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## **Braden Scale Form Word Document**

BRADEN SCALE - For Predicting Pressure Sore Risk Use the form only for the approved purpose. Any use of the form in publications (other than internal policy manuals and training material) or for profit-making ventures requires additional permission and/or negotiation.

## **BRADEN SCALE For Predicting Pressure Sore Risk**

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.

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### **BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK**

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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Braden BI, Bergstrom N. Clinical of the Braden Scale for Predicting Pressure 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 ...

### **BRADEN SCORE INTERVENTION 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.

### **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

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### **Braden Scale - PHCA**

Braden scale 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 ...

### **Skin 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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- 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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The form distributed can vary from a Medical Assessment Form to a Psychosocial Assessment Forms. This method may be reliable since it contains a standardized format but there are other methods that gather 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: 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 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 ...**

BRADEN SCALE - For Predicting Pressure Sore Risk. Use the form only for the approved purpose. Any use of 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

### **Braden Scale - NUR3130 Foundations - NSU - StuDocu**

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.

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To list care concerns identified as a result of the assessment. b. To indicate that discipline specific assessment forms have been initiated. c.

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

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