



# **PRESSURE ULCER RISK ASSESSMENT THE BRADEN SCALE**

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(Adapted from Lucy Hosie's Presentation )  
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# RISK ASSESSMENT RECAP

- Guide identification of people at risk of pressure ulcer development
- Guide preventative measure implementation
- Provide a source of documentation
- To be undertaken within 6 hours of admission/ first visit along with full skin inspection
- To be repeated when clinical condition changes or at regular intervals if patient stable
- To be used along side clinical judgement



# WHY CHANGE FROM PSPS AND WALSALL

- To promote uniformity in risk assessment – so primary and secondary care are speaking the same language (Currently 7 risk assessments in circulation in OUH ). (In preparation for transfer to EPR system OUH)
- Braden is less subjective - proven to provide high inter-rater reliability and consistency of patient risk assessment
- Recommended by NICE - Braden is the most validated and reliable risk assessment tool



# A BIT ABOUT THE BRADEN SCALE...

- Developed 1984 by Braden and Bergstrom
- Six elements that contribute to either higher intensity and duration of pressure or lower tissue tolerance to pressure therefore increasing the risk of pressure ulcer development.
  - Sensory perception
  - Nutrition
  - Friction and shear
  - Mobility (ability to change own position)
  - Moisture
  - Activity
- Each item is scored between 1 and 4 guided by a descriptor.
- The lower the score, the greater the risk.

**15 + = low risk**

**13-14 = moderate risk**

**12 or less = high risk**

**Below 9 = severe risk**

- **Limitations:** Does not consider pre existing or previous pressure ulceration



# ALERT!!



The lower the score, the greater the risk.

This is the opposite way round to the Walsall .

9 and below is now Severe risk.



# EXAMPLE OF BRADEN

| Sensory Perception |   | Moisture           |   | Activity           |   | Mobility            |   | Nutrition           |   | Friction and Shear  |   |
|--------------------|---|--------------------|---|--------------------|---|---------------------|---|---------------------|---|---------------------|---|
| No Impairment      | 4 | Rarely Moist       | 4 | Walks Frequently   | 4 | No Limitations      | 4 | Excellent           | 4 |                     |   |
| Slightly Limited   | 3 | Occasionally Moist | 3 | Walks Occasionally | 3 | Slightly Limited    | 3 | Adequate            | 3 | No Apparent Problem | 3 |
| Very Limited       | 2 | Very Moist         | 2 | Chair bound        | 2 | Very Limited        | 2 | Probably Inadequate | 2 | Potential Problem   | 2 |
| Completely Limited | 1 | Constantly Moist   | 1 | Bedbound           | 1 | Completely Immobile | 1 | Very Poor           | 1 | Problem             | 1 |



# SENSORY PERCEPTION

## Ability to respond meaningfully to pressure-related discomfort

### 1. Completely Limited

Unresponsive (does not moan, flinch or gasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.

### 2. Very Limited

Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness

### 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. Had 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 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. Chairfast

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 the room at least twice a day and inside room at least once every 2 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 per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NBM and/or maintained or clear liquids or IVs for more than 5 days.

### 2. Probably

#### Inadequate

Rarely eats a complete meal and generally eats only about ½ of any food offered. Eats only 3 servings of protein 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 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.

### 4. Excellent

Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of protein per day. Occasionally eats between meals. Does not require supplementation.

# FRICION AND SHEAR

## Friction and Shear

### 1. Problem

Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible.

Frequently slides down bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.

### 2. Potential Problem

Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets or other surfaces.

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 at all times.



# REMEMBER CLINICAL JUDGEMENT

- Risk assessments are tools – and must be supported by clinical judgement .
- You Cannot Adapt this tool .
- Current or previous pressure damage how does this effect the risk score.
- Availability of associated documents.
  
