

WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY

RING SCORES IN TABLE, ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED

BUILD/WEIGHT FOR HEIGHT	◆	SKIN TYPE VISUAL RISK AREAS	◆	SEX AGE	◆	MALNUTRITION SCREENING TOOL (MST) (Nutrition Vol.15, No.6 1999 - Australia)				
AVERAGE BMI = 20-24.9	0	HEALTHY	0	MALE	1	A - HAS PATIENT LOST WEIGHT RECENTLY YES - GO TO B NO - GO TO C UNSURE - GO TO C AND SCORE 2		B - WEIGHT LOSS SCORE 0.5 - 5kg = 1 5 - 10kg = 2 10 - 15kg = 3 > 15kg = 4 unsure = 2		
ABOVE AVERAGE BMI = 25-29.9	1	TISSUE PAPER	1	FEMALE	2					
OBESE BMI > 30	2	DRY	1	14 - 49	1					
BELOW AVERAGE BMI < 20	3	OEDEMATOUS	1	50 - 64	2	C - PATIENT EATING POORLY OR LACK OF APPETITE 'NO' = 0; 'YES' SCORE = 1		NUTRITION SCORE If > 2 refer for nutrition assessment / intervention		
BMI=Wt(Kg)/Ht (m) ²		CLAMMY, PYREXIA	1	65 - 74	3					
		DISCOLOURED	2	75 - 80	4					
		GRADE 1	2	81 +	5					
		BROKEN/SPOTS	3							
		GRADE 2-4	3							
CONTINENCE	◆	MOBILITY	◆	SPECIAL RISKS						
COMPLETE/ CATHETERISED	0	FULLY	0	TISSUE MALNUTRITION		◆	NEUROLOGICAL DEFICIT			◆
URINE INCONT.	1	RESTLESS/FIDGETY	1	TERMINAL CACHEXIA	8		DIABETES, MS, CVA		4-6	
FAECAL INCONT.	2	APATHETIC	2	MULTIPLE ORGAN FAILURE	8		MOTOR/SENSORY		4-6	
URINARY + FAECAL INCONTINENCE	3	RESTRICTED	3	SINGLE ORGAN FAILURE (RESP, RENAL, CARDIAC.)	5		PARAPLEGIA (MAX OF 6)		4-6	
		BEDBOUND	4	PERIPHERAL VASCULAR DISEASE	5		MAJOR SURGERY or TRAUMA			
		e.g. TRACTION	4	ANAEMIA (Hb < 8)	2		ORTHOPAEDIC/SPINAL		5	
		CHAIRBOUND	5	SMOKING	1		ON TABLE > 2 HR#		5	
		e.g. WHEELCHAIR	5							
				MEDICATION - CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY MAX OF 4						
SCORE										
10+ AT RISK										
15+ HIGH RISK										
20+ VERY HIGH RISK										

Scores can be discounted after 48 hours provided patient is recovering normally

© J Waterlow 1985 Revised 2005*

Obtainable from the Nook, Stoke Road, Henlade TAUNTON TA3 5LX

* The 2005 revision incorporates the research undertaken by Queensland Health.

www.judy-waterlow.co.uk

REMEMBER TISSUE DAMAGE MAY START PRIOR TO ADMISSION, IN CASUALTY. A SEATED PATIENT IS AT RISK ASSESSMENT (See Over) IF THE PATIENT FALLS INTO ANY OF THE RISK CATEGORIES, THEN PREVENTATIVE NURSING IS REQUIRED A COMBINATION OF GOOD NURSING TECHNIQUES AND PREVENTATIVE AIDS WILL BE NECESSARY
ALL ACTIONS MUST BE DOCUMENTED

PREVENTION

PRESSURE

REDUCING AIDS

Special

Mattress/beds:

10+ Overlays or specialist foam mattresses.
 15+ Alternating pressure overlays, mattresses and bed systems
 20+ Bed systems: Fluidised bead, low air loss and alternating pressure mattresses

Note: Preventative aids cover a wide spectrum of specialist features. Efficacy should be judged, if possible, on the basis of independent evidence.

Cushions:

No person should sit in a wheelchair without some form of cushioning. If nothing else is available - use the person's own pillow. (Consider infection risk)

10+ 100mm foam cushion
 15+ Specialist Gell and/or foam cushion
 20+ Specialised cushion, adjustable to individual person.

Bed clothing:

Avoid plastic draw sheets, inco pads and tightly tucked in sheet/sheet covers, especially when using specialist bed and mattress overlay systems
 Use duvet - plus vapour permeable membrane.

NURSING CARE

General

HAND WASHING, frequent changes of position, lying, sitting. Use of pillows

Pain

Appropriate pain control

Nutrition

High protein, vitamins and minerals

Patient Handling

Correct lifting technique - hoists - monkey poles
 Transfer devices

Patient Comfort Aids

Real Sheepskin - bed cradle

Operating Table

Theatre/A&E Trolley

100mm(4ins) cover plus adequate protection

Skin Care

General hygiene, NO rubbing, cover with an appropriate dressing

WOUND GUIDELINES

Assessment

odour, exudate, measure/photograph position

WOUND CLASSIFICATION - EPUAP

GRADE 1

Discolouration of intact skin not affected by light finger pressure (non-blanching erythema)

This may be difficult to identify in darkly pigmented skin

GRADE 2

Partial thickness skin loss or damage involving epidermis and/or dermis
 The pressure ulcer is superficial and presents clinically as an abrasion, blister or shallow crater

GRADE 3

Full thickness skin loss involving damage of subcutaneous tissue but not extending to the underlying fascia

The pressure ulcer presents clinically as a deep crater with or without undermining of adjacent tissue

GRADE 4

Full thickness skin loss with extensive destruction and necrosis extending to underlying tissue.

Dressing Guide

Use Local dressings formulary and/or www.worldwidewounds

IF TREATMENT IS REQUIRED, FIRST REMOVE PRESSURE