Braden Scale Interventions Guide - Adult

For those clients at risk; based on the overall Braden Scale risk assessment score & those Braden subscales which score 3 or less, use the interventions below to develop an individualized client care plan.

Braden Risk Categories

At Risk
Score 15 - 18

Moderate Risk
Score 13 - 14

High Risk
Score 10 - 12

Very High Risk
Score 9 or less

Standard Pressure Injury Prevention Interventions for Clients in all Risk Categories:

1. Address client concerns regarding risk of a pressure injury.
2. Determine and document risk factors associated with clinical conditions.
3. Repeat Braden Risk Assessment.
4. Repeat the Head-to-Toe skin assessment.
5. Manage and provide pain relief.
6. Provide skin care
7. Prevent/manage moisture associated skin damage e.g., toileting routine to manage urine/feces Avoid continence briefs/pads.
8. Promote activity/mobility.
9. Support nutritional therapy e g encourage calorie and fluid intake as per client condition.
10. Reduce/eliminate shear & friction e.g. keep head of bed (HOB) less than 30° unless for meal time or as per client condition.
11. Alleviate pressure e.g. protect heels and elbows elevate heels off the bed
12. Promote pressure redistribution through positioning/repositioning e.g., turn/reposition as per clients individualized care plan. (e.g. q2h; q3h; q4h), and include small shifts of position.

For clients with subscales scores of 2 or less, make referral(s) to appropriate HCPs & consider additional interventions.

Nutrition Subscale 2 or Less

- Encourage diet & fluid intake as per client condition/restrictions.
- If NPO, ensure adequate parenteral hydration /nutrition.
- Record/monitor intake/output.
- Record/monitor weight.
- Ensure good oral health at least twice daily.
- Ensure that dentures are in place and well-fitting.
- Ensure that client is able to swallow safely.
- Consult Dietitian.

Moisture Subscale 2 or Less

- Cleanse with a pH-balanced, non-sensitizing, fragrance-free no-rinse skin cleanser.
- Moisturize non-sensitizing fragrance-free lotion/cream as needed.
- Avoid hot water or scrubbing of skin; gently pat skin dry.
- Cleanse skin folds & perineal area after incontinent episode with no-rinse cleaner.
- Apply skin protectant barrier to protect skin from urine/ feces/perspiration.
- Avoid powder/talc.
- Consider a low-air-loss therapeutic surface or 'micro-climate manager'.
- Consult OT/PT.
- Consult Wound Clinician.

Friction/Shear Subscale 2 or Less

- When sitting, ensure feet are on floor, or supported so hips are at a 90° angle.
- Use chair / wheelchair tilt features.
- Keep HOB ≤ 30° (unless contraindicated). Elevate ≥ 30° for meals (short periods only).
- When moving client up in bed, ensure bed is flat; that hips are 10 cms above where the bedframe flexes; then raise knee gatch 10 to 20° before HOB is raised.
- Consider Trunk Release Method (TRM) to ensure proper positioning in bed (Sitting Up In Bed video).
- Consult OT/PT.

Activity/Mobility Subscale 2 or Less & Sensory Perception Subscale 2 or Less

- Follow Friction/Shear Subscale interventions.
- Use appropriate pressure redistribution surfaces (e.g., wheelchair cushion, bed mattress)
- Avoid multiple layers of bedding, padding. Keep bed linens smooth.
- Elevate heels using therapeutic devices or pillows. Do not use intravenous bags, towels or pads. Protect elbows.
- Lift, do not drag client when repositioning in bed. Use client handling equipment e.g. ceiling lift as needed.
- Use a transfer device; sliding board, lift/transfer sheet for bed-chair transfers or bed-stretcher transfers.
- Use gel pad on commode chair and bath bench.
- Do not use donut-ring type devices or sheepskin to redistribute pressure.
- Use a prophylactic silicone foam dressing on sacral/ coccyx area. Consult Wound Clinician for use on heels.
- Assess skin/ mucosal membranes under/around medical devices 2x per shift. Reposition device if possible.
- Consult OT/PT.
- Consult Wound Clinician.

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