



## Wound Competency 2007: Performance Skills

### 1. States and demonstrates how to differentiate a Stage 1 pressure ulcer from an area of redness.

- A stage 1-pressure ulcer is an area of *persistent* redness in lightly pigmented skin, whereas in darker skin tones it may appear red, blue or purple hues. The stage 1 pressure ulcer does not blanch (turn white) when direct pressure is applied. To check for blanching, press finger over reddened area for 10 to 15 seconds.
- An area of redness, or blanchable erythema, is an area that becomes white (blanches) when compressed with a finger. The redness promptly returns when the compression is removed. An area of redness will *resolve* with repositioning.

### 1. States how to determine if a wound is pressure related.

- Any area of the body subject to unrelieved pressure can result in damage of underlying tissue. Pressure ulcers are usually located over bony prominences. ONLY pressure ulcers are “staged” to indicate the degree of tissue damage. Pressure Ulcer stages are from Stage 1 (least amt of skin damage), to Stage 4, (extensive destruction). Pressure ulcers caused by unrelieved pressure tend to have round borders.
- Shear (trauma caused by tissue layers sliding against each other) and friction (surface damage caused by skin rubbing against another surface) are also contributing factors in the development of pressure ulcers. Pressure ulcers caused by shear and friction tend to have irregular jagged borders.

### 2. Differentiate a stage 1 Pressure ulcer from a Deep tissue injury (DTI).

- A **stage 1** pressure ulcer may appear as an area nonblanchable area of persistent redness, may have change in temperature (cool or warm), a change in tissue consistency (firm or boggy) and/or change in sensation (pain or itch).
- A **DTI** is a purple or maroon localized area of discolored intact skin. A DTI may also present as a blood filled blister due to damage of underlying tissues. The area may be painful, mushy, indurated, boggy, warmer or cooler than adjacent tissue.
- **Unstageable** is a pressure ulcer is full-thickness skin loss in which the base is covered by slough( yellow, tan, gray, brown) and/or eschar( tan, brown, or black)

### 3. Demonstrate how to assess the length, width and depth of a wound.

- To assess wound measurements it is helpful to imagine a clock face super imposed over the wound. Measure in centimeters!! The length will be the longest part of the wound; the width will be the widest part of the wound.
- To assess depth, gently insert cotton tipped applicator into the deepest part of wound. Slide fingers down to skin surface. Remove swab from wound, measure from fingers to cotton tip for depth.

#### 4. Identify and indicate meaning of tissue types: red, yellow, black

- **Red** tissue in wound bed indicates healthy tissue.
- **Yellow** tissue in wound bed indicates slough, a build up of fibrous tissue or a vascular tissue. Fibrin tissue can range from white, yellow to light grey, stringy to solid.
- **Black** tissue in wound bed indicates tissue death. Necrotic tissue can range from soft dusky brown or beige to hard black eschar.

#### 5. Identifies Stage 2/partial thickness

- A **Stage 2/ partial thickness** wounds present as superficial ulcer. It can resemble an abrasion, a blister or a shallow crater. Tissue loss extends to the epidermis and part of the dermis. May also present as intact or ruptured serum filled blister that is clear in color. Stage 2-pressure ulcers classification is used if cause is *pressure* related.

#### 6. Identifies a Stage 3 and Stage 4 full thickness wound.

- A Stage 3 pressure ulcer is full thickness skin loss involving damage thru to subcutaneous fat tissue. A Stage 3 may extend to but not thru underlying fascia. The ulcer presents as a deep crater that may or may not include undermining or tunneling. **The present of slough or necrosis in the wound bed**
- A **Stage 4 pressure ulcer** is full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule).

#### 7. Describe the key elements to include in documentation of wound.

- Type: Identify **type of wound**, stage if appropriate
- Location: **Where is wound** on the patient.
- Periwound: Describe **condition of surrounding skin**
- Wound bed: Color of **wound base**
- Drainage: Amount, consistency
- Odor: foul, sweet, urine

#### 8. Identifies the appropriate wound care product with rationale for necrotic wound.

- A necrotic wound bed,(may also be called avascular) indicates deep tissue destruction extending through subcutaneous tissue into fascia. Depending on location of wound the necrosis may involve muscle, bone, or supporting structures i.e. Tendon, joint capsule. Healing cannot begin until healthy red tissue is in wound base. Removal of necrotic tissue is debridement. Debridement can be autolytic, chemical, mechanical, or thru sharps.
- **Autolytic debridement**—Curasol/Nugel/duoderm
- **Chemical debridement agents**—Accuzyme, Panafil
- **Mechanical debridement**---Wet to dry saline dressings  
Sharps—removal using scalpel may be bedside or in OR.

#### 9. Identifies appropriate wound product choices for healthy shallow and deep wounds. \* Wound Care Guidelines are available on all units and on the intranet. Suggestions for product application may include the following:

- **Skin exposed to incontinence**: Peri- Wash II and Critic Aid Clear Paste/ Xenaderm.
- **Fungal Infection**: Aloe Vesta Antifungal Ointment, Mycostain powder
- **Wounds with scant to moderate drainage**: Duoderm X-Thin and Duoderm Signal.
- **Wounds with moderate to heavy drainage**: N/S moistened gauze, Aquacel, Polymem, Biatain Foam

- **If mod to large amt exudates with dead space:** Aquacel, N/S moisten gauze

Panel for the Prevention of Pressure Ulcers in Adults. *Pressure Ulcers in Adults: Prediction and Prevention. Clinical practice Guideline.* Number 3. AHCPR Publication No. 92-0047

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