care inspectorate

# Tissue Viability

## Evidence gathering tool


HAPPY TO TRANSLATE®

# Tissue Viability/Inspection/Care Trigger/Evidence Gathering Tool

**Care service name**

_____

| **CS number** | **C** | **S** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

**Date of inspection:** _____

Information contained in the tool is based on the good practice recommendations from Healthcare Improvement Scotland:

- Prevention and Management of Pressure Ulcers Standards (2016)
  http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/pressure_ulcer_standards.aspx

- Best Practice Statement (March 2009): Prevention and management of pressure ulcers
  http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/pressure_ulcer_best_practice.aspx

This care trigger/evidence gathering tool is designed to assist Inspectors in identifying appropriate tissue viability practice whilst carrying out inspection or complaint visits. The tool in its entirety does not have to be completed to establish good practice.

The tool can also be used by service providers to benchmark their practice against national best and expected practice.

This publication is also based on other tissue viability best practice guidance and documentation quoted in this tool is available to download from:
http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability.aspx

All legal references in this tool are from:

- Public Services Reform (Scotland) Act 2010
- Scottish Statutory Instrument No. 210
  The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011

## 1 Policies and Procedures/Governance

**1. Does the service have policies in place that cover the key elements below?**

- Skin assessment and care YES ☐ NO ☐
- Pressure ulcer prevention YES ☐ NO ☐
- Wound Assessment/Management YES ☐ NO ☐
- Skin tears/minor trauma injuries YES ☐ NO ☐

**2. Are the content of these policies in line with current best practice?**

YES ☐ NO ☐

**3. Are staff familiar with the policies/procedures?**

YES ☐ NO ☐

**4. Is the Pressure Ulcer Safety Cross in use?**

YES ☐ NO ☐

**5. If no, are the service using another method to monitor pressure ulcer incidence/prevalence?**

YES ☐ NO ☐

**Method** _____

**Sources of Evidence:**

- View policies and content (implementation and review dates).
- Discuss content with manager.
- Staff awareness of policy content and can use this to demonstrate good practice and their individual roles and responsibilities.
- Staff training is delivered when policy is implemented/reviewed.
- Staff have regular training updates on tissue viability for example, local TVN or other health professional, NES workbook or SVQ tissue viability module.
- Service have records of pressure ulcer free days or safety cross pressure ulcer incidence/prevalence data collection charts.
- The service/organisation have a named lead for tissue viability.

**Outcomes for people:**

Staff working in the service have access to up-to-date policies and information based on current good practice and guidance which inform their practice and care for people using the service to ensure good skin care, prevention and management of pressure ulcers and any other types of wounds.

Leadership and management within the home ensure that there is a focus on maintaining people's skin integrity and preventing pressure ulcers.

## 2 Skin Examination and Care

1. The pre admission assessment covers details of skin integrity/pressure ulcers/ wounds.

2. All individuals have a full skin examination on admission to the service and an assessment is completed, dated and signed.

3. Where skin conditions are identified for example, dry skin, dermatitis, redness, skin care topical application and continence dermatitis, there is a clear plan of care to manage this.

Skin

4. Staff refer to the Excoriation & Moisture Related Skin Damage Tool (2015) to differentiate between continence dermatitis and grade one pressure damage and to the Scottish Adapted European Pressure Ulcer Advisory Panel (EPUAP) Grading Tool for darkly pigmented skin, ungradable pressure damage or suspected deep tissue injury etc.

5. Staff have access to training/education about skin assessment and care.

**Sources of evidence:**

- Skin integrity details are recorded on pre admission assessment.
- Evidence that skin assessment is carried out on admissions and outcome of this is recorded in the personal plan for example, use of a body map to indicate any skin issues.
- Skin care and tissue viability care needs are identified/continued for example, prescribed topical applications, therapeutic equipment (static/active mattress, seat cushions etc.), wound management products.
- Individuals who have any skin issues for example, dry skin or a skin condition for example, psoriasis, have a skin care plan in place detailing prescribed care and treatment. This includes:
    - description of the skin care need for example, dry
    - aim of treatment for example, to rehydrate skin
    - the type of cream and strength where applicable
    - which part of the body it is being applied to
    - apply how much - thin or thicker layer - fingertip measurements - for steroids or other creams with active ingredients
    - application method - rubbed in gently, apply generously
    - how often applied.
- Record of administration of prescribed skin care products on TMAR charts
- Evidence of the Skin excoriation tool (2015) being used to grade/manage excoriated skin. Use of Scottish Adapted European Pressure Ulcer Advisory Panel (EPUAP) Grading Tool assessment tool for darkly pigmented skin, or suspected deep tissue injury etc., where appropriate.
- Discuss individuals skin care needs and practice with staff.

