



TOOLKIT 12 · PRESSURE-INJURY PREVENTION · TOOL 1 OF 5

Pressure-Injury Risk Assessment — Six Factors

Sensory perception, moisture, activity, mobility, nutrition, friction and shear. Score on admission, then every 48 hours or on any change

Patient (name, no.) · ward · bed	
Date · time · assessor	

Factor	1	2	3	4	Score
Sensory perception	Completely limited	Very limited	Slightly limited	No impairment	
Moisture	Constantly moist	Very moist	Occasionally moist	Rarely moist	
Activity	Bedfast	Chairfast	Walks occasionally	Walks frequently	
Mobility	Completely immobile	Very limited	Slightly limited	No limitation	
Nutrition	Very poor	Probably inadequate	Adequate	Excellent	
Friction and shear	Problem	Potential problem	No apparent problem	—	
Total (6–23): _____ ≤ 9 Very high 10–12 High 13–14 Moderate 15–18 Mild 19–23 Not at risk					

Prevention bundle by band

Band	Bundle
Mild (15–18)	Skin inspection daily; reposition every 4 h; keep skin clean and dry; heels off the bed; nutrition screen
Moderate (13–14)	Mild bundle + reposition every 2–3 h; pressure-redistributing foam mattress; moisture management; dietitian referral
High (10–12)	Moderate bundle + reposition every 2 h with 30° tilt; heel offloading device; chair time limited to 2 h; protect sacrum and heels with dressings
Very high (≤ 9)	High bundle + alternating-pressure mattress if available; hourly skin checks at bony points; document every reposition (Tool 2)

Inspect: sacrum, heels, hips, elbows, shoulders, back of the head, ears, under devices (tubes, masks, collars). Adapted from the Braden Scale as used in the AHRQ Preventing Pressure Ulcers in Hospitals toolkit.

ASF standards: Standard 4 — pressure-injury prevention (risk assessment documented); Priority Practices