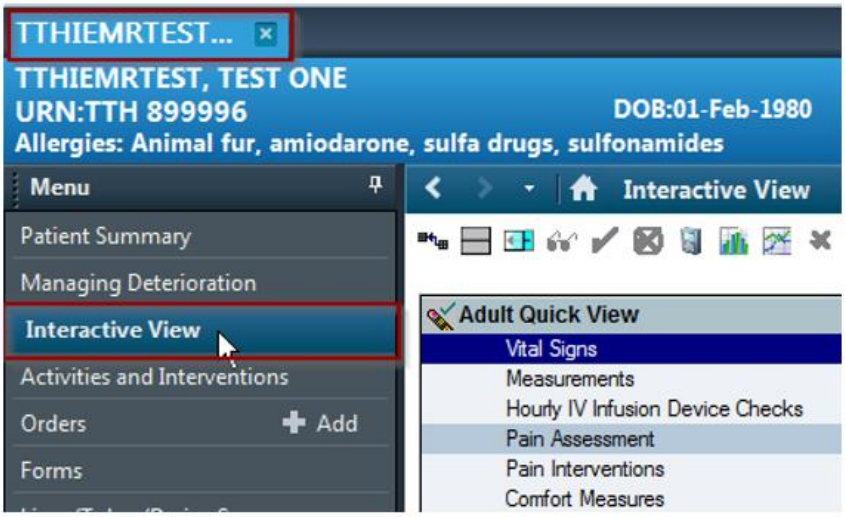
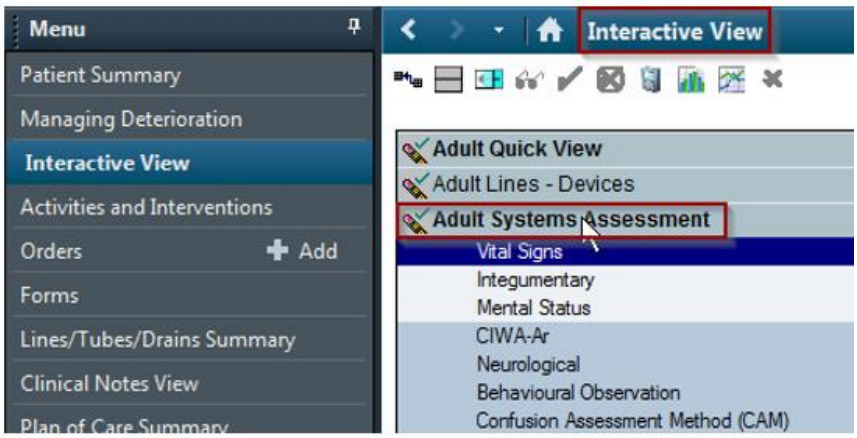
Documenting a Wound

