Public – To be published on the Trust external website

Tissue Viability Policy

Ref: CLIN-0094-v3

Status: Ratified
Document type: Policy

Contents

1 Introduction

TEWV NHS Foundation Trust provides care to a diverse range of service users across several specialties and localities, all of whom require varying degrees of need and support. As reiterated by NHS England, 2019 [online], care provision is variable, with some groups of people continuing to experience inequalities The Trust is therefore fully committed to ensuring that patients receive care that is individualised, evidence based, and that fair and equal treatment is offered to all. No one should have a poorer service or a lesser experience because care is being delivered within a mental health or learning disability healthcare setting, inclusive of care that may be required in an emergency. It is in keeping with this principle that this policy has been written.

This policy reflects the Trust's strategic direction of travel, Our Journey to Change, by supporting its values and goals by ensuring that we prevent compromising the skin and where there are instances of the skin breaking down e.g. pressure sores that we treat these as effectively as possible thus minimising the impact on the individual. This is a key part to ensuring that we deliver outstanding and compassionate care which is appropriate for the individual person in line with our patient and carer focussing goal. In addition, ensuring that staff feel competent and supported in carrying out the requirements of the policy will ensure that they feel well managed and understand why this work is meaningful.

Living our values is integral to the care we deliver. In complying with this policy our colleagues will show respect to patients and their families, by actively listening to their concerns and acting upon them. We will ensure we are always compassionate, kind, and supportive. We will be open and honest in our conversations, always receptive (listening) to how much information a person may want, and in what kind of format.

2 Why we need this policy

2.1 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.

2.2 Objectives

The overall 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 the monitoring of both risk and incidence of pressure ulcers when it takes place.

3 Scope

3.1 Who this policy applies to

This policy applies to all healthcare professionals working in all areas, departments, wards, and services of TEWV NHS Foundation Trust. However, key roles and responsibilities are outlined in **Section 3.2 Roles and Responsibilities**. The provision of this policy will apply at all locations where those employed by TEWV NHS Foundation Trust provide treatment to anyone accessing the Trust.

Consideration has also been given to those who may be affected by this policy to ensure that the document content aligns to the Trust's values, so that people who may be affected are treated with compassion, respect and responsibility.

3.2 Roles and responsibilities

Role	Responsibility
Chief Nurse	• Ensure that all Registered Nursing Staff are aware of this policy, and other policies, guidance and procedures which relate to this policy. • Ensure that adequate training is given to allow Registered Nursing staff to implement this policy.

Directors of Operations and Transformation, Associate Directors, General Managers, and Service Managers	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for the implementation and monitoring of this policy within their respective services, specialties and/or localities. • Responsible for ensuring that systems and processes are in place to monitor and meet the requirements outlined within this policy.
Matrons, Team Leaders, Departmental Heads, Ward and Unit Managers	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for ensuring that staff have read and have an awareness of the policy. • Responsible for ensuring that systems and processes to monitor compliance are implemented. • Responsible for ensuring that staff undertake appropriate training required to perform their role and to achieve and maintain a level of competence in relation to
Tissue Viability Nurses	• Develop and produce Tissue Viability training programs to be delivered by competent Tissue Viability Nurses to meet the standards required. • Provide regular reports to the Physical Health Group, and the Patient Safety Group regarding Tissue Viability incidents/update. • Coordinate and deliver Tissue Viability training and associated bespoke training. • Coordinate and undertake an annual Pressure Ulcer Point Prevalence and Waterlow Pressure Ulcer Risk Assessment audit. • Review and update this policy.
All Clinical Staff	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Ensure their approach to care is interdisciplinary, involving all those needed in the management of the patient.
Wound Resource Education Nurse (WRENs)	In addition to the above they will:

	• Act as a resource in clinical areas for advice on pressure ulcers and basic wound assessment and management. • Attend Tissue Viability updates and training to maintain their knowledge and skills. • Update and educate all clinical staff in their area.

4 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 staff to ensure they have the appropriate wound care knowledge and skills to provide effective and safe care for their patients.

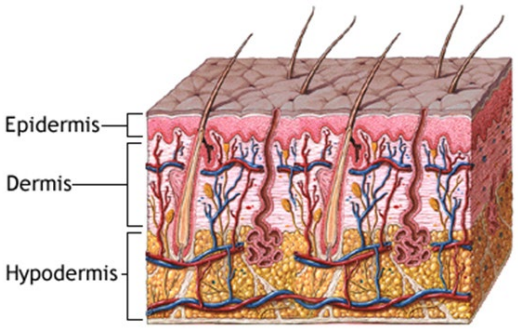
4.1 Anatomy and Physiology of Skin

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 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 can repair itself after injury.

Structure of the Skin

The skin has three basic layers:

- **Epidermis**: the outermost layer of skin, provides a waterproof barrier and creates our skin tone.
- **Dermis**: beneath the epidermis, contains tough connective tissue, hair follicles, and sweat glands.
- **Hypodermis** (Subcutaneous): largely consists of fat. It provides the main structural support for the skin, as well as insulating the body from cold and aiding shock absorption. It is interlaced with blood vessels and nerves.



4.2 Categories of Wounds

There are two types of wounds which are:

Acute: surgery and trauma, e.g. self-harm wounds.

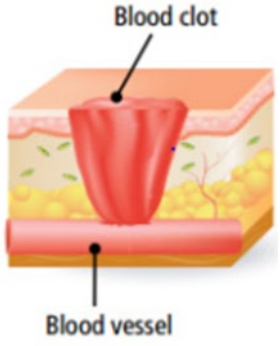
Chronic: long term – leg ulcers, diabetic foot ulcers and malignant wounds.

