Wound Care Management

POLICY AND PROCEDURE

Purpose

Wound and skin care management will be consistent with best practice, promotes wound healing and is aligned with the infection control policy and procedures

Scope

All support workers that have clients with wound care should be aware of and follow the Wound Care and Management Policy and Procedure. Support workers are not permitted to change or manage any wounds, even simple wounds.

The Registered Nurse/s of Subee Newlake are responsible for the assessment, planning and review of the client's wound Care Plan. Endorsed Enrolled Nurses can provide wound care under the guidance and supervision of Subee Newlake Registered Nurse.

Definitions

Wound Care and Management: Accurate wound assessment and effective wound management requires an understanding of the physiology of wound healing, combined with knowledge of the actions of the dressing products available. It is essential that an ongoing process of assessment, clinical decision making, intervention and documentation occurs to facilitate optimal wound healing.

Relevant Standards

National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018.

Module 1: High Intensity Daily Personal Activities

New Aged Care Standards

Australian Community Industry Standards (ACIS) 2018, 5.2

Procedure

Subee Newlake's Clinical Governance Framework ensures all staff employed have the appropriate professional qualifications to carry out clinical support to clients with high intensity daily support activities.

The Registered Nurse completes an assessment of the clients support needs and with the client and or their advocate develops a Nursing Care Plan that reflects their individual needs and choice.

A holistic approach will be adopted in the assessment and monitoring process and the management plan will be clearly documented and communicated in the client's care plan

Support workers are not permitted to change or manage any wounds, even simple wounds. Subee Newlake does not provide support to geographically isolated clients.

Nursing Care Plan reflects:

- Doctors' orders and recommendations
- Client input and choice into their wound care and management plan
- Current best practice standards for wound and skin management

An Action Plan that addresses any incidents or emergencies in relation to wound management and care.

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The client's GP or any relevant clinical professionals involved will be consulted with in regard to the client's wound and skin care management. If necessary and where required, referral and consultation with the wound specialist nurse or doctor will be made (in consultation with the client and/or representative) if the wound healing is slow or has deteriorated.

The client and or their advocate has signed the Nursing Care Plan.

A copy of the Care Plan stays with the client and a copy is placed in the clients file.

The care plan has a review date of 12 months but will be reviewed earlier if the client, support worker, or registered nurse identifies earlier review is needed.

Earlier review may occur due to change in client's needs, incident report that suggests a review of needs or emergency.

Specific wound care plans are updated as per doctors' orders as wound is reviewed by medical staff.

Support workers complete progress notes per visit.

Support staff will contact the service co-ordinator if the identify problems whilst on shift with wound care management. This information is reported back to the Registered Nurse for review.

An incident report is completed by the support staff if required. Service co-ordinator to follow up that the incident report is documented and followed up on by the registered nurse or Operations Manager.

Pressure injury and manual handling risks

Pressure injuries are preventable, and it is recognised that lengthy healing time has consequences for quality of life including susceptibility to infection, pain sleep and mood disturbance. The prevention of pressure injuries is the responsibility of all staff who work with the client and health professionals.

Effective approaches to pressure injury prevention and management include timely risk assessment to identify risk factors.

Prevention strategies that includes:

- Repositioning and/or mobilising routine, including appropriate manual task techniques
- Education of all patients/personal carers on regular repositioning and pressure relieving strategies
- Management and monitoring of pain
- Provision of appropriate products and equipment; support surfaces for beds, trolleys/wheelchairs, chairs, aids, equipment/devices, according to the patient's risk assessment
- Reduction of pressure, friction, and/or shear through:
    - Use of active support surfaces/positioning aids during care
    - Use of dressing products (note dressing products do not reduce pressure)
    - Appropriate hazardous manual task techniques

