

TISSUE VIABILITY

Bedford Hospital Training and Information Pack for ED

CONTENTS

Within this educational work book you will find information regarding the following:

Tissue Viability Service Referrals

Wound Care Guidance

Diabetic Foot Assessment

Skin Tear

Cellulitis and Lower Limb

Pressure Ulcers

Moisture Associated Skin Damage

Reporting

Documentation

Safeguarding

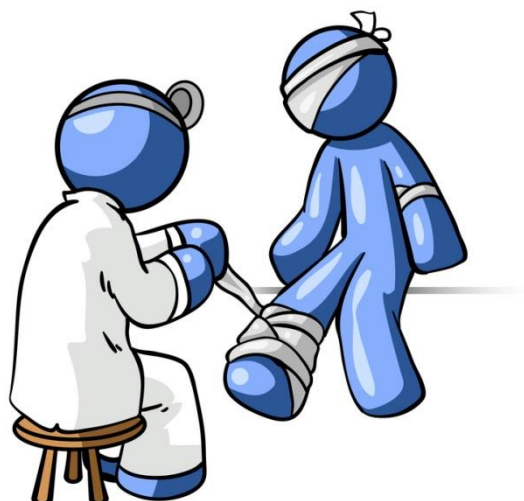
Any further questions please contact the Tissue Viability Service on:

Email: TVS@Bedfordhospital.nhs.uk

Telephone: 5457 or 6175

INTRODUCTION

The aim of this training pack is to help you understand the role of the Tissue Viability Service, how / when to refer patients, wound care advice and information regarding skin changes, including pressure ulcers – how they form, how they are treated and more importantly how they can be prevented.



The Tissue Viability Service comprises of two nurses and one admin. One full time Band 6 Tissue Viability Nurse, one part time Band 7 Lead Tissue Viability Nurse and one full time admin support, working Monday to Friday 8 – 4. The Tissue Viability Service can be contacted by telephone on 6175 (deft phone), extension 5457 (office phone) and 5933 (admin support).

REFERRALS

All dressings must be removed at point of admission for initial assessment and prior to referral, and should not be left insitu awaiting review (even compression bandages).

All referrals need to be made electronically via ICE (guidance within this booklet). All referrals should be completed in as much detail as possible, and it is expected that all wounds are reviewed, clinical judgement used to assess the wound(s) and an appropriate dressing regime commenced prior to this.

Please ensure your referral includes a full description of the wound(s). The Emergency Department has link nurses to assist with Tissue Viability matters and links to online wound care formulary are included in this guide. This can be used to aid selection of appropriate dressings for wounds.

Referrals can be made from the Emergency Department by telephone; however review will depend on availability of the Tissue Viability Nurses at the time of the call, and referral will also need to be placed on ICE.

At point of review by the Tissue Viability Service, wherever possible, the nurse looking after the patient should be present for point of care education.

Please ensure any conversations and referrals are documented within the emergency department's patient records.



HOW TO REFER

icedesktop

Search Value: X000022

Search for patient

Search Type: NHS number Patient name Hospital Number Date of birth [Advanced Search](#)

Ward List | My Patients

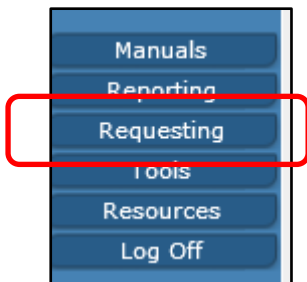
Organisation: Bedford Hospital NHS Trust

Type your patient's Hospital number in the search box and click search and select your patient

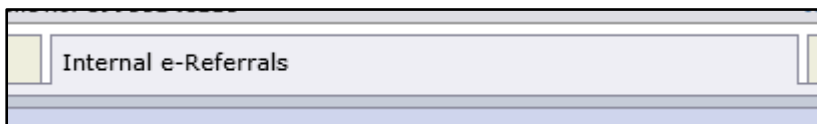
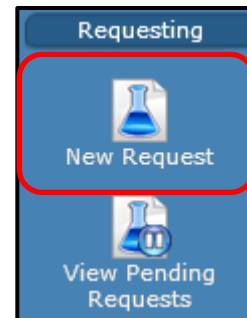
Alternatively, select your ward from the dropdown menu and select your patient.

Ward: Select a ward...

- Accident & Emergency
- Acorn Suite - Maternity
- Acute Assessment Unit
- Ambulatory Emergency Care Unit
- Ambulatory Emergency Care Unit
- Ante Natal Booking Bloods
- Antenatal Clinic



Select Requesting, and then New Request



Select the Internal e-referrals tab

Consultant Ref
Endoscopy
Paediatrics
Other
Search
Set as Default Panel

Select other then click on Tissue Viability

Tissue Viability
 Tissue Viability

Rules-- Web page Dialogue

TV-Information

TV-Brief Medical History
Please enter a brief Medical history for this patient.

TV-Reason For Admission
Please enter the reason for admission for this patient:

TV-Wound Type
Please select relevant wound type:
(Please Select)

TV-Wound Description
Please state wound position, size and tissue type (e.g. necrotic, slough):

TV-Infection Status
Please select the infection status for this patient:
Result of the wound swab (e.g. MRSA)

Complete all of the sections of the tissue viability referral and then select ok

OK

Guidance for Completing Referral Form

TV-Brief Medical History
Please enter a brief Medical history for this patient.

T2DM, HTN, AF, PVD

Record your patient's past medical history - patient's PMH can indicate any medical conditions that may be a barrier to wound healing, for example diabetes or peripheral vascular disease.

TV-Reason For Admission
Please enter the reason for admission for this patient:

Admitted with chest sepsis, being treated with IVABx

Record what your patient was brought into hospital for and what is the current working diagnosis – can include current treatments.

This may also identify barriers to healing. It also helps us to understand what is currently going on with your patient.

TV-Wound Type
Please select relevant wound type:

(Please Select)
Leg Ulcer
Pressure Ulcer
Diabetic Foot Ulcer: Complete a Podiatry referral
Trauma Injury
Other (Please specify)

What kind of wound are you referring? Select the most appropriate option on the dropdown list. If your wound type is not listed, you can select other. This will later give you another free text box to in which you can record the type of wound. Depending on what wound type you select, you may later be asked further questions relating to the wound type.

