

Braden Scale-Understanding and Implementing Risk Assessment Tools

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Objectives

- Review the Braden Risk Assessment Scale
- Discuss the benefit of subscale risk and matching interventions

Risk Assessment

- Risk assessment is a central component of clinical practice aimed at identifying individuals susceptible to pressure injuries in order to target appropriate interventions and prevent pressure ulcer development.
- International PIP guideline recommends NOT relying on the total score² but rather focusing interventions according to the sub-scale scores¹.

(NPIAP p.60)

1. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guidelines 3rd Edition. EPUAP, NPUAP, PPIA, 2019.

2. Lima-Serrano M, Gonzalez-Mendez MI, Martin-Castaño C, Alonso-Araujo I, Lima-Rodriguez JS. Predictive validity and reliability of the Braden scale for risk assessment of pressure ulcers in an intensive care unit. *Med Intensiva*, 2018; 42(2):82091.

BRADEN SCALE FOR PREDICTING PRESSURE ULCER RISK

Sensory Perception Ability to respond meaningfully to pressure related discomfort	1. <u>Completely Limited:</u> 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. <u>Very Limited:</u> 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. <u>Slightly Limited:</u> 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. <u>No Impairment</u> Reponds to verbal command. 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. <u>Constantly Moist:</u> Perspiration, urine, etc keep skin moist almost constantly. Dampness is detected every time patient is moved or turned.	2. <u>Moist:</u> Skin is often but not always moist. Linen must be changed at least once a shift.	3. <u>Occasionally Moist:</u> Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. <u>Rarely Moist:</u> Skin is usually dry; linen requires changing only at routine intervals.		
Activity Degree of physical activity	1. <u>Bedfast:</u> Confined to bed.	2. <u>Chairfast:</u> Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheel chair.	3. <u>Walks Occasionally:</u> Walks occasionally during day but for very short distances, with or without assistance. Spends majority or each shift in bed or chair.	4. <u>Walks Frequently:</u> 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. <u>Completely Immobile:</u> Does not make even slight changes in body or extremity position without assistance.	2. <u>Very Limited:</u> Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. <u>Slightly Limited:</u> Makes frequent though slight changes in body or extremity position independently.	4. <u>No Limitations:</u> Makes major and frequent changes in position without assistance.		
Nutrition Usual food intake pattern	1. <u>Very Poor:</u> 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 IV for more than 5 days.	2. <u>Probably Inadequate:</u> 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.	3. <u>Adequate:</u> 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. <u>Excellent:</u> 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. <u>Problem:</u> 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. <u>Potential Problem:</u> 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. <u>No Apparent Problem:</u> 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 (Addressograph)		

Risk Assessment & Prevention

- A score ≤ 18 in the Braden Scale has been identified as the cutoff point for risk in PI studies.
- However, interventions should be based on subscale area risk score and not total Braden score.
- As risk increases, so should implemented & documented interventions that match change in risk.

