Affix Patient Label

Northern Devon Healthcare NHS Trust

Pressure Ulcer Risk Assessment Tool for Adults

Patient Name ……..……..Date of Birth ……..

NHS Number ……..…… Date …… Time completed:..……

The object of this tool is to link the risk assessment process with a clearly documented clinical decision regarding the risk of pressure ulcer development and risk of further tissue damage. This tool is designed to support**, and not** replace your clinical judgement and must be completed within 6 hours for in-patients and in the community at the first scheduled visit within 48 hours of admission to community nursing caseload as per Policy.

Please complete all sections and sign Statement of Risk. Please use continuation form for subsequent assessments.

Pressure area skin inspection	Tick	Existing Pressure ulcer Tick which;	General Health	Tick	Medication	Tick
Healthy skin		Category 1 Non blanching erythema	Stable		Sedatives	
Blanching erythema		Category 2	Acute illness		Codeine/Opiate analgesia	
Oedematous		Category 3 Unstageable Category 4 Deep Tissue Injury (DTI)	Chronic stable illness		Steroids/NSAID's Inotropes	
Macerated (consider moisture lesion)		**Previous Pressure Ulcer** State site/s and Grade/s:	Chronic unstable illness		Anticoagulants	
Incontinence excoriation			Palliative		Immunosuppressants	

Please indicate level of risk for each category with a 'X' in each box.

Risk Description ↓ Risk Level →	LOW	MEDIUM	HIGH	← Risk Level ↓ Risk Description
Mobility/Moving and handling Fully mobile				**Mobility/Moving and handling** Immobile/wheelchair/bed bound
Independently changes position in bed/chair				Infrequent / unable to change position independently or by others
Moisture on skin Continent of urine and faeces catheterised				**Moisture on skin** Incontinent of urine / faeces
Normal skin temperature to touch				Clammy, sweating
Neurological Full sensation				**Neurological** Loss of sensation
Conscious				Unconscious
Nutritional Status Well nourished				**Nutritional Status** Not well nourished
Hydrated				Dehydrated
Vascular Disease Not present				**Vascular Disease** Known vascular disease / Anti embolic stockings / Inotropes Compression bandaging in situ
Mental Capacity Can consent to treatment / intervention				**Mental Capacity** Lacks capacity to consent and understanding

Statement of Risk

In my clinical judgement the patient's risk of developing pressure damage is Low / Medium / High. Only choose one risk level: Please document your rational in patients care plan(s)

Completed by: Print Name: …….. Signature: ……

Patient Information Leaflet supplied to patient/carer Y / N Date/Time……

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Risk Description ↓ **Risk Level** →	**Date:** **Time:** L M H	**Date:** **Time:** L M H	**Date:** **Time:** L M H	**Date:** **Time:** L M H	**Date:** **Time:** L M H	**Date:** **Time:** L M H	**Date:** **Time:** L M H	**Risk Description** ← **Risk Level** ↓
Mobility/Moving and handling Fully mobile								**Mobility/Moving and handling** Immobile/wheelchair/bed bound
Independently changes position in bed/chair								Infrequent / unable to change position independently or by others
Moisture on skin Continent of urine and faeces catheterised								**Moisture on skin** incontinent of urine / faeces
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Mental Capacity Can consent to treatment / intervention								**Mental Capacity** Lacks capacity to consent and understand
This my clinical judgement – State the patient's overall risk level – low / med / high	**Signature & risk level**	**Signature & risk level**	**Signature & risk level**	**Signature & risk level**	**Signature & risk level**	**Signature & risk level**	**Signature & risk level**	

NDDH and community hospitals need to complete a daily risk assessment as above.
Community Nursing Teams will need to complete weekly unless patient visits are infrequent.

With thanks to Gill Wicks Consultant Nurse Tissue Viability, Wiltshire Community Health Services. Adapted from PURAT by NDDH. Version 8.2 September 2018