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Tissue Viability and Wound Management Policy and Guidance

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1. Purpose of this Document

This document outlines the policy of Agincare and guidance on tissue viability and wound management by means of initial assessment, plan of care including pressure relief, skin care and advice on selection and use of wound dressing products.

This policy acknowledges the physical, psychological and social impact of living with vulnerable skin or a wound both of which for the individual can cause pain, systemic illness, an increased debility and extended absence from normal activities.

This document provides guidance on a standardised approach to skin care, pressure relief and wound care within a holistic, person centred approach to care. Staff may encounter a wide range of wounds including acute wounds and long-term chronic wounds resulting from various causes including pressure ulcers, post-surgical wounds (where patients are discharged from hospital) and injury wounds such as skin lesions, tears and burns.

The policy is based on evidence linked guidance from NICE Quality Standard 89 https://www.nice.org.uk/guidance/qs89 and https://www.nice.org.uk/guidance/cg179

Agincare recognises the need to have a policy and evidence-based guidance to inform and guide staff in safe and effective skin care and wound management, and the importance of consistent individualised care in different care settings. This policy details the requirements of Registered Nurses in Agincare's Care Homes and tissue viability and wound site management guidance for all Agincare Care Staff who provide care and support to vulnerable adults.

2. Roles and Responsibilities

2.1 Operations Managers and Directors are responsible for ensuring this policy is complied with and for contribution to policy review and updates of best practice guidance through Agincare's Policy Review Group as well as being responsible for ensuring sufficient resources are available to enable all staff to be appropriately trained commensurate with their role in tissue viability and wound management.

2.2 Registered Managers are responsible for effective implementation of this policy within their registered location and that all staff engaged with people in receipt of wound care or with high risk of tissue vulnerability are aware of this policy and guidance. Registered Managers will identify training needs and ensure staff are appropriately trained in wound management and tissue viability and will record all training which will be incorporated into staff performance review using the process of assessing competency.

2.3 Registered Nurses will be competent in and responsible for the management of wounds and pressure area care relevant to their practice area in a Nursing Home. The qualified nurse has a duty to ensure that any care delegated (NMC Code Standard 11) to a Care Worker is in line with the training the care worker has received and the competencies the care worker has achieved and demonstrated. The Registered nurse will remain accountable for the care delivered and will continue to reassess wounds and skin integrity regularly as determined in the individual's wound care and tissue viability plans; Registered Nurses are also responsible in their area of practice to assess and monitor the tissue viability risks of people in their care and ensure delegated care and support (skin care, pressure relief including repositioning, application of prescribed creams etc) are effective.

2.4 Care Workers are responsible for the implementation of person-centred care plans and following clear instruction regard skin inspection, pressure area care and reporting mechanisms. Care Workers can contribute to wound management under the supervision of a Registered Healthcare Professional; on no account should they take responsibility for wound management unsupervised. In Agincare services the Care Worker must work in cooperation with the health care professional responsible for the wound management (i.e. district nurses). Care workers have a responsibility for the safe management of people's care with acknowledgement for any assessed risks regarding the likelihood of development of pressure wounds; the Braden Scale or Waterlow assessment should be used to predict the pressure ulcer risk to individuals and Care workers are responsible for acting in accordance with the plan of care based on the results. NB: Waterlow is more frequently used in care homes with nursing whilst Braden Scale is used more frequently in non-nursing care services

