CSV-CORONERS COURT-CPU RESPONSES (CSV)

From: Jinson Thomas <jinson@adaresrs.com.au>
Sent: Wednesday, 29 April 2020 12:20 AM
To: Csv-coroners court-cpu responses (CSV)
Subject: Adare SRS- Skin Care management update
Attachments: Skin integrity assessment form Adare srs.pdf; Staff Development Adare srs.pdf

Dear Sir/Madam

This email is to update you on the current skin care management in Adare SRS to reduce pressure area wounds and complications with our residents. We took the recommendation from Coroner Jacqui Hawkins's report on the 30th January 2020 to ensure that our quality of care is given appropriately. We would like to ascertain the fact that the incident related to the coroner's report has happened prior to our ownership of Adare SRS. We (Proficient health care) took over Adare SRS on 22/12/2017.

We have ongoing education training to ensure that our staff have the most updated knowledge on the:

- different stages of pressure wound

- strategies to prevent pressure injury

- signs of pressure injury

- documentation of pressure injury

- importance of repositioning

- Adare's guideline on pressure care.

The training document is attached to this email.

We have ongoing training with the physiotherapist from United to educate our staff on the different equipment to use (air mattress, repositioning, rodo cushion). The Priceline Boxhill pharmacy also conducts training on a regular basis in relation to barrier cream and differences with dressing material that benefit with pressure wound prevention.

We have implemented a new skin assessment to be done daily on residents. This is done by PCA on each shift, to check the skin condition of the resident. Attached is the new assessment that we have implemented.

We have two different GPs that attend the Doctor rounds on a weekly basis (every Thursday and Friday). GPs will review the resident's wound and refer it to the appropriate allied health if needed. Nurses are also working closely with Bolton Clarke for wounds that require extra attention. The nursing team is also aware of contacting Hospequip to hire equipment (e.g. air mattress) for residents if necessary. There is regular training for staff from Hospequip on the set up of air pump and air mattress.

There is also a folder located in the treatment room with educational resources for wound care which acts as a reference for nurses and carers.

Ongoing assessment from our clinical team helps in the early identification of pressure areas and appropriate referrals are made. However, the resident will be transferred to a different setting if their care demands are complex and cannot be met. This will be done in consultation with family, GP and other health professionals involved.

Please advise us if there is any more we can do.

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Kind Regards

Jinson Thomas
Propritor
Adare SRS

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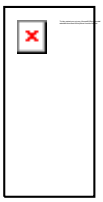


SKIN INTEGRITY ASSESSMENT FORM

YEAR : 2020 MONTH : April

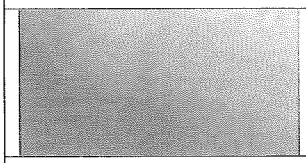
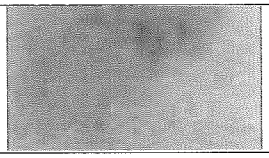
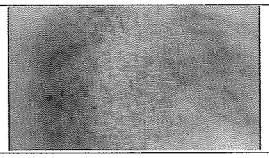
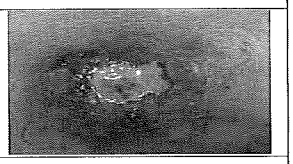
GIVEN NAME:

SURNAME:

DOB:

ROOM NO:

SKIN INTEGRITY IDENTIFICATION CHART

1	2	3	4
			
SKIN INTACT	REDNESS	BRUISE	WOUND

Date	Identification	Location	Date	Identification	Location
1			16		
2			17		
3			18		
4			19		
5			20		
6			21		
7			22		
8			23		
9			24		
10			25		
11			26		
12			27		
13			28		
14			29		
15			30		
			31		

EDUCATION AND STAFF DEVELOPMENT ATTENDANCE RECORD

Topic/subject:: Preventing Pressure Injury
Date: 27/03/2020
Time: 1315
Location: Adare
Facilitator Name: Crystal Mak
Organisation: Adare

By signing this record you are indicating that you attended & participated in the above training session.

Name (PLS PRINT)	Signature	Position
Victor Ngai		PCA
Mary		PCA
Crystal Mak		PCA
Ruo Zhou		RN
Yan Zhang		RN
Yunle Zhao		RN
Margret Kaeu		PCA
Nick Cheng		PCA

Total number of participants: 10

ADARE SRS
1405 High St Road
Wantirna Sth 3152

File in Education and Staff Development Folder

Authorised by: Crystal Mak Position: Operational Manager Date: 27/03/2020

Preventing Pressure Injuries

Background

There is increased risk of with patients with a pressure injury and significant health care costs to both patients and health care services. Pressure injuries are associated with:

- increased morbidity and mortality
- pain
- reduced mobility and loss of independence Immobility associated with hospital admissions increases the risk of pressure injuries.

