Braden Q Guidance

Braden Q has 7 elements

All are scored between 1-4 led by the descriptors.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mobility:**The 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 completely turn self independently. | **3 Slightly Limited:**Makes frequent through slight changes in body or extremity position independently. | **4 No Limitations:**Major and frequent changes in position without assistance. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activity**The 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 in chair or wheelchair. | **3 Walks Occasionally:**Walks during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. | **4 All patients too young to ambulate OR walks frequently:**Walks outside the rook at least twice a day and inside room at least once every two hours during waking hours |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sensory Perception**The ability to respond in a developmentally appropriate way 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 surface. | **2 Very Limited:**Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has sensory impairment which limits the ability to feel pain or discomfort over ½ 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 limits ability to feel or communicate pain or discomfort. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Moisture**Degree to which skin is exposed to moisture | **1 Constantly Moist:**Skin is kept moist almostconstantly by perspiration,urine, drainage, etc.Dampness is detected everytime patient is moved orturned. | **2 Very Moist:**Skin is often, but not always moist.Linen must be changed at leastevery 8 hours. | **3 Occasionally Moist:**Skin is occasionally moist,requiring linen change every 12hours. | **4 Rarely Moist:**Skin is usually dry,routine diaper changes,linen only requireschanging every 24 hours. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Friction -****Shear*****Friction:*** occurswhen skin movesagainst supportsurfaces***Shear***: occurswhen skin andadjacent bonysurface slideacross oneanother | **1 Significant Problem**:Spasticity, contracture,itching or agitation leads toalmost constant thrashingand friction. | **2 Problem:**Requires moderate to maximumassistance in moving. Completelifting without sliding againstsheets is impossible. Frequentlyslides down in bed or chair,requiring frequent repositioningwith maximum assistance. | **3 Potential Problem:**Moves feebly or requiresminimum assistance. During amove skin probably slides to someextent against sheets, chair,restraints, or other devices.Maintains relative good positionin chair or bed most of the timebut occasionally slides down. | **4 No Apparent****Problem:**Able to completely liftpatient during a positionchange; Moves in bed andin chair independentlyand has sufficient musclestrength to lift upcompletely during move.Maintains good positionin bed or chair at alltimes. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Nutrition*****Usual*** foodintake pattern | **1 Very Poor**:NPO and/or maintained onclear liquids, or IVs for morethan 5 days **OR**Albumin <2.5 mg/dl **OR**Never eats a complete meal.Rarely eats more than ½ ofany food offered. Proteinintake includes only 2servings of meat or dairyproducts per day. Takesfluids poorly. Does not takea liquid dietary supplement. | **2 Inadequate:**Is on liquid diet or tubefeedings/TPN which provideinadequate calories and mineralsfor age **OR** Albumin <3 mg/dl **OR**rarely eats a complete meal andgenerally eats only about ½ of anyfood offered. Protein intakeincludes only 3 servings of meat ordairy products per day.Occasionally will take a dietarysupplement. | **3 Adequate:**Is on tube feedings or TPN, whichprovide adequate calories andminerals for age **OR** eats over halfof most meals. Eats a total of 4servings of protein (meat, dairyproducts) each day. Occasionallywill refuse a meal, but will usuallytake a supplement if offered. | **4 Excellent:**Is on a normal dietproviding adequatecalories for age. Forexample: eats/drinks mostof every meal/feeding.Never refuses a meal.Usually eats a total of 4 ormore servings of meatand diary products.Occasionally eatsbetween meals. Does notrequire supplementation. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Tissue****Perfusion****and****Oxygenation** | **1 Extremely****Compromised:**Hypotensive (MAP<50mmHg; <40 in anew-born) **OR** the patientdoes not physiologicallytolerate position changes. | **2 Compromised**Normotensive;Oxygen saturation may be <95 %OR haemoglobin may be < 10mg/dl OR capillary refill may be> 2 seconds;Serum pH is < 7.40. | **3 Adequate:**Normotensive;Oxygen saturation may be <95 %**OR** haemoglobin may be < 10mg/dl **OR** capillary refill may be> 2 seconds;Serum pH is normal. | **4 Excellent:**Normotensive,Oxygen saturation >95%;Normal Haemoglobin ; &Capillary refill < 2Seconds. |

The Braden Q score can be from 7- 28

22-28 is low risk (mild)

17-21 is Medium risk (moderate)

Below 16 is high risk (severe)

Remember if a child has an active pressure ulcer or previous damage then you score them as High risk.

If they have any medical device applied to them (braces, pumps, O2 tubing catheters, PEG’s) then you score them at high risk.

Always use the tool with your clinical judgement.

Once a child is identified as at risk remember to give the patient education leaflets.

When a child has been identified as at risk they must always have a care plan in place to manage the risk.

Any questions contact your TV link nurse or email TV on

tissueviability@oxfordhealth.nhs.uk