**Outcomes for people:**

Individuals admitted to the home are assessed and plans of care put in place to ensure that their care needs are continued to maintain skin integrity/skin conditions.

**References to good practice:**

- Healthcare Improvement Scotland: Prevention and Management of Pressure Ulcers Standards (2016) http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/pressure_ulcer_standards.aspx
- NHS QIS (now HIS) Best practice statement (2009) Prevention and management of pressure ulcers http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/pressure_ulcer_best_practice.aspx
- NHS Fife Skin care / older people http://www.nhsfife.org/nhs/index.cfm?fuseaction=nhs.servicedisplay&objectid=D4FD9D91-A3C5-785D-0D15AC75EA54011A
- NES website Pocket guide to dermatology (2012) Common skin conditions explained. http://www.nes.scot.nhs.uk/media/705715/dermatology_guide__amended_may_2012_.pdf
- Care of the older persons skin: Best practice statement (second edition) 2012 Wounds UK http://www.wounds-uk.com/best-practice-statements/care-of-the-older-persons-skin-best-practice-statement-second-edition%26print
- Skin excoriation tool/assessment tool for darkly pigmented skin http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/grading_and_tools.aspx
- Prevention and management of Pressure Ulcers – Educational Workbook 2015 (NES) http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/healthcare-associated-infections/educational-programmes/tissue-viability/prevention-and-management-of-pressure-ulcers-an-educational-workbook.aspx
- Skin integrity in the older person: Assessment and management to optimise skin health workbook (2015) http://hub.careinspectorate.com/media/395474/skin-integrity-in-the-older-person-assessment-and-management-to-optimise-skin-health.pdf http://hub.careinspectorate.com/media/395518/skin-integrity-focus-presentation.pdf

## 3 Risk Assessment – Pressure Ulcer Prevention

1. Individuals are assessed using a formal pressure ulcer risk assessment tool on admission and at regular intervals.

2. Services who do not have nurses, may implement the PPURA, (preliminary pressure ulcer risk assessment) (2009) along with clear guidance on when to report changes in continence, nutrition and monitoring for care staff to follow.

3. Individuals identified 'at risk' have an appropriate pressure ulcer prevention care plan specific to their needs.

**Sources of evidence:**

- The service have implemented a formal risk assessment process as part of the policy for example, adapted Waterlow scale (2005)/Braden scale (1988) or preliminary pressure ulcer risk assessment (PPURA).
- Staff are trained in the use and application of the risk assessment tool.
- Initial risk assessment is carried out on admission, within a defined timescale and documented.
- Those identified at any degree of risk have a pressure ulcer prevention plan in place.
- Risk assessment is monitored at specified intervals or if the individuals condition (improves or deteriorates) or treatment changes.
- Staff are aware of their responsibilities for identifying and escalating changes in the persons skin and overall condition.
- Where PPURA is in place, care staff demonstrate that they are aware of policy guidance to report any changes and to whom.

**Outcomes for people:**

Individuals will have their pressure ulcer risk status identified and recorded on admission, at regular intervals and when there is a change in their condition as part of a preventative approach.

**References to good practice:**

http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/risk_assessment.aspx

## 4 Pressure Ulcer Prevention Care Plans

1. Individuals who are identified at any level of risk (low, medium, high) have a plan of care devised and implemented to meet their individual needs.

2. There is a person centred and multi professional approach to care planning

3. The care plan contains sufficient detail outlining pressure ulcer prevention/ actions/interventions.

4. Other contributing factors should be taken into consideration for example, continence nutrition and have separate care plans in place.

**Sources of evidence:**

- Prevention care plans should be individual to the person and contain information about the following:
  - level of risk and skin integrity
  - type of mattress in use (with settings for active mattresses)
  - type of chair cushion in use (with settings for active seat cushions)
  - required frequency of skin checks
  - required frequency of positional changes - repositioning chart or SSKIN bundle in use
  - any other relevant individual skin care interventions
  - required frequency of the risk assessment/care plan review.
- Other contributing factors for example, reduced mobility, incontinence, nutrition, pain levels have been assessed and individual care plans developed.
- SSKIN bundle (**s**urface, **k**eep moving, **i**ncontinence, **n**utrition) can be used to document care is carried out.
- Care plans are implemented, have a specific timescale for review, and are monitored and amended as the persons condition improves/deteriorates.

