YOUR AGENCY NAME

Hospitalization Risk Assessment

Purpose: Screening tool to identify those at risk for hospitalization.
Patient Name: _____ Record # _____
Date: _____

Prior pattern: Check all that apply	
❑ >1 Hospitalizations/ER visits in the past 12 months	❑ History of falls* *(see Falls Risk Assessment)*
Chronic conditions: Check all that apply	
❑ CHF	❑ Chronic skin ulcers *(Wound consult if indicated for any wounds)*
❑ Diabetes	
❑ COPD	❑ HIV/AIDS
Risk Factors: Check all that apply	
❑ Discharged from hospital or skilled nursing facility	❑ Help with managing medications needed ► ★
❑ More than 2 secondary diagnoses	❑ Non-compliance with medication regimen ♦ ★
❑ Low socioeconomic status or financial concerns ♦	❑ Confusion ♦★
❑ Lives alone ►♦	❑ Pressure ulcer ★
❑ Inadequate support network ♦	❑ Stasis ulcer ★
❑ ADL assistance needed ► ❑ Short life expectancy ■	
❑ Home safety risks ► ♦	❑ Overarll poor Status/Prognosis ■
❑ Dyspnea, Short of Breath ►	❑ Low literacy level ♦ ❑ Depresion ♦

►Consider Therapy referral (PT, OT, ST)	♦ Consider MSW referral	■ Consider Hospice referral	★Consider RN referral, if not ordered

Total # of checked boxes is ___. **Your agency may want to select a threshold score to target patients at high risk.** (*For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization.* Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)

Consider implementing any of the following interventions (coordination of care), if patient is at risk for hospitalization:

Referrals: ❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW ❑ HHA ❑ Dietary Consultant ❑ Other _____	❑ Medication Management ❑ Medication Reconciliation • Assess patient's: knowledge, ability, resources and adherence • Education	❑ Patient/family education ❑ Enrollment into a disease management program (specify): _____
❑ Hospice/Palliative Referral	❑ Phone Monitoring	Immunizations ❑ Influenza ❑ Pneumonia
❑ Individualized Patient Emergency Care Plan	❑ Front-loading Visits	❑ Care Coordination (Physicians, hospitals, nursing homes…)
❑ Fall Prevention Program	❑ Telemonitoring	❑ Other: _____

Consider notification of any/all of the following if patient is at risk for hospitalization:

❑ Patient/family/caregiver	❑ Interdisciplinary Team _____	❑ On Call Staff	❑ Payer: (e.g. Managed Care Organizations)
❑ Physician		❑ Agency Case Manager	❑ Other:

Clinician Signature: _____ Date:_____

YOUR AGENCY NAME
Individual TB Risk Assessment Tool

(a modified version from CDC)

Latent Tuberculosis Infection: A Guide for Primary Health Care Providers

Persons with any of the following risk factors should be tested for TB infection unless there is written documentation of a previous positive TST or IGRA result.

Patient Name: _____ MR #: _____

Physician: _____ phone: _____

Risk Factor	Yes	No
Recent close or prolonged contact with someone with infectious TB disease		
Foreign-born person from or recent traveler to high-prevalence area		
Chest radiographs with fibrotic changes suggesting inactive or past TB		
HIV infection		
Organ transplant recipient		
Immunosuppression secondary to use of prednisone (equivalent of ≥15 mg/day for ≥1 month) or other immunosuppressive medication such as TNF-α antagonists		
Injection drug user		
Resident or employee of high-risk congregate setting (e.g., prison, long term care facility, hospital, homeless shelter)		
Medical conditions associated with risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, and end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight [10% or more below ideal for given population])		
Signs and symptoms of TB		

Staff name completed the assessment (Name/Title): _____

Staff Signature: _____ Date: _____

If risk exist, Physician notified, order obtained for TB test: ☐ Yes ☐ No

(if yes, test results must be filed in patient's record, positive results must be compliant with TB prevention plan, treatment program, referrals needed)

Patient refuse test (document): _____ ☐ N/A

_____

Original: Medical Record *Copy: Patient*

Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program

Your Agency Name

Pediatric Fall risk assessment
Humpty Dumpty Tool and Protocol

Humpty Dumpty Falls Prevention Program™

Preventing falls, enhancing safety.

