Documentation and record-keeping in pressure ulcer management


Abstract

National and international guidelines recommend the use of clinical assessments and interventions to prevent pressure-related skin damage. This includes the categorisation of pressure ulcers as avoidable or unavoidable, which is challenging in clinical practice, mainly because of poor documentation and record-keeping for care delivered. Documentation and record-keeping are influenced by the individual's employing organisation, maintenance procedures for documentation and record-keeping, and local auditing processes. A transfer sticker to enable patient assessment and promote pressure ulcer documentation was designed and implemented. The transfer sticker captures the date, time and location of a pressure ulcer preventive risk assessment and the plan of care to be implemented. The increased clarity of record of care achieved by using the transfer sticker has enabled the number of avoidable hospital-acquired pressure ulcers resulting from poor documentation on admission or ward transfers to be reduced. The transfer sticker helps staff identify patients at risk and allows interventions to be implemented in a timely manner.

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PRESSURE ULCERS ARE defined as localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear (National Pressure Ulcer Advisory Panel (NPUAP) et al 2014). There are six different grades of pressure ulcer. Nurses will most commonly encounter and manage grades 1-4 (Figure 1). The other two grades, ‘Unstageable: depth unknown’ and ‘Suspected deep tissue injury: depth unknown’, are new to the UK classification system. It is important to remember that pressure ulcer identification and grading in the early stages of development can be subjective and unreliable.

In the UK, a zero-tolerance approach to pressure ulcers in the NHS was adopted in 2010 (National Patient Safety Agency (NPSA) 2010). Pressure ulcers have financial and non-financial implications for patients, care providers and the NHS. The mean costs per patient of treating grade 1, 2, 3 and 4 pressure ulcers are £1,064, £4,402, £7,313 and £10,551 respectively, resulting in an annual cost of £1.4-2.1 billion (Bennett et al 2004). For patients, pressure ulcers cause pain and affect their physical, psychological and social wellbeing, resulting in poor quality of life and distress for patients and their loved ones (Fox 2002, Care Quality Commission 2011, Parliamentary and Health Service Ombudsman 2011).

Definition of avoidable and unavoidable pressure ulcers

There are various definitions of avoidable and unavoidable pressure ulcers (Dealey et al 2012). The Department of Health (DH) (2010) definitions are provided in Box 1.

As part of root cause analyses of hospital-acquired pressure ulcers, it is expected that all documentation in the patient’s care will be examined to establish whether all due care was given. The documentation includes intentional-rounding sheets, skin assessments, care plans, and care evaluation sheets from days and events leading up to the identification of the pressure ulcer. Pressure area damage is associated with a number of intrinsic and extrinsic...
causes, for example poor health status, chronic medical conditions, or factors relating to care, for example poor care, ineffective interdisciplinary team work, and lack of appropriate resources, including equipment and staff (NHS Working Together 2014).

Past and present challenges

The most efficient and effective pressure ulcer prevention and pressure ulcer management strategies depend on effective communication and written documentation (Sullivan and Schoelles 2013). Other components include the simplification and standardisation of pressure ulcer-specific interventions and documentation, involvement of multidisciplinary teams and leadership, use of designated skin champions, ongoing staff education, and sustained audit and feedback (Sullivan and Schoelles 2013). This is essential given that pressure ulcers are multifactorial, with intrinsic and extrinsic factors giving rise to challenges to the delivery of nursing care. Intrinsic factors such as age, appetite, mobility and other medical conditions cannot easily be changed, while extrinsic factors such as pressure, shearing and surfaces can be addressed more easily.

Challenges to the delivery of nursing care are also precipitated by external bodies. Examples include commissioners linking higher Commissioning for Quality and Innovation (CQUIN) targets to national targets (NHS England 2014a), with the aim of achieving efficiency and reducing avoidable pressure ulcers. However, the lack of robust evidence on, or accurate measures of, avoidable and unavoidable hospital-acquired pressure ulcers, as well as the prevalence of poor documentation, makes it difficult to account for the avoidable or unavoidable status of a pressure ulcer.

