Pol_256	**Pressure Care and Wound Management Policy**

Life Choice is committed to providing the highest standard of care and support for a participant requiring Pressure Care and Wound Management. Life Choice has developed the Pressure Care and Wound Management policy consistent with legislative requirements for a high intensity support activity, ensuring a safe, efficient and effective management service to our participants and to meet the needs, comfort and goals set for a participant receiving pressure care and wound management supports.

Record of policy development		
Version	**Date approved**	**Date for review**
2020/2	February 2023	February 2025

Responsibilities and delegations	
This policy applies to	This policy applies to all staff working in the field of Pressure Care and Wound Management
Policy approval	Quality & Risk

Policy context – this policy relates to:	
Standards	NDIS Practice Standards and Quality Indicators NDIS (provider registration and practice standards) Rules 2018 NDIS (quality indicators) guidelines 2018 NDIS High Intensity Daily Personal Activities NDIS High Intensity Support Skills Descriptor
Legislation	National Disability Insurance Scheme Act NDIS Quality and Safeguards Commission (2018)
References	Ausmed Woundcare
Organisation policies	Documentation Policy Management of Waste Policy Work Health and Safety and Environment Management Code of Conduct Policy Complaints Compliments and Feedback Policy Consent Policy Reportable Incident, Accidents and Emergencies Policy Information Management of Participants Records Policy Management of Medication Policy Privacy and Confidentiality Policy Risk Management Policy Service Agreement Policy

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Forms, record keeping, other documents	Pressure Area Descriptor Chart Code of Ethics and Conduct Agreement Complaints, Compliments and Feedback Form Doctors Medication order Form Hazard Form Privacy and Confidentiality Agreement Risk Assessment Form TRAINING PLAN – Pressure Care and Wound Management

DEFINITIONS:

Burns	Injuries to tissues caused by heat, friction, electricity, radiation or chemicals.
Chronic Wounds	A failure to heal in an orderly and timely manner.
Pressure Injuries Common sites for pressure injuries	A localised injury to the skin and/or underlying tissue, usually over a bony prominence, because of pressure, friction or a combination of these factors.
Surgical Wounds	a clean cut or puncture of the skin deliberately during a surgical procedure
Trauma Wounds	a stressful event caused by either mechanical or a chemical injury resulting in tissue damage

PRINCIPLES OF PRESSURE CARE AND WOUND MANAGEMENT

- To follow personal hygiene and infection control procedures
- Recognise risk and symptoms of pressure areas,
- To identify when to refer to health practitioner;
- To follow planned instructions to inspect/replace dressings (under health practitioner supervision and only when indicated in wound management plan

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ROLES AND RESPONSIBILITIES

Life Choice will ensure that each participant requiring pressure care and/or wound management supports will receive support, relevant and proportionate to their individual needs; overseen and developed by a health practitioner (e.g. Registered Nurse, Enrolled Nurse) with specific instructions to be implemented by support workers.

Life Choice will ensure that staff/support workers have the relevant knowledge and have received specific training in order to safely support the participants in the community.
Life Choice will deploy staff with knowledge of:

- How to recognise risk and symptoms of pressure
- Identify when to refer to health practitioner
- Follow plan instructions to inspect/replace dressings (under health practitioner supervision and only when indicated in Wound Management Plan.

The participant's support plan is overseen by a relevant health practitioner (e.g. Registered Nurse, Enrolled Nurse). This support plan will be regularly reviewed where procedures and information will be given to the participant/carer/advocate.

Life Choice's participants are ensured their desired level of involvement is respected and maintained.

SUPPORT PLAN

Each participant is involved in the assessment and development of the plan for their complex wound management. With their consent, the participant's health status is subject to regular and timely review by an appropriately qualified health practitioner. The plan identifies how risks, incidents and emergencies will be managed, including required actions and escalation to ensure participant wellbeing.

A participant 's pressure area/wound management care plan will be reviewed daily or as needed to ensure there are updated strategies in place for acting upon information from the participant/carer/advocate, staff and health professionals.

