Demystifying The Braden Scale Tool: Reducing Hospital Acquired Pressure Ulcers

Fairlawn Rehabilitation Hospital
Augusta Ishola, MS, RN, CRRN, WCC

HEALTHSOUTH®

Objectives

- Simplify how to use the Braden Scale® tool for pressure ulcer prevention.
- Increase the implementation of accurate and appropriate intervention for the prevention of pressure ulcers in patients.
- Reduce the risk and development of hospital-acquired pressure ulcers and limit adverse patient outcomes due to pressure ulcers.

Method

- The Braden Scale has six subscales. Five subscales (sensory, moisture, activity, mobility and nutrition) have scores that range from one to four and one subscale (friction and shear) has a score range of one to three.
- The scores from the subscales are added together to determine the final score.
- The lower the final score, the greater the predicted risk for pressure ulcer.
- Interventions are based on the scores and interpreted as:
  19 to 23–no risk
  15 to 18–at risk
  13 to 14–moderate risk
  10 to 12–high risk
  9 or below–very high risk

Interventions per Subset

Sensory perception: the ability to respond meaningfully to pressure-related discomfort
- If the patient can verbalize, but cannot feel pain, use the lower score.
- Interventions
  - Protect fragile skin and bony prominences with skin protectant, foam or wedge.
  - Initiate turning schedule once every two hours minimum.
- Inspect skin daily
  (Ayello & Braden, 2001)

Moisture: the degree to which skin is exposed to moisture
- Repeated moisture, especially liquid stool, increases the likelihood of a patient developing a break in the skin matrix, a rash from chemical reaction of residual on the skin or macerated skin.
- Incontinence care interventions
  - Clean perineum and perianal area with mild soap, as needed, and keep skin dry.
  - Apply moisture barrier cream.
  - Retrain patient.
  - Introduce an air loss surface.

Activity: patient's degree of physical activity
- A patient that spends a lot of time in a bed or chair has an increased risk for developing pressure ulcers
- Interventions
  - Provide cushion for chair.
  - Turn every two hours in bed and weight shift every 30 minutes in chair.
  - Ambulate with assistance.
  - Apply bed surface support.
  - Elevate heels as tolerated.

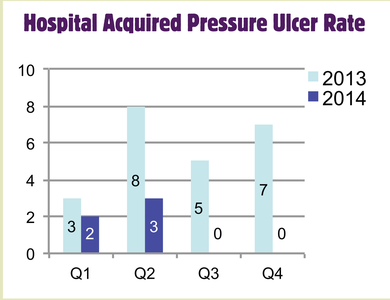
Mobility: the ability to change and control body position
- A patient's inability to move his or her body, even the slightest bit, can result in a decrease of blood flow to the tissues.
- Interventions
  - Reposition every two hours in bed and every 30 minutes in chair.
  - Position the patient appropriately to reduce sores on pressure points and bony prominences.
  - Utilize a pressure reduction support surface.
  (Ayello & Braden, 2001)

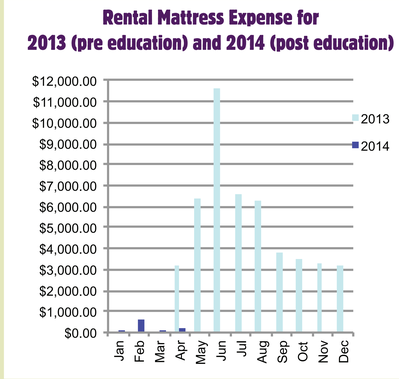
Nutrition: a patient's usual food intake pattern
- Based on the patient's preadmission intake levels
- Nurses must get adequate and reliable data on prior intake
- Interventions
  - Provide supplements and offer frequent meals as appropriate
  - Monitor protein intake
  - Refer all patients with nutritional risk and pressure ulcers to the nutritionist

Friction and shear: a precursor to pressure ulcer complications such as tunneling and undermining
- Interventions:
  - Elevate the head of the patient's bed no more than 30 degrees, if the head is elevated more than 30 degrees, elevate the foot of the bed as well
  - Use lift sheets, a trapeze and avoid dragging
  - Apply moisturizer to dry skin
  (Braden & Bergstrom, 1988)

Results

- Appropriate prevention interventions were implemented for patients who need them.
- The number of hospital-acquired pressure ulcers was reduced.
- Pressure surface reduction mattress rentals were reduced.





Conclusion

Hospitals should ensure that nurses understand how to utilize the skin assessment tool to increase collaboration in identifying interventions for the care of the patients.

References

Anthony, D., Parboteeah, S., Saleh, M., & Papanikolaou, P. (2008). Norton, Waterlow and Braden scores: a review of the literature and a comparison between the scores and clinical judgment. Journal of Clinical Nursing, 17(5), 646-653. doi:10.1111/j.1365-2702.2007.02029.x

Ayello, E. A., & Braden, B. (2001). Why is pressure ulcer risk assessment so important? Nursing, 31(11), 74-79.

http://www.ahrq.gov/professionals/systems/long-term-care/resources/pressure-ulcers/pressureulcertoolkit/putoolkit.pdf

http://www.bradenscale.com/images/bradenscale.pdf

http://www.npuap.org/wp-content/uploads/2012/03/PU_Prev_Points.pdf