The dos and don'ts of documentation

The documentation of wounds is complex and it can be difficult to know what to include. This article provides succinct advice on aspects of wound and nursing care that should be recorded, such as wound type, tissue characteristics, exudate, infection, pain, healing, photography and treatment plans.

"Understanding the history of a wound is crucial for any subsequent treatment."

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Documentation is an intrinsic part of a wound clinician's tasks; for nursing staff, record keeping is guided by the Nursing and Midwifery Council (NMC) code of professional standards (NMC, 2015). The NMC expects that "clear and accurate records must be kept at all times" (NMC, 2015). It further stipulates that records must be completed at the time or as soon as possible after the event, and that if the notes are written some time after the event this must also be stated.

Records must be completed with accuracy and succinctness, however, caring for wounds is complex and it can be difficult to know exactly what to document. This article lists the essential requirements of good documentation for generalist nurses.

Document the type of wound and its anatomical position

Understanding the history of a wound is crucial for any subsequent treatment. Clear history-taking at this stage is essential. For example, a wound on a shin could indicate a leg ulcer, but could also indicate an old pre-tibial laceration that has failed to heal. Another example is a surgical wound to the sacrum that has not healed and is erroneously described as a pressure ulcer.

The clinician should describe the site of the wound as accurately as possible. *Boxes 1* and *2* offer some anatomical locations that may prove helpful.

Document wound size, depth and whether any undermining or sinus is present

Describe whether the wound is partial or full thickness:

- Partial thickness: there is tissue destruction through the epidermis extending into but not through the dermis
- Full thickness: tissue destruction extends through the dermis to involve subcutaneous tissue and possibly bone and muscle.

If the wound is a pressure ulcer, categorise it using the 2009 European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel categorisation system.

In most dressing packs there are disposable paper rules that aid in

documenting the wound's size. Take the measurement in centimetres and document the measurement as length × width × depth, where:

- Length is measured in the head to toe direction
- Width is measured in the hip to hip direction
- Depth is measured at the deepest part of the visible wound bed.

Document any undermining or sinus tracts. This should be documented using the 'Clock System' with the headset at 12:00 (e.g. 2 cm, undermining at 3 o'clock).

Undermining is where there is tissue destruction that is beneath intact skin along the wound margins. A sinus is a drainage pathway from a deep hole through healthy tissue to an opening on the surface. It is important to understand how a sinus has come to be present.

Describe the types and characteristics of tissue in the wound bed

The tissue type at the wound bed should be described and documented as a percentage (e.g. 50% wound bed covered with soft yellow slough, 50% beefy red granulation tissue). The 'clock system' could be used in describing location of the different tissue in the wound bed. Any foreign bodies (such as sutures, clips, drains or debris) should be clearly described.

There are four main types of tissue:

- Slough: usually lighter in colour, thinner and stringy in consistency. The colour for this tissue could also be yellow, gray, white, green or brown
- Eschar: usually darker in colour, thicker and hard in consistency. The colour for this tissue could also be black or brown, or even white (e.g. in full-thickness burns)

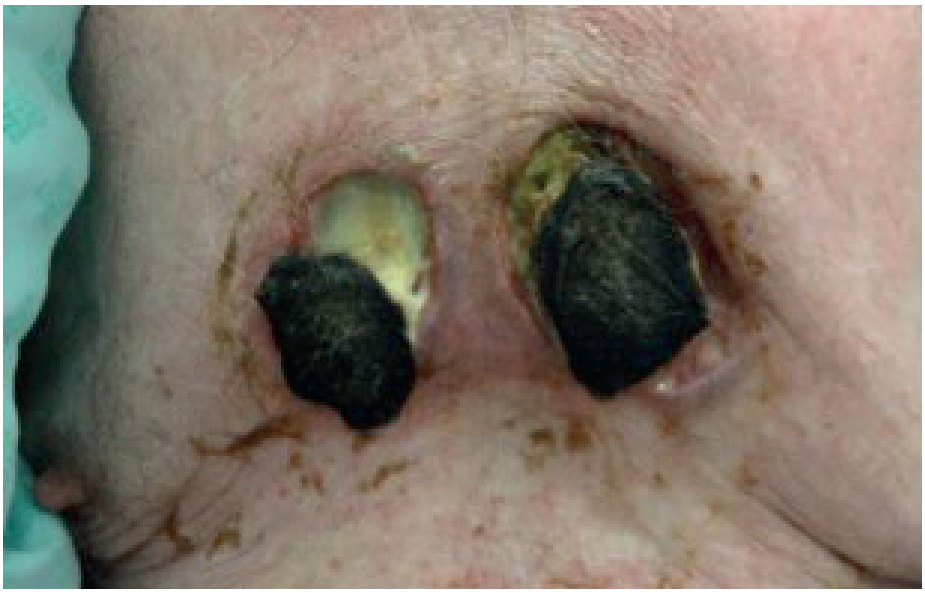

Figure 1. Note the state of any tissue that may require debriding.

- Granulation: healthy granulation tissue is usually beefy red, granular, and bubbly in appearance. It should be differentiated from a smooth red wound bed. The colour of this tissue could be also red, pink, pale pink or full dusky red
- Epithelialisation: this tissue can appear as deep pink, then progress to pearly pink/light purple from the edges of a full-thickness wound, or may form islands in the wound base with superficial wounds.

Note the adherence and state of any dead tissue that may need to be debrided (*Figure 1*):

- Non-adherent: easily separated from the wound base
- Loosely adherent: tissue that pulls away from the wound, but is still somewhat attached to the wound base
- Firmly adherent: dead tissue that does not pull away from the wound.