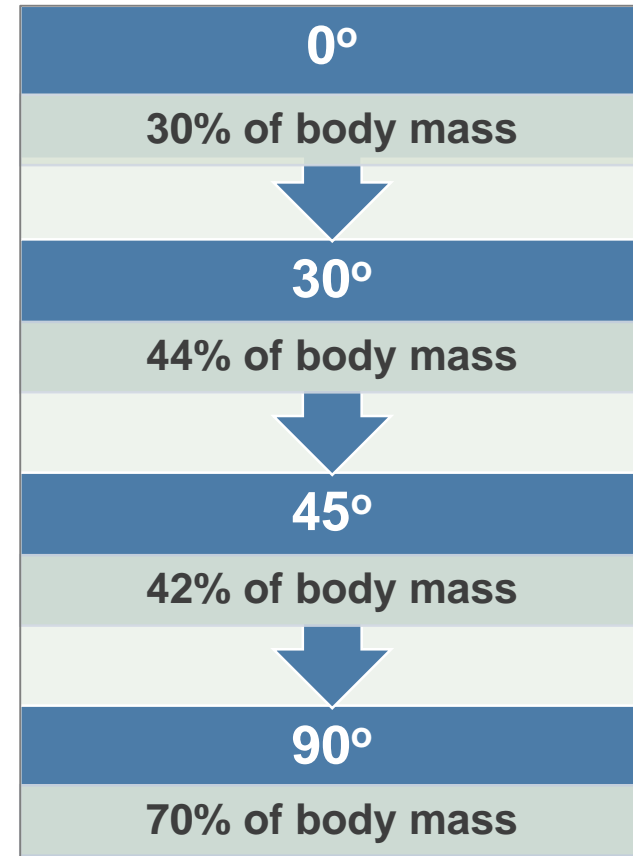
Friction and Shear Subscale

- Friction is the interaction between two surfaces which is either static or dynamic (with movement). This force occurs at the skin surface & is influenced by moisture and skin texture.
- Shear is a parallel forces that causes deformation of the deep tissues resulting in cytoskeletal damage, tissue inflammation and impairment of transport properties (perfusion, lymphatics, etc.)

