NURSING ADMISSION

Guide for nursing evaluation on first initial assessment:

Clinical judgement should be used to decide on the extent of assessment required. Assessment information includes, but is not limited to:

History of presenting complaint……..

A – Airway: noises, secretions, cough, artificial airway.

B – Breathing: breath sounds, saturations, respiratory rate, rhythm, work of breathing, laboured/supported, any oxygen required and delivery of oxygen.

C – Circulation: pulse, blood pressure, peripheral temperature, skin colour, and moisture, capillary refill time.

D – Disability: AVPU, monitoring of blood glucose (if required), GCS.

E – Exposure: Monitor temperature for signs of infection, wound sites, catheter, drain sites, pain scoring and analgesia, anti emetics, maintain comfort.

S – Surface: Waterlow = (insert number), MUST = (insert number), document the surface and if this is appropriate mattress & Cushion.

PLEASE NOTE: I**f a Waterlow is 15 – 25 and your patient doesn't need an air mattress, please document this in your evaluation.**
It is also important that we complete ALL Waterlow scores, if we don't have all information on admission please document: Waterlow complete with all information available on admission, please re-assess in 24hr.

S – Skin Inspection: All pressure areas checked / any redness? Breaks? Moisture damage?

K – Keep Moving: ? Independent, ? require assistance turning & frequency.

I – Incontinence: Urine, Bowels, have you used the 7in1 wipes?

N – Nutrition: Diet, Fluids, Supplements.

PLEASE NOTE: Structuring patient's assessments is vital to monitoring the success of care and detecting the emergence of new problems. It is important that we are documenting this first initial assessment.

We are continuing to receive multiple Datix forms from the wards regarding our documentation. If we document this first information appropriately the incidences of pressure ulcers developing in our care will be reduced significantly. If we get this initial assessment right if pressure damage does occur later in the patients' journey, our initial assessment will show a proactive approach and will then not be seen as a contributing factor.

You may be asked to attend RCA meeting in the future if pressure damage occurs and your documentation is being challenged.

Completing Waterlow Assessment

The primary assessment is the responsibility of the registered nurse delivering care to the patient. Waterlow scoring chart is used to assess patients' risk of developing pressure damage.

Build/ Weight for Height – Calculate the BMI and document.

Skin Type and Visual Risks Areas
Healthy **(0)**
Tissue Paper = Thin / Fragile **(1)**
Dry = Appears Flaky **(1)**
Oedematous = Puffy/Swelling **(1)**
Clammy = Moist to touch / Pyrexia **(1)**
Non Blanching, Erythema = Discoloured/Bruising/Mottled /Grade 1 PU **(2)**
Broken = Established Ulcer **(5)**

Mobility
Fully Mobile **(0)**
Restless/fidgety **(1)**
Apathetic = sedated/depressed/reluctant to move **(2)**
Restricted = restricted by severe pain or disease / tubes, catheters, drains **(3)**
Bedbound = unconscious/unable to change position/traction **(4)**
Chair bound = unable to leave chair without assistance / wheelchair **(5)**

Conditions included in the score as organ failure:
CCF – Heart Failure
CKD
AKI
COPD
Type 1&2 Respiratory Failure
Renal Failure
Dialysis

Any two or more score 8 = multiple organ failure.

Tissue Malnutrition
Terminal Cachexia = Weakness and Wastage of the body due to terminal illness **(8)**
Multi Organ Failure **(8)**
Single Organ Failure **(5)**
Peripheral Vascular Disease **(5)**
Anaemia = Hb <80gl **(2)**

REMEMBER: Respiratory, Renal & Heart Failure all score 5 on your waterlow!

Neurological Deficit
Diabetes (Type 1 &2), Multiple Sclerosis, Stroke (CVA), Motor/sensory loss – Parkinson's, Dementia/ Alzheimer's **(5)**

Medication
Steriods, Cytotoxics – Be aware these cause increased fragility of the skin.
Anti-inflammatory – Delay inflammatory stage of healing in acute wounds **(3)**

PLEASE NOTE: If a waterlow is 15-25 and your patient doesn't need an air mattress, please document this in your nursing evaluation. Clinical judgement and patients wishes should be taken into account.

It is important that we complete **ALL** waterlow scores on admission to the unit. This must be done with the information available at the time, if all information is unavailable document this in your nursing notes. Waterlow must then be re assessed in 24hrs.

Ensure you calculate the score correctly and plan your care appropriately.