Nine Wound Care Documentation Pitfalls to Avoid

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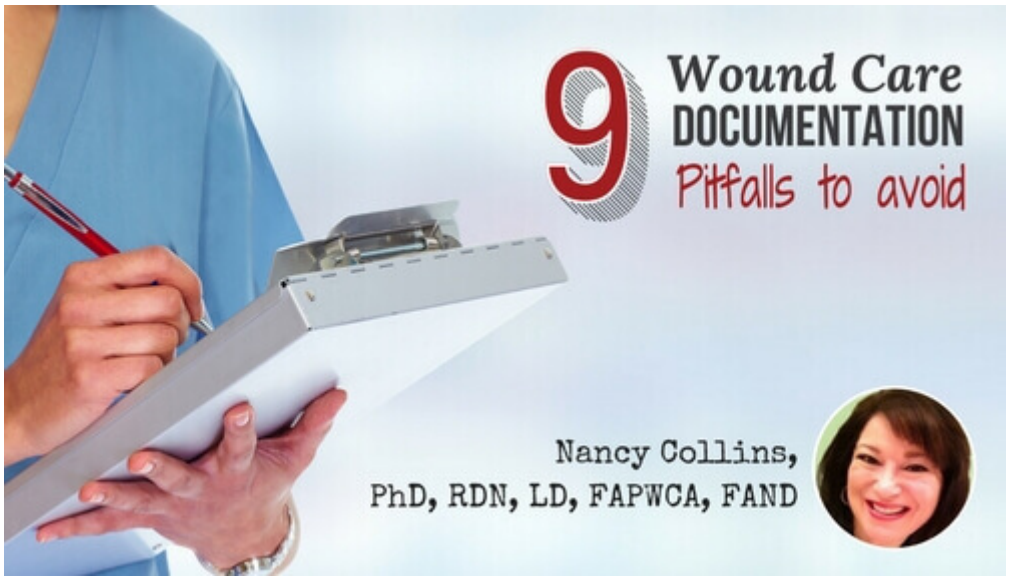
Lawsuits often are settled out of court because the medical record documentation is not defensible. Incomplete, illogical, and inconsistent records are far too common, so it is important to avoid the common pitfalls.



After reviewing hundreds of medical charts involved in litigation, I noticed many of the same problems occurring in the wound care documentation over and over again. From New York to Florida to California, it is remarkable how the same inconsistencies, errors, and oversights tend to stymie the defense of a case. The goal of every healthcare practitioner is to have complete, accurate, and timely documentation of the medical care given to each and every patient. Here are nine wound care documentation pitfalls to avoid.

1. Calling every skin integrity problem a pressure injury.

Patients suffer with a variety of skin integrity problems, including venous ulcers, arterial ulcers, sickle cell ulcers, and diabetic ulcers, to name a few. Sometimes it is hard to determine exactly what type of wound it is and sometimes healthcare professionals are inclined to call the wound a pressure injury. In a recent lawsuit, it was determined that what was labeled a pressure injury was in fact a very serious bug bite that had become infected. If you do not know the origin of the wound, do not guess.

2 `g sacrum, coccyx, and buttocks interchangeably.

These three anatomical locations are all different parts of the body. When documenting the location of a wound, it is critical to use the proper medical term. This issue gets especially confusing when one nurse documents a wound on the sacrum and another says the coccyx. This might make it seem like two distinct wounds, even though they were describing a single wound.

3. Not identifying or adequately describing wounds *present on admission*.

Patients typically arrive at hospitals and skilled nursing facilities fully dressed in street clothing with socks and shoes. Many times, patients might have a wound dressing in place, a sling, a cast, booties, an immobilizer, or other medical device. It is imperative to do a full body inspection if that is required by the care setting. It is necessary to fully document wounds that are *present on admission*. If these wounds are discovered later, they can impact payments and legal cases.

4. Confusing left and right.

It seems simple to tell the difference between left and right, but many medical records show that perhaps this is not so simple. Is it the patient's left side or the writer's left side? When wound care documentation sometimes says left and then says right, it appears that the staff does not know what it is doing. This does not reflect well on the quality of the care given.

5. Not having a consistent system to document routine care, such as repositioning.

Each institution needs to determine how to document routine care. Are you going to document it on a flow sheet? Or by shift? At the point of care? By exception only? It is necessary to have a system in place that is communicated to all and followed by all for consistency. If some caregivers document repositioning and others do not, it looks like patient care takes place only part of the time. (For additional discussion, see "The Great (Legal) Debate About Turn and Reposition Documentation".)

6. Improperly documenting wound size.

Health care professionals use many systems to record wound size. These include length x width x depth, the clock method, wound photography, wound tracing, or some combination method. It is very difficult to determine if a wound is truly changing in size when there are inconsistent measurements from week to week. Training can improve inter-rater reliability.

7. Recording verbal or stated weights as actual body weight.

Unintended weight loss is a sticky subject in wound litigation because most patients do tend to lose body weight as they become ill and certainly as they reach end of life. However, it is difficult to defend weight losses that seem implausible. For example, a recent case showed the patient weighed 195 pounds upon admission to the skilled nursing facility. One week later, the facility recorded the patient's weight as 160 pounds. Investigation revealed that the initial weight was simply a recalled weight that a family member provided to the admitting nurse. Weighing the patient using a scale would have resulted in a considerably lower weight. Yet, the documentation reflected a 35-pound weight loss in 1 week. Once again, it gives the impression of poor care and makes it seems like the facility did not know what it was doing.

8. Not acting upon risk assessments that indicate the patient is at risk.

Facilities obtain wound risk assessments upon admission and periodically thereafter. However, it does not seem th[illegible] problem is the task of completing the risk assessments. The problem arises when the risk assessment i[illegible]s some degree of risk or likelihood of a problem down the road and with no resultant action. If you ide[illegible]y risk in your wound care documentation, you must put interventions in place to mitigate that risk.

9. Failing to communicate wound status to the responsible family member.

During deposition, the responsible family member must answer a variety of questions about the care and circumstances involving the wound(s). It is remarkable how often family members state that no one told them about the wound. Medical information often is confusing, and it is possible that they were told and forgot or simply did not understand what was meant by the term *wound*. This common situation reiterates the need to do thorough education in layman's terms and then complete detailed documentation of that educational discussion.

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What do you think?

0 comments

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