Published on *WoundSource* (https://www.woundsource.com)

Submitted by Diane Krasner [1] on January 25th, 2018
Keywords: Pressure Ulcers [2], Wound Assessment [3], Wound Documentation [4]
Blog Category: Wound Assessment and Documentation [5]


[6]

By Diane L. Krasner, PhD, RN, FAAN

Editor's note:This blog post is part of the *WoundSource* Trending Topics series [7], bringing you insight into the latest clinical issues and advancement in wound management, with contributions by the *WoundSource* Editorial Advisory Board [8].

Scope of Practice and *Standards of Practice* guide nurses[1] and other members of the interprofessional wound care team[2] in caring for patients with wounds. Documentation in the medical record is a key aspect of the *Standard of Practice* and serves to record he care delivered to the patient. Your documentation should follow your facility guideline for documentation. This *WoundSource* Trending Topic blog considers general wound documentation dos and don'ts and presents 10 tips for success.

Wound Documentation Tip #1: Visual Inspection

Do describe what you see: type of wound, location, size, stage or depth, color, tissue type, exudate, erythema, condition of periwound.
Don't guess at the *type* or the *stage* of a pressure ulcer/injury (hereafter, pressure injury) or the *depth* of the wound. Write "etiology (or depth) cannot be determined" or "unstageable" and/or consult a wound care expert.

Wound Documentation Tip #2: Pressure Injury Risk Assessment

Do perform a pressure injury risk assessment (e.g., Braden Scale [9]), and document the score regularly per your facility guideline. Stay in the moment. Think of the score as a snapshot of the person at one single point in time.
Don't rely on previous risk assessment scores. Your risk assessment score is unique and should reflect the specific moment that you are performing the assessment.

Wound Documentation Tip #3: Precise Use of Language

Do be very specific in your note about any of your communications with other health care providers, the patient, or the family (e.g., "Informed Dr. Jones at 10:30 AM about change in Mr. Smith's wound status [describe]").
Don't generalize and just document statements like "Physician aware." You may be called upon at a much later date to explain what happened (e.g., in a deposition), and all you will probably have to refresh your memory is your note. So be sure it is as detailed and relevant as possible. The devil's in the detail.

Wound Documentation Tip #4: Pertinent Information to Include

Do record pertinent information in your wound care note, such as any changes in the wound parameters, pain level, overall patient condition, or interventions. Aim for consistency among providers in their wound care notes.
Don't just document "Dressing changed" or "Dressing dry and intact" or "Turned q2h" in your note. It is better to document such observations in a checklist instead of a note.[3] Avoid redundant charting.

Wound Documentation Tip #5: Wound Category Changes

Do document when a wound changes category (i.e., a skin tear evolves into a pressure injury, or a pressure injury becomes a surgical wound after a surgical repair, or a deep tissue injury evolves to a stage 4 pressure injury).
Don't document a skin tear, moisture-associated skin damage, a venous ulcer, an arterial ulcer, or a wound with any other etiology as a pressure injury.

Wound Documentation Tip #6: Patient Behaviors

Do describe in the medical record behaviors of patients who are non-adherent (non-compliant) with the plan of care. Document conversations, plans to address the behaviors, educational interventions, etc.
Don't be judgmental about a patient's non-adherence (non-compliance), and don't just continue "business as usual." The patient may have to be discharged from your care if the non-adherence continues.

Wound Documentation Tip #7: Refusal of Treatment

Do describe in the medical record the who, what, where, why, and when of a patient who refuses a treatment or care. Document how you educated the patient and other options that were offered.
Don't be judgmental about a patient's refusal of a treatment or care. It is a Patient Right to refuse.

Wound Documentation Tip #8: HIPAA-Appropriate Photography

Do follow your facility guideline regarding photography and how to store and HIPAA protect the photos.
Don't cut corners when it comes to photographs and follow your facility guideline precisely to avoid HIPAA violations.

