TENNESSEE Center for Patient Safety

HAPI Panel of Experts Topic of the Month – August 2019

Interventions for Braden Subscales

Introduction

The different categories or subscales of the Braden scale provide important information about a patient's risk for developing a pressure injury. Most hospitals direct prevention strategies toward the total Braden scale score, but patients that have a high to moderate total score can have low scores in a single subscale area and still develop a pressure injury. By focusing on subscale scores and directing interventions toward subscale score results, prevention efforts can be tailored to the patient's risks and help prevent pressure injuries. To that purpose, the HAPI Panel of Experts compiled the following list of interventions by subscale.

Braden Subscales and Related Pressure Injury Prevention Strategies

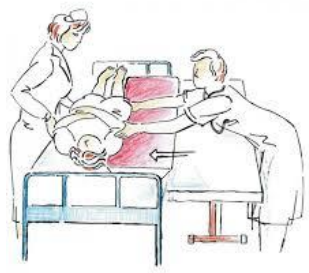
BRADEN SUBSCALE	QUESTIONS TO CONSIDER	INTERVENTION
Sensory Perception 	Is my patient able to feel or realize discomfort related to pressure from position and devices?	• Trace lines and devices to ensure they are not beneath the patient • Frequently assess skin in areas of altered perception • Turn/reposition regularly using appropriate assist devices • Consider preventive foam dressings in high-risk areas (heels, sacrum, beneath devices) • Utilize a specialty support surface • Consider therapeutic surface for OR table for surgeries lasting longer than 90 minutes

Moisture 	To what extent are areas of my patient's skin exposed to moisture?	• Utilize technologies for moisture management:
		  ○ Air flow underpads
		  ○ Barrier creams
		  ○ Fecal management devices
		  ○ Condom catheters/external female catheters
		  ○ Wicking material between skin folds
		• Change gown and linens as frequently as needed
		• Implement a toileting schedule
		• Consider a low-air-loss mattress
		• Avoid multiple linen layers beneath the patient
		• Avoid fluid pooling beneath patient during surgery

Activity 	Is my patient able to walk?	• Encourage activity as able:
		  ○ Ensure necessary assist devices are on hand
		  ○ Ensure adequate lighting and clear pathways
		  ○ Engage family in promoting activity
		  ○ Establish daily activity goals
		• Consider PT/OT consult for activity and appropriate support surfaces (chair, mattress)
		• Turn/reposition regularly using appropriate assist devices
		• Use preventive foam dressings and off-loading devices
		• Teach and remind to do weight-shifting when up in chair

Mobility 	Is my patient able to move and change positions?	• Turn/reposition frequently using appropriate assist devices; use microturns if patient cannot tolerate full turns • Utilize a specialty support surface • Utilize preventive foam dressings and off-loading devices • Trace lines and devices to make sure they are not beneath the patient • Assess skin frequently • Keep head of bed below 30° as much as possible

Nutrition
 
	How well is my patient taking in fluids and foods (especially protein)?	• Establish standing order criteria for nutrition consultation
		• Offer fluid intake on hourly rounds, unless contraindicated
		• Carefully monitor fluid and food intake
		• Encourage high-protein menu items and snacks, unless contraindicated
		• Engage family in regularly offering fluid and food intake as appropriate
		• Make provisions for family to heat/cool and store allowable favorite food or beverage items brought in from home
		• Enhance nutritional intake with meals:
		  ○ Raise head of bed or assist to chair for meals
		  ○ Assist patient with washing face and hands before meals
		  ○ Set up tray and assist with meal as needed

Fricton and Shear 	Is my patient's skin sliding against sheets, the chair, or other devices?	• Consider addition of trapeze to bed • Use transfer sheets and other devices to ensure patient skin does not drag against linens during transfers, turns, and repositionings ○ Train and audit staff; include transporters • Lower head of bed before boosting patient up in bed; keep knees elevated to prevent sliding down • Keep head of bed below 30° as much as possible • Place preventive foam dressings on high-risk areas such as sacrum, heels, elbows, and beneath devices • Assess skin frequently beneath devices and in high-risk areas

The HAPI Panel of Experts is a group of wound care and quality professionals who represent hospitals of varying sizes and geographic regions of Tennessee. The Panel convenes monthly to discuss a topic specific to pressure injury prevention and share their practices and recommendations.

Panel of Experts

Jennifer Vandiver, BSN, RN, CWON - West Tennessee Healthcare

Julie Brandt, MSHA, BSN, RN, WOCN - Erlanger Health System

Lauren White, MBA, BSN, RN - Vanderbilt University Medical Center

Sonya Clark, RN, CWOCN - Henry County Medical Center

Suzanne Kuhn, RN, CWS - Delta Medical Center

If you would like to suggest a topic for the Panel to discuss, please email your request to Rhonda Dickman at rdickman@tha.com.

Many thanks to the Adult Hospital WOCN Team of Vanderbilt University Medical Center for sharing an example, below, of aligning pressure injury prevention strategies to each of the Braden subscales. Their "P.I.P." Sheet, below, provides both text and photos to aide staff in choosing correct interventions.

VANDERBILT UNIVERSITY MEDICAL CENTER

"P.I.P." Sheet

Pressure Injury Prevention Interventions

VANDERBILT UNIVERSITY MEDICAL CENTER

BRADEN SCORE RISK FACTORS*:	Consider these INTERVENTIONS for your patient
Mobility • Makes no changes in body positions • Very limited on movements **Activity** • Bedfast • Ambulation is limited to non-existent **Sensory** • Unresponsive • Very limited response to stimuli	 Turn q 2 hours  Chair cushion  TAP system  Heel boot   Mepilex sacral/heel foam
Shear/Friction • Needs maximum or moderate assistance in moving • Slides down in bed or chair frequently	 Trapeze  TAP system  Mepilex sacral/heel foam
Nutrition • NPO or clear liquids for greater than 5 days • Eats less than 50% of meals per day • Receives less than optimum tube feeds	   Consider a **Nutrition Consult**
Moisture • Constantly wet from urine or stool • Linens changed once per shift	   **Other items to consider:** -Condom catheter -PureWick female catheter -Rectal pouch -Bowel management system Criticaid ointment 3M barrier Cleansing cloths

*based on a patient assessment of subset 1 or 2

Created by: Vanderbilt University Adult Hospital WOC Nurse Team