

Importance of accurate documentation and holistic wound assessment

Keeping clear and accurate patient records is key to safe and effective practice (Nursing and Midwifery Council [NMC], 2018). In wound management, systematic and timely wound assessment can lead to correct diagnosis, the implementation of clinically effective treatments and subsequent improvement in patient and wound-related outcomes (Atkin and Critchley, 2017). Updating records at every subsequent reassessment can ensure continuity of care between healthcare professionals. This article examines the importance, requirements and barriers to documentation in wound care, how ongoing comprehensive holistic assessment contributes to keeping records up to date and relevant, and looks at the increased use of digital photography in a virtual setting.

KEY WORDS:

- Nurse documentation
- Wound assessment
- Wound photography
- Cost-effectiveness

Kirsty Mahoney

Senior tissue viability nurse and clinical operational programme improvement lead, Welsh Wounds Innovation Centre

Nurses and midwives are aware of, and practise within the Nursing and Midwifery Council (NMC) code of professional standards of practice and behaviour (NMC, 2018). For safe and effective practice, clear and accurate records should be kept promptly, comprehensively, honestly, and securely (NMC, 2018). All records must be signed, timed and dated if handwritten. If digital, they should be traceable to the person who provided the care that is being documented (Royal College of Nursing [RCN], 2017). Documentation is vital to create a trail of the patient's condition, assessments completed, any issues identified, as well as what and how care was provided (Cathala and Moorley, 2019). All forms of documentation should aim to:

- Ensure continuity of care
- Enhance patient safety
- Stand as evidence of the nursing care delivered (Cathala and Moorley, 2019).



Photograph: Alena Dutko/Shutterstock

In the event of a complaint or legal proceedings, documentation is the most crucial record of care received by the patient, as it should outline the assessment undertaken, care plan and evaluation process (Lister, 2016). However, Lister (2016) felt that nurses do not always appreciate the importance of record keeping until something goes wrong and their documentation is scrutinised. One reason for missing information, errors and duplication has been attributed to the volume of paperwork that has to be completed, which may be repetitive and seen to take practitioners away from the patient care (Charalambous and Goldberg, 2016).

Many areas of health care are moving towards electronic and digital health records, which require practitioners to have good information technology (IT) skills and knowledge (Lister, 2016).

WOUND ASSESSMENT AND DOCUMENTATION

As in all areas of health care, wound management requires objective data collection and documentation to establish a diagnosis and assist in the planning of appropriate evidence-based treatment (Gray, 2020). The cost of wound care is significant for the NHS (Guest et al, 2015) and has recently been shown to have

increased substantially in the last five years (Guest et al, 2020; Table 1).

The key to successful wound management is accurate and comprehensive assessment (Mahoney, 2020), followed by planning and frequent evaluation and reassessment. Holistic wound assessment should always be patient-centred, so that their preferences and wound care outcomes are established (World Union of Wound Healing Societies [WUWHS], 2020). Indeed, assessment is so significant, that it is considered the only way to:

- Guarantee effective high-quality care
- Ensure accurate diagnosis
- Identify any factors that could delay healing (Atkin and Critchley, 2017).

Comprehensive documentation has been identified as particularly important in the management of patients with hard-to-heal chronic wounds, where a lack of clear structure adversely affects the continuity and quality of care (Olsson and Friman, 2020).

Statistics produced by examining the Health Improvement Network (THIN) data base by Guest et al (2015) highlighted that aspects of assessment and documentation were poorly completed, giving an example of only 16% of all cases with an ulcer of the lower limb having an ankle brachial pressure index (ABPI) recorded in their records, a figure that has reduced to 15% over the last five years (Guest et al, 2020). This and other findings are outlined in Table 2.