Older people in particular are at high risk due to decreased mobility, and other associated risk factors. In most cases, pressure injuries are preventable.
ACSQHC, 2012; Australian Wound Management Association (AWMA), 2012.

Principles of pressure injury prevention

The Pan Pacific Clinical Practice Guideline for Prevention and Management of Pressure Injury (AWMA, 2012) outlines the following key messages in pressure injury prevention:
- most pressure injuries can be prevented
- they can occur in any patient, whether that patient has only some or all risk factors
- best practice in pressure injury prevention includes:
    - o vigilant screening
    - o comprehensive assessment
    - o implementing pressure injury prevention strategies
    - o evaluating effectiveness of pressure injury prevention strategies

Risk screening and assessment

A risk screening and assessment can be used to identify patients who are at risk of developing a pressure injury and require implementation of pressure injury prevention strategies.
It is important to note that some documents refer to risk assessment and others to risk screening which can be confusing. However, the intent of the risk screening and assessment process is to identify risk factors and highlight the need for comprehensive and ongoing skin assessment.

To minimise confusion, this document will refer to:
- risk screening and assessment as the process for identification of risk factors using a validated tool
- skin assessment as the process of conducting a head to toe examination of the skin

There a number of validated tools available that assess a patient's risk of developing a pressure injury. These include the Braden, Waterlow and Norton scales for adults and the Glamorgan, Braden Q and StarKid scales for paediatric patients.
Organisational policy will determine the tools used and frequency of screening in each health care service. It is important that you make yourself familiar with the specific tools you will be using. Risk screening and assessment should occur on presentation, as soon as possible after admission (within 8 hours) and should also be repeated whenever there is a change in condition.
AWMA, 2012; ACSQHC, 2012

- increase the risk of skin breakdown
- result in poor healing

Malnutrition is common and poorly recognised, occurring in 25 – 30% of hospitalised older patients.

Many older people are already at risk of undernutrition on admission to hospital due to ageing and lifestyle. The impact of illness and hospitalisation may further compromise their nutritional status. Hospitalisation can lead to an inability to access and consume food due to:
- inadequate supply of appetising food
- inadequate staffing for meal set up and assistance
- interruptions to mealtimes
- lethargy and effects of illness

Improving Care of the Older Person, 2007

Pressure injury prevention strategies

The Pan Pacific Clinical Practice Guideline for Prevention and Management of Pressure Injury (2012) outline evidence based pressure injury prevention strategies which should be included in the development of a pressure injury prevention plan.
AWMA, 2012; ACSQHC, 2012 SKIN PROTECTION

SKIN PROTECTION
Skin protection is fundamental to the prevention of pressure injury by protecting your patient's skin from exposure to moisture, friction and shear.

This can be achieved in a number of ways including:
- encouraging and assisting patients with regular repositioning
- utilising pressure relieving support surfaces on beds, trolleys, operating tables and seat cushions
- promoting independent patient movement using assistance devices such as overhead bars
- implementing a continence management plan
- ensuring patient's skin is thoroughly dried
- using pH balanced and water based skin emollients daily or twice daily to clean and moisturise skin
- avoid trauma to skin from devices such as wheel chair footplates, wheelie frames, bed rails and lifting machine parts

Tapes and adhesives should be avoided on fragile skin but if required:
- use tapes and dressings with a gentle adhesive that won't cause trauma on removal (e.g. soft silicone dressings)
- consider using light tubular bandages to keep dressings in place
- apply the tape or dressing using gentle pressure to ensure it is firmly in place
- use caution and consider the use of adhesive removal wipes when removing dressings or tapes from fragile skin

PATIENT POSITIONING
Patients who are unable to recognise pain from pressure or who are unable to reposition themselves

adequate pressure redistribution and should not be used on top of existing pressure relieving devices.

Support cushions should be used for patients when seated in a chair or wheelchair. Devices used to prevent pressure injuries on heels need to be fitted correctly. If not fitted correctly, these devices will not only cease to provide pressure relief but can also cause harm.
AWMA, 2012

Documentation and monitoring

Skin assessment should be documented as soon as possible after admission, daily and whenever there is a change in condition. It is important to note that darker skin tones may be more difficult to visually assess.

