Paediatric Pressure Ulcer Risk Assessment – PURPOSE T Paeds

NHS Oxford Health NHS Foundation Trust

Name:	DOB:	NHS No:	Assessor Name:	Date of Assessment:

Step 1 – screening

Mobility status – *tick all applicable*

- Needs the help of another person to walk ☐
- Spends all or the majority of time in bed or chair ☐
- Remains in the same position for long periods ☐
- Moves independently with or without aids ☐

If **ONLY** blue box is ticked → **Clinical Judgment** – *tick as applicable*

- Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, oedema, steroids, poor nutrition ☐
- No problem ☐

If **ONLY** blue box is ticked → **Skin status** – *tick all applicable*

- Current PU category 1 or above? ☐
- Reported history of previous PU? ☐
- Vulnerable skin ☐
- Medical device/casts/splints/ orthotics that could cause pressure/shear at skin site ☐
- Normal skin ☐

If **ONLY** blue box is ticked → **No pressure ulcer not currently at risk** — *Tick if applicable* ☐ — **Not currently at risk pathway**

If **ANY** yellow boxes are ticked, **go to Step 2**

If **ANY** yellow or pink boxes are ticked, **go to Step 2**

If **ANY** yellow boxes are ticked, **go to Step 2**

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement / Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*

- No problem ☐
- Patient is unable to feel and/ or respond appropriately to discomfort from pressure ☐

Diabetes – *tick as applicable*

- Not diabetic ☐
- Diabetic ☐

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*

- No problem / Occasional ☐
- Frequent (2–4 times a day) ☐
- Constantly an issue/ nappies/incontinence products 24 hours a day ☐

Nutrition – *tick all applicable*

- No problem ☐
- Appears under/overweight for age ☐
- Poor nutritional intake ☐

Perfusion – *tick all applicable*

- No problem – Capillary refill <2 secs ☐
- Conditions affecting central circulation e.g. heart failure, hypotension ☐
- Conditions affecting peripheral circulation e.g. swelling/ oedema, medication ☐

Therapies – *tick all applicable*

- No problem ☐
- Splints/casts/orthotics ☐

Medical device – *tick as applicable*

- No medical device in situ ☐
- Medical device in situ ☐

Tone – *tick all applicable*

- No problem ☐
- Child suffers with dystonia/ spasm/seizures ☐

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2009)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown
Cat DTI Purple/maroon localised discolouration with intact skin

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
Sacrum	☐	☐		☐
L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Knee	☐	☐		☐
R Knee	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐		☐
Occipital	☐	☐		☐
L ear	☐	☐		☐
R ear	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Medical device skin site				
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Step 3 – assessment decision

If **ANY pink boxes** are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

→ PU Category 1 or above, DTI or scarring from previous pressure ulcers
Tick if applicable ☐
Secondary prevention and treatment pathway

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

→ No pressure ulcer but **at risk**
Tick if applicable ☐
Primary prevention pathway

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

→ No pressure ulcer **not currently** at risk
Tick if applicable ☐
Not currently at risk pathway