

PURAF Field Test 1

Pressure Ulcer Risk Primary or Secondary Evaluation (PURPOSE T) User Notes

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 qualified nursing staff.

NB: PURPOSE T is not intended to assess the risk of pressure from external devices such as naso-gastric tubes and catheters etc.

The development of PURPOSE T incorporated a systematic review of pressure ulcer risk factors and a consensus study involving international experts in the pressure ulcer field (including review of pressure ulcer evidence): this allowed the numerous risk factors associated with pressure ulcer development to be carefully considered and only the most important risk factors to be included in PURPOSE T. Furthermore the use of colour within the tool allows us to identify the presence of key and less influential pressure ulcer risk factors. PURPOSE T was also pre-tested with practicing nurses allowing ambiguous or confusing elements to be identified and clarified in Field test version of PURPOSE T.

PURPOSE T does not utilise a score as other tools do - it encourages nurses to consider the profile of a patients' risk (PU risk factors present) to identify whether they are 'not currently at risk', 'at risk', or have an existing pressure ulcer and allocate them to the appropriate care pathway.

PURPOSE T has 3 steps including:

- Step 1 – Screening: complete for all patients
- Step 2 - Full Assessment: complete for those potentially at risk as determined by step
- Step 3 – Assessment Decision: to be undertaken for all patients who have undergone step 2

1. Step 1 – Screening: Complete for all patients

Step 1 comprises of two possible sections to complete:

- Mobility Status
- Skin status

Step 1 Assessment

Colour Key		Blue	Yellow	Pink
Step 1 - screening				
Mobility status - tick all applicable				
Walks independently with or without walking aids	<input type="checkbox"/>			
Needs the help of another person to walk	<input type="checkbox"/>			
Spends all or the majority of time in bed or chair	<input type="checkbox"/>			
Remains in the same position for long periods	<input type="checkbox"/>			
If ANY yellow boxes are ticked, go to Step 2				
If ONLY blue box is ticked				
Skin status - tick all applicable				
Normal skin	<input type="checkbox"/>			
Current PU category 1 or above?	<input type="checkbox"/>			
Reported history of previous PU?	<input type="checkbox"/>			
Vulnerable skin e.g. redness, dryness, paper thin, moist	<input type="checkbox"/>			
If ANY yellow or pink boxes are ticked, go to Step 2				
If ONLY blue box is ticked				
No pressure ulcer not currently at risk				
Tick if applicable		<input type="checkbox"/>		
Not currently at risk pathway				

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 you consider and tick **all** the item boxes that **apply** to your patient: 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

Mobility status - tick all applicable		Colour Key
Walks independently with or without walking aids	<input type="checkbox"/>	Blue
Needs the help of another person to walk	<input type="checkbox"/>	Yellow
Spends all or the majority of time in bed or chair	<input type="checkbox"/>	
Remains in the same position for long periods	<input type="checkbox"/>	

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

1.2 Mobility Decision Boxes

The decision boxes and colour coding will help you decide if you need to go to step 2 of the assessment straight away or if you need to complete the Step 1 skin status items: if you have ticked any yellow boxes you should progress to Step 2 without completing the Step 1 skin status items. If you have **only** ticked the blue box you should complete the Step1 skin status items.

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

Skin status - tick all applicable	
Normal skin	<input type="checkbox"/>
Current PU category 1 or above?	<input type="checkbox"/>
Reported history of previous PU?	<input type="checkbox"/>
Vulnerable skin e.g. redness, dryness, paper thin, moist	<input type="checkbox"/>

Colour Key
Blue
Yellow
Pink

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

The item 'normal skin', requires judgement since there is no clear definition of what constitutes normal skin. It would certainly include the absence of skin vulnerability or pressure ulcers: nurses should use their clinical judgement to determine if a patient's skin is normal. The 'vulnerability' skin item gives examples of redness, dryness, paper thin and moist: these describe the visual appearance of vulnerable skin but this is not exhaustive list and you may also consider other factors. See section 2.3 for further notes on skin vulnerability and skin redness.