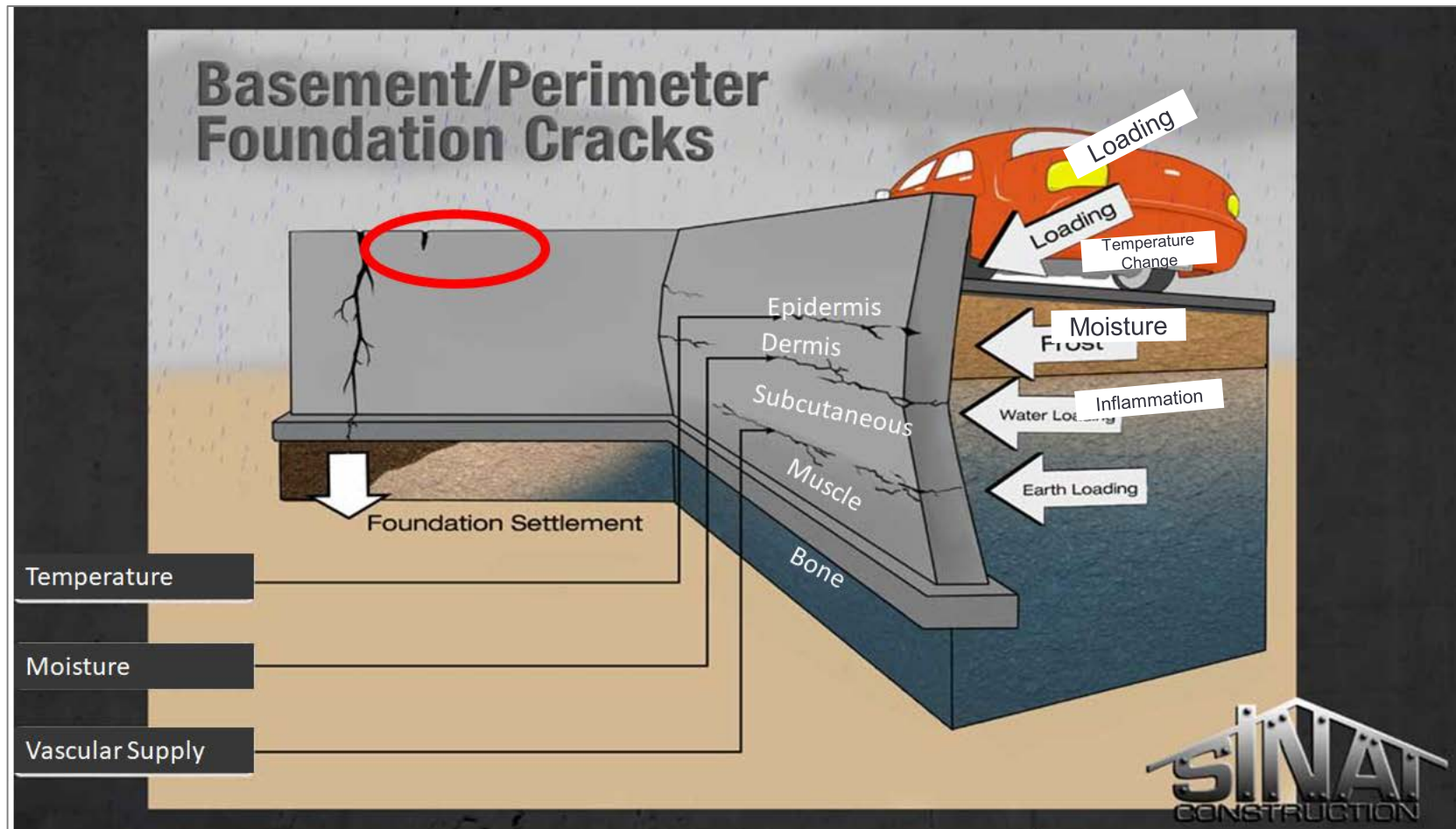
Mechanisms of Injury

Pressure, Friction, Shear & Microclimate

- Elevating the head of the bed increases pressure/shear on the pelvic region
- Additional loading of the pelvic region occurs when head of bed is raised without a profiling bed frame (accommodates pelvis as head of bed is raised preventing “closing vice” effect)
- Moisture extremes increase risk of friction and thus shear
- Dryness stiffens the skin and decreases tolerance for pressure and shear

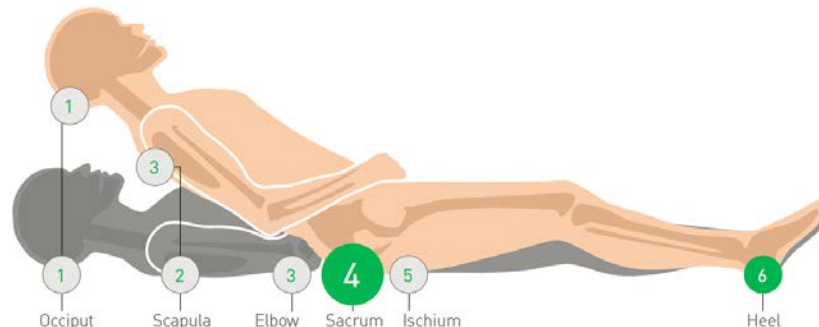


Impact of Load, Temperature Change & Moisture on Deep Structures



High Risk for Developing Pressure Injuries

- Sacrum: reported as most common location in most care settings
- Incidence of heel ulcers rising. Reported as second most common location
- Medical device related pressure ulcers - a growing concern
- Pressure injuries also found to be located in atypical locations (prone position injuries)
- Pediatrics/Neonates: Occiput is #1 secondary to disproportionate size of head compared to rest of body



Scoring Friction and Shear (1- 3)

1. Problem

Moderate - maximum assist to turn. Frequently slides down bed/chair. Spasticity, Contractures or Agitation.

2. Potential Problem

Minimal assist to turn. Occasionally slides down bed/chair.

3. No Apparent Problem

Independently moves in bed/chair. Able to lift completely to move. Maintains good position.

Friction/Shear Subscale Interventions

No Apparent Problem 3	Potential Problem 2	Problem 1	
<ul style="list-style-type: none"> Moves in bed and chair independently Has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair. 	<ul style="list-style-type: none"> Moves difficulty or requires minimal assistance During move skin probably slides to some extent against surface/sheets/chair/restraints Maintains good position in bed but occasionally slides down. 	<ul style="list-style-type: none"> Requires moderate to maximum assistance in moving Complete lifting without sliding Frequently slides down in bed or chair. Requires frequent repositioning with maximum assistance. <i>Spasticity, contracture or agitation leads to constant friction.</i> 	Definition
<ul style="list-style-type: none"> Educate patient to reposition frequently in bed and chair. Keep head of bed <30 degrees unless contraindicated. Avoid vigorously rubbing skin at risk of PI 	<ul style="list-style-type: none"> Consider addition of a trapeze to aid in repositioning Consider use of air transfer device for obese patients Provide a foot-rest or elevate legs when patient in chair Float heels Consider prophylactic heel dressings or heel offloading devices if patient unable to float heels 	<ul style="list-style-type: none"> Ensure appropriate support surface Consider pressure redistributive chair cushion Consider the use of a turning and position system Consider the use of ceiling lift systems Consider heel off-loading devices or prophylactic heel dressings. Consider prophylactic sacral dressings Consider protecting elbows with skin barriers or dressings 	Interventions

Pro tip: Moisture increases the coefficient of friction. So if the patient has high moisture levels, their friction risk is also high!