3. Definitions

a) **Skin:** The skin has three main functions: protection, regulation and sensation. Wounding affects all the functions of the skin. The skin is an organ of protection. The primary function of the skin is to act as a barrier. The skin provides protection from mechanical impacts and pressure, variations in temperature, micro-organisms, radiation and chemicals.
b) **Tissue viability:** Refers to the preservation of tissue cells
c) **Wound:** A wound is defined as a break in the epidermis or dermis (layers of the skin) related to accident/injury or to pathological changes within the skin or body.
d) **Injury:** Damage or harm, trauma/accident
e) **Pressure:** The physical force exerted on or against an object (the skin) by something in contact with it i.e. the weight of the body against a bed/chair, the weight of bed clothes on the body
f) **Shearing:** This may occur when the skin rubs against the bed sheets or other surfaces, e.g. when a person slips down the bed or is poorly moved (e.g. drag lift) up the bed or chair
g) **Friction:** a component of shearing. Areas caused by friction wounds are more susceptible to damage from pressure and shearing forces. Therefore, to prevent shearing and friction forces, appropriate moving and handling techniques and equipment (e.g. sliding sheets and hoists) should be used.
h) **Pressure area:** Any part of the body, usually bony protuberances (sacrum, shoulder blades, knees, elbows, ankles, heels) subject to chronic pressure from weight of the body without any relief.
i) **Pressure ulcer:** Sometimes called Pressure Sores, the correct term is ulcer. An area of skin that breaks down when constant pressure is placed against the skin, open wounds form whenever prolonged pressure is applied to skin covering bony parts of the body
j) **Moisture Lesion**: A moisture lesion is a reactive response of the skin to chronic exposure to urine and faecal matter. There is often a confusion in diagnosis between a moisture lesion and a pressure ulcer
k) **Abuse:** Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. In relation to this guidance, failure to recognize and treat wounds or pressure ulcers will be considered an act of neglect or omission.

4. Risk Assessment

This guidance relates to risk assessment by both Registered Nursing Staff and Care workers; (the Braden Scale or Waterlow Assessment can be used but whichever tool is chosen it must be used consistently) and to clinical wound assessment by Registered Nurses charged with responsibility for wound management.

Where end of life care is being provided, healing is not the primary aim. The goal is to ensure comfort, freedom from pain, itch, malodour and haemorrhage. A **Health and Welfare Assessment** must be carried out with all people using services at the start of their care package and care and support must be reviewed regularly at a frequency determined by the person's changing needs. This assessment requires basic initial information and requires that you assess any problems with their skin, the probable cause or diagnosis and what other health professionals are involved in treating this or helping them.

Completion of this assessment at this stage could cover any skin conditions from eczema or psoriasis to wounds or pressure ulcers; this form will also direct the assessor to consider the likelihood of risk of tissue breakdown based on a person's mobility, continence, diet etc. and lead them to decide whether the Braden Scale or Waterlow Assessment needs to be used for prediction of likelihood of tissue damage. In Care and Nursing Homes however, Agincare expects an assessment measurement on admission. (NB: The Waterlow assessment is generally used in Care Homes with Nursing and the Braden Scale in Residential homes however, whichever tool is used, it must be used consistently. Nourish electronic care management systems use both Waterlow and Braden

Where a person is unable to contribute to their assessment, you must use your judgement taking into account other aspects of the assessment such as poor mobility, continence, poor diet and hydration, over/under weight, diabetes etc all of which would increase a person's risk of developing pressure ulcers.

The most commonly recognised pressure ulcer indicator which you can see, with the person's consent at assessment, is that the skin becomes red and/or purple in colour known as erythema, this could be a normal reaction to pressure (reactive hyperaemia) or an abnormal one (non-blanching hyperaemia). This may not be noticed however until you are providing personal care. Whether noted at assessment, or review, or during personal care, any discolouration of the skin or broken area of skin (pressure related or not) must be recorded on a body map with as much detail as possible. This must be reviewed within three days and care and support plans adjusted accordingly.

To assess non-blanching hyperaemia:

- If there is an area of discolouration, apply light finger pressure to the area for 10 seconds.
- Release the pressure
- If the area is white and then returns to its original colour, the area has a good blood supply, it is healthy and the person has reactive hyperaemia
- If on release of pressure the area is the same colour as before pressure was applied, it is an indication of the beginning of pressure ulcer development and preventive strategies should be employed
- If there is an alteration in skin colour (red, purple or black), or increased heat or swelling, it may imply underlying tissue damage.

The Braden Scale and Waterlow assessments measure elements of risk each incurring a score, the total scores are added to give the overall score and the level of risk is identified at the bottom of the forms. There is some disparity between the two assessments tools so whichever tool is chosen must be continued to be used; do not change between assessments.

Whether being assessed in their own home or in nursing or residential care home the environment can be markedly different although the risk factors to the person are still the same. As well as the physical considerations such as good diet, plenty of fluids, frequent re-positioning etc, a good mattress, good quality armchair, pressure relieving cushions, and properly assessed and used moving and handling equipment are vital. Assessing consistently and reviewing at determined intervals can enable a person to receive seamless care if they move between their homes, hospital and care home as the score can transfer with them.

5. Skin Inspection

Whilst formal assessment gives a predictive indication of the risks of a person's tissue vulnerability, professional judgement must always be the first indicator of any risk. Skin inspection provides essential information for both assessment and prevention; regular assessment of the most vulnerable parts of the body will enable early detection of early pressure damage.

Skin inspection should occur regularly and the frequency determined in response to changes in the person's condition in relation to both deterioration and recovery; delivery of personal care is the ideal opportunity for care staff to undertake skin inspection and they should be vigilant to the following signs which may indicate early pressure ulcer development:

- Heels
- Sacrum
- Ischial tuberosities - one of two bony swellings found on the lower back part of the hip bone; when a person is in a seated position, his or her weight typically rests on these which are sometimes called the sitting bones
- Parts of the body that are affected by the wearing of anti-embolic stockings
- Trochanter – the part of the femur connecting to the hip bone
- Parts of the body where pressure, friction or shear is exerted in the course of a person's daily living activities e.g. on the hands of wheelchair users
- Part of the body where there are external forces exerted by equipment and clothing e.g. endotracheal tubes, catheters, shoes, elastic clothing
- Elbows
- Temporal region of the skull
- Shoulders
- Back of head
- Toes

Signs of tissue damage for care staff to look out for include:

- Persistent erythema
- Non-blanching hyperaemia
- Blisters
- Discolouration
- Localised heat
- Localised oedema
- Localised induration - Localized hardening of soft tissue of the body. The area becomes firm, but not as hard as bone

Any skin changes should be documented/recorded immediately including a detailed description of what is observed and any action taken. In nursing homes, photographs can be taken of any wound to be kept with the record; subsequent photographs will aid evidence of healing or deterioration. (In residential care and Home care, district nurses will photograph wounds)

6. Care Planning and Prevention

Agincare operates a person-centred approach to care planning and the process allows for the person to identify their desired outcomes. In relation to pressure relief, based on the risks identified in the Health and Wellbeing assessment and Braden Scale or Waterlow assessment, it is reasonable to think that any person at risk of developing pressure ulcers, or who has developed them would want the care outcome to be that they are comfortable, pain free, healing and free from infection.

If a person is at risk of developing pressure ulcers, the care plan should identify the personal care and continence care needs paying particular attention to care of the pressure site. Areas of pressure must not be 'rubbed' during the application of cream, must not be scrubbed whilst washing and drying and open wounds must be covered with a recommended or prescribed dressing (see below).

In care homes, the care plan directs staff to what is known as the **SSKIN** bundle, a five step model for pressure ulcer prevention; the principles apply in home care and live in care also where care is to be planned around:

- **Surface:** any surface that comes into contact with the skin such as the mattress, cushions, clothing, prosthetics, tubes
- **Skin inspection:** a check of all pressure areas and identifying areas at risk
- **Keep moving:** repositioning frequency, method i.e. independent, hoist, slide sheet etc bed/chair/wheelchair
- **Incontinence:** urine/faeces; hygiene, personal care, topical applications
- **Nutrition/hydration:** Diet, fluids, supplements required

The Braden Scale or Waterlow will identify the level of risk through a scoring system; the score will determine your plan for prevention of deterioration and promotion of healing.

Assessment scores must be reviewed when there is a change in clinical presentation or general health and wellbeing such as changes to the person's underlying condition, continence, mobility or nutrition. (NICE guidance 179)

*for care homes with nursing, Registered Nurses must still refer to GP services for prescription (creams/dressings etc if required).

