Hôpital St-Boniface Hospital

NICU

Neonatal Pressure Injury Risk Assessment

Assessment of risk for skin breakdown. A tissue viability care plan should ALWAYS be commenced if there is an existing wound or if in the healthcare professional's opinion the infant is at risk, regardless of the score. Adapted from the Neonatal/Infant Braden Q Scale. Sue Wilson Surgical Care Practitioner, Louise Briggs Junior Sister (2011). Adapted from Neonatal Tissue Viability Risk Assessment Tool (Ashworth and Briggs, 2011).

To be completed for all NICU inpatients within twelve hours of admission, weekly, with change in patient condition, and according to care plan on reverse.

				Date of Assessment (DD/MMM/YYYY)	/ /	/ /	/ /	/ /
				Time of Assessment (24 HOUR)				
INTENSITY AND DURATION OF PRESSURE					**Score** (circle)	**Score** (circle)	**Score** (circle)	**Score** (circle)
GENERAL PHYSICAL CONDITION	**3 – Corrected Gestational Age equal to or less than 28 weeks**	**2 – Corrected Gestational Age greater than 28 weeks and equal to or less than 33 weeks**	**1 – Corrected Gestational Age equal to or greater than 33 weeks and less than 38 weeks**	**0 – Corrected Gestational Age equal to or greater than 38 weeks**	3 2 1 0	3 2 1 0	3 2 1 0	3 2 1 0
MOBILITY The ability to change and control body position.	**3 – Completely immobile:** No changes in body position. Very edematous. Sedated and/or paralytic medication.	**2 – Very limited:** Occasionally makes slight changes in body position. Slightly edematous. Weaning/ just commencing sedation. No paralytic medication.	**1 – Slightly limited:** Frequent changes in body position, can turn head, limited extension/flexion. Not on any sedation or paralytic medication.	**0 – No limitations:** Frequent changes in position, moving all extremities, turning head, positive reflexes. Not on any sedation or paralytic medication.	3 2 1 0	3 2 1 0	3 2 1 0	3 2 1 0
ACTIVITY The degree of physical activity.	**3 – None:** Does not tolerate position changes, limited position choice due to condition or equipment.	**2 – Very limited:** Tolerates position changes, can be lifted in incubator, not able to come out of incubator.	**1 – Slightly limited:** Tolerates frequent position changes, can be held and have skin-to-skin.	**0 – No limitations:** Can be repositioned and held freely.	3 2 1 0	3 2 1 0	3 2 1 0	3 2 1 0
SENSORY PERCEPTION The ability to respond in a developmentally appropriate way to pressure related discomfort and pain.	**3 – Completely limited:** Unresponsive to environment or tactile stimuli due to diminished level of consciousness, on paralytic or sedation medication. Continual pain/discomfort.	**2 – Very limited:** Not tolerant of environmental stimuli, oversensitive to noise, lights and touch, easily agitated, difficult to calm. Intermittent pain on movement.	**1 – Slightly limited:** Easily agitated but calms with comfort measures. Few self-calming behaviors, occasionally successful at self-calming, pain on handling.	**0 – No impairment:** Age appropriate responses to aversive stimuli, preceptive with successful self-calming behaviors. Pain free.	3 2 1 0	3 2 1 0	3 2 1 0	3 2 1 0
TOLERANCE OF SKIN AND SUPPORTING STRUCTURE								
MOISTURE Degree to which skin is exposed to moisture. Condition of wound (if applicable).	**3 – Constantly moist:** Nursed in humidity. Area of skin continually moist due to wound, drain site, stoma, leakage, etc. Wound dry, broken, excoriated, red.	**2 – Very moist:** Humidity off. Skin is often, but not always moist. Increased frequency of output. Wound producing exudate.	**1 – Occasionally moist:** Skin is occasionally moist, 6–8 hourly cares. Wound is clean and dry.	**0 – Rarely moist:** Skin is usually healthy and intact, dry routine cares. Wound healed, or going home with an ostomy.	3 2 1 0	3 2 1 0	3 2 1 0	3 2 1 0
FRICTION (i.e. babies on CPAP).	**3 – Significant problem:** Agitation leads to constant friction and vigorous rubbing of head and knees or extremities. Constant agitation from equipment.	**2 – Problem:** Fragile skin, frequently slides down the bed, requiring frequent repositioning. Frequent agitation from equipment.	**1 – Potential problem:** Maintains relatively good position in chair/ bed occasionally slides down. Slight agitation from equipment.	**0 – No problem:** Maintains good positioning in bed or chair. No agitation from equipment.	3 2 1 0	3 2 1 0	3 2 1 0	3 2 1 0
NUTRITION Usual milk/fluid intake pattern.	**3 – Very poor:** NPO, on clear IV fluids, never tolerates a complete feed, losing weight.	**2 – Inadequate:** On inadequate TPN. Trophic tube feeds or titrating with clear IV fluids. No weight gain or losing weight.	**1 – Adequate:** On adequate TPN. Fully fed on tube feeds, titrating with TPN. Stable weight gain.	**0 – Excellent:** Taking all feeds orally, on adequate calories. Consistent weight gain.	3 2 1 0	3 2 1 0	3 2 1 0	3 2 1 0
TISSUE PERFUSION & OXYGENATION	**3 – Extremely compromised:** Hypotensive, MAP not appropriate for gestational age, generalized edema, high frequency, high ventilator requirements. CRT greater than 2 seconds.	**2 – Compromised:** Normal BP, but compensated – extremities cool, cardiac defects, SpO_2 less than 94%, Hb less than 100,CRT greater than 2 seconds, pH less than 7.25, unstable temperature, nursed in O_2.	**1 – Adequate:** BP in normal range (self compensating) SpO_2, greater than 92%, Hb greater than 100, CRT less than 2 seconds, pH normal, stable temperature, nursed in O_2.	**0 – Excellent:** Normal BP by self, SpO_2 greater than 92% in air, normal Hb, CRT less than 2 seconds, stable body temperature.	3 2 1 0	3 2 1 0	3 2 1 0	3 2 1 0
				TOTAL RISK SCORE				
				INITIALS				

