PURAT: is clinical judgement an effective alternative?

Risk assessment is a central concept in predicting health care needs and implementing a preventive strategy. However, risk-assessment tools are subject to misuse and it is argued that they can reduce the key role of clinical judgement in decision-making. This article explores the problems of numerical tools and describes how a non-numerical tool was developed and implemented in the author's trusts. It highlights the findings of subsequent audit and suggests that non-numerical tools can facilitate improved clinical outcomes and resource allocation and enhance professional accountability and responsibility.

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KEY WORDS
Decision-making
Professional accountability
Resource allocation
Risk assessment

Pressure ulcers are an economic burden on the NHS, to such an extent that they have become the subject of political debate and a recent early day motion in the House of Commons (Havard, 2005). This interest is predominantly driven by the staggering costs of health care for patients with pressure ulcers. According to Bennett et al (2004), these costs are as high as £321 million which equates to 0.8% of the entire health care expenditure.

In an attempt to reduce the impact of pressure ulcers, both for individual patients and across the NHS, the nursing profession has, since the early 1960s, developed, adapted and relied upon risk-assessment scores to identify those individuals at risk of developing a pressure ulcer.

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Risk assessment: its role in preventive health care

The National Institute for Health and Clinical Excellence (NICE, 2001) and, more recently, the Royal College of Nursing (RCN, 2005), have advocated that pressure ulcer risk assessments contribute to the improved quality of patient care and should be predictive, sensitive, specific, reliable, and easy and convenient to use. However, the poor performance of numerical risk-assessment tools (predictor scores) has been extensively documented (Edwards, 1996; McGough, 1999; Williams et al, 2000; Bell, 2005).

As far back as 1995, it was argued that there was little evidence that using a pressure ulcer risk scale was better than clinical judgement or that it improved outcomes (Effective Health Care Bulletin, 1995). More than 10 years later, there is still a lack of evidence to support the premise that using a predictor score yields less pressure ulcer development than using professional clinical judgement (RCN, 2005).

For many years, authors of risk assessments and eminent clinicians in the field of tissue viability have suggested that nurses should use their clinical judgement in addition to the numerical predictor scores (Norton et al, 1962; Hampton, 1997; Waterlow, 1998; Bell, 2005). This poses the question whether the actual scoring process is necessary. For example, when assessing a bed-bound patient who is unable to change position independently and who is incontinent of urine, does a nurse require a numerical indicator or predictor score to predict that this patient is at risk of developing a pressure ulcer? Or does the nurse use clinical judgement and support this with a risk-assessment score?

Sharp et al (2000) found in a survey of 444 nurses in current clinical practice that 79% did not use a tool but relied on clinical judgement alone to assess patients' risk. Thompson (2005) suggests that many clinicians view predictor scores to be inadequate, inaccurate and difficult to understand.

Furthermore, does a predictor score reliably forecast that a patient is at risk? A patient may have a high predictor score because he or she is elderly, has diabetes, a continence problem and is of below-average weight, but may be fully mobile. In contrast, a young patient with a terminal disease and who is bed-bound may have a low predictor score but in fact is at higher risk of pressure-related tissue damage. It is at this point that clinical judgement comes into play and the appropriate care plan should override the under- or over-predictive scoring.

The evidence pool to support the suggestion that numerical risk assessment over- or under-predicts is extensive (Bridel, 1993; Edwards, 1995; Edwards, 1996; McGough, 1999). As many clinicians rely on a score to determine preventive nursing intervention, under- or over-predicting may result in valuable, expensive resources being used inappropriately.

Linking assessment to resource allocation

Smith et al (1995) argued that the targeting of vulnerable patients with pressure relief interventions reduced the risk of pressure ulcer development. However, Bridel (1993) highlighted that the allocation of equipment to patients based on simple score values can lead to a failure to address the patients' specific needs — consideration of height, for example, or the type of mattress cover — therefore preventing clinicians from using clinical judgement in the decision-making process. Many trusts have a limited supply of pressure-relieving resources and therefore what does exist must be used effectively.

