
Inpatient/ED wound care is documented in the Incision/Wound Skin iView section. Wound Care documentation workflows vary depending on the type of wound. This flyer outlines the steps for documenting wound assessments, dressings, negative pressure wound therapy, and pressure injuries.

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NLH System Pressure Injury and Management – Skin Care Policy

Click [here](#) to review the NLH System Pressure Injury and Management – Skin Care policy for more information about wound care.

Photographing a Wound

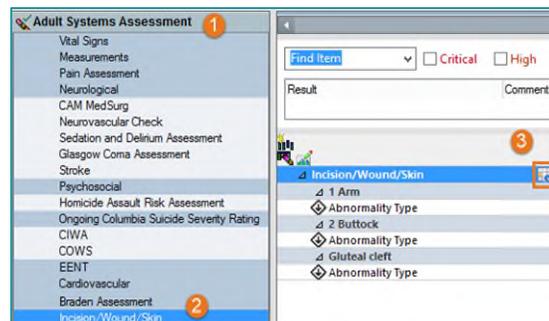
As Northern Light Health continues to focus on quality initiatives to reduce pressure ulcers, wound photography using **Camera Capture** provides an objective assessment of an identified wound.

- For more information about using Camera Capture to photograph wounds and upload to a patient's chart, click [here](#).

Wound Care iView Documentation

Wound Documentation

- Navigate to **CareCompass/ED Launchpoint**.
 - Locate the patient, and open chart to Orders.
 - Review the patient's orders and chart for wound care.
- Navigate to iView, select the appropriate assessment band.
- For instructions on how to pull in iView bands, please see the following [flyer](#).
- Select the **Incision/Wound/Skin** section.
- Create a Dynamic Group for the wound by selecting the **waffle** icon.
 - Complete fields in the New Dynamic Group label applicable to the wound.
 - Click **OK**.



NOTE: If a wound has an existing dynamic group, use it to document wound care.

- To begin documenting, double-click in the blue banner below the date and time to get a checkmark to enable the use of the **Tab** key, which pulls in last charted values for quick documentation.
- **Abnormality Type** opens.



NOTE: If the **Abnormality Type** is a Pressure Injury, go to the Pressure Injury – Suspected section for more information.

- Complete wound assessment and dressing documentation in the **Incision/Wound/Skin** section applicable to the wound.
- Once complete, sign the documentation by clicking the **green checkmark**. ✓

Documenting Pressure Injury – Suspected

Incorrectly identifying a pressure injury can have a negative impact to care delivery and quality outcomes. Pressure Injury assessment requires specialized training. Wounds identified as pressure injuries must be validated by a trained individual designated by each member organization. **Pressure Injury – Suspected** option must be selected by **all inpatient and ED nurses** to indicate a suspected pressure injury needs assessment by a designated Wound Validator.

- Follow the steps above in the **Wound Documentation** section.
- **Abnormality Type** opens.
 - Select **Pressure Injury – Suspected**.
 - Documenting **Pressure Injury – Suspected** fires a task to the **Wound Multi-Patient Task List** to notify Wound Validators that an assessment for pressure injury validation is needed.

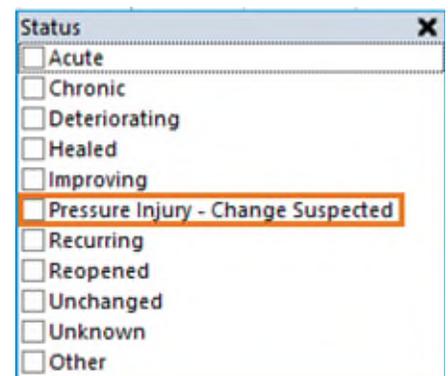
NOTE: Validated pressure injuries will be documented in the Validated Pressure Injury section by a Wound Validator. Pressure Injury Stage documented on the current inpatient encounter will pull last charted value to make documentation consistent across the inpatient stay. An inpatient or ED nurse should not alter Pressure Injury Stage documentation. If the status of a validated pressure injury has changed, Pressure Injury – Suspected Change should be documented.

- Once complete, sign documentation by clicking the **green checkmark**. ✓

Inpatient/ED Nurse Validated Pressure Injury Status Change

When an **Inpatient** or **ED nurse** determines a validated pressure injury has changed and needs subsequent assessment by a wound validator, select **Pressure Injury – Suspected Change** in the **Status** field. This option fires a re-eval task to the Multi-Patient Task List to notify Wound Validators that a validated pressure injury needs reassessment.

