

Understand the need for tissue viability risk essay sample



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1. 1 Describe the anatomy and physiology of healthy skin

The skin is an outside covering for the human body. It is an organ just like the heart, lung and liver. It provides layer of protection and plays a vital role in maintaining body temperature and by making you aware of external stimuli through the sense of touch. The skin has two layers, the epidermis and the dermis, although not part of the skin, the hypodermis lies beneath the dermis. When the skin is about to be damaged it shows signs of redness and warmth on the area. Skin gives protection against biological invasion, physical damage and ultra violet radiation. It also provides us sensation for touch, heat and pain. Thermoregulation is supported through sweating and regulation of blood flow through the skin and synthesis of Vitamin D occurs. As the body gets older, poor nutrition or disability occurs, the skin is under pressure of getting damage through pressure sores. Factors such as shearing, friction and compression are the major cause of a person to have developed a pressure sore.

1. 2 Describe the changes that occur when damage caused by pressure develops. Discoloration of intact skin not affected by light finger pressure (non blanching erythema) this may be difficult to identify in darkly pigmented skin. Full thickness skin loss involving damage of subcutaneous tissue but not extending to the underlying fascia. The pressure ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. Full thickness skin loss with extensive destruction and necrosis extending to underlying tissue.

1. 3 Explain when an initial tissue viability risk assessment may be required.

This may be required when a patient is introduced to a new care setting. And this should be done as soon as possible as there is always a risk of pressure sores developing. Also a person's condition can change which also means a change in their pressure ulcer risk. If someone is bed bound, incontinent, has limited mobility, is malnourished or severely ill then these people would be more at risk. We would carry out a tissue viability risk assessment on each individual and do a water low chart. The risk would then be identified and marked. Someone at high risk would be prioritised and would be provided with pressure relieving mattresses and cushions. People at medium risk would be on an air mattress if possible or vigilant care to the pressure areas would be highlighted as well as pressure prevention creams that would be used.

It is good practise to re-assess a person's risk of developing pressure ulcer's or sores when there is a change in their condition. In order to identify quickly a change in a person's pressure ulcer risk, undertaking of a person's pressure ulcer risk ought to be done on a daily basis. This is important in order to keep the person's pressure areas monitored and maintained. This will also give us an idea if the person's pressure areas have improved or got worse. And this will tell us if additional intervention and prevention needs to be done. If the problem persists then we would also refer the person to the tissue viability nurse who are professionally trained in this area.

1. 4 Describe what to look for when assessing the skin.

When assessing the skin for pressure ulcers/sores I would need to assess the skin for redness, warmth, hardness or swelling and any signs of infection.

I would also assess the person's pain as if there was a sore/ulcer, they could
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be in some degree of pain and discomfort. I would have the person rate his pain on a scale of 0 to 10 with 0 representing no pain and 10 representing severe pain. If I did find a sore, I would measure it and note the colour of it as this can tell you how severe the sore is, what type of sore is and how to treat it. In some cases, depending on how severe the sore is I would then refer the individual to a Tissue Viability nurse.

1. 5 Describe pre-disposing factors which may exacerbate risk of impaired tissue viability and skin breakdown. Age, continence, skin hygiene, mobility, nutrition, pressure. Incontinent problems can be damaging to the skin. Washing with soap can irritate the skin especially for those with sensitive skin.

1. 6 Describe external factors, including shearing forces, which may exacerbate risk of impaired tissue viability and skin breakdown

Moving and handling, bedding, clothing. Dressings, anything that can cause pressure, shearing and friction.

Understand when the risk assessment should be reviewed.

4. 1 Explain why the tissue viability risk-assessment should be regularly reviewed and repeated. This should be regularly reviewed and repeated because pressure sores can develop quickly. Also a person's condition can change which may mean a change in their pressure ulcer risk. So it is important to review and repeat an individual's risk assessment when there is a change in their condition in order to identify quickly any underlying risks on a daily basis.

4. 2 Explain why the tissue viability risk-assessment tool, or the current review cycle may no longer be appropriate due to changes in the individual's condition or environment.

Change to health/mobility. Prolonged bed rest. (The assessment may have initially been done when the individual was mobile) So a new assessment may need to be done as the individual may be at a higher risk now. Or rehabilitation that improves mobility. Or even worsening of the individual's condition/ example... loss of mobility