- www.serenagroupinc.com
- SerenaGroup Policies & Procedures
- SerenaGroup Clinical Practice Guidelines

THANK YOU

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