care inspectorate

Tissue viability tool for adult care homes

HAPPY TO TRANSLATE

- This tool can be used to support service providers, managers and staff to assess their policy and practice against standards and good practice guidance. This may be used to help inform your wider evaluation and improvement plan for your service and how you support improved outcomes for people who experience care.

- This tool may also help inspectors to identify appropriate tissue viability practice whilst carrying out inspection or complaint activity.

- The tool in its entirety does not have to be completed to establish good/weak practice.

- Information contained in the tool is based on the good practice recommendations from:
  Healthcare Improvement Scotland
  Prevention and Management of Pressure Ulcer Standards – October 2020
  https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/pressure_ulcer_standards.aspx

- Current tissue viability best practice tools quoted in this tool is available to download from:
  https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability.aspx

- Health and Social Care Standards My support, my life
  Scottish Government (2017)

- Appendix 1 - Tissue Viability good practice references

Standard 1 Leadership and governance

1. Does the service provider have tissue viability policies/protocols in place that cover the key points of current good and evidence-based practice for:

   - Skin assessment and care Yes ☐ No ☐
   - Pressure ulcer prevention Yes ☐ No ☐
   - Wound assessment/management Yes ☐ No ☐
   - Skin tears/minor trauma injuries Yes ☐ No ☐

2. The content of these policies is in line with current best practice and includes good practice references as cited in this document.

   Yes ☐ No ☐

3. All staff have received training on the policies/procedures and are applying expected good practice.

   Yes ☐ No ☐

4. The service provider/service has a lead person and/or a delegated deputy responsible for tissue viability issues.

   Yes ☐ No ☐

5. The service uses the pressure ulcer Safety Cross to monitor pressure ulcers.

   Yes ☐ No ☐

6. If no, how is the service monitoring pressure ulcer incidence/prevalence?

   Method ☐

7. When an individual develops a pressure ulcer, is there an appropriate mechanism in place to establish if the pressure ulcer was avoidable/unavoidable?

   - Care Home Pressure Ulcer Red Day review tool

     Yes ☐ No ☐

- SBAR

  Yes ☐ No ☐

8. If yes, is there a clear improvement plan in place, based on monitoring data and use of the Care Home Pressure Ulcer Red Day review tool/SBAR investigation to ensure improvements in pressure ulcer prevention and management care delivery and practice are made?

   Yes ☐ No ☐

9. Staff are able to identify when to escalate issues relating to pressure ulcers/ wounds and there is a pathway for referral for advice and support.

   Yes ☐ No ☐

Sources of evidence

- View policies/protocols and content (including implementation and review dates).
- Discuss content with manager.
- Registered nurse/carers' awareness of policy content and training and can use this to demonstrate their good practice.
- The lead person/deputy for tissue viability can be identified within the organisation/service.
- Evidence of multi professional involvement for advice and support regarding preventing pressure ulcers/wound management for example tissue viability nurse, care home liaison team, podiatrist and so on.
- Service has records of pressure ulcer free days using safety cross or pressure ulcer incidence/prevalence data collection charts.
- Service has records of Care Home Red Day Review Tool/SBAR investigations being carried out and adopts a lessons learned approach.
- Pressure ulcer data is monitored over time and is used to improve the delivery of care. Examples of this would be: Safety cross, graphs, run charts and so on.

Outcomes for people receiving care

Leadership and governance within the service ensures that there is a focus on maintaining people's skin integrity, promoting good skin care and preventing pressure ulcers.

People living in the service can be assured good outcomes relating to skin care, prevention and management of pressure ulcers and all other types of wounds.

Notes/areas for improvement

Standard 2 Staff education and training

1. The service has carried out a skills needs analysis for pressure ulcer prevention/ wound management training needs.

   Yes ☐ No ☐

2. The service has developed an ongoing staff training programme which covers individual staff roles and responsibilities in pressure ulcer prevention/ management.

   Yes ☐ No ☐

3. Staff training includes linking quality improvement methodology to improving care and practice in pressure ulcer prevention/wound management.