Within the author's trusts, all requests for pressure relief are made via the tissue viability service, and the risk-assessment score, which was part of the nurse's initial assessment, would initiate a referral for a pressure relieving resource if the score dictated that, irrespective of the patient's specific needs. When the nurses requested pressure relief, they would often comment that the score, if in the high-risk category, dictated that the patient should have alternating pressure relief. However, following discussion and subsequent agreement, it was found that high-risk alternating pressure relief was not always necessary and instead other more suitable resources, such as a static, pressure redistributing mattress, as well as a plan of care, were required (*Figure 1* provides an example of a patient who would have a high risk score on assessment, but who would not require an alternating pressure relieving resource). Nurses frequently stated that they felt professionally vulnerable if they did not provide expensive equipment for patients with high predictor scores, regardless of the equipment's suitability for the individual.

Mrs C was 82-years-old and had type 2 diabetes. Dietary intake was poor and she had recently lost weight, now weighing below 7 stone. She was occasionally incontinent but this was managed well with continence products of which she was self-caring. She had odematous lower limbs and had been treated on many occasions for heart failure. She had a punched out, mixed-aetiology leg ulcer on her left lower leg. All her pressure areas were intact and she was able to change her own position while in bed.

Figure 1. Example of a patient with a high risk-assessment score but who does not require a pressure relieving resource.

This finding is not unique. The RCN (2005) has highlighted that risk assessment is only one part of the approach required in the allocation of equipment. Other factors include pressure ulcer severity (if present), the patient's ability to transfer or change own position, the final height of the bed, and whether the mattress prohibits transferring, whether the patient sleeps in a bed or chair, the patient's weight, need for comfort and the care setting. All these factors need to be taken into consideration when deciding on nursing interventions and yet some clinicians feel obliged to follow a highly prescriptive approach to pressure ulcer prevention, that is to provide expensive, complex resources (Edwards, 1996).

Validity

Risk assessment is a process of highlighting the possibility of an event occurring, and the attempt to reduce or minimise risk through a subsequent plan of care. The only way to prove that an event will happen, and therefore validate a risk assessment, is by non-intervention. However, not implementing a plan of care would raise difficult ethical issues.

Clark (2005) poses the question: how do we know when a pressure ulcer has been prevented? Has prevention been achieved through appropriate intervention, or was the patient resistant to developing ulcers in the first place? A risk-assessment tool's ability to predict consistently the risk of pressure ulcer development makes it possible to consider validity. It should be judged with regard to:

- Sensitivity: of patients who develop pressure ulcers, how many were identified by the tool as being at risk (true positive)?
- Specificity: of patients who did not develop pressure ulcers, how many were identified by the tool as being not at risk (true negative)?

Thompson (2005) suggests that a good indicator of a tool's validity is its predictive ability. However, it must be considered that, as previously discussed, by intervening when a patient is at high risk of developing of pressure ulcers, the risk will be reduced.

Reliability

It is important to ensure that clinicians are assessing patients in a consistent manner. A tool should produce the same or similar results over time when used by the same clinician (intra-rater reliability) and there should be agreement between different clinicians (inter-rater reliability) in the absence of change in the patient's condition. However, the evidence suggests that nurses using current predictor numerical tools can achieve a range of scores for one patient (Bergstrom et al, 1987; Edwards, 1995; Edwards 1996).

Developing a new approach

It was decided to re-evaluate the method by which risk was assessed and attempt to develop and introduce a risk-assessment tool that could address more accurately the needs of patients, and to ascertain if clinical judgement alone could be an effective alternative to numerical scoring (predictor scores). The tool was assessed to ascertain if

Table 1.
Grades of nurses who completed the questionnaire

Grade of nurse	No of questionnaires completed
D	4
E	21
F	5
G	17
Total	47

it was able to be reliable, predictive, valid (sensitive, specific) and easy and convenient to use, as advocated by NICE (2001) and RCN (2005).

