Purpose T Pressure Ulcer Risk Assessment Information Standards Specification

User Interface Name	Field Identifier	Definition	Data Display Format	Data Value Format (code or other value)
Date of Assessment	Assessment_Date	This is the date the actual risk assessment (or review) was carried out with the patient	Short Date Format In all instances of clinical usage affecting patient treatment, including patient identification, NHS applications must display dates as short dates in the form DD-MMM-YYYY, where: DD is the two-digit day MMM is the correctly abbreviated month name YYYY is the four-digit year Exact times display both hours and minutes, but may optionally also display seconds. The required format is HH:mm:ss (this notation follows the .NET Framework Standard DateTime Format Strings specification).	8 digit numeric, CCYYMMDD 6 digit numeric: hh:mm:ss
Step 1 - screening				
Mobility status - tick all applicable	Mobility_status	This is to indicate the patients current mobility status	Radio Button (Multiple Options)	n1
Skin Status - tick all applicable	Skin_status	This is to indicate the patients current skin status	Radio Button (Multiple Options)	n1
Clinical Judgement - tick as applicable	Clinical_judgement	This is the clinical judgement of the patients condition	Radio Button	n1
Step 2 - full assessment Complete all sections				
Analysis of independent movement Tick the applicable box (where frequency and extent category meet)				
Frequency of position changes	Position_changes_frequency	This is to indicate the requency of the patients position changes	Radio Button (Multiple Options)	n1
Extent of all independent movement (Relief of all pressure areas)	Independent_movement_extent	This is to indicate the extent of the patient independent movement	Radio Button (Multiple Options)	n1

Sensory perception and response - tick as applicable	Sensory_perception_response	This is to indicate the patients sensory perception and response	Radio Button	n1
Moisture due to perspiration, urine, faeces or exudate - tick as applicable	Moisture	This is to indicate if any moisture in said form on the skin	Radio Button (Multiple Options)	n1
Perfusion - tick all applicable	Perfusion	Defined as the passage of a fluid through the circulatory system. The question indicates if there are any identified issues related to perfusion	Radio Button (Multiple Options)	n1
Nutrition - tick all applicable	Nutrition	This is to indicate the patients current nutrition status	Radio Button (Multiple Options)	n1
Medical device - tick as applicable	Medical_device	This is to indicate if a medical device affects the skin in relation to shearing and pressure damage	Radio Button	n1
Diabetes - tick as applicable	Diabetes	This is to indicate whether or not the patient is diabetic	Radio Button	n1
Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist. NPUAP / EPUAP Pressure Ulcer Classification system (2014) Cat 1 Non-blanchable redness of intact skin Cat 2 Partial thickness skin loss or clear blister Cat 3 Full thickness skin loss or clear blister Cat 4 Full thickness tissue loss (muscle/bone visible) Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown Suspected Deep Tissue Injury (Depth U known) Purple localized area of discoloured intact skin or blood-filled blister				
Previous PU history - tick as applicable	PU_history	This is to indicate the patients pressure ulcer history	Radio Button	n1
Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category)				
Scar	PU_scar	This is to indicate whether the pressure ulcer scarred the patient	Tick box	
No scar	PU_no_scar	This is to confirm that there was no scar from the pressure ulcer	Tick box	
Current Detailed Skin Assessment - tick if pain, soreness or discomfort present at any skin sites as applicable. For each skin site tick applicable column - either vulnerable skin, normal skin or record PU category				
Skin site	Skin_site	This is to indicate which skin site the patient has pain	Radio Button (Multiple Options)	n1
Pain	Pain_present	This is to indicate whether there is pain is present in any skin site	Tick Box	
Vulnerable skin	Vulnerable_skin	This is to indicate if the patient has vulnerable skin	Tick Box	

PU Category	PU_category	This is to indicate which cateory the patients pressure ulcer is	Pick List	
Normal Skin	Normal_skin	This is to indicate that the patient has normal skin	Tick Box	
Step 3 - assessment decision				

