GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Patient Risk Assessment booklet (Version 8.0 Jan. 2021)

Patient Addressograph

Date of Admission __ / __ / __

Ward _____

☐ Patient has correct identity bracelet with information verified by patient (please tick to verify)

Please ensure you provide your details below:

1. **YOU MUST complete all assessments on admission or transfer of a patient within 6 HOURS (within 24 hours for Nutrition assessment)**
2. **Please attach with treasury tags any other assessment tools that are used for individual patients.**
3. **Risk assessments must form part of the handover of care on transfers.**

Print Name	Initials	Designation	Ward/Area	Date
Example - FRED SMITH	*FS*	Staff nurse	Ward 1	10/10/10

Body Maps

Guidance for completion.

Use to document and illustrate visible signs of physical injury or harm.

The table is to be completed and recorded even if no injury/damage is present (see example)

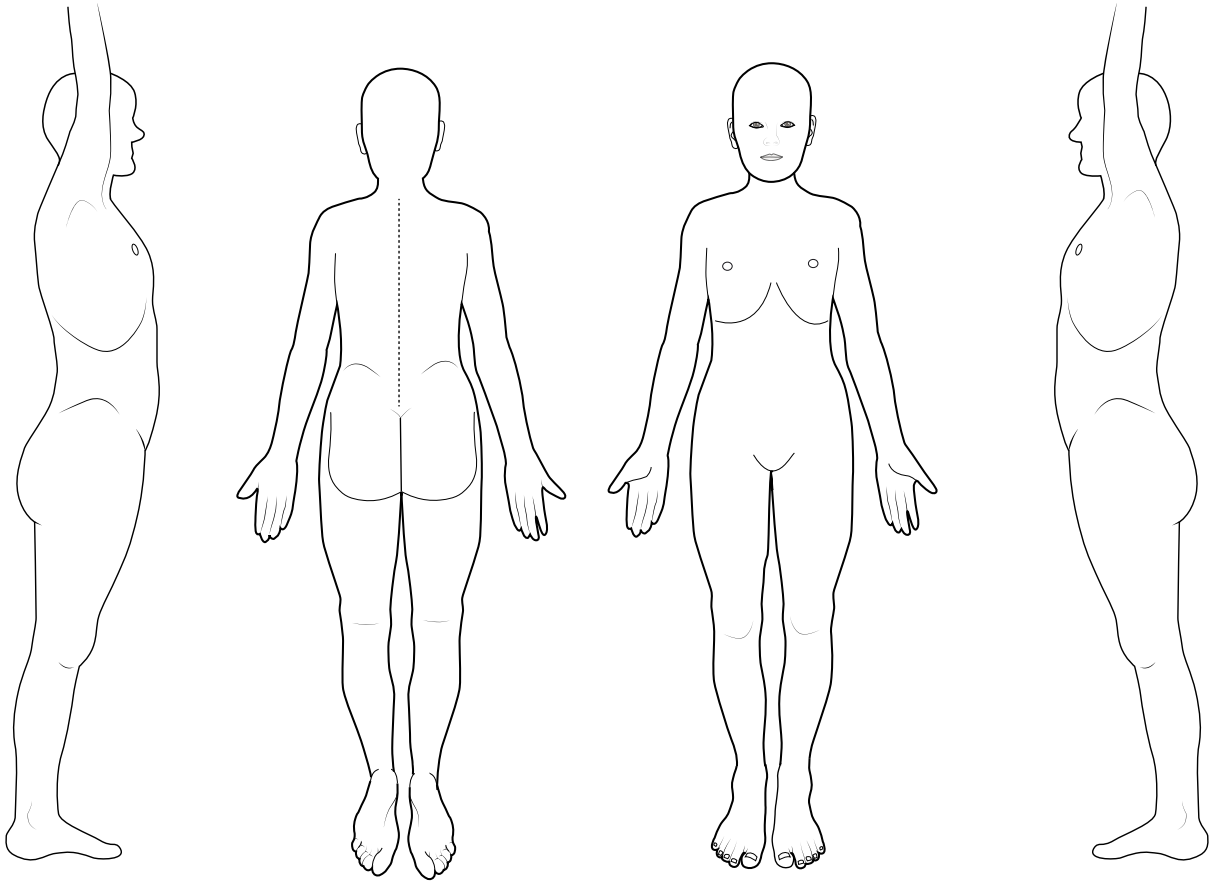
Draw on the body map in black ink, using the key to indicate the different types of injury (shading or alphabetic code).

Use the table to provide details for each injury, eg. measurements of wound, colour of bruise, widespread/localised etc.

Consider the need for a care plan, and evaluate findings and actions in nursing records.

Key

- ☐ A - Pressure ulcer
- ☐ B - Moisture lesion
- ☐ C - Wounds, cuts, abrasions
- ☐ D - Surgical wound
- ☐ E - Rash
- ☐ F - Bruising
- ☐ G - Other



The body map should be completed within 6 hours of admission or transfer to/from another area. Thereafter, record weekly and as the patient condition improves or deteriorates.

If you identify any areas of concern then a wound assessment form must be completed and the care plan updated accordingly.

Date	Time (24hr clock)	Key	Description of findings	Signature
10/10/10	0830hrs	F	Example - No damage or injury noted on admission	FS

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

ADDRESSOGRAPH

PURPOSE T PRESSURE ULCER RISK ASSESSMENT

NHS Wales v2.1 (24/07/2020)

GIG CYMRU NHS WALES

Step 1 – screening

Mobility status – *tick all applicable*

- Needs the help of another person to walk ☐
- Spends all or the majority of time in bed or chair ☐
- Remains in the same position for long periods ☐
- Walks independently with or without walking aids ☐

If **ONLY** blue box is ticked

Skin status – *tick all applicable*

- Current PU category 1 or above? ☐
- Reported history of previous PU? ☐
- Vulnerable skin ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐
- Normal skin ☐

If **ONLY** blue box is ticked

Clinical Judgement – *tick as applicable*

- Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids ☐
- No problem ☐

If **ONLY** blue box is ticked

No pressure ulcer not currently at risk

Tick if applicable ☐

Not currently at risk pathway

If **ANY** yellow boxes are ticked, **go to Step 2**

If **ANY** yellow or pink boxes are ticked, **go to Step 2**

If **ANY** yellow boxes are ticked, **go to Step 2**

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*

- No problem ☐
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural ☐

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*

- No problem / Occasional ☐
- Frequent (2 – 4 times a day) ☐
- Constant ☐

Perfusion – *tick all applicable*

- No problem ☐
- Conditions affecting central circulation e.g. shock, heart failure, hypotension ☐
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease ☐

