



Wound management module

Self teach guide – March 2018

Learning outcome

The user will understand how to complete, view and monitor wound(s) from the **Wound Management Module**.

The Wound Management option is only available when in the interRAI Long Term Care software.

This is an optional, self-directed learning module.

Introduction

The **Wound Management Module** for a resident can be accessed from the 'History and Physical' menu on the left of the screen when viewing the resident 'Resident Overview' page:

The screenshot shows the 'MOMENTUM HEALTHCARE' logo at the top left. The main title is 'Resident Overview'. Below the title are navigation links: 'Home | Help | Logout'. There are tabs for 'Resident Search', 'Resident Overview', 'ADT', 'Forms', 'Care Plan', and 'MDS'. The 'Resident Overview' tab is active. On the left, there is a list of menu items: 'Common Tasks', 'ADT', 'Assessments/Forms', 'Care Plan', 'Demographics', 'History And Physical', 'Diagnoses', 'Allergies', 'Infection Precautions', 'Advance Directives', 'Diet', 'Vital Signs and Monitoring', 'End of Life Instructions', 'Wound Management' (highlighted with a red box), 'Risk Management and Safety', 'MDS', and 'Progress Notes'. The right side of the screen displays resident information for 'Anne, Brown (Sister)', including 'Likes to be called', 'Allergies', 'Primary Diagnoses', 'Advance Directives', 'Providers', and 'Primary Contact'.

Understanding and using the Wound Management Module

The module can be used to assist the assessor to document and track a resident's wound(s) from initial identification, until it is resolved. A wound location can be charted, with multiple wound details as required, for a resident.

It also establishes basic skin information which can be drawn into the assessment in 'Section L'.

The **Wound Detail** page opens to add your wound information:

Your wound will then have a number (shown below).

If you want to add a note about the wound, click the 'file' icon next to the wound number.

Return

Add Error Out Show History

No.	Date Identifi...	Wound Type	Description	Date Resolved
2	22/11/2016	Bite/sting	Sitting out in...	
	26/11/2016	Laceration	Walking thro...	

4. Click on the folder icon next to review the required wound number

Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Wound Details

Return Save & Return Save Cancel

No. 1

Date Identified 26/11/2016

Date Resolved

Acquired Community

Wound Type Laceration

Wound Stage Area of persistent skin redness

Co-morbidities COPD, Diabetic, Obesity

Description Walking through a doorway, was knocked by another person and hit her shoulder on the door. There is a small skin tear.

Entered By: Wheeler, ...

Entered Date: 26/11/2016

Last Modified By: Wheeler, ...

Last Modified Date: 26/11/2016

5. Select **Add** to complete additional notes for this wound


Wound Assessments

Add Error Out

Assessment Date / Time	Wound Size (L W D)	Exudate type	Current wound stage	Pain intensity
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Scroll down the **Edit Wound Assessment** page to find the sub heading **Treatment**

Treatment

Treatment 

Notes









Add New Note



Photo

Wound Assessment History

Authorized By	Discipline	Effective Date	Category	Status	Text
(All)	(All)		(All)	(All)	
Wheeler, Lynda	Case Coordinator	25/09/2017 05:33...		Draft	


Wound Assessment Details

 Add New Note  Copy  Delete  Save & Return  Save  Save as Draft  Return  Print

Effective Date  

Category

Include in Shift Report ☐

Entered by Entered for  Associated Focus

6. You can add notes about the wound in this field.

The screenshot shows the 'Wound Assessment Details' form. The 'Category' dropdown menu is open, displaying a list of options. 'Wound tracking' is highlighted in yellow. A red box surrounds the 'Wound tracking' option, and a callout box points to it with the text: '7. Select **Wound Tracking** from the **Category** drop down list'.

