Clinical Documentation

JULY 2020 MONTHLY EDUCATION

EDUCATION COMMITTEE

SerenaGroup

Building the Nation's Leading Wound Care Team

POLICY NAME: Medical Record
POLICY NUMBER: OP.0011.0

SCOPE:

Entities operating under the hospital's Medicare Provider Number including, but not limited to, the following:

Clinical Staff

Provider

PURPOSE:

To establish a complete medical record for each patient treated at the wound care center.

To establish measures that safeguard medical records against loss, destruction, tampering and unauthorized access or use.

To establish that a framework is in place to describe the role of scribing for physicians in the center.

POLICY:

- It is policy to document all care provided, including procedures and the patient's response to treatment.
- All documentation must meet medical necessity per CMS guidelines.
- Documentation is to be made as soon as possible after care is provided or an event or observation is made and must be completed within 72 hours of the patient visit. All orders are to be signed off before the provider leaves the center.
    - Entries should not be made in advance of the service provided to the patient. Predating, pre-timing or backdating an entry is prohibited.
- When the course of treatment is complete, the entire medical record is stored on the contracted electronic system and is available to the contracted hospital as needed.
        - Maintenance of patient records:
        - Stored in a HIPAA compliant fashion.

SerenaGroup
Building the Nation's Leading Wound Care Team

- In some cases, the medical record may be a hybrid record consisting of both electronic and paper documentation and may physically exist in separate and/or multiple locations in both paper and electronic formats.

- It is preferable that an EMR (electronic medical record) is utilized in each center. A paper documentation may be used as necessary.

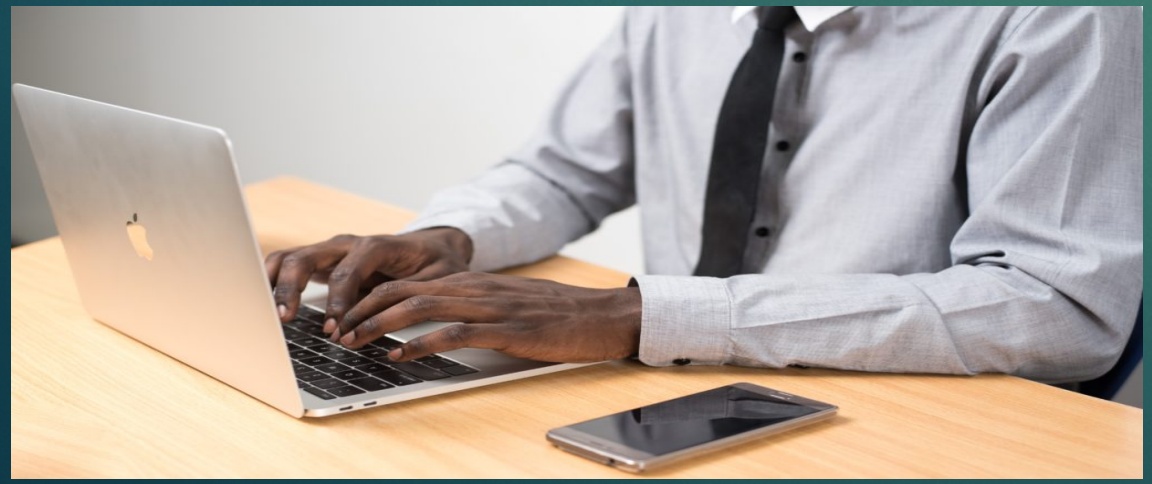
- Personnel with a “need to know” such as providers, clinical staff members and administrative staff will have access to minimally necessary information.

- When the Center is closed, the medical records are secured according to hospital policy.

- Records will be released in accordance with hospital policy.

- Additional regulations for medical records, protected by state and federal laws, will be followed including mental health records, alcohol and substance abuse records, reporting forms for suspected elder/dependent adult abuse, child abuse reporting, and HIV-antibody testing.

- Scribing for provider is permitted by SerenaGroup® within the following parameters:
  - The scribe records what the provider dictates. This individual shall not act independent of the provider.
  - The provider is accountable for the documentation. Signature is required after the review of the scribe's entry.
  - A notation of what was scribed shall be entered in the record; for example- *"As the RN, I scribed the HPI for the provider*".