TV-Wound Description
Please state wound position, size and tissue type (e.g. necrotic, slough):

Wound on gaiter region of left leg, 50mm x 50mm, 30mm depth. Rolled edges. 50% slough, 40% necrosis, 10

Before referral to tissue viability, all wounds must have been reviewed and assessed on the ward.

Within the wound description box, you should record a description of the wound, including the following

- Location of wound
- Dimensions of wound
- Tissue type – Necrosis, slough, granulation, epithelialisation
- Edges – jagged, rolled, undermining etc
- Exudate – type, colour, consistency, amount etc

TV-Infection Status
Please select the infection status for this patient:
Result of the wound swab (e.g. MRSA)

Wound swab +ve for pseudomonas

Record the infection status if known – for example swab results. If no known infection status but there are clinical signs of wound infection, this can be included within this box.

TV-Duration of Wound
Please state duration of wound:

Ongoing for 8 weeks

How long has this wound been present? Is it new, is it long standing and non-healing?

TV-Primary Dressing regime in the Community
Please state the community dressing regime for this Patient:

(Please Select)
Practice Nurse
Community Nurse
Self Care
N/A
Other (Please specify)

If your patient has come into hospital with this wound, it is important to find out what wound care provision they have prior to hospital admission – who does their wound care? If they have wound care in the community, what is it?

TV-Primary Dressing Regime
Please state the current primary dressing regime for this Patient:

Aquacel Ag+ Extra

TV-Secondary Dressing Regime
Please state the current secondary dressing regime for this Patient:

Zetuvit, Stockinet, Wool and K Lite

What are you currently dressing your patient's wound with? Please detail what their current dressing regime is. If referral is for advice on dressing selection, please utilise the wound care formulary in the first instance as this will guide you in selecting an appropriate dressing for your patient.

TV-Skincare
Please state:

Dry skin moisturised with Cetraben

Record how you are caring for that patient's general skin integrity

TV-Allergies
Please state any allergies of this Patient:

Atorvastatin

Knowing a patient's allergies is important – if a patient is allergic to certain substances that may mean a particular type of dressing is inappropriate for use.

TV-Comments
Please state any other reasons for your referral:

Has been having above dressing regime for two weeks with no improvement in wound condition, would like

The comments section is where you can tell the TVN's what input you need from them – this would be the R section of your SBAR referral

Please specify the type of Leg Ulcer:

Arterial
 Mixed
 Venous
 Other (please specify)

hold Ctrl and click to add/delete individual lines or Shift to select ranges.

OK

What type of leg ulcer does your patient have?

The most common leg ulcers are

- Venous Leg Ulcers
- Arterial Leg Ulcers
- Mixed Aetiology Leg Ulcers (mix of arterial and venous)

There are other types of leg ulcers, so if your patient's leg ulcer is another type, select 'Other', you'll then be able to write what kind of ulcer it is in a free text box after clicking 'OK'.

Rules-- Web page Dialogue

TV-Pressure Ulcer Details

TV-Pressure Ulcer Type
Please specify the type of pressure ulcer:

(Please Select) ▼

TV-Hospital Acquired
Is this hospital acquired?

Yes No

TV- Incident Report System
Has this incident been recorded on the Incident Report System?

Yes No

OK

What category of pressure ulcer does your patient have?

Select the appropriate category from the drop down list.

Was this acquired in hospital or did your patient come into hospital with the wound?

Has an incident report been completed for this pressure ulcer?

Please provide primary dressing regime in the community details


Kerracel, Kerramax Care, Yellow Like, KSoft and KLite

OK

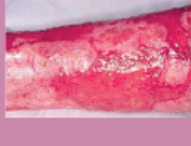


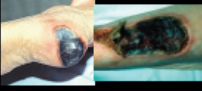
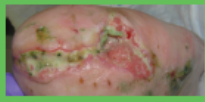
If you've identified that your patient has wound care in the community - either practice nurse, community nurse or self care – what is their normal dressing regime?

If your patient is unable to tell you, please contact their normal wound care provider to ascertain normal dressing regime. Remember – not all patients with pre-existing wounds need Tissue Viability input.

WOUND CARE GUIDANCE

Bedford Hospital 
NHS Trust

Wound Types & Suitable Dressings

Wound Type	Wound PINK (Epithelialising) 	Wound RED (Granulating) Symptoms or signs of infection, see Wounds with signs of infection 	Wound YELLOW (Sloughy) Symptoms or signs of infection, see Wounds with signs of infection. Refer to a TVN if there has been inadequate progress after 2 weeks of treatment 	Wound BLACK (Necrotic/Eschar) Do not debride until a full holistic assessment including Doppler is undertaken. See Necrotic Wounds section for guidance 	Wounds with signs of infection Consider systemic antibiotics if appropriate. Refer to S&L, CCG's Antimicrobial Prescribing Guidelines. Also consider odour-absorbent dressings. For malodorous wounds with slough or necrotic tissue, consider mechanical or autolytic debridement 
Low Exudate	Low adherence Vapour permeable film Soft polymer Hydrocolloid	Low adherence Soft polymer Hydrocolloid Foam low absorbent	Hydrogel Hydrocolloid	Hydrogel Hydrocolloid	Low adherence with honey Low adherence with iodine Low adherence with silver Hydrocolloid with silver Honey - topical
Moderate Exudate	Soft polymer Foam, low absorbent	Hydrocolloid Foam Alginate	Hydrocolloid Alginate	Hydrocolloid Foam	Hydrocolloid with silver Foam with silver Alginate with silver Honey - topical Cadexomer - iodine
Heavy Exudate		Foam with extra absorbency Hydrocolloid Alginate Absorbents	Alginate Capillary-action	Seek advice from wound care specialist	Foam, extra absorbent, with silver Alginate with honey Alginate with silver

NOTE in each section of this table the dressings are listed in order of increasing absorbency. Some wound contact (primary) require a secondary dressing

More detailed information can be found within the online wound care formulary on the intranet (please ensure you switch guide to HOSPITAL Formulary before use)

<https://viewer.microguide.global/SEPT/WOUNDFORMULARY>

All wounds must have an appropriate Wound Assessment Care Plan, which will allow for appropriate assessment and handover to colleagues.

