NHS Ayrshire & Arran

Adapted Waterlow Pressure Area

- Risk Assessment Chart

More than one score can be used in each section

Complete assessment on admission/1st visit, if there is a change in individual's condition and repeat regularly according to local protocol

Write or attach label	e
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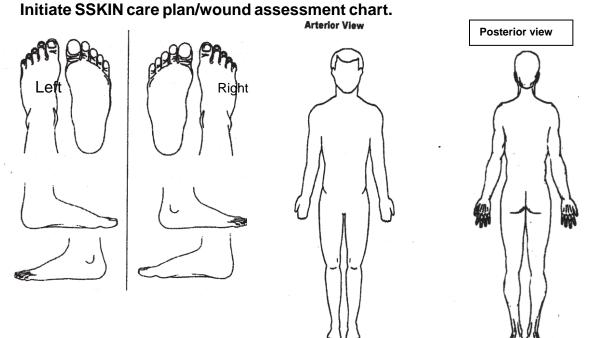
HCR No:	
	Sex:
Address:	

Date of Birth

	Date									
Sex										
Male 1 Female 2										
Age										
14 - 49	1									
50 - 64	2	·								
65 - 74										
75 - 80	·									
81+	·									
Build/Weight for Height (BMI=weight in Kg/height	$\frac{5}{2}$									
Average - BMI 20-24.9	0									
Above average - BMI 25-29.9	1	·								
Obese - BMI > 30	2	·								
Below average - BMI < 20		·								
Continence	J									
Complete/catheterised	0									
Urinary Incontinence	1	·								
Faecal incontinence	2	·								
Urinary and faecaly incontinent	2									
Skin Type - Visual Risks Area	3									
Healthy	0									
Tissue paper (thin/fragile)	U									
Dry (appears flaky)	1									
Oedamatous (puffy)	1	-								
Clammy (moist to touch) pyrexia	1	·								
Discoloured/Bruising/Grade 1	2	·								
Broken (established ulcer) Grade 2 - 4	2									
Mobility	3									
Fully mobile	0									
Restless/fidgety	1	-								
Apathetic (sedated/depressed/reluctant to m	nove) 2									
Restricted (restricted by severe pain of diseas		-								
Bedbound (unconscious/unable to change pos		·								
Chairbound (unable to leave chair without assis		·								
Special Risks - Tissue Malnutrition	stance) J									
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respir		·								
Peripheral vascular disease	·									
Anaemia = $Hb < 8$	5									
Smoking	-									
Special Risks - Neurological Deficit	1									
Diabetes/MS/CVA/motor/sensory/paraplegia	Max 6 4-6									
Special Risks - Surgery/Trauma	1100 4-0									
On table > 2 hours (up to 48 hours post op)	5									
On table for up to 6 hours (up to 48 hours post op)		-								
the rate of recovery is normal)	copy provided 5									
Orthopaedic/below waist/spinal	8	·								
Special Risks - Medication	0									
Cytotoxic, anti-inflammatory, long term/high dose	e steroid Max 4 4									
Cycocoxic, and milaminatory, long terminigh cost	Total Score									
	Initials			<u> </u>						
10 1 0 1			her -				1			
<10 Low Risk - Reassess weekly The Waterlow <u>must be reassessed</u> if the patient's condition changes /deteriorates and the plan of care should be reviewed at that point.								5		
10+ At Risk - Reassess twice weekly	At hisk - Reassess twice weekly								able	
15+ High Risk - Reassess on alternate days	after one week of admission the Waterlow can be reassessed							ante		
20+ Very High Risk - Assess daily	weekly/mont									

Pressure Ulcer Record

Indicate by circling, numbering and dating all pressure damage on diagrams, then complete box below.



All acquired pressure ulcers graded 2–4, Suspected Deep Tissue Injury, Ungradable or Mucosal must
be reported via Datix. Refer to podiatry for at risk feet.

Date	Number of ulcer	Location of ulcer	Grade of ulcer	Datix Insert reference Grade 2-4, SDTI or Ungradable	Logged on safety cross Grade 1-4	Signature	Print name

Scottish Adapted European Pressure Ulcer Advisory Panel) EPUAP - Pressure Ulcer Grading Tool - 2019

GRADE 1- Intact skin with non blanchable redness, usually over a bony prominence. Darker skin tones may not have visible blanching but the colour may differ from the surrounding skin. The area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

GRADE 2- Loss of epidermis/dermis presenting as a shallow open ulcer with red/pink wound bed without slough or bruising. May also present as a blister.

GRADE 3- Subcutaneous fat may be visible but bone tendon or muscle is not visible or palpable. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.

GRADE 4- Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.

DEEP TISSUE INJURY- Epidermis is intact but the area appears purple or maroon or is a blood filled blister over a dark wound bed. Over time the skin will degrade and develop into deeper tissue loss.

UNGRADABLE- Full thickness skin loss where the depth of the ulcer is completely obscured by

slough/necrosis. Until enough slough or necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be a grade 3 or 4 once debrided.

MUCOSAL- These develop on mucosal membranes such as the tongue, mouth, nasal passages, genitals and rectum. Mucosal tissue does not have the same layers of skin as rest of the body so it cannot be graded and should be documented as a mucosal pressure ulcer.