Nursing Documentation in Wound Management: Completeness, Accuracy, and Relevance in Inpatient and Outpatient Settings

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INTRODUCTION

Nurses are central to patient care, acting as advocates and care coordinators. In wound care, their responsibilities include assessment, treatment, and ongoing monitoring.

Accurate nursing records are essential for tracking healing progress, evaluating interventions, and guiding care plans. These records also support quality improvement by enabling data analysis to enhance outcomes and care practices.

OBJECTIVE

To evaluate the completeness, accuracy, and clinical relevance of nursing documentation for wound management, focusing on interventions performed and products prescribed, in both ambulatory and inpatient contexts.

METHOD

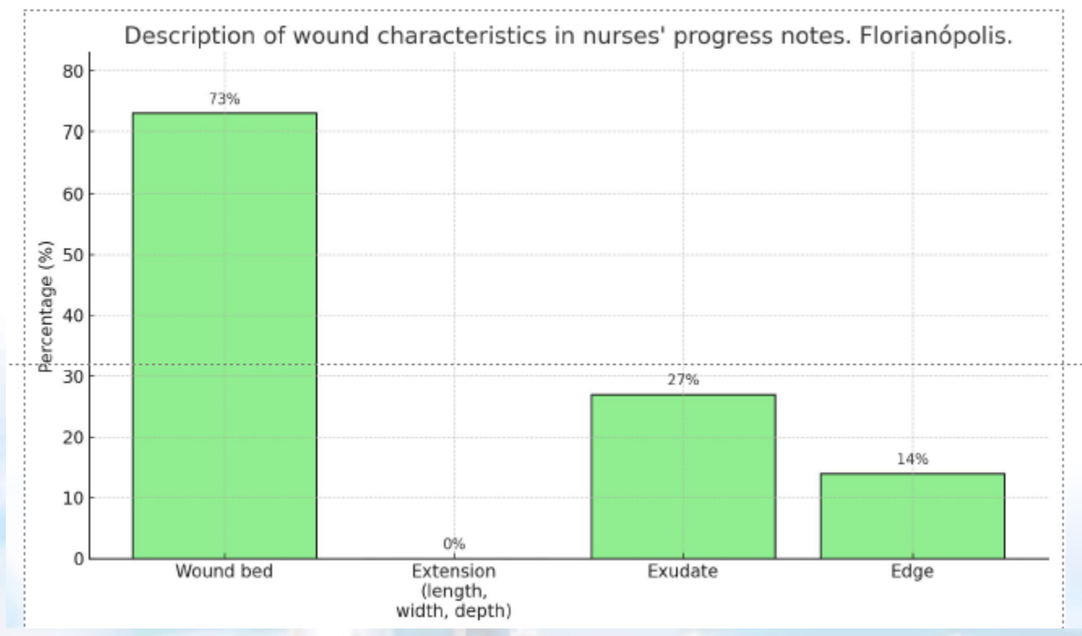
- ***Design:*** A descriptive, exploratory documentary analysis.
- ***Local:*** Polydoro Ernani de São Thiago University Hospital of the
- Federal University of Santa Catarina and abbreviated as HU-UFSC/EBSERH.
- ***Sample:*** 17 charts (Jan/2019–Dec/2020) were selected from a larger quasi-experimental project "Laser Therapy in the Treatment of Wounds in Adults" (approved by local Ethics Research Committee).
- ***Data collection:*** Data were extracted using structured forms in three categories: (1) Assessment Notes – wound size, exudate, tissue condition, infection, pain; (2) Nursing Diagnoses –based on NANDA taxonomy; (3) Prescriptions & Progress Notes – dressings, topical agents, adjunctive therapies (including laser).
- **- *Analysis:*** Quantitative data were analyzed descriptively; qualitative data were thematically coded for omissions, inconsistencies, and best practice adherence.

I have no conflict of interest

RESULTS

Fifteen patients averaged 9.3 days of inpatient stay and 8.4 nursing evolutions (SD 8.3; range 0–25); two patients were outpatients and had one evolution each.

Assessment Detail: Precise measurements were never recorded; exudate characteristics appeared in 27 % of evolutions, wound edges in 14 %, infection signs in <20 %, and pain in 12 %. **Diagnostic Use:** Nursing diagnoses were noted in 65 % of charts; nearly half of evolutions lacked any diagnostic framing. **Prescription Rigor:** Of 78 wound-care prescriptions, only 12 charts included orders justified by assessment data. Products were often listed generically, with just ten orders formally verified. **Progress Notes:** Follow-up entries largely repeated prior observations without documenting wound progression or care adjustments.



CONCLUSION

Despite investments in electronic records and ongoing training, practical application remains suboptimal. To close this gap, qualitative studies should explore nurses' perceptions and workflow barriers. Insights can inform targeted interventions—such as embedded decision-support prompts, focused training on wound assessment, and regular audit-and-feedback cycles—to reinforce precise, actionable documentation, ensure care continuity and optimize wound-healing outcomes.

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