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## Nurses' reported practice and knowledge of wound assessment, assessment tools and documentation in a selected hospital in Lagos, Nigeria

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### Abstract

**Background:** Complete wound assessment and accurate documentation are two pivots on which effective wound care is based and wound care is the traditional role of nurses. This study was designed to assess nurses' reported practice and knowledge of wound assessment, assessment tools and documentation.

**Methods:** Cross sectional descriptive design was adopted and the study was conducted in National Orthopaedic Hospital, Igbobi (NOHIL) Lagos, Nigeria which was selected because of high incidence of orthopaedic conditions with accompanying wounds of various types. A purposive sample of 251 nurses participated in the study.

**Results:** Findings show less than adequate reported practice and knowledge. Some of the respondents, 83 (33.1%) reported that they were familiar with wound assessment methods. However, only 18 (7.2%), 29 (11.6%) and 7 (2.8%) correctly cited photographic method, physical observation, and tape rule respectively while 21(25%) of them cited wrong methods such as evaluation of PH and chemical method, and the rest could not cite any method. Majority, 144(57.4%) reported they were not quite or not at all familiar with Pressure Ulcer Status Tool, and none of the respondents who claimed to be familiar with these tools could answer any questions that tested their knowledge on specific aspects of the tool. What respondents claimed they included in their documentation varies from wound dressing done/ wound is clean/wound is healing by 111(44.2%) while 40(16%) of them reported no idea of what to document. Modifiable variables like rank (NOII) and years of experience (1-5 years) were found to significantly affect their reported knowledge of wound assessment and reported practice of wound documentation.

**Conclusion:** Participants in this study are deficient in knowledge and practice of wound assessment and

documentation. Utilization of wound assessment tools and continuing professional development for nurses are necessary to improve care outcomes for all patients living with wounds.

**Keywords:** Nurses, Reported practice, Knowledge, Wound assessment, Wound assessment tools and Documentation

### Résumé

**Introduction:** La répartition complète de blessure et exact documentation sont deux pivots sur lesquels l'effectif soin de blessure est basé et le rôle traditionnel des infirmier(e)s est le soin de blessure. Cette étude était dessinée pour répartir la pratique et savoir de répartition des blessures constaté des infirmier(e)s, instruments et documentation de répartition.

**Méthode:** Un dessin descriptif de cross section était adopté et l'étude était menée à l'Hôpital Orthopédique National, Igbobi (HONIL) Lagos, Nigeria qui était sélectionné à cause du grand incidence de conditions orthopédiques avec accompagnement des blessures de divers types. Un échantillon utile de 251 infirmier(e)s participait dans l'étude.

**Résultats:** Les découvertes révèlent moins qu'adéquat pratique et savoir constaté. Certains des répondants, 83 (33,1%) rapportaient qu'ils étaient familiers avec les méthodes de répartition de blessure. Néanmoins, seulement 18 (7,2%), 29 (11,6%) et 7 (2,8%) correctement citaient méthode photographique, observation physique, et mètre de mesure respectivement tandis que 21 (25%) d'eux citaient des mauvaises méthodes telles que l'évaluation du PH et méthode chimique, et le reste ne pouvait citer aucune méthode. Majorité, 144 (57,4%) constataient qu'ils n'étaient pas tout à fait ou pas du tout familiers avec l'Instrument de Pression de la Position d'Ulçère, et aucun des répondants qui prétendaient à être familier avec ces instruments ne pouvait répondre aucune des questions qui testaient leur savoir sur les aspects spécifique de l'instrument. Ce que les répondants prétendaient qu'ils ont inclus dans leur documentation vari de pansement de blessure fait/ blessure est propre/ blessure est entrain de se cicatriser par 111 (44,2%) tandis que 40 (16%) d'eux rapportaient aucune idée de quoi à documenter. Les variables modifiables comme

rang (Infirmier II) et années d'expérience (1-5 ans) étaient trouvés à affecter significativement leur rapporté savoir de répartition de blessure et rapporté pratique de documentation de blessure.

