

Title of WI: Pressure Area Care

Custodian: Group Managing Director

Version Number: 03

Issue date: 05.01.26

Review date: 05.01.29

WORK INSTRUCTION (WI)

| | | | |
|---|---|----------------------------|--------------|
| Title of WI | Pressure Area Care | | |
| What type of document is this? | Work Instruction | WI Reference Number | HHH-W.I-0.33 |
| Purpose of WI | To support employees with clear instruction and understanding with regards to pressure area care. | | |
| Role | Responsibility | | |
| All employees working directly with customers | To ensure that safe pressure area care is maintained, by following the support plan and risk assessment. Escalate any concerns regarding skin integrity immediately to manager and relevant healthcare professional. | | |
| Branch Employees | To ensure that carers are adequately trained to identify, prevent, and manage pressure areas, and ensure that that all relevant customers have a Braden score and pressure area care risk assessment in place. | | |
| The Clinical Team | Deliver up to date and accurate training on pressure area care to branch employees in Train the trainer – level 1 delegated sessions. | | |
| Scope of WI | This work instructions details the purpose and processes to follow in relation to preventing, managing, and escalating pressure injuries for Helping Hands customers. | | |
| 1.0 Introduction | <p>A pressure injury is the breakdown of skin integrity due to pressure which may result in an open wound or an area of discoloured skin due to damage to the tissue below the surface of the skin. It is usually caused by sitting or lying in one position for too long without moving. A pressure injury can develop in a few hours. It usually starts with the skin changing colour – it may appear red and dark in</p> | | |

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colour which will be non-blanching. If pressure is not released at this stage, the skin is likely to break causing an open wound.

There are three main causes:

- Continual pressure - Mainly over bony prominences. This area becomes starved of a blood supply which provides oxygen and nutrients to all the skin cells. A lack of oxygen and nutrients cause the cells in the tissue to die.
- Shearing of the skin - Shear is when the skin moves one way, and the underlying tissues move the other way. Shearing is mainly caused by the person being dragged up the bed instead of being moved safely, although this may also occur if they slide down their bed or chair. It is important to move and reposition people safely and avoiding a dragging action.
- Friction - This happens when there is constant movement against the skin, often if someone is particularly agitated and rubbing may be their coping mechanism.

Pressure injuries are most likely to develop on parts of the body which take your weight and where the bone is close to the surface. The area's most at risk are heels, ankles, knees, hips, bottom, base of the spine, elbows and shoulders, however other areas such as the back of the head (may be concealed by hair) and ears (not a bony prominence as this is cartilage but still a vulnerable area). By recognising the early stages of a pressure injury, we can be proactive in the treatment.

2.0 Process

A Braden Score is a tool used to determine a customer's risk of developing a pressure injury. Identifying those at risk is essential to prevent pressure injuries developing. It is important to ensure that any changes to the risks are acknowledged, and the Braden score is updated, and action is taken and recorded.

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- 2.1 Completing a Braden Score will indicate the risk factor, and if a risk presents, the customer must have a completed clinical support plan and risk assessment detailing the actions required to mitigate risk of skin deterioration. Early referral to the District Nurse team is essential to ensure appropriate equipment is in place and any barrier creams prescribed and supplied.
- 2.2 One of the signs of a pressure injury is the change of colour on the skin. The skin will appear discoloured and a darker hue than usual. If the skin has discoloured the pressure area may start looking shiny and swollen. *Non-blanching erythema* - if a finger is pressed on the red area and the skin remains red it can be an early sign that a pressure injury is developing.
- 2.3 Encourage and support your customer to regularly change position, ideally every 2-4hrs, using the 30-degree tilt if your customer is in bed for long periods.
- 2.4 Encourage and support with high levels of personal hygiene for your customer. Use this intervention as an opportunity to check your customer's pressure areas.
- 2.5 All customers with pressure injuries or those who are at high risk must have pressure relieving equipment and slide sheets available within the home and carers must be competent in their use. If the customer has capacity and refuses this, ensure it is documented clearly, and customer is aware of the risks.
- 2.6 Use barrier creams and emollients as directed by the support plan only. Do not apply creams to broken skin unless there is written direction from a registered healthcare professional.

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- 2.7 Always follow the infection control policy and procedures including hand hygiene and use of disposable gloves and aprons.
- 2.8 Ensure that any early signs of pressure injuries are documented in the customer's visit record log, Body Map and immediately reported to the care manager and the community nursing team.
- 2.9 The Branch Care Manager must report pressure injuries to CQC/CIW and safeguarding. Multiple Stage 2 injuries may be considered as neglect and should be reported to CQC/CIW on the relevant notification form and a safeguarding raised. Stage 3, 4, unstageable and suspected deep tissue injury should also be reported to CQC/CIW on relevant notification form and a safeguarding raised.
- 2.10 All pressure injuries should be reviewed for the root cause analysis, your Regional Clinical Lead can support you to investigate, and identify any lessons learned so they can be implemented as necessary.
- 2.11 The Safeguarding Lead can support you with referrals if required and can be reached via email at safeguarding@helpinghands.co.uk.
- 2.12 The clinical team can be contacted via email
Clinicalcare@helpinghands.co.uk

| TRAINING | |
|-----------------------|--|
| Is training required? | <p>Yes</p> <p>All carers must complete training and competency sign off for pressure area care; this must be completed by an employee who has been signed off as competent on level 1 delegated health care activities within the last year.</p> |

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| COMPLIANCE <p>How is compliance with this document going to be monitored?</p> | | Documentation audits completed by the Independent Audit Team. |
| PROCEDURAL INFORMATION | | |
| Changes since previous version | | <ul style="list-style-type: none"> • Updates to terminology throughout • Added to new template |
| Who was involved in developing /reviewing/amending the document? (list titles) | | Clinical Manager |
| How confidential is this document | Public | Can be shared freely within and outside of Helping Hands |
| References | <p><i>References are the evidence base for the document (legislation, codes of practice etc., and need to be current)</i></p> | |
| Associated Documents | Braden Scale Risk Assessment – Care Planning Infection Prevention Control SOP | |

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