

Braden Scale Assessment - Pressure Injury Risk Flowchart

Score Interpretation	
19–23 (No risk)	Normal skin care and monitoring
15–18 (Mild risk)	Early prevention (moisture control, repositioning if mobile)
13–14 (Moderate risk)	Pressure-relieving aids, repositioning every 2–3 hrs
10–12 (High risk)	Strict prevention plan, reposition every 2 hrs
≤9 – (Very High risk)	Intensive prevention, specialty mattress, close monitoring

Braden scale assessment to be completed:

- On admission of a new resident
- Post hospital discharge?
- Developing a PI – or IAD
- Any deterioration of mobility and risk of malnutrition
- Low or mild risk—update Braden scale every 6 months, moderate risk or high or very high—update every 3 months

Moderate Risk (13-14 points)

- --Refer to PT and OT for consultation on repositioning needs
- -Encourage mobility & reposition every 3 hrs as per advice from PT and OT
- • Maintain clean, dry skin (pH-balanced cleansers)
- • Apply moisturiser & barrier cream
- • Inspect skin every shift
- • Ensure nutrition & hydration
- • Re-assess the Braden risk assessment every 3 months
- • RN, MCS and AMCS to review pressure injury prevention care plan every three months

High Risk (10-12 points)

- • Reposition every 2 -3 hrs
- • Maintain a high-protein diet (refer to Dietitian)
- • Skin integrity check every shift and bone prominence area, which is under pressure, check during repositioning
- • Refer to OT for pressure relief mattress, cushion, heel lift suspension cushion and bed cradles and relevant chairs to facilitate pressure redistribution and offloading
- • Update the Braden scale every three months
- • Register the resident in the high-risk resident register list
- • RN, MCS and AMCS to review pressure injury prevention care plan monthly

Very High Risk (≤9)

- • Reposition every 2 hrs
- • Maintain a high-protein diet (refer to dietitian)
- • Inspect skin each shift and record the skin check on the repositioning chart
- • Apply multilayer silicone dressings to the bone prominence area as discussed with MCS
- • Skin integrity checks every shift and bone prominence area, which is under pressure, check during repositioning
- • Use slide sheets/hoists to reduce friction (PT)
- • Review cushions/chairs/air mattress settings (OT)
- • Add visible sticker for air mattress settings
- • Refer to OT for pressure relief mattress, cushion, heel lift suspension cushion and bed cradles and relevant chairs to facilitate pressure redistribution and offloading
- • Update the Braden scale every three months
- • Register the resident to the high-risk resident register list
- • RN, MCS, and AMCS to review pressure injury prevention care plan monthly

Refer all pressure injury wounds up to stage 2, to the Clinical Nurse Specialist or RCL.
Refer residents with pressure injury wounds up to stage 2 to the GP for PRN analgesic.
Nurses on duty to supervise staff for regular repositioning, protection of wound dressing from being wet during showers, and optimise pain management.

RN on duty weekly wound review, wound photo and document wound evaluation review notes