All care plans for persons at risk of developing pressure ulcers should plan preventative care which should include:

- Equipment (pressure relieving mattress/cushions, bed cradle, etc.)
- Skin care including checks/observation of skin integrity
- Regular repositioning and appropriate moving and handling techniques
- Continence care
- Nutrition and hydration guidance
- Referral to other members of Multi-Disciplinary Team as appropriate (GP: Tissue Viability Nurse, OT, dietician, etc.)

Additionally, care plans should include for those:

At Risk/Moderate Risk:

- Specialist memory foam mattresses
- 100mm foam cushion
- No person should sit in a wheelchair without some form of specialist cushioning. If nothing else is available - use the person's own pillow. (Consider infection risk).

High Risk

- Alternating pressure overlays, mattresses and bed systems
- Specialist Gel and/or foam cushion

Very High Risk:

- Bed systems: Fluidised bed, low air loss and alternating pressure mattresses
- Specialised cushion, adjustable to individual person.

In home care where visits are made to people for short prescriptive periods of care and where those people are recognised as at risk, an initial assessment should lead to forward referral to the person's health professional team (GP or district nurse for instance). Care can then be planned around advice from the health professional to reduce risk and sometimes, the times of visits can be increased to help reduce the risk.

Repositioning

People who are at risk of pressure ulcer development should be supported to reposition and the frequency of this determined by the results of skin inspection and individual needs not by a ritualistic schedule. NICE QS 89 states 'For safety reasons, repositioning is recommended at least every 6 hours for adults at risk, and every 4 hours for adults at high risk' although many health professionals do not believe this to be sufficient and recommend 2 or 4 hourly for example; Agincare staff must follow the guidance of the person's health professional and in Care homes with nursing, nurses are to use their clinical judgement to determine repositioning frequency along with guidance from the Tissue Viability Nurse where appropriate.

Repositioning should take into consideration other aspects of an individual's condition, for example, medical condition, presence of contractures, comfort, overall plan of care and support surface.

Re-positioning should ensure that prolonged pressure on bony prominences is minimised; bony prominences should be kept from direct contact with one another to minimise friction and shear damage.

Moving and handling equipment should be used correctly in order to minimise shear and friction damage; all staff are trained in the proper use of equipment and of correct moving and handling techniques; after manoeuvring a person, slings should not be left underneath the person.

Where a person is cared for alternatively between their bed and a chair (including wheelchairs for transfer) staff must ensure any pressure relieving cushions required for their use are moved with them. People who are considered to be high or very high risk of developing pressure ulcers should sit out of bed for no longer than two hours. (Royal College of Nursing Clinical Practice Guidelines- Pressure ulcer risk assessment and prevention' 2001; reviewed 2017)

A written/recorded re-positioning schedule agreed with the individual, should be established for each person 'at risk' as part of the care plan and a position/observation chart should be kept and maintained.

7. Essentials of Care

Nutritional status, continence management and hygiene are essential aspects of care. Their association with pressure ulcer risk assessment and prevention is well documented and are key to raising the standards of preventative care

- Nutrition

Malnutrition is frequently cited as a risk factor for the presence, development and non-healing of pressure ulcers. Nutritional status influences the integrity of the skin and support structures, and a lack of vitamins and trace elements may predispose the patient to increased risk of pressure damage.

Best practice entails monitoring the nutritional status of people as part of a holistic assessment procedure and as an ongoing process throughout their care. Agincare's Health and welfare assessment directs the assessor to consider the person's nutritional status including any specific dietary requirements and, where a need is identified, carrying out nutritional screening using the MUST tool. Where a person is considered at risk of developing pressure ulcers or of vulnerable skin, Agincare always expects that the MUST screening tool is used to evidence good practice regarding a person's nutritional status in relation to healthy skin and tissue viability.

