Wound Care Documentation Across the Multidisciplinary Team

Recorded October 2nd, 2020

Presenter: Neely Sullivan, MPT, CLT-LANA, CDP

PhysicalTherapy.com Course #3876

- [Calista] Today's course is wound care documentation across a multidisciplinary team. It is my pleasure to welcome back Neely Sullivan of physicaltherapy.com. Neely has worked with a diverse client population ranging from pediatric to geriatric, in a variety of clinical settings. These experiences in multiple courses on the topic have allowed her to treat and develop client care programs for clients living with wounds. She has served in multiple levels of regional and corporate management positions, and in these positions, Neely has developed policies and worked closely with multidisciplinary teams to ensure that clients living with wounds have the opportunity to attain their highest level of function and quality of life. She has most recently been responsible for the identification, implementation, and evaluation of clinical programs in longterm care settings. Neely currently provides educational support to over 13,000 therapists nationwide as director of education for select rehabilitation. She's also lectured nationally and at the state level on wound care topics. So thank you again for presenting for us today, Neely, and at this time I'm going to turn the classroom and the microphone over to you.

- [Neely] All right, hi. Thank you so much for the introduction. As she said, my name is Neely Sullivan, and today we're going to be talking about wound documentation across the multidisciplinary team. I do want to go through a couple of quick notes before we get started. There are a lot of people today with different job titles and responsibilities and administrative clinical backgrounds in this presentation today, so there may be some information that might be a repeat for you, but I've tried to be very thorough so that all participants on this call have a working knowledge of what we're discussing. I also wanted to just let you know that I've worked in a variety of physical therapy settings, as you heard in my introduction, but I currently work in longterm care, so today I'm going to talk about Medicare rules and regulations and relationship with nursing, but please know that even if you don't work in longterm care settings, most payers follow the lead of Medicare. Also, most payers have similar rules and

regulations to Medicare, and it would be too much today to go into every payer's rules and regulations in regards to documentation, so today I'm going to mainly talk about Medicare's expectations, but this information should still apply generally to other payers. And then the last thing I wanted to mention is that we are going to be practicing some documentation today, so if you have your handouts in front of you, that's great. Make sure you grab a pencil or pen. If you don't have a pencil or pen in front of you, go ahead and grab one, because we will be putting our skills to use today. All right, so with that being said, I did want to mention that I don't have any disclosures I need to let you know about, and today at the end of this course, I want you to be able to discuss components of client centered collaboration between therapy and nursing and wound care, outline the roles of the multidisciplinary team in collaboration when addressing wounds, identify common errors and key elements in documentation to prevent denials, outline principles of effective documentation for nursing and therapy to support delivered wound care services, and finally, I want you to be able to describe essential wound documentation required for reimbursement.

So as you can see, there's a lot of information to cover today, so we're going to go ahead and just dive right in. I'm going to spend the first few moments reviewing some of the basics of documentation and medical review to make sure we're on the same page. I think it's important that we know who is looking at our documentation, who's reviewing this documentation before we get into the nuts and bolts of wound care documentation. So we're going to start with a case study. Meet Ms. Smith. She was admitted to a skilled nursing facility November, 2020. She is a 74 year old female admitted following a fall and diabetic ulcer of her right foot. She does have quite a complex medical history. She has obesity, polyneuropathy, hypertension, syncope and collapse, and type two diabetes. She has an open wound on her right foot. She's also demonstrating muscle weakness, balance deficits, and she's having difficulty walking. Her prior level of function, she lived in a private residence by herself. She was independent with all aspects of ADLs, transfers, and ambulations, including within the

community and without an assisted device. She's a master gardener and she cares for foster dogs on the weekends, so she was pretty active and involved before this occurred. So here's her wound. I want you to look at this picture. Right now you're just going to jot down some quick notes about how you would describe this wound in evaluation. I know you're not going to have lots of time to make it a beautiful description, but just quick notes, and I'm going to give you about one minute, one and a half minutes, to just jot down quick notes about what this wound, how you would describe it in your documentation.

So think about things like what it actually looks like, the quantity and quality of the exudate, the appearance, what type of pain that client might be having, if there's any kind of undermining. Also, if you're going to want to evaluate or reevaluate this wound, and then you want to look at the edge of the wound as well, and we'll go through that metric, I believe, on the next slide. All right, so with that being said, let's just move on to that next slide. Okay, so this is the metric that I just went through. It's MEASURE, and this is just a trigger for some areas you might want to include in your documentation. We'll go through this in greater depth later in this presentation. You're going to look at the M is measure, so the length, width, depth, and area, the exudate, quantity, and quality, appearance.

That's what the wound bed actually looks like, what kind of tissue type is in that wound bed. If that client is experiencing pain, what kind of undermining, whether or not there is undermining in the first place. R is for reevaluate, so you're making sure that you're constantly looking at all the parameters regularly, and then the edge, so what does the condition of the edge and surrounding skin look like? Again, we're going to go through more detail about this particular system later in the presentation. All right, so I also want you, as we move forward, to go ahead and write one goal for Ms. Smith. When you're thinking about goals, you want to make sure that we're addressing function, so what is actually meaningful to that client and what that client needs to accomplish in

their everyday life. So we're going to go into a lot of depth about goals. This is just your first rough draft of the goal, so go ahead and be thinking about that as we move forward. All right, so as we move forward with Ms. Smith, we find out that our intervention's working. Standard of care was met and she's being treated with debridement, offloading with contact casting. She's also being seen for strengthening of her bilateral lower extremities, transfer training, she's using a rolling walker, she's participating in balance activities, gait training, and safety instruction. And then now we've made progress with her. We are about 12 weeks in, and I want you to describe the wound as you would in a therapy progress note.

And again, you can use that MEASURE system that I went through on the previous slide, so look at length, width, depth, and area, exudate, the appearance, if there's pain, what kind of undermining, if it's present or not present, whether or not we're monitoring all the parameters regularly, and then re-evaluating that wound, and maybe we're reevaluating how we're actually treating that wound, and then we want to look at the condition of the surrounding skin of the wound. So we're going to readdress this case study at the end of the presentation today. So once again, this is your rough draft for Ms. Smith. We're going to go through, we're going to learn about wound care documentation, and then we'll use this at the end to see how far we've come with our documentation.

So I believe our next slide is just a reminder of the MEASURE. All right, so let's start from the beginning. I think we can all agree that a formal wound assessment is a necessary part of effective wound management, and regular wound assessments are required to ensure that progress or even lack of progress in wound healing is identified quickly. So accurate documentation of wound assessment and management really facilitates communication in that multidisciplinary healthcare team, and it's such a central part of the intervention to our clients receiving appropriate ongoing wound management. We will talk about the importance of that multidisciplinary team, because

without that multidisciplinary team and good communication amongst the members of that multidisciplinary team, you won't get very far with your wound care interventions. Accurate documentation of wound characteristics provide that baseline for any kind of changes the client may experience, and it can assist in mapping how we actually treat our client during the wound management process. This is probably a review, but specifically for wound care, why is correct documentation essential? Well, we know that wounds are constantly changing because of physiologic processes, meaning that measuring wound healing progress can be difficult, and good documentation is therefore essential to ensure the continuity of care.

In longterm care, where it's common for several medical and nursing staff to be involved in the client's wound care, good documentation facilitates that communication between healthcare workers, and even if you don't work in longterm care, of course there's a lot of different people looking at the wound, monitoring the wound, and so that documentation really facilitates that continuity of care along the healthcare spectrum. Wound documentation is also necessary for legal purposes. It provides a legal record of care administered and enables the assessment of wound management or standards of wound care to be undertaken retrospectively.

So quickly, I want to go through a few studies that are going to illustrate why we're even talking about the importance of multidisciplinary collaboration in wound management and wound documentation. So this first study, it was an audit of 80 patient records in a trauma unit of an acute care hospital in England. 67 wounds were identified, 40 of which had a surgical etiology, and in the surgical wound group, only one of the 40 wounds had a wound assessment documented, while only 16 had dressing type documented. So now I know the setting and circumstances are a lot different from the settings that we all work in, but later this article discusses how this hospital developed a multidisciplinary approach to devise best practice guidelines, and this was achieved really through consensus among that multidisciplinary team and

developing a clinical practice benchmark tool for clients with surgical wounds to standardize and make sure that the implementation of evidence based practice, when it came to surgical wound care, was implemented. So the next study I want to share with you reviewed a survey conducted in an urban hospital by the Illinois Department of Public Health. In this hospital was an expectation that wound assessments be documented at each dressing change. This study identified several problems with the institution's documentation of wound assessments. It did not reflect assessment of all types of wounds, and because the documentation did not occur in a central location, progress of wound healing could not be determined.

So the survey findings also highlighted it was difficult to decipher wound assessments and monitor the documented progress of wounds. In this particular study, documentation of wound assessment was inconsistent, incomplete, and scattered throughout the medical records. Now, it's from 1999, so it was a bit old, but I thought it was really important to illustrate how inconsistent wound documentation can be in the settings that we work in.

