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Introduction to Wound Care

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Goals

Describe the components of a wound care assessment
Recall the anatomy of the skin
Explain the definition of a pressure injury
Understand the legal implications of accurate wound documentation

Current State of Wound Care

More than 8.2 million Americans suffer from chronic wounds

The pandemic affected the way wounds have been treated and resulted in a delay in care

It will take years to fully understand the impact the delay in wound care treatment has had on society and the medical field

Estimated costs for acute and chronic wound treatment in the U.S. are up to $96 billion dollars

What is a Wound?

Any destruction of the normal anatomical structure and function of the skin

What is a Wound Assessment?

A written record or photograph that provides the current status and/or progress of a wound

A cumulative process of the observation, data collection, and evaluation of the wound at each encounter

Purpose of an Accurate Wound Care Assessment

Assess and determine the course of individualized treatment and care for a wound

Enhance communication

Ways to document:

- **Physical wound sheets**
- **EMR prompted documentation**
- **Free text and photography**

Wound Care Photography

Provides actual physical visual record of the wound

When done correctly – it provides clarity to physicians in their clinical care decision

Documentation = support in the case of litigation

Frequency of Wound Care Assessment

Wound severity

Patient's overall condition and environment

Goals and plan of care
Site of care

Frequency of Wound Care Assessment

Assess before and after any procedure (surgical or specialized treatment such as debridement)

Weekly or based on any changes in the patient's activity level
If the wound noticeably deteriorates

If the wound becomes malodorous, painful, or has new purulent exudate
Patient is readmitted to or returns from a facility

Basic Skin Anatomy

- **Epidermis**
  - Outermost layer of skin
  - Composed of 5 layers
  - Regenerates in 28 days
- **Dermis**
  - Composed of 2 layers
  - Network of nerve endings, lymphatics, capillaries, glands, etc.
- **Subcutaneous tissue (hypodermis)**
  - Adipose tissue and connective tissue
  - Major blood vessels, nerves, and lymphatic vessels

Assessment Components Etiology

Understanding the etiology will help facilitate the documentation of the wound

Knowing the cause of the wound will direct the treatment and care of the wound itself

If unsure review patient H&P to determine wound etiology

Assessment Components Etiology

Surgical
Arterial

Venous
Diabetic/Neuropathic

Pressure injury
Moisture-associated skin damage

Assessment Components

In addition to knowing the etiology, understanding if a wound is chronic or acute will drive treatment options and considerations

Assessment Components

Acute vs. chronic

- **Acute wounds can result from trauma or surgery**
- **A chronic wound is a wound that fails to progress towards healing and is present for at least 30 days**
- **A chronic wound can have an acute issue (i.e., infection)**

Assessment Components

Location

Describe the location of the wound as clearly and accurately as possible

Why?

The wound location can provide information around the ideology of the wound

Assessment Components

Location

The location of the wound can also guide the dressing selection and other interventions that are required to help facilitate the healing of that wound

Assessment Components

Location

When documenting the location of the wound use correct anatomical terms (e.g., left trochanter vs. left hip)

Document as specifically as possible the area of the body where the wound is located and take into consideration the surface where the wound is located

Location

If there are two or more wounds located in the same area, they should be numbered and labeled for clarity

Assessment Components

Location

Use the face of the clock to determine the location and description of wound features

Assessment Components

Assessment Components: Measurement

Determine wound progression and evaluate the effectiveness of treatment

A decrease in wound size and volume indicates *healing*

Use centimeters NOT inches to document the size of the wound
Length, width, and depth

Assessment Components: How to measure a wound

Measure head to toe, and use the face of the clock to describe the location
12 o'clock is the top or "head"
6 o'clock is the bottom or "toe"
Length – longest distance of a wound
Width – the widest part
Depth – deepest part, at time of assessment

Wound Care Documentation: Tissue destruction

Partial thickness vs. full thickness
Partial thickness – first two layers of skin (epidermis, into but not through the dermis)
Full-thickness – penetrates through the subcutaneous fat layer, involves muscle, tendon, or bone

