Tissue Viability Policy

The Prevention & Management of Wounds

Solent NHS Trust policies can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

Purpose of Agreement	This policy sets out the required standard to be delivered by Solent NHS Trust. Solent NHS Trust Care staff care for patients with / or at risk of tissue breakdown to promote optimum healing and improved clinical outcomes
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SUMMARY OF POLICY

This policy is an overarching policy and should be used in conjunction with the Leg Ulcer Standard Operating Procedure (SOP) and the Pressure Ulcer SOP. The Tissue Viability policy aims to insure that staff understand and are able to provide the standards and expectations for prevention, clinical assessment and management of wounds.

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

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

The areas included in this policy are:

- Patient assessment and management
- Identification and management of infection
- Wound care formulary
- Tissue Viability Team
- Clinical Advisory Team
- Pressure ulcers
- Wounds on the feet
- Leg ulcers

Table of Contents

Tissue Viability Policy

1. INTRODUCTION & PURPOSE

This Policy is over-arching to encompass tissue viability in its broadest sense. To support specific wound care the associated Leg Ulcer SOP and Pressure Ulcer SOP should be read in conjunction with this Policy.

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

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

1.3 This will be achieved by the following objectives:

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

2. SCOPE & DEFINITIONS

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

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

2.3 **Acute wounds** are typically traumatic or surgical in origin; they occur suddenly and move rapidly and predictably through the wound healing process and result in durable wound closure.

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

2.5 **Contamination** - All open wounds are contaminated with microbes, wound healing is not delayed as host defences respond (International Wound Infection Institute 2016)

2.6 **Colonised** -Microbes grow and divide at a non-critical level, wound healing is not impeded or delayed (International Wound Infection Institute 2016)

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

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

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

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

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

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

2.13 **Venous leg ulcer** - an open lesion between the knee and the ankle joint that occurs in the presence of venous disease and takes more than two weeks to heal (NICE 2013)

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

2.15 **A mixed ulcer** occurs in the presence of both arterial and venous disease and where a combination of disease processes contributes to the formation and persistence of the ulcer.

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

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

3. PROCESS/REQUIREMENTS

3.1 Introduction

3.1.1 Local and national guidance has been used as the framework for this Policy. It has been developed from the best available evidence and outlines the required standards and guiding principles to promote a multidisciplinary, consistent and cohesive approach to patient care.

3.1.2 Patient management must be performed in accordance with Trust Policy and SOP.

3.2 Patient Assessment and Management

3.2.1 Timely holistic assessment and re-assessment, appropriate management and referral is required for all patients with / or at risk of tissue breakdown. Refer to appropriate SOP for the type of wound.

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

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

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

3.2.5 Holistic wound assessment should include individual assessment of the characteristics of and symptoms related to each wound present, including accurate recording of the location of the wound and taking photographs with signed consent see Appendix B Appendix C and Appendix D. In accordance with, IG06 Management of Audio visual Records Policy.

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

3.2.7 Assessors should refer to the SIGN CHECKER in the latest version of the Wound Formulary Handbook, to assess for infection.

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

3.2.9 A plan of care, stating objectives, action and a review date, must be in place for the prevention and / or management of any type of wound and formulated in partnership with patient/carer.

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

3.2.11 A TIMES wound assessment should be completed weekly on SystmOne template, or more often if there is deterioration in the condition of the patient and/or wound.

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

3.2.13 All holistic wound assessments and reassessments should be documented. Documentation should include measurements of the wound, the findings of the assessments, the objectives of care, the care plan and the date for holistic wound reassessment. Guidance on measuring a wound can be found in Appendix B.

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

3.2.15 If there are difficulties with concordance, ensure that patient is aware of the potential effects of non- concordance and document this.

3.3 **Identification and Management of Infection**

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

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

3.3.3 Use of systemic antibiotics and antimicrobial dressings should be considered, as per local formulary, for wounds with clinical signs of localised and / or systemic infection and must be managed using the SIGN checker flowchart and in accordance with Trust policy and local antibiotic guidelines.

3.3.4 This policy should be used in conjunction with the Deteriorating Patient and Resuscitation Policy (2018).

3.4 **Wound care formulary**

3.4.1 The local Hampshire Wound Care Formulary must be consulted for prescribing wound management products. Prescribing outside of the formulary must be rationalised in accordance with local Trust policy and SOPs and the appropriate ‘exception reporting form’ must be completed and submitted as per local formulary.

3.4.2 Wound dressings / appliances that have been prescribed for a specific patient must not be used for another patient, this is illegal practice, even if the health professional deems that such practice would save money and reduce wastage.

3.5 **Tissue Viability Team**

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

3.5.2 The Tissue Viability referral criteria is described on the reverse of the Tissue Viability Referral Form (As per locally agreed route across Portsmouth and Southampton). Southampton Referral, Appendix E and Portsmouth referral, Appendix F.

