Patient Safety Tool Box: The Braden Scale for Assessing Pressure Ulcer Risk

Pressure ulcers cause suffering to patients. A *pressure ulcer* is a break down of the skin caused by unrelieved pressure resulting in damage of the underlying tissue.[1] They affect patients' quality of life, mobility, nutritional intake, elimination, and psychological well-being, with older patients and those who suffer from chronic illness at particular risk.[1]

National Patient Safety Goal (NPSG) Requirement **NPSG.14.01.01** requires organizations to assess and periodically reassess each patient's and resident's risk for developing a pressure ulcer and take action to address any identified risks. (*See* "Related Requirements" on page 6 for the complete requirement.) The third element of performance requires organizations to perform a risk assessment for pressure ulcers using a validated risk assessment tool.

An example of such a tool is the Braden Scale (*see* Figure 1, below), although other effective scales exist, such as the

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Figure 1. Braden Scale for Predicting Pressure Sore Risk

Patient's Name _____ Evaluator's Name_____ Date of Assessment

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 body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the 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 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 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 Limitation** 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 ⅓ 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's 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 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 (meat, dairy products per 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 & 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.					
				Total Score				

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Norton Scale. The Braden currently is the most commonly used in US health care organizations, and has the strongest evidence supporting its effectiveness.[1]

Health care providers can use the Braden scale to evaluate the patient's skin integrity and to provide a comparison of preoperative and postoperative skin status. This scale can help staff determine preoperatively whether the patient is at high risk for pressure ulcer development, and help them determine which interventions or precautions should be used.[1]

The Braden scale is used for adult patients and has been used effectively in a variety of clinical settings and among diverse ethnic groups.[1] Health care organizations have seen sharp declines in pressure ulcers when using the Braden Scale as part of a risk-assessment process along with the appropriate prevention protocols. For example, two nursing homes implemented the Braden Scale as part of a complete pressure ulcer prevention program and saw an 87% decrease in the incidence of pressure ulcers in the larger nursing home and a 76% decrease in incidence in the smaller nursing home.[1] TS

Reference

1. The Joint Commission. *Pressure Ulcer Prevention Toolkit.* Oak Brook, IL: Joint Commission Resources, 2012.

Related Requirements

National Patient Safety Goal 14
Prevent health care–associated pressure ulcers (decubitus ulcers).

NPSG.14.01.01
Assess and periodically reassess each patient's and resident's risk for developing a pressure ulcer and take action to address any identified risks.

Elements of Performance for NPSG.14.01.01

1. Create a written plan for the identification of risk for and prevention of pressure ulcers.
2. Perform an initial assessment at admission to identify patients and residents at risk for pressure ulcers.
3. Conduct a systematic risk assessment for pressure ulcers using a validated risk assessment tool such as the Braden Scale or Norton Scale.
4. Reassess pressure ulcer risk at intervals defined by the organization.
5. Take action to address any identified risks to the patient or resident for pressure ulcers, including the following:
   - Preventing injury to patients and residents by maintaining and improving tissue tolerance to pressure in order to prevent injury
   - Protecting against the adverse effects of external mechanical forces
6. Educate staff on how to identify risk for and prevent pressure ulcers.