COMMON SCREENING TOOLS

SKIN BREAKDOWN RISK ASSESSMENT

Score every patient on admission or transfer and at least once a shift

	1	2	3	4
Sensory perception	Completely limited	Very limited	Slightly limited	No impairment
Moisture	Constantly moist	Moist	Occasionally moist.	Rarely moist
Activity	Bedfast	Chairfast	Walks occasionally	Walks frequently
Mobility	Completely Immobile	Very limited	Slightly limited	No imitations
Nutrition	Very poor	Probably Inadequate	Adequate	Excellent
Friction and Shear	Problem	Potential problem	No apparent problem	-

Risk Level:

- Severe: 9 or less
- High: 10-12
- Moderate: 13-14
- Mild: 15-18
- Low or No Risk: 19-23

COMMON SCREENING TOOLS

FALL RISK ASSESSMENT SCALE

Score every patient on admission or transfer and at least once a shift

Item	Response	Score
History of falling; immediate or within 3 months	No Yes	0 25
Moisture	No Yes	0 15
Ambulatory aid	Bed rest/nurse assist Crutches/cane/walker Furniture	0 15 30
IV/Heparin Lock	No Yes	0 20
Gait/Transferring	Normal/bedrest/immobile Weak Impaired	0 10 20
Mental status	Oriented to own ability Forgets limitations	0 15
	Total Score	

Risk Level: • No Risk 0 - 24 • Low Risk 25 - 50 • High Risk ≥ 51

COMMON SCREENING TOOLS

PAIN ASSESSMENT IN CRITICAL CARE

Rates critically ill patients' pain based on clinical observation when they cannot report a numeric scale, scored from 0-8, with 8 being the highest pain score.

Item	Observation	Score
Facial Expression	Relaxed, Neutral Tense Grimacing	0 1 2
Body Movements	None or Normal Protection Restlessness	0 1 2
Ventilator Compliance OR Vocalization	Tolerating vent OR Normal, or no sound Coughing OR sighing, moaning Fighting vent OR crying, sobbing	0 15 30
Muscle Tension	Relaxed Tense, Rigid Very Tense, Rigid	0 1 2
	Total Score	

COMMON SCREENING TOOLS

PAIN SCALE FOR CHILDREN 7 MONTHS TO 2 YEARS

Based on activity related to Face, Legs, Activity, Cry, and Consolability

Behavior	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Slightly limited
Legs	Normal position or relaxed	Uneasy, restless, tense	Occasionally moist.
Activity	Lying quietly, normal position, moves easily	Squirming, shifting, back and forth, tense	Walks occasionally
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Slightly limited
Consolability	Content, relaxed	Reassured by touching, hugging or being talked to, distractible	Adequate
		Total Score	

COMMON SCREENING TOOLS

SCREENING FOR AGITATION AND LEVEL OF SEDATION

Typically used in ICU, but also in PACU and procedural areas.

Score	Term	Description
+4	Combative	Combative or violent; immediate danger to staff
+3	Very agitated	Pulls on tube(s) or catheter(s) or is aggressive toward staff
+2	Agitated	Frequent nonpurposeful movement or fighting ventilator
+1	Restless	Anxious or apprehensive but not aggressive
0	Alert and calm	Spontaneously pays attention to caregiver
-1	Drowsy	Not fully alert, but maintains eye contact for > 10 seconds
-2	Light sedation	Briefly (< 10 seconds) awakens with eye contact to voice
-3	Moderate sedation	Any movement (but no eye contact) to voice
-4	Deep sedation	No response to voice, but movement to physical stimulation
-5	Unarousable	No response to voice or physical stimulation