Nutrition – *tick all applicable*

- No problem ☐
- Unplanned weight loss ☐
- Poor nutritional intake ☐
- Low BMI (less than 18.5) ☐
- High BMI (30 or more) ☐

Medical device – *tick as applicable*

- No problem ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐

Diabetes – *tick as applicable*

- Not diabetic ☐
- Diabetic ☐

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2014)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown
Suspected Deep Tissue Injury (Depth Unknown)
Purple localized area of discloloured intact skin or blood-filled blister

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable.*

For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐	☐	☐
L Buttock	☐	☐	☐	☐
R Buttock	☐	☐	☐	☐
L Ischial	☐	☐	☐	☐
R Ischial	☐	☐	☐	☐
L Hip	☐	☐	☐	☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐	☐	☐
L Heel	☐	☐	☐	☐
R Heel	☐	☐	☐	☐
L Ankle	☐	☐	☐	☐
R Ankle	☐	☐	☐	☐
L Elbow	☐	☐	☐	☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐	☐	☐
Other as applicable *(may be medical device site)*				
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Previous PU history – *tick as applicable*

- No known PU history ☐
- PU history – *complete below* ☐
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Step 3 – assessment decision

If **ANY pink boxes** are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

PU Category 1 or above or scarring from previous pressure ulcers

Tick if applicable ☐

PU Prevention/Management Care Plan

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

No pressure ulcer but at risk

Tick if applicable ☐

PU Prevention/Management Care Plan

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

No pressure ulcer not currently at risk

Tick if applicable ☐

Reassess risk as per Pressure Ulcer Policy

Nurse Printed Name	Nurse Signature	Date	Time
		DD / MM / YYYY	HH:MM

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

ADDRESSOGRAPH

PURPOSE T PRESSURE ULCER RISK ASSESSMENT

NHS Wales v2.1 (24/07/2020)

GIG CYMRU NHS WALES

Step 1 – screening

Mobility status – *tick all applicable*

- Needs the help of another person to walk ☐
- Spends all or the majority of time in bed or chair ☐
- Remains in the same position for long periods ☐
- Walks independently with or without walking aids ☐

If **ONLY** blue box is ticked

Skin status – *tick all applicable*

- Current PU category 1 or above? ☐
- Reported history of previous PU? ☐
- Vulnerable skin ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐
- Normal skin ☐

If **ONLY** blue box is ticked

Clinical Judgement – *tick as applicable*

- Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids ☐
- No problem ☐

If **ONLY** blue box is ticked

No pressure ulcer not currently at risk

Tick if applicable ☐

Not currently at risk pathway

If **ANY** yellow boxes are ticked, **go to Step 2**

If **ANY** yellow or pink boxes are ticked, **go to Step 2**

If **ANY** yellow boxes are ticked, **go to Step 2**

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*

- No problem ☐
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural ☐

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*

- No problem / Occasional ☐
- Frequent (2 – 4 times a day) ☐
- Constant ☐

Perfusion – *tick all applicable*

- No problem ☐
- Conditions affecting central circulation e.g. shock, heart failure, hypotension ☐
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease ☐

Nutrition – *tick all applicable*

- No problem ☐
- Unplanned weight loss ☐
- Poor nutritional intake ☐
- Low BMI (less than 18.5) ☐
- High BMI (30 or more) ☐

Medical device – *tick as applicable*

- No problem ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐

Diabetes – *tick as applicable*

- Not diabetic ☐
- Diabetic ☐

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2014)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown
Suspected Deep Tissue Injury (Depth Unknown)
Purple localized area of discloloured intact skin or blood-filled blister

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable.*

For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐	☐	☐
L Buttock	☐	☐	☐	☐
R Buttock	☐	☐	☐	☐
L Ischial	☐	☐	☐	☐
R Ischial	☐	☐	☐	☐
L Hip	☐	☐	☐	☐
R Hip	☐	☐	☐	☐
L Heel	☐	☐	☐	☐
R Heel	☐	☐	☐	☐
L Ankle	☐	☐	☐	☐
R Ankle	☐	☐	☐	☐
L Elbow	☐	☐	☐	☐
R Elbow	☐	☐	☐	☐
Other as applicable *(may be medical device site)*	☐	☐	☐	☐

Previous PU history – *tick as applicable*

- No known PU history ☐
- PU history – *complete below* ☐
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Step 3 – assessment decision

If **ANY pink boxes** are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

PU Category 1 or above or scarring from previous pressure ulcers

Tick if applicable ☐

PU Prevention/Management Care Plan

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

No pressure ulcer but at risk

Tick if applicable ☐

PU Prevention/Management Care Plan

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

No pressure ulcer not currently at risk

Tick if applicable ☐

Reassess risk as per Pressure Ulcer Policy

Nurse Printed Name	Nurse Signature	Date	Time
		DD / MM / YYYY	HH:MM

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

ADDRESSOGRAPH

PURPOSE T PRESSURE ULCER RISK ASSESSMENT

NHS Wales v2.1 (24/07/2020)

GIG CYMRU NHS WALES

Step 1 – screening

Mobility status – *tick all applicable*

- Needs the help of another person to walk ☐
- Spends all or the majority of time in bed or chair ☐
- Remains in the same position for long periods ☐
- Walks independently with or without walking aids ☐

If **ONLY** blue box is ticked

Skin status – *tick all applicable*

- Current PU category 1 or above? ☐
- Reported history of previous PU? ☐
- Vulnerable skin ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐
- Normal skin ☐

If **ONLY** blue box is ticked

Clinical Judgement – *tick as applicable*

- Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids ☐
- No problem ☐

If **ONLY** blue box is ticked

No pressure ulcer not currently at risk

Tick if applicable ☐

Not currently at risk pathway

If **ANY** yellow boxes are ticked, **go to Step 2**

If **ANY** yellow or pink boxes are ticked, **go to Step 2**

If **ANY** yellow boxes are ticked, **go to Step 2**

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*

- No problem ☐
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural ☐

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*

- No problem / Occasional ☐
- Frequent (2 – 4 times a day) ☐
- Constant ☐

Perfusion – *tick all applicable*

- No problem ☐
- Conditions affecting central circulation e.g. shock, heart failure, hypotension ☐
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease ☐

Nutrition – *tick all applicable*

- No problem ☐
- Unplanned weight loss ☐
- Poor nutritional intake ☐
- Low BMI (less than 18.5) ☐
- High BMI (30 or more) ☐

Medical device – *tick as applicable*

- No problem ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐

Diabetes – *tick as applicable*

- Not diabetic ☐
- Diabetic ☐

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2014)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown
Suspected Deep Tissue Injury (Depth Unknown)
Purple localized area of discloloured intact skin or blood-filled blister

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable.*

For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐	☐	☐
L Buttock	☐	☐	☐	☐
R Buttock	☐	☐	☐	☐
L Ischial	☐	☐	☐	☐
R Ischial	☐	☐	☐	☐
L Hip	☐	☐	☐	☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐	☐	☐
L Heel	☐	☐	☐	☐
R Heel	☐	☐	☐	☐
L Ankle	☐	☐	☐	☐
R Ankle	☐	☐	☐	☐
L Elbow	☐	☐	☐	☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐	☐	☐
Other as applicable *(may be medical device site)*				
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Previous PU history – *tick as applicable*

- No known PU history ☐
- PU history – *complete below* ☐
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Step 3 – assessment decision

If **ANY pink boxes** are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

PU Category 1 or above or scarring from previous pressure ulcers

Tick if applicable ☐

PU Prevention/Management Care Plan

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

No pressure ulcer but at risk

Tick if applicable ☐

PU Prevention/Management Care Plan

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

No pressure ulcer not currently at risk

Tick if applicable ☐

Reassess risk as per Pressure Ulcer Policy

Nurse Printed Name	Nurse Signature	Date	Time
		DD / MM / YYYY	HH:MM

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

ADDRESSOGRAPH

PURPOSE T PRESSURE ULCER RISK ASSESSMENT

NHS Wales v2.1 (24/07/2020)

GIG CYMRU NHS WALES

Step 1 – screening

Mobility status – *tick all applicable*

- Needs the help of another person to walk ☐
- Spends all or the majority of time in bed or chair ☐
- Remains in the same position for long periods ☐
- Walks independently with or without walking aids ☐

If **ONLY** blue box is ticked

Skin status – *tick all applicable*

- Current PU category 1 or above? ☐
- Reported history of previous PU? ☐
- Vulnerable skin ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐
- Normal skin ☐

If **ONLY** blue box is ticked

Clinical Judgement – *tick as applicable*

- Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids ☐
- No problem ☐

If **ONLY** blue box is ticked

No pressure ulcer not currently at risk

Tick if applicable ☐

Not currently at risk pathway

If **ANY** yellow boxes are ticked, **go to Step 2**

If **ANY** yellow or pink boxes are ticked, **go to Step 2**

If **ANY** yellow boxes are ticked, **go to Step 2**

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*

- No problem ☐
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural ☐

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*

- No problem / Occasional ☐
- Frequent (2 – 4 times a day) ☐
- Constant ☐

Perfusion – *tick all applicable*

- No problem ☐
- Conditions affecting central circulation e.g. shock, heart failure, hypotension ☐
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease ☐

Nutrition – *tick all applicable*

- No problem ☐
- Unplanned weight loss ☐
- Poor nutritional intake ☐
- Low BMI (less than 18.5) ☐
- High BMI (30 or more) ☐

Medical device – *tick as applicable*

- No problem ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐

Diabetes – *tick as applicable*

- Not diabetic ☐
- Diabetic ☐

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2014)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown
Suspected Deep Tissue Injury (Depth Unknown)
Purple localized area of discloloured intact skin or blood-filled blister

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable.*

For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐	☐	☐
L Buttock	☐	☐	☐	☐
R Buttock	☐	☐	☐	☐
L Ischial	☐	☐	☐	☐
R Ischial	☐	☐	☐	☐
L Hip	☐	☐	☐	☐
R Hip	☐	☐	☐	☐
L Heel	☐	☐	☐	☐
R Heel	☐	☐	☐	☐
L Ankle	☐	☐	☐	☐
R Ankle	☐	☐	☐	☐
L Elbow	☐	☐	☐	☐
R Elbow	☐	☐	☐	☐
Other as applicable *(may be medical device site)*	☐	☐	☐	☐

Previous PU history – *tick as applicable*

- No known PU history ☐
- PU history – *complete below* ☐
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Step 3 – assessment decision

If **ANY pink boxes** are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

PU Category 1 or above or scarring from previous pressure ulcers

Tick if applicable ☐

PU Prevention/Management Care Plan

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

No pressure ulcer but at risk

Tick if applicable ☐

PU Prevention/Management Care Plan

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

No pressure ulcer not currently at risk

Tick if applicable ☐

Reassess risk as per Pressure Ulcer Policy

Nurse Printed Name	Nurse Signature	Date	Time
		DD / MM / YYYY	HH:MM

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
ADDRESSOGRAPH
Postcode:

ADULT NUTRITIONAL RISK SCREENING TOOL (WAASP)

GIG CYMRU NHS WALES

TO BE COMPLETED IN BLACK INK

*Date_____ Height _____ m Weight_____ kg (on admission) *BMI ____kg/m^2
(state if this is **M**easured, **R**eported, **E**stimated, or **U**nable to weigh and record reason in notes)

Category			DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
	Date							
	Time (24hour clock)		HH:MM	HH:MM	HH:MM	HH:MM	HH:MM	HH:MM
	Weight (kg) / indicate reason if no weight							
Weight (consider fluid retention when assessing weight history)	Weight loss of 6 kg or more (1 stone) within last 6 months, extremely thin or cachexic, *BMI < 18.5 kg/m^2	**7**						
	Unintentional weight loss 3kg (7lb) within last 6 months	**2**						
	No weight loss	**0**						
Appetite (current)	Little or no appetite or refuses meals and drinks	**4**						
	Poor – eating less than a quarter (1/4) of meals and drinks	**3**						
	Reduced – eating half of meals	**1**						
	Good – eats 3 meals/day or is fully established on tube feed	**0**						
Ability to eat (current)	NBM for more than 5 days	**7**						
	Unable to tolerate food via gastrointestinal tract due to nausea or vomiting, constipation or diarrhoea, difficulty chewing/swallowing due to dysphagia or mucositis	**4**						
	Requires prompting, encouragement or assistance to eat and drink	**1**						
	No difficulties- able to eat and drink normally and independently	**0**						
Stress Factor (if clinical condition is not listed, choose a similar condition)	Upper GI cancer – pre/post-surgery, extensive bowel resection/high output stoma/fistula. Head &neck cancer surgery, kidney & pancreatic transplant BMT, 20% and above mixed depth burn	**7**						
	Moderate surgery e.g. cardiothoracic, kidney transplant, vascular Malignant disease, with complication e.g. infection. Recent multiple injuries e.g. spinal injury/trauma, head injury, GBS Uncomplicated bowel surgery, decompensated liver disease Acute kidney injury, renal replacement therapy (HD/PD) Severe infection, sepsis, endocarditis, pneumonia, peritonitis Acute and chronic pancreatitis, HIV, 15-20% mixed depth burn	**4**						
	MND, MS, Parkinson's, dementia, heart failure, COPD, CVA Fractured neck of femur, inflammatory bowel disease Uncomplicated /stable malignant disease, 10-15% mixed depth burn	**2**						
	Uncomplicated condition with no interruption in food intake e.g. MI	**0**						
Pressure Ulcer/ Wound (if ungradable choose highest)	Cat 4 pressure ulcer or open abdomen	**7**						
	Cat 3 pressure ulcer or dehisced/infected/moderate exudate wound	**4**						
	Cat 1-2 pressure ulcer or non-healing/low level exudate wound	**2**						
	Pressure areas intact, healing or healthy wound	**0**						
	Total Score							
	Completed by (Initials)							
	Reviewed by (Initials)							

ADULT NUTRITIONAL RISK SCREENING TOOL (WAASP) GUIDANCE

Note: This nutrition risk screening tool does not supersede clinical judgement – please refer to the Dietitian if you have any concerns regarding the patient's nutrition

Guidelines for completion

Complete assessment within 24 hours of admission to hospital

Record weight and height (if unable, ask the patient or relative to estimate)

Select the **highest** score that applies in **each** section

Add the score of each section and record the **tota**l box

Assess risk depending on score and take appropriate action

Reassess weekly

SCORE and ACTION

0-2 LOW RISK

- Repeat screening in one week or sooner if patient condition changes

3-6 MODERATE RISK

Assist with meal choice

Encourage eating and drinking and assist if required

Encourage milky drinks and snacks between meals

Monitor intake on the All Wales Food Record Chart

Complete/initiate local care plans – refer to local policy

Repeat screening in one week or sooner if patient condition changes

7+ HIGH RISK

Refer to the Dietitian & follow actions as per Moderate Risk

Monitor intake on the All Wales Food Record Chart

Complete/initiate local care plans – refer to local policy

Repeat screening in one week or sooner if patient condition changes

Referral to the Dietitian should be made irrespective of WAASP score if the patient:

Requires or is receiving any form of Enteral or Parenteral nutrition support

Reports the use of prescribed nutritional supplements on admission

Newly diagnosed therapeutic diet e.g. gluten free, Type 1 Diabetic

If the patient requires a therapeutic diet e.g. texture modified diet, potassium restriction, food allergy or intolerance– inform catering of the specific dietary need and refer to the Dietitian if the patient requires additional support.

Version: 1.1 (pilot release)
Approval Date: 25/01/2019 **Approved by:** Directors of Nursing

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
ADDRESSOGRAPH
Postcode:

PATIENT HANDLING ASSESSMENT & SAFER HANDLING PLAN

GIG CYMRU NHS WALES

TO BE COMPLETED IN BLACK INK

Guidance Notes: Patient Handling Risk Assessment & Safer Handling Plan

Whom should complete this assessment: A Registered Healthcare Professional (RHP). If a suitably experienced person who is not an RHP completes the assessment form, then it must be checked and countersigned by an RHP.

Fix Patient Addressograph: Ensure correct addressograph is attached, if not available write patient's details in the box.

Functional Mobility Level: Consider the level of the patient's functional mobility i.e. what the patient is physically able to do in assisting with each task. Record this level using the Mobility classification tool (LOCOmotor ©) as detailed below **A,B,C,D or E** where indicated on the form.

Mobility Classification Tool (LOCOmotor ©)	
	A Ambulatory, but may use a walking stick for support Independent, can clean and dress oneself. Usually no risk of dynamic or static overload to carer. Simulation of functional mobility is very important
	B Can support oneself to some degree and uses walking frame or similar. Dependant on carer in some situations. Usually no risk of dynamic overload to carer. A risk of static overload to carer can occur if not using proper equipment. Stimulation of functional mobility is very important
	C Is able to partially weight bear on at least one leg. Often sits in a wheelchair and has some trunk stability. Dependant on carer in many situations. A risk of dynamic and static overload to carer when not using proper aids. Stimulation of functional mobility is very important
	D Cannot stand and is not able to weight bear. Is able to sit if well supported. Dependant on carer in most situations. A high risk of dynamic and static overload to carer when not using proper equipment. Stimulation of functional participation is very important
	E Might be almost completely bedridden, can sit out only in a special chair. Always dependent on carer. A high risk of dynamic and static overload to carer when not using proper equipment. Stimulation of functional participation is not a primary goal

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

ADDRESSOGRAPH

PATIENT HANDLING ASSESSMENT & SAFER HANDLING PLAN

GIG CYMRU NHS WALES

TO BE COMPLETED IN BLACK INK

Overall Mobility Classification	**Fully Independent**				**Risk of Falls**			
	**Yes**		**No**		**Yes**		**No**	
A B C D E	**Manual Handling Risk Factors / Constraints** (tick if present)							

Hospital:	**Ward:**	Lack of comprehension / understanding		Disability	
		Has confusion / agitation		Weakness	
Height: cms or ft, ins	**Weight:** Kg	Lack of co-operation / compliance		Pain	
	Weighed / Estimated / Patient Reported	Skin lesions / wounds		Infusion / catheter / drain etc.	
Sensory Factors		Day / Night variation		Cultural considerations	
Hearing deficit / Hearing aid **Yes** **No**		Other e.g. traction, limb oedema (state)			
Sight deficit / Spectacles **Yes** **No**		(Consult patients notes for detail)			

Moving in bed (i.e. rolling, turning & up/down bed)						**Staff 1 2 3** other
Rolling/Turning		**Up/down bed**		**Equipment** (if reqd.)		Additional information: e.g. method/manoeuvre, other equipment etc
Independent		Independent		Slide sheets		
Supervision / verbal prompt		Supervision / verbal prompt		Grab handle		
Assisted		Assisted		Other		

Supine ⟷ sitting on edge of bed				**Bed Rest**		**Staff 1 2 3** other
Supine to sitting on edge of bed		**Sitting on edge of bed to supine**		**Equipment** (if reqd.)		Additional information: e.g. method/manoeuvre, other equipment etc.
Independent		Independent		Slide sheets		
Supervision / verbal prompt		Supervision / verbal prompt		Grab handle		
Assisted		Assisted		Leg lifter		

Showering		**Equipment**			**Staff 1 2 3** other
Independent		Hi-low hygiene chair			Additional information: e.g. method/manoeuvre, other equipment etc.
Supervision / verbal prompt		Fixed Height Shower chair			
Assisted		Shower trolley			

Bathing		**Equipment**			**Staff 1 2 3** other
Independent		Bath / Hi-low bath			Additional information: e.g. method/manoeuvre, other equipment etc
Supervision / verbal prompt		Bath trolley / hoist			
Assisted		Hoist & sling		Bathing sling size **S M L LL XL**	

ADDRESSOGRAPH

PATIENT HANDLING ASSESSMENT & SAFER HANDLING PLAN

GIG CYMRU NHS WALES

TO BE COMPLETED IN BLACK INK

Washing		**Equipment**			**Staff 1 2 3** other
Independent		Bed/assisted wash			Additional information: e.g. method/manoeuvre, other equipment etc.
Supervision / verbal prompt		Chair			
Assisted					

Toileting		**Equipment**			**Staff 1 2 3** other
Independent		Toilet			Additional information: e.g. method/manoeuvre, other equipment etc.
Supervision / verbal prompt		Commode			
Assisted		Bedpan			

Walking		**Equipment**			**Staff 1 2 3** other
Independent		Walking stick			Additional information: e.g. method/manoeuvre, other equipment etc.
Supervision / verbal prompt		Walking Frame			
Assisted		Walking Hoist			

All Transfers (i.e to/from bed, chair, commode, toilet etc.)						**Staff 1 2 3** other
Independent		**Equipment**				Additional information: e.g. method/manoeuvre, other equipment etc.
Supervision / verbal prompt		Standing turntable		Standing Aid		
Assisted		Bed assist, stand		Transfer Board		
Active/Standing Hoist		Model:		Sling size **S M L XL**		
Passive Hoist		Model:		Sling size **S M L LL XL**		

Other Specific Risks e.g. environmental, equipment or task-related etc.		
Details	**Risk Reduction Measures**	
Assessor Name	**Date**	**Mobility Classification Tool (LOCOmotor ©)**

ADDITIONAL RESOURCES REQUIRED					
Resource Required	**Reason/ Justification**	**Specification**		**Date Requested**	**Date Provided**
Manager Name		**Signature**		**Date**	

ADDRESSOGRAPH

PATIENT HANDLING ASSESSMENT & SAFER HANDLING PLAN

TO BE COMPLETED IN BLACK INK

SAFER HANDLING PLAN REVIEW									
Reason for Review	Routine		More assistance reqd		Less assistance reqd.		Following Incident		
Activity	**Change(s) to Documented plan**						**Overall Mobility Classification**  **A B C D E**		
Moving in Bed									
Getting in/out of bed									
Showering / bathing / washing									
Toileting									
Transfers									
Walking									
Other relevant information:									
Assessor Name		**Signature**		**Date**					

SAFER HANDLING PLAN REVIEW									
Reason for Review	Routine		More assistance reqd.		Less assistance reqd.		Following Incident		
Activity	**Change(s) to Documented Plan**						**Overall Mobility Classification**  **A B C D E**		
Moving in Bed									
Getting in/out of bed									
Showering / bathing / washing									
Toileting									
Transfers									
Walking									
Other relevant information:									
Assessor Name		**Signature**		**Date**					

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode

FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT

FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT, ACTIONS & INTERVENTIONS FOR ALL ADULT IN-PATIENTS	
Complete within 6 hours of admission and on transfer to other clinical area. **Review:** • **Following a fall, following any change in patient's clinical condition; a deterioration or improvement, or every week as a minimum.** • **Involve patient and family in assessment and action planning, taking into account a patient's ability to understand/retain information** • **All 'YES' answers must be actioned but the examples given should be considered as prompts and are not an exhaustive list** • **Multifactorial Actions and Interventions MUST be reviewed with each reassessment and signed and dated in the right hand column**	
MANDATORY ACTIONS for all adult patients. Involve patient and family where appropriate.	**Date, sign & time when initially completed but review on-going actions as part of care plan**
Standard Guidance: • Call bell working and in reach (where applicable) • Advise on safe transfer/mobility and promote consistent messages • Advise on safe footwear • Give the 'reducing harm from falls' information leaflet • Note warfarin/anticoagulants and identify at safety briefing/handover	
Environment and/or Equipment: • Orientate patient to ward • Advise on risks from drips/tubing/aids • Mitigate any slip or trip hazards	
Post anaesthetic/procedure • Advise about transfer/mobilising following anaesthetic/procedure	
Falls History: Circle how many falls in the last 12 months (each fall increases risk) **0 1 2 3 4 5+**	
Remember: **Complete Bedrail Assessment and safe handling plan for all patients**	

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode

FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT

Answer the following questions as part of the MULTIFACTORIAL ASSESSMENT.				POTENTIAL ACTION & INTERVENTION PROMPTS	MULTIFACTORIAL ACTIONS & INTERVENTIONS CAREPLAN	Date, sign & time initial plan and on reassessment
Date of assessment or review	date	date	date			
Response yes (Y) or no(N)	**Y/N**	**Y/N**	**Y/N**			
• Has patient had an inpatient fall since last assessment? • Does the patient have a fear of falling/anxiety?				• *See Targeted Interventions* • *Re-assess if fallen (give date fall)* • *Provide reassurance and consider assisting / accompanying*		
Is the patient taking any of the following medication: • anticoagulants? • sedatives, hypnotics, antipsychotics or diuretics? • medications that lower BP or cause dizziness?				• *Liaise with doctor if on anticoagulants with h/o falls* • *Medication review by doctor or pharmacist*		
Are there any of the following associated risks: • Medically unwell, e.g. scoring on NEWS? • Risk of seizures? • Postural drop in BP?				• *Consider medical review* • *Take lying/standing BP*		
Any issues with Cognitive/Mental State: • Agitated; restless; impulsive; disorientated or confused? ***THINK DELIRIUM*** *and its cause.*				• *Delirium screen* • *Cognitive Screening Tool* • *24 hour behaviour chart* • *Utilise life-story tool e.g. 'This is me'*		