4.3 Types of wound healing

Wound healing is a complex process with overlapping phases. Two ways that wounds heal depend on the wound type and cause:

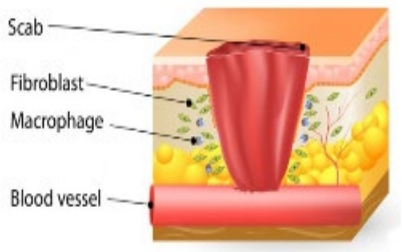
- **Primary Intention:** Acute wounds – for example, those caused by surgery where there is minimal tissue loss heal by primary intention. This means the edges of the wound can be brought together and re-aligned, using sutures, staples, or clips. Provided there are no complications, these wounds tend to heal quickly, with minimal scarring (Martin, 2013).
- **Secondary Intention**: In wounds where there is considerable tissue loss – for example, pressure ulcers or venous leg ulcers – healing occurs through secondary intention by the process of granulation and epithelisation. Wounds heal from the inside out where the edges eventually come together which is a long process.

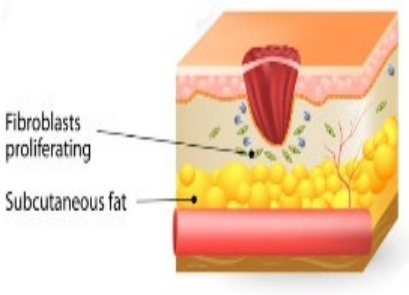
Normal wound healing follows a specific path.



Haemostasis: Blood clot prevents too much blood being lost. This phase starts immediately after the injury is caused and lasts up to 3 days Firefighting stage

Inflammation: Lasts around 3-5 days after tissue damage occurs.





Proliferation: Granulation is the new tissue, where the body grows new blood vessels leading to granulation

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

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.

4.4 Types of Wound Tissue

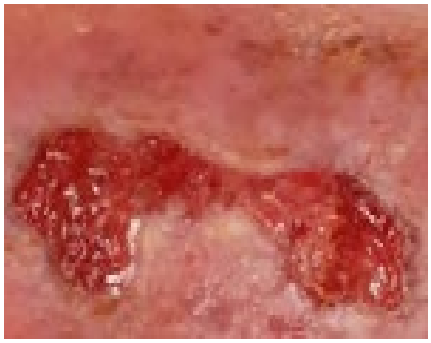
Necrotic

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

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



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.

4.5 Patient Assessment and Management

- Timely assessment, re-assessment and appropriate management is required for all patients with / or at risk of tissue breakdown and referral to the TV Service, if necessary. Not all

patients with tissue breakdown will require a referral to the TV Service as it will be the clinician's judgement whether a referral is required. However, all category 3, category 3 – unclassified, category 4 pressure ulcers and suspected deep tissue injuries (DTI) **MUST** be referred to the TV Service (Appendix 3) and reported via the Trust's InPhase reporting system.

- Treatment must be evidence based where such evidence exists in accordance with local and national guidance (NICE 2014 and EPUAP/NPIAP/PPPIAP 2019).
- A care plan, stating objectives, intervention and review date, must be in place for the prevention and/or management of any type of wound.
- Dressing selection from the Wound Dressings Formulary (available via the Trust intranet) should follow a holistic assessment completion of a wound assessment and management chart (Appendix 4). Dressings should be ordered via Cardea.
- The Wound Infection Algorithm (see Appendix 5) should be followed for the management of wound infections or suspected wound infections.
- The Lower Limb Wound Protocol (accessed via Trust intranet) **MUST** be followed for management and care of patients with a wound to their lower limb.

It is also important to acknowledge the patient's personal preferences, beliefs and wishes. Wherever possible these preferences need to be considered to promote collaborative decision making, privacy and dignity, and to prevent the breach of iatrogenic harm.

Further information can be obtained from the Consent to Examination or Treatment Policy and the Privacy and Dignity Policy, both of which are available via the Trust intranet.

4.6 Pressure Ulcer Prevention and Management

NHS Improvement (2018) defines pressure ulcers as 'a localised injury 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 or an open ulcer and may be painful.

Risk assessment is an essential part in the prevention of pressure ulcers and implementation of care. There are many pressure ulcer risk assessments that have been developed, however these represent only one part of pressure ulcer prevention.

A risk assessment tool encourages a structured approach to assessment but also complements the healthcare professional's clinical judgement. NICE (2014) states to consider using a national validated scale to support clinical judgement. Thus, the Waterlow Pressure Ulcer Risk Assessment Tool (Appendix 6) is the chosen national validated risk assessment tool used within TEWV. Risk assessment tools should not however, be used to recommend equipment and/or treatment. The Waterlow Pressure Ulcer Risk Assessment Interventions Protocol (Appendix 7) should be used to support staff when completing the Waterlow Pressure Ulcer Risk Assessment Tool.

Patients must have a body map skin integrity/assessment (Appendix 8) completed and skin condition assessed as part of the Waterlow Pressure Ulcer Risk Assessment. If this cannot be undertaken, then a clear rationale should be documented in their electronic patient record. Early assessment of the patient's skin over bony prominences can reveal the first signs of skin damage and prevent ulcerations from developing. Skin inspection should occur regularly, and the frequency will be determined in response to changes in the patient's condition either deterioration or recovery.

Patients who are identified as at being at risk of developing pressure ulcers or have existing pressure ulcers should be repositioned or encouraged to independently reposition. A repositioning schedule should be agreed with the patient and documented on their electronic patient record. A positional change chart (Appendix 9) must be used if a patient requires assistance with repositioning.

