Step-by-Step Guide: How to Complete the PURPOSE-T Assessment (PowerForm)

This guide is designed to support clinicians within OUH in completing the PURPOSE-T assessment, providing clear step by step instructions supported by visuals taken from EPR. Follow the steps below to ensure accurate and consistent pressure ulcer risk assessment using the electronic system.

What is PURPOSE-T?

PURPOSE-T stands for *Pressure Ulcer Risk Primary Or Secondary Evaluation Tool*. It is a pressure ulcer risk assessment framework designed to identify adults who are:

- At risk of developing pressure ulcers (*primary prevention*)
- Already presenting with existing pressure ulcers (*secondary prevention*)

Uses colours – rather than a score – to describe risk:

Blue – No pressure ulcer/Not at risk

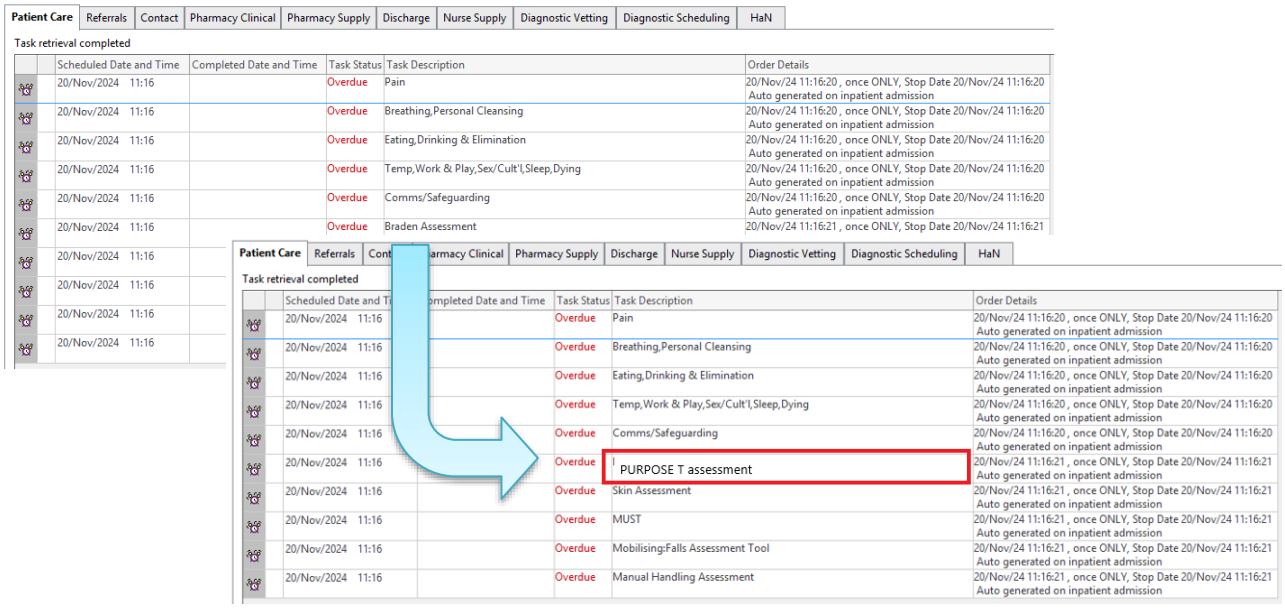
Yellow – No pressure ulcer/ At risk

Pink – Pressure ulcer category 1 or above/ scarring from previous pressure ulcer.

Incorporated 3 phases: Screening; Full assessment; and Assessment decision

PURPOSE – T assessment (PowerForm)

- The assessment task is triggered in the same way as Braden:
    - On inpatient admission
    - On ward transfer
    - Weekly during the patient's stay



When to complete the PURPOSE-T Assessment:

Screening to be completed as soon as possible following admission or internal transfer.

If full assessment is required (i.e., risk identified during screening), it must be completed within 6 hours of admission.

Purpose-T must be re-assessed weekly or sooner if there is any significant change in patient's condition.

The assessment must be completed by Registered Nurses and Registered Nursing Associates

Step 1: Screening

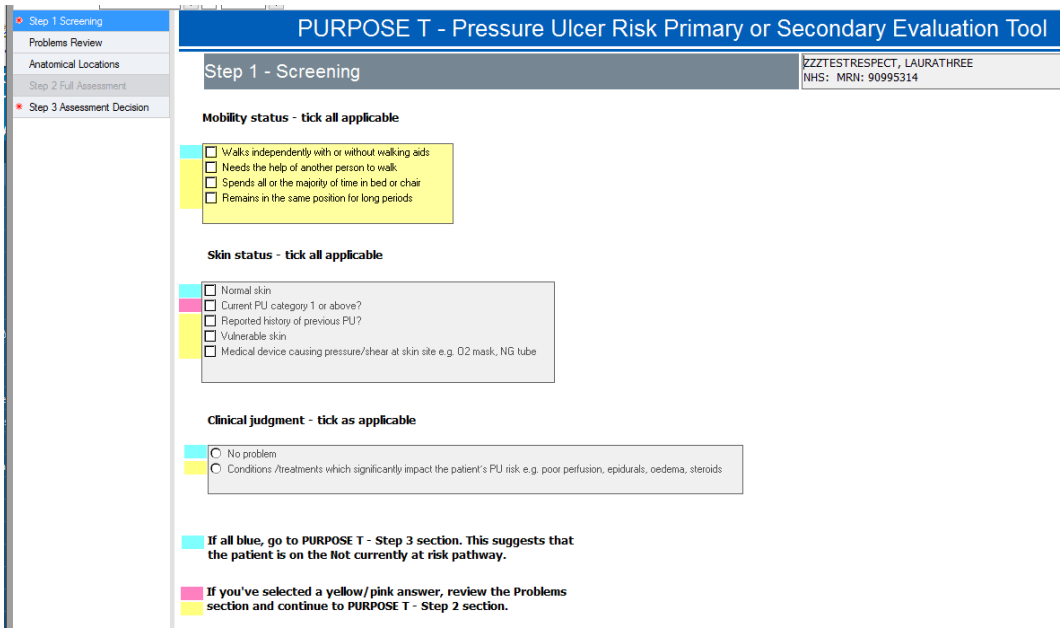
Required for every adult inpatient.

Provides a quick evaluation of immediate risk.

If no risk is identified (i.e., no yellow or pink indicators are selected), no further assessment is required.

The screening phase focuses on: Mobility; Skin Status; and Clinical Judgment.

