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Review article

The issue of documenting pressure ulcers: literary review

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Abstract
Objective: To find, analyze and compare clinical recommended practices, national recommendations, guidelines, nursing standards and assessment tools with a focus on documenting pressure ulcers.
Methodology: The selection of relevant sources was carried out in 2018 using search services and sources in electronic databases (Medline, ProQuest, PubMed), book publications, from professional societies, and professional journals. Out of 139 sources, 38 sources were selected and processed in three phases based on the ranking and exclusion criteria.
Results: By analyzing and comparing clinically recommended procedures, national recommendations, guidelines, nursing standards and assessment tools to document pressure ulcers, we have found that the most frequently reiterated requirement for pressure ulcers is: degree of pressure ulcer, its location, size, base, exudate and surroundings. The most observed items that tell us about documenting of the pressure ulcer healing process are found in the NPUAP, EPUAP, PPPIA consensus (GRADE), HSE, AAWC, and RNAO guidelines.
Conclusions: Pressure ulcer documenting is a problem addressed within national and international recommendations or guidelines. Their analysis and comparison revealed several worldwide unified documentation requirements, which are essential to multidisciplinary collaboration and decision-making on further treatment.

Keywords: Assessing and documenting pressure ulcers; Assessment tools for pressure ulcers classification; National guidelines for documenting pressure ulcers

Introduction

Consistent and timely recording of nursing care for pressure ulcers supports communication, continuity, decision-making on further treatment, and improves patient safety. Documenting of pressure ulcers is a part of the directives, standards or recommended practices in the Slovak Republic and abroad regarding the classification of pressure ulcers and the assessment of their healing during treatment. In the practice of documenting, it is recommended to record care as soon as it is provided, identify risks or problems that have arisen, fill in all records accurately and without any falsification, record your own notes in the documentation without unnecessary abbreviations (with a precise date and time), keep the documentation safe, and process and store research data and results accordingly (Nursing and Midwifery Council, 2015). Foreign studies point to a lack of nursing care tracking in line with holistic approach, legislation and professional standards (Dehghan et al., 2015; Gunningberg et al., 2008; Høgsnes et al., 2016; Vainiomäki et al., 2008; Wang et al., 2011). In Slovakia, the proper management of nursing documentation is the legislative and professional requirement of nursing practice, which is also the basis for the creation of contracts between health care providers and the health insurance company. Insufficient or absent recordings of pressure ulcer assessments as well as discrepancies between data recorded in the nursing documentation and data recorded in the health insurance information system indicate not only a reduced quality of documentation management but also suspect illegal activity. It is therefore necessary to know the correct and recommended way of assessing pressure ulcers and recording them in the documentation. An initial assessment associated with the inclusion of a pressure ulcer in a particular classification grade is decisive in determining treatment and treatment procedures. The guideline for the inclusion of pressure ulcers in the relevant classification stage is the National Pressure Ulcer Advisory Panel, and the European Pressure Injury Alliance (NPUAP, EPUAP, PPPIA, 2014). Individual countries create their own standards, guidelines or best practices, which relate not only to the inclusion of pressure ulcers into the classification stage, but also to the follow-up of the pressure ulcer healing process and its documentation. They are: Wounds Australia (AWMA, 2016), the European Wound Management Association (EWMA, 2019), which, together with the European Pressure ulcer advisory panel (EPUAP, 2014) co-operates with the OECD (2019) in the field of pressure ulcer management at European level, National Institute for Health and Care Excellence (NICE, 2014), Agency for Healthcare Research and Quality (AHRQ, 2017), Association for Advance of Wound Care (AAWC, 2010), Health Ser-

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vice Executive (HSE, 2018), Registered Nurses' Association of Ontario, Canada (RNAO, 2018); Dowsett and Newton (2005), National Health Service (NHS, 2009), Methodological Recommendation of the Ministry of Health of the Czech Republic (Journal of the Ministry of Health CR, 2009), Professional Guidance of the Ministry of Health of the Slovak Republic (Journal of the Ministry of Health SR 2004a).

The aim of the study was to find, analyze and compare clinical recommended practices, national recommendations, guidelines, nursing standards, and assessment tools to document pressure ulcers.

Materials and methods

This contribution has the character of a review study. In the course of 2018, search services for the National Center for Health Information – the Slovak Medical Library (NCZI-SLK), where 67 sources from the Medline electronic database and 6 book publications were provided to search for relevant sources. In addition, publications from ProQuest, PubMed, and professional journals were included in the analysis. We used the following keywords and their combination to search: pressure ulcer treatment, pressure ulcer treatment standard, pressure ulcer care, pressure ulcer monitoring and evaluation, pressure ulcers guidelines. Out of 139 sources, 25 sources from electronic databases, 9 sources from professional societies, 2 sources from professional journals and 2 book publications were selected. The selection was made on the basis of fulfilling the inclusion criteria, including the assessment and documentation of pressure ulcers, assessment tools for pressure ulcers classification, English, Slovak and Czech, free contribution fully containing information on pressure ulcers assessment and evaluation. Eliminating criteria included the prevention of pressure ulcers, care for primary healing wounds, other language than English, Slovak, Czech, duplicates, material requiring registration and payment. The selection was made in three phases. All sources were included in the first phase and those that contained the exclusion criteria were excluded according to their content. In the second phase, resources that contained incomplete information on the assessment and evaluation of pressure ulcers were excluded. In the third phase, the resources were divided into resources related to the Guidelines / Standards / Recommended Practices for Documenting Pressure ulcers (Tables 1 and 2) and sources containing Evaluation Tools designed to classify pressure ulcers.

Results

By analyzing and comparing clinically recommended procedures, national recommendations, guidelines, nursing standards, and assessment tools to document pressure ulcers, we found that the most frequent requirement for documentary pressure is degree of pressure ulcer, location, size, base, exudate, and environment (Table 1). The most monitored items that tell us about documenting the course of pressure ulcer healing can be found in the NPUAP, EPUAP, PPPIA (2014) guidelines with consensual approach (GRADE), HSE, AAWC and RNAO (Table 2). The recommended assessment tools for inclusion of pressure ulcers in the respective classification grade are given in Table 3.

Table 1. Guidelines / Standards / Recommended Practices for Documenting pressure ulcers

Source	Enrollment Requirements (by stage, score, multiple factors)	Detailed description of the requirement
NPUAP, EPUAP, PPPIA (2014)	classification of pressure ulcers by degree	I. degree – fading hyperemia
		II. degree – partial loss of skin cover
		III. degree – total loss of skin cover
		IV. degree – total loss of skin cover and subcutaneous tissue
		without determining degree – unknown depth
		suspected deep tissue damage
	location	
	size	writing values of length, width, and depth measured at the same neutral position
	tissue type	
	colour	skin temperature, skin sensitivity, changes in tissue consistency, pain should be recorded in patients with dark skin and pressure ulcers II.–IV.
	condition of pressure ulcer surroundings	swelling, redness
	edges	
	sinuses	
	undergrounding	recording the values after carefully probing the wound
	tunneling	
	exudate	writing the amount of exudate, its character (presence of pus)
	odour	
	pain	scales to assess pain, nonverbal and verbal manifestations, write intensity and frequency
AWMA (2016)	anatomic location	
	size	length, width, depth measured from the longest/deepest part
	undeground part	description of the range using a probe
	area	circuit and surface notation planimetry
	volume	writing values measured with sterile liquid or filler

Table 1. ***(Continued)***

Source	Enrollment Requirements (by stage, score, multiple factors)	Detailed description of the requirement
AWMA (2016)	base	agranulation, granulation, hypergranulation epithelialization, yellow tissue, necrosis/eschara, exposed
		bone or tendon, foreign body, fistula
	edges	increased, cylindrical, undergrounding, coloring
	characteristics of the surrounding skin	notation – erythema, edema, abnormal strength, maceration, drying out, dermatitis/eczema, callus, hyperkeratosis, pigmentation changes, urticaria and temperature
	exudate	type – serous, sanguinous, seropurulent, purulent, amount and odor
		consistency (thick, thin)
	healing phase	hemostasis, inflammation, reconstruction, epithelization, remodeling
	signs of inflammation or infection	range – local infection, spread of infection, systemic infection based on clinical signs and/or examinations
	pain	verbal and nonverbal manifestations; location, character, intensity; duration; noncyclic, cyclic, chronic
NICE (2014)	categorization using a classification tool (e.g. International Pressure Ulcer Classification System NPUAP-EPUAP)	
	area	
	depth	
	undergrounding	
	pain	
	color, temperature, strength, skin moisture	
AHRQ (2017)	description using Bates-Jensen (2001) Wound Assessment Tool (BWAT) and other standard treatment and intervention descriptions	
	origin, start date	acquired in the facility, present at reception, acquired at the facility
	location	
	initial phase	
	size	length, width, and depth, writing values measured with a ruler in centimeters; multiply by × width
	edge of pressure ulcer	description of appearance – diffuse, snug without side surfaces, not attached to deep base such as edge, cylindrical, fibrotic, hyperkeratosis
	undergrounding	a description of the measurement by inserting a cotton tip applicator under the wound edge
	tunneling	description of direction and length
	necrotic tissue	description of type and quantity – e.g. white/gray, non-adherent yellow tissue, loosely adherent yellow tissue, adherent soft black crust, firm, adherent hard, black crust, amount measured with a transparent metric guide
	exudate	Type and amount – e.g. serosanguinous, serous, no amount, small, medium, large
	surrounding of pressure ulcer	skin color, temperature/redness, edema and induration
	granulating tissue	writing the range as a percentage of filling the base
	epitelization	writing the range as a percentage of filling the base
	pain	selection on a range of pain by rating from 0 to 10
	classification level	I. to IV., not classifiable, suspected deep tissue damage
AAWC (2010)	anatomical location	record of location by Bates-Jensen (2001)
	size	writing length, width, depth of pressure ulcer
	exudate	character – sanguineous, serous, purulent, and many – none, small, medium, large
	signs of infection	erythema, edema, odor, purulent exudate, increasing pain, temperature
	undergrounding, sinuses	
	tunneling	
	type and amount of tissue	epithelialization, granulation, yellow / whitish fibrin / tissue or black, brown, gray necrotic tissue
	edges of pressure ulcer	abnormalities