The standard Pentaflex Premium foam mattress and Trezzo HS Advance Transfer (Duralast) (found within the Trust) are both pressure relieving and can be used for all patients (unless an anti-vandal mattress is required). This includes patients with a pressure ulcer - but only up to and including a category 2. The Trezzo 3" seat cushion, if required, along with Trezzo HS Advance Transfer (Duralast) mattresses can be purchased via Cardea.

Dynamic (air flow) pressure relieving equipment (e.g. mattresses and cushions) should only be used for the treatment of a category 3, category 3-unclassified or category 4 pressure ulcer (or on the recommendation from the Tissue Viability Service). A Pressure Relieving Equipment Protocol is available in Appendix 10 to support staff in identifying which mattress to use and when.

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

All pressure ulcers category 2, 3, 4 or category 3 – unclassified must be reported via the Trust's InPhase reporting system and documented within the electronic patient record.

All suspected deep tissue injuries, category 3, 4 or category 3 – unclassified pressure ulcers must be referred to the TV Service (via email: tewv.tissueviability@nhs.net). Alternatively, if there is immediate staff concern regarding the severity of the injury, the patient should be transferred to the local Acute Trust Emergency Department.

Any category 3, 4 or category 3 – unclassified pressure ulcers that are not present on admission/caseload must follow the Patient Safety Incident Response Framework (PSIRF). PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

Please read the Assessment, Prevention and Management of Pressure Ulcers Procedure for further information, available via the Trust intranet.

4.7 Skin Tear Prevention and Management

A skin tear is defined as a traumatic wound caused by mechanical forces, including the removal of adhesives. Classification is based on the severity of the 'skin flap' loss. A skin flap is defined as a portion of skin (epidermis / dermis) that is unintentionally separated (partially / fully) from its original place due to shear, friction, and /or blunt force' (LeBlanc et al, 2018). Partial thickness occurs when the epidermis is separated from the dermis or full thickness when both the epidermis and the dermis separate from underlying structures (full thickness wound) (LeBlanc et al, 2011).

The primary aim for staff to recognise those at risk and prevent skin tears from developing.

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. The Skin Tear Decision Algorithm (Appendix 11) explains how to treat a skin tear.

Please read the Skin Tear Prevention and Management Procedure for further information, available via the Trust intranet.

4.8 Digital Wound Photography

Digital wound photography of wounds is useful for the Tissue Viability Team when they cannot assess the patient's wounds immediately due to the locality of the patient and allows for interim advice to be given before full assessment can be undertaken.

Clinical staff that utilise digital wound photography should do so using Trust equipment only. This does include Trust mobile phones (as they are encrypted) but not the use of personal mobile phones under any circumstances. Precautions should be undertaken to reduce the risk of cross infection caused by the use of digital wound photography devices across care settings using detergent wipes to clean equipment after each use.

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

Digital wound photographs will be uploaded to a secure email and saved in a secure file where they can only be accessed by the Tissue Viability Team.

Please read the Digital Wound Photography Procedure for further information, available via the Trust intranet.

It is also important to acknowledge the patient's personal preferences, beliefs and wishes in regard to the gender of the staff member taking the photographs. Wherever possible these preferences need to be considered to promote collaborative decision making, privacy and dignity, and to prevent the breach of iatrogenic harm.

Further information can be obtained from the Consent to Examination or Treatment Policy and the Privacy and Dignity Policy, both of which are available via the Trust intranet.

4.9 Moisture Associated Skin Damage (MASD)

MASD is a common yet sometimes complex skin condition (Wounds International, 2020 [online]). The damage to skin is due to overexposure of moisture, which impairs the skin barrier. Overhydration causes the pH of the skin to increase, which disrupts the acidic environment that the skin requires, and in doing this the skin is more susceptible to damage, and the risk of infection increases. Chemical irritants present in the moisture source can also exacerbate the damage that is caused.

The appropriate management of MASD will be dependent upon the cause and the category of the MASD, therefore staff supporting a person with suspected MASD must be able to provide appropriate patient and wound assessment to identify the cause and category, to ensure the correct care plan is implemented.

If the patient declines any recommended interventions or care, then this MUST be documented on their electronic care record. If there are concerns regarding the patient's

skin (e.g. impaired skin integrity, open wound, infection, sepsis), a capacity assessment and an MDT approach may be required for interventions to be performed in the patients best interests.

All incidences of MASD must be reported via the Trust's InPhase recording system and documented within the electronic patient record.

Please read the Assessment, Prevention and Management of Moisture Associated Skin Damage Procedure for further information, available via the Trust intranet.

4.10 Wound Glue

Wound glue is becoming more commonly used for non-invasive closure of minor skin wounds, reducing the need for the more traditional methods of sutures, staples, or strips. Wound glues are often the preferred method of closure for simple, low tension, low flexion wounds due to ease of use, speed of action and good patient compliance.

The only wound glue that TEWV NHS Foundation Trust use is LiquiBand Optima skin glue and only registered healthcare professionals and nursing support staff who have received training on wound care and wound glue application are to use this product.

Please read the Wound Glue Procedure for further information, available via the Trust intranet.

4.11 Stoma Care

A stoma is an opening on the abdomen that diverts waste (urine or faeces) out of the body from the digestive system or urinary system. A stoma may be relatively flat on the abdomen or protrude out. A pouch is placed over the top of a stoma, which is either closed or have an opening at the bottom. Stomas do not have nerve endings, therefore patients should feel no pain (NHS, 2020)

There are three main stoma types:

- Colostomy - an opening from the large bowel
- Ileostomy - an opening from the small bowel
- Urostomy - an opening for the ureters

It is important for the skin around a stoma to be cleaned and dried at every bag change to prevent skin breakdown. Some patients may require assistance with their stoma care.

General stoma care advice can be accessed via the Royal Marsden Manual Online using the Trust login details.