Falls Assessment Tool
The Humpty Dumpty Scale - Inpatient

Parameter	Criteria	Score (circle)
Age	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years and above	1
Gender	Male	2
	Female	1
Diagnosis	Neurological Diagnosis	4
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments	Not Aware of Limitations	3
	Forgets Limitations	2
	Oriented to own ability	1
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4
	Patient Uses Assistive devices or Infant-Toddler in Crib or Furniture/Lighting (Tripled room)	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/Sedation/ Anesthesia	Within 24 hours	3
	Within 48 hours	2
	More than 48 hours/None	1
Medication Usage	Multiple usage of: Sedatives (excluding ICU patients sedated and paralyzed) Hypnotics Barbiturates Phenothiazines Antidepressants Laxatives/Diuretics Narcotic	3
	One of the meds listed above	2
	Other Medications/None	1
Rev: 07/2007	TOTAL	

Date:_____

Name:_____

MR#:_____

Acct#:_____

D.O.B.:_____

Age:_____

At risk for falls if score is 12 or Above

Minimum Score 7
Maximum Score 23

☞ **Patient Falls Safety Protocol on back**

The Humpty Dumpty Falls Scale: (interpretation)

Patient Falls Safety Protocol

Low Risk Standard Protocol (score 7-11)

- Orientation to room
- Bed in low position, brakes on
- Side rails x 2 or 4 up , assess large gaps, such that a patient could get extremity or other body part entrapped, use additional safety procedures.
- Use of non-skid footwear for ambulating patients, use of appropriate size clothing to prevent risk of tripping
- Assess eliminations need, assist as needed
- Call light is with in reach, educate patient/family on its functionality
- Environment clear of unused equipment, furniture's in place, clear of hazards
- Assess for adequate lighting, leave nightlight on
- Patient and family education available to parents and patient
- Document fall prevention teaching and include in plan of care

High Risk Standard Protocol (score 12 and above)

- Identify patient with a "humpty dumpty sticker" on the patient, in the bed and in patient chart
- Educate patient/parents of falls protocol precautions
- Check patient minimum every 1 hour
- Accompany patient with ambulation
- Developmentally place patient in appropriate bed
- Consider moving patient closer to nurses' station
- Assess need for 1:1 supervision
- Evaluate medication administration times
- Remove all unused equipment out of the room
- Protective barriers to close off spaces, gaps in the bed
- Keep door open at all times unless specified isolation precautions are in use
- Keep bed in the lowest position, unless patient is directly attended
- Document in nursing narrative teaching and plan of care

YOUR AGENCY NAME

Timed Get Up and Go Test

Measures mobility in people who are able to walk on their own (assistive device permitted)

*Patient's Name*_____ *MR #:* _____
*Date*_____ *Patient age:* _____

Time to Complete_____seconds (according patient's condition)

Instructions:
The person may wear their usual footwear and can use any assistive device they normally use.
1. Have the person sit in the chair with their back to the chair and their arms resting on the arm rests.
2. Ask the person to stand up from a standard chair and walk a distance of 10 ft. (3m).
3. Have the person turn around, walk back to the chair and sit down again.

Timing begins when the person starts to rise from the chair and ends when he or she returns to the chair and sits down.

The person should be given 1 practice trial and then 3actual trial. The times from the three actual trials are averaged.

Walking aid used? Type of aid: _____

Activity	***Trial 1*** *(time in seconds)*	***Trial 2*** *(time in seconds)*	***Trial 3*** *(time in seconds)*
Stand up and walk 10 ft (3m), turn around and walk back to the chair and sit down again.	*Time:* _____ *Observation:* _____ _____	*Time:* _____ *Observation:* _____ _____	*Time:* _____ *Observation:*_____ _____
Average time *(in seconds)*			

Unstable on turning? ☐ Yes ☐ No Explain: _____

NORMATIVE DATA[1]

AGE	GENDER	MEAN (seconds)	NORMAL RANGE (seconds)
60-69	MALE	8	4-12
60-69	FEMALE	8	4-12
70-79	MALE	9	3-15
70-79	FEMALE	9	5-13
80-89	MALE	10	8-12
80-89	FEMALE	11	5-17

Sensitivity and Specificity:
☐ ***If score < 14 seconds: 87 % not a high risk of falls***
☐ ***If score >= 14 seconds: 87 % high risk of falls***

Predictive Results
Seconds Rating
☐ ***<10 Freely mobile***
☐ ***10-19 Mostly independent***
☐ ***20-29 Variable mobility***
☐ ***>30 Impaired mobility***

Comments: _____
_____

Staff signature & title: _____ *Date:* _____

Braden Risk Assessment Scale

YOUR AGENCY NAME

NOTE: Bed and chairbound individuals or those with impaired ability to reposition should be assessed upon admission for their risk of developing pressure ulcers. Patients with established pressure ulcers should be reassessed periodically.