Wound Assessment Details

Effective Date: 25/09/2017 05:33 PM

Entered by: Wheeler, Lynda

Entered for: Wheeler, Lynda

Wound is moist with epithelial tissue present, healing w

Category: -- Please select an item --

- Allied Health
- Care Plan
- Client/family contact
- Falls tracking
- Level of care changes
- Medical correspondence
- Providers
- Record administration
- Registered nurse
- Review
- Service coordination
- Transfers
- Wound tracking**

At your next interRAI LTCF assessment, if you **click on Update MDS values in Section L of the MDS**, your wound data will update in this new assessment. When you **click on Save or Save & Return** this message will appear:

The screenshot shows the 'Fill out a Form' interface. The 'Wound Management' section is active, and the 'Update MDS values' button is highlighted. A 'Message from webpage' dialog box is displayed, stating: 'Data element answers will be overwritten. Press OK to continue, or Cancel to stop the retrieval of data.' The dialog box has 'OK' and 'Cancel' buttons.

Fill out a Form

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs

Return to Summary Save as Draft Check Errors Mark Complete Print Prev Next Section Help

Completed By: Title

SECTION L: SKIN CONDITION

Wound Management

Update MDS values

1 MOST SEVERE PRESSURE ULCER

0. No pressure ulcers

1. Any area of pressure

2. Partial loss of skin layers

3. Deep craters in the skin

4. Breaks in skin exposing muscle or bone

5. Not codeable, e.g., necrotic eschar predominant

Message from webpage

Data element answers will be overwritten. Press OK to continue, or Cancel to stop the retrieval of data.

OK Cancel

When you **click on OK**, the information from the **Wound Management** section (on the **Resident Overview** screen), will auto-populate the answers to the questions of 'wound stage' and 'type'.

Modify a wound assessment

1. Once assessments have been completed, the information cannot be modified. If you need to add further information about this assessment, you can add a new note.
2. To add a note to an existing assessment, select the assessment you want to edit. The *Edit Wound Assessment* page opens. Scroll down the page to find **Add New Note**

Pain Assessment

Pain frequency: Exhibited daily on last 3 days

Pain intensity: Severe

Consistency of pain: No Pain

Pain control: No issue of pain

Contributing Factors

Systemic factors affecting healing: Incontinence

Environmental factors that may affect healing/cause: Mobility limitations

Treatment

Treatment: wqewewre

Notes

08/03/2017 (Draft)

Add New Note

The Wound Assessment Details note page opens:

Wound Assessment History

Authored By	Discipline	Effective Date	Category	Status	Text
{All}	{All}		{All}	{All}	
Allen, Richard (Mr.) LT...	Administrator	08/03/2017 01:49 PM		Draft	
Allen, Richard (Mr.) LT...	Administrator	08/03/2017 01:58 PM		Draft	