If the patient is admitted with dressings insitu, contact should be made with the normal care provider to ascertain normal dressing regime.

WOUND CARE GUIDANCE

Remove all bandages at point of initial skin assessment (even compression)



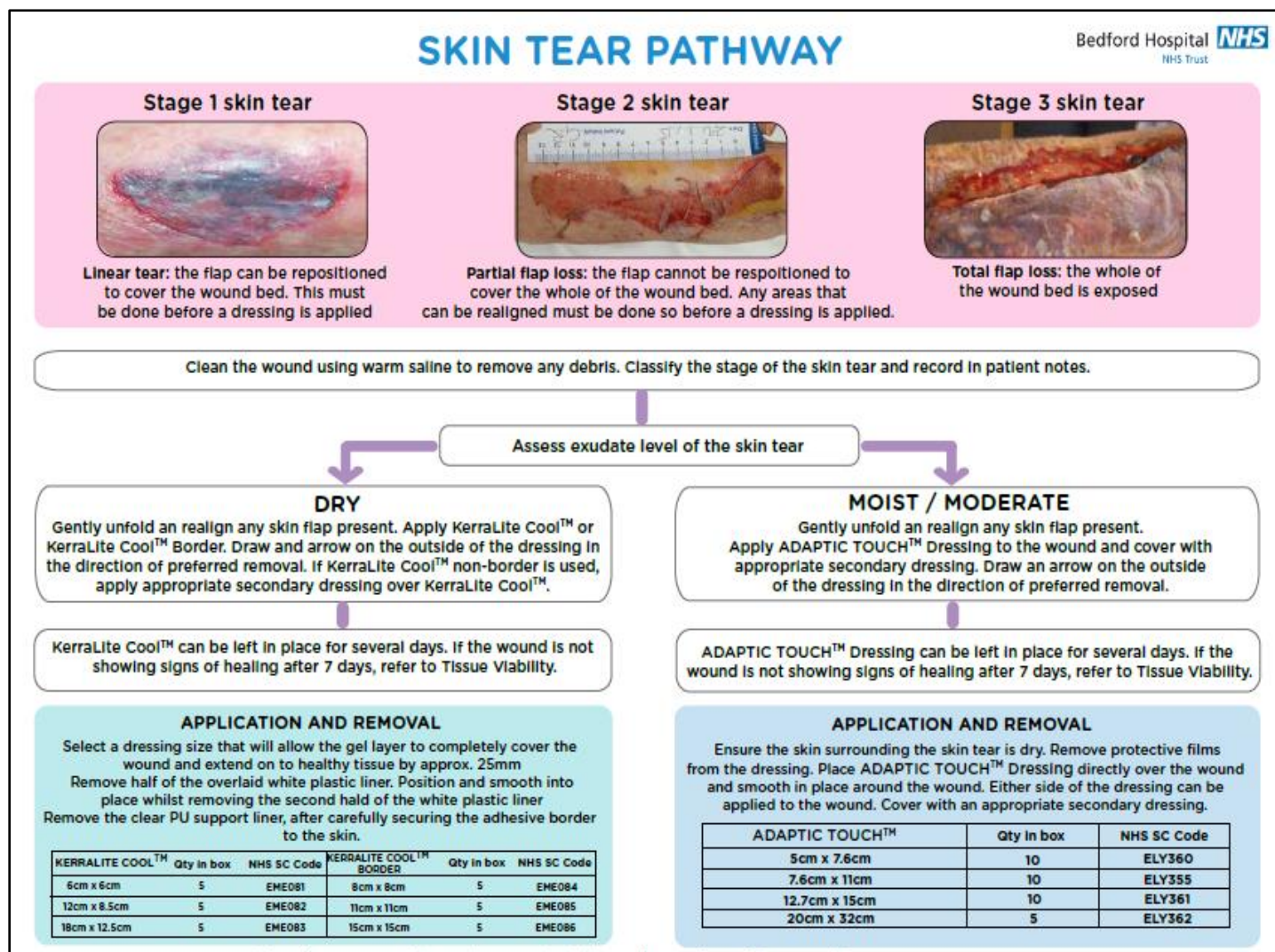
Use clinical knowledge and online wound care formulary for dressing advice. If the wound is below the ankle then dressing can be applied toe to ankle. Any other lower limb dressing needs to be applied from **toe to knee**. This is to prevent the tourniquet effect and causing oedema above and below the bandage.

After primary dressings, ensure "cotton wool" bandage is used in a spiral followed by KLite bandage - a retention dressing - applied in a spiral (if good pedal pulses two layers of KLite can be applied). Tubifast (**NOT TUBIGRIP**), or other brands of stockinet, can be used under the cotton wool bandage to prevent irritation.

Poor bandaging can result in further skin damage!!

WOUND CARE GUIDANCE

DO NOT steri-strip skin tears.



Skin tears tend to occur on fragile skin, therefore, a non-adhesive or silicone based secondary dressing is best, to prevent skin damage on dressing removal.

Always draw a directional arrow on the dressing to indicate the direction that the dressing needs to be removed, to avoid trauma at next dressing change.



CELLULITIS LOWER LIMB

Dry Cellulitis No breaks or weeping – TVN input not needed



- Elevate affected limb
- Offer analgesia
- Daily emollients
- Protect heels from pressure

Weeping Cellulitis – breaks to skin – TVN input possibly needed



- Elevate affected limb
- Offer analgesia
- Daily emollients
- Protect heels from pressure
- Appropriate absorbent dressing to manage exudate
- May require antimicrobial primary dressing

Please note it is rare to have bilateral cellulitis and other causes must be considered and explored, such as red leg syndrome, vasculitis or other dermatological problems.

DIABETIC FEET

Patients with diabetes are at higher risk of developing skin damage to their feet. They are also more likely to have significant and more rapid deterioration of foot injuries.

All diabetic patients must have the below neuropathy assessment carried out within 24 hours of admission to ascertain if they have foot problems. This is available on the intranet.