   Yes ☐ No ☐

Sources of evidence

- Service provider/manager can evidence awareness in planning training and development based on staff's role and responsibilities.
- Examine skills needs analysis/staff development plans.
- Sample training records and evaluation of training programmes.
- Nursing, care staff and others, for example, catering staff, can discuss their role and responsibilities relating to pressure ulcer prevention, wound assessment and management.
- Staff can describe identify early skin breakdown and the escalation pathway.
- A tool such as the SSSC app is used to support knowledge and awareness of early warning signs is in place. https://play.google.com/store/apps/details?id=com.SimVisResearchSSSC.SkinBreakdown&hl=en_GB&gl=US
- Services improvement plan includes information and areas for improvement about tissue viability care and practice.

Outcomes for people receiving care

People can be confident that staff have the training, knowledge and skills appropriate/relevant to their role and remit, and care and support is person centred and individualised, based on evidence, current best practice and guidance.

Notes/areas for improvement

Standard 3 Person-centred information and support

1. The organisation/service has a pressure ulcer information leaflet or other suitable formats of information in place for people using the service/their representative (developed by the provider or local NHS).

   Yes ☐ No ☐

2. There is evidence that when a person is at risk or has an existing pressure ulcer, there is a record of discussion with the person/ their representative about the risks and benefits of their care and treatment.

   Yes ☐ No ☐

Sources of evidence

- Examine content of leaflets/information for people experiencing care and their representatives.
- Evidence of leaflets being shared/discussions taking place is documented in people's personal plans.

Outcomes for people receiving care

The person and their representatives receive information appropriate to their needs and are supported to make informed decisions and choices about care and treatment.

Notes/areas for improvement

Standard 4 Initial assessment of risk of developing a pressure ulcer

1. The pre-admission assessment covers details of the person's skin integrity/ existing pressure ulcers/wounds and equipment required. This will help with pre-planning and support continuity of care needs in the care service.

   Yes ☐ No ☐

2. All individuals coming into the service have a formal risk assessment undertaken within eight hours of arrival, using a structured risk assessment tool, such as Waterlow or Braden scale, alongside professional judgement. This will assist with planning a pressure ulcer prevention care plan. There is evidence that when a person is at risk or has an existing pressure ulcer, there is a record of discussion with the person/ their representative about the risks and benefits of their care and treatment.

   Yes ☐ No ☐

3. Services who do not provide nursing care have implement a risk assessment process for care staff to follow, such as the Preliminary pressure ulcer risk assessment (PPURA). This will help staff monitor changes in mobility, continence and nutrition.
   https://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=a564d62e-a1a8-485f-99ea-40e9c17e25bf&version=-1

   Yes ☐ No ☐

4. There is evidence of monitoring any changes in the person's condition/ presentation, along with clear guidance on when and who to report to and escalate changes in mobility, continence and nutrition.

   Yes ☐ No ☐

5. All individuals coming into the service have a full skin examination carried out (at the earliest opportunity and with consent) and the Initial Skin Assessment is completed, dated and signed. (For example, body map.)

   Yes ☐ No ☐

6. Where an assessment of risk or skin inspection has not been undertaken, there is a clear record of the discussions in the person's personal plan with agreed escalation actions around this.

   Yes ☐ No ☐

7. Following skin assessment and risk assessment, if the person is identified as 'at risk', a clear prevention plan of care is developed, including equipment, to meet the individuals pressure area care needs.

   Yes ☐ No ☐

Sources of evidence

- Skin integrity details and skin care needs are recorded as part of a pre-admission assessment.
- Evidence that skin care and tissue viability care needs are continued for example, therapeutic equipment (static/active mattress, seat cushions) and wound management products.
- Evidence of risk assessment being carried out within eight hours of arrival at the service using for example, adapted Waterlow Score (2005), Braden Scale (1998) or PPURA updated (2020).
- Training records show nursing staff/care staff have had training in the use and application of the chosen risk assessment tool.
- Outcome of skin assessment is recorded in the personal plan, for example, use of a body map to indicate any skin conditions or pressure damage.
- Pressure ulcer prevention person centred plan of care is in place for people identified 'at risk' to maintain their skin integrity.
- Staff are clear who and how to escalate any changes in risk and/or condition.

