Wound Documentation & Care Coordination

MAKE THE WOUND STORY CLEAR ACROSS SHIFTS AND DISCIPLINES

GOAL **Document enough detail that the next shift knows what changed, what was done and what happens next.**

1 DOCUMENT THE BASELINE

- Location and wound type / etiology when known.
- Pressure-injury stage when applicable; do not stage non-pressure wounds.
- Length, width, depth, tissue, drainage, periwound skin and pain.
- Present-on-admission status and relevant risk factors per facility process.

2 DOCUMENT REASSESSMENT

- Use the same measurement method and compare with prior findings.
- Record improvement, stability or deterioration with specific evidence.
- Document treatments / interventions actually provided and resident tolerance.
- Use photographs only according to facility policy and consent requirements.

3 CHANGE OF CONDITION = CLOSED LOOP

- Document what changed, when it was identified and the resident's overall condition.
- Update interventions and the care plan when the clinical picture changes.
- Record who was notified, when, the response / orders received and what action was taken.
- Ensure follow-up is assigned and documented - not just the initial phone call.
- Handoffs should make the next step obvious to the next shift.

4 KEEP THE RECORD USEFUL

KEEP RECORDS CONSISTENT

Assessments, treatment records, nursing notes, care plans, provider orders and MDS-related skin documentation should tell the same story.

AVOID COPY-FORWARD TRAPS

Stale measurements, conflicting sites / stages, unchanged boilerplate or "worse" without specifics can hide meaningful change.

CARE PLAN THE CAUSE

Document interventions addressing pressure, moisture, edema, nutrition, perfusion, mobility, devices and other resident-specific risks.

CLINICAL PEARL

If the record does not clearly show what changed and what was done, the next shift cannot reliably act on it.

NEW WOUND OR CHANGE?

ASSESS / DOCUMENT / NOTIFY / UPDATE THE PLAN / FOLLOW UP