WOUND ASSESSMENT AND CARE TOOL WITH BRADEN SCALE

Patient Name					ID #	Room #			
WOUND # Wound Location: (if not numbered on body	#1	#2	#3	#4	#5	#6	Denote location of specific skin conditions/wounds by numbering		
diagrams)							appropriately on illustrations below. Proceed by completing applicable information for each numbered site		
Size cm: (Length x Width x Depth)							on chart to include ostomies.		
Type: Select for each wound – Diabetic ulcer (D), Pressure injury (P), Venous stasis ulcer (V), Arterial ulcer (A), Traumatic wound (T), Burn (B), Surgical (S), Other (specify)				CC	100	\sim			
Stage: (to be done ONLY with Pressure Injuries) 1, 2, 3, 4 or Unstageable (U), Deep tissue (DTI), or Medical device related (MD) (see Braden Scale completed: □ Yes □ No other side)			14710CC	alle o	2	\square			
Wound Bed:		50	211 Gr						
Drainage: (check) None		7816							
Small		, dS ¹ > ~				6			
Moderate		25					$\left(\right) \left(\begin{array}{c} 9 \\ 9 \end{array} \right) \left(\begin{array}{c} 1^2 \\ 3 \end{array} \right) \left(\begin{array}{c} 1 \\ 1 \end{array} \right) \left(\begin{array}{c} 1 \\ 1 \end{array} \right)$		
Large Color: Clear (C), Serosanguineous (S), Bloody (B)	- <u>2027</u>								
Yellow (Y), White (W), Green (G), Brown (Br), Other (describe)	A or				A 2		Anterior Posterior		
Odor	\square			\geq					
Tunneling/Undermining	\square		\sum						
Surrounding Tissue		\geq					$\left[\begin{array}{c} 1 \\ 1 \\ 1 \\ 1 \\ 1 \\ 1 \\ 1 \\ 1 \\ 1 \\ 1 $		
Edema									
Slough and/or Eschar present: D Yes No		\mathcal{V}							
Wound Status: Fully Granulating		0					E E		
Early/Partial Granulating									
Non-healing									
Wound Care: (List specifics below then check for each site as appropriate. With multiple orders for multiple wounds, list each with applicability by wound #, then check column when done during visit.)									
Stoma									
Satisfactory Return Demo: Q Yes Q No									
Patient Response: Poor (P), Fair (F), Good (G)							XXX 444 (14)		
Signature:				[Date:				

WOUND ASSESSMENT AND CARE TOOL WITH BRADEN SCALE*Fill out per organizational policy Deferred

