Evidence-Based Clinical Assessment Toolkit

Complex Health Assessment Pack

AACS
APPLIED AGED
CARE SOLUTIONS

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Contents

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

How to use scale: While observing the resident, score questions 1 to 6

Name of resident: _____

Name and designation of person completing the scale: _____

Date: _____ Time: _____

Latest pain relief given was _____ at _____ hours

Q1. Vocalisation
eg. whimpering, groaning, crying
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q1 ☐

Q2. Facial Expression
eg. looking tense, frowning, grimacing, looking frightened
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q2 ☐

Q3. Change in Body Language
eg. fidgeting, rocking, guarding part of body, withdrawn
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q3 ☐

Q4. Behavioural Change
eg. increased confusion, refusing to eat, alteration in usual patterns
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q4 ☐

Q5. Physiological Change
eg. temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q5 ☐

Q6. Physical Changes
eg. skin tears, pressure areas, arthritis, contractures, previous injuries
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q6 ☐

- Add scores for 1 - 6 and record here → **Total Pain Score** ☐
- Now tick the box that matches the Total

☐ 0-2 - No Pain ☐ 3-7 - Mild ☐ 8-13 - Moderate ☐ 14 + - Severe

- Finally, tick the box which matches the type of pain

☐ Chronic ☐ Acute ☐ Acute on Chronic

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 - 2002

Pain Assessment IN Advanced Dementia - PAINAD

	0	1	2	SCORE
Breathing Independent of Vocalisation	Normal	Occasional laboured breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations	
Negative Vocalisation	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial Expression	Smiling, or inexpressive	Sad. Frightened. Frown	Facial grimacing	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigids. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
			TOTAL	

Warden, Hurley and Volicer 2003

Pain Assessment IN Advanced Dementia - PAINAD

Item definitions

Breathing

1. **Normal breathing**
   DESCRIPTION: Normal breathing is characterized by effortless, quiet, rhythmic (smooth) espirations.
2. **Occasional labored breathing**
   DESCRIPTION: Occasional labored breathing is characterized by episodic burst of harsh, difficult or wearing respirations.
3. **Short period of hyperventilation**
   DESCRIPTION: Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. **Noisy labored breathing**
   DESCRIPTION: Noisy labored breathing is characterized by negative sounding respirations or inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
5. **Long period of hyperventilation**
   DESCRIPTION: Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. **Cheyne-Stokes respirations**
   DESCRIPTION: Cheyne-Stokes respirations is characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnoea (cessation of breathing).

Negative Vocalization

1. **None**
   DESCRIPTION: None is characterized by speech or vocalization that has a neutral or pleasant quality.
2. **Occasional moan or groan**
   DESCRIPTION: Occasional moaning is characterized by mournful or murmuring sounds, wails or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. **Low level speech with a negative or disapproving quality**
   DESCRIPTION: Low level speech with a negative or disapproving quality is characterized by muttering, mumbling, whining, grumbling or swearing in a low volume with a complaining, sarcastic or caustic tone.
4. **Repeated troubled calling out**
   DESCRIPTION: Repeated troubled calling out is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.

5. **Loud moaning or groaning**
   DESCRIPTION: Loud moaning is characterized by mournful or murmuring sounds, wails or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. **Crying**
   DESCRIPTION: Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial Expression

1. **Smiling or inexpressive**
   DESCRIPTION: Smiling is characterized by upturned corners of the mouth, brightening of the eyes and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. **Sad**
   DESCRIPTION: Sad is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. **Frightened**
   DESCRIPTION: Frightened is characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.
4. **Frown**
   DESCRIPTION: Frown is characterized by a downward turn of corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. **Facial grimacing**
   DESCRIPTION: Facial grimacing is characterized by a distorted, distressed look. The brow is more wrinkled as is the area around the mouth. Eyes may be squeezed shut.

