Braden Q Intervention Guide

Standard Pressure Injury Prevention Interventions for Children in all Risk Categories

1. Address client concerns regarding risk of a pressure injury
2. Determine and document risk factors associated with clinical conditions
3. Repeat pressure risk assessment
4. Repeat the Head-to-Toe skin assessment
5. Manage and provide pain relief
6. Provide skin care
7. Prevent/manage moisture associated skin damage e.g., toileting routine to manage urine/feces. Avoid incontinence briefs/pads
8. Promote activity/mobility
9. Support nutritional therapies e.g. encourage calorie and fluid intake as per client condition.
10. Reduce/eliminate shear & friction e.g., keep head of bed (HOB) less than 30^0 unless for meal time or as per client condition.
11. Alleviate pressure e.g., protect occiput, ears, under medical devices (tubes, splints).
12. Promote pressure redistribution through positioning/repositioning e.g., turn/reposition as per clients' individualized care plan (e.g., q2h, q3h, q4h) and include small shifts of position.

For clients with subscale scores of 3 or less (as indicated) follow the additional interventions and referrals below.

AT RISK 16-28	MODERATE RISK 13-15	HIGH RISK 10-12	VERY HIGH RISK 9 or less

	BQ Subscale	Subscale interventions
S - SURFACE	***FRICTION & SHEAR*** **≤2**	▪ Maintain head of bed at lowest elevation based on medical condition (i.e. head injury). ▪ Use transfer/assist devices to reduce friction & shear. ▪ Use lift sheets/devices to turn, reposition or transfer patients. ▪ Minimize wrinkles in linen under patient including removal of lift slings. ▪ Keep skin clean and dry. ▪ Pad between skin surfaces to prevent skin rubbing together. ▪ Consult Occupational Therapy/Physiotherapy (OT/PT).
	TISSUE **Perfusion and Oxygenation** **≤2**	▪ Maintain adequate oxygenation/cap refill. ▪ Apply O2 as indicated/ordered. ▪ Monitor and maintain blood pressure, blood gasses, hemoglobin. ▪ Apply warm linens prn if available. ▪ Assess newborn perfusion status.
	SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort **≤3**	▪ Follow Friction/Shear Subscale Interventions. ▪ Use appropriate pressure redistribution surfaces: (wheelchair cushion, mattress e.g. KCI, ROHO, Blake). ▪ Readjust position q2 hours if turning not tolerated (micro changes in position will redistribute pressure). ▪ If seated, encourage weight shifts q15 minutes if able or reposition patient q1 hour if unable. ▪ Visualize areas at risk of pressure with position changes. ▪ Elevate heels & protect elbows using therapeutic devices or pillows (Do not use towels, IV bags or incontinence pads to suspend heels).
K - KEEP MOVING	***ACTIVITY*** degree of physical activity **≤3**	▪ Keep pressure off at risk areas to maintain tissue perfusion. ▪ Minimize/eliminate pressure from medical devices. ▪ Protect bony prominences with cushion, foam, transparent or hydrocolloid dressing. ▪ Use gel pads on commode chars and bath benches. ▪ Do not position directly on hip. ▪ Use transfer devices, sliding boards, lift or transfer sheets. ▪ Use client handling equipment – ceiling or mobile lifts. ▪ Minimal linen between patient and support surface – Keep linens smooth. ▪ Do not use donuts rings/type devices or sheepskin to redistribute pressure. ▪ Maintain/enhance patient's activity level. ▪ Consult with OT/PT to select or customize appropriate support surface & for assistance with positioning.
	MOBILITY ability to change and control body position **≤3**	
I - INCONTINENCE	***MOISTURE*** degree to which skin is exposed to moisture **≤3**	▪ Keep perineum clean and dry. ▪ Check diapers q2 hours and PRN. Change as necessary ▪ Clean skin gently with pH liquid balanced skin cleansers, pat dry; moisturize- lotion/creams, pat dry. ▪ Avoid hot water or scrubbing of skin; gently pat skin dry. ▪ Cleanse skin folds & perineal area after incontinent episode with no-rinse cleaner. ▪ Apply skin protectant barrier to protect skin from urine/feces/perspiration. ▪ Avoid powder/talc. ▪ Change linen frequently for excessive moisture. ▪ Use Low air loss therapeutic surface ▪ Consult OT/PT, Physician and/or Wound/Ostomy/Continence Clinician for difficult to manage dermatitis
N - NUTRITION	***NUTRITION*** usual food intake pattern **≤2**	▪ Provide nutrition compatible with individual preferences and medical condition. ▪ Monitor accurate intake and output. ▪ Monitor weight. ▪ If restricted fluid/NPO, ensure adequate nutrition/hydration. ▪ Advance diet and provide /encourage intake as appropriate. ▪ Monitor TPN Bloodwork as applicable. ▪ Consult dietician when nutrition score on Braden Q or patient's condition indicates.

Created: June 2011 **Revised:** November 30th 2016