



Service Priorities and Programmes Electronic Presentations

Convention ID: 288

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Improving quality of handover through introducing a standardized wound chart

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Keywords:

wound documentation

clinical handover

Introduction

In our current practice, the documentation on wound care varied among nurses and departments, not to mention quality of the content. Referring to some past adverse events on retained dressing materials in cavity wounds, this gave us the opportunity to review the wound documentation that is so common a practice for nurses in everyday work. The quality of documentation provided important information to formulate accurate decision on intervention and effectiveness on wound care. The initiative was taken over by the Task Force on Patient Assessment of the two hospitals of Shatin Hospital and Bradbury Hospital.

Objectives

1. To develop a wound chart that encompasses documentation of all wound types.
2. To formulate a standard on wound documentation across all departments within the two hospitals.

Methodology

All wound charts and practices were reviewed by the Task Force. The revised wound chart went through series of staff consultation and trials. Two training sessions were conducted before the final chart was implemented in December 2015. A retrospective compliance check of wound documentation on the revised chart will be conducted by March, 2016.

Result

A pre and post test was conducted during the training sessions to evaluate the knowledge of wound documentation. The results of the pre and post tests were 45.8% and 70.4% respectively. The compliance audit on the charting is yet to come. The aim of the project is not only to fill up the gap of non-standardized wound documentation practice, but to improve nurses' knowledge on wound assessment and management. The targeted outcome will be on the clinical effectiveness on wound management.