Why getting documentation right is key to improving wound care

New standards aim for enhanced assessment and greater consistency in wound care by focusing on the role of record-keeping, investigating underlying causes and communication across the multidisciplinary team

By Nick Evans
health journalist

New standards on record-keeping and documentation in wound care should be available for use by nurses shortly.

The standards are part of an ongoing programme of work aiming to improve wound care. We look at what nurses need to know about the current issues and the expected changes.

**Why new standards are needed**

In wound care, one of the key challenges is a lack of documentation, record-keeping and continuity of care – about a quarter of wounds go unrecorded or undiagnosed, according to a BMJ Open study.

Salford University adult nursing lecturer and tissue viability specialist Matthew Wynn says: ‘This is a real problem. You see patients with compression socks to help wounds heal go into hospital and staff take them off and their wounds open up because the staff are not aware of why they have them on.’
‘Or I have seen patients who have reported having wounds for years, but there are little or no records on what treatment and approaches have been tried.’

To address this, the National Wound Care Strategy Programme has commissioned the Professional Record Standards Body (PRSB), which is responsible for the development of standards for clinical record-sharing, to draw up a wound care information standard. Draft standards were published in May and the PRSB is now waiting for endorsement from NHS England before making them available to front-line staff.

Framework for best practice
The six domains are:
» Wound assessment and treatment, including the cause of the wound.
» The treatment plan, including an escalation pathway.
» Self-care information provided to the patient.
» Patient details.
» General health information and relevant history.
» Contact details for those involved in the person’s care.

PRSB chair Maureen Baker says she hopes this will ensure best practice is spread across the system. ‘Wound care is a complex area of healthcare. Sharing and recording information consistently with the right professionals is key to ensuring that people receive the best wound care possible,’ she says.

What are common errors nurses need to look out for?
National Wound Care Strategy Programme director Una Adderley says nurses working in the community in areas such as general practice and district nursing are in a difficult position because they are ‘pulled in so many different directions’. ‘Carrying out an assessment takes at least 40 minutes and

Communication challenges in primary care
RCN professional lead for primary care Heather Randle says nurses working in community settings face several challenges when it comes to wound care.

‘Communication is definitely an issue,’ she says. ‘The information we get from hospital discharge is not always as good as it should be.

‘Nurses in primary care do provide wound care to patients, although the most complex cases where patients are housebound will be picked up by district nurses. The problem is we are not investing and valuing the general practice nurse role. The new nurses coming in are not getting enough training and they are so overwhelmed with other tasks.

‘What’s really important is having access to a good tissue viability service – they can advise and look at pictures of wounds to help nurses decide what is best and some run clinics in the community we can refer patients to. But there is variation in what’s available.’
usually more, and when you have so many competing priorities and you are treating patients who are in great pain or may be dying, you can see how wound assessment gets neglected.’

But Dr Adderley says even when assessments are done, there are common mistakes being made in terms of treatment.

‘One is to place too much emphasis on dressings – we do need good quality dressings, but we also need to identify what the cause of the wound is.

‘Most lower limb wounds are related to venous disease or arterial disease. Sometimes there are other causes, but they are the main ones and they need the right therapy, such as compression and surgical interventions. But if the underlying cause is not being diagnosed and dealt with you’re going to struggle to get the wound to heal.’

And when that happens, she says, the common assumption that is made is that it is because of an infection.

‘People without diabetes find it difficult to access the care that reduces the risk of amputation and death’
Una Adderley, National Wound Care Strategy Programme director

‘Sometimes this is the case, but more often there are other causes of non-healing. This is one of the reasons why we find patients struggling with wounds for a long time and that affects quality of life.

‘There are specialist tissue viability services, but we don’t think it necessarily needs a tissue viability specialist to diagnose and treat leg ulcers. A nurse in the community with the right training and skills and enough time and practice can do it.’

But, she says, many nurses struggle to access training

because they cannot take time away from their day jobs.

‘There are a lot of free education materials available online, but if nurses can’t get time away to study and train and get the necessary face-to-face education to complement the online learning, it is hard to develop the knowledge and confidence needed.’

Financial cost of wound care

The total annual cost of wound care to the NHS is estimated to be around £8.3 billion a year, according to the most comprehensive research on the issue. To put that in context, it is nearly the same as the cost of managing arthritis.

The BMJ Open study, published in 2020, involved researchers modelling the cost and prevalence of wound care in 2017-18. It estimated about 3.8 million people – 7% of the adult population – received care for wounds, a rise of 71% in five years.

Most of the cost, £5.6 billion, was accrued managing unhealed wounds and worked out as an average of £3,700 per person – 2.5 times the cost of managing a healed wound. About 80% of the costs come in the community, with district nursing and practice nursing teams playing a key role, along with specialist tissue viability services.

Dr Adderley adds that the cost is not just to the NHS, pointing out the poor management of wounds is having a ‘debilitating’ effect on people’s lives.

Other research has found one in 50 people in the UK is living with a chronic wound that reduces their quality of life, causing pain and loss of mobility. Half report suffering from depression.

‘Wound care does not get the priority it deserves,’ says Dr Adderley. ‘Although wound care involves many different types of wounds, lower limb wounds, such as leg and foot ulcers, form the largest proportion.

‘Diabetic foot ulceration probably has the highest profile, but only constitutes around 10% of wound care. If you look at the figures in relation to spend, caring for leg ulcers accounts for over half of the total. There are a lot of people with diabetic foot ulcers, but what we’ve discovered is there are at least as many people with foot ulcers who do not have diabetes.

‘More than half of all major limb lower limb amputations are in people that do not have diabetes.

‘The healthcare needs for both groups are very similar, but people without diabetes find it difficult to access the care that reduces the risk of amputation and death.’

Patients’ self-management

There are several important steps patients can take to help with healing. Advice from the NHS is that patients should stop smoking, as it is proven to delay the healing of wounds.

Nutrition, particularly eating foods rich in vitamin C to