Table 1. ***(Continued)***

Source	Enrollment Requirements (by stage, score, multiple factors)	Detailed description of the requirement
AAWC (2010)	surrounding of pressure ulcer	erythema or edema
	pain	using of evaluation scale
HSE (2018)	classification by NPUAP/EPUAP	
	location	
	size	
	type of tissue	
	color	
	surrounding	
	edges	
	sinuses	
	undergrounding	
	tunneling	
	exudate	
	odor	
RNAO (2018)	location	
	depth/ degree	categorization using a classification tool (for example the International Pressure Ulcer Classification System NPUAP-EPUAP)
	size	use ruler or photo
	odor	
	sinuses	
	undergrounding	
	tunneling	
	exudate	serous, sanguine, serosanguine, purulent, and many none, small, medium, large
	base	black, yellow, pink/red
	the appearance and condition of the surrounding skin and the edges of the pressure ulcer	
Dowsett and Newton (2005)	base	type, exudate, infection
	edges	macerated, dry, undermined, cylindrical
	surrounding	macerated, dry, excretion, hyperkeratosis, calus, eczema
NHS (2009)	categorization using a classification tool (eg International Pressure Ulcer Classification System NPUAP-EPUAP)	categorization using a classification tool (eg International Pressure Ulcer Classification System NPUAP-EPUAP)
	location	
	case	
	size	
	the appearance of base	
	exudate	
	odor	
	the condition of the surrounding skin	
	presence of infection	
	pain	
Journal of the Ministry of Health CR (2009)	the degree of tissue involvement using the Hibbs scale	levels 1 to 4 according to Hibbs
	anatomical location	
	diameter of pressure ulcer (mm)	writing an approximated average diameter of a constructed circular pressure ulcer
Journal of the Ministry of Health SR (2004a)	pressure ulcer stage or healing phase	
	location	
	size of pressure ulcer	writing length, width, depth
	colour	
	surrounding of pressure ulcer	redness, swelling, maceration
	skin turgor	

Table 2. An overview of the individual items of the guidelines / standards / recommended practices that are required for entry in the documentation

Source	Degree	Location	Size (dimension, area)	Undergrounding	Tunneling	Sinuses	Volume	Base (phase)	Exudate	Edges	Surrounding	Colour	Temperature / inflammation	Odor	Pain	Turgor
NPUAP, EPUAP, PPPIA (2014)	+	+	+	+	+	+	–	+	+	+	+	+	–	+	+	–
AWMA (2016)	–	+	+	–	–	–	+	+	+	+	+	–	+	+	+	–
NICE (2014)	+	+	+	+	–	–	–	–	–	–	–	+	–	–	+	+
AHRQ (2017)	+	+	+	+	+	–	–	+	+	+	+	–	–	–	+	–
AAWC (2010)	–	+	+	+	+	+	–	+	+	+	+	–	+	–	+	–
HSE (2018)	+	+	+	+	+	+	–	+	+	+	+	+	–	+	–	–
RNAO (2018)	+	+	+	+	+	+	–	+	+	+	+	–	–	+	–	–
Dowsett and Newton (2005)	–	+	–	+	–	–	–	+	+	+	+	–	–	–	–	–
NHS (2009)	+	+	+	–	–	–	–	+	+	–	+	–	+	+	+	–
Journal of the Ministry of Health CR (2009)	+	+	+	–	–	–	–	+	–	–	–	–	–	–	–	–
Journal of the Ministry of Health SR (2004a)	+	+	+	–	–	–	–	–	–	–	+	+	–	–	–	+