1. Open the patient's chart and go to *Interactive View* from the menu on the left-hand side

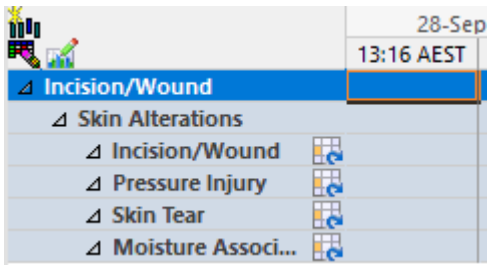


2. Click on the relevant *Adult/Paediatric Systems Assessment* band



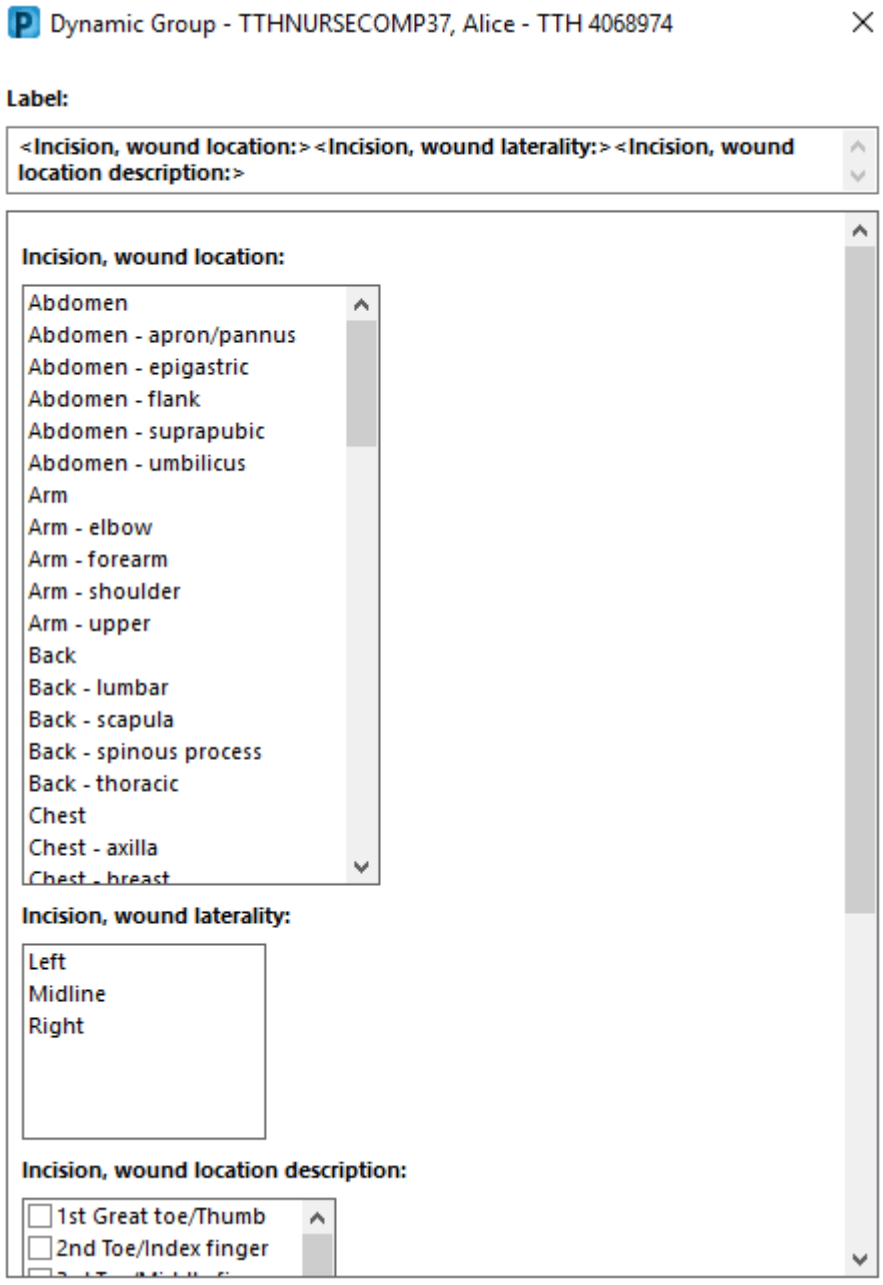
3. Click *Incision/Wound* Section

4. Click on the *Dynamic Group* icon, beside the appropriate wound and the label window will open



Documenting a Wound

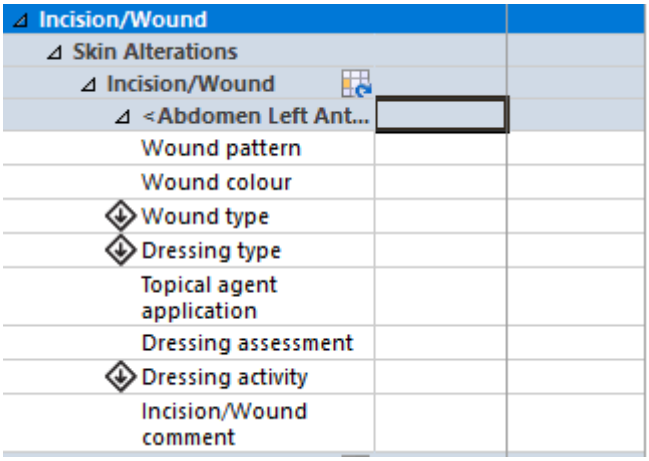
5. Complete the Dynamic Group Label window details.
   - Click the relevant wound Location, Laterality and Location Description details.
   - Use the scroll bar to see all available descriptors.