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

3.5.4 The Tissue Viability Team are responsible for communicating findings and any management plan to the referrer. However the overall responsibility for the day to day management of the patient remains the responsibility of the referrer

3.6 Clinical Advisory Team

3.6.1 The Clinical Advisory Team (CAT) provides a service to all patients who are registered with a Portsmouth City or Southampton City GP. Team members currently come from either a Nursing or Occupational Therapy background.

3.6.2 Clinical advice may include changes to routine, handling techniques, use of everyday household items to meet a need, or recommendations of specialist, or highly specialist equipment. Expertise is provided in the following four areas, all of which can have a bearing on tissue viability:

- Pressure Relief and Tissue Viability
- Posture Management
- Moving and Handling
- Equipment for Independence

3.6.3 The Clinical Advisory Team referral route is identical across both Portsmouth and Southampton (Appendix G). For more complex assessment, or specialist equipment consideration, a relevant supporting information template is required to be completed to support the referral.

3.6.4 Any referrals or supporting information templates not fully completed will be returned to the referring professional, which could result in a delay to patient care, therefore all parts of the referral form and supporting information template (if required) must be accurately completed.

3.6.5 The Clinical Advisory Team members are responsible for communicating findings and any management plan to the referrer. However the overall responsibility for the day to day management of the patient remains the responsibility of the referrer.

3.7 Pressure ulcers

3.7.1 For prevention and management of Pressure Ulcers refer to the Pressure Ulcer SOP.

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

3.8 Wounds on the foot

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

- On the day you first see them or
- On the day they first present or
- If there are any a patients with diabetes foot ulceration not already within the Diabetes foot pathway to Solent Podiatry
  See Appendix H, Referral Criteria and Appendix I, Diabetes Foot Ulceration and Charcot

3.8.2 Referral to Solent NHS Trust Podiatry for all non-diabetes patients presenting with foot ulceration within 24 hours. Referral into Podiatry is via Single Point of Access.

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

3.9 Leg Ulcers

3.9.1 For leg ulcer management and management of the healed leg refer to the Leg Ulcer SOP.

4. ROLES and RESPONSIBILITIES

4.1 **Solent NHS Trust** has a responsibility to:

- Ensure care is delivered in a context of continuous quality improvement, where implementation of the policy and associated SOPs is subject to regular feedback and audit.

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

- Ensure all healthcare staff within the service/area are aware of this policy and associated SOPs and pathways.
- Ensure staff, within the service/area are aware of the record keeping required.
- Comply with Solent NHS Trust monitoring of this Policy.
- Facilitate access to the required training for their staff.

4.3 **The Tissue Viability Steering Group** has a responsibility to:

- Ensure the policy and linked SOPs are reviewed and updated to ensure they comply with Department of Health, Patient Safety and other national/local guidance and

recommendations, in order to ensure clinically effective delivery of care regarding this speciality.

- Report to QIR (Quality, Improvement and Risk Group)

4.4 **The Tissue Viability Service** has responsibility for:-

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

Clinical Advisory Team has a responsibility for:-

- Advising and supporting individual professionals/clinicians and teams working with adults and children with long term conditions and disabilities.
- Being up to date with current evidence and guidelines
- Designing and delivery of education
- Developing local policies and SOPs
- Participating in regional and national work to shape guidelines and policies at national level and sharing national changes in tissue viability with Solent NHS Trust.

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4.5 **Clinical Staff** have a responsibility to:

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

5. TRAINING

5.1 Solent NHS Trust recognises the importance of education and training in all aspects of the prevention and management of wounds as outlined in the Training Needs Analysis led by the Tissue Viability team.

5.2 Training and education programmes are in place and available through The Tissue Viability Team and the Clinical Advisory Team.

5.3 Bespoke training can be developed as required, in line with current thinking and / or where there are existing or developing concerns.

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

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

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 This policy aims to improve optimum healing and consequently improve patient care and outcomes. As part of Solent NHS Trust policy an Equality Impact Assessment (Steps1and2 of cycle) was undertaken (Appendix A). The Tissue Viability Team are not aware of any evidence that different groups have different priorities in relation to this frame work, or that any group will be affected disproportionally or any evidence or concern that this Policy may discriminate against a particular population group. Communication with a patient and their carer(s) should be in a style and use language that empowers and engages patient participation in the planning, delivery and evaluation of care. Thus, the equality impact assessment result is: no negative impact.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

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

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

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

7.4 All actions within the Policy in relation to monitoring and review will be supported by the Tissue Viability Steering Group Action Plan. The Document Manager must be able to demonstrate the effectiveness of the document at the point of review, for example by; carrying out audits, reviewing incidents that may have occurred related to the document, discussing the document at team meetings. Any subsequent issues/findings resulting from the review should be incorporated in the new version of the document.

