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BRADEN SCALE – For
Predicting Pressure
Sore Risk Use the form
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BRADEN SCALE For Predicting Pressure Sore Risk

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK Patient's

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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.

BRADEN SCALE FOR PREDICTING

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PRESSURE SORE

RISK Document

The Braden Scale for Predicting Pressure Ulcer Risk, is a tool that was developed in 1987 by Barbara Braden and Nancy Bergstrom. The purpose of the scale is ... Rate free braden scale word document form

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Assessment Form -

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N. Clinical of the
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Score Risk. Decubitus,
1989;2:44-51. 10/12/09
. Title: Microsoft Word -
Final Braden Scale
Document October 16,
2009.doc Author:
watson Created Date:
10/16/2009 4:16:48 PM
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**BRADEN SCORE
INTERVENTION**

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GUIDE

Braden Risk Assessment Scale

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.

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Braden Risk

Assessment Scale

Braden Scale Assessing
Pressure Ulcer Risk and
Ensuring Appropriate
Prevention Measures

Sandy Kingsley, RN,
BSN, MSN, WCC July 7,
2014 . Objectives

Identify the 6
subscales comprising
the Braden Score

Understand how to
complete the Braden
Scale accurately

Braden Scale - PHCA

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completed daily Check

Braden scale for last 2
days Day 2 Yes No NA

4 Skin Integrity

problem list is initiated

Patients with Braden

<19, interventions ...

RN documents 10 Daily

Day 1 Yes No NA

condition of dressing

date last changed

Check documentation

for last 2 days Day 1

Yes No NA 12/16/10

Skin Integrity/Pressure

Ulcer Assessment ...

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Skinument **Integrity/Pressure Ulcer Assessment Documentation ...**

In the Zoom section, click the Scale To Paper Size drop-down arrow. Scroll to and select the desired sheet size. Enter how many copies you want and then click OK.

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without ...

- Risk Assessment using Braden Scale • Remember “SKIN” 1. Surface selection 2. Keep tilting (30 degree tilts minimum every 2 hrs) 3. Incontinence management (barrier creams) 4. Nutrition (good nutrition prevents skin breakdown & promotes wound healing)

Skin and Wound & Documentation

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methods that gather

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even more information
from a patient.

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The Braden Scale is a scale made up of six subscales, which measure elements of risk that contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure. These are:

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sensory perception,
moisture, activity,
mobility, friction, and
shear.

Braden Risk

Assessment tool

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The Braden Q Risk

Assessment Scale The

Braden Q Scale (see

Appendix B) is used for

assessing pressure

ulcer risk in the

pediatric populations

including neonates and

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children older than 8 years. The Braden Q was adapted from the Braden Scale for use in the pediatric population. The descriptors have been

TITLE Guideline: Braden Scale for Predicting Pressure

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the form in publications (other than internal policy manuals and training material) or for profit-making ventures requires additional permission and/or negotiation. SEVERE RISK: Total score 9
HIGH RISK: Total score 10- 12

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2.7 If unable to obtain information from the resident on admission, refer to transfer documents, and/or the family/significant other as soon as possible.

2.8 The 'Care Concerns' column is utilized: a. To list care concerns identified as a result of the assessment. b. To indicate that discipline specific assessment forms have been initiated. c.

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INITIAL **ASSESSMENT FOR** **CARE PLANNING** **(First 24 - 48 hours)**

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