Braden Risk & Skin Assessment Flowsheet

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 significant changes independently	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position 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-rich foods** (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 protein-rich foods** (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-rich foods** (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 refuses a meal. Usually eats a total of 4 or more servings of protein-rich foods** (meat or 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.	

Determine Level of Risk

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

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

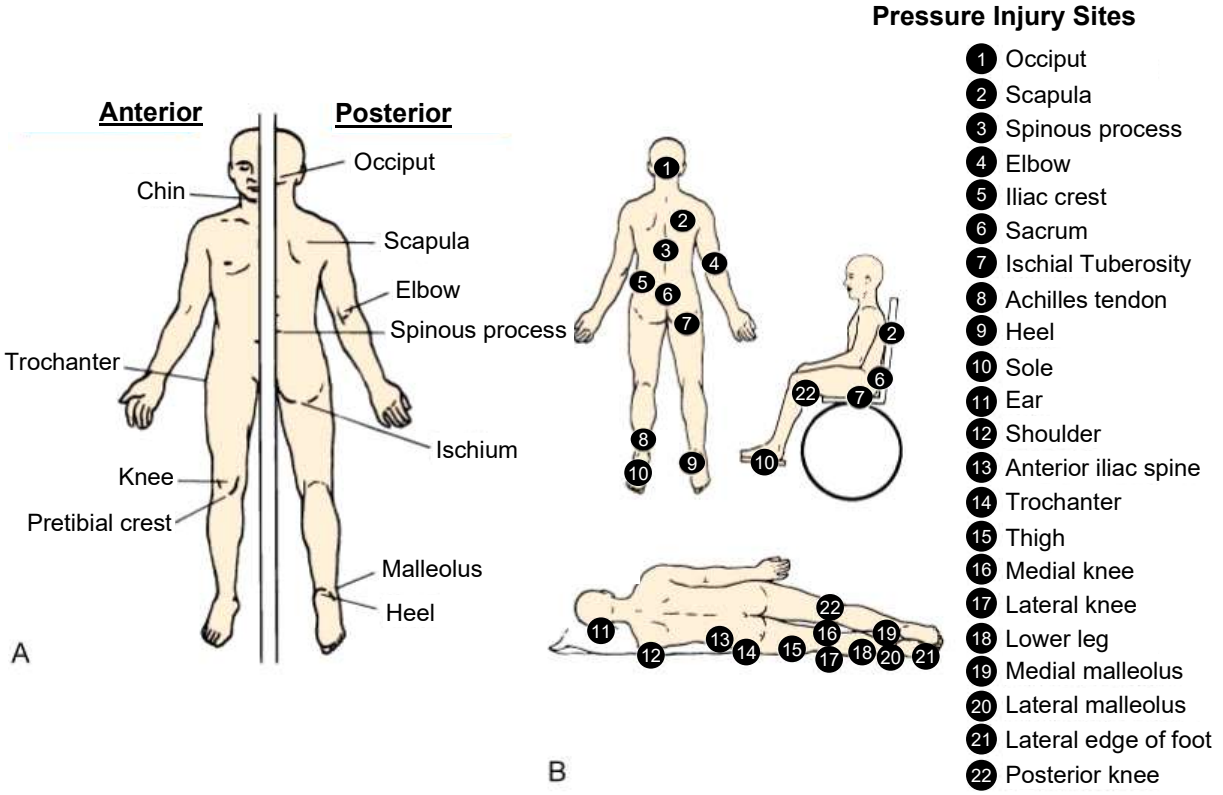
- Existing skin breakdown
- Age greater than or equal to 75 yrs
- Diastolic pressure less than 60
- Hemodynamically unstable
- Fever
- PVD/Diabetes
- Obesity

DD/MM/YY									
Time									
Sensory Perception									
Moisture									
Activity									
Mobility									
Nutrition									
Friction and Shear									
Total Risk Score									
Risk Level									
See Progress/Nursing Notes (Check box if required)									
Initials									

Please turn page over to see Head-to-Toe Skin Assessment Flowsheet

Braden Risk & Skin Assessment Flowsheet

Skin Assessment Flowsheet (Head-to-Toe)



Pressure Injury Sites

1. Occiput
2. Scapula
3. Spinous process
4. Elbow
5. Iliac crest
6. Sacrum
7. Ischial Tuberosity
8. Achilles tendon
9. Heel
10. Sole
11. Ear
12. Shoulder
13. Anterior iliac spine
14. Trochanter
15. Thigh
16. Medial knee
17. Lateral knee
18. Lower leg
19. Medial malleolus
20. Lateral malleolus
21. Lateral edge of foot
22. Posterior knee

Modified from Trelease CC: Developing standards for wound care. *Ostomy wound Manage* 20:46, 1988.

