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Braden Scale for Predicting Pressure Ulcer: An Overview

Shreya Yadav

Nursing Tutor, Regency Institute of Nursing, Kanpur, India

Abstract: ***Numerous factors, including sensory perception, moisture, activity, mobility, nutrition, and the impact of friction and shear, can affect pressure ulcers, a serious concern in patient care. A crucial tool that allows nurses to quickly and accurately assess a patient's risk of pressure sores across a range of conditions and demographics is the Braden Scale. The scale groups patients from no risk to very high risk using a scoring system that inversely links the total points to the risk level, directing therapeutic activities. The Braden Scale's complete components, which address the complex interplay of factors contributing to pressure ulcer formation, are highlighted in the article along with the importance of ongoing risk assessment and focused preventative steps to protect vulnerable patients.***

Keywords: Pressure Ulcer, Braden Scale, Risk Assessment, Nursing Care, Patient Safety

1. Introduction

In addition to shear and friction, an array of different variables put a patient at risk for Pressure Ulcer, reduced sensory perception, more wetness, less exercise, hampered mobility, and poor nutrition is some of these variables.1At admission, risk is evaluated using the Braden scale. Continuous patient risk factor assessment and appropriate actions to reduce risk to vulnerable patients are necessary for effective pressure sore prevention.[2]

Why Braden Scale is used for:
A tool designed to assist nurses in assessing patients' pressure ulcer risk is the Braden Scale for Predicting Pressure Sore Risk. It has been observed that the scale, which takes less than a minute to complete, is more accurate than other scales and has been utilized with patients of all ages and situations.[3]

Scoring with Braden Scale:
All categories are ranked from 1 to 4, with the exception of the "friction and shear" category, which is ranked from 1 - 3. A higher score corresponds to a decreased risk of getting a pressure ulcer, and vice versa. This adds up to a possible total of 23 points. The greatest danger of getting a pressure ulcer is represented by a score of 6, while a score of 23 indicates that there is no chance of getting one.[1]

The Braden Scale Assessment Score Scale:
- Very High Risk: 9 or less
- High Risk: 10 - 12
- Moderate Risk: 13 - 14
- Mild Risk: 15 - 18
- No Risk: 19 - 23

Components of Braden Scale:

1) Sensory Perception:
Inability to identify pressure - related discomfort and appropriately respond by moving or reporting pain increases the risk of pressure injury in a patient. This risk category includes two different issues that affect sensory perception. The first description refers to the patient's consciousness, while the second describes the patient's ability to perceive things with their senses.[4]

2) Moisture:
The term "moisture risk factor" refers to the degree of skin moisture exposure. Skin degradation is more likely to happen after prolonged exposure to moisture. Many processes can produce moisture, including as perspiration, faeces, urine, and wound drainage. Regular surveillance, replacing damp or soiled linens, and applying protective skin barriers all greatly reduce this risk factor.[4]

3) Activity
The activity risk factor is the degree of physical activity. For example, moving from a bed to a chair or walking reduces the incidence of pressure injuries by altering the pressure points in the body and increasing blood and oxygen flow to areas that are stressed. The patient's level of activity is determined by how often they are able to get into a chair, get out of bed, and move around with or without assistance.4

4) Mobility
The mobility risk factor is the patient's ability to change or regulate their bodily position. For example, after spending too much time sitting still, healthy people frequently shift their body posture by shifting their limbs, turning over in bed, or altering their weight in a chair. However, if professionals don't routinely realign a patient, tissue damage will happen if the patient is unable to do it.[4]

5) Nutrition
Eating a balanced diet and drinking plenty of water are essential for maintaining healthy skin. It's especially important to eat adequate protein if you want healthy skin and wound healing. The dietary risk factor is defined by two classification groups. The type and amount of oral intake is evaluated by the first group. Patients in the second category are those receiving clear liquid meals or none at all by mouth (NPO), as well as those receiving total parenteral nutrition (TPN) or tube feeding.[4]

6) Friction/Shear:

Pressure injuries are a real risk due to shear and friction. This category only has three ratings, as opposed to the four in the other categories. Whether or whether the patient seems to have an issue, a potential problem, or no problem at all determines their status in this group.[4]

2. Conclusion

The Braden Scale is a valuable tool for managing and preventing pressure ulcers because it provides a methodical and effective way to assess patient risk. The pressure sore development scale enables a comprehensive understanding of the components that contribute to the development of pressure sores by providing a full assessment of sensory perception, moisture, activity, mobility, nutrition, and the effects of friction and shear. Through the implementation of targeted preventive methods and constant risk assessment, healthcare practitioners can effectively lower the frequency of these disabling injuries, leading to better patient outcomes and care quality.

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