As a minimum, all patients must undergo initial risk screening to inform the clinical risk assessment decision making process. Risk assessment of patients using a validated tool is recommended and does not require a separate screening process.

The pressure injury risk assessment consists of two parts:

a) Use a validated pressure injury risk assessment tool/process appropriate for the patient population in accordance with best practice guidelines, and

b) Skin assessment that is based on visual inspection.

<table>
<thead>
<tr>
<th>First pressure injury screen or assessment to guide clinical decision making</th>
<th>Inpatients</th>
<th>Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities.</th>
<th>Non-inpatients (community nursing services, ambulatory facilities or clinics)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient at risk of developing a pressure injury the two part assessment to be repeated</td>
<td>Assessed within 8 hours of presentation to the health facility by health staff skilled in using the risk assessment tools/process appropriate for the patient population</td>
<td>Assessed within 8 hours of presentation to the health facility by health staff skilled in using the risk assessment tools/process appropriate for the patient population</td>
<td>Assessed at the first presentation by health staff skilled in using the risk assessment tools/process appropriate for the patient population</td>
</tr>
</tbody>
</table>
| Patient not at risk or low risk the two part screen or assessment to be repeated | Daily as a minimum and:  
- If there is a change to health status or mobility  
- Pre-operatively, and as soon as feasible after surgery  
- On transfer of care  
- If a pressure injury develops | Weekly as a minimum and:  
- If there is a change to health status or mobility  
- On transfer of care  
- If a pressure injury develops | Monthly as a minimum and:  
- If there is a change to health status or mobility  
- On transfer of care  
- If a pressure injury develops |
| Pressure injuries present - skin inspection and pain assessment | Weekly as a minimum and:  
- If there is a change to health status or mobility  
- On transfer of care  
- If a pressure injury develops | Monthly as a minimum and:  
- If there is a change to health status or mobility  
- On transfer of care  
- If a pressure injury develops | Monthly as a minimum and:  
- If there is a change to health status or mobility  
- On transfer of care  
- If a pressure injury develops |
| Additionally should occur at each patient care intervention and/or positioning change. | Additionally should occur at each patient care intervention and/or positioning change | Additionally should occur at each patient care intervention and/or positioning change |

*NB: Community nursing services that are not the primary care provider for patients who are identified at risk must provide education to the patient and/or carer or other care provider so that they understand the level of risk and their responsibility for ongoing skin assessment monitoring.

NB: Non-inpatient spinal cord injury patients are at high risk however may have little change in health status and have prevention strategies in place. Patients may have reassessments completed every three months or if there is a change in health status or mobility.