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Waterlow Risk Assessment Tool - Score Chart

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Calculate total score using the below table. More than one score per category can be used .

Patient Name		NHS No.	

A - Build / weight for height	B - Continence	C - Skin type / visual risk areas	D - Mobility	E - Sex / age	F - Tissue Malnutrition
0 Average BMI 20 - 24.9	0 Complete / catheterised	0 Healthy	0 Full mobility	1 Male	8 Terminal cachexia
1 Above average BMI 25 - 29.9	1 Urine incontinent	1 Tissue paper	1 Restless / fidgety	2 Female	8 Multiple organ failure
2 Obese BMI >30	2 Faecal incontinent	1 Dry	2 Apathetic	1 14 - 49	5 Single organ failure (resp, renal, cardiac)
3 Below average BMI <20	3 Urine & faecal incontinent	1 Oedematous	3 Restricted	2 50 - 64	5 Peripheral vascular disease
		1 Clammy, Pyrexia	4 Bedbound eg. traction	3 65 - 74	2 Anemia (Hb<8)
		2 Discoloured grade 1	5 Chairbound	4 75 - 80	1 Smoking
		3 Broken / spots grade 2 - 4		5 81 +	

G - Neurological deficit	H - Major surgery / trauma	I - Medication	J - Malnutrition Screening Tool (MST)	
4 - 6 Diabetes, MS, CVA	5 Orthopaedic / spinal	4 Cytotoxics	A - Has patient lost weight recently	B - Weight loss score
4 - 6 Motor / sensory	5 On table > 2hrs #	4 Long term / high dose steriods	Yes - Go to B	1 0.5 - 5kg
4 - 6 Paraplegia	8 On table > 6hrs #	4 Anti-inflammatory	No - Go to C	2 5 - 10kg
	# scores can be discounted after 48hrs provided patient is recovering normally.	Maximum of 4	Unsure - Go to C and score 2	3 10 - 15kg
Score			C - Patient eating poorly or lack of appetite	4 >15kg
10+ At risk			0 No	2 Unsure
15+ High risk			1 Yes	Nutrition score
20+ Very high risk				If > 2 refer for nutrition assessment intervention.

Guidance

- All patients at risk and above to be risk assessed daily
- All 'At risk' patients should have daily skin assessments
- Patients not 'At risk' to be risk assessed weekly unless condition deteriorates then risk level should be reassessed
- Patients 'At risk' and above to be commenced upon a Pressure Ulcer Prevention Plan
- Patients 'At risk' and above with a pressure ulcer commence Pressure Ulcer Treatment Plan
- Follow mattress selection guidance for appropriate equipment choice in pressure therapy rental file
- Ensure Repositioning Schedule commenced
- Ensure Dynamic Mattress Checklist commenced
- Ensure all Pressure Ulcers Grade 2 EPUAP and above are documented in medical notes and recorded on HIRS

Conversion

1kg - 2.5lb
5kg - 12.5lb
10 - 25lb
1 stone - 14lb

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Waterlow Risk Assessment Tool - Score Table

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Date	Review date	A	B	C	D	E	F	G total	H total	I total	J total	Over all score	Outcome Skin Assessment	Action taken & comments (eg. mattress used	Signature
	Admission														

