SOP GEN 20 Pressure Area Care

Procedure Number	SOP GEN 20
Purpose of Document	To inform all Acacium Group staff of their responsibilities in regard to providing effective pressure area care, to promote skin integrity and prevent infection whilst maintaining safety, self-esteem, dignity and self-respect
Target Audience	All Acacium Group Nurses, Carers and Support Workers
Version	V3.0
Author	Sharon Jolley
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Lead Director	Karen Matthews-Shard
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Review Frequency	3 yearly
Next Review Date	April 2026
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A

Document History			
Version	Date	Changes made/comments	By whom
V1	Dec 2016	Implementation of document history page	KNF/SJ
V1	April 2017	Annual Review	KNF/VM
V1.1	Feb 2020	Update to new Community Template	CC
V2	April 2020	3 yearly review	Clinical Advisory Group
V2.1	Oct 2020	Updated re rebrand	CC
V3.0	Apr 2023	Reviewed and update	Clinical Advisory Group

Acacium Group Standard Operating Procedure

1. Introduction

When an area of skin and the surrounding tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply an ulcer, moisture lesion and/or discolouration may occur. Typically, they occur in a person who is confined to bed or a chair as a result of an illness/disease or lack of mobility. They were sometimes referred to as 'bed sores' or 'pressure sores'.

All clients are at risk of developing a pressure ulcer. However, they are most likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition or poor posture or deformity.

Pressure ulcers, moisture lesions and skin discolouration, in most cases, are preventable.

2. Aim

The purpose of this SOP is to ensure that Acacium Group meets best practice standards for the prevention and management of pressure ulcers in line with national, regional and local guidelines.

3. Who may undertake this procedure

All Acacium Group healthcare workers are able to undertake this procedure providing they are trained to do so or have been trained and assessed as competent to do so.

4. Hazards/complications

The greatest hazard is causing skin to breakdown and introducing infection or creating discomfort to the client. Care should be taken to perform the procedure gently, whilst maintaining a clean and safe environment. The client's privacy and dignity is to be maintained at all times during the procedure.

5. Assessment of need

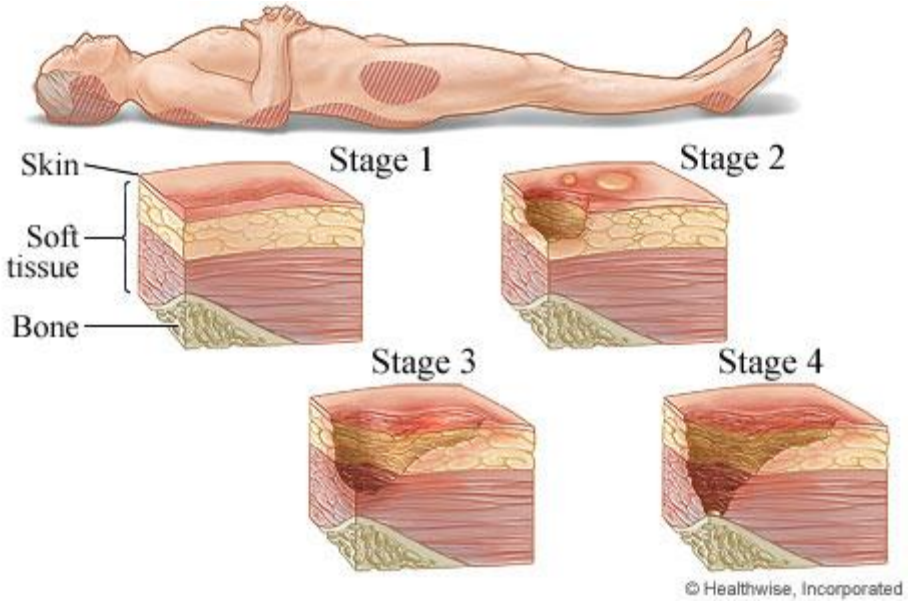
Assessment of need is based on observation and clinical judgment utilising the Waterlow Score Chart for adult client where required. See Appendix B. Braden Q for children. See Appendix C for PURPOSE-T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) - Pressure ulcers - Patient Safety Learning - the hub (pslhub.org)

Risk assessment tools combined with clinical judgment of the nursing staff are used to formulate the individual client care plan to prevent pressure ulcers developing and to treat or manage any already present.