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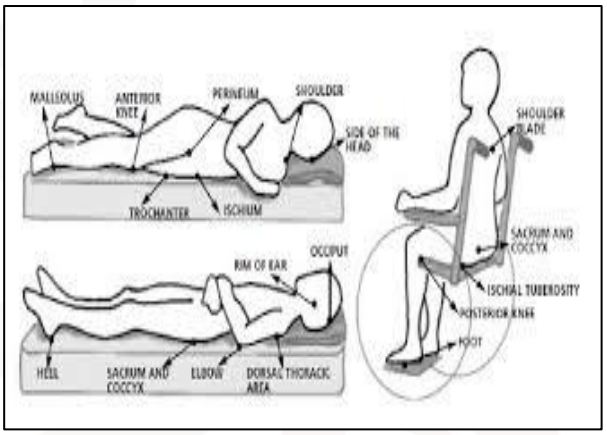
- Correct fitting, removal and checking of pressure from devices/orthoses/anti-embolic stockings, casts and other clinical equipment

- Skin protection and moisture reduction
- Continence management
- Adequate nutrition and hydration, including high protein supplements where indicated (with dietitian supervision if available)
- Referral to health disciplines as clinically indicated for assessment and treatment



Risk factors for Pressure wounds

Identified risks can include, but is not limited to, the following:

- Poor nutrition and liquid intake
- Poor skin integrity
- Comorbidities that influence impairment for example cardio vascular disease, diabetes, renal impairment, peripheral neuropathy, sensory impairment including vision problems
- Impairment of cognition
- Increasing age
- Impaired mobility
- Non-ambulant person
- Previous history of injury

All people with an identified risk of pressure injury will have a standardised, reliable and valid, pressure injury risk assessment undertaken by the Registered Nurse or the appropriate health professional. An example is the Braden Scale. Refer to Appendix A.

Skin Tears

Definition: Skin tears are traumatic injuries, first defined by Payne and Martin in 1993 and more recently by an international consensus group, which can result in partial or full separation of the outer layers of the skin.

These tears may occur due to shearing and friction forces or a blunt trauma, causing the epidermis to separate from the dermis (partial thickness wound) or both the epidermis and the dermis to separate from the underlying structures (full thickness wound)

Risk factors for Skin Tears

Skin tears are associated with falls, blunt trauma, handling and equipment injuries. A number of risk factors have been reported including:

- Age and gender
- History of previous skin tears

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- Dry, fragile skin
- Medications that thin the skin such as steroids
- Echymoses (bruising / discolouration of the skin caused by leakage of blood into the subcutaneous tissue as a result of trauma to the underlying blood vessels)
- Impaired mobility or vision
- Poor nutrition and hydration
- Cognitive or sensory impairment
- Comorbidities that compromise vascularity and skin status, including chronic heart disease, renal failure, cerebral vascular accident
- Dependence on others for showering, dressing or transferring.

Training and Competency

The Registered Nurse/s of Subee Newlake are responsible for the training and competency checking of all support workers.

Training is provided on a needs basis to support workers that are providing support to clients with current or chronic wound management. Clients personal needs can temporarily change whilst having a wound care management regime.

This would be recorded in the clients Care Plan and start, and completion date of wound care regime noted

Education and training for support workers would include changes to the client's personal needs around showering, toileting, mobility and identifying risks to wound healing or need for medical review.

Subee Newlake staff will have access to Altura e-learning management system (LMS) that will complement the above training. Altura Module:
Wound Care: An overview
Wound Care: Skin Tears.
Wound Care: Skin Tear extension

Refer to training and competency check list forms:

Support staff do not do any complex wound dressings care.

Subee Newlake Registered Nurses and Enrolled Nurses are trained to be competent within the Clinical Governance Framework.