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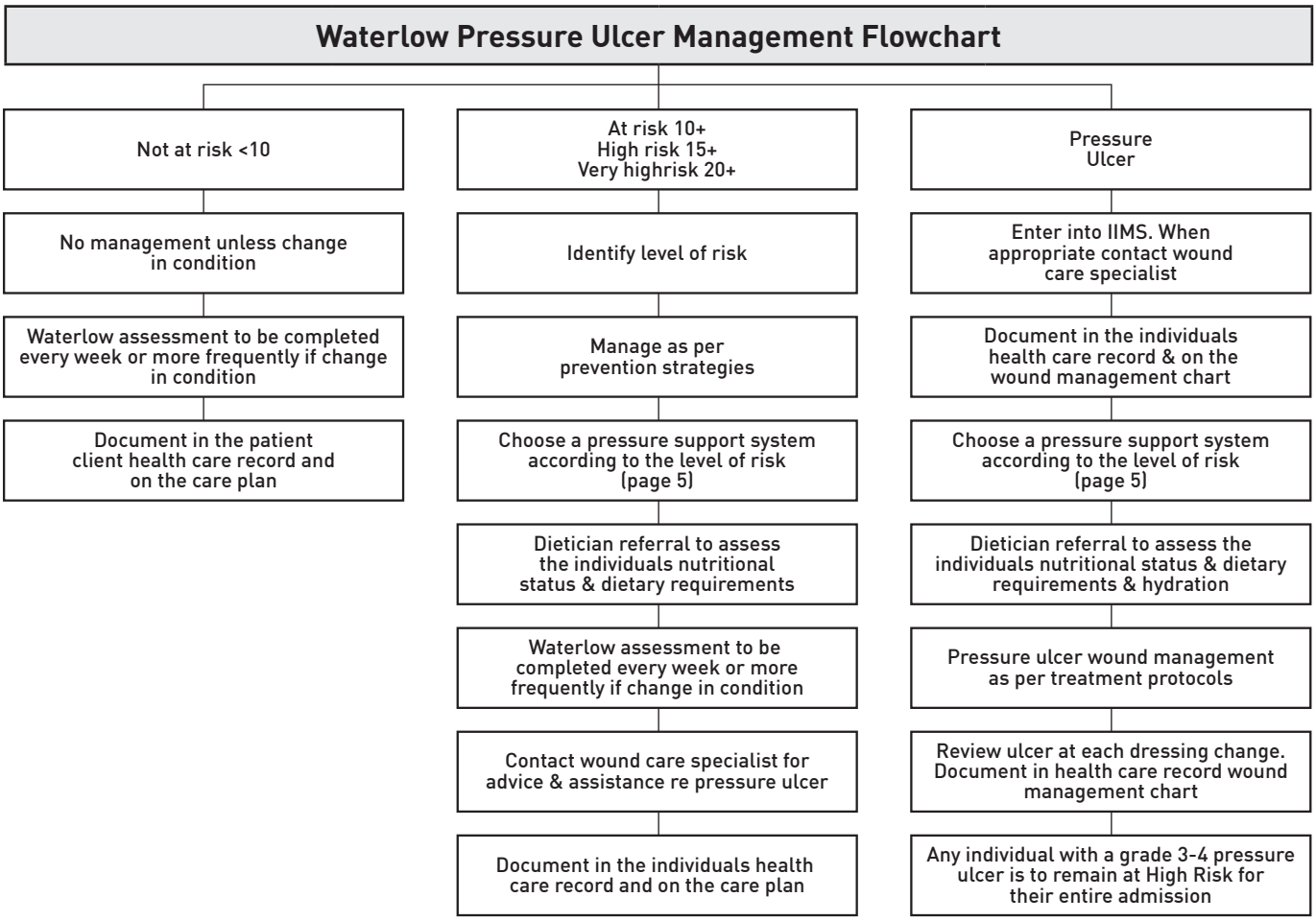
Waterlow Pressure Ulcer Management Flowchart



Service required	Yes or No	Date contacted	Signature
Entered into IIMS			
Equipment hire required			
Company contacted			
Wound care specialist			
Dietician			
Interventional strategies implemented			

Please note: any patient that has suffered a Stage 3 or 4 pressure ulcer in the past is 'At Risk' of developing another and is to be treated as HIGH RISK throughout their entire admission.

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Summary of Prevention Strategies

- Assess all patients/clients using the Waterlow Pressure Ulcer Risk Assessment Tool
- Assess the patient/clients nutrition, function, continence and general medical condition
- Involve all relevant members of the multi-disciplinary team
- Initiate the following interventions and evaluate the outcomes

Maintain skin integrity

- Conduct a daily systematic skin inspection of 'at risk individuals for signs of impaired skin integrity
- Eliminate or minimise all potentially irritating skin substances
- Stabalise skin & body temperature
- Promote continence training/ assessment & self care independence

Eliminate pressure, shear & friction

- Avoid direct contact between bony prominences with pillows or foam wedges
- Keep the head of the bed at the lowest level for the individuals condition
- Relive heel pressure in bed bound individuals or with immobilised lower limbs

Initiate positioning, turn schedule & support surface

- Employ proper lifting & manual handling techniques
- Maximise individuals activity & mobilisation consistent with medicl condition & ability
- Reposition individuals according to their risk status and as frequently as skin's tolerance dictates
- Allocate an appropriate support surface for identified level or risk. Use in conjunction with an individualised turning regimen
- Avoid prolonged uninterrupted sitting in a chair or wheelchair (> two hours)
- Avoid positioning patients on the trochanter