Ovens (2020) describes areas of failure within wound management following experience as an expert witness, as including:

- Poor documentation, e.g. frequent and inconsistent treatment changes, inaccurate documentation (e.g. anatomical site of wounds and categorisation of pressure ulcers), illegible records
- Poor communication, e.g. delays or absence of referrals to the multidisciplinary team
- Lack of holistic assessment, e.g. absent or incomplete wound assessment, limb and ABPI

Table 1: Increased cost of wound care in five years (Guest et al, 2015; Guest et al, 2020)

Study year 2012/2013	Study year 2017/2018
2.2 million adults with a wound Cost to NHS £5.3 billion	3.8 million adults with a wound (7% of adult population) — annual prevalence increase 71% Cost to NHS £8.3 billion — increase by 48% in real terms
61% wounds healed in the study year 79% acute wounds 43% chronic wounds	70% wounds healed in the study year 89% acute wounds — mean increase in healing of 13% 49% chronic wounds — mean increase in healing of 14

assessment for lower limb wounds and pressure ulcer risk assessment

- Failure to fully investigate reasons for wound, patient or pain deterioration, e.g. due to infection, moisture-associated skin damage (MASD), pressure, shear, or friction.

Ovens (2020) also highlights wound-specific problems, such as failure to determine underlying aetiology and diagnosis, for example in venous leg ulcers, where the aetiology is crucial for ongoing, clinically effective treatment with compression therapy. Guest et al (2020) also found that 25% of all wounds lacked a recorded differential diagnosis (Table 2).

Furthermore, the importance of accurate and timely assessment in reducing unwarranted variations in wound care (Vowden and Vowden, 2018), supported by findings of Guest et al (2015), prompted the inclusion of wound assessment as a key indicator in the Commissioning for Quality and Innovation (CQUIN) framework for 2017–2019 (NHS England, 2016). Its aim was to reduce the number of wounds which have failed to heal after four weeks of treatment by focusing on wound assessment (Scott-Thomas et al, 2017). Key indicators for patient safety in the CQUIN framework for 2020–2021 include assessment, diagnosis and treatment of lower leg wounds, and assessment and documentation of pressure ulcer risk (NHS England, 2020).

COMPONENTS OF HOLISTIC WOUND ASSESSMENT

It is widely accepted that to optimise and improve wound healing rates, the cause of the wound needs to be identified and factors that may delay wound healing addressed (Wounds

UK, 2018; Gray, 2020; Mahoney, 2020).

In a recent best practice statement, it was recommended that, where possible, wound assessment should be completed within six hours of admission to hospital, or at initial presentation in the community setting (Wounds UK, 2018).

Different frameworks have been developed to provide a structure for holistic assessment (Mahoney, 2020; WUWHS, 2020). Coleman et al (2017), on behalf of NHS England, outlined a minimum data set needed for wound assessment (Coleman et al, 2017) and this has been recommended for use, although additional information may be needed in specific wound types (e.g. assessment of peripheral neuropathy in diabetic foot ulcers) (Wounds UK, 2018).

Five key domains for wound assessment were identified in the minimum dataset (Coleman et al, 2017):

- General health
- Baseline information

Practice point

A common error in wound documentation is the location:

- Be as precise and as accurate as you can with the location using anatomical language (e.g. medial aspect of the right lower leg, 3cm above the medial malleolus, etc)
- Use a body map if you have one available with the location marked
- Right and left are from the patient's perspective
- Remember, everything you document can be used in a court of law.
(Wounds UK, 2018; Ovens, 2020)

- Wound assessment parameters
- Wound symptoms
- Specialist referral.

General health

This part of the assessment process will help identify risk factors for delayed healing. It should include a full medical history, identifying any comorbidities and medications, the patient’s nutritional and hydration status (Metcalf, 2020), as well as a summary of the patient’s general health and lifestyle (Mahoney, 2020). Another important consideration is how the wound is impacting on patient quality of life (Coleman et al, 2017), which is particularly relevant in the current climate when assessing their ability to undertake aspects of shared care (Wounds UK, 2018; Hiskett, 2020; Stevens, 2020).

Baseline information

This should include the number of wounds present, their location, aetiology (e.g. venous leg ulcer, category 3 pressure ulcer), how long the wound has been present, aim of treatment (e.g. wound debridement, compression therapy for venous leg ulcers), and any reassessment dates (Coleman et al, 2017). It is also useful to document how the wound has been treated previously (Mahoney, 2020).

Wound assessment parameters

In the absence of a wound assessment chart or specific wound assessment documentation, several frameworks can be used to assist in a systematic approach, such as HEIDI (history, examination, investigations/indications, diagnosis and interventions) (Harding et al, 2007) or TIMES (tissue, infection, moisture imbalance, edge of wound, surrounding skin) (Wounds UK, 2016).

The physical characteristics of the wound form this part of the assessment, including size (length, width and depth), any undermining or tunnelling present, and the category for pressure ulcers. Other parameters include wound bed tissue type and amount (e.g. 50% black necrotic tissue, 20% yellow slough and 30% red granulation tissue), and a description of the wound margins or edges (Coleman et al, 2017).

Table 2: Burden of wound care study findings from 2017/18 related to the holistic wound assessment process (Guest et al, 2020)

Area of assessment	Burden of wound care findings	Learnings for wound assessment
General documentation	<ul style="list-style-type: none"> ▪ Records lacked any evidence of consistent reporting of wound management process 	<ul style="list-style-type: none"> ▪ Documentation is vital to create a trail of the patient’s condition, assessment, issues identified, and care provided
General health	<ul style="list-style-type: none"> ▪ 95% of patients with a wound had at least one comorbidity ▪ 57% of all patients with a wound had diabetes ▪ Cardiovascular disease, immunological disorders and renal disorders were all independent risk factors for non-healing ▪ In 2012/2013*, 29% of patients with a wound had diabetes and in 2017/2018 this had increased to 57% ▪ In 2012/2013*, 65% of all patients with a wound were 65 years of age or over, in 2017/2018 this had reduced to only 33% ▪ 38% of chronic wounds healed if the patient smoked, 55% for non-smokers and 58% for ex-smokers ▪ 38% of patients with a pressure ulcer were recorded as suffering from malnutrition 	<ul style="list-style-type: none"> ▪ This part of the assessment process will help identify risk factors and comorbidities which might delay healing
Baseline information	<ul style="list-style-type: none"> ▪ Records still lacked documentation of essential investigations ▪ 16% of all wounds in the study group had no diagnosis (e.g. pressure ulcer, venous leg ulcer) ▪ 9% of all leg ulcers in the study group had no further characterisation (e.g. venous, arterial, mixed) ▪ 25% of all wounds in the study group lacked a differential diagnosis ▪ Only 15% of leg or foot ulcers had a recorded Doppler ABPI, of the remaining 85% who did not have a recorded ABPI, 29% were prescribed compression 	<ul style="list-style-type: none"> ▪ Establishing and recording the correct diagnosis of the wound is the most important step if treatment is going to be successful ▪ For foot and leg ulcers an ABPI is an essential investigation to establish arterial status, and can assist in informing the decision-making process
Wound assessment parameters	<ul style="list-style-type: none"> ▪ 59% of chronic wounds that healed in the study period had no signs of infection while only 45% of chronic wounds healed if there was a definite or suspected infection 	<ul style="list-style-type: none"> ▪ Being able to identify wound biofilm and infection is a vital skill, as its presence can have a negative impact on wound healing
Specialist referral	<ul style="list-style-type: none"> ▪ Minimal clinical involvement of tissue viability nurse or other specialist nurses, with a 2% decrease in specialist nurse visits 	<ul style="list-style-type: none"> ▪ Appropriate and timely referral to the multidisciplinary team is an important consideration
Treatment plan	<ul style="list-style-type: none"> ▪ Wound dressings were continually switched, suggesting confusion and lack of consistency — on average, patients were prescribed a mean of eight different dressing types 	<ul style="list-style-type: none"> ▪ There will be a requirement to change the dressing type during the healing process, but it should be led by the wound assessment process

* Guest et al, 2015

Assessment of the surrounding skin is also important, observing for signs of:

- Erythema — redness or inflammation
- Maceration — white soggy skin
- Oedema — fluid collecting which causes swelling
- Dry flaky skin — sometimes referred to as hyperkeratosis
- Discolouration — in venous



WHAT IF

you could rely on your dressing choice even if the exudate level increases?