Outcomes for people receiving care

People coming into the service are assessed for their level of risk and skin integrity. People identified at risk can be confident they will have an individualised, person-centred plan of care to ensure that their assessed care needs are met and their skin integrity is maintained.

Notes/areas for improvement

Standard 5 Reassessment of risk

1. Where a person is initially identified at risk of developing pressure ulcers, there is regular reassessment of the person at specified intervals.

   Yes ☐ No ☐

2. Changes in other health related assessment tools are also be taken account of, for example Falls assessment, MUST, Frailty, Continence assessments.

   Yes ☐ No ☐

3. When an at risk/not at risk person's condition changes, for example becomes unwell or immobile, the risk assessment has been repeated and documented.

   Yes ☐ No ☐

4. This information is used to update and inform care plans to ensure preventing pressure ulcers developing or experiencing further damage to existing pressure ulcers.

   Yes ☐ No ☐

Sources of evidence

- Staff can demonstrate understanding of the pressure ulcer risk assessment process, why this is undertaken and documented on an ongoing basis or if a person's condition changes.
- A visible record of ongoing re-assessment is being carried out and documented, for example, as part of the monthly review.
- Plans of care are being reviewed and updated based on level of risk and ongoing monitoring is in place.
- Care plans demonstrate a holistic person centred approach and take into account other risks and contributing factors, such as the person's mobility, nutrition, continence, pain.
- Staff can demonstrate that they are aware of the need to report and escalate any changes and to whom.

Outcomes for people

- People experiencing care can be confident their ongoing care needs are re-assessed and any changes identified are documented. Their plans of care will be updated and implemented based on this with their input.
- They are also confident that staff will know when and how to report a change in risk status or concerns about their health/wellbeing.

Notes/areas for Improvement

Standard 6 Care planning for prevention of pressure ulcer

1 Person centred prevention care plans have been developed and are tailored to meet individuals care needs and contain information about:
- level of risk, for example high risk
- general skin care
- frequency of skin checks and re-positioning
- therapeutic equipment requirements for bed and chair and information about settings.

This is also cross-referenced to any other contributing factors, for example, nutrition, continence, mobility.

Yes ☐ No ☐

2 The person's care plan is reviewed regularly, for example, monthly reviews or when the person's conditions changes and is fully implemented. This helps ensure it meets the ongoing needs of the person. It is also good practice to use this information to inform handovers, care transfers/discharges.

Yes ☐ No ☐

3 If no, is the service using an alternative method, for example, the HIS SSKIN bundle, (surface, skin, keep moving, incontinence and moisture, nutrition) to document that care is being carried out for people who are identified at risk or who have existing pressure ulcers?
https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/sskin_care_bundle.aspx

Yes ☐ No ☐

4. Individuals who are assessed as being at risk of pressure ulcer development have the appropriate level of pressure reducing equipment to suit their level of risk (low/medium/high risk). The equipment is in use when the person is in bed or sitting up.

Yes ☐ No ☐

Sources of evidence

- Sampling of care plans/SSKIN bundles to evidence content is in line with good practice, and are effective and meeting people's individual needs.
- Evidence that there has been regular reassessment/review.
- Use of other risk assessments are in place, for example, MUST tool, falls risk, bowel and bladder function tools, pain assessment.

Outcomes for people

People experiencing care are assured that their individualised care plan is informed by their needs and wishes, based on risk, good practice guidance and professional judgement.

Notes/areas for Improvement

Standard 7 Assessment, grading and care planning of identified pressure ulcers/wounds

1. Nursing staff have training in wound assessment and management, which includes information about dressing choices and techniques.

   Yes ☐ No ☐

2. People who develop or have an existing pressure ulcer have had a full initial wound assessment carried out, for example, body map which includes grading of their pressure ulcer.

   Yes ☐ No ☐

3. A wound care treatment plan has been developed based on this assessment.

   Yes ☐ No ☐

4. Nursing staff working in the service refer to their local NHS Wound Management Formulary (WMF) Guidance and/or Scottish Wound Assessment and Action Guide (SWAAG, 2021).

