

## Telehealth Wound Documentation Procedure

### 1. SCOPE

- 1.1. MCHS Telehealth
  - Registered Nurse
- 1.2. Facilities and departments included in the scope listed above are further defined in the [Scope Definition Resource Guide](#) if not specifically outlined above

### 2. DEFINITIONS & EXPLANATIONS OF TERMS

- 2.1. Abbreviations
  - MCHS: Marshfield Clinic Health System
- 2.2. Definitions
  - **Sharp/Surgical Debridement:** includes the use of a scalpel, forceps, scissors, hydro surgery devices, or lasers to remove dead tissue. Debridement is required to convert the chronic wound bed into an acute wound so that the wound healing cascade can get a fresh start. Sharp debridement is considered the “gold standard” by clinicians. It can also cause pain so a topical anesthetic such as lidocaine gels or creams may be required.
  - **Wound Debridement:** the removal of dead, damaged, or infected tissue to improve the healing potential or remaining healthy tissue.
  - **Biofilm:** is essentially an invisible “layer” formed by an extracellular matrix that binds to the wound base, whether dermis, fascia, muscle, tendon, or bone.
  - **Acute Wounds:** normally wounds proceed through an orderly process that results in sustained restoration of anatomic and functional integrity.
  - **Chronic Wounds:** have failed to proceed through an orderly and timely process to produce anatomic and functional integrity, or proceed through the repair process without establishing a sustained anatomic and functional result.
  - **Actively Infected Wounds:** contain surrounding erythema, swelling, induration, tenderness, purulence and malodor.
  - **Chronically Inflamed Wounds:** may have a rim of surrounding erythema, even without other local clinical signs of infection.
  - **Tissue forceps:** helpful in grasping the tissue.
  - **Scalpels:** used to slice off thin layers of tissue.
  - **Curettes:** useful in removing the biofilm that accumulates on top of both fresh and chronic granulation tissue.

- **Bone Rongeurs:** useful for removing hard-to-reach soft tissue and for debriding or taking biopsy of bone.
- **Wound Assessment:** is written record and picture of the progress of the wound- is a cumulative process of observation, data collection, and evaluation.
- **Edema Assessment:**
  - ◇ 1+= slight pitting: no visible change in the shape of the leg (skin indents 2mm).
  - ◇ 2+= somewhat deeper pitting; no marked change in the shape of the leg (skin indents 4mm).
  - ◇ 3+= pitting is deep; leg is full and swollen (skin indents 6mm).
  - ◇ 4+= pitting is very deep; leg is very swollen (skin indents 8mm +).
- **Drainage Assessment:** is the exudate. Be sure to note amount, color and odor.
- **Exudate:** is the accumulation of fluids in the wound, which may contain serum, cellular debris, bacteria, and leukocytes.
- **Serous exudate:** is clear or pale yellow.
- **Serosanguinous exudate:** is blood tinged serous fluid.
- **Pulse Assessment:** assess for strength (i.e. absent/present, equal) and/or a three point scale of: 3+= bounding, hyperkinetic, 2+= normal, 1+= weak, thready, hypokinetic, 0= absent; Regularity: regular or irregular; Equality: bilaterally are the pulses equal or not.
- **Induration:** Abnormal firmness of tissues with margins.
- **Fluctuance:** Wavy impulse felt in palpitation and produced by vibration of body fluid.
- **Undermining:** is tissue destruction that occurs around the wound perimeter underlying intact skin, in these wounds, the edges have pulled away from the wound base.
- **Sinus tract (tunneling):** is a channel that extends from any part of the wound and may pass away from the wound through subcutaneous tissue and muscle.
- **Fistulas:** connects viscous organs together (for example, rectovaginal fistula), or connect to the skin (for example, enterocutaneous fistula).
- **Maceration:** is a softening of the skin surrounding a wound due to excess drainage or pooling of fluid on intact skin and appears as white, waterlogged area.



- **Slough:** necrotic tissue that is moist, stringy, and yellow.