6. The normal structure and function of the skin

The skin is an amazing organ. Measuring around 2 square meters and accounting for up to 15% of your body weight, it is the largest and heaviest organ of your body. It is made up of three layers:

- The epidermis – this is the thin outer layer of the skin that you can see when you look at yourself. It is only about 0.04mm thick and does not have its own network of blood vessels, so that it has to get its nutrients from the underlying dermal layer. Every 4 weeks the epidermis completely renews itself as the outer cells are worn away and replaced with new ones from underneath.
- The dermis – this lies beneath the epidermis, it is about 0.5mm thick and is the active part of the skin. It contains blood vessels, nerves, hair follicles, sebaceous (oil), sweat glands and lymphatics. The dermis contains collagen, fat and elastin fibres which give the skin its strength and flexibility.
- The hypodermis – this is a layer of subcutaneous fat under the dermis. It also contains blood vessels and connective tissue. It forms a protective layer over the underlying organs and structures and also acts as an energy source for the body.
- Stages of Pressure Ulcers:



- Stage 1 – ulcers are not open wounds. The skin may be painful, but it has no breaks or tears. The skin appears reddened and does not blanch (lose colour briefly when you press your finger on it and then remove your finger). In a dark-skinned person, the area may appear to be a different colour than the surrounding skin, but it may not look red. Skin temperature is often warmer and the stage 1 ulcer, can feel firmer or softer than the area around it.

- Stage 2 – the skin breaks open, wears away or forms an ulcer which is usually tender and painful. The area expands into deeper layers of the skin. It can look like a scrape (abrasion), blister or shallow crater in the skin. Sometimes this stage looks like a blister filled with clear fluid. At this stage, some skin may be damaged beyond repair or may die.

- Stage 3 – during this stage, the ulcer deteriorates and extends into the tissue beneath the skin forming a small crater. Fat may show in the ulcer, but not muscle, tendon or bone.

- Stage 4 – during this stage the pressure ulcer is very deep, reaching into muscle and bone causing extensive damage. Damage to deeper tissues, tendons and joints may occur. At stages 3 and 4, there may be little or no pain due to significant tissue damage. Serious complications such as infection of the bone (osteomyelitis) or blood (sepsis) can occur if pressure ulcers progress. Sometimes a pressure ulcer does not fit into one of these stages.

- In some cases, a deep pressure ulcer is suspected but cannot be confirmed. Where there isn't an open wound but the tissues beneath the surface have been damaged, the ulcer is called a deep tissue injury (DTI). The area of skin may look purple or dark red or there may be a blood-filled blister.

- There are also pressure ulcers that are "unstageable" meaning that the stage is not clear. In these cases, the base of the ulcer is covered by a thick layer of other tissue and pus/exudate, which may be yellow, grey, brown or black.

- If you suspect a pressure ulcer please contact your local Acacium Group office immediately and provide them with as much information as possible e.g.: size, depth, colour, temperature and document your findings clearly in the clients care plan. Please speak with the clinical lead whether this needs reporting externally.

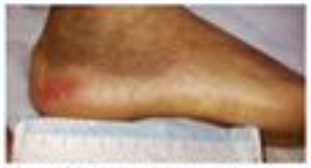
Pressure Ulcer Categories:

Blanching erythema

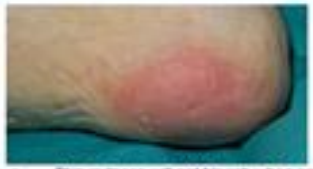
Healthy skin may develop transient redness when subjected to pressure – for example, if the legs are crossed. To test if damage has occurred, light finger pressure should be applied to see if the skin blanches (goes white). In darker skin tones, redness may present as a darker area that is grey or purplish. This is **not** a pressure ulcer.