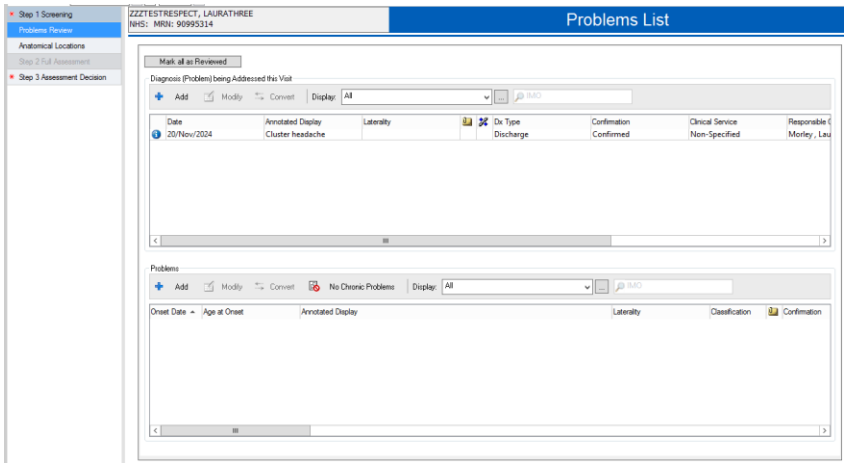
(Purpose T User Manual V2, 2014)



Problems Review

Within the **PURPOSE-T assessment**, the **Problems Review** section is available, allowing clinicians to easily review any current problems already recorded in the patient's record.

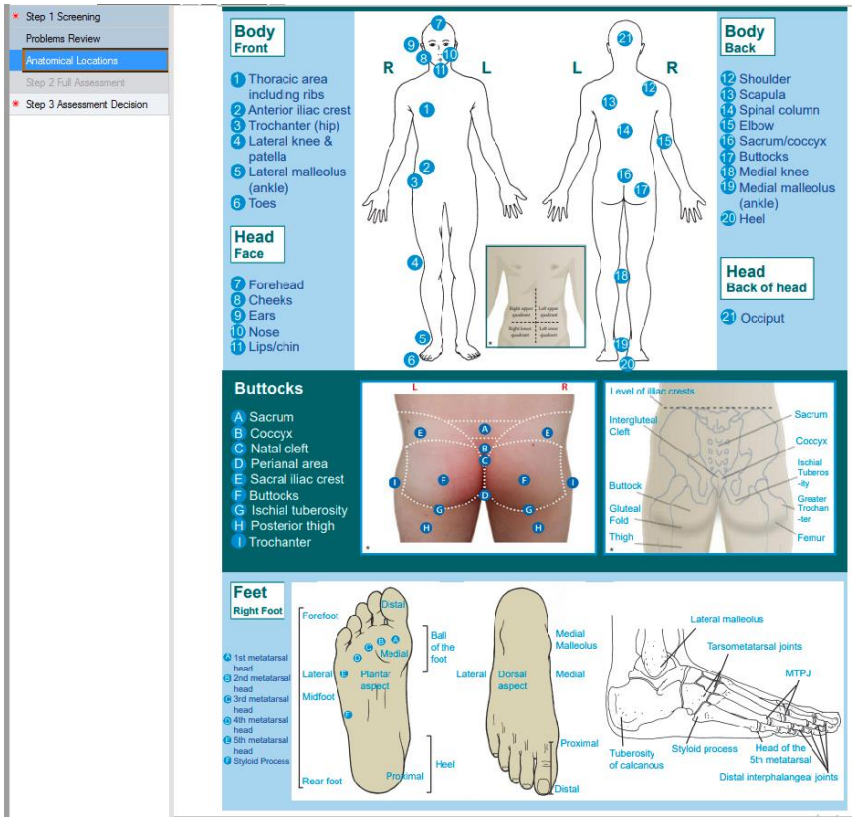
This feature supports safe, informed decision-making by ensuring that all relevant clinical concerns are considered during the assessment process.



Anatomical Locations

The PURPOSE-T assessment tool also includes anatomical location images, which support accurate identification and documentation of body sites.

These visuals help ensure clarity and consistency when describing the location of actual or potential pressure ulcers, promoting shared understanding among clinical teams and improving the quality of clinical records.



Step 2: Full Assessment

The Full Assessment is triggered automatically if any yellow or pink boxes are selected during the Screening phase.

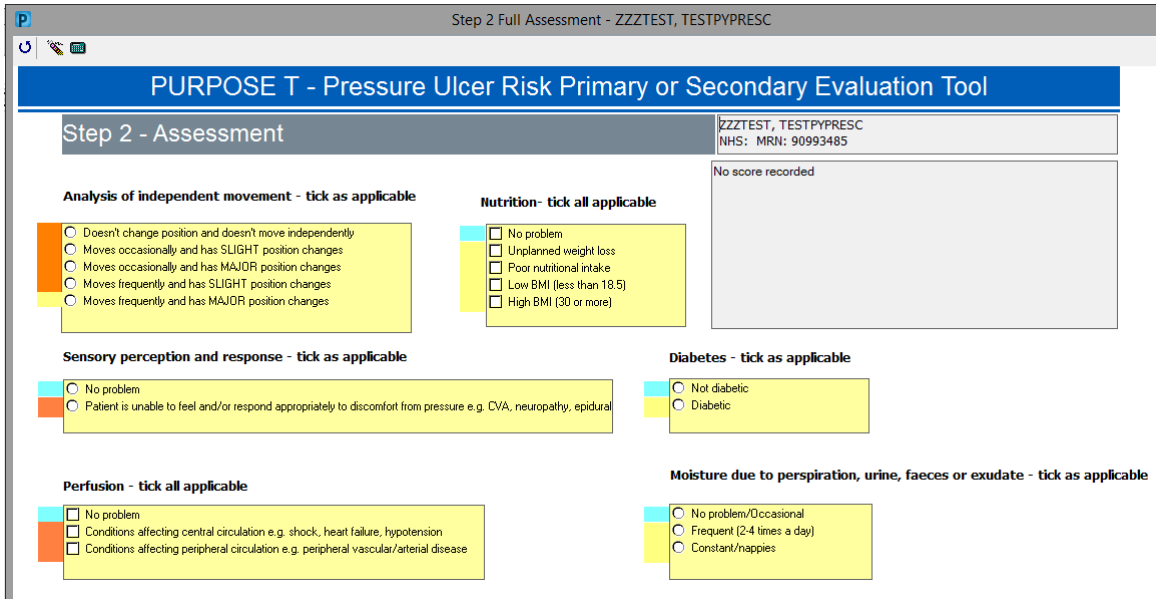
This stage requires completion of nine structured sections, designed to support a comprehensive evaluation of pressure ulcer risk:

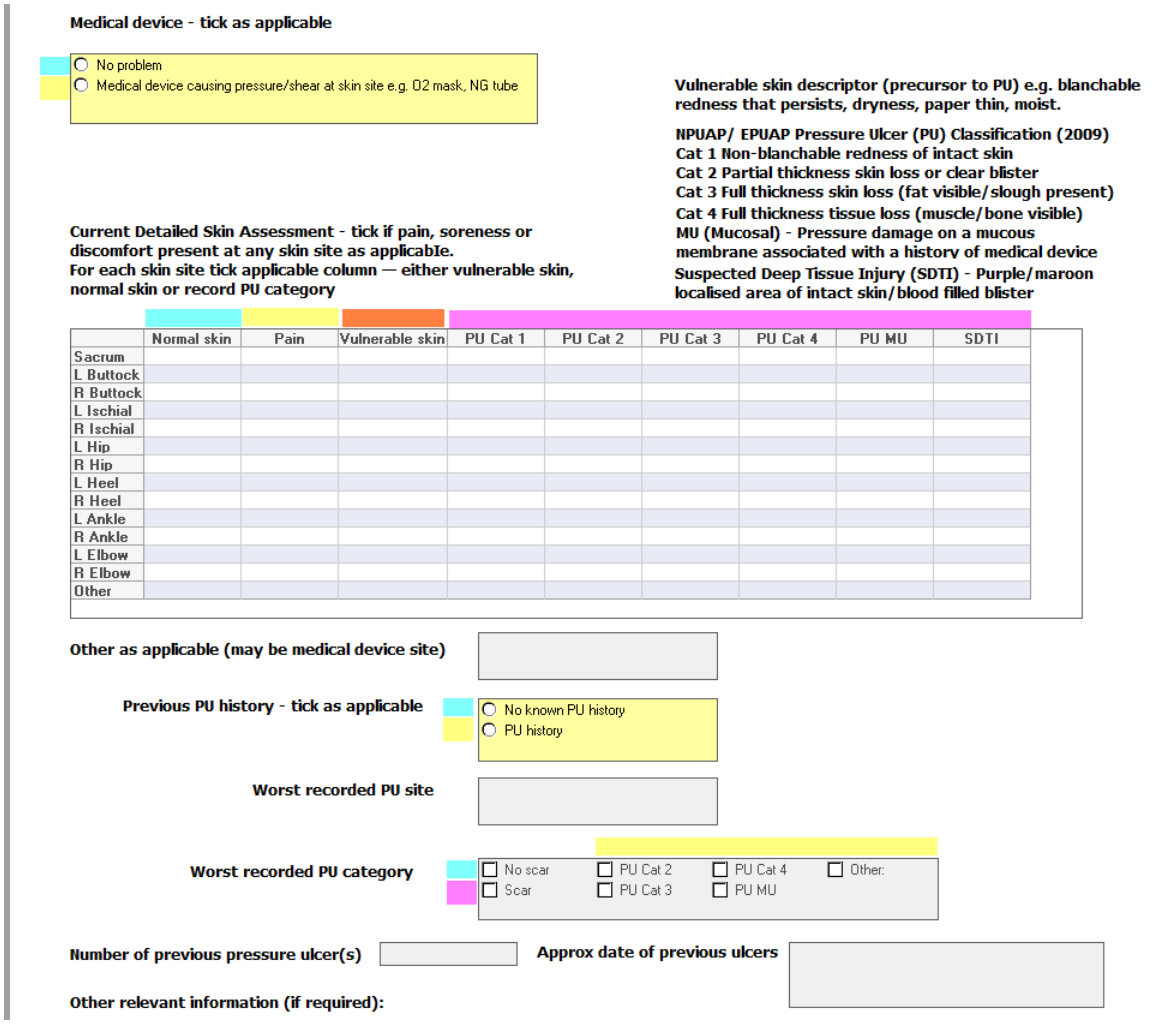
1. Analysis of independent movement
2. Sensory perception and response
3. Moisture exposure (e.g. perspiration, urine, faeces, wound exudate)
4. Presence of diabetes
5. Perfusion status (e.g. vascular compromise)
6. Nutritional needs
7. Use of medical devices (e.g. oxygen tubing, casts)
8. Detailed skin assessment
9. Previous history of pressure ulcers

(Adapted from PURPOSE-T User Manual V2, 2014)

Each section must be completed thoroughly to ensure accurate risk categorisation and to guide the appropriate prevention or treatment plan.

The full skin assessment is embedded within this section and must be completed prior to finalising the PURPOSE-T assessment. Clinicians are required to perform a head-to-toe inspection of the skin to identify any pressure damage or areas of concern.

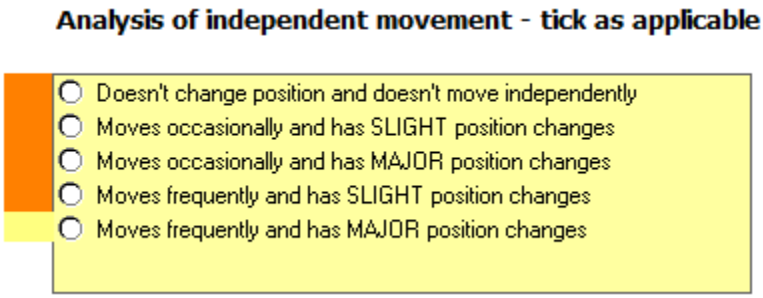

Step 2 Full Assessment - ZZZTEST, TESTPYPRESC
PURPOSE T - Pressure Ulcer Risk Primary or Secondary Evaluation Tool
Step 2 - Assessment
ZZZTEST, TESTPYPRESC
NHS: MRN: 90993485
No score recorded
Analysis of independent movement - tick as applicable
Doesn't change position and doesn't move independently
Moves occasionally and has SLIGHT position changes
Moves occasionally and has MAJOR position changes
Moves frequently and has SLIGHT position changes
Moves frequently and has MAJOR position changes
Nutrition- tick all applicable
No problem
Unplanned weight loss
Poor nutritional intake
Low BMI (less than 18.5)
High BMI (30 or more)
Sensory perception and response - tick as applicable
No problem
Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural
Diabetes - tick as applicable
Not diabetic
Diabetic
Perfusion - tick all applicable
No problem
Conditions affecting central circulation e.g. shock, heart failure, hypotension
Conditions affecting peripheral circulation e.g. peripheral vascular/arterial disease
Moisture due to perspiration, urine, faeces or exudate - tick as applicable
No problem/Occasional
Frequent (2-4 times a day)
Constant/nappies