- **Eschar:** In a wound that has become dehydrated, necrotic tissue turns thick, leathery, and black.

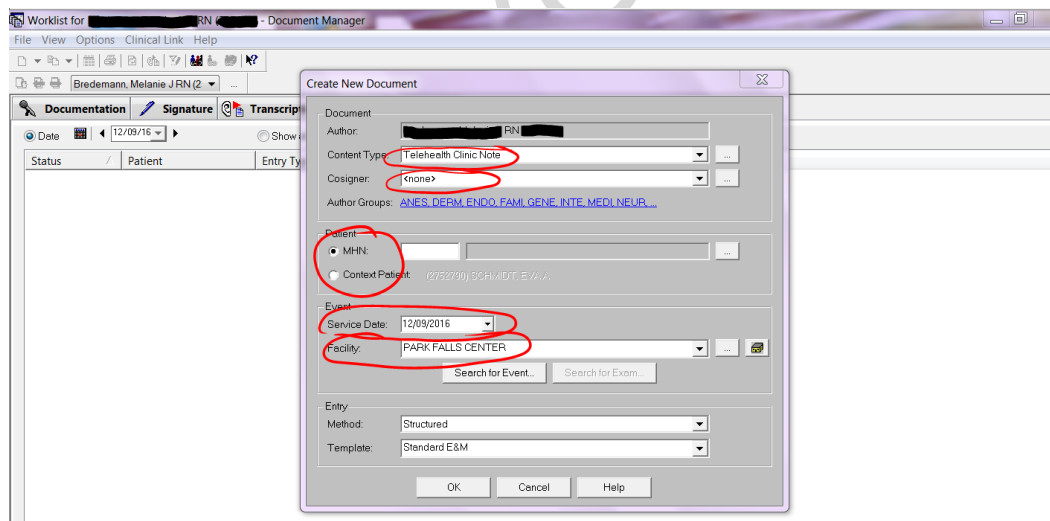


- **Codec:** refers to the use of clinical video systems.
- **Partial Thickness wounds:** refers to as damage to the epidermis and part of the dermis. Common examples are abrasions, skin tears, blisters, and skin-graft donor sites.
- **Full Thickness wounds:** extend through the epidermis, dermis, and may extend into the subcutaneous tissue, fascia, and muscle.
- **Macro Pictures:** Taking picture of the whole body part in relation to the wound.
- **Micro Pictures:** Taking pictures of just the wound.
- **AgNO3:** Refers to silver nitrate to assist in hemostasis.
- **SurgiCel:** Is a hemostatic agent (blood-clot-inducing material) made of an oxidized cellulose polymer.
- **Hemostasis:** Is the stopping of bleeding or hemorrhaging in an organ or body part.
- **Granulation:** the formation of tissue in the wound base.
- **Epithelialization:** To become or cause part of the body to become covered with epithelial tissue, as in the healing of a wound.
- **Erythema:** redness of the skin as a result of a widening of the small blood vessels near its surface.