This article resulted from a meeting of wound healing experts in June of 2003. In this article, the researcher determined that wound assessment terminology is non-uniform and the accuracy reliability of available wound assessment techniques vary, so these researchers who reviewed, and then ultimately, they did propose a new framework for clinically useful wound measurement approaches in response to that lack of uniformity in assessment terminology, and this is where that acronym MEASURE that I've already introduced to you was introduced, so MEASURE encapsulated those key wound parameters, and it addressed the assessment and management of chronic wounds. So once again, that MEASURE acronym, it was really looking at the length, width, depth, and area, the exudate, the appearance of the wound bed, including that tissue type, whether or not that client was having pain, whether or not there was undermining, what the undermining looked like, and then the edge or the condition of the edge of the

surrounding skin. So that acronym really provided some preliminary recommendations targeted to developing best practice guidelines for wound assessment, and I use this acronym all the time. So as you can see, it's the third time I've showed it to you already. It's what I use when I'm quickly trying to go through with my clients and capture all the information I need to when I'm assessing a wound. So now this, I believe it's the last research. It was an audit of acute care wound documentation in inpatient admitted to a surgical ward, conducted in 2006. It used progress notes of 49 acute inpatients in a regional Australian hospital. The audit focused on wound documentation on admission and during dressing changes. Whereas doctors and nurses documented different aspects of the wound on admission, three quarters of the clients had no documentation of wound margins, and over half had no documentations of wound dimensions, exudate, and wound bed.

Whereas 122 dressing changes were documented by nurses and 103 by doctors, only 75, or that's about 60% were reviewed by both medical and nursing staff. Doctors and nurses tended to document different aspects of dressing changes. However, in more than half the cases, there was no documentation about the wound bed, margin's, exudate, and the state of surrounding skin, whereas wound dimensions and skin sensation were recorded in less than 5%. So this is why we're talking about this topic today. The findings from these studies suggest that there is ineffective communication about wound care in multidisciplinary settings, and I just wanted to quickly go through these articles to highlight that we need to engage in a collaborative process to identify the issues that go along with poor wound documentation and to ensure best practice is achieved in documenting the skilled services that we provide for our clients who are living with wounds. And I did want to make just a quick side note that there is a gap in research looking at the quality of wound care documentation in longterm care settings, so if any of you are researchers and that is something that interests you, I think our field could greatly benefit from this kind of research. So let's look at some actual numbers. Healthcare providers are at an increasing risk for audits under Medicare as a

result of our increased focus on reducing improper payments. We know that the Medicare fee for service estimated improper payment rate has decreased from 7.25% in fiscal year 2019, and that was decreased from 8.12% in fiscal year 2018, and that was the third consecutive year that this impaired proper payment rate has been below the 10% threshold. So you might think great, we're doing great, maybe they'll stop auditing us. That's not true. Medicare believes that what they're doing is working, and so medical reviews will continue to be present going forward. Improper payments encompass both overpayment and underpayment.

Overpayment really includes payments that don't meet statutory coverage requests. They don't satisfy that medical necessity requirement, something that we'll talk about in great detail today. Also, they include payments that are incorrectly coded or insufficiently documented. Now, CMS is working on a lot of different fronts to meet its goals for reducing improper payment. And among those approaches are increasing prepayment medical review, also enhancing analytic efforts and increasing the review of pay claims by CMS recovery auditors. We'll talk about exactly who those recovery auditors are in just a few slides.

In order to minimize the risk of an audit, physical therapists need to be familiar with the various entities that are conducting Medicare audits, the rules regarding documentation, coding, and billing, and the risk areas related to the provision of healthcare services. And now this next slide, when I initially created this presentation, as of April, 2020, CMS has said that there was a public health emergency and they had suspended most of medical review. However, we now know that I believe they resumed medical review on August 3rd, 2020, so this is a great example of how fast things can change in the world of reimbursement and why we have to stay on top of all the different policies, regulations, and what their expectations are for wound care documentation. Now, why is this all important to you? We hear so much talking in the healthcare world about how many denials of payment we're receiving, and we know

that that volume just seems to be increasing. We also hear so much about the complicated and long process involved in appealing these denials. So I know you're in your facilities, your clinics every day, you're treating your clients, you're just trying to make sure that their quality of life is improved because of services you're providing, so again, why is this important to you? Well, we know that as our payers evolve, the amount of scrutiny is going to increase, and this is going to increase numbers of medical record requests. If these records requests are not responded to in an organized manner, then they result in denials, and to overturn these denials is a lengthy process that we're going to go through in a few slides, and this process, as well as potential denials, cost the facility both time and money.

So it's important to really get a grasp on why claims are being denied in your facility. Is it for technical deficiencies, such as missing pertinent signatures or dates, or is it for larger reasons, such as a claim lacking medical necessity? Also, as we've already stated, it's important to your facility because these documentation requests or denials and appeal processes have financial implications on our practice. It's important that our communities, our facilities, whatever setting you work in, it's important that we know how much these denials are costing our facility in time and resources, how are they impacting our cashflow, and then how is it really impacting the big picture, the bottom line?

And of course, the first step in answering these questions is truly understanding the healthcare environment that we're operating in, and also understanding some of the finer details of denials and appeals. So again, a lot of different job descriptions with different backgrounds on this call today, so just to make sure that we're all operating with the same information, I want to just show you the different audits that you may come into contact with, and if it's not you that comes into contact with these audits, just know that these are the people that are looking at your documentation, and your business office is in close contact with these different auditing entities. So this slide

just shows all the different entities reviewing therapy documentation, and this does include Medicare. So I want to just use a MAC as an example, which is a Medicare Administrator Contractor, and just to bring everyone up to speed on what exactly is an LCD, we know that each Medicare contractor has the discretion to establish which services are reasonable and necessary and therefore covered, and so these coverage policies are issued in a document called a local coverage determination, so that's an LCD, and these LCD, they're called LCD edits, state what services will or won't be covered, so basically they're being rewarded for saving money, and often the hope for achieving this is based on what I typically refer to as the kind of quote-unquote see-what-sticks-policy, so in other words, they deny services in hopes that we as providers, they know we're busy, and they know that the appeal process is long, so they deny services hoping that perhaps we won't appeal, and the bottom line is to ensure medical necessity can be justified in all your documentation.

Now, for these MACs, there's a lot of different ways that you can stay informed, so you can sign up on their listservs, and they send you information about different LCD or local coverage determinations as they evolve. You can visit the website regularly, and they have lots of information and news and updates, copies of newsletters, there's even conference calls that often will occur that you can hop on, and they will give providers an opportunity to ask questions, and sometimes they'll even allow for open discussion. They have frequently asked questions on these websites, and then we need to always know our local coverage determinations from our MACs, if you are working with MACs. So here's some state specific auditors. We're not going to get into these today, but I just wanted you to have these for your reference. Essentially, I just wanted you to have a good grasp of all the different reviewers, looking at the documentation from your facilities. That's why I like this slide. You can kind of see federal and state levels, how many different people are looking at your documentation. Now, along those same lines, there's different types of reviews happening for all these auditors. So first there's a probe review, and this type of review is really provider

specific and is used when they identify a problem. Now, a widespread probe is used when it's a multiple-provider issue. And then a pre-pay review is a claim reviewed prior to payment. A post pay review, it's obvious, but they look at that claim after it's paid, and then a targeted medical review is a review of a provider's records for a specific issue or billing error. There's so many different reviewing bodies and types of reviews that I admit it can make your head spin. However, the best thing that we can do is to review all of our wound care documentation through some type of auditing prior to submission, looking for accuracy of billing and making sure that we're describing the medical necessity of their service.

Trust me, I've been involved in several different types of reviews, and once you get on a review, it's difficult to get off and it's certainly not a lot of fun. Okay, so as I was sitting around last night mentally preparing for this, I thought, you know what, I'm going to be talking about wound care for two hours. How am I going to make this fun for participants? So I thought one way we can make this fun today is I'm going to incorporate some wound care humor in there today, so there will be a series of wound care jokes, so here's your first one. Why did the doctor put a flesh eating snail on the wound? And the answer to that one is to make the eshcar go. That's personally my favorite one today.

All right, so before we're getting into the nuts and bolts of wound care documentation, let's spend some time talking about that multidisciplinary team and what client-centered wound care actually looks like in means. And of course, documentation is a huge part of providing client-centered wound care. So even when our clients are receiving state-of-the-art treatments, a lot of times our plans are devised without considering their lives, what their lives actually look like, so their living situation, their health status or personal preferences. These plans don't consider the availability of resources they may have in their community, or the stress that they might place on caregivers, and as a result, clients with chronic wounds often feel like they are not

engaged in decision making regarding their care. They also often believe that their concerns about their wounds are not always aligned with concerns of their healthcare providers. I always give this example of how I used to describe wound care when I was a early clinician. People used to ask me, "Why do you like doing wound care?" And I used to say, "Well, it's very black and white. You put something on a wound and it either works or it doesn't, and then you change your plan of care," but what I was essentially describing is not client-centered care. I was just simply looking at the wound and whether or not that wound healed.

This is a medical challenge we see across the board, and we have to change the way we approach our clients. We have to change in a way that puts clients, not their wounds, at the center of our treatment efforts, and I will tie this in to how this actually applies to wound-care documentation in just a few moments. So most of our clients with wounds, I think 83% in one study that I looked at, have two or more co-morbidities that interfere with wound healing. So clinicians have to do a much better job at understanding the whole client. So for clinicians, a lot of times what I see is exactly what I just described.