- Continence management

Incontinence can increase the risk of developing pressure ulcers as the key factor is moisture to the skin, which puts it at greater risk from maceration (softening and breaking down of skin resulting from prolonged exposure to moisture), friction and shearing. As such, effective management of incontinence is an essential part of skin care and fundamental to maintaining a person's dignity and comfort.
Where the source of moisture cannot be controlled, the use of moisture-absorbing or continence aids could be considered. The use of such aids should not interfere with any pressure redistributing surface an individual may be placed on. Referral to a continence advisor should also be considered on an individual basis. (See Agincare's Continence Management Policy and Guidance).

- Hygiene

A person's skin may be exposed to a variety of moist substances – urine, faeces, perspiration and wound drainage – which may make it more susceptible to injury. Skin cleansing should occur where possible at the time of soiling; mild soaps should be used and warm (rather than hot) water to minimise irritation and drying; and moisturisers should be applied to areas of dry skin. Skin rubbing and massage, particularly over bony prominences should be avoided.

8. Review

The purpose of the review at the specified times enables you to re-plan the care as required so for instance where a person is developing red, pressure points that may be at risk of breaking down, you can plan around providing more support, using different pressure relieving equipment and/or refer back to the person's health care professional with your concerns. Often in home care, this role will already have been taken on by the district nursing service so care workers have to simply follow the plan that is in place and any changes should be communicated from the health care professionals.

Where a person has developed a pressure ulcer and has a broken area of skin, medical attention must be sought and the following guidelines followed. Any intervention required by care workers must be included in the care plan.

For details on reviewing care see Agincare's Person Centred Outcome Based Care Planning guidance

9. Wound assessment

Registered Nurses in the process of providing wound care should continuously assess the wound.

Grading of pressure damage for documentation and monitoring will be according to scale shown below; all pressure sores should be graded.

Unrelieved pressure on a specific area of the body (e.g. the heels, the hips) will affect the blood supply to the skin and underlying tissues causing that area to become damaged. Mild tissue damage results in skin discoloration, giving a brown or purple appearance. This may look darker if the skin is very fair.

More severe pressure ulcers can expose muscle and even bone. The area around the dead tissue will look red and inflamed and may become infected.

For consistency, it is recommended that the EPUAP (2019) classification system is used to identify pressure damage.

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epiboly (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

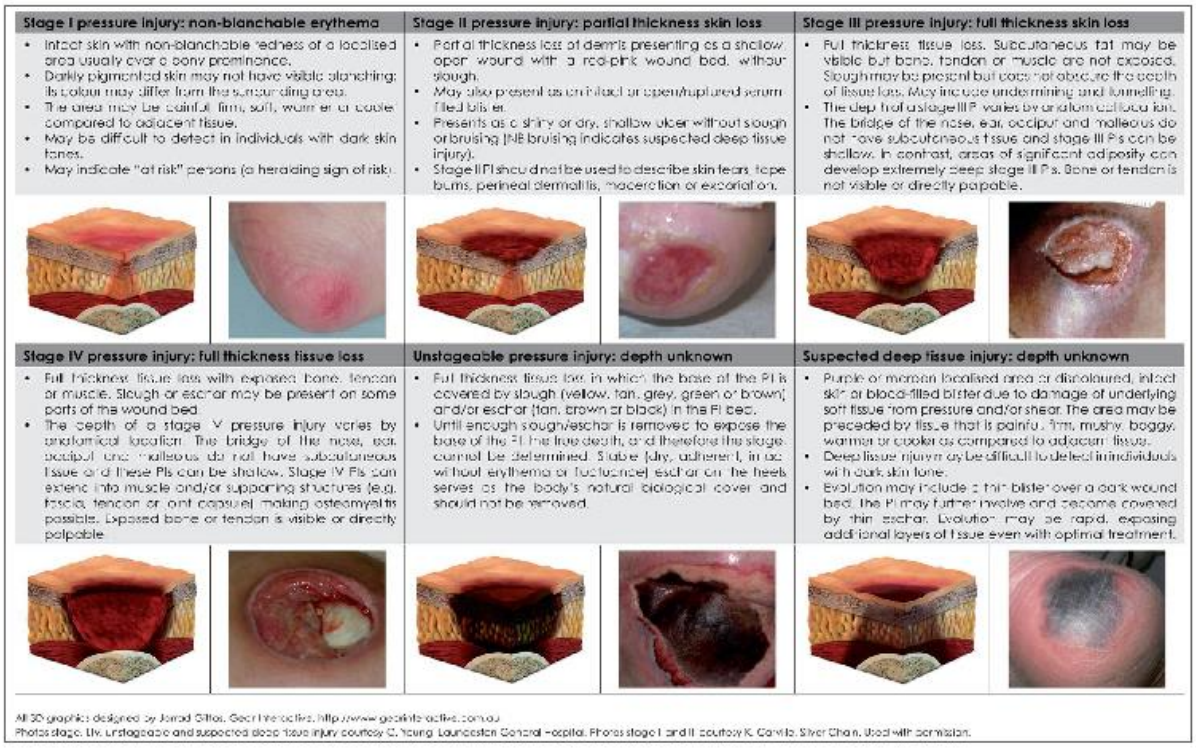
Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

