The second reason for emphasising workforce implications need to be considered. Workforce implications need to be effective, such evidence could deliver welcome news for healthcare providers but workforce implications need to be considered.

Processes versus outcomes

processes are to assess and demonstrate quality. Measures of process have significant advantages as measures of quality when once the process is measured is known to be linked to an improved outcome. An example might be “door to needle time” for patients with a myocardial infarction, where reducing the time between first presentation and intervention to unblock the coronary arteries reduces tissue damage and leads to improved outcomes. In the case of pressure ulcer prevention, as with many nursing interventions, it is hard to identify similarly evidenced elements of care which, in themselves, are known to lead to improved care. The temptation is to select care processes that are easily measured even when, as in the case of the Waterlow score, there is no real evidence to support their use.

The incidence of pressure ulcers may well be a valid nurse sensitive outcome but preventive care processes are not good quality indicators. There is not enough research to clearly establish the role of any of the existing pressure ulcer risk prediction tools in delivering effective prevention (although there may be sufficient evidence to reject some).

Of course, assessment on its own changes nothing. Evidence that outcomes are improved by using a tool is scant, even when risk as assessed by the tool is linked to an intervention. Given this limitation, it is hard to determine whether further preventive care based on the risk assessment is necessary or wasteful. It is certainly not sufficient just to assume that the presence of a risk assessment represents quality care – unless action is taken. Furthermore, the specific interventions that should result from a risk assessment of risk (or without the use of a tool) are unclear.

Ureter reporting

It seems clear that the starting point for judging the quality of pressure ulcer prevention is to measure and report the incidence of ulcers. However, simple reporting of rates will not allow meaningful comparison or benchmarking between wards and hospitals. Priorities for further research here include the development of a risk adjustment model that will allow the comparison of different provider units with different patient care mixes (Griffiths et al., 2008). But if we take the view asserted in the report on the high impact actions – that is, that pressure ulcers are “never events” – any ulcers that develop represent a potential deviation from best quality care. The significance of an ulcer is clear, whereas the significance of a completed risk assessment tool is not.

More generally, nurses should carefully consider the evidence for the link between care processes, such as risk assessment tools, and patient outcomes before deciding that a formal risk assessment should be adopted in practice and used as a marker of quality.

CONCLUSION

This brief overview of the evidence base for pressure ulcer prevention makes it clear that nursing quality cannot be easily determined by examining the specific preventive care provided.

That is not to say that there is no information to guide practice in this area. Research and expert opinion do give strong pointers on effective preventive care, which involves clinical assessment (but not necessarily the use of “tools” to do so), moving patients off standard beds on to high specification foam mattresses, overlays or alternating pressure mattresses, and the use of pressure relief devices in some circumstances. Although there is probably sufficient evidence to give some confidence that actions and decisions typically within nurses’ responsibility are likely to make a difference, there is not enough to be prescriptive about what actions should be undertaken and what circumstances.

There is a clear need for better assessment tools that predict risk accurately so overtreatment can be prevented, since none of the existing ones seems adequate. The absence of good quality evidence does not necessarily mean that the use of risk assessment tools has no place. However, based on the limited available evidence, it seems hard to justify using the presence of a completed Waterlow score as a marker of quality care and difficult to criticise practitioners who choose to use other and less formal approaches to assessment which might be superior.

The important thing is that practitioners do assess risk using their clinical judgements and, crucially, act on the assessments. Formal risk assessment tools may or may not have a place in practice – but the process is defined by good clinical judgement and appropriate intervention, not the use of a tool. Ultimately, it is shown by the absence of pressure ulcers. •

A version of this article appeared as an editorial in the International Journal of Nursing Studies (Full and Griffiths, 2010).

This article is informed by work undertaken by the National Nursing Research Unit, which receives support from the Policy Research Programme in the Department of Health. The views expressed here are not necessarily those of the DH.

REFERENCES


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