Skin, Pressure Area and Wounds Policy, Guidelines & Framework

Current Version

Service Area	Disability, Aged, Community	**Version**	1.1
Process Owner	Governance Lead | CEO | COO	**Date of Issue**	May 2023
Approved by	Chief Executive Officer	**Review**	May 2025

Modification History

Version	Date	Author	Approved by	Description of change
1.0	5/2018	Natashia Telfer	Employsure	Broaden coverage across community
1.1	5/2020	Tahla Small	CEO	Expansion on wounds and types

In conjunction with:

- All National Frameworks

Contents

Pressure Area Care

POLICY STATEMENT

A Pressure Injury is a localised injury to the skin and/or underlying tissue, usually over a bony prominence, resulting from sustained pressure, including pressure associated with shear (NPUAP 2014). National staff will assess and manage skin integrity for all clients/participants in their care.

SCOPE

This policy applies to all employees of National.

POLICY

National staff are to follow local facility policies and procedures relating to maintaining client/participant skin integrity, including the prevention and management of pressure injuries and skin tears. This includes the following:

- Ensuring a skin integrity and where necessary, chronic wound care plan has been developed for each client/participant
- Re-assess client/participants and evaluate care plan at regular intervals according to facility Policies and respond appropriately to any abnormalities.
- Assess the risk of skin breakdowns by utilising the *Waterlow Risk Assessment Scale*, or the risk assessment tool required by the Facility.
- Ensure that preventative measures are instituted to maintain healthy skin in "at risk client/participants" such as the following:
- Regular 2 hourly repositioning of confined or unconscious client/participants ensuring shearing forces are minimised by using appropriate assistance devices e.g. slide sheets, lifters and hover mats
- Use of assistance devices to relieve pressure including alternating air mattresses, chair cushions, heel troughs, and the application of silicon foam dressings to bony prominences e.g. sacrum, heels ensuring skin integrity is assed under dressings daily.
- Bath/shower/sponge client/participant in accordance with hygiene needs and client/participant preferences, paying particular attention to skin folds under breasts, between buttocks and in groin area
- Microclimate management including incontinence management e.g. pH balanced skin cleansers and application of twice daily moisturizers, and incontinence products measured to fit (Canberra Hospital and Health Service Clinical Procedure 2017)
- Ensure perianal hygiene is attended after any episodes of incontinence.
- Observe for breakdown in skin integrity, treat in accordance with contemporary wound management practice, document and evaluate effectiveness of treatment.
- Report all skin breakdowns via the Facility incident reporting system.

REFERENCES

Australian Commission on Safety and Quality in Health Care | Australian Council on Healthcare Standards – Criteria 1.5.3 "The incidence and impact of breaks in skin integrity, pressure ulcers and other non-surgical wounds are minimised through wound prevention and management programs" Australian Wound Management Association Inc, (2009) AWMA Position Document: Bacterial impact on wound healing: From contamination to infection. AWMA. http://www.awma.com.au/awma/index.php | Australian Wound Management Association. Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury. Cambridge Media Osborne Park, WA: 2012. | Carville, K. (2016), Wound Care Manual 6th Edition, Silver Chain Nursing Association WA | Canberra Hospital and Health Service

Clinical Procedure (2017), Pressure Injury Prevention and Management | National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific | Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014. | Wounds Australia (2016) Standards for Wound Management http://www.awma.com.au

Complex Wound Management

POLICY STATEMENT

A complex wound is a general term used to define difficult wounds, both acute and chronic, that present a challenge to both medical and nursing professionals. Carvalho et al (2006). National nurses will assess and manage skin integrity for all client/participants in their care.

SCOPE

This policy applies to Endorsed Enrolled Nurses and Registered Nurses of National.

POLICY

National nursing staff are responsible for the prevention, assessment, intervention and management of complex wounds, in consultation with the general medical practitioner or nurse practitioner. This includes the following:

- Registered Nurses are expected to use clinical judgement for new or simple wounds and their management.
- All complex wounds or deteriorating wounds require consultation with the general practitioner or nurse practitioner responsible for the client/participant to ensure quality care and management of the wound.
- Assess the risk of skin breakdowns by utilising the Waterlow Risk Assessment Scale, or the risk assessment tool required by the Facility.
- A skin integrity assessment has been completed and a wound care plan has been developed for each client/participant with a wound.
- General practitioner/nurse practitioner/next of kin and or guardian has been notified of the wound, providing detailed information of when/how/why and the management plan.
- Accurate documentation of the wound assessment is to be attended by the nurse on duty using ISOAP.
- All wounds require an incident form to be completed within 24 hours of the wound occurring and is to be submitted to the clinical coordinator for review.
- All complex wound management treatment plans are to be developed in consultation with the client/participant / next of kin and in collaboration with either the medical practitioner or nurse practitioner responsible for the client/participant.
- All changes in the status of the wound (signs of infection or deterioration) are to be reported to the clinical coordinator for review immediately and upline to the general practitioner or nurse practitioner for review in a timely manner.
- All alterations in the status of the wound are to be communicated to the client/participant and or next of kin / guardian, within 24 hours of new observation, communication is to be documented in the client/participants progress notes and handed over to the oncoming RN.
- RN may provide directive to carer to remove a basic would dressing.

