

Singular Wound LDA Documentation

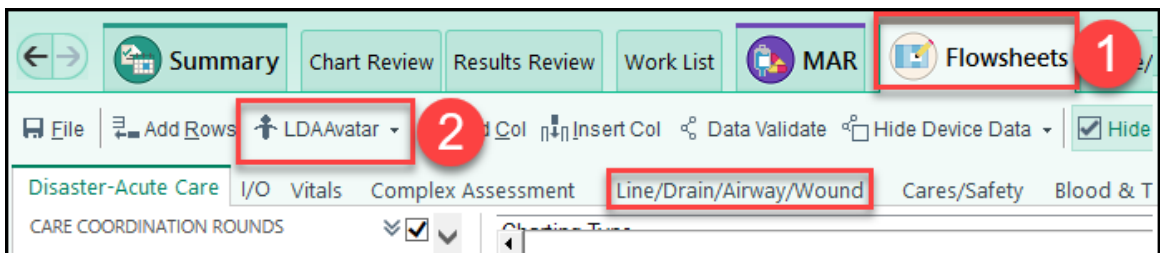
Audience: Inpatient Nurse Staff

A Singular Wound LDA is available in the Avatar when documenting a Wound Type.

Singular Wound LDA Documentation

Documenting a Pressure Injury

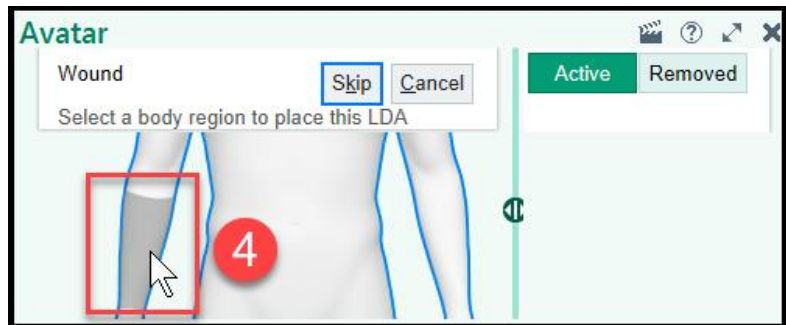
1. In the patient's chart, open **Flowsheets** activity.
2. Go to the **Line/Drain/Airway/Wound** and click **LDA Avatar**.



3. In the search field type in **Wound**.
 - a. Select **LDA IP/OP SINGLE WOUND**.



4. Select an appropriate location on the **Avatar**.



Singular Wound LDA Documentation



- The **Properties** section opens automatically. Check **Show All Choices** to expand all selections for collapsed rows.

← Back Wound 04/28/21 Pressure Injury Anterior;Right Forearm

Properties

Show All Choices

Primary Wound Type

Pressure Injury	Venous Ulcer	Arterial Ulcer	Diabetic Ulcer	Incision
Skin Tear	Burn	Traumatic	Radiation	Neuropathic
Soft Tissue Ne...	Other (comment)	Abscess	Abrasion	Amputation
Avulsion	Calciphylaxis	Dermatologic R...	Gunshot	Hidradenitis
Laceration	Lymphedema	Malignant Wound	Moisture/Incont...	Puncture
Pyoderma Gan...	Stab Wound	Surgical Dehisc...		

Location

Abdomen	Ankle	Arm	Axilla	Back	Breast	Buttocks
Calf	Cervix (G...	Cheek	Chest	Chin	Clavicle	Ear
Elbow	Eye	Eyebrow	Eyelid	Face	Femoral	Finger (C...
Flank	Foot	Forearm	Generalized	Genitalia	Groin	Hand
Head	Head - Fo...	Head - Fr...	Head - Oc...	Head - Pa...	Head - Te...	Heel

- Present on Hospital Admission
- First Assessment Date and First Assessment Time
- Primary Wound Type
- Wound Approximate Age at First Assessment (Weeks)

← Back Wound 01/24/21 Pressure Injury Anterior;Right Forearm

Properties

Responsible Restgure Show Row Info Show...

