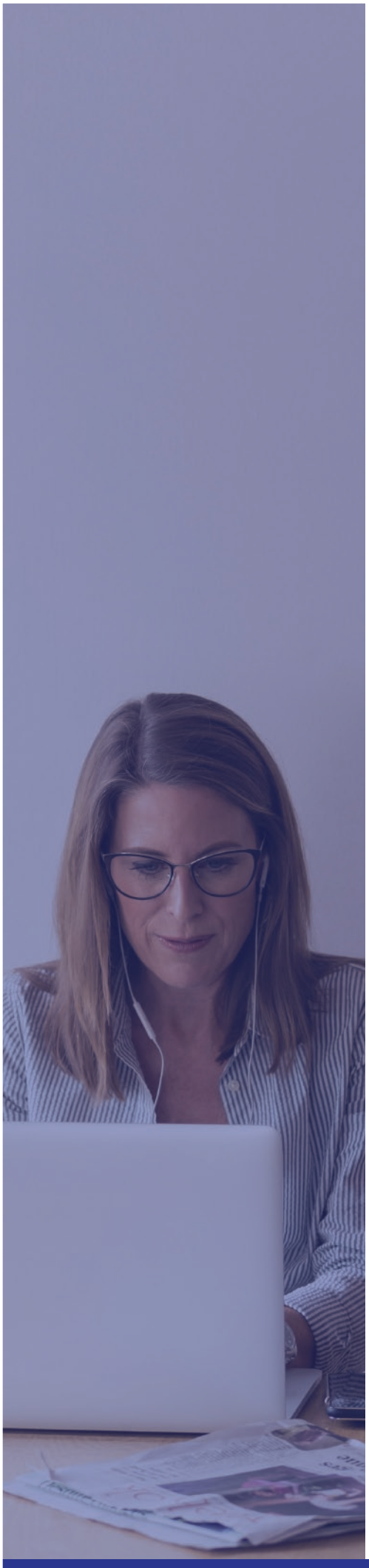
Skin & Wound Care Essentials

Personal Care Assistants in Aged and Community Care: Online Course

WOUND EDUCATION



Contents

Skin & Wound Care Essentials Online Course

Welcome to the Skin & Wound Care Essentials Online course, where we will guide you, a dedicated Personal Care Assistant (PCA), with the essential skills and knowledge to provide excellent care in maintaining skin integrity among elderly residents in aged care settings.

During your training, you will learn how to identify and review different skin conditions. This will help you take the right steps to prevent damage to the skin of elderly residents you are caring for. You will also learn practical skills that you can use on the job through practice activities. This will ensure that you provide the best possible care when it comes to skin and wound management.

As a Personal Care Assistant (PCA), you play an essential role in providing expert and compassionate care to the elderly. This course offers comprehensive learning experiences on various skin and wound care topics. You will learn how to identify skin conditions, implement preventive measures, and provide appropriate care. The course is designed to empower you to excel in your role, helping you improve the quality of life of the elderly under your care.

We encourage you to engage with the material, participate in practical activities, and reflect on the important impact you can make as a PCA. By striving to enhance and grow, you demonstrate your commitment to the well-being and contentment of the seniors under your care.

Let's begin our journey of transformation together. You will receive the tools you need to provide excellent care, promote well-being, and preserve the skin health of older adults who depend on your knowledge and skills. Let's start now!

To support your learning, we have curated a list of recommended reading articles. These articles have been carefully selected to provide you with a comprehensive understanding of key concepts and practical approaches in skin and wound care. We encourage you to read these articles thoroughly and reflect on how you can apply the knowledge gained in your practice. Happy reading and learning!

These recommended reading articles can be viewed online under the Materials tab within each lesson.

Standards for PCA's

Welcome to lesson one. This module will cover the essential guidelines, rules, and quality measures that every Personal Care Assistant (PCA) should know when caring for elderly residents in Australian Aged Care. Your role as a PCA is important in ensuring the safety, well-being, and comfort of residents. This module will equip you with the knowledge and understanding needed to excel in this responsibility.

Throughout this module, we will cover a range of topics including the Aged Care Standards, the Charter of Aged Care Rights, Aged Care Quality Indicators, Wounds Australia Standards, the role of the PCA, a workplace project, and a multiple-choice assessment. Additional readings and references are provided to help you understand the topics covered.

It is important to keep in mind the different care situations you may encounter as a PCA. To provide the best care, you must personalise your approach according to the unique needs, preferences, and cultural backgrounds of older adults. We encourage you to apply the principles learned to improve your skills and positively impact the lives of the residents you care for.

Let's begin this journey of understanding and upholding the highest standards as a PCA in Australian Aged Care.

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SKIN & WOUND CARE ESSENTIALS©

- *Personal Care Assistant (PCA)*
- *Standards Related to the PCA Role*
- *(0023BM1 S&WCE-Standards for PCAs)*

Notes

WOUND & AGED CARE STANDARDS

MODULE 1 OVERVIEW

1. Knowledge & Performance Goals
2. Aged Care Standards
   - Charter of Aged Care Rights
   - Aged Care Quality Indicators
   - Wounds Australia Standards
3. Role of the PCA

GOALS

KNOWLEDGE	PERFORMANCE
1. In Australian Aged Care, PCAs must understand rules, standards, and quality measures.	1. Provide personalised care for elderly residents based on their preferences, needs, and cultural backgrounds.
2. Taking care of the elderly safely and effectively is crucial.	
3. Understand the vital role PCA's have in the team and how they positively affect the well-being of elderly residents.	

CHARTER OF AGED CARE RIGHTS

(Aged Care Act 1997)

- Safe and high-quality care services
- Be informed about care and services in a way I understand
- Have control and make choices about my care and personal and social life, including where the choices involve personal risk.

Aged Care Act 1997

No. 112, 1997

Compilation No. 85

Compilation date:	1 April 2023
Includes amendments up to:	Act No. 47, 2022
Registered:	3 April 2023

AGED CARE QUALITY INDICATORS (QI)

- Unplanned weight loss
- Pressure injury
- Incontinence care
- Activity daily living (ADL)
- Medication
- Falls

- Physical restraint
- Hospitalisation
- Consumer experience
- Quality of life
- Workforce

National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A

QI SCENARIO

Mrs Mable Brown came to stay at the aged care facility 14 weeks ago following a long stay in hospital. She had a fall in her home where she lived alone with her cat. She suffered a broken hip and pelvis which has left her unable to walk and she now has trouble controlling her bladder. Her appetite is poor and she has lost 5 kg since arriving at the facility. Her days are spent lying in a recliner or in her bed in the afternoon watching TV.

QUESTION

PLEASE SELECT THE QUALITY INDICATORS RELATED TO MABLE'S CARE BASED ON THE BRIEF STORY

A. Medications, Quality of life, Physical restraint, hospitalisation
B. Consumer experience, Workforce, Falls, Quality of life
C. Incontinence care, Falls, Medication, Hospitalisation
D. ADL's, Weight loss, Incontinence care, Pressure Injury

D

PCA's ROLE

PCAs in aged care facilities provide personalised and dignified care to elderly residents, making sure of their safety and well-being while working with the care team to meet Australian Aged Care Standards and Quality Indicators.

PCA's ARE CLOSELY CONNECTED TO RESIDENTS

While Sally was assisting Mable with her shower, she noticed that there were red marks on both of her heels and a painful stinging rash in her groin area. Mable expressed her embarrassment about the rash and shared that she didn't want to tell anyone. Sally assured Mable that she would be discreet and asked if she could request the RN to take a look. The RN assessed both the heels and the rash and provided appropriate treatment to alleviate Mable's discomfort.

RESIDENTS FORM TRUSTING RELATIONSHIPS WITH PCA's

Sally took the chance to speak with the RN about her worries regarding Mable's weight loss and lack of interest. The RN was able to make some time to have a conversation with Mable and see how she was feeling. It was discovered that Mable was feeling sad because she missed her cat and did not like the food at the facility.

AGED CARE STANDARDS

1. Consumer dignity & choice
2. Assessment & planning
3. Personal care & clinical care
4. Services & support of daily living

5. Organisation's service environment
6. Feedback & Complaints
7. Human resources
8. Organisational governance

AGED CARE STANDARDS

STANDARD	ELEMENTS	REQUIREMENTS & RELEVANCE
1	3 (a,b,c,d)	Dignity, Respect and Culturally Safe. Make decisions about care, Supported to take risks, Information is current accurate and timely
2	3 (a,b,c,d,e)	Safe & Effective, End of life planning, Consumer partnership, Communicating outcomes, Care reviewed regularly
3	3 (a,i,b,c,d,f,gi,ii)	Best practice, pressure injury & IAD, comfort and end of life care, change in condition, escalation & referral, infection & antimicrobial stewardship.
4	3 (e,g)	Timely referrals, equipment is safe, effective, clean and well maintained.
7	3 (a,c,d,e)	Staff knowledge, skill mix to deliver safe & quality care, competent staff, recruitment involves training staff to equip and support to meet standards. Staff are reviewed regularly.
8	3 (b,c,d i. iv.e)	Governance, safe, inclusive & quality care, continuous improvement, manage high prevalence risks. Clinical governance framework for antimicrobial stewardship.

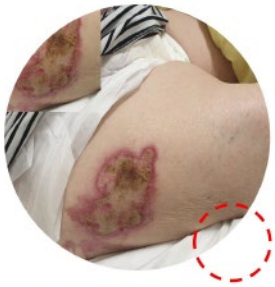
EXCEEDING, MEETING, DEVELOPING

STANDARDS FOR WOUND PREVENTION AND MANAGEMENT

- Consistency
- High level care
- Variation reduced
- Improve safety
- Positive outcomes

Wounds Australia. Standards for Wound Prevention and Management. 3rd edition. Cambridge Media: Osborne Park, WA; 2019.

1. Scope of Practice
2. Collaborative Practice
3. Clinical Decision Making: Assessment
4. Clinical Decision Making: Planning and Practice
5. Documentation
6. Education
7. Corporate Governance



WOUNDS AUSTRALIA STANDARDS

WA STANDARDS	ELEMENT	REQUIREMENTS & RELEVANCE
2 Collaborative Practice	2.2.2,2.2.3, 2.2.4, 2.3.1 2.3.3, 2.4.1	Regular documentation/communication with PCA. Timely with change in condition & preferences. Scope of practice & team development. Respecting cultural practice.
3 Assessment	3.2.1, 3.4.3, 3.4.4, 3.5.7	Skin assessment and risks for pressure injury, falls, skin tears & incontinence. Identification of lifestyle factors. Assessment of skin care products. Assess ADL's and hygiene capability. Weight & history.
4 Clinical Decision & Planning	4.2.1, 4.7.9, 4.8.1, 4.8.2, 4.11, 4.12	Preventative skin care. Application of compression therapy. Showering wounds. Prophylactic dressings application. Hand hygiene. PPE reduce contamination. Skin pH avoid soap. Pain monitoring.
5 Documentation	5.1.1, 5.1.2, 5.3.2	Documentation policy, Handwritten health record are signed-name-dated-designation. Record details collaboration & care option discussion, understanding.
6 Education	6.1, 6.2, 6.3.2, 6.4	Identified learning needs of the team, EB practice & skill development. Knowledge is shared with the PCA. New evidence is implemented in care and regularly reviewed.

WOUND STANDARDS & THE PCA

Sally has been helping Ted with his personal hygiene. She observed that Ted uses soap to wash his face and body, and rubs his skin vigorously when drying himself before applying aftershave. However, Ted's skin looks dry and irritated. Sally suggests that Ted should use a pH skin-friendly cleanser and moisturizing cream after showering to improve his skin condition.

QUESTION

WHY IS VIGOROUS RUBBING WITH A TOWEL HARMFUL?

A. Excessive rubbing can ruin towels and can be costly
B. Rubbing can increase the risk of skin damage and breakage
C. Can be the direct cause of hair loss
D. Repeated friction can make the skin less sensitive over time

B

KEY POINTS

- The PCA role requires an understanding of Aged Care Standards, Charter of Aged Care Rights, Aged Care Quality Indicators, and Wounds Australia Standards
- The PCA plays a crucial role in providing elderly individuals with respectful, personalized, and safe care.
- PCAs who follow these guidelines, can help elderly residents stay healthy and happy while receiving top-quality care

REFERENCES

- Aged Care Act 1997 https://www.legislation.gov.au/Details/C2023C00073
- Aged Care Quality Indicator Program
- https://www.agedcarequality.gov.au/providers/national-aged-care-mandatory-quality-indicator-program
- National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A
- https://www.agedcarequality.gov.au/consumers/national-aged-care-mandatory-quality-indicator-program
- Australian Aged Care Standards
- https://www.agedcarequality.gov.au/providers/standards
- Wounds Australia Standards for Wound Prevention and Management, 3rd edition
- https://www.woundsaustralia.com.au/Web/Resources/Publications/Publications_Users_Only/Standards_for_Wound_Prevention_and_Management_Third_Edition_2016.aspx

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Communicating, Reporting, Stop & Watch

Welcome to Lesson Two: Communication, Reporting, Stop & Watch. This is an essential part of your role as a Personal Care Assistant (PCA) in aged care. This module focuses on the critical aspects of communication and observation that are crucial to the safety, comfort, and well-being of the residents you care for.

The module covers several topics, including the importance of alert observation in ensuring residents' safety and well-being. You will learn how to respond appropriately to residents who display distress, discomfort, or unusual behaviour, and how to escalate and report challenging situations.

