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fastfacts
Resources for Nursing Home Professionals

California HealthCare Foundation

Pressure Ulcer Documentation

The quality of nursing documentation regarding pressure ulcers is often inadequate. Demands on nursing staff leave little time for documentation, leading to inaccurate medical records. As a result, developing or worsening pressure ulcers often are not identified in time and nursing home residents' quality of life suffers. Better pressure ulcer documentation can improve overall care, reduce the incidence of pressure ulcers, and lower health care costs. This FastFacts identifies ways to improve pressure ulcer documentation and reduce pressure ulcer rates.

Risk Management

- **Perform accurate risk assessment.** Assess residents within six hours of admission. Residents may be more likely to develop a pressure ulcer if they have reduced mobility, sensory impairment, acute illness, or a history of pressure ulcers. Avoid pressure, shearing, and friction, especially when moving residents out of beds or chairs.
- **Ensure that documentation is completed in a timely manner.** Nursing staff should not wait until the end of their shifts to document care. Documentation should be completed as soon as possible because it must be ready to be used for medical decision-making. For example, if a resident's pressure ulcer worsens and it is not documented until the end of a shift, then healing may be prolonged. Also, do not chart before the fact—don't check off items before they are completed.

Improving Documentation

- **Base assessments on objective findings.** Use your senses of sight, sound, touch, and smell. Don't leave gaps in the record that would permit speculation about what happened. Document observations, since objective descriptions are necessary in the medical record. Never cover up accidents or document care that wasn't provided.
- **Document accurately and concisely.** Good documentation correlates with high-quality care. The medical record should be concise, pertinent, and reliable so that any health care provider can read it and understand the resident's medical condition and treatment plans in order to make medical decisions. A good medical record fosters open communication among staff and allows for better collaboration on care. Always take the time to document because anything that is not documented is not done.
- **Document smarter, don't document more.** Good documentation doesn't mean writing lengthy narratives; it means documenting efficiently. Annotate the medical record completely, but without extra information that is not necessary to aid in care. Spending too much time documenting the record may leave residents' needs unmet.
- **Write legibly and with organization.** To avoid mistakes, organize your thoughts before writing them. Always write legibly so that any member of the care team can read your handwriting. If you're unsure what to write or how to phrase something, ask your supervisor for help.
- **Document changes to pressure ulcers as they heal.** Assess and document pressure ulcers with each dressing change and monitor daily even if the dressing is not being changed. Provide an accurate description of the pressure ulcer or of skin characteristics. Accurately measure the wound length, width, and depth, and note any drainage. Indicate changes in color, consistency, and odor.

Workflow Redesign

- **Understand documentation workflow.** Review your facility's workflow regarding pressure ulcer documentation to see if it can be streamlined. What are the roles of the various care staff as they relate to pressure ulcer treatment? For example, work backward or ask yourself, "What information needs to be collected and by whom?" This helps you understand the overall flow of information and not see just isolated data elements. Identify and eliminate redundancies.

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- **Standardize data.** Different members of the care staff can document differently, so strive for consistent documentation. Document pressure ulcers in a consistent place in the medical record. Create and distribute a glossary of terms to ensure that the entire care team uses the same language. Teach new employees about pressure ulcer care processes and procedures.
- **Use assessment or documentation forms.** A standard documentation form can help ease the burden of pressure ulcer documentation. It also ensures consistency and improves communication with the clinical team. Use tools such as the Pressure Ulcer Scale for Healing (PUSH), the Braden scale, or the Norton scale consistently. Ensure that all staff can identify pressure ulcer stages (I through IV) correctly and consistently. When a resident has multiple pressure ulcers, circle affected areas in a diagram and assign different letters to each wound.
- **Use photos to document progress.** Photographing pressure ulcers regularly can be an excellent way to track and document the healing process. However, photography should enhance written documentation but not replace it. Your facility should have an established policy that outlines a routine, methodical approach to pressure ulcer photography, rather than having care staff take random photos.

Web Resources

National Pressure Ulcer Advisory Panel, Photography Frequently Asked Questions www.npuap.org/faq.htm

On-Time Prevention of Pressure Ulcers: Partnering with Quality Improvement Organizations www.isisicor.com

Pressure Ulcer Scale for Healing (PUSH) Tool www.npuap.org/push3-0.htm

Wound Care Strategies www.woundcarestrategies.com

Information Technology: The Future of Pressure Ulcer Documentation

Many nursing homes are considering implementing information technology to help with care, especially pressure ulcer documentation. Data collected by clinical staff can be summarized and aggregated quickly into reports that can enhance care and speed clinical decision-making.

One promising practice: digital pen technology. The Agency for Healthcare Research and Quality (AHRQ) has funded a project to use digital pens to help improve quality and redesign operations in nursing homes. Digital pens write like ordinary pens on standardized paper forms and each stroke is recorded in the pen's internal memory. Information from the pen is then transferred to a computer where directors of nursing and managers can create reports, analyze data, and use the information to coordinate and improve care. This project is the "On-Time Prevention of Pressure Ulcers: Partnering with Quality Improvement Organizations." Facilities receive ongoing project support, on-site training, and help with implementation by improving decision-making, streamlining workflow with the goal of reducing pressure ulcers.

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