

Pressure Ulcer Risk Assessment Record

Part 1: Waterlow risk score | use with the official Waterlow Score Card

Resident / patient name		Date of birth	
Room / unit		ID / NHS no.	
Date of assessment		Completed by	

How to use this record: score each category using the **official Waterlow Score Card** (Judy Waterlow, copyright 1985, revised 2005, free to download from judy-waterlow.co.uk). Enter the score from the card in each box below. Where more than one score applies in a category, enter the combined score, as the card directs. This record does not replace the Waterlow Score Card.

PART 1: WATERLOW RISK SCORE - record findings and the score from the card

Category	Findings recorded	Score
Build / weight for height Body mass index (BMI)	Height (m) Weight (kg) BMI BMI = weight (kg) divided by height (m) squared	
Skin type / visual risk areas Look at heels, sacrum, hips, elbows and other pressure areas		
Sex and age	Sex Age	
Malnutrition screening Malnutrition Screening Tool (MST)	Weight lost recently? ☐ Yes ☐ No ☐ Unsure Eating poorly or lack of appetite? ☐ Yes ☐ No Follow the MST steps on the card to turn these answers into a score.	
Continence		
Mobility		
Special risks See the card for what counts; add the scores that apply	☐ Tissue malnutrition ☐ Neurological deficit ☐ Major surgery or trauma ☐ Medication	

TOTAL WATERLOW SCORE Add the seven category scores above.

RISK BAND ☐ Not at risk (under 10) ☐ At risk (10+) ☐ High risk (15+) ☐ Very high risk (20+)

Existing pressure damage? ☐ No ☐ Yes (record on page 2)

Reassess on

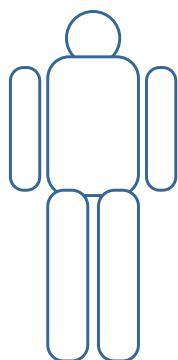
The risk bands above are the standard Waterlow thresholds. Scores are an aid to judgement, not a replacement for it. Reassess after any change in condition, and as set by your policy.

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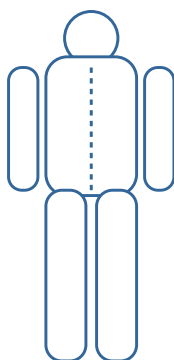
Part 2: Skin inspection and pressure damage

PART 2: SKIN INSPECTION - mark any damage on the body map

Mark and number each area of concern



FRONT



BACK

Check these areas

- Back of head and ears
- Shoulder blades and spine
- Elbows
- Sacrum and coccyx (base of spine)
- Hips (sides)
- Buttocks and thighs
- Knees and inner knees
- Ankles
- Heels and toes
- Under any medical device, such as splints, tubes, masks or stockings

Look for redness that does not fade when pressed, blisters, broken skin, swelling, heat, hardness, pain or colour change.

Skin condition overall (dry, moist, fragile, swollen, scarred, previous damage)

PRESSURE DAMAGE RECORD

No.	Site	Category	Size (cm)	Description	First noted
1					
2					
3					
4					
5					

Categories: 1 non-blanchable redness; 2 partial thickness skin loss; 3 full thickness skin loss; 4 full thickness tissue loss; unstageable; suspected deep tissue injury. Report new or worsening damage to a nurse or your tissue viability service in line with your policy.

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Part 3: Prevention plan, review and sign-off

PART 3: PREVENTION PLAN - based on the SSKIN prompts

Area	Plan	Who	How often
Surface Mattress, cushion and equipment checks			
Skin inspection Frequency and who checks			
Keep moving Repositioning and mobility			
Incontinence and moisture Continence plan and skin protection			
Nutrition and hydration Food, fluids and weight			

Other actions (referrals, equipment ordered, family informed)

Act quickly and follow your escalation policy if:

- new damage appears, or existing damage gets bigger, deeper or more painful
- there are signs of infection: spreading redness, heat, swelling, pus, a bad smell, or fever
- the person is unwell, in severe pain or very distressed (seek urgent medical advice: 111, or 999 in an emergency)

REASSESSMENT RECORD

Date	Waterlow score	Risk band	Changes / action taken	Initials

Assessed by (name / role)

Signature

Date

Next review due

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Repositioning and skin check chart

Resident / patient

Week starting

Date	Time	Position				Skin checked	Skin findings / comments	Initials
		Back ⌚	Left ⌚	Right ⌚	Chair ⌚	☐		
		Back ⌚	Left ⌚	Right ⌚	Chair ⌚	☐		
		Back ⌚	Left ⌚	Right ⌚	Chair ⌚	☐		
		Back ⌚	Left ⌚	Right ⌚	Chair ⌚	☐		
		Back ⌚	Left ⌚	Right ⌚	Chair ⌚	☐		
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		Back ⌚	Left ⌚	Right ⌚	Chair ⌚	☐		
		Back ⌚	Left ⌚	Right ⌚	Chair ⌚	☐		

Record the time, the position the person is in and whether their skin was checked. Reposition at the interval set in the care plan, and record any change in skin condition straight away.