Table 3. Evaluation tools designed to classify pressure ulcers

Title by	Enrollment Requirements (by stage, score, multiple factors)	Description of the recorded pressure ulcer assessment
NPUAP, EPUAP, PPPIA (2014)	degree I	fading hyperemia
	degree II	partial loss of skin cover
	degree III	total loss of skin cover
	degree IV	total loss of skin cover and subcutaneous tissue
	without determining degree	unknown depth, complete loss of tissue with a base covering
	suspected deep tissue damage	unknown depth, violet-colored blister
Knighton (2015)	degree I	superficial damage (epidermis, dermis)
	degree II	deep damage (interferes with subcutis)
	degree III	fascia involvement
	degree IV	muscle involvement
	degree V	affecting tendons, ligaments, bones
	degree VI	affecting large cavities
Shea (1975)	degree I	disappearing redness, the area may be painful, firm, soft, and warmer or cooler than adjacent tissues
	degree II	partial loss of skin cover, manifested as a shallow open red-pink ulcer
	degree III	tissue loss in full thickness, subcutaneous fat may be visible, but bone, tendon or muscle not visible, undergrounding presence, tunneling may be present
	degree IV	loss of full thickness tissue with exposed bone, tendon or muscle
	unclassified	base covered with yellow, gray, green or brown tissue, no depth can be determined without removal
Hibbsová (2009)	degree I	fading redness persisting even after 5 min., after relieving the exposed area, capillary blood flow within 30 min. recovers
	stage II	partial loss of skin, blister, wet surface
	stage III	complete loss of skin and subcutaneous tissue, gray or black crust, deep soft tissues (fascia, muscles) are intact
	stage IV	loss of skin with extensive damage to deep functional structures, necrosis, undergrounding, penetration into adjacent cavities and joints
Torrance (2015)	degree I	fading erythema
	degree II	unfading erythema
	degree III	superficial ulceration at the subcutaneous tissue interface
	degree IV	subcutaneous fascia ulceration
	degree V	infectious necrosis into the subcutaneous fascia
Daniel (2015)	degree I	redness of the skin
	degree II	superficial skin ulceration
	degree III	subcutaneous fat necrosis
	degree IV	affecting deep structures except bones
	degree V	extensive necrosis with osteomyelitis, joint destruction
Seiler (2015)	A	pure granular wound without necroses
	B	coated wound with residues of necroses is not infected with the surrounding
	C	coated wound with necrosis residues, infected surrounding, signs of general sepsis

Discussion

When recording the degree of pressure ulcer into the documentation, the international system of classifying pressure ulcers (NPUAP, EPUAP and PPPIA) is most often recommended in line with evidence-based practice (EBP). Historically, this has been preceded by several classification systems (Black et al., 2007) developed by several authors such as: classification according to Knighton (2015), Hibbs (currently also required by the Journal of the Ministry of Health CR, 2009), Torrance (2015), Daniel (2015), Seiler (2015), Shea (1975). A systematic literature review by Stausberg and Kiefer (2009) found that up to 31 classification systems could be identified. The classification grade system is based on anatomy and the extent of damaged tissue, and cannot be reversed in documenting

