How To try this

Predicting Pressure Ulcer Risk

Using the Braden scale with hospitalized older adults: the evidence supports it.
Eighty-six-year-old Fred Adams was hit by a car as he crossed the intersection near his house. (This case is a composite based on the authors’ experiences.) Transported by ambulance to the ED of a nearby hospital, he arrives with a blood pressure reading of 134/84 mmHg; heart rate, 92 beats per minute; respiration, 20 breaths per minute; and temperature, 36.2° C (97.2° F). He is alert and oriented and able to describe what happened: a woman driving a small car failed to see him as she made a left turn into the intersection, knocking him over and rolling him onto the sidewalk. Mr. Adams reports that he has hypertension, which is controlled with hydrochlorothiazide (HydroDIURIL and others) 12.5 mg per day. On examination his cranial nerve function is within normal limits. Motion and sensation are present in all extremities, although motion in his left leg is limited and painful because of an injury to his left hip. He does not want to be moved or have his hip or leg touched. Admission data indicate that he lives alone, drives his own car, and manages his household independently. After an X-ray confirms a fracture of the left hip in the intertrochanteric region, Mr. Adams is transferred immediately to surgery for internal fixation of the joint. After postoperative admission to the orthopedic unit, he is evaluated with the Braden Scale for Predicting Pressure Sore Risk.

**WHY USE THE BRADEN SCALE?**
The Braden Scale for Predicting Pressure Sore Risk was developed to help nurses determine patients’ risk of developing pressure ulcers. The scale, which takes less than a minute to complete, has been used with patients of all ages and in all settings and has been found to be more accurate than other scales (including the Norton and the Waterlow scales) or clinical judgment. While its use alone does not prevent pressure ulcers, its findings are the sentinel that calls nurses to employ preventive strategies. For information on preventing pressure ulcers and using guidelines, go to http://links.lww.com/A183.

It was developed in the 1980s by nurses Barbara Braden and Nancy Bergstrom, who established that the “critical determinants” of pressure ulcer development are:
1. the intensity and duration of pressure
2. the ability of the skin and supporting tissues to tolerate pressure
They also described the factors influencing these two determinants. Mobility, activity, and sensory perception contribute to the intensity and duration
Watch It!
Go to http://links.lww.com/A106 to watch a nurse use the Braden scale in an actual patient and discuss how to administer and interpret it quickly. Then watch the health care team plan preventive strategies.
View this video in its entirety and then apply for CE credit at www.nursingcenter.com/AJNolderadults; click on the How to Try This series link. All videos are free and in a downloadable format (not streaming video) that requires Windows Media Player.

ADMINISTERING THE BRADEN SCALE
The patient is evaluated on each of the six subscales, with the scoring based on the descriptions provided in the tool (see Try This, page 43). The nurse uses physical assessment and interviewing to elicit the data to complete the Braden scale. Scores for the levels of risk within each subscale range from 1 to 4, with the exception of friction and shear, which is scored from 1 to 3. Each subscale includes a title; within the subscale, each level has a key concept description and one or two phrases or sentences describing its qualifying attributes. For example, in the subscale “activity,” the lowest score—1—is given when a patient is “bedfast,” followed by a 2 for one who is “chairfast,” a 3 for a patient who “walks occasionally,” and a 4 for one who “walks frequently.” Item descriptors determine the patient’s score. For example, in order to score a 4 in the activity subscale, the patient must walk “outside [the] room at least twice a day and inside [the] room at least once every two hours during waking hours,” according to the scale. It’s important not to alter the scale by adding or deleting items or by modifying existing definitions; any such change will result in inaccuracy. The final score—obtained by totaling the scores from the six subscales—ranges from 6 to 23. To view the segment of the online video showing a nurse completing the Braden scale, go to http://links.lww.com/A107.

The Wound, Ostomy, and Continence Nurses Society (WOCN) recommends that all patients in acute, long-term, and home care be assessed for risk of pressure ulcers at the time of admission.

Mr. Adams. Upon entering Mr. Adams's room, his nurse introduces herself and begins the assessment. “I’m Frances Cornell, and I’m the nurse caring for you today,” she says. “I need to ask you some questions, some of which may seem silly. But can you tell me who you are, where you are, and what the date is?”

