Pressure Ulcer Risk Primary Or Secondary Evaluation (PURPOSE T) Version 2 User Manual

Summary of PURPOSE-T

PURPOSE-T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) is a pressure ulcer risk assessment framework (PURAF) intended to identify adults at risk of pressure ulcer development and makes a distinction between primary prevention (applicable to those at risk of pressure ulcer development) and secondary prevention (applicable to those who already have a pressure ulcer). It has been developed for use in adult populations in hospital and community settings by Registered Nursing staff.

The development of PURPOSE-T incorporated five phases:

1. systematic review of primary research to identify pressure ulcer risk factors
2. consensus study to identify the most important risk factors for summarising patient risk
3. development of a pressure ulcer conceptual framework and theoretical causal pathway
4. design and pre-testing of to assess and improve acceptability and usability with clinical nurses
5. clinical evaluation through field testing of 230 patients by expert and community/ward based nurses to ensure reliability, validity, data completeness and clinical usability

PURPOSE-T (version 2) uses colour (rather than a score) to describe risk in terms of a personal profile to help in the planning of appropriate interventions. It incorporates 3 steps:

1. a screening stage to be used for all patients to target assessment towards those in need
2. a full assessment stage to be completed for those potentially at risk as determined by step 1
3. decision pathways to be undertaken for all patients who have undergone step 2. These make a clear distinction between patients with an existing pressure ulcer(s) (or scarring from previous ulcers) who require secondary prevention and treatment and those at risk who require primary prevention.

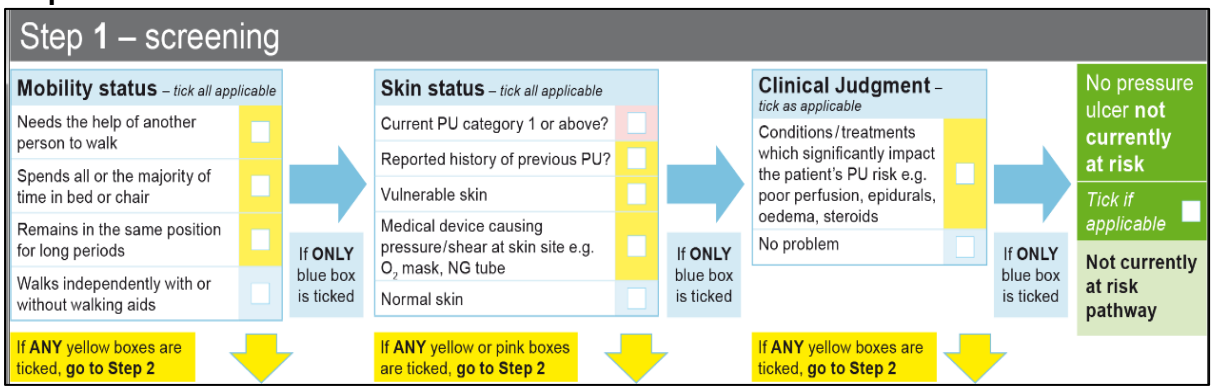
PURPOSE-T was reviewed in 2016/17 which considered new epidemiological evidence and the experience of those who had implemented the instrument in hospital and community settings. This led to the inclusion of medical devices, an additional section to prompt the use of clinical judgement in step 1 screening and minor adjustments to the ordering of some items.

1. Step 1 – Screening: Complete for all patients

Step 1 comprises of two possible sections to complete:

- Mobility Status
- Skin status
- Clinical Judgement

Step 1 Assessment

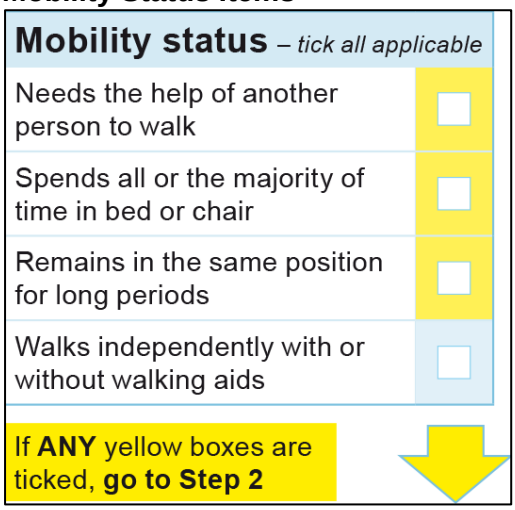


1.1 Mobility Status

This section examines mobility status items that have been developed to assess varying levels of mobility. Mobility is a key pressure ulcer risk factor, which is why it is included in the first step of the assessment.

