

Identifying risk: clinical judgement versus risk assessment tools (RATs)

Pressure ulcer risk assessment is a central component of clinical practice aimed at identifying patients who are at the highest risk in order to target and make best use of limited resources (both in terms of personnel and equipment). The recent European Pressure Ulcer Advisory panel and National Pressure Ulcer Advisory Panel (EPUAP/NPUAP, 2009) guidelines on pressure ulcer prevention and treatment contain three statements on risk assessment policy and 11 on risk assessment practice, yet it is clear that there is no 'best way' to carry out any risk assessment.

The guidelines state clearly that:

- ▶ A risk assessment policy should be established in all care settings
- ▶ Healthcare professionals should be educated on how to achieve an accurate and reliable risk assessment
- ▶ All risk assessments should be documented.

However, they go on to say that although risk assessment scales may be the foundation of risk assessment practice, they do have limitations.

In clinical practice there is much debate around the use of any named risk assessment tool (RAT) (Griffiths

and Jull, 2010). Many of the tools commonly in use (Waterlow, Braden, etc) are widely believed to over predict risk which can lead to overuse of equipment and unnecessary disturbance of the patient, who may be repositioned more frequently than is necessary. In part, this is because studies testing the adequacy of the RAT primarily use sensitivity and specificity as outcome measures. This is flawed as it suggests that all patients identified as at risk would go on to develop a pressure ulcer (and those who were not at risk would not). Clearly this is not logical, as the purpose of assessment is not only to identify risk, but also to manage/ reduce it. Using the criteria above, it would be impossible to separate those patients who did not develop pressure ulcers because they were actually not at risk from those who, because of good preventative care, did not develop a pressure ulcer despite being identified as at risk. Furthermore, the majority of RATs were developed for specific patient populations, e.g. elderly, surgery and orthopaedics, and the particular risk factors may only apply to that sub-population of patients.

In order to achieve 'best' results, individual RATs should be used in specific areas of practice, e.g. intensive care, community care, medicine, surgery, mental health and palliative care, so that appropriate risk factors are included within the tool. This, however, leads to many other complications. For example, the levels of risk used in the tool may differ and so not be transferable; patients may move between many

different settings while an inpatient; or staff may move between settings and have to learn how to use more than one RAT. All of this can lead to confusion and poor communication.

Alternative approaches to the use of RATs have been proposed, indeed, the EPUAP/NPUAP guidelines (2009) strongly state that the structured approach to risk assessment should be refined through the use of clinical judgement. Anthony et al (2008) suggest that 'nurses may be wasting their time conducting risk assessment scoring if clinical judgement and/or education are sufficient to assess pressure ulcer risk'. They also highlight evidence suggesting that clinical judgment is as effective in assessing risk as risk assessment scales (Anthony et al, 2010).

However, clinical judgement per se can be difficult to document and the use of a RAT not only provides a logical and structured approach, but also provides a clear framework for documentation.

An alternative approach to the use of a RAT is proposed by Vanderwee et al (2007), who used the presence of non-blanching erythema (NBE) as the trigger for implementing preventative actions. While equal numbers of patients developed pressure ulcers (of equal category of damage), only a third as much equipment was used in the patients who had risk identified by the presence of NBE, compared to the control group who had their risk identified using the Braden scale. Other studies, including Nixon et al (2007), have also identified NBE as a key risk factor. However, this methodology

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for assessment and identification of risk is equally as flawed as the use of RATs. NBE is difficult to detect in darkly pigmented skin as any redness is not easily seen (Anthony et al, 2002; Scanlon and Stubbs, 2004; Rosen et al, 2006), and there is good evidence to show that patients with darker pigmented skin go on to develop more severe categories of damage because of this (Rosen et al, 2006). There is also clear evidence that even in Caucasian skin, both inter and intrarater reliability of testing and identification are poor (Defloor et al, 2004; Briggs, 2006).

