Queensland Government

Adult Pressure Injury Risk Assessment

(Affix identification label here)

URN: 246802
Family name: THORNE
Given name(s): ALEX
Address: 2A Unity Drive, Pleasantville
Date of birth: 01 JAN 1924 Sex: ☐M ☐F ☐I

Pressure Injury Prevention/Management Plan

- Upon completion of Waterlow risk score tick implemented interventions.
- Care outlined in this plan **must** be altered if it is not clinically appropriate for the individual patient.
- Every person documenting on this form must supply a sample of their initials in the signature log (page 4).

Risk category	Plan									
		Date	XX/XX							
		Time	0800							
		Completed by (initials)	LR							
		Waterlow score	4							
All patients	Use water-based skin emollients to maintain skin hydration		✓							
	Use a pH appropriate skin cleanser and dry skin thoroughly		✓							
	Use transfer aids and employ appropriate manual handling techniques		✓							
	Provide pressure injury information and develop plan of care in partnership with patient/carer		✓							
At risk High risk Very high risk *(Waterlow score 10+)*	Ensure appropriate positioning and use of appropriate support surfaces: a. mattress *(type: .....)*									
	b. seating cushion									
	c. bed cradle									
	d. heel wedge/boot									
	e. other:									
	Increase turning/repositioning schedule to:									
	Increase mobility according to patient condition									
	Conduct daily skin assessment									
	Conduct continence assessment									
	Refer patient to Dietitian (if MST >2)									
	Refer patient to Allied Health (if available):									
	Other referral:									
	Provide nutritional support									
Pressure Injury	Re-categorise Suspected Deep Tissue Injury and Unstageable as soon as possible									
	Document stage, location and description in clinical notes									
	Complete incident report									
	Initiate and document wound management strategies									
	Review pressure redistribution support surfaces									

Recommended mattresses according to Waterlow score:
- **At Risk (10+)** Consider high specification reactive (constant low pressure) support foam mattress
- **High Risk (15+)/Very High Risk (20+)** Consider active powered (alternating pressure) support mattress, or speciality bed/mattress system
- Consider Bariatric mattress/bed for patients with BMI >40

Signature Log

Every person documenting in this assessment must supply a sample of their initials in the signature log below

Initials	Print name	Designation	Signature	Initials	Print name	Designation	Signature
LR	Luke Ryan	RN					

DO NOT WRITE IN THIS BINDING MARGIN

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Adult Pressure Injury Risk Assessment

(Affix identification label here)

URN: 246802
Family name: THORNE
Given name(s): Alex
Address: 2A Unity Drive, Pleasantville
Date of birth: 01 JAN 1924 Sex: ☒M ☐F ☐I

Facility: QUni Retirement Village

Conduct **Skin Inspection** (page 1) → Calculate **Risk Score** (pages 2 and 3) → Develop **Prevention +/- Management Plan** (refer page 4) → Complete **Signature Log** (page 4)

Skin Inspection

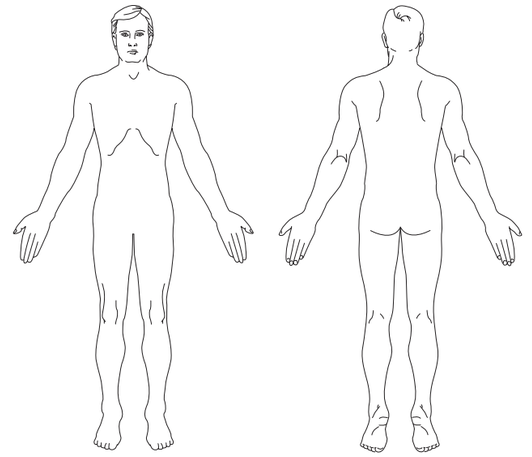
- Conduct a comprehensive skin inspection as soon as possible following admission within a minimum of **eight (8) hours**.
- Reassess at a minimum of **daily if 'at- risk'; weekly if 'not at-risk'; on transfer; if the patient's condition changes and on discharge.**
- A comprehensive skin inspection should include a head-to-toe (anterior and posterior) assessment for signs of erythema, blanching response, localised heat, oedema, induration and skin breakdown (including observation for any skin damage related to medical devices, plaster casts).
- Every person documenting on this form must supply a sample of their initials in the signature log (page 4).

Initial Comprehensive Skin Inspection on Admission

Admitted	Ward/Unit	Date XX/XX/XX	Time 0800	Initials LR
Skin inspection completed	Ward/Unit	Date	Time	Initials

Pressure Injury present?	☐ Yes ☑ No
Wound present?	☐ Yes ☑ No
Skin Tear(s) present?	☐ Yes ☑ No
Incontinence Associated Dermatitis present?	☐ Yes ☑ No
Other skin concerns?	☐ Yes ☑ No

Record skin related issues on diagram below



If yes to any of the above, ensure management strategies are initiated.