Microclimate and Pressure Injury Risk

The term used to describe the temperature, humidity and air flow of the skin surface.

Management of microclimate can provide an environment conducive to prevention AND tissue repair.



Moisture Subscale

Consider the potential impact of moist skin on PI (p. 47, SOE-C)
35% of Studies Demonstrated Moisture Subscale Was A Predictor of PI

- Incontinence exposure
- Fever and diaphoresis
- Moisture in skin folds
- Wound exudate
- Fluid pooling/Prep solutions



Effects of Moisture on Skin

- Dissolves collagen molecular cross-linking
- Reduces tensile strength
- Reduces intracellular cohesion
- Increases co-efficient of friction
- Results in increased maceration
- Alteration of skin/dermal pH = inflammation!



1. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guidelines 3rd Edition. EPUAP, NPUAP, PPPIA, 2019.
2. Black JM, Gray M, Bliss DZ, Kennedy-Evans KL, Logan S, Baharestani MM, Colwell JC, Goldberg M, Ratliff CR. MASD part 2: incontinence-associated dermatitis and intertriginous dermatitis: a consensus. *J Wound Ostomy Continence Nurs*, 2011; 38(4): 359-370.

Moisture Injury

- **Causes superficial, inflammatory injury (primary)**
 - Example: Moisture Associated Skin Damage (MASD)
- **Exacerbates the impact of pressure and shear injury to the deeper tissues:**
 - International Hill-Rom Study of 205,144 patients found type of incontinence increased the odds of full thickness pressure injury development.

TYPE OF INC	ODDS OF STAGE 1	ODDS OF STAGE 4
URINARY	2.9	19.5
FECAL	3.2	31.5
MIXED	3.0	23.7


Scoring Moisture (1- 4)

1. Constantly Moist

Moist at every assessment.

1. Very Moist

Linen changed once a shift.



**ONLY ONE
INCONTINENCE PAD
UNDER THE PATIENT!
Each additional layer
adds risk of skin injury!**

Moisture subscale interventions

Rarely Moist 4	Occasionally Moist 3	Very Moist 2	Constantly Moist 1	
<ul style="list-style-type: none"> • Skin is usually dry. • Linen changed at routine intervals. 	<ul style="list-style-type: none"> • Skin occasionally moist • Requires at least 1 extra linen change per day. 	<ul style="list-style-type: none"> • Skin is often but not always moist • Linen must be changed at least once per shift. 	<ul style="list-style-type: none"> • Skin kept moist almost constantly by perspiration, urine, exudate, etc. • Dampness detected every time patient moved or turned. 	Definition
<ul style="list-style-type: none"> • Moisturize skin daily. 	<ul style="list-style-type: none"> • Provide good hygiene care with linen change using pH balanced no-rinse products • Moisturize skin daily and after any linen change/inc. event. 	<ul style="list-style-type: none"> • Offer frequent toileting • Notify multidisciplinary team of incontinence/ identify cause • Utilize moisture wicking incontinence pads • Apply barrier cream 2x daily and after any inc. event • Avoid adult briefs or pads with plastic backing • Utilize skin barrier products • Consider low air loss support surface 	<ul style="list-style-type: none"> • Provide frequent assessments for inc. with patient repositioning • Consider external fecal or urinary inc. collection device • Consider internal fecal or urinary in collection device. • Consider high air loss support surface or topical microclimate managers 	Interventions

1. *European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guidelines 3rd Edition. EPUAP, NPUAP, PPPIA, 2019.

