

Neonatal Skin Risk Assessment (NSRA) Tool

1. Neonatal skin risk assessment on admission, then as total score indicates, prior to transfer
2. New occurrence of skin damage i.e. tissue IV/ excoriation/ infected/ pressure area, must re-score regardless of overall
3. Provide Neonatal Pressure Injury Prevention & Management (PIPM) care package as indicated by score – see over page
4. Document Neonatal PIPM care package in NSRA score sheet in clinical notes
5. Escalate any concerns to Senior Nurse or Medical teams

Category	Descriptor	Score
Current Gestational Age	Neonate <28 weeks	4
	Neonate >28 weeks and <33 weeks	3
	Neonate >33 weeks and <28 weeks	2
	Neonate >38 weeks	1
Sensory Perception	Diminished level of consciousness/ muscle relaxed/heavily sedated.	4
	Oversensitive to noise, light and touch/easily agitated/difficult to calm.	3
	Easily agitated but calms with comfort measures/few self-calming behaviours.	2
	Age-appropriate responses to stimuli, alert, good self-calming behaviours.	1
Activity/Mobility	Does not make the slightest change in position – full assistance required.	4
	Makes occasional slight changes in body or extremity position.	3
	Makes frequent changes in body or extremity position for example, turns head.	2
	Makes major and frequent changes in position, moving all extremities, turns head.	1
Moisture	Constantly moist due to high humidity/urine/wound/stoma.	4
	Skin often moist – linen needs to be changed once/8hours.	3
	Skin occasional moist – need linen change once/12hours.	2
	Skin usually dry, routine nappy changes and linen once/day.	1
Respiratory Support	Intubated and ventilated	4
	CPAP	3
	High flow and/or low flow.	2
	No respiratory support.	1
Skin Integrity	Extensive loss of skin integrity/wound/pressure injury/medical devices	4
	Localised loss of skin integrity/broken area/ oedema.	3
	Minor skin irritation/redness.	2
	Skin integrity intact.	1
Blood Collection	Many attempts for IV access – cannulation/longline/bloods/arterial line.	4
	Venepunctures resulting in large bruise around site of insertion/oedema.	3
	Heel pricks >3 in 24hour period.	2
	Blood sampling daily or weekly.	1
Nutrition	TPN/Lipids/ IV fluids/ NBM/doesn't tolerate feeds/ medications IV	4
	TPN/Lipids/ IV fluids/trophic feeds.	3
	TPN/Lipid/ IV fluids, with tube feeds.	2
	Full gastric feeds.	1
Total Score and document in NSRA Score Sheet		

Special considerations

Medical devices – CPAP mask/Prongs/Saturation probe/ Cooling mattress

Medications IV – Flucloxacillin/Vancomycin /Dextrose > 12%/ Calcium/ Inotropes

Neonatal Pressure Injury Prevention & Management (PIPM)
Care Package

Risk Score	Category	Assessment, Implementation and documentation guidelines
≤ 8	Low Risk	<ol style="list-style-type: none"> 1. Continues daily assessment and documentation of skin integrity. 2. Reassess of condition changes. 3. Educate parents/caregivers on pressure prevention
9 - 16	Moderate Risk	<ol style="list-style-type: none"> 1. Score/ Reposition every 6 – 8 hourly. 2. Reassess and document skin integrity 6 – 8 hourly. 3. Maintain adequate hydration, nutrition and oxygenation. 4. Keep skin clean and dry. 5. Reposition equipment/devices every 2 – 4 hours. 6. Observe IV line hourly for skin integrity, perfusion and placement. 7. Educate parents/caregivers on pressure prevention
17 - 24	High Risk	<ol style="list-style-type: none"> 1. Score/reposition neonate and equipment devices at least every 4 - 6 hourly. 2. Reassess and document every 4 – 6 hourly. 3. Observe IV line hourly for skin integrity, perfusion and placement. 4. Ensure adequate pain relief given to promote movement. 5. Maintain adequate hydration, nutrition and oxygenation. 6. Keep skin clean and dry. 7. Educate parents/caregivers on pressure prevention 8. Document any existing or new pressure injuries. 9. Get a senior nurse to review area of concern, to advise any further treatment required and put plan of care in place & document. 10. Think - do I need a second person to help with changing devices/position to help prevent discomfort/pain? 11. Score <i>trendcare</i> appropriately.
25 - 32	Extreme Risk	<ol style="list-style-type: none"> 1. Score / reassess, inspect skin at least 2 – 4 hourly, ensuring equipment/objects are not pressing on the skin and document. 2. Mobilise/change equipment/devices of position 2-3 hourly, if required. 3. Think - do you need to protect head and bony prominences? 4. Observe IV/central lines hourly for skin integrity, perfusion & placement 5. Ensure adequate pain relief given to promote movement. 6. Maintain adequate hydration, nutrition and oxygenation. 7. Keep skin clean and dry. 8. Educate parents/caregivers on pressure prevention. 9. Document any existing or new pressure injuries. 10. Use appropriate pressure relieving devices such as gel mattress/dermapad support 11. Get a senior nurse to review area of concern, to advise any further treatment required and put a plan of care in place, then document. 12. Think - do I need a second person to help with changing devices/position to help prevent discomfort/pain? 13. Score <i>trendcare</i> appropriately. 14. Does a medical person need to review the baby?