BRADEN RISK ASSESSMENT & INTERVENTIONS FLOWSHEET

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Braden Scale - For Predicting Pressure Sore Risk

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	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, OR Has a 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 would limit ability to feel or voice pain or discomfort.
Moisture Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often but not always moist. Linen/ continent briefs must be changed once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen/continent briefs change approximately once a day	**4. Rarely Moist** Skin is usually dry; linen only requires changing at routine intervals
Activity Degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or nonexistent. 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 majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside 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 signifi-cant changes independently	**3. Slightly Limited** Makes frequent though slight changes in body or extremity posi-tion 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 or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR Is NPO and/or maintained on clear liquids or IV's for more than 5 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 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 or dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement when offered, OR Is on a tube feeding or TPN regimen, which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never re-fuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Friction and 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 Problem** 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 chair or bed 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.	

Insert number for each section in correct box and add up column for Total Score.

Determine Level of Risk

Score	Level of Risk
15 -18	L = Low
13 -14	M = Moderate
10 -12	H = High
less than or equal to 9	VH = Very High

Consider clients with the following conditions to be more likely at a higher risk:

- Existing skin breakdown
- Age greater than or equal to 75yrs
- Diastolic pressure less than 60
- Hemodynamically unstable
- Fever
- PVD/Diabetes
- Obesity

DD/MMM/YY									
Time									
Sensory Perception									
Moisture									
Activity									
Mobility									
Nutrition									
Friction and Shear									
Total Risk Score									
Risk Level									
Head to Toe Skin Assessment (Check box if done)	☐	☐	☐	☐	☐	☐	☐	☐	☐
See Progress/Nursing Notes (Check box if required)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Initials									

For sub-scale score equal to 3 or less in Activity / Mobility / Sensory or sub-scale score equal to 2 or less in Nutrition or Friction/Shear -- make appropriate referral

☐ Occupational Therapist Date _____	☐ Physiotherapist Date _____	☐ Registered Dietitian Date _____	☐ Wound Clinician Date _____

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BRADEN RISK ASSESSMENT & INTERVENTIONS FLOWSHEET

Prevention of Skin Breakdown Interventions Flow Sheet

	DD/MMM/YY									
	Time *For **X hours**, enter the time interval eg 2h									
Reduce Pressure (for ↓ sensation, activity or mobility)	Turn every X hours*									
	Position 30° lateral									
	Use small repositioning shifts									
	Mobilize every X hours*									
	Elevate heels off the mattress									
	Use heel protectors									
	Use therapeutic cushion on wheelchair									
	Use therapeutic mattress/bed									
Control Moisture	Offer toileting every X hours*									
	Check continence brief every X hours*									
	Provide skin/continence care									
	Use moisture barrier cream									
	Use Dry Flow sheet (if on low-airloss bed)									
Reduce Friction & Shear	Moisturize skin									
	Use slider sheet									
	Use trapeze bar									
	Use mechanical lift									
	Use elbow protectors									
	Keep HOB 30° or less									
	Elevate FOB/knee gatch									
	Provide footboard									
Encourage Good Nutrition	Height and weight documented									
	Offer fluids every X hours*									
	Offer high-protein drink with meds									
	Set up for meals									
	Assist with meals									
	Provide multivitamin supplement									
Interventions added to Care Plan/Kardex										
Initials										

Therapeutic Device/Surface	Type of Therapeutic Small Device	Date Initiated	Date Discontinued
	Type of Chair Cushion		
	Type of Therapeutic Surface		

Braden Scale Interventions Algorithm

1. Complete Braden Assessment Scale and Head-to-Toe Skin Assessment on pre-operatively for the OR/PARR, on admission to intensive care, critical care, acute care, sub-acute care, rehabilitation care, psychiatry, pediatrics, community care and residential care units.
2. Reassess clients who score 18 or less:
   a. ICU / CCU at least every 48 hours.
   b. Acute care: every 48 hours post operatively.
   c. Sub-Acute and Rehabilitation Units: every 48 hours.
   d. Community care: every week for 3 weeks then quarterly and following hospitalization.
   e. Residential care: every week for 4 weeks, then monthly or quarterly (based on agency policy) and following hospitalization.
   f. Acute Psychiatry / Geriatric Psychiatry: every 48 hours.
   g. Pediatric Acute Care and PICU: every 12 hours; other units every week.
3. Reassess all clients, irrespective of previous Braden Risk Score or of the care setting, whenever their condition changes.

Client is at LOW to MODERATE RISK (Braden Score 13 to 18)

- Offer toilet as necessary to maintain continence or check for incontinence every 2-4h & change briefs if soiled or wet.
- Elevate heels off the bed at all times, even with therapeutic support surfaces.
- If not on a therapeutic support surface, then reposition every 2h.
- If on a therapeutic support surface, then reposition every 2-4h.
- Use pillows / foam slabs to avoid contact between bony prominences.
- Use devices to optimize independent repositioning & transfers.
- Inspect skin when repositioning, toileting & assisting with ADLs.
- Provide routine skin care and moisturize skin daily.
- Use elbow and heel protectors.
- Develop and document individualized care plan

Client is at HIGH to VERY HIGH RISK (Braden Score 12 or less)

Include all interventions in the At Risk to Moderate Risk category as appropriate PLUS:

- Refer to an OT, PT or Wound Clinician to determine the need for active support surface.
- Regardless of support surface, reposition every 1-2h/incorporate frequent small shifts in position between turns.
- Use foam wedges or pillows to support lateral 15 - 30° tilt.
- Reposition chair bound immobile client q1h, use support surfaces on chair & limit sifting to 1-2 h intervals.
- For bedfast clients elevate HOB 30° or less for short periods only.
- Protect sacral / perineal wounds from feces & infected urine.
- Remove slings and transfer or therapeutic aids from under the client.

Sensory Sub-scale equals 3 or less

- If mobility and sensory sub scales both score 1 out of 4, consider an active powered support surface.
- Eliminate pressure from bony prominences on extremities.
- For surgeries greater than 90 min, consider therapeutic surface for OR table
- Collaborate with OT, PT or Wound Clinician.

Moisture Sub-scale equals 3 or less

- Keep skin folds clean and dry.
- Use wicking material to separate skin folds.
- Avoid multiple layering (continence brief, soaker pad & slider sheet).
- Use moisture barrier cream.
- Use fecal collector or catheter for coccyx / sacral wounds.
- Consider low air loss support surface.
- During surgery, avoid pooling of antiseptic solutions beneath client.
- Collaborate with Wound Clinician.

Mobility/Activity Sub-scale equals 3 or less

- See Sensory sub scale.
- Avoid repositioning on a red area.
- Mobilize clients to support independent mobility & functioning.
- Collaborate with OT, PT or Wound Clinician.
- Remove slings / transfer from under client.

Nutrition Sub-scale equals 2 or less

- Maximize nutritional status through adequate protein & calorie intake
- Offer fluids every 2h to 1500 - 2000 mLs daily unless contraindicated.
- Set up & assist with meals as required.
- Collaborate with the Dietitian.

Friction/Shear Sub-scale equals 2 or less

- Raise knee gatch 10 - 20° before raising head of bed (HOB).
- Limit HOB elevation to 30° or less.
- Do lateral transfers/bed repositioning with a transfer sheet/lift & positioning sling.
- Use footboard.
- Collaborate with OT, PT or Wound Clinician.

If client has a new or deteriorating wound, unresolved moisture associated skin damage or a yeast / bacterial infection, refer to Wound Clinician as per agency policy.

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