PHOTOGRAPHIC WOUND DOCUMENTATION: CONSISTENT AND ACCURATE METHODS CAN HELP REDUCE LIABILITY

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In case of a lawsuit alleging substandard wound care, photographic documentation of wounds can help protect your organization by allowing your defense team to demonstrate wound staging and clinical progression and to educate a jury on difficult-to-treat wounds. However, haphazard photography may suggest to a jury that the standard of care was not met, potentially leading to an inflated damage award.

Effective photo documentation requires a firm commitment of time, resources and personnel. Apply the following risk management principles when reviewing existing policies or creating new protocols for pictorially recording wounds.

Legal Issues to Consider Begin the process by having legal counsel review the standard of care regarding wound documentation in your jurisdiction, which may require photographing wounds to track and monitor care. Make sure your policies reflect local laws, regulations and standards. Also, regularly review written procedures regarding photo documentation to ensure your facility’s routine is within acceptable parameters. Edit or delete those protocols that are inconsistent with your daily practice.

Continual Photography Is Key The importance of continual photography cannot be overstated. A visual record of the full course of clinical care that is well photographed, clearly organized and safely stored can be a powerful tool for the defense. The record should include

- why the photos have been taken, with relevant clinical information
- when the photographic sequence began and ended
- how the wound’s stages developed, from onset through the continuum of care
- what standards were used to track and monitor the wound, such as those of the Wound, Ostomy and Continence Nurses Society
- who took the photos, which may prove helpful in the event of a future lawsuit

Every photo taken should include standard identifying information, such as the resident’s name, identification number, date of photo and a convenient measurement grid.

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Creating Organizational Policies

It is important to inform residents and families of your organization’s written policy regarding photos – that is, when they can be taken, who can take them and how they can be utilized. When drafting your photographic documentation policy, be sure to include these important provisions:

- **Delineate the consent process** for photographic documentation, being sure to take into account relevant state laws. The American Health Information Management Association has recommended model consent language, which can be incorporated into your facility’s admission forms.

- **Clearly state the process for viewing and copying photos.** Remember that residents have the right to view photographs of themselves.

- **Keep all original photographs in the facility and provide copies only upon written request.**

In general, it is necessary to obtain the resident’s or legal representative’s written consent before undertaking photographic documentation.

Risk-reducing Strategies

These risk management principles can help your facility obtain more useful photographs and minimize exposure during the wound healing process:

- **Conduct initial admission skin assessments** to ensure that wounds already present are appropriately and fully documented in the medical record. This will help protect against possible later allegations that the wound was acquired in your facility.

- **Carefully consider whether to photograph the wounds of residents who have a circulatory or renal disorder** that may impede the healing process. It may be difficult to explain in court why a graphic wound never healed.

- **Document photos thoroughly,** as they are more likely to be admitted into evidence than textbook pictures of wounds. When necessary, explain why a wound was difficult to prevent or treat.

- **Depict the depth of wounds accurately.** Failure to do so may result in a wound that appears worse than it actually is.

- **Ensure that the medical record reflects all written and oral communication of wound status** to the resident, family members and the primary care physician.