The image shows two forms from Bedford Hospital. The left form is titled 'Diabetic Adult Foot Assessment' and includes sections for 'Patient Information', 'Neuropathy Assessment - The Semmes-Weinstein Test', 'Patient referral to podiatry', and 'Podiatry referral to podiatry'. It features a diagram of a foot with numbered points for the test. The right form is titled 'Criteria for Diabetes Nurse referrals' and lists criteria for referrals, such as 'admission for major surgery requiring vascular risk minimisation', 'diabetic foot ulcers', and 'diabetic foot infection'. It also includes a section for 'Podiatry referral to podiatry'.

Within ED you should consider whether the patient has neuropathy and put in appropriate offloading whilst in the department. A simple check of pulses within the foot should be performed and documented.

An active foot attack is ulceration with spreading infection, critical limb ischemia/gangrene, suspicion of an acute Charcot arthropathy or an unexplained hot, red, swollen foot - with or without pain. Any patient with diabetes displaying these symptoms require an **URGENT** inpatient podiatry referral.

If patients are identified as having any of the following foot problems where there is infection or acute vascular supply issues, an **URGENT** referral to inpatient podiatry is required. All diabetic foot wounds should be referred to podiatry for information purposes and review. Where ever possible do not use adhesive dressings on a diabetic foot wound as this can cause further traumatic injury on removal and skin stripping.

Diabetic Foot Infection



Diabetic Foot Ulceration



Diabetic Necrosis - Gangrene



Diabetic Suspected Charcot Foot (unilateral swelling/redness/ temperature difference between feet)



PRESSURE ULCERS

Pressure ulcers can be devastating for the people they affect. They can cause pain and distress and affect peoples' quality of life. The good news is that most pressure ulcers are preventable.

- Pressure ulcers are a key indicator of the quality and experience of patient care
- Each year 700,000 people develop a pressure ulcer in the UK
- Of which 186,000 people develop that pressure ulcer in hospital
- Treating pressure ulcers costs the NHS between £1.4 billion and £2.1 billion every year
- Pressure ulcers can develop in a very short space of time - only 1-2 hours
- Pressure ulcers have a huge impact on a person's health related quality of life
- Can have both physical and psychological detriment to a person's wellbeing.
- Pressure ulcers directly impact on staff by increasing workload and demands on time
- Pressure ulcers can increase the financial burden to hospitals due to increased length of stays and potential litigation which may damage the hospital's reputation



PRESSURE ULCERS

What is a Pressure Ulcer?

“A pressure ulcer is 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 skin or an open ulcer and may be painful.”

(NHS Improvement, 2018)

How Do Pressure Ulcers Develop?

Pressure ulcers occur as a result of intrinsic and/or extrinsic factors. The impact of these forces will vary according to the individual. When skin and tissue are directly compressed, this causes cell distortion and the occlusion of blood vessels, which results in tissue breakdown.

ISCHAEMIA

- Reduced Oxygen
- Change in Metabolism
- Accumulation of waste products
- Decrease in pH
- Cell death

DEFORMATION

- Disruption of cytoskeleton
- Cell membrane failure
- Cell permeability increase
- Loss of haemostasis
- Cell Death

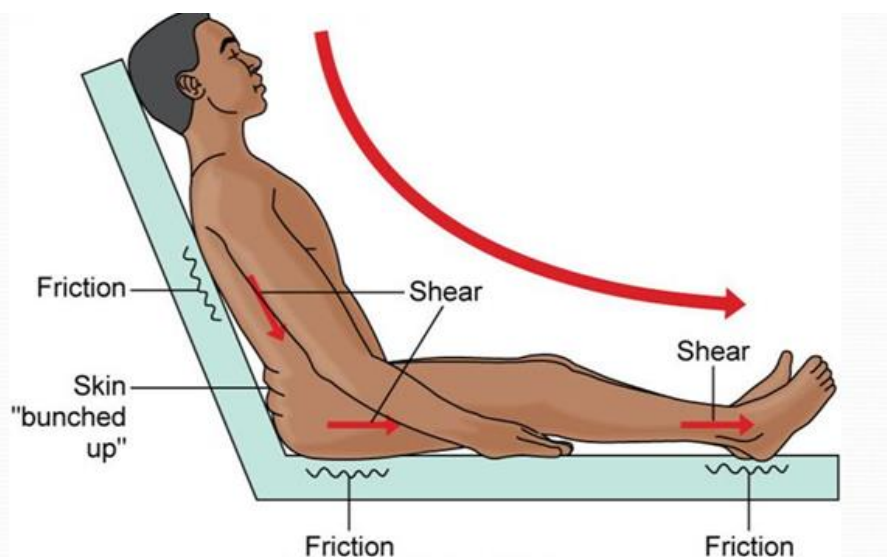
PRESSURE ULCERS

Shear (extrinsic)

When skin and tissue are stretched in different directions, shearing occurs. This usually happens when the patient is on a gradient.

Friction (extrinsic)

When two surfaces rub together, the top layer of the skin gets stripped away. Shear and friction often occur in the same clinical situations.



Moisture (extrinsic)

While moisture associated skin damage must not be confused with pressure, excessive moisture can increase the risk of pressure damage by increasing the friction on already weakened skin.

RISK ASSESSMENT

Policy

- ✓ Risk assessment tool to be completed in A&E (post skin assessment so this can be included within this assessment)
- ✓ Use the Trust approved validated risk tool within 6 hours of admission to assess a person's risk
- ✓ Trust approved validated risk assessment tool should be completed every 72hours, following any departmental transfer and/or following any changes in clinical or skin condition.



Risk assessment tools are required but they do not replace clinical judgement, and should be used to help you in your decision-making.

If a patient has been admitted following a possible "long lie" – where they've been on the floor for an extended period of time before being found and assistance provided - their risk factor is increased. It is likely that this may already have caused some underlying pressure damage that may not yet be visible. Manage these patients as being at very high risk of pressure damage development.

SURFACES

Equipment

Mattresses, cushions and heel offloading devices help to redistribute and relieve pressure but are not a replacement for effective nursing care.

