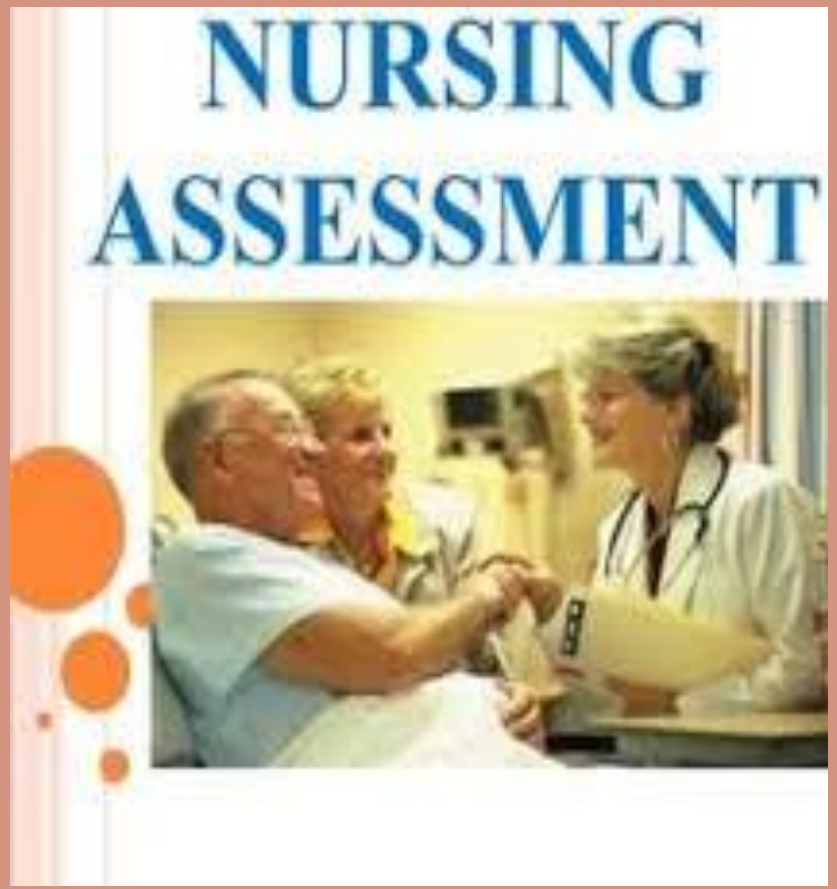
WOUND CARE IN CORRECTIONS CORRECTIONAL HEALTH CARE CONFERENCE 2024

OBJECTIVES

- Wound Care Assessment and Treatment.
- Going beyond the basics for wounds we see in corrections
- Self-Harm injuries care and treatment from emergent care with basic first aid
- Stop the bleed
- Hands on skills