*Conclusion:* Les participants dans cette étude sont déficients en savoir et pratique de répartition de blessure et documentation. L'utilisation des instruments de répartition de blessure et le développement professionnel continué pour les infirmier (e)s sont nécessaires à améliorer les résultats de soin pour tous patients vivant avec blessures.

**Mots clés :** *Infirmier(e)s, Pratique rapportée, Savoir, Répartition de blessure, Instruments de répartition de blessure et documentation.*

### Introduction

A complete wound assessment and accurate documentation are two crucial elements of effective wound care as they provide information on which subsequent plan of care is based. This however requires the use of some wound assessment tools such as pressure sore status tool, pressure ulcer scale for healing, Pat and Powell's tool and photographic method. Wound dressing which is an integral part of wound care is the traditional role of nurses. It is an important nursing procedure that must not only be carried out routinely but systematically and professionally. According to Dowsett, Dealy and Flanagan [1-3], the management of wounds makes up a considerable proportion of a nurse's workload and they should as such be familiar with wound assessment, and wound assessment tools for effective wound management.

Success of wound care therefore depends heavily on the nurse's ability to accurately assess wound and document his or her findings. This is because wound assessment and documentation offer practitioners a framework upon which to base clinical decisions aimed at maximizing healing potential. It relies heavily on basic observational skills to detect subtle differences between a healing and non-healing wound and focuses on the difficulties in identifying clinical signs of wound infection. Wound assessment and documentation however require some skills on the part of the nurse. Accurate wound assessment is a critical component of effective wound management. A skilled nurse, who can accurately assess a wound, plays a vital role in determining the appropriate management of a wound to promote healing and avoid secondary complications. The use of wound assessment tools, such as flowcharts and measuring tools are helpful in performing accurate and comprehensive assessment. Flowcharts for example allow for the comparison of a wound status

from one dressing change to the next. This streamlines and standardizes the evaluation process, allowing for accurate recognition and intervention for wounds that have reached a plateau or deteriorated.

Previous studies have identified deficits in nurses' wound assessment and documentation skills and literature indicates that nurses' knowledge in wound assessment is insufficient to inform practice and if knowledge is present it is not reflected in clinical practice [4-7]. Hon and Jones, in their study found out that statements such as "healing well", "wound is clean", "wound was dressed" or "wound is healing" were commonly used for wound care documentation, while descriptions which would provide information about the state, progress or management of wound were found to be generally omitted [8]. Other authors also reported that optimal care is not always provided by nurses, leading to delay healing, increased pain, increased risk of infection, and inappropriate care outcome [9].

Wound assessment is a cumulative process of observation, data collection, and evaluation. It is an important component of patient care as it includes a record of initial assessment, ongoing changes and treatment interventions [10]. Although there may not be a strict outline of the amount of information to be included in wound assessment, a complete wound assessment should include: a thorough assessment of the whole patient and not the hole, etiology of type of wound and wound characteristics such as location, size, depth, exudates, and tissue type present [7]. Other components are: pain, patient's nutritional status and type of surrounding tissues. Other authors [1, 11] however, expressed concerns about accurately assessing wounds. Methods of wound assessment include: physical observation techniques, tape rule or ruler for measuring the area and depth, tracing method and photographic method.

There are various wound assessment tools to assist practitioners to ensure that wounds are correctly assessed, healing is documented, and factors that could delay healing are identified and appropriately managed. Like wound assessment, no single documentation chart or tool has been designated as the most effective, however studies found that wound assessment has been documented significantly more frequently when an assessment chart was used and that using a chart improves the nurse's assessment skills [12].

Literature on this topic in the selected setting is sparse; hence this study aimed at assessing nurses' reported practice and knowledge of wound assessment, assessment tools and documentation in Lagos state becomes vital. The specific objectives

are to: Assess participants' reported practice of wound assessment and documentation; assess their knowledge of wound assessment and of the appropriate tools for wound assessment and documentation. That there was no significant effect of variables such as rank, gender and years of experience of nurses on their knowledge and practice of wound assessment and documentation was the hypothesis formulated.