Present on Hospital Admission **a**

Yes No

Was the wound present prior to the patient's admission to the hospital at which the wound was first documented?

First Assessment Date **b** 1/24/2021 First Assessment Time 1836

Primary Wound Type **c**

Pressure Injury	Venous Ulcer	Arterial Ulcer	Diabetic Ulcer	Incision	Skin Tear
Burn	Traumatic	Radiation	Neuropathic	Soft Tissue Ne...	Other (comment)
Abscess	Abrasion	Amputation	Avulsion	Calciphylaxis	Dermatologic R...
Gunshot	Hidradenitis	Laceration	Lymphedema	Malignant Wound	Moisture/Incont...
Puncture	Pyoderma Gan...	Stab Wound	Surgical Dehisc...		

Wound Approximate Age at First Assessment (Weeks) **d**

1

Orientation **6**

Right Left Midline Anterior Poster... Inner Outer Proximal Distal

Medial Lateral Superior Inferior Upper Lower Quadr... Other...

Location

Abdomen	Ankle	Arm	Axilla	Back	Breast	Buttocks	Calf
Cervix (G...	Cheek	Chest	Chin	Clavicle	Ear	Elbow	Eye
Eyebrow	Eyelid	Face	Femoral	Finger (C...	Flank	Foot	Forearm

Singular Wound LDA Documentation

6. The orientation and location are filled out by default but confirm the proper selections were made.
 - a. Add any descriptive comments as needed. If a dressing was placed in the OR, details would be viewed here.
7. Click **Accept**.

← Back | **Wound 01/21/21 Pressure Injury Anterior;Right Forearm** | + Assessment | Image Viewer

Description (Comments) **a**

Enter any additional information desired.

Dressing Placed in OR

Burn Type

Thermal burns Chemical burns Smoke inhalation Electrical injury Abrasion Other (Comment)

Sittig, K. & Richardson, K. (2010). Acute burn management. In McCulloch, J.M. & Kloth, L. C. (Ed.), Wound healing: Evidence-based management (4th ed., pp 333-356). Philadelphia, PA: F.A. Davis Company.

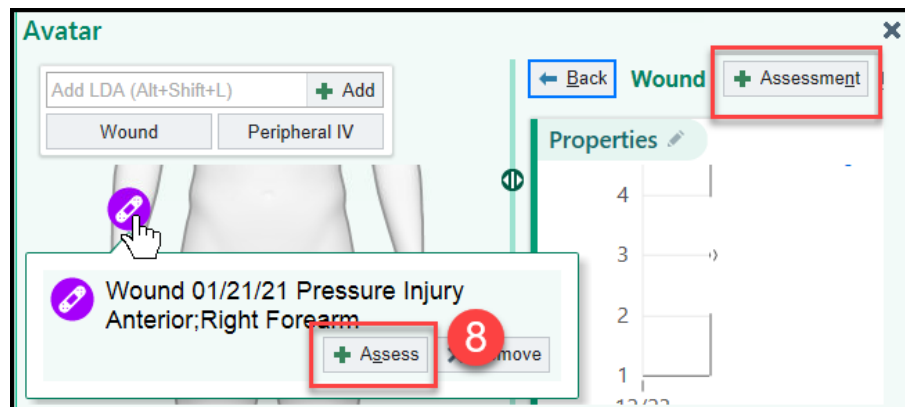
Degree of Burn

Superficial (1st) Superficial partial, deep partial thickness (2nd) Full thickness (3rd)

Superficial (First Degree) - Involves damage to the epidermis only. Initial erythematous due to vasodilation with eventual desquamation, usually resolving with scarless healing within 7 days.

Accept **7**

8. Hover over the **Band-Aid** and select **Assess** to document your assessment or click **Assessment** in the right-hand corner. Capture image via Rover if appropriate.



Singular Wound LDA Documentation

9. Complete Assessment.
 - a. Current Dressing Status.

Wound 01/24/21 Pressure Injury Anterior;Right Forearm

Assessment

Current Dressing Status **a**

Absent Clean, dry, and intact Clean Dry Intact Removed

Drainage outlined Strikethrough drainage Other (comment)

- b. Primary Injury Stage.
New options: Other (Comment), Medical device related, and Mucosal.
- c. Wound Interventions selected are based on the staging information selected.