Wound Care Documentation: Tissue destruction

Tunneling (aka sinus tract)
A pathway under the wound's edge or surface, most tunneling is not visible
Undermining
A closed pathway under the wound's perimeter
Undermining and tunneling are considered full-thickness injuries

Wound Care Documentation

Identify: shape, address wound base and edges
Oval, square, or triangular
Base color – document by percentage (e.g., 75% red granulation tissue, 25% yellow slough)

Wound Care Documentation

Slough vs. eschar: necrotic tissue present in the wound bed
Slough – stringy, yellow, gray, or green and soft (not to be confused with purulence*)
Eschar – hard/solid, tan, brown or black

***If you don't know the technical term, just describe what you see using clear, simple language**

Wound Care Documentation

Margins/edges – rolled, irregular
Peri-wound
Erythema, induration (hardness), maceration, or satellite lesions

If you don't know the technical term, just describe what you see using clear, simple language

Wound Care Documentation: Exudate

Amount – none, scant, moderate, heavy
Color – serous, serosanguineous, green, brown

Consistency – clear, purulent, thin, thick, viscous
Odor?

Exudate indicates a wound's status or indicates the cause may not have been treated

Additional Assessments: Infection

Recognize the signs and symptoms of an infection, acute wounds and the chronic wound can both become infected and present differently
Acute – pain, swelling, erythema, heat
Chronic – pain, friable granulation, foul odor, wound breakdown

Wound Care Assessment and Documentation

The ONLY wound to be classified by stages as defined by the National Pressure Injury Advisory Panel (NPIAP)

Wound Care Assessment and Documentation

“A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to medical or other devices. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.”

Wound Care Assessment and Documentation

Pressure injury staging overview

Stage 1 - Non-blanchable erythema of intact skin

Stage 2 - Partial-thickness skin loss with exposed dermis

Stage 3 - Full-thickness skin loss

Stage 4 - Full-thickness skin and tissue loss

Wound Care Assessment and Documentation

Pressure injury staging overview

Deep tissue pressure injury: Persistent non-blanchable deep red, maroon or purple discoloration

Unstageable: Obscured full-thickness skin and tissue loss

Wound Care Assessment and Documentation

Pressure injury staging overview

Medical-device related pressure injury - describes an etiology and is staged using the numeric staging system

Mucosal membrane pressure injuries: found on mucous membranes with a history of a medical device in use at the location of the injury - cannot be staged

Documentation Best Practices

- Documentation should be clear, concise, and factual
- Documentation should paint a picture of the wound and the care provided
- If you're not sure of what you're looking at, just describe what you see (vs. identifying etiology or cause)
- Consult with your wound care specialist

Documentation Best Practices Legal

- Document truthfully and objectively
- Don't assign blame in the medical record - this is considered fuel for malpractice actions
- Consistency prevents gaps in charting
- Gaps in the patient's chart can be interpreted as evidence of negligence and leaves room for suggestions vs. facts

Documentation Best Practices Legal

Documentation drives reimbursement and support from Medicare

Per Medicare standards, the patient's medical record must contain clearly documented evidence of the progress of the wound's response to treatment at each visit

Documentation Best Practices Legal

Documentation must include, at a minimum:

Current wound volume (surface dimensions and depth)

Presence (and extent of) or absence of obvious signs of infection

Presence (and extent of) or absence of necrotic, devitalized or non-viable tissue or other material in the wound that is expected to inhibit healing or promote adjacent tissue breakdown

Legal Implications: Malpractice

Most common in terms of wound care lawsuits

Most common questions brought to light in terms of wound care involve cases including incomplete or missing documentation

The most important strategy for preventive legal care is documentation

Summary

Wound care is complex and due to the pandemic, we have seen delays in care; this perpetuates the cycle of complex wound treatment
Measure in cm.
Describe the wound using accepted medical terminology - if you don't know the correct term, just describe what you see
Staging is reserved for pressure injuries ONLY

Summary

Understanding the etiology of a wound is essential to the development and assessment of a wound treatment plan
Documentation should be clear, concise, and factual, and it should paint a picture of the care provided
Consult with your wound care specialist

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The following slides address the California BON regulation that, beginning January 2023, all continuing education providers shall ensure compliance with the requirement that continuing education courses contain curriculum that includes the understanding of implicit bias.