KEY: BP - Blood Pressure; CGA - Corrected Gestational Age; nCPAP - nasal Continuous Positive Airway Pressure; CRT - Capillary Refill Time; Hb - Haemoglobin; MAP - Mean Arterial Pressure; NPO - Nil per os (nothing by mouth); RN - Registered Nurse; RRT - Registered Respiratory Therapist; SpO_2 - Oxygen saturation; TPN - Total Parenteral Nutrition

See reverse to complete Risk Assessment Care Plan

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		Date of Assessment (DD/MMM/YYYY)				
		Time of Assessment (24 HOUR)				
		Total Risk Score (from page 1)				
			Initial	**Initial**	**Initial**	**Initial**
For All Patients : ■ Skin assessment completed at least once per shift, or more often per patient condition. ■ Ensure adequate hydration and nutrition as per patient condition. ■ Ensure diaper changes on schedule per patient condition. Ensure dimethicone based ointment applied to diaper area per protocol. ■ If on respiratory support, conduct joint skin assessment per RN/RRT once per shift per protocol. ■ Inspect skin when repositioning, diaper change, and assessment as needed. ■ Discuss Pressure Injury Prevention with the patient family. For Extremely Low Gestational Age (ELGA) infants, refer to ELGA guideline for skin care strategies.						
SCORE 0 – 5	Low Risk	☐ Reassess and document Neonatal Pressure Injury Risk Assessment score weekly or as condition changes.				
		☐ Use memory foam mattress if available. Use limited layers of linen between patient and mattress.				
SCORE 6 – 10	At Risk	**In addition to above strategies, also consider**: ☐ Commence pressure injury care plan interventions in accordance with risk category. - Prophylactic dressings under medical devices.				
		☐ Reassess and document Neonatal Pressure Injury Risk Assessment score twice weekly or as condition changes.				
SCORE 11 – 19	High Risk	**In addition to above strategies, also consider:** ☐ Consult skin/wound care specialist.				
		☐ Ensure regular relief of pressure due to medical equipment as tolerated, every 3-4 hours.				
		☐ Use memory foam mattress, if not already.				
		☐ If a wound is present commence wound assessment flowsheet, or site appropriate documentation, and ensure appropriate dressing and dressing changes, if needed.				
		☐ Reassess and document Neonatal Pressure Injury Risk Assessment score daily or as condition changes.				
SCORE 20 – 24	Very High Risk	**In addition to above strategies, also consider:** ☐ Consider adding prophylactic dressings to skin folds and over bony prominences on pressure dependent surfaces.				
		☐ Consider micro-turns every 2 hours				
		☐ Reassess and document Neonatal Pressure Injury Risk Assessment score twice daily or as condition changes.				