MEDICAL TRANSCRIPTION SERVICES

Key Components of Documenting Wound Assessment and Care

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Medical Transcription Service Company
United States

In addition to documenting operative reports, **medical transcription companies** also provide accurate and timely transcripts of surgical wound care dictation. Good documentation is crucial for continuity of care, third-party reimbursement, and ensuring compliance regarding care provided. Wound assessment and care documentation must follow the facility's documentation guidelines and prove that appropriate care was rendered. Clinicians who fail to document care provided risk liability for negligence and legal problems.

Surgical site infections (SSI) are a serious post-operative complication that can lead to prolonged hospital stay, increased health care costs, and patient morbidity and mortality. A 2018 CDC report gives the estimated SSI infections in the US as 157,500 per year and deaths associated with SSI as 8,205 per year. Post-operative site infections such as cellulitis, superficial abscesses, and deep abscesses, are caused by bacteria that enter the site. Wound infections can delay healing and affect adjacent organs or tissue, or spread to distant sites through the blood stream. Treatment of wound infections may include antibiotics and/or draining of any abscess or collection of infection.

Surgical site wound assessment and documentation is a time-consuming task that requires good knowledge to perform correctly. If charting is incomplete, inconsistent or inaccurate, it will affect the efficacy of care and leave the provider or facility open to legal liability. To document wound care correctly, clinicians need to understand the rules and regulations guiding the department's documentation and billing processes.

General Documentation Guidelines

- All documentation must be maintained in the patient's medical record
- The date and time, and signature and credentials of the physician or nurse responsible for and providing the care to the patient must be included in all notes
- Documentation must be legible and include appropriate patient identification information
- When documenting care rendered, the provider must be accurate, factual, objective and truthful
- Avoid attributing blame in the medical record
- Avoid documenting information which is unrelated to the care of the patient

Surgical Wound Care Documentation Practices

- Upon admission, clinicians must perform a full body inspection of the patient. The type of wound, location, size, stage or depth, color, tissue type, exudate, erythema, condition of periwound should be clearly described. The health care team can take appropriate decisions when they are well-informed about the patient's condition.
- The anatomic location of the surgical incision should be documented, including the side of the body that was operated on.
- Mention the length of the incision in centimeters as well as the depth measurement whenever appropriate (as documented by the physician). This may be supported by a drawing or photograph of the wound. All members of the facility's nursing team who measure and document wounds should be well-versed in the wound measurement method of the facility's protocol.
- The type of materials used to keep the incision closed such as: sutures, staples or clips, retention sutures, or tape closure, should be documented.
- If there is any sign of infection, documentation should indicate when it became visible, who was notified, the interventions ordered and provided, and how the patient responded to them.
- Wound edges or margins must be assessed and documented.
- All dressing changes, including materials used, should be documented.
- To assess and record pain, the pain intensity that the patient experiences should be routinely rated on a standard pain-rating scale.
- The medical record should contain clearly documented evidence of the progress of the wound's response to treatment at each physician visit.
- All calls to the physician should be documented as well as the response and the steps taken to adhere to the physician's order.

In the case of a pressure ulcer/injury, it must be identified whether it was present on admission or developed after admission, factors that influenced its development, the potential for development of additional injuries or for the deterioration of the pressure ulcer/injury be recognized, assessed and addressed (www.amtwoundcare.com).

Surgical wounds include various types of skin ulcerations. Some have characteristics consistent with a pressure ulcer. The wound care specialist should document evidence as to why the skin ulceration is not pressure-related. The documentation should mention: the

location and shape of the ulcer, the underlying condition contributing to the ulceration, and condition of surrounding tissues.

The documentation of surgical site wounds is complex and time consuming. The health care team should have a good understanding of payer and facility documentation requirements for proper reporting. Clear and succinct medical records and physician case notes are essential to ensure proper payment for services. Under-charting will lead to loss of revenue, while over-charting of irrelevant data is a waste of resources. Moreover, documentation to show that proper care was given helps providers stay out of legal trouble. **Medical transcription outsourcing** is a practical way to ensure clear and comprehensive documentation of all aspects of wound care, including assessment, treatment and management plans, implementation and evaluation.