You will also be introduced to the ISBAR communication tool, which will help you structure your concerns to communicate clearly and competently. Additionally, we will go through the Stop & Watch process, a systematic approach that allows you to respond swiftly to resident needs by comprising Observation, Action & Escalation, and Reporting & Documentation.

Throughout the module, you will have the opportunity to gauge your understanding through a multiple-choice assessment and apply your knowledge to practical scenarios that mirror real-life situations.

As a dedicated PCA, your communication and observation skills have a large impact on residents' well-being. By incorporating the Stop & Watch process and mastering the art of effective communication, you will be well-equipped to navigate various scenarios with confidence and understanding.

Remember, your dedication to continuous learning and improvement directly contributes to the quality of care provided to elderly residents. We encourage you to actively participate, practice the skills you gain, and seek explanations from nurses whenever needed. Let's embark on this journey of enhancing your communication skills and elevating the care you provide as a dedicated PCA.

Would you like to explore the essentials of effective communication, reporting, and the Stop & Watch method? Let's discover them together.

WOUND EDUCATION

SKIN & WOUND CARE ESSENTIALS©

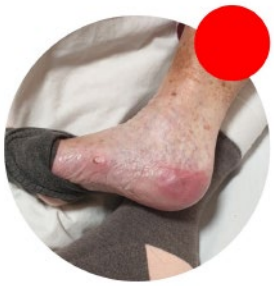
- *Personal Care Assistant (PCA)*
- *Stop, Watch & Reporting*
- *(0023CM2 S&WCE- Stop, Watch & Report)*

Notes

STOP, WATCH & REPORTING

MODULE 2 OVERVIEW

1. Knowledge & Performance Goals
2. Stop & Watch
3. Observations
4. Action & Escalation
5. Reporting & Documentation



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GOALS

KNOWLEDGE	PERFORMANCE
1. Closely observing residents to ensure their safety and well-being will be part of the PCA role.	1. Demonstrate appropriate escalation actions in a scenario-based.
2. Respond appropriately when a resident shows signs of distress, discomfort, or any unusual behaviour.	2. Practice the use of the ISBAR communication tool to communicate their concerns.

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STOP AND WATCH TOOL

- Early Warning Tool
- Consistent Communication
- Minimise the risk of health deterioration or hospitalization
- Improves resident safety
- Complete form at any sign/clue to clinical change

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"NOT THEIR USUAL SELF ... "

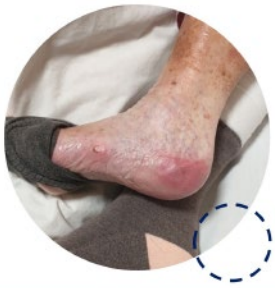
COMPLETING THE TOOL

- Mary did not attend the scheduled exercise class as planned
- In the morning Mary requested to return to bed as she was feeling tired
- Complained of a headache
- Did not eat breakfast

OTHER ASSESSMENT & COMMUNICATION TOOLS

OBSERVATIONS & ESCALATION

- The PCA reported the concerns about Mary to the RN, although the Stop and Watch form was not completed.
- Mary remained in bed and was reluctant to eat drink or move for the remainder of the day.
- The afternoon shift support worker noted the changes in Mary's skin colour & condition.
- A new Stop & Watch form was completed, adding the skin change, signed, dated and time reported to the RN for action.
- The RN assessed the resident, completed vital signs and contacted the medical officer as her BP was elevated.



KEEPING RESIDENT'S SAFE

Pressure injury prevention equipment was put in place for Mary along with regular repositioning

The support worker completed the handover about Mary according to their findings from the Stop and Watch tool

The RN promptly assessed and escalate the resident to the medical officer

The medical officer visited the resident and prescribed appropriate medication for pain and further investigations

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DOCUMENTATION

- What was the concern/issue?
- What signs or symptoms were observed by the support worker?
- Mary complained of a frontal headache and feeling tired. Did not want to eat or drink at breakfast. Remained in bed for the past 6 hours. Has a reddened left heel which did not blanch with gentle pressure.
- Heel pressure was relieved with two heel lifts which elevated the heels off the bed. Repositioned in bed every 3 hours.
- Stop & Watch completed and reported/escalated to RN at 2pm.

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QUESTION

THE STOP AND WATCH TOOL HELPS THE PCA TO ...

A. Decide what action to take
B. Communicate what they have observed
C. Provide the reason to summon an ambulance
D. Contact the resident's family

B

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QUESTION

UNUSUAL RESIDENT CONFUSION AND CONSTIPATION SHOULD BE ESCALATED USING THE STOP-AND-WATCH TOOL

- TRUE
- FALSE

TRUE

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KEY POINTS

- The PCA has a close understanding of the residents.
- The role is crucial in noticing any signs of abnormal behaviour, distress or health changes in a resident.
- Applying the Stop & Watch tool can logically communicate the PCA's concerns to a RN.
- Early detection of any change in a resident's health can reduce the risk of conditions worsening.

REFERENCES

- https://ioet.com.au/student-resources/
- http://www.spict.org.uk/the-spict/
- https://hunterprimarycare.com.au/health-professionals/ace-education-resources-2/
- https://www.hnehealth.nsw.gov.au/our_services/telehealth/pace-it
- https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-pathways/residential-aged-care-clinical-pathways/all-pathways/recognition-of-the-deteriorating-resident
- https://www.palliaged.com.au/tabid/4248/Default.aspx
- Burkett E, Cranitch E, Bandiera D, Ward T, Improving the quality and choice of care setting for residents of aged care facilities with acute healthcare needs steering committee, Queensland Dementia Ageing and Frailty Clinical Network. Management of acute care needs of RACF residents: a suite of collaborative pathways for General Practitioners and Registered Nurses. Brisbane: Clinical Excellence Queensland, Queensland Health 2019.

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Photography

Welcome to Lesson Three: Clinical Photography Introduction. This module will help you understand the importance of clinical photography in healthcare, especially in aged care. As a Personal Care Assistant (PCA), taking clear and accurate images can greatly contribute to resident care and treatment.

Throughout this module, you will learn about capturing skin and wound images, clear and consistent imaging techniques, and the rules and policies governing clinical photography. You will also learn how to identify inconsistencies in clinical images and recognise opportunities for improvement.

The module covers the fundamental purpose of clinical photography and its role in supporting resident care and treatment. You will receive ten valuable tips for capturing clear, informative, and respectful clinical images and then test your understanding through a multiple-choice assessment. You will also apply your knowledge and skills to a practical scenario, honing your ability to capture quality clinical images.

As you progress through this module, you will realise the vital role clinical photography plays in aiding healthcare professionals to make informed decisions. Your commitment to mastering this skill will contribute directly to the quality of care provided to residents. We encourage you to engage with the content, practice the skills you acquire, and seek support from the workplace whenever needed.

Let's embark on this journey of understanding clinical photography's purpose, refining our skills, and contributing to the overall well-being of residents under your care. Let's get started!

WOUND EDUCATION

SKIN & WOUND CARE ESSENTIALS©

- *Personal Care Assistant (PCA)*
- *Clinical Photography*
- *(0023DM3 S&WCE-Clinical Photography)*

Notes

Clinical Photography

MODULE 3 OVERVIEW

1. Knowledge & Performance goals
2. Purpose of clinical photography
3. Rules and policies regarding the clinical photograph
4. 10 Tips for clinical photography

GOALS

KNOWLEDGE	PERFORMANCE
1. Understand the purpose & benefit of taking skin/wound images	1. Development of practical skills in taking quality images.
2. Gain tips on how to take clear and consistent images	2. Detect image inconsistencies and identify improvement opportunities.
3. Be aware of the rules and policies regarding clinical photography	

CLINICAL IMAGE PURPOSE & BENEFIT

- Diagnosis-validation
- Wound healing progress
- Telehealth support
- RN/resident/family review
- Evidence of care – Incident reporting
- Education/Research/Product evaluation

> *Wound photographs provide a visual reference not matched by memory or the written word.*
>
> *Swann 2010*

RULES & POLICY RECOMMENDATIONS

- PCA scope of practice
- Purpose of image explained
- Publication/education consent
- Third-party consent
- Organisational policy differences
- Privacy, data protection, storage
- Legal & Insurance

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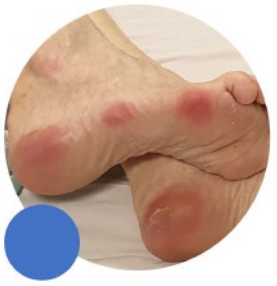
ONE:

TIMING

- On admission
- On initial discovery
- Follow-up – weekly
- Discharge image or on transfer



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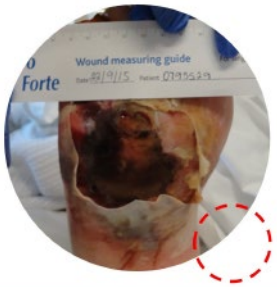
TWO:

SECURITY

- Patient identification ie MRN
- How to label images
- Upload to medical record
- Safe photo transfer



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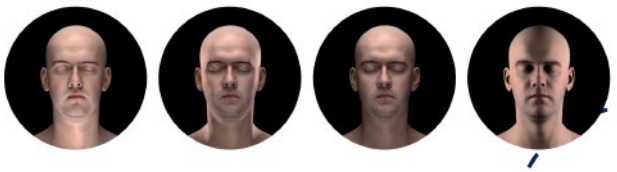
THREE:

LIGHTING



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FOUR:

DEVICE

- Organisation device
- Contractors device
- Tablet/Smart Phone or Camera
- No editing of the image
  - Factory settings
- Flash or no flash?

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QUESTION

EXPLAIN WHY THE PCA SHOULD NOT USE A PERSONAL PHONE TO TAKE IMAGES OF A RESIDENT'S WOUND?

- **Security Breach**
- **Privacy**
- **Consent**
- **Organisational Policy**

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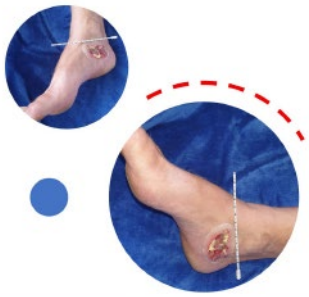
FIVE:

CONSISTENCY/POSITIONING

- Same position every time
- Do not distort the body part
- 1st Entire body or limb
- 2nd close up



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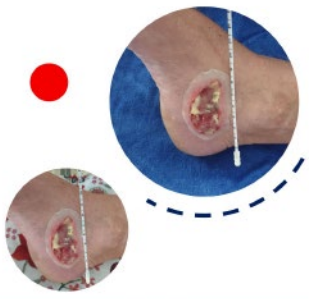
SIX:

IMAGE DISTRACTION

- Consider the background
- Clean the wound of debris
- Obscure the face
- Cover genitals for dignity



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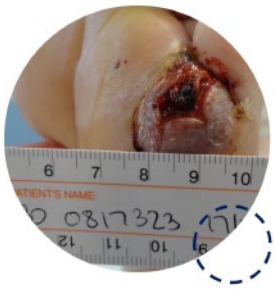
SEVEN:

MEASUREMENT

- Consistent measurement device with 2 rulers
- Length – head to toe
- Width – side to side
- Depth with a soft tip probe in position
- Same placement each time



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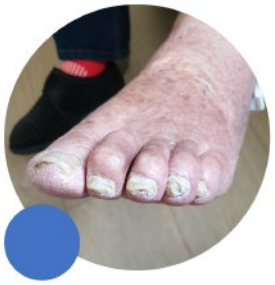
EIGHT:

ASSESSMENT FINDINGS

- Wound characteristics can also be captured
  - Exudate colour & amount on a dressing
  - Blanching for pressure injury
  - Capillary refill and temperature



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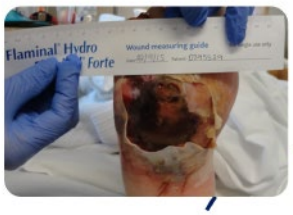
QUESTION

WHAT IS WRONG WITH THIS IMAGE?

- Wound product advertisement
- Covering some of the wound with the paper tape
- Measurement should be at the bottom of the wound
- The wound's anatomical position on the body is unclear.



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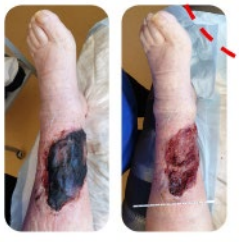
NINE:

PRE-POST

- Debridement
- Unstageable pressure injuries
- Treatment monitoring



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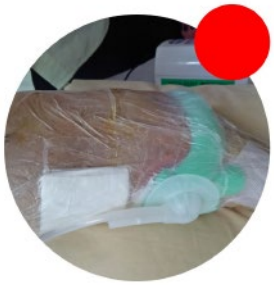
TEN:

PRINTING IMAGES

- Communicating with health care team
- Displaying progress to the patient and family
- On transfer to another facility
- Minimise dressing disturbances ie NPWT
- File in hard copy medical record



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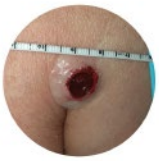
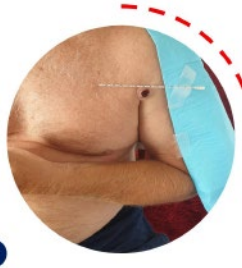
QUESTION

WHERE IS THIS WOUND LOCATED?





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KEY POINTS

- Always gain consent for the purpose of the image
- Follow an organisational policy which outline frequency of images, storage, devices, and transmitting the image
- Keep the repeated images consistent. Flash, lighting, angle, background, close up, distant, and measurement

WOUND EDUCATION SKIN & WOUND CARE ESSENTIALS®

REFERENCES

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Anatomy & Skin Frailty

Welcome to Lesson Four: Anatomy & Skin Frailty. As a Personal Care Assistant (PCA), it's important to understand skin anatomy and skin frailty in elderly residents under your care. This module covers these topics in depth.