Body Language

1. **Relaxed**
   DESCRIPTION: Relaxed is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. **Tense**
   DESCRIPTION: Tense is characterized by a strained, apprehensive or worried appearance. The jaw may be clenched (exclude any contractures).
3. **Distressed pacing**
   DESCRIPTION: Distressed pacing is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may by faster or slower.
4. **Fidgeting**
   DESCRIPTION: Fidgeting is characterized by restless movement. Squirming about or wriggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging or rubbing body parts can also be observed.
5. **Rigid**
   DESCRIPTION: Rigid is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding (exclude any contractures).

6. **Fists clenched**
   DESCRIPTION: Fists clenched is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. **Knees pulled up**
   DESCRIPTION: Knees pulled up is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance (exclude any contractures).
8. **Pulling or pushing away**
   DESCRIPTION: Pulling or pushing away is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him or herself free or shoving you away.
9. **Striking out**
   DESCRIPTION: Striking out is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. **No need to console**
   DESCRIPTION: No need to console is characterized by a sense of well being. The person appears content.
2. **Distracted or reassured by voice or touch**
   DESCRIPTION: Distracted or reassured by voice or touch is characterized by a disruption in the behaviour when the person is spoken to or touched. The behaviour stops during the period of interaction with no indication that the person is at all distressed.
3. **Unable to console, distract or reassure**
   DESCRIPTION: Unable to console, distract or reassure is characterized by the inability to soothe the person or stop a behaviour with words or actions. No amount of comforting, verbal or physical, will alleviate the behaviour.

Warden V, Hurley AC, Volicer L. Development and psychometric scale. *Journal of American Medical Directus, 4(1)*: 9-15, 2003

Modified Residents' Verbal Brief Pain Inventory (M-RVBPI)

(Adapted from Cleeland, 1989, by the Australian Pain Society, 2005, & Toye et al., 2005)
Note: This questionnaire is to be answered at interview

Date: _____ Time: _____ Name: _____

1. Have you had any pain in the past 24 hours?
Prompts: An ache; feeling tender; hurting; feeling stiff and sore; headache.

Please tick: ☐ YES ☐ NO

USE THE PROMPTS FOR PAIN FROM THIS ITEM THROUGHOUT THE QUESTIONNAIRE, AS NEEDED

Now, bearing in mind the resident's usual abilities, and to assess the resident's pain on movement, please ask the resident to move in the way that he/she is usually able to move (e.g, walk, rise to a standing position and then sit down again, turn over in bed, bend and/or raise their arms and legs, as appropriate).

Please state movement(s) made _____

2. (a) Did you have any pain when you were moving just now?

Please tick: ☐ YES ☐ NO

(b) Where was the pain when you were moving? Show body map

Location(s) _____

(c) And how bad was your pain when you were moving, just now?

Please tick: ☐ NO PAIN ☐ MILD ☐ MODERATE ☐ SEVERE

Note: use the flip chart showing these response options in large font, if the individual is able to see them. If the individual reports no pain using either of these two items, this is the end of the pain check.

Otherwise, please continue

3. Please tell me more about all the pain or pains you have had in the past 24 hours (show body map). Show me <u>all</u> the places where the pain is or has been.

List pain sites _____

_____

_____

Now please think about your pain overall, whether it is in one place or in more than one place.
Note: continue to use the flip chart showing No Pain/Mild/Moderate/Severe if the resident is able to read the font.

4. In the past 24 hours, how bad has the pain been at its worst?
Prompts: most troublesome, when it was as bad as it got.

Please tick: ☐ NO PAIN ☐ MILD ☐ MODERATE ☐ SEVERE

5. In the past 24 hours, how bad has the pain been at its least?
Prompts: least troublesome or not there at all, when it was as good as it got.

Please tick: ☐ NO PAIN ☐ MILD ☐ MODERATE ☐ SEVERE

6. How bad is your pain now?

Please tick: ☐ NO PAIN ☐ MILD ☐ MODERATE ☐ SEVERE

NOW CHANGE TO THE FLIP CHART SHOWING THE OPTIONS NO EFFECT - SEVERE EFFECT

7. In the past 24 hours, please tell me how much pain has had an effect on your walking ability (if applicable)?

Please tick here if the person is unable to walk (regardless of pain) ☐
Otherwise, please tick below:

☐ NO EFFECT ☐ MILD EFFECT ☐ MODERATE EFFECT ☐ SEVERE EFFECT

8. Please tell me how much pain has had an effect on your general activity in the past 24 hours?
Prompts: the things that you do each day (give appropriate examples such as eating breakfast, selecting clothing for the day, combing hair).