2. Creehan MS, Brindle CT. Stoptlight System for Pressure Ulcer Risk Assessment. *Nursing 2011; 41(9)*: DOI: 10.1097/01.NURSE.0000403275.14170.4b

Sensory Perception Subscale

Ability to respond appropriately to pressure-related discomfort

Can the patient feel or communicate pressure-related pain?
(On the coccyx-sacral area or with medical devices)

Patients Included:

- Confused
- Disoriented
- Over sedation
- Unresponsiveness
- Alert/ oriented on ventilator
- Non native language
- Cultural
- Paralysis
- Neuropathy

Who's at greater sensory perception risk?

Case 1

- 65 y.o. female intubated in the ICU with LVAD, on multiple vasopressors. Moans and makes facial gestures consistent with pain when turned.

Case 2

- 16 y.o. healthy female with L1 paraplegia. She is in her wheelchair with a pressure redistributive cushion and in the rehab unit progressing extremely well toward discharge.

Scoring Sensory Perception (1- 4)

1. Completely Limited

Unresponsive 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 inability feel pain or discomfort over ½ of body.

3. Slightly Limited

Responds to verbal commands. Cannot communicate discomfort or inability to feel pain or discomfort in 1 or 2 extremities.

4. No Impairment

No sensory deficit.

Sensory perception subscale interventions

No Impairment 4	Slightly Limited 3	Very Limited 2	Completely Limited 1	
<ul style="list-style-type: none"> • Responds to verbal commands. • Has no sensory deficit which would limit ability to feel or voice pain or discomfort. 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 over ½ of body. 	<ul style="list-style-type: none"> • Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished consciousness or sedation. • OR limited ability to feel pain over most of body. 	Definition
<ul style="list-style-type: none"> • Encourage patient to report pain and discomfort. • Reposition patient every 2 hours. 	<ul style="list-style-type: none"> • Turn patient every 2 hours when in bed. • Ensure 30 degree turn offloads sacrum • Reposition patient every hour in chair. • Encourage ambulation 3 times daily if applicable. • Assess skin at risk for pressure injuries at regular intervals. • Offload extremities with decreased sensation: (e.g., heel offloading boot or prophylactic dressing for affected leg/heel). 	<ul style="list-style-type: none"> • Ensure appropriate pressure redistributive surfaces. • Consider LAL surface if PI present on one turning surface. • Consider prophylactic dressing to sacrum • Float heels: consider heel offloading device for SCI patients. • Assess skin with each turn. 	<ul style="list-style-type: none"> • Turn patient every 2 hours. • Provide micro turns if ability to turn is limited. • Float heels at all times. • Consider prophylactic dressings on areas at risk. • Consider heel offloading devices at all times if possible. • Consider tuning and positioning system to ensure 30 degree turn and decrease shear. • Utilize pressure redistributive chair cushions. • Consider fluidized positioners 	Interventions

1. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guidelines 3rd Edition. EPUAP, NPUAP, PPPIA, 2019.

2. Creehan MS, Brindle CT. Stoplight System for Pressure Ulcer Risk Assessment. *Nursing 2011*; 41(9): DOI: 10.1097/01.NURSE.0000403275.14170.4b

Activity Subscale

Consider individuals with limited mobility, limited activity and high potential for friction and shear to be at risk of pressure injuries. SOE-A (p.40).



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Scoring Activity (1- 4)

1. Bedfast

Confined to bed.

2. Chairfast

Ability to walk severely limited or non-existent.

Cannot bear own weight and/or must be assisted to chair or wheel chair.

3. Walks Occasionally

Walks short distances, majority of each in bed/chair.

4. Walks Frequently

Walks outside room twice a day and inside room every 2 hours.