You'll learn about the layers and functions of the skin, as well as causes that contribute to skin problems in older adults, such as aging, health, mobility, and nutrition. You'll also discover steps to protect elderly skin and how to approach skin inspections with respect.

During the inspection process, you'll learn to identify common signs of skin frailty, such as thinning, dryness, discolouration, and skin tears. You'll have the opportunity to practice your skills by applying your learning to real-life scenarios.

Recommended readings and references are also provided to help you expand your knowledge and expertise. Remember, understanding skin anatomy and recognising signs of skin frailty is essential to delivering complete care to elderly residents. We encourage you to fully immerse yourself in the content, practice your skills, and seek explanations from nursing staff whenever needed.

Our goal is to improve the well-being of elderly residents in your care by studying skin anatomy and vulnerability. We aim to gain a better understanding of these complexities.

WOUND EDUCATION

SKIN & WOUND CARE ESSENTIALS©

- *Personal Care Assistant (PCA)*
- *Skin Frailty*
- *(0023EM4 S&WCE-Skin Frailty)*

Notes

SKIN FRAILTY

MODULE 4 OVERVIEW

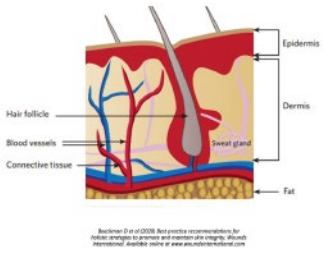
1. Knowledge & Performance Goals
2. Skin Anatomy & Aging Skin Changes
3. Skin Frailty Introduction

GOALS

KNOWLEDGE	PERFORMANCE
1. Learn about skin structure and skin frailty, which is when older people's skin becomes more delicate and prone to damage.	1. Identify the signs of aging skin and correctly record visible signs of skin aging. E.g. Dryness, Wrinkles, Discolouration, Bruising, Thinning.
2. Discover the reasons why some older adults may experience skin problems, such as getting older, having health issues, not moving much, or not eating well.	
3. Explore ways to protect the skin of elderly individuals.	

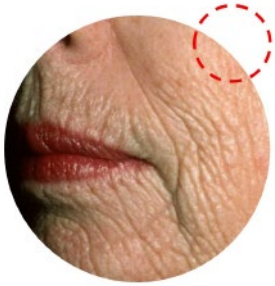
THE SKIN

- Largest Organ
- Protective Covering
- After 40 years < 10% new cells
  - Weak top layer (epidermis)
  - Dry skin
  - Skin barrier less effective
  - Shallow "anchoring area" (epidermal junction)



THE AGING SKIN CHANGES

- Protection
- Temperature control
- Sensation
- Metabolism
- Elimination
- Cosmesis



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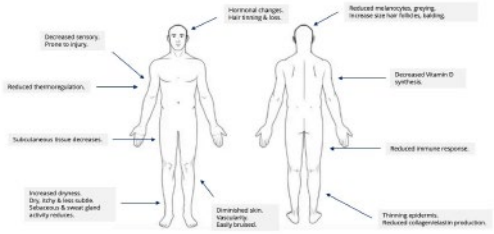
THE AGING SKIN CHANGES



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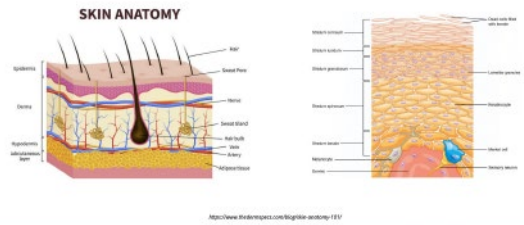
SKIN OUTER LAYER

EPIDERMIS-STRATUM



https://www.theskinrespect.com/blog/skin-anatomy-101/

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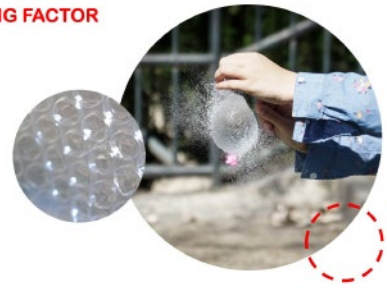
NATURAL MOISTURISING FACTOR

- Barrier Mechanism
- Inside the cell
  - Sodium PCA
  - Amino Acid
  - Lactate



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"BRICKS & MORTAR"

LAMELLAR LAYER

- Intracellular Lipids (mortar)
  - Ceramides
  - Free fatty acids
  - Cholesterol

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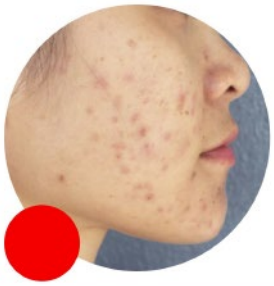
SEBUM

- Produced by the sebaceous glands
  - Squalene
  - Triglycerides
  - Wax esters
- Fine film on skin surface
- Natural lubricant
- Skin smoothness

WOUND EDUCATION SKIN & WOUND CARE ESSENTIALS©

ACID MANTLE

- Protective film over the skin- sebum
- Amino acid from sweat
- pH 5.5 antibacterial



WOUND EDUCATION SKIN & WOUND CARE ESSENTIALS©

QUESTION

AS A PERSON AGES, THEIR SKIN CAN ...

A. Bruise easily
B. Become drier
C. Thin & wrinkly
D. All of the above

D

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SKIN FRAILTY

- Older Adults
- Mobility Issues
- Children/Neonates
- Spina Bifida, Cerebral Palsy
- Bariatric
- Oncology
- Chronic Illness

Beeckman D et al (2020) Best practice recommendations for holistic strategies to promote and maintain skin integrity. Wounds International. Available online at www.woundsinternational.com

SKIN FRAILTY

VULNERABILITY RISKS

Nutrition
Weight Gain/Loss
Mobility
Disease
Medication
Incontinence

Sun Damage
Skin Conditions
Pressure
Skin Irritants
Genetics

Beeckman D et al (2020) Best practice recommendations for holistic strategies to promote and maintain skin integrity. Wounds International. Available online at www.woundsinternational.com

AGED CARE QUALITY INDICATORS (QI)

- Unplanned weight loss
- Pressure Injury
- Incontinence care
- Activity daily living (ADL)
- Medication
- Falls

- Physical restraint
- Hospitalisation
- Consumer experience
- Quality of life
- Workforce

National Aged Care Mandatory Quality Indicator Program: Manual 3.0 – Part A

SKIN FRAILTY SCENARIO

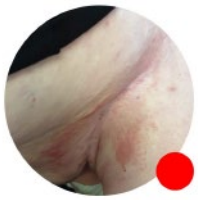
Shirley, an 87-year-old woman with dementia, is currently residing in an aged care facility for respite care.

She is experiencing urine incontinence, has a poor appetite, her clothes are loose, she requires a frame to walk, and she has lost interest in taking walks in the garden.

During the skin inspection, it was observed that the patient had a rash in her groin area, red patches on her buttocks, and dry, scaly, and thin skin with signs of bruising on her legs.

SKIN INSPECTION

- Head-to-toe visual inspection
- Feel the skin overlying bony areas - hips, in skin folds, and around/under medical devices
- Blanchable/Non-blanchable
- Colour, warmth, pain, dryness swelling, breaks, moisture.



Shirley's Skin

- Bruised & dry skin
- Falls risk
- Aging skin conditions risk
  - Pressure injury
  - Skin tear
  - Wet skin condition, IAD

DOCUMENTATION

Example

When the resident was first assessed upon admission, red areas were noticed on their buttocks. Even after changing positions, the red areas continued to be present. The registered nurse was quickly informed of the situation, and a cushion was placed under Shirley to relieve pressure while seated.

- Monitoring the care plan effect
- Changes in condition or plan
- Escalation who, when & why
- The action following the escalation
- Information for the next shift.

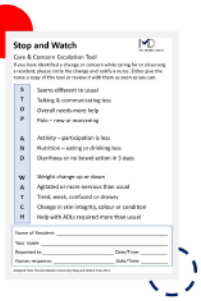
CARE PLANNING WITH SHIRLEY

- Nutrition and hydration monitoring
- Incontinence care
- Personal hygiene supervision
- Skin care and daily inspection
- Mobility supervision and group exercises
- Check-in on quality of life

REPORTING FINDINGS

ESCALATION

- The PCA alerts the RN to the findings of Shirley's skin inspection and the following actions.
- The catering staff are advised by the PCA of Shirley's food likes/dislikes
- The physio aid places protective padding over the walker's sharp edge. Shirley is encouraged to join in the exercises of the morning. Shirley sits on the offloading cushion.
- The PCA gently moisturises the skin each day while Shirley drinks lemon water
- A barrier cream is used in her groin area each day.


Stop and Watch

Care & Concern Escalation Tool

SHIRLEY'S PROGRESS

- After 6 weeks Shirley improves.
- Appetite has returned
- No red areas or rash
- Skin is moisturised with no breaks
- Mobility & balance has increased
- Shirley described herself as happy & healthy

QUESTION

SKIN FRAILTY INCLUDES THE FOLLOWING ISSUES:

A. Pressure injury, skin tear, wound infection
B. Pressure injury, skin tears, IAD,
C. Pressure injury, skin tears, skin cancer
D. None of the above

B

KEY POINTS

- The epidermis or outer skin layers are constantly rejuvenating whilst the skin provides a protective barrier.
- As a person ages the ability to maintain skin moisture reduces.
- Skin dryness, loss of the protective barrier, and thinning with wrinkles can increase the risk of skin trauma for older people.
- Best care for the older person can improve skin frailty and reduce skin injury risks.

REFERENCES

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- National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part ABeeckman D et al.
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- Beeckman D., Van den Bussche K., Alves P., Beele H., Ciprandi G., Coyer F., de Groot T., DeMeyer D., Dunk A.M., Fourie A., Garcia-Molina P., Gray M., Iblasi A., Jelnes R., Johansen E.Karadağ A., LeBlanc K., Kis Dadara Z., Long M.A., Meaume S., Pokorna A., Romanelli M.,Ruppert S., Schoonhoven L., Smet S., Smith C., Steininger A., Stockmayr M., Van Damme N.,Voegeli D., Van Hecke A., Verhaeghe S., Woo K. and Kottner J. The Ghent Global IAD Categorisation Tool (GLOBIAD). Skin Integrity Research Group - Ghent University 2017. Available to download from www.UCVVGent.be


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Skin Care

Welcome to the Skin/Foot Inspection lesson, designed to equip you as a Personal Care Assistant (PCA) with the knowledge and skills to maintain the health and well-being of elderly residents through effective skin and foot care.

Throughout this module, you will learn about the importance of a daily skincare routine, common skin conditions encountered by older adults, effective product matching, foot hygiene, skin inspection, and comprehensive skin care and foot care techniques. You will also test your understanding through a multiple-choice assessment and apply your learning to real-world scenarios.

Your attention to detail and commitment to proper care can significantly improve the lives of the residents in your care. By engaging with the content, practising your skills, and seeking further information whenever needed, you will be better equipped to contribute to their health and comfort.

Let's get on this journey of enhancing your understanding of skin and foot care. Together, we can ensure that elderly residents receive the best possible care. Let's get started!

WOUND EDUCATION

SKIN & WOUND CARE ESSENTIALS©

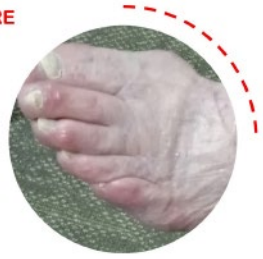
- *Personal Care Assistant (PCA)*
- *Skin Inspection, Skin Care & Foot Care*
- *(0023FMS S&WCE-Skin Inspection/Care)*

Notes

SKIN INSPECTION, SKIN & FOOT CARE

MODULE 5 OVERVIEW

1. Knowledge & Performance goals
2. Skin Inspection
3. Skin Care
4. Foot Care

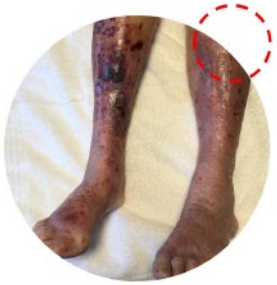


GOALS

KNOWLEDGE	PERFORMANCE
1. The importance of maintaining a gentle daily skincare routine for elderly residents, including cleansing, moisturising, and applying sunscreen.	1. Match the appropriate skin products to effectively address common skin conditions.
2. Become aware of common skin conditions that older adults may experience, such as dry skin, age spots, and the initial signs of pressure injuries.	2. Practice good foot hygiene by thoroughly washing and drying a family member's feet.

