WOUND EDUCATION

CLINICAL TRAINING MADE EASY ©

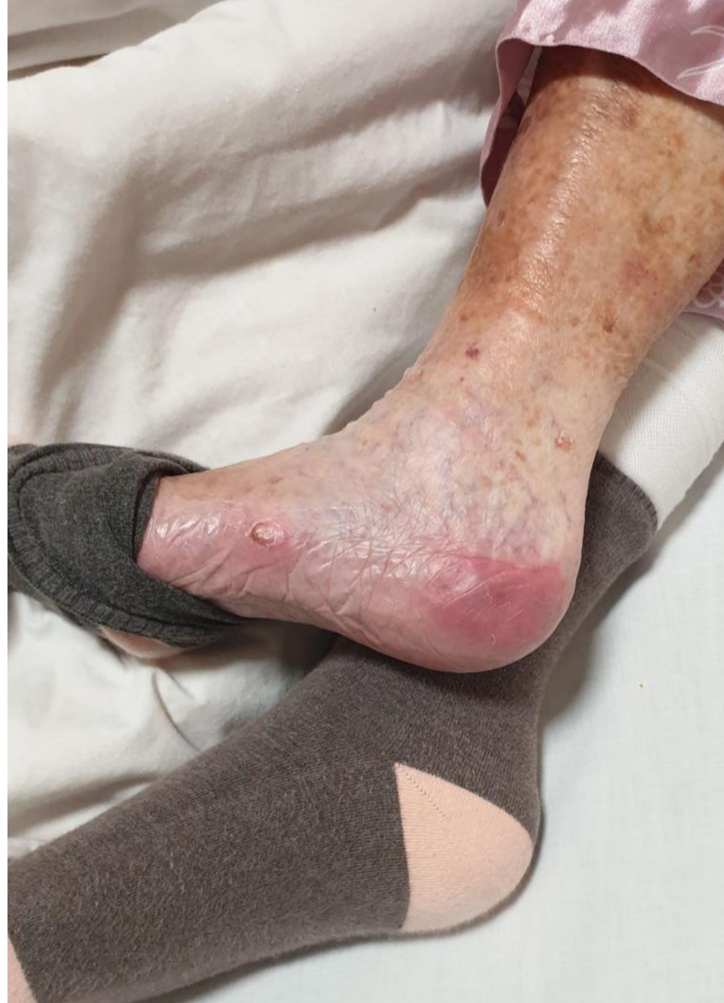
SESSION 2

MODULE 1

DOCUMENTATION

Documentation

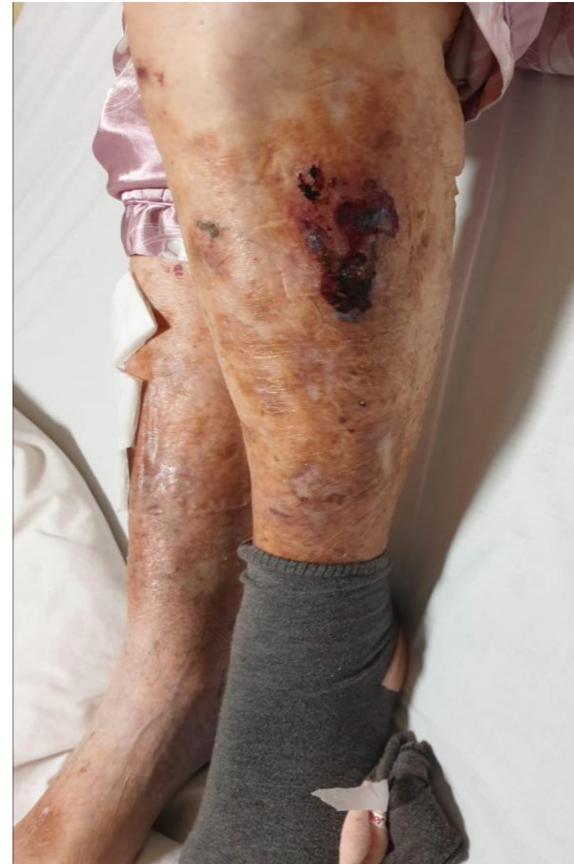
- Accurate
- Legible
- Comprehensive
- Chronological
- Legal
  - Privacy
  - Consent
  - Storage



Clinical Care Documentation

" Dressing Attended"

- Electronic documentation
  - Password – Logins
- Name, Signature, Designation, Date
- Continuity of Care & Chronological
- Multidisciplinary "Wound Management"
- Management plan & Patient Consent
- Contractors, Documentation & Access



What points should be documented following a patients skin check?

Time, date, skin intact, pressure points signs of redness, damage location, effectiveness of offloading surfaces, repositioning, signs of moisture damage, skin ie dryness, Any dressings intact?

Wound Assessment	Type: Duration:
	T
	I
	M
	E
Identified Issues	
Goal	
Recommendations	

Legal Considerations

- Accurate information, concise and systematic flow.
- Organisational policy. Data collection and reporting.
- Access and storage of medical documentation
- Methodology for referral information
- Privacy policy

Key Points

- Consider the purpose of documentation and if the patients medical record reflects the purpose.
  - Continuity of care
  - Evidence base practice
  - Demonstrates legal & policy compliance
  - Escalation & Referral