Objectives

- Identify the 6 subscales comprising the Braden Score
- Understand how to complete the Braden Scale accurately
- Identify preventative measures and interventions appropriate to each category of risk
- Understand the relationship between the driver of risk and the appropriate interventions for the patient related to that driver
What is the Braden Scale?

- Scoring system
- Evaluates patient’s risk of developing a pressure ulcer
- Braden Scale – most preferred tool
- Six categories assessed
Why Assess Pressure Ulcer Risk?

- Significant problem in older hospitalized adults
- PU and treatment negatively affect every dimension of patient’s life
- Expensive to treat
## Braden Risk Assessment Scale

**NOTE:** Bed and chairbound individuals or those with impaired ability to reposition should be assessed upon admission for their risk of developing pressure ulcers. Patients with established pressure ulcers should be reassessed periodically.

**Patient Name:**

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<tr>
<td>Ability to respond meaningfully to pressure-related discomfort</td>
<td>Unresponsive does not mean, Blanc or group to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.</td>
<td>Responds only to painful stimuli. Cannot communicate discomfort except by expression or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.</td>
<td>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.</td>
<td>Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.</td>
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<td>Degree to which skin is exposed to moisture</td>
<td>Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.</td>
<td>Skin is often, but not always, moist. Linen must be changed at least once a shift.</td>
<td>Skin is occasionally moist, requiring an extra linen change approximately once a day.</td>
<td>Skin is usually dry. Linen only requires changing at routine intervals.</td>
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<td>Degree of physical activity</td>
<td>Confined to bed.</td>
<td>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</td>
<td>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.</td>
<td>Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.</td>
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<td>Ability to change and control body position</td>
<td>Does not make even slight changes in body or extremity position without assistance.</td>
<td>Makes occasional slight changes in body or extremity position, but unable to make frequent or significant changes independently.</td>
<td>Makes frequent though slight changes in body or extremity position.</td>
<td>Makes major and frequent changes in position without assistance.</td>
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<td>Usual food intake pattern</td>
<td>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 IVs for more than 5 days.</td>
<td>Rarely eats a complete meal and generally eats only 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.</td>
<td>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. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.</td>
<td>Eats most of every meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.</td>
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<tr>
<th>Friction and Shear</th>
<th>1. Problem</th>
<th>2. Potential Problem</th>
<th>3. No Apparent Problem</th>
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<tr>
<td>Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractions, agitation lead to almost constant friction.</td>
<td>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.</td>
<td>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.</td>
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**NOTE:** Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers. (15 or 16 = low risk; 13 or 14 = moderate risk; 12 or less = high risk)

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<th>Total Score:</th>
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**Room Number:**

**Date:**
Categories

- Sensory perception
- Moisture
- Activity
- Mobility
- Nutrition
- Friction/shear
Sensory Perception

1. Completely Limited
   - Unresponsive
   - Limited ability to feel pain over MOST of body

2. Very Limited
   - Painful stimuli
   - Cannot communicate discomfort
   - Sensory impairment over HALF of body

3. Slightly Limited
   - Verbal commands
   - Cannot always communicate discomfort
   - Sensory Impairment – 1-2 extremities

4. No Impairment
   - Verbal commands
   - No sensory deficit
Moisture

1. Constantly Moist
   - Perspiration, urine, etc.
   - Always

2. Very Moist
   - Often but not always
   - Linen changed at least once per shift

3. Occasionally Moist
   - Extra linen change Q day

Rarely Moist
   - Usually dry
Activity

1. Bedfast
   - Never OOB

2. Chairfast
   - Ambulation severely limited to non-existent
   - Cannot bear own weight – assisted to chair

3. Walks Occasionally
   - Short distances daily with or without assistance
   - Majority of time in bed or chair

4. Walks Frequently
   - Outside room 2 x per day
   - Inside room q 2 hours during waking hours
Mobility

1. Completely Immobile
   - Makes no changes in body or extremity position

2. Very Limited
   - Occasional slight changes in position
   - Unable to make frequent/significant changes independently

3. Slightly Limited
   - Frequent slight changes independently

4. No Limitation
   - Major and frequent changes without assistance
Nutrition

1. Very Poor
   - Never eats complete meal/rarely > 1/3, 2 or< proteins/day
   - NPO, clear liquids, IVs > 5 days

2. Probably Inadequate
   - Rarely eats complete meal, approx. 1/2, 3 proteins
   - Occasionally takes dietary supplement
   - Receives less than optimum liquid diet or tube feeding

3. Adequate
   - Eats over 1/2 of most meals, 4 proteins
   - Usually takes a supplement
   - Tube feeding or TPN probably meets nutritional needs