Activity Subscales and Interventions

Walks Frequently 4	Walks Occasionally 3	Chairfast 2	Bedfast 1	
<ul style="list-style-type: none"> Walks outside room at least twice a day and inside room at least once every two hours during waking hours. 	<ul style="list-style-type: none"> Walks occasionally during day, but for very short distances with or without assistance. Spends majority of each shift in bed or chair. 	<ul style="list-style-type: none"> Chairfast: ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. 	<ul style="list-style-type: none"> Confined to Bed 	Definition
<ul style="list-style-type: none"> Encourage patient to reposition frequently in bed. Establish an ambulation schedule. Note side patient is positioned in bed. Consider avoiding “self turn” in documentation. 	<ul style="list-style-type: none"> Reposition in chair every hour. Back to bed if PI present after 1 hour in chair. Consider active/passive range of motion each shift Turn patient every 2 hours Float heels 	<ul style="list-style-type: none"> PT Consult Turn every 2 hours Reposition every hour when in chair. Back to bed after 2 hours in chair if skin intact Back to bed after 1 hour if PI present. Limit number of linens under patient 	<ul style="list-style-type: none"> Consider Turning and positioning system. Consider heel offloading devices at all times. Consider prophylactic dressings to sacrum and heels. Consider fluidized positioners Consider low air loss alternative surface. Consider fluidized support surface if PI present on more than 1 turning surface 	Interventions

Mobility Subscale

Consider individuals with limited mobility, limited activity,
And high potential for friction and shear to be at risk for
Pressure injuries. SOE-A (p.40).

Ability to change and control body position

- Shifting weight
- Purposeful mobility vs. agitation



1. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guidelines 3rd Edition. EPUAP, NPUAP, PPPA, 2019.

2. Creehan MS, Brindle CT. Stoplight System for Pressure Ulcer Risk Assessment. *Nursing* 2011; 41(9): DOI: 10.1097/01.NURSE.0000403275.14170.4b

Scoring Mobility (1- 4)

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.

Mobility Subscales and Interventions

No Limitation 4	Slightly Limited 3	Very Limited 2	Completely Immobile 1	
<ul style="list-style-type: none"> Makes major and frequent changes in position without assistance. 	<ul style="list-style-type: none"> Makes frequent though slight changes in body or extremity position independently. 	<ul style="list-style-type: none"> Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. 	<ul style="list-style-type: none"> Does not make even slight changes in body or extremity position without assistance. 	Definition
<ul style="list-style-type: none"> Educate patient on risks of PI and need to reposition frequently. 	<ul style="list-style-type: none"> Reposition in chair every hour. Back to bed if PI present after 1 hour in chair. Consider active/passive range of motion each shift Turn patient every 2 hours Float heels 	<ul style="list-style-type: none"> PT Consult Turn every 2 hours Head of bed <30 degrees if appropriate Reposition every hour when in chair. Back to bed after 2 hours in chair if skin intact Back to bed after 1 hour if PI present. Limit number of linens under patient 	<ul style="list-style-type: none"> Consider Turning and positioning system. Consider heel offloading devices at all times. Consider prophylactic dressings to sacrum and heels. Consider fluidized positioners Consider low air loss alternating surface. Consider fluidized support surface if PI present on more than 1 turning surface 	Interventions

Scoring Nutrition (1- 4)

1. Very Poor

No complete meals. Eats $\leq 1/3$ food. Protein: ≤ 2 srv/day. Poor fluid intake. No supplementation. NPO, on clear liquids, or IV's > 5 days.

2. Probably Inadequate

Rarely complete meals. Eats $1/2$ food. Protein: 3 srv/day.

Occasional supplementation. Suboptimal liquid diet or TF.

3. Adequate

Eats $1/2$ of most meals. Protein: 4 srv/day. Occasionally refuse meals. Drinks supplements. Optimal TF or TPN.

4. Excellent

Eats most/never refuses meals. Protein: ≥ 4 srv/day. Eats between meals. No supplementation needed.

