

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		
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 completely turn self independently.	3. Slightly limited Makes frequent though slight changes in body or extremity position independently.	4. No limitation Makes major and frequent changes in position without assistance.						
ACTIVITY degree of physical activity		1. Bedfast: Confined to bed	2. Chair fast: Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted in to chair or wheelchair.	3. Walks Occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.						
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 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 sensory impairment which limits the 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 1 or 2 extremities.	4. No Impairment: Responds to verbal commands. Has no sensory deficit, which limits ability to feel or communicate pain or discomfort.						
Tolerance of the skin and supporting structure											
MOISTURE degree to which skin is exposed to moisture		1. Constantly Moist: Skin is moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very Moist: Skin is often, but not always moist. Linen must be changed at least every 8 hours.	3. Occasionally Moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely Moist: Skin is usually dry, routine diaper changes, linen only requires changing every 24 hours.						
FRICTION & SHEAR		1. Significant Problem: Spasticity, contracture, itching or agitation leads to almost constant thrashing and friction.	2. 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.	3. Potential Problem: 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. No Apparent Problem: 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.						
NUTRITION <u>usual</u> food intake pattern		1. Very Poor: 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. Inadequate: 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. Adequate: 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. Excellent: 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.						
Tissue Perfusion and Oxygenation		1. Extremely Compromised: Hypotensive (MAP <50mmHg; <40 in a newborn) OR the patient does not physiologically tolerate position changes.	2. Compromised: 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. Adequate: 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. Excellent: Normotensive, Oxygen saturation >95%; Normal Hemoglobin ; & Capillary refill < 2 seconds.						
TOTAL SCORE		Refer to Skin Safety Policy									
ASSESS.	DATE	EVALUATOR SIGNATURE				ASSESS.	DATE				
1	/ /					3	/ /				
2	/ /					4	/ /				

Additional Risk assessments:

1. Individual able to shift weight in chair or bed independently?
 Yes No (begin Tissue Tolerance assessment)
2. Individual experiencing acute illness?
 Yes No
** (Increase risk level by one if individual has fever, ↓ Albumin or PreAlbumin, or has diastolic BP < 60)
3. Individual has chronic or terminal illness?
 Yes No
4. Previous history of pressure damage?
 Yes No
5. Extreme age consideration?
 Yes No
6. 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 – HGB, Albumin, and PreAlbumin. <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.