SerenaGroup
Building the Nation's Leading Wound Care Team

POLICY NAME: Wound Measurements
POLICY NUMBER: OP.066.0

SCOPE:

Entities operating under the hospital's Medicare Provider Number including, but not limited to, the following:
Clinical Staff
Providers

PURPOSE:

Information about the dimensions of the wounds will be appropriately collected and recorded.

PROCEDURE:

Dimensions of the wound are measured in centimeters (cm) using a disposable measuring tape and sterile cotton tip applicator when appropriate. All wound measurements will be documented in the patient medical record.

Wounds are measured:

1. At initial assessment
2. At all subsequent visits
3. Prior to and after any debridement is performed

SerenaGroup
Building the Nation's Leading Wound Care Team

❖ DEFINITIONS:

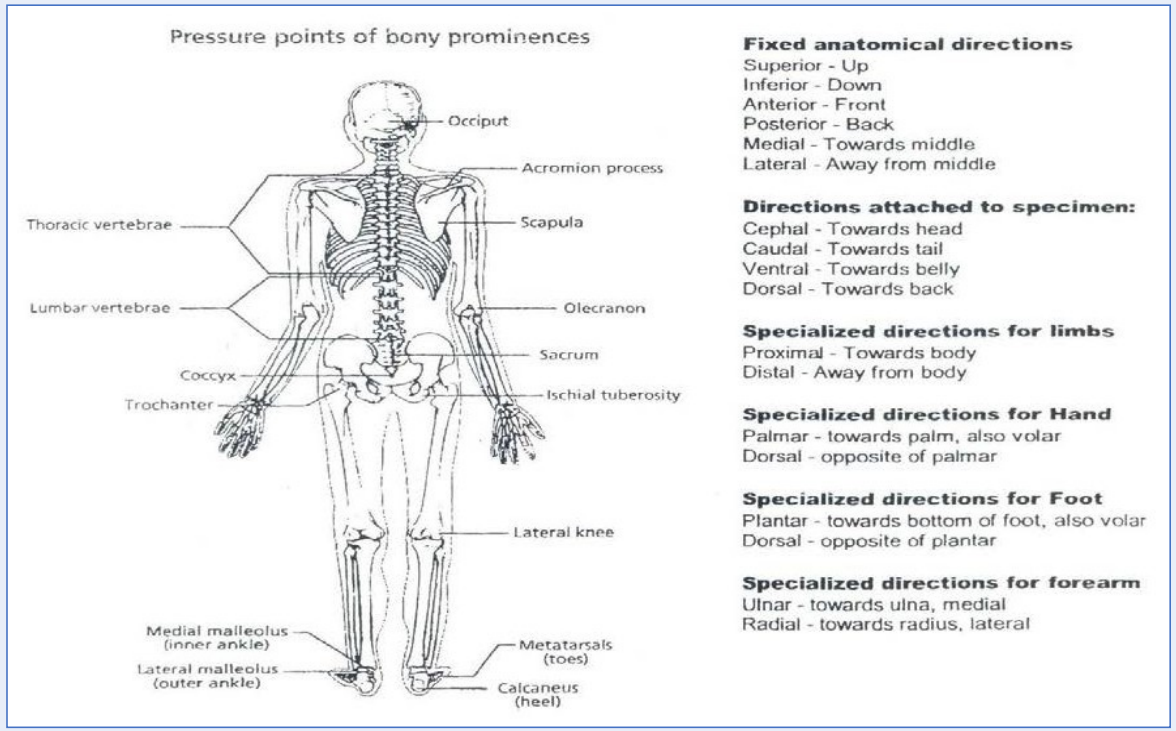
Length: The longest distance of the wound referencing head-to-toe direction.

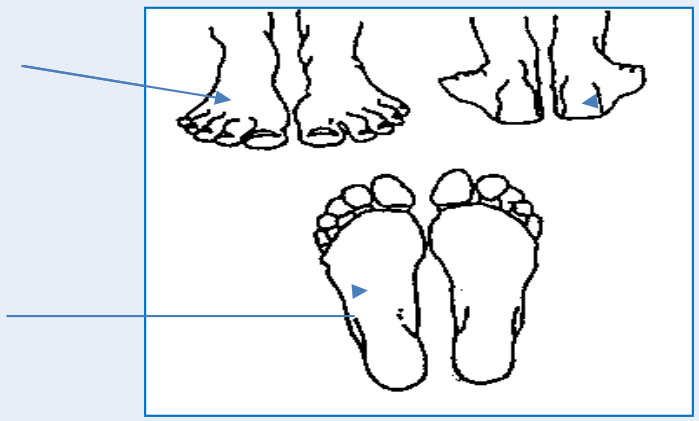
Width: The widest girth of the wound from left to right, 3 to 9 o'clock.