8. REVIEW

This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 In relation to this policy the following References have been used:-

•Alexiadou K, Doupis J. Management of diabetic foot ulcers. Diabetes Ther. 2012;3(1):4.

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

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

• Demidova-Rice, T.N. et al. 2012. Acute and impaired wound healing: pathophysiology and current methods for drug delivery, part 1 : normal and chronic wounds: biology, causes and approaches to care. Advances in Skin and Wound Care 25(7): 304–314

• European Pressure Ulcer Advisory Panel (EPUAP) (2014 2009) The prevention and management of pressure ulcers. European Pressure Ulcer and Association Panel Guidelines

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

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

• Guest JF, Ayoub N, McIlwraith T et al (2015) Health economic burden that wounds impose on the National Health Service in the UK. BMJ Open 5(12): e009283

• Guest JF, Fuller GW, Vowden P (2018b) Diabetic foot ulcer management in clinical practice in the UK: costs and outcomes. International Wound Journal 15(1): 43–52

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

• International Wound Infection Institute (IWII) (2016) Wound Infection in clinical practice. Wounds International. Menke, N.B. et al. 2007. Impaired wound healing. Clinics in Dermatology 25(1): 19–25

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

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

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

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

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

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

• RCN (2014) Specialist Nurses Make a Difference RCN Policy Briefing. Available at:- https://www.rcn.org.uk/about-us/policy-briefings/pol-1409 (accessed 6/2/19)
•Rogers LC, Frykberg RG, Armstrong DG, et al. The Charcot foot in diabetes. Diabetes Care. 2011;34(9):2123-9.
• Schultz, G.S. et al. (2003) Wound bed preparation: a systematic approach to wound management. Wound Repair Regeneration 11(2): 1–28.

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

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

9.2 Solent NHS Trust Policies

Infection Prevention and Control Standard Precautions
Aseptic technique and aseptic non touch technique guidelines
Handling and disposal of healthcare waste Management of MRSA in Community Settings Risk Management
Safeguarding Vulnerable Adults Policy
Protocol for Determining Causative Factors in the Development of Category 3 and 4 Pressure Ulcers
Serious Incident Policy
Incident Reporting Policy
Working in Partnership with Commercial Organisations
Mental Capacity Act and DOLS Records Management
Nutrition/Hydration Policy (Adults) SLT001
Depravation of Liberty Safeguards and Mental Capacity Act Policy
Consent to Treatment and care Policy
Leg Ulcer SOP
Pressure Ulcer SOP
IG06 Management of Audiovisual Records Policy

Appendix: A Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	**Answer**		
1. What are the main aims and objectives of the document?	This policy sets out the required standard to be delivered by Solent NHS Trust staff for all patients with / or at risk of tissue breakdown to promote optimum healing and improved clinical outcomes where possible.		
2. Who will be affected by it?	All clinical staff that provide tissue viability interventions. Any patient at risk of or with an actual wound		
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	Incident reporting system, existing audits, patient records.		
4. What are the outcomes you want to achieve?	Management and prevention of wounds is already widespread with existing interventions in place therefore this Policy is written to reduce the impact of wounds on patient outcomes and improve care provision.		
5. What information do you already have on the equality impact of this document?	None		
6. Are there demographic changes or trends locally to be considered?	No		
7. What other information do you need?	None		
Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document unlawfully discriminate against any group?		X	
2. Can any group benefit or be excluded?		X	Policy to be used for patients managed under the scope of this policy. House bound, patients will be cared for at home, or within Solent NHS Trust in patient units
3. Can any group be denied fair and equal access to or		X	

treatment as a result of this document?			
4. Can this actively promote good relations with and between different groups?	x		This policy is for Solent staff but elements within it, such as access to the TV team are available to groups outside of Solent such as Practice Nurses.
5. Have you carried out any consultation internally/externally with relevant individual groups?	x		Podiatry, Clinical Advisory Team,
6. Have you used a variety of different methods of consultation/involvement	X		E-mail, face to face
<u>Mental Capacity Act implications</u>			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)	X		Capacity assessments will be required regarding consent to treatment and advice
<u>External considerations</u>			
8. What external factors have been considered in the development of this policy?	x		National Guidance and Policy, other local healthcare providers policies
9. Are there any external implications in relation to this policy?		x	
10. Which external groups may be affected positively or adversely as a consequence of this policy being implemented?	x		Patients under the care of Local GPs will have elements of the policy relevant to them, such as access to training and support for the staff looking after them

If there is no negative impact – end the Impact Assessment here.

