

Standardized Wound-Ostomy Care and EMR

INTRODUCTION-PROBLEMS

- INTRODUCTION:** Standardizing wound and ostomy care using in-patient wound/ostomy protocols to empower the nursing staff to use appropriate treatments using Evidenced based treatments. Streamlining EMR documentation between In-patient, out-patient and VNA. Uploading photos directly into the chart using hospital-issued I-Phones, "Rover".
- PROBLEMS:** INCONSISTANT: wound care, photography of wounds, and documentation in the EMR prior to a WOCN consult.
- No WOCN weekend coverage for timely Wound-Ostomy consults.
- Nursing dissatisfaction with wound photography, cumbersome timely process.
- Photos of wound not done or incorrectly r/t Older Camera equipment and length of time for photography and uploading process in the EMR
- Skin Audits High Prevalence rate as not all pressure injuries being documented.
- Non-Evidence Based Wound-Ostomy care prior to WOCN Consult.
- Ostomy Care varied, poor understanding of procedure and products.

IN-PATIENT WOUND-OSTOMY PROTOCOLS

Inpatient Wound-Ostomy Nursing Protocol

Protocol Orders:

- Add LDA: By using Rover I-Phone Document site of wound, Measure, and Photograph.
- Photograph Wound weekly or as needed if changes in wound status
- Stage PRESSURE ulcers only and follow orders below depending on stage.
- Place WOCN Consult for pressure ulcers that are stage 2 or greater.
- Notify attending Provider of all wounds
- If South Shore Hospital Wound Center patient: Go to Chart Review, Notes, and find latest Wound Note for most recent Wound care orders in Epic documentation.

Please choose which protocol to follow

- Inpatient Wound Care – RN Driven Protocol
- Wound Photography
- Inpatient Ostomy Care – RN Driven Protocol

Stage 1 pressure ulcer

Stage 2 superficial pressure ulcer

Stage 3 or 4 pressure Open Ulcers with Moderate to High Drainage

Stage 3 or 4 pressure Open Ulcers or Unstageable Ulcer with Low drainage:

Deep Tissue Injuries: Purple boggy intact skin over bony prominence

Skin tear

Non-pressure wound

Moisture Associated Skin Damage- Incontinence Wounds

Ostomy Care

ROVER



Tap the Epic Button

Tap Flowsheets, then select LDA

Tap the + icon to add LDA

Tap and drag the wound icon to the desired location

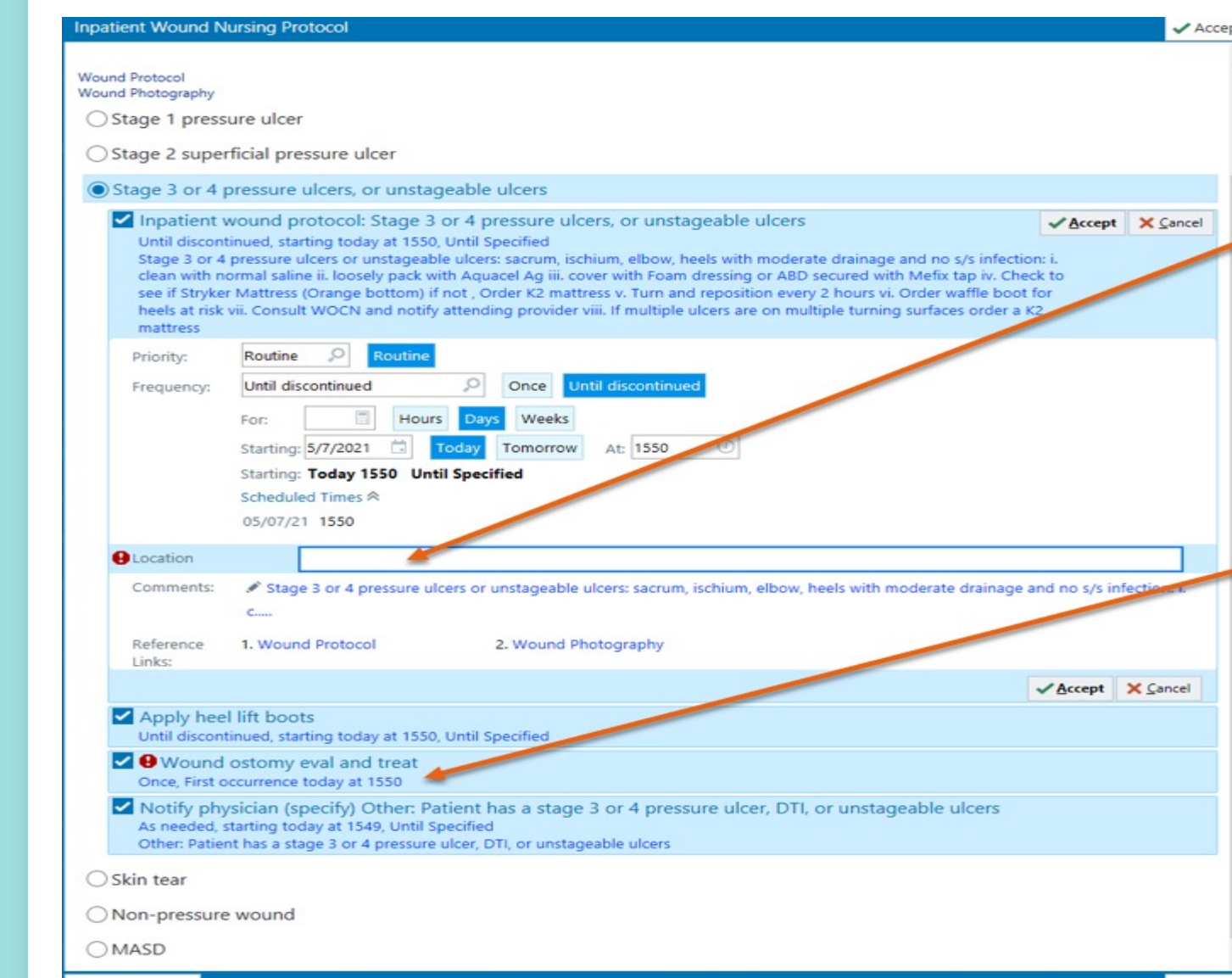
After adding the LDA, tap the LDA then the + sign to document assessment

