

**7 PARTS TO ALL WOUND CARE ORDERS:**

1. **Person** to perform Wound Care (i.e. Hospice nurse, HH nurse, WC Clinic, Facility staff, Patient, Caregiver(s) once able to demonstrate ability to perform). Include person that SN will teach if patient/patient's caregiver has the ability to learn and perform when available
2. **Type** of Wound
3. **Location** of Wound
4. **Description** of Wound Care
5. **Frequency** of Wound Care (Once patient/caregiver is proficient in WC; order needs to be updated if patient/caregiver performs on some days or PRN)
6. **Length of time** to continue wound care (e.g. **2-x week. Discontinue when healed.**)
7. **PRN** if loose or soiled (**include rationale** for as needed)

Double check that order is written accurately and professionally (grammatically correct and no spelling errors) as the doctor signs this order and it becomes a part of your patient's medical record.

**STEPS WHEN CREATING A WOUND CARE ORDER ON ADMISSION:**

*Details and screenshots:*

**1) ENTER ORDER/PATHWAYS: (Step #1 on the Quick Reference cheat sheet)**

Steps for Adding Pathways:

- **Visit Actions > Pathways**
- The screen showing the first set of options appears. Select the appropriate answer by tapping on the box.
- The associated order with the selected pathway will appear.
- To review the associated goal, tap on the goal line.
- To select this order for the Plan of Care, tap on the box next to the treatment code.
- The **text boxes for the order and goal will be available for the clinician to edit as applicable.**
- Tap **Save** at the bottom of the screen when the order / goal text is ready.

View of Pathways Screen in a RN00H – Hospice Admission Visit

View of Pathways Screen in a RN00 – Home Care Admission Visit

If the pathway chosen has corresponding Interventions and Goals, those Interventions and Goals will be listed below the Goals text box. These are the Interventions and Goals that will be available during subsequent visits.

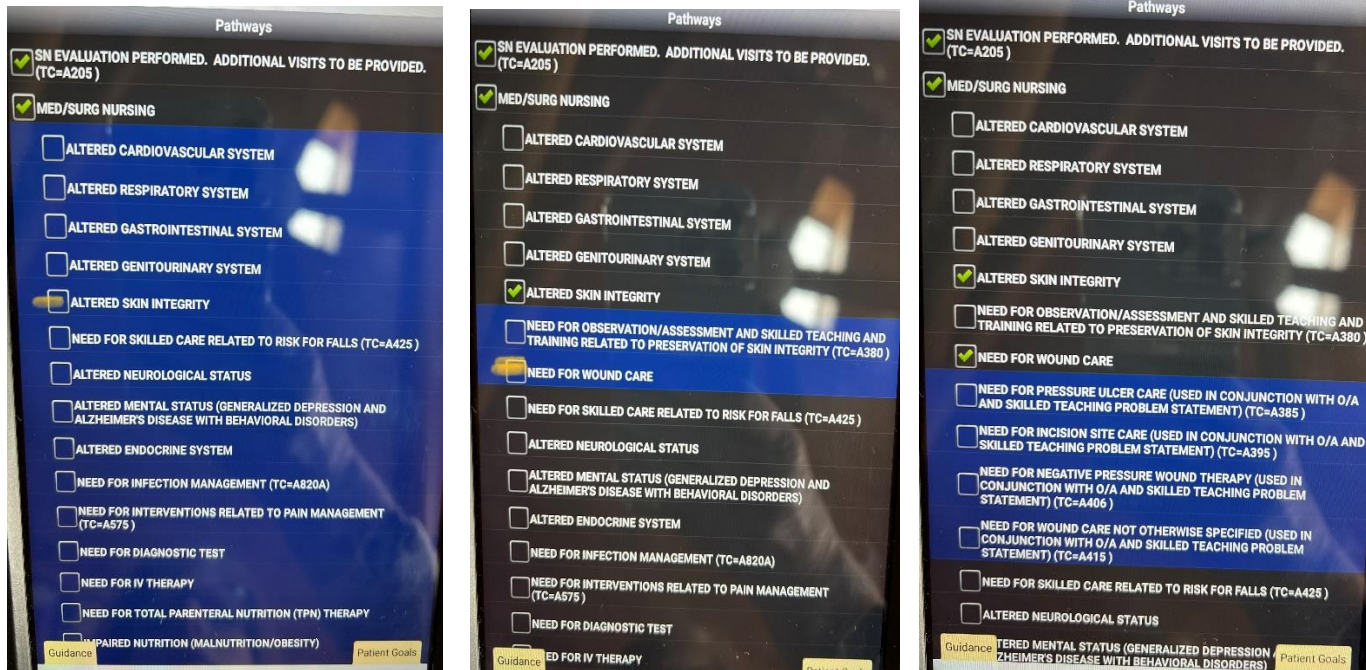
## Wound Care Orders and Process DETAILED STEPS Part 1 09.20.23 JO

