MDS Alert

Care Planning: Shore Up Pressure Ulcer Risk Assessment

This clinical scenario illustrates how a Braden scale score can be way off the mark, according to nurse QI expert.

In a talk at the recent LeadingAge annual meeting, **Karen Russell, RN,** presented a case report about a 69-year-old man with metastatic cancer admitted to long-term care following a spinal tumor resection at T-8. He was "anemic and also hypertensive, very alert and oriented" and had a stage 2 pressure ulcer on his coccyx, said Russell, who works for the Pennsylvania Restraint Reduction Initiative.

The man's "admission Braden score was 17 [and] ... one week later was 18 -- it actually got better," Russell relayed. Yet on "week three, he had a new stage 2 on a heel and the other ulcer was still not healed." And "he scored 18 again on the Braden that week."

Good question: Russell acknowledged that conferees must be thinking "how in the world can you have two pressure ulcers on your body and have such a high Braden score, which means you are low risk for breakdown?" (To review the Braden, go to www.vnaa.org/vnaa/GeneralcontentPages/HTML/Braden_Risk.pdf.)

The answer: Russell said that in reading the patient's chart, she found that the nursing facility staff "completely did not assess his sensory perception correctly" on the Braden, as he'd had numbness and tingling in his lower extremities for six months before the tumor resection at T-8. The nurses doing the Bradens had asked the resident about his lower extremity sensation, Russell added. But "they weren't doing anything specifically to touch and have him identify if he could feel." And the resident was telling the nurses that his sensation felt "normal." When Russell asked the resident what he meant by "normal," he said, "numb and tingling."

"That was one big piece that they missed," Russell said. But another "big risk area" for the resident was his nutrition, "although he ate tremendously from day one..." What the Braden couldn't capture "is the fact that ... six months prior until he had his surgery, the man had a 40-pound weight loss." As a result, his "protein stores were probably depleted. His body is fighting metastatic cancer ... [and] trying to heal a surgical incision and also heal pressure ulcers."

Also: The staff scored the man's subsequent Braden higher on activity "because after he was there for the first week, he started taking himself around the facility in a wheelchair," Russell reported. Yet she saw the man sitting in his wheelchair at the nurse's desk "rocking back and forth ... using his wheelchair as a rocker." As he rocked, "he was coming up on his heels constantly," Russell said, noting that the man had skin breakdown on his heel. When asked about that, "the resident said he didn't feel [it] at all."

Bottom line: "Everyone takes the time to do an admission risk assessment, whether it's the Braden or Norton or whatever form," says Russell. And "the forms are wonderful and a huge help to guide meaningful care plans," she adds. But "they don't answer every question about the person's risk."

Russell thus advises nursing facility staff "to investigate pressure ulcer risk with additional questions where they talk to the people in the acute-care setting. Ask what the person's activity level has been and their meal intake. Sometimes you get that information and sometimes not," she points out. "You might get a note saying 'out of bed,' but you don't know for how long."

Also: Russell says she wishes "that every risk assessment had a question about whether the person has a history of pressure ulcers." She noted in her presentation, however, that "it's not a question that's going to be on that Braden."

"If I just had one question to ask of the person at the discharging facility, that would be it -- previous history is the

biggest predictor of whether someone will break down again," Russell stresses. "Yet, you often don't see that as part of the medical record." Russell tells MDS Alert that she's "not sure why that information doesn't make it into the chart. Maybe it is because pressure ulcers are viewed so negatively."

Options: You could ask the person, if they can tell you, whether they've had a pressure ulcer or "bed sore," Russell suggested in her presentation. "Maybe the family would know if there was a history."

Sidestep This Care Planning Shortfall

Ruth Bish, RN, who co-presented with Russell, said that she finds that "people total up the numbers on the Braden scale and say, 'Oh, it's this number, so they are high risk or they are medium risk or ... low risk.'" Then the staff implements a "canned care plan intervention" for every high-risk person. But "does every high risk person develop a pressure ulcer? No. Do we have low-risk people who develop pressure ulcers? Yes."

"The key to preventing [pressure ulcers] is really to have individualized care plan interventions," stressed Bish, who is also with the Pennsylvania Restraint Reduction Initiative. "We all say that we want that and we all say that we do that." But Bish cautioned that she and Russell "read lots and lots of care plans and they all sound the same -- or pretty close to the same."

"A person's mobility, for example, could be impaired for a number of reasons," Bish tells MDS Alert. "But when you just look at the mobility score [on the Braden] and put someone on a preplanned care plan [to turn and reposition very two hours] if they are moderate or high risk ... you don't know if the person isn't moving because they are in pain or depressed. Turning and repositioning isn't going to reduce either of those risk factors whereas a good pain program or treatment for depression could modify the risk factors."

"The Braden is a good starting place and covers a lot but you have to look at additional risk factors and find what's causing each category to be a risk...," Bish concludes.

Editor's note: See the next MDS Alert for part 2 of this article on the LeadingAge presentation.

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