A search of existing tools was undertaken to identify any existing non-numerical assessment methodologies in pressure ulcer risk prediction. A paediatric risk-assessment tool, utilising clinical judgement as an outcome, was identified. Mark O'Brien, Clinical Nurse Specialist, at Great Ormond Street Hospital for Children in London developed a paediatric tool which utilised clinical judgement as a concept. With permission, this concept was developed further as the basis for this new tool, to meet the needs of the adult care environment with the objective of encouraging an individualised and holistic approach.

The Pressure Ulcer Risk-Assessment Tool (PURAT)

The resultant Pressure Ulcer Risk-Assessment Tool (PURAT) (*Figure 2*) highlights risk variables or perceived key clinical factors that put an individual at risk of developing a pressure ulcer. These variables reflect generally accepted expert opinion. It is acknowledged that there is a lack of epidemiological research to support the choice of the risk variables (McGough, 1999).

The tool is divided into two parts. The upper section considers the patient's general health, previous and present pressure ulcer development and includes a skin inspection. The skin inspection is to encourage clinicians to check the skin on all the potentially vulnerable pressure areas and to document the condition of the skin. Medication that may affect the skin is included (this is not an exhaustive list and could be adapted for individual care settings). The clinician can ring or tick the prompt boxes; if further explanation or clarification is required, this can be written in the prompt boxes.

The lower portion of the tool adopts a linear continuum between two opposing key clinical factors, which indicate risk of pressure ulcer development. As an example, patient mobility spans a range from independently mobile to total immobility. The clinician is asked to place crosses on the linear marker, guided by the low, medium, and high prompts, that most accurately reflect the patient's condition. This decision-making process continues through the various statements, highlighting to the assessor the key clinical factors affecting the patient, in order to prompt care planning of effective nursing interventions.

The objective is to guide clinicians to use their clinical judgement to make a statement of risk for the individual being assessed. At the bottom of the tool is a 'statement of risk' box. Here the clinician is asked to state, using his or her clinical judgement, if the patient is at low, medium, or high risk of developing a pressure ulcer. In addition, the clinician is asked to justify that decision and to use the decision in planning the patient's care.

A table of pressure-relieving resources is included as a guide to allocating equipment (this table can be adjusted to any care setting). However, that is not to suggest that these pressure-relieving devices are the only preventive interventions. The subsequent plan of care should include interventions to counteract all the key areas of potential risk that the clinician has highlighted on the tool.

Methods for implementing the tool

Following development, the tool was piloted for four weeks on each new patient admission in five different clinical areas. These were: a medical ward, an elderly care ward, a community team, a hospice and a stroke unit. These were selected to ascertain if the tool was effective across a variety of care settings. Each site was encouraged to ask all grades of nurses to use the new risk-assessment tool to assess its ability to be used and understood by staff with a variety of clinical experience, from novice to experienced practitioner (*Table 1*).

In addition, the nurses were asked to complete a questionnaire and a Waterlow risk assessment (Waterlow, 1998). The Waterlow risk-assessment tool had been previously advocated by the trust. To avoid later confusion, the results of the Waterlow assessment were noted and subsequently these documents were retained in the patients' notes at the end of the four-week pilot, whereas the new tool was removed.

The completion of both tools offered the potential to compare assessments and outcomes, which was the main focus of the questionnaire (*Table 2*). The nurses were encouraged to review the patients' at-risk status when there was any change to the patients' condition or after one week (as per trust guidelines).

To test the intra-rater reliability (outcomes by the same clinician) and inter-rater reliability (achieving agreement of outcomes between clinicians), a retrospective audit of the PURAT in 90 patients' notes was carried out. In addition, a focus group of eight nurses of mixed nursing grades and experience was asked to carry out the risk assessment on five case scenarios to further test the inter-rater reliability (*Table 3*).

Finally, in an attempt to test predictive validity and to consider issues of sensitivity and specificity of the PURAT, once it was in general use across two primary care trusts, trust-wide pressure ulcer incidence data were reviewed. A comparison was made of retrospective incidence data for six months before the pilot of the new tool (*Table 4*) and the incidence data for the six months after the new tool was introduced (*Table 5*).

Pressure ulcer risk assessment tool

Patient Name..... *Date of Birth*..... *Age*..... *years*

The objective of this tool is to link the risk assessment process with a clearly documented clinical decision regarding risk of pressure ulcer development or risk of further tissue damage. This tool is designed to support your clinical judgement. Please complete all sections and sign the Statement of Risk. Use a new risk assessment tool on each assessment.

Pressure area skin inspection (circle)	No problems	Dry	Tissue paper	Eczematous	Oedematous	Inflamed	Discoloured

Pressure area status	Locations – refer to body chart	State grade
Previous:		
Present:		

Wound assessment tool / care plan completed Y/N (please circle)

General health (Please circle)	Well	Acute illness	Chronic stable	Chronic unstable	Palliative	Cachexia

Medication (please circle)	Steroids	Cytotoxic	Anti-inflammatory	Sedatives	Other drugs

Please indicate level of risk for each category with an 'x' on each line. Add comments if necessary.

	Low	Medium	High
Mobility/Moving and handling	Fully mobile		Immobile/wheelchair/bed bound
	Frequent change of position in bed/chair		Infrequent / Unable to change position independently or by others
	Risk free manœuvring/manual handling		Risk of shear/friction
Moisture on skin	Urine: continent or catheterised		Incontinent of urine/frequently wet
	Faeces: fully continent		Skin in frequent contact with faeces
	Body moisture normal		Clammy, sweating
Neurological	Full sensation		Cannot perceive sensation over most of body
	Conscious		Unconscious
Nutritional status	Good		Nutritionally compromised
	Hydrated		Dehydrated
Vascular disease	Not present		Known vascular disease
Psychological	Cognitively aware		Cognitively unaware

Statement of risk

In my clinical judgement this patient is **Low/Medium /High*** risk of pressure sore development/further tissue damage

**Please circle as appropriate.*

Name of assessor:..... Signature:..... Date:.....

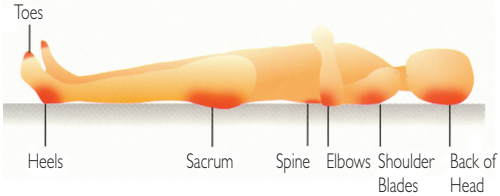
Comments/justify your decision

Consider any care issues identified, in your planning of care e.g. planned interventions; protective dressing, turning regimen, pressure-relieving aids, referral to tissue viability, etc

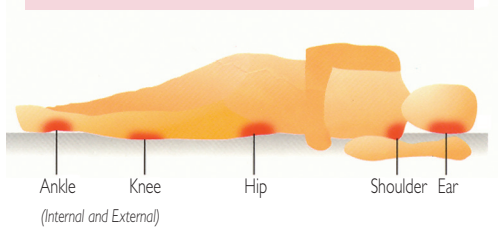
Review date:

At-risk pressure area sites

SUPINE POSITION



LATERAL POSITION



Equipment list

	Weight limit	Product name	Comment
Prevention	15 stone	Propad overlay – 8.5cm deep Propad cushion – 10cm deep	For patients at low to medium risk of developing pressure ulcers. Place mattress over an existing foam mattress
	26 stone 39 stone	Softform mattress – 17.5cm deep Softform Premier mattress – 15cm deep	For patients at high risk of developing pressure ulcers, with frequent repositioning
	Unlimited weight	Roho mattress and cushion – 10cm deep	For patients at medium to high risk of developing pressure ulcers
	22 stone	Flo-tech Solution – 7.5cm deep	For patients at high risk of developing pressure ulcers. Can be used for treatment of grade 2+ pressure ulcers when the pressure is regularly relieved.
Treatment	15 stone	Aircare alternating pressure mattress overlay	For patients at high risk and/or for patients with pressure ulcers. Good for patients who are being cared for in bed as surface is slippery for ease of manual handling, often too slippery for patients who want to sit up in bed
	17 stone	Viaclin alternating pressure mattress overlay	For high-risk patients and/or those with pressure ulcers. Has support sides built into mattress to help patient stability and movement in bed
	15 stone	Alpha X-cell overlay	For patients at high risk and/or for patients with pressure ulcers. Surface is not slippery as in Aircare.
	25 stone	Biwave alternating mattress replacement	For high risk patients who may have pressure damage
	35 stone	Trinova alternating mattress replacement	For high-risk patients who may have severe pressure damage, especially when at risk when sitting out. Has an integral cushion
	35 stone	Nimbus alternating mattress replacement	For high-risk patients who may have severe pressure damage
	40 stone	Cairwave alternating pressure mattress replacement	For patients who are at the highest of risk of pressure damage and who are unable to be repositioned.
	35 stone	Convertible II – low air loss mattress	For patients with pain who cannot tolerate an alternating pressure system or who have severe skin conditions.

Table 2.
Questionnaire results (n=47)

Question	Yes	No	Incomplete	Comments/themes
Where you able to make a clinical judgement?	45	1	1	39 questionnaires made no comment. Six questionnaires stated that a clinical judgement could be made 'very easily'. The one 'no' answer had the comment 'Difficult as I know that he is at high risk but his assessment came out 50/50, making it harder to say if he was at low or high'
Did the tool assist you by highlighting the significant factors to plan your patients' care?	43	2	2	The 'yes' questionnaires had the following comments: »Straightforward and easy to use »Very clear and easily assessed »Confirmed my own clinical judgement »Gives a realistic level of risk » Makes me very aware of potential problem areas »Draws my attention to specific needs as it highlights significant risk factors »Highlighted the risk of shear and friction »More accurate »Helped with getting suitable resources »Ensured awareness of holistic approach to patients »Easier to see on scale rather than numbers in a box »Helped me to justify use of pressure relief (commented six times) »The use of Xs on the line gives flexibility The 'no' questionnaires included comments such as: »Not very clear or straightforward
Did you find it easy to place your patient on a low, medium or high category?	43	3	1	The 'no' answers all related to the vascular line only
Comment on this tool in comparison to the Waterlow score from an outcome perspective	Comments included: »Equally happy to use either »A lot better »Easier to use than the Waterlow score »Easier to use as no adding up »Very easy to make a clinical judgement »More ambiguous »Easy to use, less to read, no adding up and rechecking »Encourages clinical decision-making based on clinical evidence »More accurate »More user friendly — visually easier to make assessment »Encourages deeper thought and care planning than Waterlow »Very user-friendly »Some difficulty with placing patients who have had a cardiovascular attack on vascular line »14 nurses commented that the outcomes corresponded with Waterlow risk assessment »Eight nurses said the Waterlow score gave a 'very high risk' outcome, whereas the risk calculated using clinical judgement was low »Counting the crosses showed that the patient was at a low risk, whereas the Waterlow score was 20 »More adaptability »Able to use own judgement			

Table 3.
Results of reliability rating

Outcomes	Retrospective audit of 90 patient assessments	Eight nurses in a focus group using case studies
No decision documented	7/90=7.8%	
Risk assessment carried out by the same clinician: intra-rater reliability	Same result was 23/24=95.8%	
Risk assessment carried out by different clinician: inter-rater reliability	Same result was 55/59=93.2%	76%

Table 4.
Incidence of pressure ulcers per Waterlow band from October 2004–March 2005 (85/3823=2.2%)

Waterlow risk-assessment tool	Number of patients	Percentage of total
At risk	39	45.9
At high risk	16	18.8
At very high risk	30	35.3
Total	85	100

Table 5.
Incidence of pressure ulcers per Pressure Ulcer Risk Assessment Tool band from April–September 2005 (87/3694=2.4%)

Pressure Ulcer Risk-Assessment Tool	Number of patients	Percentage of total
Low	6	6.9
Medium	24	27.6
High	57	65.5
Total	87	100

Results

During the preliminary testing a total of 47 patients were assessed using the PURAT and 47 questionnaires were completed. The majority of nurses involved in the study were of senior grades (see *Table 1*), and this was a local decision.

