SURNAME:________________	NHI:________
FIRST NAMES:________________	
DATE OF BIRTH:________________	SEX:________

Affix patient label here

PRESSURE INJURY RISK ASSESSMENT

PRESSURE INJURY RISK ASSESSMENT (WATERLOW) – Initial assessment to be completed by nurse within 8

Please note: more than one score per category can be used.		Date Time							
GENDER	Male	1							
	Female	2							
AGE	14 - 49	1							
	50 - 64	2							
	65 - 74	3							
	75 - 80	4							
	81 +	5							
BMI = weight/(height)^2 Weight:________________	Average BMI 20–24.9	0							
	Above average BMI 25–29.9	1							
	Obese BMI > 30	2							
	Below average BMI < 20	3							
VISUAL ASSESSMENT OF AT RISK SKIN AREA (May select one or more options)	Healthy – skin appears normal	0							
	Thin and fragile – looks transparent, tissue paper	1							
	Dry – skin flaky	1							
	Oedematous – skin appears puffy	1							
	Clammy (Temp ↑) – skin moist, cool to touch	1							
	Discoloured: pressure injury stage 1 – non blanching erythma, dark skin will differ from surrounding skin	2							
	Broken: pressure injury stages 2, 3, 4 – unstageable, suspected deep tissue injury	3							
MOBILITY (i.e bed, chair) (Select one option ONLY)	Fully able to change position independently	0							
	Restless/fidgety – prone to shear and friction	1							
	Apathetic e.g sedated/depressed reluctant to move	2							
	Restricted e.g mobility restricted by disease, severe pain	3							
	Bedbound e.g unable to change position self/traction	4							
	Chair bound/wheelchair unable to leave chair without assistance	5							
CONTINENCE (select one option ONLY)	Nocturia/Continent/Catheterised	0							
	Incontinent of Urine – risk of excoriation	1							
	Incontinent of Faeces – risk of excoriation	2							
	Doubly incontinent – high risk of excoriation	3							

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PRESSURE INJURY RISK ASSESSMENT

Please note: more than one score per category can be used									
TISSUE MALNUTRITION (select one or more options)	Terminal Cachexia/ muscle wasting	8							
	Multi Organ Failure	8							
	Single Organ Failure (Respiratory/Renal/Liver/Cardiac)	5							
	Peripheral Vascular Disease	5							
	Anaemia Hb < 80	2							
	Smoking	1							
MALNUTRITION SCREENING TOOL (MST) ASK Patient "Have you lost weight recently without trying? (in the last 6 months)" 1	No weight loss	0							
	Person is unsure if they have lost weight	2							
	Yes: 0.5 - 5 kgs	1							
	5 - 10 kgs	2							
	10 - 15kgs	3							
	> 15 kgs	4							
ASK Patient "Have you been eating poorly because of a decreased appetite?" 2	Yes	1							
	No	0							
	Total Mainscore (Box 1 + Box 2) Total MST Score								
	<0-1 No action required; **=2** Start food charts, if person eating less than ½ of meals for 3 days or more refer to Dietitian. **≥3** Start food chart. Refer to Dietitian								
NEUROLOGICAL DEFICIT (score depends on severity – maximum of 6 for this category i.e the higher the loss of sensation the higher the score)	4-6								
Diabetes, CVA, MS, Motor/Sensory Paraplegia, epidural									
MAJOR SURGERY OR TRAUMA (score can be discounted after 48 hours provided the person's recovery is normal)	Orthopaedic, spinal	5							
	>2 hours on theatre table	5							
	>6 hours on theatre table	8							
MEDICATION	Cytotoxics, high dose/long term steroids, anti-inflammatory	Max 4							
TOTAL SCORE									

NURSE INITIALS

Bundle A = 0 - 10 Not at risk Bundle B = 10+ At risk Bundle C = 15+ High risk Bundle D = 20+ Very high risk. **Copy right 1985 Revised 2005 Queensland Health**

PRESSURE INJURY RISK ASSESSMENT

SURNAME: ____________	NHI: ________
FIRST NAMES: ____________	
DATE OF BIRTH: ____________	SEX: ________
Affix patient label here	