   Yes ☐ No ☐

5. Ongoing wound assessment has been carried out, at specified intervals, using a validated tool which monitors changes in the presentation of the pressure ulcer. The wound treatment plan is updated based on this information.

   Yes ☐ No ☐

6. Wound photography is a useful approach in monitoring the progress or deterioration of a pressure ulcer or wound or for sending electronic referrals for specialist advice. Where this is used, the provider should have a clear policy in place, which outlines informed consent, the procedure, photographic equipment to be used, confidential storage of images and data protection etc.

   Yes ☐ No ☐

7. Where a person develops a pressure ulcer, a Care Home Pressure Ulcer Red Day review tool or SBAR is carried out to understand how this happened, identifying actions and learning to ensure ongoing improvement.

   Yes ☐ No ☐

8. The person's pain is assessed/managed appropriate to meet their individual needs.

   Yes ☐ No ☐

9. Specialist advice is sought for residents with complex, non-healing pressure ulcers/wounds, as appropriate.

   Yes ☐ No ☐

Sources of evidence

- A wound management care plan is in place which outlines:
  - method of cleansing if required (such as warm tap water/normal saline)
  - specific prescribed topical skin applications
  - primary/secondary dressings to be applied
  - where required, bandages and method of application (for example toe to knee)
  - frequency of dressing changes
  - frequency of re-assessment in relation to wound care.
- Separate assessments and care plans detailing care and treatment for each pressure ulcer/wound is good practice.
- Staff are aware of the Wound Cleansing Pathway (2020). https://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=a783fd3e-1d8b-48dc-ad55-958bb0d99eba&version=-1
- Evidence of NHS Wound Management Formulary or SWAGG being applied. Staff can discuss using this approach to make informed judgements re wound dressings. http://www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability_resources/wound_assessment_action_guide.aspx
- MAR charts or alternative documentation for example, wound treatment chart is examined to ensure that all prescribed dressings are signed for when administered.
- Pain in relation to wound care is assessed at intervals appropriate to individual residents and appropriate interventions undertaken through discussions with GP or ANP.
- A record of referrals for specialist tissue viability advice is documented. Clear outcomes/treatment recommendations are recorded.
- Where photographs are used, the policy contains a clear protocol for taking photographs, informed consent and storing images in line with data protection requirements.
- Examination of treatment room(s) to assess dressings/skin care products are individually stored, no excess stocks and items are returned to community pharmacy in line with medication guidance.

Outcomes for people

People are confident that their pressure ulcer/wound will be comprehensively assessed, a treatment plan will be in place based on the outcome of the assessment, reviewed regularly and appropriate specialist referrals made.

Notes/areas for improvement

Other tissue viability good practice to be considered.

Use of specialist equipment

(beds, pressure reducing mattresses, seat cushions/other aids)

1. The service providers policy contains guidance on the provision of specialist equipment for people at risk.

   Yes ☐ No ☐

2. The service has range of static and active pressure reducing specialist equipment to meet individual's needs.

   Yes ☐ No ☐

3. The manager has a record/equipment/inventory and can demonstrate how these resources are being used to meet needs.

   Yes ☐ No ☐

4. Pressure reducing foam mattresses are in place as a standard precaution for all residents to meet pressure reduction and comfort needs.

   Yes ☐ No ☐

5. Mattress cleaning/turning protocols are in place based on manufacturer's recommendations.

   Yes ☐ No ☐

6. Specific specialist equipment in use is documented in the persons care plan, with settings where appropriate.

   Yes ☐ No ☐

   The electrical mattress/seat cushion equipment are PAT tested and maintained by the service based on manufacturers recommendations.

   Yes ☐ No ☐

7. Staff have had training on the types of specialist equipment in use in the service.

Yes ☐ No ☐

Sources of evidence

- Evidence levels of specialist equipment and information is contained in policy/ protocol.
- Examine inventory of specialist equipment in place and this is up-to-date for current use to reflect individuals changing needs.
- Care plans include information about specialist equipment in use with details of settings for electric mattresses, for example by weight/other information.
- Inspection of a sample of pressure reducing foam mattresses on beds.