Subsequent options will continue to appear, based on the choices. Selecting, editing and saving each order will follow each selection.

Pathway for Hospice Wound Care Order:

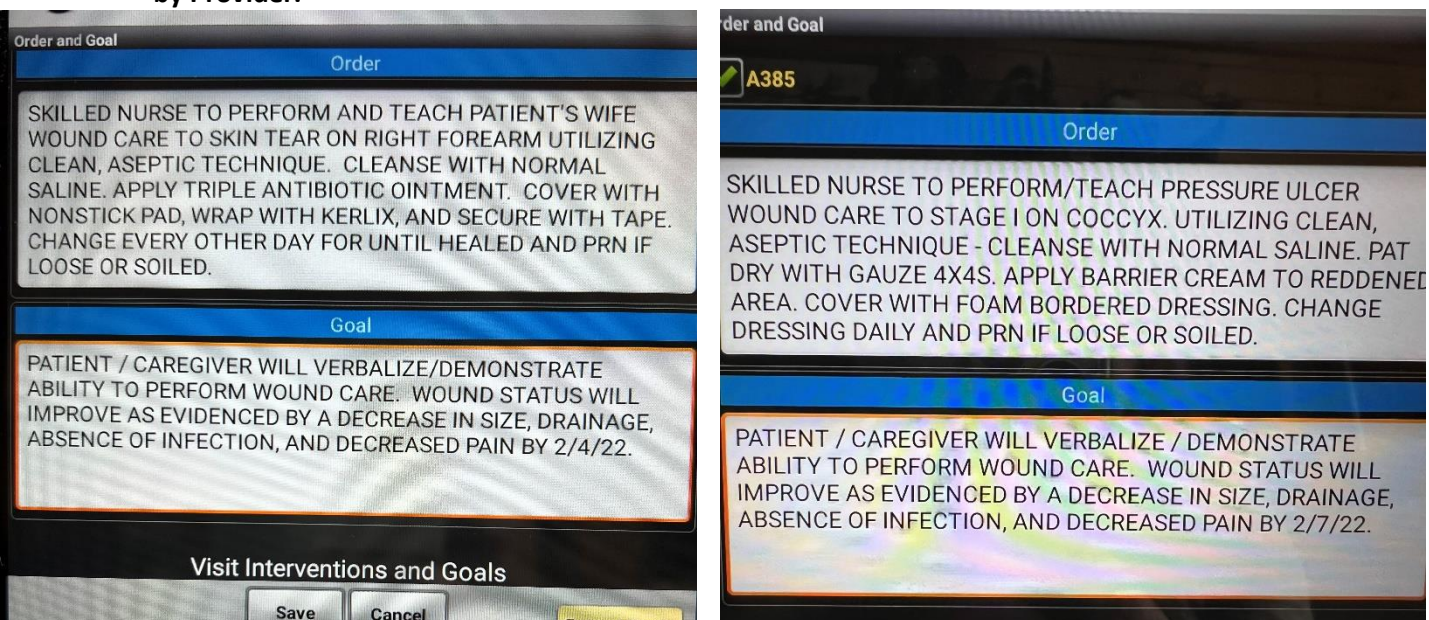
- **(1a) Scroll through Pathways. Check the box next to the Pathway: ALTERED SKIN INTEGRITY**
  - **(1b) Select NEED FOR WOUND CARE Problem Statement.**

Pathway for Home Health: > (1a) ALTERED SKIN INTEGRITY > (1b) NEED FOR WOUND CARE > choose any of the 4 options: NEED FOR PRESSURE ULCER CARE/INCISION SITE/NEGATIVE PRESSURE WOUND THERAPY/ WC NOT OTHERWISE SPECIFIED



Selecting, editing, and Saving the Wound Care Order/Pathway:

- **(1c) Edit Order text to include all 7 parts of the wound care order. Replace asterisks with the order details given by Provider.**





## Wound Care Orders and Process DETAILED STEPS Part 1 09.20.23 JO

\*\*\*ONE WOUND CARE ORDER PER WOUND\*\*\*Each wound needs to have a separate order.\*\*\*

Order text can be copied, pasted, and edited to reflect orders for each wound.