Example of skin blanch

Blanch in darker skin



This redness is persistent and does not blanch



This redness will not blanch when pressure is applied

Category 1: Non-blanchable erythema

Intact skin with non-blanchable redness of a localised area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).

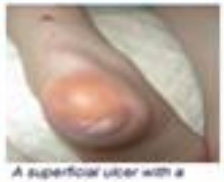
Category 2: Partial thickness skin loss

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

**Bruising indicates suspected deep tissue injury.*

An intact serum-filled blister

A shallow open ulcer with a red pink wound bed without slough



A superficial ulcer with a collapsed blister

Full thickness tissue loss. Subcutaneous fat is visible but no bone, tendon or muscle

Category 3: Full thickness skin loss

Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.

May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

Category 4: Full thickness tissue loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (eg fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

In this wound, the bone is clearly visible

This wound shows exposed muscle

This occipital ulcer is covered by softening necrosis

This heel ulcer is covered by hard dry eschar

The necrotic cap on this heel has softened and started to separate

Although still firmly attached, there is a ring of demarcation where this eschar has been rehydrated

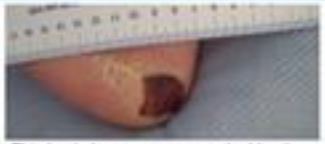
Unstageable: depth unknown

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.

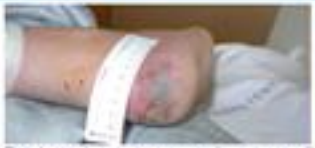
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore category, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

Suspected deep tissue injury: depth unknown

Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.



This heel ulcer appears as a dry blood blister



This heel ulcer appears as a linear area of deep purple black discolouration

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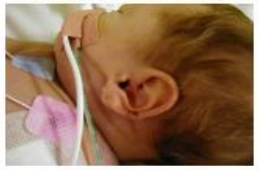
To cite this poster please use: NHS Improvement Pressure ulcer categorisation group (2019) Pressure Ulcer Categorisation. Available from http://nhs.stopthepressure.co.uk/

NHS England and NHS Improvement

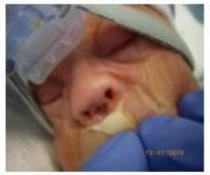
Device-related pressure ulcers (DRPU)

'Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes.'

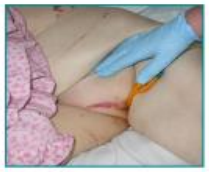
While some DRPU may also be allocated a category of damage, others may not as they are on parts of the anatomy that do not have the same structures as the skin – for example, the mucosal membrane. Where possible, a device-related ulcer should be categorised and the presence of a device noted by the addition of a (d) after the category.



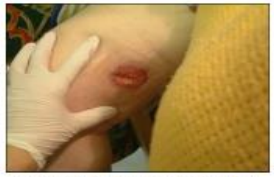
This infant has Category 1 damage to the cheeks and a small unstageable ulcer on the ear



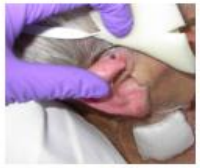
This neonate has damage to the nares that cannot be categorised



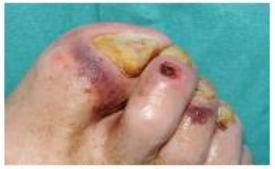
The damage caused by this urinary catheter could be categorised as a DTI (d)



Although difficult to identify, this PU was caused by the leather ring at the top of an old-fashioned calliper



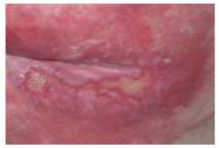
Damage has occurred where the spectacles and elastic from the oxygen mask press on the pinna of the ear