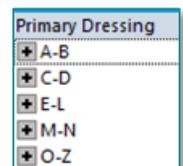
NOTE: EMMC will continue to use the Skin Response Protocol for wound re-evaluation.



The screenshot shows a dropdown menu titled "Status" with a close button (X) in the top right corner. The menu contains the following options, each with a checkbox: Acute, Chronic, Deteriorating, Healed, Improving, Pressure Injury - Change Suspected (highlighted with an orange border), Recurring, Reopened, Unchanged, Unknown, and Other.

Documenting Multi-Layer or Single-Layer Dressing

- Dressing supplies are selected from an alphabetized list of Brand Name items.



The screenshot shows a dropdown menu titled "Primary Dressing" with a close button (X) in the top right corner. The menu contains an alphabetized list of Brand Name items, grouped into ranges: A-B, C-D, E-L, M-N, and O-Z. Each range is preceded by a plus sign (+) in a small square.

- Select **Yes** to document a **Multi-Layer Dressing** in the Contact Layer, Primary Dressing, Secondary Dressing, and Compression Layer fields.

- **Typing the first letter** in Contact layer, Primary Dressing, Secondary Dressing, or Compression Layer will go to that area in the alphabet of the dressing dropdowns to decrease scrolling.

Multi-Layer Dressing	Yes
Topical Agent Application	◇
Contact Layer	◇
Primary Dressing	◇
Secondary Dressing	◇
Compression Layer	◇

- Select **No** to document a **Single-Layer Dressing**.
- Once complete, sign documentation by clicking the **green checkmark**. ✓

Documenting Negative Pressure Wound Therapy

- Navigate to **Drainage Device**.
- Select **Negative pressure wound therapy (NPWT)**.
- Once selected, fields applicable to NPWT open.

Multi-Layer Dressing	No
Topical Agent Application	◇
Single-Layer Dressing	◇

Drainage Device	Drainage Device	✕
Cleansing	<input checked="" type="checkbox"/> Negative pressure wound therapy (NPWT)	
Multi-Layer Dressing	<input type="checkbox"/> Penrose	
Topical Agent Application	<input type="checkbox"/> Self contained	
Contact Layer	<input type="checkbox"/> Sump	

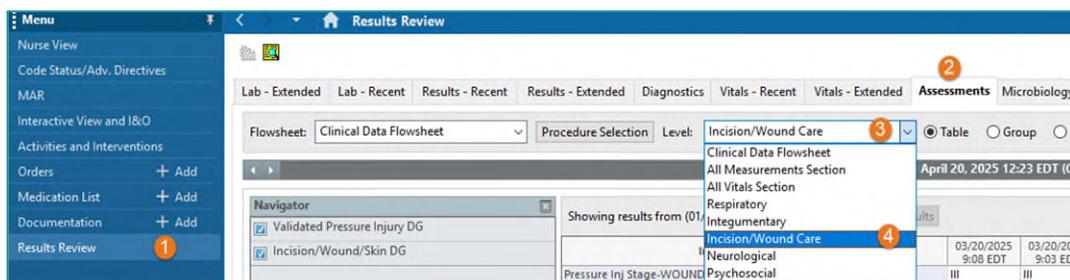
NOTE: EMMC Negative Pressure Wound Therapy (NPWT) charges in iView are labeled with **WC CHARGE – with (EMMC Only)** in the name and should not be used by other member organizations.

- Once complete, sign the documentation by clicking the **green checkmark**. ✓

Incision/Wound Care Flowsheet

Historical wound documentation is viewable in the **Incision/Wound Care** flowsheet to easily identify how the wound is changing over time in Results Review.

- Navigate to **Results Review** from the Menu.
 - Click the **Assessments** tab.
 - Select **Incision/Wound Care** in the **Level:** dropdown.
 - **Validated Pressure Injury** and **Incision/Wound/Skin** iView documentation will populate the **Incision/Wound Care** flowsheet.



- To change the Incision/Wound Care flowsheet lookback time range, right-click on the date then select **Change Search Criteria**.
- Choose the appropriate selection in the **Search Criteria** window and click **OK**.

