POL24 – Tissue Viability Policy and Procedure
Serendipity Healthcare Ltd
Unit 5 Millennium Way, Dunston, Chesterfield, Derbyshire
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1. Purpose

1.1 The purpose of this policy is to ensure that all Service Users who are at risk of pressure ulcer development, or who have pressure ulcers, are appropriately assessed, have an individualised plan of care implemented and appropriate timely reviews.

1.2 To support Serendipity Healthcare Ltd in meeting the following Key Lines of Enquiry:

Key Question	Key Line of Enquiry (KLOE)
SAFE	S1: How do systems, processes and practices keep people safe and safeguarded from abuse?
EFFECTIVE	E1: Are people's needs and choices assessed and care, treatment and support delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes?
RESPONSIVE	R1: How do people receive personalised care that is responsive to their needs?
WELL-LED	W4: How does the service continuously learn, improve, innovate and ensure sustainability?

1.3 To meet the legal requirements of the regulated activities that Serendipity Healthcare Ltd is registered to provide:

- The Care Act 2014
- Care Quality Commission (Registration) Regulations 2009
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Medicines Act 1968
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice

2. Scope

2.1 The following roles may be affected by this policy:

- Registered Manager
- Care staff

2.2 The following people may be affected by this policy:

- Service Users

2.3 The following stakeholders may be affected by this policy:

- External health professionals
- NHS
- Family
- Commissioners
- Local Authority

3. Objectives

3.1 To establish evidenced-based best practice and a standardised approach in the prevention and treatment of pressure ulcers.

3.2 To reduce the incidence and severity of pressure ulcers within Serendipity Healthcare Ltd.

4. Policy

4.1 Serendipity Healthcare Ltd is committed to providing consistent, evidence-based quality care in the prevention, management, and treatment of pressure ulcers for all Service Users. This will incorporate a holistic assessment and demonstrate Service User/carer involvement in the care provided.

4.2 Where a Pressure Ulcer Risk Assessment has been undertaken for Service Users by a professional prior to the start of any care provision, the risk level will be documented in the Care Plan. Service Users who are identified as being at risk of developing pressure ulcers will have a detailed plan of care established. This will directly reflect NICE guidance for pressure ulcer prevention and management (2014).

4.3 In the absence of a Service User's capacity to be involved, the Care Worker will make decisions in the Service User's best interest in accordance with the Mental Capacity Act (2005).

4.4 Where a pressure ulcer is identified, either on transfer from another care provider or at any time during the provision of care and support to the Service User, any concerns about skin integrity or the development of a pressure ulcer will be reported in line with local safeguarding procedures and, where required, a notification sent to the Care Quality Commission in line with statutory reporting requirements. All pressure ulcer occurrences will be investigated, and lessons learned applied to ensure continuous quality improvement.

4.5 For this policy to be effective the following is expected:

- This policy and other best practice resources will be available to and for Care Workers on induction to Serendipity Healthcare Ltd. This is in addition to ongoing training and support to maintain knowledge, skills, and competence of managing skin care
- There will be suitable, sufficient, and well-maintained equipment available at Serendipity Healthcare Ltd to meet and support the assessed needs of the Service User

- Reporting of incidences will be in accordance with Serendipity Healthcare Ltd's policy that incudes necessary reporting to the Regulator when required

5. Procedure

5.1 Contributory Factors

Pressure and shearing are significant causes of pressure ulcers but there are factors that directly contribute to an individual's overall risk of developing a pressure ulcer. A Care Worker supporting Service Users will be aware of these factors and how to implement strategies to try to minimise the risk. These include:

- Decreased/impaired level of mobility
- Sensory impairment
- Incontinence
- Level of consciousness
- Acute, chronic, and terminal illness comorbidity
- Posture
- Cognition, psychological status
- Previous pressure damage
- Extremes of age
- Nutrition and hydration status
- Moisture to the skin
- Creased bed sheets
- Tight clothing
- Incorrectly used or inappropriate type of pressure relieving device

5.2 Pressure Ulcer Prevention

- The Service User's skin condition will be assessed on every care intervention (e.g., personal hygiene, repositioning, toileting) and concerns identified will be immediately communicated to the senior Care Worker. The Care Worker must be able to identify, report and record the following skin conditions:
  - Persistent erythema (redness)
  - Non-blanching erythema
  - Blisters
  - Localised heat
  - Localised oedema (fluid)
  - Localised indurations (hardening of the area)
  - Purplish/bluish localised areas
  - Localised coolness if tissue death occurs
- Pressure ulcer prevention Care Plans will be in place for Service Users.

These will detail specific risk management strategies including repositioning regimes and the use of therapeutic equipment. Where able, Service Users will be involved in the production of the Care Plan and will receive advice and guidance on the benefits and frequency of repositioning

- Service Users who are incontinent will have their skin assessed regularly and a timely response to meeting need. Soap and water will be avoided when cleaning Service Users who are incontinent as this can promote the development of pressure ulcers. Mild PH balanced cleansers should be used as an alternative. Prescribed skin cleansers, barriers or emollients must be administered as directed by the prescriber and recorded as such on the topical medication record
- Service Users who can remain active or change their position should be encouraged to do so. Support and assistance must be provided to those who cannot easily change their position
- For Service Users who require the use of clinical devices such as nasogastric tubes, catheters, pegs etc. care must be taken to ensure that the skin surrounding the equipment is not vulnerable to pressure damage and is protected and monitored appropriately

