

# Documentation

## Considerations in Wound Care

K Kaim  
CN Wound Management  
Gold Coast University Hospital

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## What is documentation?

Within Queensland Health we have many ways in which we can record interactions with a patient. There are care pathways, care plans, paper records, electronic records, photographs, discharge plans, emails, letters, observation charts, handover sheets, SMS ... it's information overload. All of these pieces of information, together, are meant to provide a record of care for each person seen by the hospital.



And while there are plenty of reports to say that nurses all over the world are producing poor documentation there are none to state exactly what format good documentation should take. In fact, the reports even contradict themselves. For example: it is generally accepted that good documentation will show an accurate, chronological record of events, it is also generally accepted that good documentation will clearly show observation-intervention-outcome. The problem being that observation, intervention and outcome do not necessarily happen exactly one time slot after another and linking up outcomes to interventions can take some searching in a patient record which contains an accurate, chronological record of events<sup>(1)</sup>.

So why do we keep all these records? The aim clinical recordkeeping is to<sup>(2)</sup>:

- help to improve accountability
- show how decisions related to patient care were made
- support the delivery of services
- support effective clinical judgements and decisions
- support patient care and communications
- make continuity of care easier
- provide documentary evidence of services delivered
- promote better communication and sharing of information between members of the multi-professional healthcare team
- help to identify risks, and enable early detection of complications
- support clinical audits, research, allocation of resources and performance planning
- help to address complaints or legal processes

As clinicians, documentation isn't just a time consuming nuisance<sup>(3)</sup> that is "something we have to do" it's also a great tool to promote proactive care and risk management<sup>(4)</sup>. We use the historical documentation to determine if there has been improvement or deterioration, or if there are potential risks, and we use this information to modify the plan of care if necessary. A study in the UK showed that poor documentation contributed to the failure to identify when patients were deteriorating<sup>(1)</sup>. But rather than embrace this tool as a means of improving patient care it is more often thought of as just a way to address nurse accountability<sup>(1)</sup>.

## Points to remember when completing documentation



Although there is not a specific guide or plan to follow for every nursing situation there are some points to remember which will improve the quality of your clinical documentation<sup>(2)</sup>:

- **Handwriting needs to be legible.** The use of electronic records has helped with this but not all communications are typed. If it can't be read then not only is it not useful as a tool for managing patient care, but it won't help you in court either.
- **All entries should be identified** with name and title as well as be signed. EMR makes this easy as each entry is tagged by your login – do not share your login or use someone else's login to write up your notes.
- **All entries should show date and time.** Again, EMR puts a date/time stamp on each entry but we need to remember to put it on any hand-written communications, this includes letters.
- **Be accurate and clear.** Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation. Remember to use quantifiable data when you can<sup>(5)</sup>, “looks good” and “normal” are not quantifiable. BTW, it is not appropriate to use text-speak, but like OMG you should know that ;-> Consider that the people reading this will not just be the next nurse on duty but may have very varied backgrounds (possibly including legal personnel and research assistants) and use language accordingly.
- **Be concise and relevant.** You will need to use your professional judgment to decide what is relevant. Tools and frameworks can help with this (see the section on Tools) but context is also important. For example, if a person talks about how cold it is lately you would not necessarily record this, but if they explain that they have no heating, drafts through the floor, sleep on a cot and have no blankets this is a potential health and healing risk that needs to be addressed, so you would write about it.
- **You should record details of any assessments undertaken, and provide clear evidence supporting plans of care or treatments chosen.** If during your assessment you find a new issue then write in both the issue and steps taken to address it (Problem > Intervention). Equally, if you put in place a new plan you need to write about why (Assessment > Intervention)<sup>(5)</sup>.
- **You must not alter or destroy any records.** If you need to alter an entry you have made draw a single line through the original, write up the changes, and initial the error. The original entry must still be readable as changes where the original information has been obliterated may be seen as a cover-up<sup>(4)</sup>. EMR does not allow you to obliterate data.
- **You should not falsify records.** You may say A-DUH, but this is easier to get caught with than you think. Especially where there are tick and flick forms involved. Don't tick yes to “pedal pulses palpable” when the person is a bilateral below knee amputee.
- **Get patients involved,** if it is appropriate. Patients can be asked to keep diaries about their blood sugar levels, pain levels, or whatever is relevant, these can all form a part of their care documentation.

