Nursing Information 4

Important information for the use of pressure ulcer assessment scales

IGAP
Institute for Innovations in Healthcare
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Dear reader,

First of all, it is very important to determine the decubitus risk of a patient in order to prevent the development of pressure sores. To assess this risk, a standardised risk investigation should be made via an established scale. For the reliable applica-tion, a current knowledge about the origination of pressure sores and the affect of pressure sore risk factors is required. Additionally, nurses have to be trained carefully in the practical use with the scales. A training based on theories is not sufficient. Most import is, that nurses have the knowledge, which scale is most appropriate for their patients. Unfortunately, the universally applicable scale does not exist.

Which scale should be used ?

There is uncertainty above the question „Which scale shall we use in our institu-tion?“ at many of the nurses. In the past, the most common scale in Germany was the „Norton-Scale (according to Bienstein). Nowadays, other scales, like the Braden-Scale, enter the German nursing. But as already mentioned, there is no scale, which fits for every setting.

For the intensive care, the **Braden-Scale** is highly recommended.
The reliability of this scale is relatively high, as the individual points are described in great detail. In this point, the Norton-Scale is comparatively imprecise.

The **Medley-Scale** is, like the Braden-Scale, a further development of the Norton-Scale. Additionally to the risk factors of the Norton-Scale, the factors „dangerous illnesses“, „diet“ and „pain“ complete the Medley-Scale. The assessment of the pain factor is the particularity of this scale.

The **Waterlow-Scale** is suitable for the surgery area of acute hospitals. This scale is more complex and complicated in administration than the scales named above. The Waterlow-Scale is being used in Great Britain successfully for years.

Finally, we would like to point out that the modified Norton-Scale is not suitable for risk assessment of geriatric patients. The MDS (Medical Service in Germany) advises not to use this scale.

Who should carry out the risk assessment ?

The pressure ulcer assessment should be carried out by nurses only. Here, we include nurses, medical attendants, children`s nurses and old people`s nurses.

How often should the pressure sore risk be evaluated ?

The pressure sore risk should be evaluated immediately when beginning the caring order. A second assessment after 24 to 48 hours can be useful. The assessments have to be repeated according to an individually fixed timetable. These intervals are based on the general condition of the patient. For example, for intensive-care patients, a daily assessment can be necessary. However, for geriatric patients assessment intervals of 7 or 14 days can be sufficient.

For which patients should the pressure sore risk be evaluated ?

The pressure sore risk can be excluded for a lot of patients from the start. If we are talking about an active and mobile patient (no wheelchair driver) the possibility of the occurrence of a pressure sore is more than low. The estimation of the pressure sore risk has to be made always then, if a risk cannot be excluded from the start.

Decubitus-Risk-Monitoring

In the last few years, a few researches about the subject – pressure sores - have been published. One of the most outstanding researches was about the development of a Decubitus-Risk-Monitoring. This computer-assisted diagnostic system (Thevo-DeRM) measures the quality and quantity of patient movements and determines with the help of the Braden-Scale, the current and objective pressure sore risk of the patient.

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