Justice Health & Forensic Mental Health Network
PO BOX 150 Matraville NSW 2036
Tel (02) 9700 3000
http://www.justicehealth.nsw.gov.au

Wound Assessment & Management Policy

Policy Number 1.215

Policy Function Continuum of Care

Issue Date 12 March 2018

Summary This policy provides direction on accurate assessment and management of adult and adolescent civil, correctional and forensic patients that have wounds of any description. Sound assessment and accurate documentation is paramount to providing holistic wound management practice and allows effective communication of current wound management progress, both internally to Justice Health & Forensic Mental Health Network and externally to other Local Health Districts.

Responsible Officer ED Clinical Operations

Applicable Sites

- ☐ Administration Centres
- ☐ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
- ☒ Health Centres (Adult Correctional Centres or Police Cells)
- ☒ Health Centres (Juvenile Justice Centres)
- ☒ Long Bay Hospital
- ☒ Forensic Hospital

Previous Issue(s) Policy 1.215 (Oct 2016)

Change Summary

- *Updates to assessments of pressure injuries*
- *Updates to Wound photograph*

TRIM Reference POLJH/1215

Authorised by Chief Executive, Justice Health & Forensic Mental Health Network

1. Preface

The purpose of this policy is to inform clinical staff involved in wound management practices of their roles and responsibilities in relation to holistic wound assessment and management through using the appropriate educational and clinical resources provided by Justice Health & Forensic Mental Health Network (JH&FMHN).

1.1 It is important that, before deciding upon a course of treatment and management for any patient with a wound, a full medical history and wound assessment is required. It is only through this process, that a determination of a wound's aetiology can be established.

1.2 The aetiology of the wound will assist clinicians to determine an effective wound management plan, with clear treatment objectives that will achieve best practice outcomes for a patient with a wound.

2. Policy Content

2.1. Mandatory Requirements

All clinicians providing wound management for patients within JH&FMHN must refer to this policy.

a. It is the expectation of JH&FMHN that initial skin assessment must occur within the following time frames for the following specialty areas:

- For Long Bay Hospital and Forensic Hospital within eight hours of admission;
- Reception centres for custodial health within 24 hours of reception into JH&FMHN health centres;
- Upon reception into an Adolescent health centre within 48 hours or initial presentation to the health centre or whichever is sooner, as the risk for this population is significantly reduced.

This is in accordance with NSW Ministry of Health (MoH) PD2014_007 *Pressure Injury Prevention and Management*.

b. In the custodial setting, the skin integrity assessment must be a part of the initial reception screening assessment tool, under the Current Injury/Trauma segment of the *Primary Health eReception Screening Assessment tool* (found on JHeHS), or in hard copy *Reception Screening Assessment form* if the electronic form is unavailable. (Refer to JHeHS or Form number JUS060.001)

c. After initial skin integrity assessment, all patients identified as having either a pressure injury or a skin tear, must be reported in Incident Information Management System (IIMS), regardless of whether it occurred internally or externally to JH&FMHN. Please refer to *Pressure Injury Assessment and Management Guideline* and *Skin Tear Assessment and Management Guideline* available in *Wound Management Resources* on the Intranet for more information.

2.2. Implementation- Roles & Responsibilities

2.2.1 Roles and Responsibilities of Managers

a. Ensure that all clinical staff are given the opportunity to attend wound management education, have the appropriate tools and resources available and work within JH&FMHN Policy 1.215 *Wound Assessment and Management Policy* and *Wound Care Guideline* recommendations.