Ongoing Comprehensive Skin Inspection

Ward/Unit									
Date									
Time									
Completed by (initials)									
Pressure Injury present?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Wound present?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Skin Tear(s) present?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Incontinence Associated Dermatitis present?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other skin concerns?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If yes to any of the above, ensure management strategies are initiated.

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Mat. No.: 10282944
SW380

ADULT PRESSURE INJURY RISK ASSESSMENT

Queensland Government

Adult Pressure Injury Risk Assessment

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Given name(s): Alex
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Date of birth: 01 JAN 1924 Sex: ☒ M ☐ F ☐ I

Modified Waterlow Risk Score

- Calculate Risk Score as soon as possible following admission within a minimum of **eight (8) hours**.
- Reassess at a **minimum of weekly (hospital, subacute and rehabilitation) or monthly (residential care); and if the patient's condition changes.**
- Risk scoring should never replace clinical judgement.
- Every person documenting on this form must supply a sample of their initials in the signature log (page 4).

Screening: Does the patient have a history of pressure injury? ☐ Yes, site(s): ☑ No

Date			XX/XX							
Time			0800							
Assessed by (initials)			LL							
Build/weight for height Height: XXX	Weight		XX							
	Body Mass Index BMI = Weight(kg) / Height(m²)		XX							
	Average (BMI 20–24.9)	0								
	Above average (BMI 25–29.9)	1	✓							
	Obese (BMI >30)	2								
	Below average (BMI <20)	3								
Gender	Male	1	✓							
	Female	2								
Age	14 to 49	1								
	50 to 64	2	✓							
	65 to 74	3								
	75 to 80	4								
	81 or older	5								
Mobility	Fully mobile	0	✓							
	Restless/fidgety	1								
	Apathetic	2								
	Restricted	3								
	Bed bound/traction	4								
	Chair bound	5								
Medication	None of the below	0	✓							
	Cytotoxic, Steroids (long term/high dose), Anti-inflammatory (any or all)	4								
Nutrition	MST score	0–5	0							
	Sub-total 1		4							

Malnutrition Screening Tool (MST)

Calculate nutritional score from MST below and record in Nutrition section above

Question A: Has the patient lost weight recently without trying?		**Question B:** How much weight has the patient lost?		**Question C:** Has the patient been eating poorly because of decreased appetite?	
Yes	Score 0 *(Go to question **B**)*	1 kg–5 kg	Score 1 *(Go to question **C**)*	Yes	Score 1
(No)	Score 0 *(Go to question **C**)*	6 kg–10 kg	Score 2 *(Go to question **C**)*	(No)	Score 0
Unsure	Score 2 *(Go to question **C**)*	11 kg–15 kg	Score 3 *(Go to question **C**)*		
		>15 kg	Score 4 *(Go to question **C**)*		
		Unsure	Score 2 *(Go to question **C**)*		

If the patient's score is 2 or more please refer them to a Dietitian.

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Date of birth: 01 JAN 1924 Sex: ☒ M ☐ F ☐ I

Modified Waterlow Risk Score

Date			XX/XX							
Time			0800							
Assessed by (initials)			LL							
Continence	Complete/catheterised	0	✓							
	Incontinence of urine	1								
	Incontinence of faeces	2								
	Doubly incontinent	3								
Tissue malnutrition *More than one option can be selected*	Terminal cachexia	8								
	Multiple organ failure	8								
	Single organ failure	5								
	Peripheral vascular disease	5								
	Anaemia (HB <80g/L)	2								
	Smoking	1								
Skin type/ visual inspection *More than one option can be selected*	Healthy	0	✓							
	Tissue paper	1								
	Dry	1								
	Oedematous	1								
	Clammy pyrexia	1								
	Pressure injury: Stage 1	2								
	Pressure injury: Stage 2	3								
	Pressure injury: Stage 3	3								
	Pressure injury: Stage 4	3								
	Pressure injury: Unstageable	3								
	Pressure injury: Suspected deep tissue injury	3								
	Pressure injury: Mucosal pressure injury	3								
Neurological deficit	Diabetes	4–6								
	Multiple sclerosis	4–6								
	Motor/sensory paraplegia	4–6								
	Cerebro vascular accident	4–6								
Major surgery	Orthopaedic/spinal	5								
	On table >2 hrs (in the past 48 hrs)	5								
	On table >6 hrs (in the past 48 hrs)	8								
	Sub-total 2		0							
Total score (sub-total 1 + sub-total 2) **10+ At risk, 15+ High risk, 20+ Very high risk**			4							

Proceed to development of Prevention +/- Management Plan (refer page 4).