

LAKESWOOD HEALTH SYSTEM

SUBJECT: Braden Scale for Predicting Pressure Sore

Label

SOURCE: Nursing Standards

REVIEWED: 5-2008

9 or less = Very High Risk 13-14 = Moderate Risk		10-12 = High Risk 15-18 = Mild Risk		DATE OF ASSESSMENT								
RISK FACTOR		SCORE / DESCRIPTION				1	2	3	4			
SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort		1. Completely limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation, or has limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness or has some sensory impairment which limits ability to feel pain or discomfort over 1/2 of body.	3. Slightly limited Responds to verbal commands, but cannot always communicate discomfort or need to be turned, or has some sensory impairment which limits ability to feel pain or discomfort in one or two extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to voice pain or discomfort.							
MOISTURE degree to which skin is exposed to moisture		1. Constantly Moist Skin is kept moist almost always by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. Often Moist Skin is often but not always moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change about once a day	4. Rarely Moist Skin is usually dry, requiring linen change only at routine intervals.							
ACTIVITY degree of physical activity		1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair	3. Walks occasionally Walks occasionally during day but for very short distances, with or without assistance. Spends most of each shift in bed or chair	4. Walks frequently Walks outside the room at least twice a day and inside room at least once every two hours during waking hours							
MOBILITY ability to change and control body position		1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly limited Makes frequent though slight changes in body or extremity position independently.	4. No limitations Makes major and frequent changes in position without assistance.							
NUTRITION usual food intake pattern		1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings of protein (meat and dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement or is NPO and/or maintained on clear liquids or IVs for more than five days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, or receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat and dairy products) each day. Occasionally will refuse a meal, but will take a supplement if offered, or is on tube feeding or TPN regimen, which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.							
FRICION & SHEAR		1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	2. Potential problems Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in bed or chair most of the time but occasionally slides down.	3. No apparent problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.								
TOTAL SCORE		Refer to Skin Safety Policy										
ASSESS.	DATE	EVALUATOR SIGNATURE		ASSESS.	DATE							
1	/ /			3	/ /							
2	/ /			4	/ /							

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Additional Risk assessments:

- Individual able to shift weight in chair or bed independently?
 Yes No (begin Tissue Tolerance assessment
** Care Center Only)
- Individual experiencing acute illness?
 Yes No
**(Increase risk level by one if individual has fever, ↓albumin or pre-albumin or has a diastolic BP < 60.)
- Individual has chronic or terminal illness?
 Yes No

- Previous history of pressure damage?
 Yes No
- Extreme age consideration? (<16 or >80)
 Yes No
- Medication? – Chemotherapy, Psychotropic, or steroid use?
 Yes No
- Consider an Nutritional Lab Levels (Albumin, Pre-Albumin and HGB)

Nsg Diagnosis: Potential for impaired skin integrity as evidenced by Braden Score =<18 or Individual Risk Score = < 3.

Overall Braden Score: _____ Weight: _____

Goal: 1) Eliminate Pressure 2) Improve Sensory Perception, Activity, Mobility, Tissue Tolerance