Procedure: Holistic Assessment (HEIDIE)

The first thing to do before addressing any wound is to perform an overall assessment of the patient. An acronym used to guide this process step by step is HEIDIE:

- History - The patient's medical, surgical, pharmacological and social history.
- Examination - Of the patient as a whole, then focus on the wound.
- Investigations - What blood tests, x-rays, scans do you require to help make your...
- Diagnosis - Aetiology / pathology.
- Implementation - Implementation of the plan of care.
- Evaluation - Monitor, assess progress and adjust management regimen, refer on or seek advice.

The following actions are also required by the registered nurse:

- Notify support coordinator of complex wound (within 24 hours)
- Notify General practitioner (within 24 hours) and request a wound care regime
- Update service guide and or care plan

The registered nurse is to use the Bates-Jensen wound assessment tool (located on sharepoint) to conduct a comprehensive assessment of the wound. The assessment tool is to be completed on each dressing change.

Skin Tears

POLICY STATEMENT

The International Skin Tear Advisory Panel (ISTAP) defines skin tears as a wound caused by shear, friction, and/or blunt force resulting in separation of skin layers. A skin tear can be partial thickness separation of the epidermis from the dermis or full thickness separation of both the epidermis and dermis from underlying structures Carville et al (2007).

National nurses will assess and manage skin tears for all client/participants in their care.

SCOPE

This policy applies to Endorsed Enrolled Nurses and Registered Nurses of National.

POLICY

National nursing staff are responsible for the prevention, assessment, intervention, and management of skin tears in consultation with the general medical practitioner or nurse practitioner.

Australia uses the Skin Tear Audit Research (STAR) classification system to distinguish between different types of skin tear. The STAR system comprises five categories:

Silver Chain **STAR Skin Tear Classification System** Curtin University of Technology

STAR Skin Tear Classification System Guidelines

1. Control bleeding and clean the wound according to protocol.
2. Realign (if possible) any skin or flap.
3. Assess degree of tissue loss and skin or flap colour using the STAR Classification System.
4. Assess the surrounding skin condition for fragility, swelling, discolouration or bruising.
5. Assess the person, their wound and their healing environment as per protocol.
6. If skin or flap colour is pale, dusky or darkened reassess in 24-48 hours or at the first dressing change.

Silver Chain **STAR Skin Tear Classification System Glossary** Curtin University of Technology

- ***Skin Tear:*** "a traumatic wound occurring principally on the extremities of older adults, as a result of friction alone or shearing and friction forces which separate the epidermis from the dermis (partial thickness wound) or which separate both the epidermis and the dermis from underlying structures (full thickness wound)"[1].
- ***Pale, dusky or darkened skin or flap colour:*** when compared to the individual's 'normal' surrounding skin, may indicate ischaemia or the presence of haematoma, which may affect skin or flap viability.
- ***Ischaemia:*** inadequate tissue perfusion as evidenced by pale, dusky or darkened tissue.
- ***Haematoma:*** a collection of blood or clot under the flap or realigned skin.
- ***Realign:*** to replace the skin or flap into the normal anatomical position without undue stretching.
- ***Linear skin tear:*** a skin split or the skin splitting in a straight line.
- ***Flap skin tear:*** a segment of skin or skin and underlying tissue that is separated from the underlying structures.

References:

1 Payne, R., & Martin, M. (1993). Defining and classifying skin tears: Need for a common language … a critique and revision of the Payne-Martin Classification system for skin tears. *Ostomy Wound Management, 39*(5), 16-20.
2 Photographs courtesy of the Skin Tear Audit Research (STAR) photographic library, Silver Chain Nursing Association and School of Nursing and Midwifery, Curtin University of Technology.
3 Carville, K., Lewin, G., Newall, N., Haslehurst, P., Michael, R., Santamaria, N., & Roberts, P. (2007). STAR: A consensus for skin tear classification. *Primary Intention, 15*(1), 18-28.

