Wound Care Guidelines

Purpose:

Wound assessment and treatment are essential in the care of patients at the end of life. Providing staff documentation guidelines will facilitate communication between departments, teams, and team members when providing care for a patient with a wound.

Guidelines:

1. Review documentation from previous visit regarding wound assessment
2. Observe
    a. Done with every dressing change
    b. Document in assessment as indicated:
        i. Observed wound, No change in wound characteristic during dressing change
        ii. Observed wound dressing, intact, or document amount of drainage on the dressing
        iii. Describe abnormal skin area etiology
        iv. Follow agency protocol for documentation of wounds
3. Wound Assessment
    a. Complete per agency protocol and visit guidelines
4. Treatment
    a. A physician's order is necessary for treatment of wound care
    b. Any change in wound care orders requires a new physician order
    c. Treatment is documented in the physician order per agency protocol include order, performed intervention and document patient response
5. Facility Based Patients with wounds/wound care
    a. Include documentation that external agency is involved in wound care plan.
    b. Include facility collaboration as an intervention
    c. Include data from facility documentation, for example: "Dr. Smith's note- date/ time."

**** Note: These are guidelines only. Follow your agency wound care policies and procedures.***