Implicit Bias | How does it affect healthcare?

Why does implicit bias matter?

Implicit attitudes are thoughts and feelings that often exist outside of conscious awareness, and thus are difficult to consciously acknowledge and control. (Hall et al., 2015)

Implicit (subconscious) bias refers to the attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. (The Joint Commission, 2016)

Why does implicit bias matter?

Implicit biases affect behavior through a two-phase process: biases are activated in the presence of a member of a social group and then are applied so that they affect the individual's behavior related to that group member. In the healthcare context, for instance, implicit biases may be activated when a provider is interacting with an African American patient, particularly under conditions that tax her cognitive capacity (e.g., stress, time-pressure, fatigue, competing demands), and can then influence how she communicates with and makes decisions about her patient. (Burgess et al, 2017)

Why does implicit bias matter?

Implicit (unconscious) biases can create gaps between good intentions and good outcomes in the health care field. (The Ohio State University, 2020)

Based on the available evidence, physicians and nurses manifest implicit biases to a similar degree as the general population. The following characteristics are at issue: race/ethnicity, gender, socio-economic status (SES), age, mental illness, weight, having AIDS, brain injured patients perceived to have contributed to their injury, intravenous drug users, disability, and social circumstances. (FitzGerald & Hurst, 2017)

Why does implicit bias matter?

The implicit biases of concern to health care professionals are those that operate to the disadvantage of those who are already vulnerable. Examples include minority ethnic populations, immigrants, the poor, low health-literacy individuals, sexual minorities, children, women, the elderly, the mentally ill, the overweight, and the disabled. However, anyone may be rendered vulnerable given a certain context. (FitzGerald & Hurst, 2017)

Why does implicit bias matter?

Implicit biases among health care providers are associated with the following negative effects on patient care:

- inadequate patient assessments
- inappropriate diagnoses and treatment decisions
- less time involved in patient care
- patient discharges with insufficient follow-up

Why does implicit bias matter?

The terms "health care disparities" and "health care inequities" refer to the poorer health outcomes observed in minority and other vulnerable patient groups compared with those observed in majority or dominant patient populations. Disparate patient outcomes are associated with age, sex, religion, socioeconomic status, sexual orientation, gender identification, disability, and stigmatized diagnoses (for example, HIV, obesity, mental illness, and substance abuse). (Narayan, 2019)

Why does implicit bias matter?

Implicit bias isn't limited to race. The Implicit Association Test (IAT) measures attitudes and beliefs that people may be unwilling or unable to report.

For example, when the IAT was administered at an obesity conference, participants implicitly associated obese people with negative cultural stereotypes, such as "bad, stupid, lazy and worthless."

Implicit gender bias among physicians also may unknowingly sway treatment decisions.

Why does implicit bias matter?

Women are three times less likely than men to receive knee arthroplasty when clinically appropriate. One of the stereotypical reasons for this inequity and underuse problem is that men are viewed as being more stoic and more inclined to participate in strenuous or rigorous activity.

(The Joint Commission, 2016)

Why does implicit bias matter?

People of color face disparities in terms of morbidity, mortality, and health status. Black, Hispanic, and Indigenous Americans have higher infant mortality rates than White and Asian Americans. The premature death rate from heart disease and stroke is highest among Black Americans. Race and ethnicity are not the only demographic factors associated with disparity in health outcomes. Women are more likely to experience delayed diagnosis of heart disease compared to men, as well as inferior heart attack treatment. Sometimes, these disparities intersect, as in the case of childbirth, where the United States is one of the few countries experiencing a rise in the maternal mortality rate, and Black women are nearly four times as likely to die during childbirth as are White women. (Whitmer, 2020)

Why does implicit bias matter?

