



PRP pre treatment screening policy and standard operating procedure

Clinique Alpa | Alpa Care Ltd

Approved by Dr Mitesh Parmar | 20 October 2026

FINAL POLICY | VERSION 1.0 | CLINICALLY APPROVED

This policy sets out the process for assessing adults before elective autologous platelet rich plasma (PRP), identifying patients who need investigation or specialist advice, and recording a clinically justified treatment decision.

Control field	Record
Document identifier	CA-CLIN-SOP-PRP-001
Version and issue date	1.0 final 20 October 2026
Clinical owner and approver	Dr Mitesh Parmar
Operational owner	Clinic manager or registered manager
Clinical approval	Approved by Dr Mitesh Parmar on 20 October 2026
Review due	20 October 2027, or earlier following a safety alert, incident, evidence or service change
Supersedes	Version 0.1, initial draft dated 19 October 2026
Operational release	Use requires the readiness checks in section 10. Operational effective date is recorded in the controlled clinic register.

1 Scope and clinical decision rules

This screening SOP covers adult elective PRP assessment, including scalp, skin and musculoskeletal use only where separately authorised by the clinic. It does not approve a new indication or replace an indication-specific treatment protocol, device instructions for use (IFU), medicines authorisation, or anatomical injection training. It excludes intravenous administration, donor products, stem-cell products and unapproved PRP mixtures.

Before offering a service, the clinical owner must confirm practitioner competence and indemnity, the applicable CQC regulated-activity position for the actual procedure, device suitability and a written indication-specific protocol. This policy does not itself establish regulatory registration or authorise a new treatment service. For knee osteoarthritis, NICE HTG497 (formerly IPG637) requires special arrangements for governance, consent and audit or research because efficacy evidence is limited. [3,6]

Classification

- Absolute stop for the proposed session: treatment must not proceed while the identified condition or safety failure persists. This may be temporary; it does not necessarily mean lifelong exclusion.
- Relative contraindication or precaution: defer booking for treatment until the responsible clinician completes a case-specific assessment, obtains needed evidence and records a plan. A diagnosis or medicine name alone is not a universal exclusion.
- Outside this clinic pathway: refer for assessment elsewhere or to a separate approved pathway. A specialist opinion informs the decision but does not remove the treating clinician's responsibility or override a safety stop.

Absolute stops for the proposed session

- No valid voluntary consent, withdrawal of consent, unresolved identity or product mismatch, or inability to establish a safe indication and treatment plan.
- Suspected sepsis, significant acute systemic illness, or active infection at the venepuncture or treatment site; a hot swollen joint with possible infection requires urgent assessment.
- Known or suspected skin cancer or another tumour in or near the treatment field: no injection into or around the lesion while diagnosis and management are unresolved.
- Clinically significant uncontrolled bleeding, uncorrected clinically significant coagulopathy, or platelet deficiency or dysfunction that prevents safe venepuncture/injection or a suitable product.
- Acute cardiovascular instability or another medical emergency; a serious unavoidable allergy to an essential component.
- A prohibited use under the selected IFU; unavailable competent staff or emergency support; expired, damaged or untraceable consumables; contamination or breach of asepsis.

No receptionist, commercial decision, patient waiver or general "medical clearance" can override these stops. If the problem is resolved, reassess and document a fresh decision.

2 Screening the specified medical conditions

Evidence boundary: the 2025 GRIIP consensus concerns musculoskeletal PRP; most recommendations are expert opinion. It permits consideration of controlled HIV with undetectable viral load and CD4 >350 cells/mm³; HCV after antiviral treatment; and selected cured, remitted or stable haematological disease. It discourages injections near tumours and during active or unstable malignancy. These are not validated universal scalp or cosmetic eligibility rules. [1]