Medical device - tick as applicable
No problem
Medical device causing pressure/shear at skin site e.g. O2 mask, NG tube
Vulnerable skin descriptor (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP/ EPUAP Pressure Ulcer (PU) Classification (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)
MU (Mucosal) - Pressure damage on a mucous membrane associated with a history of medical device
Suspected Deep Tissue Injury (SDTI) - Purple/maroon localised area of intact skin/blood filled blister
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
Normal skin
Pain
Vulnerable skin
PU Cat 1
PU Cat 2
PU Cat 3
PU Cat 4
PU MU
SDTI
Sacrum
L Buttock
R Buttock
L Ischial
R Ischial
L Hip
R Hip
L Heel
R Heel
L Ankle
R Ankle
L Elbow
R Elbow
Other
Other as applicable (may be medical device site)
Previous PU history - tick as applicable
No known PU history
PU history
Worst recorded PU site
Worst recorded PU category
No scar
Scar
PU Cat 2
PU Cat 3
PU Cat 4
PU MU
Other:
Number of previous pressure ulcer(s)
Approx date of previous ulcers
Other relevant information (if required):

Note: In situations where a patient refuses the skin assessment, this refusal must be clearly recorded in the clinical notes, along with the reason where appropriate. Follow a 'document by exception' approach, ensuring all relevant context is captured.

While most of the nine assessment sections are straightforward, some areas may present clinical ambiguity. To support consistency and confidence in practice, this document will explore two of these sections in greater detail.
For additional support, the PURPOSE-T User Manual V2 (2014) is a valuable reference, offering expanded explanations and examples. This manual is accessible via the Tissue Viability SharePoint site.

Step 2: Full Assessment – Analysis of Independent Movement



This section focuses on evaluating the **patient's ability to move independently**, without assistance from another person. It plays a key role in determining the patient's risk of prolonged pressure and subsequent skin damage.
What to assess:

- Frequency of position changes - Use clinical judgement to determine how often the patient is changing position. This includes both spontaneous movements and intentional shifts made without help.
- Extent of independent movement - Movement is categorised based on how effectively it relieves pressure:
    - Slight position changes: These include small shifts in bed or chair that may adjust posture but do not fully offload pressure from at-risk areas.
    - Major position changes: These include turning over in bed, sitting upright from a lying position, or standing up from a chair—movements that result in complete pressure relief. (PURPOSE-T User Manual V2, 2014)

Step 2: Full Assessment – Sensory Perception and Response

This section assesses the patient's ability to feel discomfort caused by pressure and to respond appropriately to it. A reduced sensory response significantly increases the risk of pressure damage, as the patient may not reposition themselves when needed.

What to Consider:

- **Ability to perceive discomfort:** Can the patient feel pressure or pain in areas where skin damage is likely to develop?
- **Appropriate response to discomfort:** Does the patient reposition themselves or seek help when feeling discomfort? Impaired responses can result in prolonged pressure exposure.
- **Involuntary movements:** Be aware of the presence of spasms, spasticity, or contractures, which may either mask discomfort or restrict effective movement.

Factors that may impair perception or response include:

- Underlying medical conditions such as: Multiple Sclerosis (MS); Cerebrovascular Accident (CVA / stroke); Head or spinal cord injury; Peripheral neuropathy; Dementia.
- Medical treatments including: Epidural or spinal anaesthesia; Sedation or opioid analgesia *(PURPOSE-T User Manual V2, 2014)*

Step 3: Assessment Decision

The final stage of the PURPOSE-T assessment is the Assessment Decision, which determines the patient's overall risk status and guides the appropriate care pathway.

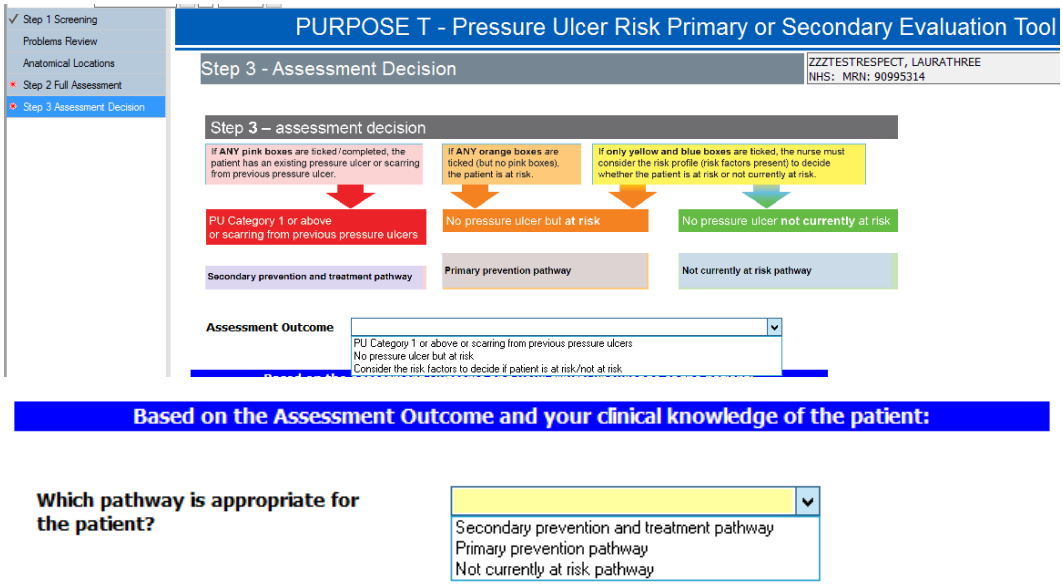
How it Works:

- The Assessment Outcome is automatically generated by the system based on the information entered during the Screening and Full Assessment phases.
- However, the outcome should not be viewed as purely objective — it should be interpreted alongside your clinical judgement.

Your Role:

- Review the automatically generated outcome and ensure it aligns with your clinical observations.
- Use your professional judgement to determine whether the suggested risk level is appropriate.
- Based on this, you should select the most suitable care and prevention pathway for the patient.

Clinical reasoning remains essential — the tool supports decision-making but does not replace it.



Key Reminders for Practice:

- Complete the screening promptly after admission or transfer.
- If triggered, the full assessment must be completed within 6 hours.
- A full skin assessment is required and should be completed before finalising the assessment.
- If the patient declines, ensure this is clearly documented in the Nursing Notes.
- Use clinical judgement in conjunction with system prompts when making the final decision.
- Activate the relevant care plan in EPR — it does not populate/update automatically.
- Use the aSSKINg bundle as a foundation for planning and delivering care.
- For further clarification, refer to the PURPOSE-T User Manual V2 (2014) and other resources available via the Tissue Viability SharePoint site.

Planning Care

Following completion of the PURPOSE-T assessment, an individualised care plan should be implemented to reflect the patient's risk profile and support effective prevention or management of pressure ulcers.

- The care plan must address the specific risk factors identified in the assessment.
- It should also take into account the patient's preferences, goals, and ability to self-care.
- Patients and/or carers should be actively involved in shared decision-making wherever possible.

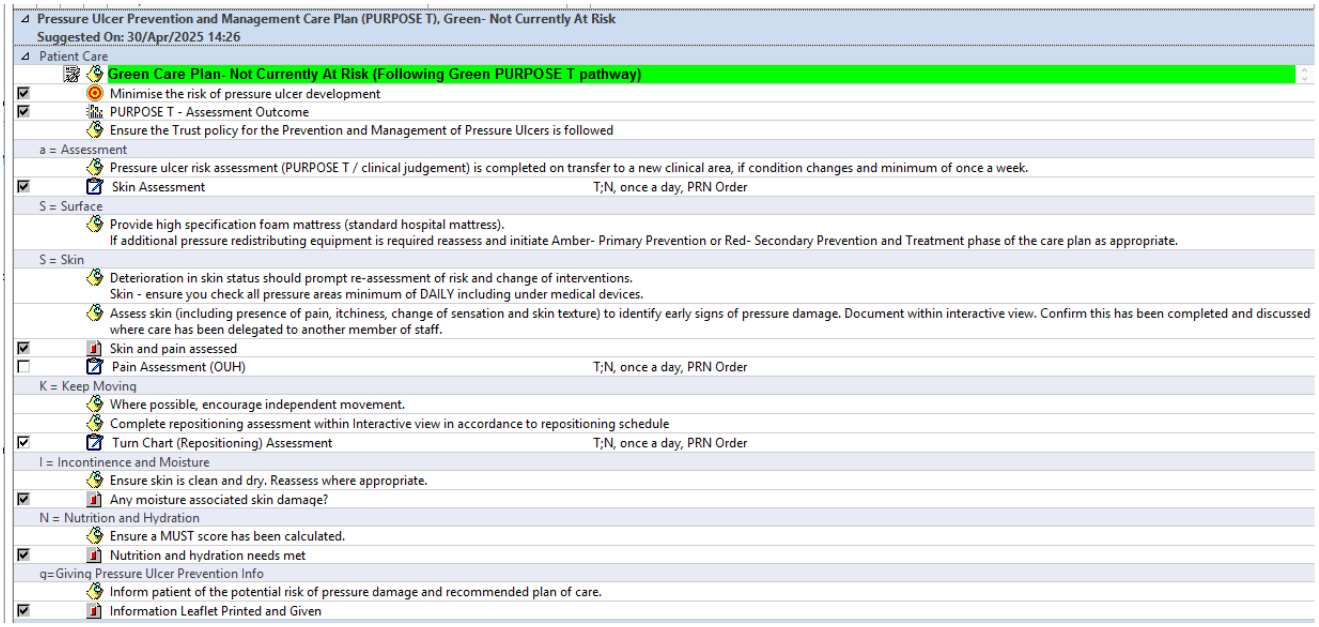
🔷 **Care plans are already embedded within EPR** — clinicians are not required to create them manually. Once the PURPOSE-T assessment is complete, the appropriate pressure ulcer prevention or management care plan will be available and simply needs to be activated.

Essential Elements of Care: The aSSKINg Framework

The aSSKINg care bundle forms the foundation of pressure ulcer prevention and should be reflected in the activated care plan:

- **a – Assess risk:** On admission, weekly, and with any significant change in condition
- **S – Skin inspection:** At least once per shift
- **S – Surface:** Ensure suitable support surfaces are in place (e.g. mattress, heel offloading)
- **K – Keep moving:** Support regular repositioning and mobility
- **I – Incontinence/moisture:** Implement moisture management strategies
- **N – Nutrition:** Assess and optimise nutritional status
- **g – Give information and involve:** Engage patients/carers in education and decision-making

PURPOSE–T: Green Care Plan – Not currently at risk



Pressure Ulcer Prevention and Management Care Plan (PURPOSE T), Green- Not Currently At Risk
Suggested On: 30/Apr/2025 14:26

Patient Care

Green Care Plan- Not Currently At Risk (Following Green PURPOSE T pathway)

- [x] Minimise the risk of pressure ulcer development
- [x] PURPOSE T - Assessment Outcome
- Ensure the Trust policy for the Prevention and Management of Pressure Ulcers is followed

a = Assessment

- Pressure ulcer risk assessment (PURPOSE T / clinical judgement) is completed on transfer to a new clinical area, if condition changes and minimum of once a week.
- [x] Skin Assessment — T;N, once a day, PRN Order

S = Surface

- Provide high specification foam mattress (standard hospital mattress).
  If additional pressure redistributing equipment is required reassess and initiate Amber- Primary Prevention or Red- Secondary Prevention and Treatment phase of the care plan as appropriate.

S = Skin

- Deterioration in skin status should prompt re-assessment of risk and change of interventions.
  Skin - ensure you check all pressure areas minimum of DAILY including under medical devices.
- Assess skin (including presence of pain, itchiness, change of sensation and skin texture) to identify early signs of pressure damage. Document within interactive view. Confirm this has been completed and discussed where care has been delegated to another member of staff.
- [x] Skin and pain assessed
- [ ] Pain Assessment (OUH) — T;N, once a day, PRN Order

K = Keep Moving

- Where possible, encourage independent movement.
- Complete repositioning assessment within Interactive view in accordance to repositioning schedule
- [x] Turn Chart (Repositioning) Assessment — T;N, once a day, PRN Order

I = Incontinence and Moisture

- Ensure skin is clean and dry. Reassess where appropriate.
- [x] Any moisture associated skin damage?

