introduction to the Medistore **Waterlow guide**

Waterlow pressure ulcer prevention/treatment policy

OBSERVATION	**BUILD / WEIGHT FOR HEIGHT (BMI)**	Average BMI (20 – 24.9)		0
		Above average BMI =25 – 29.9		1
		Obese BMI >30		2
		Below average BMI <20		3
	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
	GENDER	Male		1
		Female		2
	AGE	14 – 49		1
		50 – 64		2
		65 – 74		3
		75 – 80		4
		81+		5
	MALNUTRITION SCREENING TOOL (MST)† Ω	**A** Has patient lost weight recently?	Yes	go to **B** –
			No	go to **C** –
			Unsure	go to **C** & score 2
		B Weight loss score	0.5 – 5 kg	1
			5 – 10 kg	2
			10 – 15 kg	3
			> 15 kg	4
			Unsure	2
		C Patient eating poorly or lack of appetite	No	0
			Yes	1
	CONTINENCE	Complete / catheterised		0
		Urine incontinent		1
		Faecal incontinent		2
		Urine & faecal incontinent		3
	MOBILITY	Fully Mobile		0
		Restless / fidgety		1
		Apathetic		2
		Restricted		3
		Bedbound e.g. Traction		4
		Chairbound e.g. Wheelchair		5
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 hours		5
		On table > 6 hours *		8
	MEDICATION (MAX OF 4)	cytotoxics		1
		long term / high dose steroids, anti-inflammatory		1
				1
	SCORE TOTAL			

Ring scores in table, add and total.

More than 1 score per category can be used.

SCORE

10+ AT RISK

15+ HIGH RISK

20+ VERY HIGH RISK

BMI = weight (kg) ÷ [height (m)]²

† Nutrition Vol.15, No.6 1999 - Australia

Ω if Nutrition score is less than 2, refer for nutrition assessment / intervention

* Scores can be reduced after 48 hours, provided patient is recovering normally

www.judy-watertaw.co.uk

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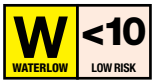
Judy Waterlow, now in her seventies, designed and researched her pressure ulcer risk assessment tool in 1985, while working as a Clinical Nurse Teacher. The tool was originally designed for use by her students.

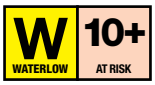
1. Consider your patient, and circle one or more score per category.

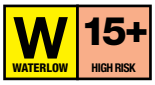
Eg

2. Add up all your circled scores at the bottom

Eg "**18"**. This is your Waterlow risk level







3. Then, turn over the card and consult the information on the back for suggestions as to what actions may assist

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Remember, therapeutic devices should only be used in accordance with manufacturers instructions and under the consent, supervision and management of a suitably qualified health professional.

Waterlow pressure ulcer treatment guidelines

Remember tissue damage may start prior to admission, in casualty • A seated patient is at risk
If the patient falls into any of the risk categories listed over, then preventative nursing is required.
A combination of good nursing techniques and preventative aids will be necessary
All actions must be documented • If treatment is required, first remove pressure

PREVENTION : PRESSURE REDUCING AIDS

	SCORE	
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 at specialist features. Efficacy should be judged, if possible, on the basis of independent evidence.
CUSHIONS	SCORE **10+**	100 mm foam cushion
	15+	specialist gel and/or foam cushion
	20+	specialised cushion, adjustable to individual person.
		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).
BED CLOTHING		Avoid plastic draw sheets, inca 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
COMFORT AIDS	Real sheepskin – bed cradle
OPERATING TABLE / A&E TROLLEY	100 mm cover plus adequate protection
SKIN CARE	General hygiene, no rubbing, cover with an appropriate dressing
DRESSING GUIDE	Use local dressings formulary and/or www.worldwidewaunds

WOUND GUIDELINES

ASSESSMENT	Odour, axudate, measure / photograph position

WOUND CLASSIFICATION - EPUAP

GRADE 1	Discolouration of intact skin not affected by light linger 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

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