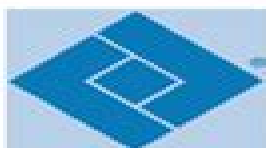


WOUND CARE



Developing the Standardized Wound Care Documentation Model

A Delphi Study to Improve the Quality of Patient Care Documentation

Ulla-Mari Kinnunen ■ Kaija Saranto ■ Anneli Ensio ■ Ansa Iivanainen ■ Patricia Dykes

OBJECTIVE: The aim of this study was to validate a set of previously developed criteria for wound care documentation and to use the validated criteria as a framework for developing a wound care documentation model. The Skin Integrity component of the Finnish Care Classification, the Finnish Classification of Nursing Diagnosis, and the Finnish Classification of Nursing Interventions serve as the basis for the wound care documentation model.

SUBJECTS AND SETTING: Finnish wound care specialists, mainly nurses, from different Finnish hospitals, and from the Finnish Wound Care Society having on average 18 years of experience in wound management. Data were collected using electronic survey technology.

METHODS: A Delphi technique was used to develop and validate the documentation system.

RESULTS: The final model consists of 7 main categories and 25 subcategories of the Skin Integrity component of the Finnish Classification of Nursing Diagnosis and 5 main categories and 25 subcategories of the Skin Integrity component of the Finnish Classification of Nursing Intervention. Based on the results of the Delphi survey, consensus was reached on all elements of the wound care documentation model.

CONCLUSION: The Delphi process was used to develop a wound care documentation model for use in an electronic record to promote systematic documentation of both wound assessment and wound care. Future research should address the utility of this documentation model for nurses with expertise in wound care and generalist nurses.

■ Introduction

Documentation of patient assessment and nursing care is of concern to nurses using electronic patient record systems.¹ Several studies have demonstrated improved quality of documentation, reduced documentation errors, and a positive attitude among nurses when using an electronic patient record system.¹⁻⁴ However, insufficient evidence exists to relate the use of information technology and electronic record systems to improved nursing-sensitive patient

outcomes. Several considerations have been suggested as beneficial in the development and implementation of nursing information systems.¹ Examples include the usage of standardized nursing documentation systems, provision of sufficient training opportunities, and the inclusion of nurses in the development and implementation of systems for documentation of nursing care.

Standardized electronic nursing documentation requires incorporation of the nursing process and standardized nursing terminology into the electronic medical record. Standardization improves the quality of documentation of patient care by increasing accuracy and uniformity.² Such systems can also contribute to improved quality of care, through prompts integrated into the system that cue the nurse regarding critical assessments and interventions based on the patient's disease process and risk factors.¹⁻⁴ Evidence also suggests that a documentation system may promote better use of resources and overall cost savings, once the nurses become skilled in using the system.¹⁻⁴ Finally, a standardized system can help to fulfill legal and regulatory requirements needed to prove the quality of care.^{1,5-7}

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The authors declare no conflict of interest.

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