IN-PATIENT WOUND-OSTOMY PROTOCOLS

- In-Patient Nursing Wound ostomy Protocols developed using Advanced Wound-Ostomy products to improve staff nursing education. Medical Executive Board Approved. Added to EMR.
- Protocol Orders cue WOCN consult, instruct staff for correct primary and secondary dressing
- Ostomy order sets standardize pouch change procedure, and Product used

EPIC EMR USING ROVER

- I-phones purchased for in-room documentation during initial phases of Covid, re-purposed for wound photography and documentation.
- Nurses instructed to add wound to Flow sheet during admission and photograph all through ROVER I-phone.



Inpatient Wound Nursing Protocol

Wound Protocol

Wound Photography

Stage 1 pressure ulcer

Stage 2 superficial pressure ulcer

Stage 3 or 4 pressure ulcers, or unstageable ulcers

Inpatient wound protocol: Stage 3 or 4 pressure ulcers, or unstageable ulcers

Unit discontinued, starting today at 1550, Unit Specified

Stage 3 or 4 pressure ulcers or unstageable ulcers: sacrum, ischium, elbow, heels with moderate drainage and no s/s infection. Clean with normal saline II, loosely pack with Aquafol Ag III, cover with Foam dressing or ABD secured with Mefix tap IV. Check to see if Striker Mattress (Change bottom) if not, Order K2 mattress II. Turn and reposition every 2 hours II. Order waffle boot for heels at risk III. Consult WOCN and notify attending provider vis. If multiple ulcers are on multiple turning surfaces order a K2 mattress.

Routine

Priority: Unit discontinued

Frequency: Unit discontinued

For: Hours

Starting: 5/7/2021

Scheduled Times: Today 1550, Unit Specified

Comments: Stage 3 or 4 pressure ulcers or unstageable ulcers: sacrum, ischium, elbow, heels with moderate drainage and no s/s infection

Reference: 1. Wound Protocol 2. Wound Photography

Apply heel lift boots

Unit discontinued, starting today at 1550, Unit Specified

Wound ostomy eval and treat

Check, first occurrence today at 1550

Notify physician (specify) Other: Patient has a stage 3 or 4 pressure ulcer, DTI, or unstageable ulcers