Wound 01/21/21 Pressure Injury Anterior;Right Forearm

Pressure Injury Stage **b**

Stage 2 taken 1/21/2021 2212 by Inpatient, Nurse, RN

Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Deep tissue pressur...
Other (Comment)	Medical device related	Mucosal			

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Wound Interventions **c**

Stage 1 pressure injury	Stage 2 pressure injury	Stage 3 pressure injury	Stage 4 pressure injury	Unstageable/Unclassified
Suspected Deep Tissue I...	Moisture/Incontinence	Skin Tear	Non-Pressure Shallow W...	Non-Pressure Deep Wound

- d. Wound Base Appearance
- e. Per-wound Assessment

Wound 01/24/21 Pressure Injury Anterior;Right Forearm

Wound Base Appearance **d**

Clean Dry Bleeding Black Brown Dark Edges Dusky Early/partial... Epithelialization

Eschar Friable Fibrin Fully granulat... Granulation ti... Gray Hyperkeratosis Hyperthroph... Light purple

Necrotic Pale Pink Red Slough Skin buds/ca... Tan White Other

Peri-wound Assessment **e**

Clean Dry Intact Black Blancha... Bleeding Blistered Brown Burgundy Callused Dark ed...

Denuded Ecchym... Edema Excoriated Fluctuance Friable Gray Hyperpig... Induration Maceration Non-bla...

Painful Pale Pink Purple Rash Red Scar tissue Shiny Swelling Tan White

Yellow-b... Other (C...

Singular Wound LDA Documentation

- f. Wound Length (cm)
- g. Drainage amount

Wound 01/24/21 Pressure Injury Anterior;Right Forearm

Wound Length (cm) **f**

3

Wound Width (cm)

Drainage Amount **g**

Copious Large Moderate Small Scant **None** UTA Other (...)

Copious = Excessive amount
Large = Wound tissues filled with fluid
Moderate = Wound tissues wet
Small = Wound tissues very moist
Scant = Wound tissues moist
None = Wound tissues dry

- h. Peri-Wound Treatment
11. Click Accept.

Wound 01/24/21 Pressure Injury Anterior;Right Forearm

Peri-Wound Treatment **h**

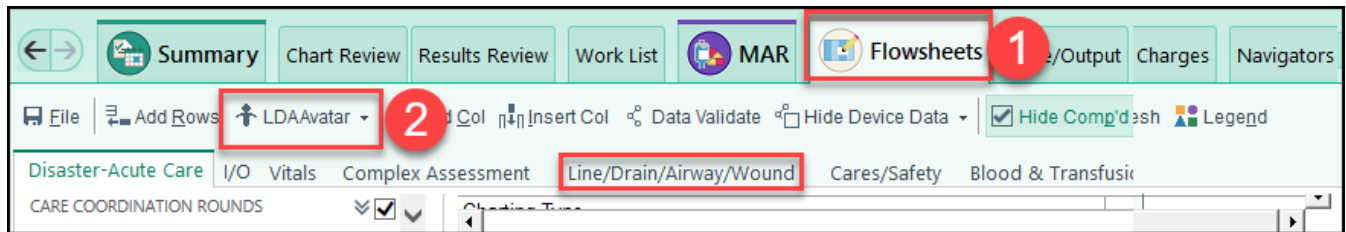
Antifungal powder	Hydrocolloid	Hydrofiber	Iodine based paste	Liquid film barrier	Medical liquid ad...	Moisturizing cream	Ostomy ring
Skin prep	Stoma paste	Zinc oxide ointment	Moisture barrier	Other			

Accept **11**

Singular Wound LDA Documentation

Documenting an Incision

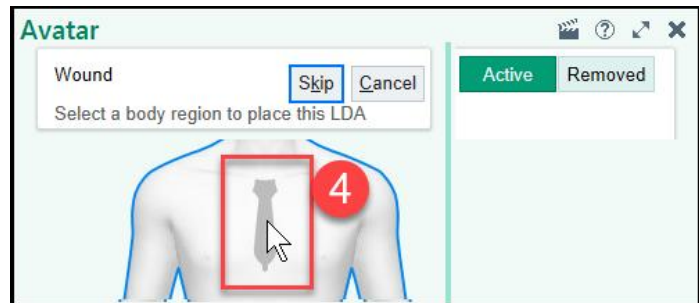
1. Open **Flowsheets** activity.
2. Go to the **Line/Drain/Airway/Wound Flowsheet** and click **LDA Avatar**.