Condition	Clinic decision and evidence required
HIV or AIDS	Relative precaution if clinically stable. Request a relevant HIV-team summary, dated viral load/CD4 and treatment information with consent. Defer for specialist review if control is uncertain, immune suppression is significant or there is an opportunistic illness. A historical AIDS diagnosis alone must not determine permanent exclusion.
Blood malignancy	Defer during diagnostic investigation, active unstable disease or cytotoxic treatment. Seek haematology advice addressing disease status, blood counts, platelet function, current therapy and the proposed indication. Stable, remitted or cured disease may be individually considered; no routine exceptional treatment under this SOP.
Local skin cancer or suspicious lesion	Absolute site-specific stop until appropriately assessed and managed. Record lesion location and referral. A previously treated lesion or remote cancer history requires an individual review; it is not an automatic permanent ban on PRP elsewhere.
Hepatitis C	Defer known active infection or incomplete antiviral treatment for hepatology/infection advice. Record treatment outcome, HCV RNA status and liver/bleeding assessment. Antibody positivity alone does not establish current viraemia. Prior clearance without treatment requires specialist interpretation, not an automatic exclusion. [9]
Cardiovascular disease and blood thinners	Assess clinical stability, reason for medication, bleeding and thrombosis risks, injection site and ability to control bleeding. Stable disease or anticoagulation alone is a relative precaution. Do not proceed with an unresolved medication plan or unstable disease; see section 4.

For scalp or cosmetic PRP in a complex case, the clinical owner must explicitly justify any extrapolation from MSK evidence, consult the relevant specialist and consider whether the elective benefit justifies residual uncertainty. If the evidence or expertise is insufficient, defer or decline the procedure with reasons and alternatives.

3 Broader precautions and clinical assessment

Other matters requiring assessment

- Bleeding history, easy bruising, anaemia, unexplained abnormal blood counts, platelet disorders, liver disease, renal impairment/dialysis, immunosuppression, transplantation, diabetes control and wound-healing problems.
- Other active malignancy, recent cancer treatment, unexplained weight loss, persistent lymphadenopathy or systemic symptoms: defer for the relevant medical assessment.
- Current or recent infection, antibiotics, dental infection or invasive dental work, skin breakdown, inflammatory dermatoses and previous treatment reactions. Postpone until recovery or a specific specialist plan is documented; do not invent a universal waiting interval.
- Pregnancy or breastfeeding: defer elective cosmetic PRP under this local policy because evidence is insufficient. This is a precautionary service decision, not proof of harm. Any therapeutic indication requires a separate approved pathway.
- Under 18 years: outside this adult elective pathway. Significant psychological vulnerability, unrealistic expectations, coercion, impaired capacity or inability to follow aftercare: defer and address the concern.
- Recent injections, surgery, systemic or local corticosteroids, NSAIDs, supplements, heavy alcohol use and smoking: assess relevance, interactions and healing; these are not automatic blanket exclusions.

Assessment before committing to treatment

A questionnaire supports, but does not replace, a consultation with the responsible clinician. Confirm two identifiers, age, contact and GP details. Establish the diagnosis, intended site, previous treatment, desired outcome, reasonable alternatives and whether PRP offers a defensible benefit. Clarify answers privately and record “unknown” where information is missing.

Take a full relevant medical and medicine history, including all five conditions in section 2, allergies to anticoagulant additives, antiseptics, local anaesthetic and latex, adverse reactions, bleeding/thrombosis history, pregnancy possibility and capacity/communication needs. Record medicine doses, indication and last dose where relevant.

Examine the proposed treatment and venepuncture sites and relevant regional anatomy. Record actual findings, not a pre-populated normal examination. Assess systemic wellbeing and appropriate observations (for example blood pressure and pulse; temperature if infection suspected). Investigate diagnostic red flags rather than attributing all symptoms to a cosmetic or MSK condition.

Use proportionate testing: FBC/platelets for suspected blood disorders, bleeding, systemic illness, relevant medicines or IFU requirements; renal/liver function, coagulation studies or other tests when clinically indicated. No single laboratory value proves safety or product effectiveness. Do not apply an arbitrary universal haemoglobin, platelet or INR threshold. The clinician must record the relevant protocol/IFU criteria and interpretation.

4 Investigations medicines and specialist review

Close the loop on evidence

Assign a named clinician to every requested test and referral. Record why it is needed, who will review it, the expected response date and how the patient will receive the result. File dated source reports and specialist correspondence. Do not release a deferred patient for treatment while a material result is outstanding, unexplained or inconsistent.

