Braden Q Guidance

Braden Q has 7 elements

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

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| **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. |

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| **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 |

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| **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. |

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| **Moisture**  Degree to which skin is exposed to moisture | **1 Constantly Moist:**  Skin is kept moist almost  constantly by perspiration,  urine, drainage, 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  every 8 hours. | **3 Occasionally Moist:**  Skin is occasionally moist,  requiring linen change every 12  hours. | **4 Rarely Moist:**  Skin is usually dry,  routine diaper changes,  linen only requires  changing every 24 hours. |

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| **Friction -**  **Shear**  ***Friction:*** occurs  when skin moves  against support  surfaces  ***Shear***: occurs  when skin and  adjacent bony  surface slide  across one  another | **1 Significant Problem**:  Spasticity, contracture,  itching or agitation leads to  almost constant thrashing  and friction. | **2 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. | **3 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 relative good position  in chair or bed most of the time  but occasionally slides down. | **4 No Apparent**  **Problem:**  Able to completely lift  patient during a position  change; 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. |

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| **Nutrition**  ***Usual*** food  intake pattern | **1 Very Poor**:  NPO and/or maintained on  clear liquids, or IVs for more  than 5 days **OR**  Albumin <2.5 mg/dl **OR**  Never eats a complete meal.  Rarely eats more than ½ of  any food offered. Protein  intake includes only 2  servings of meat or dairy  products per day. Takes  fluids poorly. Does not take  a liquid dietary supplement. | **2 Inadequate:**  Is on liquid diet or tube  feedings/TPN which provide  inadequate calories and minerals  for age **OR** Albumin <3 mg/dl **OR**  rarely eats a complete meal and  generally eats only about ½ of any  food offered. Protein intake  includes only 3 servings of meat or  dairy products per day.  Occasionally will take a dietary  supplement. | **3 Adequate:**  Is on tube feedings or TPN, which  provide adequate calories and  minerals for age **OR** eats over half  of most meals. Eats a total of 4  servings of protein (meat, dairy  products) each day. Occasionally  will refuse a meal, but will usually  take a supplement if offered. | **4 Excellent:**  Is on a normal diet  providing adequate  calories for age. For  example: eats/drinks most  of every meal/feeding.  Never refuses a meal.  Usually eats a total of 4 or  more servings of meat  and diary products.  Occasionally eats  between meals. Does not  require supplementation. |

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

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

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