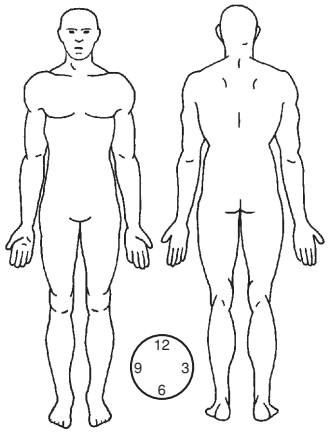
WOUND ASSESSMENT AND CARE TOOL WITH BRADEN SCALE

Patient Name_____ ID #_____ Room #_____

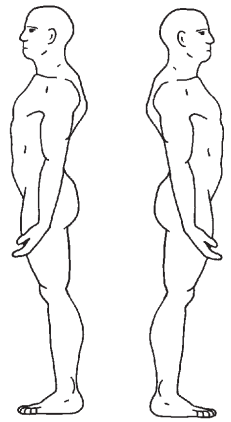
WOUND #	#1	#2	#3	#4	#5	#6
Wound Location: (if not numbered on body diagrams)						
Size cm: (Length x Width x Depth)						
Type: Select for each wound – Diabetic ulcer (D), Pressure injury (P), Venous stasis ulcer (V), Arterial ulcer (A), Traumatic wound (T), Burn (B), Surgical (S), Other (specify)						
Stage: (to be done ONLY with Pressure Injuries) 1, 2, 3, 4 or Unstageable (U), Deep tissue (DTI), or Medical device related (MD) **Braden Scale completed:** ❑ Yes ❑ No (see other side)						
Wound Bed:						
Drainage: (check) None						
Small						
Moderate						
Large						
Color: Clear (C), Serosanguineous (S), Bloody (B) Yellow (Y), White (W), Green (G), Brown (Br), Other (describe)						
Odor						
Tunneling/Undermining						
Surrounding Tissue						
Edema						
Slough and/or Eschar present: ❑ Yes ❑ No						
Wound Status: Fully Granulating						
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: ❑ Yes ❑ No						
Patient Response: Poor (P), Fair (F), Good (G)						

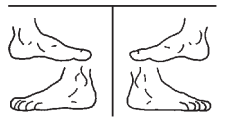
Signature:_____ Date:_____

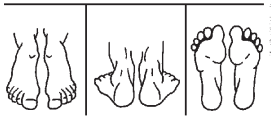
Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart to include ostomies.



Anterior Posterior







WOUND ASSESSMENT AND CARE TOOL WITH BRADEN SCALE

*Fill out per organizational policy ❑ Deferred

BRADEN SCALE - For Predicting Pressure Sore Risk

SEVERE RISK: Total score ≤ 9 **HIGH RISK**: Total score 10 - 12 **MODERATE RISK**: Total score 13 - 14 **MILD RISK**: Total score 15 - 18

RISK FACTOR	DESCRIPTION				SCORE
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 surface.	**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 1/2 of body.	**3. SLIGHTLY LIMITED–**Responds to verbal commands but cannot always communicate discomfort or 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. OFTEN 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 nonexistent. 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 the room at least twice a day and inside room at least once every 2 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 LIMITATIONS–**Makes major and frequent changes in position without assistance.	
NUTRITION Usual food intake pattern [1]NPO: Nothing by mouth. [2]IV: Intravenously. [3]TPN: Total parenteral nutrition.	**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 poorly. Does not take a liquid dietary supplement, **OR** is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	**2. PROBABLY INADEQUATE–**Rarely eats a complete meal and generally eats only about 1/2 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) 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.	**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 AND 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 at all times.		
Source: Barbara Braden and Nancy Bergstrom. © Copyright, 1988. Reprinted with permission.		**Total score of 12 or less represents HIGH RISK**		**TOTAL SCORE**	