Nutrition Subscales and Interventions

Excellent 4	Adequate 3	Probably Inadequate 2	Very Poor 1	
<ul style="list-style-type: none"> Eats most of every meal. Never refuses a meal Usually eats >4 more servings of meat and dairy products. Occasional eats b/w meals No supplement required. 	<ul style="list-style-type: none"> Eats over 1/2 of most meals. Eats total of 4 servings of protein per day. Occasionally refuses meal, but will usually take supplement OR- is on tube feeding or TPN regimen which meets most needs. 	<ul style="list-style-type: none"> Rarely eats complete meal and eats only 2 of any food item offered. Protein intake of 3 servings of meat or dairy daily Occasional will take supplement. OR- receives less than optimum amount of liquid diet or tube feeding. 	<ul style="list-style-type: none"> Never eats a complete meal. Rarely eats more than any of food offered. Eats 2 servings or less of protein. Takes liquids poorly. Does not take liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV for more than 5 days. 	Definition
<ul style="list-style-type: none"> Evaluate patient preferences and dietary restrictions specific to patient Assess independence in feeding self 	<ul style="list-style-type: none"> Assess ability to feed self. Offer fluids on each interaction if appropriate Ensure RD consult for any tube feeding or TPN needs. 	<ul style="list-style-type: none"> RD Consult Consider calorie counts Assist patient with meal set up and feeding if appropriate. Consider laboratory evaluation of nutrition status. Provide supplements as prescribed Consider multivitamin 	<ul style="list-style-type: none"> RD Consult Daily multidisciplinary evaluation of NPO necessity. Provide supplements as prescribed Monitor individualized kcal and protein requirements per RD orders 	Interventions

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2. Creehan MS, Brindle CT. Stoplight System for Pressure Ulcer Risk Assessment. *Nursing* 2011; 41(9): DOI: 10.1097/01.NURSE.0000403275.14170.4b

3. Otero TMN, Canales C, Yeh DD, Elsayes A, Belcher D, Auraishi SA. Vitamin D status is associated with development of Hospital-Acquired Pressure Injuries in Critically Ill Surgical Patients. *Nutrition in Clinical Practice* 2018; DOI: 10.1002/ncp.10184

4. Yeh DD, et al. Clinical outcomes of inadequate calorie delivery and protein deficit in surgical intensive care patients. *American Journal of Critical Care*. 2016; 25:318-326.

Totaling for Risk: Braden Scale

- Score based on six categories are evaluated and rated from 1- 4, except for Friction/Shear which is 1- 3
- Each subscale has a brief description of criteria accompanying the ratings
- The range of possible Braden Scale scores is 6 - 23
- **Lower numbers mean higher risk!***

Pressure Risk Assessment Sale	Mild Risk	Moderate Risk	High Risk	Severe Risk
Braden	15-18	13-14	10-12	< 9

Consider risk factors not covered by Braden Scale: Skin status, Diabetes, Perfusion & Oxygenation, Increased body temperature, Advanced age, Abnormal lab results, General Health Status.

Braden Scale – TAKE AWAY

- Score accurately to that point in time
- Sub-scale scores are more important in driving intervention implementation than Total Score
 - A single low sub-scale score, while others are higher drives your intervention implementation
- Remember MOM when you walk into a patient's room
 - Move(reposition) the patient
 - Offer liquids or food
 - Check for Moisture



Risks not covered by Braden

- Pain
- Diversity of risks associated with ethnicity
- Age
- Patient Refusal
- Obesity
- Perfusion/Circulation/Oxygenation
- Diabetes
- Smoking
- Vascular Disease
- Spinal Cord Injury

Include pain assessment

- Assessing pain came after the Braden Scale was developed (be clear about this and have reference)
- Consider the potential impact of pain at pressure points on PI risk (p. 42).
- What is the prevention strategy for pain?

Refusal to Turn

REFUSAL

- This becomes patients #1 Risk Factor.
- “Refuses to turn” does not cover you legally.

INTERVENTIONS MUST MATCH RISK

- Identify reason for refusal & manage
 - Pain, Knowledge Deficit, Fear
- Response: Escalating Education & Documentation
- Is the patient competent to refuse turning?

Setting Expectations & Education of Family

- Assess the knowledge and self-care capacity of patient and caregivers at risk for PI
- Educate patient and caregivers of their role in PI prevention
- Describe self-assessment basics
- Discuss the patient's risk of pressure injury with them and goals of prevention care.

SUMMARY

- Conducting a proper risk assessment ensures that staff can select and implement individualized prevention strategies.
- Do not select interventions for prevention on the Braden Total score alone. Consider sub-scale scores.
- When documenting, ensure the interventions escalate as the risk worsens.
- A patient has a right to refuse care, but documenting refusal does not cover staff from liability. Refusal requires escalating education of patient and family.