Tissue Viability Policy
The Prevention and Management of Wounds
(N-066)

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Name of approving body:	Quality and Patient Safety Group
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Date approved by Lead Director:	
Date EMT as approving body notified for information:	

Policies should be accessed via the Trust intranet to ensure the current version is used

Contents

SUMMARY OF POLICY

This policy is an overarching policy and should be used in conjunction with the Lower Leg Ulcer and Skin Integrity Assessment, Management and Prevention Guideline [LLUaSIAMaPG] and the Pressure Ulcer policy. The Tissue Viability policy aims to ensure that all staff managing wounds and skin integrity, understand and are able to provide the standards and expectations for prevention, clinical assessment and management of wounds.

It was estimated that in 2012/13 about 2.2 million patients in the UK were treated by the NHS for an acute or chronic wound at a cost of £4.5-£5.3 billion (Guest et al, 2015). That has now estimated to have risen in 2017/18 to 3.8 million wound care patients with a management cost of £8.3 billion (Guest et al, 2020). It was estimated that two- thirds of these costs occurred in the community. It has been found that there is variation in the best practice management of patients with wounds (Gray et al, 2018).

Improved wound care including effective assessment, diagnosis, treatment and prevention of wound care complications can reduce treatment costs (Guest 2015) and importantly improve outcomes and experience for people with a wound (NHS Right Care 2017). The purpose of holistic wound assessment is to ensure that the patient receives the most appropriate treatment in line with best practice that enables the primary objective of management, which usually is healing, to be met (Wounds UK 2018).

The areas included in this policy are:

- Patient assessment and management [Using the Wound Care template on System 1]
- Identification and management of infection [appendix 4]
- Wound care formulary [Wound Assessment and Formulary.pdf (humber.nhs.uk)]
- Tissue Viability Team [appendix 5]
- Pressure ulcers [appendix 6; Pressure ulcers prevention and management of pressure ulcers]
- Wounds on the feet
- Leg ulcers [Patient presenting with a leg ulcer.pdf (humber.nhs.uk)]

1. INTRODUCTION AND PURPOSE

This policy is over-arching to encompass tissue viability in its broadest sense. To support specific wound care, the associated LLUaSIAMaPG and Pressure Ulcer Policy.

This policy sets out the required standard of care for all patients with/or at risk of tissue breakdown. It has been developed in line with current evidence, national guidance and consensus opinion to reduce the incidence of tissue breakdown and where tissue breakdown has occurred, promote complete healing where possible. In the case of patients whose wound and/or disease are unresponsive to curative treatment, it sets standards to reduce wound complications, manage symptoms and provide patient comfort.

The required standard will ensure patients receive timely and regular assessment, management and review, with appropriate prevention and referral defined for their care, reflecting both their wound care and more general physical and psychological needs.

This will be achieved by the following objectives:

- Ensure appropriate staff, providing wound care are familiar with all other policies and SOPs linked to Tissue Viability and ensure accessibility to documents.
- Provide education and training linked to competency assessment for all clinical staff managing wounds in relation to assessment, diagnosis, management, prevention, monitoring and referral as appropriate to their role.
- Ensure all staff providing wound care are proactive in early assessment and intervention to prevent complications and promote wound healing.
- Ensure all staff providing wound care are compliant with consistent high-quality documentation and record keeping, providing continuity of care and to determine patient outcomes.
- Ensure all staff providing wound care use the local wound care formulary to guide clinical and cost-effective treatment choices.
- Support staff to educate patients/carers in wound management and prevention strategies by ensuring they receive up-to-date written and verbal information.
- Ensure all appropriate staff providing wound care are aware of the process for reporting and reviewing patients with a pressure ulcer.

2. SCOPE AND DEFINITIONS

This policy applies to all staff undertaking skin integrity and wound care practice including - bank, locum, permanent and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), Non-Executive Directors and those undertaking research working within the Trust, in line with the Trust's Equality, Diversity and Human Rights Policy. It also applies to Agency workers, and other workers who are assigned to the Trust.

Wound – refers to a break in the skin anywhere on the body which is either partial or full thickness skin loss due to any cause i.e., self-harm, surgery, trauma, infection, disease, pressure, friction, shear, moisture.

Acute wounds - are typically traumatic or surgical in origin; they occur suddenly and move rapidly and predictably through the wound healing process and result in durable wound closure.
Burns should be assessed on their severity; anything more than a simple scald should be considered requiring urgent Accident and Emergency assessment.
Self - harm wounds should be assessed on their severity and the ability to stop the bleed point. If the bleed point continues beyond the application of sustained pressure then the patient should be assessed at the A&E department
Support can be offered by the TV service, post A&E review [appendix 5]

Chronic wounds - are wounds that have failed to progress through the normal stages of healing and therefore enter a state of pathologic inflammation (Menke et al 2007). Chronic wounds can be classified into vascular ulcers (e.g., venous and arterial ulcers), diabetic ulcers, and pressure ulcers (Demidova Rice 2012).

Contamination – all open wounds are contaminated with bacteria/microbes, wound healing is not delayed as host defence respond (International Wound Infection Institute 2016)

Colonised – Bacteria/microbes grow and divide at a non-critical level, wound healing is not impeded or delayed (International Wound Infection Institute 2016)

Local Infection – Bacteria/microbes move deeper into wound tissue and proliferate at a rate that invokes a response in the host/biofilm, intervention is required with topical antimicrobial (International Wound Infection Institute 2016)

Spreading/Systemic Infection – spreading beyond wound border into deep tissues and leading to systemic infection which affects the body as a whole. This may be life threatening and will require urgent intervention with systemic and topical antimicrobials (International Wound Infection Institute 2016)

Biofilm – a structured community of Bacteria/microbes with genetic diversity and variable gene expression (phenotype) that creates behaviours and defences used to produce infections (chronic infection). Biofilms are characterised by significant tolerance to antibiotics and antimicrobials while remaining protected from host immunity (International Wound Infection Institute 2016).

