Documentation of pressure ulcer on Electronic Health Records vs. written reports

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In this journal article, researchers conducted a study to see if nurses’ documentation of pressure ulcers on the electronic health record were better than written documentation. A 560- bed medical center in Miami was used. One hundred and thirty nine patients participated in the study. Their criteria for eligibility included a weight of more than 70 pound but less than 500 pounds, patients who remained on a support mattress for a minimum of 2 to 10 days and admission to the hospital for a medical diagnosis or surgical procedure. The study was approved by the institutional review board at the University of Miami. The patients records which included both electronic health records and medical records were compared against the hospital wound care policy. The hospital wound care policy stated that patients skin integrity should be assessed upon admission, before every shift and at discharge for impairment and that patients with community acquired or health care acquired wounds will have their wounds isolated and photographed on admission, every Wednesday and at discharge for baseline purposes and wound progression. Overall fifteen cases of pressure ulcers were identified. The results of the study showed that documentation of pressure ulcers on electronic health records as well as written reports were poorly written because nurses lacked good documentation skills, they did not follow the frequency of documentation provided by the hospital, some written data were incongruent with electronic data, night shift nurses spent less time documenting, nurses did not give a thorough description of pressure ulcer and some nurses did not know how to properly document on the electronic health record. The study had two limitations, identification of inaccuracy of documentation in the electronic health record as well as the written record were not allowed and it only used medical and surgical patients so the results could not be generalized to patients in other departments. This study brought about the importance of documentation, proper documentation skills, the need to involve nurses in electronic health record design, teaching to help nurses properly use electronic health records and better wound care strategies for undergraduate nursing students and staff nurses.

*References*

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