Instructions for use of the *Pressure Injury Prevention Plan* (MR95A)

- Use this care plan for patients who are at medium or high risk of pressure injury to record results of reassessment and the care provided.
- This form can be used in conjunction with a wound management chart
- All patients at high risk and medium risk should be considered for dynamic or active mattress and cushion
- This form is not required where Electronic Patient Record System is in use

TABLE 1. REFERRAL / CONSULT TO MULTIDISCIPLINARY TEAM	Tick & date (if completed)	Initials	Designation
☐ **Dietitian** – nutrition assessment and supplementation	☐ ...../...../.....		
☐ **Podiatrist** – impaired sensation/circulation, assessment of feet, footwear and off-loading	☐ ...../...../.....		
☐ **Physiotherapist** – mobility, exercises, transfer or manual handling techniques	☐ ...../...../.....		
☐ **Occupational therapist** – ADL and aids / equipment inc seating, home assessment	☐ ...../...../.....		
☐ **Continence nurse** – assessment of continence and aids	☐ ...../...../.....		
☐ **Medical specialist (Circle) – Vascular, diabetic / endocrine, plastic**	☐ ...../...../.....		
☐ **Social worker or discharge coordinator** – complex discharge planning	☐ ...../...../.....		
☐ **Wound management nurse** – assessment	☐ ...../...../.....		
☐ **Speech pathologist** – assessment swallowing, chewing	☐ ...../...../.....		

TABLE 2. INVOLVEMENT OF PATIENT, FAMILY AND/OR CARER				Tick & date (if completed)	Initials	Designation
Informed about risk status	☐ patient	☐ family	☐ carer	☐ ...../...../.....		
Provided with information		☐ written	☐ verbal	☐ ...../...../.....		
Participated in care planning	☐ patient	☐ family	☐ carer	☐ ...../...../.....		

TABLE 3. DISCHARGE PLANNING			Tick & date (if completed)	Initials	Designation
Patient, family carer provided with information	☐ written	☐ verbal	☐ ...../...../.....		
Patient, family carer participated in discharge planning (who)			☐ ...../...../.....		
Referrals made to next service provider(s) and appointments made			☐ ...../...../.....		
Other: (describe):			☐ ...../...../.....		

TABLE 4. OVERALL LEVEL OF RISK

To determine level of risk, establish Braden score, then increase to next higher level if the patient is in a high risk group and / or there are areas of concern on visual skin assessment.

☐ **High risk**	☐ **Medium risk**	☐ **Low risk**	☐ **No risk**
☐ 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	☐ 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	☐ No pressure injury, and ☐ Braden Score 15-18 and also • not in a high risk clinical group and • no concerns on skin inspection	☐ No pressure injury, and ☐ Braden Score 19-23 and also • not in a high risk clinical group and • no concerns on skin inspection

INSTRUCTIONS FOR EACH SHIFT: Write Braden and pain scores. Circle Yes or No to indicate if the care has been completed. Record changes to the care plan. Fill in date and time, and sign below.	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain .....
	BRADEN SCORING	**CARE COMPLETED (add changes or comments where applicable)**						
SENSORY PERCEPTION – ability to respond meaningfully to pressure-related discomfort	1 Completely Limited 2 Very Limited 3 Slightly Limited 4 No Impairment	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
MOBILITY – ability to change and control body position (in bed, chair)	1 Completely Immobile 2 Very Limited 3 Slightly Limited 4 No Limitation	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
ACTIVITY – degree of physical activity	1 Bedfast 2 Chairfast 3 Walks Occasionally 4 Walks frequently	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
MOISTURE – degree to which skin is exposed to moisture	1 Constantly Moist 2 Very Moist 3 Occasionally moist 4 Rarely Moist	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
FRICTION, SHEAR and PRESSURE	1 Problem 2 Potential Problem 3 No Apparent Problem	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
NUTRITION – usual food intake pattern	1 Very Poor 2 Probably Inadequate 3 Adequate 4 Excellent	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Discussed with patient / carer / family		Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Name (please print)								
Signature								
Designation (please print)								
Date		...../...../.....	...../...../.....	...../...../.....	...../...../.....	...../...../.....	...../...../.....	...../...../.....
Time		:	:	:	:	:	:	:

PRESSURE INJURY PREVENTION PLAN
(MR95A)

Hospital: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

INSTRUCTIONS FOR EACH SHIFT:	Re-assessment	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain	Braden ..... Pain .....
Write Braden and pain scores. Circle Yes or No to indicate if the care has been completed. Record changes to the care plan. Fill in date and time, and sign below.	☐ each position change (skin and pain) ☐ each shift (Braden, skin and pain) ☐ each day (Braden, skin and pain) ☐ other												
BRADEN SCORING	**PLANNED CARE**	**CARE COMPLETED (add changes or comments where applicable)**											
SENSORY PERCEPTION – ability to respond meaningfully to pressure-related discomfort	**1 Completely Limited** **2 Very Limited** **3 Slightly Limited** **4 No Impairment**	**Inspect skin** ☐ each position change ☐ each shift ☐ daily	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
MOBILITY – ability to change and control body position (in bed, chair)	**1 Completely Immobile** **2 Very Limited** **3 Slightly Limited** **4 No Limitation**	**Repositioning** - assist to ☐ 1/24 ☐ bed ☐ 2/24 ☐ chair ☐ both **Manual handling technique** ☐ Hoist/lifter ☐ 1 person ☐ 2 person ☐ Slippery Sam ☐ Other ☐ Remind to change body position	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
ACTIVITY – degree of physical activity	**1 Bedfast** **2 Chairfast** **3 Walks Occasionally** **4 Walks frequently**	**Activity** ☐ **Sit out of bed** ☐ Max 1/24 ☐ Max 2/24 **Bed / chair exercises** ☐ 1 ☐ 2 ☐ 3 session(s) per shift ☐ **Walk to** toilet, bathroom, other ☐ **Walk on** ward **Assistance required to transfer / mobilise** ☐ 2 person ☐ 1 person ☐ Standby ☐ Set-up ☐ Bed mobility aid(s) ☐ Walking aid(s) ☐ Correct bed height ☐ Correct chair height ☐ Spectacles ☐ Footwear	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
MOISTURE – degree to which skin is exposed to moisture	**1 Constantly Moist** **2 Very Moist** **3 Occasionally moist** **4 Rarely Moist**	Offer toileting ☐ 1/24 ☐ 2/24 Check pads, linen ☐ 1/24 ☐ 2/24 ☐ Reduce other skin moisture..... ☐ shower ☐ daily ☐ bed sponge ☐ bd ☐ dressings / other	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
FRICTION, SHEAR and PRESSURE	**1 Problem** **2 Potential Problem** **3 No Apparent Problem**	**Check function of support surface / equipment** ☐ 2/24 ☐ 4/24 **Bed support surface** ☐ Overlay ☐ Mattress ☐ Dynamic ☐ Static **Support surface chair** ☐ Dynamic cushion ☐ Static cushion **Heel offload** ☐ Bed cradle ☐ Heel Offload set-up **Inspect under devices / orthotics / compression garment, bandages –** ☐ 1/24 ☐ pressure points. ☐ 2/24 ☐ friction/rubbing ☐ 4/24 ☐ pain ☐ each shift	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
NUTRITION – usual food intake pattern	**1 Very Poor** **2 Probably Inadequate** **3 Adequate** **4 Excellent**	☐ MUST screen and dietitian consult ☐ Intake chart ☐ provide feeding / drinking assistance ☐ nutritional supplements	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
Discussed with patient / carer / family	**Record details in TABLE 2 (front cover)**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
Name (please print)													
Signature													
Designation (please print)													
Date		...../...../.....	...../...../.....	...../...../.....	...../...../.....	...../...../.....	...../...../.....	...../...../.....	...../...../.....	...../...../.....	...../...../.....	...../...../.....	...../...../.....
Time		:	:	:	:	:	:	:	:	:	:	:	: