Service Priorities and Programmes

Electronic Presentations

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Success in Management of Complicated Wounds through

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Introduction

Orthopedic patients with complicated wound conditions contribute to long hospital stay. A local one-day survey in May 2017 in three NDH Ortho orthopedic & Traumatology (O&T) wards revealed that 18 out of 116 (15.5%) patients having chronic wounds; and average hospital length of stay (ALOS) ranged from 11 to 62 days. Those reasons for long hospital stay include: uncontrolled wound infections; prepare wound bed for operation; extensive wound requiring time for healing; complicated medical conditions requiring specialists' consultation; patients' non-compliance to wound treatment; and diverse patient expectations on hospitalization. A collaboration program between Community Outreach Services Team (COST) and O&T department in NDH – "Early Discharge Support to Orthopedic Patient (EDOP)" was thus launched in May 2017.

Objectives

1. To reduce hospital length of stay of orthopedic patients with complicated wound 2. To ensure continuity of care from hospital to community along the complicate wound pathway 3. To improve wound healing through expert wound management services in the community. 4. To improve patient experience and compliance to wound management.

Methodology

1. O&T patients with complicated wounds; and have prolonged or expected hospital stay > 2 weeks would be recruited as potential target. 2. O&T colleagues and a Deputizing Nurse Consultant (Community) qualified with wound specialty training would conduct weekly joint wound round to review the complicated wound management plan and recruited target for early discharge. 3. Pre-discharge planning was initiated in ward to ensure special dressing material be available for supporting patient's wound healing after discharge. The Deputizing Nurse Consultant (Community) would discuss with patient on an agreed, individualized care plan including adjusting patient's expectations on wound care treatment to enhance patient's compliance to the therapy; and minimize the conflicts between patients and nurses on unmet expectations after discharge. 4. The Deputizing Nurse Consultant (Community) provided post-discharge support including disease monitoring,

advanced wound management and empowerment patients on chronic disease management which was beneficial for wound healing; and communicated with O&T team regularly for the wound progress. 5. A fast-track consultation was supported by O&T team for ad-hoc clinical issue when necessary.

Result

From June-December 2017, 20 joint wound rounds were conducted Total 62 in-patients with non-healed wound history ranging from 1 week to > 120 weeks were reviewed. Then 7 patients were recruited for early discharge support. Result reveals 43%(N=2) with wound healed and 57% with wound healing in progress. Overall wound size decreased to 71%-94% in 2-months' time. No AED attendance or unplanned hospitalization was found among the target patients after discharge to community. 318 days of acute hospital LOS were saved and the notional cost was saved by $1,514,950. 100% patient/caregiver showed satisfaction to the program. Conclusion: This pilot program with collaborative approach demonstrates cost benefits to manage patient with complicated wounds in community setting; and quality outcome showed improved wound healing and patient experience.