About this Unit

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.

Your **knowledge and understanding** will be specifically related to legal requirements and codes of practice and conduct applicable to your job, and the NHS Knowledge and Skills Framework. This will relate to your work activities; the job you are doing, and the setting, eg in hospital and community, domiciliary, residential care, and the individuals you are working with.

Values — the values underpinning this Unit are embedded within the 2009 NHS Code of Conduct for Health Care Support Workers. These are stated in full within the Assessment Strategy and Guidance document for the awards.

Key Words and Concepts — a glossary of definitions, key words and concepts used in this Unit is contained in the Assessment Strategy and Guidance document.

In occupational standards it is quite common to find words or phrases used which you will be familiar with, but which, in the detail of the standards, may be used in a very particular way. **You should read the Assessment Strategy and Guidance document before you begin working with the standards and refer to it if you are unsure about anything in the Unit.**

Specific Evidence Requirements for the Unit
It is essential that you adhere to the Evidence Requirements for this Unit

SPECIFIC EVIDENCE REQUIREMENTS FOR THIS UNIT
Simulation:
♦ Simulation is **NOT** permitted for any part of this Unit.
♦ **The following forms of evidence ARE mandatory:**
♦ **Direct Observation:** Your assessor or expert witness must observe you in real work activities. Their confirmation of your practice will provide evidence for a significant amount of the performance criteria in this Unit. **For example**, how you identify individuals who may be at risk of skin breakdown and the associated assessment documentation you are required to complete. ♦ **Professional discussion:** Describes your actions in a particular situation and reflect on the reason(s) why you practice that way. **For example**, how you involve the individual in their assessment in relation to assessing their own risk.
Competence of performance and knowledge could also be demonstrated using a variety of evidence from the following:
♦ **Reflective Account:** These are written pieces of work which allow you to reflect on the course of action you took in a specific situation to identify any learning from the piece of work and to describe what you might do differently in the light of your new knowledge. ♦ **Questioning/professional discussion**: May be used to provide evidence of knowledge, legislation, policies and procedures which cannot be fully evidenced through direct observation or reflective accounts. In addition your assessor/mentor or expert witness may also ask questions to clarify aspects of your practice. ♦ **Expert Witness**: A designated expert witness, eg a senior member of staff, may provide a direct observation of your practice, or record a professional discussion they have held with you on a specific piece of practice. ♦ **Witness Testimony**: Can be a confirmation or authentication of the activities described in your evidence which your assessor or mentor has not seen. ♦ **Products:** These can be any record that you would normally use within your normal role, eg you should not put confidential records in your portfolio; they can remain where they are normally stored and be checked by your assessor and internal verifier. ♦ **Prior Learning:** You may be able to use recorded prior learning from a course of training you have attended within the last two years. Discussion on the relevance of this should form part of your assessment plan for each Unit. ♦ **Simulation:** There may be times when you have to demonstrate you are competent in a situation that does not arise naturally through your work role, eg dealing with violent or abusive behaviour. The Evidence Requirements in each Unit provide specific guidance regarding the use of simulation.
GENERAL GUIDANCE
♦ Prior to commencing this Unit you should agree and complete an assessment plan with your assessor which details the assessment methods you will be using, and the tasks you will be undertaking to demonstrate your competence. ♦ Evidence must be provided for ALL of the performance criteria, ALL of the knowledge. ♦ The evidence must reflect the policies and procedures of your workplace and be linked to current legislation, values and the principles of best practice within the Health Care sector. This will include the National Service Standards for your areas of work. ♦ All evidence must relate to your own work practice.

KNOWLEDGE SPECIFICATION FOR THIS UNIT

Competent practice is a combination of the application of skills and knowledge informed by values and ethics. This specification details the knowledge and understanding required to carry out competent practice in the performance described in this Unit.

When using this specification **it is important to read the knowledge requirements in relation to expectations and requirements of your job role**.

You need to provide evidence for ALL knowledge points listed below. There are a variety of ways this can be achieved so it is essential that you read the 'knowledge evidence' section of the Assessment Guidance.

	You need to show that you know, understand and can apply in practice:	**Enter Evidence Numbers**
1	The current European and National legislation, national guidelines, organisational policies and protocols in accordance with 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 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.	

You need to show that you know, understand and can apply in practice:		**Enter Evidence Numbers**
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		DO	RA	EW	Q	P	WT	PD
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.							

Performance Criteria	DO	RA	EW	Q	P	WT	PD
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.							

DO = Direct Observation *RA = Reflective Account* *Q = Questions*
EW = Expert Witness *P = Product (Work)* *WT = Witness Testimony*
PD = Professional Discussion

To be completed by the candidate
I SUBMIT THIS AS A COMPLETE UNIT

Candidate's name: ……

Candidate's signature: ……..

Date: ……..

To be completed by the assessor
It is a shared responsibility of both the candidate and assessor to claim evidence, however, it is the responsibility of the assessor to ensure the accuracy/validity of each evidence claim and make the final decision.

I CERTIFY THAT SUFFICIENT EVIDENCE HAS BEEN PRODUCED TO MEET ALL THE ELEMENTS, PCS AND KNOWLEDGE OF THIS UNIT.

Assessor's name: ……..

Assessor's signature: ……..

Date: ……..

Assessor/Internal verifier feedback

To be completed by the internal verifier if applicable
This section only needs to be completed if the Unit is sampled by the internal verifier

Internal verifier's name: ……

Internal verifier's signature: ……..

Date: ……..……..