The images below can be seen with more clarity on share-point here called pressure injury classification system, it is recommended this pictorial guide is printed and available in clinical rooms for Agincare nurses in Care Homes with nursing.

Pressure injury classification system



Based on National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP). Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2009, Washington DC: NPUAP cited in Australian Wound Management Association. Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury. Abridged Version, AWMA; March 2012. Published by Cambridge Publishing, Osborne Park, WA.

When caring for individuals who are at risk of pressure ulcer development, it is essential that skin assessments are carried out regularly to identify any change in skin condition which could indicate pressure damage. The most commonly recognised pressure ulcer indicator is that the skin becomes red and/or purple in colour — known as erythema — but this could be a normal reaction to pressure (reactive hyperaemia) or an abnormal one (non-blanching hyperaemia). See **Assessment** below.

The site(s) of all pressure damage will be documented using the Body Map and Wound Assessment Chart. The size and shape of all areas of pressure damage will be recorded. Where pressure damage is particularly irregular, photograph the wound using a measure/tape on the skin to show size of wound (with consent); if photographs are not to be used, measuring and sketching the area in the care record should be considered. Information to be recorded includes:

- Type of wound
- Location of wound
- Stage of healing – using recognised scale e.g. pressure ulcer category 1– 4, or ungradable (more than 4)
- Wound dimensions – length, width, depth, position/extent of sinuses, undermining of surrounding skin, using one of the following methods:
  - Measurement should be carried out at least monthly
  - Cover the wound with a sterile transparent film and measure the maximum length and width
  - Use a disposal paper tape to record maximum length and width

- Use a tracing chart to draw and record the entire wound area
- Use a sterile measuring probe to measure depth and extent of undermining
- Photography is a useful way of measuring when incorporating a rule or tape into the photograph so scale can be provided and also evidences healing

All visible areas should be re-assessed at each change of the patient's position; areas covered by dressings will be reassessed at each dressing change. Any improvement or deterioration of the site(s) of pressure damage should be documented.

10. Dressing Assessment (Nursing practice only; care staff in residential care homes or home care must not become involved in wound care/dressing and must refer to the district nurse or tissue viability nurse via the person's GP)

The selected product (section 14) should be altered to meet the changing nature of the pressure ulcer/wound, but it should be given a minimum of 5 to 7 days to take effect unless there is an adverse reaction.
Dressings should be changed in accordance with the manufacturer's instructions and the protocol for the type of wound, and to meet the requirements of the individual patient. The number of dressings inserted into the wound should be documented in the care plan. When dressing a deep wound, ensure all dressings are removable, tied together or use an alternative longer product.

11. Fluid Filled Blisters

Fluid filled blisters of lower legs associated with cellulitis - protect the blister with jelonet, if they are distended, aspirate the fluid using a fine needle and syringe to prevent the tissue tearing, then protect with jelonet. (Nursing practice only)

12. Incident Reports

If a person develops pressure damage of stage 3 or above, then an incident report should be made and a safeguarding alert made to the local authority; CQC must be notified of any safeguarding alert. If a patient is transferred to your care with existing pressure damage stage 3 or above, then an alert must be made to the local authority detailing the person's responsible for the last care provided to the patient. CQC also require notification of any 'serious injury' to a person using the service, this definition includes any pressure ulcer of stage 3 or above.

