H&H Care SA Pty Ltd	Form22. Wounds and Pressure Injuries Australian Government Support at Home Program	
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Policy and procedure 22
H&H Care SA Pty Ltd | Support at Home services

This policy sets out how H&H Care SA prevents skin breakdown, recognises wounds and pressure injuries and provides authorised wound care. It covers assessment, prevention, safe dressings, monitoring, escalation and coordinated review in home and community care.

Document control	Details
Policy number	HH SAH WOUND 022
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Prepared	24 October 2026
Policy owner	Director and Clinical Lead RN
Approved by	Director: Huy Le RN: Thi Ngoc Bich Tran
Effective date	24 October 2026
Next review	12 months after approval, or earlier following relevant change
Applies to	Nurses, coordinators, workers and approved contractors providing skin observation, pressure prevention or authorised wound services

1 Purpose and scope

Protect skin integrity and reduce avoidable injury while respecting comfort, choice, privacy and independence. Wound care must address the cause and the whole person, not only a dressing. Timely clinical assessment is needed for new or deteriorating wounds; a photograph or checklist alone is not a diagnosis.

This policy applies to Support at Home delivery on behalf of The Fig Trees and other approved registered providers. Routine workers may observe and report skin concerns and assist with assessed prevention. Wound assessment, classification and treatment require competent authorised practitioners. Complex dressings, compression, debridement, negative pressure therapy and other specialised care need separate approval, procedures and demonstrated competence before service.

2 Responsibilities

The Director and Clinical Lead RN approve scope, staffing, equipment and clinical arrangements under Policy 21. The RN undertakes or coordinates assessment, current plans, referrals, delegation and review within competence. EN care requires appropriate RN supervision and individual competence. Support workers follow approved prevention tasks and report changes without diagnosing, staging or independently changing treatment.

The Coordinator confirms supplies, visits, safe transfers, clinical cover and follow-up with the registered provider. Agree who funds and supplies products, arranges specialist review and manages between-visit care. A referral or NDIS registration does not independently authorise a specialised wound procedure. The registered provider retains its statutory responsibilities; H&H Care remains accountable for its own actions and workforce.

Assessment and individual wound planning

3 Assess the person wound and cause

Obtain consent and protect privacy, using an interpreter or supported decision-making as needed. A competent RN or relevant practitioner assesses the wound, history and likely cause and refers where diagnosis or management exceeds scope. Record baseline condition, goals, pain, allergies, medicines affecting healing/bleeding, mobility, pressure, nutrition/hydration, continence, perfusion, diabetes and other relevant health factors.

For each wound, assign a unique identifier and record site/laterality, onset/source, dimensions and method, wound bed, edges, surrounding skin, exudate, odour after cleansing where assessed, pain and infection concerns. Measure consistently using an approved method; do not probe or disturb tissue outside competence. Include undermining, depth or structures only when appropriately assessed. Note what was not assessed and why.

Use validated risk or wound tools where indicated and within competence, with clinical judgement and actual skin findings. Differentiate pressure injury, moisture-associated damage, skin tear, vascular or diabetic wound, trauma and other causes with qualified assessment; they require different management. Do not assume all buttock redness is a pressure injury or every leg wound is venous.

4 Classification and photography

Pressure injury staging/classification must be performed by a competent clinician using the current accepted system. Do not guess a stage from an image or obscure tissue, and do not reverse-stage a healing injury as though its original depth never occurred. Record the original classification and healing progress appropriately. Seek specialist advice for deep, obscured, atypical or uncertain wounds.

Clinical images require a defined care purpose, specific consent or another lawful basis, approved equipment and secure storage under Policy 3. Use consistent technique with appropriate scale and client/site/date linkage; avoid unnecessary identifying features. Do not use personal devices/accounts or public AI image tools. Images supplement, not replace, assessment and notes.

5 Written care plan and review

Document goals such as healing, comfort, symptom control or prevention of deterioration, recognising that some wounds may not heal. State cleansing and dressing method/products, frequency, aseptic technique, pain arrangements, pressure relief, monitoring, referral and escalation. Link valid orders where required. Confirm the plan author, approval, date/version and review interval.