- (1d) Copy Wound Care Order text.

Once the series of pathways selections have been completed, select **Save** at the bottom.

### 2) ADD NEW WOUND(S): (Step #2 on the Quick Reference cheat sheet)

During a SOC, ROC or SCIC/Follow Up, pathways must be completed prior to documenting in wound record to ensure any new orders are available for association. However, if there are multiple wounds, you may want to add these wounds in the ICC so that the wound can be assigned a #. After all wounds are added, then go to Pathways and create each New Order with the specific wound details and # corresponding with that wound in the ICC.

- **Visit Actions > Integumentary Command Center**
- Press the “Add New” button on the bottom right.



- Specify wound location on the human body template.
- Once you have selected the appropriate wound location. You will need to complete the required sections that follow:

#### Required:

- Select a Wound Type
- Select Wound Onset Date

A screenshot of a form for documenting a wound. It has several sections: 'Selected Location:' with a dropdown menu showing 'SUBCLAVIAN, LEFT'; 'Select a Wound Type:' with a dropdown menu showing '<Choose>' and a 'Show Wound Type Reference' button; 'Select Wound Location Descriptors' with a dropdown menu; and 'Select Wound Onset Date' with a dropdown menu.

#### Optional:

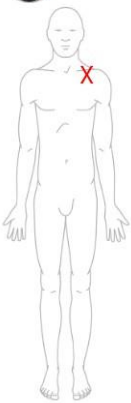
- *Show Wound Type Reference*: This will populate reference information for assistance in selecting the type of wound being documented.
- *Select Wound Location Descriptor*: Allows for additional/more specific wound location documentation

At this point, the wound has been initially recorded. Incomplete wound documentation is shown in red.

- To complete documentation, click the red text to complete the required Document section: **Orders**, Assessment, and note the **Wound Care Provided**.
- Once documentation is complete, red text turns blue.

## Wound Care Orders and Process DETAILED STEPS Part 1 09.20.23 JO

RN00 - GIBSON, APPLE



Location/Type  
#1 SUBCLAVIAN, LT - PU  
STAGE I

Onset	Visit	LxWxD (CM)	SA (SQ CM)	EXU TPE	EXU AMT	S/S INF
7/21/14						

ANTERIOR - M

Details

Add New

#1 SUBCLAVIAN, LT - PU STAGE I

Document

☐ Orders
 ☐ Assessment
 ☐ Wound Care Provided

Wound Actions

Restage Pressure Ulcer

Edit

Delete

Reports

Wound Record Report

### Required Sections:

#### Orders:

- If this is a SOC, ROC or SCIC/Follow Up visit, you must tap >>>s until you find the wound care order that was written in Pathways for wound you are documenting.

**3) Copy WC order text to the Wound Care Provided template to show the intervention performed during subsequent visits. (Step #3 on the Quick Reference cheat sheet)**

- Select **Copy** button to populate the Order into the 'Wound Care Provided' box.  
**\*\*DON'T COPY EACH ORDER INTO THE TEMPLATE BOX as you scroll through orders\*\*\*ONLY THE WC ORDER FOR THE SELECTED WOUND\*\***

## Wound Care Orders and Process DETAILED STEPS Part 1 09.20.23 JO

Select a Locator 21 Order for this Wound  
#1 LAT - MID FOREARM, RT - SKIN TEAR

<< < > >> 2/9

SKILLED NURSE TO PERFORM AND TEACH PATIENT'S WIFE WOUND CARE TO SKIN TEAR ON RIGHT FOREARM UTILIZING CLEAN, ASEPTIC TECHNIQUE. CLEANSE WITH NORMAL SALINE. APPLY TRIPLE ANTIBIOTIC OINTMENT. COVER WITH NONSTICK PAD, WRAP WITH KERLIX, AND SECURE WITH TAPE. CHANGE EVERY OTHER DAY FOR UNTIL HEALED AND PRN IF LOOSE OR SOILED.