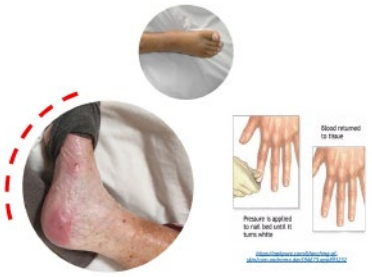
SKIN INSPECTION

- Temperature
- Texture
- Colour
- Moisture
- Integrity
- Hair
- Nails



BLANCHABLE & NON-BLANCHABLE ERYTHEMA

- Blanchable – Good
- Non-Blanchable Erythema - Bad



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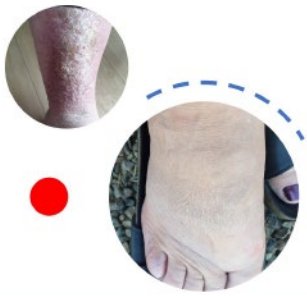
SIGNS OF SKIN DAMAGE

- Inflammation
- Redness
- Tightness
- Dryness
- Itch
- Flaky skin



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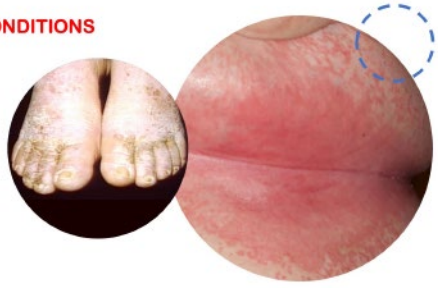
SKIN CONDITIONS

DRY

WOUND EDUCATION SKIN & WOUND CARE ESSENTIALS®

SKIN CONDITIONS

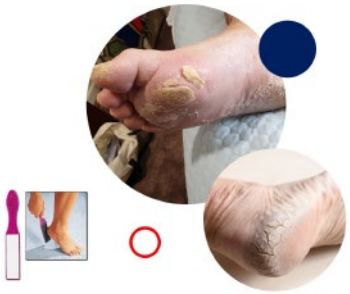
WET



WOUND EDUCATION SKIN & WOUND CARE ESSENTIALS®

CALLUS

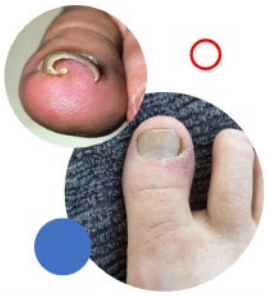
- Foot/Shoe Assessment
- Planter (Base of foot) pressure offload
- Callus sharp debridement
  - Accredited HCP
- Emollient to softening callus



WOUND EDUCATION SKIN & WOUND CARE ESSENTIALS®

INGROWN TOENAIL

- Footwear assessment
- Regular podiatry care
- Open toe shoes post treatment
- Toenails cut straight
- Treat infection



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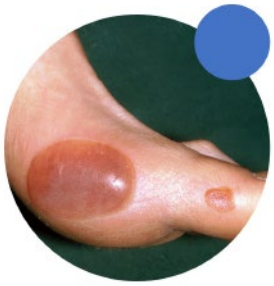
BLISTERS

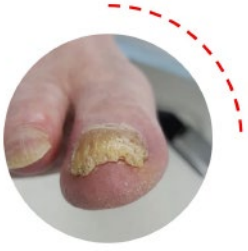
- What caused the blister?
- To rupture or to leave?
- Clean
- Cover
- Protect



WOUND EDUCATION SKIN & WOUND CARE ESSENTIALS®

THICKEN NAILS

- Trauma
- Permanent damage
- Disease (psoriasis)
- Difficult to trim
- Clean
- Moisturise
- File



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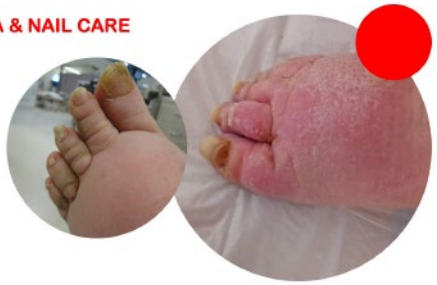
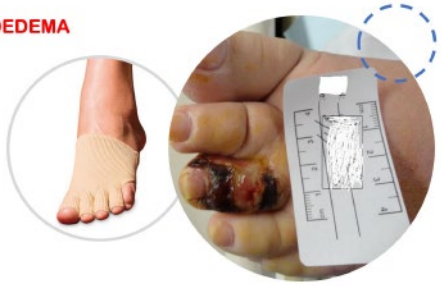
OEDEMA & NAIL CARE

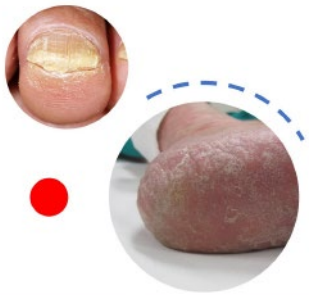


LYMPHOEDEMA

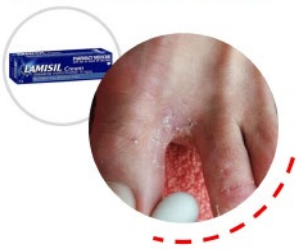


FUNGAL INFECTION

- Topical antifungal treatments
- Nail antifungal treatments
- Systemic antifungal treatments
- Clean, dry, feet & expose to air
- Treat the footwear
- Clean the socks
- Clean the bathroom



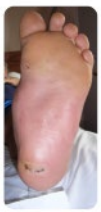
FUNGAL TOES - TOENAILS



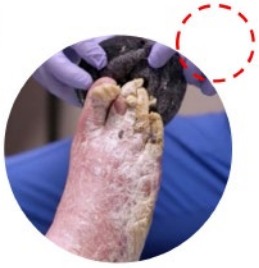
FOOT DEFORMITY

- Toe deformity
- Base of foot deformity
- Bunion
- Nerve pain

IWGDF Guidelines



MULTIPLE ISSUES



Daily Foot Care Checklist

dfa

REGULATION & CLASSIFICATIONS OF MOISTURISERS

WHAT IS SKIN CARE?

- Cleansing
- Soothing
- Restoring
- Reinforcing
- Protection

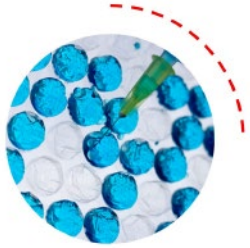
MEDICAL DEVICE

COSMETIC

MEDICINAL

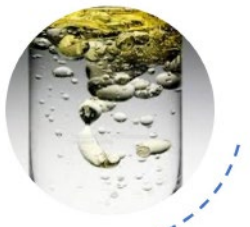
TERMINOLOGY

- **Moisturiser** – The finished product ready for skin application.
- **Emollient** – An ingredient used within a moisturiser. Oily film over the skin trapping water eg vegetable oil.
- **Humectant** – Absorbs water from the product & retains. E.g. Glycerine.
- **Occludent** – Prevent water vapour loss eg petrolatum



TERMINOLOGY

- **Emulsifier** – Stabilises the vehicle to transport ingredients.
- **Lipophilic** – Skin surface & interact with lipids. (WIO) Occlude preventing evaporation and maintain a barrier function. TEWL
- **Hydrophilic** – Low molecular weight. Act like humectants. Quick acting. Penetration remains in the skins outer layer. (OIW)
- **Xerosis** – Dry skin



PRODUCT CONFUSION

HOW TO APPLY, AMOUNT, CONSISTENCY AND FREQUENCY

SORBOLENE

INGREDIENT LIST	CLASSIFICATION/ACTION
Water	
Glycerine	Humectant
Sorbitol	Alcohol sugar. Pull water into skin
Stearic Acid	Fatty Acid. Spread & texture
Cetearyl Alcohol	Fatty oil
Mineral oil	Petroleum base
Triethanolamine	Stabiliser. Balance pH
Triticum Vulgare	Wheat germ oil
Imidazolidinyl urea	Preservative. Formaldehyde
Sodium benzoate	Preservative Paraben
Tetrasodium EDTA	Chemical salt which binds metal ions
P-chloro-m-cresol	Preservative. Methylphenol compounds

HYDRATION, PROTECTION AND NOURISHMENT

INGREDIENT	ACTION
Hyaluronic Acid:	A powerful humectant that attracts and retains moisture, helping to keep the skin hydrated, plump, and smooth.
Niacinamide (Vitamin B3):	Skin's barrier function, help even out skin tone, and reduce the appearance of age spots.
Ceramides:	Essential lipids strengthen the skin's natural barrier, preventing moisture loss and maintaining suppleness.
Glycerin:	Effective humectant that draws moisture to the skin, helping to maintain hydration levels
Antioxidants (Green Tea Extract, Vitamin E, etc.):	Protect the skin from oxidative stress, promoting a more youthful appearance and reducing inflammation
Plant Extracts (Aloe Vera, Chamomile, etc.):	Natural extracts with anti-inflammatory and soothing properties, calm sensitive skin.
Sunscreen (Broad Spectrum SPF):	Essential for protecting the skin from harmful UV rays and preventing further damage.
Oils (Jojoba, Argan, etc.):	Moisturising and nourishing oils can help replenish the skin's lipid barrier.

QUESTION

THE SKIN IS SLIGHTLY:

A. Acid
B. Alkaline
C. Neutral
D. Different pH for each person

A

SKIN HYGIENE

- Method
- Frequency
- Cleansers
  - Soap
  - Syndets
  - pH neutral
  - Disposable bath cloths
- Drying post cleanse

CLEANSERS

- pH neutral/slightly acidic
- Foam is no indication
- Soap free surfactant
  - Syndets are preferred
- Fragrance free
- Unnecessary ingredients


QUALITY CLEANSER

pH NEUTRAL SOAP FREE CLEANSER

- Gentle cleanser- syndet
- Added moisturisers
- pH- slightly acid
- Free of fragrance
- Free of colours
- Free of essential oils

SKIN HYGIENE METHOD

- Shower
- Bath
- No rinse disposable cloths



NO RINSE – DISPOSABLE BATH CLOTHS

- Viable alternative to the traditional "bed bath"
- Improved completeness of hygiene
- Reduced hospital pathogen risks
- Decreased physical strain on nurses
- Reduced procedural time frame
- No adverse effects on skin conditions
- Skin dryness improved

DRYING POST CLEANSING

- Avoid high water temperatures
- Avoid vigorous rubbing
- Soft towels to pat dry
- Moisturise whilst skin is still damp

WOUND EDUCATION SKIN & WOUND CARE ESSENTIALS©

QUESTION

SOAKING IN A BATH IS NOT RECOMMENDED

- True
- False

TRUE

Skin becomes permeable to water and creates cell dehydration as the water escapes from the cells.

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GENERAL SKIN CARE PROTOCOL

- Skin Inspection & Documentation
- Soap free pH neutral cleanser
- No rinse disposable bath cloths
- Fragrance free
- Avoid excessive cleansing
- Soft disposable wash cloths & "pat" drying
- Water based moisturisers twice a day
- Barrier creams/films that are not occludent
- Specific prescribed treatment for skin conditions

WOUND EDUCATION SKIN & WOUND CARE ESSENTIALS©

FOOT CARE RECOMMENDATIONS

- Daily foot inspection reporting the following:
  - Bleeding, cuts, sores, redness, swelling, pain or bruising
- Wear appropriate fitting footwear
- Inspect footwear lining for any soiling
- Keeping feet clean & dry, with particular care between toes
- Change socks daily
- File dry hard skin with a pumice stone or foot file
- Moisturise with heel cream to prevent cracking

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SKIN CARE DO'S & DON'TS

Do's

- Check skin folds daily
- Patch test new products first
- Use a soap free pH neutral cleanser
- Use a soft cloth to wash
- Moisturise after showering
- Apply moisturiser twice a day
- Seek continence advisor referral
- Use absorbent pads & change regularly
- Follow the care plan

Don'ts

- Avoid harsh soaps
- Avoid talcum powder
- Avoid perfumed cleansers/moisturisers
- Avoid soaking in a bath
- Shower 2nd daily if there is no soiling
- Water temperature should not be too hot
- Rough drying is discouraged

KEY POINTS

- Skin Care Products are a combination of humectant, occludent and emollients.
- Quality soap free pH cleansers and water base emollients should be recommended to all people over 60 years of age as dry skin becomes part of the aging process.
- Showers are preferable to baths
- Daily showers may reduce the lipid skin barrier protection.
- Disposable bath cloths are a good option
- Skin inspection should be conducted on all patients on a daily basis during personal care.
- A best practice general skin/foot care protocol should be implemented in all facilities to prevent or minimise skin damage.