Kurt Lewin's Change Management Theory [13] comprising three stages described as unfreezing, transition and refreezing or freezing stages provides its theoretical basis. First, a deficiency in reported practice and knowledge of wound assessment, assessment tools and documentation skills of participants was identified. The participants' desire for an educational training on wound care indicates a need for change and a desire to transit from their present stage to a better level (unfreezing). The findings of the study will provide insight to appropriate authorities to take steps toward shifting the present equilibrium by providing them with necessary equipment, tools, charts and appropriate wound care policies which will provide the reinforcing forces that will refreeze the new behavior.

## Materials and method

Cross sectional descriptive design was adopted. The study was conducted at the National Orthopaedic Hospital, Igbobi, Lagos (NOHIL), a federal government hospital established in 1947 and located in capital and commercial nerve centre of Nigeria. All the available nurses in the wards and units where patients with wounds were cared for and who were willing to participate in the study were purposively selected and included in the study. There were 300 nurses in the service area but only 260 completed the questionnaires out of which only 251 were filled appropriately and fit for analysis. A previously validated instrument was used for data collection; it was a structured questionnaire comprising three sections as follows: Respondents' demographic characteristics in section A, B consists of items to elicit information about nurses' knowledge of wound assessment, and wound assessment tools while C captured participants' reported practice of wound assessment documentation. Criteria for eligibility include: willingness to participate in the study by giving consent and being a registered nurse with the Nursing and Midwifery Council of Nigeria. Prior to data collection, the purpose of the study was explained to them and their confidentiality was guaranteed. Approval for the conduct of the study was obtained

from the ethical committee of the hospital dated 31 October, 2012.

The structured questionnaires were administered to all the nurses who were available in the service area of the hospital during the period of data collection. They were self administered by the researchers and research assistants during the duty hours and were retrieved immediately. Some of the participants however requested for more time to complete theirs and they were retrieved at stipulated time. Data collection lasted 4 weeks. Following data collection procedure, data were checked for completion, entered into the computer using SPSS version 21 and Chi square test was used to examine the relationship between identified variables.

## Results

The result presented here is the survey part of a larger intervention study.

### *Respondents' demographic data*

Out of the 251 respondents who participated in the study, majority, 198 (78.9%) were females (Table 1). The age range of the respondents is between 20 and 59 years, with majority of them (35.9%) falling within the range of 20 – 29 years. The mean age is 33.37 years with standard deviation of 8.874. Majority of the respondents (27.5%) were nursing officer II and most of them had basic and post basic qualifications. For marital status, 141 (56.2%) were married, while 41.8% were single and majority, (89.6%) were Christians.

### *Respondents' knowledge about wound assessment (WA)*

Most of the respondents claimed they had knowledge of definition of wound assessment however, only 83 (33.1%) claimed to be familiar with wound assessment methods (Table 2). Of all respondents, only 18 (7.2%), 29 (11.6%) and 7 (2.8%) correctly cited photographic method, physical assessment/ observation, and tape rule/ruler respectively as the methods they were familiar with while overwhelming 70% comprising 140 respondents could not state methods of wound assessment. Nineteen (7.6%) of them cited various wrong methods like evaluation of PH (1, 0.4%), chemical method (1, 0.4%), sterile method (2, 0.8%) and another 15 (6%) stated various wrong things that are not related with wounds in any way. Only 101 (40.2%) of the respondents claimed they assessed wound for wound characteristics, 50 (19.9%) for cleanliness/ healing / improvement, while 6 of them (2.4%) did not know what to look for during wound assessment.

