### Pressure Injury Prevention/Management Plan

**Risk category**
- Waterlow score: 4

**Plan**
- 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**
- Ensure appropriate positioning and use of appropriate support surfaces:
  - mattress type
  - seating cushion
  - bed cradle
  - heat wedge/boots
  - other:

### Skin Inspection

**Initial Comprehensive Skin Inspection on Admission**

- Conduct a comprehensive skin inspection as soon as possible following admission within a minimum of eight (8) hours.
- 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).

**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’, or on transfer, if the patient’s condition changes and on discharge.
- Every person documenting on this form must supply a sample of their initials in the signature log (page 4).

### Adult Pressure Injury Risk Assessment

#### Signature Log

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

<table>
<thead>
<tr>
<th>Initials</th>
<th>Print name</th>
<th>Designation</th>
<th>Signature</th>
<th>Initials</th>
<th>Print name</th>
<th>Designation</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
**Adult Pressure Injury Risk Assessment**

**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.

**Screening:** Does the patient have a history of pressure injury?  
- Yes, site(s): [ ]
- No [ ]

**Build/weight for height**

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Height (m)</th>
<th>Build/weight for height</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Above average (BMI 25–29.9)</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Obese (BMI ≥30)</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Below average (BMI &lt;20)</td>
</tr>
</tbody>
</table>

**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
  - 6–10: 1

**Malnutrition Screening Tool (MST)**
- Calculate nutritional score from MST below and record in Nutrition section above.

<table>
<thead>
<tr>
<th>Question A: Has the patient lost weight recently?</th>
<th>Question B: How much weight has the patient lost?</th>
<th>Question C: Has the patient been eating poorly because of decreased appetite?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes [ ]</td>
<td>Score 0 (Go to question C)</td>
<td>Yes [ ]</td>
</tr>
<tr>
<td>No [ ]</td>
<td>Score 0 (Go to question C)</td>
<td>No [ ]</td>
</tr>
</tbody>
</table>

**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
  - Peri-natal 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
- Stage 2 [ ] 3
- Stage 3 [ ]
- Stage 4 Unstageable [ ]
- Suspected deep tissue injury [ ]
- Mucosal pressure injury [ ]

**Neurological deficit**
- Diabetes [ ] 4–5
- Multiple sclerosis [ ]
- Motor/sensory paraplegia [ ]
- Cerebro vascular accident [ ]

**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

**Total score (sub-total 1 + sub-total 2)**
- 10+ At risk, 15+ High risk, 20+ Very high risk

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