As with any incident reported, if a person develops a pressure ulcer at stage 3 or above whilst receiving a care service from Agincare, the manager could use the root cause analysis form with action plan attached to identify the causal factors leading to the breakdown in order to plan care more effectively and/or manage staff responsible for the care process; this might be as part of the manager's accident/incident audit and/or tissue viability audit

13.Treatment

13.1 Selecting Products

Registered Nurses are to use their clinical judgement to determine the nature of the dressing to be used and request a prescription from the patients GP for supplies of the dressing and wound management products. Where a deep wound of stage 3 or above requires treatment, Agincare's Registered Nurses should ask the advice of the district nursing team or the tissue viability nurse specialist from the local CCG or NHS Trust. As a guide, the following dressing types can be requested:

- **Non or Low Adherent Dressing** Suitable for dry wounds or lightly exuding wounds
- **Semi-Permeable Films -** Suitable for relatively shallow wounds e.g. dermabrasion or partial thickness burn or secondary dressing to e.g. Kaltostat or Intrasite Gel
- **Hydrogels -** Suitable for de-sloughing and for light to medium exuding wounds, but not if anaerobic infection is present
- **Hydrocolloids -** Semi Permeable**;** suitable for de-sloughing and for light to medium exuding wounds, but not if anaerobic infection is present
- **Alginate Dressings** Suitable for exuding wounds only - Sorbsan (Aspen)
- **Polyurethane Foam Dressings** suitable for exuding wounds
- **Silicone Adhesive** - Suitable for fragile skin
- **Odour Absorbing Dressing**
- **Paste Bandages -** Suitable for treating skin conditions associated with leg ulcers e.g. eczema, inflammation
- **Paraffin Tulle (Non-Medicated) Dressing** Suitable for clean, superficial wounds e.g. dermabrasion or partial thickness burns, skin tears

13.2 Wound Management

Where an assessment identifies a person at risk or where skin damage occurs, the person's GP should be contacted and a professional health care assessment made to commence early treatment, this may include prescribed dressings, antibiotics, catheterisation, prescribed creams or other applications, prescribed pain relief, referral to a dietician or tissue viability specialist or even hospitalisation. In Care Homes with nursing, the registered Nurses can make this assessment and request of the GP the required treatment based on their observations.

Following any such referral and medical intervention, where Agincare is caring for a person with a pressure ulcer, instruction for management of the wound must be followed and that instruction transferred to the care plan.

The nurse (district nurse in Home Care & Care Homes without nursing) will maintain the responsibility for changing the dressing and monitoring the wound healing. In Agincare Home Care and Care Homes without nursing, Care Workers must ask the district nurse for clear instruction about managing the wound site between district

nurse visits which could be daily, every other day or even twice weekly. The Care Worker is responsible for monitoring the dressing site so for example:

When personal care is provided including continence care and moving and handling, care workers should observe that the dressing is intact; if it has become dislodged, damaged or soiled, the nurse should be called to re-dress unless clear instruction has been provided.

Whether a care plan identifies that the person likes to have a bath or shower regularly, care workers must seek advice from the nurse about whether waterproof wound/dressing protectors can be used or whether until healed, the person should be advised not to fully bathe – the care plan must be changed to reflect this.

14.3 When a care worker can dress a wound

Anybody living in the community whether it is their own home or a care home has the right to the services of their GP and as such remains a patient of their GP. The GP therefore has responsibility for a person's health care and the GP's surgery will often have a team of health professionals.

Where a GP or district nurse delegates the care of their patient to a care worker for a specific task they must be confident the care worker is able to undertake that task and as such will train or instruct them for specific interventions.