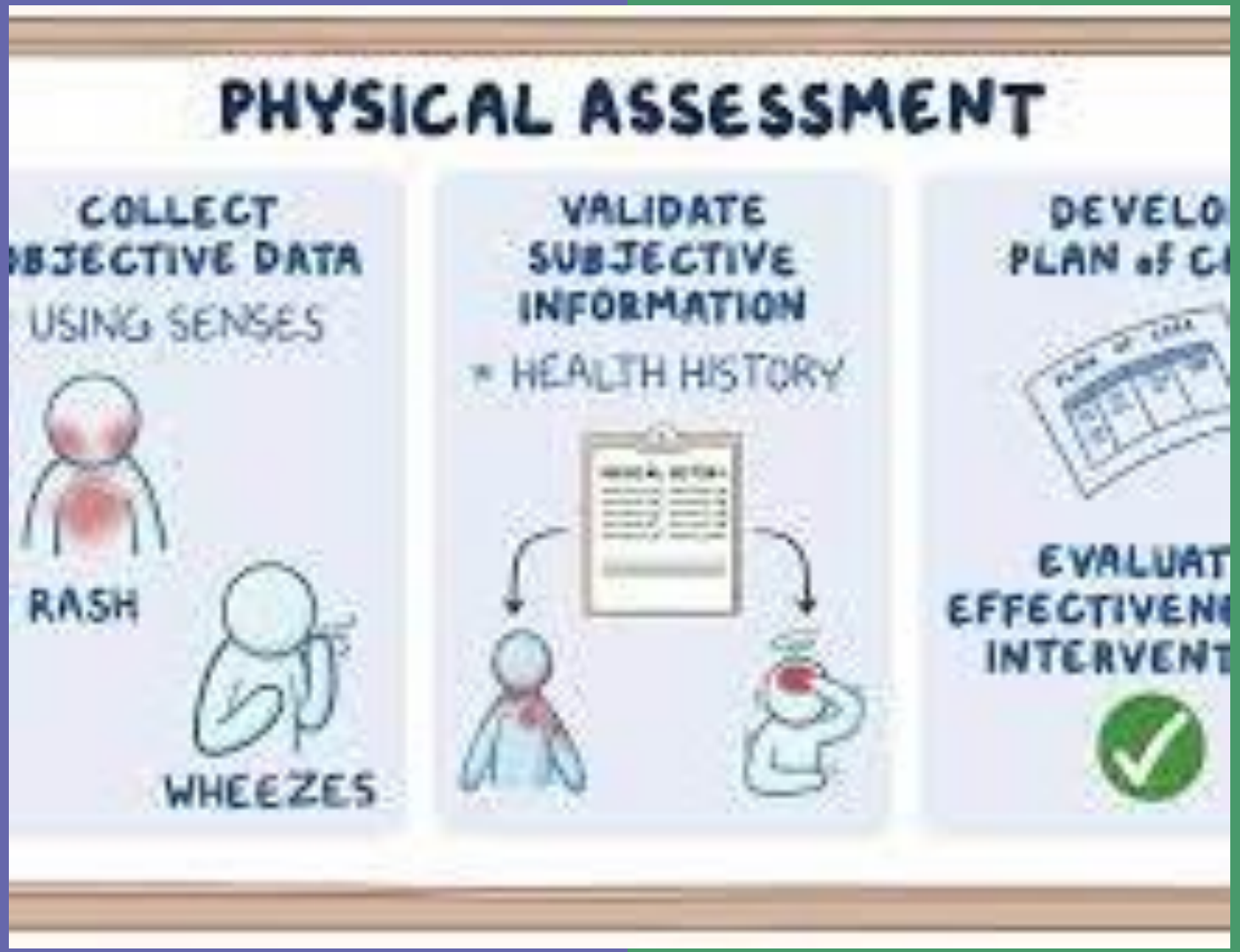
WHY ASSESS



Determines type-type drives care and treatment needs and plan of care. Looks at “Whole Patient”
Allows communication between healthcare providers
Allows continuity of care
Allows monitoring of a condition
Includes more than just the wound-is comprehensive
Risks Screens-Braden Scales
Optimizing Diabetic Control

WHY ASSESS?

- Determine severity-need to get a baseline.
- Need to be able to get a clear picture of what the wound looks like
- Determine status-getting better or worse.
- Determines if there are there complications
- Needs to occur at least weekly
- Supports us in litigation



WHY ASSESS

- Allows for a central location for wound care information to be viewed by caregivers- providing it is documented in the correct location and you can find it.
- Provides the current status of wound
- Provides cumulative data over a period of time

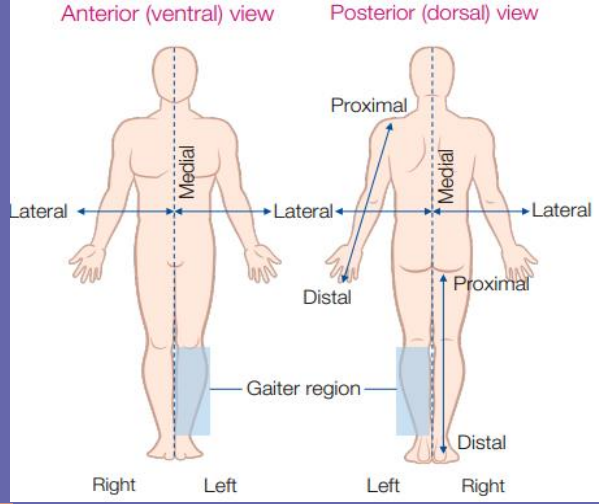
WHEN SHOULD WE ASSESS

- Based on agency guidelines
- Not less than weekly
- Based on treatment plan
- When there are noted changes in the wound
- When the patient returns from an outside facility
- Attempt to use the same staff for the assessment

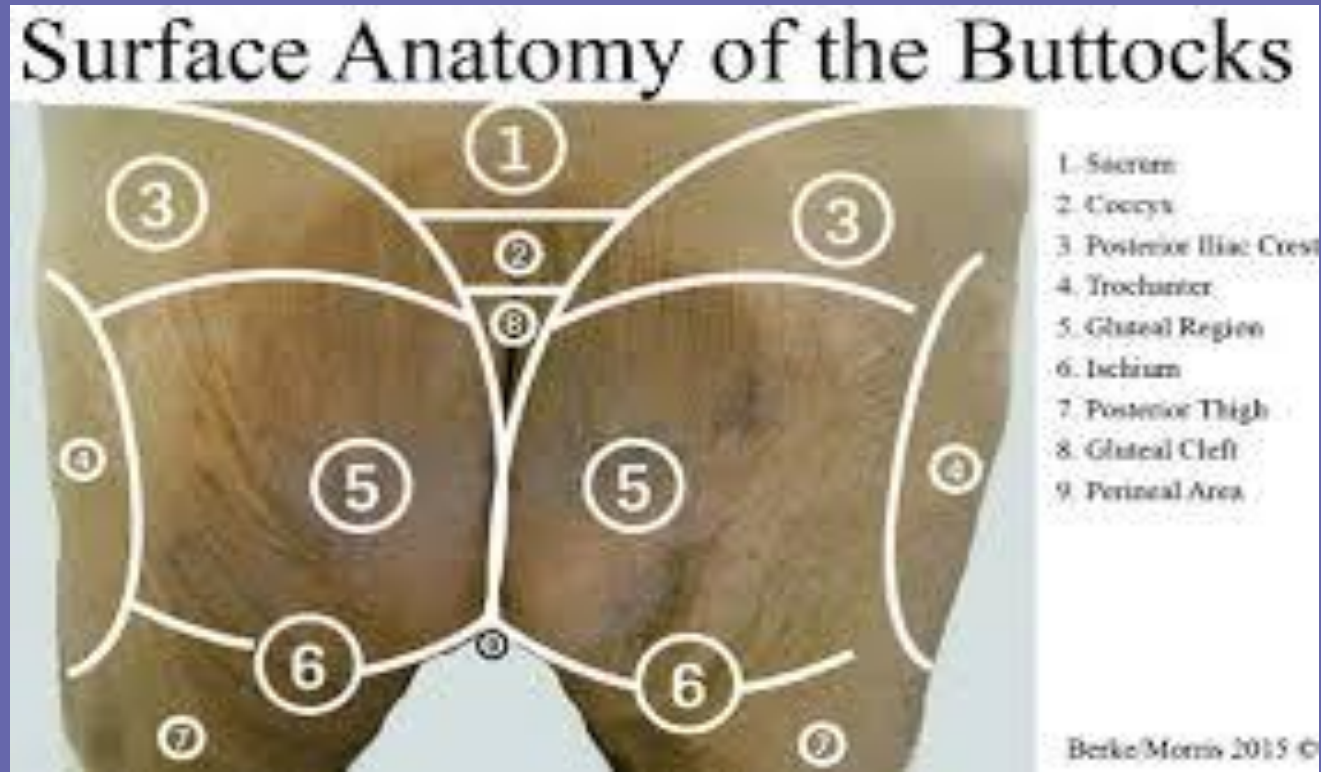
PARTS OF AN ASSESSMENT

- Location-helps with etiology determination allows you to define the type of wound
- Type of wound drives your treatment plan
- Helps with dressing selection and other modalities needed for healing

PARTS OF AN ASSESSMENT



- Location-helps with etiology determination
- Use specific anatomical terms
- Use reference such as lateral, medial, proximal, distal
- If multiple wounds are involved location description is very important.



