OASIS Alert

Assessment: Skin Assessment or Pressure Ulcer Risk Assessments -- Do You Know the Difference?

You won't gather the most accurate information when you do risk assessments at SOC.

Conducting a pressure ulcer risk assessment not only prevents patients from developing painful wounds, it demonstrates the quality of the care your agency provides. But are you sure you're getting the most from your pressure ulcer and skin assessment?

Understand Why Skin Assessments are Important

Key: It's important to document a patient's skin status on admission "so you don't get dinged for skin damage that started in the hospital, says **Dorothy Doughty, MN, RN, CWOCN, FAAN,** director of the Wound Ostomy Continence Nursing Education Center at **Emory University** in Atlanta.

Sometimes, clinicians don't understand the importance of conducting a pressure ulcer risk assessment, says **Sue Hull, MSN, RN, CWOCN** with **WoundConsultations.com** in Craig, Alaska. When the patient's skin is in good condition, there's a tendency to think of the risk assessment as "just a time-consuming, unnecessary, one more thing we have to do," she says.

Question: "If a patient has suffered a cerebrovascular accident (CVA), has hemiplegia, has made it through the hospital stay without getting a pressure ulcer, and is now home with intact skin, how long do you think that skin will stay intact without measures taken to keep it that way?" Hull asks. Probably not long, she says.

Uncover Potential Problems with Risk Assessments

Using a pressure ulcer risk assessment tool such as the Braden Scale or the Norton Scale gives you a consistent method for addressing each area of risk for skin breakdown in a consistent way so nothing is missed, Hull says.

When you "get to the home, and the patient is all spiffed up because the nurse is coming, and everyone is wearing their company smiles, it might not be obvious that he can't feel his right heel, and he neglects the whole right side of his body," Hull says. Risk assessments help make the nurse, the patient, and the caregiver aware of potential problems that might not be noticed otherwise.

Why use a tool? "It has been established that using a tool is better than relying on the clinical judgment of the assessor, or simply treating all patients as though they were high risk, which would be a poor use of agency, patient, and government resources," Hull says.

Establish Risk Assessment Frequency

In home health, everyone does some sort of risk assessment on admission, but beyond that, agency policies differ, Hull says.

Problem: Suppose your agency policy is to have RNs do the OASIS visits and LPNs do the routine visits, while only RNs do the pressure ulcer risk assessments. The start of care (SOC) risk assessment might not be accurate because the nurse doesn't yet know the patient, and the patient and family might not even know what is currently true for the patient, Hull says.

For example, the patient might have undergone recent changes, but she and her family might not yet know what the

effects of those changes will be, Hull says. Also, when asked about things, patients often answer with how things were, not how they are now, she says.

Best practice: Perform a pressure ulcer risk assessment during each of the first three visits, no matter who is doing the visits, Hull says. It's only after repeat visits that you'll start to become familiar with the patient and be better able to gather a true understanding of her pressure ulcer risk.

Don't Confuse Pressure Ulcer Risk with Skin Assessment

One common misconception is that the pressure ulcer risk assessment and the skin assessment are the same thing. Not so, Hull says.

Key difference: The pressure ulcer risk assessment indicates what might be, while the skin assessment reports what is true now, Hull says. Both assessments are necessary.

For example, suppose your patient has had a change in condition that limits his mobility. His skin might be fine now based on the skin assessment, but you can't assume it will stay that way, Hull says. The risk assessment gives you an idea about how likely he is to get a pressure ulcer if no preventive measures are taken, she says.

Technique: Things can feel uncomfortable when it comes time to do the skin assessment at SOC, Hull says. "You have just met this woman, and now you want to have a look at her backside. How awkward is that?"

"One approach I use is to ask her to go get her medications, so I can see her get up and walk," Hull says. "But before she actually gets up, I explain that I need to look at her skin, and ask if it would be okay if I do that while she is still standing, and before she sits back down. I have never had anyone question that approach," she says.

Patients in bed are easier to inspect, but patients who are in wheelchairs and can't stand up are more difficult, Hull says. Transferring the patient to his bed can help solve this problem. "If that can't be done on the first visit, I try to arrange for another visit the next day either before they get out of bed in the morning, or after they are back in bed," she says. Take advantage of the five days you are allowed to complete the OASIS-C assessment.

Report Your Findings

You'll report the risk assessment results in M1300 -- Pressure Ulcer Assessment and 1302 -- Does this patient have a Risk of Developing Pressue Ulcers? Report interventions, based on the risk assessment results, in M2250 f -- Plan of Care Synopsis; Interventions to preventpressure ulcers.

You'll record the information you gather during the skin assessment in the rest of the OASIS integumentary items, but these items only specifically address pressure ulcers, stasis ulcers and surgical wounds, Hull says. Only M1350 -- Does the patient have a Skin Lesion or Open Wound ... addresses other types of wounds.

You'll report whether interventions or treatments related to current pressure ulcers are part of the physician ordered plan of care in M2250 g -- Plan of Care Synopsis; Pressure ulcer treatment ... .

Editor's note: For a handy tool with pressure ulcer prevention intervention ideas, see page 91.