WATERLOW PRESSURE AREA CHART

Name	DOB	Admission Date	Ward	Diagnosis

Question/Area to explore	Score Value	Date	Date	Date	Date
Gender	x	x	x	x	x
Female	2				
Male	1				
Age	x	x	x	x	x
14-49	1				
50-64	2				
65-74	3				
75-80	4				
81+	5				
Height-Weight: BMI	x	x	x	x	x
Average 20 – 24.9	0				
Above average 25 – 29.9	1				
Obese above 30	2				
Below Average below 20	3				
Skin Type-Visual Risks Area	x	x	x	x	x
Healthy	0				
Tissue paper	1				
Dry	1				
Oedematous	1				
Discoloured	2				
Broken spots	3				
Mobility	x	x	x	x	x
Fully mobile	0				
Restless/fidgety	1				
Lethargic	2				
Restricted	3				
Inert/Traction	4				
Chair bound	5				
Continence	x	x	x	x	x
Complete/catheterised	0				
Occasion incontinence	1				
Cath/incontinent of faeces	2				
Doubly incontinent (urine & faeces)	3				
Appetite	x	x	x	x	x
Average	0				
Poor	1				
Naso-gastric tube/Fluids only	2				
Nil by mouth/Anorexia	3				

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Question/Area to explore	Score Value	Date	Date	Date	Date
Special Risks-Tissue Malnutrition	x	x	x	x	x
Terminal cachexia	8				
Cardiac Failure	5				
Peripheral Vascular disease	5				
Anaemia	2				
Smoking	1				
Special Risks-Neurological Deficits	x	x	x	x	x
Diabetes/MS/CVA-unconsious patient/Motor-sensory paraplegia	4-6				
Special Risks-Major Surgery/Trauma	x	x	x	x	x
Orthopaedic/below waist/spinal	5				
On table/trolley A&E more than 2 hours	5				
Special Risks-Medication high dose steroids, cytotoxics, anti-inflammatory	x	x	x	x	x
None	0				
1 medical preparation	1				
2 medical preparations	2				
3 medical preparations	3				
4 or more medical preparations	4				
Score page 1 + Score page 2 = TOTAL SCORE	x				
Signature	x				

Score: 10+ At Risk; 15+ High Risk; 20+ Very High Risk

ASSESSMENT

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 DEFINITIELY BE NECESSARY

PREVENTION

PREVENTATIVE AIDS:

SPECIAL MATTRESS/BED:

10+OVERLAY OR SPECIALIST FOAM MATTRESS I.E SPHENCO OR VAPERM OVERLAY
15+MIP ANATOMIC SUPPORT MATRESS OR LOW AIR OR ALTERNATING PRESSURE MATTRESS I.E. PEGASUS, NIMBUS, CLINIREST
20+LOW AIR LOSS AND ALTERNATING PRESSURE MATTRESS I.E.PEGASUS, NIMBUS, CLINIREST OR FLUIDISCO BEAD BED IF ORDERED

CUSHIONS:
NO PATIENT SHOULD SIT IN A WHEELCHAIR WITHOUT SOME FORM OF CUSHIONING. IF NOTHING IS AVAILABLE, USE THE PATIENTS OWN PILLOW.

10+ = 4" FOAM CUSHION
15+ = SPECIALIST GEL AND/OR FOAM CUSHION
20+ = CUSHION CAPABLE OF ADJUSTMENT TO SUIT INDIVIDUAL PATIENT

BED CLOTHING:
AVOID PLASTIC DRAW SHEETS, INCO PADS AND TIGHTLY TUCKED IN SHEETS, SHEET COVERS, ESPECIALLY WHEN USING SPECIALIST BED AND MATTRESS. OVERLAY SYSTEMS

NURSING CARE

GENERAL:

FREQUENT CHANGES OF POSITION, USE . CLINICAL JUDGEMENT
USE OF PILLOWS

PAIN
APPROPRIATE PAIN CONTROL

NUTRITION:
HIGH PROTEIN, VITAMINS, MINERALS

PATIENT HANDLING
CORRECT LIFTING TECHNIQUE
HOISTS
MONKEY POLE
TRANSFER DEVICES
REAL SHEEPSKINS
BED CRADLE
4" COVER PLUS ADEQUATE PROTECTION

SKIN CARE
GENERAL HYGIENE, NO RUBBING
CORRECT LIFTING AND POSITIONING
COVER WITH APPROPRIATE DRESSING

IF TREATMENT IS REQUIRED, FIRST REMOVE PRESSURE

WOUND CLASSIFICATION:

NON-BLANCHING HYPERAEMIA STAGE 1 IS WOUND **RED**, CLEAN BUT NOT HEALED? HYDROCOLLOID, ALGINATE, HYDROGEL, SILASTIC FOAM (DEEP)

ULCERATION PROGRESSES STAGE 2 IS WOUND **YELLOW**/INFECTED/INFLAMED? ALGINATE, HYDROGEL, HYDROCOLLOID.

ULCERATION EXTENDS STAGE 3 INFECTED? ALGINATE RIBBON OR ROPE, NON ADHERENT TOPICAL ANTI-MICROBIAL DRESSING, POLYSACCHARIDE PASTE.

INFECTIVE NECROSIS STAGE 4 IS WOUND **BLACK**/NECROTIC? DEBRIBE-SURGICAL EXCISION, HYDROCOLLOID, HYDROGEL, ENZYMATIC TREATMENT.