All support surfaces can be obtained from the portering service. Where internal equipment is unavailable, there is an escalation process to follow in order to obtain rental devices. Patients **must not** be waiting days for appropriate surfaces to be available and provided.

The escalation process can be found on the intranet, and should be visible within all clinical departments.

Decisions on equipment provision should be based on an overall holistic assessment and should consider the following:

- ❖ Appropriateness for the age, weight and size of the patient
- ❖ Level of risk
- ❖ Skin assessment
- ❖ Location, cause and category of any existing pressure damage
- ❖ General health status
- ❖ Acceptability and comfort to the patient
- ❖ Mobility of the patient
- ❖ Safety of the patient
- ❖ Availability of the equipment
- ❖ Treatment objectives
- ❖ Any contraindications

SURFACES

Care and Maintenance of Equipment

Please ensure you are familiar with all pressure relieving/redistributing equipment and refer to individual resource files provided by the companies for further information

- The equipment is only effective if it is good working order, switched on and used appropriately.
- If any piece of equipment is alarming, it is letting you know that there is a problem – you **MUST** respond to this and not mute it or ignore it, otherwise you are putting your patient at risk of pressure damage.
- If you are unable to rectify the alarms, then contact the Equipment Library.
- Please remember the air alternating mattresses are single patient use and need to be sent for decontamination after every patient.

Think ALL Surfaces

Wheelchairs, stools, equipment - are they appropriate, will they cause pressure damage? Is equipment required to reduce pressure ulcer risk?

Equipment related pressure damage

When a patient is in hospital, they have the potential to have a number of medical devices in place and all of these can cause pressure damage.

For the majority of times, this can be rectified with regular skin checks and position changes of the medical device.

Oxygen delivery devices

All **adult** oxygen masks have under ear elastic and all nasal canula have foam over-ear protectors. Please ensure these are positioned appropriately.



Kerrapro pads can help to redistribute pressure and due to their versatility, can be used in many anatomical locations.

Offloading

Ensure heels are offloaded where appropriate, especially patients who are immobile, have a lower limb problem, or have high risk co-morbidities, such as diabetic neuropathy and peripheral vascular disease.

There are a number of offloading boots as outlined below, where these are not suitable, pillows can be used but ensuring that heels are floating and pillow is not occluding blood vessels behind the knee. Ensure offloading is documented within the patients record.

All clinical areas should have a supply of single patient use safeguard foam boots and HeelPro boots are also available on most wards, or from stores.

Heel Protectors and Heel Offloaders

Low Risk

First Line

Safeguard Foam Boots



High Risk

Existing Heel Ulcers
Diabetic Neuropathy
Vascular PVD

Heel Pro



High Risk (exuding Wounds)

Existing Heel Ulcers
Diabetic Neuropathy
Vascular PVD
High Exuding / Leaking Wounds
Wipeable but Single Patient Use

Heel Pro Advance



High Risk (multiple patient use / exuding wounds)

Existing Heel Ulcers
Diabetic Neuropathy
Vascular PVD
High Exuding / Leaking Wounds
Reusable
Wipeable / Multi-Patient Use

Footsafe Boot



Safeguard Foam Boots to be stocked on wards
Heel Pro, Heel Pro Advance & FootSafe Boots to be ordered from Stores on ext. 2118
Trial Dates: 15th April - 10th May 2019

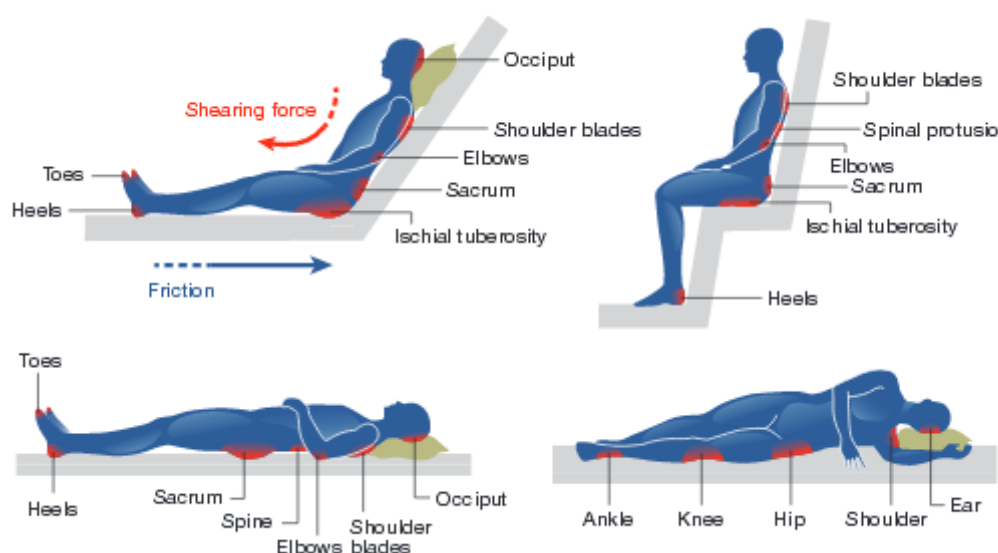
Version 2.0 April 2019

SKIN ASSESSMENT

What to Look For

Skin assessments help us to identify early changes in the skin which may lead to pressure damage.

Skin assessments should be completed on admission to the department, within six hours of arrival, and include the most vulnerable areas at risk for each patient, not forgetting underneath medical devices. **Document any skin changes on the appropriate body map .**



A description of the pressure ulcer, along with the category, should be documented in the patient record

Any pressure damage should be reported through the incident reporting system at point of identification. If there is a delay in completing the Incident Report please identify this within you report and ensure the time and date of incident is back dated to when it was initially identified

All patients should have regular skin assessments – at least once per shift, and more frequently if at high/very high risk – and these should be recorded within the patient's records, with all changes being recorded on the body map.

SKIN ASSESSMENT

Any alteration in the skin condition should be noted on the body map.