STAR Tool G 4/2/2010

Management of a Skin Tear – Procedure

SCOPE

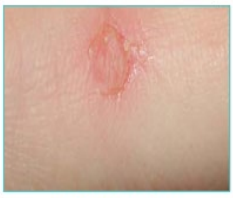
This procedure applies to Assistants in nursing (within 1a/1b), Endorsed Enrolled Nurses and Registered Nurses of National.

Process for reporting skin tears:

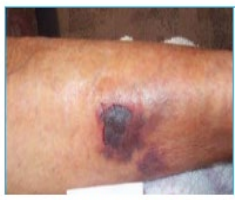
- All employees are to report to NCC intake line all skin tears; employees are to gain verbal consent from the participant before a photograph is taken.
- NCC intake line will coordinator with National Clinical Manager or Clinical Admin/ Quality Assurance Registered Nurse as to how to proceed with managing the skin tear.
- Employee who reports the skin tear is required to submit the incident form with photograph to NCC within 24 hours of notification.

Process for initial response to a skin tear:

In the event the skin tear is identified as - 1a & 1b



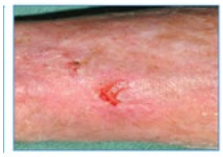
Category 1a



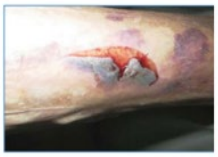
Category 1b

Step 1 - AINS employee onsite will be directed to apply a clean, wet (warmed) face washer over the site for 10 minutes to stop the bleeding.
Step 2 – AIN is to send a photograph to NCC intake with consent from the participant.
Step 3- AIN is to then apply emergency meplix boarder over the wound date of application written on the dressing.
Step 4 - NCC intake or National Clinical Manager will organise a EN/RN visit within 24 hours to review wound and undertake full wound care assessment.

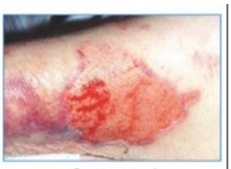
In the event the skin tear is identified as – 2a, 2b or 3



Category 2a



Category 2b



Category 3

Step 1 - Employee onsite will be directed to apply a clean, wet (warmed) face washer over the site for 10 minutes to stop the bleeding.
Step 2 – AIN is to send a photograph to NCC intake with consent from the participant.
Step 3 - AIN is to then apply emergency meplix boarder over the wound date of application written on the dressing.
Step 4 - NCC will attempt to organise EN/RN visit within 4 hours of injury, if unable to organise review the participant will be referred to their GP or emergency department.

Clinical Assessment of a Skin Tear

The registered nurse is to identify the category of the skin tear using the Skin Tear Audit Research (STAR) classification system to distinguish between different types of skin tear.

The registered nurse is then to use the Bates-Jensen wound assessment tool (located on sharepoint) to conduct a comprehensive assessment of the skin tear. The assessment tool is to be completed on each dressing change.
The following actions are also required by the registered nurse:

- Notify support coordinator of skin tear (within 24 hours)
- Notify General practitioner (within 24 hours)

- Update service guide and or care plan

National Employees Responsibilities

- All employees are to report to NCC intake line all skin tears; employees are to gain verbal consent from the participant before a photograph is taken.
- NCC intake line will coordinator with National Clinical Manager or Clinical Admin/ Quality Assurance Registered Nurse as to how to proceed with managing the skin tear.
- Attend an incident form within 24 hours of notification to NCC intake line of incident.
- Wound Assessment: a wound care regime will be developed by a senior RN and discussed with client or participant, the wound regime will be reviewed monthly or when changes occur.

Training Requirements

All service delivery registered nursing staff are required to hold a valid First Aid and CPR. Employees are required to undertake First Aid 3rd yearly. This is a part of the employee's contractual obligations and at the cost of the employee, not National.
National will provide additional resources and access to wound care training throughout the calendar year for registered nursing staff.

NDIS REPORTING REQUIREMENTS

Any unexplained serious injuries or neglect of duty of care in relation to wound care management is reportable under the NDIS Commission of reportable incidents. Further explanation on compulsory reporting requirements within *Mandatory Reporting Policy*

REFERENCES

Royal Children's Hospital

https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Wound_assessment_and_management/

Carvalho et al (2006) https://www.ncbi.nlm.nih.gov/pubmed/17187095

Carville, K., Lewin, G., et.al. STAR: A consensus for skin tear

classification. Prim Intent 2007; 15(1):18-28

ISTAP Skin Tear Classification system (2020)

http://www.skintears.org/wp-content/uploads/2020/01/Ten-Years-of-

ISTAP-2.pdf

Curtin University Technology (2010) STAR Skin Tear Classification

System https://baynav.bopdhb.govt.nz/media/1480/skin-tear-

classification-tool.pdf