Mr. Adams’s answers confirm that he is alert and oriented to time, place, and person. Next she asks, “Are you having pain? How would you describe it on a scale of 0 to 10, where 0 is no pain and 10 is the worst pain imaginable?” Mr. Adams says that his pain is an 8. Taking both of these answers into account, she records a score of 4, meaning “no impairment,” on the sensory perception subscale. This subscale measures the “ability to respond meaningfully to pressure-related discomfort” by looking at both the patient’s perception of pain and her or his level of consciousness.

Mr. Adams is perspiring heavily, probably because of his pain. The nurse finds no evidence of incontinence or wound drainage, so she assigns a score of 3, “occasionally moist,” on the moisture subscale.

Ms. Cornell checks the incision and makes sure the hip-abduction pillow is securely in place. As she settles him in, she notes that he is on bed rest today and gives him a score of 1, “bedfast,” on the activity subscale. He can make slight changes in position, but as is to be expected with this type of injury, he can’t change position independently. His mobility is “very limited,” and he receives a 2 on this subscale. Because he requires assistance to move, he also scores a 2, “potential problem,” on the friction and shear subscale.

Ms. Cornell asks for specific information on his nutritional status, noting that he reported in the ED that he lives alone and does his own shopping and cooking. “How would you describe your eating yesterday?” she asks. “Coffee and a banana for breakfast,” he answers. “I wasn’t very hungry at noon so I had cold cereal with milk. For dinner, I had a can of mushroom soup. I thought about having toast but I just wasn’t that hungry. Later, I had two chocolate chip cookies for a snack.”

Although Mr. Adams’s body mass index (BMI) is abnormal not to alter the scale by adding or deleting items or by modifying existing definitions; any such change will result in inaccuracy. The final score—obtained by totaling the scores from the six subscales—ranges from 6 to 23. To view the segment of the online video showing a nurse completing the Braden scale, go to http://links.lww.com/A107.

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Why Assess Pressure Ulcer Risk?
The importance of avoiding pressure ulcers.

Pressure ulcers are a significant problem in hospitalized older adults. In the United States, Canada, and parts of Europe, prevalence ranges from 14% to 25% and incidence from 7% to 9%.

Research shows that pressure ulcers and their treatment negatively affect every dimension of a patient’s life: emotional, mental, physical, and social. Patients in one study reported experiencing “endless pain,” and those in another said that nursing staff didn’t acknowledge or treat their discomfort and pain (although they received many pressure ulcer–related interventions). Even usual nursing care, such as turning, has been found to be painful for patients with pressure ulcers.

Challenges that may arise. Because the sensory perception subscale includes two areas for assessment—the patient’s level of consciousness and his perception of pain (see the scale on page 46)—the lower of the two scores should be assigned. For example, a patient who has had a stroke and is alert (a 4 on the subscale) but has sensory deficits in a single limb because of disease (a 3) should receive a score of 3 for the subscale.

It can be challenging to complete an accurate evaluation for the nutrition subscale. This subscale scores “usual” intake and is applicable to eating as well as to feeding methods such as ivs, total parenteral nutrition, or tube feeding. Assessment of oral intake requires knowledge of the patient’s eating patterns, so data must be gathered over several days. If a patient is nonresponsive upon admission and family or friends cannot report on intake, nutritional status can be evaluated using BMI and serum albumin level; the assessment will also take into account current plans for the patient’s nutrition (for example, if the patient has an injury that will prohibit intake or she or he is to take nothing by mouth for several days for tests or treatments). Clinical judgment is used to assign a score. The rule of thumb is to “do no harm,” so if the data are borderline, assign a lower risk score.

Similarly, because it often takes several days for tube feeding target goals to be reached, the patient may be underfed. In this case, a score of 2 should be assigned because the patient is receiving “less than [the] optimum amount of liquid diet or tube feeding.”