Depth: Using a sterile cotton tip applicator, locate the deepest point of the wound, measuring it at a 90-degree angle with the skin, to the level of the skin.
Note: *All wounds which have a depth of less than 0.1 cm but are not fully epithelialized are rounded to 0 .1cm. Only wounds which have a full layer of epithelial covering (and therefore are healed) are to be assigned a depth of 0 cm.*

Sinus Track/Tunneling: The longest or deepest area which extends through a small opening or channel from the base of the wound to be measured using gentle probing with sterile cotton tip applicator and recorded indicating the general location through the reference of a clock with the patient's head representing 12 o' clock.

Undermining: The longest area which extended from the margins of the wound into the subcutaneous tissue that runs parallel with the skin. To be measured using gentle probing with a sterile cotton tip applicator and recorded indicating the general location through the reference to a clock, the patient's head representing 12 o'clock.





Reference for Wound Documentation

- Describe the Anatomical Location of the wound

SerenaGroup
Building the Nation's Leading Wound Care Team

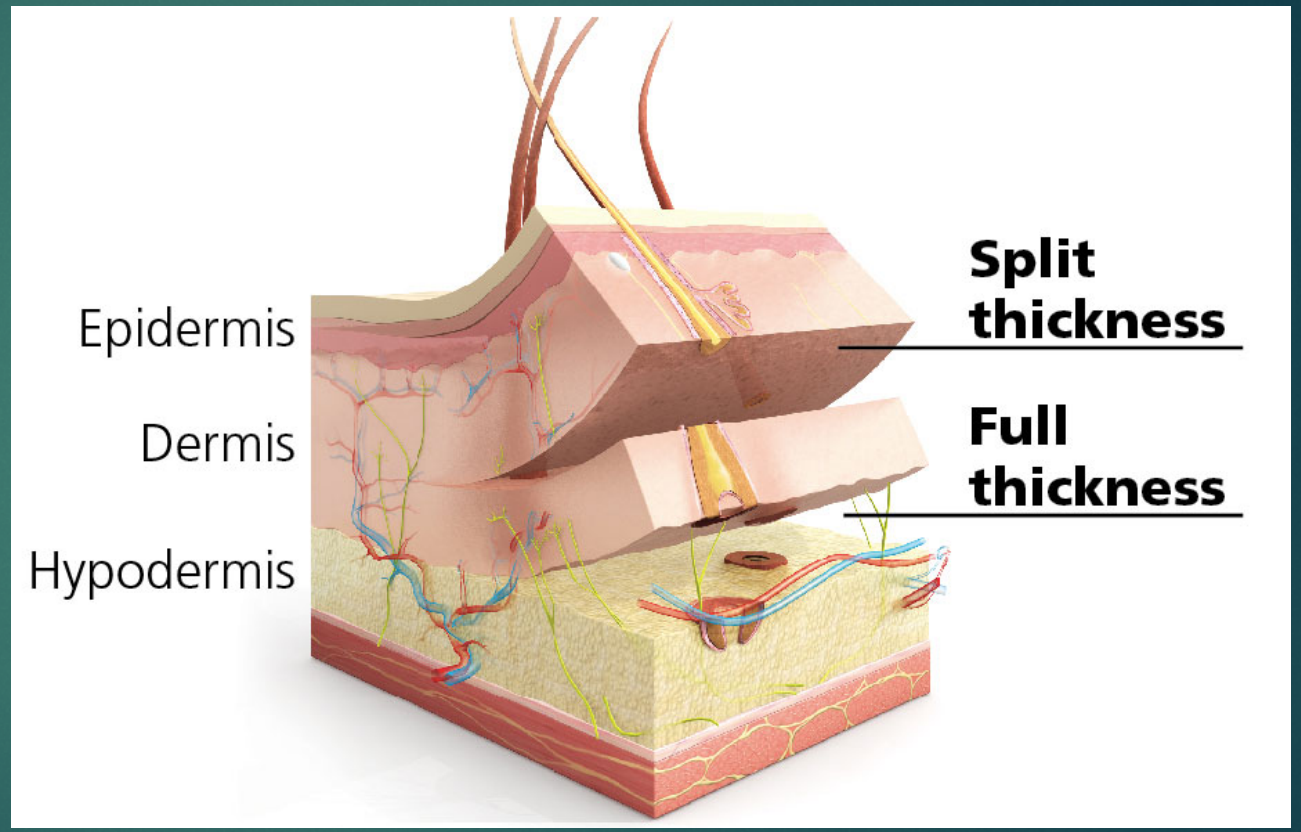
- Describe the Wound as Partial- or Full-Thickness (Non-Pressure Wounds)

Partial-Thickness Wounds

Tissue destruction through the epidermis extending into but not through the dermis.