3. In the search field type in **Wound**.
 - a. Select **LDA IP/OP SINGLE WOUND**.



4. Select an appropriate location on the **Avatar**.



Singular Wound LDA Documentation

5. The **Properties** section opens automatically. Check **Show All Choices** to expand selections for collapsed rows.

Wound Incision Sternum

Properties

Show All Choices

Primary Wound Type

Pressure Injury	Venous Ulcer	Arterial Ulcer	Diabetic Ulcer	Incision	Skin Tear
Burn	Traumatic	Radiation	Neuropathic	Soft Tissue Ne...	Other (comment)
Abscess	Abrasion	Amputation	Avulsion	Calciphylaxis	Dermatologic R...
Gunshot	Hidradenitis	Laceration	Lymphedema	Malignant Wound	Moisture/Incont...
Puncture	Pyoderma Gan...	Stab Wound	Surgical Dehisc...		

Location

Abdomen	Ankle	Arm	Axilla	Back	Breast	Buttocks	Calf
Cervix (G...)	Cheek	Chest	Chin	Clavicle	Ear	Elbow	Eye
Eyebrow	Eyelid	Face	Femoral	Finger (C...)	Flank	Foot	Forearm
Generalized	Genitalia	Groin	Hand	Head	Head - Fo...	Head - Fr...	Head - Oc...
Head - Pa...	Head - Te...	Heel	Hip	Jaw	Knee	Leg	Mouth
Neck	Nose	Oral Cavity	Pelvis	Penis	Perineum	Popliteal	Pretibial
Pubis	Rectum	Rib Cage	Sacrum	Scapula	Sclera	Scrotum	Shoulder
Sole	Spine - C...	Spine - C...	Spine - Lu...	Spine - S...	Spine - T...	Sternum	Thigh
Thorax	Throat	Tibial	Toe (Com...)	Torso	Umbilicus	Vagina	Vulva

- Present on Hospital Admission
 - First Assessment Date and Time
 - Primary Wound Type
 - Orientation and Location are filled out by default.
- Click Accept.

Wound 01/22/21 Incision Sternum

Properties

Present on Hospital Admission **a**

Yes No

Was the wound present prior to the patient's admission to the hospital at which the wound was first documented?

First Assessment Date **b** 1/22/2021

First Assessment Time 1355

Primary Wound Type **c**

Pressure Injury	Venous Ulcer	Arterial Ulcer	Diabetic Ulcer	Incision	Skin Tear	Burn
Traumatic	Radiation	Neuropathic	Soft Tissue Ne...	Other (comment)	Abscess	Abrasion
Amputation	Avulsion	Calciphylaxis	Dermatologic R...	Gunshot	Hidradenitis	Laceration
Lymphedema	Malignant Wound	Moisture/Incont...	Puncture	Pyoderma Gan...	Stab Wound	Surgical Dehisc...

Orientation **d**

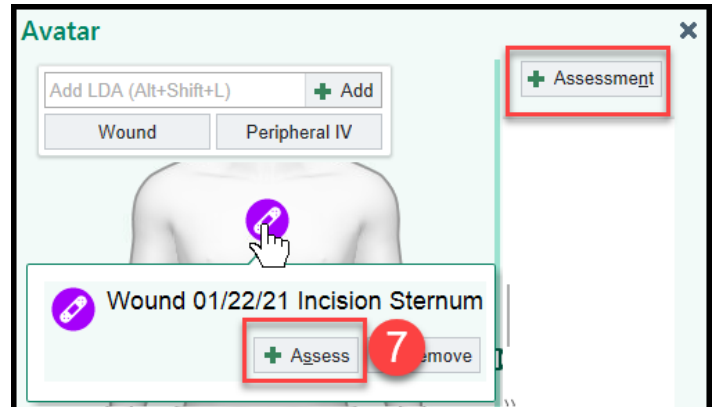
Right Left Midline Anterior Poster... Inner Outer Proximal Distal Medial