Pressure ulcer prevention targets or monitoring systems vary between organisations (Dealey et al 2012). Pressure ulcer information has been requested by commissioners and NHS England via CQUINs, High Impact Actions, Safety Express and Safety Thermometers. However, the collection of pressure ulcer prevalence data across the country has not been consistent because different organisations request the data in different formats to meet their own needs. This also leads to confusion for organisations because they are required to provide more than one set of pressure ulcer information per month, with the same data in different formats for different groups, creating a duplication of effort.

An evaluation performed in five hospitals in the Midlands and eastern England (Downie et al 2013) found that 43% of grade 2, 3 and 4 hospital-acquired pressure ulcers were avoidable.

This was in contrast with the findings of Hibbs (1988) that 95% of hospital-acquired pressure ulcers were avoidable. Clinically, 43% is likely to be a more accurate statistic because the percentage of avoidable pressure ulcers has decreased in today’s healthcare settings, compared with the period when Hibbs performed her study. Demographic and scientific comparisons show that, in the 1990s, as a result of fewer advances in medical diagnostics and treatment (Rothwell et al 2004, Dickstein et al 2008), patients with acute conditions or those who experienced accidents did not always survive long enough to experience skin failure.

Skin failure was defined by Langemo and Brown (2006) as an event in which the skin and underlying tissue die as a result of hypoperfusion.

**FIGURE 1**

Pressure ulcer grades 1-4

Grade 1: intact skin with non-blanchable erythema of a localised area usually over a bony prominence.

Grade 2: partial-thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact, open or ruptured serum-filled or sero-sanginous-filled blister.

Grade 3: full-thickness tissue loss. Subcutaneous fat may be exposed, but bone, tendon or muscle are not. Some slough may be present, and may include undermining and tunnelling.

Grade 4: full-thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present, often including undermining and tunnelling.

(National Pressure Ulcer Advisory Panel et al 2014)
Definitions of avoidable and unavoidable pressure ulcers

**Avoidable pressure ulcers**
An avoidable pressure ulcer means the person receiving care developed a pressure ulcer and the provider of care did not do one of the following:
- Evaluate the person’s clinical condition and pressure ulcer risk factors.
- Plan and implement interventions that were consistent with the person’s needs and goals and recognised standards of practice.
- Monitor and evaluate the effect of the interventions.
- Revise the interventions as appropriate.

**Unavoidable pressure ulcers**
An unavoidable pressure ulcer means the person receiving care developed a pressure ulcer even though the provider of the care had:
- Evaluated the person’s clinical condition and pressure ulcer risk factors.
- Planned and implemented interventions that were consistent with the person’s needs and goals and recognised standards of practice.
- Monitored and evaluated the effect of the interventions.
- Revised the approaches as appropriate.

Alternatively, the individual refused to adhere to prevention strategies in spite of education about the consequences of non-adherence.

Documentations and record-keeping have a role in assisting with care delivery and they are professional and legal requirements, according to the Nursing and Midwifery Council (NMC) (2009; this guidance is currently under review). However, the demands on nurse staffing levels leaves less time for documentation, and might result in the production of inadequate documentation on pressure ulcer care (FastFacts 2007, Neville et al 2012). This in turn may lead to unavoidable pressure ulcers being coded as avoidable during investigations of clinical practice, since the documentation fails to establish that every strategy was implemented to try to avoid the development of the pressure ulcer (DH 2010).

National guideline recommendations

An incident form should be completed for all pressure ulcers in grades 2-4 (National Institute for Health and Care Excellence (NICE) 2014). The investigation of all pressure ulcers grade 2 and above with a ‘mini’ or ‘full’ root cause analysis is intended to avoid the recurrence of similar events that would put other patients at risk of developing pressure ulcers. In acute care or community care settings, these unintended events are linked to local targets, such as CQUIN targets (NHS England 2014b).

Across the country, practitioners are faced with challenges such as pressure ulcer grading, as well as different views on reporting, on deterioration and on the 72-hour policy in some places. The 72-hour policy states that, if a patient develops a pressure ulcer within 72 hours of admission to a healthcare facility, that pressure ulcer should be considered as inherited from the discharging facility. The Tissue Viability Society contends that a time frame is immaterial and misleading, and that the 72-hour rule should be discarded (Dealey et al 2012).

The main challenge in conducting a root cause analysis is incomplete documentation. Clinical staff are challenged by excessive documentation and inappropriate staff patient ratios and skill mix (Neville et al 2012). For example, safe staffing levels of one qualified nurse to eight patients are being called for (Royal College of Nursing 2012, Stephenson 2014). However, these levels do not take into account dependence levels or the accommodation required for confused patients or those with a diagnosis of dementia, since these patients require reassurance and re-familiarisation to their new environment, leaving less time for nurses to document the care provided.
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The NMC (2009) exists to safeguard the health and wellbeing of the public, and it urges nurses to deliver consistently high quality care throughout their careers. Good record-keeping is an integral part of nursing practice. The NMC acknowledges that the way nurses keep records is mainly governed by their employing organisations; however, the principles of good record-keeping should be adhered to, as advocated by the NMC (2009). In pressure ulcer management and prevention, good record-keeping enables an investigator to use root cause analysis to establish whether an organisation is performing safely without causing harm to patients.

Advantages of good record-keeping
Pressure ulcer prevention and reduction is a key quality indicator among healthcare providers in England and of interest to the Department of Health and healthcare commissioners (Dealey et al 2012). Documentation and record-keeping assist in the differentiation between an avoidable or unavoidable ulcer, and indicate whether all possible actions were taken to prevent the pressure ulcer. NICE (2014) recommends that, for all patients with pressure ulcers, the following information should be documented: identified risk factors; when the damage was first observed; and the repositioning schedule. However, the reporting of pressure ulcers is poor as a result of lack of standardisation (Dealey et al 2012). Although good documentation enables differentiation between avoidable and unavoidable pressure ulcers, it also has important clinical, administrative and educational functions. These include (NMC 2009):
- Assisting in improving accountability.
- Showing how decisions related to patient care were made.
- Supporting the delivery of services.
- Supporting effective clinical judgements and decisions.
- Supporting patient care and communications.
- Making continuity of care easier.
- Providing documentary evidence of services delivered.
- Promoting better communication and sharing of information between members of the multiprofessional healthcare team.
- Helping to identify risks, and enabling early detection of complications.
- Supporting clinical audit, research, allocation of resources and performance planning.
- Helping to address complaints or legal processes.

Local practice
Local hospital practice states that a patient’s risk of developing a pressure ulcer must be assessed when they are admitted to the ward. The same assessments must be repeated when transfer occurs between wards or when a patient’s condition changes. Risk of developing a pressure ulcer is assessed using the Waterlow (2005) risk assessment scale, where the patient’s skin is assessed and the results documented.

This practice is supported by guidelines which state that patients’ risk of developing a pressure ulcer must be assessed within six hours of admission (NICE 2014). Prompt pressure ulcer risk assessment and physical assessment of individuals vulnerable to pressure damage, combined with knowledge of their previous circumstances and use of pressure-relieving equipment, can prevent or reduce pressure area damage (Dealey et al 2012, NPUAP et al 2014).

On admission, the specific procedure for each patient involves:
- Skin assessment in conjunction with a Waterlow score to assess risk of pressure damage.
- Use of the Malnutrition Universal Screening Tool (MUST) to ascertain the patient’s nutritional status, which can affect pressure ulcer development.
- Nursing the patient on an appropriate surface in relation to the patient’s risk of developing pressure ulcers, nutritional status and mobility.

To encourage good practice and consistency with assessments and documentation, a ward manager designed a transfer sticker (Figure 2). The ward manager was concerned about grade 2 and 3 pressure ulcers that had developed on the ward, and wished to address the challenges encountered when investigating the development of a pressure ulcer as part of a root cause analysis. Grade 4 pressure ulcers were not excluded.

FIGURE 2
Contents of the pressure ulcer transfer sticker

<table>
<thead>
<tr>
<th>Ward:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse’s name:</td>
<td>Signature:</td>
</tr>
<tr>
<td>Waterlow score on transfer:</td>
<td>Plan:</td>
</tr>
<tr>
<td>Pressure areas:</td>
<td>Plan:</td>
</tr>
<tr>
<td>Mattress:</td>
<td>Plan:</td>
</tr>
<tr>
<td>MUST score:</td>
<td>Plan:</td>
</tr>
<tr>
<td>Mobility:</td>
<td>Plan:</td>
</tr>
</tbody>
</table>

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but ulcers did not develop or deteriorate to that extent on the ward.

The transfer sticker enables nursing documentation to be completed in a timely manner, which is as soon as the patient arrives on the ward. This practice is consistent with the good clinical documentation advised by the NMC (2009). A new sticker is used each time a patient is admitted to a new unit as part of holistic assessment, and the sticker is attached to the patient’s notes, increasing the visibility of this aspect of care. The transfer sticker addresses such issues as the development of pressure ulcers as a result of inadequate patient assessment and equipment acquisition, because plans can be put in place and equipment sourced to mitigate the risk and/or assist with recovery (Moore and Price 2004, Hampton 2005).

The transfer sticker also helps to identify whether an individual’s risk of developing a pressure ulcer has been assessed as per NPUAP et al (2014) guidelines and whether preventive strategies have been implemented. The transfer sticker can be used as an aide-memoire, prompting the nurse to see whether the patient has been assessed for risk of pressure damage, nutritional status and mobility as part of the new admission and/or transfer process.

The transfer sticker covers the following aspects of care, as recommended by NPUAP et al (2014):

- Risk assessment.
- Skin assessment.
- Nutrition for pressure ulcer prevention.
- Mobility for pressure ulcer prevention.
- Support surfaces assessment.
- Particular risks of special patient populations.

The transfer sticker, in combination with other local strategies, enables patient assessment while promoting pressure ulcer documentation. The transfer sticker captures the date, time and location of a pressure ulcer preventive risk assessment and the plan of care to be implemented.

References


As a result of capturing this information and recording it on the sticker, efficiencies in time management, effective care delivery, and conduct of pressure ulcer root cause analysis were observed. The increased clarity of record of care achieved by implementing the transfer sticker enabled the local organisation to achieve a reduction in the number of avoidable hospital-acquired pressure ulcers.

The aim of the sticker is to improve pressure ulcer care documentation. The sticker is valuable for identifying patients with or at risk of developing a pressure ulcer on arrival at hospital and on transfer within the hospital, prompting the implementation of a preventive strategy or monitoring system.

The transfer sticker assists record-keeping on transfer because the patients' risk and skin assessments are recorded. It also helps to identify those patients at risk of developing a pressure ulcer in a timely manner, allowing interventions to be put in place to prevent the development of a pressure ulcer. However, the sticker does not replace regular risk assessment reviews.

**Conclusion**

Pressure ulcer prevention and management presents many clinical challenges. These challenges are related to grading and categorisation of avoidable and unavoidable pressure ulcers. National and international guidelines remain central to the documentation and record-keeping of avoidable and unavoidable pressure ulcers because they are used as a referencing point. Initiatives such as the transfer sticker can help to reduce pressure ulcer incidence by ensuring the patient’s needs are reassessed on admission or during ward transfers. As a result, the transfer sticker assists pressure ulcer investigation timelines and root cause analysis of pressure ulcers, whether they are avoidable or not.