

Pressure Ulcer (Risk) Assessment: Recommendations to improve Nursing Practice

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Introduction & Objectives: Pressure ulcer (risk) assessment is complex and multifactorial (Braden, 2012; Cox, 2011). National (DGS, 2011) and international (NPUAP, EPUAP, & PPPIA, 2014) guidelines give orientations about pressure ulcer (PU) management and provide important recommendations for clinical practice and clinical research. However, it's necessary to know our reality in order to improve Evidence-Based Nursing. The aims of this study were: To gain more insight into the magnitude of PU problem in general wards of a Portuguese hospital; To provide recommendations to improve clinical practice and patients outcomes.

Methods: Retrospective cohort analysis of electronic health record database from adult patients admitted to medical and surgical wards in a Portuguese hospital during one year.

Results and Discussion: Sample of 8147 participants (Sardo, 2017). 34.4% had “high risk” of PU development at the first PU risk assessment in inpatient setting (Sardo et al., 2015). 7.9% had (at least) one PU at the first skin and tissue assessment in inpatient setting (Sardo, Simões, Alvarelhão, Costa, et al., 2016). 3.4% developed (at least) one PU during the length of inpatient stay (Sardo, Simões, Alvarelhão, Simões, et al., 2016). (Im)“mobility” was the major risk factor assessed through Braden Scale for PU development. However, there are important PU risk factors (such as age, the cause and type of admission, the length of inpatient stay and the presence of a PU) that should be considered in nursing care plan (Sardo, 2017). There was no formal assessment tool to record PU/wounds characteristics and their evolution during the length of stay.

Conclusions: The systematic PU risk assessment is sensitive to patient clinical changes, should be performed since the hospital admission and should be used in combination with nursing clinical judgement in order to implement accurate nursing interventions. The systematic skin and tissue assessment identifies early changes in skin and tissue condition, should be performed since the hospital admission and should identify wounds of different aetiologies. The PU assessment could be improved with the implementation of a validated tool in order to standardised data record, to

monitor PU/wounds characteristics and their evolution during the length of stay.

Palavras-chave: *Avaliação em enfermagem; Escala de Braden, Fatores de risco; Úlcera por pressão.*

Keywords: *Braden Scale; Nursing assessment; Pressure ulcer; Risk factors.*

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