All pressure area/wounds will be assessed regularly, and outcomes will be recorded in the participants progress notes. Staff can/will use some/or the following types of documentation in relation to pressure are and wound management:

- Progress/file notes
- Assessment, Treatment and Management plans (Wound care plans/charts)
- Implementation and evalutation methods (Skin integrity assessments and Waterlow scores)
- Risk assessments (recognising risks and symptoms of pressure areas)
- Documentation with their manager and participant/carer/advocate to request for a change in a pressure are/wound care plan.

STAFF TRAINING

All staff working with a participant who requires complex wound management will receive mandatory training in relation to staff obligations under the NDIS Practice Standards and NDIS rules. The training will be

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specific to each participant's needs that are affected by their wound management regime (for example, showering, toileting and mobility) and high intensity support skills descriptor for providing complex wound management. This training will be delivered by an appropriately qualified health practitioner or person that meets the high intensity support skills descriptor for complex wound management. The training of workers is documented and regularly audited. Workers' competency to provide complex wound care supports is reviewed annually to confirm the worker has current skills and knowledge in pressure are and complex wound management. Where a worker has not delivered this support for a period of more than three months, or if a participant's support needs have changed and/or they have an updated support plan in place, the worker is reassessed before supporting the participant and undertake refresher training if required; this timeframe may vary depending on the nature of supports required and worker experience.

Appropriate policies and procedures are in place, including a training plan for workers, that relates to the support provided to each participant requiring complex wound management.
Training Plans will include:

- associated health conditions and complications that can impact on a participant who has a pressure area or wound
- common skin integrity risks and indicators of infection
- how to follow procedures and exercise judgement on when to respond/report problems such as signs of deteriorating health or infection to their manager and a qualified health practitioner
- how to monitor, chart and record participant's pressure area and wound management care
- Implications of prolonged or worsening infection
- Purpose and methods for positioning and turning to manage pressure and choking risks
- Implications of wound management for delivering daily support activities such as showering, toileting, mealtime assistance and mobility

Life Choice has policies and procedures in place which identify, plan, facilitate, record and evaluate the effectiveness of training for the frontline staff.

SAFETY CONSIDERATIONS

Life Choice will ensure that their Staff have knowledge of and are trained in infection control procedures are per their Management of Waste Policy.

<u>Equipment in the home</u>

Equipment in the home environment may include:

- Pressure area descriptor chart
- Disposable gloves (powder free)
- Disposable apron
- Gauze pads
- Normal saline or distilled water
- Cotton tipped swabs
- Basic dressing pack
- Additional dressing as per the participants pressure are/wound care plan

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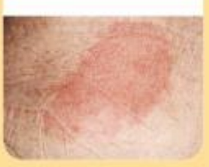
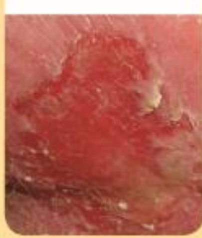
PRESSURE INJURY STAGING GUIDE



STAGE 1:

Pressure Injury: Non-blanchable erythema of intact skin

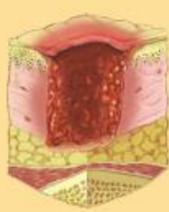
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.



STAGE 2:

Pressure Injury: Partial-thickness skin loss with exposed dermis

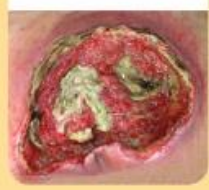
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).



STAGE 3:

Pressure Injury: Full-thickness skin loss

Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.



STAGE 4:

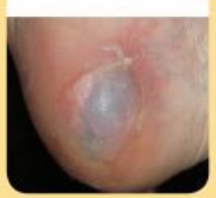
Pressure Injury: Full-thickness skin and tissue loss

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage cr bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures :he extent of tissue loss this is an Unstageable Pressure Injury.

UN-STAGEABLE

Pressure Injury: Obscured full-thickness skin and tissue loss

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.



DEEP TISSUE PRESSURE INJURY

Persistent non-blanchable deep red, maroon or purple discoloration

Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

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Monitor and document

All assessment, monitoring and outcomes will be recorded in the client’s health record. Monitoring and assessment of patients will occur as required but at least weekly.

Review of policy

This policy is subject to review [insert how frequently policy will be reviewed] by [include relevant staff/body responsible for review of this policy]. Any update in evidence-based guidelines on the identification, prevention and treatment of pressure injuries will be assessed and may be included or updated in this policy.

End of document

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