Please tick:

☐ NO EFFECT ☐ MILD EFFECT ☐ MODERATE EFFECT ☐ SEVERE EFFECT

9. In the past 24 hours, how much has pain had an effect on your interactions with other people?
Prompts: chatting, saying hello, answering when others speak to you, smiling at other people.

Please tick:

☐ NO EFFECT ☐ MILD EFFECT ☐ MODERATE EFFECT ☐ SEVERE EFFECT

THANK YOU

References:

1. Australian Pain Society (2005). *Pain in residential aged care facilities: Management strategies*
2. Cleeland, C. S. (1989). Measurement of pain by subjective report. In C. R. Chapman & J. D. Loeser (Eds.), *Advances in pain research and therapy: Vol 12. Issues in pain management* (pp 391-403). New York: Raven Press.
3. Auret, K. A., Toye, C., Goucke, R., Kristjanson, L. J., Bruce, D., & Schug, S. (2008). Development and testing of a modified version of the Brief Pain Inventory for use in residential aged care facilities. *Journal of the American Geriatrics Society*, 56 (2), 301-306.

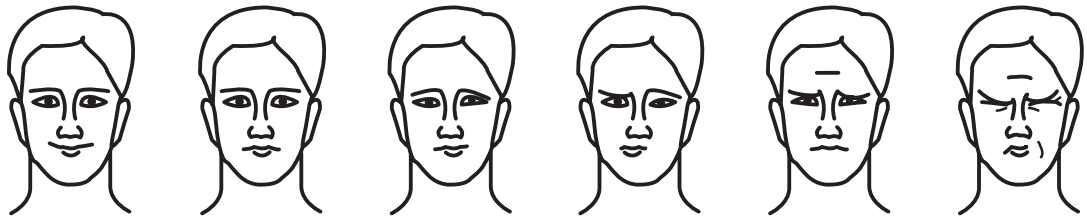
place photo here

Name:

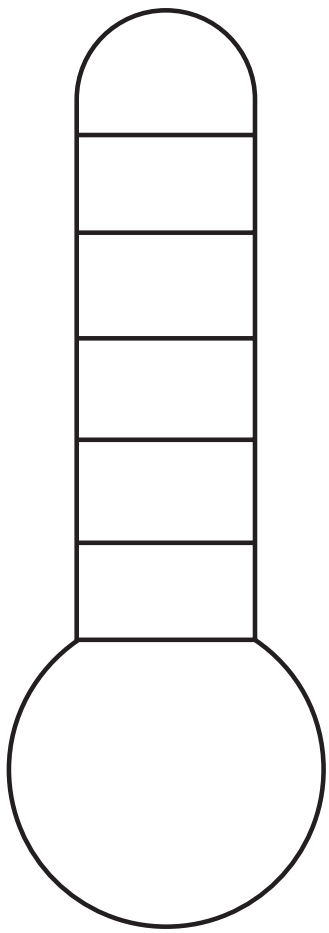
DOB: Room No:

PLACE ID LABEL HERE

VISUAL ANALOGUE PAIN SCALES



1 2 3 4 5 6



Pain as bad as it could be

Extreme pain

Severe pain

Moderate pain

Mild pain

Slight pain

No pain

Cited in Abraham & Synder (2001)

place photo here

Name:

DOB: Room No:

PLACE ID LABEL HERE

RESIDENTIAL CARE SERVICES SKIN INTEGRITY ASSESSMENT

Past history

Pressure ulcer .....

Leg ulcer .....

Sensitivities .....

Other .....

Health status

☐ Diabetes ☐ Poor circulation ☐ Poor nutrition

Other

(comment) .....

☐ Obese ☐ Thin

Oedema ☐ Yes ☐ No

Type .....

Area .....