Full-Thickness Wounds

Tissue destruction extending through the dermis to involve subcutaneous tissue and possibly bone and muscle.



SerenaGroup
Building the Nation's Leading Wound Care Team

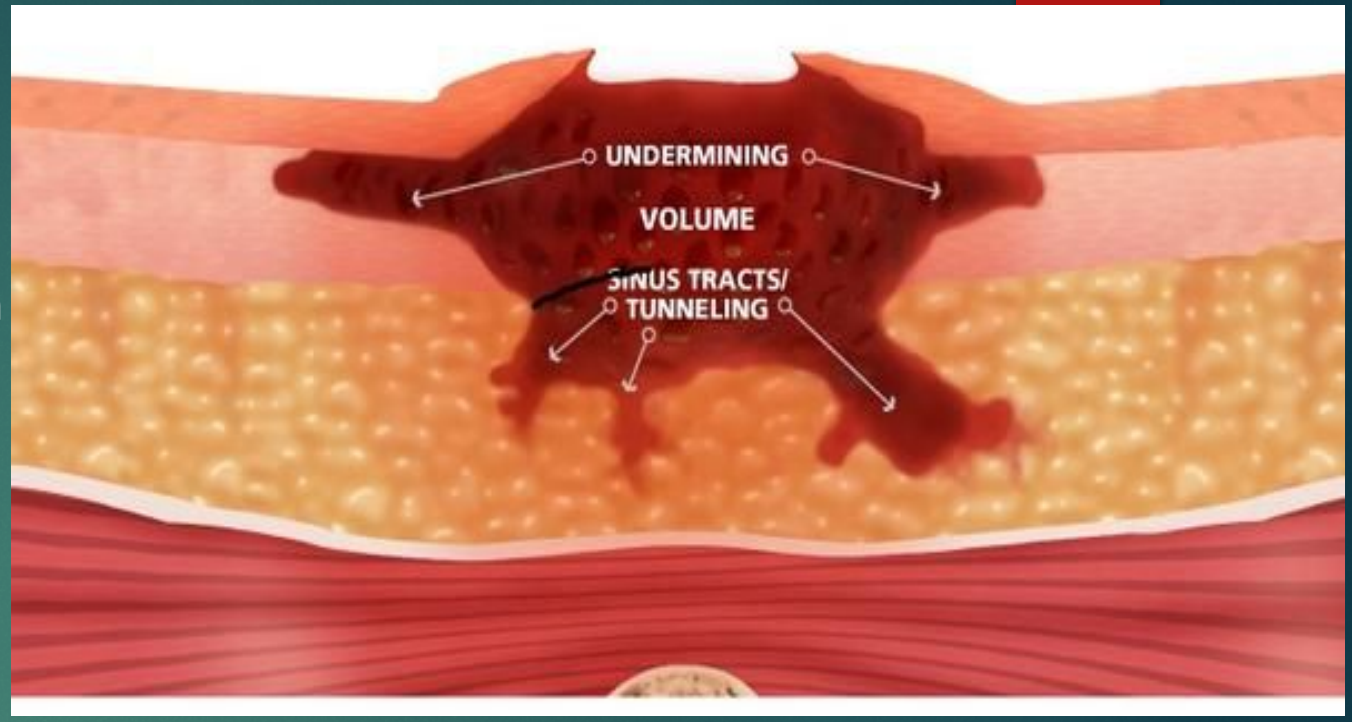
❖ Measure the Wound Size

Measure in centimeters (cm)

Measure from the greatest extent: length x width x depth

Length = head to toe direction (12:00 – 6:00) **Width** = hip to hip direction (3:00 – 9:00)

Depth = deepest part of visible wound bed



❖ Document Undermining, Tunneling or Sinus Tracts

Document the location and extent, referring to the location as time on a clock (e.g., wound tunnels 1.9 cm at 3:00).