A care worker may be instructed by a district nurse to apply wound care in emergency situations for example, where a dressing becomes damaged, falls off or becomes soiled. In such cases, the district nurse must leave written instructions on how to clean and dress the wound until her/his next visit; it is the district nurse's responsibility to provide the materials needed such as dry, sterile dressing or to leave clear instruction whether the wound can be left uncovered and for how long.

14. Dressing Procedures

14.1 Care Worker Procedure

If you are permitted (trained) to manage such a situation, you must observe the following:

Always follow infection control procedures, wash hands, and wear clean gloves and apron.

- Prepare the area making sure you have everything you need to hand
- Explain to the person what you are doing and obtain their consent, if they are prescribed PRN pain relief, ask them if they require it (check the PRN care plan first)
- Make a note of any possible infection i.e. increased discharge (blood or other fluid) or pus coming out of the wound. The discharge or pus may have an odd colour or a bad smell, increased swelling that looks red, feels painful, and feels warm to the touch; record what you see.

- Select the wound-dressing product advised by the tissue viability/district nurse
- Expose wounds for the minimum time to avoid contamination and maintain temperature.
- Carry out the procedure, following care plan or protocol from tissue viability/district nurse.
- Ensure correct disposal of any waste. Make accurate records of wound condition, procedure used and products used and inform the medical practitioner responsible for the wound care.

15.2 Registered Nurse Procedure

Registered Nurses in Care Homes with nursing must carry out the following procedure for wound care with the added information about the dressing type, frequency of changes from the wound assessment and chart and the manufacturer's instructions for the products used.

1. Identify the prescribed treatment and gather equipment:
    - Dressing pack/appropriate dressings
    - Wound cleaning/irrigation solutions
    - Hypoallergenic tape if required
    - Hand hygiene preparation
    - Any other materials required by the nature of the dressing

2. Explain the procedure to the patient; ensure door is closed/patient's privacy is protected
3. Wash and sanitise hands
4. Open sterile dressing pack and check contents
5. Where appropriate swab along 'tear area' of solution sachet; tear open sachet and pour into gallipot or tray (in dressing pack)
6. Put on gloves
7. Using bag in dressing pack; place this over hand to remove used/current dressing and inverting the bag so the dressing is inside the 'dirty' bag
8. Remove gloves
9. Assesses the wound healing with reference to volume, granulation and epithelialisation and signs of infection
10. Photographs the wound if required
11. Put on clean gloves
12. Gently clean the wound with a gloved hand using normal saline unless another solution is prescribed
13. Apply the prescribed/appropriate dressing; secure with hypoallergenic tape if required
14. Remove gloves
15. Ensure patient is comfortable and answer any questions
16. Dispose correctly of all clinical and non-clinical waste
17. Wash and sanitise hands
18. Correctly record the procedure and ensure the photograph is printed and attached to the file
19. Update Wound Care Plan on Nourish

Contractual impact

Agincare's policies and procedures are to be followed in conjunction with the requirements of the contracts under which you provide services. There may be occasions where the contract contains requirements which appear to contradict or be in addition to, standard Company policy. In these instances, you are to:

- If the requirement is in addition to standard Company policy - adhere to the terms and conditions of your contracts
- If the requirement is lesser than standard Company Policy - follow Company policies and procedures

If you require any further clarification please contact the Commercial Department for guidance.

Training

The management team of Agincare believe that, in order to provide a quality service, Agincare requires high quality staff who are suitably trained, supervised and supported.

Agincare policies and procedures are referenced in the induction programme and are available for staff in their work place (Care Home or Branch office). Staff will be informed of how to access all policies, procedures and related documentation and of how to seek further advice regarding Agincare's agreed ways of working. Staff should be provided with regular updates to encourage continuous improvement and include latest good practice.

Agincare is committed to provide an ongoing programme of support for all staff. This includes supervisions, appraisals and training which will be in line with company policy, contractual obligations and current best practice

REVIEW OF THIS POLICY

Review of this document is recorded on the controlled index and reviewed annually as part of the management review process.

Name: Policy Review Group **Date**: February 2023