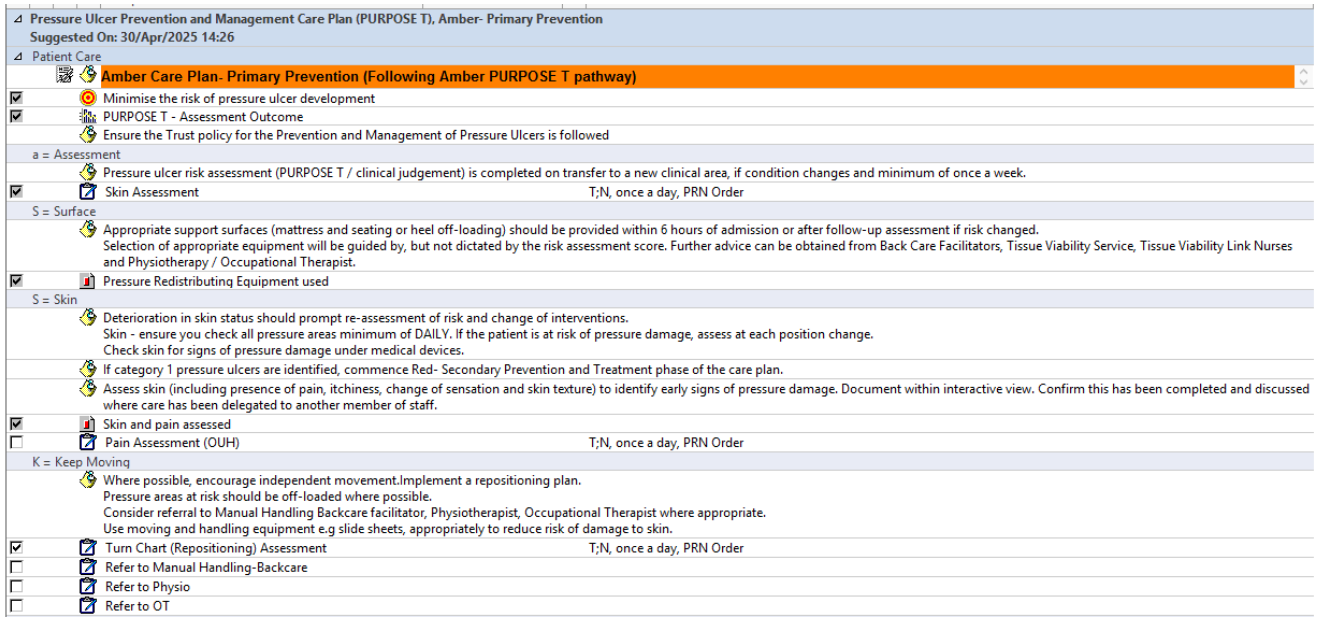
N = Nutrition and Hydration

- Ensure a MUST score has been calculated.
- [x] Nutrition and hydration needs met

q=Giving Pressure Ulcer Prevention Info

- Inform patient of the potential risk of pressure damage and recommended plan of care.
- [x] Information Leaflet Printed and Given

PURPOSE–T: Amber Care Plan – Primary Prevention



Pressure Ulcer Prevention and Management Care Plan (PURPOSE T), Amber- Primary Prevention
Suggested On: 30/Apr/2025 14:26

Patient Care

Amber Care Plan- Primary Prevention (Following Amber PURPOSE T pathway)

- [x] Minimise the risk of pressure ulcer development
- [x] PURPOSE T - Assessment Outcome
- Ensure the Trust policy for the Prevention and Management of Pressure Ulcers is followed

a = Assessment

- Pressure ulcer risk assessment (PURPOSE T / clinical judgement) is completed on transfer to a new clinical area, if condition changes and minimum of once a week.
- [x] Skin Assessment — T;N, once a day, PRN Order

S = Surface

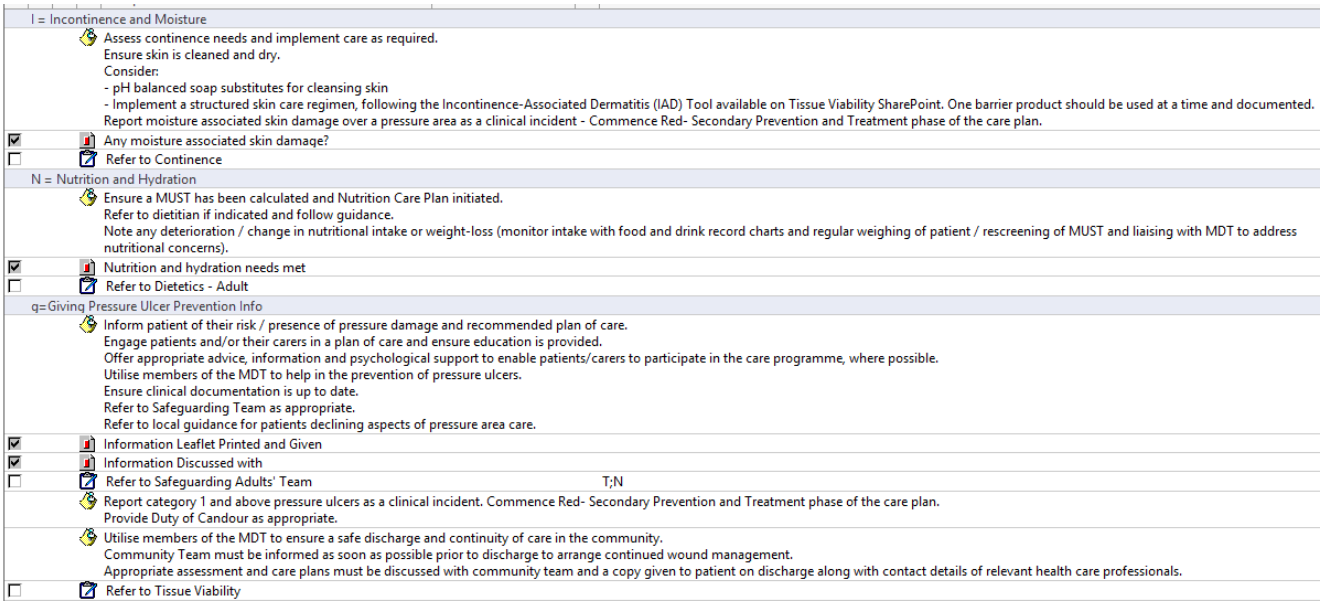
- Appropriate support surfaces (mattress and seating or heel off-loading) should be provided within 6 hours of admission or after follow-up assessment if risk changed.
  Selection of appropriate equipment will be guided by, but not dictated by the risk assessment score. Further advice can be obtained from Back Care Facilitators, Tissue Viability Service, Tissue Viability Link Nurses and Physiotherapy / Occupational Therapist.
- [x] Pressure Redistributing Equipment used

S = Skin

- Deterioration in skin status should prompt re-assessment of risk and change of interventions.
  Skin - ensure you check all pressure areas minimum of DAILY. If the patient is at risk of pressure damage, assess at each position change.
  Check skin for signs of pressure damage under medical devices.
- If category 1 pressure ulcers are identified, commence Red- Secondary Prevention and Treatment phase of the care plan.
- Assess skin (including presence of pain, itchiness, change of sensation and skin texture) to identify early signs of pressure damage. Document within interactive view. Confirm this has been completed and discussed where care has been delegated to another member of staff.
- [x] Skin and pain assessed
- [ ] Pain Assessment (OUH) — T;N, once a day, PRN Order