2.2.2 Roles & Responsibilities of All Clinical Staff

a. All clinicians providing wound management for patients within JH&FMHN must refer to this policy. In the

case of uncertainty, clinicians should seek further advice on appropriate dressing options and techniques by referring to Wound and Stoma Care Specialist.

b. Ensure that sufficient clinical resources for wound management are available by consulting with Wound and Stoma Care Specialist to establish clinical resource requirements and escalating any shortage of resources to line manager as necessary.

c. All clinical staff involved in the management of a wound must complete the initial assessment of the wound, develop a wound management plan with appropriate treatment objectives, using the JUS060.050 *Wound Assessment and Management Plan (WAMP)* (explained in section 3.2 and 3.3 of the policy) and documented in the patient's progress notes and Patient Administration System (PAS).

d. After initial assessment using the JUS060.050 *WAMP*, *Wound Care Guidelines* and clinical judgment, the patient may need to be transferred to an external hospital for acute assessment

e. When an internal review is deemed more appropriate, clinical staff must attend to appropriate internal referrals, to the onsite GP or Remote Offsite After-hours Medical Services (ROAMS) or JH&FMHN wound care specialist. Refer by phone or via PAS according to level of urgency and nature of the referral.

f. Ongoing re-evaluation of the wound and documentation in the JUS060.050 *WAMP*.

g. Clinical staff should ensure that they are up to date with current wound care practices and processes within JH&FMHN.

2.2.3 Role and Responsibilities of Wound and Stoma Care Specialist

a. Provide wound care education and educational materials as directed by JH&FMHN.

b. Provide assistance with queries on wound care resources.

c. Assess and respond to appropriate referrals and queries according to clinical priority and level of urgency.

3. Procedure Content

3.1. Assessment of Pressure Injuries

a. JUS060.820 *Pressure Ulcer Assessment and Interventions Form* must be used:

- On initial assessment for patients in the Forensic Hospital (FH) or Long Bay Hospital (LBH)
- When there are changes to the patient's skin integrity
- Upon presentation to any JH&FMHN clinic for skin integrity related presentation
- In any situation which would raise the patients risk of obtaining a pressure injury

b. For patients admitted to the FH or LBH, assessment of skin integrity is ongoing and must occur daily for patients classified as low risk, or once per shift for those identified as moderate to very high risk using the JUS060.820 *Pressure Ulcer Assessment and Interventions Form*

c. Patients identified as not at risk should have:

- Weekly skin integrity assessments in the Medical Subacute Unite and the Aged Care Rehabilitation Unit.
- Annual skin integrity assessments in the Mental Health Unit and in the FH.
- If there are changes to the patient's condition that could increase the risk of obtaining a pressure injury, reassessment must occur using the JUS060.820 *Pressure Ulcer Assessment and Interventions Form* and

subsequent skin integrity assessments must occur according to the identified level of risk.

d. Skin integrity assessments must occur when a patient returns to any JH&FMHN site from hospital following an inpatient stay as this may alter their level of risk. This must be attended within 48 hours of returning to the health centre, or within eight hours if returning to the FH or LBH.

e. Any patient identified with alterations to skin integrity in custodial or adolescent centres must have JUS060.820 *Pressure Ulcer Assessment and Interventions Form* (Norton Scale) completed and the JUS060.050 *WAMP* completed if a wound is identified.

3.2. Assessment of Wounds

a. The JH&FMHN JUS060.050 *WAMP* must be used for wound assessment and identifying treatment objectives for consistency in management of all wounds.

b. Clear and concise documentation using a standardised tool allows:

- Formation of clear wound care treatment objectives;
- Objective and accurate analysis of wound progress against predetermined wound care treatment objectives;
- Best practice in wound care using accepted clinical standards of wound care practice; and
- Consistency of care and management by utilising a standardised tool for communication of current wound treatment and progress across sites within JH&FMHN and external to JH&FMHN for improved continuity of wound care.

c. If a patient has multiple wounds, there must be a JUS060.050 *WAMP* used for each wound, unless there are multiple small wounds within close proximity to each other, with the same characteristics requiring the same treatment objectives. Page 1 of the JUS060.050 *WAMP* is to be used when conducting an initial or review wound assessment.