the healing process (Baharestani et al., 2009). To record the location of a pressure ulcer, guidelines (AAWC, 2010; AHRQ, 2017) recommend the BWAT assessment tool, which allows you to select a location from the offered options and label it with an "X" on the body map. Incontinence-related dermatitis – Associated Dermatitis Incontinence (IAD) from pressure ulcer (Pokorná et al., 2016) is necessary to localize in areas affected by incontinence. Appropriate terminology (front, back, mediolateral or proximal distance) should be used for enrollment (Melter, 2017). Often used is image plotting of the location on the so-called map of the human body (Journal of the Ministry of Health SR, 2000). The fastest and easiest method to measure pressure ulcer size is to use a disposable paper ruler to record the length and width in cm, giving you an indication of the size of the pressure ulcer surface. It is important where the measurements are made because they can fundamentally affect the outcome. One method is to measure the greatest length and the greatest width of the pressure ulcer. In the second method, the largest length and largest width are measured perpendicular to each other at a 90° angle from head to toe (Nichols, 2015). Depth should be recorded according to the deepest portion measured sterile, using a cotton tip applicator or with plastic probes marked in cm. A clock face is used in the description method assuming that 12 hours is from the head of the patient, who is laying in the same position during the measuring (Nichols, 2015). RNAO recommends the use of a ruler or a photograph to measure the size of the pressure ulcer, the recommendations of the Ministry of Health of the Czech Republic describe the writing of an approximated value of the diameter of the constructed circular pressure ulcer. The choice of the method of measuring and recording the size of the pressure ulcer in the documentation should remain unchanged during further review and documentation in the healing process. The base of the pressure ulcer of the NPUAP, EPUAP, PPPIA (2014) directive evaluates the degree of skin cover loss, AHRQ (2017) recommends the scaling of the epitalization and granulation tissue range as a percentage of the base filling and, in the case of necrotic tissue, the description of the type and quantity (e.g. white/gray, non-adherent yellow tissue, loosely adherent yellow tissue, adherent soft black crust, firm, adherent, hard, black eschar), RNAO recommends to distinguish the base by color (black, yellow, pink/red). According to Australian standards, it is assessed whether it is agranulation, granulation, hypergranulation epithelialization, yellow tissue wound slough, necrosis/eschar, exposed bone or tendon or fistula. It is recommended to record the amount and nature of the exudate in relation to the scoring. The EPUAP, NPUAP, PPPIA (2014) guidelines document the amount of exudate and its nature (presence of pus), similarly, AWMA requires documenting the type of exudate (serous, sanguineous, seropurulent, purulent), amount and its odor. According to AHRQ (2017), the type of exudate (e.g., sanguineous, serosanguinous, serous) is recorded, and is defined as none, small, medium, large, which is consistent with the AAWC guidelines. When documenting the pressure ulcer assessment, account must be taken of the consistency of the recorded data with a brief and concise record of all necessary information.

Assessing the pressure ulcer edges is important for the healing process that starts from the edges. AWMA recommends evaluating the edges as raised, cylindrical, undergrounding, while also highlighting their color. The AHRQ (2017) program suggests documenting the edges with a description of the appearance (diffuse, snug without side, not attached to a deeper base, such as edge, rolled, fibrotic, hyperkeratosis). Wound Asia recommends differentiating between macerated, dry, undergrounding or cylindrical edges. Most of the above guidelines and recommendations also agree on the need to document the environment of the pressure ulcer. The skin should be scored at least 4 cm around the wound (Melter, 2017). The AHRQ (2017) program emphasizes the need to record skin color around pressure ulcer, temperature/redness, edema, and stiffness. Similarly, the AAWC association recommends writing erythema or edema around the pressure ulcer. Canadian RNAO Association also recommends the appearance and appearance of the surrounding skin. Dowsett and Newton (2005) define a pressure ulcer environment as macerated, dry, with excoriation, hyperkeratosis, callus, eczema. The Slovak Framework Process Standard recommends that redness, swelling, and maceration in the vicinity of the pressure ulcer be recorded. In addition to the above parameters, guidelines and recommendations emphasize the need to document conditioning, tunneling, sinus, pressure ulcer volume measured with a sterile liquid, skin color, temperature/inflammation, odor, pain, and skin turgor (see Table 3).

When documenting according to the recommendations mentioned above, certain forms of individual parameter recording such as e.g. Wound Healing Continuum (WHC), which evaluates and documents the color change base, Wound Infection Continuum (WIC), recording microbial settlement and Wound Exudate Continuum (WEC) rating based on exudate volume and consistency (Gray et al., 2010), or the TIME model, which aims to relieve swelling, maintain optimal moisture removal of the biofilm with reduction of bacterial load, promote edge effect healing (Dowsett et al., 2018). Various technical and electronic pressure ulcer assessment systems are also recommended, such as e.g. Wound Healing Analyzing Tool (WHAT), which enables electronic wound analysis (W.H.A.T., 2013), or the use of working mini laptops with an electronic form software installed (ASSIDIS software) (Jarošová et al., 2012). Another method for documenting and archiving pressure ulcer data is using Visitrak (Stryja et al., 2011). In Slovakia, the documentation of pressure ulcers is based on the professional guidance of the Ministry of Health on the management of health documentation (Journal of the Ministry of Health SR, 2009), according to which the entry in the documentation should include a brief description of the performance provided and its evaluation. According to the current standard no. 85 – Nursing care for a patient with pressure ulcer in the home environment (Journal of the Ministry of Health SR, 2004a), the nurse records the assessment of the pressure ulcer according to the stage or phase of healing appearance of the surrounding skin (presence of redness, swelling and maceration), and then further records pressure ulcer location, pressure ulcer character, determines depth damage and measures the length and width of the pressure ulcer. The compliance of the record in the documentation with the valid legislation and professional recommendations is monitored by the review nurse in the framework of the inspection activity. Its job position and competencies are defined by legislation in Slovakia (Act No. 581/2004).