It is important that all items are considered and those which **apply** to the patient are ticked: a patient may walk independently but remain in the same position for long periods and /or spend the majority of time in bed or chair.

Mobility Status Items



The first item 'help of another person' could involve physical assistance or verbal prompting. The latter 2 items require an element of judgement, in terms of whether the patient's length of time in one position is considered normal. The last item 'Walks independently' means they don't need assistance from another person, and 'walking aid' could be a walking stick, walking frame or even furniture.

1.2 Mobility Decision Boxes

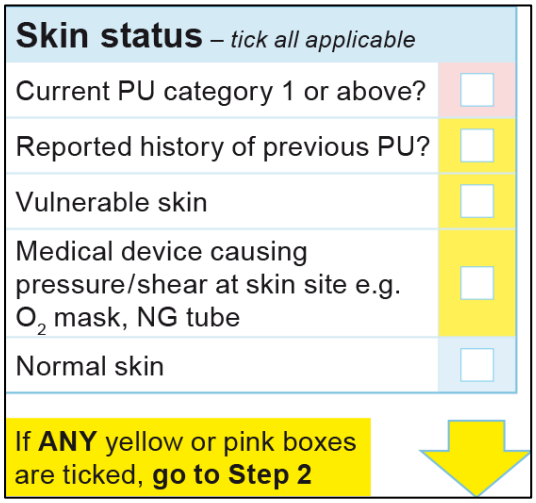
The decision boxes and colour coding help in deciding whether to go to step 2 of the assessment straight away, or if the Step 1 skin status items should be completed first: if any yellow boxes are ticked, the assessment should progress to Step 2 without completing the

Step 1 skin status items. If **only** the blue box is ticked, the Step1 skin status items should be completed.

1.3 Skin Status

This section examines skin status items which have been developed in recognition of the importance of skin status in the assessment of pressure ulcer risk. The items give a range of possibilities of pressure area skin status as commonly encountered in clinical practice.

Skin Status Items



It is important that all of the boxes that apply to the patient are ticked as they may have more than one, for example a patient may have a reported history of previous pressure ulcer **and** skin vulnerability.

The 'vulnerability' skin item gives examples of blanchable redness that persists, dryness, paper thin and moist: these describe the visual appearance of vulnerable skin but this is not exhaustive list. The impact of other conditions which may or may not affect skin vulnerability e.g. poor perfusion, oedema, steroid use should also be considered. See section 2.3 for further notes on skin vulnerability and skin redness. The medical device item relates to the presence of a medical device which causes pressure/shear at the skin site. Examples of medical devices include respiratory masks/tubing, naso-gastric tubes, catheters, drains but this is not an exhaustive list. Nurses should use their clinical judgement to assess whether the device is causing a problem, incorporating consideration of skin vulnerability, whether the device is in continuous use and whether the patient is self-caring and can attend to their own device. The item 'normal skin', requires clinical judgement since there is no clear definition of what constitutes normal skin. It would certainly include the absence of skin vulnerability or pressure ulcers.

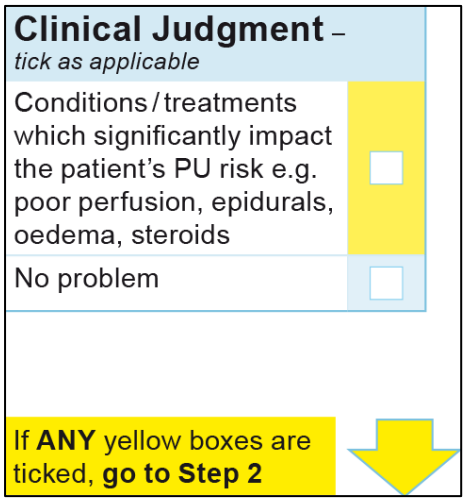
The Registered Nurse will need to make a judgement about the approach required to complete this section (i.e. history taking/ clinical records/ full skin inspection), while recognising that the most accurate way to assess skin status is to visually examine the skin: this may be influenced by the context of care and level of patient dependency. Any patients with a skin status problem (vulnerable, current or previous PU) will progress to Step 2 of the assessment (incorporating full visual skin inspection).

