The care plan must be documented and discussed with all patients and/or carers who are assessed as at risk, irrespective of degree of risk. This plan must be communicated during handover at the end of every shift in an acute, MPS long stay facility or NSW Health RAC facility, and as soon as possible (within 24 hours) of initial home visit for community services.

Care plans are to include strategies aimed at:
- Preventing the development of pressure injury/injuries
- Optimising healing and preventing complications of existing pressure injury/injuries.

**Care plan checklist**

- Is the patient and/or carer involved in the pressure injury prevention care planning process
- Is there input from the multidisciplinary team about additional assessment, recommendations and treatment

**Are there strategies for:**

- Pressure injury risk and skin assessment, monitoring and reassessment
- Mobilising to maintain function
- Position changes to relieve pressure, avoiding shear and friction
- Skin hygiene
- Pain assessment and management
- Optimising hydration and nutrition, including supplementation and feeding assistance, if required
- Promotion of continence and management of incontinence
- Wound management
- Oedema management
- Protection of skin from moisture, high temperature, skin irritants and medical devices
- Equipment, devices; manual task techniques to minimise wound pain, eliminate or reduce pressure, friction, shear and to protect existing pressure injury

**For transfer of care, is there communication outlining:**

- The goal of treatment
- Classification and progress of pressure injury
- Wound management
- Prevention strategies
- Follow-up care required.
BEST PRACTICE FOR MANAGING PRESSURE INJURIES

Prevention
All patients with a pressure injury are at a high risk of the injury worsening, or developing other pressure injuries, and therefore:

- Where possible, prevention strategies must be implemented immediately, and documented. Any exceptions and the rationale must be documented
- The two part pressure injury assessment and pain assessment must be conducted and care planned.

Assessment
Assessment of pressure injuries should occur when a pressure injury is identified, or on transfer of care at next dressing change.

Wound management
Wound Management is provided by or supervised by staff with skills, knowledge and equipment to provide treatments in accordance with best practice.

Documentation
Document the pressure injury in the patient health care record e.g. on a wound chart or care plan or in the Electronic Medical Record. Notify the pressure injury in the incident reporting and management system e.g. NSW Health Incident Information Management System (IIMS).

Wound reassessment
Wound reassessment should occur at least weekly. Wound management should be reviewed if not healing at an optimal rate, i.e. 25% reduction in four weeks.

Consultations
Consultations should occur in a timely fashion with medical or other health disciplines for their assessment and contribution, planning, and management.

Pain assessment
Pain should be assessed in accordance with best practice guidelines at least every shift/home visit using a validated tool.

Nutrition
Nutritional management provided in accordance with NSW Health Nutrition Care Policy.