Wound Nurse Notes

Wound Nurse Access

Clicking the Wound Nurse button from the Nursing Access screen opens the Wound Nurse Access screen.

Wound Nurse	Charting	Chart Review	Reports	PUSH Graphs	
Nurse Menu	Pressure Injury Assessment	View Chart	Wound Report	PUSH Scores Area 1	PUSH Scores Area 6
	Non-Pressure Wound Assessment		In House Acquired Wounds	PUSH Scores Area 2	PUSH Scores Area 7
	Braden/Norton Assessment		CNA - Meal Intake Review	PUSH Scores Area 3	PUSH Scores Area 8
	Skin Care Plan		Braden/Norton Report	PUSH Scores Area 4	PUSH Scores Area 9
			More Reports	PUSH Scores Area 5	PUSH Scores Area 10

Charting

1. Click onto a button underneath the charting column.
2. On the Name Selection screen, select a name, click OK.
3. A two-way split screen will display. The top portion is the Write screen which is where the user may develop their note. The bottom portion is a view screen which displays potentially useful documentation as the user completes their charting.
4. Work from left to right, clicking onto relevant items, and free typing where necessary.

Pressure Injury Assessment: Each new pressure area needs to be documented utilizing a separate AREA word. This is so that each area is tracked separately with the PUSH scoring tool and can be monitored as it improves/declines.

Non-Pressure Wound Assessment: Each new non-pressure area needs to be documented utilizing a separate AREA word. This is so that each area is tracked separately and can be monitored as it improves/declines.

Braden/Norton Assessment: This will default to load the Braden Assessment, however, if your facility utilizes Norton, this can be switched to be the default one loaded. Or a user may click onto ^Norton Scale to access that assessment.

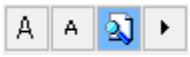
Skin Care Plan: Be sure to check the defined review screen (bottom portion of the split screen) to see if there is already a skin care plan in place on this specific name. Feel free to add in a new care plan or edit the existing one.

View Documentation

1. From the Wound Nurse Access menu, click onto the View Chart button.
2. Select name(s) and click OK.
3. Select more than one resident by holding the CTRL key on the computer keyboard.
    a. If a Control screen appears, put in a start, and end date and click OK.
        i. Click Go at the top of the view screen to retrieve the notes in the specified date range.
4. When finished viewing, click Exit, which will take the user back to the Activities Access menu.

Allows a user to select any documentation within the records granted rights to view. Click Topic or Task to choose the area of the chart to be viewed. Click Control to select a start and end date. Click the Look tab to select other options to view (*i.e.,* show names of initials, topic name, cosign, or free text highlighter). Once all options have been selected, click OK and then Go to retrieve the requested information.

- Adjust the font size by clicking More… and clicking on the big or little "A."
- Search for words within the view screen by clicking More… and onto the magnifying glass symbol. Type in the text to be searched and click OK. This feature will search both words that were clicked on within a topic as well as free text.



    - Click the arrow to the right of the search feature to have it bring you to the next found word.
- Control button > Filter Tab
    - *D/C'd Entries* – Displays all discontinued entries.
    - *Users* – Use this to narrow down the charting being viewed based on the user(s) who entered it in. This is a great tool for auditing specific user(s) charting.
    - *Free Text* – Allows the user to search within the charting on the view screen for a specific free typed word. If wanting to search through all the fall notes for a specific caregiver's name, simply enter the name in the Free Text box, click OK and Go.
- Control button > Look Tab
    - *Separator* – For ease of viewing, the user may choose to add lines/spaces between entries or topics.
    - *Order* – Allows the user to determine the order in which the entries display on the screen.

- *Show Name of Initials* – Displays the full name and title of the person who entered/discontinued each entry.
- *Free Text Highlighter* – Used frequently in troubleshooting as it will turn all free text on the view screen blue.
- *Show Topic Name* – Displays the topic that the entry was documented in.

Edit Assessments/Notes

1. Follow steps above for *View Documentation*.
2. Click the entry that needs to be edited. The entry will turn red. This is called 'tagging' the entry.
3. Click **Edit**.
4. Click the desired editing feature.
5. When using Append, DC and Explain, or DC and Copy, make the desired change and then click **Next**.
6. Click **Go** to see your changes.

Editing features which are bolded are utilized most often in Social Services Documentation.

Editing Feature	Function	Example
Append / Append All	Information is permanently attached to the entry; further editing will not be able to be done to the entry except to discontinue	Cosigning a student's documentation
New	A new, separate entry made in the same topic area	Can be used to add a new discipline approach to a care plan for example
Copy	An exact copy of the entry is made	An entry was accidentally discontinued and needs to be made active again
Copy One (All) to Other Client[s]	An exact copy of the entry is made and placed in another resident's chart	An entry was accidentally made in the wrong resident's chart. Use ALL if more than one entry was selected
Discontinue and Append	**Entry is discontinued and user is taken to a Write screen to document additional notes**	**An error was made in documenting the entry and the user would like to explain why the entry is being discontinued**
Discontinue and New	Entry is discontinued, a new entry is made in its place	Not typically used when editing department notes
Discontinue and Copy	**Entry is discontinued, copy of entry is displayed allowing user to make changes to the original entry**	**User forgot to use a button word when documenting and would like to 'insert' the word into the entry**
Discontinue	Entry is discontinued	Not typically used when editing department notes

Discontinue All	All highlighted entries are discontinued for one client	Not typically used when editing department notes
Discontinue Multiple Client Entries	All highlighted entries are discontinued for multiple clients	Not typically used when editing department notes
Skip	Allows user to skip a highlighted entry	Highlighted an entry that does not need editing

View/Print Reports

1. From the Wound Nurse Access menu, click the desired report button under the **Reports** column.
2. From the Name Selection screen, select the desired name(s) and click **OK**.
3. Select more than one resident by holding the **CTRL** key on the computer keyboard.
4. Choose the appropriate date range if prompted to do so.
5. The report preview appears.
6. Click the printer icon in the upper left corner to print.
7. Click **Close** to return to the Activities Access menu.

Wound Report: Displays all documentation related to wound development and healing for the selected date range. This report will display all wounds, whether they were in-house acquired or not.

In House Acquired Wounds: This report displays only in-house acquired wounds for the selected date range. The wound, onset date, stage, and condition will display.

CNA – Meal Intake Review: Displays the last five days of meal intakes for breakfast, lunch, and dinner. This information populates based on CNA documentation.

Braden/Norton Report: The user will first be prompted to select whether they need to view the Braden on Norton. Once that is selected, input the date that the assessment was completed (or a general date range if unsure of the exact date).

More Reports: Displays all reports available within the system that the user has rights to. The user may select any report to view and click **OK.**

PUSH Graphs

The **PUSH Graph** buttons will load a graph on the resident's pressure injury areas. These reports are only for pressure injuries and will not display anything in relation to non-pressure wounds.