Wound Assessment Details

Effective Date: 08/03/2017 01:58 PM

Entered by: Allen, Richard (Mr.) LTC System Clinician

Entered for: Allen, Richard (Mr.) LTC System Clinician

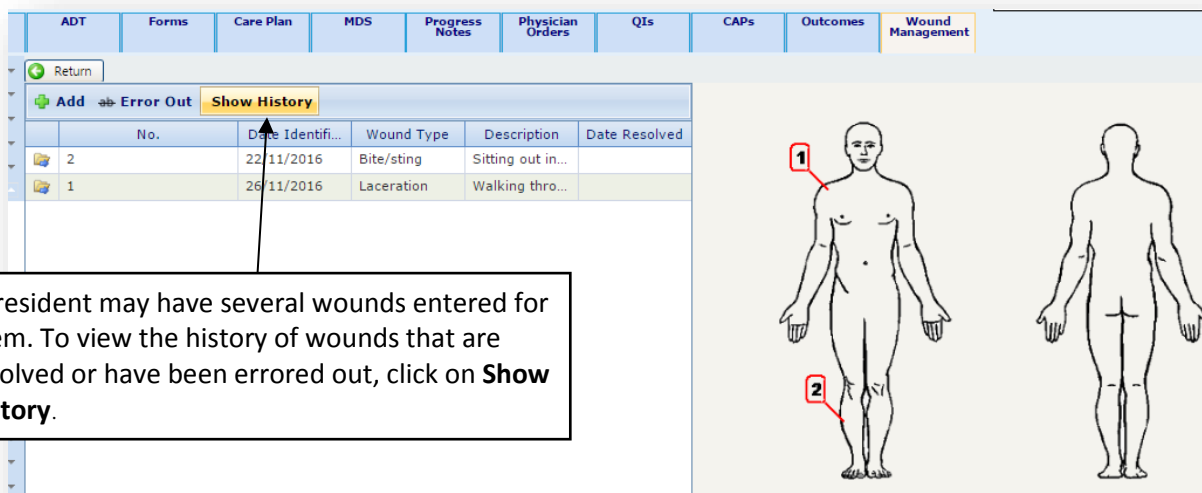
Category: -- Please select an item --

Include In Shift Report: ☐

Associated Focus: -- Please select an item --

Select **add** to complete additional notes for this wound

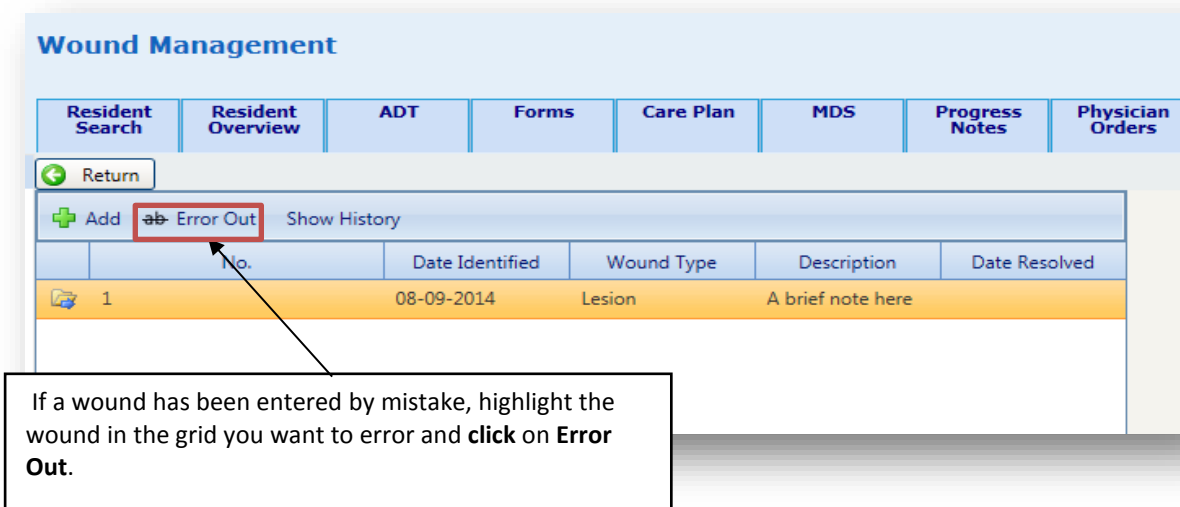
Wound history



The screenshot shows the 'Wound Management' module interface. At the top, there is a navigation bar with tabs: ADT, Forms, Care Plan, MDS, Progress Notes, Physician Orders, QIs, CAPs, Outcomes, and Wound Management. Below this, there is a 'Return' button and a table with columns: No., Date Identified, Wound Type, Description, and Date Resolved. The table contains two entries: one with No. 2, Date Identified 22/11/2016, Wound Type Bite/sting, and Description Sitting out in...; and another with No. 1, Date Identified 26/11/2016, Wound Type Laceration, and Description Walking thro... To the right of the table are two anatomical diagrams of a human body, one front view and one back view. Red boxes with numbers 1 and 2 are placed on the diagrams, indicating wound locations. A callout box points to the 'Show History' button in the table header.

A resident may have several wounds entered for them. To view the history of wounds that are resolved or have been errored out, click on **Show History**.