- **Records should be readable when photocopied or scanned.** Quite a bit gets scanned into EMR and there is still a need for documents to be photocopied for things like inter-hospital transfers and coroner investigations.

Remember, the information recorded is for you and your colleagues to use to ensure completeness of care for your patients.

## Legal-eeze

There are also a few things to consider from a legal standpoint:



- **Tone.** Ensure all wording is professional. Communication which is seen to be derogatory or written in such a way as to humiliate / anger / prejudice may be considered slanderous in a court of law. As an example, “Patient arrived at 1330 for an 1100 appointment”, not “Patient couldn’t be bothered to arrive on time”. Reference to other staff or the organization in this manner can also result in a defamation suit<sup>(4)</sup>.
- **Timely.** Notes written some time after the service was given are subject to recall errors<sup>(4)</sup>. Documentation is often seen as less important than patient cares and is therefore left to last in the shift and then hurried because we run out of time. This can lead to a lack of relevant information being recorded<sup>(3)</sup>.
- **Missing information/Illegible.** Where there is a lack of information to make a legal ruling it may come down to patient recollection. Pt is more likely to remember the occasion but might not remember education, cautions, risks<sup>(4)</sup>. Illegible – falls back to recollection<sup>(4)</sup>.
- **Abbr.** I’d like to say no abbreviations but they are almost part of the natural language of health (Pt BIBA c/o SOB, etc...). Minimize what abbreviations are used, ensure that they are considered universally known and not just specific to your specialty, and if in doubt, spell it out<sup>(4)</sup>.

The record you write today could be used in an investigation in years to come. It may be the primary source of information in deciding the outcome of an investigation<sup>(1)</sup>. “The test of a good clinical record – Will this clinical record tell the whole story in a year?<sup>(4)</sup>” Queensland Health’s “Good Clinical Documentation Guide” is contained in this document (Appendix A)

## Barriers

In the literature there are a number of reasons given to explain why documentation is not optimal. These include:



- Rapid patient turnover<sup>(1)</sup> and plethora of ‘mandatory forms’ means too much paperwork to be completed.
- Lack of time<sup>(3)</sup>. With more patients, higher acuity, broader range of responsibilities and minimal staffing nurses are spread thin.
- Documentation is seen as being “less important” than patient care<sup>(3)</sup>.

- Belief that you don't need to document the obvious<sup>(1)</sup>. Things that seem so fundamental to care they shouldn't need to be written still do! If it's not written, it's not done, and this may be seen as neglect.

The creation of care plans, pathways, observation forms and other standard forms are intended to ensure important information is not missed and that treatment is guided by protocols. Data collection forms also try to display trends in such a way as to make it easier and quicker to identify changes. But are they all necessary for every patient? Also, nurses are very resourceful and we come up with many ways to make things easier/quicker. We may have a standard entry that says "meds as charted, cares as documented in care plan". Is this good documentation? Think about the barriers in your area and what could be done remove these barriers and improve your documentation.

## Tools

The notes you write are not just for good patient care and legal reasons but these are also notes to yourself, to help you jog your own memory later<sup>(5)</sup>. So you need to write these in a format that makes sense to you. There are a number of general formats you could adopt and a few wound specific ones:



Format	Strength	Weakness
Observation, Decision, Action, Outcome <sup>(3)</sup>	Good for single problem, records reasoning-action-result, quick	Problem focus, can miss risk factors
SOAP (subjective, objective, assessment, plan) <sup>(3)</sup>	Good for single problem, records reasoning-action but not result, quick	Problem focus, can miss risk factors
HOAP (history, observations, assessment, plan) <sup>(3)</sup>	Better patient focus, records reasoning-action but not result	Takes longer, not as detailed so things may get missed
ADPIE* (assess, diagnose, plan, implement, evaluate) <sup>(3)</sup>	Records reasoning-action-result. "Diagnose" may indicate history taking which would mean better patient focus	Takes longer, not as detailed so things may get missed
HEIDI (history, examination, investigation, diagnosis, implementation) <sup>(6)</sup>	Records reasoning-action-result. Includes investigations.	Takes longer, not as detailed so things may get missed

\* One study showed that having a focused heading (ie mobility) and then the subheadings (APIE) made auditing easier and staff found it easy to document. Nursing diagnoses, which do not appear widely used in Australia, can also contribute to the care plan<sup>(7)</sup>. This format has also just been simplified to PIE (Problem, Intervention, Evaluation)<sup>(5)</sup>.