1.4 The Skin Status Decision Boxes

The decision boxes and colour coding will help in deciding whether to progress to Step 2 of the assessment, or if the Step clinical judgement items should be completed first: if a yellow or pink box is ticked, the assessment should progress to Step 2 without completing the Step 1 clinical judgement items. If **only** the blue box is ticked, the Step1 clinical judgement items should be completed.

1.5 Clinical Judgement

This item prompts the nurse to use his/her clinical judgement and wider knowledge of the patient to assess whether there are any other significant factors that may impact the patients pressure ulcer risk (requiring the more detailed second step assessment or whether they can be screened out at step 1). This could include factors such as perfusion problems, oedema, epidurals, steroids but this is not an exhaustive list. Other wider factors such as increasing or fluctuating dependency should also be taken into consideration.



1.6 Clinical Judgement Decision Boxes

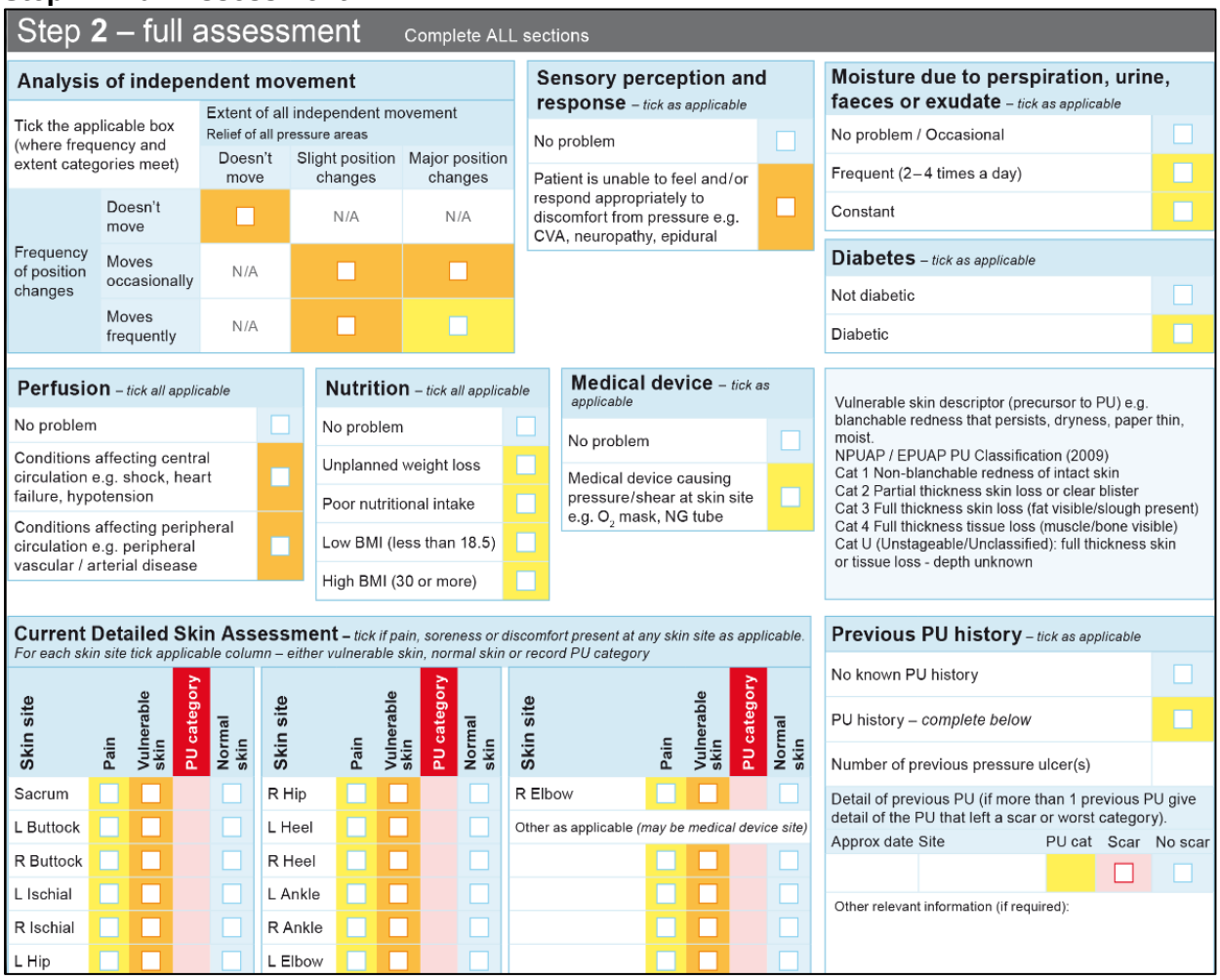
The decision boxes and colour coding will help in deciding whether to progress to Step 2 of the assessment: if a yellow box is ticked, the assessment should progress to Step 2. If only the blue box is ticked then the patient is not currently at risk which should be indicated by ticking the 'not currently at risk' box and the assessment is complete without the need to progress to Step 2.

2. Step 2 - Full Assessment: Complete for those potentially at risk as determined by step 1

Step 2 consists of 8 sections which must be fully completed. The sections comprise:

- Analysis of independent movement
- Sensory perception and response
- Current detailed skin assessment
- Pain
- Previous pressure ulcer history
- Perfusion
- Nutrition
- Moisture
- Diabetes

Step 2 – Full Assessment

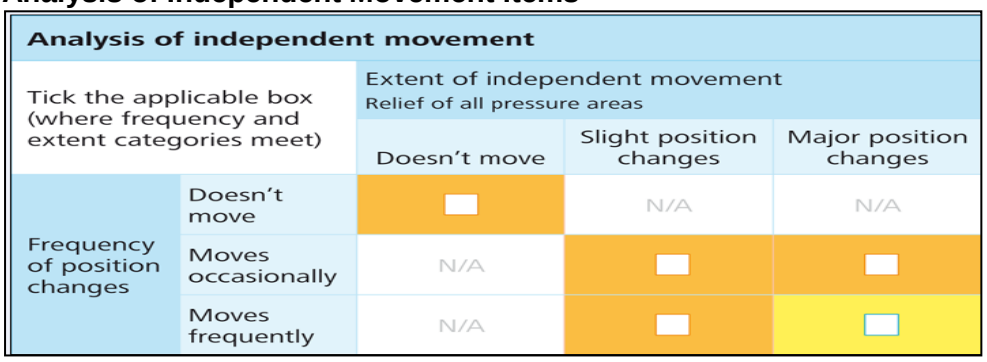


Each section will give a range of possibilities that may be encountered in clinical practice. It is important to indicate if the patient does not have a problem with a particular risk factor by ticking the 'no problem' item, as this shows that the assessment has been undertaken. The flow of the sections should be followed from top to bottom and left to right to avoid missing any sections.

2.1 Analysis of Independent Movement

This section was developed to capture information about the patient's independent movement. 'Independent movement' relates to movement that is undertaken by the patient without the assistance of another person, i.e. it does not relate to the movement encountered when the patient is given physical assistance to change position.

Analysis of Independent Movement Items



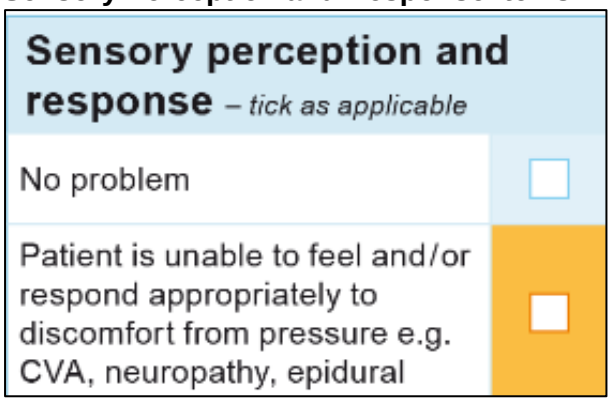
A matrix is used to bring the frequency (i.e. how often) and extent (i.e. amount) of movement together and each component has a range of options to be considered in light of the patient's movement pattern. When completing the frequency element, consideration of what would be considered normal frequency of movement and clinical judgement should be used to determine the appropriate category for the patient.

The 3 options relating to the extent of movement include 'the patient doesn't move', 'minor position changes' and 'major position changes'. Major position changes could include the patient turning over in bed or standing up resulting in complete pressure relief. Minor position changes could include the patient shifting their position a little when in the bed or chair which may result in some but not complete pressure relief. The patient doesn't move item relates to no pressure relief of pressure areas.

To complete the section the Registered Nurse must consider both frequency and extent of independent movement in the matrix and tick the box where the two elements meet.

