WATERLOW PRESSURE INJURY PREVENTION & TREATMENT POLICY

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

BUILD/WEIGHT FOR HEIGHT	◆
AVERAGE BMI = 20-24.9	0
ABOVE AVERAGE BMI = 25-29.9	1
OBESE BMI > 30	2
BELOW AVERAGE BMI < 20	3
BMI=Wt(Kg)/Ht $(m)^2$	

SKIN TYPE VISUAL RISK AREAS	◆
HEALTHY	0
TISSUE PAPER	1
DRY	1
OEDEMATOUS	1
CLAMMY, PYREXIA	1
DISCOLOURED GRADE 1	2
BROKEN/SPOTS GRADE 2-4	3

SEX AGE	◆
MALE	1
FEMALE	2
14 - 49	1
50 - 64	2
65 - 74	3
75 - 80	4
81 +	5

MALNUTRITION SCREENING TOOL (MST)
(Nutrition Vol.15, No.6 1999 - Australia

A - HAS PATIENT LOST WEIGHT RECENTLY	B - WEIGHT LOSS SCORE
YES - GO TO B NO - GO TO C UNSURE - GO TO C AND SCORE 2	0.5 - 5kg = 1 5 - 10kg = 2 10 - 15kg = 3 > 15kg = 4 unsure = 2
C - PATIENT EATING POORLY OR LACK OF APPETITE 'NO' = 0; 'YES' SCORE = 1	**NUTRITION SCORE** If > 2 refer for nutrition assessment / intervention

CONTINENCE	◆
COMPLETE/ CATHETERISED	0
URINE INCONT.	1
FAECAL INCONT.	2
URINARY + FAECAL INCONTINENCE	3

MOBILITY	◆
FULLY	0
RESTLESS/FIDGETY	1
APATHETIC	2
RESTRICTED	3
BEDBOUND e.g. TRACTION	4
CHAIRBOUND e.g. WHEELCHAIR	5

SCORE
10+ AT RISK
15+ HIGH RISK
20+ VERY HIGH RISK

SPECIAL RISKS

TISSUE MALNUTRITION	◆
TERMINAL CACHEXIA	8
MULTIPLE ORGAN FAILURE	8
SINGLE ORGAN FAILURE (RESP, RENAL, CARDIAC,)	5
PERIPHERAL VASCULAR DISEASE	5
ANAEMIA (Hb < 8)	2
SMOKING	1

NEUROLOGICAL DEFICIT	◆
DIABETES, MS, CVA	4-6
MOTOR/SENSORY	4-6
PARAPLEGIA (MAX OF 6)	4-6

MAJOR SURGERY or TRAUMA	
ORTHOPAEDIC/SPINAL	5
ON TABLE > 2 HR#	5
ON TABLE > 6 HR#	8

MEDICATION - CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY MAX OF 4

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

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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 hygene, 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