

Documentation in pressure ulcer prevention and management

KEY WORDS

- ▶ Documentation
- ▶ Pressure ulcer
- ▶ Risk assessment

Effective record keeping underpins service delivery and provides a record of the quality of care delivered. Pressure ulcer risk assessment, prevention strategy and pressure ulcer care provision are a key element in the nursing process and are correctly a focus area within the safety agenda. This article reviews issues related to the documentation of pressure ulcer risk assessment and prevention and asks whether the time is right to move towards a universal system of pressure ulcer care documentation, linked to reporting within the NHS.

The purpose of documentation and accurate record keeping has been described by the Nursing and Midwifery Council (NMC, 2009) and forms part of their Code of Practice (NMC, 2015). Documentation should aid communication and is the vehicle by which healthcare professionals share information between members of the multi-professional team responsible for the care of an individual. Effective documentation should provide evidence of the services and care delivered, showing how decisions related to patient care were made, and by so doing ensure continuity and consistency in care provision. Effective record keeping should support the delivery of services by aiding effective clinical judgement and decision making. It should also support clinical audit, research, the allocation of resources and performance planning (NMC, 2009).

The quality of nursing documentation, indeed all patient care documentation, is an important issue as documentation provides a record of the standard of care rendered not only by an individual but by the entire clinical team and the institution or service provider. Nursing documentation should, but often fails to, demonstrate the rational and critical thinking that underpin clinical decision making and interventions while also providing a timeline for patient care and progress. There is no standardised format for documentation and a number of frameworks exist to assist nurse including narrative charting, clinical pathways, problem-orientated records and care-element focused notes (Blair, 2012). The recent introduction of electronic patient

record systems can allow healthcare professionals access to more complete, accurate and legible and up-to-date patient data (Wang, 2011). Wang et al (2011) also state that standardised nursing language is essential because a uniform and controlled vocabulary enables electronic documentation systems to aggregate data. Tubaishtat et al (2015) comment, however, that it remains uncertain whether electronic records of pressure ulcer data offer advantages over paper records.

Irrespective of the documentation system employed, all record entries should, whenever possible, be contemporaneous and should always be factual, legible, signed and dated. *Table 1* outlines the basic requirements. Wang et al (2011) detail the quality criteria for nursing documentation

Table 1. Effective note-taking

Your basic notes should be:

- ▶ Contemporaneous
- ▶ Accurate
- ▶ Objective
- ▶ Legible
- ▶ Free of:
 - ▶ Grammatical/spelling errors
 - ▶ Abbreviations
 - ▶ Errors/erasures
 - ▶ Initial and date/time any alterations
- ▶ Completed in blue or black ink
- ▶ Dated, times and signed:
 - ▶ Print name

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highlighting the structure, process, content, nursing assessment, nursing problem/diagnosis, goal, intervention and evaluation themes that should be reflected in the records. Jefferies et al (2010), in a meta-study of the essentials of quality nursing documentation, identify seven essential components for quality nursing records and conclude that producing quality nursing documentation is a complex and challenging area.

Accurate documentation improves communication and continuity of care delivery as well as providing accountability, ensuring an accurate data trail with which to address complaints and litigation. Actions taken and the documentation of events should conform to local and national guidelines and policies and if a deviation from these occurs the reason for the deviation should be clearly documented. Records do not only have a role in a patient's care but may also be evidence in a court of law so personal comments and criticism of patients, staff and care should be avoided. When litigation occurs, it is frequently long after the care event. Documentation has to be adequate and written in such a way for others to be able to follow the assessments and decision-making process and support the care delivery.

Lowson (2004) commenting on the Health Service Ombudsman reports on referred cases states that many have three things in common:

- ▶▶ Poor communication
- ▶▶ Poor documentation
- ▶▶ A failure to identify or involve the practitioner concerned in the initial investigation.

It is clear, therefore, that changes are required to enable better coordination and continuity of care provision and that improvements can be made. However, a balance needs to be met between standardised documents and the requirements for individualised care.

PRESSURE ULCER DOCUMENTATION

Pressure ulceration is regarded as a quality indicator for the standard of nursing. In 2001, Culley highlighted the problems associated with inadequate record keeping in tissue viability in relation to a number of legal proceedings. Has the situation improved? In 2015, White et al, when contributing to a debate, highlighted that most of the legal case reports where substantial damages were awarded showed one key factor: poor documentation.