2.2 Sensory Perception and Response
This section relates to sensory perception and response and comprises just 2 items. It is a tick **as** applicable section and only **one** item applies, i.e. does the patient have a problem with sensory perception and response or not.

Sensory Perception and Response Items



The ability of the patient to feel and/or respond appropriately to discomfort from pressure should be considered in the assessment. This item recognises that patients will vary in terms of whether they can do both i.e. some patients will not be able feel discomfort from pressure and so will not respond, while others may be able to feel but not respond appropriately and may have involuntary movements, spasms or spasticity/contractures. Either of these scenarios indicates there is a problem with sensory perception and could lead to reduced movement and pressure relief.

Factors that *may* (though not always) influence the patient's ability to feel and respond appropriately to discomfort from pressure, comprise underlying medical conditions or treatments such as MS, CVA, head injury, spinal injury, neuropathy, dementia, depression, epidural, anaesthetics and opiates. When undertaking the assessment the Registered Nurse must consider whether the presence of such factors affects the patient's sensory perception. They should also consider whether the patient's sensory perception and response varies over the day or may be for a limited period e.g. following an epidural.

2.3 Current Detailed Skin Assessment and Pain Assessment
Requires a visual skin inspection and assessment of skin sites listed in the table: these include the most common pressure area skin sites though patients sometimes develop pressure ulcers in other areas and there is space for 'other' skin sites if required. This should be completed for **all** skin sites shown in the table.

Current Detailed Skin Assessment and Pain Assessment Items

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable. For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category*

Skin site	Pain	Vulnerable skin	PU category	Normal skin	Skin site	Pain	Vulnerable skin	PU category	Normal skin	Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐		☐	R Hip	☐	☐		☐	R Elbow	☐	☐		☐
L Buttock	☐	☐		☐	L Heel	☐	☐		☐	Other as applicable *(may be medical device site)*				
R Buttock	☐	☐		☐	R Heel	☐	☐		☐		☐	☐		☐
L Ischial	☐	☐		☐	L Ankle	☐	☐		☐		☐	☐		☐
R Ischial	☐	☐		☐	R Ankle	☐	☐		☐		☐	☐		☐
L Hip	☐	☐		☐	L Elbow	☐	☐		☐		☐	☐		☐

Clinical judgement based on information from a holistic patient assessment should be used while undertaking the skin assessment. Each skin site should be inspected to identify normal skin, vulnerable skin (e.g. blanchable redness that persists, dryness, moist, paper thin) or pressure ulcer present (also see section 1.3). When considering skin redness in relation to vulnerability, the Registered Nurse should consider if the blanchable redness is a normal transient response. They must also consider the holistic patient assessment along with other elements of the PURPOSE T assessment when making a decision about skin, e.g. if a patient is fully mobile but has been sat out and has some blanchable redness this could be viewed as a normal response and not as skin vulnerability. However if a patient is immobile and the blanchable redness persists or is intense it might be considered vulnerable. Only one option should be chosen (normal skin, vulnerable skin or pressure ulcer category) for each skin site by ticking the appropriate box. The category of any existing pressure ulcer should be recorded in the pink column. Guidance regarding skin vulnerability and the abbreviated NPUAP/EPUAP Pressure Ulcer Classification System (2009) are listed within the PURPOSE T to assist in the assessment.

When considering the pain element it is important to identify the cause of the pain. In the context of this element of the assessment we are specifically concerned with pain that is related to a pressure area or ulcer rather than pain due to a pre-existing health condition e.g. arthritis (though the impact of this pain on independent movement would be an important consideration and would need effective management). Asking the patient where the pain is, what makes the pain worse and what reduces the pain will help to identify the cause of the pain. It is also important to use additional terms which may be more relevant to the patient and to relate it to their situation as in the examples below:

- At any time, do you get pain, soreness, or discomfort on a pressure area?

Prompt – back, bottom, hips, elbows, heels, or other as applicable to the patient?

- Do you think this is related to either: your pressure sore; laying in bed for a long time; sitting for a long time (*as appropriate*)?

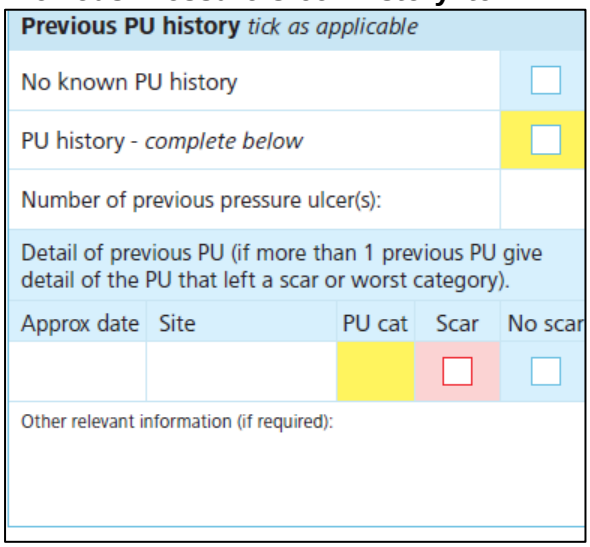
The patient may report pain before any visual sign of tissue damage. The presence of pressure area or ulcer pain should be indicated as applicable in the appropriate skin site box (see current detailed skin assessment item at 2.3).

2.4 Previous Pressure Ulcer History

The first 2 items relate to whether the patient has a reported history of a pressure ulcer and is a tick **as** applicable section and only **one** item applies, i.e. the patient either has a reported history of pressure ulcer or they don't. This could relate to a recent superficial ulcer or older severe pressure ulcer. Some patients may not know whether they have had a previous pressure ulcer, particularly if it was superficial. Evidence of a previous pressure ulcer may be recorded in the patient's clinical record though this is not always the case. If the patient

doesn't recall having a previous pressure ulcer, there is no evidence in the clinical record and there is no scarring on a pressure area site, no previous history may be presumed.

Previous Pressure Ulcer History Item



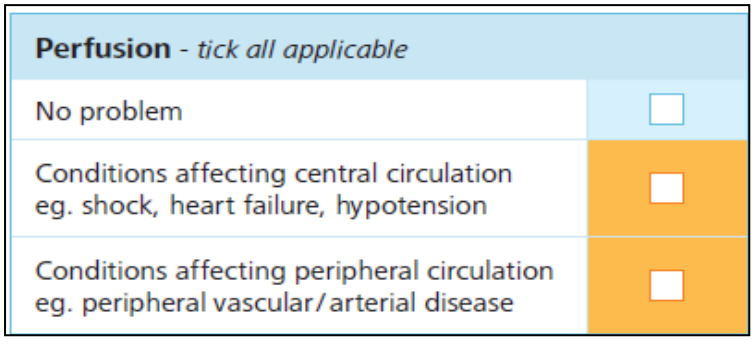
If the patient has a reported history, the number of previous pressure ulcer(s) should be recorded. Further details of the previous pressure ulcer incorporating the approximate date, site, category (at its most severe) and whether or not a scar is present (this could be ascertained when undertaking the current detailed skin assessment) should also be recorded. This is important as scarring results in ongoing skin vulnerability to pressure. If more than one, the previous pressure ulcer that left a scar should be recorded. If there is no scarring the previous pressure ulcer with the worst category should be recorded. Other relevant information may be recorded if required.

2.5 Perfusion

The perfusion section includes 'no perfusion problems' and 2 items relating to conditions that affect the central circulation (shock, heart failure or hypotension) and conditions that affect peripheral circulation (peripheral vascular/arterial disease). These give some examples of conditions affecting perfusion, but this is not exhaustive list and other factors such as poor capillary refill may also be considered.

If the patient doesn't have any perfusion problems then the 'no problem' box should be ticked. If the patient does have perfusion problems this should be indicated by ticking **all** the applicable items (some patients may have both central and peripheral circulatory problems).

Perfusion Items

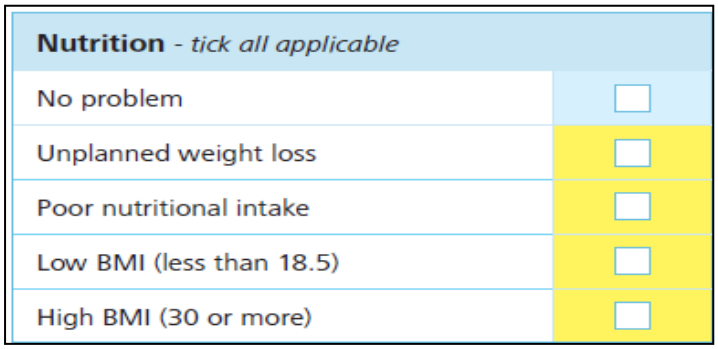


2.6 Nutrition

The nutrition items have been developed to capture patients with the varying nutrition problems that may be encountered in clinical practice. It is important to consider all the items and tick **all** the item boxes that **apply** to the patient (there may be more than one applicable

item). However, if the patient has no problems with nutrition the applicable box should be ticked.