<u>Step 3 - Recommendations and Action Plans</u>	**Answer**
1. Is the impact low, medium or high?	
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	
3. Are there likely to be different outcomes with any	

modifications? Explain these?	
Step 4- Implementation, Monitoring and Review	**Answer**
1. What are the implementation and monitoring arrangements, including timescales?	
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	
Step 5 - Publishing the Results	**Answer**
How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	

Appendix B:

Measuring a wound

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

When measuring length:

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

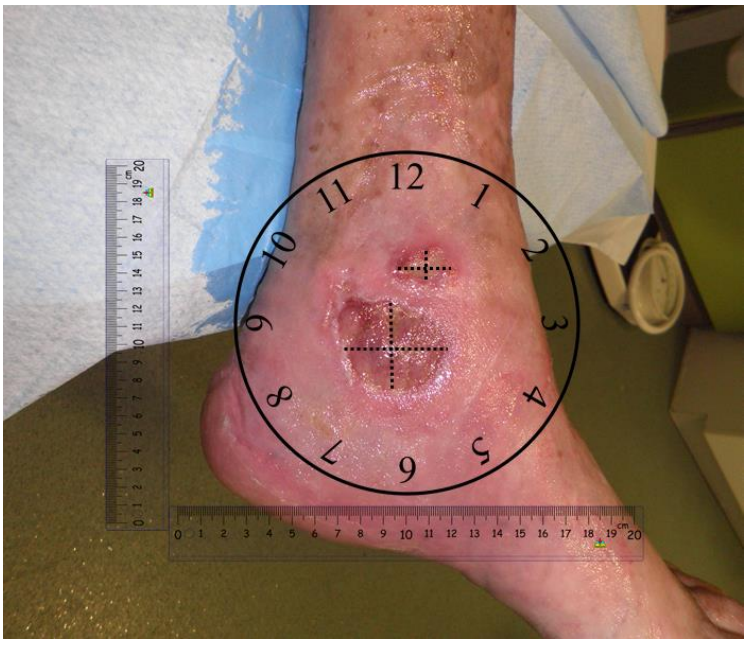
When measuring width:

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

When measuring depth:

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

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

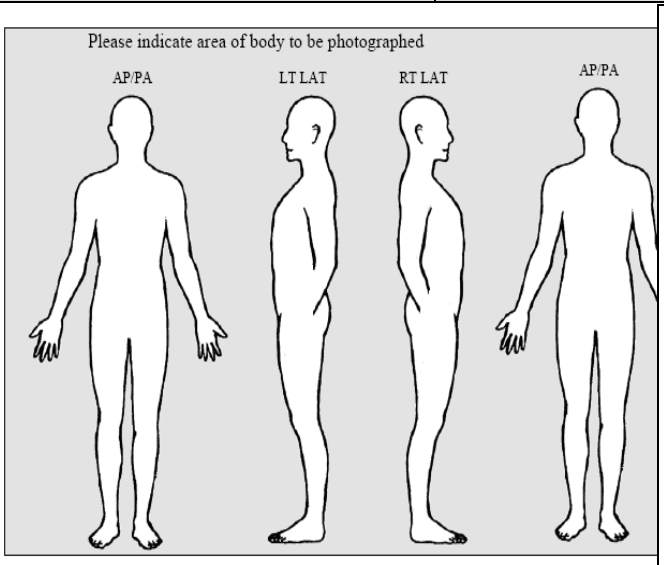


Appendix C: Patient Consent Form for Wound Photographs

The Community Nurses would like to take a photograph(s) of your wounds (See diagram) so we can monitor and record the changes in your wound(s). The photo will be taken with the Solent mobiles, which is password protected and then downloaded onto the computer at the GP surgery where they will be kept secure in a folder in your name. The photos will then be printed out for your Nursing notes for yourself and our reference.

If you need to ask any questions please do not hesitate to ask the nurses. If you do not wish the nurses to take photographs of your wound then please sign the box below. In addition you can also decline to have the photographs used for training purposes.

Name:	**DOB:**	**NHS Number:**



(Highlight the areas the wound(s) are located and tick the wounds that have been consented)

Wound Area Index

(Please tick if patient consents or cross if they decline)

Wound Area A……Consent ☐

Comments…….....

…….

Wound Area B…….. …..... Consent ☐

Comments……

…….

Wound Area C…… Consent ☐

Comments…….

……..

Wound Area D…….Consent ☐

Comments…….

……..

Level One Consent I CONSENT for the photographs to be part of my Nursing notes ☐

Signature…… (Patient/Family member/Carer) **Print** ……..

Date.....

Level Two Consent I CONSENT for the photographs to be part of my Nursing notes and to be used for NHS staff and student training. ☐

Signature…… (Patient/Family member/Carer) Print ……..

Date.....

