STANDARD 6: DOCUMENTATION

Wound-related documentation provides a legal, comprehensive and chronological record of assessments, investigations, wound prevention and management planning and monitoring, and evaluation at the individual and organisation level.

Rationale

Accurate, comprehensive and chronological health records promote the safety of the individual, continuity of care and ability to determine if the care plan is effectively meeting the goals of care. Maintenance of health records in an accurate and clear manner is a legal requirement that protects the individual, their family carer and the multidisciplinary team. A comprehensive wound-related documentation system facilitates service level monitoring and auditing.

Criteria for wound care practitioners

To meet the criteria for the *Documentation Standard*, the wound care practitioner:

6.1. Maintains wound-related health records that meet legislative, regulatory and service provider requirements.

Evidence Criteria

6.1.1. Implements local documentation policies and procedures when collecting, storing, accessing, transferring and/or destroying health and wound-related information.

6.1.2. Maintains, stores, transfers and accesses health records in a manner consistent with relevant legislation.[1-7]

6.1.3. Maintains legible written health records that include name, designation, signature and date.[8-11]

6.2. Documents wound assessment, prevention and management comprehensively, chronologically and accurately.

Evidence Criteria

6.2.1 Documents assessments, care planning, care delivery and care evaluation[8, 9, 12-16] related to wound care,[10, 17-21] including:

- A comprehensive initial and assessment of the individual, the wound and the environment.[10, 13, 14, 17, 19]
- Diagnostic investigations and results.[9, 17, 19, 22]
- An evidence-based wound care plan.[10, 12-14, 17, 19]
- Evaluation of progress towards goals of care[23] using valid and reliable

documentation methods (e.g., assessment and monitoring tools, electronic records, digital photography) and effectiveness of the wound care plan.[6, 11, 24-30]

- Any changes to the wound care plan, including the rationale.[13, 14, 23]
- Any adverse effects or risks associated with wound care.[16]

6.2.2. Documents collaboration between the individual, their family carer and the multidisciplinary team, including:[8, 13, 14]

- The individual and their informal care givers' ability and willingness to participate in care decisions.
- The individual and their informal care givers' care preferences, expectations, goals of care and care decisions.[13, 14, 16]
- The individual and their informal care givers' ability and willingness to participate in care delivery.[21, 31]
- A record of multidisciplinary team meetings/care reviews.[31]
- Provision of information and education to the individual and their family carers.[8, 19, 31]

6.3. Consults with the individual and their family carer regarding the use of health information.

Evidence Criteria

6.3.1. Provides the individual and/or their family carer with information relating to collection, storage and transfer of health information and its use by the multidisciplinary team.[5, 9]

6.3.2. Obtains and documents informed consent relating to wound assessment and care delivery.[9, 31, 32]

Criteria for wound service providers

To meet the criteria for the *Documentation Standard*, the wound service provider:

6.4. Ensures that health and wound related records are maintained in a manner that meets legislative, regulatory and care provision requirements.

Evidence Criteria

6.4.1. Develops and regularly reviews documentation policy and procedures that include the ways in which health and wound-related information will be collected, recorded, accessed, and stored.[20, 21, 23, 27, 28, 33]

6.4.2. Provides for storage, access, and transfer of health records according to relevant legislative and regulatory requirements.[1-7]

6.4.3. Provides a wound-related documentation system that facilitates wound care delivery, monitoring and evaluation, auditing and research.[21, 23, 33, 34]

6.4.4. Provides for health records stored in a manner consistent with privacy legislation, with back-up mechanisms in place.[35, 36]

