Organisation name Site or unit		STANDARD OPERATING PROCEDURE **Pressure Injury Risk Assessment and Prevention**	
Document ID	CLN-SOP-004-EN	**Version**	1.2
Status	To be issued	**Issue date**	
Review date		**Replaces**	1.0
Owner	Clinical lead for this procedure	**Approved by**	
Classification	Internal	**Applies to**	All clinical areas
Signature			

This is a controlled copy when approved. Printed copies are uncontrolled; check the version against the document register before use.

Contents

1. Purpose 2
2. Scope 2
3. Definitions 2
4. Background 2
5. Responsibilities 3
6. Materials and equipment 3
7. Safety and exceptions 3
8. Procedure 3
9. Worked examples 4
10. Decision points 5
11. Escalation 6
12. Monitoring and compliance 6
13. Records 6
14. Training and competence 6
15. Related documents 6
16. References 7
17. Change history 7
Abbreviations 1
Annex A. Pressure injury audit record 7

Abbreviations

Abbreviation	Meaning
CG179	NICE clinical guideline 179, Pressure ulcers: prevention and management

Abbreviation	Meaning
NICE	National Institute for Health and Care Excellence
SOP	Standard operating procedure

Key points

- Assess every adult admitted to secondary care for pressure ulcer risk, and document it [1].
- Reassess after any change in clinical condition [1].
- Reposition an at-risk adult at least every 6 hours, and a high-risk adult at least every 4 hours [1].
- Use a high-specification foam mattress for an adult admitted to secondary care [1].
- Where a patient has non-blanching redness, start prevention and repeat the skin assessment at least every 2 hours until it resolves [1].

1. Purpose

To prevent pressure ulcers, which can develop within hours in a patient who cannot move freely, and to make sure every at-risk patient has a documented assessment, a written plan and reviews. Pressure ulcers are among the most preventable harms in hospital. This SOP supports criterion 1.6.

2. Scope

Element	Coverage
Who	Clinical and support staff who assess, nurse or move patients.
Where	All wards, clinics and departments of the facility.
When	On admission; at each set reassessment; after any change in clinical condition; before and after surgery.
Not covered	Treatment of an established wound, which follows the wound care procedure.

3. Definitions

Term	Meaning
Pressure ulcer	Localised damage to skin or underlying tissue, usually over a bony area, caused by pressure, or by pressure combined with shear [1].
Non-blanching erythema	Redness that does not fade when pressure is applied with a finger or a clear glass (diascopy). It is an early warning sign [1].
Validated scale	A risk tool such as the Braden, Waterlow or Norton scale, used to support clinical judgement [1].
High-specification foam mattress	A pressure-redistributing mattress of the specification set by the facility’s equipment standard [1].

4. Background

Pressure ulcers form when pressure, and shear, are sustained over a bony area, and the tissue there is starved of blood. A patient who is immobile, sedated, incontinent, malnourished or unable to feel discomfort is at high risk. NICE guideline CG179 recommends that adults admitted to secondary care have their pressure ulcer risk assessed and documented, that a validated scale support clinical judgement, that risk be reassessed after a change in clinical status, and that the equipment and repositioning described below be used for at-risk patients [1]. The guideline also recommends a nutritional assessment for patients who already have a pressure ulcer [1].

5. Responsibilities

Role	Responsibility
Clinical director	Approves this SOP and receives the quarterly pressure injury report.
Ward or unit manager	Ensures equipment is available and in working order, and that staff are trained.
Ward nurse	Completes the risk assessment and skin examination, sets the plan, and reviews it at each reassessment.
Care assistant	Carries out the repositioning schedule and reports any change in the skin at once.
Tissue viability lead	Advises on surfaces, wounds and complex cases.

6. Materials and equipment

Item	Requirement
Risk tool	The validated scale adopted by the facility, with the score and date recorded.
Pressure-redistributing equipment	High-specification foam mattress and cushions, checked for function each shift.
Repositioning chart	Records the time and position at each change.
Clear glass or diascopy tool	For checking whether redness blanches.

7. Safety and exceptions

- Do not place a patient with a pressure ulcer on a standard-specification foam mattress. Use a high-specification foam mattress and consider a dynamic support surface if needed [1].
- A suspected deep tissue injury (a purple or maroon area of intact skin, or a blood-filled blister) is reviewed by the tissue viability lead the same day.
- Lift the patient rather than drag them, because friction and shear damage the skin. Keep heels free of pressure with a pillow or heel device.

8. Procedure

Before you start

- Check that the risk tool, the equipment and the repositioning chart are available and current.
- Check for any existing pressure ulcer or redness, and the last skin check.

Step 1. Assess risk

1. Assess each adult admitted to secondary care, and document the result [1].
2. Score the patient with the validated scale to support clinical judgement [1]. The score informs the plan; it does not replace the examination.
3. Consider the factors the scale does not capture: pain, sedation, continence, nutrition, and the ability to change position independently.

Step 2. Examine the skin

1. Examine the skin over the sacrum, heels, hips, elbows, shoulder blades and back of the head, and any area under medical devices.

2. Check the skin for integrity, colour, temperature, firmness and moisture. Note any change from the last check.
3. Press a finger, or a clear glass, over any redness. Redness that does not blanch is non-blanching erythema [1].
4. Record the findings on the chart, with a body map where the facility uses one.

Step 3. Set the prevention plan

1. **Repositioning:** for an at-risk adult, change position at least every 6 hours; for a high-risk adult, at least every 4 hours. Encourage frequent movement between these times [1].
2. **Surface:** provide a high-specification foam mattress for an adult admitted to secondary care [1]. Provide a high-specification cushion for an adult who uses a wheelchair or sits for long periods [1].
3. **Nutrition:** do not give nutritional supplements to prevent a pressure ulcer where intake is adequate [1]. Refer for a nutritional assessment where intake is poor or a pressure ulcer is present [1].
4. Record the plan, the repositioning interval, and the date of the next review.

Step 4. Review and respond to change

1. Reassess risk at the set interval and after any change in clinical condition [1].
2. Where non-blanching erythema is found, start preventative action and repeat the skin assessment at least every 2 hours until it resolves [1].
3. Where a pressure injury develops, assess its size and depth, inform the tissue viability lead, and review the whole plan the same shift.

9. Worked examples

Situation	What to do
A 78-year-old man is admitted after a hip fracture. He is sedated and cannot turn in bed. His validated score is high risk.	He is high risk: reposition at least every 4 hours, using a turn chart. Provide a high-specification foam mattress. Examine the sacrum and heels on admission and at each turn. Refer to the dietitian because intake is poor [1]. Reassess after surgery, because his condition has changed.
A nurse finds a 2 cm area of redness on the sacrum that does not fade when pressed.	This is non-blanching erythema. Start preventative action: reposition at the high-risk interval (at least every 4 hours, or more often if the plan requires), keep pressure off the area, and use the high-specification mattress. Repeat the skin assessment at least every 2 hours until it resolves [1]. Inform the tissue viability lead the same shift. Record the finding and the time.
A patient with a dark purple, intact area over the heel.	Treat as a suspected deep tissue injury. Offload the heel completely, and inform the tissue viability lead the same day.

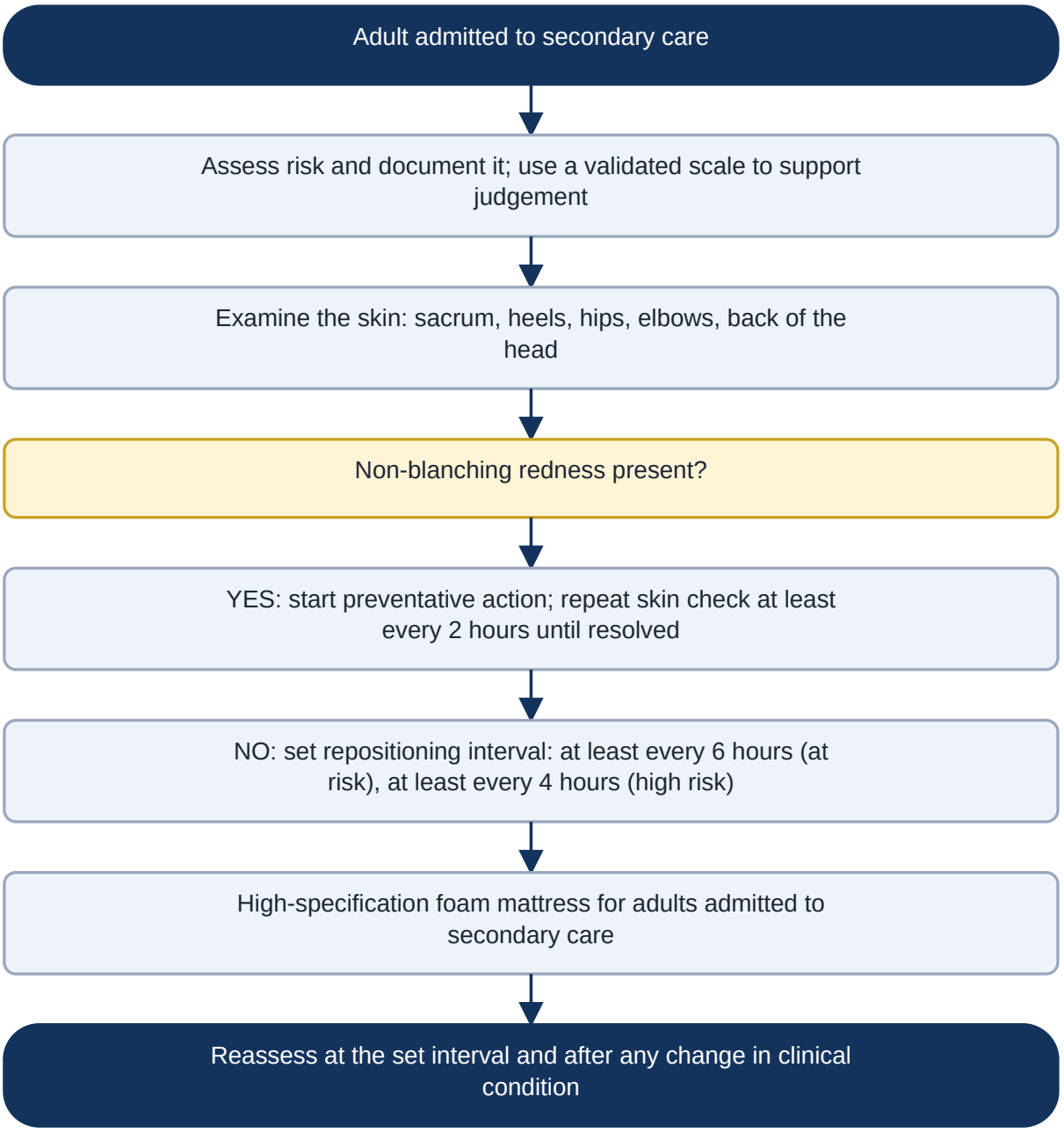


Figure 1. Pressure injury risk, repositioning and review



Figure 2. Minimum repositioning in 24 hours, by risk

10. Decision points

If	Then
Risk assessment is high	Reposition at least every 4 hours; provide the high-specification mattress.

If	Then
Non-blanching erythema is found	Start preventative action; repeat the skin check at least every 2 hours until resolved.
Suspected deep tissue injury	Offload, and inform the tissue viability lead the same day.
Pressure injury develops	Assess, escalate, and review the whole plan the same shift.

11. Escalation

Event	Inform	Timescale
Non-blanching erythema or suspected deep tissue injury	Clinician in charge and tissue viability lead	Same shift
Pressure injury acquired in hospital	Unit manager, risk team and the patient's family	Immediately; incident report within 24 hours
Unit rate above the facility threshold	Clinical director and quality team	Within one week

12. Monitoring and compliance

Indicator	Target	Method	Frequency	Owner
Admission risk assessment documented	100% of eligible admissions	Audit of 20 records per unit	Monthly	Ward manager
Repositioning as planned	100% of at-risk patients	Review of turn charts for 10 patients per unit	Monthly	Ward manager
Hospital-acquired pressure injuries	Set and reviewed by the facility	Incident data	Quarterly	Quality team

13. Records

Record	Kept in	Retention
Risk assessment, skin examination, plan and turn chart	Patient record	As set by the institutional retention policy
Incident reports	Incident management system	As set by the institutional retention policy

14. Training and competence

- **Induction:** the risk tool, skin examination and blanching test, the equipment on the unit, and the repositioning rules. Competence is assessed by a supervised skin examination.
- **Annual update:** skin assessment and repositioning, with direct observation.

15. Related documents

ID	Title	Relationship
CLN-SOP-003-EN	Nutritional risk screening and therapeutic diets	Nutrition referral
CLN-SOP-001-EN	Structured clinical assessment on admission	Admission assessment

16. References

1. National Institute for Health and Care Excellence. Pressure ulcers: prevention and management (NICE guideline CG179). Recommendations 1.1.2–1.1.17, 1.2.1–1.2.8 and 1.4.4–1.4.10 as read from the guideline. Available from: https://www.nice.org.uk/guidance/cg179. Status to be confirmed before publication.

17. Change history

Version	Date	Summary of change	Approved by
1.0		First approved version.	ASF Expert Committee
1.2		Substantive revision: skin examination method, prevention plan, non-blanching erythema and deep tissue injury steps, worked examples; references checked against CG179.	

Annex A. Pressure injury audit record

Use this record for each audit session. Record one line per patient or observed task. Enter Y, N or NA as shown in the column heading.

Date	Unit	Patient reference	Risk assessed on admission (Y / N)	Plan in place (Y / N / NA)	Repositioning as planned (Y / N)	Skin checked (Y / N / NA)	Comment