To error out wounds



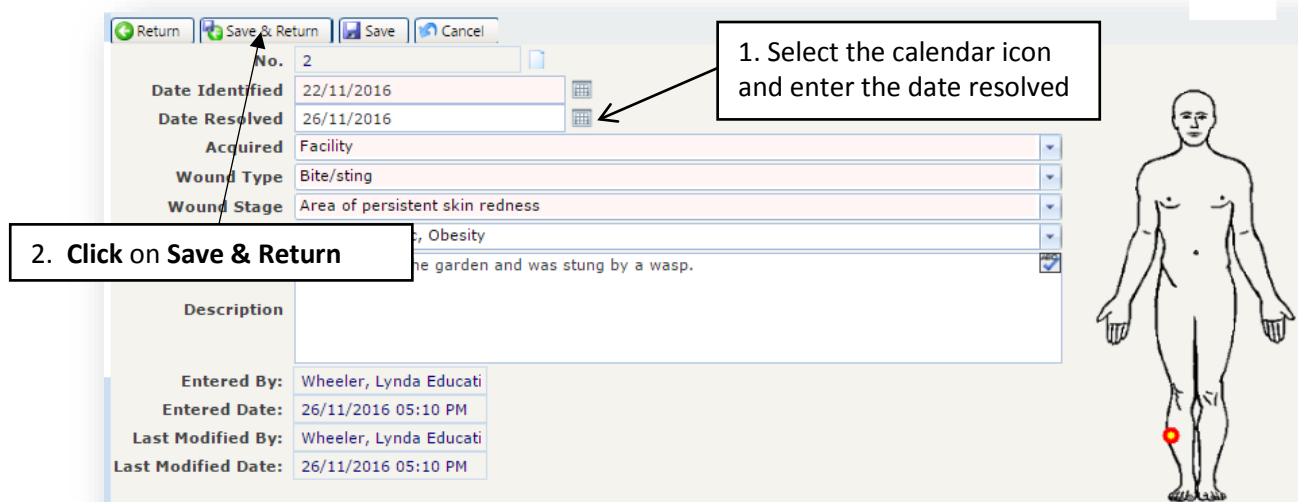
The screenshot shows the 'Wound Management' module interface. At the top, there is a navigation bar with tabs: Resident Search, Resident Overview, ADT, Forms, Care Plan, MDS, Progress Notes, and Physician Orders. Below this, there is a 'Return' button and a table with columns: No., Date Identified, Wound Type, Description, and Date Resolved. The table contains one entry: No. 1, Date Identified 08-09-2014, Wound Type Lesion, and Description A brief note here. To the right of the table is an anatomical diagram of a human body. A red box highlights the 'Error Out' button in the table header. A callout box points to the 'Error Out' button.

If a wound has been entered by mistake, highlight the wound in the grid you want to error and **click on Error Out**.

If you have designated a wound site on the diagram, it will no longer appear on the diagram. Any notes that have been created for this episode will be displayed with a strikethrough in the entry and in the progress notes section.

Note: The errored-out wounds will appear in the list when you click **Show History**.