Risk Factors	Interventions		
	All Patients	Bedfast	Chairfast
<input type="checkbox"/> Total Score 18 or less <input type="checkbox"/> Scored 3 or lower in Sensory Perception <input type="checkbox"/> Scored 3 or lower in Activity <input type="checkbox"/> Bedfast <input type="checkbox"/> Chairfast <input type="checkbox"/> Scored 3 or lower in Mobility	<input type="checkbox"/> Pressure support surfaces to re-distribute (reduce/relieve) pressure <input type="checkbox"/> If > 300#, consider a bariatric bed <input type="checkbox"/> Free-float heels by elevating calves on pillows – keeping heels free of all surfaces / Use Heel boot <input type="checkbox"/> Elbow protectors as indicated <input type="checkbox"/> Minimize/eliminate pressure from medical devices - assess Q shift <input type="checkbox"/> Referral to WOC nurse if total score is 12 or less	<input type="checkbox"/> TTT - Tissue Tolerance Testing (if unable to or non-compliant w/ shifting weight independently) **Care Center Only <input type="checkbox"/> Initiate Stage I protocol as directed by TT <input type="checkbox"/> Encourage individual to make frequent small position changes <input type="checkbox"/> Use pillow or wedges to reduce pressure on bony prominences <input type="checkbox"/> At a MINIMUM – turn every 2 hours <input type="checkbox"/> PT/OT consults <input type="checkbox"/> Assist w/ PROM	<input type="checkbox"/> TTT - Tissue Tolerance Testing (if unable to or non-compliant w/ shifting weight independently) **Care Center Only <input type="checkbox"/> Initiate Stage I protocol as directed by TTT <input type="checkbox"/> Encourage individual to weight shift every 15 minutes <input type="checkbox"/> Reposition every 1 hour if patient unable to reposition self as directed by TTT <input type="checkbox"/> PT/OT consults <input type="checkbox"/> Assist w/ PROM <input type="checkbox"/> Utilize pressure re-distribution cushion while sitting

Goal: Eliminate Friction / Shear

Risk Factors	Interventions
<input type="checkbox"/> Total Score 18 or less <input type="checkbox"/> Scored 3 or lower in Friction / Shear	<input type="checkbox"/> Utilize transfer or assistive devices to reduce friction / shear <input type="checkbox"/> Use lift sheets or devices to turn, reposition or transfer patients <input type="checkbox"/> Maintain HOB at or below 30 degrees or lowest possible level of elevation base on medical condition of individual. <input type="checkbox"/> Match knee angle with angle of the HOB <input type="checkbox"/> Keep skin clean and dry <input type="checkbox"/> Use trapeze for assist in repositioning when not contraindicated <input type="checkbox"/> PT/OT consults <input type="checkbox"/> Consider non-slip surface for bed or W/C to decrease shear

Goal: 1) Manage/reduce moisture against skin 2) Protect intact skin

Risk Factors	Interventions
<input type="checkbox"/> Total Score 18 or less <input type="checkbox"/> Scored 3 or lower in Moisture <input type="checkbox"/> Incontinent of Bowel <input type="checkbox"/> Incontinent of Bladder <input type="checkbox"/> Wound dsg. saturated daily	<input type="checkbox"/> Implement toileting schedule as appropriate <input type="checkbox"/> Cleanse skin gently w/ pH-balanced cleansers, dry well and apply moisture barrier w/ each incontinent episode <input type="checkbox"/> Use Pro-shield Plus on Intact skin. <input type="checkbox"/> EPC Zinc oxide ointment on red, irritated skin. If no effect obtain referral to WOC nurse. <input type="checkbox"/> Contain urine and stool. Only use chux/diapers/ pads when appropriate <input type="checkbox"/> Communicate incontinent episodes to primary care nurse <input type="checkbox"/> Contain wound drainage – consider Wound / Ostomy nurse referral. <input type="checkbox"/> Keep skin folds dry

Goal: 1) Improve/maintain Nutrition / Hydration 2) Protect intact skin

Risk Factors	Interventions
<input type="checkbox"/> Total Score 18 or less <input type="checkbox"/> Scored 3 or lower in Nutrition	<input type="checkbox"/> Provide nutrition compatible w/ individual choices/wishes and medical condition <input type="checkbox"/> Alert the staff when hydration has been withheld (i.e. -NPO) and intervene with food / fluids when restriction is lifted <input type="checkbox"/> Dietary consult if Score 18 or less. Consider order for nutritional values – HGB, Albumin, and PreAlbumin. <input type="checkbox"/> Advance diet and provide / encourage intake of supplement & fluids as medically indicated.

Other Interventions

Primary Nurse to complete a **DAILY Braden** of all IP, ICU, OP 24 hour stay, SW & BHU patients. Care Center residents - Weekly x4 wks and then quarterly. Comprehensive skin assessment by RN at admit, then daily skin inspection by primary nurse on IP, ICU, OP 24 hour stay, SW and BHU patients and weekly on SW, Care Center and Home Care patients.