☐ Incontinent urine ☐ Incontinent faeces

☐ Chair fast ☐ Bed fast ☐ Limited mobility

Skin

Dry skin

☐ Arms ☐ Legs ☐ Torso ☐ Face

Tissue-paper skin

☐ Arms ☐ Legs ☐ Torso

Other

(comment) .....

Excoriation or reddened areas

☐ Groin ☐ Abdominal flap ☐ Under breasts

☐ Axilla ☐ Neck ☐ Hands

Other

(comment) .....

Rash or allergies

☐ Arms ☐ Legs ☐ Torso ☐ Face

(describe) .....

Name:		PLACE ID LABEL HERE
DOB:	Room No:	

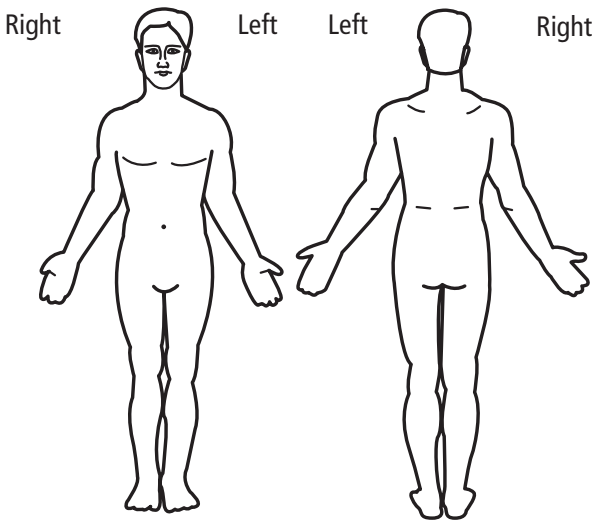
Bruises

☐ Arms ☐ Legs ☐ Torso

Other

(comment) .....

Show bruises, wounds, scars, excoriations, rashes, skin tears on diagram



Hair

☐ Stringy ☐ Dull ☐ Dry ☐ Thinning

☐ Lustrous ☐ Shiny ☐ Bald

Condition of scalp

☐ Healthy ☐ Dry ☐ Scaly

Other

(comment) .....

Nails

Fingernails

☐ Ingrown ☐ Overgrown ☐ Thickened

☐ Brittle ☐ Discoloured ☐ Corns or callouses

Toenails

☐ Ingrown ☐ Overgrown ☐ Thickened

☐ Brittle ☐ Discoloured ☐ Corns or callouses

☐ Overlapping ☐ Hammer toe ☐ Hallus vagus

Completed by:	Signature	Date
		/ /

place photo here

Name:

DOB: Room No:

PLACE ID LABEL HERE

RESIDENTIAL CARE SERVICES
WOUND ASSESSMENT AND PROGRESS CHART

Diabetes: ☐ Yes ☐ No

State type & management: .....

Smoker: ☐ Yes ☐ No

Respiratory illness: ☐ Yes ☐ No

Anaemia: ☐ Yes ☐ No

Nutritional status (eg, poor appetite, underweight, nil orally PEG feed) .....

.....

Type of wound (describe): .....

.....

Duration of wound: .....

Quality of surrounding skin .....

☐ Inflamed ☐ Macerated ☐ Friable ☐ Dry ☐ Crusty ☐ Fragile

Other (state): .....

Wound microbiology:

Swab taken: ☐ Yes ☐ No If yes, date taken: ___/____/____

Result: .....

Sensitivities: .....

Antibiotics required: ☐ Yes ☐ No If yes, type & dosage: .....

Allergies to dressings ☐ Yes ☐ No

Specify: .....

Dressings

Date	Cleansing agent	Primary dressing	Secondary dressing	Bandage/ retention dressing	Frequency for change

Name:	PLACE ID LABEL HERE
DOB: Room No:	