Copy

Edit Wound Care Provided Template

Select a Locator 21 Order for this Wound  
#1 LAT - MID FOREARM, RT - SKIN TEAR

<< < > >> 2/9

SKILLED NURSE TO PERFORM AND TEACH PATIENT'S WIFE WOUND CARE TO SKIN TEAR ON RIGHT FOREARM UTILIZING CLEAN, ASEPTIC TECHNIQUE. CLEANSE WITH NORMAL SALINE. APPLY TRIPLE ANTIBIOTIC OINTMENT. COVER WITH NONSTICK PAD, WRAP WITH KERLIX, AND SECURE WITH TAPE. CHANGE EVERY OTHER DAY FOR UNTIL HEALED AND PRN IF LOOSE OR SOILED.

Copy

Edit Wound Care Provided Template

SKILLED NURSE PERFORMED AND TAUGHT PATIENT'S WIFE WOUND CARE TO SKIN TEAR ON RIGHT FOREARM UTILIZING CLEAN, ASEPTIC TECHNIQUE. CLEANSED WITH NORMAL SALINE. APPLIED TRIPLE ANTIBIOTIC OINTMENT. COVERED WITH NONSTICK PAD, WRAPPED WITH KERLIX, AND SECURED WITH TAPE.

### 4) CHANGE the verbiage of wound care order to reflect PAST tense. (Step #4 on the Quick Reference cheat sheet)

- \* This is created with the Order and is NOT editable on subsequent visits.
- \* Reflects the intervention performed **ed** each visit.
- \* Don't change in any other way since this correlates with the order received from Provider.
- **You must change the tense of this text to past tense** so that documentation will read correctly when wound care is provided on future visits.

Assessment: Complete all assessment items in this section. When you complete this section, a "WAT" (Wound Assessment Tool) score will generate. If the wound is not assessed, click "Not Assessed" and enter the reason most applicable.

**Wound Care Provided:** The purpose of this section is to document patient response and any additional details in regards to the wound care provided. The order text verbiage that was changed into past tense will populate into the upper, un-editable portion.

Optional Sections:

- Wound Actions: Here you can make edits to the existing wound
- Reports: This will display any past assessments that were done on the patient.

### 5) Add Wound Care Supplies – (Step #5 on the Quick Reference cheat sheet)

Visit Actions >Plan of Care Supplies/DME

### 6) Add Medications (include topical ointments, barrier creams, etc.) – (Step #6 on the Quick Reference cheat sheet)

Visit Actions >Client Meds

### 7) Add Calendar (assign Buddy Codes to visits if needed) – (Step #7 on the Quick Reference cheat sheet)

Visit Actions >Client Calendar

**STEPS WHEN CREATING NEW WOUND & WOUND CARE ORDERS ON SUBSEQUENT VISITS:**

*Details and Screenshots:*

**1) GO TO THE ICC AND ADD WOUND (Step #1 on the Quick Reference cheat sheet)**

- Press the “Add New” button on the bottom right. (see screenshots in previous process)
- Specify wound location on the human body template.
- Once you have selected the appropriate wound location. You will need to complete the required sections that follow:

**Required:**

- Select a Wound Type
- Select Wound Onset Date

**Optional:**

- *Show Wound Type Reference:* This will populate reference information for assistance in selecting the type of wound being documented.
- *Select Wound Location Descriptor:* Allows for additional/more specific wound location documentation
- At this point, the wound has been initially recorded. Incomplete wound documentation is shown in red.
- To complete documentation, click the red text to complete the **Orders**, Assessment, and note the **Wound Care Provided**. Once documentation is complete, the red text will turn blue.

**Orders:** A wound care order can be added by someone in Back Office but usually a new wound care order needs to be written, select “Associate New Order” below and write the new wound care order.

