Wound Management Documentation

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Objectives
1. To describe the essential elements to include in wound management documentation.
2. To identify tools utilized for the assessment of healing.

Purpose of Documentation
- Provides tool for health care team:
  - Collaboration.
  - Coordination.
  - Communication.
- Helps develop comprehensive wound management plan.
- Monitors outcomes of healing.
Key Elements
- Reason for consultation.
- Brief patient and wound history.
- Factors impacting healing.
- Wound assessment.
- Goals for management.
- Recommended treatment/management plan.
- Plan for follow-up.
- Assessment of healing.

Factors Impacting Healing
- Tissue perfusion and oxygenation.
- Nutritional status.
- Infection.
- Diabetes.
- Corticosteroids.
- Age.
- Immunosuppression.
- Psychosocial issues.
- Local wound barriers.

Wound Assessment Parameters
- Anatomic location.
- Wound size.
- Wound classification.
- Wound base.
- Wound edges.
- Signs and symptoms of infection.
- Exudate.
- Peri-wound skin condition.
- Pain.
Long-Term Goal

- Healing vs. maintenance vs. comfort?
- All members of team must be on board.
  - Patient.
  - Caregivers and family.
  - Physicians.
  - Health care providers.

Short Term Goal Examples

- Pressure redistribution
- Absorb exudate
- Decrease edema
- Control odor
- Decrease bioburden
- Promote granulation tissue formation
- Debride non-viable tissue

Agreeing on goals helps to reduce conflict.
Treatment Recommendation

Perform the following to (location) wound (frequency) and prn:

1. Solution and delivery system for wound cleansing.
2. Periwound skin protection.
3. Primary dressing.
4. Secondary dressing.
5. Securing method if needed.

Sample Treatment Recommendation

Perform the following to RLE wound qday and prn:

| 1. Solution and delivery system | Cleanse with NS. |
| 2. Periwound skin protection   | Apply moisture barrier ointment to periwound skin. |
| 3. Primary dressing            | Apply calcium alginate dressing. |
| 4. Secondary dressing          | Cover with gauze. |
| 5. Securing method             | Secure with roll gauze. |

Assessment of Healing

- True area measurement and % area reduction useful.
- 20-40% reduction in wound area in 2-4 weeks reliable indicator.
- Determine wound status: static, deteriorating, improving.
- Staging system doesn't track progress of healing over time.
Assessment Tools

• Using a valid tool can provide objective way to monitor healing outcomes.
• Tools and instruments available:
  ◦ BWAT: Bates-Jensen Wound Assessment Tool.
  ◦ PUSH: Pressure Ulcer Scale for healing.
  ◦ MDS and Oasis – regulatory documents that shouldn’t replace comprehensive wound assessment.

Bates-Jensen Wound Assessment Tool (BWAT)

• Developed by Dr. Barbara Bates-Jensen.
• Research based instrument for the assessment and documentation of wound characteristics.
• Modified Lickert scale of 13 wound assessment characteristics.
• Total score plotted on continuum from 1 (tissue health) - 60 (wound degradation).

Pressure Ulcer Scale for Healing (PUSH)

• Developed by NPUAP in 1997, now version 3.0.
• Monitors pressure ulcer healing over time.
• Three critical parameters: size, exudate and tissue type.
• Total score = 0 (wound has healed) - 17.
Documentation Formats
- Narrative.
- SOAP note.
- Flow sheets.
- Photography.

Electronic Medical Records for Wound Management
- Integration of patient information: demographic, financial and medical information.
- Organization of data; healing, patient satisfaction and cost.
- Time saving features.
- Create management reports.
- Benchmarking capabilities.
- Integrate evidence based pathways and/or algorithms.

Electronic Medical Records for Wound Management
- May include operational policies and procedures.
- Auditing functions.
- Regulatory compliance with documentation and coding for billing for professional services.
- Can improve patient outcomes, efficiency of care and reduce costs.
- HIPPA compliant.
Legal Issues Regarding Photography

- Not a substitute for comprehensive written assessment.
- Follow HIPAA guidelines when taking pictures.
- Get patient consent.

Purpose of Photography

- Documentation support.
- Outcome monitoring.
- Quality improvement.
- Reimbursement request support.
- Successful litigation.
Value of Photography

- Confirm measurements.
- Document undermining/tunneling.
- Monitor wound progress.
- Document condition of periwound skin.

Series of photographs showing wound closure.

Photography Frequency

- Upon admission or when wound is noted.
- Upon discharge.
- Every 2-4 weeks.
- Any significant change.

Key Elements of Documentation

- Reason for consultation.
- Brief patient and wound history.
- Factors impacting healing.
- Wound assessment.
- Goals for management.
- Recommended treatment/management plan.
- Plan for follow-up.
- Assessment of healing.
Get paper and pen.

Look at the following four photographs.

Review the photo and patient history provided. Make up any additional information to support your documentation that has not been provided.