Healthcare providers in a certain geographic area may equate certain races and ethnicities with specific health beliefs and behaviors (e.g., "these patients" engage in risky behaviors, or "those patients" tend to be noncompliant) that are more associated with the social environment (like poverty) than a patient's racial/ethnic background or cultural traditions. (Stanford University, 2020)

How does implicit bias develop?

The ability to distinguish friend from foe helped early humans survive, and the ability to quickly and automatically categorize people is a fundamental quality of the human mind. Categories give order to life, and every day, we group other people into categories based on social and other characteristics.

This is the foundation of stereotypes, prejudice and, ultimately, discrimination.

Social scientists believe children begin to acquire prejudices and stereotypes as toddlers.

How does implicit bias develop?

Once learned, stereotypes and prejudices resist change, even when evidence fails to support them or points to the contrary.

People will embrace anecdotes that reinforce their biases, but disregard experience that contradicts them. The statement "Some of my best friends are _____" captures this tendency to allow some exceptions without changing our bias. (Learning for Justice, 2022)

How does implicit bias develop?

Scientific research has demonstrated that biases thought to be absent or extinguished remain as "mental residue" in most of us. Studies show people can be consciously committed to egalitarianism, and deliberately work to behave without prejudice, yet still possess hidden negative prejudices or stereotypes.

A growing number of studies show a link between hidden biases and actual behavior. In other words, hidden biases can reveal themselves in action, especially when a person's efforts to control behavior consciously flags under stress, distraction, relaxation or competition. (Learning for Justice, 2022)

How does implicit bias develop?

Research has frequently focused on the amygdala, a structure in the medial temporal lobes. The amygdala receives direct input from all sensory organs, enabling it to respond rapidly to immediate threats in advance of more elaborative cognitive processing. It plays a central role in arousal, attentiveness and triggering the flight-or-fight response, reacting to social threats in exactly the same way it reacts to physical ones. Unconscious bias, then, is the immediate, reflexive, defensive reaction to the "other." (Korn Ferry Institute, 2022)

How do I recognize implicit biases?

One way to discover implicit biases is to pay attention to gut feelings.

Nurses can ask themselves if they anticipate unpleasant experiences when caring for any particular group of patients, or if any particular group of patients makes them feel uncomfortable, anxious, or fearful.

Such feelings may indicate implicit bias and prompt self-reflection. Thoughtfully reflecting on the meaning and origin of such feelings and whether they influence the quality of relationships with patients can help nurses acknowledge and control previously unrecognized biases. (Narayan, 2019)

How do I recognize implicit biases?

Take one or more of the free Implicit Association Tests (IATs) available at Project Implicit (https://implicit.harvard.edu/implicit/education.html). Developed by Harvard, there are 14 instruments for measuring some of the most prevalent biases—those related to race, ethnicity, skin color, religion, age, gender, overweight or obesity, sexual orientation, or disability.

Learning about potential biases can enable people to employ strategies to reduce them or mitigate their effects on future interactions. The IATs are reliable and valid research instruments, and should not be used to diagnose bias but rather as educational tools.

How do I recognize implicit biases?

Implicit bias is different from prejudice. Implicit bias means we have the instinctive tendency to evaluate other groups against the norms of our own groups. Prejudice, on the other hand, means that one feels consciously and overtly that some groups are inferior, an attitude that can be used to justify discriminatory actions. (Narayan, 2019)

But I really don't think I'm biased

There's a reason it's called unconscious bias.

It's because hard-wired biases operate at a level that is beneath our conscious awareness. Even if we sincerely believe we're being fair and objective, stereotypes may still be influencing our opinions -without us being aware of it. (Stanford University, 2020)

We may consciously reject negative images and ideas associated with disadvantaged groups (and may belong to these groups ourselves), but we have all been immersed in cultures where these groups are constantly depicted in stereotyped and pejorative [derogatory] ways. (FitzGerald & Hurst, 2017)

Challenges in reducing implicit biases

Some types of interventions focus more on declarative knowledge – what you know – than on procedural knowledge – knowing how to do something.