Pressure ulcers are also expensive to treat. Beckrich and Aronovich estimated in 1999 that the annual cost of hospital-acquired pressure ulcers was $2.2 billion to $3.6 billion. Costs vary by the severity of the ulcer, its location, and the goals of treatment, but they may include the nursing time required to treat ulcers and turn position patients; pressure-relieving devices (mattresses, cushions); dressings, antibiotics, and surgical treatment (such as debridement); and physicians’ fees. Other expenses include hospital and nursing home room fees and additional hospitalization for people who develop ulcers while hospitalized for another condition.

To view the segment of the online video discussing Braden scale scores, go to http://links.lww.com/A109.

SCORING AND INTERPRETING RESULTS
Levels of risk have been defined as the following categories of scores:
• 19 to 23: not at risk
• 15 to 18: at risk
• 13 to 14: at moderate risk
• 10 to 12: at high risk
• 6 to 9: at very high risk

Lower scores suggest higher risk and require more aggressive preventive efforts. Care for those with a score of 19 or higher can proceed without special attention to pressure ulcer risk. The Braden scale’s characterization of pressure ulcer risk as a numerical value makes a change in status easy to identify and act upon. To view the segment of the online video discussing Braden scale scores, go to http://links.lww.com/A109.

Mr. Adams’s Braden scale score upon admission was 13 out of 23, indicating a moderate risk of pressure ulcers. Of foremost concern were his results on the activity, mobility, and friction and shear subscales; his scores on the nutrition and moisture subscales also indicated possible risk.

Following the hospital’s protocol, a nurse evaluates Mr. Adams’s skin at all major pressure points: heels, ankles, sacrum, ischial tuberosities, the trochanteric area, elbows, shoulder blades, spine, and the back of the head. She documents the status of his surgical incision. His skin is intact and there are no areas of redness over bony prominences. Special care is taken to assess his heels and sacrum, which are the most common sites of pressure ulcers. Mr. Adams is particularly susceptible to damage in these areas because he will be spending considerable time in the supine position, and he will be using the heel of his good leg to help him turn.
and use the bedpan. Both of his heels are suspended above the bed with pillows under the calves. The hospital recently replaced all of its mattresses with pressure-relieving mattresses. In hospitals that have older mattresses, a mattress overlay or a low air loss mattress can be used, although some data indicate positive outcomes for hip fracture patients for whom a pressure reducing overlay or mattress is not routinely used in postoperative care.13

The nurse writes a plan of care that incorporates pressure ulcer prevention. To make sure Mr. Adams is repositioned regularly, two cues are used in the room. A navy blue sticker is attached to the white board at the foot of his bed (where daily activities are listed), which reminds the staff to keep the head of the bed at 30° or lower, except at mealtimes. Also, a clock-shaped repositioning schedule is posted on the board to serve as a reminder of when and how Mr. Adams should be repositioned. In addition, every two hours the overhead paging system plays a four-note jingle to remind the staff that it’s time to turn patients.

The nurse also asks the dietitian to perform a routine nutritional evaluation to ensure that Mr. Adams is taking in enough calories, protein, and fluids. His blood will be drawn for laboratory analysis of total protein, albumin, and prealbumin levels, which will help determine whether nutritional supplementation is needed.

Daily Braden scale scoring and skin reassessment will indicate whether Mr. Adams’s plan of care should be modified.

Reassessment schedules are set by the health care facility, according to the nature of its population. Reassessment is recommended when a patient’s condition changes, as well as at regular intervals.16-18 In home care, reassessment at each visit is recommended.17 There is some disagreement, however, on how often reassessment should be done in hospitals and long-term care facilities. In hospitals, the Institute for Healthcare Improvement recommends daily reassessment,16 while the WOCN recommends reassessment every 48 hours.17 For patients in long-term care, the WOCN recommends weekly assessment for four weeks and then quarterly,17 while the American Medical Directors Association recommends that high-risk patients be reassessed quarterly.18