PARTS OF AN ASSESSMENT LOCATION

- Location significance
- Venous ulcer above ankle, medial lower leg
- Lipodermatosclerosis is evident.
- Varicose Veins present
- Hemosiderin staining may be present if chronic
- Edema sometimes can be significant

PARTS OF AN ASSESSMENT LOCATION

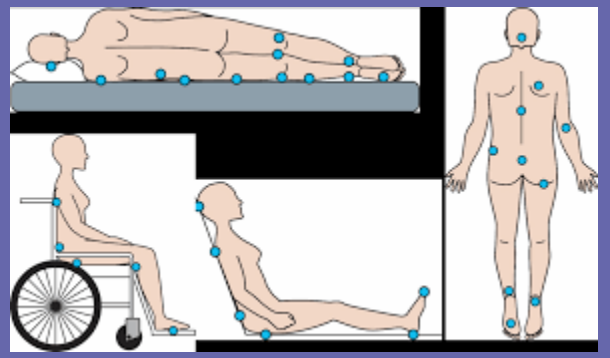
- Location significance
- Arterial
- Lower dorsum of leg, foot, toe joints, over boney prominences or malleolus
- Even shape and punched out appearance
- Often has slough, eschar or gangrene

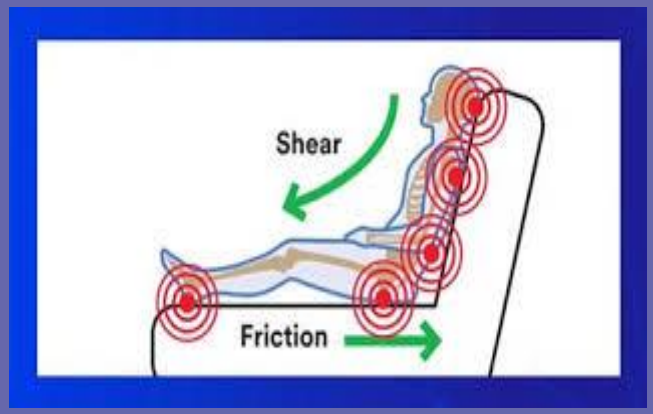
PARTS OF AN ASSESSMENT LOCATION

- Location significance
- Diabetic foot ulcers
- Lower dorsum of leg, foot, toe joints, over boney prominences
- Areas of repeated trauma-walking surface or where shoes rub
- Callous formation tells you there is still pressure occurring
- Frequent osteo-suspect if not healing
- Wagner classification scale

Wagner Grade	Description
Grade 0	No open skin lesions
Grade 1	Superficial ulcer without penetration to deeper Layers
Grade 2	Deep ulcer reaching tendon, bone, ligament or joint cap
Grade 3	Involvement of deeper tissues with abscess, Osteomyel tendonitis
Grade 4	Gangrene of toe, toes, and/ or forefoot

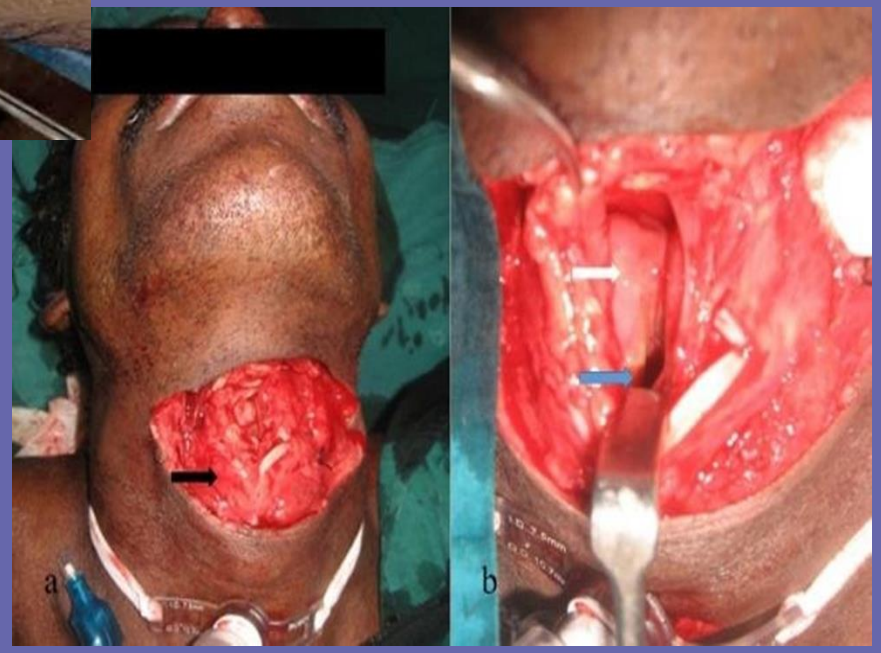
PARTS OF AN ASSESSMENT LOCATION





- Location significance
- Pressure Injury
- Located over boney prominences or under medical related devices
- This is the only wound that is staged
- Staging is based on the extent of tissue damage.
- 6 stages can be present