INTERVENTION INSTRUCTION GUIDE

	Rationale	① Completely Limited	② Very Limited	③ Slightly Limited	④ No Impairment
SENSORY PERCEPTION	The ability to respond meaningfully to pressure related discomfort impacts the risk of pressure ulcer development	__See MOBILITY, Completely Limited	__See MOBILITY, Completely Limited __Assess non-verbal signs of pain and/or discomfort	__See MOBILITY, Completely Limited __Assess for verbal and non-verbal sign of pain and/or discomfort	__Systematically inspect skin, paying particular attention to bony prominences __Reassess sensory perception status if condition changes or per routine risk assessment protocol
		① Constantly Moist	② Very Moist	③ Occasionally Moist	④ Rarely Moist
MOISTURE	An excess of moisture on intact skin is a potential source of maceration and skin breakdown	__Utilize appropriate nursing intervention for incontinence __Utilize appropriate incontinence device as ordered __Cleanse perineum prn __Assess for fungal/yeast infection and treat with Antifungal med as ordered	__Apply Moisture Barrier prn __Utilize low airloss support surface if indicated __Avoid use of harsh soaps and rubbing when cleansing skin __Instruct caregiver on importance of keeping skin clean and dry		__Systematically inspect skin, paying particular attention to areas prone to moisture __Reassess moisture status if condition changes or per routine risk assessment
		① Bedfast	② Chairfast	③ Walks Occasionally	④ Walks Frequently
ACTIVITY	Frequent turning, repositioning, and mobility are reported to be essential in reducing risk of pressure ulcers.	__See MOBILITY, Completely Limited	__See MOBILITY, Completely Limited __Instruct patient to shift weight q 15 min. if able __Avoid pressure to heels while sitting __Utilize appropriate wheelchair cushion	__See ACTIVITY, Chairfast prn __Written schedule for ambulation/activity __Instruct caregiver on safety during ambulation	__Written schedule for ambulation/activity prn __Instruct caregiver on safety during ambulation __Reassessment activity status if condition changes or per routine risk assessment protocol
		① Completely Limited	② Very Limited	③ Slightly Limited	④ No Impairment
MOBILITY	Frequent turning, repositioning, and mobility are reported to be essential in reducing risk of pressure ulcers	__Initiate a turn schedule, minimum q 2 hours __Utilize pillows/foam wedges for placement between bony prominences __Avoid positioning directly on the trochanter when in side lying position __Utilize appropriate pressure reducing surface	__Use only one draw sheet and one incontinence pad under patient when possible __Raise heels off of bed __Avoid massage over bony prominences __Systematically inspect skin, paying particular attention to bony prominences __Instruct the caregiver on above		__Systematically inspect skin, paying particular attention to areas prone to bony prominences __Reassess mobility status if condition changes or per routine risk assessment
		① Very Poor	② Probably Inadequate	③ Adequate	④ Excellent
NUTRITION	Poor dietary intake contributes to the development of pressure ulcers	__Assess height/weight on admit, initiate I&O, and food diary __Request dietary consult and lab tests (serum alb., transferrin, TLC). F/U with MD any recommendations __Assess patient ability to chew/gag reflex. Consult ST prn __Requests MSW consult to evaluate patient resources prn __Assess caregiver ability to obtain prepare meals/tube feeding __Instruct caregiver on appropriate interventions		__Assess height/weight on admit __Request lab tests (serum alb., transferrin, TLC) if wound present and not progressing __Reassess nutrition status if lab values abnormal	__Assess height/weight on admit __Reassessment nutrition status if condition changes or per routine risk assessment protocol
		① Problem		② Potential Problem	③ No Apparent Problem
FRICTION AND SHEAR	Most shear and friction injuries can be prevented with proper interventions	__Keep HOB in lowest degree of elevation consistent with medical condition. Limit the amount of time the HOB is elevated __Utilize lifting device to move/reposition the patient __Apply moisturizers/lubricants to dry/flaky skin __Apply protective dressing (ex. MVP dressing or thin hydrocolloid) to high-risk areas __Eliminate or limit the amount of soap used when bathing patients __Raise heels off of bed __Utilize appropriate pressure reducing surface __Systematically inspect the skin, paying particular attention to bony prominences, heels, and elbows __Instruct caregiver on above		__See FRICTION AND SHEAR, Problem __Refer to policy on restraints if utilized	__Systematically inspect skin paying particular attention to bony prominences, heels and elbows __Reassess friction and shear status if condition changes or per routine risk assessment protocol