Do not make a generic product list into an individual treatment order. Resolve missing or conflicting instructions before the affected procedure, seeking safe interim clinical advice rather than simply leaving necessary care undone. Obtain provider service authorisation separately; funding approval does not establish clinical authority.

Pressure injury prevention and skin protection

6 Identify risk and observe skin

Assess risk before affected care and review after deterioration, immobility, hospital discharge, falls, pain, reduced intake, continence changes, new equipment or existing skin damage. Relevant risks include reduced movement or sensation, frailty, poor perfusion, moisture, nutrition concerns, previous injury and pressure from devices. A low tool score does not override actual skin changes or clinical concern.

With consent, check areas relevant to the risk and care task, including heels, sacrum, hips, elbows and device contact sites as indicated. Look and feel within competence for persistent colour change, pain, warmth/coolness, swelling or altered firmness. Redness may be less visible in darker skin tones; do not rely on colour alone. Workers report observations promptly rather than independently staging.

7 Individual prevention plan

- Support movement and participation within the mobility plan. Use a clinician-set repositioning schedule based on risk, skin response, support surface, comfort and goals; do not impose one universal two-hourly rule or assume a mattress removes the need for movement.
- Use safe transfer and repositioning techniques and prescribed aids to reduce pressure, friction and shear. Do not drag the person or perform an unsafe lift. Required staff and equipment must be available.
- Use appropriate assessed mattresses, cushions, heel offloading or other supports and follow fitting, maintenance and device instructions. Avoid improvised ring/doughnut cushions or devices that concentrate pressure.
- Keep skin clean and appropriately dry, manage moisture and continence promptly and apply agreed skin protection under the plan. Do not massage areas with persistent redness or suspected pressure damage.
- Support the individual nutrition/hydration plan and refer concerns for professional assessment. Do not prescribe supplements or override a fluid restriction independently.
- Check medical devices, tubing, footwear and seating for pressure and friction. Adjust only within approved instructions; escalate concerns rather than compromising an essential clinical device.

8 Between visits and refusal

Specify who assists with pressure relief, skin checks, continence and equipment between visits and overnight. Verify availability and competence rather than assuming family support. If the authorised roster cannot meet assessed prevention needs, notify the provider promptly, document the gap and arrange safe interim care and review.

Respect refusal and discuss pain, distress, fatigue or preferred positions; offer alternatives and seek clinical advice. Record the client's wishes, information, controls and follow-up. A signed risk form does not waive duties or authorise force. A palliative plan may prioritise comfort with agreed clinical review, not automatic neglect of skin or distress.

Safe wound care and specialised treatment limits

9 Dressing procedure for approved services

- Read the current individual plan and verify the client, wound site, consent, allergies, pain needs and any change in condition. Confirm task competence and required supervision.
- Prepare a suitable private work area, adequate light, correct supplies and waste/sharps arrangements. Perform hand hygiene and use assessed PPE and the planned aseptic technique under Policy 13.
- Remove the existing dressing gently using the approved method. Record relevant findings and account for removed packing or other components according to the procedure. Stop for unexpected pain, bleeding or uncertainty and obtain help.
- Assess and cleanse only within role and the current plan. Protect key parts/sites and do not touch or contaminate them. If asepsis is compromised, correct it before continuing.
- Apply the specified treatment/dressing as directed, avoiding excessive tension, pressure and fragile-skin trauma. Do not substitute products or improvise packing without qualified direction.
- Ensure comfort and required positioning/offloading, dispose of waste, clean equipment and perform hand hygiene. Give the client agreed advice on protection, leakage and when to seek help.
- Record actual assessment findings, products, care, response, contacts and next visit/review. Communicate relevant changes directly and verify handover.

10 Specific boundaries

Do not independently initiate compression without appropriate vascular/perfusion assessment and a qualified treatment plan. Severe arterial compromise or other conditions may make compression unsafe. Apply only within assessed competence and current instructions; urgent pain, colour or circulation changes require prompt clinical review.

Do not remove necrotic tissue, perform sharp debridement, probe wounds, cut adherent skin flaps or disturb stable eschar without an appropriately qualified assessment and authorised procedure. Tissue removal may be harmful, particularly where perfusion is poor. Skin tears require a taught, assessed method that preserves fragile tissue and minimises adhesive injury.