Zetuvit® Plus Silicone Border

Now available
on Drug Tariff
and NHS
Supply Chain



Effective:

Absorb. Retain. Maintain optimal microclimate^[1,2]



Versatile:

Simple to choose, simple to use



Patient-friendly:

Atraumatic dressing changes^[3]

BE PREPARED
*and prevent
exudate-related
complications*



Product Illustration

Product	Size/Wound pad	Product Code	PIP Code	NCP Code	Pack size
Zetuvit® Plus Silicone Border	10 × 10 cm / 5 × 5 cm	413910	4137071	EJA254	10
	12.5 × 12.5 cm / 7 × 7 cm	413920	4137055	EJA255	10
	17.5 × 17.5 cm / 11.5 × 11.5 cm	413930	4137063	EJA256	10
	15 × 25 cm / 9 × 19 cm	413940	4137048	EJA257	10
	20 × 25 cm / 14 × 19 cm	413950	4136030	EJA258	10

For more information contact your local HARTMANN representative or contact our customer services team
HARTMANN UK & Ireland +44 (0) 1706 363200
Email: info@uk.hartmann.info | www.hartmann.co.uk

Never miss an update from HARTMANN UKI -
Join www.hartmannmarketing.com online now

HARTMANN UKI Healthcare Professionals

HARTMANN GROUP

disease, dark purple staining of haemosiderin (Mahoney, 2020).

Wound symptoms

Wound symptoms include wound pain, exudate (volume, consistency, type and colour), odour and any signs of local or systemic wound infection (Coleman et al, 2017).

Measuring symptoms such as pain, odour and exudate can be subjective. In the absence of a specifically designed and validated tool, it helps if the same person makes the assessment to reduce variance. It may help to record the signs, for example, with exudate record staining, presence of strikethrough and leakage, and how the dressing is controlling exudate volume (Ousey and Cook, 2011). With pain documentation, there are a number of pain assessment tools validated for use in clinical practice for adults and children (Brown, 2014).

Specialist referral

Appropriate and timely referral to the multidisciplinary team is an important consideration and may include seeking advice from available tissue viability services. This is particularly important in wounds where the aetiology has been difficult to determine and not been established, e.g. inflammatory ulcers or suspected malignancy. However, a recent study found that in wound management records from GP practices, there was minimal clinical involvement of tissue viability or other specialist nurses in direct patient management, despite the high number of non-healing wounds (Guest et al, 2020). Other referrals may include hospital consultants, such as vascular services. Specialist services may also be required to carry out investigations, for

Table 3: Involving patients in record keeping

The Code. Professional standards of practice and behaviour for nurses, midwives and nursing associates (NMC, 2018)

- 2.1 work in partnership with people to make sure you deliver care effectively
- 2.2 recognise and respect the contribution that people can make to their own health and wellbeing
- 2.3 encourage and empower people to share in decisions about their treatment and care

Table 4: Top 10 tips for wound photography (Sperring and Baker, 2014)

■ Use a digital camera owned by your place of work — it should be simple to use, have an SD memory card of at least 4GB and should have a macro function (close-up mode)
■ Set the time and date on the camera — this is important to confirm the exact date and time the photograph was taken
■ Get the light right — set the flash function to 'on'
■ Take the first photograph of patient data — to ensure the correct photograph is attributed to the correct patient and wound
■ Make the wound the only focus — remove all clutter from the background to aid clarity
■ Standardise the views taken of the wound — take the photograph in the same way as others have been taken before to assist with subsequent reviews
■ Get the angle right to take a proportional image — make sure the camera is parallel to the subject to ensure accurate proportions
■ Establish the wound location for the viewer — the first photograph should show the location and area of the body for a sense of perspective
■ Close-up images establish detail for the viewer — preferably with a ruler placed near the wound to give an accurate indication of the wound size
■ Securely save and store the images — upload to a secure location and delete from the camera

example, ABPI measurement in the management of lower limb leg ulcers (Wounds UK, 2018), or specialised X-rays for sinus or cavity wounds, or if osteomyelitis is suspected. Referral to dermatology should also be considered if a wound looks suspicious or a biopsy is needed.