## Specific to wound care

There are also a range of assessment and management tools/frameworks specific to wound care:

- Wound care pathway. This is a tool currently used on the wards in the Gold Coast Hospital and Health Service. It allows for measurement and description of the



wound as well as records what was done for wound care. It is a reasonable wound management recording tool but not broad enough to be used as an assessment tool for all wound types. It also does not provide an easy to read way to determine if the wound is improving or deteriorating.

- TIME (tissue, infection, moisture, edges)<sup>(8-10)</sup> – While this has been designed as a way to prepare a wound bed for healing, these four areas have also been used for dressing selection and documentation. It provides for a very focused assessment of the “hole in the patient” but may miss other risk factors for healing.
- PUSH (pressure ulcer score for healing)<sup>(11)</sup>. This is a tool for measuring wound progress. It looks at the parameters of size, tissue type and exudate levels and turns them into a single score that can be charted, giving a visual representation of wound progress. This tool has been validated for use in pressure ulcers, diabetic foot ulcers and venous ulcers<sup>(12)</sup>. It is good for measurement but not for assessment.
- Student Tool (Appendix B) – This tool is being designed to help students learn how to collect and use data to create a comprehensive care plan for wound management. It is very time consuming.
- Chronologic – This is basically just recalling the steps taken from the start of the episode of care to the end. This may best be used when focused on a specific task by considering the steps completed in the task and making a reporting framework from them. For example, when writing about a dressing change you would use the headings clean, emollient, primary dressing, secondary dressing, compression or retention and other.

There is no single tool or strategy that fits all needs, is comprehensive and is lightning fast to complete. It's a matter of keeping in mind the purpose of the documentation and working out what format best suits your nursing/writing style.

## Using Photos

Wound photography is a whole education session in itself. Consent, storage, privacy, as well as the actual taking of the photo all need to be considered. But the main points for us to remember are:

- Ensure consent
- Consider privacy and dignity
- Have something in the photo to use as a scale reference
- Upload photos into a specific “clinical photograph” document type in EMR
- Do not use personal phones or anything that is not secured
- Date and sign photos just like all other documentation

## Privacy

Privacy and confidentiality are paramount in health care (again, this takes up an entire education session in itself). Privacy must be considered in relation to documentation, including photographs (as mentioned above), emails and other correspondence. Some tips when writing your notes include:

- Do not refer to patients other than your patient by name. So if Mr Jones in bed 30 rang the buzzer



because your patient's breathing sounded funny you would just refer to him as the patient in bed 30.

- Do not share/take home patient information. This is one of the reasons why you do not use your own phone to take photographs. Documentation can only be shared with other health professionals in the course of treatment IF the patient consents. There are some other instances but it is best to refer any requests to your Nurse Unit Manager.
- If you need to carry results, charts or other patient documentation from one location to another ensure that you keep it covered so that patient information is not revealed.
- If you are completing notes in a public area (ie. Computer visible to public) discuss this with your team leader to work out options for maintaining patient privacy.

## **Appendix A – QH's Good Clinical Documentation Guide**



# GOOD CLINICAL DOCUMENTATION – ITS IMPORTANCE FROM A LEGAL PERSPECTIVE

## Clinical documentation functions

Good clinical documentation:

1. ensures a complete record of health care is created;
2. substantiates decisions and management plans;
3. supports continuity of care;
4. facilitates proactive and reactive risk management;
5. helps prevent and defend legal claims; and
6. provides useful information for quality improvement and research purposes.

These functions are the most obvious and important from the perspective of Queensland Health's (QH) core business of health service delivery.

Clinical documentation practices to which this factsheet refers apply to all components of clinical health records including electronic and hard copies of progress notes, consent forms, clinical findings and investigations e.g. x-rays, scans, pathology etc.

## Medico-legal implications

Patient confidentiality in QH services is strictly regulated under the *Hospital and Health Boards Act 2011* (Qld). Maintaining the confidentiality of health records must be a paramount consideration of QH staff at all times.

