PRESSURE INJURY RISK ASSESSMENT FORM (MR95)

Hospital: _____

Affix patient identification label in this box

UR No: _____

Surname: _____

Given Name: _____

Second Given Name: _____

D.O.B: _____ Sex: _____

When to use the *Pressure Injury Risk Assessment Form* (MR95)

- Within 8 hours of admission for all inpatients / residents, except where Electronic Patient Record is in use or on first visit to other services as appropriate.

How to use the *Pressure Injury Risk Assessment Form* (MR95)

- Complete Section A – Skin history and high risk clinical groups.
- Complete Section B – Skin assessment. Indicate areas of concern on the body map, using the legend abbreviations.
- Complete Section C – Braden Scale and Pain Score.
- Use Section D (below) to determine overall level of risk.
- Sign and date below.

Next steps

- If the overall risk is medium or high discuss this with the patient and carer. Develop a Pressure Injury Prevention Plan. MR95A can be used.

SECTION D (tick applicable)	OVERALL RISK (circle)	KEY ACTIONS
☐ Existing pressure injury, or one of the following: ☐ Braden Score 12 or below ☐ Braden Score 13-14 AND in a high risk clinical group, OR concerns on skin inspection	**High risk**	• Off-load affected area. Eliminate pressure, friction, shear and moisture as much as practicable • Arrange active (dynamic) pressure mattress and chair cushion • 1-2/24 position changes with careful manual handling • Reassess Braden and pain scores and inspect skin each shift • Commence Pressure Injury Prevention Plan. MR95A can be used. • Commence wound chart and management • Notify medical officer and refer to dietitian. Consider other referrals
☐ No pressure injury, and any one of the following: ☐ Braden Score 13-18 ☐ In a high risk clinical group ☐ Concerns on skin inspection, visible issues with skin integrity	**Medium risk**	• Eliminate pressure, friction, shear and moisture as much as practicable • Consider active (dynamic) pressure mattress or active (dynamic) overlay, and chair cushion • 2-4/24 position changes • Reassess Braden and pain scores and inspect skin each shift • Commence Pressure Injury Prevention Plan. MR95A can be used. • Consider referrals to multidisciplinary team
☐ No pressure injury, and ☐ Braden Score 15-18 and also • not in a high risk clinical group and • no concerns on skin inspection	**Low risk**	• Pentaflex or equivalent mattress • For those with low or no risk, repeat this assessment at least weekly in acute settings, or monthly in other settings, **or** if any of the following occur > there are any skin integrity concerns > a change in health status > more than 4 hours of immobility (e.g. theatre, sedation) > a pressure injury develops > prior to discharge
☐ No pressure injury, and ☐ Braden Score 19-23 and also • not in a high risk clinical group and • no concerns on skin inspection	**No risk**	

DETAILS OF HEALTH PROFESSIONAL COMPLETING THIS FORM		
Full name *(Please print)*	Designation *(Please print)*	
Signature	Date __ __/__ __/__ __	Time __ __ : __ __ AM PM

PRESSURE INJURY RISK ASSESSMENT FORM (MR95)

SA Health

Created September 2014

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How to use the *Pressure Injury Risk Assessment Form* (MR95)

- Complete Section A – Skin history and high risk clinical groups.
- Complete Section B – Skin assessment. Indicate areas of concern on the body map, using the legend abbreviations.
- Complete Section C – Braden Scale and Pain Score.
- Use Section D (below) to determine overall level of risk.
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- If the overall risk is medium or high discuss this with the patient and carer. Develop a Pressure Injury Prevention Plan. MR95A can be used.

