Are we overcomplicating pressure ulcer risk assessment?

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Risk assessment is a key component of any pressure ulcer (PU) prevention strategy and is mentioned in both national and international guidelines (National Institute for Health and Care Excellence [NICE], 2014; National Pressure Ulcer Advisory Panel [NPUAP] European Pressure Ulcer Advisory Panel [EPUAP] and Pan Pacific Pressure Injury Alliance [PPPIA], 2014) with standards being set around how quickly it should occur. The first risk assessment tool (RAT) was the Norton score created in the 1960s, which proposed the use of specific risk factors that were weighted to indicate the level of risk rather than identifying a binary at risk/not at risk. Since then, a plethora of these RATs have been developed of varying levels of complexity and scope, some being for general populations others for very specific populations such as critical care patients or paediatrics (Fletcher, 2017). There has been a significant research burden to determine if these tools do indeed predict risk, or even identify risk better than other methods such as using clinical judgement (Gould, 2002), checking the skin for early signs of damage (Vanderwee et al, 2007; Moore et al, 2016) or even using other risk assessment tools such as frailty scores.

There has been no evidence produced to indicate that completing the RAT actually results in a reduced risk for the patient by triggering preventative care (Balzar et al, 2013; Samuriwo and Dowding, 2014) as the research has primarily focussed on metrics of statistical probability measuring sensitivity and specificity, reliability and validity — all measures about the robustness of the tool with little link or thought to the gap in between the tool and the changing of risk — the implementation of preventative actions. In some countries, such as Norway, RATs are not used, yet Johansen et al (2014) indicate there is little difference in the number of patients developing PU or the preventative care delivered.

There is much discussion around the utility of RATs; in a Cochrane review of RATs, Moore and Cowan (2014) concluded that there is no reliable evidence to suggest that the use of a structured systematic Pressure Ulcer Risk Assessment Scale (PURAS) reduces the incidence of PUs. Samuwiro and Dowding (2013) suggested that asking nurses to spend a lot of time, energy and effort assessing the risk may not be the best use of resources, given that they do not objectively measure the risk. Nationally and internationally, however, they remain an almost compulsory component of care.

In the practice setting, evaluation of the process of care often focusses on the easily auditable factors, e.g. was a risk assessment completed rather than was preventative care delivered. This encourages staff to focus on the risk assessment rather than the preventative care — the tool rather than the action that makes a difference.

While many risk assessment tools exist, it appears that no single one is universally liked or used. Perhaps nurses should be encouraged to use a combination of clinical judgement, information they have collected from PU risk assessment and other tools to develop a more focussed plan of care? (Fletcher, 2017)
Jacqui Fletcher

1. Which risk assessment tool do you use and why did you select that one?

AS: In our Trust we have recently updated the risk assessment tool in the acute Trust and will be adapting this for the community as well. The risk assessment tool was adapted from one created by Doncaster and Bassetlaw Trust and is currently in the pilot phase in 3 of our acute sites. This has the basis of a traffic light system which points to care planning depending on the patients risk level, which is identified after assessment. Every patient admitted into hospital gets the assessment and a 27-point skin inspection and risk assessment within 6 hours and on transfer to another department. It had been identified at RCA meetings that the current risk assessment tool had not been completed effectively- there were many gaps in documenting and a lack of PUP planning. A more guiding tool was sought to ensure plans of care were put into place.

EJ: I hold a combined position between Higher Education and an Intensive Care Unit (ICU). In ICU, where patients are seriously ill, immobile and in need of either Non Invasive Ventilation (NIV) or ventilator support, they are all at risk. A numerical or non-numerical tool is therefore redundant.

There is, however, a need to be aware of all those risks threatening patient safety in ICU and place PU prevention on equal terms with the prevention of Ventilator Associated Pneumonia (VAP) and catheter-related SEPSIS, which together with PU constitute the most important complications in the ICU population (Soh et al, 2012).

JM: The Waterlow risk assessment tool is used and this had already been implemented before starting in the Trust. This particular risk assessment tool is often considered the most suited for an acute setting. Other tools can be more focused on particular populations i.e. older persons. Most nurses will be either aware of or have already used the Waterlow tool in previous practice. I am unable to comment on which PU risk assessments are included in undergraduate training. Risk assessment scores can be problematic when organisations utilise different risk assessment tools. This can be confusing for our non-medical colleagues such as social workers when they are involved in complex discharges. For example, a hospital setting may refer to the Waterlow score, which ascends with the level of risk, whereas a community setting may utilise the Braden tool where a descending score identifies the increasing level of risk.

JS: Waterlow. The Waterlow was considered more comprehensive for use in the acute setting than other risk assessment (RA) tools. It is a very structured tool that identifies a wide range of different risk factors to consider when planning care. A higher score relates to higher risk, which was felt to be easier to understand than a low score relating to high risk.

2. In your experience, do you see that completing the risk assessment leads to the planning of appropriate care?

AS: No, it was almost a tick box exercise, it had to be done and was not always completed fully and utilised with clinical judgement to form care planning in PU prevention. I have also used Maelor in a previous Trust and feel numerical risk tools should be combined with clinical judgement to plan care, but they are not. Nursing in the current climate is very task orientated and requires prompts for repositioning regimens, off-loading heels and which equipment to supply. The tools are seen as 'another form to complete', so therefore it has to add purpose and combine care planning within it. The risk tools and care plans are very separate entities as I see it across the NHS.

EJ: Risk assessment or care plans have no value if they are just a "tick-the-box" exercise. Care provided to patients does however not rely on risk assessment or care plans alone. Knowledge, skills, awareness and access to necessary equipment for prevention are just as important. A culture within a ward may also promote or hinder best practice care. Risk assessment, with or without a tool, may therefore not necessarily lead to appropriate preventive care if other factors impede best practice for prevention.

JM: I do not believe that completing a risk assessment can guarantee an appropriate care plan for a patient. This can be influenced by several factors such as the responsible nurses knowledge/ experience. Other factors must also be taken into consideration such as staffing and time pressures- both will affect the investment into the care plan. I do believe however that completing a risk assessment tool can act as a prompt to implement further provisions of care. In order to complete the Waterlow risk assessment scores the responsible nurse must: assess nutritional status and weigh the patient (prompt: nutritional intake monitoring and/or a referral to a dietician), complete a skin inspection (prompt: pressure redistributing equipment and an indication of the level of repositioning intensity required/provision of continence management) and review the past medical history/medications (prompt: optimise any concerns i.e. suboptimal blood sugar levels/ medication review). On the contrary, it must be understood that nurses will respond to prompts to a varying degree, again, influenced by their knowledge/experience and external factors.

JS: Not always. I think there is a disconnection between RA and the development of prevention strategies. Sometimes it is seen as a "tick box exercise", once completed they move onto the next task. The registered nurse role has changed over the years with much greater numbers of unregistered nursing staff providing "basic nursing care". Maybe this is why a disconnection exists, one group of staff assess and plan the care whilst another tends to deliver the care. In addition, no RA tool picks up all aspects of patient risk particularly in certain patient groups such as oncology. These patients may be mobile and seen as at less of a risk for PU development, yet we still see PU developing in these patients. Nurses need to have an understanding of the groups of patients they are assessing and "beware the independent patient", they be more at risk than they first appear.

3. Do you believe that risk assessment tools are well understood?

AS: No. Numerical risk tools give a score that is susceptible to variance on completion by clinicians, such as ambulation and mobility in Maelor — it is often interpreted differently. A score that does not always give any value and is very vague on risk level can lead to insufficient care planning and keep patients at high risk instead of any reduction and preventative planning. Even new versions such as Purpose T were initially completed, but how often are patients reassessed on risk if their

condition changes? How often do we reassess community patients at home? Weekly/monthly? Many clinicians report that tools look too busy, unclear and are lengthy to complete with little time and staffing available to them. It is evident at RCA meetings that risk assessments are really not fully considered at all or utilised effectively.

EJ: Numerical risk assessment tools should give meaning to health care workers, be easy to use and successfully support clinical decision making together with clinical judgment. From a practical perspective, it is unclear to me how low/moderate/high/very high risks should affect preventive care provided to patients. To me, it is easier to regard a patient at risk or not at risk and apply appropriate preventive care to all at-risk patients. One concern with some risk assessment tools is how they equally weigh risk factors that for obvious reasons have different importance to PU development, for example immobility and nutritional status. A concern is therefore how the importance of immobility for PU development could be misunderstood or underestimated.

JM: I think it's worth noting that nurses complete several risk assessments as part of an admission and frequently thereafter. There are risk assessments for PUs, falls and malnutrition to name a few. Yes, generally I believe the need for risk assessments is understood. We shouldn't confuse a lack of time and subsequent non-completion for straightforward misunderstanding. With adequate training on risk assessment tools nurses can view risk assessments as a whole, less laborious and time consuming.

JS: It's a mixed picture despite education and resources readily available to staff around PU RA. Often there are inaccuracies but rarely does this change the risk group of the patient. It is vital that nurses are educated and understand what and why they are scoring when using a RA tool. Yet, there has to be some accountability and responsibility of individual nurses to ensure they utilise the education and resources available. In my experience when a nurse has been involved in caring for a patient with a deep PU there is a greater understanding of the devastating consequences this has and subsequently attitudes change towards all aspects of PU RA and education and care provision. When completed well Waterlow can guide care planning, but poor completion can lead to missed opportunities to address risk.

4. Do you think there is too much focus on the assessment of risk but not enough on preventative care? For example, many organisations audit how quickly risk assessment is undertaken — but not how quickly care is implemented?