FRICTION AND SHEAT		NUTRITION	MOBILITY	ACTIVITY	MOISTURE	SENSORY Perception	Source	FRIC	NUTRI Usual NPO: ۲UV: In TPN: tera	MOBILIT Ability to and cont position	ACTIVITY Degree of activity	MOIS Degra skin i to mo	PERC Abilit mean press disco	RISI	S
© Copyright 1998, 2001 P.J	Most shear and friction injuries can be prevented with proper interventions	Poor dietary intake contributes to the development of pres ulcers	Frequent turning, repositioning, and mobility are reported to be essential in reducing risk of pressure ulcers	Frequent turning, repositioning, and mobility are reported to be essential in reducing risk of pressure ulcers.	An excess of moisture on intact skin is a potential source of maceration and skin breakdown	Rationale The ability to respond meaningfully to pressure related discomfort impacts the risk of pres- sure ulcer development	Source: Barbara Braden and Nancy Bergstrom. ©	SHEAR	TION food intake n Nothing by Whth. travenously. Total paren- I nutrition.	Y) change rol body	physical	MOISTURE Degree to which skin is exposed to moisture	SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	RISK FACTOR	SEVERE RISK:
		s B □					nd Nancy Bergstro	1. PROBLEM maximum assi Complete liftin Sheets is impo down in bed on repositioning v Spasticity, con leads to almos	1. VERY POOR meal. Rarely ex food offered. E protein (meat o Takes fluids pc liquid dietary s and/or maintai for more than	1. COMPLETEL make even slig extremity posit	1. BEDFAST –C	1. CONSTANTL moist almost c urine, etc. Dan time patient is	1. COMPLETE Unresponsive u grasp) to painf ished level of c OR limited abil of body surfac		C: Total score ≤
Apply moisturizers Apply moisturizers Eliminate or limit 1 Raise heels off off Utilize appropriate Systematically ins and elbows Instruct caregiver Johnston, RN, CWOCN	Keep HOB in lo amount of time Utilize lifting de	Very Poor Assess height/, Request dietar, recommendation resess actient Assess patient Assess caregiv Assess caregiv Instruct caregiv	J Completely Limited Initiate a turn schedule, Utilize pillows/foam wei prominences Avoid positioning direct Vyng position Utilize appropriate press	Bedrast See MOBILITY, Completely Limited	Utilize appropriate n Utilize appropriate ir Utilize appropriate ir Cleanse perineum p Cleanse for fungal/ye med as ordered	Completely Limited See MOBILITY, Completely Limited	m. © Copyright, 1988.	1. PROBLEM-Requires moderate to maximum assistance in moving. Complete lifting without siding 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.	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 poorty, IDees not take a liquid dietary supplement. OR is NPO' and/or maintaned on claur liquids or IV ^e for more than 5 days.	1. COMPLETELY IMMOBILE-Does not make even slight changes in body or extremity position without assistance.	BEDFAST-Confined To bed.	1. CONSTANTLY MOIST-Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	 COMPLETELY LIMITED- Unresponsive (does not mean, flinch, or grasp) to painful stimuli, due to dimin- ished level of consciousness or sedation, OR limited ability to feel pain over most of body surface. 		9
Apply protective dressing (ex. MVP dressing or thin hydrocolloid) to high Elminate or limit the amount of soap used when bathing patients Elminate or limit the amount of soap used when bathing patients Raise heels off of bed Utilize appropriate pressure reducing surface Utilize appropriate pressure reducing surface Systematically inspect the skin, paying particular attention to bony pro and elbows Instruct caregiver on above Instruct Caregiver on above	west degree of o the HOB is elev vice to move/re) Very Poor (2) Probably Inadequal Assess height/weight on admit, initiate I&O, and food diary Request dietary consult and lab tests (serum alb., transferrin, recommendations to chew/gag reflex. Consult ST pm Assess patient ability to chew/gag reflex. Consult ST pm Requests MSW consult to evaluate patient resources pm Assess caregiver ability to obtain prepare meals/tube feeding Instruct caregiver on appropriate interventions	Completely Limited ② Very Limited Unitate a turn schedule, minimum q 2 hours Unitate a turn schedule, minimum q 2 hours Unitate a pillows/foam wedges for placement between bony prominences Avoid positioning directly on the trochanter when in side Ving position Utilize appropriate pressure reducing surface	, Completely	Utilize appropriate nursing intervention for incontinence Utilize appropriate incontinence device as ordered Clearse perineum prin Assess for fungal/yeast infection and treat with Antifung med as ordered	L imited Completely	1988. Reprinted wi	ate to gagainst g against ty slides g frequent assistance thitation	omplete or less of s) per day. take a uids or IV ²				n, flinch, or to dimin- or sedation, over most		BRADE
VP dry/naky skin VVP dressing o f soap used whe lucing surface h, paying partici	elevation consis ated position the pati	(2) Probably Inadequa initiate I&O, and food clary tests (serum alb., transferrin, ag reflex. Consult ST prn uate patient resources prn in prepare meals/tube feeding te interventions	(2) Very Limited ind 2 hours placement between bo e trochanter when in si lucing surface	(2) Chairfast See MOBILI able Avoid pressi Utilize appro	vention for incontinence e device as ordered on and treat with Antifungal	2 Very I See MO Assess	Reprinted with permission.	PGTENTIAL P r requires mini r move, skin pro xtent against si r other devices r other devices he time but occ	PROBABLY IN complete mea bout 1/2 of any ntake includes c rr dairy product rr dairy product rr dairy product r dairy produc	2. VERY LIMITED-M slight changes in bo position but unable t significant changes 1	CHAIRFAST-/ mited or nonex veight and/or m mair or wheelch	2. OFTEN MOIST-Ski always moist. Linen r least once a shift.	VERY LIMITE hainful stimuli. (liscomfort exce essness, OR has evhich limits the liscomfort over		EN SCALE - Total score 10 -
r thin hydrocollc en bathing patie	tent with medica ient		imited veen bony en in side	स्ट देठ	red red red Antifungal	Very Limited See MOBILITY, Complet Assess non-verbal sign	h permission. Total score of 12 or less represention INSTRUCTION GIUDE	2. POTENTIAL PROBLEM—Moves feebly or requires minimum assistance. During a move, skin probaby slides to some extent against sheets, chair, restrams, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	2. PROBABLY INADEQUATE-Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein indate includes only 3 servings of meat of dairy products per day. Occasionally will take a dietary supplement, OR receives.less than optimum amount of liquid diet or tube feeding.	. VERY LIMITED-Makes occasional light changes in body or extremity osition but unable to make frequent or ignificant changes independently.	2. CHAINFAST-Ability to walk severely limited of nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	OFTEN MOIST -Skin is often but not ways moist. Linen must be changed ast once a shift.	 VERY LIMITED-Responds only to painful stimuli. Cannot communicate discomfort except by moaning or rest- lessness, OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body. 		12 N
