POLICY STATEMENT

Clients of Beata Homecare will be appropriate assessment, monitoring and management for all skin conditions.

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

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.

The client’s GP will be consulted with in regards to the management of the client’s wound and skin care management, 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.

RESPONSIBILITIES

The Program Manager is responsible for:

- Providing relevant staff with training related to Wound Management in older adults;
- Recording completion of training on the Staff Training Register.
- Co-producing a wound management plan, where appropriate, in consultation with the client and/or representative, GP and allied health (wound specialist nurse or treating team);
- Liaising and coordinating care with the client’s preferred GP and allied health (wound specialist nurse or treating team);
- Assisting the client with budgeting for any external services or purchase of wound products;
- Reviewing the wound management plan with the client and/or representative as per individualized plan.

The Nurse (EN, EEN or RN) is responsible for:

- Ensuring the wound assessment and management is consistent with the contemporary practice;
- Accurately documenting the wound assessment and management plan;
- Adhering to the client’s individualized skin and wound care management plan;
- Report and consult any changes to the skin and wound condition to the Program Manager, GP and wound specialist (where required).
- Ensuring any skin or wound products are used with minimal wastage.
All Staff is responsible for:

- Maintaining the client’s skin integrity through pressure area care and reporting to the Program Manager for early identification of pressure sores and skin breaks.
- Adhering to the client’s individualized skin and/or wound management plan.
- Reporting to the Program Manager of any abnormalities to the client’s skin or wound (i.e., increased pain to the wound site despite already taking pain medications, reports of fevers, signs of dehiscence, swelling, offensive smell, dressing requires changing by the registered nurse due to saturation of fluid etc.);
- Documenting the abnormal observations made in the progress note and what was done about it.

### PROCEDURES

#### 1 PRINCIPLES OF WOUND MANAGEMENT

1. Identify etiology (medical history, clinical examination, investigations)
2. Reduce or eliminate factors causing the wound
3. Select and apply topical treatment/dressings
4. Plan, implement and evaluate an individual care plan with the client and/or representative and other key health care professionals.

#### 2 SKIN CARE

On entry to Beata’s services, the client’s skin will be assessed under the Physical Health Domain.

If the client have any skin conditions/problems, the Residential Care Services Skin Integrity Assessment will be done.

All wounds are to be documented on the following forms:

- Incident Report
- Residential Care Services Wound Assessment and Progress Chart.
- Wound Data Summary

All clients will be assessed for the risk of developing pressure ulcer by using the Braden Risk Assessment Scale.

Management strategies for the prevention and treatment of skin integrity problems is to be documented in the client’s care plan.

All skin integrity issues will be discussed at the Quality Committee Meeting. At the Quality Committee Meeting, skin and wound analysis will be done and improvement actions will be developed (where required) to address the identified trends.
3 WOUND ASSESSMENT

Accurate wound assessment, documentation and product selection is key to promoting wound healing. Assessment is an on-going process of monitoring the wound and the client’s overall health and the evaluating whether the treatment plan is achieving the desired outcome.

The NATFRAME Residential Care Services Wound Progress Chart is used every time the wound is reviewed.

3.1 Factors affecting the wound healing process

Identifying factors by collecting the client’s past medical history and other triggering factors that will assist the nurse with an understanding of the factors affecting the wound healing process. For example, the nurse should consider the following factors:

- Wound trigger: surgical, trauma, pressure, infection, oedema, previous treatments.
- Medical history: conditions that affects the blood flow to the wound such as diabetes, anaemia and cardiovascular disease.
- Nutritional status: nutrition is linked to impaired wound healing,
- Other factors: age, smoking, incontinence, immobility and pain.
- Environmental factor: clutter, financial difficulties, pets.
- Psychological factor: stress and cognitive impairment.

3.2 Wound Examination

Wound assessment should have the following descriptions:

- Date of the wound assessment
- Wound location
- Wound size
- Wound shape
- Wound depth
- Tissue type in the wound, surround the wound and peri-wound area
- Any undermining
- Odour
- Heat
- And exudate volume
### INFLAMMATION VS INFECTION

It is important to differentiate the difference between inflammation and infection when assessing the wound.

