

ALL WALES PAEDIATRIC PRESSURE ULCER RISK ASSESSMENT (PURPOSE T)

(Paediatrics 0-18 years) NHS Wales v1.2 (08/11/2024)

ADDRESSOGRAPH

PU = Pressure Ulcer

Hospital		Ward	
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Step 1 - Screening

Mobility status – tick all applicable		Skin status – tick all applicable		Clinical Judgement – tick all applicable		No pressure ulcer – not currently at risk Tick if applicable <input type="checkbox"/> Not currently at risk pathway Go to Step 3
Needs the help of another person to walk	<input type="checkbox"/>	Current PU category 1 or above?	<input type="checkbox"/>	Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids, poor nutrition	<input type="checkbox"/>	
Spends all or the majority of time in bed or chair	<input type="checkbox"/>	Reported history of previous PU?	<input type="checkbox"/>	No problem	<input type="checkbox"/>	
Remains in the same position for long periods	<input type="checkbox"/>	Vulnerable skin	<input type="checkbox"/>	If ONLY blue box ✓		
Moves independently with or without aids	<input type="checkbox"/>	Medical device causing pressure/shear at skin site e.g. O ₂ mask, NG tube	<input type="checkbox"/>	If ONLY blue box ✓		
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 applicable box (where frequency and extent categories meet) Extent of all independent movement Relief of all pressure areas				Sensory perception and response – tick as applicable		Moisture due to perspiration, urine, faeces or exudate – tick as applicable	
	Doesn't move	Slight position changes	Major position changes	No problem		No problem / Occasional	<input type="checkbox"/>
Frequency of position changes	Doesn't move	N/A	N/A	Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. paralysis, neuropathy, epidural	<input type="checkbox"/>	Frequent (2 – 4 times a day)	<input type="checkbox"/>
	Moves occasionally	<input type="checkbox"/>	<input type="checkbox"/>			Constant	<input type="checkbox"/>
	Moves frequently	<input type="checkbox"/>	<input type="checkbox"/>			Vulnerable skin (precursor to PU) e.g. dryness, paper thin, moist, blanchable redness that persists. Darkly pigmented skin may not have visible blanching, its colour may differ from surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. (PPPIA 2020) Cat 1 Non-blanchable redness of intact skin, may be difficult to detect in individuals with darkly pigmented skin tone. Cat 2 Partial thickness loss of dermis presenting as a shallow open blister with a red/ pink wound bed without slough. Cat 3 Full thickness tissue loss (fat/slough may be present) Cat 4 Full thickness tissue loss (bone, muscle or tendon visible) Cat U (Unstageable) full thickness tissue loss with slough and/or necrotic tissue. Cat SDTI Suspected Deep Tissue Injury. Purple or maroon localised area of discoloured skin or blood-filled blister may be difficult to detect in individuals with darker skin tones.	
Perfusion – tick all applicable		Nutrition – tick all applicable		Diabetes – tick as applicable			
No problem- Capillary refill <2 secs	<input type="checkbox"/>	No problem	<input type="checkbox"/>	Not diabetic	<input type="checkbox"/>		
Conditions affecting central circulation e.g. shock, heart failure, hypotension	<input type="checkbox"/>	Unplanned weight loss	<input type="checkbox"/>	Diabetic	<input type="checkbox"/>		
Conditions affecting peripheral circulation e.g. meningitis, medication, inotropes	<input type="checkbox"/>	Poor nutritional intake	<input type="checkbox"/>	Medical device – tick as applicable No problem	<input type="checkbox"/>		
		<2 centiles below weight	<input type="checkbox"/>	Medical device causing pressure/shear at skin site e.g. O ₂ mask, NG tube	<input type="checkbox"/>		
		>2 centiles over weight	<input type="checkbox"/>				

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	Vulnerable skin				Normal skin				Skin site	Vulnerable skin				Normal skin				
	Pain	Vulnerable skin	PU category	Normal skin	Pain	Vulnerable skin	PU category	Normal skin		Pain	Vulnerable skin	PU category	Normal skin	Pain	Vulnerable skin	PU category	Normal skin	
Sacrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Add medical device sites:			
L Buttock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Heel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occipital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
R Buttock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Heel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
L Ischial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
R Ischial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
L Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Step 3 Assessment Decision

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

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

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.

PU Category 1 or above or scarring from previous pressure ulcers Tick if applicable <input type="checkbox"/> Secondary prevention and treatment pathway	No pressure ulcer but at risk Tick if applicable <input type="checkbox"/> Primary prevention pathway	No pressure ulcer not currently at risk Tick if applicable <input type="checkbox"/> Reassess risk as per Pressure Ulcer Policy
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Name	Signature	Designation	Date	Time
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