

**South West Regional Wound Care Program**

**Interdisciplinary Pressure Injury Contributing Factors  
Assessment Tool**

Person's Name:

ID Number:

Assessment Date:

**NEUROLOGICAL CONDITION(S) PRESENT** ( Not Applicable)

Neurological Condition(s):	
Date of Onset:	
Level of Spinal Cord Involvement:	
Motor Loss:	
Spasticity:	
Sensation:	
Autonomic Dysreflexia:	

**BOWEL & BLADDER CONTROL**

Bowel:	<input type="checkbox"/> Continent	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Incontinent of feces
Bladder:	<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent of urine	<input type="checkbox"/> Indwelling catheter	
Comments:				

**CRITERIA FOR A NURSE CONTINENCE ADVISOR ASSESSMENT** ( Not Applicable /  Already Involved)

<input type="checkbox"/> Unexplained bowel or urinary incontinence	<input type="checkbox"/> Chronic constipation or diarrhea
<input type="checkbox"/> Recurrent urinary tract infections	<input type="checkbox"/> To assess and recommend appropriate skin care protocol
<input type="checkbox"/> To determine type of urinary incontinence, i.e. stress, urgency and frequency, retention, urge, mixed, iatrogenic, overflow, functional	<input type="checkbox"/> To assess for appropriate containment garments

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**MOBILITY & FUNCTION (indicate the level of assistance required)**

<b>Bed Mobility:</b>	<b>Indep.</b>	<b>Sup.</b>	<b>Ax1</b>	<b>Ax2</b>	<b>Lift</b>	<b>Comments:</b>
Rolling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bridging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lying ↔ Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Transfers:</b>	<b>Indep.</b>	<b>Sup.</b>	<b>Ax1</b>	<b>Ax2</b>	<b>Lift</b>	<b>Comments:</b>
Weight-Shift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sit ↔ Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bed ↔ Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tub/Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Ambulation:</b>	<b>Ind</b>	<b>Sup</b>	<b>Ax1</b>	<b>Ax2</b>	<b>Bed</b>	<b>Comments:</b>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Weight-Bearing: Status:</b> <input type="checkbox"/> FWB <input type="checkbox"/> WBAT <input type="checkbox"/> PWB <input type="checkbox"/> FeWB <input type="checkbox"/> NWB						
<b>Aids:</b> <input type="checkbox"/> None <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> 2 wheeled walker <input type="checkbox"/> 4 ww						
<input type="checkbox"/> Scooter <input type="checkbox"/> Manual wheelchair <input type="checkbox"/> Power wheelchair						
<b>Comments:</b>						

**PRESSURE REDISTRIBUTION AIDS IN USE ( Not Applicable)**

	Type	Supplier	Date Purchased or Funded
<b>Bed</b>			
<b>Chair</b>			
<b>Wheelchair</b>			
<b>Wheelchair Cushion</b>			



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Person's Name: \_\_\_\_\_

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Date: \_\_\_\_\_

<b>Other:</b>			
<b>Chair/Wheelchair Measurements:</b>	Seat Width:	Seat Depth:	

**BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK**

					Score
<b>Sensory Perception</b> (Ability to respond meaningfully to pressure related discomfort)	1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment	
<b>Moisture</b> (Degree to which skin is exposed to moisture)	1. Constantly Moist	2. Very Moist	3. Occasionally Moist	4. Rarely Moist	
<b>Activity</b> (Degree of physical activity)	1. Bedfast	2. Chairfast	3. Walks Occasionally	4. Walks Frequently	
<b>Mobility</b> (Ability to change and control body position)	1. Completely Immobile	2. Very Limited	3. Slightly Limited	4. No Limitations	
<b>Nutrition</b> (Usual food intake pattern)	1. Very Poor	2. Probably inadequate	3. Adequate	4. Excellent	
<b>Friction/Shear</b>	1. Problem	2. Potential Problem	3. No Apparent Problem		

**TOTAL SCORE =**

**PERSON'S ACTIVITY IN PAST 24 HOURS (i.e. transfers, time in bed/chair, etc.)**

Time	Activity	Time	Activity
# of Transfers/Day:	# of Hours in Bed/Day:	# of Hours Sitting/Day:	Other:






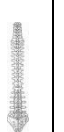












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**MAT EVALUATION (To be complete ONLY for those who require wheeled mobility or seating intervention, by a registered health care provider TRAINED in mat evaluations, i.e. physiotherapist, occupational therapist, etc.)** ( Not Applicable)

	Posture	Function	Comments:	Support Needed:
<b>Head &amp; Neck</b>	<input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Rotated <input type="checkbox"/> Side flexion  <input type="checkbox"/> Cervical hyperextension	<input type="checkbox"/> Good head control <input type="checkbox"/> Adeq. head control <input type="checkbox"/> Limited head control  <input type="checkbox"/> Absent head control		
<b>Shoulder &amp; Elbow</b>	<b>SHOULDER &amp; SCAPULA</b>		<b>ROM:</b>	
	<b>Left</b> <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> Pro / retract <input type="checkbox"/> Subluxed	<b>Right</b> <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> Pro / retract <input type="checkbox"/> Subluxed	<b>Strength:</b>	
	<b>ELBOW</b>		<b>ROM:</b>	
	<b>Left</b> <input type="checkbox"/> Flexed <input type="checkbox"/> Extended	<b>Right</b> <input type="checkbox"/> Flexed <input type="checkbox"/> Extended	<b>Strength:</b>	
<b>Hand &amp; Wrist</b>	<b>HAND &amp; WRIST</b>			
	<b>Left</b>	<b>Right</b>	<b>Strength/Dexterity:</b>	