In the context of the above-mentioned international recommendations for the documentation of pressure ulcers, the notation should also be supplemented with an assessment of the base, exudate and pressure ulcer margins, but if these parameters are understood as "pressure ulcer character" as given in standard no. 85, the required data should be comprehensive in view of the most frequently encountered requirements for documenting pressure ulcers. However, the problem remains that the registration of the pressure ulcer assessment in the documentation in the context of the above requirements re-

mains time-consuming and burdensome for the nurse. The availability of electronic devices and their proper use in documenting the assessment of pressure ulcers could reduce the time-consuming work of the nurse while ensuring clarity of the pressure ulcer assessment and healing process.

Conclusions

Documenting pressure ulcers is a problem addressed within national and international recommendations or guidelines. Their analysis and comparison revealed several worldwide unified documentation requirements, which are essential to multidisciplinary collaboration and decision-making on further treatment. In the initial assessment of pressure ulcers, the international pressure ulcer classification system NPUAP, EPUAP, PPPIA, which classifies pressure ulcer into four grades and two separate stages with unknown depth and suspected deep tissue damage, is most commonly recommended. It is evident from the overview of the individual guidelines/standards/recommended procedures required for entry into the documentation (Table 2) that the pressure ulcer documentation should, in particular, include: determination of location, size, base, exudate and surrounding of pressure ulcer, what is identical in all recommendations, and according to local recommendations, the recording is supplemented by an assessment of pressure ulcer boundary, tunneling, sinuses, pressure ulcer volume, margins, skin color, temperature/inflammation, odor, pain, and skin turgor. In Slovakia, documentation is monitored as part of the review activity (Journal of the Ministry of Health SR, 2004b) and in addition to the actual assessment and treatment of pressure ulcer, it also monitors its compliance with the reported nursing care to the health insurance company.

Conflict of interests
The authors have no conflict of interests to declare.

Ethical aspects of the work
The ethical aspects of resource citation have been followed. The authors declare that ethical aspects have been followed when processing the results.

Problematika dokumentovania dekubitov: literárny prehľad

Súhrn
Cieľ: Vyhľadať, analyzovať a porovnať klinické odporúčané postupy, národné odporúčania, smernice, ošetrovateľské štandardy a hodnotiace nástroje so zameraním na dokumentovanie dekubitov.
Metodika: Výber relevantných zdrojov sa realizoval v priebehu roka 2018 s využitím rešeršných služieb a zo zdrojov v elektronických databázach Medline, ProQuest, PubMed, knižných publikácií, zo stránok odborných spoločností a odborných časopisov. Zo 139 zdrojov bolo vybraných 38 zdrojov, ktoré boli spracované v troch fázach na základe stanovených zaraďujúcich a vyraďujúcich kritérií.
Výsledky: Analýzou a porovnaním klinicky odporúčaných postupov, národných odporúčaní, smerníc, ošetrovateľských štandardov a hodnotiacich nástrojov so zameraním na dokumentovanie dekubitov sme zistili, že pri posudzovaní dekubitov sa najčastejšie opakuje požiadavka na dokumentovanie: stupňa dekubitu, jeho lokalizácie, veľkosti, spodiny, exsudátu a okolia. Najviac sledovaných položiek, ktoré nám hovoria o dokumentovaní priebehu hojenia dekubitov sa nachádza v smerniciach NPUAP, EPUAP, PPPIA s konsenzuálnym prístupom (GRADE), HSE, AAWC a RNAO.
Záver: Dokumentovanie dekubitov je problém riešený v rámci národných i medzinárodných odporúčaní, smerníc alebo guidelinov. Z ich analýzy a porovnania vyplynulo niekoľko celosvetovo jednotných požiadaviek dokumentovania, ktoré sú nevyhnutným podkladom k multidisciplinárnej spolupráci a rozhodovaní o ďalšom postupe liečby.