Negative pressure therapy, drains, complex packing, surgical wounds, diabetic foot disease and other specialised wounds need specific service approval, equipment, emergency instructions and trained staff. Do not disconnect, alter settings or treat an alarm by guesswork. Obtain the responsible specialist's advice and follow the device plan. Skin antiseptics, topical antimicrobials and antibiotics are not automatic treatment for every wound; use current clinical directions and medicine controls.

If products, staff or instructions are unavailable, seek prompt RN/specialist advice for a safe interim arrangement, notify the provider and track resolution. Do not conceal missed care or use an unsuitable household product as a substitute.

Deterioration escalation and review

11 Recognise concerning wound changes

Report new or increasing pain, redness/warmth or colour change, swelling, exudate, odour, wound enlargement, breakdown, bleeding or delayed progress. Consider systemic illness, feverishness, chills, new confusion, reduced intake or function. No single sign proves infection, and absence of fever does not rule out serious infection. The clinician assesses need for examination, testing and treatment; workers must not diagnose or start antibiotics.

Situation	Response
Emergency	Call 000 for uncontrolled major bleeding, collapse, abnormal breathing, severe systemic deterioration or other emergency signs. Follow first aid and Policy 12; notify management after emergency help starts.
Rapidly worsening wound or possible serious infection	Obtain urgent clinical assessment, including rapidly spreading changes, severe disproportionate pain, deep involvement or an acutely unwell person. If emergency signs or timely safe assessment is unavailable, call 000.
New diabetic foot wound or possible poor circulation	Seek urgent qualified review, especially with pain, discolouration, coldness or infection concerns. Do not continue routine pressure or initiate compression while awaiting clarification.
New pressure-related skin change or worsening existing injury	Relieve pressure safely under the plan and notify the RN promptly for assessment and revised controls; do not wait for open skin or the next scheduled audit.
Unexpected bleeding packing/device issue or dressing failure	Pause the affected procedure, protect the site within training and obtain prompt RN/specialist advice; escalate immediately if serious. Do not replace uncertain packing or alter a device by guesswork.

12 Clinical review and follow up

The treating clinician sets wound reassessment intervals, dressing frequency, observation parameters and healing/symptom targets appropriate to the cause and goals. Document progress with consistent measurements and client feedback, and refer deterioration, no expected progress or uncertain cause promptly. Do not impose a universal weekly dressing or review schedule regardless of need.

Notify the Coordinator and The Fig Trees of material changes, increased care needs and equipment or authorisation gaps. Track specialist referrals until accepted and action confirmed. Update the plan, supply and roster and brief workers before the next affected visit. Assess incidents and SIRS under Policy 9 where care failures or qualifying circumstances exist; a pressure injury is not automatically reportable under every scheme. Use open disclosure where care has gone wrong.

A wound that was present at commencement still requires monitoring and prevention of further harm. Record its baseline and source; do not use present-on-admission status as a reason to ignore progression or classify responsibility without evidence.

Individual wound and pressure prevention plan

WOUND F01 | Complete with the client and competent clinician. One wound ID per site; attach current procedure and specialist directions. This template is not a prescription.

Client identifiers: _____
Assessor role and date: _____
Wound ID site/laterality and onset/source: _____
Assessment/classification by qualified clinician: _____
Relevant conditions medicines allergies and goals: _____
Consent communication and image consent reference: _____
Current wound assessment/clinical directions reference: _____

Care requirement	Individual directions and responsible role
Cleansing dressing products and method	_____ _____
Frequency and next visit	_____
Pain consent and monitoring	_____ _____
Positioning movement and pressure relief	_____ _____
Mattress cushion offloading and device checks	_____ _____
Skin moisture continence and nutrition support	_____ _____
Between-visit/overnight support and gaps	_____ _____
Escalation signs contacts and emergency plan	_____ _____

Required competencies/staff/supervision: _____
Equipment supplies responsibility and provider approval: _____
Specialist referral and action owner: _____
Client agreement refusal or alternatives: _____
Clinical approval/date: _____
Workers briefed and current version location: _____
Review date targets and earlier triggers: _____