Please read the Stoma Care Advice and Support Protocol for further information, available via the Trust intranet.

4.12 Nutrition

Eating a well-balanced diet, drinking plenty of fluids and maintaining a stable healthy weight are vital in preserving tissue, reducing the risk of developing pressure damage and supporting the repair of tissue following damage. Conversely, having a poor nutrient and fluid intake can increase the risk of pressure ulcers and delay wound healing.

Certain conditions can increase the likelihood of developing pressure ulcers such as:

Being underweight – as there is less natural padding under the skin to protect bony areas such as hips and sacral area.

Living with overweight or obesity – as there is an increase weight bearing load on pressure areas such as bottom and may be accompanied which reduced mobility.

Diabetes and Heart Disease – as these conditions have a negative impact on circulation. Our skin needs a good supply of nutrients and fluids to keep it healthy and supple.

Wound healing is a complex process and can be complicated further by chronic illness, infection, dehydration, and malnutrition. The body needs protein, energy (calories), vitamins and minerals (such as vitamin C, iron, and zinc), and plenty of fluids to support wound healing.

All patients with Category 2, Category 3, Category 4 or Category 3 - unclassified pressure ulcers must be referred to their respective Dietetic Team highlighting they have a pressure ulcer.

It is also important to acknowledge the patient's personal preferences, beliefs and wishes to promote collaborative and informed decision making around nutrition.

4.13 Aseptic Technique

Asepsis is defined as the absence of potentially pathogenic (harmful) micro-organisms. Aseptic technique is the practice of carrying out a procedure in such a way as to minimize the risk of introducing contamination into a vulnerable area or an invasive device. The area or device will not necessarily be sterile – wounds, for example, will be colonized with micro-organisms – but the aim is to avoid introducing additional contamination.

Aseptic Non-touch Technique (ANTT) is best practice based on research evidence. It provides a standard for safe and effective aseptic practice. Aseptic technique is the practice of carrying out a procedure in such a way as to minimise the risk of introducing contamination into a vulnerable area or an invasive device. The area or device will not necessarily be sterile – wounds, for example, will be colonised with micro-organisms – but the aim is to avoid introducing additional contamination.

Please refer to the Aseptic Non-Touch Technique (ANTT) Procedure for further information, available via the Trust intranet.

5 Definitions

Term	Definition
ANTT	• Aseptic Non-Touch Technique
CQC	• Care Quality Commission
MASD	• Moisture Associated Skin Damage
NICE	• National Institute for Health and Care Excellence
TV	• Tissue Viability

6 Related documents

- Aseptic Non-Touch Technique (ANTT) Procedure
- Assessment, Prevention and Management of Moisture Associated Skin Damage Procedure
- Assessment, Prevention and Management of Pressure Ulcers Procedure
- Consent to Examination or Treatment Policy
- Digital Wound Photography Procedure
- Privacy and Dignity Policy

- Skin Tear Prevention and Management Procedure
- Stoma Care Advice and Support Protocol
- Wound Glue Procedure

7 How this policy will be implemented

- This procedure 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.
- Each team/ward manager will ensure that staffs training needs are met in accordance with the Trust's training needs analysis.
- Each healthcare professional is responsible for their own professional development and individual needs should be addressed through appraisal and training needs analysis.
- An education programme, which incorporates wound care, is available for all healthcare professionals. Staff to contact the Tissue Viability Service, if required.

7.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Registered Healthcare Professionals	Face to face as part of WREN programme	3 x Full day training days which incorporates various topics i.e. pressure ulcer prevention, self-harm and burns.	Annually as part of a rolling programme
Nursing Support Staff	Face to face as part of WREN programme	3 x Full day training days which incorporates various topics i.e. pressure ulcer prevention, self-harm and burns.	Annually as part of a rolling programme

8 How the implementation of this policy will be monitored

Number	Auditable Standard/Key	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will

	Performance Indicators		usually be via the relevant Governance Group).
1	Pressure Ulcer Point Prevalence Audit	Frequency = Annually Method = Audit Responsible = Tissue Viability Service	The Fundamental Standards of Holistic Care, Clinical Advisory Group and The Physical Health Group.
2	Waterlow Pressure Ulcer Risk Assessment Audit	Frequency = Annually Method = Audit Responsible = Tissue Viability Service	The Fundamental Standards of Holistic Care, Clinical Advisory Group and The Physical Health Group.

9 References

Acton, C (2013) The Importance of nutrition in wound healing. Wounds UK 9(3), pp. 61-64.

European Pressure Ulcer Advisory Panel (EPUAP) National Pressure Injury Advisory Panel (NPIAP) and Pan Pacific Pressure Injury Alliance Prevention (PPPIAP). Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline: the International Guideline 2019. Emily Haesler (ed) EPUAP/NPIAP/PPPIA:2019

LeBlanc, K and Baranoski, S (2011) Skin tears– State of the science: Consensus statements for the prevention, prediction, assessment, and treatment of skin tears. Advances in Skin & Wound Care 24(9), pp. 2-15.

LeBlanc, K and Woo, K (2018) Best practice recommendations for the prevention and management of skin tears in aged skin: an overview. Wound International 9(3), pp.66-70.

National Institute Clinical Excellence (2019) Diabetic foot problems: prevention and management: NICE Guidelines 19 [online]
https://www.nice.org.uk/guidance/ng19
[Accessed 15th December 2021]

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

NHS (2020) Colostomy [online] https://www.nhs.uk/conditions/colostomy/ [Accessed 6th January 2022]

NHS Improvement (2018) Pressure ulcers: revised definition and measurement. Summary and recommendations. NHS Improvement. https://improvement.nhs.uk/documents/2932/NSTPP_summary__recommendations_2.pdf

NHS England (2019) The NHS Long Term Plan (LTP) [online] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf [Accessed 15th December 2021]

Rowley, S and Clare, S (2011) ANTT: A standard approach to aseptic technique. Nursing Times 107(36), pp. 12-14.

