Adult Pressure Injury Risk Assessment

Pressure Injury Prevention/Management Plan
- Use water-based skin emollients to maintain skin hydration
- Use a pH appropriate skin cleanser and dry skin thoroughly
- Use transfer aids and employ appropriate manual handling techniques
- Provide pressure injury information and develop plan of care in partnership with patient/carer
- Ensure appropriate positioning and use of appropriate support surfaces:
  a. mattress type:
  b. seating cushion
  c. bed cradle
  d. heel wedge/boots
  e. other:
- Increase turning/repositioning schedule to: ____________________________
- Increase mobility according to patient condition
- Conduct daily skin assessment
- Conduct continence assessment
- Refer patient to Dietitian (if MST >2)
- Refer patient to Allied Health (if available):
- Other referral: ____________________________________________________
- Provide nutritional support

Initial Comprehensive Skin Inspection on Admission

Skin Inspection
- Conduct a comprehensive skin inspection as soon as possible following admission within a minimum of eight (8) hours.
- Reassess at a minimum of daily if "at-risk"; weekly if "not at-risk"; 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).

Ongoing Comprehensive Skin Inspection

If yes to any of the above, ensure management strategies are initiated.
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

Build/weight for height

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BMI = Weight(kg) / Height(m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1.20</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1.20-1.29</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1.30-1.39</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.40-1.49</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>&gt; 1.50</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Gender

- Male 1
- Female 2

Age

- 14 to 49 1
- 50 to 64 2
- 65 to 74 3
- 75 to 80 4
- 81 or older 5

Mobility

- Fully mobile 0
- Restless/fidgety 1
- Apathetic 2
- Restricted 3
- Bed bound/traction 4
- Chair bound 5

Medication

- None of the below 0
- Cytotoxic, Steroids (long term/high dose), Anti-inflammatory (any or all) 4

Nutrition

MST score

- 0–5 0
- Sub-total 1

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

<table>
<thead>
<tr>
<th>Question A: Has the patient lost weight recently without trying?</th>
<th>Question B: How much weight has the patient lost?</th>
<th>Question C: Has the patient been eating poorly because of decreased appetite?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Score 0 (Go to question B) 1 kg–5 kg</td>
<td>Score 1 (Go to question C) Yes</td>
</tr>
<tr>
<td>No</td>
<td>Score 0 (Go to question B) 6 kg–10 kg</td>
<td>Score 2 (Go to question C) No</td>
</tr>
<tr>
<td>Unsure</td>
<td>Score 2 (Go to question C)</td>
<td>Score 3 (Go to question C)</td>
</tr>
<tr>
<td>Unsure</td>
<td>Score 4 (Go to question C)</td>
<td>Score 3 (Go to question C)</td>
</tr>
</tbody>
</table>

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

Continence

| Complete/catheterised 0 | Incontinence of urine 1 | Incontinence of faeces 2 | Doubly incontinent 3 |

Tissue malnutrition

More than one option can be selected

| Terminal cachexia 8 | Multiple organ failure 8 | Single organ failure 5 | Peripheral vascular disease 5 | Anaemia (HB <80 g/L) 2 | Smoking 1 |

Skin type/visual inspection

More than one option can be selected

| Healthy 0 | Tissue paper 1 | Dry 1 | Oedematous 1 | Clammy pyrexia 1 |

Pressure injury

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

Neurological deficit

| Diabetes 4–5 | Multiple sclerosis | Motor/sensory paraplegia | Cerebrovascular accident |

Major surgery

| Orthopaedic/spinal 5 | On table >2 hrs (in the past 48 hrs) 5 | On table >6 hrs (in the past 48 hrs) 8 |

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).