Value Sets	Business Rules	Additional Information/definitions/formats	Source
1 - Needs the help of another person to walk 2 - Spends all or the majority of time in bed or chair 3 - Remains in the same position for long periods 4 - Walks independently with or without walking aids	If field id Mobility_Status = 1, 2 or 3 go to field id Independent_movement If field id Mobility_status = 4 go to field id Skin_Status		
1 - Current PU category 1 or above? 2 - Reported history or previous PU? 3 - Vulnerable skin 4 - Medical device causing pressure/shear at skin site e.g. O, mask, NG tube 5 - Normal skin	If field id Skin status = 1, 2, 3 or 4 go to field id Independent_movement If field id Skin_status = 5 go to field id Clinical_Judgement		
1 - Conditions/treatments which significantly impact the patients PU risk e.g. poor perfusion, epidurals, oedema, steroids 2 - No problem	If field id Clinical Judgement =1 go to field id Independent_movement If field id = 2 end of assessment		
1 - Doesn't move 2 - Moves occasionally 3 - Moves frequently	If field id "position_changes_frequency" and field id "independent_movement_extent" = 1, patient is at risk and primary prevention pathway should commence If field id "position_changes_frequency" and field id "independent_movement_extent" = 2, patient is at risk and primary prevention pathway should commence If field id "position_changes_frequency" = 2 and field id "independent_movement_extent" = 3, patient is at risk and primary prevention pathway should commence If field id "position_changes_frequency" = 3 and field id "independent_movement_extent" = 2, patient is at risk and primary prevention pathway should commence If field id "position_changes_frequency" = 3 and field id "independent_movement_extent" = 3, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk then commence primary prevention pathway		
1 - Doesn't move 2 - Slight position changes 3 - Major position changes			

1 - No problem 2 - Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural	If field id "sensory_perception_response" = 1, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk then commence primary prevention pathway If field id "sensory_perception_response" = 2, patient is at risk and primary prevention pathway should commence		
1 - No problem / occasional 2 - Frequent (2-4 times a day) 3 - Constant	If field id "moisture" = 1, 2 or 3 the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk then commence primary prevention pathway		
1 - No problem 2 - Conditions affecting central circulation e.g. shock, heart failure, hypotension 3 - Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease	If field id "perfusion" = 1 , the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk then commence primary prevention pathway If field id "perfusion" = 2 or 3, the patient is at risk and primary prevention pathway should commence		
1 - No problem 2 - Unplanned weight loss 3 - Poor nutritional intake 4 - Low BMI (less than 18.5) 5 - High BMI (30 or more)	If field id "nutrition" = 1, 2, 3, 4 or 5, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk then commence primary prevention pathway		
1 - No problem 2 - Medical device causing pressure/shear at skin site e.g. O, mask, NG tube	If field id "medical_device" = 1 or 2, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk then commence primary prevention pathway		
1 - Not diabetic 2 - Diabetic	If field id "diabetes" = 1 or 2 the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk then commence primary prevention pathway		
1 - No known PU history 2 - PU - History (complete below)	If field id "pu_history" = 1 or 2, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk then commence primary prevention pathway If field id "pu_history" = 2, answer field id "number_of_previous_pressure_ulcers" "Approx_date" "site" "pu_cat" "scar" "no_scar" "relevant_information"		
	If field id "scar" populated the patient has an existing pressure ulcer or scarring from previous pressure ulcer and must commence secondary prevention and treatment pathway		
	If field id "no_scar" populated, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk then commence primary prevention pathway		
1 - Sacrum 2 - L Buttock 3 - R Buttock 4 - L Ischial 5 - R Ischial 6 - L Hip 7 - R Hip 8 - L Heel 9 - R Heel 10 - L Ankle 11 - R Ankle 12 - L Elbow 13 - R Elbow			

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 visable) Cat U - (Unstageable / Unclassified): Purple localized area of discoloured intact skin or blood filled blister			
1 - 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 or scarring from previous pressure ulcers PU Prevention/Management Care Plan 2 - If ANY orange boxes are ticked (but no pink boxes), the patient is at risk. No pressure ulcer but at risk PU Prevention/Management Care Plan 3 - 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. Reassess risk as per Pressure Ulcer Policy			