Location

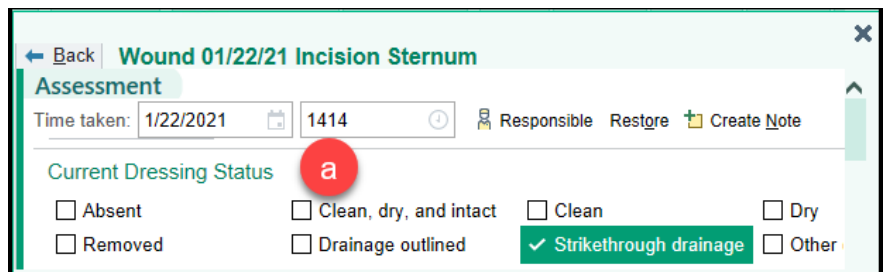
Rib Cage	Sacrum	Scapula	Sclera	Scrotum	Shoulder	Sole	Spine - C...	Spine - C...	Spine -
Spine - S...	Spine - T...	Sternum	Thigh	Thorax	Throat	Tibial	Toe (Com...)	Torso	Umbili
Vagina	Vulva	Wrist	Other (Co...						

Singular Wound LDA Documentation

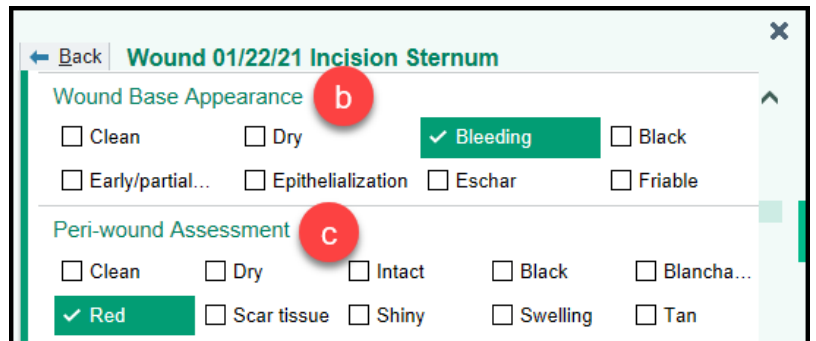
7. Hover over the **Band-Aid** and select **Assess** to document your assessment or click **Assessment** in the right-hand corner.



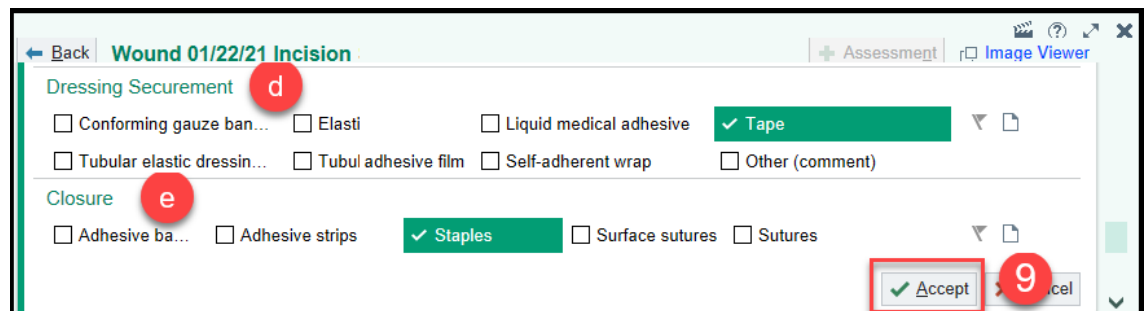
8. Complete Assessment.
 - a. Current Dressing Status



