Electronic Screening
Braden Assessment
SBAR Tab Access

To be completed upon admission to Critical Care and change of patient condition.
Step One – Choose SBAR from Menu
Step Two – Choose Assessment Tab
Step Three – Choose Screening Tool
Step Four – Choose Tool
Step Five – Complete Screen

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<th>Braden Risk Assessment</th>
<th>Interventions</th>
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**Sensory Perception**
- **Complete Limited**
  - Very limited
  - Slightly limited
  - No impairment

**Moisture**
- **Constantly moist**
- **Often moist**
- **Occasionally moist**
- **Rarely moist**

**Activity**
- **Walks frequently**
- **Walks occasionally**
- **Cheerful**
- **Bedfast**

**Mobility**
- **Completely immobile**
- **Very limited**
- **Slightly limited**
- **No limitations**

**Nutrition**
- **Very poor**
- **Probably inadequate**
- **Adequate**
- **Excellent**

**Fricion and Shear**
- **Problem**
- **Potential problem**
- **No apparent problem**

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**Braden Risk Assessment**

Initial risk assessment and skin assessment within 12 hours of admission. Re-assess weekly, with change in patient condition, and with transfer of care.

- **Complete Limited (1)**
  - Unresponsive (does not move, 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.
- **Very Limited (2)**
  - 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.
- **Slightly Limited (3)**
  - 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.
- **No Impairment (4)**
  - Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.

**Bedfast (1)**
- Confined to bed.

**Cheerful (2)**
- Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.

**Walks Occasionally (3)**
- Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.

**Walks Frequently (4)**
- Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.

**Completely Immobile (1)**
- Does not make even slight changes in body or extremity position without assistance.

**Very Limited (2)**
- Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.

**Slightly Limited (3)**
- Makes frequent though slight changes in body or extremity position independently.

**No Limitations (4)**
- Makes major and frequent changes in position without assistance.

**Very Poor (1)**
- 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 liquid dietary supplement. OR: Is NPO and/or maintained on clear liquids or IV for more than 3 days.

**Probably Inadequate (2)**
- 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.

**Adequate (3)**
- 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.

**Excellent (4)**

**Problem (1)**
- Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent positioning with maximum assistance. Sorely, contractures or agitation leads to almost constant friction.

**Problem (2)**
- Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains good position in chair or bed most of the time but occasionally slides down.

**No Apparent Problem (1)**
- Moves in bed and in chair independently and has sufficient muscle strength to lift up completely.
Step Six—Adjust Risk for Critical Illness

The risk will be automatically calculated based on your Braden score selection. This will usually UNDERSCORE critically ill patients. **YOU MUST ALSO SELECT the additional risk factors, then MANUALLY upgrade the risk level to High or Very High** (adding risk factors does not automatically adjust the score). **Choose very high if you select additional risk factors.**
Step Seven – Choose Interventions Tab

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<th>Interventions</th>
<th>Reduce Pressure (or decreased sensation, activity, or mobility)</th>
<th>Turn</th>
<th>Position &amp; Pressure Reducing Aids</th>
<th>Ambulate</th>
<th>Control Moisture</th>
<th>Reduce Friction and Shear</th>
<th>Encourage Good Nutrition</th>
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### Braden Scale Plan of Care Guidelines

**If Patient Is Low to Moderate Risk for Developing Pressure Ulcers**  
(Braden Scale = 13-18)

1. Toileting as necessary to maintain continence or check for incontinence every 2-4 hours
2. Use absorbent pads to wick and hold moisture
3. Provide routine skin care
4. Manage moisture, friction and shear, and nutrition
5. Assess need for friction redistribution surface
6. Inspect skin when repositioning, toileting and assisting with ADLs
7. Elevate heels off the bed at all times, even with therapeutic support surfaces
8. Use heel protectors
9. Consult dietitian to maximize nutritional status
10. Maximize mobility
11. Develop and document individualized plan of care

**If Patient Is High to Very High Risk for Developing Pressure Ulcers**  
(Braden Scale is 12 or less)

1. Consultation with PT/OT to maximal mobilization
2. Identify and initiate appropriate redistribution surface
3. Reposition every 1-2 hours regardless of support surface. Incorporate small shifts in positions between turns.
4. Use devices to support lateral 15-30 degree turns/positions
5. Reposition chair bound immobile patients every hour. Use appropriate chair devices for pressure relief and limit sitting to 2 hour intervals.
6. Maintain head of bed at 30 degrees or less
7. Protect sacral/perineal wounds from incontinence
8. Remove slings and transfer devices from under patient
Step Eight — Select all Interventions that Apply

High risk interventions are in place for all Critical Care patients as per our standards of care. NOTE that HOB elevation in critical should be 30 degrees for VAP reduction unless contraindicated (HOB elevation may need to be customized for patient risk/priority need.)
Step Nine – Upload Results

Submit screen results by selecting:

✅ (top left corner)
Step Ten – View Previous Entries

Refresh screen. Go to Results tab and choose Assessment/Intervention from Flowsheet option. Note: Selecting the Dialysis Treatment Tab is a quick way to access all assessment screens.