K = Keep Moving

- Where possible, encourage independent movement.Implement a repositioning plan.
  Pressure areas at risk should be off-loaded where possible.
  Consider referral to Manual Handling Backcare facilitator, Physiotherapist, Occupational Therapist where appropriate.
  Use moving and handling equipment e.g slide sheets, appropriately to reduce risk of damage to skin.
- [x] Turn Chart (Repositioning) Assessment — T;N, once a day, PRN Order
- [ ] Refer to Manual Handling-Backcare
- [ ] Refer to Physio
- [ ] Refer to OT



I = Incontinence and Moisture

- Assess continence needs and implement care as required.
  Ensure skin is cleaned and dry.
  Consider:
  - pH balanced soap substitutes for cleansing skin
  - Implement a structured skin care regimen, following the Incontinence-Associated Dermatitis (IAD) Tool available on Tissue Viability SharePoint. One barrier product should be used at a time and documented.
  Report moisture associated skin damage over a pressure area as a clinical incident - Commence Red- Secondary Prevention and Treatment phase of the care plan.
- [x] Any moisture associated skin damage?
- [ ] Refer to Continence

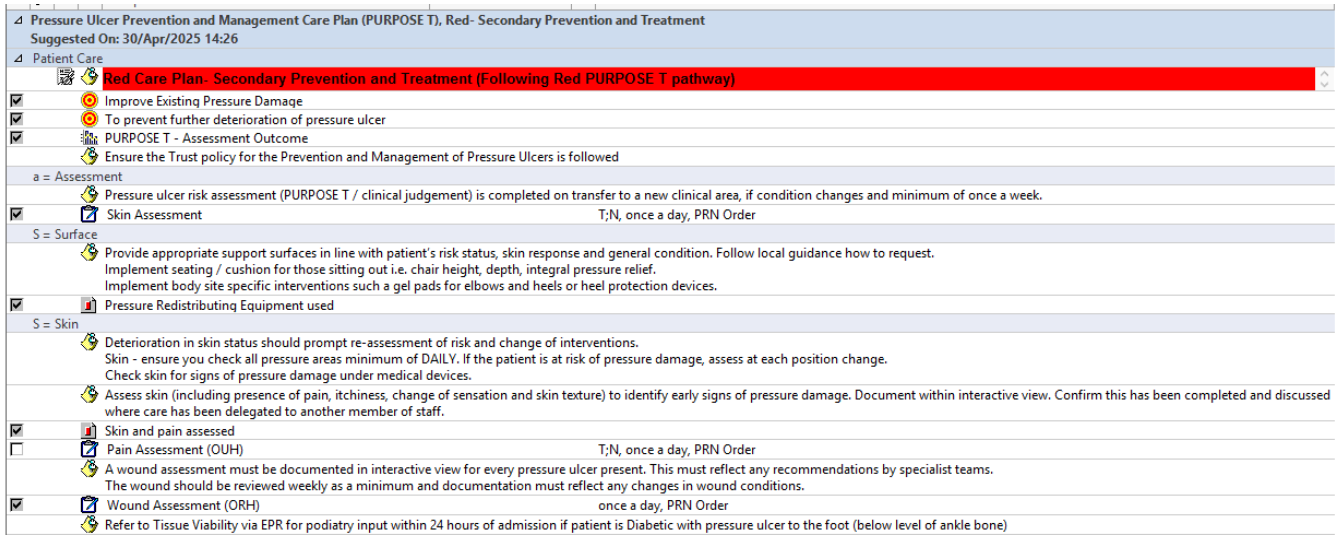
N = Nutrition and Hydration

- Ensure a MUST has been calculated and Nutrition Care Plan initiated.
  Refer to dietitian if indicated and follow guidance.
  Note any deterioration / change in nutritional intake or weight-loss (monitor intake with food and drink record charts and regular weighing of patient / rescreening of MUST and liaising with MDT to address nutritional concerns).
- [x] Nutrition and hydration needs met
- [ ] Refer to Dietetics - Adult

q=Giving Pressure Ulcer Prevention Info

- Inform patient of their risk / presence of pressure damage and recommended plan of care.
  Engage patients and/or their carers in a plan of care and ensure education is provided.
  Offer appropriate advice, information and psychological support to enable patients/carers to participate in the care programme, where possible.
  Utilise members of the MDT to help in the prevention of pressure ulcers.
  Ensure clinical documentation is up to date.
  Refer to Safeguarding Team as appropriate.
  Refer to local guidance for patients declining aspects of pressure area care.
- [x] Information Leaflet Printed and Given
- [x] Information Discussed with
- [ ] Refer to Safeguarding Adults' Team — T;N
- Report category 1 and above pressure ulcers as a clinical incident. Commence Red- Secondary Prevention and Treatment phase of the care plan.
  Provide Duty of Candour as appropriate.
- Utilise members of the MDT to ensure a safe discharge and continuity of care in the community.
  Community Team must be informed as soon as possible prior to discharge to arrange continued wound management.
  Appropriate assessment and care plans must be discussed with community team and a copy given to patient on discharge along with contact details of relevant health care professionals.
- [ ] Refer to Tissue Viability

PURPOSE–T: Red Care Plan – Secondary Prevention and Treatment



Pressure Ulcer Prevention and Management Care Plan (PURPOSE T), Red- Secondary Prevention and Treatment
Suggested On: 30/Apr/2025 14:26

Patient Care

Red Care Plan- Secondary Prevention and Treatment (Following Red PURPOSE T pathway)

- [x] Improve Existing Pressure Damage
- [x] To prevent further deterioration of pressure ulcer
- [x] PURPOSE T - Assessment Outcome
- Ensure the Trust policy for the Prevention and Management of Pressure Ulcers is followed

