

Tissue viability

Template policy for adult services



Tissue Viability Policies / practice – care home / care at home services

Purpose

There is a requirement for care services to have policies and procedures in place which cover tissue viability care, where this is provided.

We have produced this guidance for Care Inspectorate staff to help them review tissue viability care and practices.

This template is NOT a tissue viability procedure for care services. However, it may be of help to support care providers developing and reviewing policies/procedures.

This template is intended to provide general advice only, on the legal requirements and best practice guidelines and does not preclude more stringent local protocols being in place.

Tissue Viability overview

The skin is the largest multi-functional organ of the body and the most visible. To keep skin healthy, the skin must be intact, and that is its barrier function must not be compromised.

Promoting healthy skin does not only prevent physical deterioration, it also has a major impact on quality of life.

Policies, care and practice must be focused on good skin care for people to prevent any skin break down and be based on evidence and current best practice.

Service provider's tissue viability policies / good practice guidance should cover the following areas:

- Skin assessment and general skin care
- Pressure ulcer prevention
- Wound assessment and management
- Minor trauma injuries / skin tears.

Governance for Tissue Viability Policies:

- Policies should have a review date and be reviewed at that date or when there is a change in good practice guidance.
- Policy should be audited by the provider / managers to ensure that staff are complying with policy content.
- Pressure ulcer monitoring should be in place, e.g. use of the pressure ulcer safety cross.
http://www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability/key_resources/nhsscotland_safety_cross.aspx
- Any pressure ulcer which develops in the service should be investigated with a lessons learned approach with appropriate referral pathways to escalate concerns.
- The provider / service should follow Care Inspectorate notifications guidance about all pressure ulcers.
- All pressure ulcer data should also be completed within the electronic annual return using the information from the pressure ulcer safety cross.

Service provider's policy content will be guided by the Prevention and Management of Pressure Ulcers Standards (2016) Healthcare Improvement Scotland

http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/pressure_ulcer_standards.aspx

Skin assessment and general skin care - outcome is to keep the persons skin in optimum condition and maintain skin integrity

Clear guidance within the policy for staff on the following:

Pre admission assessment and documentation takes account of a discussion of skin condition and any skin issues, skin care and any wounds, breaks etc. with the current care area.

Skin assessment is carried out on admission, within a specific timescale, at an opportune time in an unobtrusive manner and this is documented. Method of documentation must be consistent and providers can use a body map or similar, for this purpose.

Any residents with skin issues will have a care plan detailing care and treatment, both prescribed and over the counter topical products. This is monitored and reviewed on a regular basis.

Prescribed topical products are recorded by the person applying the treatments and a method of documenting this is clear. (Usual practice is for RN to record on MAR charts / carers to record on Topical MAR.)

Staff who administer these topical applications have appropriate training on the products and their application. This includes when to report any adverse effects / changes in skin condition, e.g. redness, dry skin or allergies, to the person in charge.

Guidance is given about when it is appropriate to use skin foam cleansers as opposed to mild soap and water and the use of any prescribed barrier products.

Guidance is given about identifying incontinence dermatitis and moisture lesions and their management. Refer staff to Excoriation and Moisture Related Skin damage tool (2014). This should be implemented as part of policy and practice.

References to best practice:

Healthcare Improvement Scotland (2016) Standards for prevention and management of pressure ulcers

http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/pressure_ulcer_standards.aspx

Care Inspectorate: Tissue viability evidence gathering tool.

<http://hub.careinspectorate.com/media/509303/tissue-viability-evidence-gathering-tool.pdf>

Best practice statement - Wounds UK. Care of the older person skin

<http://www.woundsoundinternational.com/clinical-guidelines/best-practice-statement-care-for-the-older-persons-skin>

NES (2011) Your dermatology pocket guide: common skin conditions explained

http://www.nes.scot.nhs.uk/media/705715/dermatology_guide_amended_may_2012.pdf

Skin excoriation / moisture lesion grading

http://www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability_resources/excoriation_tool.aspx

Skin Integrity in the Older Person – Assessment and management to optimise skin health. (2015) Workbook and Resources

<http://hub.careinspectorate.com/media/395474/skin-integrity-in-the-older-person-assessment-and-management-to-optimise-skin-health.pdf>

Pressure Ulcer Prevention – outcome is to adopt a preventative approach and ensure that individuals are accurately risk assessed and have appropriate pressure area care to ensure that their skin integrity is maintained.

There is a zero tolerance approach to pressure ulcers in Scotland. The terminology used is:

Avoidable pressure damage – where the service provider did not:

- Evaluate the person's condition and pressure ulcer risk factors.
- Plan and implement interventions that are consistent with the person's needs and recognised standards of practice.
- Monitor and evaluate the impact of the interventions, or revise the interventions as appropriate.

Unavoidable pressure damage – the person receiving care develops a pressure ulcer even though the care provider had:

- Evaluated the person's condition and pressure ulcer risk factors.
- Planned and implemented interventions that are consistent with the person's needs and recognised standards of practice.
- Monitored and evaluated the impact of the interventions, or revise the interventions as appropriate.
- The person refused to adhere to prevention strategies in spite of consequences and non-adherence.

Black JM et al (2011) Pressure ulcers: avoidable or unavoidable? Results of the National Pressure Ulcer Advisory Panel Consensus Conference. Ostomy Wound Management 57(2) 24-37

To determine whether a pressure ulcer is unavoidable, there must be documented evidence to support the actions taken to prevent pressure damage occurring during the episode of care.

Staff need clear guidance on the following points:

Risk Assessment

Risk assessment is carried out formally within 6 to 8 hours of admission by a registered nurse using a recognised risk assessment tool – Braden Scale or Waterlow Score. Where a registered nurse is not available, this assessment can be carried out by NHS district nurse or community nurse, or care workers who have had sufficient training. Risk assessment should also form part of the nurses clinical

judgement and the policy / staff training should stress that the risk score should not be used in isolation

Care homes who do not provide nursing care can implement the PPURA (preliminary pressure ulcer risk assessment tool) which covers Nutrition, Mobility and Continence. Care staff can use this on a regular basis to monitor residents and if there is any change to these three areas of care, then the district or community nurse / GP, or other appropriate healthcare professional, e.g. tissue viability nurse, must be contacted to discuss changes in the person's presentation / condition. The policy should detail frequency of how often the risk assessment should be repeated, e.g. as part of a monthly review or more frequently depending on the risk level and / or when the individual's condition or treatment changes.

Training should also be provided in the use of these assessment tools to ensure that staff have an understanding of applying the tools and also promote consistency in scoring risk levels.

References to best practice:

Waterlow Risk Assessment

http://www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability_resources/waterlow_risk_assessment_chart.aspx

Braden Risk Assessment

http://www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability_resources/braden_risk_assessment_tool.aspx

Preliminary pressure ulcer risk assessment (PPURA)

http://www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability/key_resources/pura_pressure_ulcer_assessment.aspx

Care Planning

For individuals identified at risk, a pressure ulcer prevention care plan is developed taking into account:

- Level of risk and skin integrity status
- Type of mattress/seat cushion in use with details of settings of electric pumps etc
- Frequency of skin checks
- Frequency of positional changes / use of turning chart / SSKIN bundle
- Any prescribed skin care regime
- Any other relevant individual care interventions e.g. use of other aids
- Monitoring and frequency of the care plan review.

SSKIN bundle

The care bundle methodology is designed to facilitate consistency in practice and consists of a small number of interventions. The SSKIN bundle covers:

Skin – regular skin inspection to monitor condition and early detection of breakdown

Surface – make sure the person has the right mattress / seat cushion for their level of risk

Keep moving – encourage person to keep mobile or assist with regular repositioning

Incontinence – manage the person's incontinence and reduce skin excoriation

Nutrition – ensure good dietary intake and hydration.

Providers require to make a policy decision to include the SSKIN bundle as part of their policy and practice and decide the criteria for e.g. all residents with a pressure ulcer, all residents who are deemed high risk. The benefits of using the bundle is that there will be a consistent approach to pressure ulcer prevention, providing a simple reminder of key prevention interventions and ensuring that the combination of tasks are carried out in a person centred way. Training will require to be provided for staff on the implementation of the bundle. Information can be found at:

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

Pressure reducing equipment

The use of pressure redistributing equipment is an integral part of the prevention plan and if there is a delay in obtaining the appropriate surface, this may result in further tissue damage for the individual. The policy should cover the following key areas clearly:

- As a minimum, a pressure reducing foam mattress or overlay is provided to maintain comfort and pressure reduction.
- There should be a clear company / home policy statement on:
 - what types of beds, mattresses, seat cushions and other pressure reducing aids which are available
 - staff training on the appropriate choice and use of this equipment
 - mattress cleaning and turning is followed as per manufacturers' recommendations and is documented
 - planned maintenance for electric bed frames, alternating pressure mattresses and seat cushions
 - where equipment can be obtained from in an emergency or if there is a malfunction
 - the manager maintaining an overview in the form of a register or inventory of residents' risk status and use of pressure reducing equipment.

Staff training

NES The prevention and management of pressure ulcers online course / workbook <http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/healthcare-associated-infections/online-short-courses/the-prevention-and-management-of-pressure-ulcers.aspx>

Information for residents / carers

<http://www.nhs.uk/Conditions/Pressure-ulcers/Pages/Introduction.aspx>

References to good practice

NHS Scotland: Best practice statement: prevention and management of pressure ulcers (2009). (Currently under review).

http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/pressure_ulcer_best_practice.aspx

Tissue viability toolkit

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

Wound assessment and management – outcome is to assess wounds, initiate appropriate wound dressings and treatments, assess and manage pain to enable the optimum healing environment and prevent deterioration.

The service provider should incorporate clear guidance for staff on the following:

- Pre admission assessment should establish any pressure ulcers or other types of wounds. A clear treatment plan should be received from the transferring area.
- Initial wound assessment and on-going assessment process / documentation. This enables a baseline assessment to be carried out and on-going assessments at specified intervals to monitor / evaluate effectiveness of wound treatment
http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/general_wound_assessment_chart.aspx
- Pressure ulcer grading tool should also be in place to assist staff with grading pressure damage appropriately.
<http://healthcareimprovementscotland.org/default.aspx?page=12620>
- Care plan in place outlining:
 - Method of cleansing
 - Dressings (primary and secondary)
 - Any other fixatives required
 - Frequency of dressing changes and evaluation
 - Wound pain assessment / management.
- Guidance / information on dressing choice. This should come from the local NHS wound management formulary for prescribing and product information. Pictorial guides are also useful.
http://www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability_resources/wound_assessment_action_guide.aspx
- Dressings should be carried out using an aseptic technique
NES aseptic technique – online programme.
<http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/healthcare-associated-infections/online-short-courses/aseptic-technique.aspx>
- Information on referral methods, specialist resources available e.g. tissue viability nurse, leg ulcer or foot ulcer clinics.

Skin tears / minor trauma injuries – outcome is to ensure that risk of skin tears are minimised for those individuals at risk and in the event of occurrence these are managed appropriately.

Skin tears are viewed as an increasing problem for older people and if appropriate treatment is not given, these injuries may become chronic wounds with prolonged healing subsequently causing unnecessary pain and distress.

NHS Education for Scotland (NES) has produced a skin tears resource based on best practice in prevention, assessment and management of skin tears which is appropriate for any care setting.

Skin tears resource

<http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/healthcare-associated-infections/training-resources/skin-tears-prevention,-assessment-and-management.aspx>

Online Workbook

http://www.nes.scot.nhs.uk/media/3213856/nes_skin_tears_interactive_workbook_final.pdf

Video

<https://vimeo.com/107907101>

National Association of Tissue Viability Nurse Specialists (Scotland) - Best practice in the prevention, assessment and management of skin tears.

http://www.tissueviabilityscotland.org/downloads/NATVNS_Best_Practice_-_Skin_Tears_2012.pdf

Clear guidance within the policy for staff on the following:

All nursing and care staff work through the skin tears resource as part of their learning and development.

Pre admission assessment and documentation takes account of any history of repetitive skin tear injuries. This should be re assessed if the persons condition changes and documented.

A prevention plan will be developed which covers individual s preventative measures based on risk assessment.

Consideration of:

- Clothing
- Equipment - shin guards/leg protectors
- Skin care – use of emollients / moisturisers
- Safe handling techniques – minimise pressure friction shear
- Safe environment – furniture, adequate lighting, padding
- Involvement of individuals and families in prevention strategies
- Consult dietician to ensure adequate nutrition and hydration.

Management – first aid and key points:

- Stopping bleeding – apply pressure
- STAR skin tear classification system is used to assess the type of skin tear and aid a treatment plan
- Preventing infection – cleanse / cover area with dressings from minor trauma kit
- Minimise pain and discomfort
- Where necessary, discuss with GP / NHS 24 for advice / support
- Aim of treatment plan – recover skin integrity - use of appropriate dressings
- Complete accident / incident documentation /report incident to the Care Inspectorate where appropriate
- Ongoing management, wound assessment charts should be in place and GP should prescribe appropriate dressings
- Criteria for specialist referral should be in place.

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