OTHER CONSIDERATIONS
Differences between nurses’ or patients’ cultures are unlikely to affect the accuracy of the Braden scale since there is little in the scale that asks for interpretation of meaning or symbols. On the other hand, a patient’s skin tone can affect a nurse’s ability to detect pressure ulcers. Risk assessment with the Braden scale has been examined in different racial groups. For example, Bergstrom and Braden compared cutoff scores (the number at or below which the patient is considered at risk) for black and white patients and found that the cutoff score of 18 “best predicts risk for both groups.”19 Lyder and colleagues explored pressure ulcer prediction with the Braden scale in black and Hispanic patients and found that a cutoff score of 18 was valid for predicting pressure ulcer risk in black patients ages 75 years and older.20

Translations of the Braden scale are available in Chinese, Japanese, Dutch, French, German, Italian, Portuguese, and Swedish.5, 21, 22

COMMUNICATING THE RESULTS
Because patients are a part of the health care team, they should be apprised of their pressure ulcer risk status. It’s important also to give them an overview and explanation of the prevention plan. With the patient’s approval, family members may also be apprised of this information and enlisted to help with prevention efforts.

The patient’s permanent record is used to communicate pressure ulcer risk to other health care professionals; report at change of shift is also important. Various “bedside” strategies used to alert staff to a patient’s increased pressure ulcer risk include putting a sticker denoting risk on the white board at the foot of the patient’s bed and posting a turning schedule near the bed (for sample schedules see www.bradenscale.com/turning.htm). The video segment demonstrating how to communicate the results of the Braden scale assessment in preparation for discharge is available at http://links.lww.com/A110. Mr. Adams. Ms. Cornell tells Mr. Adams that her assessment suggests he’s at risk for pressure ulcers and explains why that’s an important concern. She discusses the hazards of being immobile with Mr. Adams and his younger sister, Jane Diehl, who is visiting him in his hospital room. She explains that Mr. Adams is at risk for pressure ulcers because of his fracture and its treatment, and she describes the preventive care that has been implemented. She asks them to help with turning and positioning and fluid intake when possible. “Mr. Adams, you can help the nurse position you when you’re turned every two hours. Also, if you find that two hours have gone by and you haven’t been turned, or if you need help between the scheduled turns, please let us know. Ms. Diehl, if you come in and see that it’s time for him to be turned, don’t hesitate to ask one of the staff to reposition him. Mr. Adams, we also want you to drink a lot of liquids to stay well hydrated, so we’ll try to leave your water pitcher within your reach. If we forget, please remind us.
Predicting Pressure Ulcer Risk

By: Elizabeth A. Ayello, PhD, APRN, BC, CWOCN, FAPWCA, FAAN
Excelsior College School of Nursing

WHY: Pressure ulcers (PUs) occur frequently in hospitalized, community-dwelling and nursing home older adults, and are serious problems that can lead to sepsis or death. Prevalence of PUs ranges from 10-17% in acute care, 0-29% in home care, and 2.3-28% in institutional long-term care (LTC); incidence ranges from 0.4-38% in acute care, 0-17% in home care, and 2.2-23.9% in institutional LTC. A key to prevention is early detection of at-risk patients with a valid and reliable PU risk assessment instrument and timely interventions.

BEST TOOL: The Braden Scale for Predicting Pressure Sore Risk is among the most widely used tools for predicting the development of PUs. Assessing risk in six areas (sensory perception, skin moisture, activity, mobility, nutrition and friction/shear), the Braden Scale assigns an item score ranging from one (highly impaired) to three/four (no impairment). Summing risk items yields a total overall risk, ranging from 6-23. If a patient has major risk factors such as fever, diastolic pressure below 60, hemodynamic instability, advanced age, then move them to the next level of risk. Scores 15 to 18 indicate at risk, 13 to 14 indicate moderate risk, 10 to 12 indicate high risk, ≤ 9 indicate very high risk. In addition to assessing total overall risk, basing prevention protocols on low sub-scores are required by Centers for Medicare and Medicaid Centers in the revised Tag F 314 for long term care. Targeting specific prevention interventions that address low risk sub-scores can offer effective resource use.

TARGET POPULATION: The Braden Scale is commonly used with medically and cognitively impaired older adults. It has been used extensively in acute, home, and institutional LTC settings. New PUs are more common in the first two weeks of admission to a hospital or LTC. Recommendations for assessment are on admission or when the patient’s condition changes (including cognition or functional ability) and at the following intervals: acute care—every 48 hours; critical care—every 24 hours; home care—every RN visit; institutional LTC—weekly first 4 weeks after admission, monthly to quarterly.