Decline Consent I Decline for the photographs to be taken and to be part of my Nursing notes ☐

Signature…… (Patient/Family member/Carer) Print ……..

Date.....

Appendix D: Tips for photographing wounds

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

Appendix E:

Southampton Tissue Viability Service Referral Form

Please Ensure the Referral Form is Completed in Full

Patient			
Patients Name		DOB	
Address & Postcode	Phone number	NHS No.	
GP Practice		Referral date	
Communication Needs		Consent for referral ☐	
Relevant Medical History	Visit Summary Attached: ☐ Diabetes (Type): ☐ Cardiovascular Disease: ☐ CVA (Stroke): ☐ Rheumatic/auto-immune conditions: ☐ End of Life: ☐		
	Allergies		
Current Medication & Dosage	Medication sheet attached: ☐		
Patient Mobility (please tick)	Fully Mobile: ☐ Reduced Mobility: ☐ Mobile with Aids: ☐ In wheelchair, can stand & transfer: ☐ Wheelchair bound: ☐ Housebound: ☐		BMI
Wound			
Wound Location		Duration	
Leg Ulcer: ☐ Pressure Ulcer: ☐ Stage: ☐ Pressure relieving equipment in use: ☐ Skin Tear: ☐ Moisture Lesion: ☐ Non-healing surgical wound: ☐ Diabetic Foot: ☐ Burn: ☐ Fungating wound: ☐			
Reason for Referral			
Current Treatment (dressing/bandages)		Doppler Results	Date attempted . . . . . . Results on SystmOne ☐ Left ABPI . . . . . Right ABPI . . . . . . Sounds . . . . .
Referrer			

Referrers Name		Designation	
Phone no.		Base	
Please send form and accompanying Documents via e-referral for SystmOne users or email to snhs.tissueviability@nhs.net			
Office use only	Registered: ☐ Scanned: ☐ Recorded: ☐		

Guidance for Appropriate Referral to Tissue Viability

The Southampton Tissue Viability Team is based at Adelaide Health Centre and will see patients in the Community, Community Hospital, GP Practice, Nursing Homes and in Clinic.

We provide:

- Complex wound assessment and advice undertaken with the referrer.
- Leg ulcer service, including complex lower limb assessment and management.

Send form and accompanying documents via e-referral for SystmOne users.
Email to, snhs.tissueviability@nhs.net
Post to, Tissue Viability/Leg Ulcer Service, Adelaide Health Centre
William Macleod Way
Millbrook
Southampton
SO16 4XE

Referral Inclusion Criteria

Patients:-

- Must have a Southampton GP or currently in Solent Care.
- Must have a wound or be at risk of developing a wound.
- Must have up-to-date medical history and medications list completed/attached.
- Must have a clinical question for Tissue Viability to address.

Patients with a Leg Ulcer:-

- Must have a recent recorded/attempted ABPI
- Must have commenced compression therapy if ABPI's are between 0.8 and 1.3 and there is less than 30-40% healing at 4-6weeks or non-healing after 8 weeks.
- The patients ABPI is recorded between 0.6-0.8 or >1.3 and further advice is required.

Exclusion Criteria

- Incomplete referral form.

Patients with a Leg Ulcer:-

- No ABPI recorded or attempted.
- ABPI's are between 0.8 and 1.3 and appropriate compression therapy has not been commenced.

Advice Line

If you wish to discuss the patient please contact the Tissue Viability Team on the Advice Line for guidance.
Monday to Friday between 2pm-3.30pm for telephone advice **07789 505 102**

Appendix F:

Portsmouth Tissue Viability Service Referral Form

Please Ensure the Referral Form is Completed in Full

Patient			
Patients Name		DOB	
Address & Postcode		NHS No.	
GP Practice		Referral date	
Communication Needs		Consent for referral ☐	
Relevant Medical History	Visit Summary Attached: ☐ Diabetes (Type): ☐ Cardiovascular Disease: ☐ CVA (Stroke): ☐ Rheumatic/auto-immune conditions: ☐ End of Life: ☐ Allergies		
Current Medication & Dosage	Medication sheet attached: ☐		
Patient Mobility (please tick)	Fully Mobile: ☐ Reduced Mobility: ☐ Mobile with Aids: ☐ In wheelchair, can stand & transfer: ☐ Wheelchair bound: ☐ Housebound: ☐		BMI
Wound			
Wound Location		Duration	
Leg Ulcer: ☐ Pressure Ulcer: ☐ Stage: ☐ Pressure relieving equipment in use: ☐ Skin Tear: ☐ Moisture Lesion: ☐ Non-healing surgical wound: ☐ Diabetic Foot: ☐ Burn: ☐ Fungating wound: ☐			
Reason for Referral			
Current Treatment (dressing/bandages)		Doppler Results	Date attempted . . . . . . Results on SystmOne ☐ Left ABPI . . . . . Right ABPI . . . . . . Sounds . . . . .