On an acute wound, inflammation stage will occur 3-5 days post wounding, where the capillaries are dilated to allow the white cells to remove debris by phagocytosis. The inflammation should reduce by day 3.

Whereas infection, the following signs and symptoms will be present:

- Redness extending 2-3 cm outside the wound margin
- Heat (with or without swelling/oedema)
- Odour
- Pain
- Increased exudate with a change in colour, viscosity and type
- Delayed healing or wound breakdown
- Wound bed discolouration/granulating tissue which bleeds easily
- Pocketing at the base of the wound.

Exudate that is gold coloured can indicated staphylococcus aureus.

Exudate that is green/blue can indicated pseudomonas aeruginosa.

Report to the GP is you suspect that the wound is infected.

**Principles for management of a clinical infection:**

- Avoid occlusive and adhesive dressing until the infection has resolved
- Consult with the wound care consultant and consider the need for topical antimicrobial dressing such as silver dressing or cadexomer iodine.
- Daily dressing change and thorough cleansing of the wound.

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**Wound Image:**

To assist with monitoring the wound healing process, obtaining the client’s consent to allow an image to be taken of the wound is highly encouraged.

The wound image and descriptions is to be placed on the *Residential Care Services Wound Assessment and Progress Chart.*

The wound image should be taken every time when the dressing is required to be changed.
### INVESTIGATIONS

In consultation with the GP and depending on the type of the wound, the following investigations may occur:

- Blood test (FBC, INR, CRP, electrolytes, lipids, HbA1c)
- Wound swabs (taken if client is symptomatic and GP plans to treat with antibiotics)
- Tissue sample (done by a dermatologist to rule out malignancy and/or immune diseases that lead to chronic wound development).

### SKIN TEAR MANAGEMENT

#### 2 Skin Tear Management

Skin tear is to be managed by using the STAR acronym:

**S** – Stop the bleeding & clean
- Select an appropriate cleanser
- Assist is bleeding control
- Clean the wound bed

**T**- Tissue Alignment
- Align the skin flaps (if possible) over the wound bed

**A** – Assess and dress
- Complete a holistic health assessment
- Inspect the surrounding skin
- Categorise the skin tear according to the STAR classification
- Draw an arrow on the dressing, indicating the direction of the skin flap.

**R** – Review and re-assess
- If the skin flap is pale and dusky/darkened, reassess within 24-48 hours.
- Document the determined date of review and dressing change.
- Remove the dressing in direction of the arrow.
- Monitor for changes in the wound status by observing the wound pictures (taken by a camera) on the assessment chart.
- Assess maintenance of the overall skin integrity.
7 PRESSURE AREA CARE MANAGEMENT

Pressure injury is caused by unrelieved pressure of the tissue that is compressed between a bony prominence and an external surface either through shear, friction force or moisture. This leads to the occlusion of the vascular and lymph node vessels that supply oxygen and nutrients to the tissue.

7.1 Pressure Injury Risk factors

The following risk factors have been found to contribute the development of pressure sores:

- Frail persons
- Immobility
- Impaired sensation or impaired ability to respond to pain or discomfort
- Malnutrition
- Obesity
- Circulation disorders
- Smoking

7.2 Pressure Injury Classifications

Pressure injuries are classified according from Stage 1 to Stage 4.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Intact skin with observable changes including areas of persistent redness.</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Partial thickness skin loss involving epidermis and/or dermis.</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Full thickness involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Full thickness skin loss with extensive tissue destruction to muscle, bone, or supporting structures i.e. tendon, joint capsule. May have undermining or sinus formation.</td>
</tr>
</tbody>
</table>
When documenting the pressure sore in the Wound Assessment Chart, the stage of the wound must be documented.

### 7.3 Pressure Injury Management

Staff in direct care of the client who is at risk of developing pressure sores should adhere to the client’s skin integrity care plan.