- We go **Live** on the 3rd of November



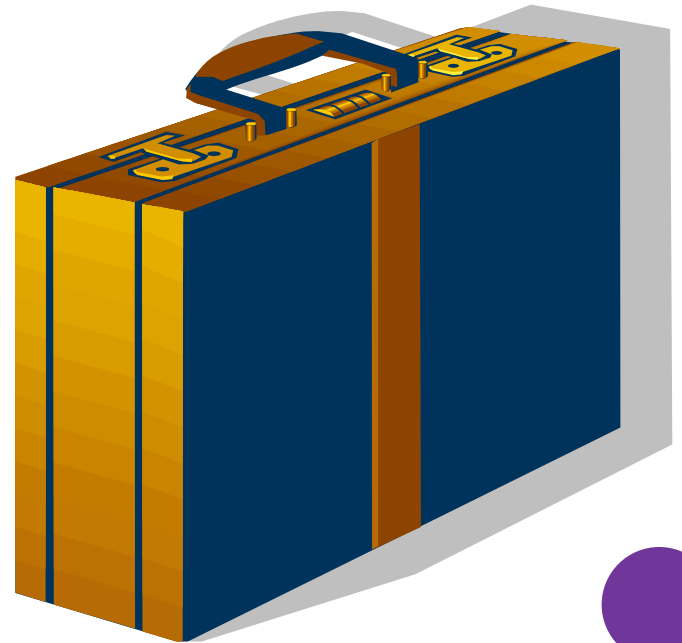
# RISK ASSESSED...WHAT NOW?

- Ensure risk assessment fully documented along with full skin inspection
- Implement preventative measures according to identified risk – and document interventions
- Regularly evaluate effectiveness of interventions
- Provide patient and relative education regarding pressure ulcer prevention
- Ensure degree of risk fully communicated with next clinical area – enable time to get equipment in place for at risk patients



# PRACTICE CASE STUDIES

You now have the opportunity to  
Practice with the new tool.



# CASE STUDY 1 BOB

Bob is a 52 year man who had a motor bike accident 10 years ago it has left Him with paraplegia and minor brain damage which makes him forgetful and uncooperative at times .

Bob core stability is poor and needs all help to move and position him. At present he has no pressure damage .

Bob's wife is his main carer and has 4x a day care to help with his care .

He has a conveen on as he has refused a catheter .The conveen is not very successful and he is frequently wet .

Bob does not always eat well but his wife can usually get Him to eat at least half of his meals.

What is Bobs Risk score?

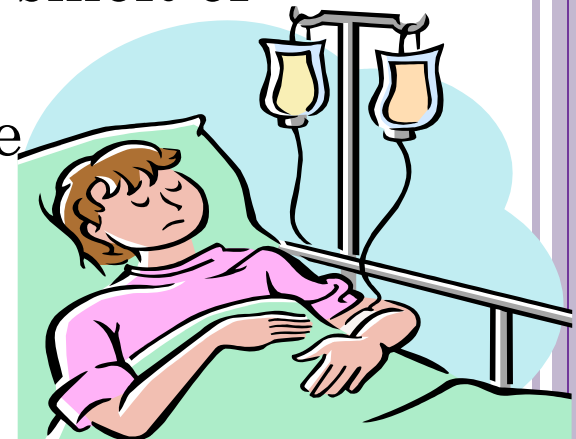




## CASE STUDY 2 SISSY

- Sissy was an 87 year old lady who was admitted to hospital after a fall at home .
- She has broken her right neck of femur .
- Sissy was found in a very unkempt state she was very thin and was suffering from dehydration she had very red heels which did blanch ,but her sacrum was also pink and non blanching.
- After an skin examination she was found to have a moisture lesion on her buttocks and smelt of urine on admission .
- On admission she was difficult to wake responded to painful stimuli .

What is her risk score ?



## CASE STUDY 3 –BRENDA

- Brenda was a 47 year old women who had had a stoke 6 months ago .
- She had mild right sided weakness ,but was still mobile with a stick.
- She had problems with her swallowing so was on a soft diet she now has a very poor diet and has lost weight.
- Brenda now had difficulties communicating which has made her very withdrawn and her GP has started her on medication for depression.
- What is her risk score ?



## CASE STUDY 4 BILL

- Bill has end stage Multiple sclerosis which he has had for the last 20 years.
- Bill now is bed bound and totally immobile needing assistance for all his positioning needs.
- His diet has reduce but at present he still manages at least half of his meals
- Bill has a catheter and is hoisted to the toilet for his bowels so is totally continent.
- Bill has equipment in place to maintain his position (profiling bed)

What is the risk score ?



THANK YOU ANY QUESTIONS ?

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