It is clear that the assessment of pressure ulcer risk is high on the agenda both for healthcare providers and also for patients for whom the costs may be high. Yet, it appears that there is little consensus on how to best achieve good reliable assessment. Research in the area suggests that there may be several ways to identify risk, but that provision of education on the method and implementation of appropriate support are crucial. However, it seems in many areas of practice that this education is lacking. It is unsurprising, therefore, that risk assessment is neither valid nor reliable.

JF

Do you use a RAT in your practice and, if so, which one?

PC: We use Waterlow in both the acute and care of the elderly setting, with the majority of primary care and care homes in my area also adopting it. However, our paediatric hospital has

just recently adopted the Glamorgan Paediatric Risk assessment score.

BP: When I have been on placement I have noticed that on some of the wards we have not been shown which risk assessment tools are used on that particular ward. However, myself and the other students usually assume that if it is a surgical ward or intensive care unit, where the patients are not able to move freely, the Waterlow scale should be put in place.

KF: We use Waterlow in the community and intermediate care bed-based units. The residential and nursing homes in the area also mostly use Waterlow.

Do you have a protocol/guidelines to support the use of your RATs and, if so, what are its key points?

PC: Our practice is based on the Best Practice Statement for the Prevention and Treatment/Management of Pressure Ulcers 2009. Risk assessment should be carried out within six hours of admission, or at the first visit at the home or community setting. Risk assessment should be based on both formal risk assessment (the use of a recognised risk assessment score), and informal risk assessment (the use of clinical expertise and awareness of the patient group being cared for). The frequency of risk assessment should be based on any change in the patient's overall condition. Therefore, it ranges from a daily assessment to at least every seven days for those identified as being at risk but with little change in their condition.

BP: If there are any other protocols or guidelines to support the Waterlow

Scale I have not been shown any. There is a minimal amount of guidance on the sheet to show how to score a patient, but I have not seen any guidelines in addition to this.

KF: Currently there are no local community pressure ulcer prevention and treatment guidelines available to support the use of a RAT. These are in the process of being written by the pressure ulcer working group. Waterlow has been used for many years in line with local acute trust guidelines. National Institute for Health and Clinical Excellence (NICE) guidelines (2005) are adopted within the community, with a risk assessment performed within six hours of admission to the community bed-based units or during the first assessment of patients at home.

In your opinion are the RATs used well, i.e. systematically and regularly, and do they inform practice/trigger preventative action?

PC: I think that risk assessment can act as a support to staff by providing a framework within which the patient should be assessed and areas of concern identified. It does not replace clinical judgement but acts as an adjunct. If carried out effectively, RATs can support the clinician in ensuring that resources are effectively used and made available. However, the problem with risk assessment as a whole is that it is often regarded as another tick box to be completed. The score is often not interpreted in conjunction with the patient's condition, with any care then being appropriately adjusted and resources implemented

BP: From my experience it is clear to see which wards are familiar

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with the Waterlow Scale and which are not. In an orthopaedic or surgical ward, the Waterlow is used almost religiously to ensure the safety and skin integrity of patients' pressure areas, especially if they are unable to move due to surgery or an accident. Once the Waterlow is in place, it is then included in the patient folders to be viewed by any healthcare professional.

KF: On the whole, the RAT is used well in our trust and is normally acted upon. A clinical priority scoring system has been adopted by the trust's equipment services and this considers risk factors when pressure-relieving strategies need to be put in place.

Do you know where the RAT's score should be recorded and the frequency of review?

PC: It is part of the organisation's standard patient admission document. Risk assessment should be carried out within six hours of admission or at the first visit to the home or community setting

BP: Once the Waterlow risk assessment is in place, the score is recorded in either the patient's medical notes or if an emergency treatment booklet is/has been used, there is a specific page for it to be recorded. It has to be reviewed weekly, or as the patient's condition changes to ensure that their care is appropriately adjusted.