Some of the preventative measures that can be incorporated in the client’s care to reduce the risk of developing pressure sores or further break down, may include:

- Regular position changes (wheelchair bounded clients - reposition every 15mins and bed bounded clients every 2 hours and to avoid putting pressure on the hip bone)
- Pillows and hip protectors should be used as a soft buffer between the skin and the surface of the bed or chair
- Use special mattresses and beds.
- Perform skin inspection every time care is delivered to monitor signs of redness or discolouration.
- Ensure the skin is not too dry or too moist.
- Apply moisturising creams to ensure the skin is supple.
- Avoid message in bony areas as the skin can be delicate.
- Ensure that the client has a nutritious diet.
- Ensure good hygiene practice around the perianal and sacral region.
- Encourage the client to maintain activity levels where appropriate.
- Encourage the client to quit smoking with support and assistance.
- Apply dressings over the sores to ensure the wound bed is moist and the surrounding skin dry.
- Light packing of empty skin spaces with dressings to prevent infections.
- Apply specific topical medications as prescribed by the GP or wound specialist, if the wound is infected.

### 8 GOALS IN THE MANAGEMENT OF THE WOUND AND THE SELECTION OF DRESSING PRODUCT

The goals in the management of wounds are:

- Reduce the pressure and shear forces
- Management of exudate
- Prevention of contamination in the wound by ensuring the principles of aseptic techniques and hang hygiene is applied during all dressing change.
- Create a moist wound environment

The goals on selecting the most appropriate dressing is to:

- Provide a barrier to bacteria
- Absorb excess exudate
- Be atraumatic on removal
- Allow gaseous exchange
- Provide thermal insulation
• Protect the wound from further damage

9 TREATMENT GUIDELINES

9.1 Wound Bed Preparation

The aim of the wound bed preparation is to remove barriers to wound healing by:

• Creating a vasculated wound bed by removing necrotic tissue and slough;
• Reduce the inflammation or infection; and
• Manage the exudate levels to avoid maceration or desiccation.

To prepare the wound bed, the TIME framework is utilised:

T – Tissue non-viable or deficient

Is removal of necrotic/sloughy tissue needed?
If Yes:
Clinical Action: Remove necrotic tissue or slough present
Clinical Process: Debride

I – Infection and/or inflammation

Is the wound infected?
If Yes:
Clinical Action: Remove or reduce bacterial load
Clinical Process: Topical antimicrobials, debridement of devitalized tissue

M- Moisture balance

Do I need to hydrate the wound, absorb exudate or maintain exudate?
If Yes:
Clinical Action: Risk of desiccation. Restore moisture balance
Clinical Process: Absorb exudate or add moisture to dry wound

E- Edge of wound: non-advancing or undermined

Clinical Action: Address T/I/M issues, and reassess after 2 weeks. If there is minimal improvement, report to the GP and consider referral to the wound specialist nurse.
## 9.2 Dressing Selection Guideline

### Generic Product name: Trade Name: Low Exudate: Medium Exudate: High Exudate: Haemostatic property: Use in clinical infection: Support debriement: Zndry dressing: Dressing frequency:

<table>
<thead>
<tr>
<th>Hydrogel</th>
<th>Intrasit e</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>Film, passive dressing</th>
<th>1-3 days (usually daily)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocolloids (wafer, paste, powder)</td>
<td>Comfeel</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Paste: film, hydrocolloid wafer or passive dressing</td>
<td>1/52 or when it is fully saturated</td>
</tr>
<tr>
<td>Polyurethane foam</td>
<td>Mepilex</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Not required</td>
<td>1/52 or when it is fully saturated</td>
</tr>
<tr>
<td>Calcium Alginate (sheet &amp; rope)</td>
<td>Kaltosat</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Film, passive dressing</td>
<td>1-3 days</td>
</tr>
<tr>
<td>Hydrofibre (sheet &amp; ribbon)</td>
<td>Aquacel</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Film, passive dressing</td>
<td>1-3 days</td>
</tr>
<tr>
<td>Transparent Film</td>
<td>Mepor e Film</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Avoid, (unless requires daily change)</td>
<td>Not required</td>
</tr>
</tbody>
</table>

### Properties of the Generic Dressing products:

#### Hydrogel:
- High water content to allow rehydration of the wound
- Supports autolytic debridement of dry and moist slough and necrotic tissue
- Can act as a carrier for medications such as metronidazole
- Keeps exposed nerve ends moist, hence promotes pain relief
- Irrigate the wound to remove the gel
- Maybe associated with wound edge macerations
Hydrocolloids:
- Contains gelatine, pectin, sodium carboxymethylcellulose
- Wound exudates interact with hydrocolloid by the fluid being adsorbed by the hydrocolloid causing a gel consistency.
- There are various forms of hydrocolloids products (wafer or paste). Do not use wafer on infected wounds.
- Use for low to moderate exudates.
- Used over bony prominent areas and superficial or partial thickness wounds.
- Leave 3-4 cm wound clearance when using wafer.