The treatment goal is closure of the wound. This narrow focus fails to take into account that the prescribed treatment will affect other aspects of the client's health, as well as his or her work and personal life. As an example, when we prescribe offloading to a client, we don't always consider the impact that prolonged immobilization is going to have on the client's physical and mental health. Similarly, we may not consider that putting a boot on a client to cure an ulcer on the bottom of the foot may cause another ulcer on the shin. In addition, clinicians who treat people with wounds at times have little specialized knowledge about the specific disease or injury that's actually led to why that client developed a wound in the first place. As a result, that treatment often tends to be centered around what to put on the wound, rather than on how to improve the underlying medical problem. We tend to approach treatment from our own medical

silo, and this can impede our ability to treat the broader health issues faced by that client. Now, admittedly, when it comes to treatments, guidelines often limit what treatments can be used. So for instance, for clients with diabetic wounds, insurers will pay for contact casts, although many clients are unable to wear them. Various cushions and assistive devices, including protective cast and wheelchairs, can help heal wounds, but these devices are often difficult for some clients to access or afford. It's also essential that a device such as a wheelchair actually fit the client for whom it's being prescribed. I wish you were in a room and I could have you raise your hand, but how many of you see your clients given standard ill-fitting wheelchairs which then may develop, it may result in the development of even new wounds?

So some of the technologies used to treat people with chronic wounds do work, but there's a lot out there that don't. There really isn't a lot of strong evidence-based approach to evaluating these treatment approaches. In addition, the technologies continue to focus only on treating the wound, not the client as a whole. So this is one of my favorite gatherings that has occurred. I use this gathering all the time because some of the ideas that came out of this gathering were just truly innovative and downright inspirational.

So how do we address these barriers? The angiogenesis foundation brought together 27 experts from across the country, and they talked about ideas for the future of client-centered wound care. So here are some of their ideas about how to actually address the barriers we face when treating wounds. They suggested that clients with chronic wounds would have multidisciplinary team of professionals caring for them, including a podiatrist, a social worker, a psychologist, and a nutritionist. The physical, emotional, social, and cultural needs of the client would be recognized by all members of his or her clinical team, and they would play a central role in devising a treatment plan and evaluating its progress, and that the client not the wound will be at the center of the care, and each client would receive the right care at the right time by the right

professional, and I feel like this is what we are all trying to do every day in our clinical practice. It's really walk that tight rope of providing the right care at the right time, by the right discipline. Some other ideas, clients and caregivers will be listened to and respected by clinicians. So it's sad that I see this so often, but this is not happening across the board. In fact, I see it all the time that we just simply don't incorporate into our plan of care what is important to the client and what they're actually saying to us. The interest of clients, caregivers, clinicians, payers, and society would be integrated to create a more holistic approach to care. So for example, treatment plans would offer home health assistance, or respite help for caregivers, or even if that client has difficulty with transportation, they might assist in transportation so that the client can get to their clinic visits.

Another example, easily accessible exercises and physical therapy programs would be provided. And then finally, treatment for people with chronic wounds would be proactive rather than reactive. A reimbursement to clinicians and hospitals would be restructured in ways that reward efforts to prevent wounds from redeveloping or reoccurring, rather than just closing the wounds. Now, I admit that some of these ideas are a bit idealistic, especially in the United States healthcare system, but I like to imagine how implementing some of these changes would have a profound effect on managing wounds in our healthcare environment, and sometimes we can implement some of these changes on a local level in our own facilities and communities.

So before we start talking about multidisciplinary wound documentation, let's understand who the members of the multidisciplinary team are, what role they play in wound management, because they're all going to be participating in that wound care documentation. I like this quote by the World Health Organization. They argue that professionals who actively bring the skills of different individuals together with the aim of clearly addressing the healthcare needs of patients and the community will strengthen the health systems and lead to enhanced clinical and health-related

outcomes. I do think that one of the biggest challenges in wound care is that lack of coordinated services, which is really aimed at addressing all the healthcare needs of an individual living with wounds. That client-centered approach ensures that the skills and knowledge of the multidisciplinary team are focused on the needs of the client-caregiver unit, and then the active involvement of individual team members would therefore depend on the needs of the client-caregiver unit at any point. The intensity and mix of intervention is responsive to the presenting needs. As the client becomes more independent, the focus of that service provision then reflects this independence. So as an example, we might have a reduction in the amount of acute services needed, with an increase in social support provision, or even of supportive care at home.

This shouldn't be any surprise. This should go across the board with any kind of documentation, but that multidisciplinary approach to wound management includes the assessment of the client, care planning, intervention, and then of course, ongoing management of the wound and quality of life, and this has to be captured in the wound care documentation. I will give you examples of this in just a bit. So who exactly is on that wound care multidisciplinary team?

Well, there's people that you would expect. Of course the client and their family is the center of that team, but then there's people, you would expect the physician, administrator, if you're in a longterm care facility, nursing would be in there, but then there's people that you wouldn't expect, people like housing and maintenance if you're in a longterm care facility. They're people that are in these client's living spaces all the time, and they see how these clients function, and they can clearly have a conversation with therapy, nursing, the administrative team, about what they're seeing when they're in their living spaces. Other people, corporate teams, dietary, social services, et cetera. So that multidisciplinary team really has to work together to make sure that clients are able to actively participate to their maximum capabilities during all tasks, and that

multidisciplinary team is in charge of identifying anyone in their vicinity that is appropriate for skilled intervention. It's also important to ensure that clients are provided the opportunity to maintain their highest level of independence during activity participation with the least amount of supervision or assistance. They also are in charge of promoting activities designed for staff and caregivers to perform with the client, not for the client. That multidisciplinary team provides best practice guidelines for documentation to support medical necessity and skilled treatment, and then ensure the continuity of care with emphasis on staff, physician, caregiver, training on how activities programming or any, or just various activities that that client's involved in, how these activities may be used as an adjunctive therapy by providing a means to preserve skills previously learned in therapy.

So I think of it as there being three C's, collaboration, coordination, and communication. This applies to all members of that team and it's essential in maximizing the potential for wound healing documentation of the three C's. They also demonstrate to the medical reviewer that the coordinated, consistent multidisciplinary care was provided. Now, most facilities with a wound care team have policies that specify consultations for certain types of lesions.

So just as an example, many wound ostomy and continence nurses provide both consult services and hands on care at our facility. These consultants provide recommendations on the care plan, but they also educate other providers on their specialty and rationale for the recommendations for this particular client. Now, with our consultants, we always make sure that we educate them on documenting in a similar manner. So consults, ideally, should be based on the format at your facility and include a care plan and follow up, and wound care services are provided by PT in so many facilities. As with these nurses, adequate followup, either by nursing or the wound ostomy and continence nurses should be insured prior to the patient being discharged from PT services. The client's medical record is the main way that we communicate

among that multidisciplinary team through the client's responses to care. So we need to make sure that across that multi disciplinary team that the client's record is legible, thorough, professional, and factual, and ensure that all information is correct and accurate. Consistent documentation is a reflection of quality, a multidisciplinary care provided to an individual. Wounds are often symptoms of many underlying medical, physical, and psychosocial problems, so documentation of these multiple issues requires well-structured documentation system in your community. You want to ensure that your documentation system allows healthcare providers to consistently and concisely communicate and access their findings, and then policies should be updated as new research and practices appear.

The documentation system should incorporate and reflect these new practices, and these interventions really maximize communication among that multidisciplinary team and help to improve client outcomes. The communication between nursing and therapy is such a big deal. Both verbal and written thorough appropriate documentation in that medical record is really essential in identifying appropriate candidates for therapy and supporting their intervention. Now, this can be done via a form or rounds or many clinics or whatever format works best at your facility, but the key is to really make it a habit. We should always be looking for clients who have skill needs.

So who is declining in function? Who's doing better cognitively and medically or could benefit from therapy? And most importantly, we have to document what we see and discuss. Now, you may have heard or been told about the three-time rule with respect to nursing documentation. You may have been told that there needs to be three separate instances of documentation of an issue before therapy's allowed to get involved. This is not wholly true. What needs to be reflected in the nursing documentation is a pattern of a change in function. So for example, if the client normally requires min assist to complete their hygiene task, a referral would be made

to therapy, not after one incident or more assist, but after a pattern has been established. Maybe this is a few days or a week. Now, on the flip side, if a client's developed a pressure injury because of difficulties with positioning, then we're not going to wait for a pattern. These are of serious enough consequence that an immediate referral to therapy would be made. If your nurses or your multidisciplinary team's in doubt, encourage them to ask the therapist, so keep that line of communication open and keep in mind that if a decline or deficits are noticed and referrals are made, it has to be supported in the documentation in the nursing notes.

The note wouldn't just say PT notified, but instead it would say something like observed poor safety awareness during transfers on two occasions this week, PT notified. Now, prior to therapy's involvement with our clients living with wounds, the nursing documentation has to support the prior level of function and the need for therapy. While therapy is treating, the gains they see in therapy also needs to be documented in the nursing's notes, and to do otherwise would make it appear as though the client's showing no progress and therefore no carry-over.

