



Key Points

- In certain environments like Home Health, treatment orders must be very specific not only for the Agency to be protected but the nurses must have very specific directives to follow.
- Treatment notes are added on the mobile (voice-dictated or typed) or on the web (typed). Notes are saved and can also be viewed on the last page of the PDF report
 - PDF report can be provided to Home Health nurses who are then able to follow the directives in the notes.

Report PDF – Treatment Notes

Treatment notes dictated or typed on mobile or web are saved and displayed on the last page of the Assessment Report.

STEP 1 – Document Notes

Wounds, Assessments & Treatments

Add / Edit Treatment

Dressing & Securement (Required) Frequency & Duration / Notes (Required) Goals, Interventions & Address (Optional)

FREQUENCY

☐ Weekly

☐ 2x / week

☒ 3x / week

☐ Every Other Day

☐ Daily

DURATION

☐ 15 Days

☒ 30 Days

☐ Others (Enter Days)

Treatment Notes

Effective 11/22/21:

SN to complete wound care to left ischium per aseptic technique as follows:

Cleanse wound with Vashe and pat dry with gauze. Apply skin prep to Peri-wound area, apply collagen and cover with bordered foam dressing three times per week. Caregiver can change dressing in absence of SN. Wound to be re-evaluated in 2 weeks.

Save Return Place New Order

10:33

Test, Amanda

1 - 1 - Type Not Assigned

Arm Left Posterior

Assessment Date: 11/18/2021

Assessed by: Nurse, Betty

IMPROVING DETERIORATING NO CHANGE NA

Measurement & Tissue

Tunneling & Undermining

Treatment Plan

Email Assessment Report (PDF)

Treatment Plan Notes

Effective 11/22/21:

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STEP 2 – View Report

Assess & Treat Details by Date

Add Assessment/Treatment

Edit/View

11/18/2021

View Report

Patient Wound Assessment Report

Report Generated: 11/03/2020 1:17 PM By: Heland, Scott

ARCHANGEL

PATIENT

First Name: Jumbo

Last Name: Tron

Date of Birth: 10/27/1986

Sex: Male

Patient Consent: -

Medical Record: -

Agency Name: Scotts Home Health

Nurse: Heland, Scott

Nurse Phone #: (333) 333-3333

WOUND

Number: 3

Wound Type: Pressure Injury / Ulcer

Stage/Thickness: Stage 4

PCA: No

Onset Date: -

Wound Age: Between 3 and 5 months

Location: Anterior right shoulder

ICD-10 Code: -

Status: deteriorated

Discharged: No

Healed: No

ASSESSMENT

Number: 4

Assessment Date: 11/03/2020

Next Assessment: 11/11/2020

Comorbidity: -

Interfering Factors: -

Medications: -

Others: -

Wound measure

Length(cm)	Width(cm)	Depth(cm)
5.35	6.22	2.00

MANUAL Wound Bed %

Epithelial	Granulation	Slough	Eschar	Scabbed
-	60	20	20	20

Fluid Filled Blister: -

Blood Filled Blister: -

Intact Skin Light: -

Intact Skin Dark: -

Granularization Details (if any): -

Eschar Details (if any): -

Slough Details (if any): -

Exposed Bed (if any): -

Edge: -

Peri-wound: -

Exudate Amount: -

Exudate Type: -

Odor: -

Temp: -

Pain At Rest (1-10): -

Pain At Movement (1-10): -

Desc Pain: -

Wound Image Date: 11/03/20

Wound Image Time: 08:33 AM

Tunneling [Depth (cm)]: -

Undermining [Depth (cm)]: -

Last page

NOTES

Treatment Plan Note

Nurse, Betty (Clinician)

11/24/2021 10:27 PM

Effective 11/22/21:

SN to complete wound care to left ischium per aseptic technique as follows:

Cleanse wound with Vashe and pat dry with gauze. Apply skin prep to Peri-wound area, apply collagen and cover with bordered foam dressing three times per week. Caregiver can change dressing in absence of SN. Wound to be re-evaluated in 2 weeks.

STEP 3 – Download Report

Report is downloadable for printing, emailing or archiving

Future feature planned – Ability for the clinician who performed the Assessment and Treatment to SIGN the report