TIMES (tissue, inflammation/infection, moisture, edge, surrounding skin) – a systematic approach to wound assessment and management (Schultz 2004).

Malnutrition Universal Screening Tool (MUST) – a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese.

Pressure ulcer – localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful (NHSi 2018).

Venous leg ulcer – an open lesion between the knee and the ankle joint that occurs in the presence of venous disease and takes more than two weeks to heal [National Wound care strategy programme 2020. Recommendations for Lower Limb Ulcers]

Arterial ulcers - also referred to as ischemic ulcers, are caused by poor perfusion (delivery of oxygen and nutrient-rich blood) to the lower extremities.

A **mixed ulcer** - occurs in the presence of both arterial and venous disease and where a combination of disease processes contributes to the formation and persistence of the ulcer. Intravenous drug use - may cause mixed aetiology leg ulceration. Please see trust Leg ulcer guidelines.

Charcot Foot - is an inflammatory condition that causes the bones in the foot to become weak and lead to dislocations, fractures and changes in the shape of the foot or ankle. It is a consequence of various peripheral neuropathies; however, diabetic neuropathy has become the most common aetiology (Rogers et Al 2011).

Diabetic foot ulcer - is defined as a foot affected by ulceration that is associated with neuropathy and/or peripheral arterial disease of the lower limb in a patient with diabetes (Alexiadou and Doupis 2012).

3. PROCESS/REQUIREMENTS

3.1. Introduction

Local and national guidance has been used as the framework for this Policy. It has been developed from the best available evidence and outlines the required standards and guiding principles to promote a multidisciplinary, consistent and cohesive approach to patient care. It Has been reviewed and amended by the Pressure Ulcer review and Learning panel prior to submission

Patient management must be performed in accordance with Trust Policy.

3.2. Patient Assessment and Management

Timely holistic assessment and reassessment, appropriate management and referral is required for all patients with/or at risk of tissue breakdown. Refer to appropriate Policy/Guideline or Care plan for the type of wound. Resources to be found on the Tissue Viability intranet page

Communication with a patient who has a wound and their carer(s) should be in a style and language that empowers and engages patient participation in the planning, delivery and evaluation of care.

Holistic wound assessment should be performed on first presentation of the wound.

Holistic wound assessment should include determining the type/cause of the wound(s), identifying factors that may delay healing or increase risk for future wounds, establishing the impact of the wound on the patient's quality of life and determining capacity for self-care.

Holistic wound assessment should include individual assessment of the characteristics of and symptoms related to each wound present, including accurate recording of the location of the wound and taking photographs with signed consent [appendix 8].

The assessment process should be carried out as per Trust assessment documents; this will also include a pressure ulcer risk assessment, pain assessment, MUST and may include a lower limb assessment if appropriate [appendix 7].

Treatment and prevention strategies must be evidence based where such evidence exists in accordance with local and national guidance.

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 and formulated in partnership with patient/carer.

At each dressing change, the patient and the wound should be monitored for signs of improvement or deterioration and progress against the objectives of management should be reviewed.

A wound assessment should be completed weekly [Ideally a Monday in preparation for PURL] on SystmOne template or more often, if there is deterioration in the condition of the patient and/or wound. This should include a wound photograph including a labelled sterile paper tape measure. The image should include one close up of the wound and one image of the anatomical position of the wound. Please appendix 2. At this point the wound size should be recorded, length, width and depth. Please see appendix 1.

Following holistic wound reassessment, the objectives of management and the individual care plan should be adjusted as necessary.

All holistic wound assessments and reassessments should be documented. Documentation should include measurements of the wound, the findings of the assessments, the objectives of care, the care plan and the date for holistic wound reassessment.

Where concordance cannot be achieved between patient and health care professional assess capacity as per Deprivation of Liberty Safeguards and Mental Capacity Act Policy and escalate to senior managers and tissue viability team.

If there are difficulties with concordance, ensure that patient is aware of the potential effects of non-concordance and document this. Provide them with the option to decline treatment document. Consider if a VARM might be a required. Please see Safeguarding section for the link.

3.3. Identification and Management of Infection

This policy is to be used in line with any relevant Infection Prevention Control Policies to ensure all aspects of aseptic technique, waste disposal, Personal Protective Equipment and risk assessment are performed.

Management of known wound colonisation with Methicillin Resistant Staphylococcus Aureus (MRSA) must be performed in accordance with the Trust Policy for the Management of Methicillin Resistant Staphylococcus Aureus, SOPs, local and national guidance.

Use of systemic antibiotics and antimicrobial dressings should be considered, as per local formulary, for wounds with clinical signs of localised and / or systemic infection. Please see TV AMS pathway for appropriate use of Antimicrobials, Antibiotics and Swabbing. Appendix 4.

This policy should be used in conjunction with other Trust patient policies [Aseptic Non-Touch Technique Protocol].

3.4. Wound care formulary

The Trust Wound Care Formulary must be consulted for prescribing wound management products. Prescribing outside of the formulary must be rationalised in accordance with local Trust policy. The appropriate exception reporting form must be completed and submitted to the TV service lead.

Wound dressings/appliances that have been prescribed for a specific patient must not be used for another patient, this is illegal practice, even if the health professional deems that such practice would save money and reduce wastage [Wound Assessment and Formulary.pdf (humber.nhs.uk)].

3.5. Tissue Viability Team

The Tissue Viability Service is nurse-led providing specialist advice and care to patients with, or at risk of, developing wounds and the staff caring for them. This is achieved by the provision of specialist advice, support and training.

The Tissue Viability referral criteria are described on the Tissue Viability Referral Form (as per locally agreed route across the Trust) Please see the TV intranet site.

Any referrals not fully completed will be returned to the referring professional, which could result in a delay to patient care, therefore all parts of the referral form must be accurately completed.

The Tissue Viability Team is responsible for communicating findings and any management plan to the referrer. However, the overall responsibility for the day-to-day management of the patient remains the responsibility of the referrer [appendix 5].