Documentation

Documentation systems can help to guide wound assessment, be they paper-based or electronic records (Wounds UK, 2018). They can also be used to measure, monitor and evaluate patient- and wound-related outcomes. New wound management platforms, such as app and camera technology for use on a mobile or tablet, have also been developed to aid data collection and documentation while avoiding the subjectivity of traditional methods, i.e. in quantifying the percentage of viable and non-viable tissue within a wound bed (Gray, 2020). However, not everyone will have access to such platforms.

Involving patients in the assessment process is also a key part of record keeping (Table 3) and new wound management platforms are particularly useful for engaging with patients during the process of assessment and documentation (Gray, 2020). For example, being visual, patients can see improvements, especially in photography and measurements.

Wound photography

In some clinical settings, wound photography is now a normal part of documentation (Queen and Harding, 2020), with its use increasing in the current climate with more virtual approaches to care and greater use of images in virtual clinics (National Wound Care Strategy Programme [NWCSP], 2020). Indeed, wound photography is part of an ongoing project for the NWCSP (2021), which is making recommendations for:

- Using digital images in wound care
- Standardising the practice of taking and using wound images
- Promoting adequate mechanisms for safeguarding and quality control
- Encouraging the use of digital wound images to support learning.

Red Flag

Identification of wound infection is a vital skill, with diagnosis being based on clinical signs and symptoms (Wounds UK, 2018). Local wound infection may show the classic signs of erythema, warmth, swelling and pain, but also hypergranulation, bleeding and friable tissue, wound breakdown, delayed wound healing and malodour (International Wound Infection Institute [IWII], 2016).

While technology has made it easier to use digital photography, there are simple best practice steps that improve the quality of the resulting image (Queen and Harding, 2020). Sperring and Baker (2014) provide some tips for unskilled photographers to help produce clear, crisp images of wounds that will be clinically useful (Table 4).

BARRIERS TO COMPLETING WOUND ASSESSMENT

There are many barriers or reasons why a full, holistic wound assessment may have not been completed, some of which have been summarised in a recent consensus document (WUWHS, 2020). To achieve changes in the implementation of wound assessment across services, barriers to change must first be addressed (National Institute for Health and Care Excellence [NICE], 2007). These have been identified as:

- Lack of awareness and knowledge — e.g. of the importance of wound assessment and the specific skills required
- Lack of motivation — because wound assessment is a complex process and progress may be slow
- Practicalities — of delivering care (Table 5)
- Acceptance and beliefs — clinician uncertainty and disagreement over the process and treatment, e.g. disagreement on how wound assessment should be performed and conflict over treatment plans, such as do we carry on with this silver dressing? Should the patient have compression, although the ABPI reading is ok?
- Skills to enhance critical thinking, while fostering an environment that sustains and disseminates best practice (NICE, 2007; WUWHS, 2020).

Table 5: Practicalities of delivering care that may lead to poor outcomes (WUWHS, 2020)

■ Lack of time and confidence to undertake assessment
■ Inequalities in the availability of competent experienced clinicians
■ Lack of referral pathways
■ Confusion over who is responsible for wound management
■ Lack of access to advanced aggressive treatment plans when in community settings
■ Frequent changes of wound treatment through failure to follow evidence-based guidance
■ Lack of consistent relationship between patient and nurse
■ Lack of clarity regarding access to appropriate equipment, such as ABPI devices, advanced wound dressings and other medical devices, such as negative pressure wound therapy (NPWT)
■ Local environment may produce a difficult working environment, such as poor lighting, positioning or unhygienic conditions in patients' homes

WOUND ASSESSMENT AND PRODUCT SELECTION

It is estimated that there were 3.8 million patients with a wound managed by the NHS in 2017/2018 at a cost of £8.3 billion, with 81% of the total cost incurred by the community (Guest et al, 2020). As discussed, accurate and timely wound assessment can lead to an accurate diagnosis, implementation of clinically effective treatments, and subsequent improvement in patient and wound-related outcomes (Atkin and Critchley, 2017; Vowden and Vowden, 2018; Gray, 2020). Furthermore, appropriate treatment will result in the efficacious and cost-effective use of wound care products (Atkin et al, 2019), for example, the use of therapeutic compression therapy for venous leg ulcers and the appropriate use of superabsorbent dressings for highly exuding wounds. 'Betty's story' (NHS England, 2017) is a perfect example of how failure to assess, diagnose and treat a venous leg ulcer led to unnecessary spend, multiple visits to healthcare providers, extended healing times, and reduced patient quality of life (Atkin et al, 2019).

