JOHNSTON PRESSURE ULCER RISK ASSESSMENT INTERVENTION GUIDE™

Sensory Perception	1 Completely Limited	2 Very Limited	3 Slightly Limited	4 No Impairment
The ability to respond meaningfully to pressure related discomfort impacts the risk of pressure ulcer development.	☐ See MOBILITY, Completely Immobile.	☐ See MOBILITY, Completely Immobile. ☐ Assess non-verbal signs of pain and/or discomfort.	☐ See MOBILITY, Completely Immobile. ☐ Assess for verbal and non-verbal signs of pain and/or discomfort.	☐ Systematically inspect skin, paying particular attention to bony prominences. ☐ Reassess sensory perception status if condition changes or per routine risk assessment protocol.

Moisture	1 Constantly Moist	2 Often Moist	3 Occasionally Moist	4 Rarely Moist
An excess of moisture on intact skin is a potential source of maceration and skin breakdown.	☐ Utilize appropriate nursing intervention for incontinence. ☐ Utilize appropriate incontinence device as ordered. ☐ Cleanse perineum prn. ☐ Assess for fungal/yeast infection and treat with Antifungal med as ordered.		☐ Apply Moisture Barrier prn. ☐ Utilize low airloss support surface if indicated. ☐ Avoid use of harsh soaps and rubbing when cleansing skin. ☐ Instruct caregiver/patient on importance of keeping skin clean and dry.	☐ Systematically inspect skin, paying particular attention to areas prone to moisture. ☐ Reassess moisture status if condition changes or per routine risk assessment protocol.

Activity	1 Bedfast	2 Chairfast	3 Walks Occasionally	4 Walks Frequently
Frequent turning, repositioning, and mobility are reported to be essential in reducing risk of pressure ulcers.	☐ See MOBILITY, Completely Immobile.	☐ See MOBILITY, Completely Immobile. ☐ Instruct patient to shift weight q 15 minutes if able. ☐ Avoid pressure to heels while sitting. ☐ Utilize appropriate wheelchair cushion.	☐ See ACTIVITY, Chairfast prn. ☐ Written schedule for ambulation/activity. ☐ Instruct caregiver/patient on safety during ambulation.	☐ Written schedule for ambulation/activity prn. ☐ Instruct caregiver/patient on safety during ambulation. ☐ Reassess activity status if condition changes or per routine risk assessment protocol.

Mobility	1 Completely Immobile	2 Very Limited	3 Slightly Limited	4 No Limitation
Frequent turning, repositioning, and mobility are reported to be essential in reducing risk of pressure ulcers.	☐ Initiate a turn schedule, minimum q 2 hours. ☐ Utilize pillows/foam wedges for placement between bony prominences. ☐ Avoid positioning directly on the trochanter when in side lying position. ☐ Utilize appropriate pressure reducing surface.		☐ Use only one draw sheet and one incontinence pad under patient when possible. ☐ Raise heels off of bed. ☐ Avoid massage over bony prominences. ☐ Systematically inspect skin, paying particular attention to bony prominences. ☐ Instruct the caregiver/patient on above.	☐ Systematically inspect skin, paying particular attention to bony prominences. ☐ Reassess mobility status if condition changes or per routine risk assessment protocol.

Nutrition	1 Very Poor	2 Probably Inadequate	3 Adequate	4 Excellent
Poor dietary intake contributes to the development of pressure ulcers.	☐ Assess height/weight on admit, initiate I & O, and food diary. ☐ Request __dietary consult and lab tests: serum __Albumin, __Prealbumin, __Transferrin, __Total Lymphoctye Count. F/U with MD any recommendations. ☐ Assess patient ability to chew/gag reflex. Consult ST prn. ☐ Request MSW consult to evaluate patient resources prn. ☐ Assess caregiver ability to obtain/prepare meals/tube feeding. ☐ Instruct caregiver/patient on appropriate interventions.		☐ Assess height/weight on admit. ☐ Request lab tests: serum __Albumin, __Prealbumin, __Transferrin, __ Total Lymphoctye Count, if wound present and not progressing. ☐ Reassess nutrition status if lab values abnormal.	☐ Assess height/weight on admit. ☐ Reassess nutrition status if condition changes or per routine risk assessment protocol.

Friction and Shear	1 Problem	2 Potential Problem	3 No Apparent Problem
Most shear and friction injuries can be prevented with proper interventions.	☐ Keep HOB in lowest degree consistent with medical condition. ☐ Limit the amount of time the HOB is elevated. ☐ Utilize lifting device to move/reposition the patient. ☐ Apply moisturizers/lubricants to dry/flaky skin. ☐ Apply protective dressing (ex. MVP dressing or thin hydrocolloid) to high risk areas. ☐ Eliminate or limit the amount of soap used during bath. ☐ Raise heels off of bed. ☐ Utilize appropriate pressure reducing surface. ☐ Systematically inspect skin, paying particular attention to bony prominences, heels, and elbows. ☐ Instruct the caregiver/patient on above.		☐ Systematically inspect skin, paying particular attention to bony prominences, heels, and elbows. ☐ Reassess friction and shear status if condition changes or per routine risk assessment protocol.

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Date:

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Patient Name:

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Clinician Name:

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Clinician Signature: