Clinical innovation: SEE & WRITE — a new approach for effective recording

A fundamental element of nursing is accurate record keeping and this article introduces a new approach developed in Italy, which aims to provide clinicians with the means to prompt both a thorough assessment of the wound and an accurate written record of observations made. Proper documentation ensures safe and effective care, supports clinical decision-making, as well as promotes a more efficient sharing of information among clinicians.

Accurate record-keeping is fundamental to the nursing profession. Filling in nursing records means acting like a notary to certify and show the work performed in the exercise of care. In addition, legally it is considered a public act, according to the article 2699 of the Italian Civil Code. Accurate documentation is also essential to ensure safe and effective care, to support clinical decision-making, as well as to promote more efficient sharing of information among the team members.

In the complex world of wound care, there are many systems that can be used to guide assessment and documentation of wound healing. Ulcer rating scales are an example. Some of them rate wounds according to severity, while others focus on the healing process. The National Pressure Ulcer Advisory Panel/European Pressure Ulcer Advisory Panel (NPUAP/EPUAP) defines how deep the tissue damage is, while the Texas University classification focuses on the diabetic foot. There are also specific tools for measuring wounds, for example, the Push Tool 3.0 developed by NPUAP, the Bates-Jensen Wound Assessment Tool for pressure ulcers (PUs), or the Leg Ulcer Measurement Tool (LUMT) for the definition of progress in the vascular lesions of the lower limb.

The purpose of this article is not to focus on the reliability of existing rating scales, but on some important aspects regarding the way healthcare professionals describe wounds, and the subjective nature of the assessment and written record of the observations made. A new conceptual model is introduced, designed to provide a simple and accurate tool to assist with improving clinical documentation.

The scientific literature shows there is disagreement in the definition and terminology used to describe an ulcer and, therefore, nurses have the opportunity for creativity and subjectivity in the use of clinical descriptors. Maylor in his clinical survey demonstrated that the lack of a pre-established model or of a dedicated reference form for staff, allowed for many omissions, for example, clinicians often failed to describe key features of wound healing, such as exudate or the characteristics of the wound bed in their patient records.

SEE & WRITE

The ‘SEE & WRITE’ tool has been developed by the author to provide clinicians with the means to prompt both a thorough wound assessment and an accurate written record of observations that are made. It was developed primarily for nurses, but is also used by the medical staff. The acronym is central to the tool, reminding the clinician that the assessment has to go through an observational analysis (SEE), as well as the execution of the written record (WRITE). Each letter is connected to an important wound descriptor. Although the concept of TIME is similar in approach and uses an acronym to prompt effective wound bed preparation, the SEE & WRITE model is focused on effective observation and achieving an accurate description of the wound.

The components of the SEE & WRITE tool capture the most important features of wound management that should be included in the nursing documentation forms during the continuum of care. The concept adopts the fundamental framework of the nursing process with the focus on data collection, planning, implementation of interventions and evaluation. Here is a breakdown of the SEE & WRITE acronym:

- **S**ee: Describes the appearance and characteristics of the wound.
- **E**xudate: Describes the amount and type of fluid present in the wound.
- **A**ccurate: Ensures that the documentation is precise and complete.
- **N**ote: Records the date and time of the assessment.
- **W**ritten: Ensures that the observations are documented accurately.
- **R**ecord: Maintains a record of the patient’s progress.
- **I**mprovement: Monitors changes in the wound condition.
- **T**reatment: Lists the wound management plan.
- **E**valuation: Evaluates the effectiveness of the care plan.

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S: Size
Wound measurement
Wound measurement is an essential component of the evaluation. It provides an initial indication of the extent of the lesion, is used to track the rate of progress and is essential to monitor whether the wound is healing, static or deteriorating. There are many measurement systems, some are extremely simple, while others are complex and can use IT, such as Vistrak (Smith & Nephew)\(^\text{15}^{\text{–}20}\).

Usually, the measurement takes into account three fundamental aspects: area, depth and volume. We consider only the wound area, while the depth and the volume will be discussed later. Despite the availability of various measurement systems, tracing of the lesion seems to be one of the most accurate and practical systems\(^\text{14}\) as it allows a more precise evaluation of the lesion. The sheets of acetate usually have a grid and each square represents a cm\(^2\). Calculating techniques can be manual or digital.

The lesions should be measured weekly as this offers a good guide to progress. It is estimated that a decrease of the surface area of about 25–30% in 4 weeks is the best predictor of healing\(^\text{11}\).

E: Edges
Assessment of the wound edges
The wound edge is the place where epithelialisation starts with the active division, migration, and maturation of epidermal cells from the wound margin across the open wound\(^\text{16}\). The condition of the wound edges is an indication of healing progress and is also of considerable importance in differential diagnosis. The final stage of healing is re-epithelialisation with maturation and migration of cells from the margins (edges) into the interior of the lesion\(^\text{16}\). Although new epithelium can grow from islands of epithelium, for example, around hair follicles.

In written descriptions of a wound, the margins should be described using words such as ‘distinct’, ‘fibrosed’, ‘calloused’, ‘jagged’ or ‘punched out’, ‘hyperplastic’ or can be described as having ‘areas of necrosis adherent or non-adherent to the margins’, as all these features are indicative of certain conditions that must be considered carefully. To assist with this part of the assessment, the author intends to create a legend and picture guide, illustrating the various presentation of wound edges with the appropriate descriptor. An example can be found in Figure 1.

E: Exudate
Analysis and description of exudate
Exudate is a key feature of chronic ulceration. Although there have been numerous studies, there is still no valid classification system for its description and measurement\(^\text{17}\). The measurement of exudate is a subjective process, because in daily practice it is not easy to accurately quantify the amount of exudate produced by a lesion. The LUMT assessment tool\(^\text{18}\) describes five descriptors for the level of exudate volume ranging from 0 to 5, but the evaluation is subjective.

The colour of exudate varies from pale yellow (usually considered normal), to milky white (sign of possible infection), amber: (Staphylococcus aureus) to pink/red (excessive amount of red blood cells), from blue-green (in the presence of Pseudomonas aeruginosa) to brown (faecal enterococci infection or colliquative necrosis material)\(^\text{18,19}\).

The viscosity is usually linked to the level of proteins present. When protein levels are low, exudate will be aqueous, while it will tend to be more adhesive and thick when there is a high presence of proteins\(^\text{18,19}\).

Odour associated with exudate has a social impact on individuals as it can often be a source of shame and isolation. It can be caused by autolysis (self-digestion) of necrotic tissue, or more frequently by infected lesions\(^\text{20,21}\). Rating scales for odour do exist, but these are highly subjective\(^\text{21}\).

The clinician will use a locally agreed tool to measure the amount of exudate and to make a record of exudate volume. In addition to the purely quantitative criterion of volume, the expectation is that the colour, viscosity and odour are also observed and recorded.

W: Wound bed appearance
Description of the wound bed
The evaluation of the wound bed is one of the most important aspects in the management of wounds. It involves the description of the type of tissue in the ulcer. In general, the use of the colour scale Red-Yellow-Black (RYB) is widely used in clinical settings. The RYB system offers the opportunity to simplify and standardise the classification of parameters that are universally recognised\(^\text{22}\).

Viable tissue (granulation tissue) is highly vascularised and delicate. It has a colour ranging from light red to dark red and it looks grainy. If this type of tissue is present, it is a sign the lesion is in the process of healing and that a dense network of capillaries, a large number of fibroblasts, macrophages and new collagen fibres will be present in the wound and will facilitate the process of re-epithelialisation\(^\text{23}\). In some cases, this new granulation tissue may over-proliferate, which is sometimes described as ‘proud flesh’, overgranulation or hypergranulation. This tissue is fragile and shiny, it can appear as a result of

Figure 1. Edges: well defined, attached and pink.
infection, minor trauma, and/or continuous friction, or application of occlusive dressings\textsuperscript{24}. Yellowish tissue or slough is a sign of a lack of vitality, it is considered to be the result of a prolonged inflammatory process. This tissue is composed of many protein derived elements, such as fibrin, albumin and fibrinogen. Such non-viable tissues is favoured by bacteria and may support development of infection and obstruct re-epithelialisation\textsuperscript{25}. The slough may be adherent, loose or with a filamentous look on the wound bed.

Black or brown tissue is a tangible sign of tissue destruction and is caused by prolonged lack of oxygen with relative local ischaemia\textsuperscript{26}. An example can be found in Figure 2.