3.6. Pressure ulcers

For prevention and management of Pressure Ulcers refer to the Pressure Ulcer Policy [appendix 6].

Wound assessment of pressure ulcers must follow the guidance in this policy.

3.7. Wounds on the foot

To ensure the most appropriate management and improve clinical outcomes, refer any patients with diabetes foot ulcer or Charcot:

- On the day you first see them or
- On the day they first present or
- If there are any patients with diabetes foot ulceration not already within the Diabetes foot pathway refer to Podiatry.

Referral to York/Scarborough Trust Podiatry for all non-diabetes patients presenting with foot ulceration within 24 hours.

Any patient diagnosed with a wound on the foot, must have foot pulses assessed by a competent health care professional.

3.8. Leg Ulcers

For leg ulcer management and management of the healed leg refer to the Lower Leg Ulcer and skin integrity, assessment, management and prevention guideline Patient presenting with a leg ulcer.pdf (humber.nhs.uk)

4. ROLES AND RESPONSIBILITIES

The Trust has a responsibility to 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.

Service Managers or equivalent and Modern Matrons or equivalent, have a responsibility to:

- Ensure all healthcare staff within the service/area are aware of this policy and associated SOPs and pathways.
- Ensure staff, within the service/area are aware of the record keeping required.
- Comply with Trust monitoring of this policy.
- Facilitate access to the required training for their staff who are managing patients with wounds and skin integrity related problems

The Tissue Viability Service has responsibility for:

- Advising and supporting staff in the care of patients with complex tissue viability needs.
- Being up to date with current evidence and guidelines
- Designing and delivery of education
- Developing local policies and SOPs
- Participating in regional and national work to shape guidelines and policies at national level and sharing national changes in tissue viability with the Trust.

Clinical Staff have a responsibility to:

- Be accountable and responsible for all aspects of their practice, providing up to date evidence-based care, including maintaining a working knowledge of their responsibilities in relation to the prevention and management of wounds.
- Highlight any difficulties in understanding and implementing the processes, and any training requirements in relation to tissue viability, to their line manager.
- Discharge their duties in accordance with their role, level of expertise and the requirements of their professional body where applicable.
- Have evidence of regular updating and current competency in relevant aspects of wound assessment, management and prevention that they are involved in.
- Ensure their approach to care is - interdisciplinary, involving all those needed in the management of the patient.

5. TRAINING

The Trust recognises the importance of education and training in all aspects of the prevention and management of wounds.

Training and education programmes are in place on ESR and are available through The Tissue Viability Team (face-to-face when safe and appropriate to do so).
Bespoke training can be developed as required, in line with current thinking and / or where there are, existing or developing concerns.

Training and education linked to competency-based assessment, is provided for all staff undertaking tissue viability care, for those involved in the implementation of the policy and associated SOPs.

Training must be demonstrated through informed evidence-based practice and documentation of attendance at relevant training. Under Revalidation all nurses must maintain their registration in line with the Nursing and Midwifery Council revalidation process.

6. SAFEGUARDING

If there is a significant concern about the person with capacity who is self-neglecting and declining input from professionals this maybe escalated to consider what is known as a VARM within Humber NHS Teaching Foundation Trust. This could relate to Tissue Viability especially in the case of pressure ulcer damage. The VARM process is currently under review.
Please refer to appendix 6 for clear instruction on when to escalate a patient with a wound as a safeguarding concern.
If Staff feel they need additional support and guidance, consider contacting the Humber Safeguarding team to discuss their concerns
For up-to-date information and guidance please see the Safeguarding intranet page and the Safeguarding policy [Safeguarding Adults Policy.pdf (humber.nhs.uk)].

7. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

This policy aims to improve optimum healing and consequently improve patient care and outcomes. The Tissue Viability Team are not aware of any evidence that different groups have different priorities in relation to this framework, or that any group will be affected disproportionally or any evidence or concern that this Policy may discriminate against a particular population group. Communication with a patient and their carer(s) should be in a style and use language that empowers and engages patient participation in the planning, delivery and evaluation of care. Thus, the equality impact assessment result is: no negative impact.

8. SUCCESS CRITERIA/MONITORING EFFECTIVENESS

Wound management audits may be carried out as part of the Organisational or Service Specific Audit Plans.

Services will review adverse incidents forms pertaining to tissue viability, and identify actions for learning, ensuring improvements in performance.

Any subsequent findings resulting from reviews will be incorporated into the new version of the document.

All actions within the Policy in relation to monitoring and review will be supported by the Tissue

Viability team. The Document Manager must be able to demonstrate the effectiveness of the document at the point of review, for example by; carrying out audits, reviewing incidents that may have occurred related to the document, discussing the document at team meetings. Any subsequent issues/findings resulting from the review should be incorporated in the new version of the document.

9. REVIEW

This document may be reviewed at any time at the request of either staff side or management but will automatically be reviewed three years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

10. REFERENCES AND LINKS TO OTHER DOCUMENTS

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Augustin M, Carville K, Curran J et al (2012) International consensus. Optimising wellbeing in people living with a wound. An expert working group review. London: Wounds International. Available at: www.woundsinternational.com

BAPEN (2011) The 'MUST 'explanatory booklet: a guide to the malnutrition universal screening tool for adults. Available at www.bapen.org.uk/screening-and-must/must/must-toolkit/the-must-explanatory-booklet (accessed 6/2/19)

Demidova-Rice, T.N. et al. 2012. Acute and impaired wound healing: pathophysiology and current methods for drug delivery, part: normal and chronic wounds: biology, causes and approaches to care. Advances in Skin and Wound Care 25(7): 304-314

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Flanagan, M. (1996) The role of the clinical nurse specialist in Tissue viability British Journal of Nursing 5(11): 676 – 681.

Fletcher, J. 2008. Differences between acute and chronic wounds and the role of wound bed preparation. Nursing Standard 22(24): 62–68.

