Tees, Esk and Wear Valleys
NHS Foundation Trust

Tissue Viability Policy

Ref CLIN-0094-v1

Status: Ratified
Document type: Policy

Contents

1 Why we need this policy

1.1 Purpose

The purpose of this policy is to:

- Ensure that all staff is aware of the agreed Tissue Viability (TV) measures required to effectively manage wound care.
- Comply with CQC standards and Local and National Guidance

1.2 Objectives

The objectives of this policy are to:

- Protect patients through promoting safe and high quality clinical care.
- Outline the roles and responsibilities of staff in relation to tissue viability and pressure ulcer prevention.
- Ensure appropriate preventative and curative measures are implemented as required to reduce incidence of tissue damage.
- Ensure systems are in place for monitoring of both risk and incidence of pressure damage when it takes place

NICE Quality Standards (2015) identifies key standards in relation to acute and secondary care which are as follows:

- People admitted to hospital have a pressure ulcer risk assessment within 6 hours of admission
- People have a skin inspection/assessment within 4 hours of admission
- People have pressure ulcer risk assessments re-assessed at least monthly if very low score or weekly.
- People at risk of pressure ulcers receive advice on the benefits and frequency of repositioning
- Staff implement pressure ulcer prevention strategies to include use of, repositioning regimes and use of appropriate pressure relieving equipment
- Staff to ensure patients/carers receive adequate information on how pressure ulcers are prevented.

2 Scope

2.1 Who this policy applies to

- All Trust staff.

2.2 Roles and responsibilities

Role	Responsibility
Chief Executive	• The safety of patients in the Trust's care and having systems in place to ensure this.
The Trust	• Ensure care is delivered in a context of continuous quality improvement, where implementation of the policy and associated SOPs is subject to regular feedback and audit.
Infection Prevention and Control Committee	• Ratification of Trust-wide Tissue Viability policies, procedures and guidance; • Providing advice and support on the implementation of policies;
Managers	• Ensuring all staff are aware of and follow this policy and are aware of their own roles and responsibilities to ensure safe practice. • Facilitate access to the required training for their staff.
Trust staff	• Ensuring this policy is followed; • Advising patients, carers and relatives as appropriate. • Ensure their approach to care is interdisciplinary, involving all those needed in the management of the patient.
Tissue Viability Link Nurses (WRENs)	• In addition to above they will: • Act as a resource in clinical areas for advice on pressure ulcers and basic wound assessment and management. • Attend updates and study sessions to maintain their knowledge. • Update and educate the nurse staff in their area. • Ensure they attend Link Nurse Meetings to enable them to have input into development of the Tissue Viability Service.

3 Policy

Tissue Viability (TV) standards are essential to ensure that those who use health and social care within Tees Esk and Wear Valleys Trust receives safe and effective care. It is the responsibility of all Trust staff who is involved with patients ensures they have appropriate knowledge and skills within wound care.

3.1 Anatomy and Physiology of Skin

The skin is the largest organ of the human body. The skin has multiple layers of tissue and guards the underlying muscles, bones, ligaments and internal organs. The skin accounts for up to 15% of total body weight. The skin forms a barrier that helps to prevent micro-organisms and chemicals from entering the body and also prevents the loss of life sustaining body fluids. It protects the vital structures inside the body from injury and from potentially damaging ultraviolet rays of the sun. The skin also helps to regulate body temperature and is an important sensory organ. The skin is both delicate and resilient; it constantly renews itself and has the ability to repair itself after injury.

Structure of the Skin

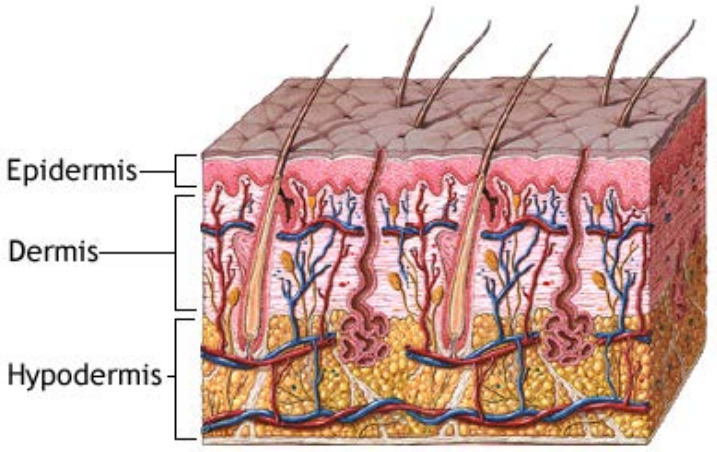
The skin has three basic layers:

-Epidermis: epithelial cells with no blood

-Avascular

Dermis: True skin made of connective tissue and is vascular

-Hypodermis- also known as the Subcutaneous



3.2 Categories of Wounds

There are two types of wounds which are:

Acute: surgery and trauma.