Type of wound

☐ Skin tear ☐ Surgical ☐ Other

☐ Pressure ulcer ☐ Diabetic

☐ Leg ulcer ☐ Skin Cancer

Colour of wound

Estimate record % of wound surface that is covered by the corresponding colour

- B Black
- Y Yellow
- R Red

Volume of exudate

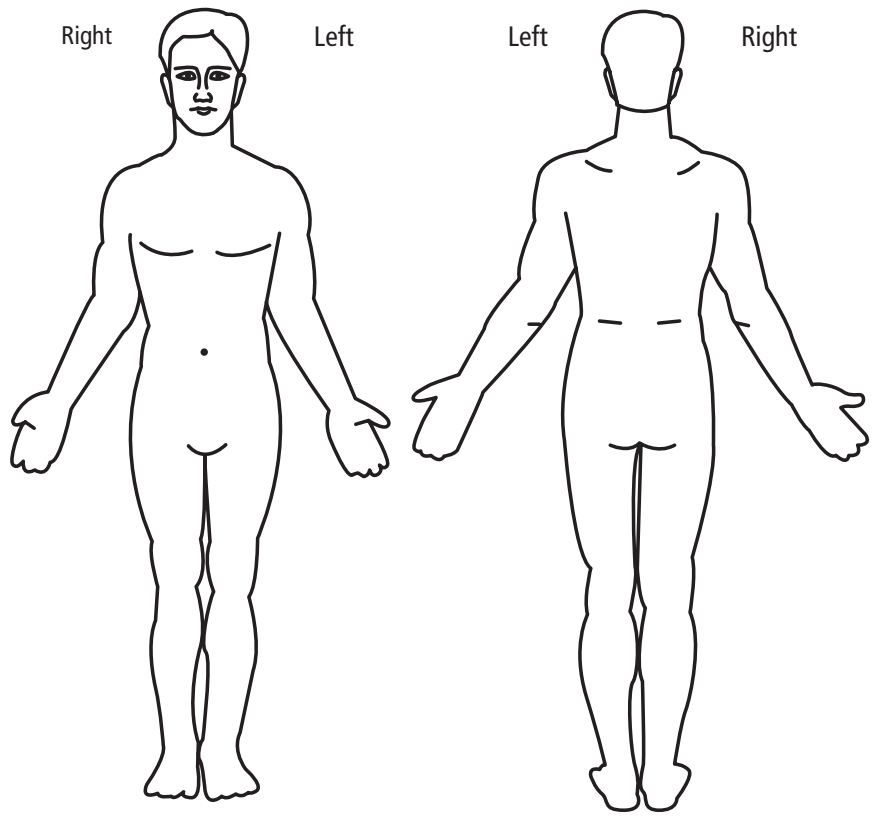
- N None
- S Small
- M Moderate
- H Heavy

Odour

- L Nil
- O Offensive

Wound depth score

Score	Description
1	superficial/epidermal layer
2	extending to dermal layer
3	extending to subcutaneous layer
4	extending to muscle/tendon/bone



Location (detail on diagram)

Intructions: Draw wound at each review (eg weekly, fortnightly etc) not at each dressing change

Completed by:	Signature	Date
		/ /

Name:		PLACE ID LABEL HERE
DOB:	Room No:	

Review date				
Dimension (draw wound & show measurement) A ↔ cm B ↕ cm				
Depth score				
Colour				
Volume of exudate				
Pain				
Comments				
Sign & date				
Review date				
Dimension (draw Wound & show Measurement) A ↔ cm B ↕ cm				
Depth score				
Colour				
Volume of exudate				
Pain				
Comments				
Sign & date				
Review date				
Dimension (draw Wound & show Measurement) A ↔ cm B ↕ cm				
Depth score				
Colour				
Volume of exudate				
Pain				
Comments				
Sign & date				

With permission from Vision Australia Fountain Slightly adapted

place photo here

Name:

DOB: Room No:

PLACE ID LABEL HERE

WATERLOW PRESSURE UCLER RISK SCALE

Circle scores in table, add total. Several scores per category can be used.

