

Wound Charting Best Practices



1. Document Timely

Record observations immediately after assessment to maintain accuracy.



2. Detail Wound Description.

Include size, depth, location, odor, color, and exudate type.



3. Consistent Measurement

Use the same technique for measuring the wound to ensure consistency.



4. Photographic Documentation

Take regular photographs to visually track healing progress.



5. Record Pain Levels

Note patient-reported pain levels during each assessment.



6. Use Standardized Tools

Employ tools like the Pressure Ulcer Scale for Healing (PUSH) to standardize documentation.



7. Note Treatment Changes

Clearly document any changes in treatment plans and rationale for these changes.



8. Include Patient Responses

Record patient's response to treatment and any complaints or concerns.



9. Follow Privacy Laws

Ensure documentation is compliant with HIPAA and other privacy regulations.



10. Educational Notes

Document any patient education provided regarding wound care and management.