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INTRODUCTION

Accurate and timely skin assessments are critical in preventing hospital-acquired conditions and ensuring patient safety in surgical settings. Our Unit-Based Shared Governance found inconsistencies in documentation within the outpatient surgery unit and led an initiative to standardize skin assessment practices. The initiative began in January of 2025 and continues to be ongoing.

OBJECTIVE & SMART GOAL

Objective: To increase compliance with documented skin assessments in all outpatient surgeries, including those admitted to the hospital after a planned surgery.

SMART Goal: Achieve $\geq 95\%$ compliance with documented skin assessments in the electronic health record within one year, with sustained compliance thereafter.



ACKNOWLEDGEMENTS

A special thanks to all nursing staff, wound care specialists, informatics, leadership, and the Evidence-Based Practice Council for their dedication!

RESULTS

- Documented compliance with skin assessments exceeded the 95% SMART Goal with improved accuracy and consistency in skin documentation.
- Table 1 shows a significant increase in skin exceptions charted over time.
- Table 2 illustrates how non-compliance in skin assessments has decreased over time.
- The success of the project has led to ordering rovers (handheld computers) to support bedside documentation and a re-evaluation of the use of wound care supplies, such as non-adherent foam pads applied to bony prominences before surgery.

TABLE 1

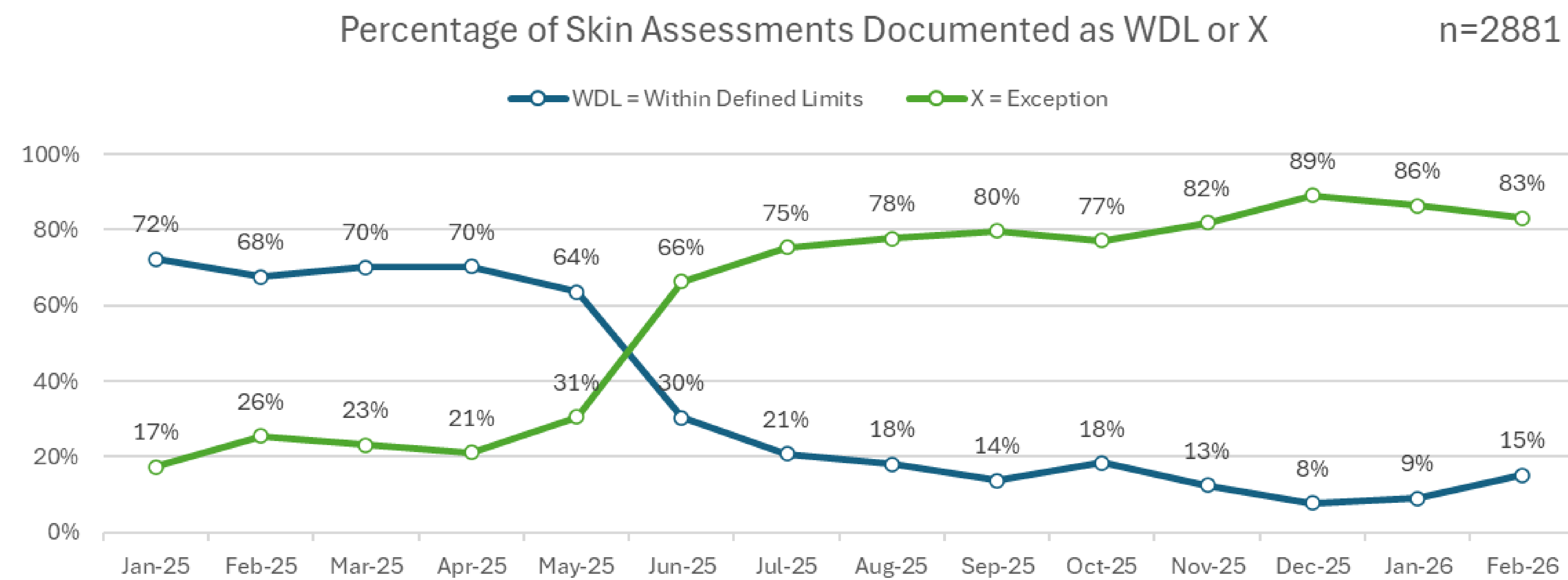
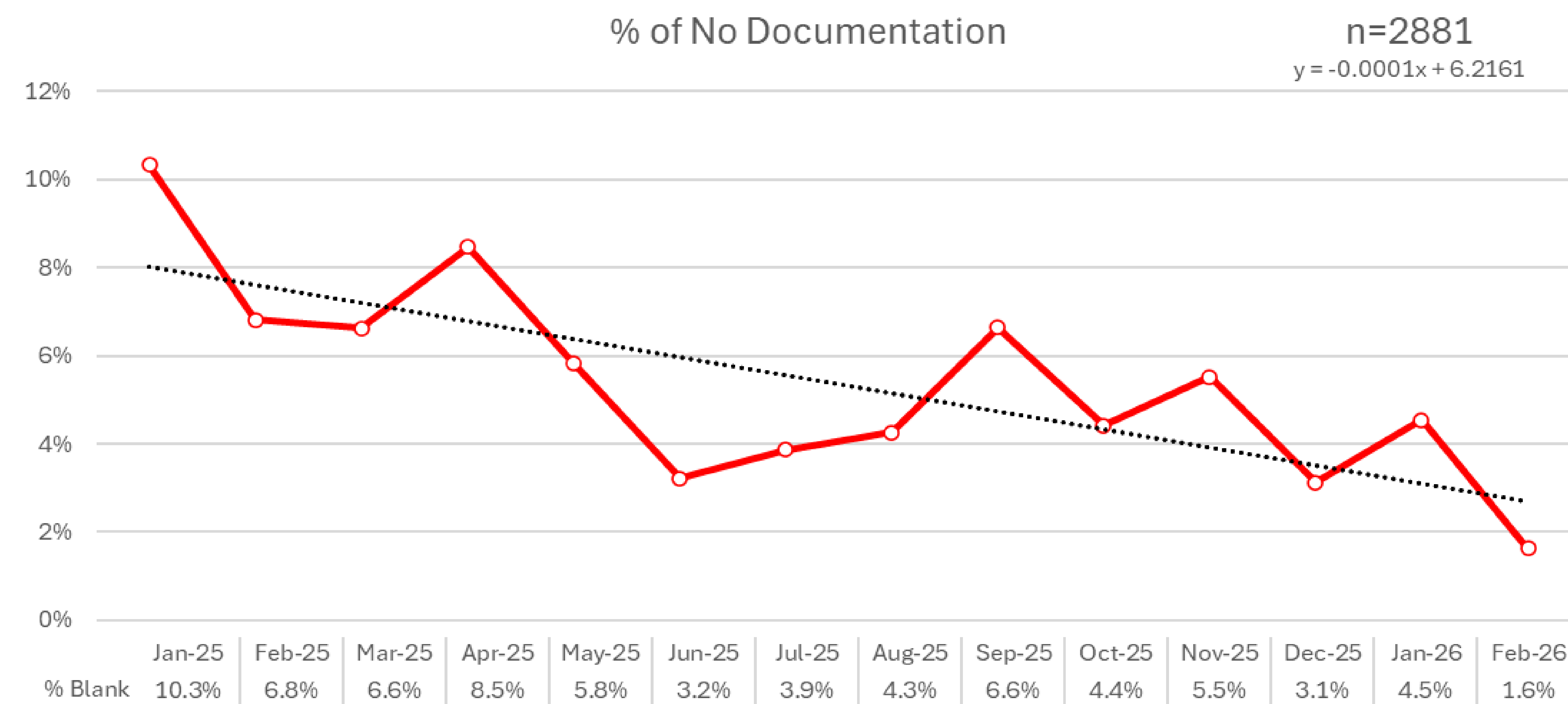