**2) ASSOCIATE NEW ORDER TO WOUND (Step #2 on the Quick Reference cheat sheet)**

Select Wound to Document: Orders. Select “Associate New Order”

- a. Choose Order Type: **Plan of Care Update Order**
  - b. Populates Warning: By selecting this order type, you will be required to complete the pathway that updates the plan of care. Do you want to proceed?
  - c. Select UPDATE POC. All Pathways will be displayed.
  - d. Select ALTERED SKIN INTEGRITY
  - e. Change from No to YES. Secondary Problem Statements will display.
  - f. NEED FOR WOUND CARE. Choose YES.
  - g. Scroll through other Pathways by selecting Next tab at the bottom. Save.
  - h. Under Order Instructions. Choose View Instructions.
  - i. Scroll through Pathways on POC using > tab, until you get to the Wound Care Pathway. Check the box above Order Text.
  - j. Edit Order Text to include all 7 parts of the wound care order. Replace asterisks with the order details given by Provider. \*\*\*If there are multiple wounds, each wound needs to have a separate order\*\*\* This order text can be copied, pasted, and edited for each wound.
  - k. Edit Goal Text to be specific to patient.
  - l. View all orders by using > tab. At the end of orders, Select Save.
  - m. Populates List of Orders, Select Wound Care Order on List.
- 3)** Wound Care Order is populated into the Wound Care Provided template. Edit the displayed order to create a Wound Care Provided Template; used to show wound care provided for this and subsequent visits unless/until the order has changed. **(Step #3 on the Quick Reference cheat sheet)**
- 4) CHANGE** the tense of this text to past tense so that documentation will read correctly when wound care is provided on future visits. **(Step #4 on the Quick Reference cheat sheet). Select SAVE.**

## Wound Care Orders and Process DETAILED STEPS Part 1 09.20.23 JO

Edit the displayed order to create a Wound Care Provided template.

This template will be used to document wound care provided for this and subsequent visits unless / until the order has changed.

SKILLED NURSE PERFORMED WOUND CARE TO STAGE II PRESSURE ULCER ON COCCYX USING CLEAN/ASEPTIC TECHNIQUE. CLEANSSED WITH NORMAL SALINE. APPLIED SKIN PREP TO PERIWOUND AND SMALL AMOUNT OF MEDIHONEY TO SLOUGH-COVERED WOUND BED. COVERED WITH 4X4 FOAM DRESSING.]

Save Discard

< THE CHANGE THIS IT ...

1 2 3 4 5 6 7 8 9 0 Del

Q W E R T Y U I O P

A S D F G H J K L

↑ Z X C V B N M , ! . ? ↓

Ctrl i#1 English (US)

After editing, Select Save.

You will then be directed to Indicate Additional Wound Details Including Patient Response. This is your opportunity not to repeat that the wound care was provided as ordered but how the patient responded to the wound care and document other details related to wound or care.

#1 MED - COCCYX - PU STAGE II

**Wound Care Provided:**

SKILLED NURSE PERFORMED WOUND CARE TO STAGE II PRESSURE ULCER ON COCCYX USING CLEAN/ASEPTIC TECHNIQUE. CLEANSSED WITH NORMAL SALINE. APPLIED SKIN PREP TO PERIWOUND AND SMALL AMOUNT OF MEDIHONEY TO SLOUGH-COVERED WOUND BED. COVERED WITH 4X4 FOAM DRESSING.

**Indicate Additional Wound Details Including Patient Response:**

Save Cancel

#1 MED - COCCYX - PU STAGE II

**Wound Care Provided:**

SKILLED NURSE PERFORMED WOUND CARE TO STAGE II PRESSURE ULCER ON COCCYX USING CLEAN/ASEPTIC TECHNIQUE. CLEANSSED WITH NORMAL SALINE. APPLIED SKIN PREP TO PERIWOUND AND SMALL AMOUNT OF MEDIHONEY TO SLOUGH-COVERED WOUND BED. COVERED WITH 4X4 FOAM DRESSING.

**Indicate Additional Wound Details Including Patient Response:**

PATIENT PRE-MEDICATED 30 MINUTES PRIOR TO WOUND CARE; TOLERATED WOUND CARE WELL; REPORTS PAIN LEVEL 0 OUT OF 10 ON PAIN SCALE. NO CONCERNS WERE NOTED OR REPORTED.