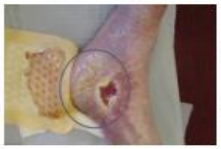
Although difficult to identify, this PU was caused by the patient having their feet caught in the bed sheets which were tightly twisted across the toes

Moisture-associated skin damage

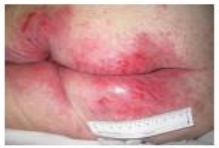
This can occur due to the presence of any type of moisture on the skin, including incontinence, leakage from stoma, saliva, wound exudate and sweat



These multiple superficial lesions with diverse edges are typical of Incontinence Associated Dermatitis



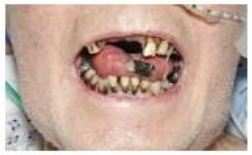
The white cobblestone appearance of the tissue around this wound show evidence of significant maceration due to wound exudate remaining on the skin

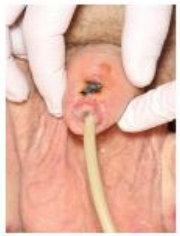


Wounds related to IAD such as these are often extremely painful

This wound demonstrates how the epidermis can easily be stripped away by incontinence

Mucosal pressure ulcers





Mucosal pressure ulcers can not be categorised as the tissue does not have the same layers as the skin and therefore does not conform to the definitions. These PU are therefore uncategorisable (NOT unstageable) . They are usually caused by devices and therefore should be recorded as PU (d), locally you may wish to denote them as "Mucosal" or "Uncategorisable".

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Device-Related Pressure Ulcers (DRPU)

7. Consent

Clients have a fundamental legal and ethical entitlement to determine what happens to their bodies. Valid consent to treatment is central to all forms of healthcare. Consent is a client agreement for a health professional to provide care orally, or in writing. For consent to be valid the client must be competent to take that decision, be fully informed of the action and its consequences, and not be under duress. Consent should be sought verbally for the purposes of giving pressure area care.

If a client declines treatment or equipment recommended by the Community Team health care professional, this should be documented in accordance with the Consent Policy.

Risks and benefits to the procedure should be explained along with the risks of not having the procedure and any possible alternatives to the proposed procedure.

Acacium Group staff should be aware that carers and relatives do not have the right to give consent on behalf of the client however staff may be able to act as long as they are able to demonstrate that any actions are in the best interest of the client. There may be a representative legally appointed to provide consent on the client's behalf.

Please read Acacium Group policy on consent for full details.

8. Client and relatives/carers involvement

The client and relatives or carers may be taught to provide pressure area care if they wish to support the care needs of the client, support should be sought from the appropriate specialist team such as District Nurses or Tissue Viability nurses.

9. Client information

As part of obtaining valid consent the risks, benefits and alternatives to treatment will have been discussed.

The procedure must be explained fully in order to gain full cooperation with the procedure.

10. Clinical Assessment

- Risk assessment is to be undertaken utilising the Waterlow chart or Braden Q chart depending on the clients age or PURPOSE-T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) - Pressure ulcers - Patient Safety Learning - the hub (pslhub.org).
- Initial assessment should be completed with the client and annually reviewed (or sooner if clinical assessment or information is received which alters the risk assessment).
- The risk assessment must be documented in the clients care plan following a clinical assessment that formulates the clients individual needs to prevent pressure ulcers developing or to treat any that are already present.
- Moving and handling assessment should be completed to ensure that appropriate equipment is used to reduce the risk of pressure ulcers developing and should be kept up to dated.

