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
Document Type	X Policy
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Amendments Summary:

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date
1	Version 2	28	Definitions	
2		7	Wound Infection Checklist	
3		9	Community Tissue Viability Specialist Nurse	
4		10	References	

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
1	01/05/2019	Monique Rosell	Policy Steering Group, Assurance Committee	Complete rewrite
2	May 2022	Monique Rosell and Samantha Haynes	Policy Steering Group, Clinical Executive Group	Changes outlined above

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 ensure that staff understand and can 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' who's 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 providing 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 locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers and Patient Safety Partners), bank staff, 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 external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Definitions can be found in Appendix J.

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 or advanced techniques

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 a lower limb assessment if appropriate.

3.2.7 Assessors should refer to the Wound Infection Checklist 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 Methicillin Resistant Staphylococcus Aureus (MRSA) must be performed in accordance with the Trust Policy for the Management of Methicillin 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 Wound Infection Checklist and 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 formulary**

3.4.1 The local Wound 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 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 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** including the Community Tissue Viability Nurse Specialist 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 with Solent NHS Trust.

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 regarding 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 evidence 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 (Steps 1 and2 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 framework, 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

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• 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.

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

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http://www.nice.org.uk/nicemedia/pdf/CG74FullGuideline.pdf

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• 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
Policy for Aseptic technique and Aseptic Non-Touch Technique
MRSA Policy
Safeguarding Children, Young People and Adults at Risk Policy
Incident Reporting, Investigation and Learning Policy

The Deprivation of Liberty Safeguards and The Mental Capacity Act 2005 Policy
Nutrition and Hydration Policy
Consent to Examination and Treatment Policy
Leg Ulcer SOP
Pressure Ulcer SOP
Management of Clinical Audio-visual Records Policy

Appendix: A Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

You can find further information via the e-learning module here

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims		
Service Line / Department	Adults Southampton/Portsmouth Community Nursing, CAT and Specialist services	
Title of Change:	Review of policy	
What are you completing this EIA for? (Please select):	Other	*Standard operating procedure*
What are the main aims / objectives of the changes	To Ensure that the policy provides the most up to date best practice on the care of patients with tissue viability needs	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			NA	

Gender reassignment			NA	
Disability			NA	
Age			NA	
Sexual Orientation			NA	
Pregnancy and maternity			NA	
Marriage and civil partnership			NA	
Religion or belief			NA	
Race			NA	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	Yes	This was developed with Tissue Viability Podiatry and Clinical Advisory team
Have you taken into consideration any regulations, professional standards?	Yes	Consideration was taken on all the regulations and professional standards for staff employed by Solent NHS trust.

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	☐	☐	■
What action needs to be taken to reduce or eliminate the negative impact?	Adherence to the policy and procedures		
Who will be responsible for monitoring and regular review of the document / policy?	Tissue Viability Steering Group		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	*Monique Rosell*	*Date:*	*18/07/2022*

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.

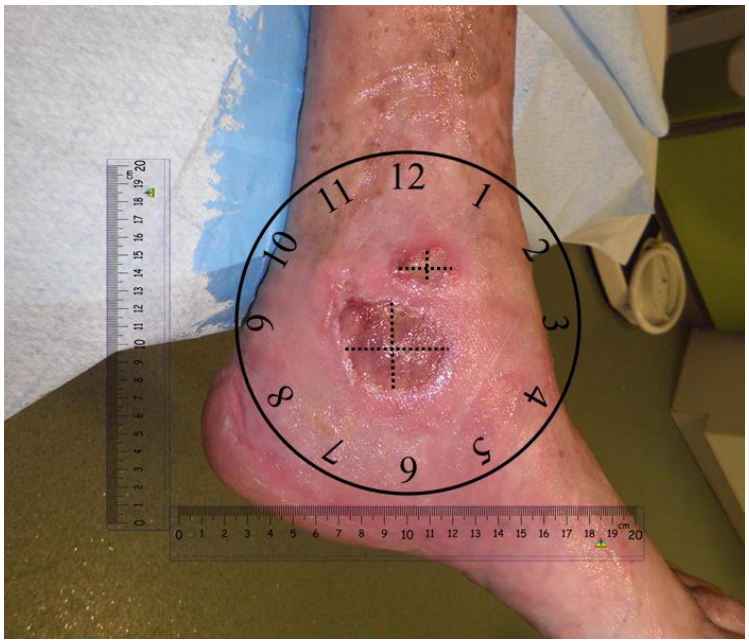
When measuring width:

- 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

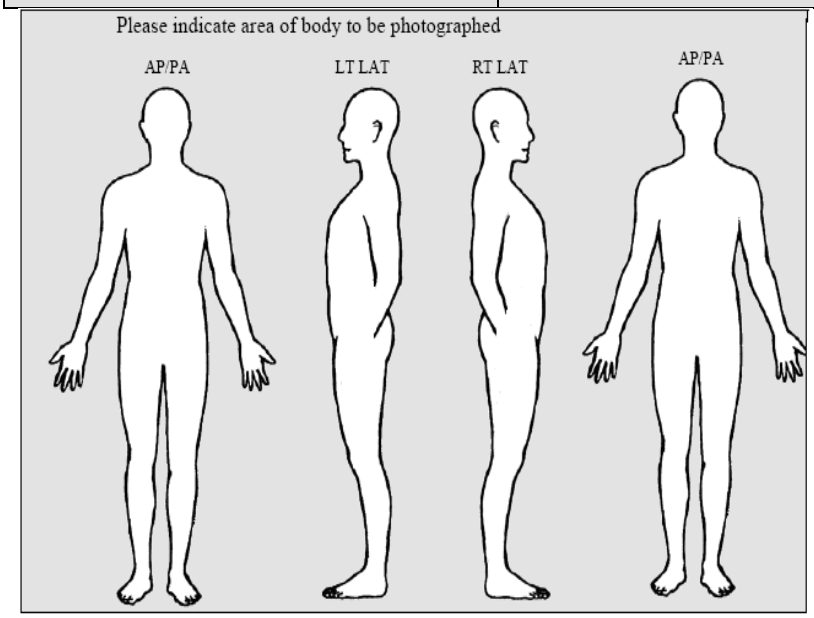


Appendix C: Patient Consent Form for Wound Photographs

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:**



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……
……..

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

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: ☐ Category: ☐ 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: ☐ Category: ☐ 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

Solent NHS Trust

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 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

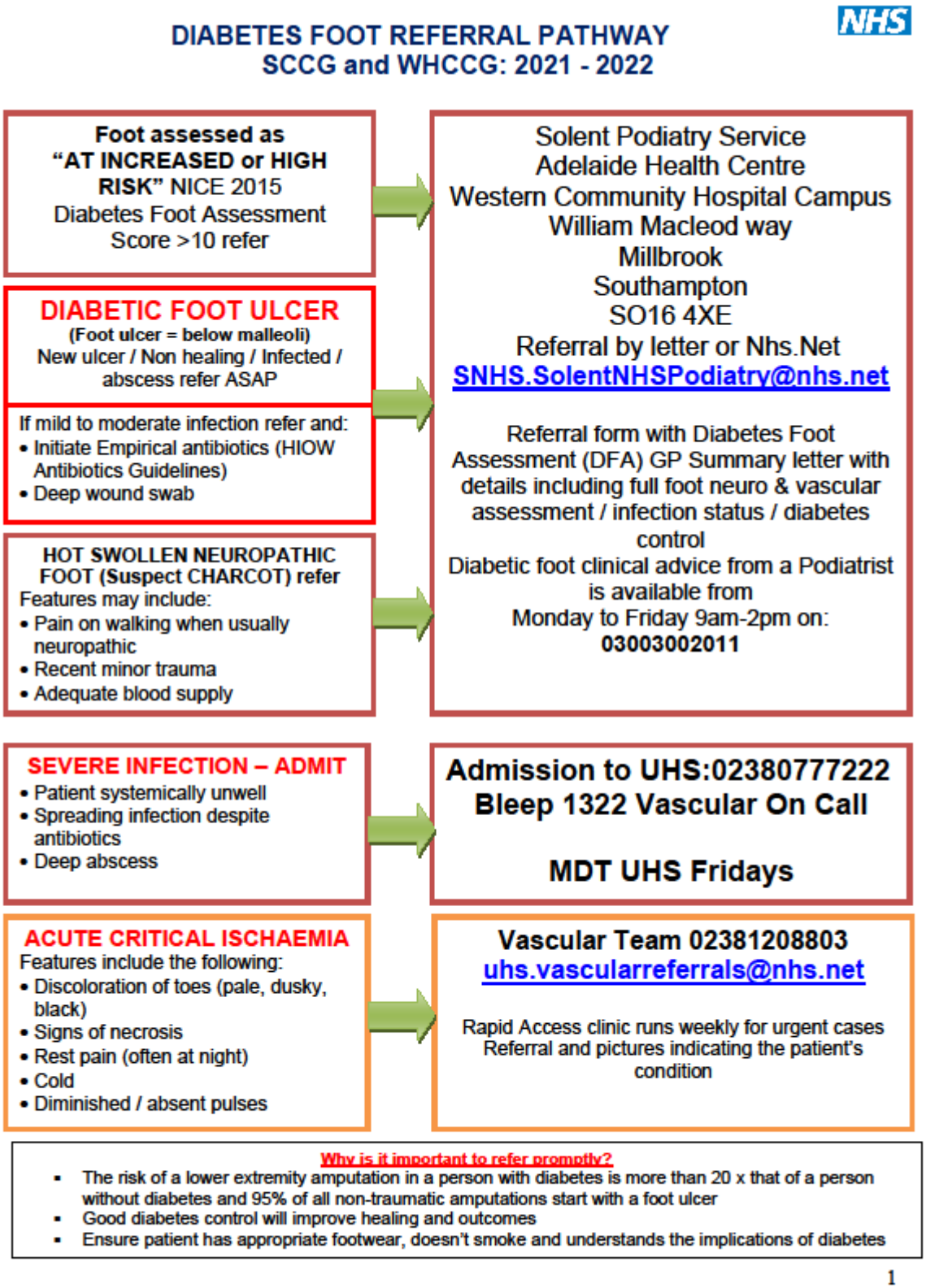
- Size of the ulceration
- Duration
- Infection status / antibiotic therapy
- Treatment to date
- Any addition supporting information

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 do not delay in referring foot ulceration to Podiatry. If in doubt, refer in for Podiatry opinion.