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Guest JF, Fuller GW, Vowden P [2020] Cohort study evaluating the burden of wounds to the UKs National Health service in 2017/18: update from 2012/13. BMJ Open 2020;10

Gray, T.A. et al. 2018. Opportunities for better value wound care: A multiservice, cross- sectional survey of complex wounds and their care in a UK community population. BMJ Open 8(3), pp. 1–9. doi: 10.1136/bmjopen-2017-019440.

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NHS RightCare (2017) NHS RightCare scenario: the variation between sub-optimal and optimal pathways. Available at www.england.nhs.uk/rightcare/products/ltc (accessed 6/2/19)

National Institute Clinical Excellence (2005) (2014) Quick reference guide. Prevention and treatment of pressure ulcers.

National Institute of Clinical Excellence (2008) Surgical Site Infection; Prevention and Treatment of Surgical Site Infection. CG74. Accessed online 25/08/10 www.nice.org.uk/nicemedia/pdf/CG74FullGuideline.pdf

National Wound Care Strategy Programme: [2020] Recommendations for Lower Limb Ulcers

Neil, J. A. and Barrell, L. M. 1998. Transition theory and its relevance to patients with chronic wounds. Rehabilitation Nursing 23(6): 295-299.

Persoon, A. et al. 2004. Leg ulcers: a review of their impact on daily life. Journal of clinical nursing 13(3): 341-354.

Platsidaki, E. et al. 2017. Psychosocial Aspects in Patients with Chronic Leg Ulcers. Wounds 29(10): 306-310

RCN (2014) Specialist Nurses Make a Difference RCN Policy Briefing. Available at www.rcn.org.uk/about-us/policy-briefings/pol-1409 (accessed 6/2/19)

Rogers LC, Frykberg RG, Armstrong DG, et al. The Charcot foot in diabetes. Diabetes Care. 2011;34(9):2123-9.

Schultz, G.S. et al. (2003) Wound bed preparation: a systematic approach to wound management. Wound Repair Regeneration 11(2): 1-28.

Schultz et al (2004) Wound bed preparation and a brief history of TIME. International Wound Journal 1(1):44-45

Wounds UK (2018) Best Practice Statement: Improving holistic assessment of chronic wounds. London: Wounds UK.

Humber Safeguarding Adults Policy Safeguarding Adults Policy.pdf (humber.nhs.uk)

Department of Health & Social Care ‘Safeguarding Adults Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry’ available on the GOV.UK website Pressure ulcers: safeguarding adults protocol - GOV.UK (www.gov.uk)

Appendix 1: Measuring a Wound

An essential part of weekly wound assessment is measuring the wound. It is important to use a consistent technique every time the wound is measured. The measurement technique used in HTNHSFT is linear measurement, also known as the “clock” method. In this technique, the longest length, greatest width, and greatest depth of the wound, use the body as the face of an imaginary clock. Document the longest length using the face of the clock over the wound bed, and then measure the greatest width. On the feet, the heels are always at 12 o’clock and the toes are always 6 o’clock. Document all measurements in millimetres, as L x W x D. Remember – sometimes length is smaller than width.

When measuring length:

- the head is always at 12 o’clock
- the feet are always at 6 o’clock
- your single use ruler should be placed over the wound on the longest length using the clock face.

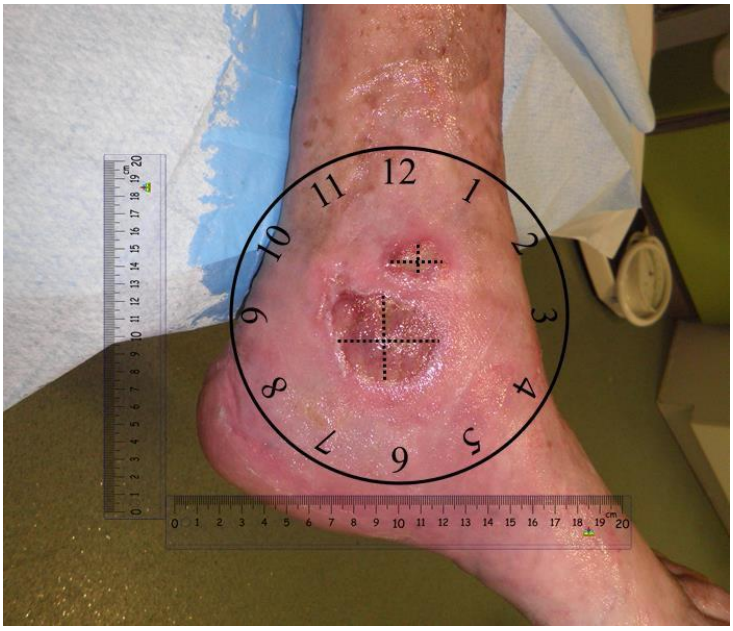
When measuring width:

- measure perpendicular to the length, using the widest width
- place your single use ruler over the widest aspect of the wound and measure from 3 o’clock to 9 o’clock.

When measuring depth:

- Gently place a wound probe into the deepest part of the wound bed and document the depth.