6. Click OK button

The *Dynamic Group* label information will now display as a sub heading under the *Incision/Wound* field – see example below.

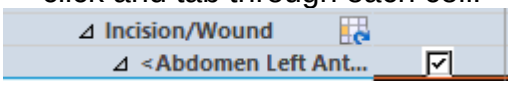
Documenting a Wound



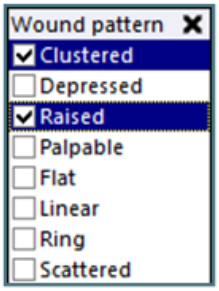
Check the correct wound description is displayed, e.g. <Abdomen Left Anterior> To edit the Dynamic Group label, double click on the wound label/heading to open the window, amend as required.

Documenting in the Incision/Wound Cells

1. Double click the grey cell next to the wound Label. This will allow you to sequentially click and tab through each cell.



2. Click the relevant empty boxes within the *Wound Pattern* window, eg Raised, press Tab.

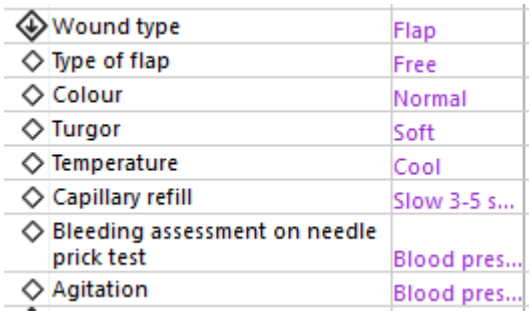


Sections that have square check boxes can have multiple options checked.

3. Continue through, appropriately documenting against all relevant areas.

Documenting a Wound

Note: Conditional Field symbol. Some wound types will trigger further fields and cells to display eg. Burn, Pressure Injury and Rash – see example below. Document in each additional cell as required



4. Click *Sign*

You can also perform several functions from a populated cell.

- To add a free text comment, right click, and click *Add comment.*
- To clear cells, right click, click *Clear*
- To add a flag, right click, and click *Add Flag.*
- To add a flag with a comment, right click, and click *Flag with Comment.*

Flagged Comments can be viewed in the *Patient Summary* menu page, in the *Flagged Events* widget.

Staff may also add information to a Progress Note in order to provide extra description and particularly number of pieces of foam in dressings. Please see the example below.

Documenting a Wound

NPWT application to the Right outer heel.

* Prontasan soak for 10mins to the wound cavity.

Wound description:

The wound is located on the right outer aspect of the heel. The cavity has necrotic slough is some parts of the wound. There is also bone and tendon on show. The wound edges are well defined but there is one section at the 7 O'clock position that was extremely macerated and slightly boggy.

Wound Size:

The length is 4.5cm
The width is 4.5cm
The depth is 2.5cm

Dressing plan:

* Cavilon to surrounding skin edges
* The wound edges are covered with duoderm
* Small piece of white foam cut to size to fit over the exposed bone and tendon.
* small spiraled piece of black foam placed down the side of the white foam and then spiraled to cover the rest of the wound.
* VAC drape to cover the foam.
* TRAC pad placed in the center of the wound
* Suction achieve with nil leaks at 125mmHg (125mmHg used because of the white foam in the base not the 100mmHg as requested)

NO INTERFACED USED
TWO PIECES OF FOAM (ONE WHITE AND ONE BLCAK)

Wound review to occur on Monday.

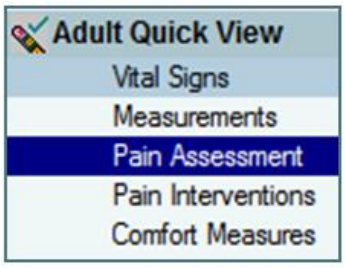
Pain Documentation

If wound pain is present or experienced during dressing change, this will need to be documented under the *Pain Assessment* section in *Adult* or *Paediatric Quick View* section. Document only what is applicable to your patient's pain experience.