Nutrition Items



Nutrition - *tick all applicable*	
No problem	☐
Unplanned weight loss	☐
Poor nutritional intake	☐
Low BMI (less than 18.5)	☐
High BMI (30 or more)	☐

The 4 items indicating there is a problem with nutrition comprise 'unplanned weight loss, 'poor nutritional intake', 'low BMI' and high 'BMI'. 'Unplanned weight loss' relates to weight loss that isn't sought by the patient, i.e. they haven't been trying to lose weight and may have lost it due to illness. At present there is a lack of consensus amongst nutritional experts about the amount of unplanned weight loss and time periods to present a problem (Meijers et al 2009). As a guide if the patient has lost any of the following it should be considered a risk factor: 5% of their body weight over 1-3 months, 10% of their body weight over 3-6 months or 3kg weight loss in 1 month, 6kg weight loss in 6 months (Meijers et al 2010).

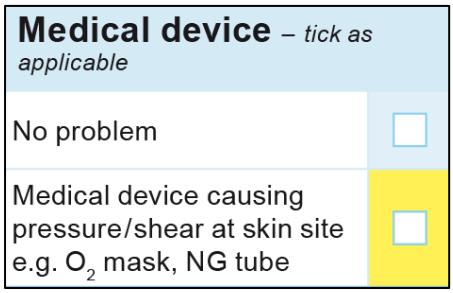
'Poor nutritional intake' may be relevant to patients with poor appetite who are not eating well. It may also be applicable for those who are nil by mouth and obtaining no other form of nutritional support. Clinical judgement should be used when assessing poor nutritional intake as some patients may receive nutritional support but not tolerate it well (e.g. not drink the full amount of supplement) and so would be considered to have poor nutritional intake.

The World Health Organisation (WHO) classifies a BMI of less than 18.5 as underweight and a BMI of 30 or more as obese. Clinical judgement may be needed when assessing BMI as it is recognised that measuring the patient's weight and height is not always possible in clinical practice.

2.7 Medical Devices

The medical device section comprises 2 items and is a tick **as** applicable section (only **one** item applies). They relate to the presence of a medical device which causes pressure/shear at the skin site or not. Examples of medical devices include respiratory masks/tubing, naso-gastric tubes, catheters, drains but this is not an exhaustive list. Nurses should use their clinical judgement to assess whether the device is causing a problem, incorporating consideration of skin vulnerability, whether the device is in continuous use and whether the patient is self-caring and can attend to their own device. If a device is not causing a problem then the blue box should be ticked. However, if the device is causing pressure/shear at a site which may impact the patients skin status the yellow box should be ticked. The specific skin site should be assessed and documented in the current detailed skin assessment section under 'other skin site'.

Medical Device Items



Medical device – *tick as applicable*	
No problem	☐
Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube	☐

2.8 Moisture

The moisture section comprises of 3 items and relates to moisture due to perspiration, urine, faeces or exudate. This is a tick **as** applicable section and only **one** item applies. The first item relates to patients' without a moisture problem or with occasional moisture which does not impact on the risk of pressure ulcer development. The other items relate to the frequency of moisture with some guidance of these parameters i.e. 'frequent (2-4 times a day)' and 'constant' meaning all of the time.

Moisture Items

Moisture due to perspiration, urine, faeces or exudate - *tick as applicable*	
No problem/Occasional	☐
Frequent (2-4 times a day)	☐
Constant	☐