Kľúčové slová: hodnotiace nástroje pre klasifikáciu dekubitov; národné smernice dokumentovania dekubitov; posudzovanie a dokumentovanie dekubitov

References

1. AAWC – Association for the Advancement of Wound Care (2010). Guideline of pressure ulcer guidelines. [online] [cit. 2018-10-13]. Available from: https://s3.amazonaws.com/aawc-new/memberclicks/AAWCPressureUlcerGuidelineofGuidelinesAug11.pdf
2. Act No. 581/2004. [Zákon č. 581/2004 Z. z., o zdravotných poisťovniach, dohľade nad zdravotnou starostlivosťou a o zmene a doplnení niektorých zákonov. In: Zbierka zákonov Slovenskej republiky, čiastka 246/2004].
3. AHRQ – Agency for Healthcare Research and Quality (2017). On-time pressure ulcer assessment. [online] [cit. 2018-10-13]. Available from: http://www.ahrq.gov/professionals/systems/long-term-care/resources/ontime/pruhealing/pruhealing-assessment.html
4. AWMA – Wounds Australia (2016). Standards for wound prevention and management. 3rd edition. Osborne Park, WA: Cambridge Media.
5. Baharestani M, Black J, Carville K, Clark M, Cuddigan J, Dealey C, et al. (2009). International guidelines. Pressure ulcer prevention: prevalence and incidence in context. A consensus document. London: Medical Education Partnership (MEP) Ltd.
6. Bates-Jensen B (2001). Bates-Jensen wound assessment tool. [online] [cit. 2018-02-19]. Available from: http://wwwoundcare.ca/Uploads/ContentDocuments/BWAT.pdf
7. Black J, Baharestani MM, Cuddigan J, Dorner B, Edsberg L, Langemo D, et al. (2007). National pressure ulcer advisory panel's updated pressure ulcer staging system. Dermatol Nurs 19(4): 343–349.
8. Daniel (2015). Historie a současnost klasifikace dekubitů. Klasifikace dekubitů podle Daniela. In: Koutná M, Ulrych U, et al. (Eds). Manuál hojení ran v intenzivní péči. Praha: Galén.
9. Dehghan D, Dehghan M, Sheikhrabori S (2015). The quality of clinical documentation of patients admitted to an iranian teaching hospital: a two-year impact of clinical governance. AJNER 5(2): 159–166. DOI: 10.5958/2349-2996.2015.00033.6.
10. Dowsett C, Newton H (2005). Wound bed preparation: TIME in practice. Wounds UK 1(3): 58–70.