Clinical Competency Assessment:
Simple Wound Dressing F-40
Aseptic Wound Dressing F-029

Related Forms

Wound Care Plan F-108
Wound Assessment Chart F-01

Resources

Wounds Australia
www.woundsaustralia.com.au

STAR Skin Tear Classification System
http://www.awma.com.au/publications/2010_wa_star-skin-tear-tool-g-04022010.pdf

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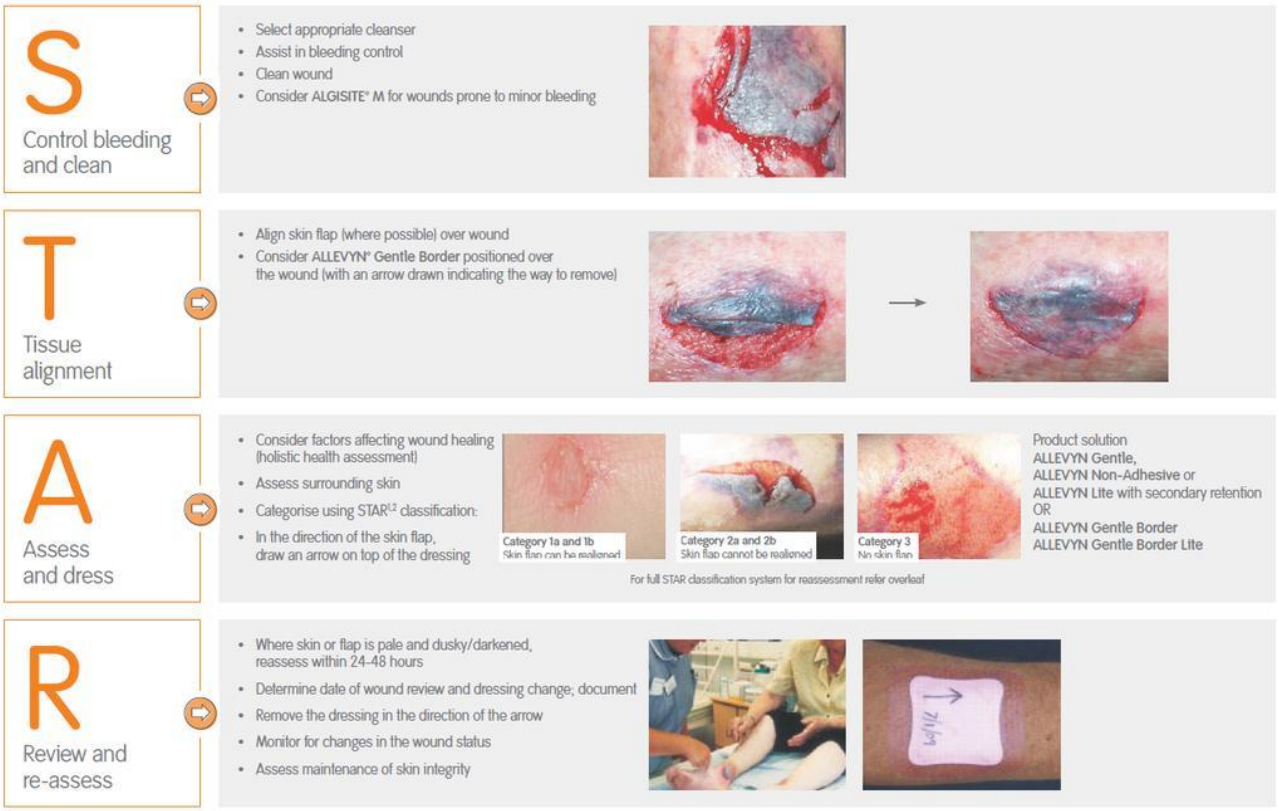
Promoting Healthy Skin – A self directed learning resource:
http://promoting-healthy-skin.qut.edu.au/

Related Policies & Procedures

Waste Management Policy & Procedure
Infection Control Policy & Procedure
Medication Policy and Procedure
Clinical Governance Framework Policy and Procedure
Incident Reporting Policy
Confidentiality Policy

