LOOK - A New Approach to Wound Prevention

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HEALTHSOUTH®

Abstract

In 2013, hospital leadership noted that on average 38% of wounds identified as present on admission (POA) were healed by discharge, and 20% were worsened by discharge – often times, finding that wounds were likely present on admission and were not identified in assessment, causing the hospital to "own" a wound that they shouldn't have. It was also noted that documentation of wound care and treatment including photographed assessments and reassessments were inconsistent in content, quality and thoroughness.

"When it comes to clinical documentation, the 'Cs' have it. Good documentation is consistent, concise, chronological, continuing and reasonably complete. However, good documentation must be balanced with good patient care" (Fife, 2010).

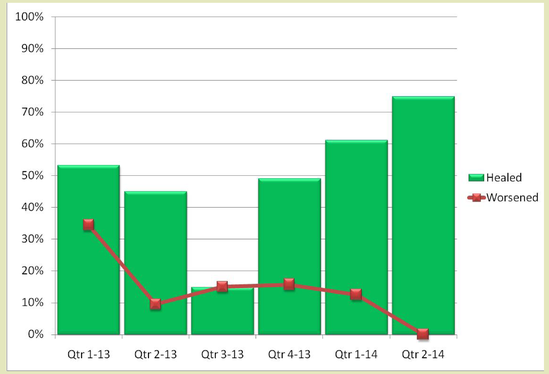
Objective

- Reduce worsened and new wounds and heal wounds identified as present on admission
- Improve nursing documentation and competencies related to wound assessment, care and treatment delivery:
  - Initial assessment and physician notification
  - Plan of care implementation and documentation
  - Daily assessments and treatment delivery
  - Weekly reassessments
  - Discharge assessment

Methods

- Weekly full-body assessments by all RNs – focus on pressure points
- Physician notification form and wound care protocol
- Daily assessment & treatment record for each identified skin variance – including incisions
- System for reporting all wounds in a concise manner to the wound care RN
- System for educating and holding accountability for poor wound performance
- Ensure documentation format is basic and understandable to all RNs
- Weekly audits and data review
- Model wound care RN to a less hands-on role (similar to infection control nurse)
- Physician champion to assist in program development, staff education and rounding on high risk/problem skin variances

2013 - 2014: Healed and Worsened Wounds



LOOK!

L- Learn about your patient's history – it all starts here. If the patient has risk factors such as immobility, stroke, or diabetes, we know that they may be at higher risks for skin breakdown than other individuals.

O- Observe your patient's skin upon admission and during each shift, making sure to assess the entire body for any risks of breakdown.

O- Own your assessment and document accordingly. Your documentation will drive this patient's stay and plan for healthy skin.

K- Keep up this process and be proud of the outcome we can create for our patients by using this simple mnemonic.

Results

- Significant increase in initially known skin issues
- Significant decrease in initial, daily and discharge wound assessment and treatment documentation – including photos
- Significant increase in wounds healed by discharge – representing appropriate treatment plans and treatment deliveries
- Significant decrease in wounds worsened and identification of new wounds not present on admission
- Purchase of additional wound cameras and printers necessary
- Change in washcloths to prevent excoriation
- New skin products targeting tears and abrasions in place

References

Fife, C. E., (2005, November). Legal Issues in the Care of Pressure Ulcer Patients: Key Concepts for Healthcare Providers – A Consensus Paper from the International Expert Wound Care Advisory Panel. *Advances in Skin & Wound Care. 23(11), 493-507.*

Reddy M., Gill S. S., & Rochon P. A. (2006). Preventing Pressure Ulcers: A Systematic Review. *JAMA. 296, 974-84.*

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