Wound Care Medical Record Documentation

Cathy Thomas Hess, BSN, RN, CWCN

The goal of documentation is to provide the highest possible degree of clinical specificity to ensure accurate interventions and diagnosis as well as to adequately demonstrate medical necessity for the services rendered and substantiate the billed services. Let's review components of skin and wound documentation that may comprise your medical record.

Chief Complaint

The chief complaint is the first step toward complete documentation for the skin and wound care patient. The chief complaint bridges the reason for the patient's visit and the detailed history and physical data captured by the practitioner about the medical necessity for the visit. The clinician should document the specific reason the patient is visiting. This statement should be clearly written, describing the reason in the patient's own words.

History of Present Illness

The history of present illness (HPI) is a key element of medical necessity and provides subjective information for the practitioner to review in conjunction with the review of symptoms; physical examination; risk assessments and screening tools; and skin and wound assessments. The HPI should include a complete chronological account of the presenting problem to date. Most of this information is subjective and interview-based. If there is more than one chronic condition discussed, make sure to document each finding in the HPI. This will assist in justifying the needed orders.

Past Medical, Family, and Social History

There are many factors that can lead to poor wound healing. A review of the patient's past medical history, family events, and social activities should be captured. The clinician should pay attention to:

- Chronic illnesses that lead to chronic insufficiencies, autoimmune diseases, blood disorders, bowel disorders, cancer, cardiovascular disease, cerebral vascular disease, diabetes, heart disease, hypertension, and so on.
- Medications such as chemotherapeutic agents, steroids/corticosteroids, and so on.
- Allergies to dressings and securement products, medications, and others.
- Vascular tests
- Radiologic tests
- Dressing, ostomy, and modality history, to review products that were previously effective or inhibited healing.
- Laboratory values to review nutrition, chemistry, hematologic, immunologic, and microbiology values, and so on.
- Activities of daily living including alcohol use, illicit drug use, modality use, smoking, eating patterns, and other.

This thorough documentation will provide complete information needed for the clinician to link all disorders to the patient with the chronic wound.

Review of Systems

The review of systems is defined by Current Procedural Terminology (CPT)* as ''an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.'' Generally, it is a question-and-answer discussion related to the patient's complaints or problems identified during the visit. The review of symptoms provides necessary subjective information for the practitioner to review in conjunction with the HPI; past medical, social, and family history; physical assessment; and wound/skin/ostomy assessment.

Physical Examination

The physical examination is generally focused on the skin condition, ostomy, or wound healing history. Generally, it is based on the patient's history and the nature of the presenting problems. Documentation of the affected system(s) is mandatory. The physical examination provides necessary objective information for the practitioner to review in conjunction with HPI; past medical, social, and family history; review of systems; and wound/ostomy/skin assessment.

Assessments and Supplemental Screening Tools

Risk Assessments. These are screening tools used as predictors to ensure systematic evaluation of individual risk factors. Risk assessment tools exist for areas of the skin at risk such pressure injuries and diabetic foot ulcers. Nutrition risk assessment tools assist the practitioner in understanding the strategies necessary to identify the levels of nutrition risk. Manual risk assessment tools are part of the prevention of many disease states. Other factors (ie, laboratory values, radiologic studies, vascular studies) should be taken into consideration when evaluating risk. The

Cathy Thomas Hess, BSN, RN, CWCN, is Vice President and Chief Clinical Officer for Wound Care, Net Health. Ms Hess presides over Net Health 360 WoundExpert Professional Services, which offers products and solutions to optimize process and workflows. Address correspondence to Ms Hess via e-mail: chess@nethealth.com.

*CPT is a registered trademark of the American Medical Association.

risk assessment provides necessary objective information for the practitioner to review in conjunction with the HPI; past medical, social, family history; review of systems; physical examination; and wound/ostomy/skin assessment.

Manual Screening Techniques. These are objective findings that may assist the clinician in determining an accurate diagnosis; they include the ankle brachial index, cultures, lower leg and foot assessments, palpation of pulses/Dopplers (ultrasound), segmental blood pressures, the Semms-Weinstein monofilament test, transcutaneous oxygen tension, vibration perception threshold assessment, and so on. The results from the manual screening techniques process provides necessary objective information for the practitioner to review in conjunction with the HPI; past medical, social, and family history; review of systems; physical examination; and wound/ostomy/skin assessment.

Wound/Skin Assessment. Wound care documentation can combine a variety of information reflecting the wound's status across the healing continuum. Providing an accurate description of the wound's characteristics is critical during each patient visit. These objective findings assist the clinician in mapping the care during the wound management process. The values obtained include etiology, qualitative information, and quantitative information.

Establishing the etiology or cause of the wound or skin condition will help identify the correct classification and management process. Underlying medical conditions such as poor nutrition, diabetes, or neuropathy may explain why the wound is healing slowly. These underlying conditions need to be treated concurrently. Finally, treatment history is significant because the clinician may lean which management modalities have been successful or unsuccessful.

Qualitative information should capture the anatomical location, classification of tissue layer destruction, edema or swelling of tissues, wound exudate, odor, pain, periwound skin description, type of tissue exposed, wound bed description, wound color, and wound margin condition.

Quantitative information may include the ankle and calf circumference, a photograph of the wound, the surface area of wound, and so on.

Procedures Performed

Components of the procedure performed include, but are not limited to, consent for the procedure, timely physical examination completed, time-out parameters, name of the practitioner performing the procedure, preoperative diagnosis, procedure description, anesthesia used, noted complications, postoperative diagnosis, and the procedure performed. Read your local coverage determination policies as they relate to the specific procedure performed to ensure your documentation is compliant.

Ordering Supplies and Tests

The practitioner must supply an order for the care the patient receives related to the treatment. This justifies the actions of the ordering practitioner for wound care supplies, ostomy supplies, prescription drugs, modalities, adjunctive therapies and support, radiology tests, vascular tests, laboratory tests, support surfaces, and referrals.

Patient Education

Patient education and compliance are the cornerstones of successful wound and skin care. The education needs of the patient should be evaluated on an individual basis beginning with the nonjudgmental assessment of the patient's current knowledge base relevant to the plan of care determined. An educated clinician should direct the educational activities. Principles of adult learning should be used to develop, implement, and evaluate the effectiveness of the educational activity. Validating the impact of the education by measuring retention of the material is paramount for success.

Plan of Care

Designing, developing, and executing a plan of care is paramount. The medical record must include a plan of care containing treatment goals and provider follow-up.[1,2]

Patient Discharge Instructions/Summaries

Discharge summaries and instructions should be provided to patients in writing or through the patient's portal at the end of the visit.

The goal of your documentation is to provide the highest possible degree of clinical specificity to ensure accurate interventions and diagnosis. Documentation is the key for your quality reporting too. Streamline your clinical workflows to facilitate efficient documentation and remember to conduct internal or external documentation audits to measure your documentation compliance. ●

References

1. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Wound Care (L35125). 2017. www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35125. Last accessed August 22, 2018.
2. Medicare Learning Network. Evaluation and Management Services. 2017. www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf. Last accessed August 22, 2018.