The clinician decides whether results remain sufficiently recent for the patient's stability and the proposed procedure, and repeats them after relevant change. Do not impose routine HIV or hepatitis testing solely as a substitute for infection precautions. Offer testing with informed consent when clinically justified; explain purpose, limitations, confidentiality and referral arrangements. [5,9]

Anticoagulants and antiplatelet drugs

Identify warfarin, direct oral anticoagulants, heparins, aspirin, clopidogrel and other antiplatelets, including combination therapy. Distinguish procedural bleeding risk from uncertain effects on the PRP product. Evidence that many joint injections are low bleeding risk cannot automatically be applied to multiple scalp or facial injections or deep non-compressible sites. [2]

Assess previous bleeding, renal/liver impairment, interacting medicines, the injection technique and site, and thrombotic indication (for example atrial fibrillation, valve replacement, coronary stent or recent venous thromboembolism). Review INR for warfarin when appropriate against the patient's prescribed range and procedure plan. INR is not a reliable measure of direct oral anticoagulant effect.

Do not advise routine interruption, dose reduction or bridging to enable elective PRP. Any change must be agreed with the responsible prescriber or relevant anticoagulation/cardiology team, with written stop/restart instructions and a named owner. If risk is unacceptable on necessary treatment, defer PRP rather than expose the patient to avoidable thrombosis. Recent acute coronary syndrome, recent stenting or thromboembolism warrants particular specialist input.

NSAIDs and antiplatelets can affect platelet function, but laboratory effects do not establish the size of any clinical PRP benefit lost. Do not use a generic washout rule. Record a medication-specific decision; never stop medically necessary aspirin simply to optimise PRP. [10]

Decision and escalation

The responsible clinician records one outcome: proceed; defer pending specified evidence or recovery; refer; or decline with reasons. For a specialist query, describe the exact PRP indication/site and ask about disease control, relevant results, treatment interactions, residual risk and follow-up. Record the specialist's name, date and advice. The treating clinician then signs the final decision. Disagreement or uncertainty goes to the clinical owner; the default is deferral.

5 Consent and the treatment day safety check

Consent discussion

Discuss the expected benefit for the actual indication, evidence limitations, alternatives including no intervention, likely course, costs and the possibility of no benefit or deterioration. Explain the autologous collection and preparation process and all intended additives, anaesthetic and associated procedures. Avoid claims that PRP is risk free, guaranteed, or generally “NICE approved”. [3,4]

Explain risks material to this patient: pain, bruising, bleeding/haematoma, infection, fainting, inflammatory flare, scarring or pigment change, allergy to associated products, and injury to surrounding structures. Include site-specific risks and rare serious outcomes under the approved treatment protocol. Facial/scalp pathways must specifically address vascular injury and reported visual complications where relevant to the proposed technique. [11] Record the patient’s particular concerns, medical risk modifiers and answers.

For cosmetic interventions the treating or supervising medical professional must conduct the consent discussion. Allow adequate reflection without time pressure, assess capacity and voluntariness, offer an interpreter or other reasonable communication adjustment, and explain that consent may be withdrawn. Obtain written consent and give the patient a copy and accessible aftercare information. Separate consent for clinical photography; do not use patient material for marketing. [4]

Recheck before every session

- Confirm two identifiers, indication, intended site/side and the agreed treatment plan; reconfirm the patient still wishes to proceed.
- Ask about new illness, infection, diagnoses, pregnancy possibility, medicines and adverse effects since assessment. Recheck the skin and relevant observations. Earlier clearance is not automatic clearance for a repeat session.
- Verify all required results and specialist advice have been reviewed and signed; check the medication plan and last relevant doses.
- Confirm the correct sterile kit and IFU, in-date additives, allergies, traceability, equipment readiness and appropriate emergency support.
- Complete and sign the time-out before venepuncture and recheck patient/product identity immediately before administration. If anything is unresolved, stop and reassess.

Aftercare and urgent help

Provide procedure-specific written advice, a named clinical contact and a working out-of-hours route before treatment. Record the follow-up interval and outcome measure. Advise prompt assessment for increasing redness, heat, swelling, fever, worsening pain, discharge, persistent bleeding or new neurological symptoms. Sudden visual disturbance, stroke-like symptoms, chest pain, severe breathlessness, collapse or suspected anaphylaxis requires emergency help via 999. A possible septic joint requires urgent same-day hospital assessment.