Remember, for our clients with wounds, we're looking at the whole client, not just the wound, so nursing documentation should ask about and document the changes in daily activities that would make a client more susceptible to developing wounds. Perhaps they've developed incontinence, or they had decreased mobility, or they would also capture if the client's now unable to manage the current wounds that he or she may have. So the next few slides give us some of those areas of deficits that would make a client more susceptible to developing wounds or being unable to manage current wounds that they may have. So for instance, if a client's being treated by PT for bed mobility or transfers, then in the documentation nursing should answer all the questions on this slide, and I won't read them all to you, I'll just pick a few. They would document, is assistance more or less than usual? Are there safety concerns? Is there a loss of balance? If a client's being treated by PT for functional mobility, then

nursing should answer questions like how much assistance do they need to walk to the bathroom? If you left the client's side, would he or she fall? Is this distance more or less than usual when they're ambulating? Is assistance more or less than usual when they're ambulating? So let's run through a documentation example. Here's an example of a nursing note that I see all the time. Client is ambulating ad-lib. Now we know that this does not support PT intervention or functional status. So the better way to state this might be, client walks in corridors independently with rolling walker, able to go to and from activities in dining room with verbal cues for safely maneuvering around obstacles. So this is a much better statement. It's a lot more thorough. We have specific information regarding the assistive device. We also knew a lot more about their ability to ambulate and their level of assistance needed.

So if we are treating a client for positioning in either the bed or wheelchair, then we want nursing to answer questions, like, is the client less comfortable than before? What do they look like in that wheelchair? Are they leaning, sliding? Are there new safety concerns? So collaboration's a huge part of success. I know, again, not everyone works in longterm care, but I want it to use the longterm care system that I work in as an example of something that works.

So we utilize Medicare meetings to communicate, coordinate, and capture opportunities, and on these meetings, each part of the team has a specific role and provides the team a guide for meeting content, and we expect each member of this team to come prepared to assure accountability. So in this example, the director of nursing's role is to take information from that meeting and verify that nursing documentation is present in the medical record to support a decline in function or a reason for referral. We check that clients treated by therapy demonstrating a slow decline or maintaining their function, they have supportive nursing documentation in the record that really shows that. The social worker's role is to bring multiple copies of all Medicare denials. We want the social worker to be able to give us information about

upcoming client care planning conferences. We also rely on our social workers to provide that brief interview of mental status scores for all of our clients receiving therapy, and this triggers the need for additional documentation of our clients at a lot of different and various times. Therapy's role is that we come to the Medicare meeting prepared to identify the current therapy caseload as well as tentative discharge dates for these clients. We also have to be able to identify different assessments, and then we work together with nursing on these assessments. We also have to be able to update the team regarding the basic mobility and ADL function as well as cognitive status of the clients on caseload, and then provide a checklist for nursing to trigger additional documentation if that's needed.

So let's move on to our second joke before getting into common errors in wound care documentation. So our second joke, what did the wound care doctor say to the uncooperative patient? The answer is, "You could just suture yourself." All right, on to common areas in wound documentation to prevent denials. So here's a question for you. Would you pay a mechanic a thousand dollars for car repairs if he or she didn't have an itemized receipt to report his charges?

So the answer is probably no. So why then do we get upset when Medicare or any other payer asks to see the receipt for services that we've provided? Isn't this really all that medical review is? We're paid almost all the time without having to show anyone what we provide or even having to show them the receipt. If our facility receives a request for additional documentation, then in essence, the payer's asking to see the receipt. Is it not reasonable for them to want to make sure that they're paying for a worthwhile, cost effective, and skilled service? In today's world, payers are asking for receipts more and more often. Because of practices in the past, payers are asking us to justify why we're so special. Why do we deserve to be paid? Why are we essential to the client's recovery? This is really not unreasonable in my mind. So let's look at those top five reasons for denials across the board, and the first, actually, here are those top

five reasons, and this area's be reviewed by all different reviewers, and these reasons are cited across the board upon medical review as not being documented appropriately to support medical necessity and justify the services billed. These items are key to justifying payment for the services rendered. So let's go through reason for referral. Rehab really begins when the skills of a therapist are necessary to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitations. We all know that this is what we do every day. That reason for referral is not the same thing as the treatment diagnosis.

It should describe what change in function the client has experienced that resulted in the need for referral to you, the physical therapist. What acute change in condition has that client experienced? Now, clients are referred to therapy for wound management and care because of wound drainage or pain, and the client's inability to change dressings or delayed healing in that wound. The documentation that accompanies this client's referral can include information on wound status, etiology, and the treatment plan.

The referral information may be incomplete, especially the wound etiology and treatment over time, and our client records should contain a history and physical exam from the referral source. If this isn't present in the records, then obtaining this data from the referral source is the first step in planning the client's care. We also want to include any kind of factors affecting healing. While taking the client's health history, we need to gather information about diseases and conditions frequently associated with delayed or disrupted healing. We want to capture significant contributors to impaired healing, and these are things like cardiovascular disease, diabetes, kidney failure. If the client has any kind of immuno suppression or GI disease, or if they have any kind of trauma or infection or pulmonary disease, et cetera. Really, essentially any kind of condition that affects healing. Some other examples, if they have impaired oxygenation, impaired perfusion, malnutrition, if they have things such as increased sympathetic nervous

outflow or pain or treatment related factors like the longterm use of antibiotics or chemotherapy or steroids. So let's run through an example of an appropriate reason for referral. The first one is not an inappropriate one. Therapy order status post venous ulcer on right anterior calf. So this is not adequate. We don't have a lot of information about the problems that we're going to treat. We don't know what's meaningful to that client. So here's a more appropriate way to write that reason for referral. Status post-venous ulcer on right anterior calf. Client requires increased assistance with community ambulation and ascending, descending stairs.

So now we know that functional deficit we're going to address in therapy, and I do want to mention here that having orders for therapy is not a reason for referral. It does not justify therapy. We really need to know a lot more about how this deficit is impacting that client's function. So we move on to our second reason for denial, which is the prior level of function. That prior level function has to be clearly documented in every therapy evaluation.

The prior level of function is that functional status of the client prior to the current episode of illness or injury, and a prior level of function has to be discipline-specific and it has to relate to the client's current functional status and the client's longterm goals. We want to clearly establish a baseline and a realistic functional goal for therapy intervention. The first place to start is the history of the wound site. So how long has it been there? How did it start? Was it from arterial insufficiency? Venous insufficiency? Was it trauma related, surgical? Is it a diabetic ulcer or a pressure injury? Remember also that only pressure-related wounds should be staged. As physical therapists, we have to ask the question, how is their wound affecting their functional status, and when comparing the client's prior level of function to objective documentation in the medical record, especially the client's current level of function, there has to be a definite change in the client's impairments and function. The evaluation as a whole has to support the necessity of therapy intervention, and is key to establishing skilled need and

demonstrating a change in functional status. So let's run through some examples of prior level of function. Our first example, lives with wife in two story home. This is not a good prior level of function. We don't know anything about the client's functional status or abilities. Now, we do know that they, he lives with his wife in a two story home. This is important. We want to know this information for discharge, but did that wife assist at all? We have no idea. Does that patient have to go up and down stairs? We don't know, so let me give you a more appropriate, and I should mention that all of these examples actually come from documentation that I've audited recently, and so with permission, of course, I wanted to show them in this presentation because they're just great examples of real documentation of what works and what doesn't.

So our second example, client is the independent and community ambulation with quad cane and up-down 12 stairs with rail to second floor bedroom. So this is adequate because we have a lot more information on the assisted device that client's using, as well as what they look like using the stairs and if they can do stairs and the level of assistance.

This is going to impact our goals and potentially the client's discharge plan. So our longterm goals have to directly relate to that prior level of function. We're going to talk about goals in just a second. A detailed, specific prior level of function lends itself to identify functional longterm goals. So I'm going to give you a trick that I use as I'm documenting to write my goals and my longterm, and my prior level of function. So essentially I write my goals first after interviewing my clients, seeing what they want to accomplish in therapy, and then comparing that to my evaluation and what I think they should accomplish in therapy. I write those goals first. Then I go back and write my prior level of function statement. So this way I know that my prior level of function will reflect every area or deficit that I'm writing a goal for, and we're going to talk more about setting goals starting on the next slide. Now this should be a review, but short and longterm goals are one of the main components of the plan of care, and the outline

of what treatment will consist of, for what diagnosis, how often and how long, as well as what outcome we're hoping that this client will achieve. Our goals need to reflect our description of what the client's expected to achieve as a result of therapy. In general, we're aiming to get the clients back to their prior level of function, correct? So therefore what we just discussed related to a specific and detailed prior level of function is key to establishing appropriate functional longterm goals, and those long longterm goals should reflect the final functional level the client's expected to achieve in the current setting, whether that be outpatient, inpatient, skilled nursing, whatever the setting is.

Your goals have to be functional, objective, measurable, in terms of a predicted date for achieving the goal, so we want a timeframe, and many of the goals of the therapist right for patients with wounds focus on that wound, not on the individual with the wound. So for instance, I see this all the time, decrease wound size by 50%, that's the goal. I also see goals like prevent infection. These are common pathophysiology-oriented goals, but decreasing wound size and preventing infection, this is important, but it doesn't address the larger picture of the individual and the functional limitations that the wound causes.