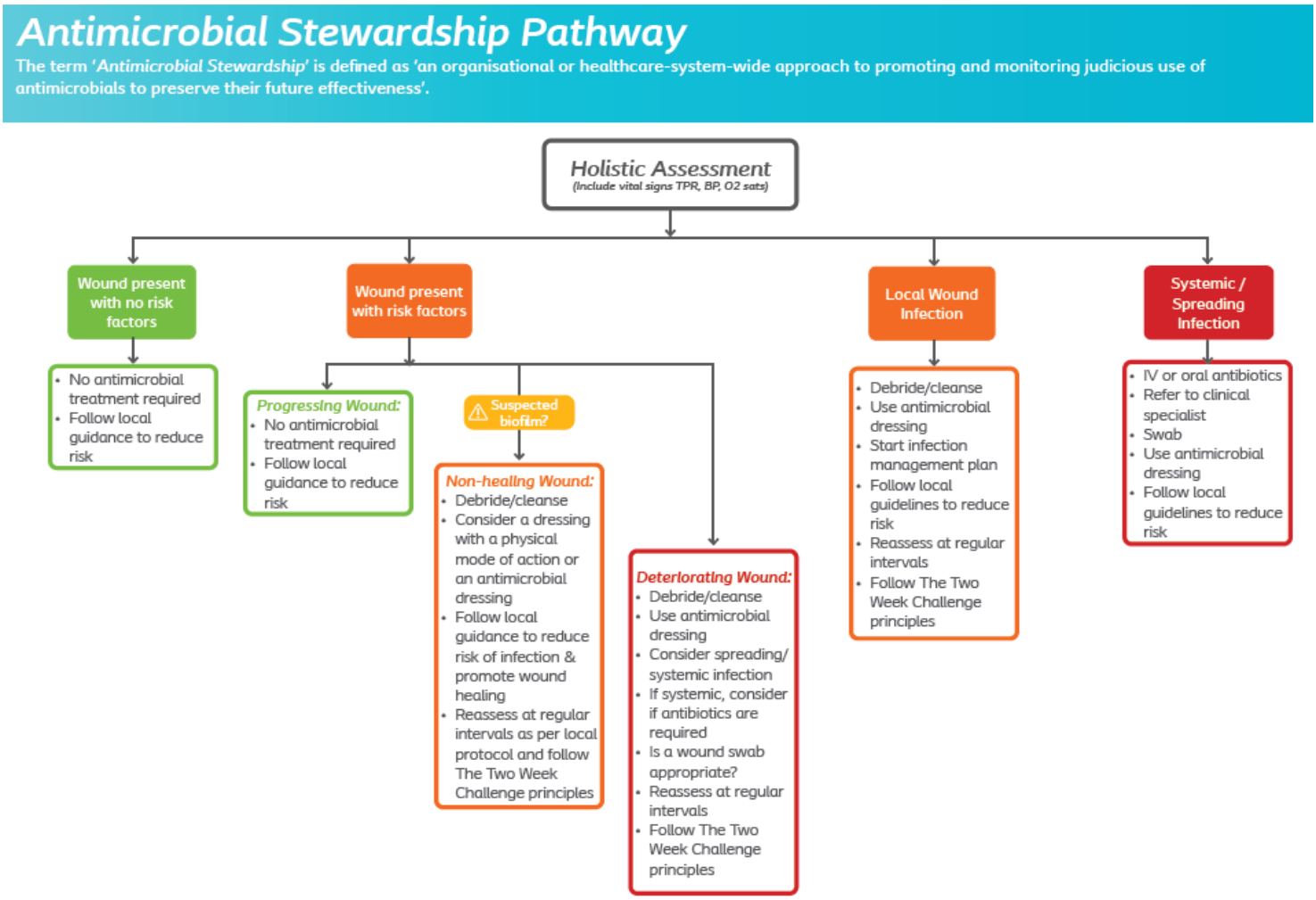
Morgan, N. (2012) Measuring wounds Wound Care Advisor found on the internet at http://woundcareadvisor.com/blog/measuring-wounds accessed 8 May 2017



Appendix 2: Tips for Photographing Wounds

1. Use a digital camera/phone owned by your place of work
2. Set the time and date on the camera
3. Get the light right – ensuring flash is on
4. Included patient data in the first photograph (date of birth, location of the wound and measurements) to help identify images (ensuring that appropriate patient consent has been obtained and documented)
5. Make the wound the focus – remove clutter from background and use a plain backdrop where possible
6. Standardise the views taken of the wound each time you assess and record
7. Get the angle right to record proportions accurately – the camera body should be parallel to the subject
8. Establish the wound location on the patient's limb
9. Use close-up images to establish detail, placing a single use ruler near the wound to give an accurate indication of size also take a perspective shot to establish location.
10. Do not include patients face, refer to local management of clinical audio-visual recording policy
11. Securely save and store the images