Save Cancel

< REPORTED REPORTS REPORTEDLY REPORTER ...

1 2 3 4 5 6 7 8 9 0 Del

Q W E R T Y U I O P

A S D F G H J K L

↑ Z X C V B N M , ! . ? ↓

Ctrl i#1 English (US)



**5) ADD WOUND CARE SUPPLIES (Step #5 on the Quick Reference cheat sheet)**

- a. Add New order.
- b. Add Order description (i.e. Wound Care Supplies Added)
- c. Scroll to bottom and click Supplies.
- d. Add all supplies needed to order.

**6) ADD MEDICATIONS (Step #6 on the Quick Reference cheat sheet)**

- a. Add New order.
- b. Add Order description (i.e. Add Medications used for Wound Care ....)
- c. Scroll to bottom and click Add Medications.
- d. Add all medications needed to order.

**7) ADD VISITS TO CALENDAR & BUDDY CODES IF NEEDED (Step #7 on the Quick Reference cheat sheet)**

- a. Add New order.
- b. Add Order description (i.e. SNV increased to 3x week for wound care)
- c. Scroll to bottom and click Add Medications.
- d. Add all medications needed to order.

**Wound Care Supplies, Medications, and Calendar can be added to the same Order.**

**STEPS WHEN DISCONTINUING WOUND CARE ORDERS:**

- 1) Go to ICC and select Wound.
- 2) Following Document section, under Wound Actions, Choose Inactivate.
- 3) After selecting "Inactivate", select a reason from the list.
- 4) New Order: Plan of Care Update Order
  - a. Warning: By selecting this order type, you will be required to complete the pathway that updates the plan of care. Do you want to proceed?
  - b. Select UPDATE POC. All Pathways will be displayed.
  - c. Select ALTERED SKIN INTEGRITY
  - d. Change from Yes to NO.
  - e. End NEED FOR WOUND CARE Problem Statement. Save.
- 5) Discontinue Wound Care Supplies in Order.
- 6) Discontinue Medications from Wound Care in Order.
- 7) Update Calendar and remove Buddy Codes, if needed, in Order.



## ADDITIONAL TIPS:

### *How does the order, Pathway, and ICC work together?*

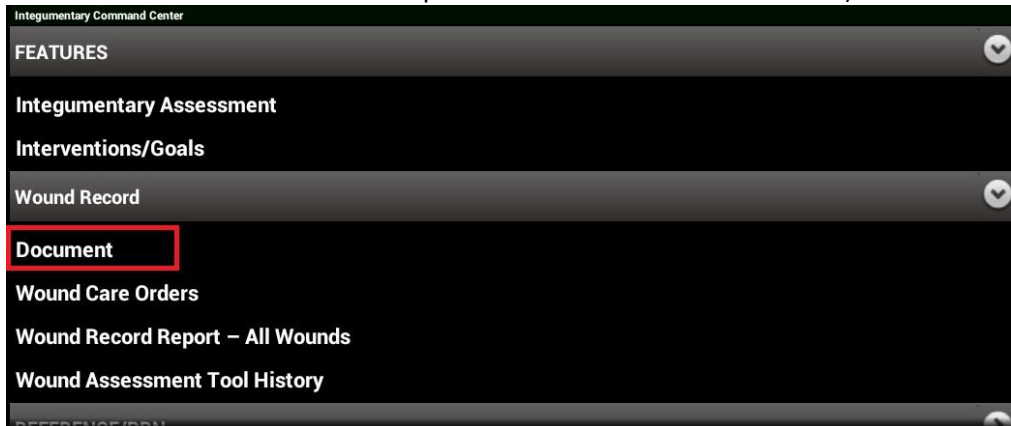
- Pathways develop your orders.
- In the ICC, when you choose wound-related pathways, you select them as your wound orders under the ICC Order section to designate your wound orders.
- From there, you develop intervention-like text to guide your clinicians as to what to do each visit in regards to wound orders. (Wound Care Provided)
- It is a manual process to choose the specific wound orders, but the system allows you to associate the orders with your wounds.