11. Dowsett C, Protz K, Drouard M, Harding KG (2018). Triangle of wound assessment. Wounds Asia. [online] [cit. 2018-10-23]. Available from: https://www.woundsasia.com/resources/details/triangle-wound-assessment
12. EWMA – European Wound Management Association (2019). [online] [cit. 2018-09-18]. Available from: http://ewma.org/
13. Gray D, White R, Cooper P, Kingsley A (2010). Applied Wound Management and using the Wound Healing Continuum in Practice. Wound Essentials 5: 131–139.
14. Gunningberg M, Dahm MF, Ehrenberg A (2008). Accuracy in the recording of pressure ulcers and prevention after implementing an electronic health record in hospital care. Qual Saf Health Care 17(4): 281–285. DOI: 10.1136/qshc.2007.03341.
15. Hibbsová P (2009). Metodika hodnocení stupně postižení tkáně u dekubitů. Škála stupně postižení tkání u dekubitů dle Hibbsové. In: Věstník MZ ČR. Metodické doporučení. Metodika prevalenčného sledování dekubitů na národní úrovni. Částka 6: 69–82.
16. Høgsnes L, Danielson E, Norbergh KG, Melin-Johansson C (2016). Healthcare professionals' documentation in nursing homes when caring for patients with dementia in end of life – a retrospective records review. J Clin Nurs 25(11–12): 1663–1673.
17. HSE – Health Service Executive (2018). HSE National wound management guidelines. Dublin: The Office of Nursing and Midwifery Services Director.
18. Jarošová D, Sikorová L, Marečková J, Pajorová H (2012). Elektronická dokumentace pro ošetřovatelskou diagnostiku v domácí péči. Praktický lékař 92(2): 105–107.
19. Journal of the Ministry of Health of the Czech Republic (2009). [Věstník MZ ČR] Metodické doporučení. Metodika prevalenčního sledování dekubitů na národní úrovni. Částka 6: 69–82.
20. Journal of the Ministry of Health of the Slovak Republic (2004a). [Vestník MZ SR] Odborné usmernenie MZ SR č. 22701/2004-00, ktorým sa mení a dopĺňa odborné usmernenie MZ SR pre tvorbu, implementáciu a hodnotenie štandardov v ošetrovateľstve a pôrodnej asistencii z 30. augusta 2004 č. 16138-2/2004-OO.
21. Journal of the Ministry of Health of the Slovak Republic (2004b). [Vestník MZ SR] Koncepcia odboru Revízne ošetrovateľstvo č. 14100/2006 – OZSO. Vol. 54, čiastka 1–5.
22. Journal of the Ministry of Health of the Slovak Republic (2000). [Vestník MZ SR] Odborné usmernenie MZ SR č. SZS-1373/2000 pre poskytovanie zdravotnej starostlivosti v Agentúrach domácej ošetrovateľskej starostlivosti. Vol. 48, čiastka 35–56.
23. Journal of the Ministry of Health of the Slovak Republic (2009). [Vestník MZ SR] Odborné usmernenie MZ SR č. 07594/2009-OZS o vedení zdravotnej dokumentácie. Vol. 57, čiastka 42–48.
24. Knighton (2015). Historie a současnost klasifikace dekubitů. Klasifikace chronických ran podle Knightona. In: Koutná M, Ulrych U, et al. (Eds). Manuál hojení ran v intenzivní péči. Praha: Galén.
25. Melter C (2017). Pressure ulcer prevention and treatment assessment, wound care, and healing. Wild Iris Medical Education. [online] [cit. 2018-10-28]. Available from: https://wildirismedicaleducation.com/courses/pressure-ulcer-assessment-treatment-ceu
26. NHS – National Health Service (2009). Prevention and management of pressure ulcers. [online] [cit. 2018-10-28]. Available from: http://nhs.stopthepressure.co.uk/path/docs/Prevention%20and%20management%20of%20pressure%20ulcers%20v5%20DRAFT.pdf
27. NICE – National Institute for Health and Care Excellence (2014). Pressure ulcers: prevention and management. [online] [cit. 2018-09-13]. Available from: https://www.nice.org.uk/guidance/cg179/chapter/recommendations#healthcare-professional-training-and-education
28. Nichols E (2015). Wound assessment part 1: how to measure a wound. Wound Essentials 10(2): 51–55.
29. NPUAP – National Pressure Ulcer Advisory Panel, EPUAP – European Pressure Ulcer Advisory Panel and PPPIA – Pan Pacific Pressure Injury Alliance (2014). Prevention and treatment of pressure ulcers: quick reference guide. Haesler E (Ed.). Perth: Cambridge Media.
30. Nursing and Midwifery Council (2015). The Code. Profesional standards of practice and behaviour for nurses and midwives. [online] [cit. 2018-09-18]. Available from: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
31. OECD – The Organisation for Economic Co-operation and Development (2019). [online] [cit. 2018-09-13]. Available from: http://www.oecd.org/
32. Pokorná A, Jarkovský J, Mužík J, Vasmanská S, Saibertová S, Krejčiříková P (2016). A new online software tool for pressure ulcer monitoring as an educational instrument for unified nursing assessment in clinical settings. Mefanet J 4(1): 26–32.
33. RNAO – Registered Nurses' Association of Ontario (2018). Educational Workshop for RNs and RPNs: Assessment and Management of Pressure Ulcers [online] [cit. 2018-09-13]. Available from: https://rnao.ca/sites/rnao-ca/files/Assessment_and_Management_of_Pressure_Ulcers_-_Part_A.pdf
34. Seiler (2015). Historie a současnost klasifikace dekubitů. Klasifikace dekubitů podle Seilera. In: Koutná M, Ulrych U, et al. (Eds). Manuál hojení ran v intenzivní péči. Praha: Galén.
35. Shea JD (1975). Pressure sores: classification and management. Clin Orthop Relat Res 112: 89–100.
36. Stausberg J, Kiefer E (2009). Classification of pressure ulcers: a systematic literature review. Stud Health Technol Informa 146: 511–515. DOI: 10.3233/978-1-60750-024-7-511.
37. Stryja J, et al. (2011). Repetitorium hojení ran 2. Semily: GEUM.
38. Torrance G (2015). Historie a současnost klasifikace dekubitů. Klasifikace dekubitů podle Torrance. In: Koutná M, Ulrych U, et al. (Eds). Manuál hojení ran v intenzivní péči. Praha: Galén.
39. Vainiomäki S, Kuusela M, Vainiomäki P, Rautava P (2008). The quality of electronic patient records in Finnish primary healthcare needs to be improved. Scand J Prim Health Care 26(2): 117–122. DOI: 10.1080/02813430701868806.
40. W.H.A.T. – Wound Healing Analyzing Tool (2013). [online] [cit. 2018-02-18]. Available from: http://www.what-world.com/index.html
41. Wang N, Yu P, Hailey D, Oxlade D (2011). Developing measurements of quality of electronic versus paper-based nursing documentation in Australian aged care homes. eJHI 6(1): e7.