

Wound Assessment Documentation Example

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Wound Assessment Documentation Example The term “packed” is a common example of a wound assessment documentation term often used in healthcare facilities and in the courthouse. If a wound gets worse or fails to heal, lawyers may argue that the clinician packed the wound too tightly, causing additional damage. Tips for Wound Care

Documentation | Relias “WOUND PICTURES” (adapted from Hess 2004) organizes key aspects of wound assessment that should be documented (Box 1). Each item can further be described as either qualitative (descriptive) and/or quantitative (measurable). An example is wound drainage or exudate colour, consistency and odour (qualitative) and amount (quantitative). Wound Measurement, Assessment and Documentation - Swift Wound Assessment

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before, during and after treatment; episodic or chronic

- Interventions for pain Wound Progress: • Improving, deteriorating, no change • Interventions in place; pillows, low air loss beds, special devices, nutritional supplements, etc. • Continued treatment or notify MD

and Wound Measurement & Documentation Guide final092112 Documentation Guideline: Wound Assessment & Treatment Flow Sheet (WATFS) (portrait version) Practice Level . All NP, RN, LPN, ESN, SN.

Background The WATFS is used to document all parameters of a comprehensive wound assessment which provides the basis for the wound treatment plan of care. The WATFS is a permanent part of the Health Record. Documentation Guideline: Wound Assessment & Treatment Flow ...

2. Wound reassessment and monitoring frequency/rationale are affected by the overall patient condition, wound severity, patient care environment, goal of care and plan of care. B.

Preparation

1. Place patient in the same anatomical position each time wound assessment completed.
2. Place the wound as far from sleep surface as possible.
3. Wound Assessment - ADL Data Systems The amount of exudate you document will dictate the type and quantity of dressings you can order "Light" Exudate. Less than 5cc of wound fluid . within a 24 hr period. Front and back of . Gentell's . Waterproof 4x4 foam dressing "Moderate" Exudate. 5cc - 10cc of wound fluid . within a 24 hr period. Front and back of .

Gentell's The Basics of Wound Assessment Various assessment tools are available to help with recording a wound's condition and progress if a local tool is not available. Examples include HEIDI, TIME, TELER (Box 3) and Bates-Jensen. All assist with accurate

documentation and nurses should use the one required by local policy or select the one that best suits the needs of the patient. Wound management 4: Accurate documentation and wound ... Reference for Wound Documentation . Document Wound Etiology/Cause . Describe the Anatomic Location of Wound + Wound location should be documented using the correct anatomical terms. Plantar Aspect . Heel . Dorsal Aspect + Document the cause of the wound: pressure, venous, arterial, neurotrophic, surgical, etc. Reference for Wound Documentation SKIN & WOUND & DOCUMENTATION Revised October 2013, by Yvette Barnes. Objectives • Pressure Ulcer (PU) prevention (6 minutes) • Early Identification (6 minutes) • Management of Wounds (6 minutes) • Introduction to NYGH Documentation process ... • Risk Assessment using Braden Scale Skin and Wound & Documentation Wound Documentation Tip #5: Wound Category Changes. Do document when a wound changes category (i.e., a skin tear evolves into a pressure injury, or a pressure injury becomes a surgical wound after a surgical repair, or a deep tissue injury evolves to a stage 4 pressure injury). Dos and Don'ts for Documentation of Wounds | WoundSource assessment item over time, in objective terms and show the changes in the wound status, including: • Periwound skin attributes • Wound tissue attributes • Wound exudate characteristics • Examples of valid, reliable wound healing tools: • Pressure Ulcer Scale for Healing (PUSH) • Bates-Jensen Wound Assessment Tool (BWAT) Skin and Wound Assessment Wound location should be documented using the correct anatomical terms—for example, right

greater trochanter rather than right hip. Include an anatomical figure or diagram of the human body, with the wound's location noted in your assessment record to provide complete admission documentation. Wound Assessment | Nurse Key WATCH MORE NURSING SKILLS HERE: https://nursing.com/course/nursing-skills/?utm_source=youtube&utm_medium=social In our Nursing Skills course, we show you the... Wound Assessment for Nursing (skills documentation example ... Skin pink, cool and dry. Braden score- 17. Abdominal sagittal midline well approximated incision with packed wound at inferior and superior ends, both approx 1 cm in circumference and 11-12 mm in depth, no site redness or swelling, scant serosanguineous drainage. ... 61 thoughts on "Assessment Documentation Examples" Melissa says: September ... Assessment Documentation Examples | Student Nursing Study Blog The following is an example of documenting the wound assessment in CIS. 1. Right Ischial Stage IV Pressure Ulcer is added to the Problem List in both the Acute and Intensive Care areas. 2. On the Acute Care Unit, modify form to add cell for the specific wound under the Assessment Tab on CIS: 3. Notes - University of Washington Wound Assessment/Documentation. Specialties Wound posted Mar 24, 2007.... Here is an example of my first issue. I have a wound that is very superficial it may measure 0.2 cm by 0.2 cm and I don't feel like I can measure the depth because I am unable to see the wound bed clearly and I am unable to put a measuring device in there (sterile tips ... Wound Assessment/Documentation - Wound / Ostomy ... Pressure Ulcer Assessment • Purpose of staging is for consistent communication of depth of

tissue destruction • Once staged, the ulcer should not be back staged, rather the wound should be described in terms of size, shape, color, drainage, and odor using one of the wound assessment measures

(www.npuap.com) Measuring the Open Area

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