Create your own documentation for wound #1 and #2, and compare to the sample documentation.

Create documentation for wound #3 and #4 and bring to Seattle for review in class.

72 year-old male admitted to the hospital with pneumonia. A sacral wound was noted by the nursing staff on admission as pictured.

Hx: CHF, arthritis, pneumonia.

Wound present for six months. Current treatment calcium alginate dressing q.day by home health RN. Pt. has a low-air loss overlay on his bed at home.

Exudate: moderate amount of yellow without an odor.

Make up any additional information to support your documentation that has not been provided.

Wound consultation requested by primary care MD for evaluation and treatment of a chronic pressure ulcer. 72 year-old male was admitted with pneumonia. He has a six month history of a sacral pressure ulcer that is currently being treated with a calcium alginate dressing daily by home health. He has a history of CHF and arthritis. The Stage IV sacral pressure ulcer measures 15 cm x 10 cm with 3.5 cm depth, no bone is exposed or palpable. MRI negative for osteo. The wound base had 25% adherent slough present and 75% clean, non-granulating tissue. The wound edges are attached and proliferative. The exudate is a moderate amount of yellow without an odor. The periwound skin is intact with scar tissue present. The patient is continent of urine and stool.

The long-term goal is for healing. The short term goals are for pressure reduction and redistribution using an air fluidized therapy bed. Additional goals are to remove the nonviable slough with sharp conservative debridement and initiate Negative Pressure Wound Therapy (negative 125 mmHg cont. suction, changing dressing q Mon.-Wed.-Fri) to stimulate granulation tissue formation and wound contraction. Consult dietician to assess patient's nutritional status and recommend appropriate plan to support healing. Awaiting results of current blood work including a serum prealbumin.
Wound #2 & Patient History

- 60 year-old female who works as a cook in a cafeteria. During an outpatient clinic visit she reports a six week history of RLE wound as pictured. She has a history of a deep vein thrombosis and reports “heaviness and aching” in her legs at the end of the work day that is relieved with elevation. The exudate is a moderate amount of clear yellow without an odor.
- Make up any additional information to support your documentation that has not been provided.

Click here for sample documentation.

Requested by MD to evaluate RLE ulceration and make treatment recommendations. 60 year-old female arrives from her primary care MD’s office with a six week history of an RLE ulcer. She has a history of a DVT. She denies any recent trauma or past surgical intervention. Current labs are WNL. She works as a cook in a school cafeteria and is on her feet most of the day. She reports her legs feel “heavy and aching” by the end of the day, which is relieved with leg elevation. The RLE full thickness to the medial malleolus measures approx. 6 x 4 cm with 0.1 cm depth. The wound base is 40% viable with granulation buds scattered throughout and 60% adherent slough. The wound edges are attached and proliferative. There is a moderate amount of yellow non-odorous exudate. The ankle circumference is 33 cm, varicosities, 2+ edema and hemosiderin staining are also noted. DP and PT pulses palpable and good capillary refill noted. The Ankle-Brachial Index is 0.84 to the RLE with a biphasic Doppler signal. Erythema and warmth are noted around the entire perimeter of the wound. No pain reported. Wound culture was obtained at the MD office and pt. is receiving oral antibiotics.

Click here to continue sample documentation.

- The long term goal is for healing of the RLE venous ulcer. Short term goals are to decrease the edema and promote venous return with use of 4-layer compression wrap providing 40 mmHg at the ankle, to absorb exudate and decrease the bacterial load using a silver hydrofiber primary dressing and for autolysis with supplemental sharp conservative debridement of the nonviable slough. Plan on reassessment in three days to evaluate wound and treatment plan.
- Instructed patient on etiology of venous insufficiency and the use of compression to promote healing and reduction of edema. Discussed indications for removal of compression bandage and method of protection of bandage when showering. She verbalizes a good understanding of concepts. She plans to take the remainder of the week off from work.
- Local Care to RLE wound, pt. to return to clinic in three days.
  - Cleanse with NS with 4x4 gauze.
  - Apply a moisture barrier cream to the periwound skin surface.
  - Apply silver hydrofiber dressing to wound base.
  - Apply a 4-layer compression bandage (Profore).

Click here for Wound #3.
Wound #3 & Patient History

- 78 year-old female with a sacral wound as pictured. Hx of recent CVA and pneumonia. She is dependent for all care. Serum albumin is 2.8. She is incontinent of urine and stool.
- Bring your sample documentation to class for review.

Wound #4 & Patient History

- 84 year-old female with sacral wound as pictured. Receiving hospice care for underlying lung cancer. Bone exposed at the wound base. Exudate is a moderate amount of non-odorous pink. Current local care is NS wet-to-dry daily.
- Bring your sample documentation to class for review.

End of Lecture

- Remember to bring your documentation for Wound #3 and #4 to class with you.
- Please close the presentation window and return to class.