

An initial assessment
will provide a
baseline nursing
essay



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Waterlow and assessment

Mrs A is a 84 year old lady who has been referred to the district nurses by the G. P. as he has concerns regarding her pressure areas . Following a recent fall Mrs A has lost her confidence and is now house bound, spending more time in her chair. She has a history of high blood pressure for which she currently takes medication. She has no history of previous falls or problems with her balance.

Mrs A is more vulnerable to pressure damage as her skin has become more fragile and thinner with age. Due to Mrs A spending more time sitting in her chair she has become at a higher risk of developing a pressure sore. A pressure sore is an area of localised damage to the skin and underlying tissue this can be caused by pressure, friction or sheering. (EPUAP 1998). It becomes difficult for the blood to circulate causing a lack of oxygen and nutrients to the tissue cells. Furthermore, The lymphatic system also begins to suffer and becomes unable to properly remove waste products. If the pressure continues and is not relieved by equipment or movement, the cells begin to die leaving an area of dead tissue resulting in pressure damage.

In order to establish Mrs A's current risk of developing a pressure area a assessment must take place. An initial assessment will provide a baseline that will identify Mrs A's level of risk as well as identifying any existing pressure damage. The assessment tool used throughout my area of work is The Waterlow Scale was researched and developed by Judy Waterlow. The Waterlow Scale is used to measure a patient's risk of developing a pressure sore and can also be used as a guide for the ordering of effective pressure

relieving equipment. The Waterlow scale assessment tool was first put into practice in 1985 (Waterlow, 1985). The use of the Waterlow tool enables the nurse to assess each patient according to their individual risk of developing pressure sores (Pancorbo-Hidalgo et al., 2006). The scale illustrates a risk assessment scoring system and on the reverse side provides information and guidance on wound assessment, dressings and also preventative aids. Also equipment surrounding the three levels of risk highlighted on the scale. It also provides guidance concerning the nursing care given to patients. Although the Waterlow score is used in the community setting when calculating the risk assessment score it is vital that the nurse is aware of the difference in environment the tool was originally developed for.

The tool covers two factors intrinsic which include Disease, medication, malnourishment, age, dehydration / fluid status, lack of mobility, incontinence, skin condition and weight. Also extrinsic factors which refers to external influences which cause skin distortion such as Pressure, Shearing Forces, Friction, and moisture. There is also a special risk section of the tool which can be used if the patient is on certain medication or recently had surgery. This contributes to a holistic assessment of a patient and enables the practitioner to provide the most cost effective and appropriate pressure relieving equipment.

The score is calculated by counting the scores given in each category which apply to your patient's current condition. Once these have been added up you will have your 'at risk' score, this will then indicate the steps that need to be taken in order to provide the appropriate level of care to the patient.

Identification of a patient's risk of developing a pressure sore is often
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considered the most important stage in pressure sore prevention (Davis 1994).

When using the Waterlow tool to assess Mrs A's pressure risk I found she had a score of 9. According to the Waterlow scoring system Mrs A is not considered as being at risk as her score is less than 10. As I had identified in my assessment she had a score of 2 for her skin condition due to grade 1 pressure damage I felt it necessary to highlight her as being at risk.

During the assessment of Mrs A I have identified she has a grade 1 pressure sore on her sacral area this maybe due to her recent loss of confidence and spending more time in her chair. Grade 1 pressure damage is defined as a non-blanchable erythema of intact skin. Indicators can be discolouration of the skin, warmth, oedema, induration or hardness particularly in people with darker pigmentation (EPUAP, 2003). It is believed by some practitioners that blanching erythema indicates grade 1 pressure damage (Hitch 1995) others suggest that grade 1 pressure damage is present when there is non-blanching erythema (Maklebust and Margolis, 1995; Yarkony et al, 1990). The majority of clinicians agree that temperature and colour play an important role in identifying grade 1 pressure ulcers (European Pressure Ulcer Advisory Panel, 1999) and erythema is a category in almost all classifications (Lyder, 1991). The pressure damage usually occurs over bony prominences (Barton and Barton 1981). The skin in a grade 1 pressure ulcer is not broken but it requires protection and monitoring. At this stage it will not be known how deep the pressure damage is and regular monitoring is essential. The pressure ulcer may fade but if the damage is deeper than

the superficial layers of the skin, this wound could develop into a much deeper pressure ulcer over the following days or weeks.

A grade 1 pressure ulcer is classed as a wound and so I have commenced a wound care plan and also a pressure area care plan. I will also ensure Mrs A has regular pressure area checks in order to prevent the area breaking down. Dressings can be applied to a grade 1 pressure ulcer they should be simple and offer some level of protection. Also to prevent any further skin damage a film dressing is often used or a hydrocolloid to protect the wound area. These dressings will assist in reducing further friction or shearing if these factors are involved.

The advice given to practitioners on the reverse of the Waterlow tool is to provide a 100mm foam cushion if a patients risk score is above 10 (Waterlow, 2005). As Mrs A has an ' at risk' of 9 with a grade 1 pressure sore evident I feel it appropriate to provide the pressure relieving cushion to prevent any further pressure damage developing. As I am providing a cushion it is not felt necessary to apply a dressing at this point. However the area will need regular monitoring as at this stage it is unknown how deep the pressure damage is. If proactive care is given in the prevention and treatment of pressure ulcers with the use of risk assessments and providing pressure-relieving resources the pressure area may resolve. Pressure ulcers can be costly for the NHS, debilitating and painful for the patient. With basic and effective nursing care offered to the patients this can often be the key to success.

Bliss (2000) suggested that majority of grade I ulcers heal or resolve without breaking down if pressure relief is put into place immediately. However, experiences in a clinical settings supports observations that non-blanching erythema can often result in irreversible damage (James, 1998; Dailey, 1992).

Although there are various tools which have been developed to identify a patients individual risk of developing pressure sores. The majority of scales have been developed based on ad hoc opinions of the importance of possible risk factors (EHCB, 1995). The predictive validity of these tools has also been challenged (Franks et al, 2003; Nixon and Mc Gough, 2001) suggesting they may over predict the risk, incurring expensive cost implications as preventative equipment is put in place when it may not always be necessary. Or they may under predict risk so that someone assessed as not being at high risk develops a pressure ulcer.

Although The Waterlow (2005) scoring system now includes more objective measurements such as BMI and weight loss after a recent update. It is still unknown due to no published information whether the inter-rater reliability of the tool has been improved by these changes. It has been acknowledged that this is a fundamental flaw of these tools and due to this clinical judgement must always support the decisions made by the results of the risk assessment. This is clearly recognise by NICE as they advise their use as an aide-mémoire (2001).

Assessment of the intrinsic factors that may increase a person's risk of pressure ulcer development usually involves the use of a formal assessment

tool such as Waterlow (2005, 1985) or Braden (Bergstrom et al, 1987).

Despite the plethora of risk-assessment tools there is little robust evidence clearly identifying the risk factors that have a direct correlation with pressure damage (Clark, 2004). If this were the case the tools would identify correctly all those who will develop a pressure ulcer (sensitivity) and all those who will not (specificity) (Nixon and McGough, 2001).