Wounds International (2020) International Best Practice Recommendations. Preventions and Management of Moisture-Associated Skin Damage (MASD). Recommendations From and Expert Working Group. https://woundsinternational.com/best-practice-statements/best-practice-recommendations-prevention-and-management-moisture-associated-skin-damage-masd/

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	18 March 2025
Next review date	18 March 2028
This document replaces	CLIN-0094-v2 Tissue Viability Policy
This document was approved by	The Fundamental Standards of Holistic Care, Clinical Advisory Group
This document was approved	05 February 2025
This document was ratified by	Management Group
This document was ratified	18 March 2025
An equality analysis was completed on this policy on	13 December 2024
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
1	10 Apr 2019	New Policy	Withdrawn
2	20 Jan 2022	Full policy review and update of contents and relevant references.	To be withdrawn
3	18 Mar 2025	Full policy review and update of contents and relevant references. Main changes being: - Update of pressure ulcer terminology and mattresses used within the Trust - Addition of section 4.9: Moisture Associated Skin Damage (MASD) - Update of Skin Tear Decision Algorithm following update of Skin Tear Prevention and Management Procedure - Addition of Appendix 7- Waterlow Pressure Ulcer Risk Assessment Interventions Protocol	Approved pending ratification

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Nursing and Governance/ Tissue Viability Service
Title	Tissue Viability Policy
Type	Policy
Geographical area covered	Trust-wide
Aims and objectives	• Ensure that all staff is aware of the agreed Tissue Viability (TV) measures required to effectively manage wound care. • 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 the monitoring of both risk and incidence of pressure ulcers when it takes place.
Start date of Equality Analysis Screening	13 December 2024
End date of Equality Analysis Screening	13 December 2024

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Trust staff and patients
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities)**NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	This procedure will not negatively impact upon any of the protected characteristic groups.
Describe any positive impacts / Human Rights Implications	Service users receive safe, effective and appropriate wound care and interventions

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	See appendix 9 for references used within document
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	This procedure has been discussed with the Fundamental Standards of Holistic Care Clinical Advisory Group who support patients from a range of protected characteristics on a daily basis.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	N/A

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	Training will be delivered to Trust staff to implement and embed the standards of this policy across the Trust.
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2. Rationale		
Are reasons for development of the document stated?	Yes	
3. Development Process		
Are people involved in the development identified?	Yes	
Has relevant expertise has been sought/used?	Yes	
Is there evidence of consultation with stakeholders and users?	Yes	
Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4. Content		
Is the objective of the document clear?	Yes	
Is the target population clear and unambiguous?	Yes	
Are the intended outcomes described?	Yes	
Are the statements clear and unambiguous?	Yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	
Are key references cited?	Yes	
Are supporting documents referenced?	Yes	

6. Training		
Have training needs been considered?	Yes	
Are training needs included in the document?	Yes	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Yes	
8. Equality analysis		
Has an equality analysis been completed for the document?	Yes	
Have Equality and Diversity reviewed and approved the equality analysis?	Yes	13 Dec 2025 ah
9. Approval		
Does the document identify which committee/group will approve it?	Yes	
10. Publication		
Has the policy been reviewed for harm?	Yes	
Does the document identify whether it is private or public?	Yes	Public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Yes	
Do all pictures and tables have meaningful alternative text?	Yes	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Yes	

Appendix 3 – Tissue Viability Referral Request Form

TISSUE VIABILITY REFERRAL REQUEST FORM

PATIENT NAME …….…….. **D.O.B.** ……..

PARIS ID ……..…… **WARD & HOSPITAL**……

REASON FOR ADMISSION

CONTRIBUTING FACTORS / MEDICAL CONDITIONS

Was the Wound Present on admission to Hospital **YES/NO**

Type of Wound ……

……..

Wound Site ……

……...

Duration of wound ……

All Pressure Ulcers and Moisture Associated Skin Damage MUST have an InPhase completed

REASON FOR REQUEST

……...

……

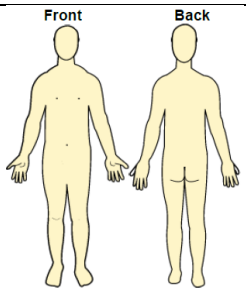
SIGNATURE ……..…… **PRINT NAME**……..
Contact Tel No…… **DATE** ……