For resolved wounds

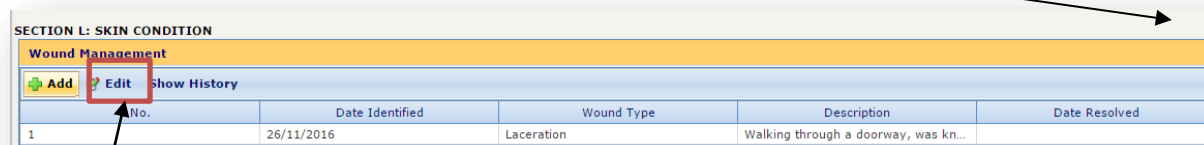


1. Select the calendar icon and enter the date resolved

2. Click on Save & Return

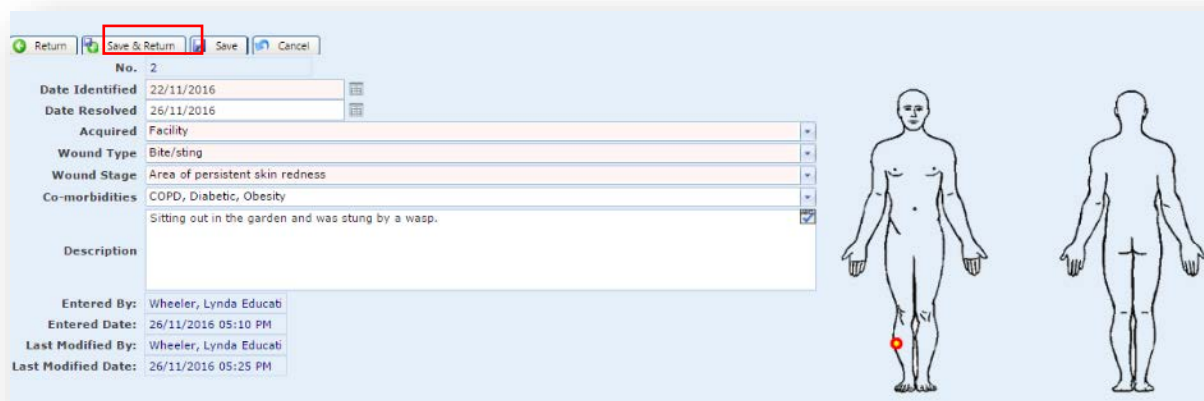
Reviewing the Wound Management Module

You can review a resident's wound(s) within the 'Section L – Skin Condition'. To do this you need to click on the arrow on 'Wound Management' bar.



Then select

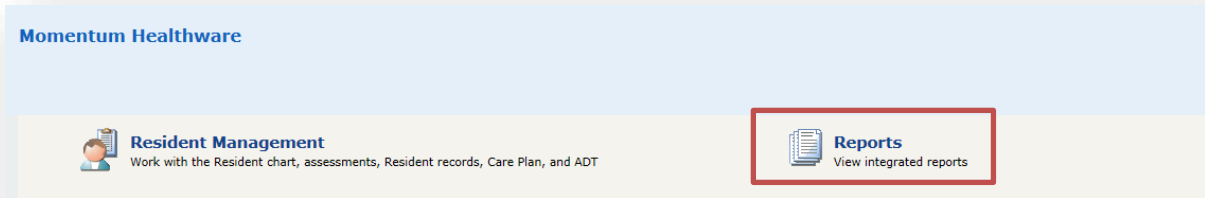
The screen will then be updated.



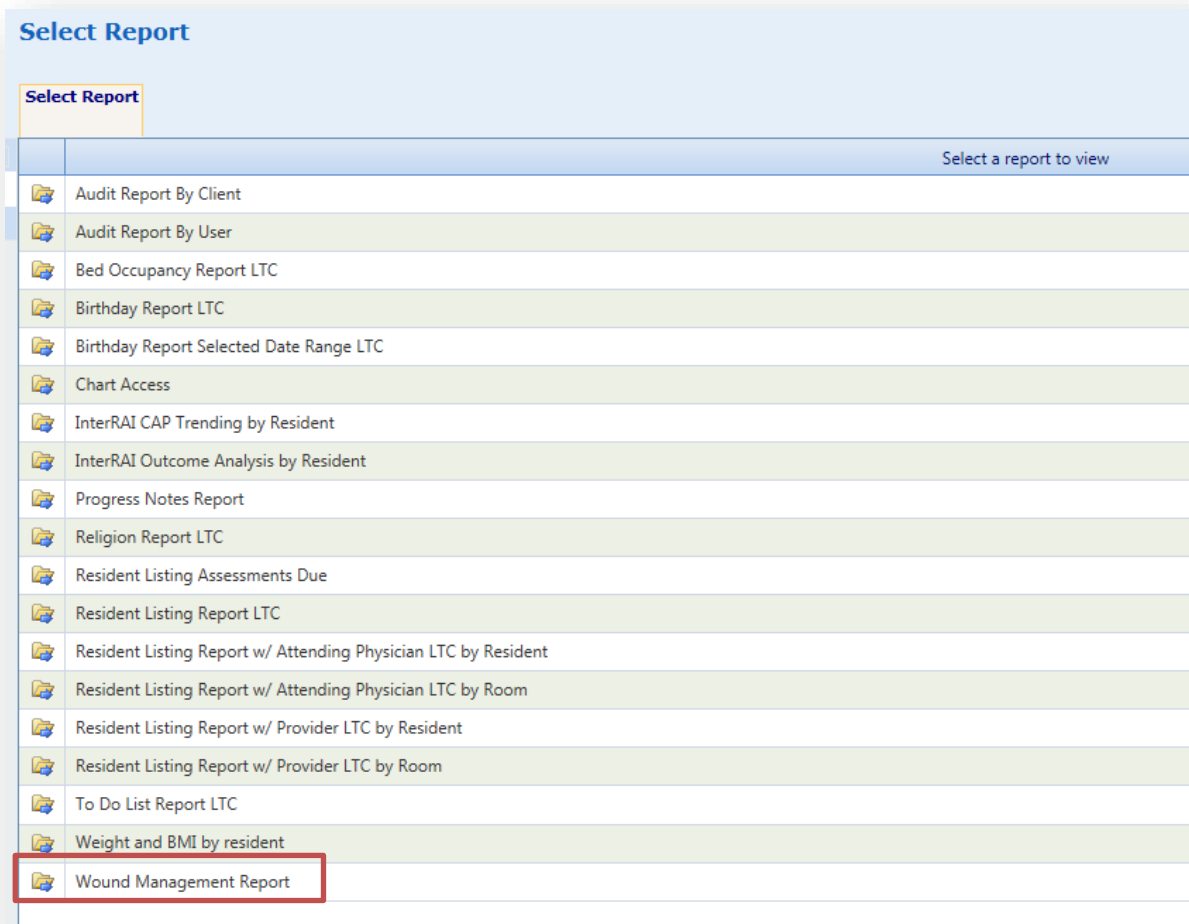
To return back to your assessment (MDS) click on **Save & Return**.