ASSESSMENT LOCATION



Traumatic Wounds

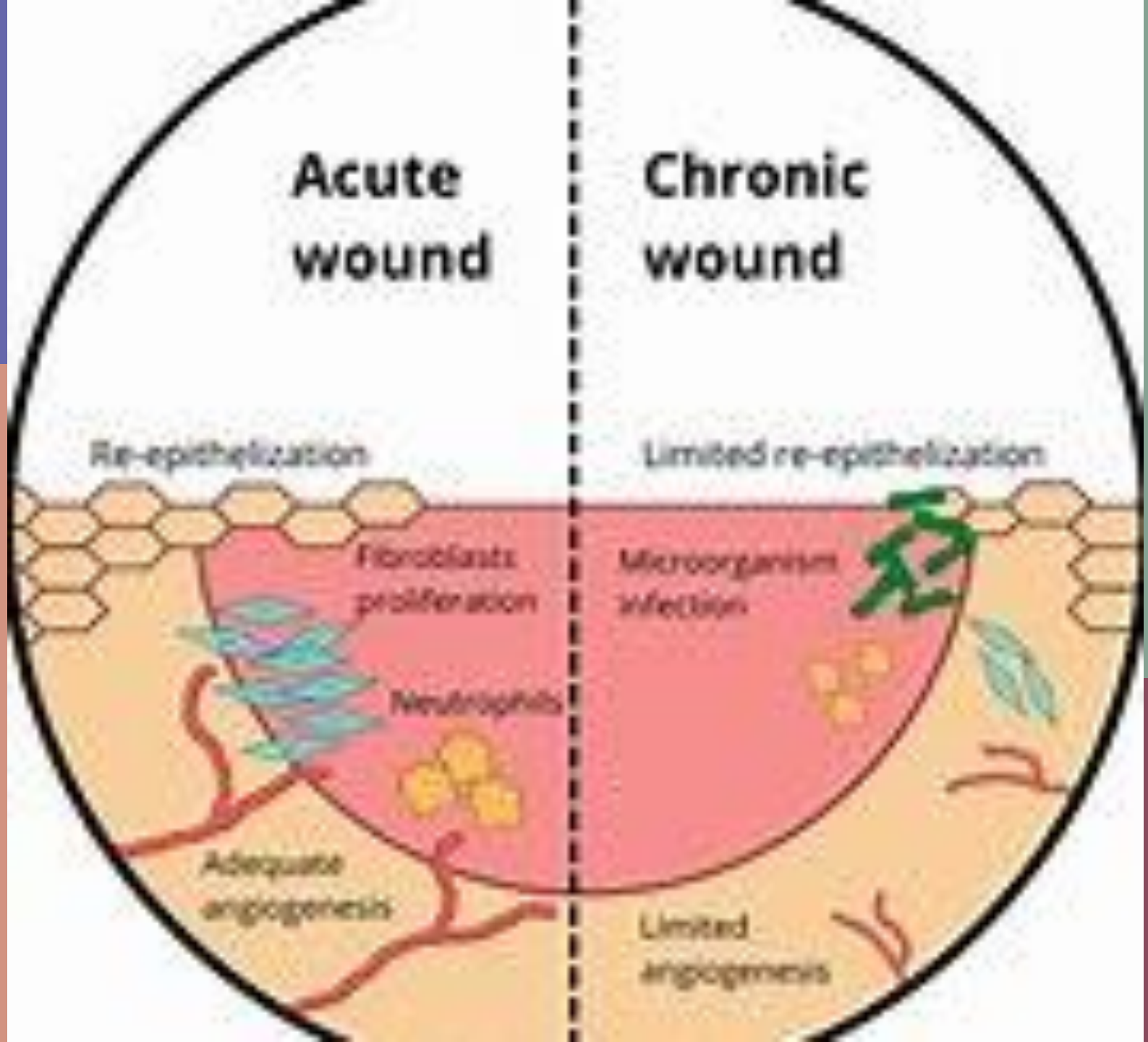
- Lacerations
- Skin Tears
- Abrasions
- Avulsions
- Crush Injuries
- Traumatic Amputation
- Punctures
- Penetrating Wounds
- Surgical Wounds
- Self Harm

ASSESSMENT

- Need to determine type of Wound-Etiology
- Where located
- Size
- Cause of wound
- How long has it been present
- What is the blood flow like
- Is there an increase in pain
- Responding to current treatment
- Tunneling or undermining present
- Is there exposed bone