Alterations in the skin condition could include:

- ❖ Dryness
- ❖ Cracking
- ❖ Erythema
- ❖ Maceration
- ❖ Localised oedema
- ❖ Fragility
- ❖ Blisters
- ❖ Localised temperature change
- ❖ Localised pain
- ❖ Induration
- ❖ Discoloration

SKIN ASSESSMENT

In patients with darker skin tones, skin changes such as non-blanching erythema, may be difficult to detect. Instead of redness, a purple/blue hue may be evident. There may also be a change in the feel of the skin, in comparison to the surrounding skin, or a change in the temperature of the affected area, in comparison to surrounding skin.



It is important that we react to any skin changes, remember **red skin** is not normal, **purple skin** may not be bruising; you need to act on what you find!

Any pressure damage identified 6 hours after commencement of care (first initial review in A&E) is New Pressure Damage (NPU). Prior to this, it is Present on Admission (POA).

Skin assessment should be discussed at handover to any transferring ward and, where possible, skin checked at point of admission to ward with accepting nurse.

Pressure Ulcer Categorisation

Category 1 – Non Blanching Erythema



Intact skin with non-blanchable redness of a localised area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).

Category 2 – Partial Thickness Skin Loss

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.



Category 3 – Full thickness skin loss



Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

Category 4 – Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (eg: fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.



Unstageable – Depth Unknown



Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and therefore category cannot be determined. Stable eschar on the heels serves as the body's natural cover and should not be removed.

Deep Tissue Injury – Depth Unknown

Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler compared to adjacent tissue. DTI may be difficult to detect in individuals with dark skin tones. May include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

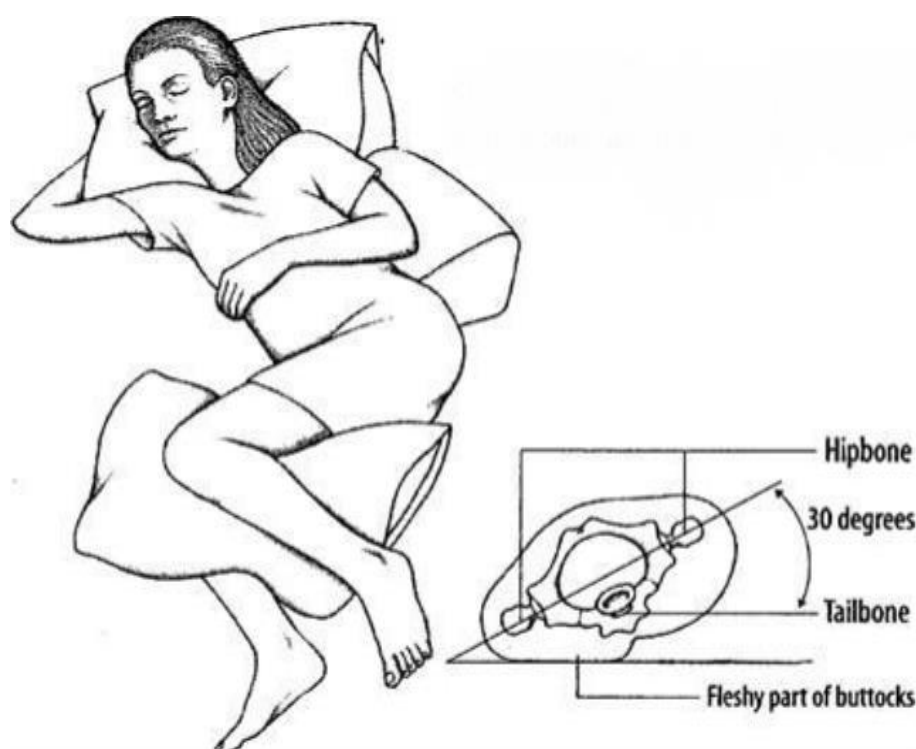


KEEP MOVING

Repositioning

- Repositioning is one of the essential elements of caring for someone at risk of developing a pressure ulcer, and is equally as important in patients with existing pressure damage, to prevent deterioration or new areas of pressure ulceration occurring.
- Repositioning regimes should be implemented on an individual basis, encompassing the patient's tissue tolerance.
- If patients are able to change their own position then this should be encouraged and documented in the patient's record.
- Any repositioning needs to be evidenced within the patient's record and should be appropriate for the patient's needs and risk.
- Avoid positioning on pressure ulcers

30° Tilts

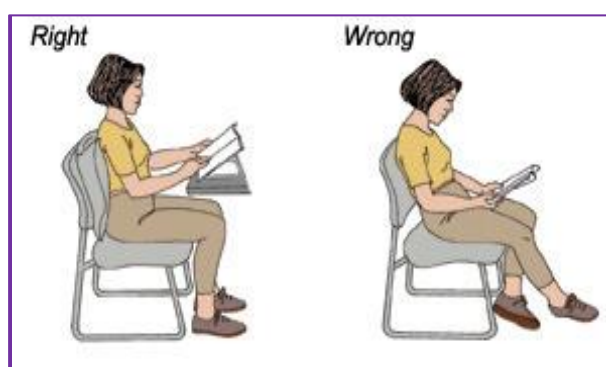


KEEP MOVING

Equipment

Chairs

- All patient bedside chairs have a high density foam cushion.
- Some chairs have height adjusters on the legs, so the chairs can be altered for each individual person.
- Orange chairs have more pressure relieving qualities
- Ensure the patient is sitting correctly and for appropriate lengths of time



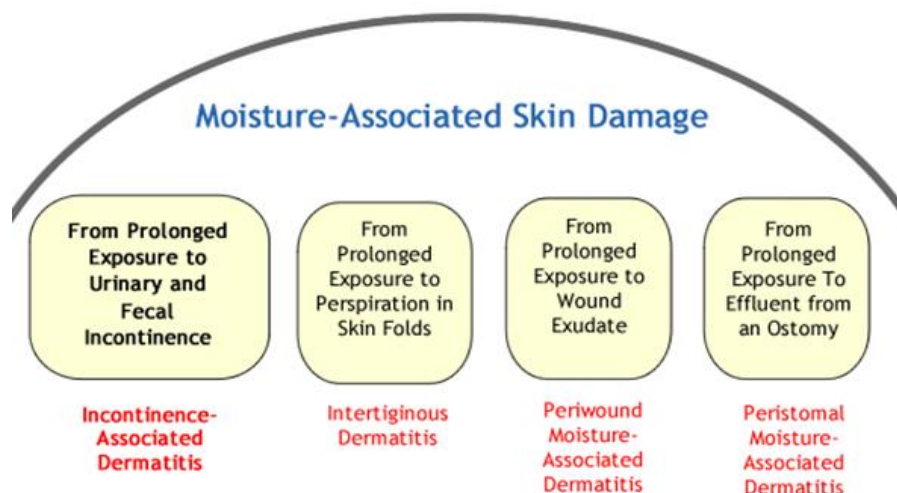
Slide Sheets

There is no excuse for not using slide sheets. They are for protection of your patients and yourself.



