

 <p>Connecticut Valley Hospital Nursing Policy and Procedure</p>	<p>SECTION D: PSYCHOLOGICAL ADAPTATION CHAPTER 19: WOUND CARE</p> <p>POLICY AND PROCEDURE 19.2 Injury Assessment and Reassessment Flow Sheet</p>
<p>Authorization: Nursing Executive Committee</p>	<p>Date Effective: May 1, 2018 Scope: Registered Nurses and Licensed Practical Nurses</p>

Standard of Practice:

The registered nurse will immediately assess all patient injuries upon discovery and institute care/treatment measures until such time as the injury is resolved.

Standard of Care:

The patient can expect a professional assessment of his/her injury and appropriate care and monitoring of the injury based on best practices.

Policy:

Registered nurses shall initiate assessment and required care for injuries as they occur, provide follow up treatment as ordered and document his/her findings and care provided until the injury is healed.

Procedure:

- A. Upon discovery of any closed skin injuries, such as fractures, bruises, burns, abrasions, insect bites, soft tissue damage, cellulitis, the RN will:
 1. Assess the Injury using the Injury Assessment/Reassessment Flow Sheet CVH-635. This assessment will include a description of injury, noting type, color, and location which shall also be designated on the figure provided. The size of the injury should be noted as well in terms of length, width as measured in centimeters.
 2. The Attending Psychiatrist/On-Call Physician is notified of the injury and assesses the patient, prescribing necessary treatments and the frequency of monitoring to occur until such time as the injury is resolved.
 3. Infection prevention will be notified as warranted (i.e. infection at the site, or progression to open wound).
 4. The RN upon discovery of an injury documents his/her initial assessment of the injury in the Progress Note Section of the Medical Record, describing the context in which the injury was discovered, assessment findings, care provided and follow up. A statement from the patient describing his/her understanding of what happened should be included.

5. The RN will fax a copy of the *Initial Injury Assessment* to the Nurse Supervisor upon completion so that the discipline of nursing can institute appropriate monitoring activities.
6. Based on the prescribed frequency of monitoring, the RN will document the results of each ongoing assessment on the Injury Assessment/Reassessment Flow Sheet CVH-635, noting the date, time of his/her assessment, progression of the injury in terms of size, color, pain and treatments administered.
7. All injuries will be identified on the patients Nursing Plan of Care with corresponding interventions.

B. Upon resolution of the injury, the RN will:

1. Notify the MD that the injury has healed, noting this on the Injury Assessment/Re-Assessment Form (CVH-635) with date.
2. Document a progress note regarding this evaluation in the Progress Note Section of the patient's medical record.

Injury Assessment Forms will be kept in the Treatment and/ or Medication Kardex on the units. When completed, the form will be filed in the Progress Note section of the chart.

C. Monitoring of Patient Injuries

1. The RN Supervisor upon receipt of a patients initial injury assessment form will note on a Division Tracking Log . This information will also be reviewed in the Division's Morning Report.
2. The RN Supervisor will ensure through regular supervisory rounds that the unit is following the prescribed treatment regime and documenting care given as prescribed.
3. Once the injury is resolved the RN Supervisor will note on the Division Tracking Log and forward monthly information to the Division Chief of Patient Care Services.
4. The Division Chief of Patient Care Services will present monthly data to the Nurse Executive Committee.

Note: Please refer to the *Wound Tracking Form CVH-617*.