Acute Wound Aetiology		**Chronic Wound Aetiology**	
Traumatic wounds can include:	*Surgical wounds can include:*	*Autoimmune/ dermatological wounds can include:*	*Chronic Wounds can include:*
Abrasion Crush injury Bite De-gloving Burn Skin Tear Pressure Injury Laceration Puncture	Suture Line Dehiscence Graft/Flap Donor site Debridement	Vasculitis Pyoderma Gangrenosum Calciphylaxis	Haematoma Fungating wound Pressure Injury Leg Ulcer Non-healing acute wound Foot Ulceration (diabetic) Sinus/tract Fistula

Page two of the JUS060.050 *WAMP* provides the relevant information to create a wound management plan, detailing wound care objectives (goals of treatment) that have been identified and implemented.

d. For complex wounds requiring referral or the use of a wound diagram, use the JUS060.051 *Wound*

Grid and Referral Summary. The strategies implemented must be evidence based, following the *General Wound Assessment and Management Guideline* for general wounds or *Infected Wound Assessment and Management Guideline* for infected wounds. For specialty wounds such as burns, skin tears and pressure injuries or wounds requiring negative pressure wound therapy (NPWT), the appropriate specialty wound care guideline should be referred to. All wound care guidelines are available on *Wound Management Resources*.

e. Dressings utilised to manage the wound and thereby meeting wound care treatment objectives (Goals of Treatment), should be selected from the JH&FMHN approved wound care dressing formulary, see JH&FMHN wound care and bandages tab within JH&FMHN *Clinical Consumables Catalogue*. Wound management dressings, pharmaceuticals and devices must be used in accordance with the manufacturer's instructions or research protocols.

f. The JUS060.050 *WAMP* is completed after initial assessment of the patient and the wound. The JUS060.050 *WAMP* must be kept within the patient's Health Record. The wound should be measured, preferably using a wound grid (available on JH&FMHN wound dressing formulary) and can be transcribed onto the JUS060.051 *Wound Grid and Referral Summary* provided.

g. A comprehensive medical history should also be collected, identifying comorbidities that may delay or impair the wound healing process. If wound aetiology has not been previously determined or easily recognisable, then referral to JH&FMHN Wound and Stoma Care Specialist service or GP should be attended via appropriate referral processes mentioned above in Section 2.2.2 (e).

h. Page 3 and 4 of the JUS060.050 *WAMP* will be used for reassessment and ongoing documentation if the treatment objectives have not changed.

i. Review of the treatment objectives should be attended regularly according to a combination of clinical judgment, JUS060.050 *WAMP* and *Wound Care Guidelines*. Wound care treatment objectives and dressings used for wound management, should only be changed if the wound has deteriorated or the wound treatment objectives have changed. This review assessment should be documented on a new JUS060.050 *WAMP* and identified as a review assessment on page 1.

j. Treatment will be developed in consultation with the patient. The patient should be educated and informed regarding all aspects of their wound care. Parents/guardians/carers of young people should also be consulted and informed of ongoing care as necessary. This helps provide continuity of wound care for the patient and gives the patient ownership over their own wound care. The patient's choice not to follow an agreed management plan should be documented in the patient's health record.

3.3. Wound Referral

a. In addition to the General Practitioner referrals, Wound and Stoma Care Nurse referrals are to be made when indicated i.e. if margins are increased, increased pain, or signs of wound infection or wound deterioration are noted. Referrals are to be made in PAS.

b. Appropriate specialist wound referral may also be required for specialty wounds such as burns. (See *Burns Assessment and Management Guideline*).

c. A separate *Wound Grid and Referral Form* must be utilized if wound requirements are more complex. A drawing of the wound is required if patients are referred to JH&FMHN Wound and Stoma Care Clinical Nurse Specialist 2, GP or Drug and Alcohol services in relation to their wound management. Please refer to JUS060.051 *Wound Grid and Referral Summary* available on *Wound Management Resources* for further information.

