



SURNAME: _____ NHI: _____
 FIRST NAMES: _____
 DATE OF BIRTH: ____ / ____ / ____ SEX: _____
 Please attach patient label here

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

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: _____ Height: _____	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 erythema, 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 idependently	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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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)"	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?"	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)	Diabetes, CVA, MS, Motor/Sensory Paraplegia, epidural	4-6							
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									