Chronic: long term – leg ulcers, diabetic foot ulcers and malignant wounds.

3.3 Types of healing

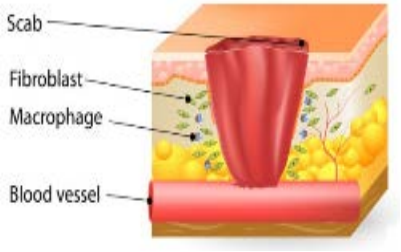
Primary Intention – closure by sutures/clips and healing is generally quick.

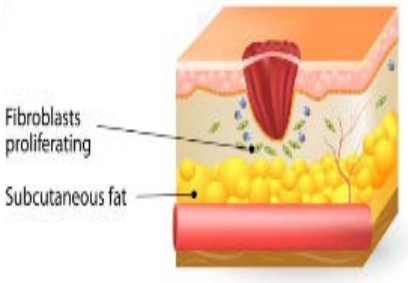
Secondary Intention - heal from the inside out where the edges eventually come together – long process.

Normal wound healing follows a specific path for healing

Haemostasis: Blood clot prevents too much blood being lost

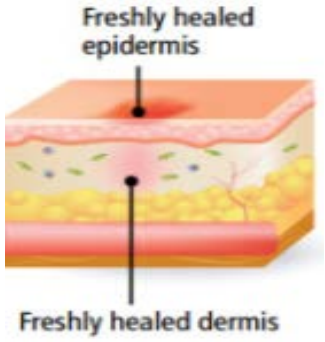
Inflammation: Lasts around 3-5 days after tissue damage occurs. (**Firefighting stage it is the body's emergency response to the injury)**





Proliferation: Granulation is the new tissue, where the body grows new blood vessels leading to granulation (**Builders stage starts the rebuild of new tissue and structures)**

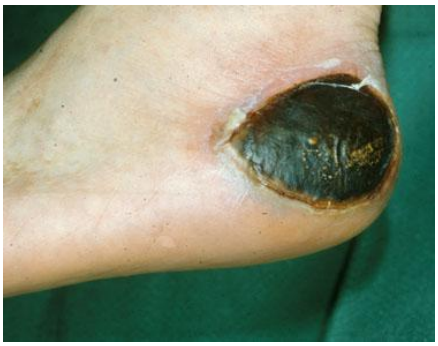
Maturation: Can take up to 18month- remodelling stage where layers are organised and blood supply is less, producing a less red scar and leaving a silver/white scar **(Decorators stage when the body starts to repair and heal itself and reduce scar tissue).**



N.B It is important to remember there are many factors that can affect these stages of wound healing such as infection and acute illness which can contribute to delay in wound healing.

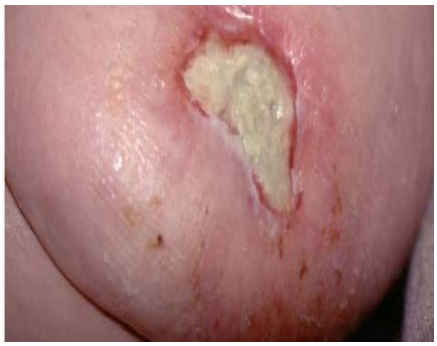
3.4 Types of wounds

Necrotic Wound



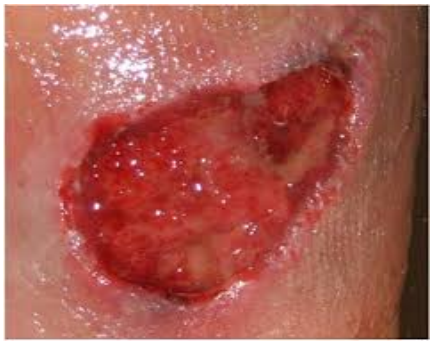
Necrotic refers to the presence of dead tissue (non-viable) in the wound. It may be black or brown, often referred to as a scab or eschar (dark dry skin). Necrosis may be wet or dry.