Referrer			
Referrers Name		Designation	
Phone no.		Base	
Please send form and accompanying Documents via email to snhs.portsmouthtissueviability@nhs.net			
Office use only	Registered: ☐ Scanned: ☐ Recorded: ☐		

Guidance for Appropriate Referral to Tissue Viability

The Portsmouth Tissue Viability Team will see patients in the Community and Community Hospital. We provide:

- Complex wound assessment and advice undertaken with the referrer, including complex lower limb assessment and management.

Send form and accompanying documents:
Email to, snhs.portsmouthtissueviability@nhs.net

Referrals will not be taken over the phone

Referral Inclusion Criteria

Patients:-

- Must have a Portsmouth GP or currently in Solent Care.
- Must have a wound or be at risk of developing a wound.
- Must have up-to-date medical history and medications list completed/attached.
- Must have a clinical question for Tissue Viability to address.

Patients with a Leg Ulcer:-

- Must have a recent recorded/attempted ABPI
- Must have commenced compression therapy if ABPI's are between 0.8 and 1.3 and there is less than 30-40% healing at 4-6weeks or non-healing after 8 weeks.
- The patients ABPI is recorded between 0.6-0.8 or >1.3 and further advice is required.

Exclusion Criteria

- Incomplete referral form.

Patients with a Leg Ulcer:-

- No ABPI recorded or attempted.
- ABPI's are between 0.8 and 1.3 and appropriate compression therapy has not been commenced.

Advice

For advice and support please email:

snhs.portsmouthtissueviability@nhs.net
If emailing for advice please include contact information.

Appendix G

Clinical Advisory Team - Request for Clinical Advice or Joint Assessment

- **Please send all completed forms to SNHS.ClinicalAdvisoryTeam@nhs.net**
- **Referrals cannot be accepted via SystmOne or as Tasks**
- **All areas marked with a * MUST be completed.**

Is your referral relating to (please tick appropriate box/es)

Hospital Discharge ☐ **Preventing Hospital Admission** ☐ **Care Package review** ☐

Supporting the deteriorating patient ☐

*** Surname:**	***Title:**
*** Forename:**	*** D.O.B:**
***Address:**	**NHS No./SS Ref No:** ***GP:**
Client's height:	**Client's weight:**
***Diagnosis:** ((i.e. – CVA, COPD)	
***Prognosis:** (if known)	
***Pressure Ulcer status inc. pressure ulcer category & location:-** Previous – Current –	
Continence:	

	INDEPENDENT	REQUIRING SUPERVISION	ASSISTANCE OF 1	ASSISTANCE OF 2	EQUIPMENT USED Please state
*Chair					
*Bed					
*Mobility Indoors					

Where is the client at present?

***Reason for referral/ What is current problem?**

***Requested By:**	***Designation:**	***Date:**

Appendix H

Referral to Podiatry for any foot wound / ulceration

1. **Diabetes Patients:**

Update for Diabetes Foot Ulceration and Charcot
To help us manage these patients most appropriately and aim to improve their clinical outcomes, please can you refer any diabetes foot ulcer or Charcot:

- **on the day you first see them or**
- **on the day they first present or**
- **if there are any a patients with diabetes foot ulceration not already within the Diabetes foot pathway to Solent Podiatry (see enclosed pathway).**

Solent NHS Trust Podiatry will then triage and aim to see these patients within 48 hours of receipt of the referral and aim to ensure the following are optimised:

- Infection control
- Offloading
- Debridement and pressure relief
- Wound care
- Link with Vascular and Diabetes teams via the MDT

If the wound is in a non-weight bearing area and does not require debridement and offloading the patient can be seen within community by the nursing team with podiatry reviews as appropriate and agreed within the treatment plan.

Please find enclosed the Diabetes Foot Pathway with contact numbers and additional resource to help and guide you
Referral to Solent NHS Trust Podiatry within 24 hours is required for all diabetes related foot ulceration and any diabetes patient presenting with a red hot swollen neuropathic foot. Referral is into SPA with a podiatry referral and please state:

- Location of diabetes related foot ulceration
- Size of the ulceration
- Duration
- Infection status / antibiotic therapy
- Treatment to date
- Any addition supporting information

Key Diabetes Foot Ulceration information:

- **80% of all diabetes lower limb amputations are preceded by at least one foot ulcer**
- **The average healing time for a diabetes related foot ulcer is 12 months**
- **The National Diabetes foot Audit states that those patient with a diabetes foot ulcer that are seen within 2 weeks of presentation are more like to be ulcer free and alive at 24 weeks than those referred later than 2 weeks Patients with**
- **Diabetes foot ulceration have a 50% mortality at 5 years**
- **On average a Diabetes Foot Ulcer cost £12,000 to manage per year**
- **Patients need to follow the strict advice given to change their footwear, only wear their bespoke footwear once made for them or their offloading device to ide resolution of their foot ulcer**
- **Once healed, a patient has a 40% chance of reulceration at the same site within 12 months**
- **Please refer any Diabetes patients identified as Moderate Foot Risk or High risk Foot Risk into Solent Podiatry.**

2. Non Diabetes Patients

Referral to Solent NHS Trust Podiatry for all non diabetes patients presenting with a foot ulceration within 24 hours. Referral into Podiatry is via SPA and please state:

- Aetiology of the ulceration
- Location of diabetes related foot ulceration
- Size of the ulceration
- Duration
- Infection status / antibiotic therapy
- Treatment to date
- Any addition supporting information

Podiatry will then be able to review any foot wounds / ulceration and undertake appropriate assessment for:

- Debridement
- Pressure relief / offloading
- Wound care
- Infection management
- Onward referral

Please don't delay in referring foot ulceration in to Podiatry. If in doubt, refer in for Podiatry opinion.

Appendix I

DIABETES FOOT REFERRAL PATHWAY

SCCG and WHCCG

Foot assessed as "AT INCREASED or HIGH RISK" NICE 2015 Diabetes Foot Assessment Score >10 refer

DIABETIC FOOT ULCER

(Foot ulcer = below malleoli)

New ulcer / Non healing / Infected / abscess refer ASAP

If mild to moderate infection refer and:

- Initiate Empirical antibiotics (HIOW Antibiotics Guidelines)
- Deep wound swab

HOT SWOLLEN NEUROPATHIC FOOT (Suspect CHARCOT) refer

Features may include:

- Pain on walking when usually neuropathic
- Recent minor trauma
- Adequate blood supply

Solent Podiatry Service
Adelaide Health Centre
Western Community Hospital Campus
William Macleod way
Millbrook
Southampton
SO16 4XE
Referral by letter or fax
Fax: 02380825283
Tel: 03003002011

Referral form with Diabetes Foot Assessment (DFA) GP Summary letter with details including full foot neuro & vascular assessment / infection status / diabetes control
Diabetic foot clinical advice from a Podiatrist is available from
Monday to Friday 9am-2pm on:
03003002011

SEVERE INFECTION – ADMIT

- Patient systemically unwell
- Spreading infection despite antibiotics
- Deep abscess

Admission to UHS
02381208999

ACUTE CRITICAL ISCHAEMIA

Features include the following:

- Discoloration of toes (pale, dusky, black)
- Signs of necrosis
- Rest pain (often at night)
- Cold
- Diminished / absent pulses

Vascular Team
02381208803
Rapid Access clinic runs weekly for urgent cases
Referral by letter / fax / telephone as indicated by the patient's condition

Why is it important to refer prompt!?

- The risk of a lower extremity amputation in a person with diabetes is more than 20 x that of a person without diabetes and 95% of all non-traumatic amputations start with a foot ulcer
- Good diabetes control will improve healing and outcomes
- Ensure patient has appropriate footwear, doesn't smoke and understands the implications of diabetes

DIABETES FOOT REFERRAL PATHWAY

Portsmouth, Fareham & Gosport, & East Hampshire revised contacts 2018

Complete Diabetes Foot Assessment:

MODERATE or HIGH RISK NICE 2015

Low Risk managed in Primary Care

→ **Solent Podiatry Service –SPA**
Attached DFA with referral form to:
Podiatry Service, 1st Floor Adelaide Health Centre, William Macleod Way, Southampton, Hampshire, SO16 4XE
Email: *snhs.solentnhspodiatry@nhs.net*
Tel: 0300 300 2011
Fax: 023 8078 4009

DIABETIC FOOT ULCER

Refer all new foot ulcerations
(Foot ulcer = below malleoli)

If mild to moderate infection refer and also
- Initiate Empirical antibiotics
- Deep wound swab
- Review response to antibiotics

→ **Diabetes Multidisciplinary Foot Clinic QAH**

Referral by letter / fax / phone as indicated by patients' condition to MDFC at the Diabetes Centre, Queen Alexandra Hospital
Tel: 023 92286260 Fax: 023 92286791
Email:pho-tr.diabetesendocrinology@nhs.net
Podiatry Clinical advice via SPA Tel: 0300 300 2011
Referral form on PIP or by GP Summary + letter detailing foot neuro/vasc/infection status

SEVERE INFECTION
- Systemically unwell
- Osteomyelitis- Typically red swollen foot
- Cellulitis>2cm from ulcer/lymphangitis
- Deep ulceration with tendon, joint capsule or bone expose