**Outcome:**

There is a risk assessment carried out and an individualised plan of care devised to suit persons pressure ulcer prevention needs and that their skin integrity is maintained.

**References to good practice:**

SSKIN bundle
http://www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability/sskin_bundle.aspx

Repositioning and skin inspection chart
http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/repositioning_skin_inspection.aspx

## 5 Use of Specialist Equipment (beds, pressure reducing mattresses, seat cushions/other aids)

1. The service provides a range of static/active pressure reducing equipment. There is an inventory of this equipment in place and kept up-to-date to reflect individual changing needs.

2. Pressure reducing foam mattress should be in place as a precaution on all beds in the service.

3. All individuals assessed as being at risk of pressure ulcer development have the appropriate level of pressure reducing equipment to suit their level of risk (low/medium/high risk).

4. The required equipment is in use when the person is in bed or sitting up.

**Sources of evidence:**

- The service has guidance on the provision and allocation of equipment for at risk residents as part of the pressure ulcer prevention policy.
- The service provides a range of static and active pressure reducing specialist equipment to meet individual's needs.
- The manager has a record/equipment/inventory and can demonstrate how these resources are being used to meet individuals needs.
- Other pressure aids can be in use such as heel protectors.
- Specific specialist equipment in use is documented in the residents care plan, with settings where appropriate. This is observed to be in use by the person.
- The electrical mattress/seat cushion equipment is tested and maintained by the service.
- Mattress cleaning/turning protocols are in place based on manufacturer's recommendations.
- Staff have training in the use and application of tis equipment to ensure it is used safely, effectively and appropriate to need.

**Outcomes for people:**

People at risk or with pressure ulcers have access to appropriate pressure reducing equipment and aids to promote comfort as well as pressure reduction to ensure that skin integrity is maintained.

**References to good practice:**

NES (2012) Preventing infection in care
http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/healthcare-associated-infections/training-resources/preventing-infection-in-care.aspx

Guidance on the provision of Equipment and Adaptations (2009)
http://www.sehd.scot.nhs.uk/publications/CC2009_05.pdf

NHS Scotland: Infection Control in Adult Care Homes: Final Standards (2005)
http://www.gov.scot/Resource/Doc/37428/0012530.pdf

## 6 Wound Assessment, Management and Grading

1. The service has implemented an objective pressure ulcer/wound assessment process.

2. All pressure ulcers are graded using the Scottish Adapted EPUAP grading tool (2015).

3. Wound management/treatment is planned for each individual based on a full assessment of the wound.

4. Pain is assessed/managed appropriate to individual need.

5. Specialist input is sought for residents with complex, non-healing pressure ulcers/wounds such as Tissue viability nurse, District nurse or Care home liaison nurse, as appropriate.

**Sources of evidence:**

- All residents with pressure ulcers or wounds have initial (for example, body maps) and on-going assessments (tick box chart) in place.
- A care plan is in place which outlines:
  - The aim of treatment for example, to debride
  - Method of cleansing if required (for example, warm tap water/normal saline)
  - Specific prescribed topical skin applications
  - Dressings to be applied in order of application
  - Where required, bandages and method of application for example, toe to knee, spiral application etc.
  - Frequency of dressing changes
  - Frequency of re-assessment (tick box chart) in relation to wound care.
- Separate assessments and care plans for each pressure ulcer/wound is good practice.
- Following assessment, nursing staff should refer to the local NHS wound management formulary and the Scottish wound assessment and action guideline (SWAGG) for dressings and treatment.
- MAR charts or alternative documentation for example, wound treatment chart is examined to ensure that there is a record of all prescribed dressings being applied and are signed for when administered.
- Pain in relation to wound care is assessed at intervals appropriate to individuals needs and appropriate interventions undertaken for example, discussions with GP. It may be appropriate to use a separate pain assessment tool.
- A record of referrals for specialist advice is documented. Clear outcomes and treatment recommendations are recorded.
- Examination of treatment room(s) to assess dressings/skin care products are individually stored, no excess stocks and items are returned to community pharmacy in line with medication guidance.
- The home have a system in place for example, minor trauma kit or first dressing initiative where they can demonstrate there is a supply of dressings available to residents to manage pressure ulcers when they occur.

**Outcomes for people:**

People who have pressure ulcers or wounds are assessed and have a treatment plan in place that meets their treatment aim for the pressure ulcer/wound.