- b. Wound Base Appearance
- c. Peri-wound Assessment



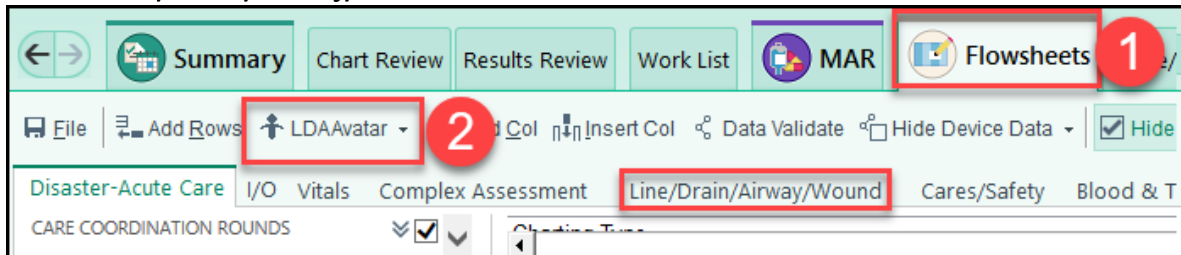
- d. Dressing Securement
 - e. Closure
9. Click Accept.



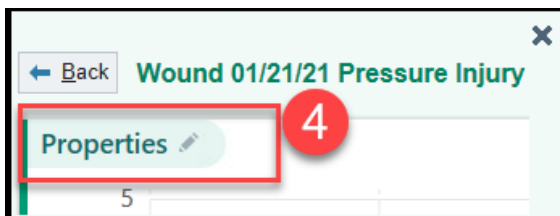
Singular Wound LDA Documentation

Documenting Final Assessment When Wound Outcome Is Selected

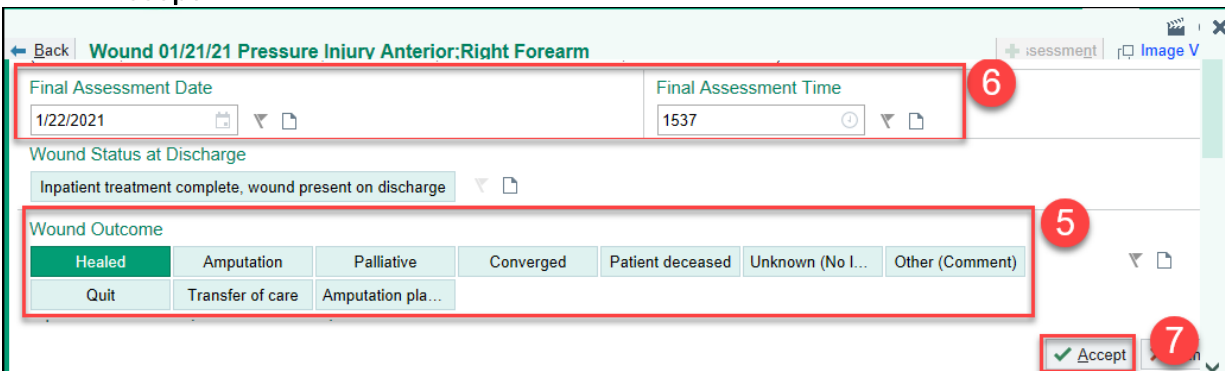
1. Open **Flowsheets** activity.
2. Go to the **Line/Drain/Airway/Wound Flowsheet** and click **LDA Avatar**.



3. Select the **LDA Wound** that is being resolved.
4. Click **Properties**.



5. Document **Wound Outcome**. If a **Wound Outcome** is selected, the **Wound** needs to be resolved.
6. Enter a **Final Assessment Date** and **Final Assessment Time** (this will auto-resolve the wound).
7. Click **Accept**.



Singular Wound LDA Documentation

- Active and Removed Wounds.