Sloughy Wound



Slough refers to the presence of non-viable tissue and is usually yellow/ or darker in appearance. It can appear dry, moist or wet and is usually heavily loaded with bacteria.

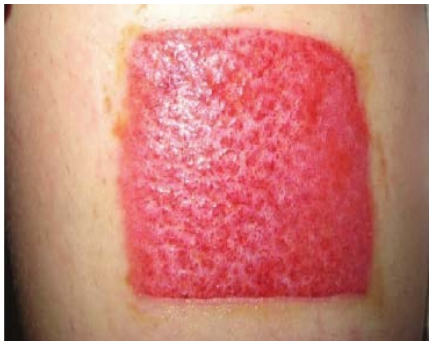
Granulating Wound



Granulating refers to the formation of new healthy tissue. It is usually red and glistening in appearance and indicates the wound is healing.

.

Epithelialisation



Epithelialisation refers to the outer layer of cells which grow over granulated tissue and will finally close a wound. These new cells form a new epidermis (top layer of the skin) which results in scar tissue formation.

3.5 Patient Assessment and management

- Timely assessment and re-assessment, appropriate management and referral is required for all patients with / or at risk of tissue breakdown (Refer to appendix 3)
- Treatment must be evidence based where such evidence exists in accordance with local and national guidance (NICE 2014; RCN 2006; EPUAP 2014).
- A plan of care, stating objectives, action and a review date, must be in place for the prevention and / or management of any type of wound.
- 'This Policy is to be used in line with any relevant Infection Prevention Control Policies to ensure all aspects of aseptic technique, waste disposal, PPE & risk assessment are performed'

3.6 Pressure Ulcer Prevention and Management

A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.'

(European Pressure Ulcer Advisory Panel (EPUAP) - Prevention and Treatment of Pressure Ulcers 2014)

A risk assessment using the waterlow tool must be undertaken for all patients this is to identify at risk patients and implement prevention plan prior to patients developing pressure damage.

Assessment for pressure redistribution must also be undertaken along with the risk assessment and equipment ordered and put in place for patients identified as being at risk or has existing pressure damage. How to order equipment and helpline can be found on Arjo Huntleigh electronic resource file.

Category 2, 3 and 4 pressure damage must be reported appropriately using the locally agreed reporting processes.

Any category 3 or 4 hospital acquired pressure ulcers must be investigated as a potential Serious Untoward Incident (SUI). Tissue viability will establish if a SUI is appropriate.

For more detailed procedures around pressure ulcers, follow the:

- Assessment, Prevention and Management of Pressure Ulcers (hyperlink)

A preventative strategy must be implemented to reduce the risk of development and recurrence of pressure damage. This must be documented in the patient records.

3.7 Skin Tear Prevention and Management

A *skin tear* is defined as a traumatic injury caused by friction, or a

combination of shear and friction forces strong enough to separate the epidermis from the

dermis (partial thickness wound) or separate both the epidermis and the dermis from

underlying structures (full thickness wound). **Le Blanc et al 2011**

Primary aim for all patients is prevention and identifying those patients at risk of developing skin tears.

All staff must be aware of the classification and treatment recommendations for skin tears as this could lead to further tissue damage if not treated using the recommendation.

For more detailed information on classification and treatment of skin tears, follow the:

- Skin Tear Prevention and Management procedure

3.8 Wound Photography

Wound photography is recommended for use for referral purposes only and must be taken on Trust purchased equipment, excluding the use of mobile phones.

The patient's confidentiality should not be compromised and the identity of the patient should be protected at all times.

For more detailed information, follow the:

- Wound photography procedure

3.9 Wound Dressing Formulary

- The Trusts Wound Dressing Formulary must be followed when ordering dressings and dressings that are not on formulary may only be ordered after discussion and review of wound by the physical healthcare practitioner or tissue viability team.
- Patient referral to tissue viability (process can be found on Trust intranet)
- Any referrals not completed fully may cause delay in treatment for patient, therefore ensure the referral form is completed fully.
- The tissue viability team will aim to contact referrer within 24-48 hours within the working week to discuss the referral and determine if a visit is required. However the overall responsibility for the day to day management of the patient remains the responsibility of the referrer.