The question, what activities that you want to do is your wound keeping you from doing probably will generate a number of activities that the client is now unable to do because of the wound, and these activities could include self care such as bathing or showering, or work or leisure activities. They may be as basic as "I can't lie on my back and watch TV," but client-centered goals for clients with wounds have to focus on activities that are important to the client while considering the wound and the methods to prevent wound, or I'm sorry, to promote wound healing. When treating our clients with wounds, therapists still need to measure and document wound size and other aspects of impairments and pathophysiologies, but the goal should focus on the functional limitations and impairments and disabilities caused by the wound. So let's

run through some goals. So here's a goal I saw. Decrease edema in periwound right anterior calf. We have no timeframe. It's not specific. We don't know what that client needs to accomplish in terms of function. So here's a better example, and I'm actually going to include a timeframe in this. So it would say in four weeks, the client will decrease edema in periwound in the right interior calf as evidenced by decrease in periwound from four centimeters at 12 o'clock to two centimeters at 12 o'clock to allow the client to ambulate 100 feet without pain. Now, this is an adequate goal because it's very specific in regards to measurement, and we know what that client needs to accomplish functionally as well. Now we come to the fifth of our top five documentation elements, documenting skilled interventions in the daily notes. Remember, the purpose of that daily note is to justify what's billed to the payer. The description of your skilled intervention is your itemized receipts to support your charges, so to that end, think of your skilled intervention as the unique, complex service that only you can provide.

These are the skills that you paid big bucks to go to school to learn to do. So what can physical therapists offer that other wound specialists don't? Well, we can offer modalities that can jumpstart the healing process. We can debride wounds. We can increase circulation. We can decrease edema, decrease bacterial burden. Our historical role in the assessment and treatment of all the different disease processes that we treat could offer insight and treatment options that can enhance the care provided by doctors, podiatrists, nurses, and other specialists. We also have tools like mobility and balance assessment training, and therapeutic exercise to improve muscle pumping and to lengthen tendons. We have tools like soft tissue work to break up adhesions, scar tissue, or fibrosis. We know if you do any kind of lymphedema, we are skilled in manual lymph drainage and decongestive exercises, and this is just a few areas to which we lay claim as physical therapists. So this statement is taken directly from the Medicare benefit policy manual chapter 15, section 220. If what you can do can be done by someone else, a CNA or a client's spouse, or by the client, him or herself once

educated, then it's not skilled and shouldn't be billed to the payer. No payer knowingly pays for non-skilled services. It's up to us to make sure that our receipt shows that the skilled service justifies the payment. So there's two main things, according to Medicare, that make a service complex and skilled. So one, the skill required to deliver the service, and two, the condition or the complexity of the client, and both of these elements should be documented in the medical record. The co-morbidities and condition of the client should be clearly describe in the evaluation and then reiterated throughout the course of treatment as it impacts progression of the wound care plan and goal attainment for your client. Under ICD-10, there are very specific codes that will trigger a modality being covered, even when the standard of care has been met.

More frequently, modality treatments are being denied in wound care treatments due to medical and treatment diagnosis, so does this mean that we need to decrease the intervention due to fear of denial? No, of course not. We just have to be more efficient and work as a cohesive team so that we can provide the best possible care that our clients deserve and allow them to benefit from our skilled intervention. So let's practice.

This is a documented statement I took from a chart. The clinician said "Estim for wound healing times 60 minutes," so this obviously does not give a full description of services that are skilled that this physical therapist has provided, so a better way to write this statement might be, "Skin inspection revealed intact skin. no redness noted in periwound area. Client positioned in right side lying. Electrostimulation, electrodes applied to medial and lateral borders of wound that is presented on left greater trochanter. Gauze with saline moistened gauze applied to the wound bed and held in place with dry gauze and tape. Settings of negative polarity. 80 pulse per second, 150 volts utilizing high volt, high volt stim. Treatment time, 60 minutes. Skin inspection after treatment. Skin intact. No redness noted." So here's another example of therapeutic activity, 97530. What the clinician originally documented, it's client treated bedside for

bed mobility activities. Client dependent for all activities. A more skilled statement would be "Client seen bedside for training in right left rolling to improve function mobility and complete a positioning scheduled for pressure reduction. Client requires minimal assist for reaching with upper extremity for bed rail to assist and max assist of one to complete rolling task. Client requires 100% cues and assistance to complete tasks. When side lying, client positioned with bolster behind back to maintain side lying with a pillow between knees and ankles to avoid pressure. CNA's included in training and required 50% verbal cues and demonstration to complete proper positioning in bed for pressure reduction."

So it's absolutely critical the therapist show in their documentation services can only be provided by a therapist. In all documentation, that's including our plan of care, progress notes, daily notes, this skill component has to be emphasized and we need to describe our skilled intervention. Additionally, we have to be sure we provide comprehensive and descriptive documentation that clearly paints the picture of the client's function and why treatment is needed.

Our documentation starts with choosing the appropriate medical diagnosis, and ICD-10 gives us the opportunity to be specific in our diagnosis coding choices, because it's opened the door for a lot more denials because we have so many more code choices. So we now have to consider the billing office as part of that multidisciplinary team as well. We already talked about our MACs, that CMS has established Medicare administrative contractors for all states, private healthcare insurers, so even if you're not in longterm care, private health care insurers that are rewarded a specific geographic jurisdiction process to look at claims, also medical durable equipment claims for Medicare beneficiaries are also kind of grouped according to specific geographic jurisdiction. So the take-home message for this is that we have to be familiar with our state's MACs and the edits, the LCDs, that they put in place for coverage. Throughout the course of documentation, our codes are also

changing. So as an example, in 2018, there were 169 new ICD 10 codes added for pressure injuries. Coding revisions are also made to the national coverage determinations, and you can find this spreadsheet at the link listed on this slide. So to stay up to date on these ICD-10 code changes, you have to make sure that you visit this link or someone in your community is visiting this link. CMS also has a Medicare coverage database, and it gives you up to date information about those national coverage determinations, those LCDs, local coverage determinations. There's a public comment tool. So you can see the link at the bottom of this slide, and this link's another great tool to help us stay on top of coding updates and changes, which is difficult, I admit, but it's essential with our documentation. It also helps us stay on top of what services will be or will not be covered.

There are no hierarchical condition categories. So what that means is there is a risk adjustment that calculates risk scores for our Medicare beneficiaries, and so it's important that we include underlying diagnoses in our medical record that are gonna affect our client's ability to heal, and we want to clearly show the medical condition of the client at that moment, so the current level of function and how that medical condition is affecting the client's ability to heal that wound.

One thing that is a part of wound care is that regardless of what state you practice in the CMS interpretation of the standard of care has to have been in place for 30 days before modality can be introduced to the plan of care. So that standard of care includes that the client must have an optimized nutritional status. They have to have received debridement to remove any devitalized tissue if that's appropriate. They need maintenance of a clean, moist wound bed, and treatment of any infection that might be present. So again, that has to be a place for 30 days before you can initiate that modality. So are you confused yet? Is your head spinning? We are PTs. We are clinicians. We can't possibly be expected to manage all this, and that again is why we have to partner with our billing experts to really get a grasp on this and keep us

updated. They are a essential part of that multidisciplinary team. All right, so we are about a little bit more than halfway through presentation. I'm going to tell my third joke. As I'm telling this third joke, go ahead and stand up, take a quick stretch break, touch your toes, march in place, complete a side stretch if you need to. Here's our third joke. What's the difference between a man with multiple stab wounds and a knife juggler? And the answer is practice. And with that, we will move on to principles of effective wound documentation for nursing and therapy.

Because therapy and nursing work so closely together with our clients living with wounds, I wanted to quickly touch on how we communicate about our roles in documentation in regards to working with our clients with wounds. So we can't really move forward with wound care documentation if nursing is not on board with the documentation. So our documentation has to support the need for therapy, intervention, and care.

Our nursing documentation has to support the reason therapy's needed for care, and this includes documenting that standard of care that we just talked about, consistent tracking of wound status that is uniform and clear, documentation of any kind of lack of progress with the standard of care, and especially if that standard of care hasn't been met and that client is now receiving or now needing to receive a modality intervention. Supportive daily nursing documentation has to reflect a coordination of efforts between nursing and the interdisciplinary team. The vocabulary utilized prior to a client's referral to therapy and during therapy treatment can impact a billing claim if it's reviewed. So nursing documentation can support what effect or impact therapy's having on the client, and they make a difference in whether the therapy claim's covered or not. Good nursing documentation is really important for reimbursement and minimizes the loss for your facility or your clinic. So we want that nursing documentation to avoid subjective terms that may conflict with rehab documentation. When in doubt, check the therapy progress news or ask the therapist prior to writing the note for the day. So this is

something that you're going to be teaching your nursing staff through education in your community. Really, supportive nursing documentation is important for anyone in the community, really anyone that's in treatment in therapy and referred for a decline of function. It's also essential for people that are referred to therapy for a decline of function, treated in therapy, really receiving any kind of therapy service. This slide is a bit of a repeat, so I'm going to skip through this. We know that communication between nursing and therapy is very important. We want to make sure that it's a habit that we're documenting any kind of pattern of change.

We also know that before we can evaluate a client that nursing needs to support in their documentation why we're actually evaluating this client, so what kind of change of function has there been? So this slide just gives us a list of phrases that should be avoided in our nursing documentation. If the client's being treated in therapy, I'm not going to go through all of these. I'll just highlight a few. So we don't want nursing to document refused to participate in treatment, or little change, or status quo, or plateau. We need to educate nursing about how their documentation should support therapy, and we need to learn from nursing in return about what they need from us as physical therapists and our documentation.

