Healthcare Improvement Scotland NATVNS SCOTLAND

WRITE IN PRINT OR ATTACH

Adapted Glamorgan Pressure Ulcer Risk Assessment Scale

Suitable for use from Birth-18yrs

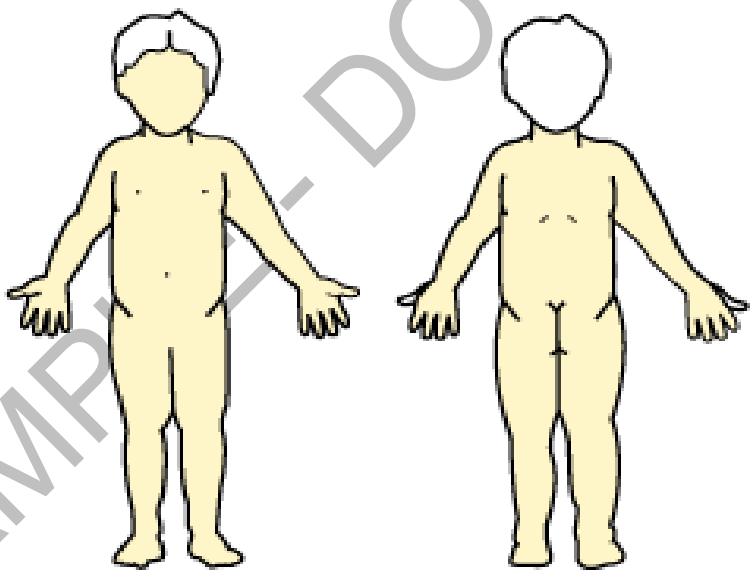
Admission Date……..Time…….
Consultant/GP……

N.B. This tool should be used to support **not replace** your clinical judgement as to whether the child is at risk of pressure ulcer development.

Risk Factor *(If data such as serum albumin or haemoglobin is not available then score 0)*	**Score**	**Date and time of assessments (reassess at least daily and every time condition changes)**						
Child cannot be moved without great difficulty or deterioration in condition / under general anaesthetic >2 hours	20							
Unable to change his/her position without assistance /cannot control body movement	15							
Some mobility, but reduced for age	10							
Normal mobility for age	0							
Equipment / objects / hard surface pressing or rubbing on skin	15							
Significant anaemia (Hb <9g/dl)# Not Known	1 0							
Persistent pyrexia (temperature > 38.0ºC for more than 4 hours)	1							
Poor peripheral perfusion (cold extremities/ capillary refill > 2 seconds / cool mottled skin)	1							
Inadequate nutrition/PYMS score >2 (discuss with dietician if in doubt)	2							
Low serum albumin (< 35g/l) Not Known	1 0							
Incontinence (inappropriate for age)	1							
Total score								
Action Taken: Yes or No If Yes complete SSKINS care plan. Refer to relevant Specialist Service, i.e. Dietetics, Tissue Viability, Orthotics								
Signature								
Designation								

Risk score	Category	Suggested action
0	Not at risk	Continue to reassess daily and every time condition changes.
10+	At risk	Inspect skin at least twice a day. Relieve pressure by helping/ encouraging the child to move at least every 2 hours. Use a size and weight appropriate pressure redistribution surface for sitting on &/or sleeping on if necessary.
15+	High risk	Inspect skin with each repositioning. Reposition child / equipment/ devices at least every 2 hours. Relieve pressure before any skin discolouration develops. Use a size and weight appropriate pressure redistribution surface for sitting on &/or sleeping on.
20+	Very high risk	Inspect skin at least hourly if condition allows. Move or turn if possible, before skin becomes discoloured (refer to EPUAP grade 1). Ensure equipment / objects are not pressing on the skin. Consider using specialised pressure relieving equipment. Refer to local guidelines/protocol if available, if not contact / refer to TVN.

Paediatric Pressure Ulcer Record



Using numbers, indicate on the diagram above any discoloured areas or pressure ulcers. Use the box below enter the number, the date it was first observed, grade and location and the outcome (resolved or not resolved).

Ulcer Number	Date ulcer first observed	Grade & Location of Ulcer(s)	Outcome (resolved/not resolved)	Date of Reassessment	Signature

Guidance on Using the Glamorgan Scale

A child's risk of developing a pressure ulcer should be assessed within 8 hours of admission and re-assessed daily and every time there are significant changes in his/her condition.

Dates & Times of assessments must be inserted in the appropriate box.