2.9 Diabetes

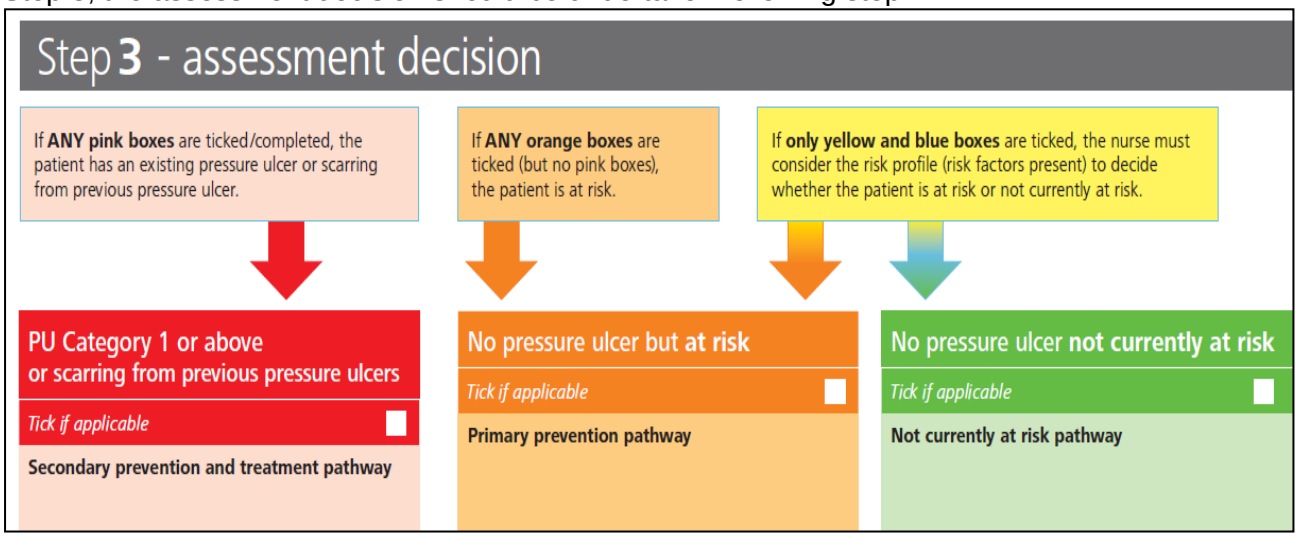
This item relates to the presence of diabetes and gives 2 options. This is a tick **as** applicable section and only **one** item applies.

Diabetes Items

Diabetes - *tick as applicable*	
Not diabetic	☐
Diabetic	☐

3. Step 3 – Assessment Decision

Step 3, the assessment decision should be undertaken following step 2.



Each item in Step 2 is highlighted by a blue, yellow, orange or pink box. These colours represent the importance of the risk factors as indicated by the level of scientific or epidemiological evidence and/or the results of the consensus study:

- Pink box items indicate the patient has an existing pressure ulcer or scarring from a previous pressure ulcer
- Orange box items indicate the presence of a key pressure ulcer risk factor
- Yellow box items indicate the presence of less influential pressure ulcer risk factors (but still important in considering the overall risk profile of a patient and in the delivery of appropriate preventative care)

- Blue box items indicate the absence of a risk factor.

When completing step 3 the Registered Nurse must carefully review the step 2 assessment to decide whether the patient should be allocated to the secondary prevention and treatment pathway, primary prevention pathway or the not currently at risk pathway.

This is facilitated by decision boxes in the PURPOSE T which indicate:

- If any pink boxes are ticked it indicates that the patient has an existing pressure ulcer or scarring from a previous pressure ulcer. The patient should be allocated to the secondary prevention and treatment pathway indicated by ticking the red box in the pathway.
- If any orange boxes (but no pink boxes) are ticked the patient does not have a pressure ulcer but is at risk of pressure ulcer development and should be allocated to the primary prevention pathway indicated by ticking the orange box in the pathway.
- If only yellow or blue boxes are ticked the risk profile of the patient must be considered and clinical judgement should be used to determine whether the patient is 'at risk' or 'not currently at risk'. This should be influenced by number of yellow boxes ticked (i.e. patients with a number of yellow boxes ticked are more likely to be considered 'at risk') and consideration of the patient's individual circumstances. For example a patient may only have the presence of unplanned weight loss but may be terminally ill and nearing the end of life. Here the general trajectory of dependence will increase and the patient may therefore be considered to be 'at risk'. In another example a young diabetic patient may have undergone acute surgery but be recovering well. Here the general trajectory is increasing independence so the patient may therefore be considered to be 'not currently at risk', (this would need to be reviewed if the patient's condition changed).

References

Meijers, J M M, van Bokhorst-de vander schueren, R. D, Schols, J. M.G. A, Soeters P. B, Halfens R. J. G. 2010. Nutrition.26(4):432-40.

NPUAP/EPUAP (2009) Prevention and treatment of pressure ulcers:clinical practice guideline. National Pressure Ulcer Advisory Panel Washington DC.

World Health Organisation BMI Classification System. Accessed 10th June 2013. http://apps.who.int/bmi/index.jsp?introPage=intro_3.html