Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | *À l'écoute de notre santé*

Home Care Braden Scale for Predicting Risk of Pressure Injury and Interventions Flowchart

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address

Complete on admission, after any hospitalization with significant change in client's condition and/or every 6 months					A	B	C	D
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 ½ of the 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 client is moved or turned.	**2 Very Moist** Skin is often but not always moist. Linen /continent briefs must be changed as often as 3 times in 24 hours.	**3 Occasionally Moist** Skin is occasionally moist requiring an extra linen/continent brief 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 Chair fast** 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 bedroom 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 change 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 (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 for more than 5 days.	**2 Probably Inadequate** 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 dietary supplement ***OR*** receives less than optimum amount of liquid diet or tube feeding.	**3 Adequate** Eats over ½ of most meals. Eats a total of 4 servings of protein (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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
Friction and Shear	**1 Problem** Requires moderate to maximum assistance with 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.					

Low Risk 15-18 **Moderate Risk 13-14** **High Risk 10-12** **Very High Risk: 9 or less**

Clients may be at higher risk if they have any of the following factors (check all that apply):

☐ existing skin breakdown ☐ diastolic pressure less than 60 mmHg
☐ age 75 or older ☐ Peripheral Vascular disease or Diabetes

Clients with one or more of these factors may need to have their risk level adjusted to the next level.

Modified level of risk: _____

SCORE ***If client scores 18 or less fill out page 2***				
Palliative Performance Scale (Palliative Only)				

	Date of Assessment (D D M M M Y Y Y Y)	Initials	Printed Name	Signature/Designation
A:				
B:				
C:				
D:				

LEGEND: CTS - Community Therapy Services mmHg - millimetres of mercury OT - Occupational Therapist TPN - Total Parenteral Nutrition TSS - Therapeutic Sleep Surface

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Choose appropriate client centered interventions for management of pressure injury risk based on clinical assessment	**Initials**	**Date** DD/MMM/YYYY
SKIN ASSESSMENT		
• Skin assessment completed (for all clients at risk).		
• Teach skin care/ hygiene and need to moisturize daily.		
REVIEW PRESSURE INJURY PREVENTION PAMPHLETS (indicate with whom _____)		
MOBILITY/ACTIVITY		
• Teach client/caregiver how to turn, reposition and move in bed. Include frequency of repositioning and utilization of 30 degree lateral turning position. Refer to CTS for mobility assessment if needed or contact Case Coordinator.		
• Screen repositioning on other surfaces such as chairs, wheelchairs and commode. Refer to CTS if needed.		
• Teach client/caregiver regarding maintaining the head of bed at 30 degrees or less.		
• Assess if slings or other items are being left under the client.		
CONTINENCE		
• Establish toilet routine to maintain continence.		
• Refer to CTS OT for functional assessment/equipment recommendations.		
• Consult Case Coordinator regarding receiving assistance or different products.		
HEELS		
• Assess if heels are being floated in bed (pillow under calf, heel boots or heel slopes on mattress). Teach client/family how to off-load heels.		
• Assess footwear and footrests on equipment such as wheelchair or commode. Refer to CTS if equipment recommendations are required.		
HYDRATION AND NUTRITION		
• Promote/Educate on adequate hydration and nutrition.		
• Refer to dietitian if needed (e.g. Stage 3 or 4 pressure injury, Braden subscale of nutrition score of 1 or 2 with unintentional weight loss).		
INITIATE APPROPRIATE CARE PLAN		
• Standardized Nursing Care Plan for Pressure Injury http://home.wrha.mb.ca/hinfo/chif/files/WCC-00213.pdf.		
• Standardized Nursing Care Plan for Risk for Pressure Injury http://home.wrha.mb.ca/hinfo/chif/files/WCC-00214.pdf.		
ASSESS CURRENT SUPPORT SURFACES		
• Assess all support surfaces to determine what may be a risk factor/cause of a pressure injury and refer to CTS OT if needed (e.g. commodes, beds, recliner chairs, wheelchairs, bath seats).		
• Assess whether an electric bed would be beneficial. Complete electric bed assessment tool and WRHA Community order/script if client meets criteria for a bed.		
• Clients at low or medium risk of pressure injuries should be on a high-specification foam mattress. If client is at a high or very high risk a TSS request should be considered. If client is at moderate risk with special circumstances (e.g.one turning surface, in bed 24 hours or palliative symptom management), a TSS request could be considered.		
OTHER:		
IF CLIENT HAS A CURRENT PRESSURE INJURY THEN PLACE A CHECK BESIDE ROOT CAUSE(S) OF PRESSURE INJURY: ☐ Wheelchair ☐ Positioning while in bed ☐ Transfer methods ☐ Recliner ☐ Commode ☐ Bath seat ☐ Footwear ☐ Splint ☐ Braces ☐ Other: _____ Location of Pressure Injury: _____		

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