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 Scale-Table 7-4

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: _____ Room Number: _____ Date: _____

Sensory Perception	1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment	Indicate Appropriate Numbers Below
Ability to respond meaningfully to pressure-related discomfort	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.	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.	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.	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	
Moisture	**1. Constantly Moist**	**2. Very Moist**	**3. Occasionally Moist**	**4. Rarely Moist**	
Degree to which skin is exposed to moisture	Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	Skin is often, but not always, moist. Linen must be changed at least once a shift.	Skin is occasionally moist, requiring an extra linen change approximately once a day.	Skin is usually dry. Linen only requires changing at routine intervals.	
Activity	**1. Bedfast**	**2. Chairfast**	**3. Walks Occasionally**	**4. Walks Frequently**	
Degree of physical activity	Confined to bed.	Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	
Mobility	**1. Completely Immobile**	**2. Very Limited**	**3. Slightly Limited**	**4. No Limitations**	
Ability to change and control body position	Does not make even slight changes in body or extremity position without assistance.	Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	Makes frequent though slight changes in body or extremity position independently.	Makes major and frequent changes in position without assistance.	
Nutrition	**1. Very Poor**	**2. Probably Inadequate**	**3. Adequate**	**4. Excellent**	
Usual food intake pattern	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 I.V.'s for more than 5 days.	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.	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.	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.	
Friction and Shear	**1. Problem**	**2. Potential Problem**	**3. No Apparent 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 lead to almost constant friction.	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.	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:	

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)

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

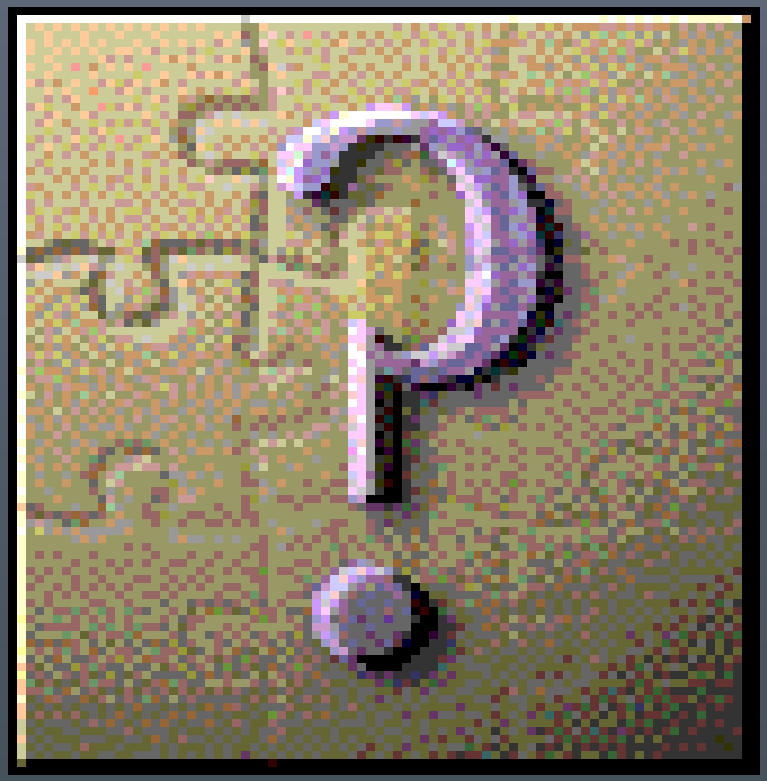
Score

- 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

Wound Rounds, *What is the Braden Scale?* , https://www.woundrounds.com/wound-care-technologies/what-is-the-braden-scale/, WWW May 19, 2014.

Stotts, N.A., EdD, RN, FAAN, Gunningberg, L., PhD, RN. *How to Try This: Predicting Pressure Ulcer Risk.* American Journal of Nursing, Nov 2007, 107(11), pgs 40-48. http://www.nursingcenter.con/Inc/cearticle?tid=751548, WWW May 19, 2014.

References

- Revis, D.R., MD. *Pressure Ulcers and Wound Care.* Medscape Reference Drugs, Diseases & Procedures. Updated March 12, 2014. http://emedicine.medscape.com/article/190115-overview