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- Grieve K. Cleansers and moisturisers the basics. Wound Practice and Research 2015 Vol 23 Number 2 pp 76-81
- © 2023 The International Working Group on the Diabetic Foot Nicolaas C. Schaper1, Jaap J. van Netten2,3, Jan Apelqvist4, Sicco A. Bus2,3, Robert Fitridge5, Fran Game6, Matilde Monteiro-Soares7,8,9, Eric Senneville10, on behalf of the IWGDF Editorial Board
- https://www.diabetesfeetaustralia.org/wpcontent/uploads/2020/12/DFAPassportToFootDiseasePrevention_2020.pdf
- https://www.dva.gov.au/sites/default/files/files/providers/cn/dva-pcv-resource-basic-foot-care-may2020.pdf

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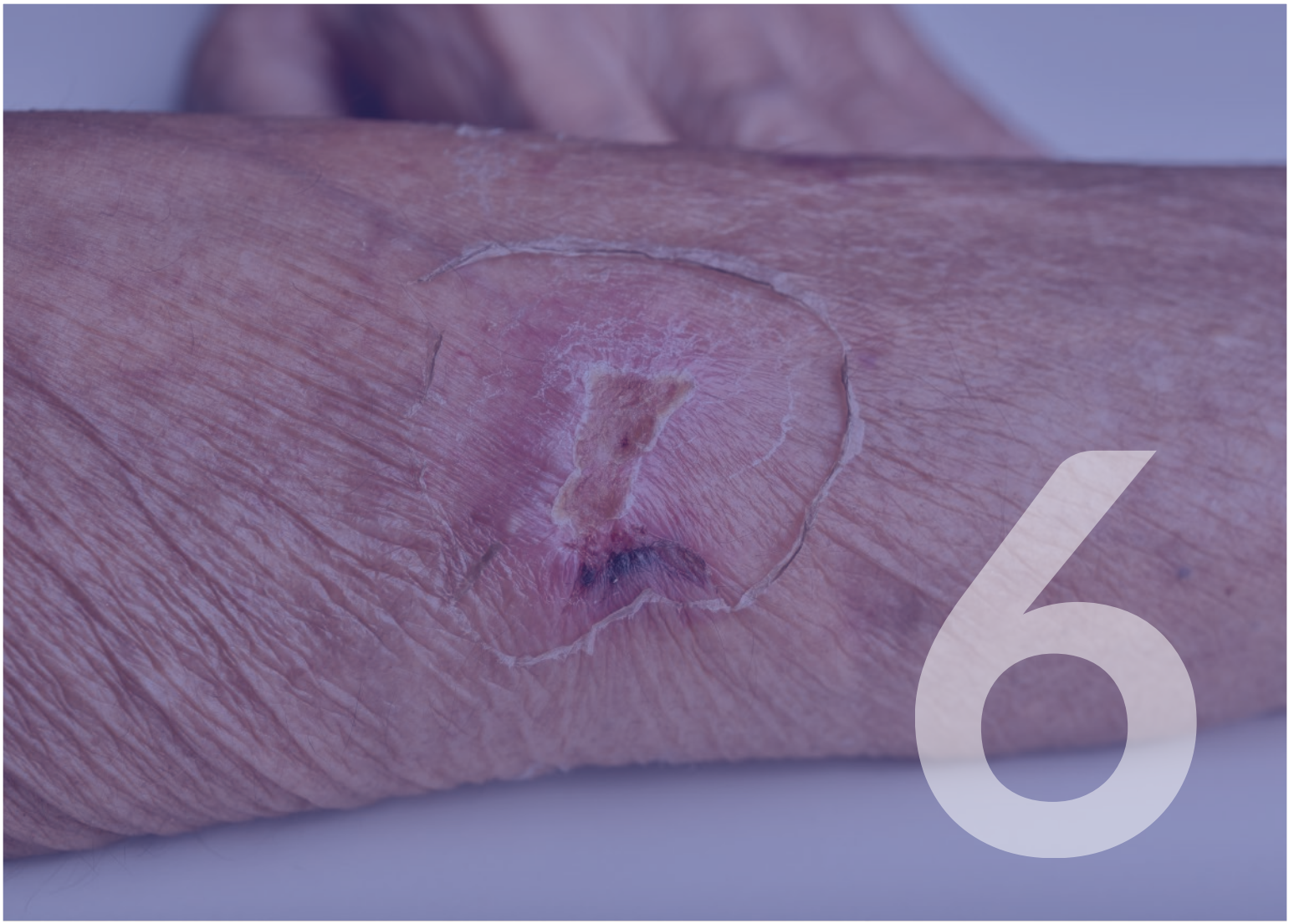


Skin Tear First Aid

Welcome to Lesson Six, which focuses on Skin Tear First Aid. This module will provide you with comprehensive information on how to prevent, assess, and provide first-aid care for skin tears. As a Personal Care Assistant (PCA), your knowledge and skills in skin tear care are crucial for ensuring the comfort and well-being of the elderly residents under your care.

This module offers valuable knowledge on skin tears and how to handle them with first aid care. It equips you with the skills to respond promptly in skin tear scenarios and teaches methods to take immediately to facilitate wound healing. Additionally, it covers the best practices for taking care of older adults with at-risk skin. It emphasizes the importance of high-quality skin tear reporting.

Practical tasks and simulated scenarios demonstrate critical steps in skin tear treatment, allowing you to apply your knowledge in a controlled environment. A multiple-choice assessment is included to evaluate your understanding of the module's concepts. Recommended readings and references are also provided to deepen your learning. We encourage you to engage with the content, practice the skills you acquire, and seek further information at your workplace whenever needed.

Let's begin this journey of mastering skin tear first aid together. By equipping you with the knowledge and skills to make a positive difference in the lives of the elderly residents under your care, we can enhance their well-being and wound-healing potential.

WOUND EDUCATION

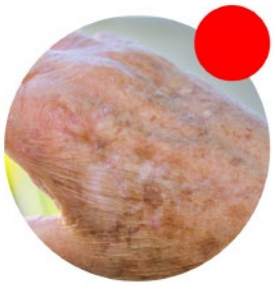
SKIN & WOUND CARE ESSENTIALS©

- *Personal Care Assistant (PCA)*
- *Skin Tear First Aid*
- *(0023GM6 S&WCE-Skin Tear)*

SKIN TEAR FIRST AID

MODULE 6 OVERVIEW

1. Knowledge & Performance goals
2. Defining what is a "skin tear"
3. Risk factor reduction
4. Severity of skin tears
5. 1st aid goal & Implementation of best practice



WOUND EDUCATION SKIN & WOUND CARE ESSENTIALS©

GOALS

KNOWLEDGE	PERFORMANCE
1. Further develop the PCA's knowledge and understanding of the prevention, assessment & 1st aid care of skin tears.	1. The PCA will complete a practical task demonstrating the key steps in best practice 1st aid skin tear management.
2. Improve the quality of skin tear documentation	
3. Promote best practices in the care of older adults with at-risk skin integrity.	

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SKIN TEARS

"

A skin tear is a traumatic wound caused by mechanical forces, including removal of adhesives. Severity may vary by depth (not extending through to the subcutaneous or fatty layer of the skin)

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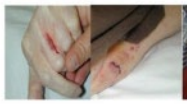
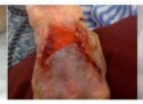
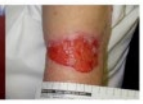
Notes

BEST PRACTICE

RISK FACTOR REDUCTION

Skin Tear Classification

Type 1: No Skin Loss	Type 2: Partial Flap Loss	Type 3: Total Flap Loss
		
Linear or Flap* Tear which can be repositioned to cover the wound bed	Partial Flap Loss which cannot be repositioned to cover the wound bed	Total Flap Loss exposing entire wound bed

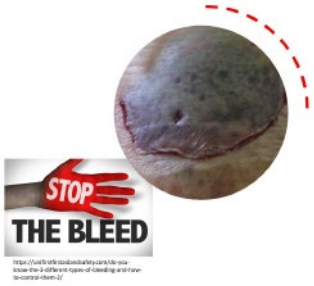
Beeckman D. & Van Tiggelen H. (2016) International Skin Tear Advisory Panel (ISTAP) Classification System – English version. Skin Integrity Research Group (SKINT), Ghent University. Available to download from www.skintears.net

GOAL:

STOP BLEEDING & CLEAN THE SITE

- Rinse the site with warm clean water or sterile saline
- Direct pressure on the site with a clean gauze
- Elevate the area above the heart
- Reassess if bleeding has stopped

Note: Bleeding caution if the resident is prescribed regular blood thinners



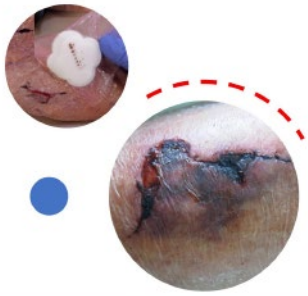
https://uwfirstaidandsafety.com/do-you-know-the-3-different-types-of-bleeding-and-how-to-control-them-2/

TISSUE RE-ALIGMENT

1. Cotton tip applicators
2. Roll flap back into place
3. Gently realign the flap into position
4. Use a skin prep film to secure the flap into position.
5. Assess the amount of skin loss to classify the tear
6. Protect the surrounding skin with the skin prep wipe
7. Cover with a silicone dressing and secure into position
8. Mark an arrow on the outside of the dressing (waterproof marker)
9. Use remover wipes if required
10. The RN should assess and determine the improvement/deterioration of the "flap take"

INCIDENT INFORMATION

1. How did the injury occur
2. What was associated with the incident
3. Consider factors; Skin, Mobility and General Health
4. Has the patient suffered from skin tears previously
5. How will care be changed to minimise risk
6. Wound description & image photo completed
7. Escalation "Stop & Watch"
8. Documentation & Reporting



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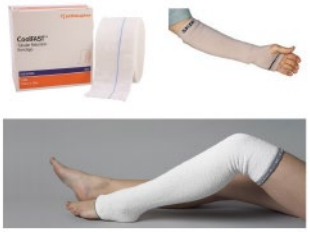
PREVENT RECURRENCE

- Skin moisturising
- Limb protection
- Adhesive remover wipes
- Avoid adhesive
- Daily skin inspection
- Apply protective padding to equipment
- Safe Safe manual handling – slide sheets
- Carer – short nails & no jewellery



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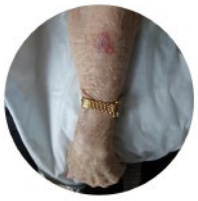
QUESTION

CAN YOU IDENTIFY A RISK FACTOR/S IN THIS IMAGE



ANSWER

Jewellery
Dry Skin

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KEY POINTS

- Bleeding must be stopped before dressing the wound
- Realigning the flap at the time of injury
- Reduce any blood between the flap and the wound bed
- Secure in position with a silicone dressing
- Date and arrow on the outside of the dressing
- Escalate, document and report the injury

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- https://www.skintears.org/
- Patricia Idensohn, Dimitri Beeckman, Vera Lucia Conceição de Gouveia Santos, Heidi Hevia Campos, Diane Langemo, Kimberly LeBlanc, Mary Gloeckner, Kevin Woo , Samantha Holloway. Ten top tips: skin tears. Wounds International 2019 | Vol 10 Issue 2 | ©Wounds International 2019 | www.woundsinternational.com
- www2.health.vic.gov.au/ageing-and-aged-care/residential-agedcare/safety-and-quality/improving-resident-care/standardised-care-processes
- Wounds UK (2020) Best Practice Statement: Management of lower limb skin tears in adults. Wounds UK, London. www.wounds-uk.com

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Wet Skin Conditions

Welcome to Lesson Seven: Wet Skin Conditions. This module focuses on preventing, assessing, and treating common wet skin conditions that affect older adults. As a Personal Care Assistant (PCA), your expertise in managing wet skin conditions is crucial for ensuring the well-being and comfort of the residents under your care.

The module will teach you best practices for preventing, assessing, and treating common wet skin conditions in older adults. You will learn how to assess skin conditions and select appropriate skincare products to prevent damage and preserve vulnerable skin.

Common wet skin conditions covered in the module include incontinence-associated dermatitis, moisture-associated skin damage, peristomal damage, and tinea. You will have the opportunity to apply your knowledge and skills in a workplace activity and reinforce your understanding with a multiple-choice assessment.

By completing this module, you'll be able to prevent, assess, and treat wet skin conditions, which will have a positive impact on the comfort and well-being of the residents you care for. We encourage you to engage with the content, practice the skills you acquire, and ask for clarification whenever needed.

Let's start mastering wet skin conditions and equipping you with the knowledge and skills to contribute to the health and quality of life of the elderly residents you care for. Let's get started!

WOUND EDUCATION

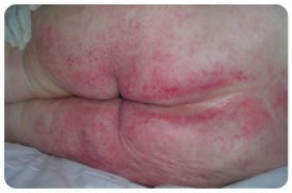
SKIN & WOUND CARE ESSENTIALS©

- *Personal Care Assistant (PCA)*
- *Wet Skin Conditions*
- *(0023HM& S&WCE-Wet Skin Conditions)*

WET SKIN CONDITIONS

MODULE 7 OVERVIEW

1. Knowledge & Performance Goals
2. Incontinence Associated Dermatitis
3. Moisture Associated Skin Damage
4. Peristomal Damage
5. Tinea

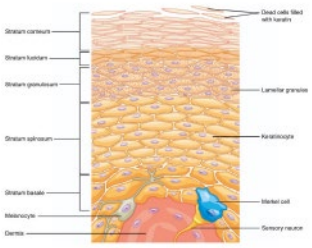


GOALS

KNOWLEDGE	PERFORMANCE
1. PCA training will improve skin health by learning best practices for preventing, assessing, and treating common wet skin conditions.	1. The PCA will demonstrate skin assessment and selection of skincare products to support healing.

SKIN BARRIER FUNCTION COMPROMISE

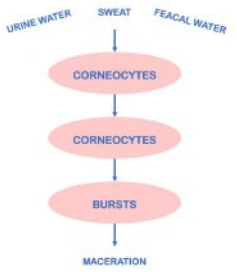
- Lamellar Lipids
- Natural Moisturising Factor (NMF)
- Sebum
- pH Acid Mantle
  - Contact with bodily fluids
  - Sweating
  - Wound Exudate
  - Mechanical force, friction.



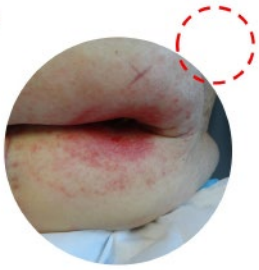
Notes

HOW DOES MOISTURE ASSOCIATED SKIN DAMAGE OCCUR?