Outcomes for people

People experiencing care have access to the appropriate pressure reducing equipment and aids to promote comfort as well as pressure reduction to ensure that skin integrity is maintained.

References

Care Home Equipment Protocol (2012)
https://www.gov.scot/publications/care-home-equipment-protocol/

Notes/areas for improvement

Skin care

1. Where skin conditions are known or identified for example, dry skin, dermatitis, redness, continence dermatitis, requiring prescribed or over the counter skin care topical applications, there is a clear plan of care in place to manage this. This includes:
   - description of the skin care need, for example, dry
   - aim of treatment, for example, to rehydrate skin
   - the type of cream and strength where applicable
   - which part of the body it is being applied to
   - apply how much - thin or thicker layer - fingertip measurements- for steroids or other creams with active ingredients
   - application method– rubbed in gently, apply generously
   - how often applied
   - record of administration of prescribed skin care products on TMAR charts/e recording systems.

   Yes ☐ No ☐

2. Staff refer to the Healthcare Improvement Scotland's Pressure Ulcer grading and excoriation tool (2023) to differentiate between continence dermatitis and grade 1 pressure damage and to the assessment tool for darkly pigmented skin.

   Yes ☐ No ☐

3. All staff have access to training/education about skin assessment and care.

Sources of evidence

- Evidence of the Scottish Skin Excoriation and Moisture Damage Related Skin Damage Tool (2020) being used to grade/manage excoriated skin. https://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=c462e1d5-b16e-43ed-a5ac-d90c7e142aa5&version=-1
- Awareness and use of assessment tool for darkly pigmented skin (2019) where appropriate.
- Discuss persons individual skin care needs and practice with staff.
- Examine care plans/TMAR charts.

Outcomes for people

People with skin care needs can be assured that these will be assessed, managed with appropriate skin care products and reviewed regularly.

Care of the older person's skin: Best Practice Statement. (Second edition) Wounds UK (2012)
https://www.wounds-uk.com/resources/details/care-older-persons-skin-best-practice-statement-second-edition

Notes/areas for improvement

Wound infection: prevention and control

1. Local infection prevention and control policies are applied, for example use of appropriate PPE and aseptic technique.

   Yes ☐ No ☐

2. Staff can recognise and document the signs of clinical infection and when these are present obtain a wound swab.

   Yes ☐ No ☐

3. Personal plans document a record of discussion and outcomes with GP/TVN regarding individuals with a suspected wound infection.

   Yes ☐ No ☐

4. A record of wound swab investigations, results and treatment initiated is recorded (for example dressings/antibiotics).

   Yes ☐ No ☐

5. A clear record of the wound infection is documented in a short-term care plan.

   Yes ☐ No ☐

6. Dressings and wound care products are being disposed of according to local protocols.

   Yes ☐ No ☐

Sources of evidence

- Examine Infection and Prevention and Control (IPC) policies and protocols.
- Evidence of recognising wound infection as part of training for nursing staff/carers as appropriate.
- Sample personal plan(s) of individual who have a wound infection to establish a record of care and treatment and ongoing monitoring.
- Discuss care and support with staff.
- Examine treatment rooms/speak to staff to assess if there is appropriate disposal of dressings and so on.

Outcomes for people

People can be confident that their suspected/confirmed wound infection will be managed within parameters of good practice guidance and infection prevention and control measures.

Notes/areas for improvement

Leg ulcer/diabetic foot ulcers

Definition

Leg ulcer – a leg ulcer is a break in the skin below the knee (and above the ankle) which has not healed within two weeks. (NICE, 2012). They can be venous, arterial or mixed aetiology.

Diabetic foot ulcer - an open wound on the foot that is slow to heal. These are common in people with diabetes due to loss of sensation, poor circulation.

These types of ulcers require **urgent specialist referral** for assessment and treatment.

Sources of evidence

- People with leg/foot ulcers have an urgent referral for specialist advice and treatment and this forms part of the care plan and is being followed by the service.

Notes/areas for improvement

Debridement

1. The presence of necrotic dead, devitalised tissue delays the healing process.
2. Sharp debridement is a specialist technique.
3. Sharp debridement is usually only undertaken by NHS competent personnel.