11. Prevention/Care Planning

Following assessment, if the client is scored at risk, medium or high, the clinical nurse should provide tailored information to the client. This must be documented in their care plan. Information should include:

- Why they are most likely to be at risk of developing a pressure ulcer
- How to identify early signs of pressure damage and damage due to moisture
- What steps to take to prevent new or further pressure damage/moisture lesions
- Who to contact for further information and advice and escalation procedure
- Ensure that the client is free from laying or sitting on any equipment that may cause pressure e.g., catheter tubing, ventilator tubing etc.
- Sheets and clothing should be free from creases, wherever possible.
- Where personal care is being provided, clients should be cleaned and dried thoroughly.
- The division should provide annual update training for healthcare workers
- Health care workers in the settings are identified as having appropriate opportunity for visual assessment of vulnerable areas on the skin and should therefore be informed of clients who score medium or high risk.
- Training should include: who is most likely to be at risk of developing a pressure ulcer, how to identify pressure and moisture damage, what steps to take to prevent new or further pressure/moisture damage including how to reposition and who to contact for further information and advice
- Records of training must be kept for evidence

- P = Press reddened skin to check for blanching
- U = Uncover the skin and remove stockings and socks
- L = Lift and check heels with a mirror
- S = Search for redness on the sacrum
- E = Evaluate elbows for redness

12. Equipment for Pressure Area Care

There are many pressure relieving aids used to deliver pressure area care and relief. Below are some examples of some of the more popular devices used including moving and handling equipment but this is not exhaustive.

- Slide sheets

- Manual or electronic hoist

- Banana/snake transfer board

- Stand aid

- Pressure relieving mattress

- Pressure relieving cushion

- Heel and elbow pads

13. Procedure for Pressure Area Care

	Action	Rationale
1	Explain and discuss the procedure with the client.	To ensure that the client understands the procedure and gives his/her valid consent (NMC 2018)
2	Prepare relevant equipment required to perform the task	To confirm that all equipment is suitable for purpose and in working order.
3	Assess the environment and ensure there is sufficient space to carry out the task	To minimise the risk of slips, trips or falls and maintain client and staff safety
4	Establish the routine/regime in place for the client's pressure area care	To plan the care required for the day and to ensure it is carried out in a timely manner
5	Encourage the client to reposition themselves if able	To maintain skin integrity and promote independence

	to do so	
6	Wash hands using soap and water or bactericidal hand rub, and dry. Apply non-sterile gloves	To minimise the risk of transmitting infection
7	Inform the client of what is proposed, giving step by step instructions	To ensure understanding and clear instructions are received by the client and to confirm again, their consent
8	Reposition/turn the client using appropriate aids	To prevent friction, abrasion or damage to the skin by relieving pressure
9	Apply prescribed barrier/other creams if applicable	To prevent the breakdown of the skin
10	Assess and monitor the clients skin each time they are repositioned	To allow early detection of any potential ulcers
11	Wash hands using soap and water or bactericidal hand rub, and dry	To minimise the risk of transmitting infection
12	Complete the client's care record and update the care plan.	To maintain accurate records. To provide a point of reference in the event of any queries. To prevent any duplication of treatment (NMC 2018).

13. Remember – treatment that should never be offered is skin massaging or rubbing of the area in an attempt to prevent a pressure ulcer. This could damage fragile skin and cause ulcers to develop.

14. Related Documents

POLICY:

CLIN 06 Consent Policy
CLIN 18 Manual Handling
CLIN 22 General Care Policy

15. References

- Pressure Ulcers: Prevention and Management – NICE guidelines CG179 – April 2014 updated February 2019
- How to Prevent Pressure Ulcers - EPUAP (European Pressure Ulcer Advisory Panel) – November 2014; updated November 2019
- Preventing Pressure Ulcers in Hospitals – AHRQ (Agency for Healthcare Research and Quality) – October 2014
- NHS Stop the Pressure – 10th May 2017
- The Waterlow Score – Judy Waterlow – 2007
- Pressure Ulcers: applying all our Health Pub; 01 April 2015, updated 10th June 2022 https://www.gov.uk/government/publications/pressure-ulcers-applying-all-our-health#full-publication-update-history
- www.gov.uk/government/publications/pressure-ulcer-applying-all-our-health

