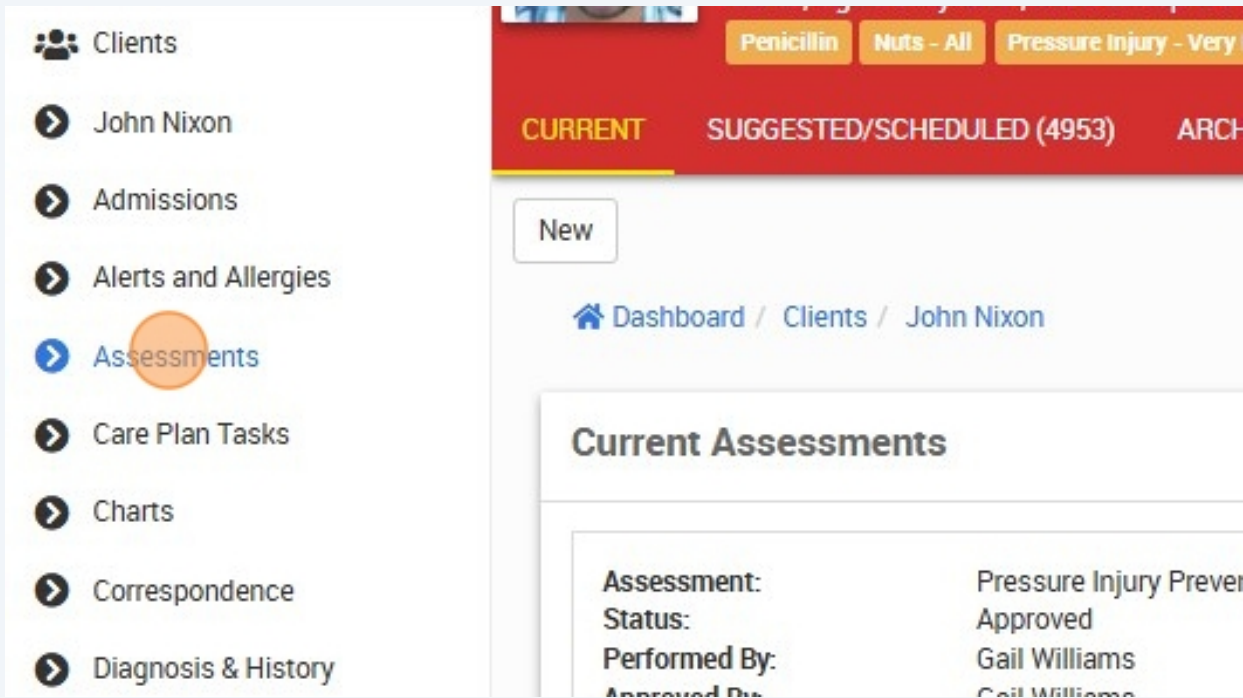


Pressure Injury Risk Assessment and Pressure Injury Prevention Plan

A how to guide for completing the pressure injury risk assessment and the pressure injury prevention plan adapted from the Glamorgan Risk Assessment Scale in Care Right

Pressure Injury Risk Assessment

- 1
- Click "**Assessments**" within the client dashboard to open all current assessments



2

After finding the correct assessment, to open the pressure injury risk assessment, click **"Show"**.

New

Dashboard / Clients / John Nixon

Current Assessments ☐ Include chart updates Please select... Newest Created Any State Search...

Assessment:	Pressure Injury Prevention Plan 29 - Pressure Injury Prevention Plan Filter	Created:	28/10/2025 at 13:35	Show
Status:	Approved	Performed At:	28/10/2025 at 13:35	
Performed By:	Gail Williams	Approved At:	28/10/2025 at 13:35	
Approved By:	Gail Williams	Assessed At:	28/10/2025 at 13:35	
Assessment:	Pressure Injury Risk Assessment 11 - Pressure Injury Risk Assessment Filter	Created:	28/10/2025 at 13:33	Show
Status:	Approved	Performed At:	28/10/2025 at 13:33	
Performed By:	Gail Williams	Approved At:	28/10/2025 at 13:33	
Approved By:	Gail Williams	Assessed At:	28/10/2025 at 13:33	
Assessment:	Care Plan 17 - Care Plan Filter	Created:	27/10/2025 at 11:17	Show
Status:	Approved	Performed At:	27/10/2025 at 11:17	
Performed By:	Gail Williams	Approved At:	27/10/2025 at 11:17	
Approved By:	Gail Williams	Assessed At:	27/10/2025 at 11:17	
Assessment:	Incident Report 12 - Incident Report Filter	Created:	30/09/2025 at 12:58	Show
Status:	Approved	Performed At:	30/09/2025 at 12:58	
Performed By:	Gail Williams	Approved At:	30/09/2025 at 13:11	
Approved By:	Gail Williams	Assessed At:	30/09/2025 at 13:11	
Date of Incident:	Time of Incident:	Incident Summary/Title:		
2025-09-30	12:00:00	Fall		