6 Infection prevention and blood product safety

Apply standard precautions to every patient, irrespective of known infection status. A negative blood-borne-virus test does not replace asepsis. The infection-control lead must approve the local workflow, environmental cleaning, equipment decontamination and exposure arrangements before release. [5,7]

- Perform hand hygiene before and after patient contact and aseptic tasks and after glove removal. Select gloves, apron and eye/face protection according to exposure risk. Use an appropriate aseptic technique and protect key parts and sites.
- Use a clean designated preparation area; keep clean supplies separate from contaminated equipment. Follow the site-appropriate skin antiseptic instructions, allergy precautions, contact time and drying requirements.
- Use sterile, single-use blood-contact consumables and a validated PRP system suitable for the intended clinical application. Follow the exact manufacturer IFU for collection, anticoagulant, processing, centrifuge settings, administration and time limits.
- Process one patient's material at a time. Label at collection with two identifiers, date/time and preparer. Maintain identity through every transfer and check against the patient before injection. Never pool samples, share products or use unlabelled material.
- Use only the patient's own preparation for that patient in the approved same-session pathway. No storage, transfer for another patient or unvalidated modification. Record any additive with its batch and expiry. An open process requires a separately validated aseptic workflow.
- Keep equipment servicing, cleaning and training records. Contamination, tube breakage, identification error or processing deviation requires immediate quarantine of affected material and a clinical safety review; do not administer it.
- Use safer sharps where reasonably practicable; dispose immediately into the correct nearby sharps container. Do not recap used needles. Segregate blood-contaminated waste and manage spills under the approved local procedure.

Exposure or incident response

Stop safely, give first aid and obtain urgent occupational-health or emergency assessment for a blood exposure; do not wait for a source test before seeking advice about prophylaxis. For a sharps injury, encourage gentle bleeding, wash with soap and running water, avoid scrubbing or sucking, and cover. Irrigate exposed mucosa as appropriate. Record the incident and arrange source testing only with appropriate consent. [7]

For suspected patient infection, wrong-patient product, significant bleeding or device failure, the clinician arranges immediate care and informs the clinical owner. Preserve traceability and investigate possible wider exposure. The manager assesses applicable duty-of-candour, CQC notification, MHRA Yellow Card and HSE reporting duties; record the decision and actions. No affected process restarts until the safety issue is controlled.

7 Records and responsibilities

Minimum contemporaneous record

Record the consultation and questionnaire, diagnosis/site, relevant history and examination, medicines/allergies, risk classification, test results with dates and interpretation, specialist advice, decision and rationale, consent discussion and signed form, day-of-treatment changes, time-out, treatment details, aftercare, follow-up and any incident. Distinguish patient-reported information from verified records, measured results, observed findings and clinical opinion. Identify conflicts and how they were addressed; never silently convert an unknown answer to “no”.

Record operator and assistant, collection/preparation/administration times, kit manufacturer/model/lot/expiry, device identification and processing parameters, blood and PRP volumes, additives/anaesthetic and batches, injection sites/technique and any image guidance. Retain enough information to identify all affected patients if a product is recalled. [4]

Store clinical information in the approved access-controlled clinical record with audit trail, backups and the clinic’s approved retention schedule. Share only the necessary information through an authorised secure route. Record permission for GP/specialist contact, or refusal and its effect on safe decision-making. Patient information must never be repurposed for promotion.

Role	Accountability
Clinical owner	Approve indication-specific pathways, eligibility rules and exceptions process; resolve uncertainty; review evidence, incidents and audit; authorise release and revisions.
Treating clinician	Assess competence and indication; examine, interpret evidence, seek advice, obtain consent, make and sign the final decision; perform safety checks and manage complications.
Trained assistant	Carry out only delegated tasks within documented competence; maintain identity, asepsis and traceability; escalate concerns immediately.
Clinic or registered manager	Maintain controlled copies, appointment/competency evidence, equipment and emergency readiness; track audits, actions and regulatory reporting.
Infection control lead	Validate preparation and decontamination processes, sharps/exposure arrangements and monitoring; investigate infection concerns.
Administrative team	Supply forms and flag unanswered or positive responses for clinical review; no independent clinical clearance or medicine advice.

Named role holders and deputies must be entered in the local governance register before implementation. Every staff member may stop an unsafe procedure.