The results of risk screening and assessment and the individual pressure injury prevention strategies are to be used to inform the development of a pressure injury prevention plan. This should be developed in consultation with the patient and their family or carer to ensure correct information, education and collaboration in developing and implementing prevention strategies

Pressure injury risk and prevention strategies should be communicated during clinical handover and on transfer or discharge. This ensures that all clinicians, the patient and their families can manage pressure injury risk. All clinicians should monitor and evaluate the effectiveness of pressure injury prevention strategies and document in the clinical record.
ACSQHC, 2012

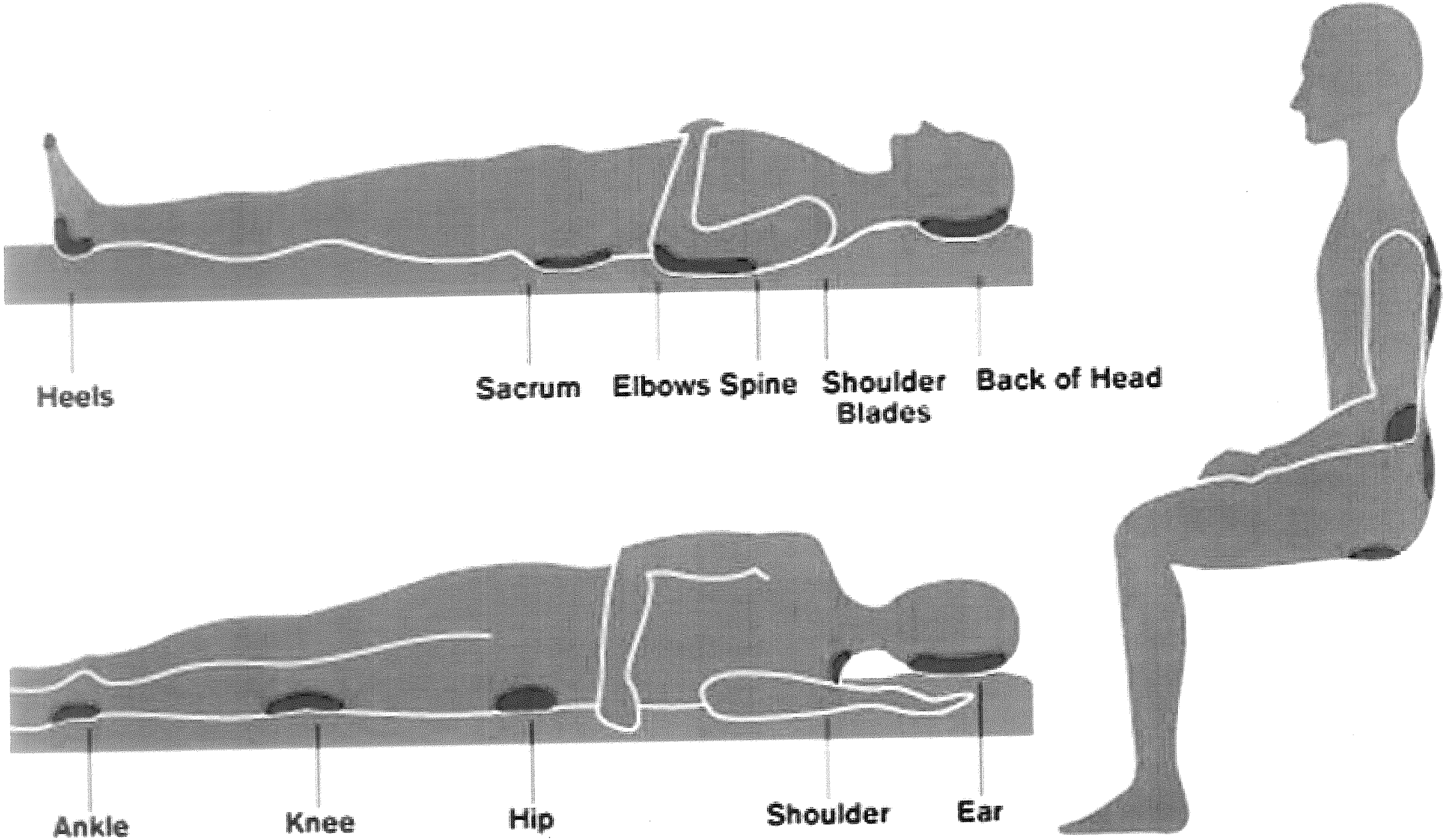
Engaging with patients and carers

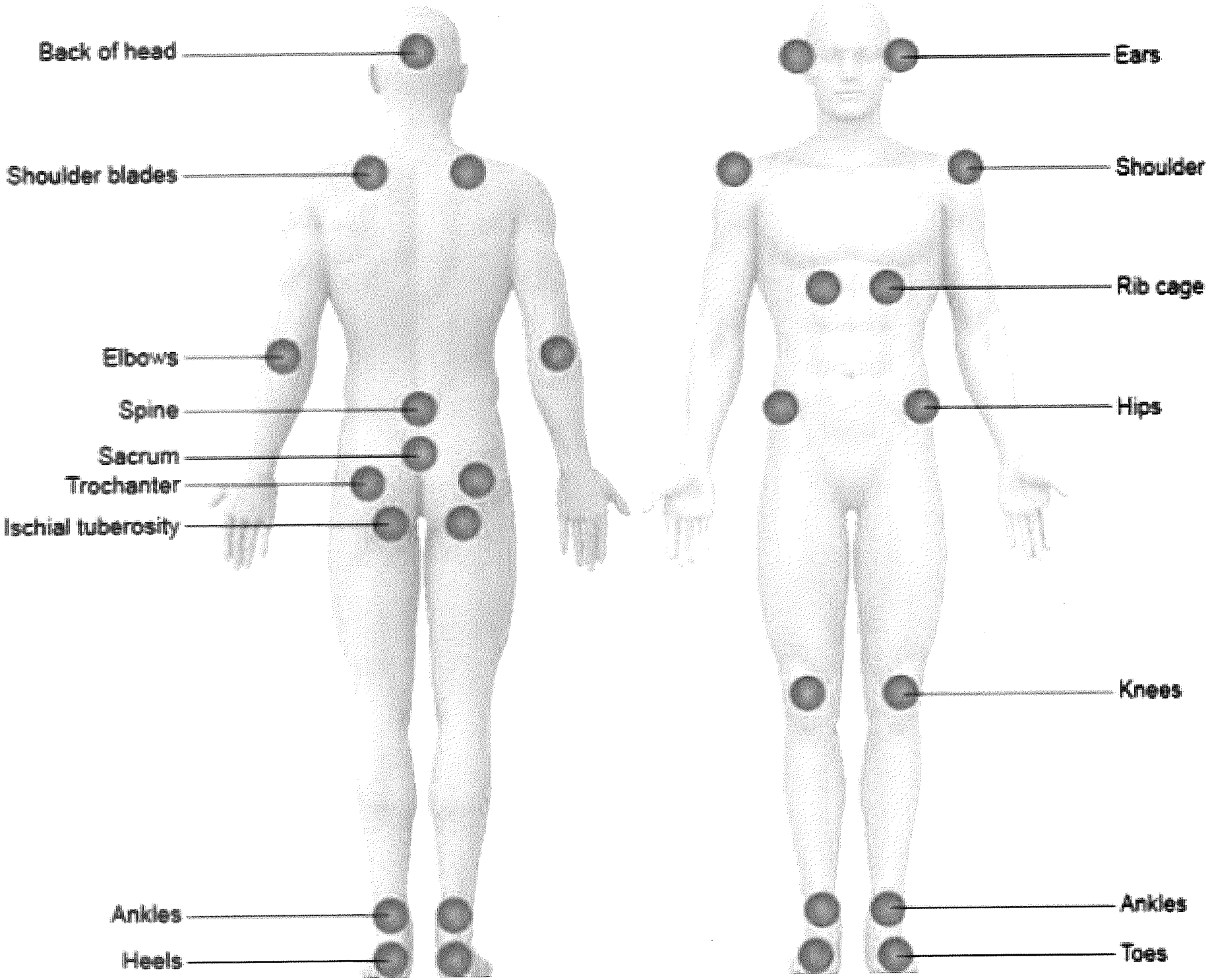
Education should be provided to patients and carers about pressure injury risks and prevention strategies. They should be engaged in the development of a pressure injury prevention plan.

This collaboration enables an opportunity for patients, carers and clinicians to share information which may impact on the effectiveness of the pressure injury prevention plan.

Health care professionals should consider the following in order to encourage patients to participate in pressure injury prevention:
- provide relevant, easy to understand information to allow patients and carers to take part in discussions and decisions about preventing pressure injuries
- offer information in languages other than English, where appropriate, and do not assume literacy
- ask the patient, family members or carers to assist with pressure injury prevention strategies
- utilise pressure injury prevention posters in ward areas commonly used by patients and family members
- ensure pressure injury prevention strategies are included as part of patient discharge information

ACSQHC, 2012


Heels
Sacrum
Elbows
Spine
Shoulder Blades
Back of Head
Ankle
Knee
Hip
Shoulder
Ear