- https://www.nice.org.uk/guidance/cg179/evidence/appendix-o-pdf-19713978329
- Recognising, managing and preventing deep tissue injury (DTI) – Consensus Document 2017NHS ENGLAND (2017) National Stop the Pressure programme: One Year on – our focus for improvement. https://www.england.nhs.uk/wp-content/uploads/2020/08/Stop_the_Pressure_one_year_on.pdf
- NHS Improvement Pressure ulcer categorisation group (2019) Pressure Ulcer Categorisation. http://nhs.stopthepressure.co.uk/
- PURPOSE-T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) - Pressure ulcers - Patient Safety Learning - the hub (pslhub.org) - https://www.pslhub.org/learn/patient-safety-in-health-and-care/patient-management/pressure-ulcers/purpose-t-pressure-ulcer-risk-primary-or-secondary-evaluation-tool-r7729/

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group standard operating procedure (SOP), the SOP herein applies to all trading companies detailed below:

Thornbury Community Services (TCS)

At Thornbury Community Services (TCS), high quality care is our number one priority. With a team of exceptional and conscientious nurses and care staff, we're able to deliver the best complex care at home or in the community, 24/7 or whenever you need it. With compassion, integrity and dedication, we help empower individuals to achieve personal aspirations, as well as providing care tailored to their needs. Making a positive difference to our client's lives is our passion and it's this that sets us apart.

Thornbury Community Services Learning Disability & Autism (TCS LDA)

Thornbury Community Services (TCS), provide specialist outcome-focused support for children and adults who are diagnosed with a learning disability and/or autism, who may present with behaviours of concern. Working in close partnership with commissioners, local authorities, hospital teams, our clients and their families; providing bespoke healthcare services, offering tailored care for every individual we support. We have a proven track record of supporting individuals with learning disabilities and/or autism and a reputation for delivering excellence across all aspects of case management.

Our vision is to increase personal choice and to empower people with a learning disability and/or autism to live fulfilling and rewarding lives and be an active member of their own community.

Pulse Nursing at Home

Pulse Nursing at Home provides flexible, bespoke care for people living in their own homes and communities. We provide a lifetime solution that can adapt to changing healthcare needs.

We're passionate about our people and proud that the services we provide achieve the highest standards of compassionate care, supporting choice and empowering our clients to live the life they want.

Thornbury Nursing Services (TNS)

Established in 1983, TNS is one of the UK's leading independent nursing agencies, providing skilled nurses on a temporary or permanent basis throughout England and Wales.

Thornbury Nursing Services
Part of Acacium Group

TNS believe it is more important than ever to offer high quality, clinical care at home and in the community.
TNS specialist community nurses and carers provide temporary nursing and care support for clients at home. They're ready to step in to support discharge plans, prevent hospital admissions, maintain client safety and support uncertain rosters.

Service TNS offers

- Temporary staffing to cover shortfalls in existing shift rotas
- Backfilling for interim cover during recruitment periods
- Rapid response to facilitate early discharge and to avoid hospital admission
- A staffing solution to stabilise complex mental health cases in crisis
- A CQC registered staffing service – currently rated 'outstanding'
- Assistance in stabilising staffing in long term complex care packages
- Support for both adults and paediatrics
- A nurse-led team contactable 24 hours a day, 7 days a week

Scottish Nursing Guild (SNG)

Established in 1995, SNG, as part of Acacium Group, is one of Scotland's leading independent nursing agencies, providing skilled nurses on a temporary basis to major NHS trusts, and private sector clients, throughout Scotland, Northern Ireland and Republic of Ireland.