Adapted 1988 Terlease CC. Used with permission May 2016 British Columbia Provincial Intraprofessional Skin & Wound Committee.

	DD/MM/YY									
	Time									
	Overall Head-to-Toe Skin Check Done (Y/N)									
	Areas at High Risk for Injury Checked:									
	Occiput (Y/N)									
	Sacral / coccyx (Y/N)									
	Bilateral Ischial tuberosities (Y/N)									
	Bilateral Achilles tendon / heel (Y/N)									
	Bilateral medial / lateral malleolus (Y/N)									
Remember to check skin folds, beneath medical device (tubes, splints, etc) & mucous membranes - describe as needed	Skin folds: (Y/N/NA)									
	Medical Device: (Y/N/NA)									
	Mucous Membranes: (Y/N/NA)									
	Other: (Y/N/NA)									
	Refer to WATFS if wound present (Check box if required)									
	See Progress Notes/Nursing Notes (Check box if required)									
	Initials									

Please see the Braden Interventions Guide for the subscale specific interventions

Braden Scale Interventions Guide - Adult

For those clients at risk based on the overall Braden Scale risk assessment score & those Braden subscales which score 2 or less, use the interventions below to develop an individualized client care plan

Braden Risk Categories

At Risk
Score 15 - 18

Moderate Risk
Score 13 - 14

High Risk
Score 10 - 12

Very High Risk
Score 9 or less

Standard Pressure Injury Prevention Interventions for Clients 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 Braden 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 continence briefs/pads.
8. Promote activity/mobility.
10. Support nutritional therapy e.g., encourage calorie and fluid intake as per client condition.
11. Reduce/eliminate shear & friction e.g., keep head of bed (HOB) less than 30º unless for meal time or as per client condition.
12. Alleviate pressure e.g., protect heels and elbows elevate heels off the bed.
13. Promote pressure redistribution through positioning/repositioning e.g., turn/reposition as per client's individualized care plan, Q2H; Q3H; Q4H, and include small shifts of position.

For clients with subscales scores of 2 or less, make referral(s) to appropriate HCPs & consider additional interventions.

Nutrition Subscale 2 or Less

- Encourage diet & fluid intake as per client condition/restrictions.
- If NPO ensure adequate parenteral hydration /nutrition.
- Record/monitor intake/output.
- Record/monitor weight.
- Ensure good oral health at least twice daily.
- Ensure that dentures are in place and well-fitting.
- Ensure that client is able to swallow safely.
- Consult Dietitian.

Moisture Subscale 2 or Less

- Cleanse with a pH balanced, non sensitizing, fragrance-free, no rinse skin cleanser.
- Moisturize non-sensitizing fragrance-free lotion/cream as needed.
- 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.
- Consider a low-air-loss therapeutic surface or 'micro climate manager'.
- Consult OT/PT.
- Consult Wound Clinician.

Friction/Shear Subscale 2 or Less

- When sitting, ensure feet are on floor, or supported so hips are at a 90º angle.
- Use chair / wheelchair tilt features.
- Keep HOB ≤ 30º (unless contraindicated). Elevate ≥ 30º for meals (short periods only).
- When moving client up in bed, ensure bed is flat; that hips are 10 cms above where the bedframe flexes; then raise knee gatch 10 to 20º before HOB is raised.
- Consider Trunk Release Method (TRM) to ensure proper positioning in bed (Sitting Up In Bed video).
- Consult OT/PT.

Activity/Mobility Subscale 2 or Less & Sensory Perception Subscale 2 or Less

- Follow Friction/Shear Subscale interventions.
- Use appropriate pressure redistribution surfaces e.g., wheelchair, cushion, bed mattress.
- Avoid multiple layers of bedding padding. Keep bed linens smooth.
- Elevate heels using therapeutic devices or pillows. Do not use intravenous bags, towels or pads. Protect elbows.
- Lift, do not drag client when repositioning in bed. Use client handling equipment e.g., ceiling lift as needed.
- Use a transfer device sliding board lift/transfer sheet for bed-chair transfers or bed stretcher transfers.
- Use gel pad on commode chair and bath bench.
- Do not use donut-ring type devices or sheepskin to redistribute pressure.
- Use a prophylactic silicone foam dressing on sacral/ coccyx area. Consult Wound Clinician for use on heels.
- Assess skin/ mucosal membranes under/around medical devices 2x per shift. Reposition device if possible.
- Consult OT/PT.
- Consult Wound Clinician.

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