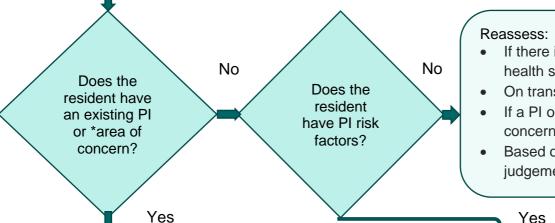
## Pressure Injury Prevention & Management for Multi-Purpose Service Long Stay Facility Residents and NSW Health Residential Aged Care Facility Residents

## Resident presents to facility

Within 8 hours of presentation complete the admission screening/assessment process to guide clinical decision making. If pressure injury (PI) risk factors are identified attend a skin assessment



- If there is a change to health status or mobility
- On transition of care
- If a PI or \*area of concern develops
- Based on clinical judgement

Reassess as per BOX A

For residents with PI or an \*area of concern, skin and pain assessment should occur during each shift as a minimum and documented

## **BOX A** – Reassess:

Daily skin assessment and review care plan/prevention strategies monthly and:

- If there is a change to health status or mobility
- When clinical change impacts on the needs, goals or preferences of the consumer
- On transition of care
- If a pressure injury or \*area of concern develops
- Based on clinical judgement
- Develop the care plan in consultation with the resident and/or carer considering the goal of care and preferences
- Provide education for resident and/or carer on management/prevention strategies
- Implement prevention strategies appropriate to the risk factors within two hours of identification
- Make referrals as appropriate (e.g. Wound Care clinician, Occupational Therapist, Physiotherapist, Dietitian etc.)
- Document the PI in the health care record, including wound chart
- Report the PI in IMS+ if it occurred during the current episode of care or significantly deteriorated
- Communicate PI risk factors, PI present and management at handover and transition of care

<sup>\*</sup>Area of concern examples are blanching erythema or an area of incontinence associated dermatitis that requires increased monitoring