3.10 Nutrition

Nutrion and hyrdration are vital in preserving tissue and supporting the repair of tissue following damage. Eating a well balanced diet and maintaining a stable healthy weight are also very important and can reduce the risk of several conditions such as heart disease, diabetes and obesity, which could predispose an individual to wounds and ulcers.

Wound healing is a complex process and can be complicated further by chronic illness. Malnutrition and poor nutritional status can impair wound healing and increase the risk of infection.

3.11 Aseptic Technique

The impact of healthcare associated infections is of a high priority for all healthcare professionals. Prevention and management of infection are the responsibility of all staff that work within the NHS. The Health and Social care act (2008) states that all health care providers should have policies and procedures in place to prevent and control HCAIs.

Asepsis is defined as the absence of pathogenic (harmful) organisms. Aseptic technique is a clinical procedure to ensure cross contamination of micro-organisms between the patient, practitioner and environment is prevented and underpins many clinical procedures. Aseptic technique must be used when carrying out an invasive procedure, that breaches the bodies natural defence, such as skin, mucous membranes or when entering a sterile body cavity.

Principles of aseptic technique include:-

- Reducing activity in the immediate vicinity of the area in which the procedure is to be performed
- Keep the exposure of a susceptible site to a minimum
- Checking all sterile packs to be used for evidence of damage or moisture penetration
- Ensuring all fluids and materials to be used are in date
- Do not re-use single use items
- Ensure contaminated/non-sterile items are not placed in the sterile field
- Ensure appropriate hand decontamination prior to the procedure
- Protecting uniform/clothing with a disposable apron
- Use standard precautions
- Dispose of waste as per local policy

Sterile equipment and fluids should only be used during any medical and nursing procedures. For example, urinary catheterisation, intravenous cannulation, central line insertion etc.

An Aseptic technique assessment will be undertaken on all staff, who wound dressings, annually.

For a detailed step by step guide to aseptic technique, follow:

- Royal Marsden Manual

4 Definitions

Term	Definition
TV	Tissue Viability
CQC	Care Quality Commission
QuAC	Quality Assurance Committee
SUI	Serious Untoward Incident

5 Related documents

The following documents/procedures are all relevant to Tissue Viability.

5.1 Pressure Ulcer Procedure

Purpose	
This document details the Trust procedure for the Assessment, Prevention and Management of Pressure Ulcers.	Pressure ulcer procedure

5.2 Skin tear procedure

Purpose	
This document details the Trust procedure for skin tear prevention and management.	Skin Tear Prevention and Management procedure

5.3 Arjo huntleigh resource file

Purpose	
This document details how to order rental equipment and what equipment is best for certain patients.	Arjo Huntleigh

5.4 Wound Photography Procedure

Purpose	
This document details the Trust procedure for taken wound photography for the purpose of referrals and progress of wound helaing.	Wound photography procedure

5.5 Wound Dressing Formulary

Purpose	
This document details the Trust procedure for taken wound photography for the purpose of referrals and progress of wound healing.	https://www.gwh.nhs.uk/media/304620/wiltshire-dressings-formulary-guidelines-2017-2018-update-final-v4.pdf

5.6 Aspetic technique

Purpose	
This document details the Trust procedure for aseptic technique .	http://flc-intouch:35000/Docs/Documents/Policies/TEWV/Infection%20Control/Aseptic%20Technique%20Procedure%20redirection.pdf

6 How this policy will be implemented

- This policy will be published on the Trust's intranet
- Line managers will disseminate this policy to all Trust employees through a line management briefing
- This policy has been produced and ratified by the Tissue Viability Team, Physical Health and Wellbeing Group and the Quality Assurance Committee.
- Managers and Heads of Service ensure that all staff is made aware of the policy and its contents. If training is identified as part of the implementation process this will be accessed via the Tissue Viability Nurses
- More targeted training is delivered by the Tissue Viability Nurses to the WRENs group

• This policy will be published on the Trust's intranet and external website.
• Line managers will disseminate this policy to all Trust employees through a line management briefing.
• This policy has been produced and ratified by the Tissue Viability Team, Physical Health and Wellbeing Group and the Quality Assurance Committee. • Managers and Heads of Service ensure that all staff is made aware of the policy and its contents. If training is identified as part of the implementation process this will be accessed via the Tissue Viability Nurses • More targeted training is delivered by the Tissue Viability Nurses to the WRENs group