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode

FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT

Any Mobility issues: • Needs help to stand, transfer and/or walk? • Tries to walk unaided but unsafe, e.g. to toilet? • Uses walking aids? • Gait or balance problems? • Seating? e.g. slipping out of chair				• *Refer to physiotherapy Record/and use individual plan for safe transfer/mobilising/toileting* • *Place aids within reach* • *Consider one way glide sheet*		
Response yes (Y) or no (N)	**Y/N**	**Y/N**	**Y/N**	• **POTENTIAL ACTION & INTERVENTION PROMPTS**	**MULTIFACTORIAL ACTIONS & INTERVENTIONS CARE PLAN**	**Date, sign & time initial plan and on reassessment**
Any foot health issues: • Does the patient have appropriate footwear? • Foot health/pain?				• *Advise patient on appropriate footwear* • *Assess for problems that would impede safe mobilisation e.g. overgrown toenails that require social nail cutting, dressings, pressure damage, oedema, etc* • *Consider referral to podiatry for other foot health or pain issues* • *Consider other core assessments including the use of body maps*		
Any Sensory Deficits: • Vision and/or hearing impairment? • Glasses or hearing aid unavailable? • Numbness, weakness or spatial perception problems?				• *Request relatives bring in glasses/obtain a hearing aid battery/refer appropriately* • *Undertake actions for individual care needs*		
Are there any issues with the following: e.g. Equipment, nutrition and hydration, continence bundle, dementia, pain assessment, substance misuse etc?				• *Consider how these contribute to falls risk e.g. continence urgency, dehydration etc* • Refer to national and local pathways and other core risk assessments		
Does the patient and family identify any other risks?				• *With patient consent involve family in care planning*		

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode

FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT

Is there any history of fracture or osteoporosis?				• *Liaise with doctor re anti osteoporotic medications/screening*		
Based on this assessment are there any targeted interventions required?				• *Describe measures in use e.g. low bed, bed in observable position, close observation, intentional rounding, safety mat, sensors etc*		
Initial and record **Time** of assessment						

POST FALL ASSESSMENT and ACTION LOG (Nov 2015, V4)

Post Fall Actions	Fall 1	Fall 2	Fall 3	Fall 4
Date of Fall				
Time of fall				
Has a Multifactorial Assessment, Actions & Interventions been completed within the 7 days prior to the fall?				
Has a bedrail assessment been completed?				
Were the bedrails in use as specified in the assessment?				
Was an ultra low bed assessed as required?				
Was an ultra low bed in use?				
Was the fall witnessed? If yes by whom?				
Was the patient injured? (Specify)				
Were appropriate Neurological Observations indicated and initiated as per flow chart Immediate actions following adult in patient fall? (Frequency & duration in hours) ***NB required for all actual and suspected head injuries including unwitnessed falls***				
Was the patient reviewed by Site Practitioner or Dr? (specify)				
Does the patient have current cognitive impairment/delirium?				
Were individual risks identified within the Safety Briefing?				
Was the call bell working and within reach where appropriate?				
Were other interventions assessed as required, e.g. observable bed area; intentional rounding; 1:1; 1:2; 1:3 or 1:4 etc Was the intervention in place as documented in the assessment?				
Was safe footwear available and worn?				
Was any unfamiliar equipment involved?				
Were there any slip/trip obstructions or defects in the area?				
Revisit- was the patient assessed? Was a plan put in place? Was the plan followed? Has the patient handling plan been updated? What lessons have been learnt? ***(review is mandatory - document findings in patient notes)***				
Have family/carers been informed if applicable?				
Complete edatix				
Ensure all staff are aware by reporting at handover and safety briefing (add to ward clinical workstation).				
Completed by:				

All patients who suffer a fall and are cognitively aware should be asked the following questions:

Patient Experience & additional actions	Fall 1	Fall 2	Fall 3	Fall 4
What do you believe caused the fall and is there anything we could have done to help prevent your fall?				
Have you or your carer/ relative been given and read an advice leaflet on reducing falls?				

USE OF BEDRAILS DECISION AID & RECORD

There are various types of beds, bedrails and mattresses. Always take into consideration appropriate combination and individual patient need.

INITIAL DECISION

If you are unfamiliar with the patient (e.g. he/she is newly admitted) and have little information about them, you will need to make an initial decision about whether or not to use bedrails.

DO NOT ROUTINELY USE FULL BEDRAILS –

Indication 1. **If their use is to prevent the patient from getting out of bed e.g. to try to stop the patient getting up and falling**

Indication 2. **If patient is agitated and has attempted/may attempt to climb over or around bedrails- use ultra-low bed and consider floor safety mats**

Indication 3. **If their use would reduce the patient's independence**

For patients who lack capacity to consent to bedrails, remember that their use is a form of restraint, so they can only be used where it's in the patient's best interests, is to prevent harm to the patient and is a proportionate response to the likelihood and seriousness of harm (see Mental Capacity Act web page).

PROCEED WITH CAUTION IF –

The patient is an unusual body size - e.g. hydrocephalic, microcephalic, growth restricted, very emaciated or has other risk for entrapment.

WHEN TO USE BEDRAILS –

Indication 4. If patient is on a trolley (under normal circumstances)
Indication 5. To transport a patient on a bed/ trolley
Indication 6. To prevent the patient from slipping, sliding or rolling out of bed
Indication 7. To assist a patient to move themselves independently in and out of bed (commonly ½ rail top is recommended)

PRESENTING CONDITIONS TO CONSIDER FOR USE OF BEDRAILS –

Indication 8. Reduced levels of consciousness
Indication 9. Partial paralysis / poor trunk control
Indication 10. Seizures or spasms
Indication 11. Sedated, drowsy or recovering from anaesthesia
Indication 12. Patient decision

If you require high-sided ¾ length bedrails please liaise with Medstrom.

USE OF BEDRAILS DECISION AID AND RECORD

RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON FOR DECISION (HOSPITAL) TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE												
Left side	½ rail top		½ rail bottom		None		Reason for decision:					
Right side	½ rail top		½ rail bottom		None		Reason for decision:					
Other	Full or ¾ length bedrails		Floor safety mat		Left side		Right side		Ultra-low bed		Other (please state)	
If full or ¾ rails are used for both left and right sides the rationale must be made explicit as this may be overly restrictive and is not without risk. Record reason for decision of use (use indication numbers) and 'other' equipment.												
Date and time		Name							Designation			

RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON FOR DECISION: HOSPITAL TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE												
Left side	½ rail top		½ rail bottom		None		Reason for decision:					
Right side	½ rail top		½ rail bottom		None		Reason for decision:					
Other	Full or ¾ length bedrails		Floor safety mat		Left side		Right side		Ultra-low bed		Other (please state)	
If full or ¾ rails are used for both left and right sides the rationale must be made explicit as this may be overly restrictive and is not without risk. Record reason for decision of use (use indication numbers) and 'other' equipment.												
Date and time		Name							Designation			

RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON FOR DECISION (HOSPITAL) TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE												
Left side	½ rail top		½ rail bottom		None		Reason for decision:					
Right side	½ rail top		½ rail bottom		None		Reason for decision:					
Other	Full or ¾ length bedrails		Floor safety mat		Left side		Right side		Ultra-low bed		Other (please state)	
If full or ¾ rails are used for both left and right sides the rationale must be made explicit as this may be overly restrictive and is not without risk. Record reason for decision of use (use indication numbers) and 'other' equipment.												
Date and time		Name							Designation			

RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON FOR DECISION (HOSPITAL) TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE												
Left side	½ rail top		½ rail bottom		None		Reason for decision:					
Right side	½ rail top		½ rail bottom		None		Reason for decision:					
Other	Full or ¾ length bedrails		Floor safety mat		Left side		Right side		Ultra-low bed		Other (please state)	
If full or ¾ rails are used for both left and right sides the rationale must be made explicit as this may be overly restrictive and is not without risk. Record reason for decision of use (use indication numbers) and 'other' equipment.												
Date and time		Name							Designation			

USE OF BEDRAILS REVIEW AND CONTINUATION SHEET

Complete on admission/ transfer to different clinical area
Review : following **any** change in the patient's condition

- Acute care: at least weekly
- Long stay: if new patient or known to be at risk, review in one week; if not review in one month

RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON FOR DECISION **TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE**											
Left side	½ rail top		½ rail bottom		¾ length		full length		none		**Date:** **Time:**
Right side	½ rail top		½ rail bottom		¾ length		Full length		none		**Sign:**
Other	Ultra low bed		Floor safety mat		left side		right side		**Print name:**		
Record reason for decision of use and e.g. use of bedrail bumpers or 'safer sides'											
Record any variance and action taken to reduce risks											

RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON FOR DECISION **TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE**											
Left side	½ rail top		½ rail bottom		¾ length		full length		none		**Date:** **Time:**
Right side	½ rail top		½ rail bottom		¾ length		Full length		none		**Sign:**
Other	Ultra low bed		Floor safety mat		left side		right side		**Print name:**		
Record reason for decision of use and e.g. use of bedrail bumpers or 'safer sides'											
Record any variance and action taken to reduce risks											

RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON FOR DECISION **TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE**											
Left side	½ rail top		½ rail bottom		¾ length		full length		none		**Date:** **Time:**
Right side	½ rail top		½ rail bottom		¾ length		Full length		none		**Sign:**
Other	Ultra low bed		Floor safety mat		left side		right side		**Print name:**		
Record reason for decision of use and e.g. use of bedrail bumpers or 'safer sides'											
Record any variance and action taken to reduce risks											

Please report any equipment failures/difficulties/near miss to Medstrom, complete an incident form and, if appropriate contact your Health and Safety Advisor

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
ADDRESSOGRAPH
Postcode:

CONTINENCE / TOILETING RISK ASSESSMENT TOOL

TO BE COMPLETED IN BLACK INK

GIG CYMRU NHS WALES

Continence/Toileting Risk Initial Assessment to be completed within 4 hours of admission. A review to be undertaken on each transfer to a Clinical Area/Ward.

If continence / toileting needs are identified the patient must be re-assessed at least **weekly** or sooner if their condition changes and their care plan updated accordingly.

If answered **YES** to **any** questions the patient is at High Risk of becoming incontinent or may already be experiencing incontinence. If risk identified implement an individual **Treatment / Toileting or Management Care Plan.**

Continence status, needs and preferences must be discussed and confirmed at each nursing handover.

At this CURRENT time does your patient:	**Date**	DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY	
	Time	HH:MM		HH:MM		HH:MM		HH:MM		HH:MM		HH:MM		HH:MM	
Need help to get to the toilet		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have any cognitive problems		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have mobility problems		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Need to rush to the toilet		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Need to use the toilet frequently		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Leak urine		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick): Occasionally															
Regularly															
Leak faeces		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick): Occasionally															
Regularly															
Have constipation		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have diarrhoea		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Bristol stool type															
Have difficulty passing urine		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have difficulty passing faeces		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Normally wear a pad or use other devices		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Normally use a catheter		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick): Indwelling															
Intermittent Self Catheterisation															
Normally use any equipment to help with toileting		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Signature															
Designation															