Appendix 3: Antimicrobial Stewardship Pathway



Appendix 4: SOP Tissue Viability Referral Pathways

Please see the intranet links for the following SOPs

Tissue Viability page on the intranet

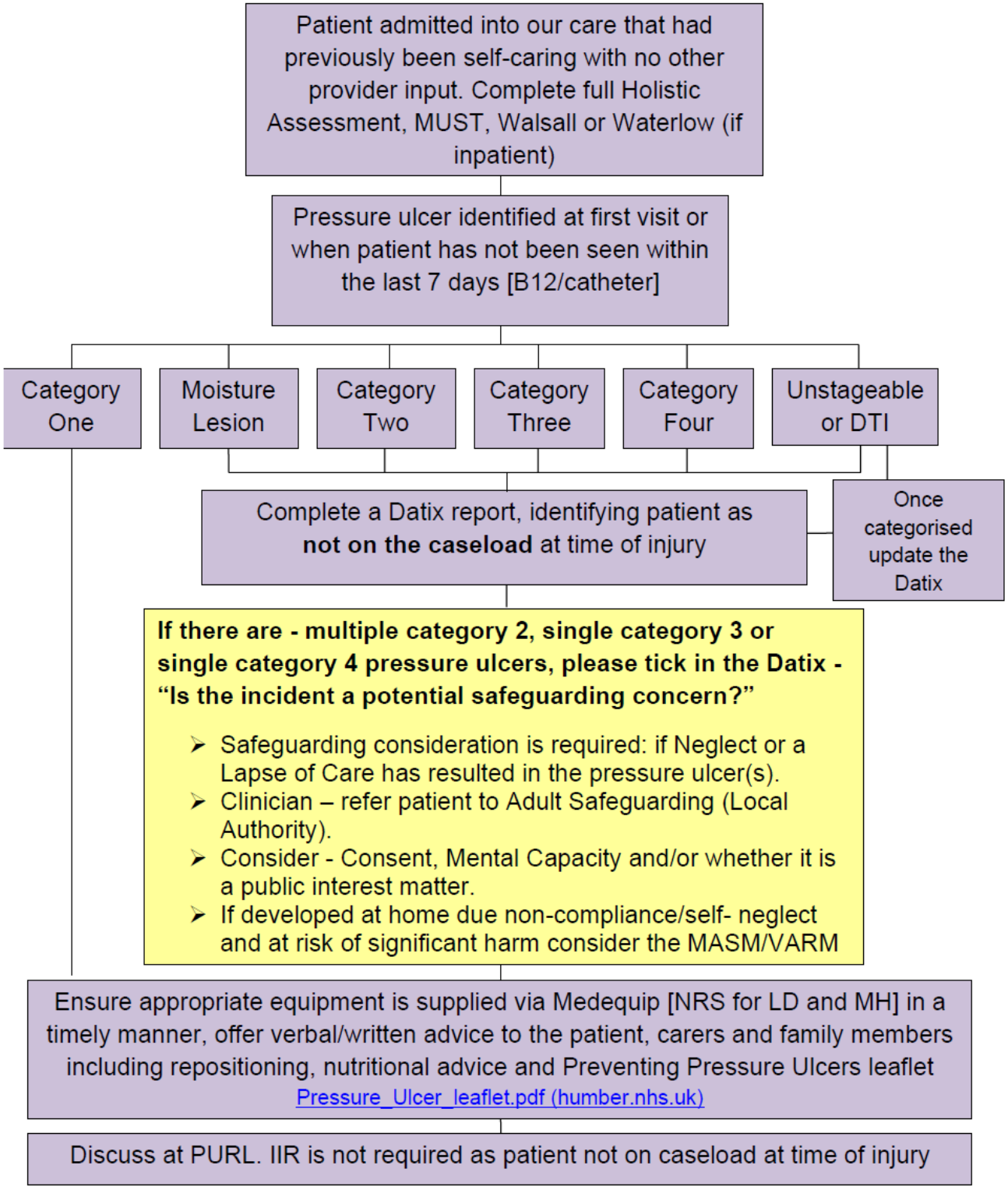
Tissue Viability Referral – Pocklington, Learning Disabilities, Mental Health and Primary Care (SOP21-024)

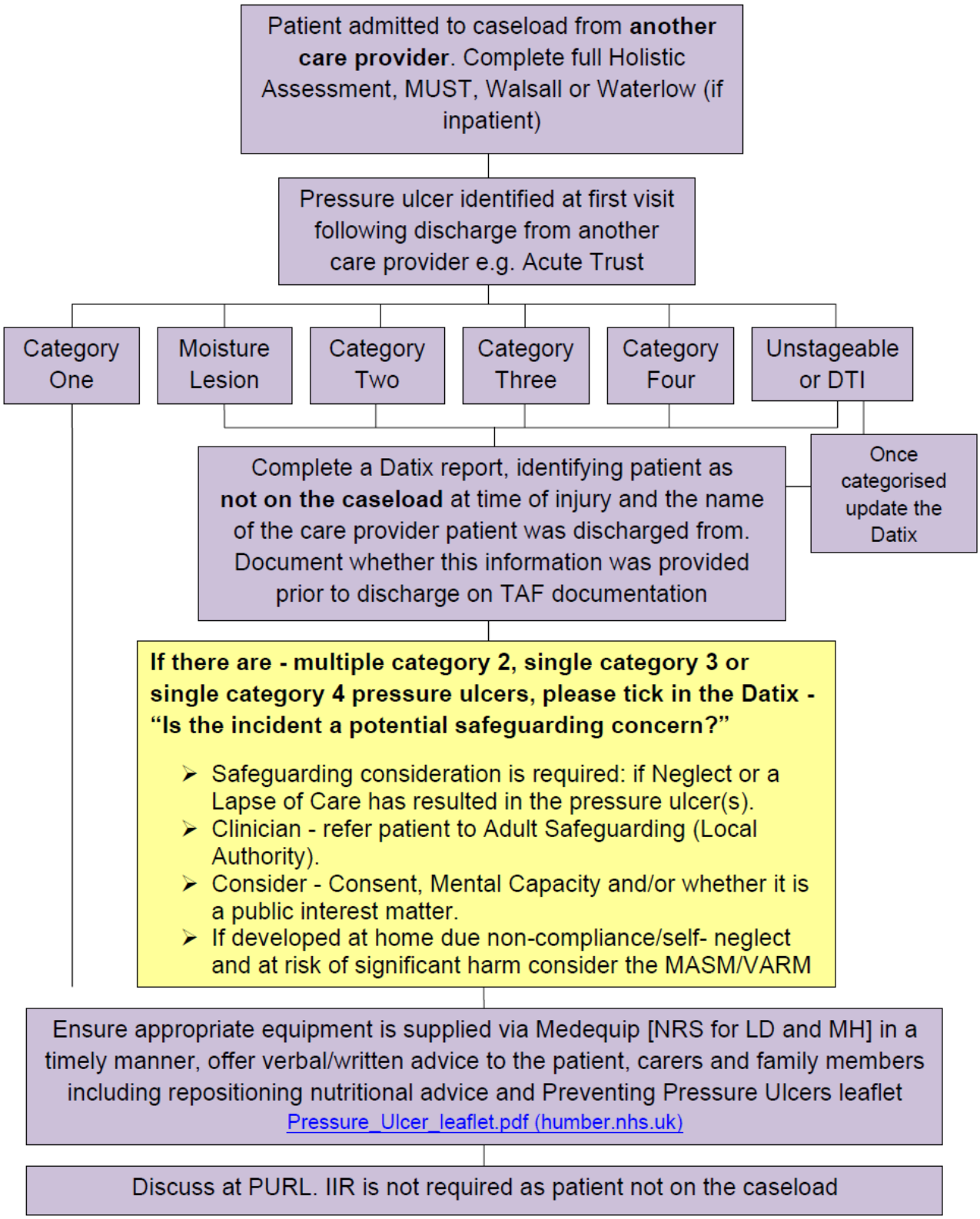
Tissue Viability Referral – Scarborough and Ryedale (SOP21-025)v