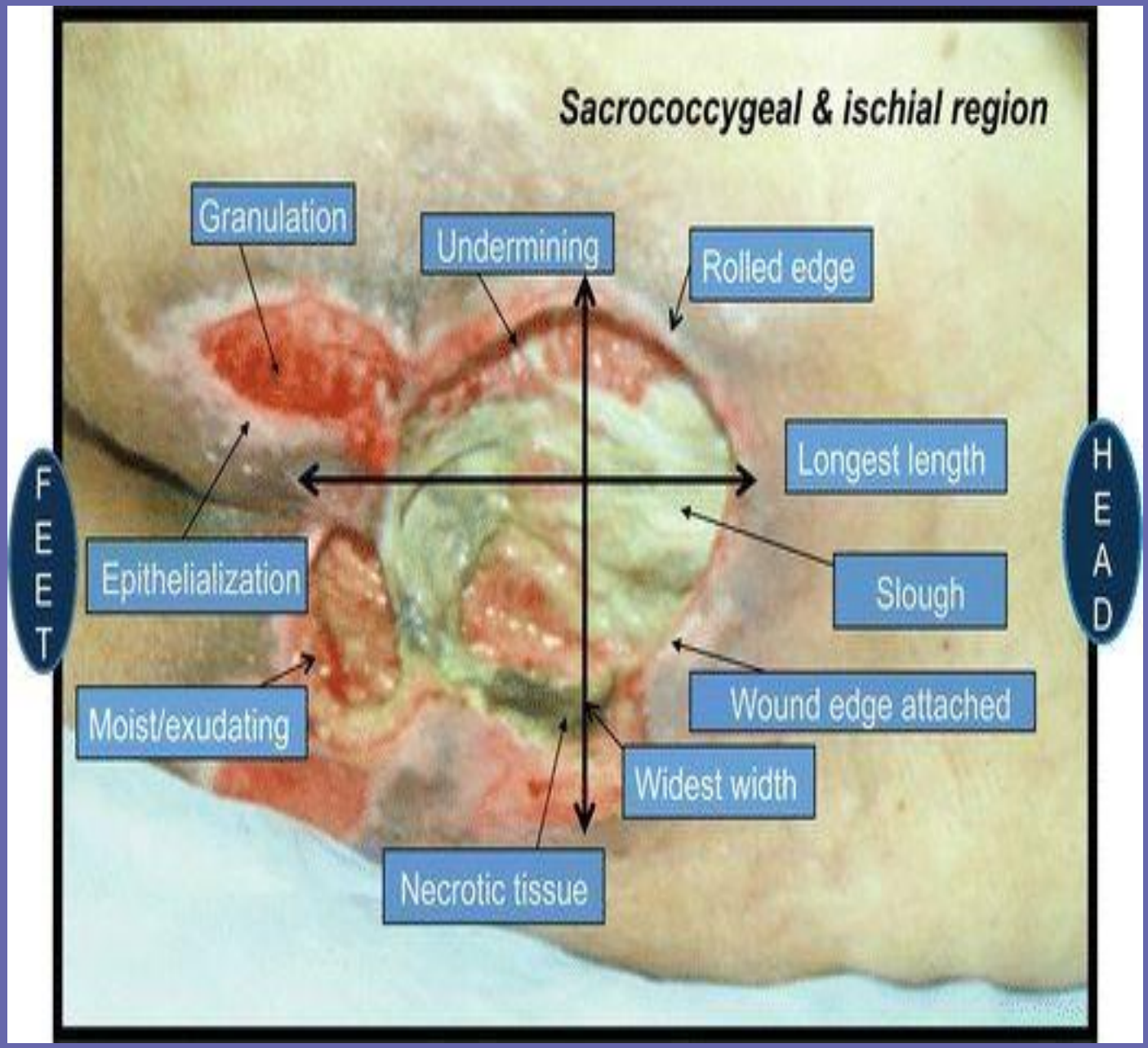
PARTS OF AN ASSESSMENT

- Age of wound
- Acute vs. Chronic



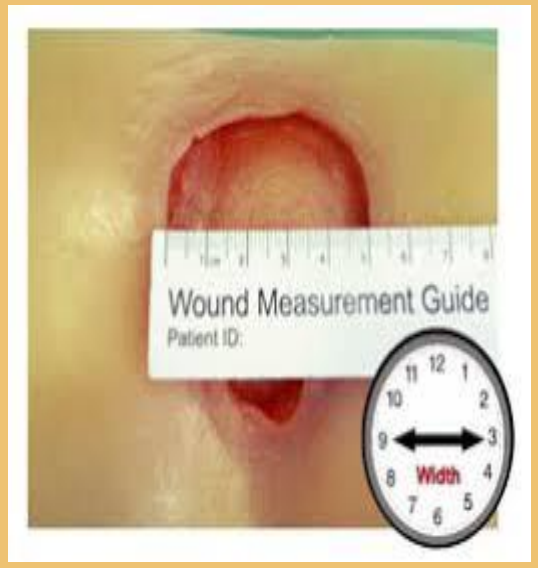
PARTS OF AN ASSESSMENT

- Size of wound
- Shape of wound
- Tissue present in the wound



ASSESSMENT-MEASURING

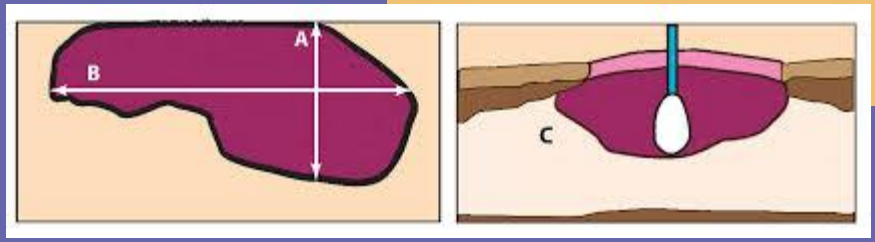
- Size-All measurement to be in centimeters.
- Use L x W x D
- Length Head to toe (12-6)
- Width (3-9)
- Depth Deepest part of the wound to where it meets the margin



Use the longest areas of the wound

ASSESSMENT-MEASURING

- Depth
- No depth can be recorded as 0 (Stage 1 pressure injuries, deep tissue injuries)
- Open without depth are < 0.1

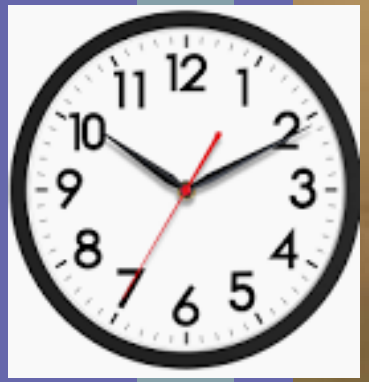


ASSESSMENT-MEASURING

- Do not uses sizes of fruit.
- Do not use sizes of coins
- Do not use sports balls
- Do not estimate
- Actual measurements are important