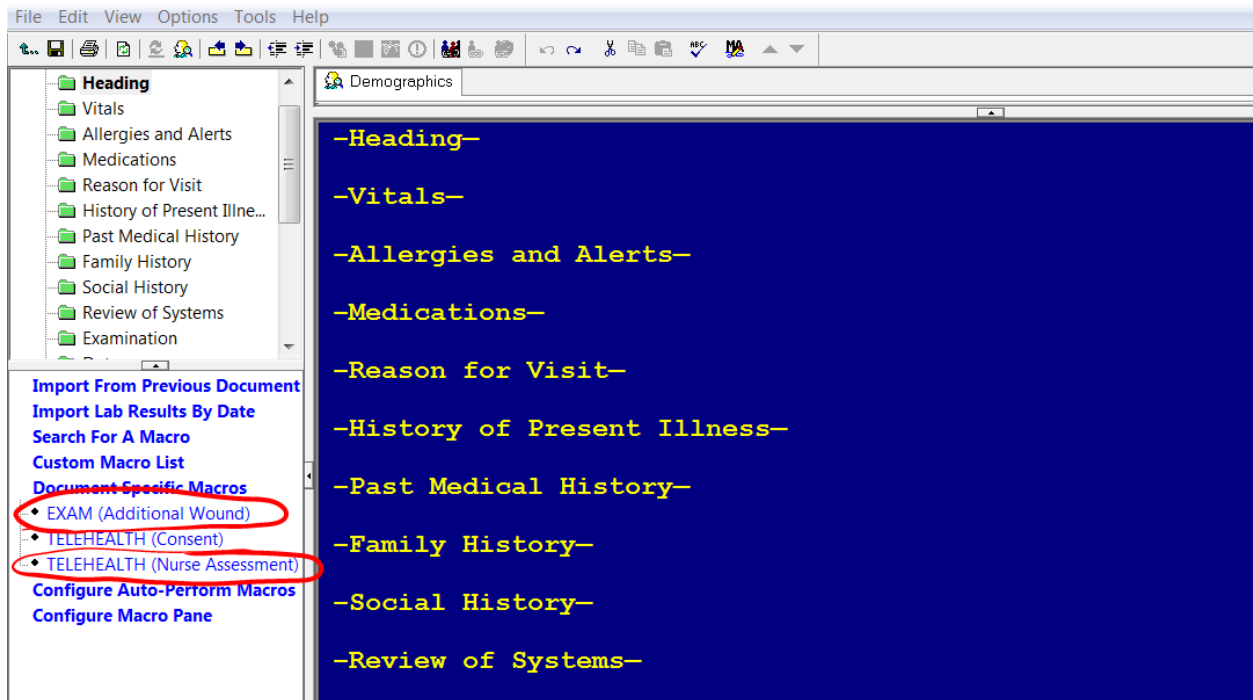
### 3. PROCEDURE BODY

**Purpose Statement:** All clinical staff responsible for presenting patients to the Wound Healing Program will document according to the standard as stated in the below procedure.

- 3.1. Verify drug allergies, medications and enter vital signs on Dashboard
- 3.2. The nurse who collects assessment information and performs wound care. The nurse will prepare a structured document under his/her worklist in Document Manager making sure to select the appropriate information for the visit. The content type should be Telehealth Clinic Note, the cosigner is the ordering MD etc.