Active LDAs and Wound Care 8 Active Removed

- Wound Incision**
No First Assessment Date or First Assessment Time found. —
- Wound 01/12/21 Skin Tear**
First Assessment Date/First Assessment Time: 01/12/21 08 12 days

Removed LDAs and Finalized Wound Care Active Removed

Show LDAs removed in the last: 30 days 60 days 90 days

- [REMOVED] Wound 01/21/21 Pressure Injury Anterior;Right Forearm**
Final Assessment Date/Final Assessment Time: 01/22/21 20:
01/21/21 0900 Present on Hospital Admission: Yes Primary V
Location: Forearm Wound Out...

- Go to **Flowsheets** activity.
- Click **Line/Drain/Airway/Wound**.
- See **Removed Wound LDA** properties.

Summary Chart Review Results Work List MAR **Flowsheets** 9 Output Notes Chrg Navigators Restraints

Flowsheets

File Add Rows LDAAvatar Add Col Insert Col Data Validate Hide Device Data Last Filed Refre Legend

Disaster-Acute Care I/O Vitals Complex Assessment **Line/Drain/Airway/Wound** 10 Safety Blood & Transfusion

	1/21/21	2306	1238
[REMOVED] Wound 01/21/21 Pressure Injury Anterior;Right Forearm 11			
Wound Properties	Final Assessment Date/Final Assessment Time		
Wound Image			
Current Dressing Status			Absent
Pressure Injury Stage			Stage 1
Wound Interventions			Stage 1 pressu...

Charting Type - LDAs

[REMOVED] Wound Pr...

Wound 01/12/21 Skin ...

Wound Incision

[REMOVED] Wound 01...

[REMOVED] Wound Pr...

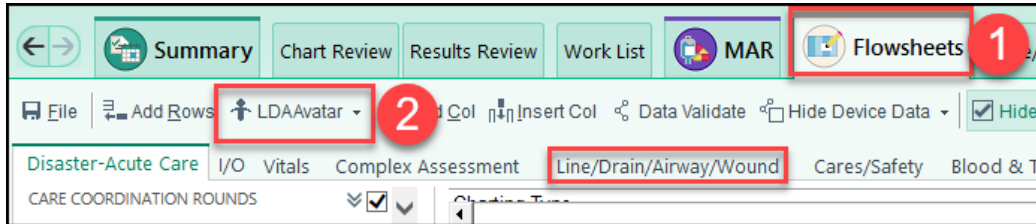
Charting Type: Select Single Option: (F5)

- Admission
- Shift assessment
- Reassessment - no char
- Reassessment - change:
- Comment (F6)

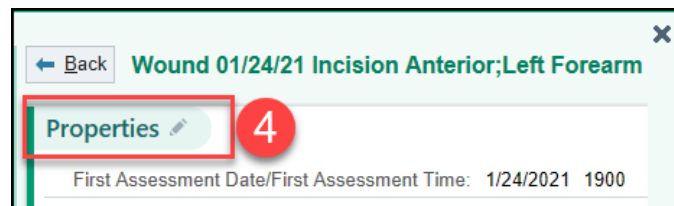
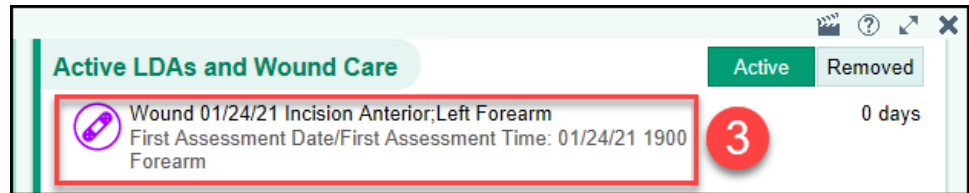
Singular Wound LDA Documentation

Documenting Final Assessment When Wound Outcome Is Not Selected (LDA Will Remain Active at Discharge)