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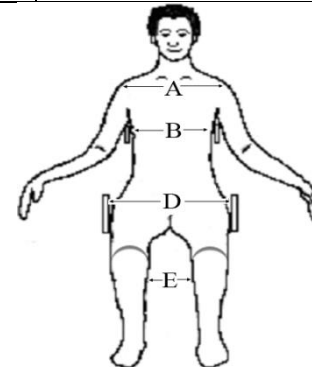
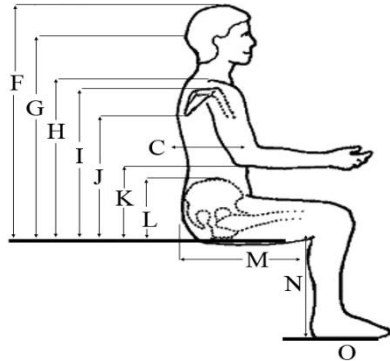
<b>Trunk</b>	<b>Anterior / Posterior:</b>			<b>Left / Right</b>			<b>Rotation</b>			<b>Comments</b>
	<input type="checkbox"/>  WFL	<input type="checkbox"/>  ↑Kyphosis	<input type="checkbox"/>  ↑Lumbar lordosis	<input type="checkbox"/>  WFL	<input type="checkbox"/>  Convex left	<input type="checkbox"/>  Convex right	 <input type="checkbox"/> Neutral <input type="checkbox"/> Left <input type="checkbox"/> Right			
<input type="checkbox"/> Flexible <input type="checkbox"/> Partly flexible <input type="checkbox"/> Fixed			<input type="checkbox"/> Flexible <input type="checkbox"/> Partly flexible <input type="checkbox"/> Fixed			<input type="checkbox"/> Flexible <input type="checkbox"/> Partly flexible <input type="checkbox"/> Fixed				
<b>Pelvis</b>	<b>Anterior / Posterior:</b>			<b>Obliquity</b>			<b>Rotation</b>			<b>Comments</b>
	<input type="checkbox"/>  Neutral	<input type="checkbox"/>  Posterior	<input type="checkbox"/>  Anterior	<input type="checkbox"/>  WFL	<input type="checkbox"/>  Convex left	<input type="checkbox"/>  Convex right	<input type="checkbox"/>  WFL	<input type="checkbox"/>  Left	<input type="checkbox"/>  Right	
<input type="checkbox"/> Flexible <input type="checkbox"/> Partly flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other:			<input type="checkbox"/> Flexible <input type="checkbox"/> Partly flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other:			<input type="checkbox"/> Flexible <input type="checkbox"/> Partly flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other:				



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Hips	Position			Windswept			Range of Motion			Comments
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Left	Right		
							Flex: _____°	_____°		
	Neutral	Abducted	Adducted	Neutral	Right	Left	Ext: _____°	_____°		
	<input type="checkbox"/> Flexible			<input type="checkbox"/> Flexible			IR: _____°	_____°		
	<input type="checkbox"/> Partly flexible			<input type="checkbox"/> Partly flexible			ER: _____°	_____°		
	<input type="checkbox"/> Subluxed			<input type="checkbox"/> Subluxed						
	<input type="checkbox"/> Dislocated			<input type="checkbox"/> Dislocated						
	<input type="checkbox"/> Fixed			<input type="checkbox"/> Fixed						

Knees & Feet	Knee Range of Motion		Strength:	Foot Positioning:			Comments
	Left	Right		Left	Rt		
	WNL <input type="checkbox"/>	_____°		<input type="checkbox"/> WNL	<input type="checkbox"/>	<input type="checkbox"/>	
	Flex: _____°	_____°		<input type="checkbox"/> Dorsi-flexed	<input type="checkbox"/>	<input type="checkbox"/>	
	Ext: _____°	_____°		<input type="checkbox"/> Plantar-flexed	<input type="checkbox"/>	<input type="checkbox"/>	
	Comments: _____			<input type="checkbox"/> Inversion	<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/> Eversion	<input type="checkbox"/>	<input type="checkbox"/>	



Measurements in Sitting:	Left	Right	
Shoulder width			Hip flexion



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	Chest width			Top of shoulder
	Chest depth (front-back)			Acromium process (tip of shoulder)
	Hip width			Inferior angle of scapula
	* Asymmetrical width(windswept, scoliosis)			Elbow
	Between knees			Iliac crest
	Top of head			Sacrum to popliteal fossa
	Occiput			Knee to heel

**SEATING GOALS** ( Not Applicable)

<input type="checkbox"/> Increase Sitting Tolerance	<input type="checkbox"/> Reduce Pressure	<input type="checkbox"/> Improve Head Position
<input type="checkbox"/> Improve Postural Alignment	<input type="checkbox"/> Accommodate Deformity	<input type="checkbox"/> Improve Visual Field
<input type="checkbox"/> Control Tone	<input type="checkbox"/> Accommodate Joint Limitations	<input type="checkbox"/> Improve Posture For Swallowing
<input type="checkbox"/> Reduce # Of Repositioning's	<input type="checkbox"/> Allow For Growth/Weight Gain	<input type="checkbox"/> Accommodate Foot Propulsion

**RECOMMENDATIONS**

Mobility Base & Components

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Seating System & Components ( Not Applicable)

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Person's Name: \_\_\_\_\_

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**FUNDING OPTIONS**

<input type="checkbox"/> ADP	<input type="checkbox"/> Social Assistance (OW, ODSP) ACSD	<input type="checkbox"/> The Person
<input type="checkbox"/> Insurance	<input type="checkbox"/> DVA	<input type="checkbox"/> WSIB
<input type="checkbox"/> OMOD	<input type="checkbox"/> Easter Seals	<input type="checkbox"/> Other:

**PREFERRED VENDOR**

Vendor list provided: \_\_\_\_\_



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