Foams:
- Majority have 2 layers (some have 3)
- Has hydrophilic action
- Used for superficial wounds with moderate to high exudates
- Retains absorbent capacity under compression bandage
- Leave 3-4 cm clearance around the wound
- Available with adhesive border

Hydrofibre:
- Contains sodium carboxymethylcellulose
- Comes as a sheet or rope dressing
- Used for high exudate wounds
- Causes less maceration of the surrounding skin
- Cut to size of the wound
- Requires secondary dressing

Films:
- Transparent adhesive coated polyurethane semipermeable film
- Traps wound exudate at wound surface
- Has little or no absorbent property
- Commonly used as a secondary dressing or on pressure ulcer dressings (as a secondary dressing) to assist in the reduction of the friction force.

Alginates:
- Used for moderate to high exudate wounds
- Interacts with the wound exudate by exchanging the ions causing a gel
- Gel facilitates autolytic debridement
- Lightly pack cavities.

9.3 Dressing Selection for surgical wounds
- Refer to the client’s post-operative medical order or plan.
## INCIDENT REPORT

If the wound was caused by a trauma, such as Skin Tears, Bruise or Pressure Sores, an Incident Report must be done, using the form **DOC 5.06 Workplace Incident and Accident Report**.

Direct Care Workers must apply first aid, complete an incident report and report to the Program Manager (who is a Registered Nurse). The Program Manager will then assess the wound, create a wound management plan and monitor.

EN and RNs who made the initial discovery of the wound must also complete an incident report, assess the wound and create a wound management plan and report to the Program Manager.

The Program Manager must log in the wound to the Wound Register (REG 34.13 Wound Register) and is responsible for:

- monitoring the wound;
- Amending the Client’s care plan (in consultation with the client and/or representative);
- making referrals as required; and
- reporting the updated wound condition/progress/management of the allocated client in the Quality Committee Meeting on a monthly basis.

## REFERRAL TO OTHER HEALTH CARE PROFESSIONALS

The Program Manager is responsible for:

- Notify the GP if the wound condition has not improved in 2 weeks and is deteriorating;
- Make a referral to the Wound Care Consultation, in consulting with the client and/or representative, if the wound is poor in healing or has deteriorated; and
- Document the referral in the Wound Register.

## HEALING OF WOUND

Once the wound is healed, the wound register is to be updated by documenting the date of when the wound was healed and also to document in the client’s progress notes.

Inform the client and representative when the wound is healed and no longer requiring management.

## COMMUNICATION WITH THE CLIENT AND/OR REPRESENTATIVE

Ensure that the client and representative has been regularly consulted and updated of the current wound condition, management plan and any changes required to assist in the improvement of the wound condition.
EXPECETD OUTCOME

- 100% of the wounds are appropriately assessed, documented, monitored and managed according to the policy and procedures and best practice.

RELATED DOCUMENTS

- Workplace Safety Records: DOC 5.06 Workplace Incident and Accident Report Form
- Clinical Care Records: DOC 4.08 ISBAR FORM
- NATFRAME Residential Care Services Skin Integrity Assessment
- NATFRAME Residential Care Services Wound Assessment.
- NATFRAME Braden Risk Assessment Scale.
- NATFRAME Residential Care Services Wound Progress Chart.

RELATED REGISTER

- REG 34.13 Wound Register

RELATED POLICIES

- Clinical Care Policy: POL 01.09 Clinical Assessment, Planning, Review and Coordination
- Workplace Safety Policy: POL 02.06 Safe Work Practices
- Clinical Care Policy: POL 03.09Hand Hygiene

References

- Australian Commission on Safety and Quality in Healthcare, National Safety and Quality Health Service Standards, ACSQHC, Editor.2011, Commonwealth of Australia: Sydney.
• Department of Health and Aging, NATFRAME – a National Framework for Documenting Care in Residential Aged Care Services.