Patient Name: _____ Med. Rec. Number: _____ Date: _____

Sensory Perception	**1. Completely Limited**	**2. Very Limited**	**3. Slightly Limited**	**4. No Impairment**	*Indicate Appropriate Numbers Below*
Ability to respond meaningfully to pressure-related discomfort	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.	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.	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.	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	
Moisture	**1. Constantly Moist**	**2. Very Moist**	**3. Occasionally Moist**	**4. Rarely Moist**	
Degree to which skin is exposed to moisture	Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	Skin is often, but not always, moist. Linen must be changed at least once a shift.	Skin is occasionally moist, requiring an extra linen change approximately once a day.	Skin is usually dry. Linen only requires changing at routine intervals.	
Activity	**1. Bedfast**	**2. Chairfast**	**3. Walks Occasionally**	**4. Walks Frequently**	
Degree of physical activity	Confined to bed.	Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	
Mobility	**1. Completely Immobile**	**2. Very Limited**	**3. Slightly Limited**	**4. No Limitations**	
Ability to change and control body position	Does not make even slight changes in body or extremity position without assistance.	Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	Makes frequent though slight changes in body or extremity position independently.	Makes major and frequent changes in position without assistance.	
Nutrition	**1. Very Poor**	**2. Probably Inadequate**	**3. Adequate**	**4. Excellent**	
Usual food intake pattern	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 and/or maintained on clear liquids or I.V.'s for more than 5 days.	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.	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.	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**	**2. Potential Problem**	**3. No Apparent 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 lead to almost constant friction.	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.	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.		

NOTE: Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers.
(15 or 16 = low risk; 13 or 14 = moderate risk; 12 or less = high risk)

Total Score:

Staff Signature/Title: _____ Date: _____

Your Agency Name

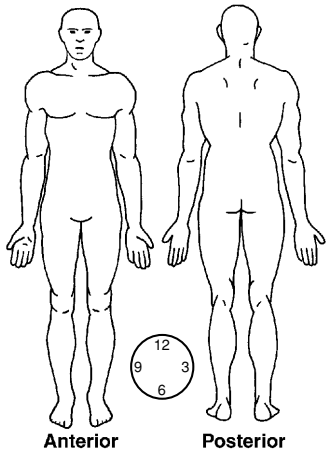
WOUND ASSESSMENT AND CARE TOOL WITH BRADEN SCALE

Patient Name_____ ID #_____ Room #_____

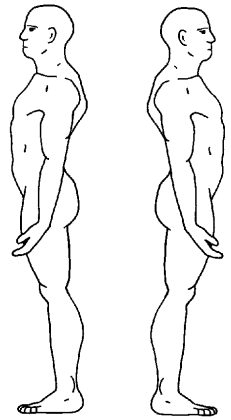
WOUND #	#1	#2	#3	#4	#5	#6
Wound Location: (if not numbered on body diagrams)						
Size cm: (Length x Width x Depth)						
Type: Select for each wound – Diabetic ulcer (D), Pressure ulcer (P), Venous stasis ulcer (V), Arterial ulcer (A), Traumatic wound (T), Burn (B), Surgical (S), Other (specify)						
Stage: (to be done ONLY with Pressure Ulcers) 1, 2, 3, 4 or non-observable (NO) **Braden Scale completed:** ❑ Yes (see other side) ❑ No						
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						
Stoma						
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.)						
Satisfactory Return Demo: ❑ Yes ❑ No						
Patient Response: Poor (P), Fair (F), Good (G)						

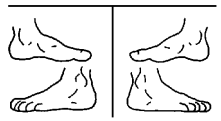
Signature:_____ Date:_____

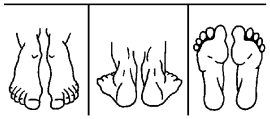
Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart to include ostomies.