### Integumentary Command Center (initial screen) has 4 main sections:

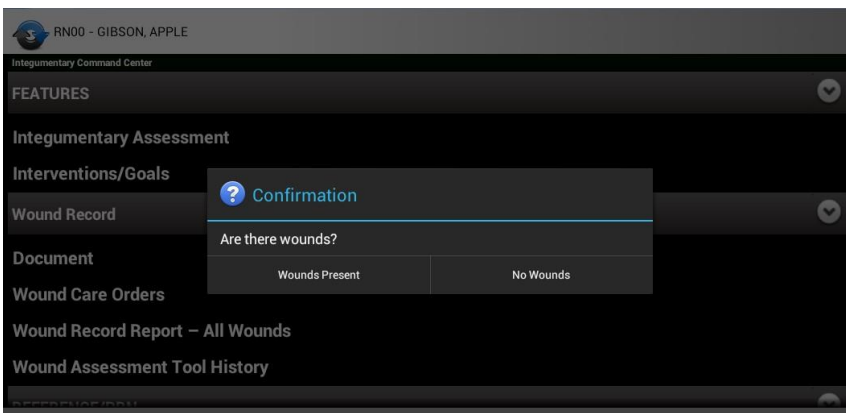
1. Features
2. Wound Record (required)
3. Reference/PRN
4. Other

### Required Sections:

**Wound Record:** Wound documentation (for both new and existing wounds) **must** be completed in the “Document” section. (You will also find access to wound care orders and past assessments in the links below).



**NOTE:** In a start of care visit, regardless of whether the patient has a wound, the following question must be answered after hitting “Document:”



### Optional Sections:

The remaining 3 sections provide quick links to other sections outside of the ICC, which include:

- **Features:** Includes a link to the integumentary assessment completed within the physical assessment, as well as a quick link to the interventions and goals section.
- **Reference/PRN:** This section provides quick links to the patient’s medical record and the section for infection control documentation.

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- *Other*: This section provides a quick link to both supply requisitions and deliveries for the patient.

### INACTIVATING/REACTIVATING AND RESTAGING/EDITING WOUNDS:

Since this wound was created in a previous visit, there will not be an option to delete the wound. A wound may be inactivated or restaged if applicable during a visit.

#1 HEEL, LT - PU STAGE II

Document

- ☒ Orders
- ☒ Assessment
- ☒ Wound Care Provided

Wound Actions

**Inactivate**

Restage Pressure Ulcer

Reports

Wound Record Report

**Inactivate** – An existing wound may be inactivated if treatment is no longer needed. After selecting “Inactivate”, select a reason from the list:

RN11 - COLORS, JACOB

#1 HEEL, LT - PU STAGE II

Document

- ☒ Orders
- ☒ Assessment
- ☒ Wound Care Provided

Wound Actions

Inactivate

Restage Pressure Ulcer

Reports


Wound Record Report

**Inactivate Wound Reason**

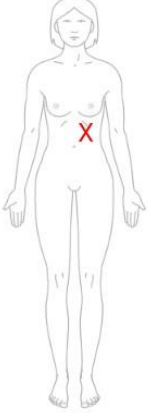
ACTIVATED IN ERROR
COMPLETELY EPITHELIALIZED
HEALED
NO FURTHER ORDERS
NO LONGER BEING TREATED
OBSERVATION ONLY
OCCLUDED BY DRESSING / DEVICE
PRIMARILY CLOSED
REFUSED CARE
DISCHARGED

Select the applicable reason. Please note that the reason “healed” will be disabled for stage three or four pressure ulcers. Any inactivated wound will no longer show in the wound summary. To display inactive wounds, select “Menu” button, then “Show Inactive Wounds” button.

## Wound Care Orders and Process DETAILED STEPS Part 1 09.20.23 JO

 RN11 - DECLINE, DANIELLE

Location/Type	Onset	Visit	LxWxD (CM)	SA (SQ CM)	EXU TPE	
#2 ABDOMINAL LT UP QUAD - PU STAGE I	7/23/14					Show Inactive Wounds




ANTERIOR - F

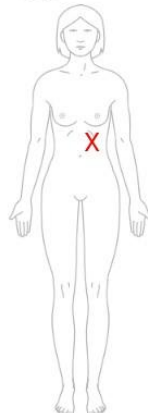
Details

Add New

Inactivated wounds will show in wound summary including the date the wounds were inactivated. To hide inactive wounds, select “Menu” button, then “Hide Inactive Wounds”.