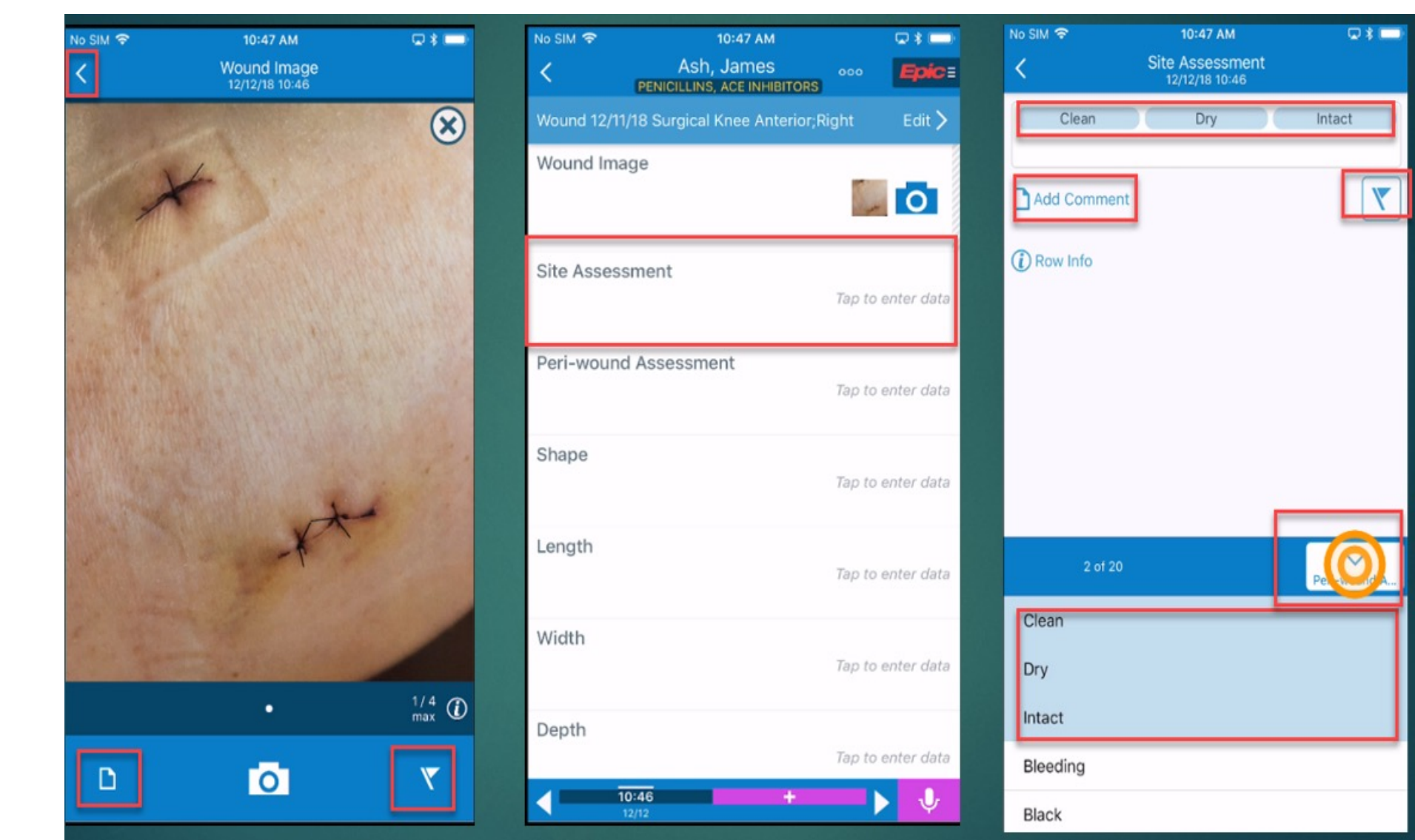
As needed, starting today at 1549, Unit Specified

Other: Patient has a stage 3 or 4 pressure ulcer, DTI, or unstageable ulcers

Skin tear

Non-pressure wound

MASD



Wound Image

Site Assessment

Peri-wound Assessment

Shape

Length

Width

Depth

Clean

Dry

Intact

Bleeding

Black

GOALS

- Improved Skin Audit outcomes
- Increased Nursing education, satisfaction, and productivity using I-phones for photography on all units.
- Standardized approach to wound-ostomy care on all shifts. Same care approach transferred to outpatient clinic and VNA upon d/c to home automatically.

RESULTS

- SKIN AUDIT Pressure ulcer Prevalence rates below state average 1.83 to 2.5 over past 6 months.
- Standardized documentation and care between South Shore Health System, Wound Center, VNA.
- Improved communication regarding Wound and Ostomy care between Nursing and Providers.