INCONTINENCE

Moisture Associated Skin Damage



Moisture associated skin damage (MASD) is an umbrella term that describes damage to the skin caused by prolonged exposure to moisture.

All MASD needs to have an incident form completed (IAD and Non IAD).




Incontinence Associated Dermatitis

Incontinence associated dermatitis (IAD) is a form of contact dermatitis that results from a chemical irritation of the skin caused by prolonged exposure to urine and/or faeces.

This alters the skin's pH and makes it more alkaline, which results in the skin being more hospitable to micro-organisms.



Incontinence skin care protocol

Clinical presentation**		Clean the skin	What to use	When to use	How much to use
Prevention	At risk No redness and skin intact	Clean daily and after each episode of faecal incontinence	3M [®] Cavilon [™] Durable Barrier Cream	 Day and night	
	Mild Red but skin intact	Clean daily and after each episode of faecal incontinence	3M [®] Cavilon [™] Durable Barrier Cream	 Day and night	
Management	Moderate Red* with skin breakdown	Clean daily and after each episode of faecal incontinence	Medihoney [®] Barrier Cream	Apply after each incontinence episode	As per product guidance
	Severe Red* with skin breakdown	Clean daily and after each episode of faecal incontinence	Treat as moderate skin damage but refer to Tissue Viability Service 3M [®] Cavilon [™] Advanced Skin Protectant may be appropriate		

Important considerations



Apply Cavilon durable barrier cream in successive pea-sized amounts. A little goes a long way!



Apply twice per week only

Cavilon Advanced skin protectant is a highly durable, long lasting barrier and is applied as per tissue viability service instruction.

TVN Contact

Dept Phone 6175
Bleep 319
Tissue Viability Service,
Bedford Hospital

*Or pale, dark, purple, dark red or yellow in patients with darker skin tones. **MAD Severity Categorisation Tool taken from Baseman D et al. Proceedings of the Global WAD Report Panel: Incontinence-associated dermatitis: involving prevention research. Wounds International 2016; 28(10):418-422

Non Incontinence Associated Dermatitis

Intertriginous Dermatitis

Intertrigo occurs when moisture, usually perspiration becomes trapped within skin folds. It is more likely to occur in hot and humid conditions.

Periwound Moisture Associated Skin Damage

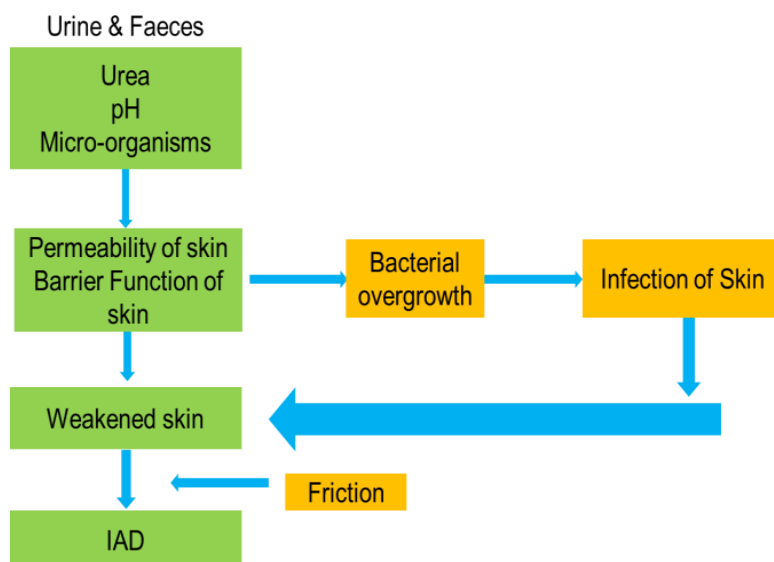
This occurs when wound fluid or exudate comes into prolonged contact with the skin surrounding the wound. The excess moisture puts the skin at higher risk of friction and prevents migration of cells, delaying wound healing.

Peristomal Moisture Associated Skin Damage

Peristomal skin damage is caused by poor appliance fit, which allows urine or faeces to collect under the seal, causing erosion of the skin.

Pathology of IAD

- **Overhydration**
 - Increased fragility
 - Increased “drag” against the sheets
- **Repeated cleansing**
 - Loss of skin oils
 - Removal layers of skin
- **Irritants/bacteria**
 - Enter through “gaps” in the skin
 - Inflammatory response
- **Change in pH**



Differences between MASD and Pressure

Pressure Ulcer	MASD
History of immobility, short or long term	History of incontinence, perspiration or contact with exudate
Usually circular and symmetrical in shape	May be associated with sweating in skin folds or natal cleft
May take on a butterfly wing shape if it spans out from sacrum	Irregular and asymmetrical shape
Will be over a bony prominence (unless a piece of equipment is the cause)	Lesions will be over fatty parts of the buttocks and thighs, and are not isolated to being located over the bony prominences
May have necrotic or thick sloughy tissue present	Lesions may extend into perineal area, scrotum and vulva
If associated with an external device causing the pressure the lesion will take the shape of the device	Usually there is no necrotic tissue
Categorise according to EPUAP classification tool	Do not categorise

