What is a comprehensive risk assessment?

By Jeri Lundgren, BSN, RN, PHN, CWS, CWCN

Prevention of pressure ulcers and skin breakdown begins with a comprehensive risk assessment. Most providers use a skin risk assessment tool, such as the **Braden** or **Norton** scale. While these tools have been validated to predict pressure ulcer development, their use alone isn't considered a comprehensive assessment, and frequently the individual risk factors they identify aren't carried through to the plan of care.

A comprehensive assessment

A comprehensive assessment for risk of skin breakdown should include a validated tool such as the Braden scale, but clinicians should also look for risk factors not included on the tool. For example, if your staff uses the Braden scale, you would also want them to consider other risk factors, including diagnoses, medications such as steroids, history of skin breakdown, cognition, the patient's choice to follow the interventions, and the use of medical devices. (See *Prevention points*.)

In addition, staff should evaluate the validated tool's scale subscores to help identify what is putting the patient at risk (for example, a person scored poorly under mobility and nutrition, so these areas should be addressed in the plan of care).

After completing the comprehensive risk assessment, the next step is creating the plan of care. All individual risk factors must be reviewed as the interdisciplinary team develops individualized interventions to help modify, stabilize, or remove the factors that are putting the patient at risk for skin breakdown.

A valuable tool

Managers should audit the current system to ensure it prompts staff to conduct a comprehensive risk assessment, not just complete the validated tool. Audit patient health records to ensure that everything that was identified on the comprehensive risk assessment has correlating interventions. The goal is to move away from paper compliance of filling out a risk assessment to truly developing a plan of care that will prevent skin breakdown. ■

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Prevention points

The National Pressure Ulcer Advisory Panel lists the following pressure ulcer prevention points:

Risk assessment

- Consider all bedbound and chairbound persons, or those whose ability to reposition is impaired, to be at risk for pressure ulcers.
- Use a valid, reliable, and age-appropriate method of risk assessment that ensures systematic evaluation of individual risk factors.
- Assess all at-risk patients/residents at the time of admission to healthcare facilities, at regular

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intervals thereafter, and with a change in condition. A schedule is helpful and should be based on individual acuity and the patient-care setting.
  - **Acute care:** Assess on admission; reassess at least every 24 hours or sooner if the patient's condition changes.
  - **Long-term care:** Assess on admission, weekly for 4 weeks, then quarterly and whenever the resident's condition changes.
  - **Home care:** Assess on admission and at every nurse visit.
- Identify all individual risk factors (decreased mental status, exposure to moisture, incontinence, device-related pressure, friction, shear, immobility, inactivity, nutritional deficits) to guide specific preventive treatments. Modify care according to the individual factors.
- Document risk assessment subscale scores and total scores and implement a risk-based prevention plan.

Skin care
- Perform a head-to-toe skin assessment at least daily, especially checking pressure points, such as sacrum, ischium, trochanters, heels, elbows, and the back of the head.
- Individualize bathing frequency. Use a mild cleansing agent. Avoid hot water and excessive rubbing. Use lotion after bathing. For neonates and infants, follow evidence-based institutional protocols.
- Establish a bowel and bladder program for patients/residents with incontinence. When incontinence can't be controlled, clean skin at time of soiling, and use a topical barrier to protect the skin. Select underpads or briefs that are absorbent and provide a quick drying surface to the skin. Consider a pouching system or collection device to contain stool and to protect the skin.
- Use moisturizers for dry skin. Minimize environmental factors leading to dry skin, such as low humidity and cold air. For neonates and infants, follow evidence-based institutional protocols.
- Avoid massage over bony prominences.

Nutrition
- Identify and correct factors compromising protein/calorie intake consistent with overall goals of care.
- Consider nutritional supplementation/support for nutritionally compromised persons consistent with overall goals of care.
- If appropriate, offer a glass of water when turning to keep the patient/resident hydrated.
- Administer multivitamins with minerals as prescribed.

Mechanical loading and support surfaces
- Reposition bedbound persons at least every 2 hours and chairbound persons every hour consistent with overall goals of care.
- Consider postural alignment, distribution of weight, balance and stability, and pressure redistribution when positioning persons in chairs or wheelchairs.
- Teach chairbound persons who are able, to shift weight every 15 minutes.
- Use a written repositioning schedule.
- Place at-risk persons on pressure-redistributing mattresses and chair cushions.
- Avoid using donut-type devices and sheepskin for pressure redistribution.
- Use pressure-redistributing devices in the operating room for patients at high risk for pressure ulcer development.
- Use lifting devices (such as a trapeze or bed linen) to move patients/residents rather than drag them during transfers and position changes.

- Use pillows or foam wedges to keep bony prominences, such as knees and ankles, from direct contact with each other. Pad skin subjected to device-related pressure and inspect regularly.
- Use devices that eliminate pressure on the heels. For short-term use with cooperative patients, place pillows under the calf to raise the heels off the bed. Place heel suspension boots for long-term use.
- Avoid positioning directly on the trochanter when using the side-lying position; use the 30-degree lateral inclined position.
- Maintain the head of the bed at or below 30 degrees or at the lowest degree of elevation consistent with the patient's/resident's medical condition.
- Institute a rehabilitation program to maintain or improve mobility/activity status.

Nutrition

- Implement pressure ulcer prevention educational programs that are structured, organized, comprehensive, and directed at all levels of healthcare providers, patients, families, and caregivers.
- Include mechanisms to evaluate program effectiveness in preventing pressure ulcers.

Download a PDF of these points.