8 Audit and document control

Audit schedule

After adoption, the clinical owner reviews the first 10 consecutive assessed patients, or all patients at three months if fewer than 10. Thereafter audit quarterly using all cases if 20 or fewer, or a random sample of 20 plus every deferred/declined case and every incident. [8]

Measure	Target and action
Screening and decision	100% have all five specified conditions addressed, medication/allergy review, site assessment, risk decision and clinician sign-off.
Required tests and referrals	100% of material results/advice reviewed before treatment; zero treatment with an unresolved stop.
Consent and day-of-treatment check	100% have documented individual consent, reconfirmation and time-out.
Medication safety	Zero unapproved interruption of necessary anticoagulants/antiplatelets; 100% of applicable cases have a documented plan.
Traceability and aftercare	100% have required product/operator records and written escalation/follow-up advice.
Safety and effectiveness	Review infection, bleeding, fainting, unexpected reactions, unplanned contacts and referral outcomes; collect indication-specific benefit and patient experience.

Report numerator, denominator and missing records, not percentages alone. Any missed safety stop, product mismatch, avoidable serious harm or unsafe medicine instruction triggers immediate review and restriction of the affected pathway where needed. Assign every gap an owner and deadline; re-audit within six weeks of corrective action. Record the outcome at governance review.

Version and distribution rules

The clinical owner approves content; the manager assigns the effective date, review date, named owners and controlled master location. Record approval signatures and distribution/read acknowledgements. Superseded copies are retained as read-only archive records and clearly marked; staff must be directed to the current version. Material changes require renewed briefing and, where needed, competency assessment.

Version	Date	Change and approval
0.1	19 Oct 2026	Initial draft prepared for clinical review.
1.0	20 Oct 2026	Clinical approval confirmed by Dr Mitesh Parmar. Final clinic policy with branding and public presentation.

9 Screening and decision record template

Complete in the approved clinical record for each assessment and reconfirm at each session. This blank template is not a patient record. Use Yes / No / Unknown and explain every positive or unknown response.

Patient name _____ DOB _____ Record ID _____
Assessment date _____ Clinician _____ Indication/site _____

Screen	Yes No Unknown and details or record reference
HIV or AIDS; current control and specialist care	
Blood malignancy or other cancer; status and treatment	
Skin cancer or suspicious lesion in the treatment field	
Hepatitis C or other liver/viral disease; treatment outcome	
Cardiovascular disease; anticoagulants or antiplatelets	
Bleeding, anaemia, platelet or other blood disorder	
Infection, antibiotics, dental work or immunosuppression	
Renal disease, diabetes, pregnancy/breastfeeding or healing risk	
Allergies, other medicines/supplements and previous reactions	
Capacity, expectations, communication and aftercare needs	

Relevant examination and observations _____

Tests and specialist advice required / reviewed, with dates _____

Decision: Proceed / Defer / Refer / Decline

Risk classification and reasons _____

Outstanding action, owner and due date _____

Medication plan and prescriber agreement if needed _____

Clinician signature and date _____

Treatment day: identity, new history/medicines, site, results, consent, medication plan, kit/IFU, asepsis and emergency readiness all rechecked: Yes / No

Changes and action _____

Time-out and product identity signed by _____ Date/time _____

Link to procedure, consent, traceability and aftercare records _____

10 Operational release and document control

Clinical approval of this policy was given by Dr Mitesh Parmar on 20 October 2026. Before operational use, the clinic manager and clinical owner must complete and record the following readiness checks in the controlled governance register.

- Confirm authorised indications, relevant regulatory scope, practitioner competence and indemnity. Record the operational owner, infection-control lead and deputies.
- Retain the current PRP kit instructions and indication-specific protocol, including contraindications, laboratory criteria, preparation settings and time limits. Resolve any conflict with this policy before treatment.
- Verify local laboratory, specialist referral, urgent care, out-of-hours and occupational-exposure arrangements. Ensure staff and patient information contains working contact details.
- Confirm current consent, infection-control, medicines, emergency, incident and candour, device, waste and records policies. Record their document identifiers and versions.
- Complete role-appropriate briefing and observed competency assessment, including patient and product identity, asepsis, medicine escalation and emergency responses. Retain dated evidence; acknowledgement alone is not competence.
- Record the operational effective date, controlled master location and distribution list. File the approved policy in the clinic document register and inspection index. Preserve the earlier draft as superseded.
- Schedule the first audit and nominate its reviewer. Record corrective actions, owners and completion evidence through clinical governance.