Please email this form and wound image to tewv.tissueviability@nhs.net

Appendix 4- Wound Assessment and Management Chart

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

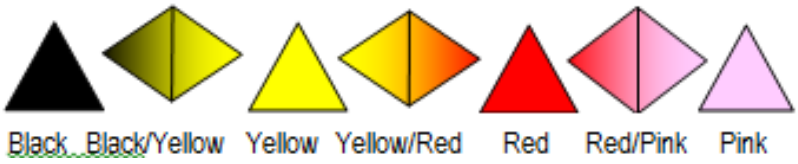
Initial Assessment



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)**			

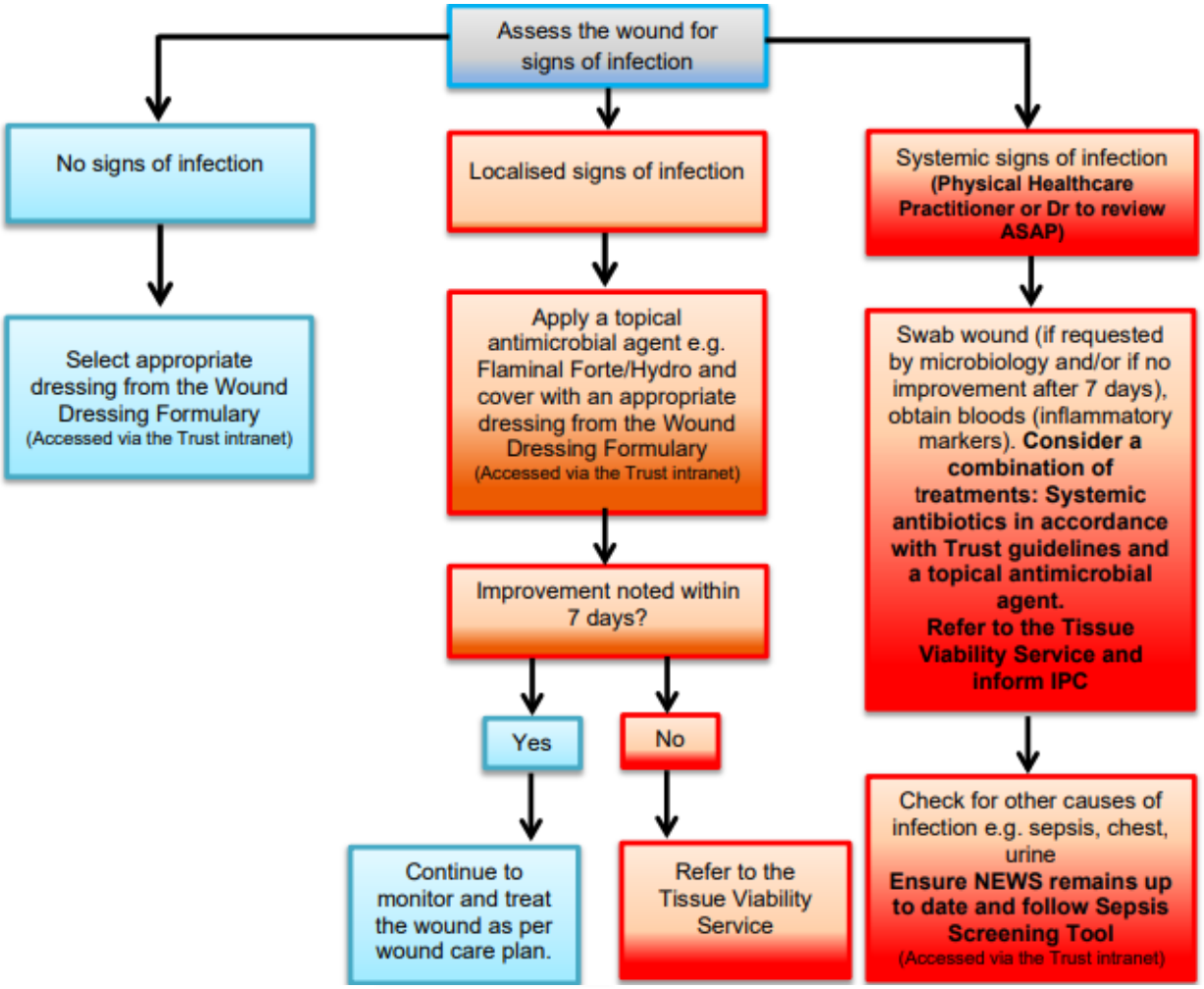
Reassessment of treatment plan should be considered at least weekly

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**

Appendix 5 - Wound Infection Algorithm

The Management of Wound Infections or Suspected Wound Infections

This protocol should be read alongside the Consent to Examination or Treatment Procedure.



Common signs of a localised wound infection:	Some of the common signs of a systemic wound infection in addition to the signs of a localised wound infection:
Increase in pain	Fever and chills
Surrounding wound may be red (which may present differently depending on the individual's skin tone)	Increased heart rate
Increase in swelling	Nausea and Vomiting
Wound has an offensive smell	Diarrhoea
Increase in exudate (yellow, brown or green)	Fatigue or weakness
Local warmth	High temperature
 	 
****This list is not exhaustive****	

A more accessible version of the wound infection algorithm is available on request.

Appendix 6 – Waterlow Pressure Ulcer Prevention

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**
E.g. 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 7 - Waterlow Pressure Ulcer Risk Assessment Interventions Protocol

All inpatients **must** have a Waterlow Pressure Ulcer Risk Assessment completed as close as possible to the time of admission/transfer to ward/unit. Interventions must be implemented depending upon the person's level of risk and skin integrity.

Pressure Ulcer Interventions:

If Waterlow score 2-10 (low risk) and no pressure ulcer present:

- Encourage and/or support the person to change their position regularly throughout the day
- Discuss vulnerable sites for development of pressure ulcer specific to the person's circumstance
- Encourage and/or support the person with personal hygiene and skin care
- Document all care that is offered (whether accepted or declined) in electronic care record

If Waterlow score 10+ (at risk) and no pressure ulcer or category 1 pressure ulcer present implement all of the above plus:

- Encourage and/or support the person to change their position at least every 4 hours
- Offer daily skin inspections which must be documented on a body map

Waterlow score 10+ (at risk) and category 2 pressure ulcer present implement all of the above plus:

- Report the pressure ulcer via InPhase
- Complete full wound assessment and implement wound care plan in accordance with TEWV Wound Care Formulary (accessible via Tissue Viability intranet page)

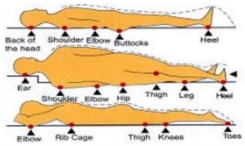
Waterlow score 10+ (at risk) and category 3 , category 4 or category 3- unclassified pressure ulcer or deep tissue injury present implement all of the above plus:

- All category 3 or 4 pressure ulcers or deep tissue injuries need referral to Tissue Viability Service
- Refer patient to dietician
- Upgrade to an airflow mattress following discussion with Tissue Viability Nurse

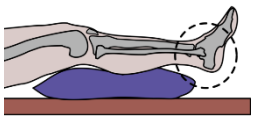
All patients need their Waterlow Pressure Ulcer Risk Assessment regularly reviewed whilst an inpatient. Frequency of reassessment is dependent upon type of ward/unit **and** the person's individual score:

	Monthly	Once a week	Three times a week	Daily
MHSOP/Eating Disorder ward/unit	N/A	2-15	15-20	20+
Adult Mental Health/Learning Disability ward/unit	2-10	10-15	15-20	20+

It is also recommended to complete a Waterlow Pressure Ulcer Risk Assessment upon discharge.



Common pressure ulcer sites



Heel float

30-degree tilt

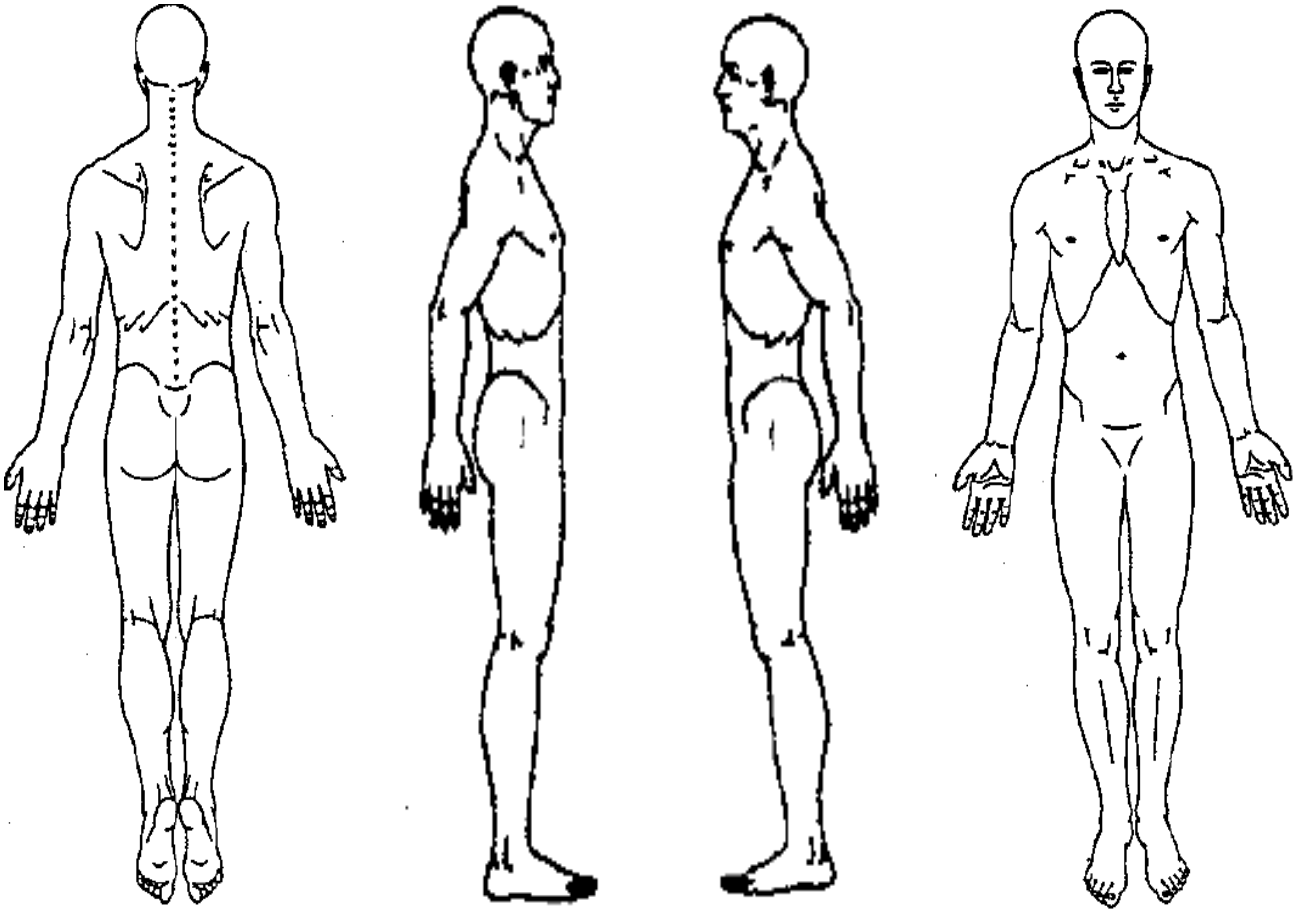
Important considerations:

- The above guidance does not replace clinical judgement. A person may require a higher level of interventions depending upon their current presentation.
- Staff must acknowledge the patient's personal preferences and wishes. Wherever possible these preferences need to be considered to promote collaborative decision making, privacy and dignity, and, to prevent iatrogenic harm. Patient consent must be gained prior to assessment and/or implementation of care, considering capacity assessments where appropriate.
- Frequency of repositioning **may need to be increased from every 4 hours** depending on the person's current presentation.
- A positional change chart must be used if a person requires assistance with repositioning.
- A person who cannot relieve their own pressure independently should spend **no longer than 2 hours at any one time sitting in a chair.**
- Repositioning of the patient should be undertaken in a way that minimises the pressure on bony prominences and any existing pressure ulcers (see above pictures).
- **An airflow mattress should only be ordered for those patients identified with a category 3, category 4 or category 3 – unclassified pressure ulcer and the use of an airflow mattress does not mitigate the need for regular positional changes.** All TEWV foam mattresses are pressure relieving as standard (unless an anti-vandal mattress is required).

