Adult Pressure Injury Risk Assessment

Pressure Injury Prevention/Management Plan
- Conduct comprehensive risk assessment and develop a care plan.
- Reassess at a minimum of daily if ‘at-risk’; weekly if ‘not-at-risk’, or on transfer; if the patient’s condition changes and on discharge.
- A comprehensive skin inspection should include a head-to-toe (anterior and posterior) assessment for signs of erythema, blanching response, localised heat, oedema, induration and skin breakdown (including observation for any skin damage related to medical devices, plaster casts).
- Every person documenting on this form must supply a sample of their initials in the signature log (page 4).

Skin Inspection
- Conduct a comprehensive skin inspection as soon as possible following admission within a minimum of eight (8) hours.
- A comprehensive skin inspection should include a head-to-toe (anterior and posterior) assessment for signs of erythema, blanching response, localised heat, oedema, induration and skin breakdown (including observation for any skin damage related to medical devices, plaster casts).
- Every person documenting on this form must supply a sample of their initials in the signature log (page 4).

Initial Comprehensive Skin Inspection on Admission
- Record skin related issues on diagram below.

Ongoing Comprehensive Skin Inspection
- If yes to any of the above, ensure management strategies are started.

Risk Assessment

<table>
<thead>
<tr>
<th>Risk category</th>
<th>Plan</th>
<th>Completed by (initials)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>Use water-based skin emollients to maintain skin hydration</td>
<td>✔</td>
</tr>
<tr>
<td>High risk</td>
<td>Use a pH appropriate skin cleanser and dry skin thoroughly</td>
<td>✔</td>
</tr>
<tr>
<td>Very high risk</td>
<td>Use transfer aids and employ appropriate manual handling techniques</td>
<td>✔</td>
</tr>
<tr>
<td>Waterlow score</td>
<td>Provide pressure injury information and develop plan of care in partnership with patient/carer</td>
<td>✔</td>
</tr>
</tbody>
</table>

Skin inspection completed
- Admitted by: [Signature]
- Date/Time: [Date] [Time]

Pressure Injury Prevention +/- Management Plan
- Consider Bariatric mattress/bed for patients with BMI >40
- High Risk (15+)/Very High Risk (20+): Consider high specification reactive (constant low pressure) support foam mattress
- At Risk (10+): Consider active powered (alternating pressure) support mattress, or specialty bed/mattress system
- Consider Bariatric mattress/bed for patients with BMI >40

Signature Log
- Every person documenting in this assessment must supply a sample of their initials in the signature log below.

Initials | Print name | Designation | Signature | Initials | Print name | Designation | Signature
---------|------------|-------------|-----------|---------|------------|-------------|-----------
[Signature] | [Signature] | [Signature] | [Signature] | [Signature] | [Signature] | [Signature] | [Signature]
Modified Waterlow Risk Score

- Calculate risk score as soon as possible following admission within a minimum of eight (8) hours.
- Reassess at a minimum of weekly (hospital, subacute and rehabilitation) or monthly (residential care); and if the patient's condition changes.
- Risk scoring should never replace clinical judgement.

Every person documenting on this form must supply a sample of their initials in the signature log (page 4).

Screening: Does the patient have a history of pressure injury?

- Yes, site(s):
- No

Date
Time
Assessed by (initials)

Build/weight for height
- Weight
- Height
- Body Mass Index
  - Average (BMI 20–24.9)
  - Above average (BMI 25–29.9)
  - Obese (BMI >30)
  - Below average (BMI <20)

Gender
- Male
- Female

Age
- 14 to 49
- 50 to 64
- 65 to 74
- 75 to 80
- 81 or older

Mobility
- Fully mobile
- Restless/fidgety
- Apathetic
- Restricted
- Bed bound/traction
- Chair bound

Medication
- None of the below
- Cytotoxic, Steroids (long term/high dose), Anti-inflammatory (any or all)

Nutrition
- MST score
- Sub-total

Malnutrition Screening Tool (MST)
- Calculate nutritional score from MST below and record in Nutrition section above

Question A: Has the patient lost weight recently weighing?

- Yes
- No

Question B: How much weight has the patient lost?

- Score 0 (Go to question C)
- Score 0 to 5 kg
- Score 6 kg to 10 kg
- Score 11 kg to 15kg
- Score 16 kg to 19 kg
- Score 20 kg or more

Question C: Has the patient been eating poorly because of decreased appetite?

- Yes
- Score 1
- Score 2 (Go to question C)
- Score 3 (Go to question C)
- Score 4 (Go to question C)
- Score 5 (Go to question C)
- Score 6 (Go to question C)

If the patient's score is 2 or more please refer them to a Dietitian.

Continen
t Complete/catheterised
- Incontinence of urine
- Incontinence of faeces
- Doubly incontinent

Tissue malnutrition
- Terminal cachexia
- Multiple organ failure
- Single organ failure
- Peripheral vascular disease
- Anaemia (HB <80g/L)
- Smoking

Skin type/visual inspection
- Healthy
- Tissue paper
- Dry
- Oedematous
- Clamy pyrexia

Pressure injury
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable
- Suspected deep tissue injury
- Mucosal pressure injury

Neurological deficit
- Diabetes
- Multiple sclerosis
- Motor/sensory paraplegia
- Cerebro vascular accident

Major surgery
- Orthopaedic/spinal
- On table >2 hrs (in the past 48 hrs)
- On table >6 hrs (in the past 48 hrs)

Sub-total

Total score (sub-total 1 + sub-total 2)
- 10+ At risk, 15+ High risk, 20+ Very high risk

Proceed to development of Prevention +/- Management Plan (refer page 4).