3.4. Wound Photography

Wound photography may also be used as a form of wound assessment and can be used when referring to internal and external referral agencies. Only approved digital cameras and approved digital software can be used. Technologies such as wound photography are under development in JH&FMHN and updates will be communicated via the Wound and Stoma Committee. Relevant policies on the use of this equipment will be communicated to staff when finalised. In the FH, a digital camera is kept in the After Hours Nurse Manager Office and in LBH a camera is kept in the Operations Managers office for this purpose. Staff must use a ruler to record the size of the wound during photography where possible. Colour printed copies of the wound can be attached for external referrals or electronic copies for internal referrals. Alternative camera access may be attained locally by health centres through use of a CSNSW digital camera, in this instance images are to be downloaded and emailed to the NUM of the Health Centre for forwarding to the Wound and Stoma Care Nurse.

3.5. Documentation

a. JUS060.050 *WAMP* for each wound

b. Any additional comments are to be documented in the patient's Health Record.

c. JUS060.050 *WAMP* should be contained within the patient's Health Record and transferred with them internally or externally to other Local Health Districts. This allows improved continuity and communication of wound care initiatives.

d. PAS entries must be made for all occasions of service.

e. IIMS notification must be attended when appropriate wounds are identified, such as pressure injuries and skin tears, including deliberate self-harm (See *Pressure Injury Assessment and Management Guideline* and *Skin Tear Assessment and Management Guideline* available on *Wound Management Resources*.

3.6. Auditing/ Compliance

NUMs or delegates should conduct a yearly audit of the use of the JUS060.050 *WAMP* by auditing ten random Health Records of patients that are identified as having regular occasions of wound care provision in PAS extending beyond a two week period. The audit will be conducted using the *Wound Assessment and Management Plan Auditing Tool*. The process of auditing should include compliance with utilisation of the JUS060.050 *WAMP* and should be attended annually and increased to quarterly if compliance is less than 80%. The audit is to be attended and saved by the NUM or approved delegate as a PDF document titled as "JH&FMHN WAMP compliance by site and cluster" in HPRM container G475/15 - Wound and Stoma Care Reporting. Compliance below 80% should be actioned locally, with an action plan in consultation with the Wound and Stoma Care nurse.

4. Definitions

Acute Wound

Refers to traumatic or iatrogenic (surgically created) wounds that heal through the standardised process of haemostasis, inflammation, maturation and remodeling.

See Acute wounds table in Section 3.2.c

Chronic Wound

A chronic wound is any wound that fails to follow the above standardised process of healing. This delayed healing process is usually as a result of intrinsic and/or extrinsic factors as well as local factors such as infection.

Must

Indicates a mandatory action required that must be complied with.

Palliative Wound

A palliative wound does not have the potential to heal, for example fungating/cancerous wounds. In this instance the goal of wound management is not to heal but simply to manage the characteristics of the wound aimed solely at improving the patient's quality of life.

Should

Indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.

Wound Management

Refers to assessment, treatment and care provided to meet wound treatment objectives and a plan for re-evaluation.

5. Legislation and Related Documents

JH&FMHN Policies and Procedures	*Wound Management Resources, including:* *Burn Assessment and Management Guidelines* *General Wound Assessment and Management Guideline Infected Wound Assessment and Management Guideline Medicated Dressing Flowchart* *Negative Pressure Wound Therapy Guideline* *Pressure Injury Assessment and Management Guidelines* *Skin Tear Assessment and Management Guideline*
JH&FMHN Forms	*Wound Management Resources, including:* JUS060.050 *Wound Assessment & Management Plan* JUS060.051 *Wound Grid & Referral Summary* JUS060.820 *Pressure Ulcer Assessment and Interventions Form*
External Publications	Carville, K. 2012, *Wound Care Manual* 6th edition, Silver Chain Foundation, Perth The Australian Wound Management Association Inc. March 2010, *Standards for Wound Management*. 2nd edition NSW Agency for Clinical Innovation *Clinical practice guidelines: Burn patient management*, August 2011

Carville, K. 2010 *Star Skin Tear Classification Tool.*

AWMA/Pan Pacific clinical practice guideline for the prevention and management of Pressure Injury, 2012.

Clinical Excellence Commission website for educational resources 2016.

http://www.cec.health.nsw.gov.au/programs/pressure-injury-prevention - project