Tunneling – A narrow passageway that may extend in any direction within the wound bed.

Undermining – The destruction of tissue extending under the skin edges (margins) so that the pressure injury is larger at its base than at the skin surface. Often develops by shearing forces.

Sinus Tract – An elongated cavity that forms, allowing purulent material from an abscess to drain to the body surface.

❖ Document Wound Exudate (Drainage)

Document Drainage *Type*

Serous – thin, watery, clear

Sanguineous – thin, bright red, fresh bleeding

Serosanguinous – thin, watery, pale-red to pink

Purulent – thick or thin, opaque-tan to yellow
Foul Purulent – thick opaque-yellow to green with offensive odor

Document Drainage *Amount*

None – wound tissue dry

Scant – wound tissue moist, no measurable drainage

Minimal – wound tissue very moist, < 25% of dressing saturated with drainage in a 24 hour period **Moderate** – wound tissue is wet, 25% – 75% of dressing saturated with drainage in a 24 hour period **Large** – wound tissue is filled with fluid, > 75% of dressing saturated with drainage in a 24 hour period

❖ Document Wound Odor

Describe presence or absence of odor *after* cleansing the wound.
Descriptors include: strong, foul, pungent, fecal, musty, sweet, etc.

❖ Document Method of Debridement

Debridement involves the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process.

Document Debridement *Type*

Autolytic – use of moisture retentive dressings to cover a wound and allow devitalized tissue to self- digest by the action of enzymes present in wound fluid

Enzymatic – the topical application of substances (i.e., enzymes) to break down devitalized tissue

Mechanical – the removal of foreign material and devitalized or contaminated tissue from a wound by physical, rather than by enzymatic or autolytic means

Sharp or Surgical – the removal of foreign material or devitalized tissue by surgical instruments

❖ Describe Wound Bed Characteristics

Non-Adherent – easily separated from the wound base

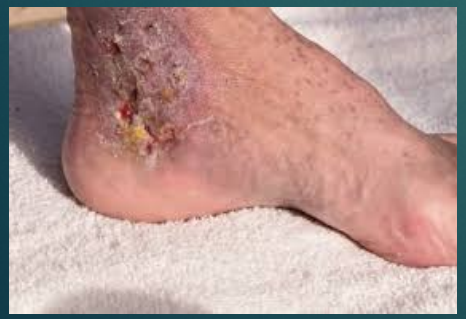
Loosely Adherent – pulls away from the wound but is attached to wound base

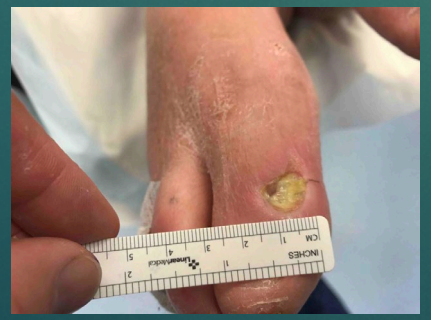
Firmly Adherent – does not pull away from the wound base

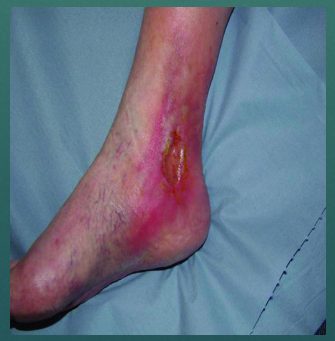
- Tissue Amount

  Describe in percentages (e.g., 50% of wound bed is covered with loosely adherent yellow slough; 50% beefy, red granulation tissue).

  May also utilize the "clock system" in describing location of necrotic tissue in the wound bed.







- Tissue Types

  Granulation – temporary structure composed of vascularized connective tissue that fills the wound void; may be red, pink, pale, or dusky red

  Slough – necrotic/avascular tissue that is yellow or tan in color and has a stringy or mucinous consistency

  Eschar – is described as thick, leathery, frequently black or brown in color, necrotic or devitalized tissue

  Epithelialization – process by which keratinocytes resurface the wound defect—can appear as deep pink, then progress to pearly pink; may form islands in the wound