Table 1: Socio-Demographic Data

Characteristics	Frequency	Percentage
<i>Age</i>		
20-29	90	35.9
30-39	62	24.7
40-49	35	13.9
50-59	14	5.6
No response	50	19.9
<i>Gender</i>		
Male	49	19.5
Female	198	78.9
No response	4	1.6
<i>Religion</i>		
Christianity	225	89.6
Islam	19	7.6
No response	7	2.8
<i>Marital Status</i>		
Single	105	41.8
Married	141	56.2
Divorced	1	.4
Widowed	2	.8
No response	2	0.8
<i>Highest Academic Qualification</i>		
General nursing	70	27.9
Post basic nursing	126	50.2
Others (such as B.Sc Nursing)	38	15.1
Student	41	1.6
No response	3	5.2
<i>Rank</i>		
NOII	69	27.5
NOI	41	16.3
SNO	32	12.7
PNO	21	8.4
ACNO	5	2.0
CNO	22	8.8
STUDENT	55	21.9
No response	6	2.4
<i>Highest Professional Qualification</i>		
RN	72	28.7
RN/RM	55	21.9
RN/RON/RAEN	72	28.7
Others	39	15.5
No response	13	5.4
<i>Years of Experience</i>		
1-5 years	115	45.8
6-10 years	48	19.1
11-15 years	32	12.7
16 years & above	51	20.3
No response	5	2.0

Pressure Ulcer Status Tool respectively, 201 (23.5%) and 142 (56.6%) gave the same response to Pat & Powell’s Tool, 52 (20.7%) and 149 (59.4%) to Davidson Marsha’s Tool, 53 (21.1%) and 96 (38.2%) to Photographic method, 48 (19.1%) and 129 (51.4%) to Bates-Jensen tool, 50 (19.9%) and 135 (53.8%) to Wound Assessment Parameter Scoring Tool and 54 (21.5%) and 119 (47.4%) to Pressure ulcer Score for Healing. None (0%) of the respondents who claimed to be familiar with these tools could answer any questions that tested their knowledge on specific aspects of the tool correctly while majority had no idea according to Table 3b.

Table 2: Respondents’ knowledge about wound assessment (WA)

	Frequency	Percentage
<i>Wound assessment (WA)</i>		
A cumulative process of observation, data collection and evaluation of wound	171	68.1
Checking the state of wound during wound dressing	34	13.5
Checking wound for cleanliness	16	6.4
Checking wound for signs of improvement	22	8.8
No response	8	3.2
<i>Familiar with any method of WA?</i>		
Yes	83	33.1
No	140	55.8
No response	28	11.2
<i>State methods of WA</i>		
No idea	176	70.1
Evaluation of PH	1	.4
Natural chemical	1	.4
No response	2	.8
Others(wrong)	15	6.0
Photographic method	18	7.2
Physical assessment/ observation	29	11.6
Sterile method	2	8
Tape rule and ruler	7	2.8
<i>What to look for during WA</i>		
Wound characteristics	101	40.2
Cleanliness/Healing/ Improvement	50	19.9
No idea	6	2.4

*Respondents’ knowledge of wound assessment tools and their specific aspects*

As shown in Table 3a, one hundred and forty-four respondents (50 (19.9%) and 94 (37.5%) respondents reported they were not quite/not at all familiar with

*Reported practice of wound assessment and documentation*

One hundred and ninety- nine (79.3%) of the respondents claimed to carry out wound assessment in their hospital as seen in Table 4. Thirty-six (14.3%)

**Table 3a:** Respondents' Knowledge of Wound Assessment Tools (WATs)

WATs	Very well	Fairly well	Not quite	Not at all	No response
Pressure ulcer status tool: Frequency.	45	48	50	94	14
%	17.9	19.1	19.9	37.5	5.6
Pat & Powell's tool: Frequency.	6	24	59	142	20
%	2.4	9.6	23.5	56.6	8
Davidson Marsha's Tool: Frequency	10	18	52	149	71
%	4	7.2	20.7	59.4	5.8
Photographic method: Frequency	48	33	53	96	21
%	19.1	13.1	21.1	38.2	8.4
Bates – Jensen W.A. tool: Frequency	19	33	48	129	22
%	7.6	13.1	19.1	51.4	8.8
W.A Parameter scoring tool: Frequency	14	29	50	135	23
%	5.6	11.6	19.9	53.8	9.2
Pressure ulcer scoring for healing: Frequency	22	34	54	119	22
%	8.8	13.5	21.5	47.4	8

gave a negative response while 16 (6.8%) did not respond. When respondents were asked how often they performed wound assessment, 82 (32.7%) claimed they performed it during every wound dressing, 63 (25.1%) cited during ward rounds, 27 (10.8%) rarely did it, 6 (2.4%) claimed they assessed wounds every time, while 3 (1.2%) did it whenever there was time to do so. When they were asked further on the methods they adopted for wound assessment, majority of them, 41 (16.3%) cited physical examination/observation, 11 (4.4%) cited clinical photography while most of them 165 (65.7%) had no idea.