Appendix 8 - Body Map Skin Integrity Assessment Sheet

Patient Name:	PARIS ID Number:
Completed by:	Designation:

Please see diagram to illustrate location of any skin damage including pressure ulcers, abrasions, rashes, wounds and red/darkened areas.



The body map skin integrity assessment sheet should be completed in conjunction with the advice and guidance outlined in the relevant policy and/or procedure (Skin Tear Prevention and Management Procedure, Tissue Viability Policy and the Assessment, Prevention and Management of Pressure Ulcers Procedure)

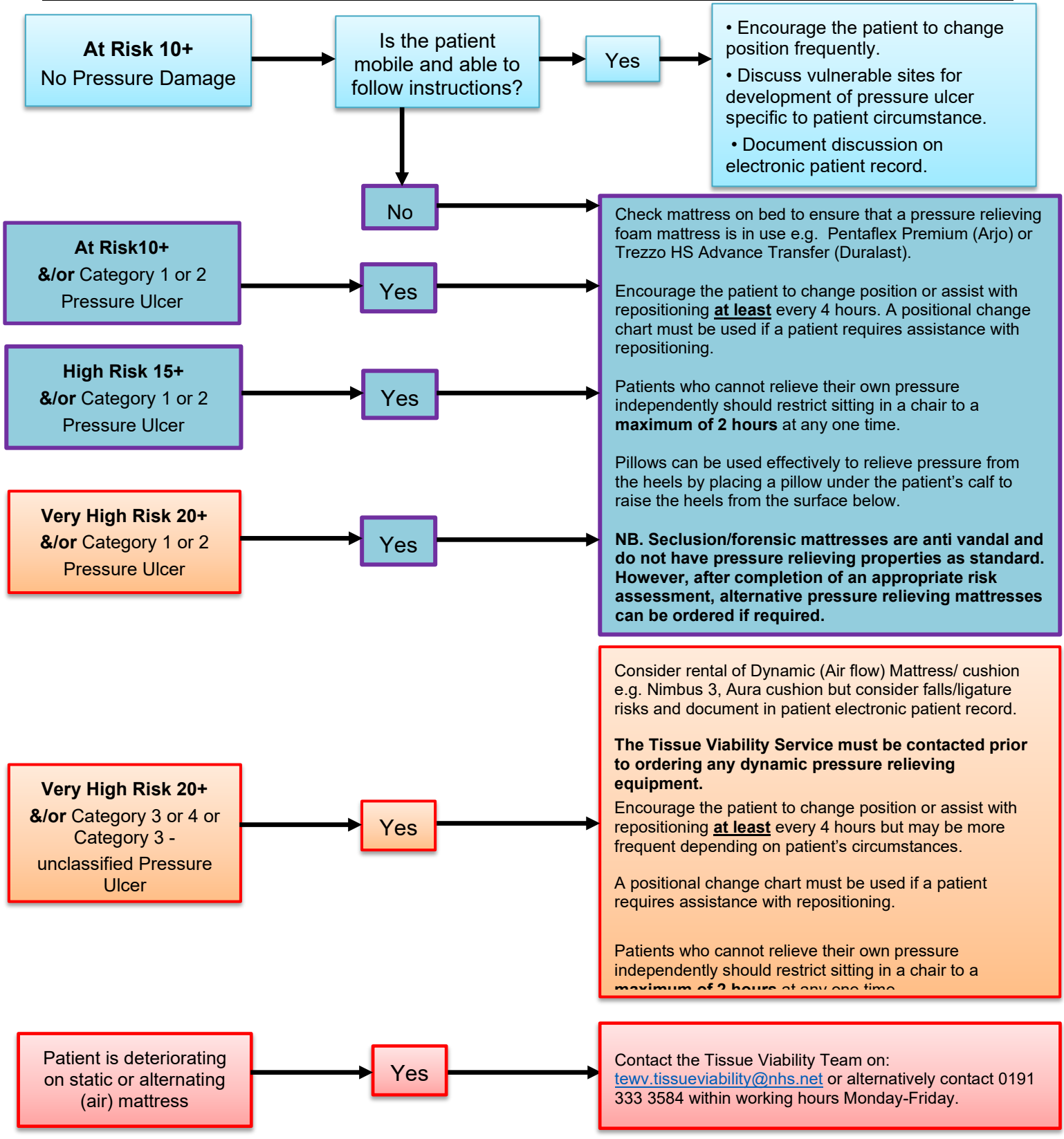
Appendix 9 - Positional Change Chart

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

Appendix 10 - Pressure Relieving Equipment Protocol



Appendix 11 - Skin Tear Decision Algorithm

SKIN TEARS

ASSESS

CONTROL BLEEDING

CLEANSE

APPROXIMATE WOUND EDGES
If skin is viable, ease the skin flap into position using an aseptic technique.

CLASSIFY (MEASURE & DOCUMENT)

GOALS OF TREATMENT

- Treat the cause.
- Implement an appropriate intervention plan.
- Moist wound healing.
- Avoid further trauma.
- Protect peri wound skin.
- Manage exudate.
- Avoid infection.
- Pain control.
- Refer to the tissue Viability Service if required.

TREATMENT OPTIONS DEPENDENT OF WOUND CONDITION

Type 1: No skin loss

Linear or flap tear that can be repositioned to cover the wound bed.

Type 2: Partial flap loss

Partial flap loss that cannot be repositioned to cover the wound bed.

Type 3: Total Flap Loss

Total flap loss exposing the entire wound bed.