TABLE 2



NOTE: Data were limited to patients with a recovery phase of care in the OR surgical log and were extracted from the last documented response in the integumentary section of the basic assessment flowsheet. A filter was applied to include only patients either classified as 'surgery admit' or 'surgery outpatient'. Patients whose surgery date did not match the date of their last documented integumentary assessment were omitted.

METHOD

- Implemented standardized electronic health record (EHR) charting practices.
- Developed consistent patient screening questions and assessment procedures.
- Promoted a culture valuing skin integrity through team collaboration and consistent practice.
- Engaged Wound Care and Informatics teams for training and data tracking.
- Educated staff to document in the flowsheets as "Intact/WDL" or an "X" for exceptions.
- Maintain the of accuracy the EHR by removing previously healed surgical sites, discontinued lines, and devices for accuracy in returning patients.

BARRIERS & DISCUSSION

- Initial resistance to workflow changes.
- Variability in documentation habits.
 - Addressed through ongoing education, leadership support, and interdepartmental teamwork.

CONCLUSION AND NEXT STEPS

- Standardization and collaboration led to sustainable improvements by fostering a proactive, patient-centered culture.
- Future plans include:
 - Continued Education
 - Supply Improvement
 - Expanding efforts to other perioperative areas

ABSTRACT AND REFERENCES