The 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 you decide if you need to go to Step 2 of the assessment, or if the patient is not currently at risk.

If you have ticked any yellow or pink boxes you should progress to Step 2 of the assessment. If you have only ticked the blue box then the patient is not currently at risk and you should indicate this by ticking the 'not currently at risk' box and end the assessment without progressing 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
- Previous pressure ulcer history
- Perfusion
- Nutrition
- Moisture
- Diabetes

Step 2 – Full Assessment

Colour Key		Blue	Yellow	Orange	Pink						
Step 2 - full assessment Complete ALL sections											
Analysis of independent movement											
Tick the applicable box (where frequency and extent categories meet)		Extent of independent movement Relief of all pressure areas									
		Doesn't move	Slight position changes	Major position changes							
Frequency of position changes	Doesn't move	<input type="checkbox"/>	N/A	N/A							
	Moves occasionally	N/A	<input type="checkbox"/>	<input type="checkbox"/>							
	Moves frequently	N/A	<input type="checkbox"/>	<input type="checkbox"/>							
NPUAP/EPUAP Pressure Ulcer Classification System (2009)											
Category I: Non-blanchable redness of intact skin											
Category II: Partial thickness skin loss or blister											
Category III: Full thickness skin loss (fat visible)											
Category IV: Full thickness tissue loss (muscle/bone visible)											
Category U: (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown											
For descriptions please see full classification system (NPUAP/EPUAP 2009)											
Current Detailed Skin Assessment - tick applicable column for each skin site. Record the category of current PU if applicable.											
Skin site	Normal skin	Vulnerable skin (e.g. eg. red, dry, PU) eg. red, dry, moist, paper thin	PU category	Skin site	Normal skin	Vulnerable skin (e.g. eg. red, dry, PU) eg. red, dry, moist, paper thin	PU category	Skin site	Normal skin	Vulnerable skin (e.g. eg. red, dry, PU) eg. red, dry, moist, paper thin	PU category
Sacrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Buttock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Heel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - detail below if applicable			
R Buttock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Heel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
L Ischial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
R Ischial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
L Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Perfusion - tick all applicable						Nutrition - tick all applicable					
No problem			<input type="checkbox"/>	No problem			<input type="checkbox"/>	Unplanned weight loss			<input type="checkbox"/>
Conditions affecting central circulation eg. shock, heart failure, hypotension			<input type="checkbox"/>	Poor nutritional intake			<input type="checkbox"/>	Low BMI (less than 18.5)			<input type="checkbox"/>
Conditions affecting peripheral circulation eg. peripheral vascular/arterial disease			<input type="checkbox"/>	High BMI (30 or more)			<input type="checkbox"/>				<input type="checkbox"/>
Previous PU history tick as applicable						Moisture due to perspiration, urine, faeces or exudate - tick as applicable					
No known PU history						<input type="checkbox"/>					
PU history - complete below						<input type="checkbox"/>					
Approx date	Site	PU cat NPUAP/EPUAP		Scar (if applicable)							
No problem/Occasional						<input type="checkbox"/>					
Frequent (2-4 times a day)						<input type="checkbox"/>					
Constant						<input type="checkbox"/>					
Diabetes - tick as applicable											
Not diabetic						<input type="checkbox"/>					
Diabetic						<input type="checkbox"/>					








Each section will give a range of possibilities as you would encounter in clinical practice. It is important that if the patient does not have a problem with a particular risk factor that this is indicated by ticking the 'no problem' item showing the assessment has been undertaken. If you follow the flow of the sections from top to bottom and left to right you are less likely to miss any sections out, though some nurses have found it more practical to complete the visual skin inspection at the end of the assessment.

2.1 Analysis of Independent Movement

This section was developed to capture information about the patients' 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 nurses changes the patients' position or turns the patient.