 RN11 - DECLINE, DANIELLE

Location/Type	Onset	Visit	LxWxD (CM)	SA (SQ CM)	EXU TPE	
#1 HEEL, LT - PU STAGE II	5/30/14	5/29/14	1x2x0.5	2	SEROSANG	Hide Inactive Wounds
#2 ABDOMINAL LT UP QUAD - PU STAGE I	7/23/14					




ANTERIOR - F

Details

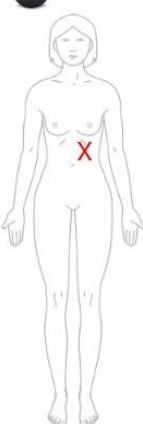
Add New

**Reactivate** – Once a wound has been inactivated, it can be reactivated again. From the wound summary table, select “Menu” then “Show Inactive Wounds”. Select the wound to be reactivated.

## Wound Care Orders and Process DETAILED STEPS Part 1 09.20.23 JO

 RN11 - DECLINE, DANIELLE

Location/Type	Onset	Visit	LxWxD (CM)	SA (SQ CM)	EXU TPE	EXU AMT	S/S INF
#1 HEEL, LT - PU STAGE II	5/30/14	5/29/14	1x2x0.5	2	SEROSANG	SMALL	NO
#2 ABDOMINAL LT UP QUAD - PU STAGE I	7/23/14						



ANTERIOR - F
 Details
Add New

Select "Reactivate" from the wound actions. Select a reason from list.

 RN11 - DECLINE, DANIELLE

#1 HEEL, LT - PU STAGE II [Inactivated 7/23/14]

**Wound Actions**

**Reactivate**

**Reports**

**Wound Record Report**

The following reasons will prompt for physician notification (based on set up of wound reasons):

- New Order
- Recurrence

Historical wounds are retained as inactive and wound numbers continuously increment for subsequent episodes and admissions. The message below will display within the wound record in PointCare.



**Integumentary Assessment**

**Interventions/Goals**

Wound Record

Document

Wound Care Orders

Wound Record Report – All Wounds

Wound Assessment Tool History

REFERENCE/PRN

OTHER

Historical wounds are retained as inactive and wound numbers continuously increment for subsequent episodes and admissions.

**Edit** – If a wound is created during a visit, users have the ability to edit the wound location, type, onset date, and descriptors.

#2 ABDOMINAL LT UP QUAD - PU STAGE I

**Document**

☐ Orders

☐ Assessment

☐ Wound Care Provided

**Wound Actions**

Restage Pressure Ulcer

**Edit**

Delete

**Reports**

Wound Record Report

**Restage Pressure Ulcer** – Pressure ulcers may be restaged if active. Select “Restage Pressure Ulcer.” Select the restage wound reason from list.

#2 ABDOMINAL LT UP QUAD - PU STAGE I

**Document**

☐ Orders

☐ Assessment

☐ Wound Care Provided

**Wound Actions**

Restage Pressure Ulcer

**Edit**

Delete

**Reports**

Wound Record Report

Restage Wound Reason

DETERIORATED

ERROR IN STAGING

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Select the new wound type from list. Pressure ulcers cannot be reverse-staged.

The screenshot shows a software interface for wound care. At the top, it says "#2 ABDOMINAL LT UP QUAD - PU STAGE I". Below this is a "Document" section with three checkboxes: "Orders", "Assessment", and "Wound Care Provided". To the right of these checkboxes is a dropdown menu that is currently open, showing the text "Select the new wound type" in blue. Below this text are three options: "PRESSURE ULCER STAGE II", "PRESSURE ULCER STAGE III", and "PRESSURE ULCER STAGE IV". To the left of the dropdown menu, there are several buttons: "Wound Actions", "Restage Pressure Ulcer", "Edit", "Delete", "Reports", and "Wound Record Report".

The wound summary table in Wound Summary Report will now show the restaged wound.

At discharge, all active wounds will be inactivated with an inactivation reason of "Discharged".

Historical wounds are retained as inactive. Wounds previously inactivated will be hidden by default, but available to be reactivated if necessary. Wound numbers continuously increment for subsequent episodes and admissions.