→ **Admit to Queen Alexandra Hospital via Emergency Department**
patient to be reviewed by surgical SpR
IN HOURS 0830-1700 case may be discussed with Oncall Vascular Surgeon via switchboard
Tel: 023 92286000

OUT OF HOURS: Admission via ED

ACUTE CRITICAL ISCHAEMIA
Features include the following:
- Discoloration of toes (pale, dusky, black)
- Signs of necrosis
- Pain at rest (often at night)
- Cold
- Diminished / absent pulses

→ **Urgent Refer to Vascular Team**

Mr Pemberton, Mr Grewal or Miss Sonnenberg
Tel: 023 92286000 – oncall vasc surgeon
Fax:023 92286263

OUT OF HOURS: Admission via ED

HOT SWOLLEN NEUROPATHIC FOOT
(Suspect CHARCOT)
Features may include:
- Pain on walking when usually neuropathic
- Adequate blood supply
- Recent minor trauma

→ **Diabetes Multidisciplinary Foot Clinic QAH**
1. Avoid weight bearing
2. Refer to orthotics for offloading walker boot by email pho-tr.orthoticsenquiries@nhs.net
3. Refer by letter / fax to Diabetes MDT Foot Clinic details as above

Why refer to an MDT?
- The risk of a lower extremity amputation in a person with diabetes is more than 20 x that of a person without diabetes
- 95% of all non-traumatic amputations start with a foot ulcer

1

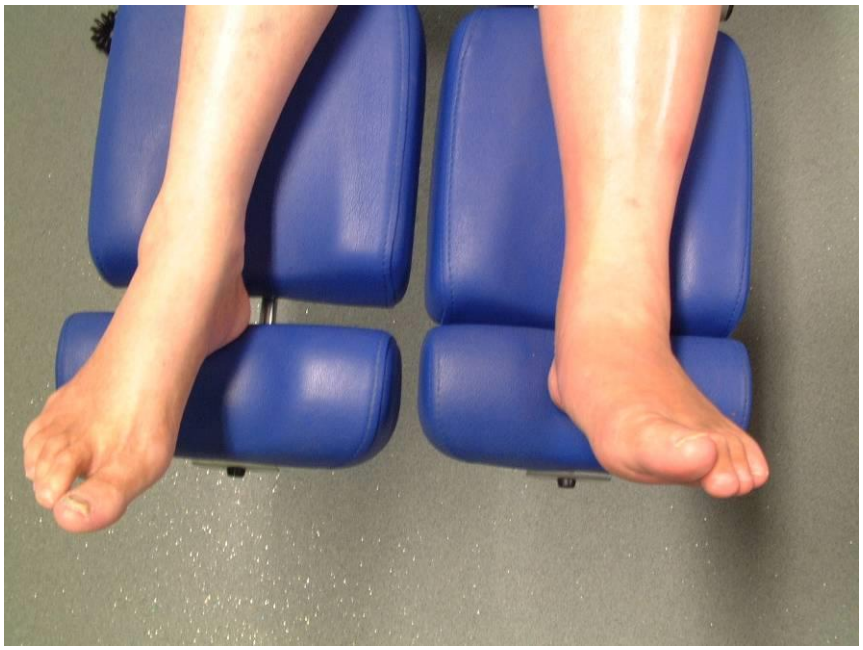
Charcot Alert

Hot, swollen, neuropathic, diabetic foot?

Think Charcot until proven otherwise. Advise to non-weight bear and refer urgently following the pathway.

Commonly mistaken for: cellulitis, acute gout, sprain/strain, DVT

An example of early Charcot:



Diabetic Foot Infection Management

Mild Infection: Presence of 2 or more clinical signs of inflammation but cellulitis/erythema extends no more than 2cm from the ulcer and infection is limited to superficial tissues

Prescribe Empirical Oral Antibiotics for 7-14 days:

First line: **Flucloxacillin** 500mg qds

If penicillin allergic **Clarithromycin** 500mg bd

Consider adding Metronidazole 400mg tds to cover anaerobes (e.g. if foul odour)

If known to be colonised with MRSA: Doxycycline 100mg bd

Review response. Modify regime if indicated by cultures and arrange onward referral

Moderate Infection: As above in a patient who is systemically well and metabolically stable but also has 1 or more of: cellulitis extending more than 2cm, lymphatic streaking, spread beneath the superficial fascia, deep tissue abscess, gangrene and involvement of muscle, tendon, joint or bone.

Requires referral for MDT assessment and consider IV antibiotics

Severe Infection: As above but patient is systemically unwell – admit to hospital for medical management

For advice on antibiotic therapy or culture results contact Microbiology at UHS

Advise patient to keep well hydrated and report any diarrhoeal symptoms