Understanding implicit bias as a score on the IAT also may engender the view of implicit bias as a fixed trait that one can do little about.

Issues of race and racism are emotionally fraught and politically charged. The idea that healthcare providers may contribute to racial disparities may contradict their core beliefs and values, including beliefs that they treat everyone equally and that racial inequality is a thing of the past. (Burgess, 2017)

How to reduce implicit bias

1. **Stereotype replacement** — Recognizing that a response is based on stereotype and consciously adjusting the response
2. **Counter-stereotypic imaging** — Imagining the individual as the opposite of the stereotype.
3. **Individuation** — Seeing the person as an individual rather than a stereotype (e.g., learning about their personal history and the context that brought them to the doctor's office or health center)
4. **Perspective taking** — "Putting yourself in the other person's shoes"

How to reduce implicit bias

5. **Increasing opportunities for contact with individuals from different groups** — Expanding your network of friends and colleagues or attending events where people of other racial and ethnic groups, gender identities, sexual orientation, and other groups may be present
6. **Partnership building** — Reframing the interaction with the patient as one between collaborating equals, rather than between a high-status person and a low-status person

How to reduce implicit bias

7. **Emotional regulation** — People who have good emotional regulation skills and who experience positive emotion during clinical encounters may be less likely to view patients in terms of their individual attributes, and to use more inclusive social categories. It's easier to empathize with others when people view themselves as being part of a larger group. (The Joint Commission, 2016).
8. **Mindfulness** — A "mode of awareness" that can be enacted in different situations, including those which are emotionally challenging (Burgess, 2017).

How to reduce implicit bias

9. **Habit replacement** — Implicit bias is like a habit that can be broken through a combination of awareness of implicit bias, concern about the effects of that bias, and the application of strategies to reduce bias. (Devine et al, 2012)
10. **Take care of yourself** — Protect your mental resources. Do things to protect your mental energy, such as getting sufficient sleep, finding ways to reduce stress and taking mental breaks throughout the day to refocus on being present with your patients. (van Ryn, 2016)

The Institute for Healthcare Improvement (2017)

How to reduce implicit bias

The Institute for Healthcare Improvement (2017) also offers practical tips to combat implicit bias in healthcare, drawn from the book Seeing Patients: Unconscious Bias in Health Care, by Dr. Augustus White.

- Have a basic understanding of the cultures your patients come from.
- Don't stereotype your patients; individuate them.
- Understand and respect the tremendous power of unconscious bias.
- Recognize situations that magnify stereotyping and bias.

How to reduce implicit bias

The Institute for Healthcare Improvement (2017) also offers practical tips to combat implicit bias in healthcare, drawn from the book Seeing Patients: Unconscious Bias in Health Care, by Dr. Augustus White.

- Know the National Culturally and Linguistically Appropriate Services (CLAS) Standards. (Available at https://thinkculturalhealth.hhs.gov/clas/standards)
- Do a "Teach Back." Teach Back is a method to confirm patient understanding of health care instructions that is associated with improved adherence, quality, and patient safety.
- Assiduously practice evidence-based medicine.

Recommended viewing

Institute for Healthcare Improvement. (2020)

- How Does Implicit Bias Affect Health Care? http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Anurag-Gupta-How-Does-Implicit-Bias-Affect-Health-Care.aspx
- What Are the Harms of Not Addressing Bias in Health Care? http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Anurag-Gupta-What-Are-the-Harms-of-Not-Addressing-Bias-in-Health-Care.aspx

Recommended viewing

Institute for Healthcare Improvement. (2020)

- What Is Bias, and What Can Medical Professionals Do to Address It? http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Anurag-Gupta-What-Is-Bias,-and-What-Can-Medical-Professionals-Do-to-Address-It.aspx
- Why Shouldn't Providers Judge Patients' Choices? http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Nia-Zalamea-Why-Shouldnt-Providers-Judge-Patients-Choices.aspx

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