**Table 3b:** Respondent's knowledge of specific aspects of the tools

	Frequency	%
<i>How PUSH differ from Davids on's tool</i>		
Don't know	6	2.4
Focuses on granulating wound	1	.4
<i>Limitations of Pat and Powell's tool</i>		
Don't know	4	1.6
<i>Advantages of Photographic tool over Pat and Powell's tools</i>		
Don't know	8	3.2
It may delay in wound healing	1	.4
keeping record	1	.4
<i>Similarities between BWAT and WAPST</i>		
Don't know	4	1.6
The method of using them	3	1.2

On whether respondents document their wound assessment or not on Table 5, 162 (64.5%) respondents gave a 'Yes' answer while 58 (23.1%)

**Table 4:** Respondents' reported practice of wound assessment

	Frequency %	
<i>Do you carry out WA in your hospital?</i>		
Yes	199	79.3
No	36	14.3
No response	16	6.4
<i>How often do you carry out WA in your hospital</i>		
Rarely	27	10.8
Occasionally	63	25.1
During every wound dressing	82	32.7
During ward rounds	32	12.7
Whenever there is time to do so	3	1.2
Every time	6	2.4
<i>Methods used by participants for WA</i>		
No idea	165	65.7
Assessment	1	4
Clinical Photography	11	4.4
Inspection by Doctors	5	2.0
observation during dressing	2	8
Others	21	8.4
photographic method	2	8
Physical examination/Observation	41	16.3
Tape rule	3	1.2

gave a 'No' answer. One hundred and thirty (130, 51.8%) reportedly documented after each wound assessment, 9 (3.6%) whenever they remembered, 6 (2.4 %) for patients with special cases, one (1, 0.4%) whenever time permitted while, 16 (6.6%) gave no response. What respondents claimed they included in their documentation varies from wound dressing done/ wound is clean/wound is healing by 111(44.2%), state of the wound by 5 (2%), everything

assessed by 3 (1.2%), wound is granulating by 2(0.8%) and presence or absence of necrotic tissues by 1(0.4%). Forty (40, 16%) of the respondents had no idea. Majority, 203 (80.9%) of the respondents admitted that there were no guideline or chart for wound documentation in their facility while 187 (74.5%) similarly agreed that their hospital had no particular tool used for wound assessment (Table 5).

**Table 5:** Reported Practice of wound documentation

	Frequency	%
<i>Do you document your WA</i>		
Yes	162	64.5
No	58	23.1
<i>How often do you document WA</i>		
After each assessment	130	51.8
Whenever I remember	9	3.6
Whenever time permits	1	4
For patients with special cases	6	2.4
No response	16	6.6
<i>What do you usually include in your WA documentation</i>		
Wound dressing done/ Wound is healing/ Wound is clean	111	44.2
Necrotic tissue (present or not)	1	.4
State of wound	5	2.0
Everything observed	3	1.2
Wound is granulating	2	8
No response/ no idea	40	16
<i>Does your hospital have a particular tool used for WA?</i>		
Yes	30	12.0
No	187	74.5
<i>Does your institution have a guideline/ chart for Wound documentation</i>		
Yes	27	10.8
No	203	80.9
No response	21	8.4

**Table 6:** Self-assessment of respondents' wound assessment and documentation skills

	Frequency	%
<i>Nurse's Grade of present WA and documentation skills</i>		
Very high	18	7.2
High	67	26.7
Low	80	31.9
Very low	52	20.7

**Table 7:** Whether Participants Have Ever Attended Training Programme on Wound Care and their training need.

	Frequency	%
<i>Ever attended WA and documentation training programme</i>		
Yes	17	6.8
No	209	83.3
No response	26	10.4
<i>When last did you attend such programme?</i>		
2008	1	.4
2009	5	2.0
2010	1	.4
2011	2	.8
2013	6	2.4
No response	2	0.8
<i>Do you need a training on WA and documentation skills?</i>		
Yes	223	88.8
No	7	2.8
No response	21	8.4