Evaluating treatments and documenting the rationale for product choices, e.g. debridement, exudate management, can help to prevent unnecessary treatment changes. Indeed, selection of wound products needs to be based on the condition of the wound bed, surrounding skin and wound-related factors. Furthermore, with the advent of self-care, it is important to choose products with

which the patient is happy and feels confident and competent to use.

Healthcare professionals should also follow local formularies to promote clinical governance and consistencies in product usage.

CONCLUSION

Wound assessment is considered the only way to guarantee effective high-quality care, to ensure accurate diagnosis of the underlying aetiology and identify any factors that could delay healing. Wound assessment and subsequent reassessment is often poorly completed, illegible, and containing inaccuracies and omissions (Ovens, 2020). Different frameworks have been developed to provide a structure for holistic wound assessment, including a minimum data set which has been recommended as a minimum requirement. Wound photography is an integral part of the assessment process, particularly in the current climate of more patients needing to be seen remotely, and there are several things the unskilled photographer can do to ensure photographs are clinically useful.

Comprehensive wound assessment will lead to clinically and cost-effective treatments, helping to reduce the huge costs associated with wound care and improve clinical outcomes. Nursing documentation must be completed to the highest standard to ensure the safety and quality of the healthcare services (Akhu-Zaheya, 2017), and to assist in promoting continuity of care and monitoring effectiveness of prescribed treatment. **GPN**

Remember...

Managing wound images and patient information involves issues of consent, confidentiality, privacy and security (Sperring and Baker, 2014).

REFERENCES

Atkin L, Critchley A (2017) The leg ulceration pathway: impact of implementation. *Wounds UK* 13(4): 107–12

Atkin L, Schofield A, Kilroy-Findley A (2019) Updated leg ulcer pathway: improving healing times and reducing costs. *Br J Nurs* 28(2 Tissue Viability Suppl): S21–S26

Akhu-Zaheya L, Al-Maaitah, Hani SB (2017) Quality of nursing documentation: paper-based health records versus electronic based health records. *J Clin Nurs* 27(3–4): e578–e589

Brown A (2014) Strategies to reduce or eliminate wound pain. *Nurs Times* 110(15): 12–15

Callum M (2020) Role of nutrition and hydration in wound healing. *J General Practice Nurs* 6(4): 30–6

Cathala X, Moorley C (2019) Skills for newly qualified nurses 1: understanding and managing accountability. *Nurs Times* [online] 116. Available online: www.nursingtimes.net/roles/newly-qualified-nurses/skills-for-newly-qualified-nurses-1-understanding-and-managing-accountability-15-10-2020/

Charalambous L, Goldberg S (2016) Gaps, mishaps and overlaps. Nursing documentation: how does it affect care? *J Res Nurs* 21(8): 638–48

Coleman S, Nelson EA, Vowden P, et al (2017) Development of a generic wound care assessment minimum data set. *J Tissue Viability* 26(4): 226–40

Gray L (2020) Standardising accurate wound assessment and documentation. *J Community Nurs* 34(1): 14

Guest JF, Ayoub N, McIlwraith T, et al (2015) Health economic burden that wounds impose on the National health service in the UK. *BMJ Open* 5:e009283. doi:10.1136/bmjopen-2015-009283

Guest JF, Fuller GW, Vowden P (2020) Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013. *BMJ Open* 10:e045253. doi:10.1136/bmjopen-2020-045253

Harding K, Gray D, Timmons J, Hurd T (2007) Evolution or revolution? Adapting to complexity in wound management. *Int Wound J* 4(2 Supp 2): 1–12

Hiskett G (2020) Shared care in wound management: a significant opportunity. *J General Practice Nurs* 6(3): 44–9

International Wound Infection Institute (2016) *Wound infection in clinical practice*.