3

If this is a review of the risk assessment, click **"Perform"** at the top of the screen to edit the assessment.

ah

John Nixon ALLERGY NOTICE Medication Chart EMMA medica

Print A4 Portrait Perform

Pressure Injury Risk Assessment Authored by Gail Williams (Registered Nurse) on

Pressure Injury Risk Assessment

Adapted from the Glamorgan Risk Assessment Scale

Determine total risk score and enter below.
Note: This tool does not replace clinical judgement.

Select one score per section.

Mobile

Unable to change his/her po

4

Select the appropriate mobility and equipment responses. The total score will automatically add up and display at the bottom in blue.

Enter below.
your clinical judgement.

Mobility:

Cannot be moved without great difficulty or causing deterioration in condition = 20

Unable to change his/her position without assistance /cannot control body movement = 15

Some

Normal mobility for age = 0

Equipment:

Equipment / objects / hard surface pressing or rubbing on skin = 15

N/A = 0

Total Score:

35

Risk Categories



Tip! The risk score, risk category and suggested actions table has been adapted from the Glamorgan Risk Assessment Tool.

Risk Score	Risk Category	
0	Not at Risk	Continue to reassess daily and every time condition changes.
10+	At Risk	Inspect skin at least twice a day. Relieve pressure by helping/ encouraging the ch
15+	High Risk	Inspect skin with each repositioning. Reposition child / equipment/ devices at lea
20+	Very High Risk	Inspect skin at least hourly if condition allows. Reposition client / equipment/dev

5

Type in the total risk score and select the appropriate risk category as per the table

10+	At Risk	Inspect skin at least twice a day. Relieve pressure by helping/ encouraging the child to move at least every 2 h sitting on &/or sleeping on if necessary.
15+	High Risk	Inspect skin with each repositioning. Reposition child / equipment/ devices at least every 2 hours. Relieve pre appropriate pressure redistribution surface for sitting on &/or sleeping on.
20+	Very High Risk	Inspect skin at least hourly if condition allows. Reposition client / equipment/devices at least every 2 hours and pressing on the skin. Consider using specialised pressure relieving equipment.

Risk Summary

Total Risk Score*

Enter total score generated by risk factors table above here

Risk Category*

Very High Risk

Use Risk Categories table

Results

Very High Risk ,Inspect skin at least hourly if condition allows. Reposition client / equipment/devices at least every 2 hours and before skin



• **Tip!** The results section will now populate with the chosen risk category and the preset suggested actions for this risk category.

• **Tip!** A notice will now appear on the client's banner for clients categorised as, at risk, high risk and very high risk as per below.

Results

Very High Risk ,Inspect skin at least hourly if condition allows. Reposition client / equipment/devices at least every 2 hours



John Nixon

ALLERGY

NOTICE

MRN: 000036

Male , aged 31 years , born on April 16, 1994 , las

Penicillin

Nuts - All

Pressure Injury - Very High Risk

SP



Alert! A pressure injury prevention plan is required for all clients who score 10 or higher

If the score is 10 or more, a Pressure Injury Prevention Plan is required.
Click the link below or go to Assessments to complete the Plan



Tip! Click the blue link to open the pressure injury prevention plan in a new tab



Click here complete Pressure injury Prevention Plan

Current Assessments		☐ Include chart updates	Please select...	Newest C
Assessment:	Pressure Injury Prevention Plan 22 - Pressure Injury Prevention Plan Filter			
Status:	Approved	Created:		
Performed By:	Gail Williams	Performed At:		
Approved By:	Gail Williams	Approved At:		
		Assessed At:		

Pressure Injury Prevention Plan	
Complete this form when a patient score is > 10 from the Pressure Injury Risk Assessment OR a pressure injury is identified.	
Date plan completed / reviewed:	23/09/2023
Pressure Injury Risk Assessment	
Total risk score:	23.0
Pressure Injury Rating:	Very High Risk
Mobility:	
Equipment:	
Very High Risk. Inspect skin at least hourly if condition allows. Reposition client / equipment devices at least every 2 hours and before skin becomes discoloured. Ensure	
Repositioning Frequency	
Frequency of repositioning:	2nd hourly
Pressure Redistributing Equipment	
	☒ Alternating Pressure Mattress
	☐ Wedges
	☐ Memory Foam
	☐ GelPad
	☐ Cushions
	☐ Other
Medical Devices	
Is there a medical device in situ?	