Scottish Nursing Guild
Part of Acacium Group

Service SNG offers

- A nurse-led team with full case management if needed, including compiling individualised care plans and risk assessments with ongoing support from Case Manager
- Care support for as long as you need us, from a few hours to 24/7
- Our office is contactable 24 hours a day, 7 days a week
- Rapid response to make early discharge possible or to avoid hospital admission
- Highly skilled nurses to provide home-based specialist care tailored to the specific needs of clients with complex care requirements
- Ad-hoc staffing to cover shortfalls in existing shift rotas or provide interim cover during recruitment periods
- Help stabilising staffing in long term complex care packages
- Palliative / end of life nursing care for clients who wish to remain at home
- Care provision for clients who need assistance with personal and/or social care support
- Support for both adults and children
- Support for clients no matter how complex their care needs
- Respite care to support clients either at home or away from home

Appendix B: Waterlow Chart

Name: _____ Hospital No: _____

Instructions for use:

1. Complete on admission and recalculate daily **Waterlow Chart**
2. Add scores together and insert total score.
3. If total score is 10+ initiate SKIN bundle care plan.
4. If total score 15+ initiate SKIN Bundle form at Bed side

WATERLOW SCORE CHART Date (Day/Month/Year) Time												
Gender	Male	1										
	Female	2										
Age	14 - 49	1										
	50 - 64	2										
	65 - 74	3										
	75 - 80	4										
	81 +	5										
Build	Average BMI 20 – 24.9	0										
	Above average BMI 25 – 29.9	1										
	Obese BMI > 30	2										
	Below average BMI < 20	3										
VISUAL ASSESSMENT OF AT RISK SKIN AREA (May select one or more options)	Healthy	0										
	Thin and fragile	1										
	Dry	1										
	Oedematous	1										
	Clammy (Temp ↑)	1										
	Previous pressure sore or scarring	2										
	Discoloured Grade 1	2										
	Broken Grade 2 - 4	3										
MOBILITY (Select one option ONLY)	Fully	0										
	Restless/fidgety	1										
	Apathetic	2										
	Restricted/Bed bound	3										
	Inert (due to ↓consciousness/traction)	4										
	Chair bound/Wheelchair	5										
CONTINENCE (select one option ONLY)	Continent/catheterised	0										
	Occasional incontinence	1										
	Incontinent of Urine	2										
	Incontinent of Faeces	2										
	Doubly incontinent	3										
Tissue Malnutrition (select	Terminal Cachexia	8										
	Multi Organ Failure	8										
	Single Organ Failure (Respiratory/Renal/Cardia	5										

one or more options)	c)											
	Peripheral Vascular Disease	5										
	Anaemia HB < 8	2										
	Smoking	1										
Appetite (select one option)	Average	0										
	Poor	1										
	N.G Tube/ Fluids only	2										
	NBM/anorexic	3										
Neurological Deficit (score depends on severity	Diabetes, CVA, MS, Motor/Sensory Paraplegia, epidural	4 - 6										
Major Surgery Trauma (up to 48 hours post-surgery)	Above waist	2										
	Orthopaedic, below waist, spinal >											
	2 hours on theatre table	5										
	6 hours on theatre table	8										
MEDICATION	Cytotoxic high dose/long term steroids Anti-inflammatory	4										
TOTAL SCORE												
NURSE INITIALS												
Mattress (Please tick as appropriate) Enter name of other mattress if used	Pentaflex											
	Alpha Xcell											
	Autologic											
	Nimbus											
	Other mattress:											
	Chair cushion											

Risk Score: 10+ AT RISK 15+ HIGH RISK 20+ VERY HIGH RISK

Adapted from Waterlow Risk Score (Waterlow 2005)

Appendix C for PURPOSE-T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) - Pressure ulcers - Patient Safety Learning - the hub (pslhub.org)

PURPOSE-T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) is an evidence-based pressure ulcer risk assessment instrument that was developed by the University of Leeds using robust research methods.

PURPOSE-T identifies adults at risk of developing a pressure ulcer and supports nurse decision-making to reduce that risk (primary prevention), but also identifies those with existing and previous pressure ulcers requiring secondary prevention and treatment. It uses colour to indicate the most important risk factors and forms a three-step assessment process.

To register for the tool, visit the CTRU Leeds Research Portal - https://ctru.leeds.ac.uk/purpose/purpose-t/