Northern Light Health

From the Office of Clinical Informatics

Inpatient/ED Nurse Wound Care

October 5, 2023

Inpatient/ED wound care is documented in iView in the Incision/Wound Skin 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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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.

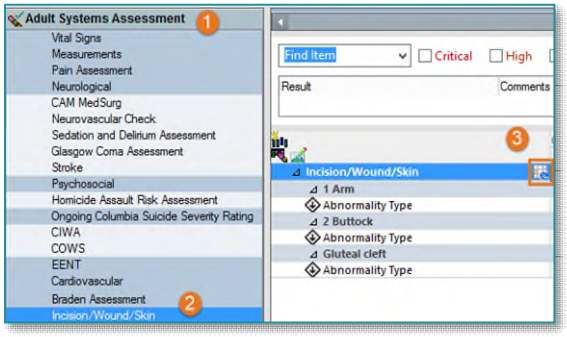
- For more information about using Camera Capture to photograph wounds to a patient's chart, click here.

Wound Care iView Documentation

Wound Documentation

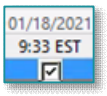
- Navigate to **Patient List** in the toolbar, locate the patient, and open the chart.
  - Review the patient's chart and orders for wound care.
- Navigate to iView, select the appropriate assessment band.
  - For instructions on how to pull in iView bands, please see the following flyer.

- 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 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 delivery of care 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 pressure injury validator.

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

NOTE: **Validated pressure injuries with documentation on the current inpatient encounter will pull last charted values for Abnormality Type, Wound Validator Clinical Role, Validator Name, Validated Pressure Injury, Pressure Injury on Admission, and Pressure Injury Stage to make documentation consistent across the inpatient stay. Unless the wound status has changed, this documentation should not be altered.**

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

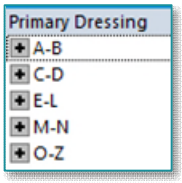
Inpatient/ED Nurse Wound Status Change

When an **inpatient or ED nurse** determines a validated wound has changed and needs subsequent validation, select **Pressure Injury – Suspected Change.** This option fires a re-eval task to the Multi-Patient Task List to notify Pressure Injury Validators that a validated wound needs to be reassessed to determine if it is a pressure injury or if the pressure injury has worsened.

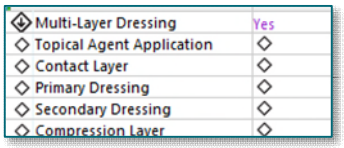
NOTE: **EMMC will continue to utilize the Skin Response Protocol for wound re-evaluation.**

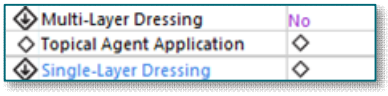
Pressure Injury Eval and Pressure Injury Re-Eval tasks will only fire to the Multi-Patient Task List once in a 24-hour period.

Documenting Multi-Layer or Single-Layer Dressing



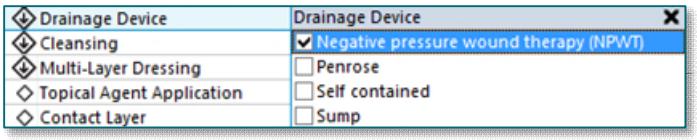
- Dressing supplies are selected from an alphabetized list of Brand Name items.
- Select **Yes** to document a **Multi-Layer Dressing** in the Contact Layer, Primary Dressing, Secondary Dressing, and Compression Layer fields.
- Select **No** to document a **Single-Layer Dressing**.
- Once complete, sign 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.

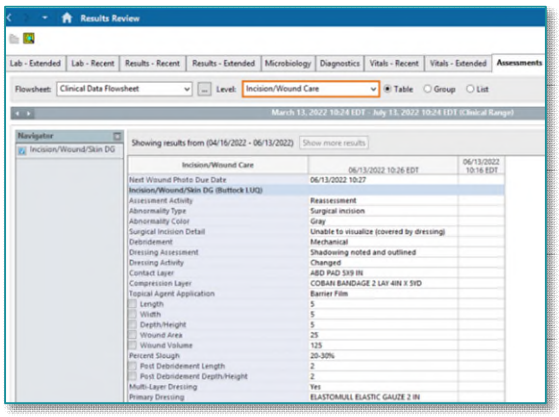


NOTE: **EMMC Negative Pressure Wound Therapy (NPWT) supply charges in iView are labeled with WC CHARGE – the name of the supply Quantity – EMMC Only. In iView, entering a quantity for NPWT supplies automatically generate charges for the patient. Charge fields should have a documented quantity when applying, changing, or reinforcing a NPWT dressing at EMMC.**

- 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.