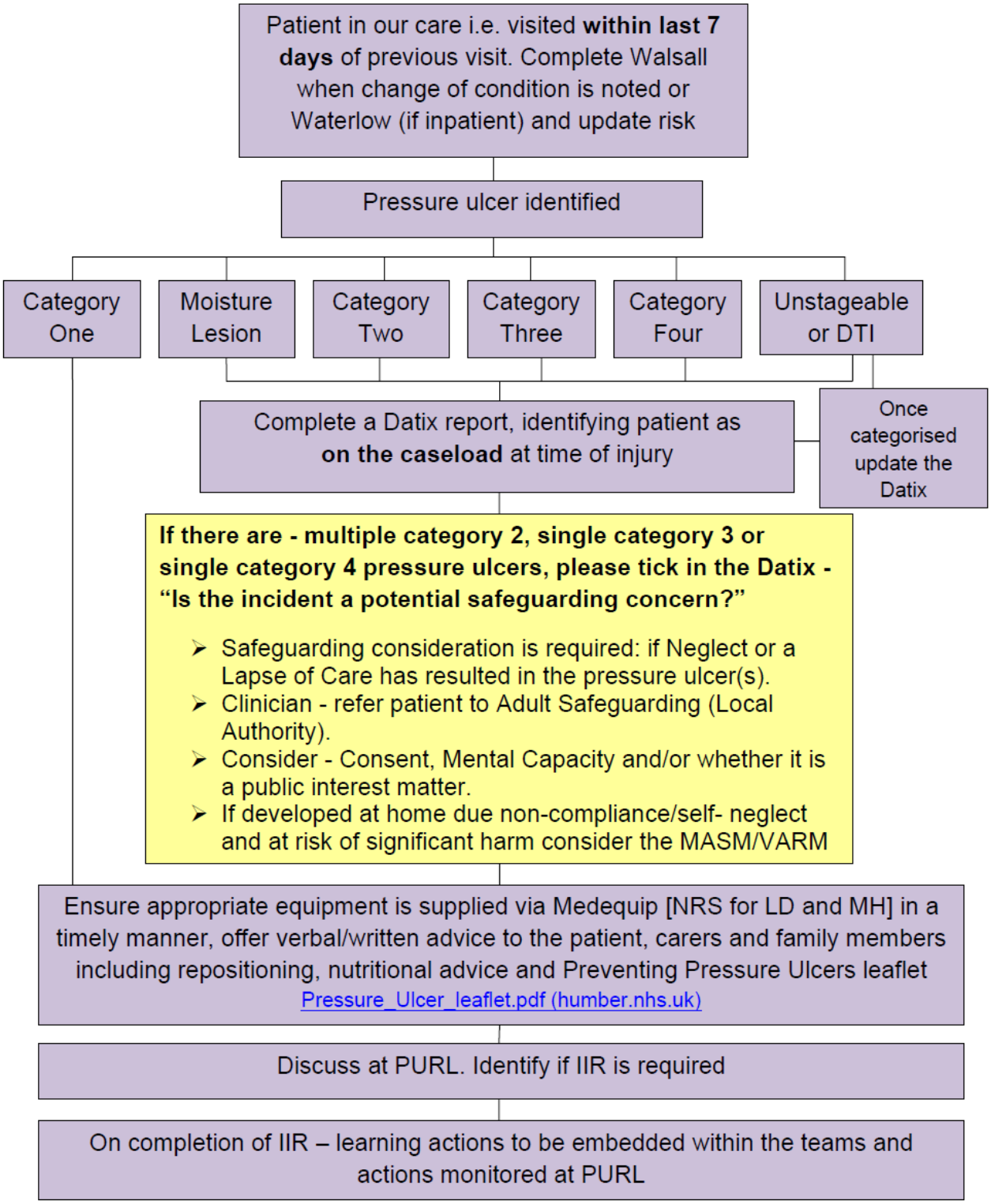
Appendix 5: Pressure Ulcer Pathway

NHS
Humber Teaching
NHS Foundation Trust

A Pathway for Humber Teaching NHS Foundation Trust Nursing Staff on Identification of a Pressure Ulcer




Patient admitted to caseload from **another care provider**. Complete full Holistic Assessment, MUST, Walsall or Waterlow (if inpatient)
Pressure ulcer identified at first visit following discharge from another care provider e.g. Acute Trust
Category One
Moisture Lesion
Category Two
Category Three
Category Four
Unstageable or DTI
Complete a Datix report, identifying patient as **not on the caseload** at time of injury and the name of the care provider patient was discharged from. Document whether this information was provided prior to discharge on TAF documentation
Once categorised update the Datix
If there are - multiple category 2, single category 3 or single category 4 pressure ulcers, please tick in the Datix - "Is the incident a potential safeguarding concern?"
Safeguarding consideration is required: if Neglect or a Lapse of Care has resulted in the pressure ulcer(s).
Clinician - refer patient to Adult Safeguarding (Local Authority).
Consider - Consent, Mental Capacity and/or whether it is a public interest matter.
If developed at home due non-compliance/self- neglect and at risk of significant harm consider the MASM/VARM
Ensure appropriate equipment is supplied via Medequip [NRS for LD and MH] in a timely manner, offer verbal/written advice to the patient, carers and family members including repositioning nutritional advice and Preventing Pressure Ulcers leaflet
Pressure_Ulcer_leaflet.pdf (humber.nhs.uk)
Discuss at PURL. IIR is not required as patient not on the caseload


