MDS Alert

Quality of Care: Boost Your Braden Scale Expertise

QI nurse explains positioning techniques.

In a talk at the recent LeadingAge annual meeting, nurses **Ruth Bish and Karen Russell** presented inside tips for acing the Braden scale and care planning.

"The first section on the Braden is sensory perception," said Bish, who is with the Pennsylvania Restraint Reduction Initiative. And "as I look at a lot of Braden scales, this is probably the one section that is most often coded incorrectly," she told conferees.

What the Braden is "looking for on the sensory perception is the ability to feel pressure-related discomfort," said Bish. "And a lot of nurses interpret that as if the person can feel pain, their sensory perception is fine. But we all know of a lot of diabetics who have neuropathies," Bish pointed out. And "while they have a lot of pain in their legs, they can't feel that pressure-related discomfort," said Bish.

"Nurses often sit at the nurses' station and fill this out," Bish observed. But "you really have to go back and look at the resident and touch them to determine what the sensory perception is," she emphasized. "If you do not have a procedure in place for how to do this, this is something you should work on," Bish said. "The one that we have felt has worked successfully for a lot of facilities is using the monofilaments," she added. "When you start looking and researching this, you can find procedures that have you touch 28 parts of the foot down to about four. So it's what you come up with that works for you."

Also: "As you build your policy, one of the things that you want to make sure is that you have a time when you [ask the resident] 'can you feel this?' when you're not touching anything," Bish added.

Pointers: "Floating heels" is a very common intervention, observed Bish. But it's "not an appropriate intervention for every single person who falls in whatever risk category that you are putting it for," she cautioned. "If a person is able to move their legs independently and does, this isn't appropriate because who of us would lay there with our heels suspended over a pillow all night long? We are going to move our legs. And so are those residents," Bish said. "So it's really just for residents who are not capable of repositioning themselves."

"One of the things that we have learned from facilities ... is that once we determine that bed pillows are too flat to be used under the head, we decide we should reposition with them," Bish relayed. And "so what we have run into a number of times is residents whose heels are properly floated except that the pillows are so flat that the heels are touching the bed," she said. "If that is the case, and you're using really thin pillows that don't get the feet up, then you need to ... get thicker pillows or come up with a different thing. There are commercial devices out there that also help lift the heels, but if you do pillows correctly, most of the time they work well."

Problem: "Sometimes you will get people who are really exuberant in what they do and make the pillows too high," said Bish. And when "the heels are elevated high off the bed, it can hyperextend the knees and make pain."

Focus on More Than Incontinence

"The next section on the Braden has to do with moisture," Bish told conferees. "And when we think of moisture, we think of urine and feces, but what they actually are

talking about is not only moisture from incontinence," but also perspiration, wound drainage "and any other kind of moisture that there be."

Bish said her "big point" with this one, however, "is something where we really miss the boat in long-term care." And that is "we have residents who are incontinent and once they are incontinent, we assume that they are incontinent and there's nothing we can do about it."

"We really need to be looking at that person to determine the type of urinary incontinence that they have," Bish stressed, noting that "CMS in the urinary incontinence regulation has identified six different types of incontinence." (See page 20 of this issue.)

Someone with urge incontinence and bladder spasms "may feel that urge to go 15 minutes after they have been toileted," Bish pointed out." So "a two-hour toileting program isn't appropriate for that person," she added. "And if they have stress incontinence -- again, cough or sneeze or laugh -- you can have all the toileting programs you want, but it's not going to prevent that type of incontinence," Bish said.

"We also need to make sure that we are looking for reversible types of incontinence," such as UTI which "is one of the most common where when the person gets a UTI, all of a sudden they are incontinent," Bish said.

"Overflow incontinence is another one that I think often affects our residents' skin," Bish said.

Activity and Mobility

"What activity means when it's on the Braden scale is how we get from one place to another for our residents," Bish said. "Are they chair-bound? Are they able to ambulate?" Bish recounted hearing a phrase that she "just loved and it is 'We need to be moving toward a culture of mobility.'"

"We need to think about what opportunities can we create through the day to get that person up and moving; or if they are chair bound, let's get some opportunities to sit in a different chair," Bish said.

"If a person is ambulatory, my big frustration with restorative programs is I will see 'resident will ambulate 50 feet twice a day with a wheeled walker and assist of two,'" Bish noted. But when she asks staff how often the resident walks, they answer "twice a day with restorative." Yet "nobody else ever walks them," Bish said. "It doesn't mean that we can't park the wheelchair 10 or 15 feet from the dining seat and walk in or walk into the bathroom instead of wheeling the wheelchair directly up to the toilet for a stand pivot," she added.

"As you are looking at the Braden and care planning opportunities that come out of this, look to see what can we do to get that person more active."

"Mobility is the next section on the Braden," Bish said. "And oftentimes people get activity and mobility mixed up. But activity really is how do you move from place to place and the mobility part is how does that person change position in their chair or in their bed?"

Clinical gem: "Take a look at people who are lying on their sides," advised Bish. She noted that while doing wound rounds in one facility, she saw that patients with pressure ulcers located mostly on their bottoms "looked like they were beautifully [positioned] on their sides." But "when we pulled the sheet down ... what we found was that instead of the weight being up off of their bottoms, their bottoms had fallen ... flat on the bed and the shoulders were turned," said Bish.

The person's "pelvis should be a 30 degree angle from the bed because we don't want them the whole way over on their trochanter," Bish explained. "And an easy way to teach your staff to do that is when you have that person propped on their side with the pillow or whatever you are using behind their back, you should be able to slide your hand on the bed and not touch their bottom."

Brush Up on Nutrition

"We all know that adequate nutrition is the foundation for healthy skin," said Russell, who is also with the Pennsylvania Restraint Reduction Initiative. And "if you do use the Braden, you realize that what it's actually asking you on the Braden is portions of protein that a person takes in," she added.

Russell noted that in the facilities she works with intakes are typically "recorded in either a point system ... or a percentage -- they ate 50 percent or 75 percent of their breakfast. But when I'm looking at the way that information is recorded, I have no idea what it means that [the residents] are eating. So if everyday when they eat and there is a certain percentage of something left there, are they leaving the protein all the time?"

"For anybody, we need to jump on when that appetite really starts to decrease and find out what it is they are actually eating in a meal so that we can supplement where we need to," Russell stressed.