Build/weight for height

Average 0
Above average..... 1
Obese..... 2
Below average..... 3

Skin type visual risk areas

Healthy 0
Tissue paper..... 1
Dry 1
Oedmatous 1
Clammy (temp) 1
Discoloured..... 2
Broken spot..... 3

Sex/age

Male..... 1
Female 2
40-49 1
50-64 2
65-74 3
75-80 4
81+..... 5

Special risks

Tissue malnutrition
e.g. Terminal
cachexia..... 8
Cardiac failure 5
Peripheral
vascular disease..... 5
Anaemia 2
Smoking..... 1

Continence

Complete/
Catheterised..... 0
Occasionally
Incontinent..... 1
Cath/incontinent
of faeces 2
Doubly incont..... 3

Mobility

Fully 0
Restless/Fidgety 1
Apathetic ..... 2.
Restricted..... 3
Inert/Traction..... 4
Chairbound 5

Appetite

Average 0
Poor 1
N.G. Tube/
Fluids only..... 2
NBM/anorexic 3

Neurological Deficit

e.g. Diabetes, MS, C.V.A,
Motor sensory Paraplegia
Moderate 4
Mod-severe..... 5
Severe 6

Major Surgery/ Trauma

Orthopaedic—below
waist, spinal..... 5
On table>
2 hours..... 5

Medication

Cytotoxics 4
High dose Steriods
Anti-inflammatory

SCORE **10+ at risk** **15+ High risk** **20+ Very high risk** **Total**

Completed by: Signature Date

/ /

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Name:		PLACE ID LABEL HERE
DOB:	Room No:	

If the resident falls into any of the risk categories then preventative care is required.

Prevention:

PREVENTATIVE AIDS:

Special Mattress/Bed:

10+ Overlays or specialist foam mattresses.

15+ Alternating pressure overlays, mattresses and bed systems.

20+ Bed Systems: Fluidised, bead, low air loss and alternating pressure mattresses.

Note: Preventative aids cover a wide spectrum of specialist features. Efficacy should be judged, if possible, on the basis of independent evidence.

Cushions:

No patient should sit in a wheelchair without some form of cushioning. If nothing else is available—use the patient's own pillow.

10 + 10cm Foam cushion.

15+ Specialist gel and/or foam cushion.

20+ Cushion capable of adjustment to suit individual patient.

Bed Clothing:

Avoid plastic draw sheets, incontinent pads and tightly tucked in sheets/sheet covers, especially when using specialist bed and mattress overlay systems.

Use duvet—plus vapour permeable cover.

NURSING CARE

General:

Frequent changes of position, lying/sitting. Use of pillows.

Pain:

Appropriate pain control.

Nutrition:

High protein, vitamins, minerals.

Patient Handling:

Correct lifting technique: Hoists, Monkey Pole, Transfer Devices.

Patient Comfort Aids:

Real sheepskins, Bed Cradle

Operating Table:

Cover plus adequate protection

Theatre/A&E Trolley Skin Care:

General Hygiene, NO rubbing, cover with an appropriate dressing.

If treatment is required first remove pressure.

9 PHYS

Waterlow Pressure Ulcer Risk Scale

Name:		PLACE ID LABEL HERE
DOB:	Room No:	

Wound classification:

STIRLING PRESSURE SORE SEVERITY SCALE (SPSSS)

Stage 0

No clinical evidence of a pressure sore.

0.1 Healed with scarring.

0.2 Tissue damage not assessed as a pressure sore.

Stage 1

Discolouration of intact skin.

1.1 Non blanchable erythema with increased local heat.

1.2 Blue/purple/black discolouration— The sore is at least Stage 1 (a or b).

Stage 2

Partial thickness skin loss or damage.

2.1 Blister

2.2 Abrasion

2.3 Shallow ulcer, undermining of adjacent tissue.

2.4 Any of these with underlying blue/purple/black discolouration or induration. The sore is at least Stage 2 (a, b or c + d for 2.3, + e for 2.4).

Stage 3

Full thickness skin loss involving damage of subcutaneous tissue, not extending to underlying bone, tendon or joint capsule.

3.1 Crater, without undermining adjacent tissue.

3.2 Crater, with undermining of adjacent tissue.

3.3 Sinus, the full extent of which is uncertain.

3.4 Necrotic tissue masking full extent of damage.

The sore is at least Stage 3 (b, +/- e, f, g + h for 3.4).

Stage 4

Full thickness loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or capsule.

