Several factors place a patient at risk for developing a pressure injury, in addition to shear and friction. These factors include decreased sensory perception, increased moisture, decreased activity, impaired mobility, and inadequate nutrition. The **Braden Scale** is a standardized, evidence-based assessment tool commonly used in health care to assess and document a patient’s risk for developing pressure injuries. See Figure 10.21[^1] for an image of a Braden Scale. Risk factors are rated on a scale from 1 to 4, with 1 being "completely limited" and 4 being “no impairment.” The scores from the six categories are added, and the total score indicates a patient’s risk for developing a pressure injury based on these ranges:

- Mild risk: 15-18
- Moderate risk: 13-14
- High risk: 10-12
- Severe risk: less than 9
How to Score the Braden Scale

Each risk factor on the Braden Scale is rated from 1 to 4 based on the patient’s assessment findings. When using the Braden Scale, start with the first category and review each description listed across the row for each of the ratings from 1 to 4, and choose the one that best describes the patient’s current status. Continue this process for all rows. Add all six numbers to determine a total score, and then use the total score to determine if the patient is at mild, moderate, high, or severe risk for developing a pressure injury. The lower the score, the higher the risk of developing a pressure injury. Additionally, customized nursing interventions are implemented based on the rating in each category. The higher the score, the more aggressive actions are taken to prevent or heal a pressure injury. Descriptions of the ratings from 1-4 for each risk factor, along with targeted interventions for each rating, are further described in the following subsections.

Sensory Perception

The sensory perception risk factor is defined as the ability to respond meaningfully to pressure-related discomfort. If a patient is unable to feel pressure-related discomfort and respond to it appropriately by moving or reporting pain, they are at high risk of developing a pressure injury. This risk category describes two different issues that affect sensory perception. The first description refers to the patient’s level of consciousness, and the second description refers to the patient’s ability to feel cutaneous sensation. See Table 10.5a for a description of each level of risk from 1-4 with associated interventions for each level.\(^2\)

<table>
<thead>
<tr>
<th>Assessment Category</th>
<th>Rating Description</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory Perception</td>
<td>4–No Impairment</td>
<td>• Encourage the patient to report pain over bony prominences.</td>
</tr>
</tbody>
</table>

Table 10.5a Descriptions and Interventions by Level of Risk for Sensory Perception

https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_(OpenRN)/10%3A_Integumentary/10.05%3A_Braden…

Updated: Wed, 21 Sep 2022 10:03:57 GMT
Powered by
### Sensory Perception

#### 3–Slightly Limited
Responds to verbal commands, but cannot always communicate discomfort or the need to be turned.

* OR

Has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.

#### 2–Very Limited
Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness.

* OR

Has a sensory impairment that limits the ability to feel pain or discomfort over half of the body.

#### 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 the body.

### Interventions

- Check heels daily.
- Assess and inspect skin every shift. Pay attention to heels.
- Elevate heels and use protectors.
- Consider specialty mattress or bed.
- Use pillows between knees and bony prominences to avoid direct contact.

### Moisture

The moisture risk factor is defined as the degree to which skin is exposed to moisture. Prolonged exposure to moisture increases the probability of skin breakdown. Moisture can come from several sources, such as perspiration, urine incontinence, stool incontinence, or wound drainage. Frequent surveillance, removal of wet or soiled linens, and use of protective skin barriers greatly reduce this risk factor. See Table 10.5b for specific interventions for each level of risk.

[3]

https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_(OpenRN)/10%3A_Integumentary/10.05%3A_Braden…

Updated: Wed, 21 Sep 2022 10:03:57 GMT
Powered by 3
<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moisture</td>
<td>4–Rarely Moist</td>
<td>• Encourage the patient to use lotion to prevent skin cracks.</td>
</tr>
<tr>
<td></td>
<td>Skin is usually dry; linen only requires changing at routine intervals.</td>
<td>• Encourage the patient to report any moisture problem (such as under breasts).</td>
</tr>
<tr>
<td>Moisture</td>
<td>3–Occasionally Moist</td>
<td>All interventions mentioned in 4–Rarely Moist plus:</td>
</tr>
<tr>
<td></td>
<td>Skin is occasionally moist, requiring an extra linen change approximately once per day.</td>
<td>• Use moisture barrier ointments (protective skin barriers).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Moisturize dry unbroken skin.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Avoid hot water. Use mild soap and soft cloths or packaged cleanser wipes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Routinely check incontinence pads.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Avoid use of diapers but if necessary, check frequently (every 2-3 hours) and change as needed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If stool incontinence, consider bowel training and toileting after meals.</td>
</tr>
<tr>
<td>Moisture</td>
<td>2–Often Moist</td>
<td>All interventions mentioned in 3–Occasionally Moist plus:</td>
</tr>
<tr>
<td></td>
<td>Skin is often but not always moist. Linen must be changed at least once per shift.</td>
<td>• Check incontinence pads frequently (every 2-3 hours).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider a low air loss bed.</td>
</tr>
<tr>
<td>Moisture</td>
<td>1–Constantly Moist</td>
<td>All interventions mentioned in 2–Often Moist plus:</td>
</tr>
<tr>
<td></td>
<td>Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time the patient is moved or turned.</td>
<td>• Assess and inspect skin every shift.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Check incontinence pads frequently (every 2-3 hours) and change as needed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Apply condom catheter if appropriate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If stool incontinence, consider bowel training and toileting after meals or rectal tubes if appropriate.</td>
</tr>
</tbody>
</table>
Activity