SerenaGroup
Building the Nation's Leading Wound Care Team

❖ Describe Wound Edges

Wound Edge Characteristics

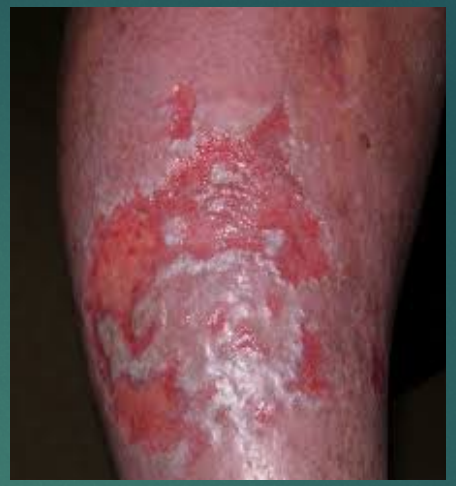
Definition – defined (well-demarcated) or undefined wound edges

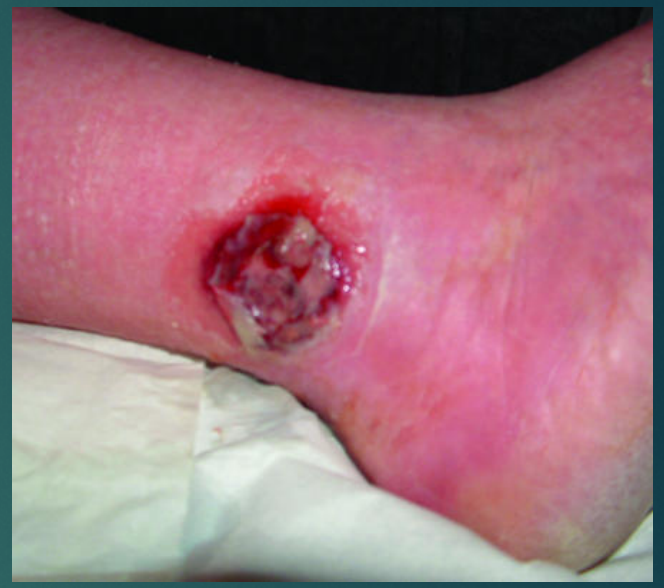
Attachment – attached or unattached wound edges

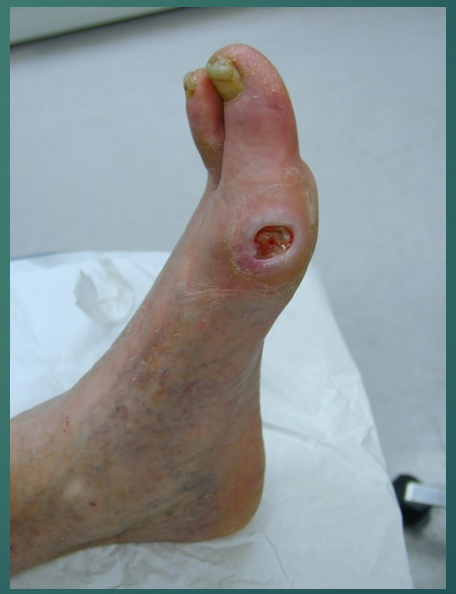
Epibole – rolled wound edges

Maceration – skin that is white and sometimes wrinkled and soft due to supersaturation

Callused / Fibrotic – build-up of tissue at wound margin due to hyperkeratosis







❖ Describe Surrounding Tissue (Periwound)

Describe the color, presence/lack of edema, tissue consistency (e.g., indurated (firm), boggy, etc.), temperature, etc.

SerenaGroup
Building the Nation's Leading Wound Care Team

❖ Document Indicators of Infection

Document fever, erythema (redness), increased drainage, odor, warmth, edema, elevated WBC, induration, pain, etc.

❖ Document Complaints of Pain

Document location, causative factors, intensity, quality, duration, alleviating factors, patterns, variations, interventions, etc

❖ Document Interventions to Promote Healing

Examples include: dietary supplements, vitamins, lab tests, turning and repositioning schedules, support surfaces, padding, pillows, elevation, offloading, heel protection, incontinence management, skin care, barrier ointments, etc

❖ List Conditions Which May Adversely Affect Healing

Examples include: impaired mobility, nutritional status, abnormal labs, infections, deterioration of medical condition, non-compliance, etc.

SerenaGroup
Building the Nation's Leading Wound Care Team

❖ Document Anticipated Wound Outcome

Based on provider evaluation of co-morbid conditions, circulation, medication; and based on discussions and desires of the resident, advanced directors, anticipated life span, goals and wishes

Is the wound good for healing, maintenance or palliative?