Analysis of Independent Movement Item

Analysis of independent movement		Extent of independent movement Relief of all pressure areas			Colour Key  Yellow  Orange
Tick the applicable box (where frequency and extent categories meet)		Doesn't move	Slight position changes	Major position changes	
Frequency of position changes	Doesn't move	 <input type="checkbox"/>	N/A	N/A	
	Moves occasionally	N/A	 <input type="checkbox"/>	 <input type="checkbox"/>	
	Moves frequently	N/A	 <input type="checkbox"/>	 <input type="checkbox"/>	

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 for you to consider in light of patients movement pattern. When completing the frequency element the nurse must consider what would be considered normal frequency of movement and use her clinical judgement to inform which category the patient falls into.





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 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

Sensory perception and response <i>tick as applicable</i>	Colour Key  Blue  Orange
No problem	 <input type="checkbox"/>
Patient is unable to feel and/or respond appropriately to discomfort from pressure	 <input type="checkbox"/>

In your assessment you need to consider if the patient is unable to feel and/or respond appropriately to discomfort from pressure. 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. 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 patients' 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 nurse must consider whether the presence of such factors affects the patients' sensory perception.

2.3 Current Detailed Skin 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 Items

Colour Key			
<input type="checkbox"/>	Blue	<input type="checkbox"/>	Orange
<input type="checkbox"/>		<input type="checkbox"/>	Pink
Current Detailed Skin Assessment - tick applicable column for <i>each</i> skin site.			
<i>Record the category of current PU if applicable.</i>			
Skin site	Normal skin	Vulnerable skin (precursor to PU) eg. red, dry, moist, paper thin	PU category NPUAP/EPUAP
Sacrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Buttock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R Buttock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Ischial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R Ischial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin site	Normal skin	Vulnerable skin (precursor to PU) eg. red, dry, moist, paper thin	PU category NPUAP/EPUAP
R Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Heel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R Heel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin site	Normal skin	Vulnerable skin (precursor to PU) eg. red, dry, moist, paper thin	PU category NPUAP/EPUAP
R Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other - detail below if applicable</i>			
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

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. persistent redness, dry, moist, paper thin) or pressure ulcer present (also see section 1.3). When considering skin redness in relation to vulnerability, the nurse should consider if the redness is a normal transient response. The nurse 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 blanching redness this could be viewed as a normal response and not as skin vulnerability. However if a patient is immobile and the redness is persistent or intense it might be considered vulnerable.

The nurse should only choose one option (normal skin, vulnerable skin or PU category) for each skin site by ticking the appropriate box. The category of any existing pressure ulcer is recorded in the pink column. The abbreviated NPUAP/EPUAP Pressure Ulcer Classification

System (2009) is listed to help you and the full version of this will be available in the study documentation.

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. Some patients may not know and the patients' clinical record could provide a good source of information.

Previous Pressure Ulcer History Items

Previous PU history <i>tick as applicable</i>			
No known PU history			<input type="checkbox"/>
PU history - complete below			<input type="checkbox"/>
<i>Approx date</i>	Site	PU cat NPUAP/EPUAP	Scar (if applicable)
			<input type="checkbox"/>
			<input type="checkbox"/>

Colour Key

	Blue
	Yellow
	Pink

If the patient has a reported history of pressure ulcer development the approximate date, site and PU category should be recorded. The nurse should also indicate if a scar is present which could be ascertained when undertaking the current detailed skin assessment. This is important as scarring results in ongoing skin vulnerability to pressure.

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 you may also consider other factors such as poor capillary refill.

If the patient doesn't have any perfusion problems then the nurse should tick 'no problem'. If the patient does have perfusion problems the nurse should tick the **all** applicable items as some patients' may have both central and peripheral circulatory problems.

