



Medical Protocol and Procedure

Wound Care/Pressure Management

Policy

The skin care and wound management needs and preferences of Individuals will be assessed and managed effectively. Care needs will be evaluated and reviewed regularly and in response to the individual's needs. Individuals will have access to appropriate health professionals when required.

Wound care, dressings and pressure relief activities may be performed by a DSP or direct care staff that have been trained to provide ordered task by a licensed nurse or certified professional in wound care management.

Procedure

1. Information regarding individual care needs and preferences is collected from assessments, progress notes, GP notes, Specialist medical practitioner notes/ letter, letters from other health care providers, discharge notes/ letters or correspondence from allied and other health care providers.
2. Skin Assessment that identifies risk category (mild, moderate, high or severe risk of developing pressure ulcers) will be referred to nursing for preventative assessment and education of direct care staff.
3. Individuals with identified skin conditions or problems are referred to the appropriate Health Professional, such as the GP, Skin Specialist, Wound Consultant, Physiotherapist, Dietician, Podiatrist etc.
4. Wound care will be individualized by physician order where a deficit is identified.
5. Strategies for the management and prevention of pressure ulcers will be included in care of the individual where a mild, moderate, high or severe risk is identified.
6. Preferred supplier of health services is documented on the care plan (Medical Specialist, GP, Wound Consultant, Podiatrist etc.)
7. Care plan detail specific skin care management instruction, individualized by physician order, that include but not limited to:
 - Skin care regimes (use of barrier/ emollient creams);
 - Repositioning times (write actual time on chart);
 - Aids (including pressure reducing foam mattresses, alternating surface mattress, sheep skin products, wedges, cushions (air, gel or water), limb protectors, splints, guards and other equipment as required);
 - Moisture reduction (refer to Continence Management);
 - Relevant lifting/ transferring procedures.

8. Direct care staff will receive education on skin care and wound management regularly and in response to identified knowledge deficits or incidents.
9. New or ineffectively managed problems are reassessed and where necessary Residents are referred to appropriate health professionals.
10. Braden Score is reviewed if an individual experiences a wound, change in mobility or continence status or if there is a change in their skin condition or general condition.
11. All skin tears, bruises, burns, pressure areas or other traumatic injuries of unknown cause or as a result of an accident/ incident are recorded on an Incident Report and in the individual's support notes.
12. The following information is included in nurses note when a dressing is changed by skilled nursing:
 - Size of wound (length and width in cms);
 - Condition of the wound;
 - Whether the wound is improving in appearance;
 - Pain experienced by Resident;
 - Exudate &/ or signs of infection;
 - The dressing material used;
 - When the dressing/ wound is to be reviewed;
 - When the dressing is to be replaced.
13. Any changes in the condition or status of a wound is reported to the RN or individuals physician. Signs to be instructed to report include:
 - swelling, redness, or pain increases or if the wound feels warm to touch
 - there is a red streak extending from the wound
 - fever of 101.5°F (38.6°C) or higher
 - chills, nausea, vomiting, or muscle aches
 - wound seems to be opening up or you notice any drainage
 - stitches or staples are loose
 - adhesive film is loosening before it is suppose to
 - Any symptoms that worry you
14. Direct care staff are to be instructed and adhere to infection control guidelines when providing wound care including the following:
 - Advise individual of need to dress wound;
 - Clean surface to be used before commencing dressing;
 - Attach a small rubbish bag to the side of the area.
 - Wash hands before commencing dressing and handling dressing materials;
 - Ensure you have all required equipment ready for use and do not have to stop during the procedure to retrieve required articles (dressing pack, dressing materials, cleaning solutions, tapes etc.);



- If individual has multiple wounds, attend to the cleanest wound first. Infected or wounds with a large amount of exudate should be attended to last;
- Throughout the procedure, use a hand sanitizer gel to cleanse hands after touching an unclean surface, such as individuals skin;
- Dispose of all used dressing materials into rubbish bag. Tie bag up and remove gloves;
- Dispose of rubbish in infectious waste bags or double plastic bag, wash hands and clean down area that has been used again.