❖ What & When to Document

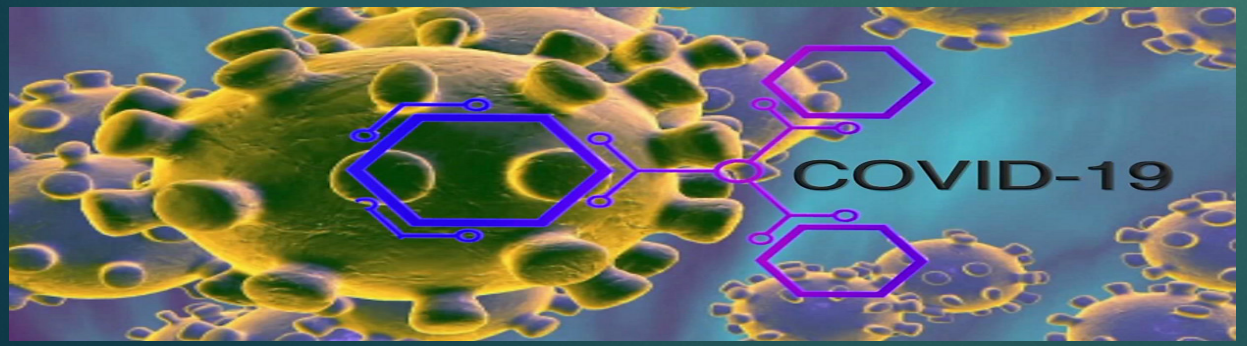
Examples include: initial intake, daily notes, weekly progress notes, weekly skin reports, change in treatment plan, signs or symptoms of infection, resident and caregiver education, MD notification, current treatment plan, response to treatment, modifications to the treatment plan, implementation of new orders, reason for not changing treatment plan, justifications, referrals, etc.

SerenaGroup
Building the Nation's Leading Wound Care Team

The Covid-19 Pandemic has affected all aspects of nursing care including wound care.

In an effort to minimize unnecessary contact with patients and decrease the spread of the virus, wound providers need to consider alternative strategies to evaluate wounds using telehealth or telemedicine.

Wound Consults
(either in person or remotely) can be managed using principles of basic wound assessment and photography (e.g. may be digital or video based dependent on facility approved methods) as described below:



SerenaGroup
Building the Nation's Leading Wound Care Team

A. Follow facility guidelines for handwashing and donning & doffing personal protective equipment (PPE).

B. Gather all supplies necessary for the wound assessment and treatment before entering isolation room; limit supplies taken in that need to be removed from the room

Did you know?

Researchers have found that the virus can live up to 24 hours on cardboard and 2 to 3 days on plastic and stainless steel.

SerenaGroup
Building the Nation's Leading Wound Care Team

C. Wound assessment

1. Location
2. Wound measurements

3.Wound drainage
4.Wound drainage consistency and color

5.Wound edges
6. Skin around wound: normal & warm, red (less than 5cm) & warm, red (extending more than 5cm) & hot to touch, pale and cool to touch (may not be able to discern temperature through the PPE, do NOT remove PPE to feel for warmth/coolness)

7. Photo
a. Maximize lighting by turning on all exam lights in the room
b. Transfer images to the medical record (EMR) per facility guidelines; if the facility does not use an EMR, follow facility guidelines for photo storage

c. Dispose of measuring tape/guide per facility infection prevention policy.
d. Wipe the device (e.g. phone, tablet, camera)according to facility guidelines, set aside on clean surface away from direct patient care area and let dry as recommended based on solution used prior to removal from patient's room

SerenaGroup
Building the Nation's Leading Wound Care Team

Quiz Questions

Clinical Documentation July 2020

1. WHICH OF THE FOLLOWING IS NOT AN ANATOMICAL LOCATION?
   A. Superior
   B. Posterior
   C. Dorsal
   D. Anterior

SerenaGroup
Building the Nation's Leading Wound Care Team

- 2. What are the 4 types of debridement in an outpatient wound care clinic?
  - 1. _____
  - 2._____
  - 3. _____
  - 4._____

- 3. Which of the following are indicators of infection?
  - A. redness
  - B. pain
  - C. black periwound
  - D. Edema

- 4. What are potential characteristics of a periwound on a lower extremity open wound?
  - _____
    _____
- 5. List 2 changes to your documentation in the clinic since the COVID-19 pandemic.
  - _____
    _____
    _____
    _____

SerenaGroup
Building the Nation's Leading Wound Care Team