nts b bony prominences,	al condition. Limit	te TLC). F/U with I	Use only on patient wher Raise heels Avoid massa Systemática bony promir Instruct the	mpletely Limited shift weight q 15 mi heels while sitting wheelchair cushion	Apply Mois Utilize low a Avoid use c Instruct care	Completely Limited bal signs of pain and/or discomfort	otal score of 12	e. During be some su traints, pl tively pl nost of al	of meat of meat of meat ount of w		_)/	at		DESCRIPTION	Predicting Pressure
areas nces, heels,	nit the	MD any	(3) Sile Use only one draw Sheft and one in patient when possible Raise heels off of bed Avoid massage over bony promineer Systematically inspect skin, paying bony prominences Instruct the caregiver on above	n. if	3 Uccasionally Mois Apply Moisture Barfer orn Utilize low airloss support surface if indicated Avoti use of hards scaps and rubbing when cleansi Instruct caregiver on importance of keeping skin clean	discomfort	f 12 or les	3. NO APPARENT PROBLEM-Moves in beef and in chair-independently and has sufficient muscle strength to lift up com- pletely during move. Maintains good position in bed of chair at all times.	3: ADEQUATE-Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN regimen, which probably meets most of nutritional needs.	 SLIGHTLY LIMITED-Makes frequent though slight changes in body or extremity position independently. 	 WALKS OCCASIONALLYWalks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift bed or chair. 	3. OCCASIONALLY MOIST-Skin occasionally moist, requiring ar linen change approximately once a day.	3. SLIGHTLY LIMITED-Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR has some senory impair- ment which limits ability to feel pain or discomfort in 1 or 2 extremities.	TION	g Pressi RISK: Tota
	 Potential Problem See FRICTION AND SH Problem Refer to policy on rest 	Adequate Assess heiging admit Assess heiging admit Admit admit Request lab transferrin, 1 Pressent and pressen	3 Sighty Limited and one incontinence pa prominences n paying particular atter above	Walks Occasionally See ACTIVITY, Chairfast — Written schedule for ambulation/activity _ Instruct caregoliver on sa during ambulation	Occasionally Moist surface if indicated and rubbing when cleansin ance of keeping skin clean a ance of keeping skin clean	3 Slightly Limited See MOBILITY Cor Limited Assess for verbal a verbal sign of pain discomfort	less represents	PROBLEM- M independently e strength to lif ove. Maintains r chair at	at over half of at of 4 serving iny products) - refuse a meal, pplement if off ing or TPN reg meets most of	I TED- Makes fr anges in body n independent	sionALLY-Wall ing day but for with or withour ajority of each	Y MOIST-Skin i st, requiring an proximately	ITED-Respond s but cannot a scomfort or nei scomfort sensory i ome sensory i s ability to feel s ability to feel r 2 extremities.		SSURE SORE R
	 Botential Problem See FRICTION AND SHEAR, Problem Refer to policy on restraints i 	3 Adequate Assess height/weight on admit tasts (serum alb., readerin, TLC) if wound present and nct progressing Aeassess nutrition status if lab values abnormal	ar attention to	3 Warks Occasionally See ACTIVITY, Chairfast prm Written schedule for ambulation/activity Instruct caregiver on safety during ambulation	ated ated skin cleansing skin skin clean and dry	3 Slightly Limited See MOBILITY, Completely Limited Assess for verbal and non- verbal sign or pain and/or discomfort	/ HIGH		most s of but will ered, OR bet sub		II. IS.	n extra		1 1	- 14 MILD
			(4) No Im — System promine — Reasses — changes		(4) Kar Systei partic moist Reass chang		RISK		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.	 NO LIMITATIONS—Makes major and frequent changes in position without assistance. 	4. WALKS FREQU the room at least room at least onc waking hours.	 BARELY MOIST-Skin is usually dry; linen only requires changing at routine intervals. 	 NO IMPAIRMENT-Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort. 		RISK:
n changes or p nent protocol	Apparent Problem matically inspect skii ular attention to bon and elbows	l ent height/weight c ssment nutrition s or per routine	No Impairment Systematically inspect particular attention to a prominences Reassess mobility stat hanges or per routine	ks Frequently n schedule for arr ct caregiver on s lation lation tessment activity less or per routine col	Rarely Moist systematically inspect skin, paying varticular attention to areas prone to noisture eassess moisture status if condition hanges or per routine risk assessm	Impairment ematically inspect cular attention to t sees sensory pero lition changes or p lition changes or p	TOTAL S		ats most of even neal. Usually ere servings of m loccasionally eat Does not requir	NS- Makes majo ; in position ;e.	QUENTLY-Walks outside ast twice a day and inside once every 2 hours during	F-Skin is usual s changing at	NT-Responds t no sensory def t ability to feel rt.		Total score 15 - 18
per routine risk	3) No Apparent Problem Systematically inspect skin paying particular attention to bony prominences, heels and elbows	 Excellent Assess height/weight on admit Reassessment nutrition status if condition changes or per routine risk assessment protocol Protocol	 (a) No impairment Systematically inspect skin, paying particular attention to areas prone to bony prominences Reassess mobility status if condition changes or per routine risk assessment 	Witks Frequently Writen schedule for ambulation/activity prm Instruct caregiver on safety during ambulation Reassessment activity status if condition changes or per routine risk assessment protocol	By Moist matcally inspect skin, paying ular attention to areas prone to ure ess moisture status if condition es or per routine risk assessment	No Impairment Systematically inspect skin, paying particular attention to bony prominences neassess sensory perception status if condition changes or per routine risk assessment protocol	SCORE		ery meal. ats a heat and s e	or and	outside Id inside 's during	lly dry;	to verbal icit or voice		5-18
	ces,	nt	bony nt	y prn ion nt	nt	sao								SCORE	

WOUND ASSESSMENT AND CARE TOOL WITH BRADEN SCALE

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