4. Excellent
   - Eats most of meals, never refuses, 4 or more proteins
   - Occasionally eats between meals
   - Does not require supplements
Friction and Shear

1. Problem
   - Moderate to maximum assistance in moving
   - Frequently slides down in bed or chair
   - Spasticity, contractures or agitation leads to almost constant friction

2. Potential Problem
   - Moves feebly, requires minimum assistance
   - Skin probably slides against sheets, etc.
   - Relatively good position in chair or bed with occasional sliding

3. No Apparent Problem
   - Moves in bed and chair independently
   - Sufficient muscle strength to lift up completely during move
   - Good position in bed or chair
Scoring

- 19-23 – not at risk
- 15-18 – preventative interventions
- 13-14 – moderate risk
- 10-12 – high risk
- 6-9 – very high risk
Braden Score 15-18 Preventative Interventions (At Risk)

- Regular turning schedule
- Enable as much activity as possible
- Protect the heels
- Use pressure redistribution surfaces
- Manage moisture, friction and shear
- Advance to a higher level of risk if other major risk factors are present
Braden Score 13-14 Preventative Interventions (Moderate Risk)

- Use the same protocol as for “at risk” patients
- Position patient at 30 degree lateral incline using foam wedges
Braden Scale 10-12 Preventative Interventions (High Risk)

- Follow the same protocol as for moderate risk
- In addition to regular turning schedule
  - Make small shifts in their position frequently
Braden Scale = 9 or < Preventative Interventions (Very High Risk)

- Use same protocol as for “high risk” patients
- Add a pressure redistribution surface for patients with severe pain or with additional risk factors.
Best Use of Braden Scale

- Dependent on nurses focus and attention on which Braden sub-categories are driving the overall risk level.
- Understanding of all the definitions and scoring rules.
Mr. P; A Case Study

- Status post fractured left hip with total hip replacement, lives alone
- Incision dry, intact, no signs of infection and edges well approximated
- Skin assessment on admission and in 24 hours
  - Special attention to heels and sacrum
  - No reddened areas noted
- Cognitively alert; Pain 8/10
  - Sensory perception subscale
Case Study Cont’d

- Perspiring heavily; no evidence of incontinence or wound drainage
  - Moisture subscale
- Out of bed with assistance and wheeled walker, PT 5 x per week, toe touch weight bearing left leg
  - Activity subscale
  - Mobility subscale
  - Friction and shear subscale
Case Study Cont’d

- Eating habits at home
  - Banana, coffee for breakfast
  - Cereal for lunch
  - Canned soup and cookies for dinner
- Normal BMI (23.5)
- States he has little appetite and often eats only if he feels like it
- Does not take a dietary supplement
Braden Score Total

- Sensory perception = 4
- Moisture = 3
- Activity = 3
- Mobility = 2
- Nutrition = 1
- Friction and shear = 2

TOTAL = 15 preventative interventions
Interventions Based on Risk Assessed

- Heels offloaded
- Turning and repositioning regularly
- Encourage as much activity as possible
- Pressure redistribution surfaces for bed and chair
- Manage moisture, friction and shear
  - Specific turning sheet
- Daily inspection of skin with attention to heels and sacrum
Putting the Pieces Together

- Use interview questions AND physical assessment to complete the scale.
  - Include the family and/or caregiver if unable to answer questions appropriately
- If in doubt, always give the lower score which will increase the level of risk
- Determine the subscale that is driving the highest risk
- Put interventions in place to address the highest risk subscale as a priority as well as those needed to address the level of risk from the other subscales
- If other risk factors are identified that are not addressed within the subscales, implement appropriate strategies to address them.
2nd Case Study

- Mrs. C. has had dementia for many years and is non-verbal and does not follow any commands
- Incontinent of bowel and bladder multiple times throughout the day with no indication of awareness
- No longer able to bear weight. OOB with mechanical lift and 2 assistants.
- Weight 95 lbs. Height 5’10”; unable to feed herself
- Skin assessment – stage 1 sacrum, bilateral heels with unstageable areas due to dry, black eschar
Score/Interventions

Score

- Sensory/perception – 2
- Moisture – 2
- Activity – 2
- Mobility – 1
- Nutrition – 1
- Friction and shear – 1
- Total – 9  – very high risk

Interventions

- TAPS
- Incontinence care
- Weight shifting in chair
- Pressure redistribution mattress and cushion
- Heel offloading
- Dietary consult with dietary interventions /supplementation
- Turning/pull device
Questions
References


References