a = Assessment

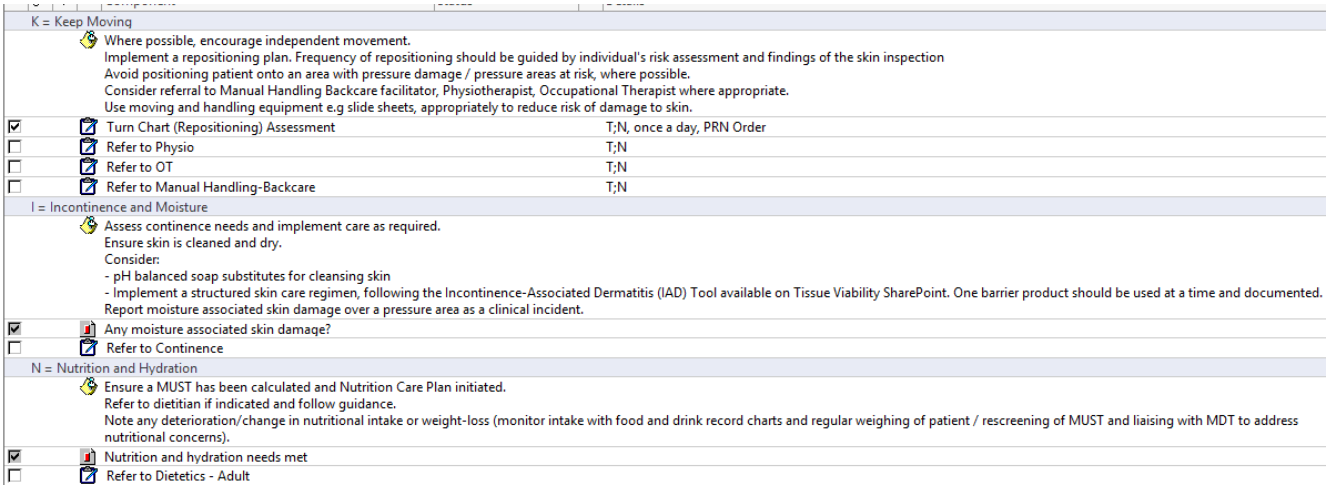
- Pressure ulcer risk assessment (PURPOSE T / clinical judgement) is completed on transfer to a new clinical area, if condition changes and minimum of once a week.
- [x] Skin Assessment — T;N, once a day, PRN Order

S = Surface

- Provide appropriate support surfaces in line with patient's risk status, skin response and general condition. Follow local guidance how to request.
  Implement seating / cushion for those sitting out i.e. chair height, depth, integral pressure relief.
  Implement body site specific interventions such a gel pads for elbows and heels or heel protection devices.
- [x] Pressure Redistributing Equipment used

S = Skin

- Deterioration in skin status should prompt re-assessment of risk and change of interventions.
  Skin - ensure you check all pressure areas minimum of DAILY. If the patient is at risk of pressure damage, assess at each position change.
  Check skin for signs of pressure damage under medical devices.
- Assess skin (including presence of pain, itchiness, change of sensation and skin texture) to identify early signs of pressure damage. Document within interactive view. Confirm this has been completed and discussed where care has been delegated to another member of staff.
- [x] Skin and pain assessed
- [ ] Pain Assessment (OUH) — T;N, once a day, PRN Order
- A wound assessment must be documented in interactive view for every pressure ulcer present. This must reflect any recommendations by specialist teams.
  The wound should be reviewed weekly as a minimum and documentation must reflect any changes in wound conditions.
- [x] Wound Assessment (ORH) — once a day, PRN Order
- Refer to Tissue Viability via EPR for podiatry input within 24 hours of admission if patient is Diabetic with pressure ulcer to the foot (below level of ankle bone)



K = Keep Moving

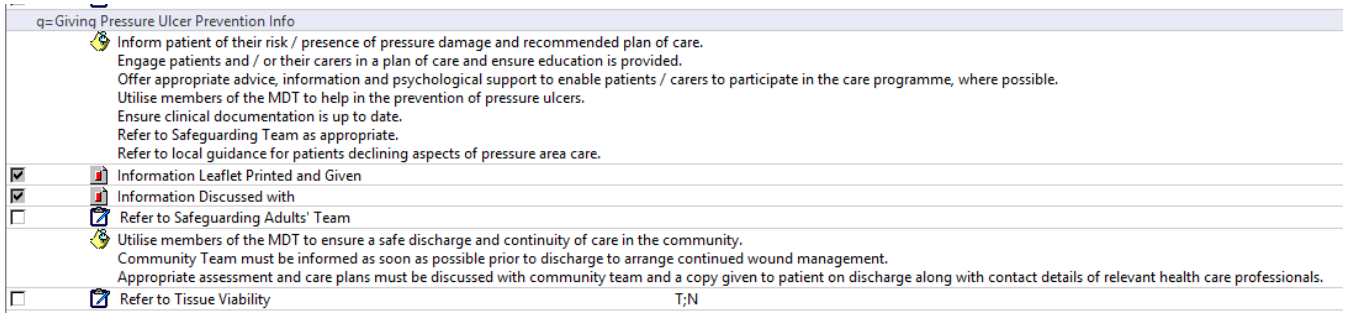
- Where possible, encourage independent movement.
  Implement a repositioning plan. Frequency of repositioning should be guided by individual's risk assessment and findings of the skin inspection
  Avoid positioning patient onto an area with pressure damage / pressure areas at risk, where possible.
  Consider referral to Manual Handling Backcare facilitator, Physiotherapist, Occupational Therapist where appropriate.
  Use moving and handling equipment e.g slide sheets, appropriately to reduce risk of damage to skin.
- [x] Turn Chart (Repositioning) Assessment — T;N, once a day, PRN Order
- [ ] Refer to Physio — T;N
- [ ] Refer to OT — T;N
- [ ] Refer to Manual Handling-Backcare — T;N

I = Incontinence and Moisture

- Assess continence needs and implement care as required.
  Ensure skin is cleaned and dry.
  Consider:
  - pH balanced soap substitutes for cleansing skin
  - Implement a structured skin care regimen, following the Incontinence-Associated Dermatitis (IAD) Tool available on Tissue Viability SharePoint. One barrier product should be used at a time and documented.
  Report moisture associated skin damage over a pressure area as a clinical incident.
- [x] Any moisture associated skin damage?
- [ ] Refer to Continence

N = Nutrition and Hydration

- Ensure a MUST has been calculated and Nutrition Care Plan initiated.
  Refer to dietitian if indicated and follow guidance.
  Note any deterioration/change in nutritional intake or weight-loss (monitor intake with food and drink record charts and regular weighing of patient / rescreening of MUST and liaising with MDT to address nutritional concerns).
- [x] Nutrition and hydration needs met
- [ ] Refer to Dietetics - Adult



q=Giving Pressure Ulcer Prevention Info

- Inform patient of their risk / presence of pressure damage and recommended plan of care.
  Engage patients and / or their carers in a plan of care and ensure education is provided.
  Offer appropriate advice, information and psychological support to enable patients / carers to participate in the care programme, where possible.
  Utilise members of the MDT to help in the prevention of pressure ulcers.
  Ensure clinical documentation is up to date.
  Refer to Safeguarding Team as appropriate.
  Refer to local guidance for patients declining aspects of pressure area care.
- [x] Information Leaflet Printed and Given
- [x] Information Discussed with
- [ ] Refer to Safeguarding Adults' Team
- Utilise members of the MDT to ensure a safe discharge and continuity of care in the community.
  Community Team must be informed as soon as possible prior to discharge to arrange continued wound management.
  Appropriate assessment and care plans must be discussed with community team and a copy given to patient on discharge along with contact details of relevant health care professionals.
- [ ] Refer to Tissue Viability — T;N