Controlled publication

The public version states the approved screening and governance requirements. Publication does not itself verify completion of staff training, operational readiness or audit. Operational evidence and patient records are maintained separately in the clinic's controlled systems.

The policy is reviewed at least annually and earlier if evidence, device instructions, the service or safety information changes. The clinical owner approves substantive revisions. The clinic manager updates the controlled master, version history and public copy, and archives superseded versions.

Approval record

Policy identifier: CA-CLIN-SOP-PRP-001

Version: 1.0 final

Clinical owner and approver: Dr Mitesh Parmar

Clinical approval date: 20 October 2026

Scheduled review date: 20 October 2027

11 References and evidence limits

Evidence review completed on 19 October 2026. References support the clinical and governance principles; workflow and audit intervals are clinic policy requirements. Apply the current manufacturer instructions for the actual PRP system, and reconcile them with this policy before operational release. The MSK evidence limits described in section 2 remain applicable.

[1] Eymard F et al. Indications and contraindications to platelet-rich plasma injections in musculoskeletal diseases in case of infectious, oncological and haematological comorbidities. GRIIP formal consensus, 2025. DOI 10.1002/ksa.12682. MSK scope; predominantly Grade D recommendations, with selected Grade C recommendations.
<https://pmc.ncbi.nlm.nih.gov/articles/PMC12104799/>

[2] Uson J et al. EULAR recommendations for intra-articular therapies. Ann Rheum Dis, 2021. DOI 10.1136/annrheumdis-2021-220266. General joint-injection and antithrombotic risk guidance, not validation of every PRP technique.
<https://pmc.ncbi.nlm.nih.gov/articles/PMC34035002/>

[3] NICE. Platelet-rich plasma injections for knee osteoarthritis. HTG497, formerly IPG637, originally published 23 January 2019. Indication-specific governance, consent and audit requirements.
<https://www.nice.org.uk/guidance/htg497>

[4] General Medical Council. Cosmetic interventions, updated 13 December 2024; communication, partnership and teamwork. Consent, competence, follow-up and traceability.
<https://www.gmc-uk.org/professional-standards/the-professional-standards/cosmetic-interventions/communication-partnership-and-teamwork>

[5] NHS England. National infection prevention and control manual for England, Chapter 1, Standard infection control precautions. Live web guidance.
<https://www.england.nhs.uk/infection-prevention-and-control/nipcm-for-england/chapter-1-standard-infection-control-precautions-sicps/>

[6] Care Quality Commission. Regulation 12, Safe care and treatment. Risk assessment, competence, equipment and infection prevention.
<https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-12>

[7] Health and Safety Executive. Needlestick or sharps injuries in health and social care; HSIS7 guidance on the Sharp Instruments in Healthcare Regulations 2013.
<https://www.hse.gov.uk/healthservices/needlesticks/overview.htm>

[8] Care Quality Commission. Regulation 17, Good governance. Monitoring, records and improvement systems.
<https://www.cqc.org.uk/guidance-providers/regulations/regulation-17-good-governance>

[9] UK Health Security Agency. Hepatitis C information for GPs. Antibody and RNA testing distinguish prior exposure from current infection.
<https://www.gov.uk/government/publications/hepatitis-c-patient-re-engagement-exercise/hepatitis-c-information-for-gps>

[10] Schippinger G et al. Autologous platelet-rich plasma preparations: influence of nonsteroidal anti-inflammatory drugs on platelet function. Orthop J Sports Med, 2015. DOI 10.1177/2325967115588896. Small laboratory pilot; does not establish clinical outcome or justify stopping necessary cardiovascular medication.
<https://pmc.ncbi.nlm.nih.gov/articles/PMC4622369/>

[11] Visual Loss after Platelet-rich Plasma Injection into the Face. Neuro-Ophthalmology, 2020. Case series describing severe ocular harm after facial PRP; does not establish incidence.
<https://pmc.ncbi.nlm.nih.gov/articles/PMC7722697/>