Dina Dang
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Quality Improvement Activity: Wound Dehiscence Post ORIF

A 71-year-old woman was admitted to the orthopedics med/surg unit from the ED after she arrived by ambulance from a fall when attempting to get out of her shower due to a hypoglycemic episode. An x-ray of her left hip revealed a a complete break of the femur bone indicating a hip fracture. Once moved to the unit that night, the next morning the orthopedic team came by to consult and spoke to the patient about treating her hip fracture with an ORIF surgical procedure later that afternoon as she has been NPO since admitted the previous night. Later that evening she had surgery and returned to the unit in time for the shift change and report to the night nurse. While giving report the day shift nurse, she mentioned the patient's history included type 2 diabetes mellites with insulin dependency and obesity, but the night nurse did not ask any questions regarding the previous blood sugar readings. A couple days later, the same admitting nurse took the same patient back for her shift. After realizing her she had the same patient assignment from a couple days ago, she was confused why that patient was still on unit and had no plans of discharge for the day as well. Typically, patients post ORIF and discharged to a rehabilitation center to regain strength and independence before going back home. When the dayshift nurse received report from the night shift nurse, the night shift nurse reported that the patient's surgical site had dehisced and developed an infection at the site. The site did not show any signs of healing and the patient has been experiencing extremely high blood glucose readings that have been difficult to control via insulin. The night shift nurse had also reported that she just found out last night that the patient was diabetic, and that the nurses in the previous days had no idea of the patient's diabetic history. The night nurse continued to report that the patient's culture results were still pending and later that day the orthopedic surgeon would come by to determine th

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

In this situation, the patient's care was neglected and not communicated efficiently between members of the care team. The simple mistakes of not questioning or being fully engaged during report, lack of not reviewing your own patient's chart prior to providing care, and not communicating with the patient caused a larger problem and secondary diagnosis to the patient's original diagnosis. Wound dehiscence is a common post-op complication typically caused by many disposing like age, diabetes, obesity, and malnutrition, but it can be prevented when proper and attentive care is given. A patient's medical history and presence of chronic illnesses should be noted and considered during the hospital stay to ensure complications are prevented.

What circumstances led to the occurrence?

The circumstances that directly led to this occurrence was the first night nurse not relaying the patient's diabetic history in report to the next nurse. This break in communication followed on throughout the care of the patient until it was caught on by the original admitting nurse.

In what way could you measure the frequency of the occurrence? (interview nurses, examining charts, patient surveys, observation, etc.)

The frequency of wound dehiscence is common, but it is something that can be prevented for the most part. Ideally monitoring patients' surgical wounds post op and performing appropriate dressing changes every shift per physician orders is something that can provide frequent monitoring of the site to assess

for wound dehiscence. Another way to measure the frequency of this occurrence is through using the patient safety indicators (PSI) developed by the Agency for Healthcare Research and Quality (ARHQ). This protocol helps identify potentially preventable complications of acute patient care related to wound dehiscence. It requires frequent patient interviews, chart review, and consideration of comorbidities.

What evidence-based ideas do you have for implementing interventions to address the problem?

Enforcing a no distractions policy during report time could be the first step in fixing the adequate transfer of vital information. Nurses should also be interviewing and questioning all their patients at each shift to ensure that the nurse is aware of all issues past and present related to the patient. For patients with diabetes that require insulin, nurses should be required to report all the blood sugars and insulin coverage for those patients. A diabetic crisis is something that can be prevented and plays a huge role in wound healing. Finding a specific protocol, similar to a MEWS scale, can also allow nurses to rate wounds on the basis of no risk, some risk, and high risk for wound dehiscence issues related to comorbidities or eruptions of unwarranted complications.

How will you measure the efficacy of the interventions?

Measuring efficacy of these interventions can be accomplished by catching the signs early and promptly intervening prior to a worsening condition erupting. Any time a would dehiscence case occurs, the unit should investigate how and why it occurred, along with how it can be prevented in the future. By dissecting and figuring out why it occurred, the unit will be able to reflect on how care is provided to improve patient satisfaction and decrease care costs.