We would like to share an essential article on Wound Care Documentation and will recommence our studies on Debridement next newsletter.

G.S. Dhillon MD PhD

Hi Healers!

In the LTC setting, we face much scrutiny for our documentation due to the strict oversight by CMS and the department of health. During our annual inspections we can be cited for wound care related F tags. Furthermore, pressure injuries are the second most common lawsuit in healthcare, after falls. In Texas, number one lawsuit. The thing is, common areas of citation are oftentimes related to poor documentation, not poor care. Our documentation must paint an accurate picture of what is going on. Another area to pay close attention to is incorrect staging of pressure ulcers and inconsistent wound assessment. These are "hot topics" and can be avoided with proper wound care education and training. Upon initial admission from the hospital is a critical time to assess those wounds accurately. To further dive into this topic, check out this great article in ***WOUND*** *SOURCE* by Cheryl Carver about ***Common Wound Care Documentation mistakes and how to avoid them*****.**

Keep on healing!

Tara Frazier, RN, BSN, WCC

DON & Nurse educator - Advantage Surgical & Wound Care

WOUND SOURCE™

WEEKLY ENEWS August 3, 2018 www.woundsource.com

Common Wound Care Documentation Mistakes and How to Avoid Them

Cheryl Carver, LPN, WCC, CWCA, CWCP, DAPWCA, FACCWS, CLTC – Wound Educator

Most of my experience has been in the hospital wound center setting. However, in the last five years you could say I was converted into the long-term care arena, where I felt I could help most from an education and documentation standpoint. I have trained many physicians on how to best document inside the long-term care setting, because of the federal guidelines and annual surveys. Documentation in long-term care is substantially different from documentation in the hospital, and providers have a higher liability in this setting, given all the wound-related lawsuits. However, the documentation discrepancies can vary. I have given you a few case scenarios in this blog to help define consistent documentation.

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Case Scenarios: Accidentally Retained Dressings and Standardized Documentation

Margaret Heale RN, MSc, CWOCN

Wound care can be so straightforward. The process starts with a comprehensive assessment, and then the wound care regimen can be planned and the frequency of dressing changes determined. A well-written order will include all of the relevant components of a wound care regimen: clean, debride, address bioburden, actively manage wound bed, hydrate or maintain moisture balance or absorb drainage, protect periwound skin, secure and maintain a

semi-occlusive environment, support venous return, optimize arterial supply, address pain, supplement nutrition, prevent infection, offload pressure, address continence issues, and refer to therapies and social services.

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