



Singapore Healthcare Management 2018

Streamlining Wound Dressing Referrals to Community

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Background of the problem

Nurses in SGH are documenting progress and treatment of pressure injuries and open surgical wounds on an electronic wound chart on SCM. When patient needs to go home with wound care follow up, nurse will need to fill up a hardcopy form to indicate progress and treatment of wound and attached it with a Doctor's memo.

The proposal was to explore the current SCM Wound Chart and create a workflow for the nurse to print out the report instead of writing on the hardcopy form.

This will eliminate transcribing errors and repeated documentation. This also reduces the risk of error in labeling any discharge documents required for follow-up in the community.

If wrong labeling was done, it will create confusion for the follow-up center and there will be errors that a dressing treatment meant for another patient was carried out instead.

Interventions / Initiatives

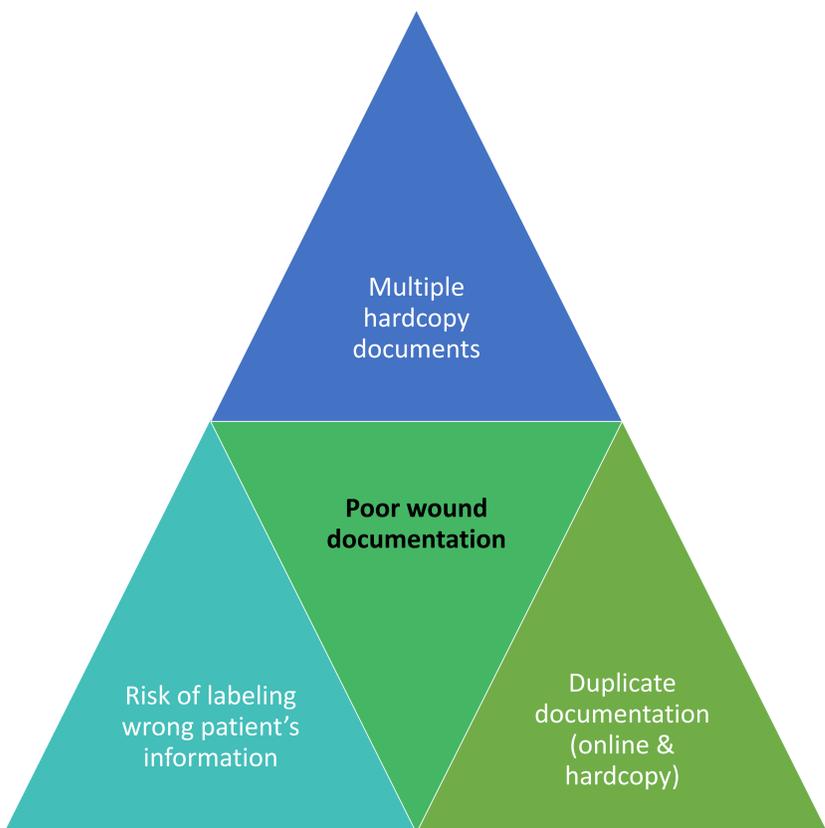
A team of nurses meet together with SingHealth Polyclinics (SHP) to understand what our nursing colleagues require upon receiving patient from SGH for wound dressing follow-up. SHP nurses shared that: Type of wound, location of wound, type and frequency of wound dressing used would be useful knowledge to them to continue treatment.

We identified that SCM Wound Chart is a common platform that nurses are documenting the progress of the wound. A workflow was created for nurses to update the latest changes of the wound management before the patient is discharged. This same documentation that will be printed out for reference to the follow-up centers. As it is an electronic documentation, there will be no transcribing errors and ineligible handwriting. This also reduces additional documentation for the SGH nurses.

Aims

Team wanted to streamline process of discharge needing wound dressing follow-ups at polyclinics across all inpatient areas.

Analysis of problem



Results

The implementation was well-received by the inpatient nurses as there has been a reduction in document entry.

Conclusion

This newly standardized process had been efficiently embraced by nurses from the inpatient areas. There is lesser documentation to be done and it reduces time taken to complete additional hardcopy documentation hence improving discharge process.