Despite pressure ulcer development being a recognised focus of concern and a marker of care quality, there remains anxiety in relation to nursing documentation. O'Brien and Cowman (2011) comment that pressure ulcer care is not standardised and requires further development. Thoroddsen et al (2013) report in a study of pressure ulcer documentation in Scandinavia that the purpose of documentation in terms of pressure ulcer prevention and care was not met, which had the potential to jeopardise patient safety and negatively impact on the continuity and quality of care provided. The greatest lack of accuracy related to early skin damage and category 1 pressure ulcers. Moore and Cowman (2012) comment that the current practice of pressure ulcer prevention show several areas for improvement, particularly those of risk assessment, care planning and documentation. An area of particular concern related to the documentation of repositioning, 76% of patients with an existing pressure ulcer had no repositioning care plan documented. This is clearly unacceptable, placing both the patient and the care provider at risk.

Guidelines (National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance [NPUAP], 2014; National Institute for Clinical Excellence [NICE], 2014) state that pressure ulcer risk assessments are an ongoing process that should be undertaken at first patient contact and should be repeated regularly, if the patient moves between care facilities, including ward areas, or if their medical condition changes. Guidelines (NPUAP, 2014; NICE, 2014) also demand that patients have an individualised care plan that reflects this risk assessment and that it is regularly reviewed and adapted to accommodate changes in their medical condition or social situation. Deviations from local or national guidance or the agreed care plan should be clearly documented and the rationale for those actions noted. Pressure ulcer documentation should record linked areas of care:

- ▶▶ Skin assessment and damage categorisation
- ▶▶ Risk assessment
- ▶▶ Care plan
- ▶▶ Pressure ulcer wound care.

These should be integrated with other care strategies such as nutritional status, use of devices and hosiery for deep vein thrombosis prevention. Modern care provision focuses on the role of

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Table 2. Levels of photography consent (Institute of Medical Illustrators, 2007)

Level 1 consent:

- ▶▶ For patient records only
- ▶▶ Verbal consent
- ▶▶ Photos taken in the “patient’s best interests”

Level 2 consent

- ▶▶ For patient records and teaching
- ▶▶ Signed consent must be obtained

Level 3 consent

- ▶▶ For publication (the specific publication must be included in the consent form)
- ▶▶ Signed consent must be obtained.

the multidisciplinary team. Pressure ulcer prevention and treatment documentation must reflect this, integrating the role of dietician, physiotherapist and medical staff in the pressure ulcer prevention strategy and care delivery records (Samuriwo, 2012).

How good are our notes? Review of case notes from a variety of institutions and care settings identifies a number of common failings.

- ▶▶ Variation in the type and quality of the assessment and care documentation and structure between institutions and even within institutions
- ▶▶ Failure of accurate and specific initial risk assessment
- ▶▶ Failure to repeat adequate skin and risk assessments
- ▶▶ Failure to determine the correct aetiology and category of a wound
- ▶▶ Inconsistency among staff
- ▶▶ Using and failing to complete adequately/consistently multiple documentation forms
- ▶▶ Lack of empowerment to report abnormal findings.

SKIN ASSESSMENT

Basic skin assessment should record skin integrity, especially in areas of pressure, colour changes and discoloration and variations in temperature, firmness or moisture and take into consideration any pain or discomfort reported by the patient (NICE, 2014). Initial assessment should occur as soon as possible (within 8 hours of admission or at first contact in the community) and be repeated as part of an ongoing risk assessment process, the frequency being defined by the clinical setting, and individuals, risk and changes in their clinical status. Skin status should also be recorded on discharge or transfer to another care setting (NPUAP, 2014; NICE, 2014).

Inter-observer variation must be minimised if changes in skin and pressure ulcer status are to be recognised. Standardised descriptors should be used that are clear and unambiguous, defining the location, size, nature and probable aetiology of any skin damage. Where skin redness is observed, note if it is blanching or non-blanching. This applies to both intact skin and to areas surrounding a pressure ulcer.

If skin damage is considered to be possibly pressure-related note its category and complete any reporting documentation required. Johansen et al (2014) observed that the documentation improved when a wound was present and a wound assessment was completed. This observation may be important in the recognition and documentation of deep tissue injury (DTI). Documenting and illustrating areas of intact skin damage on a wound chart could improve the nursing record and help identify issues in the patient journey by providing a more detailed timeline.

