Health Guidance

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Health Guidance on Risk Assessment: Pressure Ulcer Prevention

Introduction and Purpose of Guidance

This guidance note aims to share with Care Inspectorate Inspectors information regarding risk assessment tools for pressure ulcer prevention and how they are applied in practice.

Background

Risk assessment tools for pressure ulcer prevention are commonly applied in a variety of care settings such as care homes for older people, hospices and independent hospitals.

The purpose of a risk assessment tool is to predict which residents are liable to sustain pressure damage to skin. The aim of a care service using these tools is to establish the individual resident ‘at risk’ status of potential pressure ulcer development and following this put an appropriate prevention plan in place to maintain their skin integrity.

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A variety of these risk assessment tools for pressure ulcer prevention have been devised and implemented in clinical practice. The tool selected should be based on the needs of the client group being assessed, for example, acute care for older people.

It is important to note that any risk assessment tool is a method to assist a trained nurse in assessment of the individual (formal assessment) and is not a replacement for the registered nurses clinical judgement (informal assessment). NHS QIS Management of Pressure Ulcers (2009) states that risk assessment should be carried out and a risk status identified within six hours of admission.

The most commonly used risk assessment tools used in care homes in Scotland are
• The Waterlow Risk Assessment Score (1988) Revised 2005
• The Braden Scale for Pressure Ulcer Prediction (1987).

The Waterlow Pressure Ulcer Prevention/Treatment Policy

This risk assessment tool was first launched in 1988. It is a popular risk assessment tool in the UK as it has been well marketed by the author, Judy Waterlow. It is aimed at physically ill people in an acute care environment. The tool is a scoring system which covers 10 risk factors. It was revised in 2005 and includes a more comprehensive overview of the resident’s nutritional status.

The higher the score, the greater the risk and the tool makes useful recommendations for general nursing care and the use of pressure reducing aids. It also incorporates a wound classification for those who have already gone on to develop a pressure ulcer.
There is an accompanying manual which outlines the use and application of the tool and is a valuable training aid. This system does tend to over predict the potential of pressure ulcer development, especially in older people, which may lead to unnecessary use of valuable equipment resources.

The Braden Scale for Predicting Pressure Sore Risk

The Braden score was developed in the USA for use in nursing homes and primarily identified malnutrition as a marker for the development of pressure ulcers. The scoring system has six risk factors and uniquely includes friction and shear which as well as pressure are external forces present in ulcer development. The lower the scores with this tool, the greater the risk. An educational package and video were developed to accompany the tool but are not widely available in the UK. The authors have found this tool has greater levels of specificity and sensitivity in the application for older people as well as 92% inter rater reliability, where nurses have had training in the use of the tool.

More information about these tools can be found on their websites www.judy-waterlow.co.uk and www.bradenscale.com

Further information about these risk assessment tools can be found on the www.tissueviabilityonline.com/risk-assessment

All registered nurses should be trained and receive regular updates in the use and application of the tool selected as this will improve levels of inter-rater reliability. (EPUAP and NPUAP, 2009). In some areas carers/senior carers or healthcare assistants may be applying these risk assessment tools to residents. They should also be appropriately trained and competent in their use and also be aware of what actions to take when a resident is identified ‘at risk’.

Care Homes for Older People/Hospice/Independent Hospital

Application of the Risk Assessment Tool

What to look for on inspections:
• The service provider has implemented a recognised ulcer risk assessment tool. The chosen risk assessment tool should reflect the care setting.
• Staff training has been provided regarding the implementation and application of the chosen risk assessment tool.
• All residents have their risk assessment status identified within six hours of admission or within the timescale stated in the services Pressure Ulcer Prevention Policy.
• The risk score is recorded in the personal plan.
• Any residents identified as being at any level of risk requires to have a care plan devised and implemented which meets their individual needs.
• The risk assessment is monitored at specified intervals.
• It is also re-evaluated if the residents’ physical or mental condition changes, for example, deteriorates or improves.

Summary

Risk assessment tools for pressure ulcer prevention are used to:
• Identifies residents’ ‘at risk status’ for potential pressure ulcer development
• Assist with identifying the risk factors which are unique to that individual and allow care to be planned appropriately
• Aid the allocation of limited pressure reducing resources to those who will benefit from them.

Risk assessment tools are:
• a formal assessment which works alongside the nurse’s clinical judgement which is referred to as informal assessment.
• an aide memoiré and not be used in isolation from knowledge of resident’s condition and clinical judgement.

References/Useful Links

European Pressure Ulcer Advisory Panel, Pressure Ulcer Prevention: Quick reference guide and National Pressure Ulcer Advisory Panel (2009)

NHS QIS Best Practice Statement (2009)

Prevention and Management of Pressure Ulcers

Pressure Ulcer Prevention: Quick reference guide
www.judy-waterlow.co.uk/index.htm

www.bradenscale.com/braden.PDF

www.tissueviabilityonline.com/risk-assessment