Procedure

- Responsibility for wound care must be undertaken by an Appropriately Qualified Health Professional (AQHP) with nursing qualifications.
- Only staff who have been trained by the AQHP can provide support with wound and pressure injury care.
- This procedure is a guide only and may not be appropriate in all circumstances. Instructions from a Health Professional must always be obtained and followed.
- This procedure should be read in conjunction with the NDIS LWB 5501 Health and Wellbeing – Procedure, LWB National Medication Procedure and in consultation with the person we support or their care plan.

Emergency Response

The following are sign of serious infection that needs to be treated immediately and you should seek medical advice:

- redness, swelling or localised heat to any part of the body
- pus coming from a pressure ulcer or wound
- cold skin and a fast heartbeat
- severe or worsening pain
- a high temperature (fever) of 38C or above

Always seek medical advice if there are any concerns about the person we support or their injury.

Pressure Area Care

Skin care is an ongoing process which should always be incorporated into achieving a holistic approach to care. Some people we support are more vulnerable to pressure injury and will require closer observation and support.

Pressure injury is an injury to the skin resulting from pressure, shear and/or friction.

Pressure causes a loss of oxygen and nutrients to the area leading to tissue damage and skin breakdown. A shear or friction injury can occur by rubbing or dragging, for example sliding down the bed or putting on clothing.

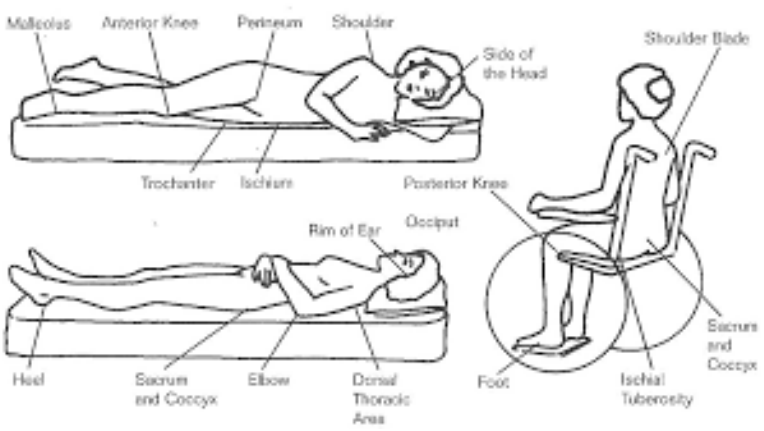
Risk factors include:

- unrelieved pressure
- reduced mobility and/or sensation

- incontinence
- psychological disorders
- poor blood circulation
- inadequate hygiene
- moisture
- hydration or nutritional status
- injury
- weight gain or loss
- clothing
- medical devices – for example C-PAP mask or plaster cast

Pressure injury can affect any part of the body. Common sites are bony prominences such as the heels, elbows, spine and back of the head. (*Refer* ***Image 1 – High Risk Areas for Pressure Injury***).

Image 1 – ***High Risk Areas for Pressure Injury***



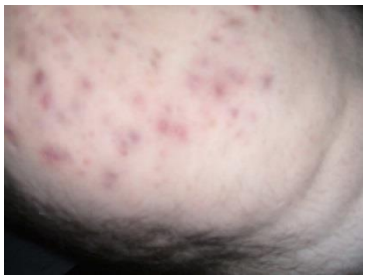
Early Symptoms of a Pressure Injury

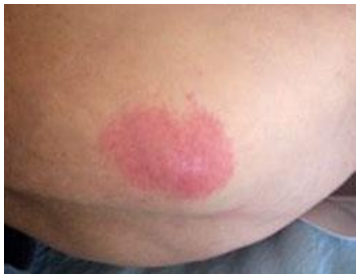
Pressure injuries are defined into four grades or classifications.