Patient in our care i.e. visited **within last 7 days** of previous visit. Complete Walsall when change of condition is noted or Waterlow (if inpatient) and update risk
Pressure ulcer identified
Category One
Moisture Lesion
Category Two
Category Three
Category Four
Unstageable or DTI
Complete a Datix report, identifying patient as **on the caseload** at time of injury
Once categorised update the Datix
If there are - multiple category 2, single category 3 or single category 4 pressure ulcers, please tick in the Datix - "Is the incident a potential safeguarding concern?"
Safeguarding consideration is required: if Neglect or a Lapse of Care has resulted in the pressure ulcer(s).
Clinician - refer patient to Adult Safeguarding (Local Authority).
Consider - Consent, Mental Capacity and/or whether it is a public interest matter.
If developed at home due non-compliance/self- neglect and at risk of significant harm consider the MASM/VARM
Ensure appropriate equipment is supplied via Medequip [NRS for LD and MH] in a timely manner, offer verbal/written advice to the patient, carers and family members including repositioning, nutritional advice and Preventing Pressure Ulcers leaflet
Pressure_Ulcer_leaflet.pdf (humber.nhs.uk)
Discuss at PURL. Identify if IIR is required
On completion of IIR – learning actions to be embedded within the teams and actions monitored at PURL

Appendix 6: Adapted Walsall Score Pressure Risk Assessment Calculator

NHS Humber Teaching NHS Foundation Trust

Adapted Walsall Score Pressure Ulcer Risk Assessment Calculator for use by- AHP and HCAs to escalate and be triaged by a Registered community Nurse						
Risk Categories		Date				
		Time (24hr)				
See over for category guidance		Score	Score	Score	Score	Score
Awareness	No deficit	0				
	Deficit	3				
Mobility	Walks independently	0				
	Walks or transfers with the assistance of an aid	3				
	Unable to walk or dependent on care	8				
Skin condition of bony prominences	Healthy	0				
	Skin changes	2				
	Significant skin changes or pressure ulcer *	4				
	Verbal (VB) or visual (VS) check?					
Nutritional status	No dietary issues	0				
	Dietary issues	4				
Bladder incontinence	None	0				
	Occasional	1				
	Frequent	4				
Bowel incontinence	None	0				
	Occasional	4				
	Frequent	6				
Carer input	No carer	0				
	Active carer (daily visits)	0				
	Intermittent carer (irregular)	2				
Total score (state number) *Patients scoring 4 or more should be escalated to and discussed /triaged with a Registered nurse. Triage will determine further action. Please document discussion on S1.*	0-3	No risk				
	4-9 (3-monthly check)	Low risk				
	10-14 (alternate months check)	Medium risk				
	15 or above (monthly check)	High risk				
* Automatic high risk						
Name						
Position (i.e. RN, RA, HCA, AHP)						
Signature						

Appendix 7: SOP Clinical Digital Photography

See intranet link – Clinical Digital Photography SOP21-016

Appendix 8: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Tissue Viability Policy (N-066)
2. EIA Reviewer (name, job title, base and contact details): Simon Barratt - Tissue Viability Lead Nurse
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service
This policy aims to improve optimum healing and consequently improve patient care and outcomes.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern (Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	See summary
Disability	Where the impairment has a substantial and long-term adverse effect on the ability of the person to carry out their day-to-day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	See summary
Sex	Men/Male Women/Female	Low	See summary
Marriage/Civil Partnership		Low	See summary
Pregnancy/ Maternity		Low	See summary
Race	Colour Nationality Ethnic/national origins	Low	See summary
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	See summary
Sexual Orientation	Lesbian Gay men Bisexual	Low	See summary

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	See summary

Summary

Please describe the main points/actions arising from your assessment that supports your decision. The Tissue Viability Team are not aware of any evidence that different groups have different priorities in relation to this framework, or that any group will be affected disproportionally or any evidence or concern that this Policy may discriminate against a particular population group. Communication with a patient and their carer(s) should be in a style and use language that empowers and engages patient participation in the planning, delivery and evaluation of care. Thus, the equality impact assessment result is: no negative impact.	
EIA Reviewer: Simon Barratt	
Date completed: July 2024	Signature: S Barrett

Appendix 9: Document Control Sheet

Document Type and Title:	Tissue Viability Policy (N-066)		
Document Purpose:	This policy is over-arching to encompass tissue viability in its broadest sense. To support specific wound care, the associated LLUaSIAMaPG and Pressure Ulcer Policy.		
Consultation/ Peer Review	Date	Group / Individual	
list in right hand columns consultation groups and dates	July 2021	Tissue viability Team	
	August 2021	Pressure Ulcer Review and Learning Panel	
	September 2021	QPaS Group	
Approving Body:	QPaS	Date of Approval:	8 August 2024
NB All new policies and policies subject to significant amendments require approval at EMT and Board ratification.		*(see document change history below for minor amendments and dates)*	
Ratified at:	Trust Board	Date of Ratification:	N/A
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to EMT as the approving body that this has been delivered)*	Training and education programmes are in place on ESR and are available through The Tissue Viability Team	Financial Resource Impact:	-
Equality Impact Assessment undertaken?	Yes [√]	No [ ]	N/A [ ]
	If N/A, state rationale:		
Publication and Dissemination	Intranet [√]	Internet [ ]	Staff Email [√]
Master version held by:	Policy Management Team [√]	Author to send final document to HNF-TR.PolicyManagement@nhs.net	
Implementation:	-		
Monitoring and Compliance:	Wound management audits and reviewing adverse incidents.		

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
1.0	*New policy*	*July 21*	*New policy as identified by PURL (Pressure Ulcer Review and Learning Group) t5o ensure a standardized approach to tissue viability across the organisation ensuring best practice guidance is embedded.* *Policy approved through QPaS September 2021 and QC November 2021* *Review date set at one year as new policy (as per the document control policy)*
1.1	*Policy review*	*Nov 2022*	*Review of policy to update and align with safeguarding, clinical competency training and swabbing of wounds. Outdated photography consent removed. Skin tone bias paragraph added to section 3.2. Reference to Appendix 4 added to section 3.3. ESR role requirement paragraph added to section 5. Additional guidance paragraph added to section 6. Approved at QPaS (16 November 2022).*
1.2	*Policy review*	*August 2024*	*Reviewed with minor amends made and the EIA updated. Approved at QPaS (8 August 2024).*