AS: Yes, but also it seems focus is on 'after the horse has bolted' and we have a problem. PU management care plans once it has occurred and RCA focus on what was done after identification instead of the months leading up to this point, which is very frustrating. Preventative care generally is lacking in funding, education and needs more support from the CCGs and into primary care- not just in PUP. Prevention planning embedded into clinical practice, even just linking chronic condition and change in health (mental and physical) to skin health, should be standard practice. PU monitoring has created almost a fear culture in clinicians but still prevention is not a priority. Even in areas where great focus has been given with PU teams, still there are omissions in care, lack of skin inspections and suitable equipment provision. Self-care focus also needs to be addressed more, patient and carer focus and self-accountability, especially in community own homes and with concordance issues/national focus.

EJ: This is an interesting question because to separate risk assessment from preventive action is unnatural. In Norway, the Patients Safety Programme uses risk-assessment as a natural part of the care package for prevention. My experience from audits is therefore that risk assessment is, and should be, an integral part of the care plan for prevention.

JM: The time from admission to risk assessment can form part of key quality indicators explored as part of a PU root cause analysis investigation. This timeframe varies considerably between organisations. I agree there is a delay between risk assessment completion and implementation of care. This can be seen when reviewing associated documentation i.e. SSKIN bundle. I do not believe we focus on risk assessment too much, but do feel we should move towards placing more and possibly equal emphasis on the time frame from admission to implementation of a prevention care plan.

JS: Yes. This is probably driven by NICE (2015) guidance suggesting RA should be carried out within 6 hours of admission which commissioners' then request is audited as a measure of quality. Yet it is accepted that accurate RA is the first step in the provision of quality patient care (Latimer et al, 2016). PU rates are measured but it could be argued that the most important aspect of care i.e. the prevention of PU, does not have as much focus in terms of measurement from external bodies. PU prevention care plans are in use in many organisations; however measuring how quickly strategies are implemented could be a difficult task. Regular auditing of PU prevention documentation provides assurance regarding appropriate care; where gaps exist they can be picked up quickly and staff can be supported to ensure high quality care is in place.

5. Would you be prepared to stop using a risk assessment tool and use an alternative, such as clinical judgement or a skin-scanning device?

AS: I personally would. I have found the use of pressure mapping to be useful in giving patients an insight into where the risks are to their body. I have not seen a skin scanner in practice and would need to see the effectiveness, ease of use, cost etc., but would this also replace clinical judgement and skin inspection? Holistic assessment and activities of daily living assessments should incorporate the risk levels and shape care planning. Maybe we have become too reliant on different tools and templates for every aspect of care, especially in the advent of shared IT records and ease of pulling information for audit purposes. There is no doubt of the challenges in PU prevention, as a PUP nurse for several years I found when we scratched the surface we opened Pandora's box and it was more prevalent than anyone had envisaged. But the target reductions and expectations from Government and CCGs have led to a lot of clinicians feeling like they have failed in some ways. Does it matter if we categorise correctly and get into a big discussion at RCA over this or is it more important to identify the purpose of PUP for all patients in our care? I think so.

EJ: In Norway, most clinicians do not use a numerical risk assessment tool but a non-numerical 3-risk-approach based on existing PU, immobility and clinical judgment. Personally, I do not even need to use the 3-risk-approach because all ICU patients I care for are immobile and therefore at risk or in need of devices that may cause PU. It could be interesting to test out a skin-scanning device to investigate non-visible skin and underlying tissue damages on admission to identify pre-existing non-visible tissue damages.

JM: I think the absence of a risk assessment tool would cause much anxiety for nurses and senior managers alike. Without a risk assessment in use it would have to be replaced with a prompting algorithm to provide decision-making guidance for nurses. Relying on clinical judgement alone would vary in success and would reflect the skill mix of staff on that particular day/night. Nurses have many competing demands and fluctuating priorities and I feel that it's important for them to be provided with tools and support that make it easy and clear for them to make appropriate and informed decisions. As we become more aware of potential litigation around PUs, some believe that a completed risk assessment tool provides physical evidence that the risk of PU development was considered. A skin-scanning device will be considered by organisations as time and evidence of the accuracy and impact on patient outcomes becomes clear.

JS: In principle, yes, but a reliable alternative is required. A review by Moore and Cowman (2014) found no reliable evidence that a structured RA was a better predictor of PU risk than clinical judgment. Conversely Pancorbo-Hidalgo et al (2006) found clinical judgement was less effective than using an RA tool. This difference may be due to staff groups involved, experience and/or education of staff in using RA tools or the confidence staff have in the tools in use. It seems clear one size does not fit all and therefore, currently, I think risk assessment tools are necessary. Scanning devices (SD) may have their place, particularly at the front door, however it would still require staff to act on their assessment and put preventative strategies in place. There would be a huge educational requirement to ensure the devices were used accurately and assessments may be seen as too time consuming by staff. Other risks would still need to be taken into account so an RA tool or clinical judgement would still be required for holistic management. SD for use throughout organisations for on-going assessment could be cost prohibitive.

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