Appendix I


DIABETES FOOT REFERRAL PATHWAY
SCCG and WHCCG: 2021 - 2022
NHS
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 Nhs.Net
SNHS.SolentNHSPodiatry@nhs.net
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:02380777222
Bleep 1322 Vascular On Call
MDT UHS Fridays
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
uhs.vascularreferrals@nhs.net
Rapid Access clinic runs weekly for urgent cases
Referral and pictures indicating the patient's condition
Why is it important to refer promptly?
▪ 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
1

DIABETES FOOT REFERRAL PATHWAY

Portsmouth, Fareham & Gosport, & East Hampshire Revised Dec 2020

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

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 phone/ email as indicated by patients' condition Diabetes Foot Clinic, Queen Alexandra Hospital
Email: pho-tr.diabetesendocrinology@nhs.net
Tel: 023 92286260

Referral form on PIP or by GP Summary + letter detailing foot neuro/vasc/infection status and **wound photograph**

SEVERE INFECTION
- Patient systemically unwell &/or
- Spreading infection (moderate/severe) despite antibiotics &/or
- Deep abscess

→

Admit to Queen Alexandra Hospital via Emergency Department
patient to be reviewed by surgical SpR

Podiatry admit via **AMU admissions** and, where possible, discuss in advance with
On call Vascular Surgeon **In hours** 0830-1700 via switchboard **Tel: 023 92286000**
OUT OF HOURS: Admission via ED

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

Discuss with On Call Vasc Surgeon
Tel: 023 92286000
Email - pho-tr.qahvascular@nhs.net

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

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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

2

Appendix J

Definitions:

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.

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.

Chronic wounds indicate a wound that will not heal, that will persist, and may even be viewed as incurable (Murphy et al. 2022).

Hard-to-heal wound are wounds that presents with factors that impede achievement of healing. These factors may present at any time, and hard-to-heal wounds may be defined as such from the start—for example, due to underlying factors or difficult anatomical location. They may also be judged as hard-to-heal after failure to respond to evidence-based standard of care (Murphy et al. 2022).

Contamination - a stage in which there is presence within the wound of microorganisms that are presumed not to be proliferating. No significant host reaction is evoked and no delay in wound healing is clinically observed (International Wound Infection Institute 2022).

Colonised - a stage in which the presence of microorganisms within the wound that are presumed to be undergoing limited proliferation. In a colonised wound, no significant host reaction is evoked, and no delay in wound healing is clinically observed (International Wound Infection Institute 2022).

Local Infection - a stage of infection in which there is presence and proliferation of microorganisms within the wound that evoke a response from the host, often including a delay in wound healing. Local infection is contained within the wound and the immediate peri wound region (less than 2cm). Local infection often presents as covert (subtle) signs and symptoms that may not be immediately recognised as a sign of infection including hyper granulation, friable granulation, epithelial bridging and pocketing in the granulation tissue, increased exudate and delayed wound healing beyond expectations. As local infection progresses, classic cardinal (overt) signs of infection become evident, including erythema, local warmth, swelling, purulent discharge, wound breakdown and enlargement, new and increased pain, increasing malodour (International Wound Infection Institute 2022).

Spreading infection- the stage of infection in which there is invasion of the surrounding tissue by infective microorganisms that have spread from a wound. Microorganisms proliferate and spread to a degree that signs and symptoms extend beyond the wound border. Signs and symptoms include extending induration, lymphangitis (swelling of lymph glands), crepitus, wound breakdown/dehiscence with or without satellite lesions, spreading inflammation or erythema greater than 2cm from the wound edge (International Wound Infection Institute 2022).

Systemic Infection - the stage of infection in which microorganisms spread throughout the body via the vascular or lymphatic systems, evoking a host response that affects the body as a whole. In the context of wound infection, microorganisms spread from a locally infected wound. Systemic inflammatory response can also be triggered by a local wound infection through other pathways, for example release of toxins or a dysregulated immune system. Signs and symptoms include malaise, lethargy or nonspecific general deterioration, loss of appetite, fever/pyrexia, severe sepsis, septic shock, organ failure, death. (International Wound Infection Institute 2022).

Biofilm - Biofilms are aggregate microorganisms that have unique characteristics and enhanced tolerance to treatment and the host defences. Wound biofilms are associated with impaired wound healing and signs and symptoms of chronic inflammation (International Wound Infection Institute 2022).

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

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

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)

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)

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

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.

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)

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)