7 How the implementation of this policy will be monitored

Auditable Standard/Key Performance Indicators		Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	An annual audit will be undertaken using evidence based audit tool.	Annually	Head of IPC and documented in the monthly, quarterly and annual reports
2	A database of who has passed the annual assessments of Aseptic technique will be kept and updated to ensure staff is still competent to carry wound care out	Annually	Ward managers and head of IPC
3			

8 References

- RCN (2006). The Nursing Management of Patients with Venous Leg Ulcers: Recommendations. Royal College of Nursing. London.
- European Pressure Ulcer Advisory Panel (EPUAP) (2014 2009) The prevention and management of pressure ulcers. European Pressure Ulcer & Association Panel Guidelines
- National Institute Clinical Excellence (2005) (2014) Quick reference guide. Prevention and treatment of pressure ulcers.

9 Document control

Date of approval:	10 April 2019	
Next review date:	10 April 2022	
This document replaces:	N/A	
Lead:	Name	Title
	Carol Johnson	Tissue Viability Matron
Members of working party:	Name	Title
	Carol Johnson	Tissue Viability Matron
This document has been agreed and accepted by: (Director)	Name	Title
	Elizabeth Moody	Director of Nursing and Governance

This document was approved by:	Name of committee/group	Date
	Physical Health and Wellbeing Group	28 January 2019
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	10 April 2019
An equality analysis was completed on this document on:	14 March 2019	

Change record

Version	Date	Amendment details	Status
1	10-Apr-19	New policy	Ratified and published.

Appendix 1 - Equality Analysis Screening Form

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Tissue Viability					
Name of responsible person and job title	Caroline Renwick Tissue Viability Nurse					
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Physical Health and WellBeing Group					
Policy (document/service) name	Tissue Viability Policy					
Is the area being assessed a…	Policy/Strategy	X	Service/Business plan		Project	
	Procedure/Guidance				Code of practice	X
	Other – Please state					
Geographical area covered	All inpatients within Tees Esk and Wear Valleys NHS Foundation Trust					
Aims and objectives	To set standards in practice to ensure the delivery of patient care is carried out safely and effectively by the trust staff					
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	29th January 2019					
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	14th March 2019					

You must contact the EDHR team if you identify a negative impact. Please ring Sarah Jay or Julie Barfoot on 0191 3336267/3046

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
Trust staff and patients					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Sex** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No
Yes – Please describe anticipated negative impact/s **No** – Please describe any positive impacts/s					

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	**X**	**No**	

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

Yes – Please describe the engagement and involvement that has taken place

Discussed at the Physical Health and Wellbeing Group who approved the policy.
Following patients consent and assessment of wounds, patients were actively involved in their care planning.

No – Please describe future plans that you may have to engage and involve people from different groups

5. As part of this equality analysis have any training needs/service needs been identified?					
Yes	Please describe the identified training needs/service needs below Since Service Level Agreement was implemented in Trust staffs confidence and competence has improved in relation to wound care.				
A training need has been identified for;					
Trust staff	Yes/No	Service users	Yes/No	Contractors or other outside agencies	Yes/No
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					
The completed EA has been signed off by: You the Policy owner/manager: Type name: Caroline Renwick				Date: 14/03/2019	
Your reporting (line) manager: Type name: Carol Johnson				Date: 14/03/2019	
If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046					

Appendix 3 Contacts

Tissue Viability Team

- Carol Johnson, Tissue Viability Matron
- Caroline Renwick, Tissue Viability Nurse

Darlington Office: 01325 743179

Durham Office: 0191 333 2912

Infection Prevention and Control Team, TEWV

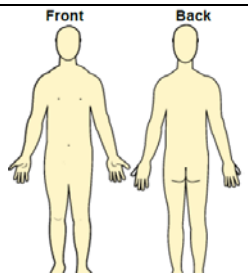
- Angela Ridley, Head of Infection Prevention and Control (Nursing)

Team Office: Telephone: 0191 333 3584

Appendix 4 - Wound Assessment Chart

Wound Assessment and Management		
Patients Name:		**DOB:**
Ward:	**Consultant**	**Hospital No/CRN:**
Nutritional Assessment: **Waterlow Score:**		**Pressure Aid:**
Reason for admission: **Predisposing Factors:**		