The activity risk factor is defined as the degree of physical activity. For example, walking or moving from a bed to a chair reduces a patient’s risk of developing a pressure injury by redistributing pressure points and increasing blood and oxygen flow to areas at risk.

Level of activity is defined by how frequently the patient is able to get out of bed, move into a chair, or ambulate with or without help. See Table 10.5c for a description of each level of risk from 1-4 with associated interventions for each.

<table>
<thead>
<tr>
<th>Assessment Category</th>
<th>Rating Description</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| 4–Walks Frequently  | Walks outside the room at least twice a day and inside the room at least once every two hours during waking hours. | • Encourage ambulation outside the room.  
• Check skin daily.  
• Monitor balance and endurance. |
| 3–Walks Occasionally | Walks occasionally during the day, but for very short distances, with or without assistance. Spends the majority of each shift in bed or chair. | • Provide a structured mobility plan.  
• Consider a chair cushion.  
• Consider physical therapy consult. |
| 2–Chair fast        | Ability to walk is severely limited or nonexistent. Cannot bear their own weight and/or must be assisted into chair or wheelchair. | • Consider a specialty chair pad.  
• Consider postural alignment, weight distribution, balance, stability, and pressure relief when positioning individuals in chairs or wheelchairs.  
• Instruct the patient to reposition every 15 minutes when in the chair.  
• Stand every hour.  
• Pad bony prominences with foam wedges, rolled blankets, or towels.  
• Consider physical therapy consult for conditioning and wheelchair assessment. |
| 1–Bedfast           | Confined to bed. | • Perform skin assessment and inspection every shift.  
• Position prone if appropriate or elevate head. |
Mobility

The mobility risk factor is defined as the patient’s ability to change or control their body position. For example, healthy people frequently change body position by rolling over in bed, shifting weight in a chair after sitting too long, or by moving their extremities. However, tissue damage will occur if a patient is unable to reposition on their own power unless caregivers frequently change their position. See Table 10.5d for interventions for each level of risk from 1-4. [6]

Table 10.5d Interventions by Level of Risk for Mobility [7]

<table>
<thead>
<tr>
<th>Assessment Category</th>
<th>Rating Description</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Mobility            | 4–No Limitations   | • Check skin daily.  
                      | Makes major and frequent changes in position without assistance. | • Encourage ambulation outside the room at least twice daily.  
                                                                                               | • No interventions required. |
| Mobility            | 3–Slightly Limited | • Check skin daily.  
                      | Makes frequent though slight changes in body or extremity position independently. | • Turn/reposition frequently.  
                                                                                               | • Teach frequent small shifts of body weight. |
## Assessment

<table>
<thead>
<tr>
<th>Assessment Category</th>
<th>Rating Description</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Mobility            | 2–Very Limited    | • Consult physical therapy for strengthening/conditioning.  
|                     |                   | • Use a gait belt for assistance.  
|                     | Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. |
|                     |                   | • Perform skin assessment and inspection every shift.  
|                     |                   | • Turn/reposition 1-2 hours.  
|                     |                   | • Post turning schedule.  
|                     |                   | • Teach or do frequent small shifts of body weight.  
|                     |                   | • Elevate heels.  
|                     |                   | • Consider a specialty bed. |
| Mobility            | 1-Completely Immobile | Same interventions as for 2–Very Limited  
|                     |                   | Does not make even slight changes in body or extremity position without assistance. |

## Nutrition

Adequate nutrition and fluid intake are vital for maintaining healthy skin. Protein intake, in particular, is very important for healthy skin and wound healing. The nutrition risk factor is defined by two categories of descriptions. The first category measures the amount and type of oral intake. The second category is used for patients receiving tube feeding, total parenteral nutrition (TPN), or are prescribed clear liquid diets or nothing by mouth (NPO). See Table 10.5e for interventions for each level of risk from 1-4.  

