A

CHS4.2012 Undertake tissue viability risk assessment for individuals

OVERVIEW

This standard covers undertaking risk assessment in relation to pressure area care and the risk of skin breakdown. This assessment will take place across a variety of health and social care settings, throughout hospitals, including operating departments, hospices, nursing and residential homes, day centres, and individual's own homes. Risk assessment will include the use of different assessment tools selected for use to fit the individual and the environment. The assessment could be undertaken by a variety of staff within the varied care settings and is an ongoing process demanding constant review and evaluation. Users of this standard will need to ensure that practice reflects up to date information and policies. Version No 2

KNOWLEDGE AND UNDERSTANDING

You need to know and understand:

1. the current European and National legislation, national guidelines, organisational policies and protocols in accordance with any Clinical/Corporate Governance which affect your work practice in relation to undertaking tissue viability risk assessment for individuals
2. your responsibilities and accountability in relation to the current European and National legislation, national guidelines and local policies and protocols and any Clinical/Corporate Governance
3. the duty to report any acts or omissions in care that could be detrimental to yourself, other individuals or your employer
4. the importance of working within your own sphere of competence when undertaking assessment of risk of skin breakdown and seeking advice when faced with situations outside your sphere of competence
5. the importance of applying standard precautions to undertaking the assessment of skin breakdown and the potential consequences of poor practice
6. relevant research that has been undertaken in respect of risk assessment for pressure area care
7. how you might involve the individual and their carers
8. the risk assessment in relation to the holistic care of individuals
9. other health and social care staff who might be involved in the assessment of risk in the context of this competence
10. what you will look for when you assess the skin

11. when initial assessment should take place and why
12. the frequency of review and re-assessment
13. the degree of help needed by the individual
14. the anatomy and physiology of the healthy skin
15. the changes that occur when damage caused by pressure develops
16. what is meant by “shearing forces”
17. the pre-disposing factors to pressure sore development
18. the sites where pressure damage may occur
19. the assessment tools available for use in the assessment of risk of pressure sore formation
20. safe handling techniques
21. the importance of sharing your findings with other care staff and the individual concerned
22. the importance of accurately reporting and recording required information related to pressure area care and risk assessment
23. the information which should be recorded in relation to pressure area care and risk assessment
24. the types of change in patients' condition which should be reported and/or recorded
25. the importance of immediately reporting any issues which are outside your own sphere of competence without delay to the relevant member of staff

PERFORMANCE CRITERIA

You must be able to:

1. apply standard precautions for infection prevention and control and other appropriate health and safety measures
2. identify individuals in your care environment/case load who may be at risk of impaired tissue viability and skin breakdown
3. identify any pre-disposing factors which might exacerbate risk
4. identify any external factors which you should consider in your assessment
5. undertake risk assessment within an appropriate time scale after admission/referral of the individual to the care environment in which you work
6. work within your own sphere of competence and involve the individual or other carers in the assessment as appropriate, referring to others when the assessment is outside of your remit
7. collect the relevant documentation, including agreed assessment tool for use before starting the assessment
8. involve the individual concerned asking them to assess their risk where possible and appropriate, communicating to them in a manner which they understand and can respond to
9. obtain the individual's permission before undertaking the assessment
10. assess the individual's risk of tissue breakdown using the criteria laid down in the assessment tool you are using
11. inspect the general condition of the individuals skin, identifying risk factors, using safe handling techniques when assisting the individual to move during the assessment
12. inspect specific areas of skin for pressure or risk of pressure, identifying risk against the tool and “scoring” the risk of pressure area damage

13. document all findings and/or pass on your findings to others involved in the care of the individual, including the individual themselves and incorporate the risk assessment into the overall plan of care for that individual
14. agreed, in consultation with others, how often the risk assessment should be reviewed and record the frequency of assessment in the care plan and other relevant records
15. undertake the review as necessary using the criteria involved in the initial assessment if appropriate
16. identify when the current assessment tool, or frequency of review are no longer appropriate due to changes in the individuals condition or environment
17. where applicable, record and report your findings to the appropriate person

ADDITIONAL INFORMATION

This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):Dimension: HWB2 Assessment and care planning to meet people's health and wellbeing needs