

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Client/Resident Name _____		BRN/DOB _____		Date of Assessment: _____			
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 2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the 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	Score		
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 must be changed at least once a shift.	3. Occasionally Moist: Skin is occasionally moist, requiring an extra linen 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. Chair fast Ability to walk severely limited or non-existent. 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 significant changes 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.			
NUTRITION Usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than a 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 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	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per 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 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 & 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.				
Total Score							
Provider Name, Designation: _____			Signature: _____		Initials: _____		

Prevention of Pressure Injuries– Interventions Based on Braden Risk Score – Nursing and Rehabilitation

Braden Score	At RISK (15-18)	MODERATE RISK (13-14)	HIGH RISK (10-12)	VERY HIGH RISK (6-9)
INTERVENTION CONSIDERATIONS	• Turn, turn, turn • Maximal remobilization • Protect heels • Manage moisture, nutrition, friction and shear • Pressure redistribution support surface if bed – or chair-bound • Manage Nutrition	• Turning schedule with 30° rule • Pressure redistribution support surface • Maximal remobilization • Protect heels • Manage moisture, nutrition, friction and shear	• Pressure redistribution support surface • Increase frequency of turning, 30° with foam wedges, supplement with small shifts • Maximal remobilization • Protect heels • Manage moisture, nutrition, friction and shear	
NOTES: • Pressure Sore Risk assessment is to be completed on first visit, again if there is a change in the client's/resident's condition or as determined by the therapist. • Pressure management surfaces do not replace a turning schedule. - No donut cushions → they increase pressure • If other major risk factors are present (advanced age, fever, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability) advanced to the next level of risk on the Braden Scale				

Interventions Implemented (date and initial the box next to intervention)	
Referral to Interprofessional (IP) Team Member ☐ No ☐ Yes: ☐ OT ☐ PT ☐ RD ☐ MD ☐ Nursing ☐ Pharmacy ☐ Chiropractic ☐ ID ☐ Continence Nurse/NSWOC ☐ SW ☐ Other: _____ ☐ Date Requested: _____	Functional Mobility Assessment required by OT/ PT: ☐ No ☐ Yes: _____ Transfer/Mobility Equipment in place: _____
Repositioning ☐ Plan was created with family/caregiver ☐ OT/PT referral required ☐ Other repositioning plan in place _____ <i>The Following has been Reviewed:</i> ☐ N/A ☐ Elevate head of bed no more than 30° (unless contraindicated) ☐ Pillow/other device to float heels ☐ How to protect elbows and heels if being exposed to friction (film dressings, specialty protectors etc.) ☐ Repositioning off occiput/sacral area depending on risk and/or age ☐ Red bony prominences should not be massaged <i>Equipment to aid turning/repositioning in bed:</i> ☐ N/A ☐ Not needed ☐ Needs equipment: _____ ☐ In place (list): _____	Pressure Management Support Surface (e.g. cushion/mattress): ☐ Needed ☐ N/A ☐ In Place: Type of Support Surface: _____ <i>Support surface concerns reported:</i> ☐ N/A ☐ No ☐ Yes; ☐ reassessment required ☐ Reviewed/developed plan/plan in place for regular checks of the condition of the support surface (bottoming out, damage, deflation etc.): _____ ☐ Pressure related to equipment use (e.g. O ₂ cannula, catheter etc.) ☐ No ☐ Yes <i>(List concerns & monitor):</i> _____ ☐ Contact made with IP team: _____
Incontinence/Moisture: Moisture cause addressed (e.g. perspiration/wound fluid/incontinence/physical contact with soiled/soaked linens/clothing): ☐ No ☐ Yes: Manage incontinence (<i>nursing</i>): ☐ absorbent briefs/pads that wick moisture/ ☐ moisture barrier preparations / ☐ ability to change clothes/briefs when soiled ☐ Avoid drying the skin: (no harsh soaps, avoid hot water, moisturize)	Nutrition: Client/resident is at risk of/malnourished: ☐ No ☐ Yes ☐ N/A ☐ <u>Mini Nutritional Assessment</u> has been completed to assess malnutrition risk. ☐ Encourage protein and calorie intake (<i>approach</i>) _____ ☐ Encourage fluid intake/ Max intake for this client is: _____ mL/24 hours ☐ Multi Vitamins (A,C& E) ☐ Order requested ☐ No order ☐ N/A ☐ Contact made with IP team
Dressing/Wound/Pressure Injury/Infections Concerns Reported: ☐ No ☐ Yes; ☐ contact made with IP team: _____	<i>(Adapted from: Registered Nurses' Association of Ontario (2005). Risk assessment and prevention of pressure ulcers. (Revised). Toronto, Canada: Registered Nurses' Association of Ontario)</i>

Client Name: _____ DOB/SE HR#: _____ Provider Name, Designation & Signature: _____