Complete Picture of Health
Documentation and Coding Improvement Initiative

Proper Medical Documentation

Subjective: Jane Doe returned to ABC Wound Care for follow-up of right plantar foot wound. Jane came in without any dressing on her foot for the fifth time in the last few weeks. Jane states that she was too tired after work to put her dressing on. She recently took a medical leave from work for the next 60 days to stay off her feet. She has been taking her antibiotics and denies any constitutional symptoms at this time.

Objective: Jane has a large wound on the plantar aspect of her right forefoot area. There is a large amount of periwound callus with maceration. Jane also has a malodor coming from the foot wound. The wound bed is fibrotic with bleeding with debridement. Jane's foot appears to be much more swollen than last visit. There is no streaking or purulent drainage. At this time, no bone is visible in the wound. Jane is status post right first ray amputation and left BKA. Right plantar foot wound is cultured today. The patient is also being sent for hemoglobin A1c to assess her diabetes.

Assessment:

1	Right plantar foot wound.
2	Chronic osteomyelitis.
3	Diabetes and peripheral neuropathy.
4	Status post left below-knee amputation.

Plan:

1	The wound on the right foot is sharply debrided.
2	The patient is to continue doing daily dressing changes with silver alginate.
3	Discussed with patient about not wearing a dressing and explained the health risk to both herself and others of not wearing a dressing. A history of MRSA is not present in patient, therefore, it is unacceptable for her to enter the clinic without a dressing for her foot wound.
4	Discussed the usage of a special boot to help offload the forefoot when she does walk.
5	Prescription to have a specialty molded CROW boot made to help offload the forefoot and help allow for would healing was sent.
6	After culture results are received, we will follow-up with patient if antibiotics need to be changed.
7	Follow-up with patient is scheduled for one week.

Documentation is clear, detailed and accurate, providing a clear description of care. The patient's diabetes and a prior amputation are addressed during the visit, as it was a factor in the decision-making process.

Incomplete Documentation

Incomplete Documentation:

Subjective: Jane Doe returns to the wound care center for follow-up.

Objective: The patient has a large wound on the plantar aspect of her right forefoot area. There is a large amount of periwound callus with maceration. She also has a malodor coming from the foot wound.

Assessment:

1	Right plantar foot wound.

Plan:

1	The patient is to continue doing daily dressing changes with silver alginate.
2	Patient is to follow-up in one week.

Lacks detail and does not provide a true picture of care.