

Documentation

Wound Clinician & Bedside RN Documentation (page 1 of 2)

- Wound Clinicians document on the **WO Wound & PU Assessment**.
- Nursing documents on the **Physical Assessment** under **RN Wound Assessment** and **RN Pressure Ulcer Assessment**.

HOWEVER- Currently Nursing & Wound Clinicians share occurrences when documenting wound and pressure ulcers.

- This means the occurrences charted in either assessment crosses to the other.
- Therefore, if an RN or a Wound Clinician adds or discontinues an occurrence or their assessment, they are affecting the occurrence documentation of the other.

Critical Reminders:

- The Wound Clinician documentation should not be changed. They are considered the expert in wound and pressure ulcer care.
 - ✓ The Bedside RN should not discontinue any occurrence started by a Wound Clinician
 - ✓ The Bedside RN should not restart a discontinued occurrence without investigating why it was discontinued.
 - ✓ Consult the Wound Clinician, Charge Nurse, or a skin resource nurse for any discrepancy.
- Review wound & pressure ulcer documentation before charting to see what the Wound Clinicians have documented.
 - ✓ This can be done in the Care Trends section of the EMR and or through “Associated Data” on the Intervention Worklist.
 - ✓ It is important to drill down and click “ALL” in Care Trends detail view.
 - ✓ Do NOT use drag & drop in Document Spreadsheet when documenting wounds & pressure ulcers. The risk of error is too high.

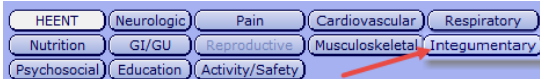
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Documentation

Wound Clinician & Bedside RN Documentation continued (page 2 of 2)

Navigating Care Trends – Initial View

- From the **Care Trends** panel of the EMR, click **Integumentary**



- The initial view is the most current documentation in a collapsed view. To see a Detailed View related to specific occurrences (active and/or discontinued) and who it was documented by click the Wound Assessment or Pressure Ulcer row.

Row Label	1/6/15 19:30	1/6/15 22:00	1/7/15 08:00
Skin Risk Score	High Skin Risk		Moderate Skin Risk
Skin Temperature			
Skin Assessment	Left Lower Breast Lower Abdomen Left Upper Thigh Right Upper Thigh		Left Lower Breast Lower Abdomen Left Upper Thigh Right Upper Thigh
Wound Assessment General Appearance	Left UNDERBREAST RAS... Intact Skin Moist ABOMINAL FOLD RASH,... Moist SCALP Abscess Slough Eschar-Dry		Left UNDERBREAST RAS... Intact Skin Moist ABOMINAL FOLD RASH,... Moist SCALP Abscess Slough Eschar-Dry
IV/Invasive Line Site Observation	Left Forearm Periphe...	ancef 1 gm	Left Antecubital Per... Asymptomatic

Navigating Care Trends – Detailed View:

You can view documentation in one of 3 ways:

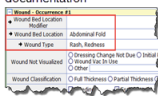
- Active:** shows all occurrences which have been documented against during the patients stay even if they have been discontinued.
 - NOTE: Details about discontinuation of occurrence **is not** seen in this view
- Discontinued:** shows only discontinuation details for an occurrence.
- All:** shows the active and discontinued documentation details, so the user can see a true progression of documentation for a wound/PU.

NOTE: All is the **preferred way to view** Wound/PU documentation in Care Trends.

3.26.20/

The documentation viewing correlates to the button highlighted in white

The buttons relate to the occurrences on the documentation



	1/6/15 15:23	1/6/15 19:30	1/7/15 08:00
Wound Classification	Superficial	Superficial	Superficial
General Appearance	Moist	Moist	Moist
Wound Bed Color	Red	Red	Red
Wound Surrounding Tissue Description	Red And Irritated	Red And Irritated	Red And Irritated
Drainage Amount	None	None	None
Drainage Odor	None/Absent	None/Absent	None/Absent
Wound Tunneling	No	No	No
Wound Undermining	No	No	No
Wound Photo Taken	No	No	No
Wound % Viable Wound Bed	100 % Viable	No	No
Wound Culture Taken	No	No	No
Skin Temperature	Warm		
Recorded By	Davis, Carrie	Kaplan, Debbi	Davis, Carrie

Who completed the documentation.