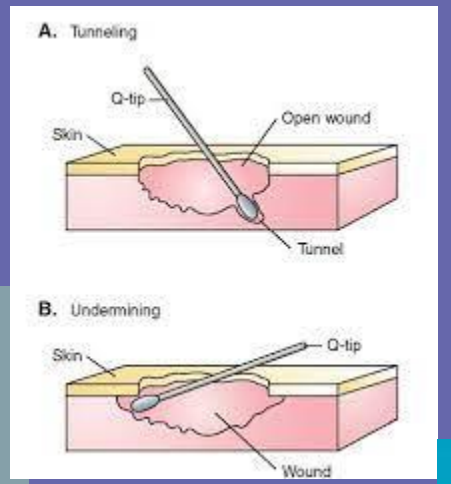
ASSESSMENT-UNDERMINING

- Wound is unattached from the edge
- Creates a pocket under the surface
- Need to document the location and distance
- Use the clock method to describe the location



ASSESSMENT-TUNNELING

- Wound develops a channel that extends from wound base.
- Creates a dead space
- Caused by destruction of tissue Need to document the location and distance
- Use the clock method to describe the location

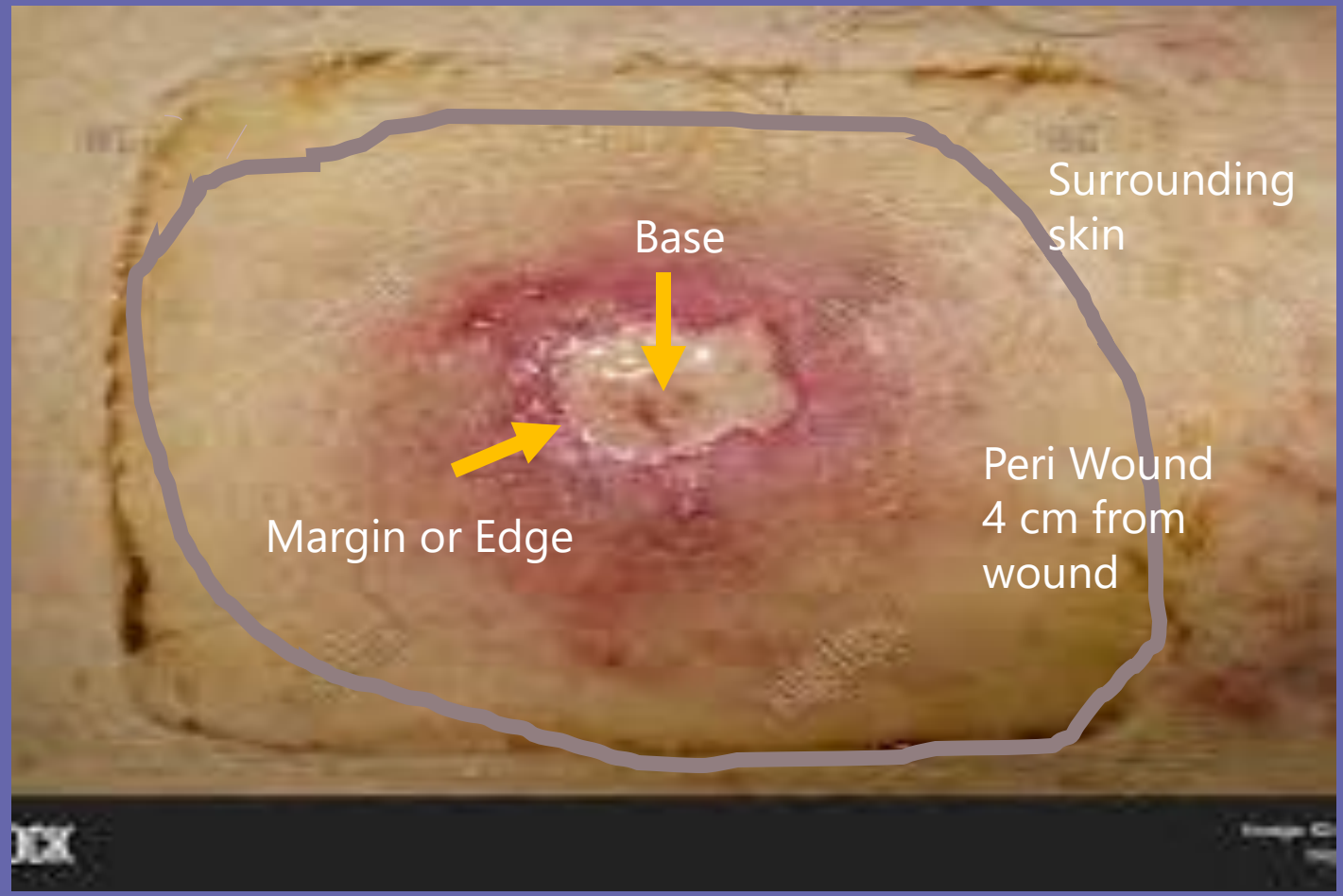


ASSESSMENT-SHAPE AND CHARACTERISTICS

- Describe as:
- Oval
- Round
- Linear
- Regular
- Irregular

PARTS OF AN ASSESSMENT

Wound bed tissue type
Wound edge
Peri-wound
Surrounding skin



WOUND BASE ASSESSMENT

What is the tissue present at the base of the wound?

WOUND EDGE ASSESSMENT

What do we see?

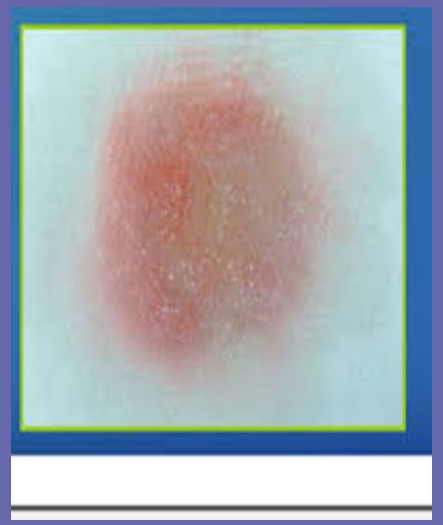
How does the edge effect wound healing?