- Contact with bodily fluids
- Sweating
- Wound Exudate
- Mechanical force, friction



PERISTOMAL SKIN BREAKDOWN



INCONTINENCE ASSOCIATED DERMATITIES

Continence Foundation of Australia

CLINICAL PRACTICE IMPORTANCE

- Duration of urine & faeces exposure
- Incontinence devices remaining in contact with the skin
- Skin protectants can reduce continence products absorption
- Frequent skin hygiene can increase risks of further breakdown. Corneocyte damage, lipid reduced, dryness, & friction forces.
- Abrasive cleaning techniques & products
- Use of occlusive products
- Malnutrition, Diabetes, Medications, Immobility

IAD CATEGORISATION TOOL (GLOBIAD)

IAD Categorisation Tool [2]	
Category	**Category Description**
Category 1A	Persistent redness without signs of infection. A variety of tones may be present. It could be pale or purple in dark skin.
Category 1B	Persistent redness WITH clinical signs of infection. Such as white scaling of skin or satellite lesions.
Category 2A	Skin loss without clinical signs of infection. Such as excoriation, denudation or skin erosion.
Category 2B	Skin loss WITH clinical signs of infection. White scaling skin/slough may be visible, shiny wound with excess exudate, green appearance may suggest a bacterial infection with Pseudomonas aeruginosa.

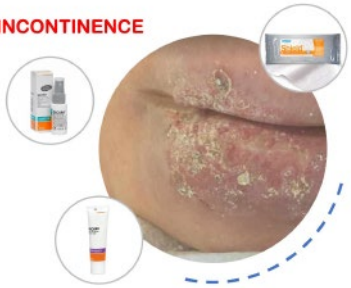
References: 1. Doughty,D et al. Incontinence-associated dermatitis. Consensus statements, evidence-based guidelines for prevention and treatment, and current challenges. J Wound Ostomy Continence Nurse. 2012;39:303-315. 2. Beeckman D, et al. The Ghent global IAD categorization tool (GLOBIAD). Skin integrity research group.- Ghent University 2017. 3. Beeckman D, et al. Incontinence-associated dermatitis: moving prevention forward. London: Wounds International, 2015.

PREVENTION

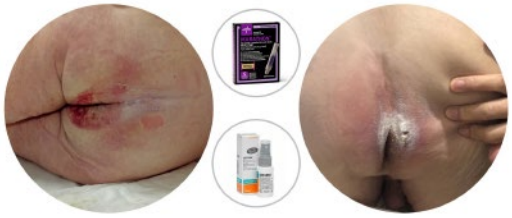
- Skin damage must be avoided by preventative treatment early
- If faecal incontinence is suspected a barrier film may be preferred
- Frequent application of barrier creams may be required if frequent liquid faeces occurs

BROKEN SKIN OR FAECAL INCONTINENCE

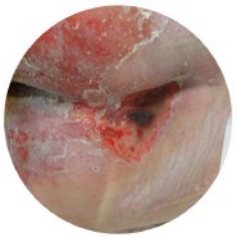
- Compatible to use on broken skin
- Permits incontinence pads to continue absorption
- Removes from the skin with minimal force
- Visualisation of skin



PREDICT THE RISK & PREVENT APPROPRIATELY



IAD & PRESSURE INJURIES CO-EXIST!



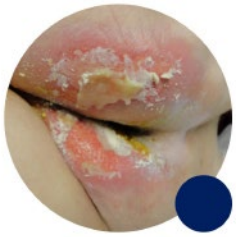
IAD

Fungal

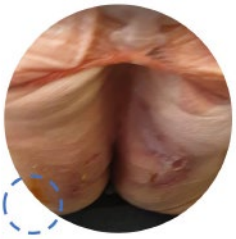
Zinc Problems

Pressure Injury

DIFFICULT BARRIER REMOVAL



SILICONE DRESSINGS



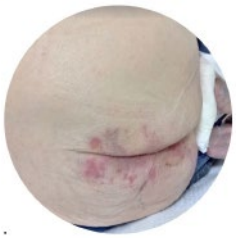
SKIN PROTECTANTS

TABLE 4 | Characteristics of the main types of skin protectant ingredients (adapted from[XXX17,18,XXX])

Principal skin protectant ingredient	Description	Notes
Petrolatum (petroleum jelly)	Derived from petroleum processing Common base for ointments	▪ Forms an occlusive layer, increasing skin hydration ▪ May affect fluid uptake of absorbent incontinence products ▪ Transparent when applied thinly
Zinc oxide	White powder mixed with a carrier to form an opaque cream, ointment or paste	▪ Can be difficult and uncomfortable to remove (e.g. thick, viscous pastes) ▪ Opaque, needs to be removed for skin inspection
Dimethicone	Silicone-based; also known as siloxane	▪ Non-occlusive, does not affect absorbency of incontinent products when used sparingly ▪ Opaque or becomes transparent after application
Acrylate terpolymer	Polymer forms a transparent film on the skin	▪ Does not require removal ▪ Transparent, allows skin inspection

Beeckman D et al 2015

WHAT IS THE CAUSE?



COMBINATION
Stage 1 pressure injury & IAD

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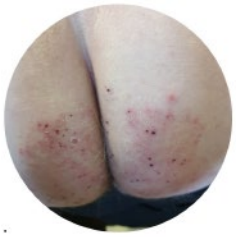
WHAT IS THE WOUND CAUSE?



SCABIES

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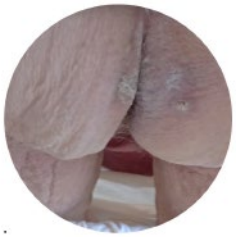
WHAT IS THE WOUND CAUSE?



IAD

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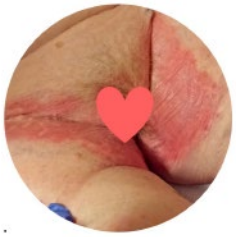
WHAT IS THE WOUND CAUSE?



IAD

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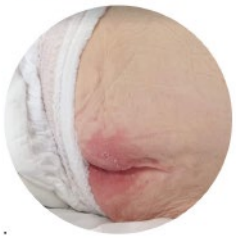
WHAT IS THE WOUND CAUSE?



COMBINATION
IAD & Stage 1 pressure injury

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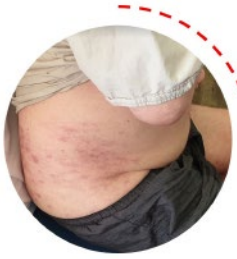
INTERTRIGO SKIN FOLDS (RASH)

- Inflammatory skin condition
- Opposing skin surfaces
- Friction forces
- Humidity
- Lack of air circulation



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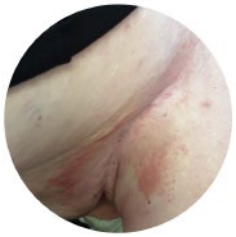
INTERTRIGO (WET RASH) GROIN



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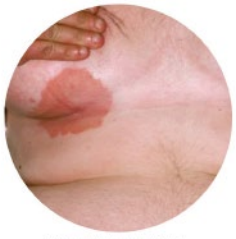
INTERTRIGO BREASTS



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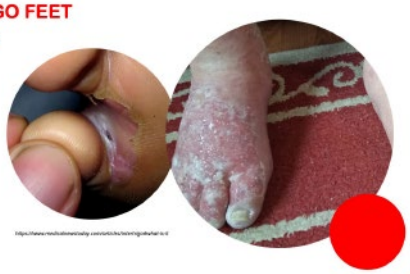
INTERTRIGO FEET

BETWEEN TOES



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Oedema Care

Welcome to lesson eight on leg swelling care. We'll cover a range of topics to help you understand the causes and effective care for leg sores and lower leg swelling.

Some of the key things you'll learn include how to correctly wear lower leg compression stockings to prevent skin damage, insights into the various causes of swelling, and strategies for providing help to individuals dealing with swelling.

You'll also have the opportunity to watch an instructional video on compression application techniques to enhance your practical skills. Your knowledge and understanding will be evaluated through a multiple-choice assessment.

By mastering leg swelling care, you'll be equipped with the knowledge and skills to contribute to the health and well-being of the elderly residents entrusted to your care. Let's begin this journey together!

WOUND EDUCATION

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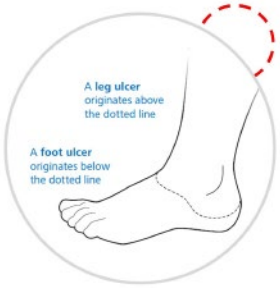
- *Personal Care Assistant (PCA)*
- *Leg Oedema & Care*
- *(0023)M8 S&WCE- Leg Oedema & care)*

Notes

LEG OEDEMA & CARE

MODULE 8 OVERVIEW

1. Knowledge & Performance goals
2. Leg Ulcers/Venous Leg Ulceration
3. Causes of oedema
4. Caring for oedema



GOALS

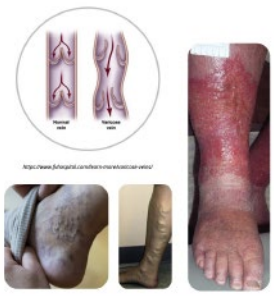
KNOWLEDGE	PERFORMANCE
1. Learn about the different causes of leg ulceration.	1. Imitate the safe method to put on lower leg compression hosiery to avoid skin trauma.
2. Best practice care for lower leg swelling caused by problems with the venous blood flow.	

VENOUS LEG ULCERATION

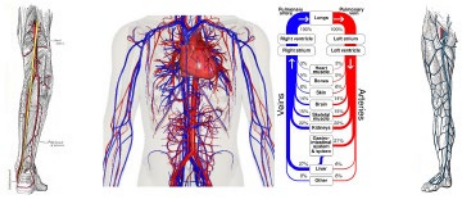
The vein system in the leg fails to return blood back up to the heart against gravity.

Prolonged high pressure in the veins due to:

- Muscle pump failure
- Venous obstruction
- Valve incompetence



ARTERIES & VEINS



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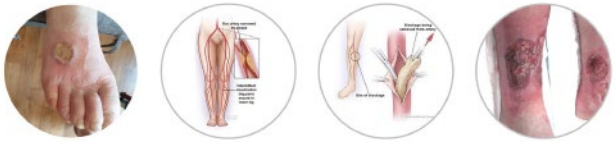
ARTERIAL ULCERATION

The arterial blood flow is reduced due to blockages in the vessel which limits tissue perfusion.



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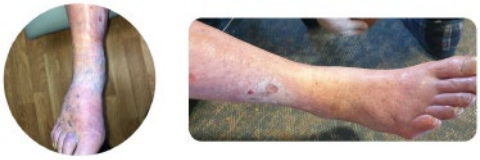
MIXED VENO-ARTERIAL LEG ULCERATION

Combination of venous & arterial disease. Blood supply is adequate that limb does not suffer gangrene.



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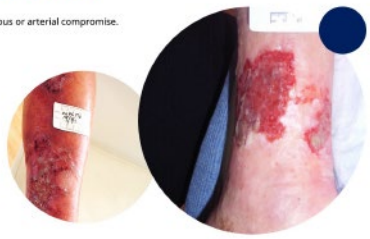
ATYPICAL LEG ULCERATION

Atypical symptoms unrelated to venous or arterial compromise.



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SWELLING NOT RELATED TO VENOUS ISSUES
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LYMPHOEDEMA WITH LEG ULCERATION
Tissue swelling due to failure of lymph drainage
Stage 1
Stage 2
Stage 3
Stage 4
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CAUSES OF OEDEMA
TYPE
Chronic Venous Insufficiency
Lymphoedema
Acute: DVT/Infection/Trauma
Systemic disease: Cardiac, Liver, Renal/Hypoalbuminemia, Pulmonary hypertension
Medication
Pregnancy/Obesity
Idiopathic
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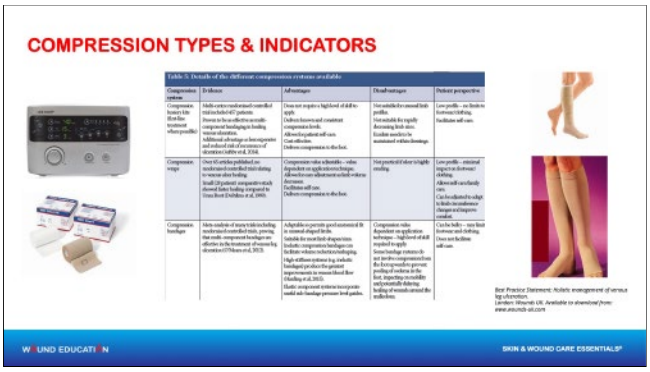
COMPRESSION TYPES & INDICATORS
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QUESTION

PEOPLE WITH SWOLLEN LEGS AND VARICOSE VEINS MAY SUFFER FROM LEG ULCERS.

- True
- False

TRUE

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WHAT IS PNEUMATIC COMPRESSION?