Wound treatment and prevention records

Wound assessment and treatment record

WOUND F02 | Client/wound ID: _____ Date/time: _____
Author role/competence and current plan: _____
Consent pain and client report: _____
Dimensions/units/method where assessed: _____
Wound bed edges/periwound observations: _____
_____
Exudate odour and relevant infection concerns: _____
_____
Cleansing treatment dressing and components used/removed: _____
_____
Photo reference and consent where appropriate: _____
Client response and actual monitoring: _____
Deviation/concern contacts advice and action/time: _____
_____
Next care/review owner and date: _____
Author authentication/entry time: _____

Pressure prevention and skin check record

WOUND F03 | Client: _____ Plan/version: _____
Clinician-set schedule and equipment reference: _____

Actual date/time and author	Position/activity/skin care delivered	Skin response refusal or escalation
_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____

Record actual care, not pre-filled future turns. Describe relevant skin findings factually; stage/classify only where qualified. Equipment in use does not prove prevention was adequate.

Missed care reason and safe alternative: _____
RN/provider notified and follow-up accepted by: _____
Effectiveness/client comfort and plan changes: _____

Implementation assurance and references

13 Clinical readiness and quality monitoring

Before offering wound services, approve the exact scope and procedures, appoint clinical cover, verify worker authority and practical competency and confirm current plans, equipment and specialist access. Do not assign assessment or treatment beyond professional limits. Verify client consent for observation during competency assessment.

As internal controls, the Coordinator checks urgent wound/skin alerts and unresolved essential care gaps each service day, escalating sooner when needed. The RN and management review wound progress, new/worsening pressure injuries, infection concerns, pain, missed care, equipment and client feedback monthly. Audit a risk-based sample of plans, records and practical technique quarterly and reassess competence annually or earlier on change/concern. Clinical reassessment follows the individual need, not the audit calendar.

Use findings to improve resources, prevention, referrals and documentation. Assign actions, owners and dates and verify effects, including comfort and participation. Do not claim every pressure injury was avoidable or unavoidable without appropriate review. Preserve records and communicate openly with the client and provider.

14 Records and related policies

Maintain assessment, classification source, images/consent, treatment and prevention plans, product directions, competence, monitoring, referrals, incident reviews and outcomes in controlled records under Policy 8. Share images and clinical information securely on a lawful basis. Apply current clinical versions without overwriting historical findings.

Related documents: Policies 1 to 21, especially assessment, care planning, deterioration, IPC, mobility, personal care/continence, medicines and clinical governance; task-specific wound, compression, device and pressure management procedures.

15 References

- Aged Care Act 2024 and Aged Care Rules 2025; applicable strengthened Quality Standards and professional standards; relevant South Australian consent, medicines, privacy and WHS requirements; The Fig Trees agreement and variations.
- Australian Commission on Safety and Quality in Health Care — Preventing pressure injuries and wound management resources, adapted to home care. https://www.safetyandquality.gov.au/resources/nsqhs-standards-preventing-pressure-injuries-and-wound-management
- SA Health — Pressure injury prevention and management. https://www.sahealth.sa.gov.au/ Search the current resource title and use relevant clinical guidance within scope.
- SA Health — Acute Minor Wound Management Clinical Practice Guideline, current resource and relevant scope. https://www.sahealth.sa.gov.au/
- Aged Care Quality and Safety Commission — Clinical care and current safety of clinical care guidance. https://www.agedcarequality.gov.au/strengthened-quality-standards/clinical-care
- Australian Commission on Safety and Quality in Health Care — Aged Care Infection Prevention and Control Guide. https://www.safetyandquality.gov.au/resources/aged-care-infection-prevention-and-control-guide

Official guidance checked 24 October 2026. Apply current accepted classification, specialist recommendations and product/device instructions. Hospital guidance is a practice reference, not an assertion that every hospital requirement applies to H&H Care. This framework does not replace qualified assessment or procedure-specific training.

Director approval: _____ Clinical Lead RN approval: _____
Effective date: _____ Next review: _____
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