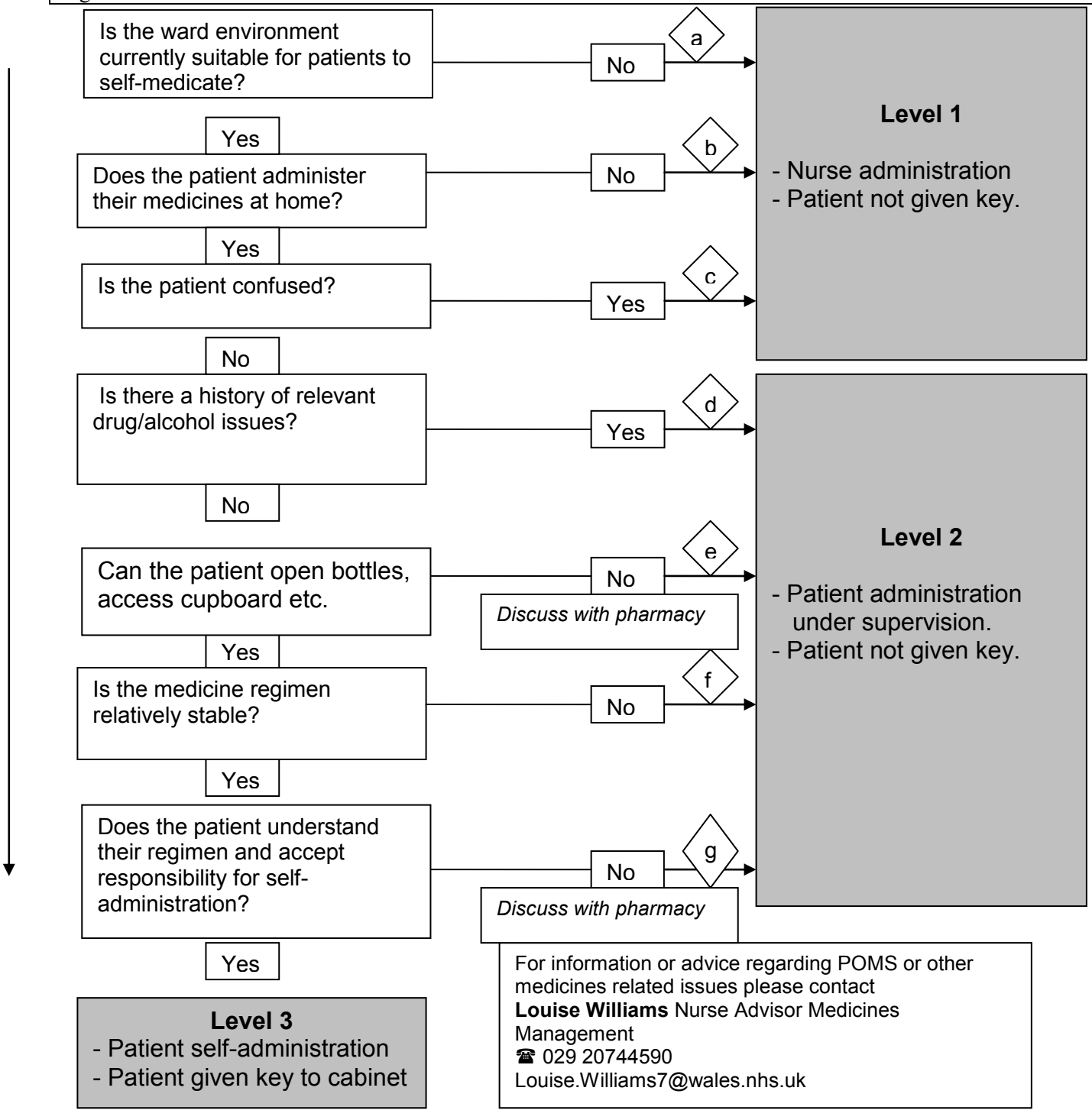
PATIENT ORIENTATED MEDICATION SYSTEM (POMS) ASSESSMENT

1. Each patient should be assessed on admission to the ward as soon as their condition allows
2. Re-assessment must be scheduled as determined by patients condition and treatment
3. Patients can move up and down level as required

Assessment date						
Level						
Reason						
Nurse signature						

Patient agreement for self medication (level 3) – I have received and understand the information given to me on self administration of medicines and I agree to self administer. I am aware that I may change my mind at any time but must inform my named nurse. I understand that in future the nursing staff may also advise against self-administration if my condition changes.

Signed …… ……Print……Date……..



For information or advice regarding POMS or other medicines related issues please contact
Louise Williams Nurse Advisor Medicines Management
☎ 029 20744590
Louise.Williams7@wales.nhs.uk

I.V. Dressings

• Tegaderm 1633 Peripheral I.V. Dressing • Tegaderm 1635 Central Line Dressing • Tegaderm 1610 Paediatric I.V. Dressing • Tegaderm 1650 PICC and Midline Dressing

V.I.P. Score (Visual Infusion Phlebitis Score)

I.V. site appears healthy	**0**	No signs of phlebitis **OBSERVE CANNULA**
One of the following is evident: • Slight pain near I.V. site or slight redness near I.V. site	**1**	Possible signs of phlebitis **OBSERVE CANNULA**
Two of the following is evident: • Pain near I.V. site • Erythema • Swelling	**2**	Early Stage of phlebitis **RESITE CANNULA**
ALL of the following is evident: • Pain along path of cannula • Erythema • Induration	**3**	Medium Stage of phlebitis **RESITE CANNULA CONSIDER TREATMENT**
ALL of the following is evident& extensive: • Pain along path of cannula • Erythema • Induration • Palpable venous cord	**4**	Advanced Stage of phlebitis or start of thrombophlebitis **RESITE CANNULA CONSIDER TREATMENT**
ALL of the following is evident & extensive: • Pain along path of cannula • Erythema • Induration • Palpable venous cord • Pyrexia	**5**	Advanced Stage of thrombophlebitis **INITIATE TREATMENT RESITE CANNULA**

Document a section for each cannula

Remember

Observe cannula 8 hourly or more frequently if clinically indicated

Secure cannula with an appropriate dressing – change if soiled or contaminated

Aseptic technique must be followed for insertion

Consider resiting the cannula every 48-72 hours or as indicated by VIP score

Plan and document care

Cannula site Size Lot Number Date of Insertion

Clinical indication for insertion ☐ **IV medication** ☐ **iv Fluids** ☐ **Blood** ☐ **Emergency** ☐ **Other (provide details)**

Date and Time																
Clinical indication for continued use																
VIP SCORE																
Needs observation = O **Removal = R**																
Dressing intact = I Dressing changed = C																
Sodium Chloride 0.9% flush if required must be prescribed on the drug chart																
Signature																

Cannula site Size Lot Number Date of Insertion

Clinical indication for insertion ☐ **IV medication** ☐ **iv Fluids** ☐ **Blood** ☐ **Emergency**

☐ **Other (provide details)**

Date and Time																	
Clinical indication for continued use																	
VIP SCORE																	
Needs observation = O **Removal = R**																	
Dressing intact = I Dressing changed = C																	
Sodium Chloride 0.9% flush if required must be prescribed on the drug chart																	
Signature																	

Cannula site Size Lot Number Date of Insertion

Clinical indication for insertion ☐ **IV medication** ☐ **iv Fluids** ☐ **Blood** ☐ **Emergency**

☐ **Other (provide details)**

Date and Time																	
Clinical indication for continued use																	
VIP SCORE																	
Needs observation = O **Removal = R**																	
Dressing intact = I Dressing changed = C																	
Sodium Chloride 0.9% flush if required must be prescribed on the drug chart																	
Signature																	

Cannula site Size Lot Number Date of Insertion

Clinical indication for insertion ☐ **IV medication** ☐ **iv Fluids** ☐ **Blood** ☐ **Emergency**

☐ **Other (provide details)**

Date and Time																	
Clinical indication for continued use																	
VIP SCORE																	
Needs observation = O **Removal = R**																	
Dressing intact = I Dressing changed = C																	
Sodium Chloride 0.9% flush if required must be prescribed on the drug chart																	
Signature																	

Patients Property Liability Disclaimer

To be completed within 6 hours of arrival at hospital, as part of the patient admission process.

I _____ acknowledge that the opportunity has been given to me to hand over my personal property, medications and valuables to be placed in safekeeping in accordance with the Cardiff and Vale University Health Board's policy on Patient's Property.

I _____ have declined the offer to hand over my personal property, medications and valuables to be placed in safekeeping in accordance with the Cardiff and Vale University Health Board's policy on Patients Property.

Name of Patient _____ Signature _____

Dated _____

Name of Witness *(must be staff member)* _____

Designation _____

Signature Date _____

<u>Valuables have been handed over for safekeeping</u>

Name *(must be staff member)* _____

Designation _____

Signature Dated _____

Patient's Property Book Reference _____

<u>Please file completed disclaimer in the patient's records.</u>