Appendix A

Star Skin Classification



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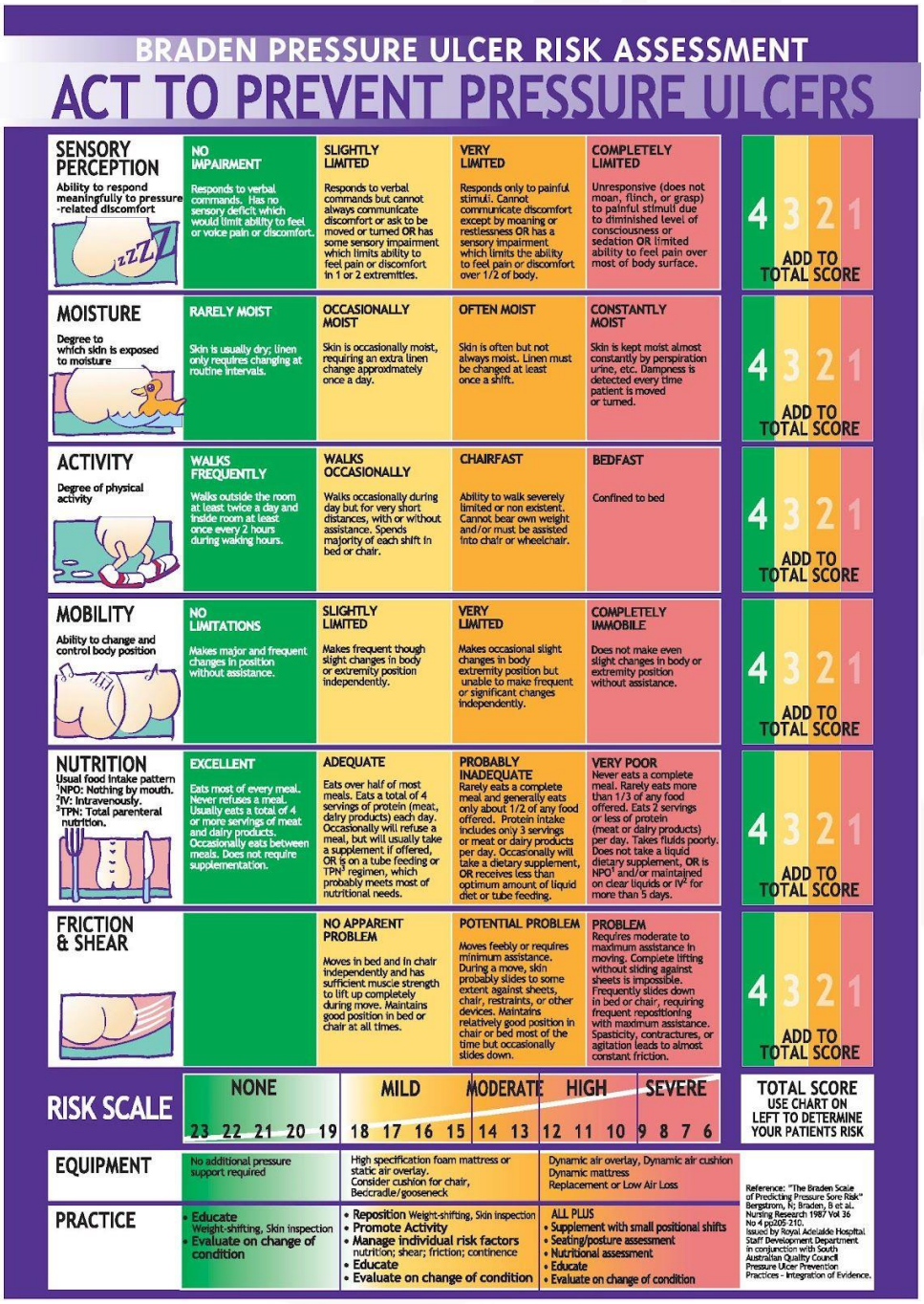