Printing the wound mangement report



Go to **Reports** from Home page:



Select **Wound Management Report**



Note: dependent on your screen settings, the wound module report may appear on the second page of available reports:


	Weight and Vital Signs	Integrated Report	Displays weights and vital signs for residents
	Weight Change Indicators	Integrated Report	LTC Weight Change Report

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Report Criteria - Wound Management Report

Report Criteria

Last Name <input type="text"/>	First Name <input type="text"/>	Record Status Active	Provider All
Facility NZ Long Term Care Testing Facility	Identifier Value <input type="text"/>	Unit All	Wound Status All

 View Report

You can choose to report on an individual resident, a particular unit in your Facility, the residents you are responsible for, or the whole Facility.

Wound Management - By Resident
 Provider: All Unit: All

No	Date identified	Date resolved	Type	Stage	Description
RAE1111	Example, Ronald Andrew Rest Home - 1 - 1				
1	02/04/2013		Bruise	NA	Bruised by hitting shin on bed end
2	16/07/2013		Pressure Ulcer	Area of persistent skin redness	

Fig. 1: Example of an individual report

Wound Management - By Resident						
Provider: All						
Unit: All						
No	Date identified	Date resolved	Type	Stage	Description	
mar1234	Fairfax, Jane Elizabeth (Mrs.)			Rest Home - 3 - 3		
1	03/04/2013		Lesion	Area of persistent skin redness	small red and lumpy lesion on right lower leg	
MEL3333	Johnson, Mary (Mrs.)			Hospital - 2 - 2		
BLH1973	Johnson, Mary (Mrs.)			Rest Home - 11 - 11		
1	04/04/2013		Venous Ulcer	NA	Lower right leg Ulcer, moist granulating base with irregular border	
REA6543	Johnson, Mary (Mrs.)			Rest Home - 14 - 14		
qwe1234	Johnson, Mary (Mrs.)			Hospital - 4 - 4		
1	04/04/2013		Venous Ulcer	Stage 2	Moist grade 2 wound with granulating borders.	
AMC3890	Johnson, Mary (Mrs.)			Rest Home - 12 - 12		

Fig. 2: Example of Facility report

All the above reports can be printed off as required.

Additional Help

Please note that further information can also be found in the interRAI software when using the wound management module.