So in general, nursing documentation should focus on words listed on the slide and supportive rehab services to demonstrate prior level of function or a decline or improvement in function, so things such as the amount of assistance required, safety awareness, adaptive equipment. If the client is experiencing any kind of cognitive issues, if there has been functional activity tolerance issues, if the client's using compensatory strategies. What does their ability to communicate look like? Are they experiencing dysphasia? Are they having problems with positioning? Is there any kind of pain that's impacting a client's ability to function? Now, nursing and therapy should have a consistent method of communication regarding clients with wounds, and you really have to decide what works best for your clinic. For us, we're all housed in the

same building, so we can have different types of meetings. We can have wound meetings. We can have Medicare meetings. It can be part of morning meetings. We can have wound rounds, et cetera. Your nursing that you're working with may not be underneath the same roof, so you have to figure out what works best for your facility. What can interfere with effective communication? If we don't all respect each other, if we're not being understood by each other, and if we are controlling work patterns, scheduling, if this is routine in our clinic, so there has to be a concerted effort to learn from each other about our disciplines and about how we all approach clients living with wounds.

So the next slide I'm gonna go through pretty fast. Hopefully we're not feeding into stereotypes. There's a lot of stereotypes out there about nursing. At the same time, there's a lot of stereotypes out there about therapy, so given all these stereotypes, how can we work together on the same team for the best outcome for our clients? And so this, again, may seem a bit idealistic, but we have to assume the best. How often have we heard someone make a negative comment about another discipline or nursing?

And have we ever made the same type of negative comments? And I hate to say this, but yes, throughout the course of my career, I have fed into those stereotypes at times, but that does not ever end well for you developing a cohesive team that can work together to provide the best care for your clients living with wounds and capture that care in your documentation. You don't want to jump to conclusions. So once again, have you ever acted without having all the facts? Have you ever misunderstood or misread the situation? I know I definitely have. Have you ever acted upon some stereotypes instead of accurate information? So we want to gather all the information before we actually act. We need to understand and accept personal cultural and professional differences. Have we ever thought to ourselves that we know more than nursing does? I know I'm guilty of that. Without fully understanding the role, have we ever felt that nursing doesn't do enough work or carry their fair share? Have we ever

gotten angry or upset because someone has a different work ethic than you? And I know I'm very guilty of that, or because they couldn't address your need or concern at the exact moment you wanted? Again, guilty. So how do we establish this effective communication? We have to set boundaries. We need to make sure that we're keeping it professional at work, that any relationships we have with our colleagues is professional, especially in terms of communication. We want to be respectful. Are we listening to everybody's input at the team meeting? Do we feel that therapy's input is the only real or important input? And do we value the work that nursing does day to day? So for example, do we value them bathing our clients, dressing our clients, medications they'll like?

Do we involve the multidisciplinary team in our decision making? Do we respect the function that others have on the multidisciplinary team, including nursing and social work and activities, et cetera? Other things to consider is whether or not our teams have synergy. Do we recognize that we're all here for the same reasons, to care for our clients? Does our documentation support the other disciplines, and that's why we're ultimately talking about effective communication, because if our documentation doesn't support all the disciplines involved in that client, then we're not going to make as much progress with the client as we could. Are we defensive during our communication?

Have we oriented nursing to what role our discipline plays on the multidisciplinary wound care team, and have we openly listened when they define their role? So we always want to place the client at the center of care, and this is why we went into therapy, right? We care about our clients. We want to understand, respect each other's contribution. Use positive words versus negative speech about other disciplines, and obviously we would never include any kind of negative verbiage about disciplines in our documentation. We want to try to best as we can to coordinate treatments with things like medicine and dressing changes and voids, et cetera, with the client

schedule in mind, especially tasks that may take longer. Now, I know this is difficult, but ultimately it's better for the client if we can get a handle on their schedule and how we coordinate that schedule. And then we want to collaborate with nursing regarding these schedules. We want to know our responsibilities and be open to go beyond our job description, to do what's best for the client. We're all seeing this a lot during COVID-19, so if there's any silver lining to COVID-19, perhaps it's that we have expanded our jobs beyond just what our job descriptions say we can do. Also, we want to promote open communication and mutual respect. All right, thank you for letting me go off on that quick tangent. Back to what our documentation actually needs to include. So what do the regs actually say about clinical records?

A federal tag 514 outlines the regulation that a facility has to maintain clinical records on each client that are based on professional standards and evidence-based practice. So that complete medical record contains an accurate representation of the actual experience of the client while they are participating in skilled care. So per the regulation, these records have to be complete. They have to be accurate. They have to be readily accessible and systematically organized. Before we had electronic records, that was a lot more difficult, but now with electronic records, it's a lot easier to stay organized and complete with our records.

If we don't meet these regulations, we can't jeopardize clients, our facility's certification. The client's clinical record has to have enough information to identify the client and should include any results of any kind of pre-admission screening that occurred, a record of their assessments, the ongoing plan of care, all the different orders, and of course those orders have to be signed and dated. Progress reports, supportive clinical documentation, any kind of labs, diagnostics, medication, treatments, administration records, any kind of flow form, the various types, such as CNA charting, and supportive activities of daily living documentation. All of this information paints the picture of the client's condition while the client's in or receiving

care by physical therapy, and it's necessary to support our skilled services. The principles of determining skilled care are the service has to be so inherently complex that a client can only receive these services effectively or under the general supervision of skilled nursing or skilled rehab personnel, and your documentation has to illustrate and answer the question why, so why does this take a therapist to care for the patient? The documentation has to reflect any of those medical conditions or complications that require the provision of services by a skilled personnel. When the medical condition is a valid factor, or the diagnosis or prognosis really should never be the sole factor in determining that a service is not skilled.

This guidance comes directly from CMS and it's the reason why documentation piece is so important when we talk about wound care and the process of healing wounds with our clients. It's essential that all staff, especially nursing and therapy, know why the client's skilled, and the most clear cut way to support medical necessity of treatment is to document that decision making process along the way. So this slide is specifically for our therapists on the call today, working in SNFs, but when it comes to practicality, this is a consideration of economy and efficiency that these skilled services can only be provided in a SNF related to the client's complex medical status, intensity of therapy being provided, or the fact that less than 24 hour per day care would place the client at risk for adverse medical or safety complications.

The documentation provided by the licensed personnel has to support that the SNIF care was reasonable and necessary by illustrating everything that was listed on this slide. So we know that skilled care is a process, of assessment, of diagnosis, planning, implementation, evaluation and adjustments as needed, and documentation of this process is critical because again, this is our receipt that skilled care was delivered. For skilled care, that clinical record has to prove that the client needed and received skilled services on a daily basis as defined by that Medicare policy benefit manual that I read to you a few slides ago. the documentation of this process is really important to

success, and the content of that documentation has to be specific to the clinical reasons for coverage, as well as detailed documentation of any new problems that may arise while that client is receiving skilled services. We need to illustrate in our documentation that critical thinking process by the clinician that illustrates that approach to solving the problem and facilitating how we're going to accomplish the goals with our clients, and what exactly is our desired outcome of care. So that's a lot of talk about documenting critical thinking, but how do we actually do this? We need to illustrate why it's necessary for the therapist to be involved, or the nurse for that matter, to be involved in the client's treatment and recovery. The documentation needs to outline the assessment of a client's condition, causative factors, risk factors, and concerns for safe function.

So is the client a fall risk? Are they at risk for skin breakdown? The documentation should outline the analysis of current condition and level of function and potential outcomes or consequences, so link back to those goals as well, based on whatever their level of function is. And the documentation should include the evaluation of the client's response to the treatment plan, including details of necessary revisions to existing treatment approaches in the plan of care to help better meet the needs of individuals.

So at a minimum, the clinical record should include descriptions of changes in conditions that might have precipitated any change. It should include details of any unusual occurrences that may have happened, as well as details of communications that took place with the physician and the responsible party about any events. It's also key to provide documentation to support the provision of care and services and the client's response. It's the responsibility of the staff to review these orders and to begin their own assessment of the client to identify potential care issues and problems. So if you're in a SNF, within 48 hours of admission to the facility, the facility is required to implement a baseline care plan for the client that includes the instructions needed to

provide effective and client centered care of the client that meets professional standards of care. So what do we need to document? Any kind of assessment information, any kind of action taken, so what did we do with the actual findings, the response of the client, how did the client react to our intervention? What are we communicating to others about the client's condition? And then of course, the evaluation of the above for the effectiveness of the treatment plan or the need for plan revision. Part of this process includes documenting the future planning of what the clinician anticipates they're going to observe, assess, manage, and evaluate related to risk factors and concerns for medical safety and function moving forward, and then the rationale to support this, so perhaps we communicate that client's risk for skin breakdown and why we think that client's at risk and how that's going to impact them functionally.

And what did we the clinician do to communicate to others about the client's condition? And so in our case, for instance, what did we do to communicate that this client might be at greater risk for skin breakdown? Now, when it comes to documenting, we need to always follow your clinic's policy. So this should be a review, but every clinic's policy on documentation is a little different, so we need to make sure we know what that policy is.

Our regs don't exactly tell us how frequently to document for skilled patients, but the rule of thumb is at very least daily. If you do work in longterm care, you can document every shift, and this will provide an even clearer picture of the client's overall condition on a daily basis. Sometimes that's why education to that multidisciplinary team is so important, so they can see how providing this clear picture is a better illustration of the client. We need to also provide proper documentation, meaning that we document events as they occur in chronological order, which then provides a nice timeline of events of the client's care. We never ever want to document anything in advance or prior to actually providing the treatment or provision of care. We want to be very

professional in our verbiage. We're going to stick to observations, facts, details. We're not going to be vague. Of course, this is a review, but we don't want to document for others. We're only documenting for ourselves, and that might seem obvious, but sadly, I see that occur in clinics often. We want to document only what we're qualified to do and what is in our practice act, so that's why it's important for you to know your practice act. We want to avoid using abbreviations that can be misinterpreted. If you're going to use abbreviations, then make sure you use a list approved by your facility. You wanna avoid any kind of red flag statements. We went through some of those, but some other ones might include writing things like "in error" or "by mistake" or "by accident." And then as always, we want to make sure our entries are complete.