Mobility - Include the total of ALL relevant scores in this section

Child cannot be moved without great difficulty or deterioration in condition – add 20 to total score for this section.
E.g. ventilated child who de-saturates with position changes, a child who becomes hypotensive in a certain position.
Children with cervical spine injuries are limited in the positions they can lie in.
Some children with contracture deformities are only comfortable in limited positions.
General anaesthetic >2hours – add 20 to total score for this section **only on day of surgery**
E.g. a child who is on the theatre table may not have their position changed during an operation for a prolonged period and is placed on a firm surface for stability during the operation.

Unable to change his/her position without assistance – add 15 to total score for this section.
E.g. a child may be unable to move themselves, but carers can move the child and change his/her position.
Cannot control body movement – add 15 to total score for this section.
E.g. the child can make movements but these may not be purposeful (repetitive dyskinetic movements), the child is unable to consciously change his/her own position.

Some mobility but reduced for age – add 10 to total score for this section.
The child may have the ability to change their own position but this is limited / restricted. E.g. a child with developmental delay, a child in traction who is able to make limited movements, or a child on bed rest.

Normal mobility for age –score 0 for this section.
Mobility is appropriate for developmental stage.
E.g. a newborn baby is able to move his/her limbs but is not able to roll over; a 1 year old is able to roll over, bottom shuffle or crawl, sit up and pull up to standing.

Equipment / objects / hard surface pressing or rubbing on the skin – add 15 to total score.
Any object pressing or rubbing on the skin for long enough or with enough force can cause pressure damage. (These areas must be observed closely).
E.g. pulse oximeter probes, ET tubes, masks, tubing/wires, tight clothing (anti-embolic stockings), plaster casts/splints.

Significant anaemia (Hb <9g/dl)

If the haemoglobin has been measured during this admission and is below 9g/dl – score 1.
If the haemoglobin is 9g/dl or above score 0.
If the haemoglobin is unknown, write NK and score 0.

Persistent pyrexia (temperature >38.0ºC for more than 4 hours)

If temperature is 38.0ºC and above for more than 4 hours - score 1.
If temperature is less than 38ºC and/or pyrexia lasts less than 4 hours - score 0.

Poor peripheral perfusion (cold extremities / capillary refill > 2 seconds / cool mottled skin)

If the child has any of the above symptoms whilst in a warm environment (i.e. not due to low environmental temperature) – score 1.

Inadequate nutrition / PYMS score >2 (discuss with a dietician if in doubt)

If a child is identified as being malnourished (exclude pre-op fasting) - score 1.
A child who has a normal nutritional intake - score 0.

Low serum albumin (<35g/l)

If serum albumin is less than 35g/l - score 1.
If serum albumin is 35g/l or above – score 0.
If serum albumin has not been measured write NK and score 0.

Incontinence (inappropriate for age)

Inappropriate incontinence - score 1
E.g. A 4 year old child who needs to wear nappies during the day and night.
Include children with special needs in this category.
Normal continence – score 0
E.g. A 5 year old who is dry during the day but may be occasionally incontinent during the night, a 12 month old who needs to wear nappies during the day and night.
Moisture lesions should not be confused with pressure ulcers.

Risk Score

Document total score, **however scores for individual risk factors should be acted on** i.e. optimise nutrition and mobility.
If the child scores 10 or higher, he/she is at risk of developing a pressure ulcer unless action is taken to prevent it. This action may include normal nursing care, such as frequent changes of position (document how often position is changed), encouraging mobilisation, lying the child on a foam hospital mattress or on an air-filled mattress overlay, changing the position of pulse oximeter probes regularly, ensuring the child is not lying on objects in the bed such as tubing or hard toys.

Suggested action is indicated in the table; however nurses should also use their own discretion and expertise, and if possible seek advice from a tissue viability specialist if a high specification pressure redistributing surface is considered necessary.

Complete SSKINS Care Plan to evidence these actions and review daily and/or if any changes to care. Adjust SSKINS Care Plan according depending on patients' needs/requirements.

Pressure Ulcer Record

The diagram of the child can be used to indicate the position of any skin lesions.
If lesions are near to, or associated with any equipment such as BIPAP mask, nasogastric tube or splint, these should also be indicated. The skin lesions indicated in the diagram should be numbered so that they can be referred to in the table below the diagram. In the table the lesions can be described more fully, with the date they were first observed and the outcome.

Please use the Scottish adapted EPUAP grading tool to grade ulcers, no other grading tool should be used.