Braden Scale Interventions Algorithm

1. Complete Braden Assessment Scale and Head-to-Toe Skin Assessment on pre-operatively for the OR/PARR, on admission to intensive care, critical care, acute care, sub-acute care, rehabilitation care, psychiatry, pediatrics, community care and residential care units.
2. Reassess clients who score 18 or less:
   a. ICU / CCU at least every 48 hours.
   b. Acute care: every 48 hours and post operatively.
   c. Sub-Acute and Rehabilitation Units: every 48 hours.
   d. Community care: every week for 3 weeks then quarterly and following hospitalization.
   e. Residential care: every week for 4 weeks, then monthly or quarterly (based on agency policy) and following hospitalization.
   f. Acute Psychiatry / Geriatric Psychiatry: every 48 hours.
   g. Pediatric Acute Care and PICU: Every 12 hours. Other pediatric units: Every day.
3. Reassess all clients, irrespective of previous Braden Risk Score or of the care setting, whenever their condition changes.

Client is at LOW to MODERATE RISK (Braden Score 13 to 18)

- Offer toilet as necessary to maintain continence or check for incontinence every 2-4h & change briefs if soiled or wet.
- Elevate heels off the bed at all times, even with therapeutic support surfaces.
- If not on a therapeutic support surface, then reposition every 2h.
- If on a therapeutic support surface, then reposition every 2-4h.
- Use pillows / foam slabs to avoid contact between bony prominences.
- Use devices to optimize independent repositioning & transfers.
- Inspect skin when repositioning, toileting & assisting with ADLs.
- Provide routine skin care and moisturize skin daily.
- Use elbow and heel protectors.
- Develop and document individualized care plan

Client is at HIGH to VERY HIGH RISK (Braden Score 12 or less)

Include all interventions in the At Risk to Moderate Risk category as appropriate PLUS:

- Use a Therapeutic Support Surface Decision Algorithm or refer to an OT, PT or Wound Clinician to determine the need for active support surface
- Regardless of support surface, reposition every 1-2h/incorporate frequent small shifts in position between turns.
- Use foam wedges or pillows to support lateral 15 - 30° tilt.
- Reposition chair bound immobile client q1h, use support surfaces on chair & limit sitting to 1-2 h intervals.
- For bedfast clients elevate HOB 30° or less for short periods only.
- Protect sacral / perineal wounds from feces & infected urine.
- Remove slings and transfer or therapeutic aids from under the client.

Sensory Sub-scale equals 3 or less

- If mobility and sensory sub scales both score 1 out of 4, consider an active powered support surface.
- Eliminate pressure from bony prominences on extremities.
- For surgeries greater than 90 min, consider therapeutic surface for OR table
- Collaborate with OT, PT or Wound Clinician.

Moisture Sub-scale equals 3 or less

- Keep skin folds clean and dry.
- Use wicking material to separate skin folds.
- Avoid multiple layering (continence brief, soaker pad & slider sheet).
- Use moisture barrier cream.
- Use fecal collector or urinary catheter to protect coccyx / sacral wounds.
- Consider low air loss support surface.
- During surgery, avoid pooling of bodily fluids/ solutions beneath client
- Collaborate with Wound Clinician.

Mobility/Activity Sub-scale equals 3 or less

- See Sensory sub scale.
- Avoid repositioning on a red area.
- Mobilize clients to support independent mobility & function.
- Remove transfer sling / sheet / board from under client.
- Collaborate with OT, PT or Wound Clinician.

Nutrition Sub-scale equals 2 or less

- Maximize nutritional status through adequate protein & calorie intake
- Offer fluids every 2h to 1500 - 2000 mLs daily unless contraindicated.
- Set up & assist with meals as required.
- Collaborate with the Dietitian.

Friction/Shear Sub-scale equals 2 or less

- Raise knee gatch 10 - 20° before raising head of bed (HOB).
- Limit HOB elevation to 30° or less.
- Do lateral transfers/bed repositioning with a transfer sheet/lift & positioning sling.
- Collaborate with OT, PT or Wound Clinician.

If client has a new or deteriorating wound, unresolved moisture associated skin damage or a yeast / bacterial infection, refer to Wound Clinician as per agency policy.

Algorithm revised November 17, 2014