Describe the tissue at the wound edges and the periwound skin

- Definition: whether it has defined or undefined edges
- Attachment: whether it is attached or has unattached edges, is rolled under, cliff edge, etc
- Periwound skin: whether this is macerated, fibrotic or callused.

If necessary, describe the surrounding tissue. The description should include the colour, presence of oedema, firmness, whether it is intact, induration, pallor, presence of lesions, texture, any scarring, rash, staining or moisture.

Describe any drainage (exudate)

Document the type of exudate, the amount and odour using the descriptions below.

1. Type

- Sanguineous: thin, bright red
- Serosanguineous: thin, watery,

Box 1: Specialised directions.

Upper and lower limbs:

- Proximal: towards the body
- Distal: away from the body

Hand:

- Palmar: towards the palm
- Dorsal: opposite of palmar

Foot:

- Plantar: towards the bottom of the foot
- Dorsal: opposite of plantar.

pale red to pink
- Serous: thin, watery, clear
- Purulent: thick or thin, opaque tan to yellow
- Foul purulent: thick opaque yellow to green with offensive odour.

2. Amount
- None: wound tissues are dry
- Scant: wound tissues are moist and there is no measurable drainage
- Small: wound tissues are very moist, and drainage covers <25% of the dressing
- Moderate: wound tissues are wet, and drainage involves 25–75% of the dressing
- Large: the wound tissues are filled with fluid that involves > 75% dressing.

3. Odour
Document the presence or absence of odour as strong, foul, pungent, faecal or sweet.

Describe any indicators of infection
Document if the wound is streaking (redness that is expanding, leaving linear patterns), has redness, has increased drainage or weeping, the odour has changed, there is a new warmth, oedema, induration, increased pain at the wound side or any discolourations. Note if there is an elevated white blood cell count or if the patient is feeling systemically unwell, with a high temperature and shivering. All of these are indications of a systemic infection.

Box 2: Anatomical directions.

- Lateral: towards the side
- Distal: away from the centre
- Medial: towards the middle
- Dorsal: on the back
- Posterior: back, underside
- Superior: top, up
- Anterior: front, top
- Inferior: below, down
- Proximal: towards the centre, nearest.

Document pain
It is important to document pain location, causative factors, intensity, quality, duration, alleviating factors, patterns, variations, interventions and any activities that may distract from pain, especially important with children or patients with cognitive impairment to prevent dressing changes from becoming traumatic experiences.

Document interventions for healing or wellbeing
It is recognised that there are instances when a wound will never heal and the aim becomes to achieve the greatest level of comfort possible for our patients. Dietary supplements, hydration, vitamins, turning/repositioning schedules, support surfaces, cushions, padding, pillows, elevation, heel protection, incontinence management and skin protection (barrier ointments) are a small number of interventions that must be documented. Conversely, any deterioration in medical condition or challenges relating to concordance should be documented, as they will affect wound healing. Allergies and/or previous sensitivities to dressing products/bandages need to be included in documentation.

Document the patient's current treatment plan
Dressing regimes, response to treatment, modifications to the treatment plan and also any reason for not changing the treatment plan if it is not achieving its aim should be documented. Any referrals to specialised teams, such as plastics, vascular, dermatology, tissue viability, podiatry, need to be included in the records. Last, but certainly not least, one must document any patient and caregiver education that has been offered in the form of verbal education or leaflets.

It is recognised that documenting wound care is a complex affair and most Trusts have developed tailor-made documentation to assist clinicians in recording their activities. Designing documentation is not easy either, and in my experience the simpler the form, the easier it is to complete.

A word of warning is necessary at this point: if a care plan or a turning chart is provided by the organisation, it is essential that all the fields are completed accurately, as any blank fields may be construed as being omissions of care. In the eyes of the law, 'If it is not documented, it has not been done'. De Marinis et al (2010) discovered that only 40% of the

Box 3: Dos and don'ts.

Dos:
- Write legibly, clearly, in black ink (if handwritten)
- Sign and date all entries
- Use your organisation's approved wound forms/charts where they exist and complete all fields
- Set clear, measurable, specific goals in the care plan, with planned dates to review
- Review the wound and care plan at planned intervals (or adhere to planed review dates) and set new goals

Don'ts:
- Leave gaps in charts/forms
- Rely on photographs only
- Deviate from the care plan without documenting the reason why
- Use abbreviations without spelling it out in full first (unless using the local organisation's approved abbreviation list).

nursing activities they observed in their study were documented in the nursing records. This indicates that nurses undertake more activities than they report. They found that nurses were especially poor at recording educational activities with patients and carers. Nevertheless, as litigation increases, the requirement for accurate documentation becomes essential. Often, clinicians are required to recall the care they have given to patients many years after the events, and without good documentation this can be an impossible task.

Digital photography

Digital photography is advocated as best practice in wound care (Hayes, 2003). Photographs should be in focus, using a scale to demonstrate the wound size. Being two-dimensional, photographs cannot be used to describe depth. Cameras can distort reality and a wound can be misrepresented, as depth and colour may not necessary 'come out' well. Furthermore, taken out of context, photographs can be misleading and should, therefore, be accompanied by the above standards of documentation.

Consent for digital photography must be obtained, either verbal or written depending on each individual organisation's policy, which will also guide clinicians on governance when patients lack capacity to give consent.

Conclusion

The documentation of wounds is a complex affair. Most Trusts have developed bespoke documentation that includes all the standards listed in the article; however, documentation has to be conducive for clinicians to complete, as any fields left blank are seen as a 'gap in care', even if the care has been given. WE

References

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