SECTION D (tick applicable) | OVERALL RISK (circle) | KEY ACTIONS

☐ Existing pressure injury, or one of the following:
☐ Braden Score 12 or below
☐ Braden Score 13-14 AND in a high risk clinical group, OR concerns on skin inspection

High risk

• Off-load affected area. Eliminate pressure, friction, shear and moisture as much as practicable
• Arrange active (dynamic) pressure mattress and chair cushion
• 1-2/24 position changes with careful manual handling
• Reassess Braden and pain scores and inspect skin each shift
• Commence Pressure Injury Prevention Plan. MR95A can be used.
• Commence wound chart and management
• Notify medical officer and refer to dietitian. Consider other referrals

☐ No pressure injury, and any one of the following:
☐ Braden Score 13-18
☐ In a high risk clinical group
☐ Concerns on skin inspection, visible issues with skin integrity

Medium risk

• Eliminate pressure, friction, shear and moisture as much as practicable
• Consider active (dynamic) pressure mattress or active (dynamic) overlay, and chair cushion
• 2-4/24 position changes
• Reassess Braden and pain scores and inspect skin each shift
• Commence Pressure Injury Prevention Plan. MR95A can be used.
• Consider referrals to multidisciplinary team

☐ No pressure injury, and
☐ Braden Score 15-18 and also
• not in a high risk clinical group and
• no concerns on skin inspection

Low risk

• Pentaflex or equivalent mattress
• For those with low or no risk, repeat this assessment at least weekly in acute settings, or monthly in other settings, **or** if any of the following occur
> there are any skin integrity concerns
> a change in health status
> more than 4 hours of immobility (e.g. theatre, sedation)
> a pressure injury develops
> prior to discharge

☐ No pressure injury, and
☐ Braden Score 19-23 and also
• not in a high risk clinical group and
• no concerns on skin inspection

No risk

DETAILS OF HEALTH PROFESSIONAL COMPLETING THIS FORM

Full name *(Please print)* | Designation *(Please print)*

Signature | Date __ __/__ __/__ __ | Time __ __ : __ __ AM PM

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D.O.B: _____ Sex: _____

SECTION A

Part 1 – HIGH RISK CLINICAL CONDITIONS (tick all that apply)

- ☐ High BMI (skin folds) above 30.0 kg/m^2
- ☐ Low BMI (bony prominences) below 18.5 kg/m^2
- ☐ Current smoker
- ☐ 85 years or more and / or frail or emaciated
- ☐ Incontinent
- ☐ At risk of malnutrition (refer MUST screen)
- ☐ Severely anaemic
- ☐ Diabetes or peripheral vascular disease
- ☐ Palliative
- ☐ Immunosuppressed; chemotherapy; radiotherapy; long-term corticosteroid use;
- ☐ Spinal cord injury or other neurological condition affecting mobility and / or sensation
- ☐ Major organ failure – cardiac, respiratory, hepatic, renal
- ☐ Rheumatoid arthritis, connective tissue disease

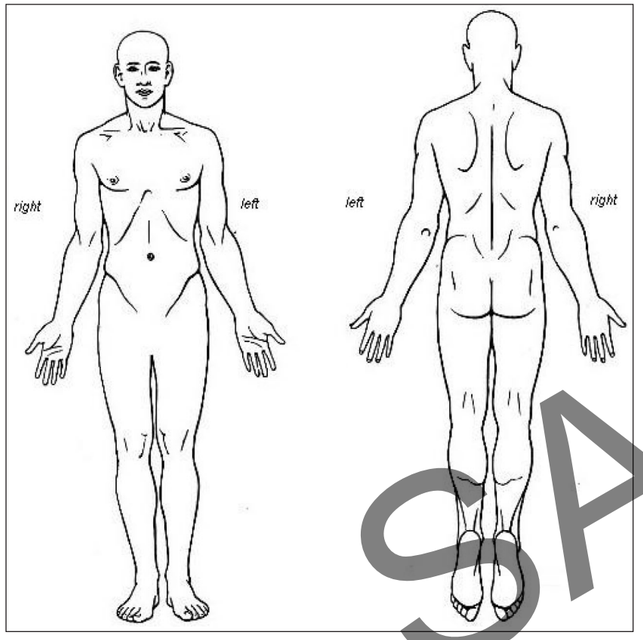
Part 2 – SKIN HISTORY

History of pressure injury ☐ Current pressure injury ☐ Never ☐ Healed Date / year (specify).....