They have a start, middle, and ending, and are of course signed and dated by you, the physical therapist. We need to know correct medical and anatomical terminology. This is especially important with wound care because it is so anatomical how we approach these wounds. We don't want to have spelling errors. We need to know our ICD 10 coding, and our documentation needs to support that ICD 10 coding. It needs to tell a story throughout the whole course of the documentation, why those codes are appropriate for that client.

Accuracy and specificity are required in order to minimize potential risk of claims and denial. So this is kind of all saying the same thing, that we need to be professional in our verbiage and really capture what is individualized about that client and why that client needs our skilled services. And then of course, we need to do all of this and keep it as concise as possible. We don't need to be writing novels about our clients. We need to really capture why we're treating this client in a concise manner. All right, I think that we've said this a lot today. We know now that we have to have, make sure that our services are inherently complex and something that only we as therapists can provide, so we're going to skip through that pretty quickly. Reasonable and necessary are buzzwords we hear about all the time. We know that skilled care may be necessary

to improve or prevent slower, to improve, I'm sorry, or prevent further deterioration of that client's condition. So we have to make sure our documentation clearly illustrates the details of these efforts by the clinical team and that our repetitious documentation is not present, because that's often not giving necessary support for skilled services. All right, in order to support our medical necessity, we have to make sure that we, the medical record captures and documents the history and physical exam, skilled services provided, client responses to skilled services, plans for future care, detailed rationale, explaining the continued need for skilled care, complexity of services to be performed, and any other pertinent characteristics of the client. I think this is things that we've said throughout today, and we don't need to spend a lot of time on that. So the facts and details. State the facts.

Documenting "wound appears to be healing" tells us what? So it essentially tells us nothing. We can't compare this to anything. It's not an objective statement supported by facts. We need to be working to describe the client's current condition. State the facts. Indicate, as evidenced by, and then provide details in support of your clinical observations. Use professional terminology that indicates, assess, implement, modify, facilitate, instruct, all of this verbiage hint at skills being implemented by the clinician. As clinicians, we need to always indicate what risk and concerns continue.

For example, if the client has poor oral intake, the proper wound healing may be delayed, so what as a healthcare team are we doing to address this concern? And we should provide insight into that continued plan and the rationale to support that plan. What details are we using to back up our statement, "Wound appears to be healing?" So let's run through an example, and these are some of the examples of what I mentioned on the prior slide, where the details are provided to support the facts. So this was written by nursing. Left lateral calf wound healing, as evidenced by decrease in size and amount of drainage from last week. Wound measures 0.2 centimeters by 0.5 centimeters. No drainage observed on dressing or in wound bed at time of

scheduled dressing change. Oral intake has been optimal with client consuming at least 75% at every meal in the last week. The client's condition is improving since admission, as evidenced by client now able to ambulate entire distance from room to dining room for meals without requiring a rest break, and without evidence or complaints of shortness of breath. So we can see from this documentation, it's detailed, it's specific. We know exactly how this client is healing, and we know functionally why it's important for this client to continue with this plan of care.

So again, important for us as physical therapists to give examples of nursing documentation, give stellar examples of nursing documentation to that multidisciplinary team and constantly be educating that multidisciplinary team about the importance of documentation that supports the skilled services that physical therapy provides. All right, I'm going to go through this next bit very quickly. This is a bit of a departure away from strictly wound care documentation, but I think the next few slides are too important to exclude, but I am going to go through that quickly since I know not everyone on the webinar today is in a SNF setting, but we said this before, but we consider it a skilled service when it's so inherently complex that it can only be provided by a registered nurse. If the services can safely be performed by an unskilled person, then it's not considered skilled. So what are those?

Management and evaluation of the care plan, so really looking at developing the care plan, implementing the care plan, evaluating, making changes to that care plan if it's not working. And this is going to veer away from wound care for just a few minutes, but we're going to return to wound care in just a second. So this is just an example. 84 year old client with history of diabetes, angina pectoris, is recovering from open fall reduction of neck of femur post-fall and the client needs careful skincare, appropriate oral medications, diabetic diet, therapy services to regain prior level of function, observations for signs of deterioration or complications resulting from age. Multiple comorbidities, risk factors, and restricted mobility. So this is how we would capture

this, or we would encourage nursing to capture this in their documentation. We also would include observation assessment of the client condition, so this includes when there's a likelihood of change in their condition which would require the skills of nursing or therapy to evaluate the need for possible treatment. The modification or treatment plan or initiation of additional medical procedures is skilled until that client is essentially stable. So nursing can provide supportive documentation by creating that care plan that describes the client's conditions or symptoms and the potential risk factors that complicate the client's overall conditions. Indicate the daily or more frequent need to assess vitals, and other indicators of the client's condition. Document the communication to the client's members of that multidisciplinary team, and then illustrate in detail the critical thinking in the nursing process from assessment to development or revisions to the treatment plan, including that rationale for selected interventions in the nursing notes. It's skilled observation and assessment until that client's treatment regimen is considered stabilized.

That daily documentation has to support the fact that observations and assessments are being completed and are requiring changes to the treatment plan. So here's an example of that skilled observation, a client with arterial arteriosclerotic heart disease with congestive heart failure. Requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medications, such as Digoxin or Lasix. In the interest of time we'll go through this quickly. Of course, if they're experiencing any kind of respiratory concerns, you want to make sure that you capture those respiratory concerns. Everything listed on this slide needs to be captured in the documentation, and this is really important because of course we're seeing right now a lot of clients living with respiratory deficits, but we also know that respiratory concerns have a big impact on our clients living with wounds as well. There's just an example of the nursing documentation, painting that picture of care, which I'll run through quickly. And then finally, we want to make sure that we are capturing, teaching, and training activities and documentation. We know

that our nurses that we work with are teachers all the time, and that teaching and training activities that require skilled nursing personnel consist of teaching a client how to manage their treatment regimen. For teaching and training to be skilled, we have to document the who, the what, and the response, and once the subject matter to be taught is identified, then that teacher has to identify the client, family, or caregiver, whoever they're teaching, and assess their readiness to learn. We also have to identify and report the response to instruction and identify any barriers to learning. The learner needs to be required to perform return demonstration in order for the instructor to assess any kind of carry over of the learned skill, and then we want to document or illustrate everything listed on this slide.

So let me give you a quick example of what that would look like in actual documentation. A wife was instructed in tube feeding formula and potential side effects by a dietician. Nursing demonstrated how to check placement of gastric tube prior to administration of feeding, and then how to check for residual. Wife instructed in use of stethoscope today. Wife voices concerns about, I'm not sure I'm listening right now, or I'm listening to the right thing. Nursing will continue with additional demonstration in skill practice this evening using the teaching stethoscope so nurse can verify the wife's observation.

Will progress to the mechanics of administering the bolus feeding as wife demonstrates comfort with current information. So the key here is about providing the detail rather than just a vague statement, such as client caregiver education provided. This note really identifies who was taught, what they were being taught and by whom, and it reports the feedback from the caregiver. So she voiced concerns, what they were, and the documentation identifies the plan and response to those concerns, and for the continued teaching and training activities. All right, so we're going to go on to our last joke. What do alligators with wounds drink? In our last joke, the answer is Gatorade. So let's move on now to essential elements of wound documentation. I

know a lot of you, this is what you've been waiting for. We know once the referral for wound assessment's received, it's very important that all aspects of the wound are documented. We need to give a clear impression of the wound for anyone that's involved with the care. Our nursing and therapy documentation, they have to mirror each other. That's why we just spent so much time talking about the communication between nursing and therapy, and the importance of nursing documentation. We have to all support ourselves in the nursing documentation, or in all of our documentation, really. So some of the essential elements of wound documentation. We of course need to include location of the wound. So if there's more than one wound, then we need to number those wounds with anatomical reference of the location of each. So let's look at an actual example. Wound located on right greater trochanter, best visualized in left side lying. We want to document the wound etiology. We have to stage pressure injuries if your client has them. Now, it's acceptable to state unstageable if the wound's not visible.

Also, if the client has deep tissue injury, then that should also be documented. We don't want to downstage or decrease the size of the wound, so consider and document also any kind of etiologies that could be arterial or venous or diabetic or mixed etiology or traumatic. So here's an example of the etiology. Stage three pressure injury. Recently underwent surgical debridement. No visible evidence of bone, muscle, or tendon. We want to document measurements of length, width, and depth, and these are taken using the face of a clock for reference, and this is essential for tracking progress of our clients. That clock also needs to have an anatomical reference, like the head or the foot. Our measurements have to be consistent and reproducible, so this is why we are communicating to anyone coming behind us that we work with so they can reproduce whatever kind of measurements that we have taken. So once again, that's why our communication is so important. So here's an example of a measurement. Longest point of wound is four centimeters measured from 12 to six o'clock, using the head as the reference for 12 o'clock. Widest point is three centimeters measured from

nine to three o'clock. Deepest point measured in center of the wound at two centimeters. We want to document the composition of the wound. What does a wound look like using percentages? And of course, I'll give you an example of that in just a second. We want to document changing composition, and this may be objective documentation of healing progression of the wound, or even when the wound isn't healing. We want to document changing composition, and this also helps to define when the wound is going through the various phases of wound healing, so that inflammatory phase, the proliferative phase, the maturation phase. So here's an example. Wound is 70% red granulating tissue, including wound walls and 30% fatty tissue following surgical debridement. We want to document the drainage. Was it minimal, moderate, maximal? Was it scant?