Samuriwo and Dowding (2014) in a systematic review concluded that assessment tools were not routinely used to identify pressure ulcer risk, nurses tending to rely on their own knowledge and experience rather than research evidence to deliver skin care. They concluded that further research was needed into nursing judgement and decision-making in relation to pressure ulceration.

PHOTOGRAPHY

Photo-documentation of pressure damage is a useful communication tool and can assist in assuring consistent pressure ulcer categorisation; it can also help in patient communication. Jesada et al (2013) found that a digital photograph, in combination with clinical information, increased the accuracy of pressure ulcer assessment and documentation, while Baumgarten et al (2009) found that digital imaging was a valid tool for defining pressure ulcer grade. The appropriate level of consent (*Table 2*) should be obtained for any photograph taken of a patient by a healthcare professional. The photograph forms part of the patient’s medical records and as such is subject to the Data Protection Act. The photograph should be of good quality and be accurately labelled, which should include the date, time and patient ID and a measurement scale and colour reference (*Figure 1*). Images should be stored and transferred securely in their original format.

RISK ASSESSMENT SCORES

A variety of risk assessment tools are available to assist in patient assessment and risk prediction. Of those available, the most commonly used in a hospital setting is the Waterlow score. However, the Waterlow score in some domains is led by clinical judgement and can therefore be open to an individual nurse’s interpretation of items in the scoring system. This can potentially have a significant impact on the calculated risk score.

Confusion can exist in the interpretation of simple descriptors such as patient's mobility, but most doubt is in the interpretation of special risks. What constitutes single and multi-organ failure and how to combine scores in areas of special risk? The weighting of events in the special risk categories means that misinterpretation has the potential to markedly change a patient's calculated risk status and the under- or over-prescription of equipment and care. In her booklet on Waterlow (2005), Judy Waterlow comments:

"This is another area where it is expected that the assessor will use their clinical knowledge and not just make an arithmetic total."

CARE PLAN

Recording the plan of care, the ongoing assessment and noting the implementation of the prescribed care and skin observations in a way that provides all elements of care, audit and communication requires a complex and dynamic user-friendly document. Despite this need, there are multiple documents available. Not all record the required detail that truly provides continuity and safe practice. Any ambiguity or complexity without instruction to complete will result in inaccurate data or even no data completed.

This is not an issue limited to secondary care: commenting on care planning in nursing homes, Nazarko (2007) reports that the most common problems are:

- ▶ Incomplete initial assessment
- ▶ Unrealistic care plans that lack a clear objective
- ▶ Incomplete or absent evaluation.

CARE BUNDLES

Care bundles are widely seen as a method to improve care by ensuring a consistent approach to both risk assessment and patient monitoring. Care bundles are 'a structured way of improving the processes of care and patient outcomes: a small, straightforward set of evidenced-based practices — generally three to five — that, when performed collectively and reliably, have been proven to improve patient outcomes (Resar et al, 2005). Chaboyer and Gillespie (2014) conclude that the benefit from using pressure ulcer related care bundles may include acting as a prompt for both patients and staff to implement appropriate preventative and care strategies.

Pressure ulcer care bundles provide a pre-constructed plan of care that includes five care elements (e.g. SSKIN) in an easy to follow document

structure, providing reminders to the care required. However, they are not necessarily individualised and vary greatly in design and detail. While some versions provide a linked and structured care strategy, they can become a sea of meaningless ticks that do not accurately define a problem or detail the specific care provided in response to an observation. Johansen et al (2014) support this observation, commenting that care plans were sometimes regarded as a "tick the box" exercise. They can also fail to integrate with other documentation, repeating details required elsewhere in the care record.

CONCLUSION

A common theme of systematic failure resonates through a decade of studies and reviews of nursing documentation, particularly those related to pressure ulcer prevention and treatments, where there remains a gulf between risk assessment and care planning. Lessons can be learned from a retrospective review of care and the impact that the style and structure of standardised forms have on care delivery. Pressure ulcer prevention documentation must allow individualised patient-specific details to be recorded by the whole multidisciplinary team.

Pressure ulcer risk assessment and prevention is rightly regarded as a quality indicator and safety issue within the healthcare community. There is a requirement for a universal documentation system that is managed within nursing time allocation and allows contemporaneous data entry with dynamic risk assessment and care provision. WUK

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