1. Access the *Interactive View* patient menu page

2. Select *Adult/Paediatric Quick View* band

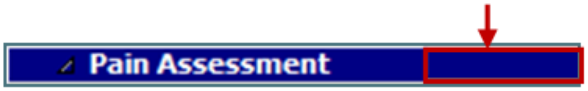
3. Select *Pain Assessment* section



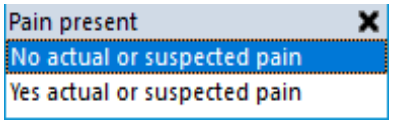
4. The Pain Assessment fields and cells will now be on view.

5. Double-click in the dark blue cell next to Pain Assessment to start documentation

Documenting a Wound



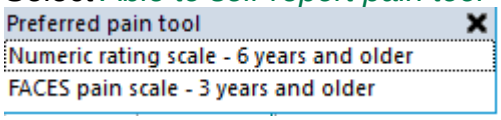
6. Document *Pain Present*



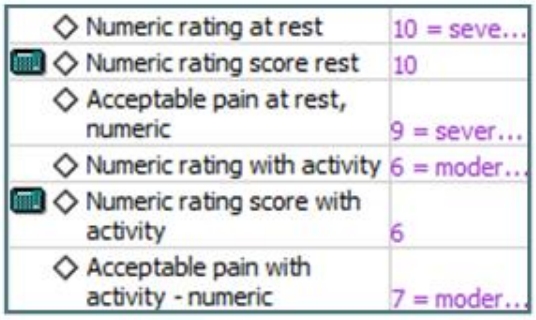
If the child is unable to self report you may choose between the PIPP and the FLACC pain scale. If able to self report (child or adult) your options are Numeric rating scale or FACES pain scale.

Adults who are unable to self-report have two options, *unable to use pain scale and advanced dementia* (similar to the Abbey pain scale).

7. Select *Able to self-report pain tool*



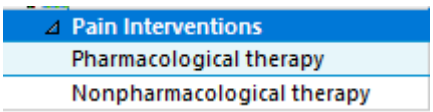
8. Document in each additional cell e.g. Numeric rating at rest.



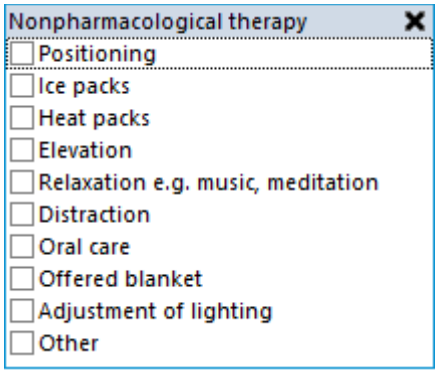
9. Continue documenting all relevant fields for this section and click *Sign* ✔

Document Pain Intervention for Patients

1. Select the appropriate Intervention



Documenting a Wound



2. Continue documenting all relevant fields for this section and click *Sign* ✔

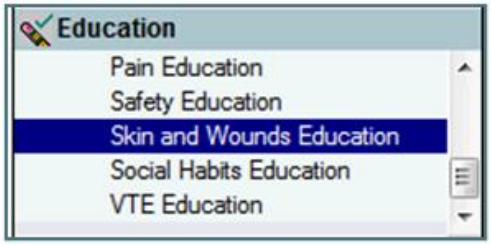
Skin and Wound Education Documentation

Education given to the patient regarding skin and wounds can be documented within Interactive View.

1. Access the *Interactive View* patient menu page

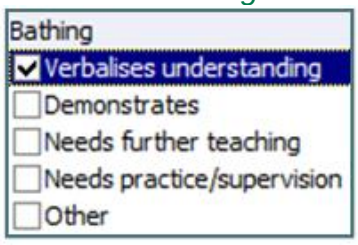
2. Select the *Education* band

3. Select *Skin and Wounds Education* section



4. Double click on the dark blue cell next to *Skin and Wound Education* to start documentation

5. Document *Bathing*



6. Continue documenting all relevant fields for this section and click *Sign* ✔