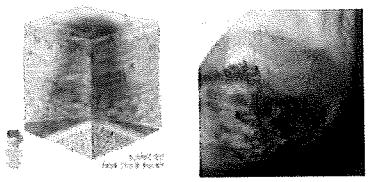
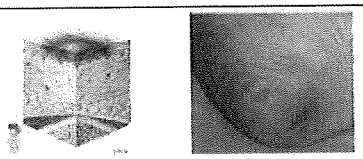
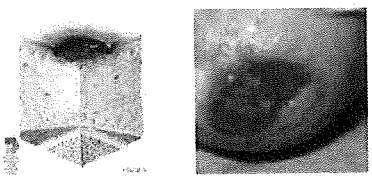
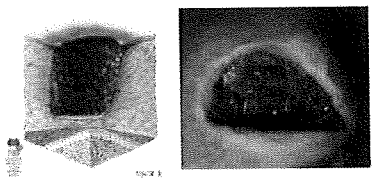
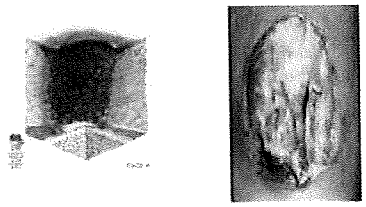
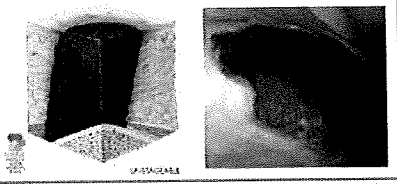

Back of head
Shoulder blades
Elbows
Spine
Sacrum
Trochanter
Ischial tuberosity
Ankles
Heels
Ears
Shoulder
Rib cage
Hips
Knees
Ankles
Toes

Adare SRS

Skin Integrity

Pressure Injury Assessment & Management Guidelines

- Assess the person's nutritional state by completing the nutritional risk assessment tool & hydration risk tool. Refer to dietician if required. Ensure high protein diet. Consider arginine supplements if pressure injury stage II or greater as per GP/Expert advice
- Undertake a holistic assessment of the person and their wound including clinical history, mobility, continence & cognition
- Undertake a risk assessment using the Norton scale & document result along with strategies to manage risks
- Assess the persons skin integrity
- Assess intrinsic & extrinsic factors which may impair healing
- Assess wound-relate pain using a validated pain scale (VAS & Abbey)

DEFINITION	PRESSURE ULCER STAGE	MANAGEMENT
SUSPECTED DEEP TISSUE INJURY (SDTI) Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue		***Aim to relieve all pressure off the area*** • Closely monitor the skin and protect the area with an absorbent dressing whilst still intact. • Is the skin breaks, refer to a wound consultant to complete a comprehensive lower limb assessment and provide recommendations for care • Check at least once each shift
STAGE I Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.		***Aim to relieve all pressure off the area*** • Closely monitor the skin and moisturize at least daily with Cavilon durable barrier cream • Do not cover with a dressing • Keep skin clean and dry • Check capillary refill
STAGE II Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.		***Aim to relieve all pressure off the area*** • Ensure a moist healing environment • Apply Mepilex Border and change when dressing is 75% saturated • Check dressing each day
STAGE III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling		***Aim to relieve all pressure off the area*** If wound base is sloughy & moderate to heavily exuding: • Apply Aquacel as primary dressing and Mepilex Border as secondary dressing If wound is infected and heavily exuding: • Apply Aquacel Ag or Mesalt as primary dressing and Zetuvit Plus as secondary • Apply Cavilon cream to periwound skin when using Zetuvit dressing *If frequent dressing changes are required, use Zetuvit Plus instead of Mepilex Border.*
STAGE IV Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling.		***Aim to relieve all pressure off the area*** If wound base is sloughy & moderate to heavily exuding: • Apply Aquacel as primary dressing and Mepilex Border as secondary dressing • Flaminal gel may also be considered If wound is infected and heavily exuding: • Apply Aquacel Ag or Mesalt as primary dressing and Zetuvit Plus as secondary • Apply Cavilon cream to periwound skin when using Zetuvit dressing *If frequent dressing changes are required, use Zetuvit Plus instead of Mepilex Border.*
UNSTAGEABLE Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.		***Aim to relieve all pressure off the area*** Depending on result of a comprehensive assessment of the person, the lower limb and their wound will depend on management plan. If in doubt, apply a Betadine paint and dry dressing until further review by a wound consultant. *Systemic antibiotic therapy may need to be considered in stage III, IV, SDTI & unstageable pressure injuries*

Ensure residents with a pressure injury are on a reactive (constant low pressure) or active (alternating pressure) support surface. Ensure regular repositioning of the resident.

O3C Version 2.0

Reference: Australian Wound Management Association. Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury. Cambridge Media Osborne Park, WA: 2012. EPUAP/NPUAP 2009.