Sources of evidence

- Where a person has necrotic tissue present in their pressure ulcer/ wound, this requires to be assessed to ensure the appropriate treatment is advised. For example, necrosis be removed by using autolytic (use of moist wound dressings) or other debridement techniques.
- People who are terminally ill/other co-morbidities have specialist assessment (GP/TVN/Vascular) to decide whether/how to debride, for example, pressure ulcer/wound may be left dry at end of life care.
- Care plan specifically states how the debridement method will be carried out with regular re-assessment.

Outcomes for people

People with necrotic wounds/pressure ulcers have a referral for specialist advice/ treatment and this forms part of the care plan and is being followed by the service.

Notes/areas for improvement

Prevention and management of skin tears

1. Staff have undertaken the NES Skin Tears – Prevention, Assessment and Management workbook.

   Yes ☐ No ☐

2. People at risk of skin tears are identified and a prevention plan is initiated based on skin condition, mobility, general health and environmental factors.

   Yes ☐ No ☐

3. Where a skin tear develops, staff have initiated first aid and it is then assessed applying the International Skin Tears Advisory Panel (ISTAP) classification system and treatment is based on this.

   Yes ☐ No ☐

4. A wound care plan is developed outlining cleansing, dressings and frequency of dressing changes.

   Yes ☐ No ☐

5. If the skin tear has not healed within a two week period, the person is referred for specialist advice.

   Yes ☐ No ☐

Sources of evidence

- Evidence of staff training and staff can demonstrate an understanding of best practice in prevention, assessment and management of skin tears.
- Where skin tears occur, it is documented and categorised using the recommended assessment tool and the treatment guidance is followed.
- Wound care plan and documentation is in place and evidence of seeking advice/support within recommended timescales.

Outcomes for people

People who are at risk of skin tears can be confident that there will be a prevention plan in place. Where skin tears occur, they will be assessed and managed within parameters of good practice guidance.

NES Skin Tears – Prevention, Assessment and Management workbook. (version 3 October 2018)
https://studylib.net/doc/18635311/skin-tears---nhs-education-for-scotland

Notes/areas for improvement

Burns and scalds – first aid management

Where a person experiencing care sustains a burn or scald:

1. Staff have received first aid training in burns/scalds.
2. Staff should start cooling the area as soon as possible following the injury. (Cool or tepid running water for at least 20 minutes)
3. Ice or very cold water should not be used.
4. Ensure the person is kept warm with a blanket.
5. Depending on the severity of the burn/scald, staff should make a decision to:
   - call the emergency services for the person to be admitted to hospital
   - call the GP/community nurse for advice / support.
6. Ensure that any care and prescribed treatment is carried out and a care plan developed

Sources of evidence

- Personal plan contains a record of the incident.
- People who sustain a burn or scald are confident that staff will manage the emergency situation and apply first aid as per good practice guidance.
- People experiencing care receive specialist advice/prescribed treatment and this forms part of the care plan and is being followed by the service. https://cks.nice.org.uk/topics/burns-scalds/diagnosis/assessment/
- Person has a clear plan of care to manage the burn/scald.
- Incident is reported to the Care Inspectorate.
- Risk management is undertaken.

Outcomes for people

People who sustain a burn or scald are confident that staff will manage the emergency situation and apply first aid as per good practice guidance.

People experiencing care receive specialist advice/prescribed treatment and this forms part of the care plan and is being followed by the service.

https://cks.nice.org.uk/topics/burns-scalds/diagnosis/assessment/

References to pressure ulcer standards and good practice

Whe Healthcare Improvement Scotland. Prevention and Management of Pressure Ulcer Standards – October 2020
https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/pressure_ulcer_standards.aspx

All resources/tools cited in this document can be found on Healthcare Improvement Scotland's website – Tissue Viability
https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability.aspx

Education/training/professional development

Prevention and management of Pressure Ulcers – Reference Book 2017 (NES)
https://learn.nes.nhs.scot/3886/infection-prevention-and-control-ipc-zone/sipcep-intermediate-layer/skin-integrity/prevention-and-management-of-pressure-ulcers

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