Be sure to remove the dressing and irrigate before you document the drainage. We know now that some dressings interact with fluid, which can give a false impression of infection or pus or the wound bed just sometimes looks different depending on the dressing that you have put on it, so make sure that you're aware of any kind of systemic components of infection. Also be aware of characteristics of dressings that are used by nursing. So in general, you need to know your wound care products, correct? So that's why really you should figure out what works for clients in your facility and then stick with those products.

Don't play wound care product roulette, where you're changing all the time, because if you do this, then you don't know what to expect from those wound care products and what those, how they affect wounds and how that actually looks when you look at a wound and assess that wound and then ultimately have to document that wound. So let me give you an example of drainage. So dressing removed and wound irrigated with normal saline. Minimal amount of serosanguinous drainage noted. You want to document the periwound area. Is there erythema? Is it indurated? What does it look like? So it's important to document as well as measure. The area may be predisposed

to breakdown, and we want to of course capture that if it is. Here's an example, periwound area unremarkable. Residual skin barrier. Cream present around the wound. Tunneling or undermining should also be captured in our documentation. We need to know the location. If it's even present at all, where is it on the face of the clock? So now in this picture, the wound doesn't have undermining or tunneling, but I wanted to give you an example of that documentation. So undermining present at nine o'clock using the head as reference point for 12 o'clock for two centimeters. And then we want to know the phase of healing. Clinicians have to know the different phases of healing, so the inflammatory phase versus the proliferative phase versus the maturation phase. So if you don't know those, make sure that you brush up on them and then you include them in your documentation.

So here's an example. Wound is in the proliferative phase of healing with primary function at this time to fill depth to allow for contraction. You want to include odor. Is it present or absent? Description? Some odors are indicative of an infection. And of course, signs of infection that we're looking for, redness around the wound, yellow-green discharge, red streaking from the wound, fever, swelling, pain. So here's an example of odor. Dressings removed, wound is irrigated with normal saline, no odor present. Now we talked about this a bit already. Our goals need to be measurable and functional. We can't say that the goal is for the wound to heal. This is not client-centered.

So what does that mean? Why do we care that the wound's closed? I always ask myself, so the wound's closed, so what? So essentially we want the outcome to be meaningful to our clients. So as an example, client can now sit in wheelchair with proper pressure relief, cushion and good posture for one hour increments, which will allow her to attend church services and bingo in the community. Let's go through some more examples of goals for our clients with wounds. Here's an example of longterm goal. Upon wound closure, client will be able to sit in a wheelchair with pressure relief

cushion and good positioning for one hour intervals to allow her to attend a daily church service, which was one of her goals. Or short term goal. Client to tolerate less side lying with pillows between knees and ankles and bolsters behind back for 30 minutes, 30 minute intervals, to allow for pressure relief of right greater trochanter region. Our documentation has to support the skill being provided. That is what we've been working up to throughout this presentation today. Details should allow for anyone that needs to perform treatment the exact information on the modality set up, including the positioning of the client, the placement, the parameters, the time, the tolerance to treatment. We want everyone performing the treatment to perform the treatment the same way, and then we want to always include skin inspection before and after treatment.

Okay, so we are back to our case study that we started from the very beginning. Now we read this at the very beginning. I'll read it to you now. Ms. Smith admitted to a skilled nursing facility 1/25/20. She's a 74 year old female admitted following a fall and diabetic ulcer of the right foot. She has a complicated medical history. You can see obesity, polyneuropathy, type two diabetes. She has that open wound on the right foot that we've already talked about, muscle weakness, balance deficits, difficulty walking, she has pain. She was very independent prior to rehab. She really loves to garden and she cares foster dogs on the weekend.

So back to what we started at the beginning, and this is where we will do our poll. You don't have to worry about describing the wound as you would in the PT evaluation, but I do want you to go ahead and write one goal for Ms. Smith right here. I'm going to give you two minutes to do this, and then I'm going to share some goals, and I want you to not look ahead because I do have some examples, but go ahead and include one goal, and while you're including that, I will go back to the very beginning to that MEASURE acronym, things that you might be considering as you're evaluating if this wound is closing. So things like the length, width, depth, and area, quantity and quality,

wound bed, including tissue type and amount, suffering, so are they in any kind of pain, undermining, monitoring all the parameters regularly and then the edge, so the condition of the edge and the surrounding skin. So I'm going to give you about one more minute. If anybody wants to chime in with a goal for this, again, our goals need to be very specific for function. They need to incorporate why we want this wound to close, why is it important for this client functionally for this wound to close and how does this wound really impact a client's ability to function in their everyday life? Okay, I'm going to go ahead and I want you, all right, thank you.

So we have a couple of people that responded. One of the answers I got was, "Ms. Smith will have full wound closure to allow her to wear a shoe." I think that that's terrific. Thank you so much for answering. I'm going to go ahead and close this poll and I'm going to give you my example of how I would describe this wound. So I would describe the location, the planar surface of the right foot, just distal to great toe and goes lateral to under third digit, the etiology, diabetic foot ulcer grade two on Wagner Scale. Measurements using the face of a clock, the length measured from seven to two o'clock, to be whatever the centimeters were. It's hard to tell from a picture, Width measured nine to three o'clock to be whatever the centimeters are, and then no measurable depth.

The appearance, 90% red granulating tissue and 10% tan necrotic tissue. Wound edges are irregular and from 12 to eight o'clock there is callus formation. Surrounding skin is dry. There's evidence of foot deformity in forefoot as well as hammer toes, which can change the weight bearing surface. Drainage, I would describe whatever the drainage is, depending on what it actually looked like in real life. Odor, of course you can't tell from this slide, and pain, we would ask the client if they're in any kind of pain, and then we would address that pain if they are in pain and document it. So in terms of goals, client to ambulate safely with a wheeled walker on level surfaces with supervision due to new unsteadiness and gait deviations created by total contact cast.

Client to verbalize 100% understanding for use of wheeled walker for safety. Another goal, wound to be 100% red granulating tissue and free of callous formation to allow for wound to progress in healing process and enable client to increase ability to participate in grooming activities. All right, so as we go through, Ms. Smith is progressing. The standard of care was met and she's being treated with debridement, offloading with contact casting. She's being seen for strengthening of her bilateral lower extremities, transfer training, using a rolling walker, balance activities, gait training and safety instruction. In therapy, they're working on things that she needs to do to be able to go home, so essential things like ADLs and ambulation, but they're also working on leisure activities like gardening and walking the dog.

So in the interest of time, this was going to be a skill, another poll question, but I want you to look back at what you wrote at the very beginning, and just in your brain, think about how you might enhance that progress note based on some of the principles that we talked about here today on this webinar. So here's an example of how you might enhance that note. Wound is in the maturation phase of healing, small area of fresh scar tissue, just distal to second digit. I would address all things that we did in the initial measurements, but also, are we done with this patient? No, we're not. We're working on offloading, so we would document that.

If we don't have a plan and good education for this client, then she's still going to have further breakdown and she's not going to be able to return to her functional activity, so we're gonna describe in detail any kind of plans for education. So let me give you an example. Client to demonstrate good balance as evidenced by Berg Balance score while wearing custom diabetic shoes to enable her to return to gardening activities, and I might actually be more specific with the Berg Balance scores as to what score I want her to achieve. So it's really important that our staff is educated regularly on skill document techniques, especially when it comes to wound care. It's helpful for our staff to know the why and the what that can come about when documentation to support

skilled care comes under review. That's why we spent so much time at the beginning of this talking about all the different people that are reviewing your documentation. You want to find those folks who document well and then make them the mentors and the leaders and champions for wound care documentation in your facility. Provide re-education for those who need it. We're not all perfect at everything, so you might just need to do a refresher on documentation for some of those people in your community or in your clinic. And then have an effective new hire training in place to teach staff at the start of their employment. I know not everyone here is a manager, but if you are a manager, then make sure in that onboarding that that's being addressed. So that's all the content I have for you today, but now we're going to allow some time and space for questions. So if you have a question, go ahead and type it in the Q and A.

- [Calista] All right, well, I don't see any questions yet. We'll give it another minute here, but before we end, see if there's any questions that come in, I want to thank you so much Neely, for sharing your expertise with us today. Another great course on wound care. And we just have some comments coming in about a great class, so thank you. All right, well, I don't see any questions. Is there anything else you want to leave us with today, Neely, before I go ahead and close out today's course?

- [Neely] I just wanted to reemphasize that the reason we went through nursing communication in the first, and how important that multidisciplinary team is in the first place is because really providing client-centered wound care is the key to making sure that our clients progress with their wound healing and then capturing that in the documentation is so important, and so I really appreciate you wanting to be here today to learn about documentation. I know on a Friday afternoon that that's not always the most fun thing to talk about, so thank you so much for being here and wanting to learn about how we can really elevate the care for our clients living with wounds.

- [Calista] All right, well thank you everyone for attending, and I'm going to officially close out today's course. Have a great day everyone.