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 r**eceives 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

SENSORY PERCEPTION

Rationale

The ability to respond meaningfully to pressure related discomfort impacts the risk of pressure ulcer development

① Completely Limited
- __See MOBILITY, Completely Limited

② Very Limited
- __See MOBILITY, Completely Limited
- __Assess non-verbal signs of pain and/or discomfort

③ Slightly Limited
- __See MOBILITY, Completely Limited
- __Assess for verbal and non-verbal sign of pain and/or discomfort

④ No Impairment
- __Systematically inspect skin, paying particular attention to bony prominences
- __Reassess sensory perception status if condition changes or per routine risk assessment protocol

MOISTURE

An excess of moisture on intact skin is a potential source of maceration and skin breakdown

① Constantly Moist ② Very Moist ③ Occasionally Moist
- __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

④ Rarely Moist
- __Systematically inspect skin, paying particular attention to areas prone to moisture
- __Reassess moisture status if condition changes or per routine risk assessment

ACTIVITY

Frequent turning, repositioning, and mobility are reported to be essential in reducing risk of pressure ulcers.

① Bedfast
- __See MOBILITY, Completely Limited

② Chairfast
- __See MOBILITY, Completely Limited
- __Instruct patient to shift weight q 15 min. if able
- __Avoid pressure to heels while sitting
- __Utilize appropriate wheelchair cushion

③ Walks Occasionally
- __See ACTIVITY, Chairfast prn
- __Written schedule for ambulation/activity
- __Instruct caregiver on safety during ambulation

④ Walks Frequently
- __Written schedule for ambulation/activity prn
- __Instruct caregiver on safety during ambulation
- __Reassessment activity status if condition changes or per routine risk assessment protocol

MOBILITY

Frequent turning, repositioning, and mobility are reported to be essential in reducing risk of pressure ulcers

① Completely Limited ② Very Limited ③ Slightly Limited
- __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

④ 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

NUTRITION

Poor dietary intake contributes to the development of pressure ulcers

① Very Poor ② Probably Inadequate
- __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

③ Adequate
- __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

④ Excellent
- __Assess height/weight on admit
- __Reassessment nutrition status if condition changes or per routine risk assessment protocol

FRICTION AND SHEAR

Most shear and friction injuries can be prevented with proper interventions

① Problem
- __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

② Potential Problem
- __See FRICTION AND SHEAR, Problem
- __Refer to policy on restraints if utilized

③ No Apparent Problem
- __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

YOUR AGENCY NAME

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	SCORE/DESCRIPTION				DATE OF ASSESS ➡ 1	2	3	4
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 ½ 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 ½ 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[3] 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.					
TOTAL SCORE	**Total score of 12 or less represents HIGH RISK**							

ASSESS.	DATE	EVALUATOR SIGNATURE/TITLE	ASSESS.	DATE	EVALUATOR SIGNATURE/TITLE
1	/ /		3	/ /	
2	/ /		4	/ /	

NAME–Last	First	Middle	Attending Physician	Record No.

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	SCORE/DESCRIPTION				DATE OF ASSESS ➡ 5	6	7	8
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 ½ 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 ½ 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 [3] 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.					
TOTAL SCORE	**Total score of 12 or less represents HIGH RISK**							

ASSESS.	DATE	EVALUATOR SIGNATURE/TITLE	ASSESS.	DATE	EVALUATOR SIGNATURE/TITLE
5	/ /		7	/ /	
6	/ /		8	/ /	

NAME–Last	First	Middle	Attending Physician	Record No.

YOUR AGENCY NAME

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name _____ Evaluator's Name _____ Date of Assessment

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.	**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 ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the 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. Very 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 non-existent. 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 room at least twice a day and inside room at least once every two 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 Limitation** Makes major and frequent changes in position without assistance.				
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ 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 and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ 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) per day. Occasionally will refuse a meal, but will usually take a supplement when 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 & 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.					
				Total Score				

Braden Scale for Predicting Pressure Sore Risk

Instructions:

Use the Braden Scale to assess the patient's level of risk for development of pressure ulcers. The evaluation is based on six indicators: sensory perception, moisture, activity, mobility, nutrition, and friction or shear.

Scoring:

The Braden Scale is a summated rating scale made up of six subscales scored from 1-3 or 4, for total scores that range from 6-23. A lower Braden Scale Score indicates a lower level of functioning and, therefore, a higher level of risk for pressure ulcer development. A score of 19 or higher, for instance, would indicate that the patient is at low risk, with no need for treatment at this time. The assessment can also be used to evaluate the course of a particular treatment.

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