Describe as:

- Defined
- Undefined
- Attached
- Unattached-Undermining
- Epibole-Rolled
- Calloused
- Dry
- Macerated

PARTS OF AN ASSESSMENT

- Exudate/drainage
  - Type
  - Color
  - Consistency



PARTS OF AN ASSESSMENT

Exudate/drainage

- Amount
- Odor

None: No drainage is present, wound is too dry

Scant: Wound is moist but no measurable amount of drainage is on the dressing

Minimal: Covers less than 25% of the dressing

Moderate: Wound tissue is wet and saturates between 25 and 75% of the bandage

Large or copious: Wound tissue is filled with fluid and more than 75% of the bandager is covered.

Odor is determined after the dressing is removed and the wound is cleaned.

Odor can affect the patient's compliance with a treatment plan

PARTS OF AN ASSESSMENT

Peri Wound

Surrounding skin

Periwound skin problems:

- Maceration
- Excessive dryness
- Callous formation
- Allergic reactions
- Dressing adherence
- Eczema or rashes and inflamed skin around the wound
- Edema control

- Managing the Periwound skin
  - Protect the Periwound-use barrier films or creams
  - Select the appropriate dressings-manage exudate

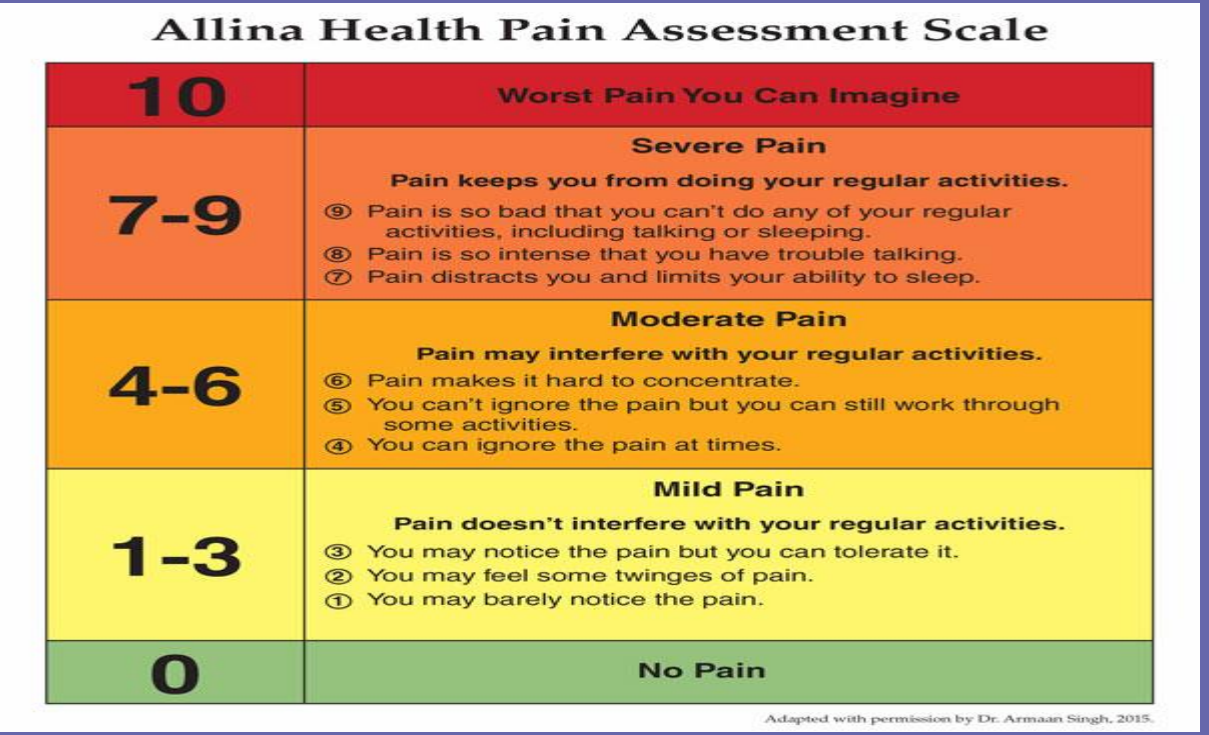
PARTS OF AN ASSESSMENT

Pain

Pain can indicate:

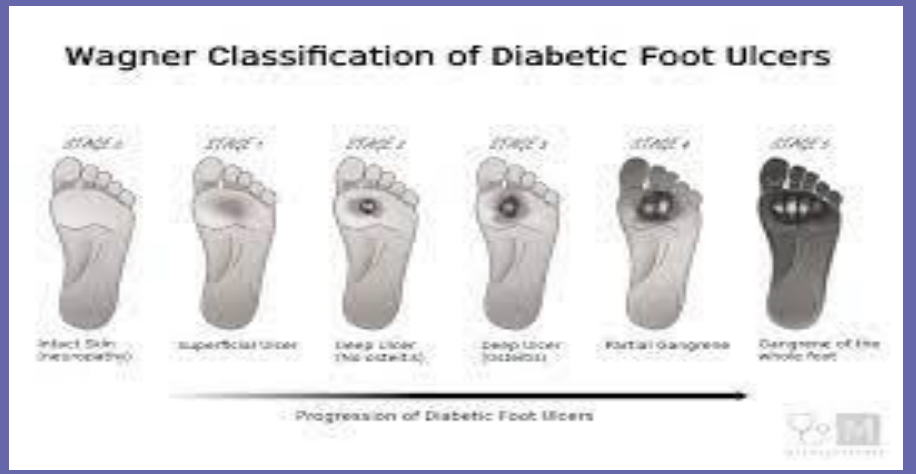
- Poor wound healing
- Signs of infection

Can be related to dressing selection
Related to improper dressing selection
Use pharmacological and non-pharmacological techniques to manage pain



PARTS OF AN ASSESSMENT

- Stage
- Category
- Classification
- DFU-Diabetic
- Pressure Injury Stages
- Skin tear classifications
- General Wounds Full or partial thickness