- Care Workers must use correct positioning, moving, and handling techniques and equipment to minimise the risk of shearing

5.3 Categorisation

- Pressure ulcers will be graded according to the European Pressure Ulcer Advisory Panel (EPUAP) Grading (2014) Pressure Ulcer Grading Tool
- If a Care Worker is in any doubt about the correct categorisation of a wound, a second opinion should be sought from a Registered Nurse e.g., the District Nurse
- Regarding record keeping, pressure ulcers should not be reverse graded. A grade 4 pressure ulcer does not become a grade 3 as it heals. As the ulcer heals it should be described as a healing grade 4 pressure ulcer
- Body maps and photographs (with Service User's consent) of any pressure damage must be documented and a specific wound care plan implemented. Serendipity Healthcare Ltd should be aware of their Data Protection responsibilities where photographs are taken
- Serendipity Healthcare Ltd should refer to the Royal Marsden Manual of Clinical Nursing Procedures for current recommendedpractice

5.4 Therapeutic Equipment

Pressure reducing surfaces or devices are used to reduce and redistribute the overall pressure to the vulnerable bony prominences, such as the sacrum

(bottom of the spine), hips, buttocks, and heels (NICE 2014).

- Following an assessment by the district nursing team or tissue viability specialists, Service Users at high risk of developing pressure ulcers may be assessed as requiring a pressure redistribution mattress. The type of device a Service User needs will depend on their circumstances, mainly:
  - Mobility
  - Skin assessment outcome
  - Level ofrisk
  - Site that is atrisk
  - Service User's weight
  - General health
- Pressure redistribution devices should be introduced as soon as possible when required and the Care Worker must be aware of how to refer to other members of the multi-disciplinary team to obtain equipment in a timely manner
- The setting and correct functioning of the pressure mattress must be checked and recorded daily
- Pressure relieving mattresses must be properly cleaned and maintained in line with Serendipity Healthcare Ltd's cleaning schedules and manufacturers' guidance
- Air mattresses should be annually PAT (Portable Appliance Testing) tested and the Care Workers should have access to the manufacturer's guidance regarding settings and alarm support
- Cushions – appropriate pressure-relieving cushions may be provided for Service Users at high risk of, or with existing pressure ulcers, who are able to sit out of bed
- This policy **does not** support the use of the following as pressure reducing aids or devices:
  - Synthetic or genuine sheepskins
  - Water filledgloves
  - Donut ring type seat cushions
- Portable pressure relieving devices such as heel lift boots and silicone gel pads are single use only and should only be used for those Service Users intended. Portable devices should be subject to proper cleaning and maintenance

5.5 Record Keeping

In addition to maintaining a Care Plan and pressure prevention risk assessment, the following apply:

- Ensure relevant documentation is updated and reflective of any changes to a Service User's condition
- For Service Users nursed in bed, repositioning charts should be used
- Charts must clearly state the frequency of repositioning to be undertaken and clearly document when this wasundertaken

- Fluid and nutrition charts, when used, must be completed accurately so that level of risk can be accurately judged. If the Service User refused food or drink when offered, this should also be recorded

5.6 Reporting

- Cases of single category/grade 1 and 2 pressure ulcers must be considered as requiring early intervention to prevent further damage. If there are concerns regarding poor practice, it should be escalated and recorded as a clinical incident in line with local safeguarding procedures and a statutory notification made to the CQC
- Pressure damage grade 3 and 4 will be reported to the local safeguarding teams and the Regulator. This will be for all pressure ulcers including those that may develop in other settings
- To support learning and reflection, Serendipity Healthcare Ltd will complete a root cause analysis investigation for any home-acquired pressure damage grade 3 or 4
- For Service Users who present with a grade 3 or 4 ulcer, or deteriorating pressure ulcer, an urgent referral to a specialist support professional (e.g., tissue viability nurse) will be made for advice and guidance
- All incidents of pressure ulcers should be recorded internally, investigated and a root cause analysis conducted to improve care practice. Staff should be made aware of the findings in line with Serendipity Healthcare Ltd's audit procedures
- Where a Service User transfers from another care setting (e.g., hospital or respite) or from another care provider and develops any category/grade 3 or 4 pressure ulcer within 72 hours, it must be escalated and reported to the previous care provider as a clinical incident and Serendipity Healthcare Ltd must follow their own safeguarding and regulatory reporting procedures

6. Definitions

6.1 Pressure Ulcers

- Also sometimes called pressure sores, bed sores or decubitus ulcers are defined as a localised injury to the skin and or underlying tissue usually over a bony prominence, because of pressure, or pressure in combinations with shear (EPUAP 2014)

6.2 Pressure

- This is continuous physical force exerted on or against an object by something in contact with it

6.3 Shearing

- Is the force which frequently accompanies both friction and direct pressure. Shear forces develop in the tissues that are distorted and pulled so that the blood supply is disrupted

6.4 Comorbidity

- This is the presence of two or more diseases or conditions in an individual at the same time

6.5 Oedema

- A condition characterised by an excess of watery fluid collecting in the cavities or tissues of the body

6.6 Erythema

- Superficial reddening of the skin, usually in patches, because of injury or irritation causing dilatation of the blood capillaries

6.7 European Pressure Ulcer Advisory Panel (EPUAP)

- "An organisation of experts whose aim is to provide relief for persons suffering from, or at risk of, pressure ulcers, through research and the education of the public and by influencing pressure ulcer policy in all European countries towards an adequate patient-centered and cost-effective pressure ulcer care."

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