4.1 Visible exposure of bone tendon or capsule.

4.2 Sinus assessed as extending to same. (b, +/- e, f, g, h, I).

Guide to types of dressing/treatment

a Semi-permeable membrane

b Hydrocolloid

c Foam dressing

d Hydrogel

f Alginate rope/ribbon

g Foam cavity filler

h Enzymatic debridement

i Surgical debridement

Completed by:	Signature	Date
		/ /

place photo here

Name:

DOB: Room No:

PLACE ID LABEL HERE

BRADEN RISK ASSESSMENT SCALE

NOTE: Bed and chairbound individuals or those with impaired ability to reposition should be assessed upon admission for their risk of developing pressure ulcers. Residents with established pressure ulcers should be reassessed periodically.

Sensory Perception

Indicate Appropriate Numbers Below

Ability to respond meaningfully to pressure-related discomfort

1 Completely Limited

Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface.

2 Very Limited

Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort in over 1/2 of body.

3 Slightly Limited

Responds to verbal commands, but cannot always communicate discomfort or need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.

4 No Impairment

Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.

Moisture

Degree to which skin is exposed to moisture

1 Constantly Moist

Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.

2 Very Moist

Skin is often, but not always, moist. Linen must be changed at least once a shift.

3 Occasionally Moist

Skin is occasionally moist, requiring an extra linen change approximately once a day.

4 Rarely Moist

Skin is usually dry. Linen only required changing at routine intervals.

Name:		PLACE ID LABEL HERE
DOB:	Room No:	

Activity

Degree of physical activity

1 Bedfast

Confined to bed.

2 Chairfast

Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.

3 Walks occasionally

Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.

4 Walks frequently

Walks outside the room at least twice a day and inside room at least once very 2 hours during waking hours.

Mobility

Ability to change and control body position

1 Completely Immobile

Does not make even slight changes in body or extremity position without assistance.

2 Very Limited

Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.

3 Slightly Limited

Makes frequent though slight changes in body or extremity position independently.

4 No Limitations

Makes major and frequent changes in position without assistance.

Name:		PLACE ID LABEL HERE
DOB:	Room No:	

Nutrition

Usual food intake pattern

1 Very Poor

Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is nil by mouth and/or maintained on clear fluids or I.V.'s for more than 5 days.

2 Probably Inadequate

Rarely eats complete meals and generally eats only about 1/2 of any food offered. Protein intake includes 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.

3 Limited

Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy product) each day. Occasionally will refuse a meal, but will usually take a supplement if offered OR is on a tube feeding or TPN regimen which probably meets most nutritional needs.

4 Excellent

Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.

Friction and Shear

1 Problem

Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.

2 Potential Problem

Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.

3 No Apparent Problem

Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.

NOTE: Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers.

15 or 16 = low risk; 13 or 14 = moderate risk, 12 or less = high risk

Total Score:

Completed by: Signature Date

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place photo here

Name:

DOB: Room No:

PLACE ID LABEL HERE

NORTON SCALE FOR PREDICTING RISK OF PRESSURE ULCER

Overview:

The Norton scale can be used to predict if a patient is at risk for development of a pressure ulcer.

The five basic categories are: Physical Condition, Mental Condition, Activity, Mobility and Incontinence. Each category is scored on a scale of 1–4 (where 1 denotes least favourable and 4 denotes most favourable) with overall scores ranging from a maximum of 20 to a minimum of 5.

Instructions for use:

1 **Assess the patient's condition and circle score accordingly (1–4).**

2 **Total the scores together.**

3 **A total score of 16 or below indicates a patient is at risk and preventative measures should be taken. The lower the total, the higher the risk.**

4 **Assess the patient regularly.**

NORTON SCALE ASSESSMENT

Scoring System Key: Total Score of 16 or below—AT RISK

A Physical condition		B Mental condition		C Activity		D Mobility		E Incontinent	
Good	4	Alert	4	Ambulant	4	Full	4	Not	4
Fair	3	Apathetic	3	Walks with help	3	Slightly limited	3	Occasionally	3
Poor	2	Confused	2	Chairbound	2	Very limited	2	Usually urine	2
Very Bad	1	Stuporous	1	Bedfast	1	Immobile	1	Urine & Faeces	1

Total

Completed by: Signature Date

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