Grade I

- skin discolouration –red in light coloured skin, purple or blue patches in darker skin colour
- unusually warm, spongy or hard area on the skin
- pain or itching

Image 2 – *Grade 1 Pressure Injury*

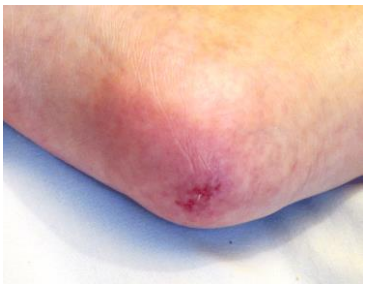


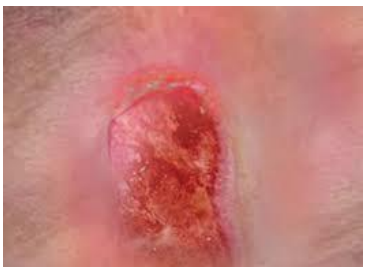


Grade II

- superficial damage to the top skin layers
- open wound or blister

Image 3 – *Grade 2 Pressure Injury*

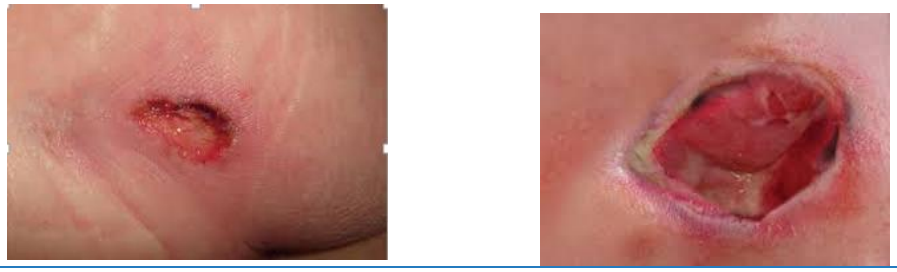




Grade III

- complete skin loss
- damage to the underlying tissues
- often presents as a crater

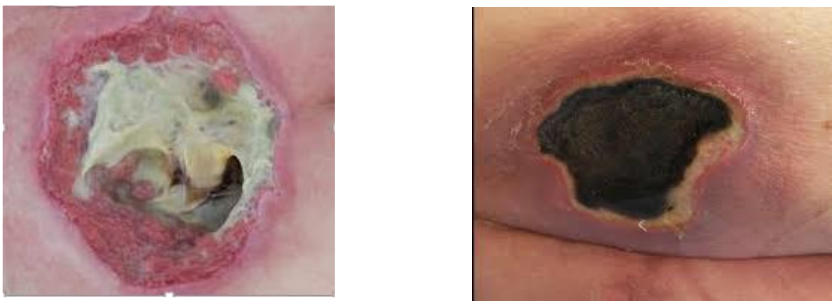
Image 4 – *Grade 3 Pressure Injury*



Grade IV

- full thickness skin loss
- base of the injury is covered with slough (yellow, grey, green or brown colour) and/or there is necrosis (dead black tissue)
- bone, tendons or joints may be visible

Image 5 – *Grade 4 Pressure Injury*



Prevention

Pressure ulcers can occur rapidly and quickly progress deep into the muscle, leading to pain and infection of the local area, bloodstream, bones and joints. Preventative measures should be discussed with the person we support, their family and the appropriate health professional. Always refer to the person's Health Care or Wound Management Plan.

Change of Position

The person we support should be encouraged and supported to change position at least every two hours. This relieves pressure and restores blood supply to the area.

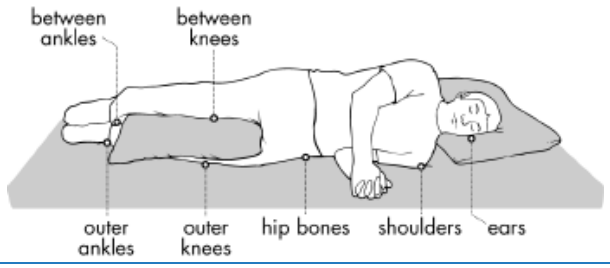
Always ensure correct lifting techniques are used when supporting a person to change position. A slide sheet or hoist may be appropriate. All Disability Support Workers should receive training in the use of equipment by an appropriate health professional.