Wound Documentation Tip #9: End-of-Life Wounds

Do distinguish end-of-life wounds (also known as Kennedy terminal ulcers, SCALE [10] [Skin Changes at Life's End] wounds, skin failure, terminal ulcers) from pressure injuries or other wounds.
Don't document end-of-life wounds as "pressure injuries" in patients who are on the dying trajectory. Consider these wounds as having their own category.

Wound Documentation Tip #10: Unavoidable Pressure Injuries

Do document, if applicable, in the medical record the circumstances that make a pressure injury "unavoidable" for an individual patient: risk factors, comorbidities, conditions.
Don't avoid addressing the issue of "unavoidability" in the medical record if it is relevant to an individual patient's wound.

> *Interested in more wound management strategies? Click here [11] to view Dr. Krasner's webinar program, "Seven Strategies for Pressure Ulcer/Injury Prevention"*

References

1. American Nurses Association (ANA). *Nursing: Scope and Standards of Practice Nursing*, 2nd edition. Silver Spring, MD: ANA, 2010.
2. Krasner DL (ed.). *Chronic Wound Care: The Essentials*. Malvern, PA: HMP Communications, 2014.
3. Gawande A. *The Checklist Manifesto: How to Get Things Right*. New York: Picador, 2011.

Other Resources:

Black JM, Edsberg LE, Baharestani MM, et al. Pressure ulcers: avoidable or unavoidable? Results of the National Pressure Ulcer Advisory Panel Consensus Conference. *Ostomy Wound Manage*. 2011;57(2):24-37.
Edsberg LE, Langemo D, Baharestani MM, Posthauer ME, Goldberg M. Unavoidable pressure injury: state of the science and consensus outcomes. *J Wound Ostomy Continence Nurs*. 2014;41(4):313-34.
Mosby's Surefire Documentation, 2nd edition. St. Louis, MO: Mosby Elsevier, 2006.
Sibbald RG, Krasner DL, Lutz JB, et al. SCALE: skin changes at life's end. *Wounds*. 2009;21(12):329-36.
Wound, Ostomy and Continence Nurses Society. *WOCN Society Position Paper: Avoidable Versus Unavoidable Pressure Ulcers(Injuries)*. Mt. Laurel, NJ: Wound, Ostomy and Continence Nurses Society, 2017.

About the Author

Diane Krasner, PhD, RN, FAAN is a Wound and Skin Care Consultant in York, PA. She is a former Clinical Editor of *WoundSource* and has served on the *WoundSource* Editorial Advisory Board since 2001. Check out Dr. Krasner's website for complementary resources on Skin Changes At Life's End (SCALE), wound pain, and the Why Wound Care? Campaign at www.dianelkrasner.com [12].

Source URL (modified on 2020-05-06 18:12): https://www.woundsource.com/blog/wound-documentation-dos-don-ts-10-tips-success

Links
[1] https://www.woundsource.com/users/diane-krasner
[2] https://www.woundsource.com/tags/pressure-ulcers
[3] https://www.woundsource.com/tags/wound-assessment
[4] https://www.woundsource.com/tags/wound-documentation
[5] https://www.woundsource.com/blog-category/wound-assessment-and-documentation
[6] https://www.woundsource.com/sites/default/files/blogs/wound_care_documentation.jpg
[7] http://www.woundsource.com/blog-category/trending-topics
[8] http://www.woundsource.com/editorial-advisory-board
[9] http://www.woundsource.com/tags/braden-scale
[10] http://www.woundsource.com/blog/introduction-skin-changes-life-s-end-scale
[11] https://event.on24.com/eventRegistration/EventLobbyServlet?target=reg20.jsp&referrer=http%3A%2F%2Fpages.woundsource.com%2Fwoundsource-practice-accelerator-pressure-injury-prevention%2F&eventid=1540031&sessionid=1&key=804BADCCD31466E6C7087483DC94EDC5&regTag=&sourcepage=register
[12] http://www.dianelkrasner.com