6 Click "Approve" to submit assessment

S

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ary

Results

Very High Risk, Inspect skin at least hourly if condition allows. Rep skin. Consider using specialised relieving equipment.

If the score is 10 or more, a Pressure Injury Prevention Click the link below or go to Assessments to complete

[Click here complete Pressure injury Prevention Plan](#)

Approve

Pressure Injury Prevention Plan

7 To open the **pressure injury prevention** plan, in assessments, locate the correct assessment and click 'show'

IVED

☐ Include chart updates

Please select... ▼ Newest Created ▼ Any State ▼ Pressure Injury

ntion Plan 29 - Pressure Injury Prevention Plan Filter	Created: 28/10/2025 at 13:35	Show ▼
	Performed At: 28/10/2025 at 13:35	
	Approved At: 28/10/2025 at 13:35	
	Assessed At: 28/10/2025 at 13:35	
ssessment 11 - Pressure Injury Risk Assessment Filter	Created: 28/10/2025 at 13:33	Show ▼
	Performed At: 28/10/2025 at 13:33	
	Approved At: 28/10/2025 at 13:33	
	Assessed At: 28/10/2025 at 13:33	

8

If this is a review of the risk assessment, click "**Perform**" at the top of the screen to edit the assessment.



John Nixon ALLERGY NOTICE Medication Chart EMM

MRN: 000036
Male, aged 31 years, born on April 16, 1994, last admitted to Allowa

Penicillin Nuts - All Pressure Injury - Very High Risk SPOC 12 Years Wound Cha

Print A4 Portrait **Perform**

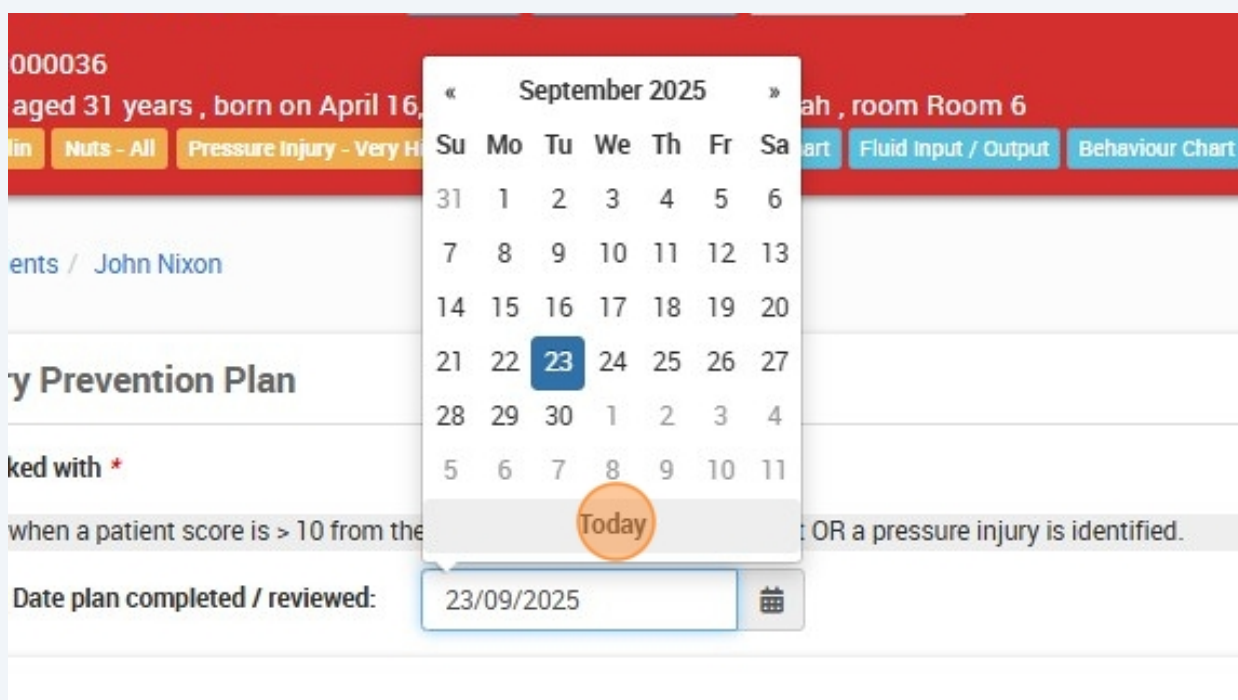
[Dashboard](#) / [Clients](#) / [John Nixon](#)

Pressure Injury Prevention Plan Authored by Gail Williams (Registered Nurse) on 28

Pressure Injury Prevention Plan

9

Select the date and time the plan is being completed



000036
aged 31 years, born on April 16, 1994, last admitted to Allowa, room Room 6

lin Nuts - All Pressure Injury - Very H Fluid Input / Output Behaviour Chart

[Clients](#) / [John Nixon](#)

y Prevention Plan

ked with *

when a patient score is > 10 from the OR a pressure injury is identified.