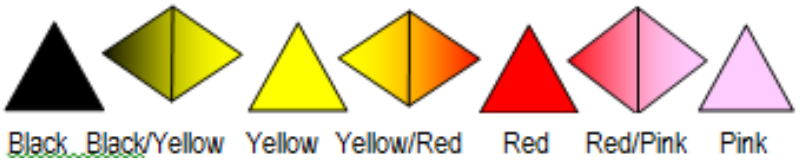
Initial Assessment



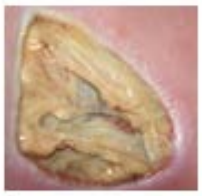
Mark location of each wound and number each wound

Type of wound	
Leg ulcer	☐
Surgical wound	☐
Diabetic	☐
Rheumatoid	☐
Malignant lesion	☐
Cellulitis	☐
Pressure Ulcer	☐

Colour of wound



Necrotic



Slough

Granulating

Epithelisation

	Date Assessed: **Wound 1**	**Date Assessed:** **Wound 2**	**Date Assessed:** **Wound 3**
Site			
Type of wound			
Size of wound			
Depth of wound			
Pain			
Odour			
Exudate **(How much? What colour?)**			
Surrounding skin (What colour is it? Does it look healthy? Is it intact?)			
Wound tissue: **(Granulating, Sloughy, Necrotic, Infected Other)**			

Reassessment of treatment plan should be considered at least weekly

Date & Time	Wound Number	Treatment choice	Size of wound	Signature
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**

Appendix 5 - Waterlow Assessment Chart

WATERLOW CONTINUOUS ASSESSMENT CHART									
SEVERAL SCORES PER CATEGORY CAN BE CALCULATED					**ID LABEL**				
Categories			**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**
Body Mass Index (kg/m^2)		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Average	20-24.9	**0**							
Above Average	25-29.9	**1**							
Obese	>30	**2**							
Below Average	<20	**3**							
Continence		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Complete/Catheterised		**0**							
Incontinence of urine		**1**							
Incontinent of faeces		**2**							
Doubly incontinent		**3**							
Mobility		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Fully mobile		**0**							
Restless/Fidgety		**1**							
Apathetic		**2**							
Restricted		**3**							
Bed bound		**4**							
Chair Bound		**5**							
Nutrition **A – Has patient lost weight recently**									
Yes	**Go to B**								
No	**Go to C**								
Unsure	**Go to C and score 2**	**2**							
B – Weight Loss Score		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
0.5 – 5kg		**1**							
5 – 10kg		**2**							
10 – 15kg		**3**							
>15kg		**4**							
Unsure		**2**							
C – Patient eating poorly or lack of appetite		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
No		**0**							
Yes		**1**							

Categories		Date	Date	Date	Date	Date	Date	Date
Skin type visual risk areas	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Healthy	**0**							
Tissue Paper	**1**							
Dry	**1**							
Oedematous	**1**							
Clammy/pyrexia	**1**							
Discoloured – stage 1	**2**							
Pressure Ulcer – stage 2-4	**3**							
Sex/Age	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Male	**1**							
Female	**2**							
14 to 49	**1**							
50 to 64	**2**							
65 to 74	**3**							
75 to 80	**4**							
81 plus	**5**							
Tissue Malnutrition	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Eg terminal Cachexia	**8**							
Single Organ failure	**5**							
Multiple organ failure	**8**							
Peripheral vascular disease	**5**							
Anaemia (HB<8)	**2**							
Smoking	**1**							
Neurological deficit	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Diabetes	**4-6**							
Multiple Sclerosis	**4-6**							
Motor/sensory paraplegia	**4-6**							
Cerebro vascular accident	**4-6**							
Major surgery/Trauma	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
On table >2 hrs (past 48hrs)	**5**							
On table >6 hrs (past 48 hrs)	**8**							
Orthopaedic spinal	**5**							
Medication	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Cytotoxics	**Max 4**							
Steroids (Long term high dose)	**Max 4**							
Anti-inflammatory	**Max 4**							
Total								
Risk Category **10+ At risk** **15+ High Risk** **20+ Very high risk**								
Signature								

Appendix 6 - Positional Change Chart

Positional Change chart

PATIENT NAME:	HOSPITAL NUMBER:
WARD	PLAN- FREQUENCY OF POSITIONAL CHANGES AS PER CARE PLAN

Date & Time	Time position changed	Patient position	Skin condition	SIGNED