- Pneumatic compression **pump** that is attached to inflatable **garments**
- Air filled garments exert a pressure on the limb in sequential pattern
- Treatment **setting variation**:
  - Pressure
  - Cycle time
  - Duration
  - Order of inflation

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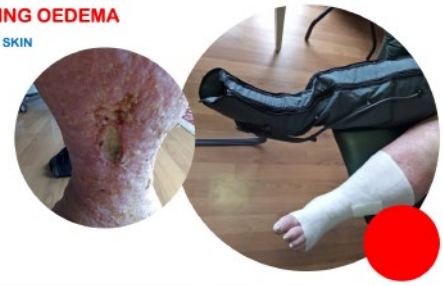
REDUCING OEDEMA

IMPROVING SKIN



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HOISERY APPLICATION HINTS

- Ensure skin is dry
- Use gloves to apply
- Nails trimmed no jewellery, hands moisturised
- Stocking inverted to heel section
- Use stocking applicator or slide to glide hosiery onto leg
- Slide to heel and position

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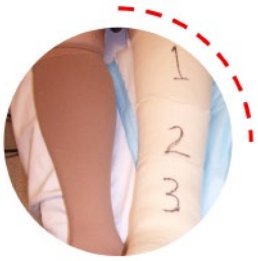
LIGHTER COMPRESSION

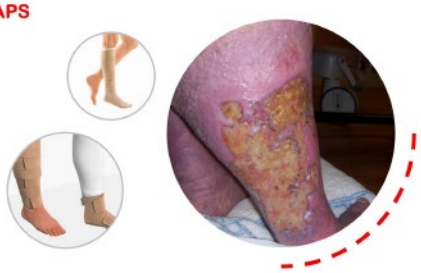
> *... patients can be prescribed up to 17 mmHg compression in the absence of a full vascular assessment if no risk factors for arterial insufficiency are identified.*



Best Practice Statement: Holistic management of venous leg ulceration. London: Wounds UK. Available to download from www.wounds-uk.com

COMPRESSION WRAPS

- Ease of application
- OH&S issues
- Durability
- Flexibility
- Footwear
- Cost effectivenss

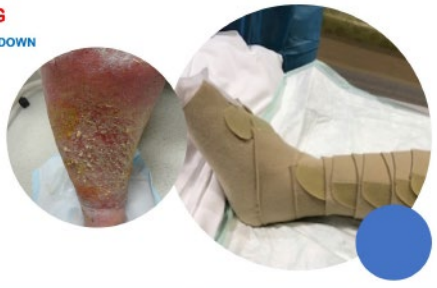


APPLICATION GUIDE – STEP BY STEP

For video on "How to Apply a Knee FarrowWrap™ see www.youtube.com/watch?v=ikAAgdH-gsnM

WET LEG

SKIN BREAKDOWN



SCENARIO

COMPRESSION APPLICATION

Mary has been wearing compression hosiery for over five years since being diagnosed with vein problems in her lower legs. In the past week, Mary has complained of aching legs, tight shoes, and skin breakdown from weeping fluid from her legs. Mary decides not to wear the stockings as they hurt trying to get on over her sore skin. Do you have any recommendations for the PCA on what they should do next?

- **Stop & Watch form**
- **Alert the RN**
- **Take an image of the skin breakdown**
- **Explain to Mary that you will arrange for the RN to review.**

KEY POINTS

- Most leg ulcerations are a result of the veins not taking blood back up to the heart
- Correct diagnosis of the cause of the leg swelling (oedema) is pivotal to selecting the correct treatment
- Compression is the best treatment for vein or calf causes of oedema
- Safe effective compression can be achieved with compression wraps that a PCA could apply.

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Pressure Injury Development

Welcome to lesson nine, where we'll focus on Pressure Injury Development in the aged population and the impact this can have on an individual's well-being. As a Personal Care Assistant (PCA), understanding pressure injury causes, risk factors, and stages is crucial to providing the best care to residents.

Throughout this module, you'll learn about the forces that cause pressure injuries, recognise risk factors that make individuals more susceptible to them, and understand the depth or staging of pressure wounds. You'll also engage in practical tasks to gain hands-on experience and familiarise yourself with relevant terminology.

At the end of the module, you will gain knowledge about the development of pressure injuries, which will help you identify individuals under your care who are at higher risk.

Let's get started!

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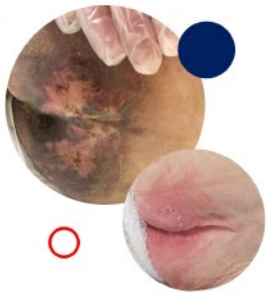
- *Personal Care Assistant (PCA)*
- *Pressure Injury Development*
- *(0023KM9 S&WCE- Pressure Injury Development)*

Notes

PRESSURE INJURY DEVELOPMENT

MODULE 9 OVERVIEW

1. Knowledge & Performance goals
2. Terminology
3. What is a pressure injury?
4. What causes a pressure injury?
5. Who is vulnerable
6. Pressure injury stages



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GOALS

KNOWLEDGE	PERFORMANCE
1. Learn what forces contribute to pressure injury development	1. By completing activities that mimic friction, shear, & pressure forces, the learner will understand prevention strategies.
2. Highlight the risk factors which make a person more vulnerable to developing a pressure injury	
3. Recognise the severity staging of a pressure wound	

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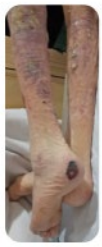
PRESSURE INJURY DEFINITION

"A pressure injury is a 'localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction'.



Australian Commission on Safety and Quality in Health Care, Safety and Quality Improvement Guide Standard 8: Preventing and Managing Pressure Injuries (October 2012). Sydney: ACSHQC 2012.(Accessed June 2017)

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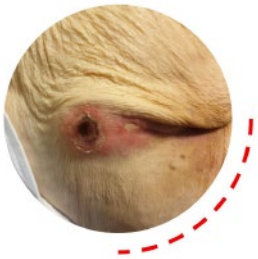
TERMINOLOGY

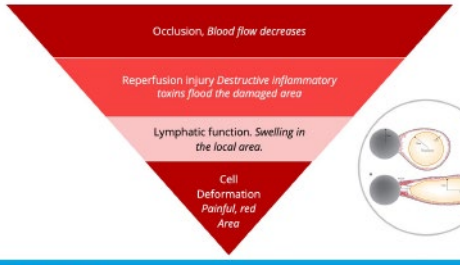
- Decubitus 'dead tissue due to lying down', (Wohlleben 1777)
- Bedsore (Glasgow 1975)
- Pressure Sore (1980's)
- Pressure Ulcer
- Pressure Injury
- Cause
  - Avoidable/Unavoidable

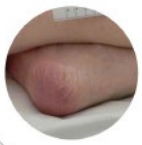


FRICTION

MICROCLIMATE FRICTION + Shear or Pressure	SUPERFICIAL INJURY
SHEAR PRESSURE	DEEP PRESSURE INJURY

PRESSURE (THE INSIDE OUT WOUND



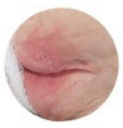


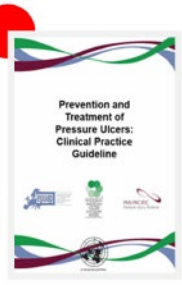
PRESSURE FORCE SCENARIO

Jack cannot mobilise by himself around the facility. The nurses have secured an alternating pressure mattress over his existing mattress to minimise pressure on his body.

On Friday nights, Jack enjoys watching the two televised football games in the lounge room.

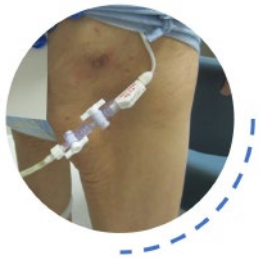
On Saturday, the PCA caring for him noticed two red areas on Jack's sacrum.





MEDICAL DEVICE RELATED PRESSURE INJURY (MDRPI)

- Scope of the MDRPI problem
- Risk Factors
- Common causes
- Common sites
- Avoidable or Unavoidable



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FRICTION STRESS NOT A PRESSURE INJURY

- Fluid filled blister from rubbing.
- Superficial damage to the epidermis.
- Not associated with sustained pressure or shear force.

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FRICTION FORCE SCENARIO

Bill Jones is bedridden and unable to communicate verbally. The PCA notices he has become more agitated following repositioning. He witnessed him vigorously rubbing his heel across the sheet-covered mattress. This has caused a small fluid-filled blister on the heel. The RN assesses Bill and determines he is in discomfort from his arms contracting. The healthcare team notifies his GP and asks them to review his pain medications.

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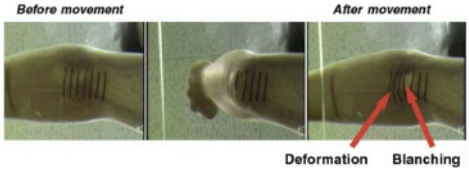
SHEAR STRESS

Shear strain, deforms the cell wall and interferes with cell metabolism causing cell death.



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SHEAR STRAIN

- Shear strain requires mechanical force and friction.
- Sliding bare skin on a slippery dip – no friction BUT tissue loading
- Add a sliding sack reduces friction

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SHEAR FORCE SCENARIO

June is a frail lady who has been unwell for the past seven days. Her appetite is poor and she is reluctant to sit out of bed as she feels weak. Cathy her PCA sits her upright in bed to assist her with her lunchtime meal. After lunch, Cathy notices that June has gradually slid down the bed.

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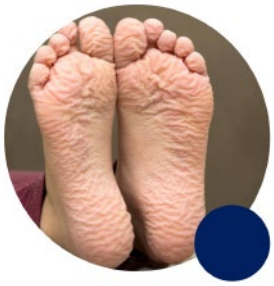
MICROCLIMATE

A small area of increased skin temperature and moisture.
Increases the risk of pressure injury development.



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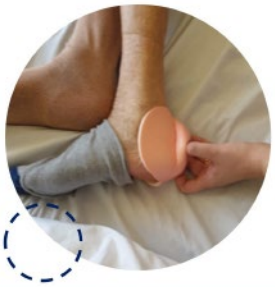
MICROCLIMATE SCENARIO

Two days ago, Fred returned to the facility following a day surgery procedure. During his stay in the recovery ward, he noticed a slight burning pain in his left heel. The nurse quickly fixed the issue by covering the heel with a waterproof silicone dressing. The dressing has remained in place since being back at the facility. Today, he felt his sock to be damp. The PCA removed the dressing to find wet soggy skin.



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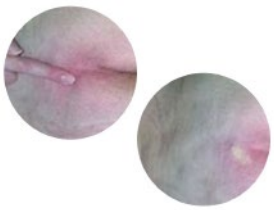
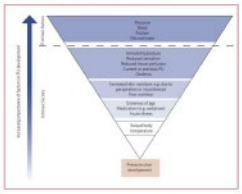
SKIN ASSESSMENT



- Colour
- Temperature
- Oedema
- Turgor
- Moisture
- Integrity
- Sensation
- Medical Device

- Daily Inspection
- Head to Toe
- Nails & Hair
- Skin Folds
- Pressure Points

FACTORS OUTSIDE THE BODY & INSIDE THE BODY



World Union of Wound Healing Societies (WUWHS) Consensus Document. Role of oncology in pressure ulcer prevention. Wounds International, 2016

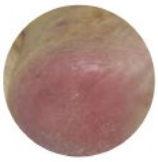
QUESTION

WHO IS MORE AT RISK OF PRESSURE DAMAGE

A. A resident independent in mobilising with a walking frame
B. An elderly resident confined to bed and requires assistance to reposition
C. A 55-year-old resident who mobilises unaided but suffers from dementia
D. A 20-year-old male admitted to hospital with appendicitis

B

SKIN ISPECTION CHART



Skin Check


STAGE 1
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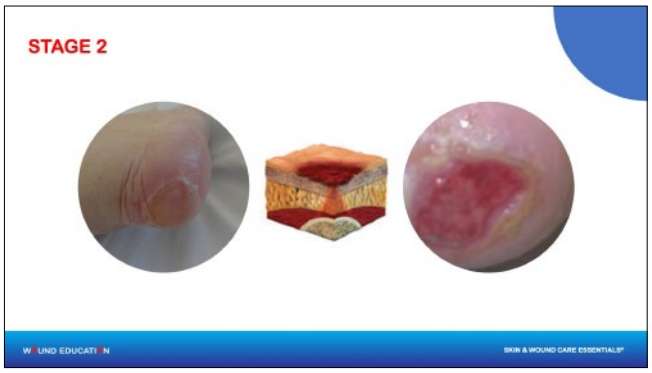
STAGE 2
WOUND EDUCATION
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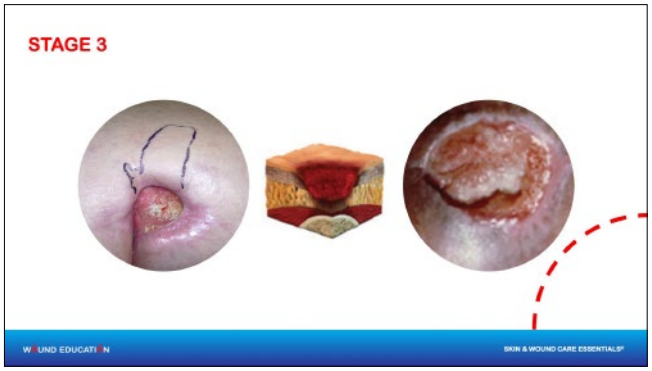
STAGE 3
WOUND EDUCATION
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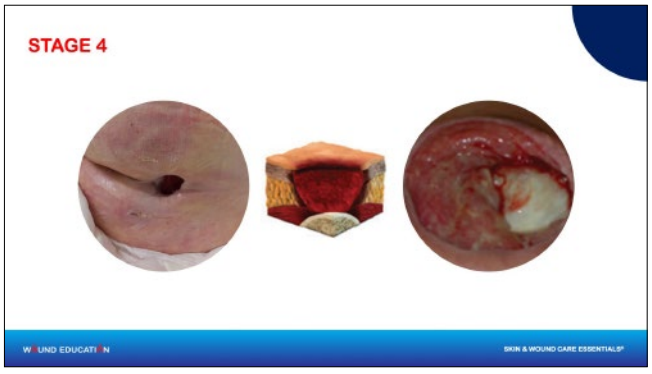
STAGE 4
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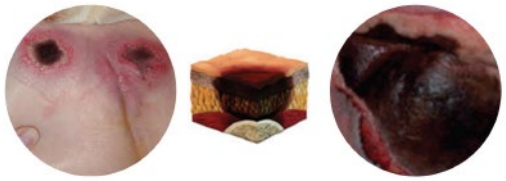
UNSTAGEABLE



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DEEP TISSUE INJURY

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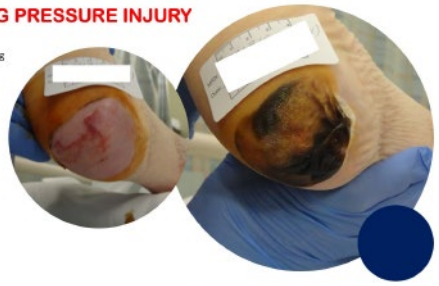
HEALING PRESSURE INJURY

No reverse staging



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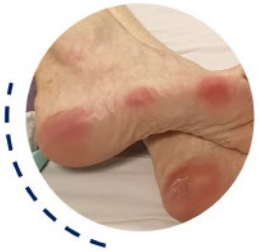
QUESTION

WHAT STAGE?