**References:**

Scottish adapted EPUAP pressure ulcer grading tool
http://www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability_resources/pressure_ulcer_grading_tool.aspx

Wound assessment chart
http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/general_wound_assessment_chart.aspx

Scottish wound assessment and action guide (SWAAG)
http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/general_wound_assessment_chart.aspx

British Geriatric Society
Best practice statement: Minimising pain and trauma in wound management.
Wounds UK (2004)
http://www.bgs.org.uk/Publications/pubdownlds/Sep2007PainAssessment.pdf

## 7 Wound Infection: Prevention and Control

1. All pressure ulcers are colonised with bacteria.

2. Most local infections can be managed using antimicrobial wound products.

3. Systemic antibiotics should not be used for localised infection.

4. Assessment and regular review of localised infection is documented.

**Sources of evidence:**

- Local infection prevention and control policies are applied for example, use of appropriate PPE and aseptic dressing technique.
- Staff recognise and document the signs of clinical infection and when these are present obtain a wound swab.
- Personal plans document a record of discussion and outcomes with GP/TVN etc. regarding residents with a suspected wound infection.
- A documented record of wound swab investigations, results and treatment initiated (for example, dressings/antibiotics).
- A clear record of the wound infection is documented in a short term care plan.
- Dressings and wound care products are disposed of according to local protocols.

**Outcomes for people:**

Staff follow local infection, prevention and control policies and good practice procedures to ensure that infection risks to individuals are minimised.

**References to good practice:**

Health Protection Scotland National Infection Prevention and Control Manual (2012)
http://www.nipcm.hps.scot.nhs.uk/

Healthcare Improvement Scotland (2015) HAI standards
http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hei_policies_and_procedures/hai_standards_2015.aspx

NES (2012) Preventing infection in care
http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/healthcare-associated-infections/training-resources/preventing-infection-in-care.aspx

NHS Scotland: Infection Control in Adult Care Homes: Final Standards (2005)
http://www.gov.scot/Resource/Doc/37428/0012530.pdf

## 8 Skin tears/minor trauma injuries

1. Skin tears and minor trauma injuries are a common occurrence in an older population due to changes in their skin

2. Prevention of skin tears and minor trauma injuries should be a priority.

3. Staff should identify who is at risk and develop a prevention plan which covers clothing, equipment, skin care, handling techniques and environment.

4. When they occur, accurate assessment using the STAR skin tear classification system and appropriate treatment will minimise further trauma and aid healing.

5. Care homes have a 'minor trauma kit' to manage these incidents.

**Sources of evidence:**

- Individuals identified at risk have a prevention care plan in place which covers the key points:
    - suitable clothing to protect limbs
    - safe use of equipment
    - good skin care
    - safe handling techniques – remove pressure friction shear
    - safe environment – furniture, adequate lighting.
- Skin tears/minor trauma injuries are documented in the accident reporting system.
- First aid management is recorded in the personal plan.
- Evidence that the trauma is assessed using the STAR classification and documented actions/treatment and wound documentation is in place.
- Staff may seek advice from GP/DN re management.
- Staff have training in the prevention, assessment and management of these types of injuries.

**Outcomes for people:**

Individuals admitted to the home will be assessed to establish if they are at risk of skin tears and minor trauma injuries. Plans of care are put in place to ensure that their risk is minimised as needs part of a preventative approach to ensure their skin integrity is maintained.

**References to good practice:**

NES Skin tears workbook (2015)
http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/healthcare-associated-infections/training-resources/skin-tears-prevention,-assessment-and-management.aspx

Best practice in the prevention and management of skin tears. (2012) National Association of Tissue Viability (Nurses Scotland)
http://www.tissueviabilityscotland.org/downloads/NATVNS_Best_Practice_-_Skin_Tears_2012.pdf

http://www.tissueviabilityscotland.org/downloads/skin_tear_management_flow_chart.pdf

**Updated December 2016**
**Review December 2018**

**Headquarters**
Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY
Tel: 01382 207100
Fax: 01382 207289

**Website: www.careinspectorate.com**
**Email: enquiries@careinspectorate.com**
**Care Inspectorate Enquiries: 0345 600 9527**

This publication is available in other formats and other languages on request.

Tha am foillseachadh seo ri fhaighinn ann an cruthannan is cànain eile ma nithear iarrtas.

অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

هذه الوثيقة متوفرة بلغات ونماذج أخرى عند الطلب

本出版品有其他格式和其他語言備索。

Na życzenie niniejsza publikacja dostępna jest także w innych formatach oraz językach.


Published by: Communications

HCR-0217-127