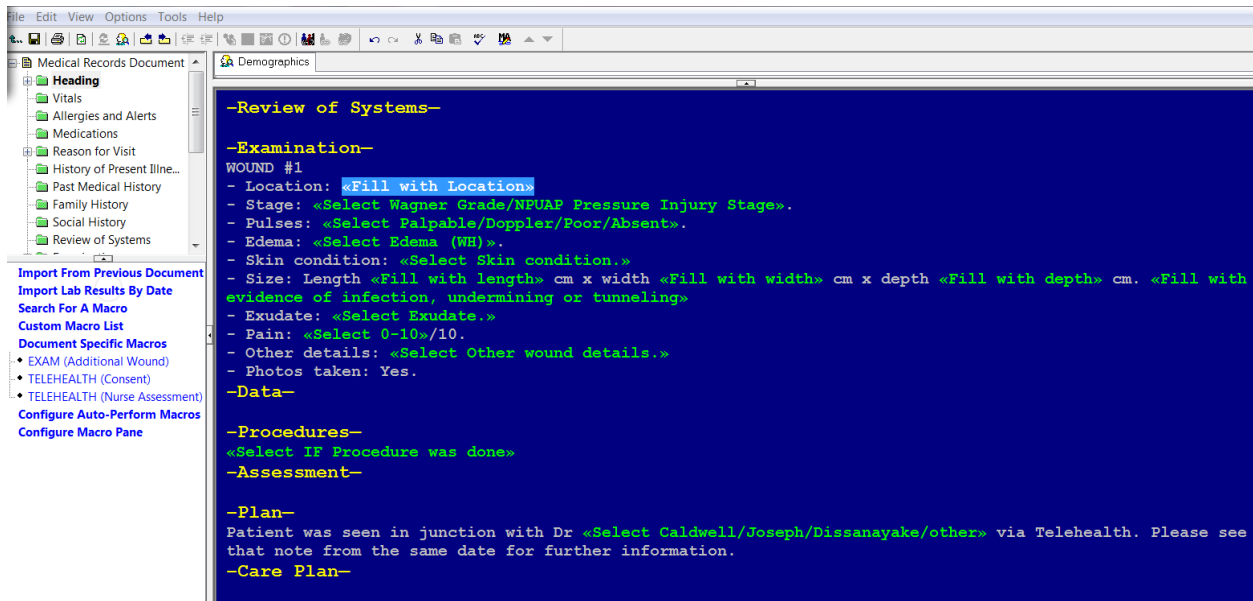


- 3.3. Loading the wound healing document:
  - a. Step 1: look to the left of the document under Macros.
  - b. Step 2: find the macro labeled: Telehealth (Nurse Assessment)
  - c. Step 3: Click on the document. The macro will pull the template into use. If the patient has more than one wound to document, use macro labeled: Exam (additional wound) for each additional wound.
  - d. If you do not have these Macros in your list, you will need to contact a Document Trainer at 1-715-221-8551



### 3.4. Examination:

- a. Once the macros are loaded, go through the document and fill in the green highlighted areas (location, stage, pulses etc.) and any other pertinent information. Some of these will have drop down boxes to select from and others the nurse will have to type the information in.



When document is printed it becomes an uncontrolled copy. Please refer to DCS system for most current version.

Medical Records Document

Demographics

**--Review of Systems--**

**--Examination--**

WOUND #1

- Location: **«Fill with Location»**

- Stage: **«Select Wagner Grade/NPUAP Pressure Injury Stage»**

- Pulses: Wagner Grade 0, intact skin

- Edema: Wagner grade 1, superficial ulcer

- Skin color: Wagner grade 2, deep ulcer through the dermis, no bone involvement

- Size: **«Fill with size»** cm x **«Fill with depth»** cm. **«Fill with evidence»**

- Exudate: Wagner grade 3, subcutaneous ulcer with bone involvement

- Pain: Wagner grade 4, localized gangrene of toes or forefoot

- Other details: **«select other wound details.»**

- Photos taken: Yes.

**--Data--**

**--Procedures--**

**«Select IF Procedure was done»**

**--Assessment--**

**--Plan--**

Patient was seen in junction with Dr **«Select Caldwell/Joseph/Dissanayake/other»** via Telehealth. Please see that note from the same date for further information.

**--Care Plan--**

- b. Grade (Wagner classification-foot ulcers): Select one of the following from the dropdown menu. May find from previous note. Diabetic foot ulcers will ALWAYS remain the same through its entirety until healed. If this is for a new patient; the NP or MD will assess.
- c. Stage - pressure ulcer stage: Communication with the provider is the best way for the nurse to determine this. It will remain the same through its entirety until healed. Telepresenter will need to communicate with the provider or reference the previous wound healing note to obtain this.
- 3.5. Documentation is completed when all of the highlighted green fields have been filled and any other information pertinent to the visit is entered (reinforced teaching, educational handouts given etc.) Sign and save document.

#### 4. ADDITIONAL RESOURCES

4.1. References:

- None

4.2. Supporting documents available:

- None

Live

PROCEDURE

**5. DOCUMENT HISTORY**

Version No.	Revision Description
1.0	Conversion from Policy Handbook to Document Control. Procedure #4299.0
2.0	Removed Marshfield Clinic Logo, Updated Quick Parts in Header, Reformat of Section 2.
3.0	Updated scope statement to include Registered Nurse in 1.1 sub bullet and added 1.2.
4.0	DCS Checklist; updated file name per DCS titling schematic. Updated 3.2., removed 3.5 and the image.



**6. DOCUMENT PROPERTIES**

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PROCEDURE