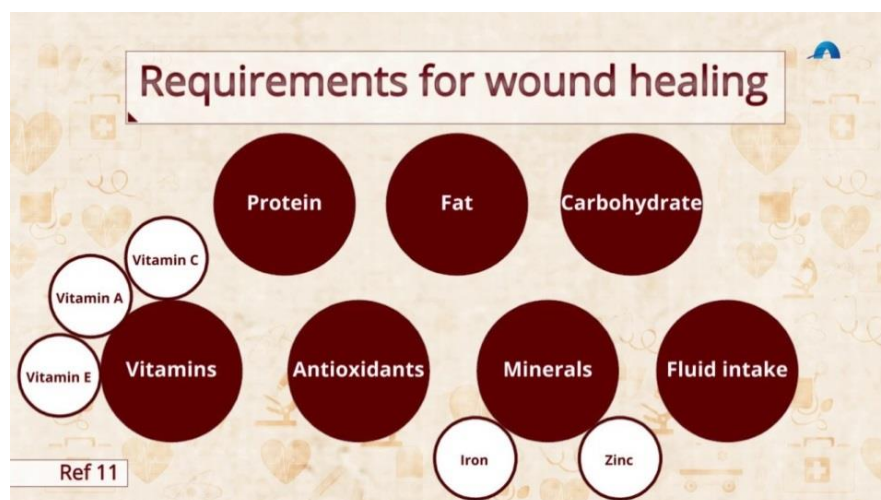
NUTRITION & HYDRATION

The MUST assessment needs to be completed within 6 hours of admission and reassessed weekly. An accurate MUST score is also essential to being able to complete an accurate pressure ulcer risk assessment.

Evidence shows that there is a correlation between malnutrition and the development of pressure ulcers, therefore it is important to optimise a patient's nutritional state for pressure ulcer prevention.

The skin requires oxygen and nutrients to keep it healthy and repair any tissue damage that may occur. If the patient is not getting enough nutrients, then this cannot occur.

Use the medical notes and patient history to establish if there is any recent weight loss.



All patients with significant wounds and/or category 2 pressure damage and above will need additional nutritional support to aid in wound healing. Patients will require increased protein, calories and micronutrients. Please ensure appropriate nutritional support is sought and referral to dietician made, where referral criteria is met.

GIVING INFORMATION

Ensure all patients are educated of their risk of pressure ulcer development. Bedford Hospital has a Patient Information Leaflet available on the intranet. This is available to print in English, Polish, Italian and Punjabi. Other translations can be arranged via Comms.

If there is concordance issues, providing patients with the appropriate education enables them to make informed decisions about their care. It must always be documented if a patient has declined interventions, and that they have received the appropriate education.

Ensure risk and management is communicated to appropriate staff and on transfer/discharge.

Ensure the above and below is documented in the patient record.



REPORTING & SAFEGUARDING

Incident Reports

All pressure ulcers and moisture damage **MUST** be reported on The Incident Reporting System.

Any skin damage must be reported on The Trust incident reporting system at point of identification. If there is a delay in completing, the incident report please identify this within your report and ensure the time and date of incident is backdated to when it was initially identified.

Please include a description of the skin damage with the categorisation on the report.

Harm

Even if skin damage is present on admission, a harm level has to be assigned. – Although we have not caused the harm, there is harm to the patient's skin.

Moisture Lesion **Low Harm**

Category 1 Pressure Ulcer **Low Harm**

Category 2 Pressure Ulcer **Low Harm**

Category 3 Pressure Ulcer **Moderate Harm**

Suspected Deep Tissue Injury **Moderate Harm**

Unstageable Pressure Ulcer **Moderate Harm**

Category 4 Pressure Ulcer **Severe Harm**

If reporting numerous pressure ulcers or combination of moisture and pressure ulcers always categorise with the greatest harm level.

Safeguarding

If the patient is admitted with skin damage from a care facility or has formal care provision at home, safeguarding should **ALWAYS** be considered. Refer to transfer documentation from care facilities, information from patient / relatives and community nurse information as appropriate.

Questions to consider:

- How did the pressure damage occur?
- Is it historical or something new to the patient?
- Have you received transfer documentation regarding the pressure damage?
- Have they got appropriate pressure ulcer prevention equipment at home?
- Have they received appropriate prevention management?
- Are they aware of the pressure damage?

If unable to ascertain the correct information, ensure this is documented in the patient's records and on the incident report form. On transfer to another ward/department, ensure that staff are made aware that further investigation is required in regards to care provision and to question safeguarding further.



DOCUMENTATION

“If it wasn't documented it wasn't done”

- Documentation must evidence care given and any variation must have documented rationale within the patient record.
- Documentation of pressure ulcer prevention management (aSSKINg) should be documented within the patient record.
- Do NOT use terms such as “skin intact” as pressure damage could still be evident but skin not broken e.g. Category 1 and DTI
- Body maps should be completed for every skin change identified
- Evidence of wound checks should be evident in the patient record, with dressing provision clearly stated – if wounds are present then a wound care plan must be filled in for each wound.



Questions

Please complete all questions and **send to the education team**.
If you have any feedback or have any questions, please contact
to TVS@bedfordhospital.nhs.uk

Q.1 When should dressings be removed and why?

Q.2 Where in the first instance would you look for dressing advice?

Q.3 Why do we bandage toe to knee for lower leg wounds?

Q.4 Should you use steri-strips on skin tears?

Q.5 When would you refer cellulitis to the Tissue Viability Service?

Q.6 If there is diabetic foot ulceration / pressure damage who should you refer to?

Q.7 Why would a diabetic patient be at higher risk of foot ulcers?

Q.8 What are effective ways of offloading heels?

Q.9 When should you inspect the skin and pressure areas?

Q.10 Where should you document repositioning?

Q.11 If a pressure ulcer or moisture lesion is identified after 6 hours of admission to ED is this NEW or Present on Admission?

Q.12 If the pressure damage is POA is there a harm level on the Trust incident reporting system or no harm?

Q.13 When should safeguarding be considered in regards to skin and pressure damage?

Q. 14 If a patient is admitted with dressings insitu from the community who should you contact to identify what dressings are in use?

Q. 15 If a patient is identified as having incontinence, when should barrier cream be used?

Please sign and date below to acknowledge you have read and completed the Tissue Viability ED Training Work Book. Please send completed strips to the education centre.

Name:

Role:

Sign:

Date:

Completed with the kind assistance of Chesterfield Royal Hospital
Foundation Trusts

April 2023