Date plan completed / reviewed: 23/09/2025



Tip! The results from the pressure injury risk assessment will automatically populate into this space within the plan

Pressure Injury Risk Assessment

Total risk score:

35

Pressure Injury Rating:

Very High Risk

Mobility:

Cannot be moved without great difficulty or causing deter

Equipment:

Equipment / objects / hard surface pressing or rubbing or

Very High Risk, Inspect skin at least hourly if condition allows. Reposition client / equipment/devices at least every 2 hours and before st

10

Select the reposition frequency from the dropdown box as per the suggested actions or more frequently if indicated

Inspect skin at least hourly if condition allows. Reposition client / equipment/devices at least every 2 hours and before st
Consider using specialised relieving equipment.

Repositioning Frequency

Frequency of repositioning:

2nd hourly



Redistributing Equipment

☒ Alternating Pressure Mattress

☐ Wedge

11

Select appropriate pressure redistributing equipment being or intended to be used

Frequency of repositioning: 2nd hourly

Pressure Redistributing Equipment

- ☒ Alternating Pressure Mattress
- ☐ Wedges
- ☐ Memory Foam
- ☒ GelPad
- ☒ Cushions
- ☐ Other

12

Select medical devices which are currently being used by the client

☐ Other

Medical Devices

Is there a medical device insitu?

- ☒ CPAP
- ☐ BiPAP
- ☐ Cast
- ☐ Splint (e.g. AFOs, Hand splints)
- ☐ CVAD
- ☐ Orthotics

13 Type in information relating to medical device and repositioning frequency

☒ Enteral Feeding Tube
☒ Gastrostomy
☐ Pulse Oximeter Probes
☐ Other

Medical device repositioning frequency:

Parents/Carer specific requests:

Please include any specific requests from parents/carers:

14 Type in any parent carer requests and indicate by selecting yes/no if the plan has been discussed with parents/ carers

Parents/Carer specific requests:

Please include any specific requests from parents/carers:

Further Actions

Has the prevention plan been discussed with the child's parent/carer?

Does the child have a pressure injury?

15

Indicate if the client has a pre-existing pressure injury by clicking '**yes/no**'. If yes is selected, further detail will be required

Does the client have a pressure injury?

Is this a pre-existing injury?

How many injuries have been identified?

First pressure injury staging:

[Pressure Injury Staging Guide](#)



Tip! Click on the '[pressure injury staging guide](#)' to open a PDF outlining the different pressure injury stages

[Pressure Injury Staging Guide](#)

PRESSURE INJURY STAGING GUIDE

STAGE 1:
Pressure Injury: Non-blanchable erythema of intact skin. Often seen with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or texture may provide visual changes. Color changes do not include purple or mottled discoloration; these may indicate deep tissue pressure injury.

STAGE 2:
Pressure Injury: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis. The wound bed is visible, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Slough and eschar are not present. These injuries commonly result from adhesive microclimate and shear in the skin over the heels and shins in the heel. This stage should not be used to describe moisture-associated skin damage (MASD) including incontinence-associated dermatitis (IAD), intertrigo-associated skin damage (IASD), or traumatic wounds (skin tears, burns, abrasions).

STAGE 3:
Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep ulcers. Undermining and burrowing may occur. Fat, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

STAGE 4:
Pressure Injury: Full-thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and burrowing often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

UN-STAGEABLE
Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage is not visible cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Slough (pale, dry, anhydrous) is not without erythema or discoloration on an ischemic limb or the heels) should not be removed.

DEEP TISSUE PRESSURE INJURY
Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled ulcer. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, tendon, muscle or other underlying structures are visible, this indicates a full-thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DPTS to describe necrotic, traumatic, neurovascular, or dermatologic conditions.

16 Enter a review date as per the guidelines listed

Does the child have a pressure injury?

Comments:

Review date: 

Pressure Injury Risk Assessment and Management Plan are to be reviewed monthly, when client condition changes and if a pressure injury develops.

Wound chart and wound management plan for each pressure injury identified

17 Click "Approve" to submit plan

▶ Notices

▶ Pictures

▶ Progress Notes

▶ Referrals

▶ Summary

☰ Tasks

Does the child have a pressure injury?

Yes No

Comments:

Review date:

Pressure Injury Risk Assessment and Management Plan

Reminder: Please complete a wound chart and wound management plan for each pressure injury identified.

Approve