**Table 8:** Effect of socio-demographic variables on respondents' knowledge of wound assessment

Effect	Model Fitting Criteria		Likelihood Ratio Tests	
	-2 Log Likelihood of Reduced Model	Chi-Square	Df	Sig.
Intercept	299.028	83.922	4	.000
Rank (NOII)	233.082	17.976	4	.001
Gender	215.891	.788	4	.940
Years of Experience	222.368	7.282	4	.123
<i>Knowledge of wound assessment methods</i>				
Effect	Model Fitting Criteria		Likelihood Ratio Tests	
	-2 Log Likelihood of Reduced Model	Chi-Square	Df	Sig.
Intercept	185.725	29.826	2	.000
Rank	158.767	2.867	2	.238
Gender	156.045	.145	2	.930
Years of Experience (1-5 years)	163.472	7.573	2	.023

### *Respondents' self evaluation of wound assessment and documentation skill and training need*

When respondents were asked to evaluate their own level of knowledge of wound assessment and documentation skill, only 18 (7.2%) rated themselves very high, while majority, 80 (31.9%) rated themselves low and 52 (20.7%) rated themselves very low (Table 6). Most of the respondents, 209 (83.3%) denied having ever attended any training programme on wound assessment and documentation (Table 7), 17 (6.8%) claimed to have attended such programme, while 26 (10.4%) gave no response. Out of the 17 (6.8%) who claimed to have ever attended such programme, 1 (0.4%) last attended it in 2008, 5 (2%) in 2009, 1 (0.4%) in 2012, 2 (0.8%) in 2011, 6 (2.4%) last attended in 2013 while 2 (0.8%) gave no response. Majority of the respondents, 223 (88.8%) believed they needed training on wound assessment and documentation.

### **Discussion of finding**

Nursing is largely a female dominated profession and as such it is no surprise that gender in favor of female respondents along with rank has significant effect on respondents' reported practice of wound assessment and documentation. This trend may be due to the fact that nursing officer IIs are younger and may have more current knowledge than those in higher rank. Those in higher rank on the other hand because of their years of experience may be more thorough regarding what is included in documentation. In a study conducted by Cook [11], majority of the participants (36%) had more than 3 years experience with 17% of them reported to have been practicing for 1 to 3 years while 15% had less than 1 year experience. This study is however in contrast with the current study in that no relationship was established between years of experience and their knowledge of wound care. It is worthy of note that although the respondents in the present study work in an orthopaedic hospital where wound care is paramount yet none of them was a wound care nurse. This is in consonance also with the finding of Adejumo *et al* [4]. In the same vein, it is at variance with the finding of Cook [11] where 8% were tissue viability nurses, 1% were leg ulcer specialists and 1% a podiatrist. That in Nigeria, there is no institution for wound and ostomy nursing may provide explanation for this and this is a pointer to an urgent need in this area. The implication is that wound care will not be based on sound knowledge but on routine, tradition and "Trial and error" as shown in the current study. This will adversely affect the quality of wound care rendered, the quality of life of the patients, cost

of health care as well as positive patient outcome if situation remains like this for a longer time.

Majority of the participants (55.8%) were not familiar with any wound assessment method, and those who claimed to be familiar with the methods, cited different wrong examples while others could not cite any method. This means the participants were generally not familiar with the wound assessment tools and it can be inferred that the participants' knowledge about wound assessment was inadequate. This finding is in agreement with the findings of Karen and Kerry [14] that knowledge of nurses about wound care was inadequate as described in the National Best Practice and Evidence Based Guidelines for Wound Management. It however contrasts the findings of McCluskey and McCarthy [7] in a study conducted in an acute hospital setting in United Kingdom to explore nurses' knowledge and competency in wound assessment documentation. The findings of the study revealed that nurses' general knowledge about wound assessment was very good. The low/poor knowledge of nurses in this present study may be due to the fact that only 17 (6.8%) of the population claimed to have ever attended any training programme on wound care.