\textbf{pRobe: Sinus tracts and depth}

\textbf{Measurement of sinus tracts and depth}

The depth of the wound and the presence of undermining or sinus tracts must be observed, measured and recorded. Generally, a cotton-tip applicator (sterile swab) can be used to explore sinus tracts and undermining, and they should be marked in order to record the length of the wound\textsuperscript{27}.

\textbf{I: Infection/inflammation}

\textbf{Search for clinical signs of infection and inflammation}

Another important aspect in the management and description of wounds, whether chronic or acute, is linked to the recognition of wound infection. The ability to recognise the clinical signs of infection and to accurately document them is extremely important, even though the characteristics of true infection may not always be clear, especially when masked by diseases, such as diabetes, neuropathy or skin changes. The Australian Wound Management Association\textsuperscript{28} proposes a number of clinical indicators of infection associated with the degree of involvement of the lesion.

It should be considered that the signs that show the highest diagnostic reliability in the detection of infection are pain, delayed healing and friability of the granulation tissue\textsuperscript{29}.

Occasionally, the signs of the infection can be confused with the signs of inflammation and the latter are not always caused by the presence of microbes, for example, vasculitic ulcers may display strong inflammatory signs in the absence of infection\textsuperscript{30}.

\textbf{T: Texture perilesional skin}

\textbf{Description of the surrounding skin}

The surrounding skin is important and must be observed carefully. The most salient features are: colour, temperature, maceration, dryness, presence of satellite lesions, desquamation, hyperkeratosis, dermatitis, eczema, signs of injury, such as bacterial folliculitis, induration, presence of callus tissue, pitting oedema, variation of the local temperature, erythema and the level of skin elasticity. In addition, the condition of the surrounding skin is a useful indication of tolerance and sensitisation in relation to dressings.

The presence of thin, delicate skin — which is similar to cellophane — with a tendency towards the formation of spontaneous bruising (dermatoporosis — chronic cutaneous insufficiency/fragility syndrome)\textsuperscript{31}, especially in the lower limbs and the upper ones, requires precaution on behalf of the clinician in order to protect against epidermal stripping caused by adhesive.

It is also important to note if there is tissue maceration, since it acts as a barrier to the migration of new cells. In addition, hyperexudation may be suggestive of a potential infection. Action needs to be taken if the dressings and interventions used are not adequately managing the volume of exudate\textsuperscript{32}. An example of unhealthy perilesional skin can be found in Figure 3.

\textbf{E: Evaluation and treatment}

\textbf{Evaluation}

At the end of the recording process, there should be a comprehensive evaluation of the wound and healing progress. SEE & WRITE encourages the clinician to help establish the aetiology of the wound; identify factors that interfere with or hinder healing; describe/document the state of a wound at a given time; monitor the progress (or lack of progress) of the wound toward the therapeutic goal; and evaluate the effectiveness of ongoing treatment\textsuperscript{33}.

As previously mentioned, a decrease in the size of the lesion by 25–30\% is an important prognostic factor for healing and must be documented in this continuum of care.

\textbf{Treatment}

The last component of SEE & WRITE is dedicated to treatment, ie the description of the planned treatment regimen based on the findings and observations made during the assessment. After a detailed description of the characteristics of the wound and its overall assessment, the clinician plans the treatment they consider most appropriate.

\textbf{Conclusion and future developments}

The purpose of SEE & WRITE is to be able to provide a new framework in order to
encourage nurses in Italy to make detailed observations, which are reflected in accurate and detailed records.

This framework is not a substitute for using validated assessment tools, which can and should form an integral part of the assessment. The aim is to simplify and to place the essential features of assessment in a logical order to prompt accurate recording in the medical records during each visit. The system SEE & WRITE needs to be formally evaluated, it will then become the subject of study by researchers at the Associazione Infermieristica per lo Studio delle Lesioni Cutanee (AISLeC), and will be officially presented at the fifth Congress of the WUWHS[19] to be held in Florence in September 2016.

Future developments should also take into account the possibility to input data into a computer system. Many studies have shown that an IT system is able to improve the quality of documentation, to reduce errors significantly and to increase the satisfaction of clinicians[20,21].

References