- Multiple non-blanchable areas bilateral feet

STAGE 1



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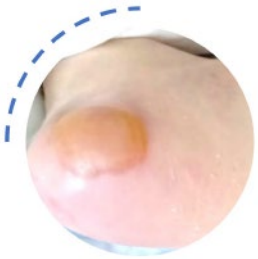
QUESTION

WHAT STAGE?

- Painful fluid filled blister on the heel

STAGE 2 WATCH & ACT



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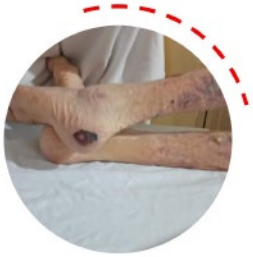
QUESTION

WHAT STAGE?

- Dry blood blister on the heel.

UNSTAGEABLE



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KEY POINTS

- Regular skin checks and assessing risk factors are essential in preventing pressure injuries.
- The degree of mechanical strain or load on the body surface will determine the tissue strain or damage.
- Pressure applied to the skin against an internal bone causes small blood vessels to be squeezed closed, which reduces blood flow.
- Educating residents and families can help prevent pressure injuries and support the healthcare team.
- Different ways of learning are available for training preferences
- The PCA can reinforce critical messages using appropriate terminology and language.

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REFERENCES

- Australian Commission on Safety and Quality in Health Care March 2018, last updated June 2018. https://www.safetyandquality.gov.au/sites/default/files/2019-05/saq7730_hac_factsheet_pressureinjury_longv2.pdf
- National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014
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- https://clinicalexcellence.qld.gov.au/sites/default/files/docs/safety-and-quality/pressure-injury-brochure.pdf
- https://clinicalexcellence.qld.gov.au/sites/default/files/docs/safety-and-quality/pressure-injury-brochure.pdf
- https://www.sahealth.sa.gov.au/wps/wcm/connect/58cc1380420ca0749a0cbff8b1e08c6d/13132.1+Pressure+Injury+FS+%28v4%29Oct2014web5ecure.pdf?MOD=AJPERES&CACHE
- https://nhs.stopthepressure.co.uk/docs/NHS_Midlands_East-How_to_educate_patients.pdf
- Renae O'Toole Clinical Practice Improvement Nurse Quality & Risk Unit St Vincent's Hospital Melbourne https://www.svhm.org.au/ArticleDocuments/3201/Stop%20Pressure%20Injury.pdf.aspx?embed=y

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Pressure Injury Prevention

Welcome to Lesson Ten: Pressure Injury Prevention & Care! This module is dedicated to helping you prevent and care for pressure injuries, which is a crucial aspect of your role. Throughout this module, you will gain knowledge and skills to reduce pressure injury risks and provide essential care.

In this module, you will learn how to minimise skin damage caused by different forces and choose appropriate equipment that prevents pressure damage and aids in providing effective care. You will also understand when certain equipment is not suitable for specific situations, which is critical in preventing harm and ensuring safe care. Through simulated activities, you will assess the level of pressure reduction achieved through different strategies, increasing your understanding.

Your commitment to learning demonstrates your dedication to providing safe and effective care. This knowledge will help you to make a big difference in the lives of those in your care. Join me on a journey to learn more about pressure injury prevention and care. Together, you will acquire the necessary skills and insights to provide the best possible care.

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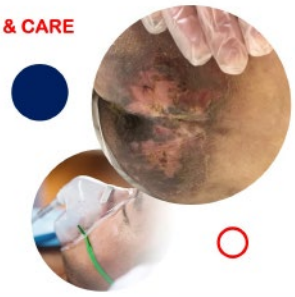
- *Personal Care Assistant (PCA)*
- *Pressure Injury Prevention & Care*
- *(0023LM10 S&WCE- Pressure Injury Prevention & Care)*

Notes

PRESSURE INJURY PREVENTION & CARE

MODULE 10 OVERVIEW

1. Knowledge & Performance goals
2. Pressure injury prevention actions
3. Appropriate equipment
4. Inappropriate equipment



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GOALS

KNOWLEDGE	PERFORMANCE
1. Learn what equipment and/or action minimises skin damage from the various forces.	1. The PCA will complete activities to evaluate the pressure reduction amount.
2. Choose appropriate equipment to avoid pressure damage	
3. Recognise why equipment can be inappropriate	

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MOBILITY & REPOSITIONING

- Assess independence
- Monitor tissue tolerance
- Minimise shearing force
- Slide sheets & movement devices
- Bed sticks and independent movement
- Tilting & load shift
- Turning clocks & documentation

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EQUIPMENT

PREVENTION DRESSINGS

- Use a prevention dressing to reduce heel/sacrum injuries.
- Several layered silicone dressings
- Elastic adhesive dressing
- Effective for friction, microclimate & shear forces.

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PREVENTION DRESSING INDICATION

- Immobility or Planned immobility
- Reduced spontaneous movement
- Unusual/uncontrolled movements
- Medical device in place
- Previous pressure injury

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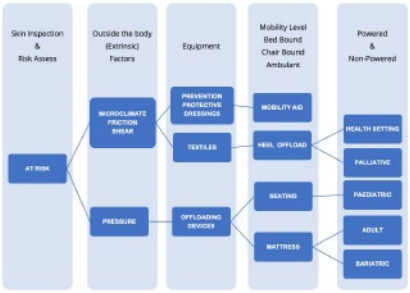
EQUIPMENT

SELECTION PREVENTION



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EQUIPMENT

EFFECTIVENESS & MAINTENANCE

- Inflation pressure to weight
- Interface pressure mapping
- Valves and effective inflation
- Cleaning standard
- Reusable equipment pool
- Skin assessment

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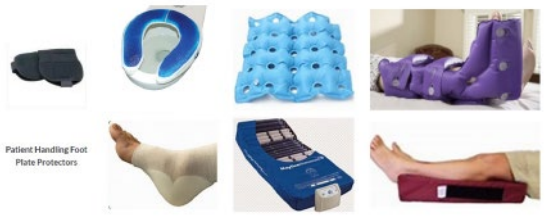
APPROPRIATE EQUIPMENT



Patient Handling Foot Plate Protectors

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QUESTION

IS IT INAPPROPRIATE FOR A NURSE OR PCA TO ACCEPT A RESIDENT'S/FAMILY'S PREFERENCE NOT TO HAVE AN ALTERNATING MATTRESS IN PLACE?

- **YES.**
  It is important to consider the wishes of the resident and family when a patient is receiving palliative care.
- **Importantly the patient & family must be educated in pressure injury prevention/management to allow an informed decision and all alternative offloading options should be offered.**

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INAPPROPRIATE EQUIPMENT

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INAPPROPRIATE EQUIPMENT

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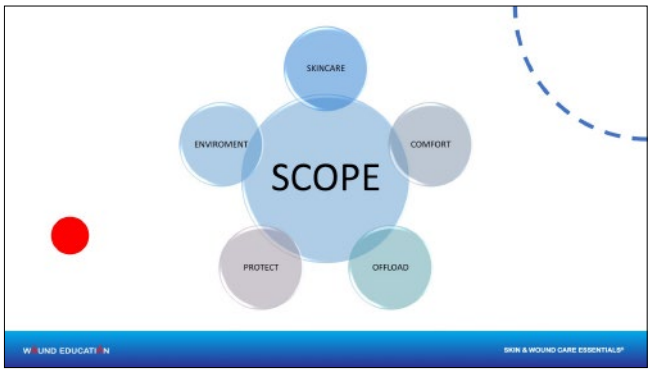
QUESTION

DESCRIBE WHEN A NURSE WOULD APPLY A PREVENTATIVE DRESSING FOR A RESIDENT WITHOUT SIGNS OF PRESSURE DAMAGE ON THEIR SKIN.

- Immobility or Planned immobility
- Reduced spontaneous movement
- Unusual or uncontrolled movement
- Medical device in place
- Previous pressure injury



KEY POINTS

- Equipment continues to grow and improve. Addressing the cause of the pressure risk/damage will support appropriate equipment selection.
- Dressings have a role in preventing micro-climate, friction, and shearing forces.
- Medical Device Related Pressure Injury (MDRPI) can be avoided if pre-empting potential damage and preventing injury with appropriate products

REFERENCES

- Australian Commission on Safety and Quality in Health Care March 2018, last updated June 2018. https://www.safetyandquality.gov.au/sites/default/files/2019-05/saq7730_hac_factsheet_pressureinjury_longv2.pdf
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- https://www.woundsource.com/blog/tools-trade-pressure-injuryulcer-prevention-and-medical-devices


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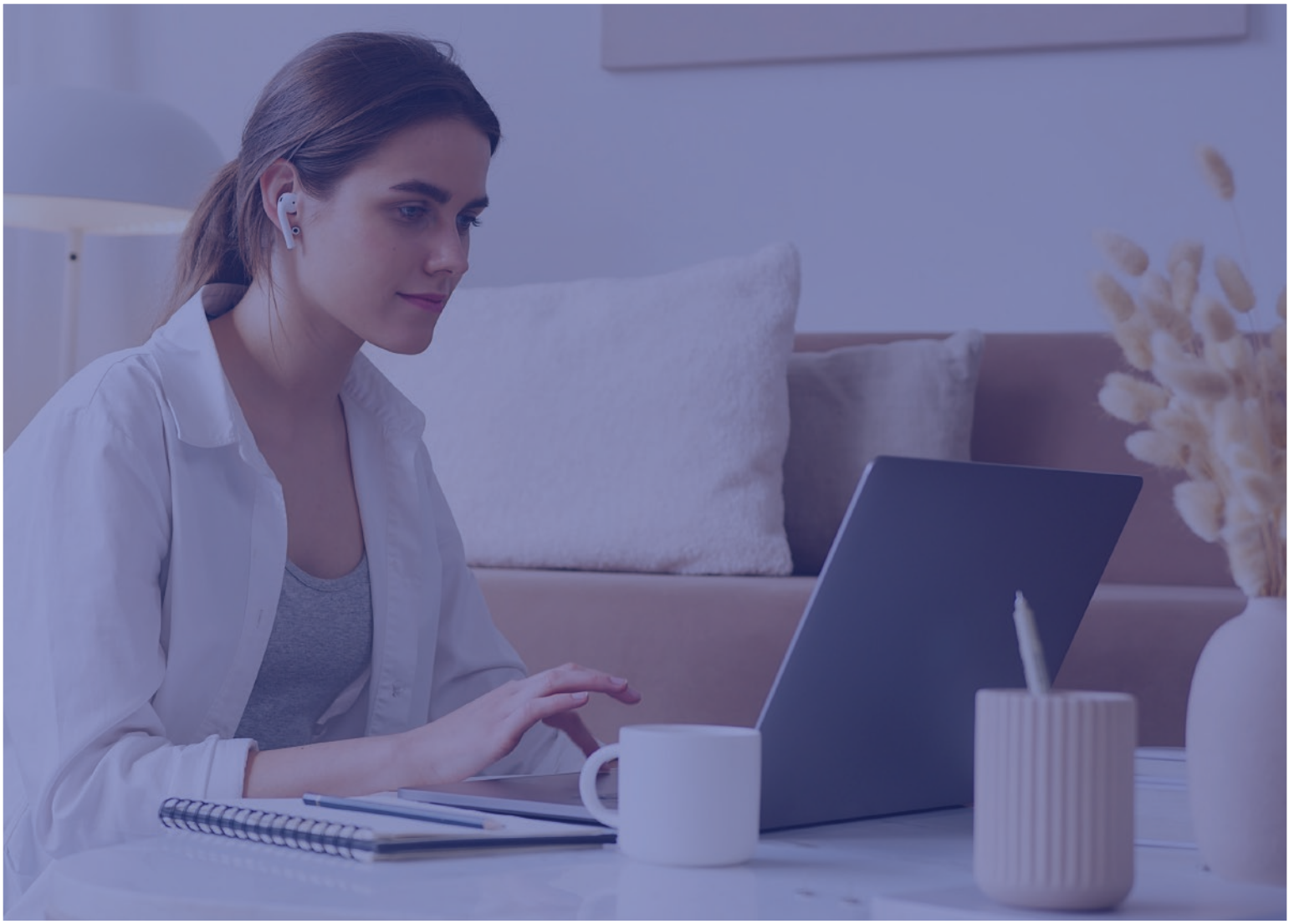

Conclusion

Congratulations for completing the Skin and Wound Care Essentials Course for Personal Care Assistants.

Your ongoing learning experience will make a difference in the lives of the older adults you care for. In our final video we emphasise the importance of your role in ensuring the safety and well-being of the older adults. We highlight the significance of the stop and watch reporting system and the ISBAR tool in communication.

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