Ensure the person is not sitting or lying on creased clothing or sheets. Buttons, zippers or clothing with thick seams will also increase pressure to areas of the skin.

Encourage the person to maintain a good posture when sitting in a chair by sitting well back in the chair and maintaining an upright posture. Check elbows are not at risk of increased pressure when resting on the arm rest

Pillows and cushions can be used to protect bony prominences. (*Refer **Image 6 – Correct Positioning for Management of Pressure Injury).***

Image 6 – Correct Positioning for Management of Pressure Injury



Pressure area care should be taken into consideration for all equipment prescribed for the person. This includes wheelchair, bed, shower/commode chair and sling. All equipment should be checked prior to use.

Many wheelchairs have an option to tilt the seat to change position or a pressure relieving cushion can be used. The cushion should be selected in consultation with an Occupational Therapist or Physiotherapist as not all cushions are suitable as some may increase pressure.

Never use a ring or donut cushion to relieve pressure.

A pressure relieving mattress can be used in bed. This should be ordered by an Occupational Therapist to ensure it is appropriate for the person we support.

Be aware that the use of pressure relieving equipment should be used in conjunction with other pressure area care as indicated in the person's Health Care Plan. Pressure relieving equipment does **NOT** replace other aspects of pressure area care.

Daily Skin Care

People thought to be at risk of developing pressure injuries should have a skin check at least twice a day. This can be incorporated into their daily personal care routine. Any redness, discolouration or bruising should be documented on the NDIS LWB 5553 Bruising and Skin Integrity Recording Chart and reported immediately.

Use a gentle soap or soap substitute to prevent the skin from becoming dry. Ensure the skin is dried thoroughly after washing. Check skin folds and creases for redness and breakdown. Apply a moisturising product to any dry skin. Topical agents such as fungal creams may be ordered and should be applied as prescribed.

If the person we support wears a continence pad ensure this is changed at frequent intervals and the skin washed and dried thoroughly. Barrier creams can be used as prescribed but these should not be relied upon. Good continence management is most effective.

Skin over bony areas such as elbows, sacrum and heels is often delicate. Apply cream gently and avoid massaging the area.

Diet and Lifestyle

A healthy and nutritious diet should always be encouraged, but especially in those at risk of pressure injury. Weight loss and malnutrition have been linked to the development of pressure ulcers. A Dietician should be consulted if there are concerns about the person's diet.

Encourage the person we support to participate in activities as appropriate. A Physiotherapist or Exercise Physiologist may be useful to assist the person to select appropriate activities.

Other medical conditions such as Diabetes should be taken into consideration and managed accordingly.

Risk of Choking and Aspiration

Always ensure the person we support is sitting in an upright position at mealtimes, or as advised by the Dietician if tube feeding. If they are confined to bed, raise the head of the bed or use pillows to support the person into a sitting position. This should be maintained for 30 minutes following the meal.

The head of the bed should not be left raised, unless indicated by a health professional, as this will cause the person to slip down the bed causing a friction and shear injury.

Aspiration occurs when a person inhales food or fluid and it enters the lungs. Symptoms and signs include, coughing, wheezing, shortness of breath, cyanosis (blue colour around the mouth and nose), unexplained temperature.

*****Aspiration can lead to pneumonia – seek medical advice immediately*****

Complex Wound Care

Pressure injury wound care is complex. Disability Support Workers are only able to provide wound care following training and whilst the overall responsibility for the wound care is under the supervision of a health professional, such as a Registered Nurse.

All pressure should be immediately removed from the area. If pressure is not able to be removed, for example the injury is on the sacrum, bed rest may need to be considered.

A detailed assessment and plan outlining the wound care should be provided by a Health Professional. The NDIS LWB 5552 Complex Wound Management Protocol template can be used to:

- assess and monitor the wound
- record information about dressings and when they are changed
- record details about staff who have been trained in the person's complex wound support

Medical advice should be obtained as soon as a pressure injury is identified or when an existing wound fails to respond to treatment.

Further Advice

For further advice, please contact the AQHP who developed the person's support protocol.