

# LAKEWOOD HEALTH SYSTEM

SUBJECT: Braden Q Scale for Predicting Pressure

Score Use for individuals under age 16

Label

SOURCE: Nursing Standards

REVIEWED: 5-2008

Score <16 = High Risk		17-21 = Moderate Risk		22-25 = Mild Risk		DATE OF ASSESSMENT					
RISK FACTOR		SCORE / DESCRIPTION				1	2	3	4		
<b>MOBILITY</b> ability to change and control body position		1. <b>Completely Immobile</b> Does not make even slight changes in body or extremity position without assistance.	2. <b>Very Limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. <b>Slightly limited</b> Makes frequent though slight changes in body or extremity position independently.	4. <b>No limitation</b> Makes major and frequent changes in position without assistance.						
<b>ACTIVITY</b> degree of physical activity		1. <b>Bedfast:</b> Confined to bed	2. <b>Chair fast:</b> Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted in to chair or wheelchair.	3. <b>Walks Occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. <b>All patients too young to ambulate OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.						
<b>SENSORY PERCEPTION</b> ability to respond meaningfully to pressure-related discomfort		1. <b>Completely Limited:</b> Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface.	2. <b>Very Limited:</b> Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	3. <b>Slightly Limited:</b> 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 1 or 2 extremities.	4. <b>No Impairment:</b> Responds to verbal commands. Has no sensory deficit, which limits ability to feel or communicate pain or discomfort.						
<b>Tolerance of the skin and supporting structure</b>											
<b>MOISTURE</b> degree to which skin is exposed to moisture		1. <b>Constantly Moist:</b> Skin is moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. <b>Very Moist:</b> Skin is often, but not always moist. Linen must be changed at least every 8 hours.	3. <b>Occasionally Moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	4. <b>Rarely Moist:</b> Skin is usually dry, routine diaper changes, linen only requires changing every 24 hours.						
<b>FRICTION &amp; SHEAR</b>		1. <b>Significant Problem:</b> Spasticity, contracture, itching or agitation leads to almost constant thrashing and friction.	2. <b>Problem:</b> 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.	3. <b>Potential Problem:</b> Moves feebly or requires minimum assistance. During a move skin slides to some extent against sheets, chair, restraints, or other devices. Maintains good position in chair or bed most of the time but occasionally slides down.	4. <b>No Apparent Problem:</b> Able to completely lift during a position change; Moves independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.						
<b>NUTRITION</b> <u>usual</u> food intake pattern		1. <b>Very Poor:</b> NPO and/or maintained on clear liquids, or IVs for more than 5 days OR Albumin <2.5 mg/dl OR Never eats a complete meal. Rarely eats more than 1/2 of any food offered. Protein intake is only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. <b>Inadequate:</b> Is on liquid diet or tube feedings/TPN which provide inadequate calories and minerals for age OR Albumin <3 mg/dl OR 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.	3. <b>Adequate:</b> Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. <b>Excellent:</b> Is on a normal diet providing adequate calories for age. For example: eats/drinks most of every meal/feeding. 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.						
<b>Tissue Perfusion and Oxygenation</b>		1. <b>Extremely Compromised:</b> Hypotensive (MAP <50mmHg; <40 in a newborn) OR the patient does not physiologically tolerate position changes.	2. <b>Compromised:</b> Normotensive; Oxygen saturation may be <95 % OR hemoglobin may be < 10 mg/dl OR capillary refill may be > 2 seconds; Serum pH is < 7.40.	3. <b>Adequate:</b> Normotensive; Oxygen saturation may be <95 % OR hemoglobin may be < 10 mg/dl OR capillary refill may be > 2 seconds; Serum pH is normal.	4. <b>Excellent:</b> Normotensive, Oxygen saturation >95%; Normal Hemoglobin ; & Capillary refill < 2 seconds.						
<b>TOTAL SCORE</b>		<b>Refer to Skin Safety Policy</b>									
<b>ASSESS.</b>	<b>DATE</b>	<b>EVALUATOR SIGNATURE</b>				<b>ASSESS.</b>	<b>DATE</b>				
1	/ /					3	/ /				
2	/ /					4	/ /				

**Additional Risk assessments:**

- Individual able to shift weight in chair or bed independently?  
 Yes  No (begin Tissue Tolerance assessment)
- Individual experiencing acute illness?  
 Yes  No  
\*\*(Increase risk level by one if individual has fever, ↓ Albumin or PreAlbumin, or has diastolic BP < 60)
- Individual has chronic or terminal illness?  
 Yes  No
- Previous history of pressure damage?  
 Yes  No
- Extreme age consideration?  
 Yes  No
- Consider an Nutritional Lab Levels (Albumin, Pre-Albumin and HGB)

Nsg Diagnosis: Potential for impaired skin integrity as evidenced by Braden Score = <25 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 25 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 25 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 25 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 25 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 – <b>HGB, Albumin, and PreAlbumin.</b> <input type="checkbox"/> Advance diet and provide / encourage intake of supplement & fluids as medically indicated.

**Goal: 1) Maintain tissue Perfusion/Oxygenation 2) Protect intact skin**

Risk Factors	Interventions
<input type="checkbox"/> Total Score 25 or less <input type="checkbox"/> Scored 3 or lower in Nutrition	<input type="checkbox"/> Apply O2 as indicated by MD order <input type="checkbox"/> Apply warm blanket PRN <input type="checkbox"/> Assess newborn perfusion status per Newborn assessment criteria

**Other Interventions**

Primary Nurse to complete a **DAILY Braden Q** on all IP 16 yr and younger. Daily skin assessment by primary nurse.