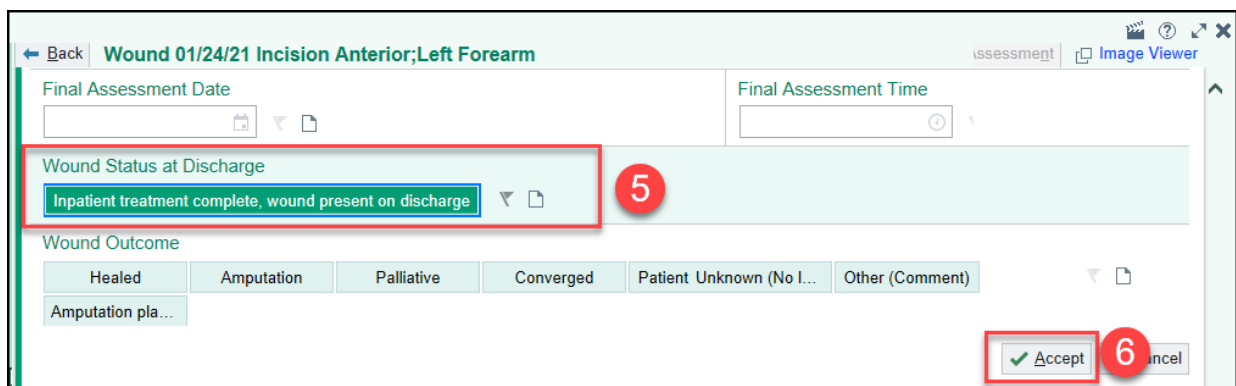
1. Open **Flowsheets** activity.
2. Go to the **Line/Drain/Airway/Wound** and click **LDA Avatar**.



3. Select **Wound LDA** to resolve. If not selecting wound outcome, do not resolve the wound. Wound will remain active at discharge.
4. Click **Properties**.



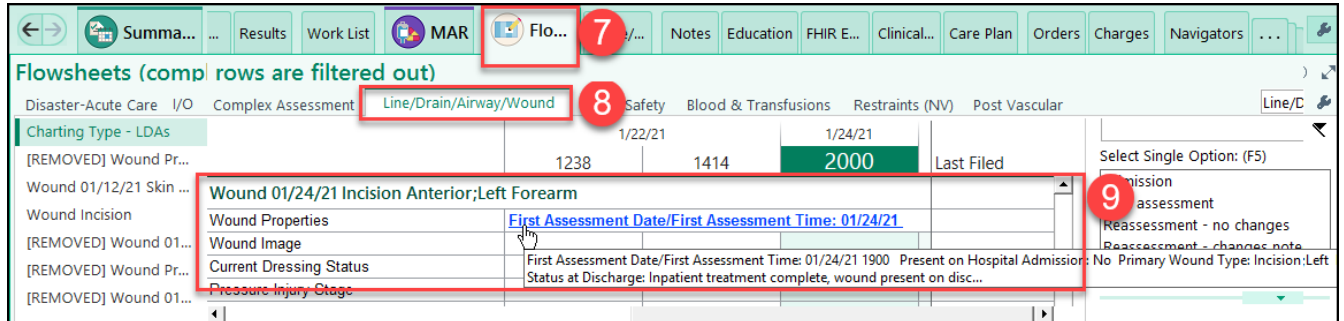
5. **Wound Status at Discharge** – Select **Inpatient treatment complete, wound present on discharge**.
6. Click **Accept**.



Singular Wound LDA Documentation



7. Go to **Flowsheets** activity.
8. Click **Line/Drain/Airway/Wound**.
9. Hover over the selected **Wound LDA** to see the **Wound Status at Discharge**: Inpatient treatment complete, wound present on discharge.



Retired Wound LDA options:

- LDA Wound Incision
- LDA Wound Burns
- LDA Wound Pressure Ulcer
- LDA Wound Other Ulcers
- LDA Wound

When the **Wound LDA** is selected, in **Properties**, select **Wound Type** (see options).

Pressure Injury	Venous Ulcer	Arterial Ulcer	Diabetic Ulcer
Incision	Skin Tear	Burn	Traumatic
Radiation	Neuropathic	Soft Tissue Necrosis	Other (Comment)
Abscess	Abrasion	Amputation	Avulsion
Calciphylaxis	Dermatologic Rash	Gunshot	Hidradenitis
Laceration	Lymphedema	Malignant Wound	Moisture/Incontinence Dermatitis
Puncture	Pyoderma Gangrenosum	Stab Wound	Surgical Dehiscence