KF: There is a set of standard paperwork for recording RAT scores and this is used at any first assessment in the community. At present this is not reviewed frequently unless there

is a significant deterioration that warrants further assessment, or if extra equipment needs to be ordered. The pressure ulcer working group is currently reviewing the need for standardised paperwork that can be used in regular reviews throughout the community setting.

Do you feel that clinical judgement is important in predicting/identifying patients at risk?

PC: Clinical judgement is essential and should support the risk assessment. Often assessments are made on first patient contact (i.e. ensuring that a patient who requires a pressure-reducing mattress is admitted to a bed with one in place), and then followed up by risk assessment.

BP: I believe that clinical experience is important when identifying a patient who could potentially be at risk. Even as students, we can tell just by looking at a patient who is more at risk of pressure ulcers than others. I believe that nurses should be better prepared and taught about the different types of risk factors there are while at university. As it is, we are only given an hourly session on different types of dressings, and nothing to help us identify more vulnerable patients. In my opinion, this would be useful.

KF: Clinical judgement based on expertise, reflection, confidence and intuition is very important. However, experience and intuition do not necessarily make for sound clinical decision-making and more formal measures may need to be adopted with

inexperienced staff who have not yet developed extensive clinical judgement or received enough education.

Do you feel that risk assessment overrides clinical judgement or supports/works with clinical judgement?

PC: The two should be married together, to ensure that best outcomes are achieved and at-risk patients are identified promptly and resources and care plans are altered appropriately.

BP: The Waterlow scale can sometimes override people's clinical judgement, as people can often forget other conditions or issues that the patient may have.

KF: There is a danger that RATs could become a substitute for clinical judgement. I feel it is important that education programmes highlight the importance of formal risk assessment as an aide-mémoire, rather than as a replacement for clinical judgement.

Does using RATs help support your clinical decision-making and care-planning?

PC: Yes, if you have a patient who through risk assessment has been identified as having reduced mobility, poor nutrition and incontinence, a plan of care can be developed including an appropriate surface, evidence of monitoring nutritional intake and referral to dietician and assessment of continence.

BP: Using the Waterlow Scale is vital when making decisions regarding a patient's care. Without understanding their skin integrity or risk factors, a plan

could be put into place which could potentially cause harm to pressure areas.

KF: Yes, if a patient is identified as at risk it is important to have a baseline for planning care and for future reference.

Do you feel RATs lead to overuse of preventative equipment?

PC: They can do, but it is dependent on each clinician and their understanding and interpretation of the individual components of the risk assessment tool.

BP: I think that risk assessment tools could lead to the overuse of prevention equipment because nurses or other healthcare professionals may slightly overreact to a low risk patient by allowing them to use equipment which is specifically designed for higher risk patients. However, some patients who are classed as a higher risk may not receive the correct or sufficient treatment because there are insufficient guidelines to assist with assessment.

KF: While RATs should support the correct allocation of preventative equipment, it is possible to record inappropriately elevated scores in patients whose mobility or self-care abilities are masked by disease processes.

What do you consider as preventative measures in the prevention of pressure ulcers?

PC: The skin should be directly examined and assessed for any changes. Appropriate support surfaces, i.e. mattresses, seating and heel protection should be put in place. Mobility and any

specialist resources currently being used should be assessed. It is also essential to ensure that nutritional intake is adequate and that continence is monitored so that any issues can be acted on promptly.

BP: The first thing I would do if I was handed a patient who was at risk of pressure ulcers would be to order a pressure mattress and an electric bed. I would also ensure that a turn chart was used and that this was recorded in the patient's notes.

KF: Prevention is key, therefore a structured approach should be taken that considers the Waterlow score in conjunction with a comprehensive skin assessment, nutritional assessment, and mobility, positioning and repositioning interventions for all patients identified as at-risk. The correct use of pressure-reducing and relieving surfaces is also crucial, as is an awareness of continence problems. Regular and up-to-date education for clinicians is essential as is a knowledge of local and national guidelines. Finally, good communication and documentation within teams will help to ensure that all possible measures are in place early enough to protect patients. **WUK**

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