Document & communicate

- Involve relevant members of the multi-disciplinary team
  - physiotherapist
  - occupational therapist
  - dietician
  - medical staff
  - nursing staff
- Document clearly all risk assessments, interventions & outcomes
- Document clearly all risk assessments, interventions & outcomes

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Pressure Ulcer Grades

Grade	Definition	Explanatory notes
One	Observable pressure-related alteration(s) of intact skin may include changes in one or more of the following: skin temperature (warmth or coolness) tissue consistency (firm or boggy feel) and/or sensation(pain/itching).	The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue and purple hues.
Two	Partial thickness skin loss involving epidermis and/or dermis.	The pressure ulcer is superficial and presents clinically as an abrasion, blister or shallow crater. Can present as necrotic tissue or eschar.
Three	Full thickness skin loss involving damage or necrosis to subcutaneous tissue and extending down to, but not through, the underlying fascia.	The ulcer presents clinically as a deep crater with or without undermining of the adjacent tissue.
Four	Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures(for example, tendon or joint capsule).	Undermining and sinus tracts may also be associated with Grade 4 pressure ulcers.

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Intervention Guidelines

Pressure Ulcer Grade 1

Objective	Recommendation
Relive pressure	Establish a repositioning regime. If indicated, use pressure relieving devices according to Pressure Score Risk Assessment and the Pressure Ulcer Prevention Protocol Flow Chart.
Prevent friction and sheering	Do not drag patient. Use correct manual handling technique and appropriate equipment
Protect skin from moisture	Use continence management systems. Use barrier skin cream to prevent skin maceration. Gently clean site, rinse and dry well daily. Keep site clean and dry.
Protect fragile skin and bony prominences	Dermal pad, heel protector, hydrocolloid

Pressure Ulcer Grade 2 & 3 - Grade 1 plus the following

Objective	Recommendation
• Promote new tissue formation • Remove / conrtol exudate	• Attend dressing using appropriate materials Change dressing when strike through occurs or PRN. • Change dressing daily if wound infected.

Pressure Ulcer Grade 4 - Grade 1,2 & 3 plus the following

Objective	Recommendation
Treat infection and control any odour	In addition to surgical debridement systemic antibiotic cover is recommended.
Debride necrotic area	Surgical debridement is required for all necrotic wounds or as per Facility / Community Health Centre Policy. The size of the wound will determine if debridement is attended in OT or in the clinical area.

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Devices

Establish a repositioning regime. If indicated, use pressure relieving devices according to Pressure Score Risk Assessment and the Pressure Ulcer Prevention Protocol Flow Chart.

Type of device	Description	Example	Waterlow score
Static pressure relieving/ reducing device	• Support Surfaces can contain foam, gel, air or water. • Reduce pressure by increasing the supporting surface area (by) conforming to the body. • Decrease friction and shearing. • Also includes seating devices.	Standard Hospital Mattress Pressure relieving mattress • Contoured foam • Different density foam Mattress Overlay (Placed on top of hosp mattress) • Foam Fibre Filled • Air filled	10 + Medium risk
Dynamic pressure relieving/reducing	• Non-powered overlay support surface • Dynamic air filled chambers that allow air exchange between compartments when compressed.	Mattress Overlay • Air-filled chambers	15 + High risk
Alternating pressure relieving/reducing system	• Consists of rows of cells that deflate and inflate alternately. • Transfer pressure loading from one body part to another. • Come as mattress overlay or mattress replacement • Also includes seating devices	1. **Mattress Overlay** (Placed on top of hosp mattress) • 2 Cell Cycle	15 + High risk
		2. **Mattress Replacement** • 2 Cell Cycle	20 + Very high risk Existing pressure ulcers
Speciality beds	**Low Air Loss**: Pressure reduction for very high Risk patients. Ideal for patients who are unable to tolerate moving surface. For example: Plastic Surgery	Mattress Replacement • Overall low air loss cells	Burns Unit and Critical Care

Note: The above is not an exhaustive list of products available. Manufacturer's instructions need to be followed.

Devices not recommended for the prevention of pressure ulcers

- Doughnut cushion- not recommended as it reduces tissue oxygenation and the centre of the ring can create tissue congestion and pressures in the areas surrounding the donut.
- Massage - Not necessary and no evidence that prevention of pressure ulcers occurs.
- Sheep skin - Can relieve friction but does not relieve pressure.
- Cream – No evidence to support it relieves pressure or friction.
- Water filled gloves / casks – Not recommended