Improve Wound Care Documentation after Paediatric Heart Surgery

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Introduction
As the majority of patients admit to Paediatric Cardiac Ward for surgical treatment, wound care is therefore an essential component for discharge planning. However, we noted that wound documentation by nurses was often ad hoc and incomplete.

Objectives
1. Standardise wound care documentation 2. Ensure wound care follows best practice as stated in wound dressing guidelines 3. Facilitate communication between staff members to work on the discharge plan for patients

Methodology
1. Review 20 inpatient wound care notes, 15 November to 31 December 2014, on Paediatric Cardiac Ward. All these patients had a surgical wound, either sternotomy or thoracotomy after heart surgery 2. Check the frequency of wound characteristics documentation for routine checks on day 5 after operation or dressing changes

Result
1. Nurses documented information about wound site, number of stitches or clips, dressing type and next review date in all dressing changes 2. Information about wound bed and state of surrounding skin was not documented in all dressing changes 3. There was poor documentation about the wound exudate. Nurses documented the exudate type in only one of the five instances, others used the word "oozing". The exudate amount and odour were not recorded

Conclusion: In order to ensure wound documentation conforms to best practice standards, we designed a standardised wound care chart based on the practice guidelines and feedbacks from staff nurses. This chart uses systematic assessment format instead of previous free writing style, providing comprehensive information about the wound condition. It also allows documentation to be more effective and easier to use.