### Table 10.5e Interventions by Level of Risk for Nutrition

<table>
<thead>
<tr>
<th>Assessment Category</th>
<th>Rating Description</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Nutrition           | 4–Excellent       | • Move the patient out of bed for all meals.  
|                     |                   | • Provide food choices.  
<p>|                     | 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. |</p>
<table>
<thead>
<tr>
<th>Assessment Category</th>
<th>Rating Description</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Nutrition           | 3–Adequate         | • Offer nutrition supplements.  
                    | Eats over half of most meals. Eats a total of 4 servings of protein (meat and dairy products) each day. Occasionally refuses a meal, but will take a supplement if offered  
                    | • Discuss a plan with the provider if the patient is NPO for greater than 24 hours.  
                    | OR  
                    | Is on a tube feeding or TPN regimen that most likely meets most of nutritional needs  
                    | • Record dietary intake.  
                    | Nutrition           | 2–Probably Inadequate | All interventions mentioned in 3–Adequate plus:  
                    | Rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dairy supplement  
                    | • Encourage fluid intake as appropriate.  
                    | OR  
                    | Receives less than optimum amount of liquid diet or tube feeding.  
                    | • Obtain nutritional/dietary consult.  
                    | Nutrition           | 1–Very Poor          | All interventions mentioned in 2–Probably Inadequate plus:  
                    | Never eats a complete meal. Rarely eats more than one third of any food offered. Eats two servings of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement  
                    | • Perform skin assessment and inspection every shift. |
Friction/Shear

Friction and shear are significant risk factors for producing pressure injuries. This category only has three ratings, unlike the other categories that have four ratings, and is rated by whether the patient has a problem, potential problem, or no apparent problem in this area. See Table 10.5f for interventions for each level of risk.\[10\]

<table>
<thead>
<tr>
<th>Assessment Category</th>
<th>Rating Description</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friction/Shear</td>
<td>3–No Apparent Problem</td>
<td>- Keep bed linens clean, dry, and wrinkle free.</td>
</tr>
<tr>
<td></td>
<td>Moves in bed and chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.</td>
<td></td>
</tr>
<tr>
<td>Friction/Shear</td>
<td>2–Potential Problem</td>
<td>All interventions mentioned in 3–No Apparent Problem plus:</td>
</tr>
<tr>
<td></td>
<td>Moves feebly or requires minimal assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains a relatively good position in a chair or bed most of the time but occasionally slides down.</td>
<td>- Avoid massaging pressure points.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Apply transparent dressing or elbow/heel protectors to intact skin over elbows and heels.</td>
</tr>
<tr>
<td>Friction/Shear</td>
<td>1–Problem</td>
<td>All interventions mentioned in 2–Potential Problem plus:</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>- Perform skin assessment and inspection every shift.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Use a minimum of</td>
</tr>
</tbody>
</table>
Team Member Roles to Prevent Pressure Injuries

Each member of the health care team has an important role in preventing the development of pressure injuries in at-risk patients. A registered nurse can delegate many interventions for preventing and treating a pressure injury to a licensed practical nurse (LPN) or to unlicensed assistive personnel such as a certified nursing assistant (CNA). See Table 10.5g for an explanation of the role of the RN in preventing pressure injuries, as well as tasks that can be delegated to LPNs and CNAs.

<table>
<thead>
<tr>
<th>Role</th>
<th>Tasks</th>
</tr>
</thead>
</table>
| RN    | • Conducts or supervises accurate assessment and documentation of head-to-toe skin assessment and pressure injury risk (Braden Scale or Braden Risk Assessment) on admission, daily, and if condition deteriorates (or according to facility policy)  
  • Documents care plan tied to identified risk:  
    ◦ Sensory perception  
    ◦ Moisture  
    ◦ Activity  
    ◦ Mobility  
    ◦ Nutrition |

Table 10.5g Team Member Roles in Preventing Pressure Injuries
Friction/Shear

- Performs or supervises performance of care plan procedures or treatments
- Collaborates with other staff to ensure timely and accurate reporting of any skin issues
- Notifies wound nurse of any skin conditions or high-risk patients
- Notifies physician of any skin problems
- Educates patient/family about risk factors

- Conducts accurate assessment and documentation of head-to-toe skin assessment and pressure injury risk (Braden Scale) on admission, daily, and if condition deteriorates (or according to facility policy)
- Documents care plan tied to identified risk:
  - Sensory perception
  - Moisture
  - Activity
  - Mobility
  - Nutrition
  - Friction/Shear
- Performs care for risk as needed
- Informs RN of any skin issues

LPN

- Performs or supervises performance of care plan procedures or treatments
- Collaborates with other staff to ensure timely and accurate reporting of any skin issues
- Notifies wound nurse of any skin conditions or high-risk patients
- Notifies physician of any skin problems
- Educates patient/family about risk factors

- Conducts accurate assessment and documentation of head-to-toe skin assessment and pressure injury risk (Braden Scale) on admission, daily, and if condition deteriorates (or according to facility policy)
- Documents care plan tied to identified risk:
  - Sensory perception
  - Moisture
  - Activity
  - Mobility
  - Nutrition
  - Friction/Shear
- Performs care for risk as needed
- Informs RN of any skin issues

CNA

- Checks skin each time person is turned or cleaned or bed is changed
- Reports any skin issues to nurse
- Turns/repositions patient as ordered
- Offers liquids each time in room
- Keeps skin clean and reapplies protective skin barrier
- Applies products (lotion, cream, skin sealant, etc.) as needed