Improving Quality and Comprehensiveness in Wound Documentation by the Introduction of Standardized Wound Documentation Chart in CNS
TAM KYG(1)(2), MAK MY(1)(2), LEE MSV(1)(2)
(1) Department of Community Nursing Services, (2) Pamela Youde Nethersole Eastern Hospital

Keywords:
Wound Documentation
PUSH Tool
SBAR
Community Care

Introduction
Wound care is challenging and costly. It is the sources of economic, psychological, and legal complexities in healthcare. Comprehensive and accurate wound documentation is pivotal to effective wound management yielding best positive clinical and financial outcomes. Lacking of proper wound documentation guideline locally may result in poor and incomplete wound documentation. In order to promote effective and quality wound documentation throughout busy daily nursing care, a preformatted wound documentation chart with international standard parameters including PUSH Tool 3.0 and TIME Principle was introduced. Further to promote holistic wound care and improve communication among nurses and multidisciplinary teams, SBAR elements was added into the content as well as in the home visiting card to enhance our current practice since February 2015.

Objectives
1. To improve the comprehensiveness and quality of content in wound documentation so as to ensure quality and safe culture wound care in community
2. To promote effective and efficient wound documentation
3. To ensure better communication among multidisciplinary teams
4. Ensure continuity and guidance of appropriate ongoing wound management

Methodology
A 15-items wound documentation audit form was generated based on validated international guidelines on wound management. Nursing documentations of forty patients requiring wound care in the community were randomly selected for
retrospective audit in December 2013. Initial intent was to assess free-text wound documentation made against standard parameters on preformatted wound chart. An ongoing evaluation on the use of new standardized wound documentation chart will be commencing.

**Result**

Statically significant improvements in quality and comprehensiveness in wound documentation was identified. Further, 86% respondents expressed positively that preformatted wound documentation chart provides standardized information that guide proper documentation and facilities evaluation of treatment plan which enable continuity of care. Over 80% respondents agree with better communication among multidisciplinary teams with use of preformatted wound documentation chart. In conclusion, the use of preformatted wound documentation chart is helpful in guiding and performing accurate comprehensive assessments. It allows clear comparison of wound conditions, standardizes evaluation process; enable early triage of potential wound complications and initiate respective consultation instantly, effective communication among multidisciplinary teams, and provide directions on ongoing wound management process. Ultimately, quality wound care can be attained in community.