Widespread dermatological condition ☐ None known ☐ Yes (specify).....

Known skin sensitivity to ☐ Dressing(s) ☐ Adhesive(s) ☐ Skin products, perfumes, soaps, other

(Specify).....



SECTION B – SKIN ASSESSMENT

Inspect skin and document the location of areas of concern on body map using abbreviations as follows

Current lesions / wounds	Risk areas	Early warning signs
PI Pressure injury (s)	Sens Sensory loss	H Localised heat
ST Skin tear	P Painful skin	BR Blanching response
U Venous or arterial ulcer	X Body prominences	E Erythema
SW Surgical wound	M Moist area(s)	I Induration
T Tube/device	O Oedema / swelling	Bl Blister
R Rash	F Skin folds	
Ab Abrasion	Sc / B Scar / bruise	

SECTION C

BRADEN SCALE (circle score and add)

SENSORY PERCEPTION – ability to respond meaningfully to pressure-related discomfort	1. Completely Limited 2. Very Limited 3. Slightly Limited 4. No impairment
MOBILITY – ability to change and control body position (in bed, chair)	1. Completely Immobile 2. Very Limited 3. Slightly Limited 4. No Limitation
ACTIVITY – degree of physical activity	1. Bedfast 2. Chairfast 3. Walks Occasionally 4. Walks Frequently
MOISTURE – degree to which skin is exposed to moisture	1. Constantly Moist 2. Very Moist 3. Occasionally Moist 4. Rarely Moist
FRICTION, SHEAR and PRESSURE	1. Problem 2. Potential Problem 3. No Apparent Problem
NUTRITION – usual food intake pattern	1. Very Poor 2. Probably Inadequate 3. Adequate 4. Excellent
TOTAL Score	
Skin Pain *(Mark location on body chart) using P to indicate*	**Score / severity** ..... **Description** e.g. burning, itching .....

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☐ Spinal cord injury or other neurological condition affecting mobility and / or sensation
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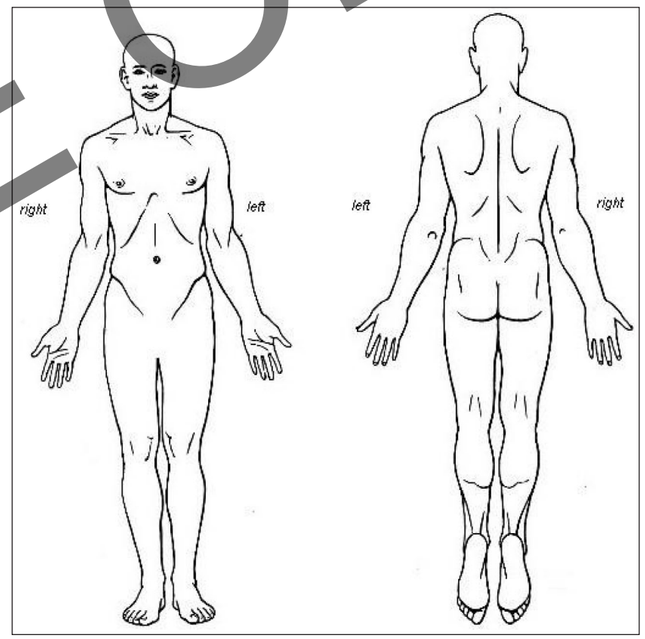
Widespread dermatological condition ☐ None known ☐ Yes (specify).....

Known skin sensitivity to ☐ Dressing(s) ☐ Adhesive(s) ☐ Skin products, perfumes, soaps, other

(Specify).....



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TOTAL Score	
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