BRADEN PRESSURE ULCER RISK ASSESSMENT

ACT TO PREVENT PRESSURE ULCERS

SENSORY PERCEPTION Ability to respond meaningfully to pressure -related discomfort	**NO IMPAIRMENT** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	**SLIGHTLY LIMITED** Responds to verbal commands but cannot always communicate discomfort or ask to be moved or turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**VERY LIMITED** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**COMPLETELY LIMITED** Unresponsive (does not moan, flinch, or grasp) to painful stimuli due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface.	4 3 2 1 ADD TO TOTAL SCORE
MOISTURE Degree to which skin is exposed to moisture	**RARELY MOIST** Skin is usually dry; linen only requires changing at routine intervals.	**OCCASIONALLY MOIST** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**OFTEN MOIST** Skin is often but not always moist. Linen must be changed at least once a shift.	**CONSTANTLY MOIST** Skin is kept moist almost constantly by perspiration urine, etc. Dampness is detected every time patient is moved or turned.	4 3 2 1 ADD TO TOTAL SCORE
ACTIVITY Degree of physical activity	**WALKS FREQUENTLY** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	**WALKS OCCASIONALLY** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**CHAIRFAST** Ability to walk severely limited or non existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**BEDFAST** Confined to bed	4 3 2 1 ADD TO TOTAL SCORE
MOBILITY Ability to change and control body position	**NO LIMITATIONS** Makes major and frequent changes in position without assistance.	**SLIGHTLY LIMITED** Makes frequent though slight changes in body or extremity position independently.	**VERY LIMITED** Makes occasional slight changes in body extremity position but unable to make frequent or significant changes independently.	**COMPLETELY IMMOBILE** Does not make even slight changes in body or extremity position without assistance.	4 3 2 1 ADD TO TOTAL SCORE
NUTRITION Usual food intake pattern [1]NPO: Nothing by mouth. [2]IV: Intravenously. [3]TPN: Total parenteral nutrition.	**EXCELLENT** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	**ADEQUATE** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN[3] regimen, which probably meets most of nutritional needs.	**PROBABLY INADEQUATE** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings or meat or dairy products per day. Occasionally will take a dietary supplement, OR receives less than optimum amount of liquid diet or tube feeding.	**VERY POOR** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	4 3 2 1 ADD TO TOTAL SCORE
FRICTION & SHEAR		**NO APPARENT PROBLEM** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	**POTENTIAL PROBLEM** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**PROBLEM** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	4 3 2 1 ADD TO TOTAL SCORE
RISK SCALE	**NONE** 23 22 21 20 19	**MILD** 18 17 16 15	**MODERATE** 14 13	**HIGH** 12 11 10	**SEVERE** 9 8 7 6	TOTAL SCORE USE CHART ON LEFT TO DETERMINE YOUR PATIENTS RISK
EQUIPMENT	No additional pressure support required	High specification foam mattress or static air overlay. Consider cushion for chair, Bedcradle/gooseneck	Dynamic air overlay, Dynamic air cushion Dynamic mattress Replacement or Low Air Loss			
PRACTICE	• **Educate** Weight-shifting, Skin inspection • **Evaluate on change of condition**	• **Reposition** Weight-shifting, Skin inspection • **Promote Activity** • **Manage individual risk factors** nutrition; shear; friction; continence • **Educate** • **Evaluate on change of condition**	**ALL PLUS** • **Supplement with small positional shifts** • **Seating/posture assessment** • **Nutritional assessment** • **Educate** • **Evaluate on change of condition**			Reference: "The Braden Scale of Predicting Pressure Sore Risk" Bergstrom, N; Braden, B et al. Nursing Research 1987 Vol 36 No 4 pp205-210. Issued by Royal Adelaide Hospital Staff Development Department in conjunction with South Australian Quality Council Pressure Ulcer Prevention Practices - Integration of Evidence.

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