Wounds International, London. Available online: www.woundsinternational.com

Lister S (2016) Accurate record keeping. *Independent Nurse*. Available online: www.independentnurse.co.uk/professional-article/accurate-record-keeping/117281/

Mahoney K (2020) Clinical skills. Part 1: Wound assessment. *J Community Nurs* 34(2): 28–35

Metcalf C (2020) Role of nutrition and hydration in wound healing. *J General Practice Nurs* 6(4): 30–6

NHS England (2016) *CQUIN 2017–19 Guidance*. Available online: www.england.nhs.uk/nhs-standard-contract/quinn/cquin-17-19/

NHS England (2017) *Betty's story: Leg ulcer wound care*. Available online: www.england.nhs.uk/rightcare/products/lte/

NHS England (2020) *CQUIN 2020–21 Guidance*. Available online: www.england.nhs.uk/wp-content/uploads/2020/01/FINAL-CQUIN-20-21-Core-Guidance-190220.pdf

National Institute for Health and Care Excellence (2007) *How to change practice. Understand, identify and overcome barriers to change*. NICE, London. Available online: www.nice.org.uk/Media/Default/About/what-we-do/Into-practice/Support-for-service-improvement-and-audit/How-to-change-practice-barriers-to-change.pdf

Nursing and Midwifery Council (2018) *The Code. Professional standards of practice and behaviour for nurses, midwives and nursing associates*. Available online: www.nmc.org.uk/standards/code/

National Wound Care Strategy Programme (2020) *Remote consultation and support for wound care. Results of COVID wound care survey*. Available online: www.ahsnnetwork.com/wp-content/uploads/2020/07/Remote_Video_Consultation_in_Wound_Care_services_15072020-1.pdf

National Wound Care Strategy Programme (2021) *Data and Information Enabler Workstream*. Available online: www.ahsnnetwork.com/about-academic-health-science-networks/national-programmes-priorities/national-wound-care-strategy-programme

Olsson M, Friman A (2020) Quality of life of patients with hard-to-heal leg ulcers: a review of nursing documentation. *Br J Community Nurs* 25(Sup12): S13–S19

Usey K, Cook L (2011) Understanding the importance of holistic wound assessment. *Practice Nurs* 22(6): 308–14

Ovens E (2020) Expert witness: role and

Key points

- In the event of a complaint or legal proceedings, documentation is a crucial record of care received by the patient.
- Key to successful wound management is accurate and comprehensive assessment, which will also help reduce unwarranted variations in care.
- Wound photography is an integral part of wound assessment, particularly in the current climate, and there are simple things to do to ensure photographs are clinically useful.

benefits in improving wound care practice. *Wounds UK* 16(1): 78–82

Queen D, Harding K (2020) Is wound photography becoming too sloppy? *Int Wound J* 17(1): 5–6

Scott-Thomas J, Hayes C, Ling J, et al (2017) A practical guide to systematic wound assessment to meet the 2017–19 CQUIN target. *J Community Nurs* 31(5): 30–4

Sperring B, Baker R (2014) Ten top tips for taking high-quality digital images of wounds. *Wound Essentials* 9(2): 62–4

Stevens D (2020) New initiative supports shared care in wound management. *J Community Nurs* 34(6): 26

Vowden P, Vowden P (2018) The importance of accurate methodology in ABPI calculation when assessing lower limb wounds. *Br J Community Nurs* 23(Sup3): S16–S21

World Union of Wound Healing Societies (2020) *Strategies to reduce practice variation in wound assessment and management: The T.I.M.E. Clinical Decision Support Tool*. Wounds International, London. Available online: www.woundsinternational.com

Royal College of Nursing (2017) *Record keeping: the facts*. Available online: www.rcn.org.uk/professional-development/publications/PUB-006051

Wounds UK (2016) *Best practice statement: holistic management of venous leg ulceration*. Wounds UK, London

Wounds UK (2018) *Best practice statement: improving holistic assessment of chronic wounds*. Wounds UK, London