Perfusion Items

Perfusion - tick all applicable		Colour Key
No problem	<input type="checkbox"/>	Blue
Conditions affecting central circulation eg. shock, heart failure, hypotension	<input type="checkbox"/>	Orange
Conditions affecting peripheral circulation eg. peripheral vascular/arterial disease	<input type="checkbox"/>	

2.6 Nutrition

The nutrition items have been developed to capture patients with the varying nutrition problems as you would encounter in clinical practice. It is important that you consider all the items and tick **all** the item boxes that **apply** to your patient as there may be more than one applicable item. However, if your patient has no problems with nutrition you will only tick the applicable box.

Nutrition Items

Nutrition - tick all applicable		Colour Key
No problem	<input type="checkbox"/>	Blue
Unplanned weight loss	<input type="checkbox"/>	Yellow
Poor nutritional intake	<input type="checkbox"/>	
Low BMI (less than 18.5)	<input type="checkbox"/>	
High BMI (30 or more)	<input type="checkbox"/>	

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. 'Poor nutritional intake' may be relevant to patients with poor appetite who are not eating well. It may also be applicable for those are nil by mouth and obtaining no other form of nutritional support. Low BMI is less than 18.5 and high BMI is 30 or more.

2.7 Moisture

The moisture section comprises of 3 items and relates to moisture due to perspiration, urine, faeces or exudates. 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 patients' 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		Colour Key
No problem /Occasional	<input type="checkbox"/>	Blue
Frequent (2-4 times a day)	<input type="checkbox"/>	Yellow
Constant	<input type="checkbox"/>	

2.8 Diabetes

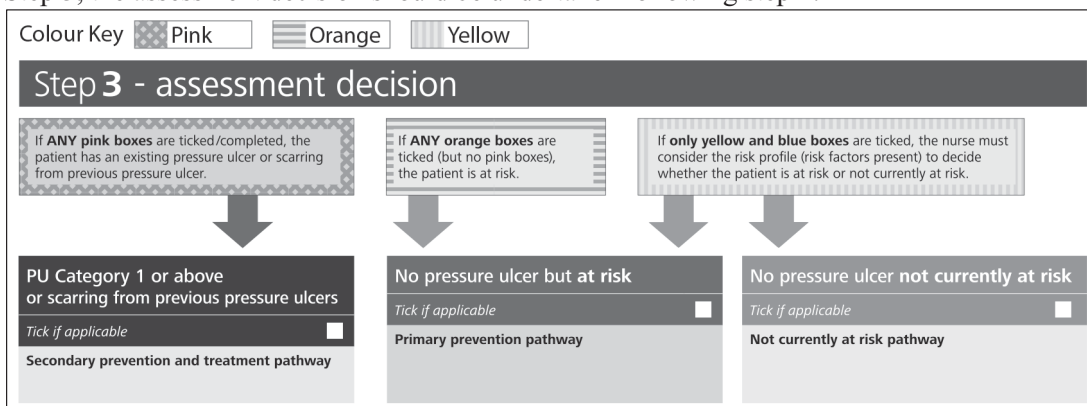
This item relates to the presence of diabetes and gives 2 options. This is a tick **as** applicable section and only **one** item applies.

Diabetes Items

Diabetes - tick as applicable		Colour Key
Not diabetic	<input type="checkbox"/>	Blue
Diabetic	<input type="checkbox"/>	Yellow

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 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 nurse must consider the risk profile of the patient and use clinical judgement to determine whether the patient is 'at risk' or 'not currently at risk'. The nurse should consider the number of yellow boxes ticked and the patients' individual circumstance, for example a patient may only have the presence of unplanned weight loss but may be terminally ill and nearing the end of life where the general trajectory of dependence will increase and the nurse may therefore consider the patient to be 'at risk' or a young diabetic patient may have undergone acute surgery but be recovering well where the general trajectory is increasing independence so the nurse may consider the patient to be 'not currently at risk', but would want to review this if the patients' condition changed. Patients with a number of yellow boxes ticked are more likely to be considered 'at risk'.