6.4.5. Ensures that wound documentation is accessible to current and future multidisciplinary teams.[11, 23, 27, 28, 37]

Related resources

Relevant Federal and jurisdictional legislation (Health Records Act, Health Privacy Principles, Health Records Regulations, Health Care Act, Privacy Act and/or Freedom of Information Act), including: • Commonwealth Government of Australia, Privacy Act 1988, Compilation No. 86, 17 February 2021, Schedule 1: Australian Privacy Principles. 2021. https://www.legislation.gov.au/Details/C2021C00139 • Australian Capital Territory Legislative Assembly, Health Records (Privacy and Access) Act 1997, Schedule 1: The Privacy Principles. Republication 27, Effective 01 April 2016. 2016. https://www.legislation.act.gov.au/a/1997-125/default.asp • New South Wales Government, Health Records and Information Privacy Act 2002, No 71. 2020, New South Wales Government. https://legislation.nsw.gov.au/view/html/inforce/current/act-2002-071 • Queensland Government, Information Privacy Act 2009, Reprint current from 1 July 2019. 2019. https://www.legislation.qld.gov.au/view/html/inforce/current/act-2009-014 • Victorian Government, Health Records Act 2001, Version No. 046, No. 2 of 2001, amendment 27 August 2020, in 046. 2020. http://www.austlii.edu.au/au/legis/vic/consol_act/hra2001144/sch1.html	S
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Background and Context

Documentation of wound assessment, prevention and management is important from a variety of perspectives. The individual's health record details the efficacy of the management plan and the progress toward care goals. It is one of many methods through which the multidisciplinary team communicate with each other regarding the individual's progress and any issues that may

arise in care delivery and referrals. Documentation also forms an ongoing legal account of the care provided.

Maintaining legible and lawful health records

Legible records are important to ensure continuity of care and are required from a medico-legal perspective. Record entries should be signed and dated, and the identity of the team member completing the record should be legible. Documentation should be accurate, specific and use only standard abbreviations. Documented health records should not be altered or erased. If changes are required, additional information can be added to a record (and dated) or information can be deleted by ruling through the mistaken entry and initialling and dating changes.[38, 39] These principles promote continuity of care and protect the individual, regulated health professionals and unregulated health care workers in the event of complaints or legal action.[6]

Under Australian Privacy Principle One[5] health service providers are required to clearly express how health-related information will be collected and managed. This information should be available for the individual, family carers and members of the multidisciplinary team. The kind of information that should be included in the health service's privacy policy includes the kind of information that is collected and how it is used, for what purposes information is disclosed to other people or service providers, the process for an individual to access their documented medical record, and how individuals can make a complaint if their privacy is breached.[5] Other Commonwealth and State legislation includes guidance on ways in which medical records must be stored, who may access records, the length of time records must be stored and how records are transferred or destroyed.[1-3, 5, 7, 35]

Documenting decision making

The right to engage in decisions regarding one's care is a foundation health care principle. Informed consent requires the individual to have engaged in an informed decision-making process with the support of the multidisciplinary team and their family carers. Counselling the individual about the role and outcome of wound assessment, risk assessment and options for care should be thoroughly documented in the health record, including the education with which the individual was provided, the individual's goals for care, alternative care strategies that have been discussed, and the choices the individual has made with respect to ongoing care planning and delivery. This documentation serves as a both a legal record, and communication to the regulated health professionals and unregulated health care workers regarding the education and consultation that has been undertaken.[31]

Documentation systems

An advanced documentation system provides a wound service with advantages in achieving best practice in wound care and working towards continuous quality improvement. Many facilities have introduced, or are developing, electronic medical records that provide the opportunity to integrate best practice into documentation, care planning and quality improvement. Evidence suggests that an advanced (and specifically, electronic) medical record is associated with more effective care delivery and superior patient outcomes.[40] An ideal comprehensive documentation system includes standardised assessment and monitoring tools, clinical decision tools or flow charts and flagging or alert systems to draw attention to assessment outcomes that are of concern (e.g., identified as having a high risk of pressure injuries).[41] An electronic documenting

system ensures that wound assessment is stored in one place, ensuring care continuity across the multidisciplinary team.[24, 41] More advanced documentation systems integrate wound photography, healing trajectory for wounds, consumer education material and relevant clinical guidelines and/or recommendations. Organisation level wound prevalence and incidence rates and healing outcomes can also be derived from wound documentation systems and are therefore useful for quality improvement planning and reporting.[41]

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