Level of Risk Bundle of Care	Bundle A – 0-10 Not at Risk		Bundle B – 10+ At Risk	
Initial assessment on admission	☐ Complete Waterlow Risk assessment ☐ Full visual check of skin		☐ Complete Waterlow and risk assessment ☐ Full visual check of skin ☐ Educate person and whanau about PI prevention, and give Pamphlet - 'Preventing Pressure Injuries'	
Surface Keep person moving to minimise pressure	☐ Ensure person changes their position every 3 hours when in bed ☐ Ensure person changes their position every 2 hours when sat in a chair		☐ Ensure heels are free off the surface of the bed or use heel protectors ☐ Discourage elevation of the head of the bed above 30 degrees for more than 1 hour ☐ Ensure person changes their position every 3 hours when in bed ☐ Ensure person changes their position every 2 hours when sat in chair	
Incontinence or moisture management	☐ Ensure skin remains free of excessive moisture if person is incontinent		☐ Moisturise skin daily if skin is dry ☐ Manage incontinence with appropriate products ☐ Wash area at each pad change	
Nutrition and hydration	☐ Record persons weight weekly ☐ Refer to Dietitian if MST ≥ 3. If ≤ 2 weigh and keep food charts		☐ Ensure adequate fluid and nutritional intake ☐ Record weight weekly ☐ Refer to dietitian if MST ≥ 3 or if PI Stage 3+	
Skin inspection	☐ Weekly check for broken areas, redness, localised heat, oedema, induration, tissue consistency and pain, document outcome		☐ Once a day during the am shift; Check for broken areas, redness, localised heat, oedema, induration, tissue consistency and pain, document outcome	
Implementation of Bundle	Date	Print Name	Date	Print Name
Level of Risk Bundle of Care	**Bundle C – 15+ High Risk**		**Bundle D – 20+ Very High Risk**	
Initial assessment on admission	☐ Complete Waterlow and risk assessment ☐ Full visual check of skin ☐ Educate person and whanau about PI prevention, give Pamphlet- 'Preventing Pressure Injuries'		☐ Complete Waterlow and risk assessment ☐ Full visual check of skin ☐ Educate person and whanau about PI prevention, give Pamphlet- 'Preventing Pressure Injuries'	
Surface Keep person moving to minimise pressure	☐ Implement the use of support surface mattresses /cushions ☐ Ensure heels are free off the surface of the bed or use heel protectors ☐ Discourage elevation of the head of the bed above 30 degrees for more than 1 hour ☐ Do not turn person onto red areas or broken skin **Bed** at Least ☐ 2-3 hourly change of position ☐ 3-4 hourly when on a pressure mattress **Sitting** at least ☐ 2 hourly change of position		☐ Implement the use of pressure relieving/reducing mattresses/ cushions ☐ Ensure heels are free off the surface of the bed or use heel protectors ☐ Discourage elevation of the head of the bed above 30 degrees for more than 1 hour ☐ Do not turn person onto red areas or broken skin **Bed** at Least ☐ 2-3 hourly change of position ☐ 3-4 hourly when on a pressure mattress **Sitting** at least ☐ 2 hourly change of position	
Incontinence or moisture management	☐ Moisturise daily if skin is dry ☐ Manage incontinence with appropriate products ☐ Use barrier cream sparingly if required ☐ Change incontinent pads 3 hourly ☐ Wash area at each pad change		☐ Moisturise daily if skin is dry ☐ Manage incontinence with appropriate products ☐ Use barrier cream sparingly if required ☐ Change incontinent pads 3 hourly ☐ Wash person at each pad change ☐ Wash groin, buttocks perianal areas twice a day	
Nutrition and hydration	☐ Ensure adequate fluid and nutrition nal intake ☐ Record Fluid & food intake ☐ Record weight weekly ☐ Refer to Dietitian if MST ≥ 3 or if PI Stage 3+. If ≤ 2 weigh and keep food charts.		☐ Ensure adequate fluid and nutritional ☐ intake Record weight weekly ☐ Record fluid & food intake ☐ Refer to Dietitian if MST ≥ 3 or if PI Stage 3+. If ≤ 2 weigh and keep food charts.	
Skin inspection	☐ Twice a day on am and pm shift Check for broken areas, redness, localised heat, oedema, induration, tissue consistency and pain, document outcome		☐ Once on each nursing shift ☐ Check for broken areas, redness, localised heat, oedema, induration, tissue consistency and pain, document outcome	
Implementation of Bundle	Date	Print Name	Date	Print Name
Re-assessment of Waterlow tool	Date: Bundle of Care (circle): A B C D		Date: Bundle of Care (circle): A B C D	
	(To be completed when there is a change in condition otherwise weekly and on discharge. Date and circle bundle of care A, B, C, D)			

If Pressure Injury Identified: Complete Incident report Yes ☐ No ☐ Incident no: __________ Wound Care Chart completed: Date: __________

ACC Number: ____________________ NB: ACC 46N & 2152 must be completed for Stages 2, 3, & 4 Hospital Acquired Pressure Injuries.

If Stages 2, 3, or4 persons should be managed under a high risk bundle