Records may be openly scrutinised in cases where, for example:

1. an allegation has been made that a health care practitioner has been negligent, or the care received has been sub-optimal, which results in a claim for compensation; and/or
2. investigations are conducted by the Coroner, the Health Ombudsman or another entity authorised to take evidence (such as the Medical Board of Australia or Nursing and Midwifery Board of Australia).

## What is good clinical documentation?

Characteristics defining good clinical documentation from a medico-legal perspective are similar to those required from a clinical perspective.

That is, clinical notes should be accurate, contemporaneous, objective, detailed and legible.

The following examples highlight pitfalls that experience has shown arise in practice where these characteristics are not present.

## Amendments and obliterations

Records should not be amended by deleting or obscuring notes in any way. To do so, may support an argument that there has been an attempt to cover up a mistake.

Any errors may be crossed out with a single line so that the original text remains legible. The amendment should be authenticated by the time, date and signature of the author, and an explanatory note written, for example, 'incorrect patient record'.

## Contemporaneous notes

Notes that are written at a time considerably after an event are more likely to have their accuracy questioned.

The existence of notes that are not made contemporaneously may give rise to an inference that there has been a lack of attention to detail in the patient's care.

If notes cannot be made contemporaneously, staff should not attempt to back-date the health record. Notes should indicate the day and time that they were written.

## Objective

Subjective statements about a patient's condition should be avoided. If an opinion is recorded, it should be limited to a clinical opinion backed up by the recording of objective data or observations.

The absence of recorded objective information limits a person's capacity to later verify the reasonableness of a diagnosis made or treatment provided. For example, notes indicating that a patient was 'pale, sweating, shaking', are preferable to those which simply state the patient was 'in shock'.

## Derogatory comments

Clinical records are never an appropriate place for demeaning or derogatory comments, which are likely to embarrass, humiliate or anger a patient and/or those who are making a decision about a matter.

Recorded notes which may be damaging because of their derogatory nature may also concern colleagues. For example, a note that states a colleague 'arrived at 10.15pm' should never be supplemented to read 'arrived late at 10.15pm'.

A civil cause of action for defamation may arise if a person communicates any matter that is defamatory about another person to at least one other person. The courts have determined that an imputation (attributing something discreditable to a person) is likely to be defamatory when, in the

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view of a reasonable member of the community, it causes injury to a person's reputation, their profession or trade, or makes others shun, avoid, ridicule or despise the person. A number of defences may be available to a person who communicates defamatory matter. These include situations where it is determined on the balance of probabilities that the matter in question is 'substantially true'.

## **Lack of details**

In the absence of compelling evidence to the contrary, courts may take the view that a patient's recollection of events in the course of receiving treatment is more credible than that of an individual clinician providing that treatment.

The basis for reaching a conclusion of this nature is that the experience of receiving treatment may be more noteworthy and memorable to a patient, than it is for health care providers who are likely to have been involved in providing similar treatment to many patients.

For this reason, clinicians ought to make appropriately detailed notes in the health record about all aspects of health care provided and communication with consumers. For example, include explanations about conditions, treatment and associated, risks and potential side-effects.

Illegible notes are likely to weaken any argument that the treatment provided to a patient was reasonable.

In this instance, a claim would rely more heavily on individuals' recollections. Entries should be written in black ink, include the date and time at the commencement of the entry, be signed by the author and include the author's name and designation.

Avoid the use abbreviations or acronyms unless they are in common use and are commonly understood in health care.

**The test of a good clinical record – Will this clinical record tell the whole story in a year?**

***This summary, prepared by the Legal Branch, Queensland Health, discusses matters of general principle only and is not a substitute for legal advice.***

***Any specific legal queries should be forwarded to Chief Legal Counsel at [legal@health.qld.gov.au](mailto:legal@health.qld.gov.au)***

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## Appendix B – Student Tool

History	
• What is the complaint?	
• How long has it existed?	
• What has been done about the complaint so far?	
• Medical History	
• Surgical History	
• Medications	
• Social History	
• Ever Smoked	
• Alcohol Intake	
• Mobility	
• Allergies	
Examination	
• Systemic	
• Regional	
• Local	Location Size
○ Tissue	
○ Inflammation	
○ Moisture	
○ Edges	

Investigations	
Diagnosis	
Intervention	
	Cleansing
	Emollient/Barrier
	Primary Dressing
	Secondary Dressing
	Retention/Compression

Review:

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