WOUND CARE TREATMENTS

Application of a 2 layer Compression

Application of 4layer compression

Application of Unna Boot

MANAGING A SKIN TEAR

Mepitel or Versitel

- Stop bleeding-Apply pressure
- Clean the wound gently
- Approximate the edges
- Apply silicone contact layer
- Draw arrow for the direction of the flap
- Apply cover dressing.
- Leave silicone layer in place for 7-14 days

STOP THE BLEED

Emergency care of significant injuries

First aid to control bleeding

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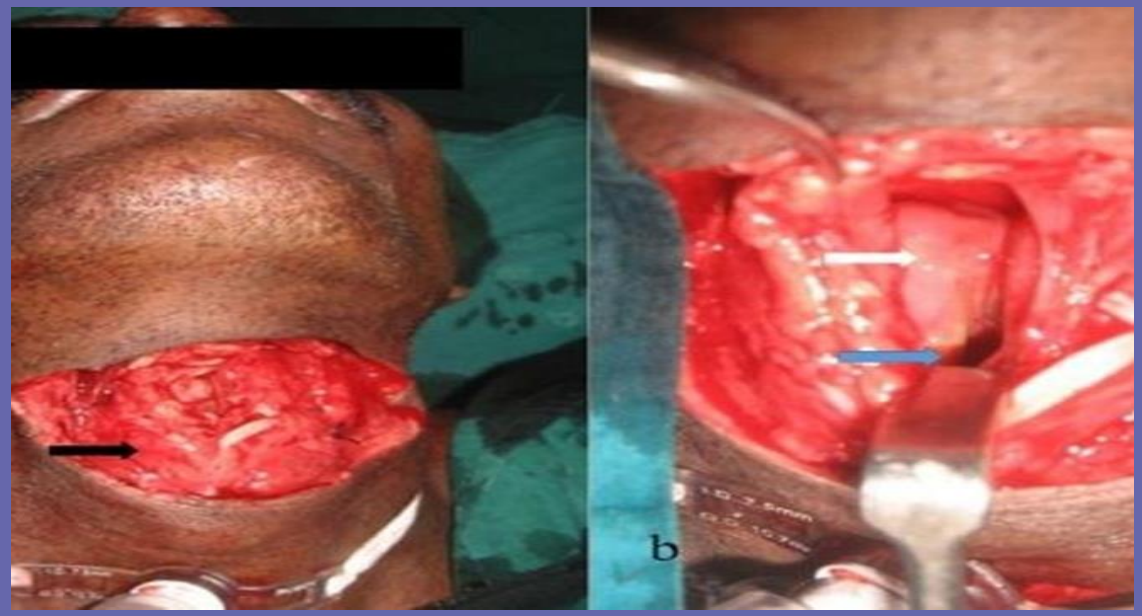

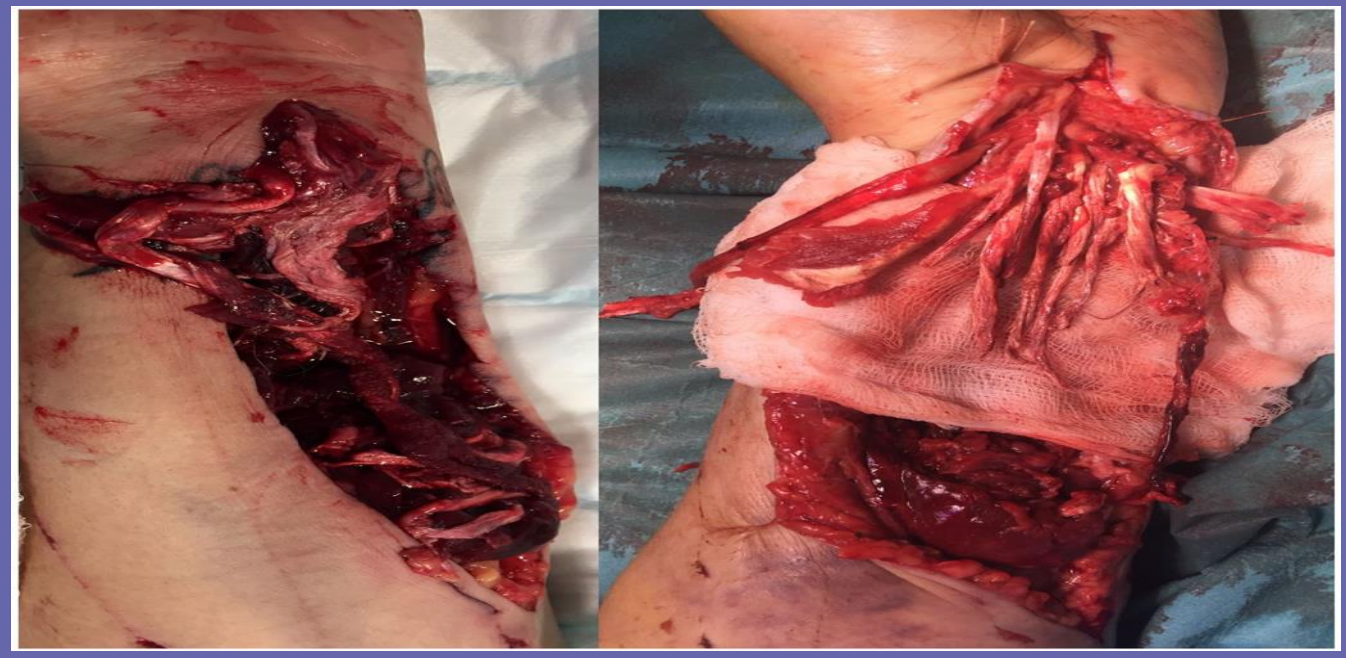

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Stop the Bleed.Org