

# DOCUMENTATION REFERENCE CARD

## PRESSURE ULCERS

### Documentation Considerations

- Review and document:
  - History
  - Comorbid conditions & risk factors
  - Nutritional intake/status: Dietary consult
  - Medication(s)
- Document the condition of the skin (i.e. Skin integrity and bony prominences) in the Physical Exam
- Review and incorporate pertinent findings:
  - Lab tests - PE outcome, Serum albumin & CBC
  - Functional Assessment: Braden Scale, Norton Scale

**Note:** Documentation is acceptable from a non-physician practitioner (i.e. wound care nurse). HIPAA appropriate photography encouraged.

### Diagnosis Considerations

- Documentation MUST specify “pressure” and include:
  - Site
  - Severity
  - Laterality
  - Stage
    - **Stage 1:** Skin changes, Non-blanchable erythema
    - **Stage 2:** An abrasion, blister & Partial thickness skin loss involving dermis and epidermis
    - **Stage 3:** Full thickness skin loss involving damage & necrosis to subcutaneous tissue
    - **Stage 4:** Full-thickness tissue loss, necrosis of soft tissues through underlying muscle, tendon, bone
    - **Deep Tissue Damage:** Etiology is pressure and/or ischemia and may resolve without tissue loss
    - **Unstageable:** Based on clinical documentation stage undetermined

### Additional Considerations

- Document the type & efficacy of treatment:
  - Management of underlying medical conditions
  - Appropriate pressure -relieving support surfaces
  - Dressings
  - Wound debridement:
    - Autolytic debridement
    - Surgical debridement
    - Mechanical debridement
    - Wet to dry dressings
    - Wound irrigation
  - Electric Stimulation
  - Education of Family/Care takers
  - Promotion of a healing environment
  - Review identification of early signs of pressure ulcer formation