As one of the aims of the pilot study was to evaluate the ease of use of the tool across all nursing grades and experience, it was of paramount importance to establish whether a novice practitioner could complete the tool. Three D-grade staff nurses commented in the questionnaire that the tool was 'very clear and easily assessed', 'user-friendly and visually easier'. None highlighted any difficulties in making a clinical judgement (see *Table 2*). One of the D-grade staff nurses, however, counted the crosses instead of using them as a guide as intended. This highlights the importance of effective education when introducing a new tool.

A total of 95.7% (n=45) of the 47 nurses agreed that they could make a clinical judgement, 91.5% (n=43) felt that the tool assisted them to plan patient care and 91.5% (n=43) agreed that they found it easy to place the patient in the low, medium or high category. The questionnaire results indicate that the nurses found the PURAT user-friendly and generally easy to use.

The retrospective incidence data, which continued before and throughout the implementation of the tool, yielded interesting results. Both tools acknowledge that all patients have the potential for pressure ulcer development. However, before the introduction of the new tool, 45.9% (n=39) of patients who developed pressure ulcers had been assessed as being 'at risk' using the Waterlow risk assessment tool (see *Table 4*). This figure reduced to 6.9% (n=6) in the equivalent 'low-risk' category on the PURAT (see *Table 4*).

Conversely, the upper risk groups showed a significant shift. Previously, 35.3% (n=30) of those who developed pressure ulcers were classified as being at 'very high risk', while with the new tool, 65.5% (n=57) of the pressure ulcers occurred in the 'high-risk' group.

Although this may suggest that more patients assessed at 'high risk' had developed pressure ulcers, which may raise questions of appropriate intervention, the total pressure ulcer population throughout the change period remained at a little over 2%, which was within the historical range for the local population (1.8%–4%). Therefore, this tool predicts that those who are at 'high risk' will develop pressure ulcers.

It is important to highlight that these incidence data reflect the 87 patients who developed pressure

ulcers in trust care out of a total of 3694 admissions. It is unknown how many of the 3694 patients had a 'high-risk' assessment, which would indicate how many pressure ulcers had been prevented. Conversely, the total number of patients admitted who had a 'low-risk' assessment is also unknown. It is therefore not possible to state the proportion of those at 'low risk' who did not develop damage; therefore, specificity cannot be measured using these data.

Finally, the reliability data collection (*Table 3*) also yielded interesting results. In clinical practice, the intra-rater reliability data showed that 95.8% of nurses who carried out a risk assessment on the same patient got the same result. In addition, agreement between nurses in the absence of change in the patient's condition (inter-rater reliability) was 93.2%. However, 7.8% of the risk assessments had no decision documented. The data collection using case studies with a group of nurses resulted in the nurses achieving 76% inter-rater reliability.

On discussing this with the nurses in the group they established that they were all envisaging different patients and imposing the descriptions on a patient they knew and therefore the outcomes were sometimes different. This highlights the importance of having succinct descriptions when using case studies or examples.

Discussion

It is understood that all patients are potentially at risk of pressure ulcer development, but it is the severity of the perceived risk that will determine intervention. The higher the risk, the greater the resources or intervention needed to avoid potential tissue damage. The patients (45.9%) assessed as being 'at risk' using the Waterlow risk-assessment tool and 'low risk' on the PURAT (6.9%) are interpreted as being at a lower priority than those in the 'at very high risk' or 'high risk' categories of the Waterlow and PURAT tools, respectively. They therefore are potentially less likely to have intervention and pressure-relieving resources. Failure to predict accurately the level of risk potentially puts a patient at an even higher risk of damage as resources and preventive strategies are denied to them.

Introducing a new risk-assessment tool and incorporating a new concept into clinical practice produces many challenges... using clinical judgement without the support of a score is an alien concept in pressure ulcer risk assessment.

Conversely, over-prediction of risk may result in inappropriate use of expensive resources. The PURAT suggests predictive validity, as 65.5% of patients who developed pressure ulcers were assessed in the 'high risk' category and only 6.9% of those patients who were in the 'low risk' category developed pressure damage, proving that the tool is sensitive. However, it must be acknowledged that there was an extensive teaching programme before the pilot that may have resulted in a more accurate assessment and subsequent care planning; the accuracy of care planning was not audited before the pilot.

Some clinicians may lack the confidence to use their professional judgement, as indicated in the questionnaire (2.1%) and in the reliability data (7.8% did not offer a decision). However, the majority of nurses found the tool user-friendly and generally easy to use, with 95.7% (n=45) stating that they could make a clinical judgement, supported by 91.5% (n=43) who agreed that the tool assisted them in the planning of their care. The reliability data support the premise that the tool is easy to use, as the tool showed 93.2% inter-rater reliability between clinicians and 95.8% intra-rater reliability when the same nurse repeated the risk assessment. There appeared to be no differences in the outcomes or comments across the various care settings.

Conclusion

The European Pressure Ulcer Advisory Panel highlights that the assessment of risk should involve more than just the use of an appropriate risk-assessment tool (European Pressure Ulcer Advisory Panel, 2001). The rationale for using a pressure ulcer risk-assessment tool is to identify an individual's level of risk, highlight factors that put an individual at risk and encourage clinicians to prioritise care to minimise the risk of pressure ulcer development.

The aim of this article was to consider if clinical judgement alone could be an effective alternative to a numerical system as a means of assessing pressure ulcer risk. It also wanted to examine whether the PURAT was predictive, reliable, sensitive, specific and easy and convenient to use, as advocated by NICE (2001) and the RCN (2005).

Introducing a new risk-assessment tool and incorporating a new concept into clinical practice produces many challenges. Pressure ulcer risk assessment is an established area of nursing entrenched in numerical predictors, but the PURAT asks nurses to use their ability to make a clinical judgement and to document this and thereby exercise their professional accountability.

Using clinical judgement without the support of a score is an alien concept in pressure ulcer risk assessment. However, nurses make clinical judgements throughout their clinical practice when interpreting predictor scores and planning patient care, including choosing resources, timings on repositioning, involvement of other allied professionals, and planning for nutrition and continence care. The risk-assessment tool is an integral part of that care planning and ensures that patients have the most effective care to prevent development or further development of pressure ulceration.

Some nurses during the pilot expressed concerns over not using a predictor score to support their clinical judgement, which may raise questions of individual confidence, clinical and management support, and education. To turn this negative stance into a positive one, the PURAT offers the clinician the flexibility to make a clinical judgement without being swayed by a score, and to take responsibility and accountability for planning preventive interventions and using resources appropriately for those with a real need. Clinical judgement underpins nursing as a profession and we should have the confidence to rely on our own professional clinical judgement, without the need for predictor scores to reinforce that judgement.

Referrals for pressure-relieving resources are now more appropriate in the author's trusts as decision-making is no longer based on a predictor score. Nurses are now asking for appropriate pressure-relieving resources after having made a clinical judgement as part of the problem-solving process that a nurse follows when planning pressure ulcer prevention and treatment. The nurses are allocating and reviewing pressure-relieving resources more appropriately and the monthly checking of use of resources no longer yields a glut of inappropriately placed pressure-relieving equipment.

Limitations and future work

This new PURAT has been piloted in a primary-care setting, this limitation could be rectified by piloting the tool in secondary care. In addition, the numbers of nurses involved in the pilot were low and some of the results were not significant, therefore to establish the ease of use and accuracy of the tool requires further research. The use of the tool is in its infancy, and further research is required to ensure that the tool is predictive, sensitive, specific and reliable and that interventions are adequate and targeted appropriately. This should be carried out across a defined population and include risk-assessment data, information on preventive interventions and further incidence data. The tool is, at present, being simplified for use in care homes, both residential and nursing. WUK

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Key Points

- In an attempt to reduce the impact of pressure ulcers, the nursing profession relies upon risk-assessment scores to identify those at risk of developing a pressure ulcer.
- Eminent clinicians in the field of tissue viability have suggested that nurses should use their clinical judgement in addition to the numerical predictor scores.
- PURAT was developed to see if clinical judgement alone could be an effective alternative to numerical scoring..
- Referrals for pressure-relieving resources are now more appropriate in the author's trusts as decision-making is no longer based on a predictor score.