Nonetheless, 32.7% of the participants, 82 (32.7%) reportedly carry out wound assessment during every wound dressing and this finding is similar to another part of Cook's finding (11) where 81% of nurses in the study assessed wound during dressing change. Although, the parameter in Cook's study are similar to the present study; her study participants seem to practice wound assessment better than the participants in the present study. Several studies have confirmed improvement in wound assessment and documentation whenever nurses use a particular wound assessment tool [15, 16, 17, 18, 19, 20], unlike the findings of the present study where no chart or specific tool is used and the institutions have no specific guideline. The reported practice of wound assessment among participants in the current study is therefore inadequate. Furthermore, on what parameters included in their documentation, majority, 111 (44.2%) included wound was dressed or wound is healing or wound is clean. This implies that although the participant claimed to be documenting wound assessment, vital parameters that actually give information or clues about the state and progress of the wound are generally omitted. This is consistent with the findings of Hon and Jones [5] that a statements such as "healing well" was commonly used by nurses to document wound care while descriptions that would



provide information about the state, progress or management of wound were generally omitted.

Rank (NO II) and years of experience (1-5 years) are statistically significant ( $p = 0.001$  and  $p = 0.023$  respectively) on participants' knowledge of wound assessment. Incidentally, many of people with 1-5 years of experience are likely to be NO II. This could mean that the younger generation are more knowledgeable in relation to wound assessment and documentation than the older participants. Female participants reported practice wound assessment significantly more than their male counterparts ( $p = 0.000$ ). While participants who had 11-15 years of experience document more frequently ( $p = 0.000$ ) and those in rank of CNOs document more parameters ( $p = 0.011$ ). This may be due to the fact that traditionally, very senior officers do less of practice but more of report writing in the selected setting. These findings are similar to findings in a survey of Nurses' wound care knowledge [9], where younger nurses were found to be more knowledgeable about wound care than older nurses; it is however different from Ayello's study in that years of experience had little effect on wound care expertise of their study participants.

There is a significant relationship between knowledge of nurses about wound assessment and their practice of wound documentation. It therefore means that if frequent education programmes on wound assessment are organized, their practice of wound care documentation will be more accurate and relevant. This will eventually lead to improve client care outcome and should therefore be encouraged.

#### *Implications for nursing practice*

Although, wound care requires a multidisciplinary approach, the role of nurses in this all-important aspect of care cannot be over emphasized. Nurses who are the major custodians in wound care should realize that much is expected of them. Cost of wound care is generally high, but could be made higher and worse for the clients if their wounds are not competently assessed and findings adequately documented. This will interrupt the continuity of the client's care, increase the cost and length of hospitalization, as well as increase the burden of care on them and consequently reduce their quality of life. Nurses must therefore equip themselves with adequate knowledge and skill in wound care, especially, wound assessment and documentation that are the major elements on which effective wound care is based.

Nurses are responsible and accountable for their actions and inactions, they must therefore seek opportunities to update their knowledge and familiarize themselves with international wound-care guidelines to keep abreast of current practices. This is especially important in areas such as the setting for this study where wound care is an essential nurses' daily routine. Nurse administrators should seek and formulate policies that will enhance positive changes in the clinical practice of all nurses, thus enhancing evidence based care. Nurses should also collaborate with other health team members for effective management of patients with wounds and seek modern technologies in wound care from their hospital management.

#### **Conclusion**

Practitioners managing patients with wounds need to be most familiar with wound assessment, and wound assessment tools for effective wound management. An accurate and detailed assessment facilitates the planning of successful wound management. Comprehensive documentation provides a baseline for subsequent evaluation, and affects continuity of care as it ensures that different nurses (and other health team members) have the same information about the wound and provide the same care. However, adequate wound assessment and accurate wound care documentation still remain a Herculean task to nurses in this setting. Constant focused wound care education will improve their knowledge in addition to availability of wound assessment tools and guidelines for wound care documentation, relevant policy, motivation and adequate supervision and monitoring to ensure compliance with best practices are all pivotal to improving the practice of wound assessment and documentation.

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