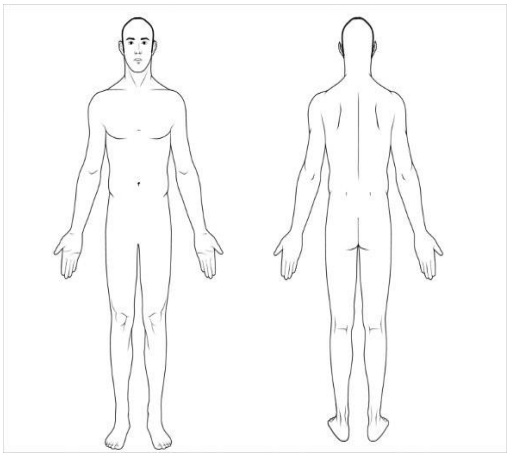
Community Exeter Pressure Risk Assessment Tool (C) EPRAT

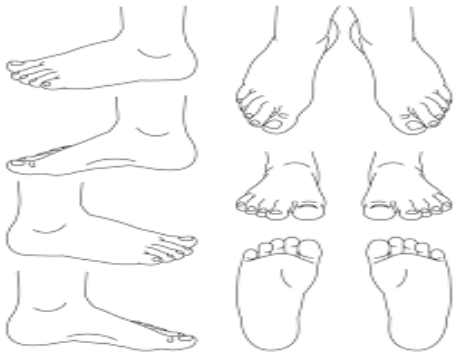
Royal Devon and Exeter NHS Foundation Trust

Patient name: .....
NHS no: .....
Hospital no: ..... *Please affix patient ID label within this box*
DOB: .....

Risk Factors		
Skin	History of /or existing pressure damage	
Mobility	Unable/Unlikely to reposition independently	
	Is wheel chair dependant or other wheeled device	
Intrinsic factors	Reduction in cognition/understanding	
	Any organ failure or impaired function	
	PVD/Diabetes/loss of sensation to peripheries	
	Terminal Illness/Acutely unwell or significant deterioration in condition.	
	Incontinence/Oedema/Excess moisture	
Nutrition	Visually underweight or obese	
	History of on-going weight loss	
	Significant wounds requiring increase in nutritional support	

Consider that all patients are at risk and plan care accordingly for each risk factor identified & Red categories -Very High Risk review with nurse specialists community and formulate a care plan
Immediate action
Surface……
Skin Assessment……
Keep moving ……
Incontinence/moisture ……..
Nutrition/Hydration……
Referrals **Tissue Viability** ☐ **Podiatry** ☐ **GP**☐ **Other**☐……
Date: DD/MM/YYYY DD/MM/YYYY DD/MM/YYYY DD/MM/YYYY





Full body assessment completed ☐ Yes ☐ No N/A ☐

If yes, please indicate any wounds/tissue damage on the body map and complete a wound assessment and care plan as appropriate.

If no or N/A give rationale:……..

Date: DD/MM/YYYY Time: HH:MM

Name……..…..Signature…….……Role……
Datix…☐…….Photograph ☐……..

Review date: DD/MM/YYYY

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All patients and their carers should have the information relating to potential harm from pressure damage to enable them to make informed decisions in their care. This may need to be revisited repeatedly at each visit.

Skin	History of previous pressure damage	Review at safety handover and devise a care plan
	History of /or existing pressure damage • Any damage amends your care plan. • Existing category 3, unstageble, category 4 pressure damage or suspected deep tissue injury.	Datix all damage Review seating and equipment for any new damage. Review at safety handover, devise a care plan and as part of this refer to Tissue Viability with oversight of community nurse specialist Band 6/7
Mobility	Unable to/unlikely to reposition independently • Is dependent on carers to reposition	Review at safety Handover and devise a care plan with oversight of community nurse specialist Band 6/7 Care plan to support the patients decisions alongside their carers Consider all equipment/manual handling/OT referral Conversation with carers and care plan devised
	Is dependent on a wheelchair/other wheeled device	Review at safety handover and devise a care plan Therapy or EMC review is required if skin deterioration noted.
Intrinsic Factors	Reduction in cognition/understanding • New or existing	Review at safety Handover and devise a care plan with oversight of community nurse specialist Band 6/7 Care plan to support the patients decisions alongside their carers
	Any organ failure or impaired function • Consider how this will impact on the patients skin	GP/Safety Handover
	PVD(Peripheral vascular disease)/Diabetes/ loss of sensation • to peripheries or other areas	CNS Safety Handover/GP/Consider podiatry/Nutritional support/Vascular
	Terminal illness • May develop SCALE (skin changes at life's end) lesion	EOL care to include effective pressure relieving strategies supported by effective pain control
	Deterioration of condition/acutely unwell • Pressure damage is much more likely to occur	Escalation to GP or safety handover Review all care plans
	Incontinence/Oedema/Excess moisture • Is unable to maintain continence or personal hygiene or • Has significant oedema/lymphedema **(significant risk of heel damage for this patient group)**	Review at safety Handover and devise a care plan with oversight of community nurse specialist Band 6 Carer/family/Bladder and bowel nurses/continence assessment/referral Refer to IAD protocol, use px products Px heel protection/offloading equipment
Nutrition/Hydration	Visually underweight or obese	Weight management/nutrition/hydration GP if new weight loss Carer/family
	History of on-going weight loss/new weight loss	
	Significant wounds requiring increase in nutritional support • e.g. Burns	Review at safety Handover and devise a care plan with oversight of community nurse specialist Band 6