VALIDITY AND RELIABILITY: The ability of the Braden Scale to predict the development of PUs (predictive validity) has been tested extensively. Inter-rater reliability between .83 and .99 is reported. The tool has been shown to be equally reliable with Black and White patients. Sensitivity ranges from 83-100% and specificity 64-90% depending on the cut-off score used for predicting PU risk. A cut-off score of 18 should be used for identifying Black and White patients at risk for pressure ulcers.

STRENGTHS AND LIMITATIONS: When utilized correctly and consistently, the Braden Scale will help identify the associated risk for PU so that appropriate preventive interventions can be implemented. Although the Braden Scale has been used primarily with White older adults, research addressing Braden Scale efficacy in Black and Latino populations suggests that a cut-off score of 18 or less prevents under-prediction of PU risk in these populations.

MORE ON THE TOPIC:
Best practice information on care of older adults: www.ConsultGeriRN.org

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# Braden Scale for Predicting Pressure Sore Risk

<table>
<thead>
<tr>
<th>Sensory Perception</th>
<th>MOISTURE</th>
<th>Activity</th>
<th>MOBILITY</th>
<th>Nutrition</th>
<th>Friction &amp; Shear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to respond meaningfully to pressure-related discomfort</td>
<td>Degree to which skin is exposed to moisture</td>
<td>Degree of physical activity</td>
<td>Ability to change and control body position</td>
<td>Usual food intake pattern</td>
<td>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</td>
</tr>
<tr>
<td>Unresponsive (does not moan, whimper, or grab) to painful stimuli, due to diminished level of consciousness or sedation.</td>
<td>Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.</td>
<td>Confined to bed.</td>
<td>Does not make even slight changes in body or extremity position without assistance.</td>
<td>Rarely eats a complete meal. Rarely eats more than 1/3 of any food offered. Does not take a liquid dietary supplement.</td>
<td>Requires moderate to maximum assistance.</td>
</tr>
<tr>
<td>Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness.</td>
<td>Skin is often, but not always moist. Linen must be changed at least once a shift.</td>
<td>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</td>
<td>Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.</td>
<td>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.</td>
<td>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.</td>
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<tr>
<td>Responds to verbal commands, but cannot always communicate discomfort or the need to be turned.</td>
<td>Skin is occasionally moist, requiring an extra linen change approximately once a day.</td>
<td>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.</td>
<td>Makes frequent though slight changes in body or extremity position independently.</td>
<td>Eats a total of 4 servings of meat, dairy products per day. Occasionally will take a supplement when offered.</td>
<td>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.</td>
</tr>
<tr>
<td>Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.</td>
<td>Skin is usually dry, linen only requires changing at routine intervals.</td>
<td>Walks outside room at least twice a day and inside room at least once every two hours during waking hours.</td>
<td>Makes major and frequent changes in position without assistance.</td>
<td>Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products per day. Occasionally eats between meals. Does not require supplementation.</td>
<td></td>
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**NPO:** Nothing by mouth; **IV:** Intravenously; **TPN:** Total Parenteral Nutrition

**Score:**
- 15-18 AT RISK
- 13-14 MODERATE RISK
- 10-12 HIGH RISK
- ≤ 9 VERY HIGH RISK

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And Ms. Diehl, feel free to help place it within his reach and to bring him some special liquids that he might like.” They also discuss the importance of daily skin evaluation and reevaluation with the Braden scale.

Mr. Adams’s postoperative course is uneventful. His surgical incision heals well, his nutritional intake improves; ultimately, he is discharged with his skin intact. He follows his hospital stay with 20 days of a nearby skilled nursing facility, where additional physical therapy enables him to resume his independent life. To view the segment of the online video on use of the tool as a continuous quality improvement intervention, go to http://links.lww.com/A108.

CONSIDER THIS

The widely used Braden Scale for Predicting Pressure Sore Risk is regarded as the best tool for identifying pressure ulcer risk and indicating the need for preventive measures. Here are some additional considerations.

What evidence supports relying on the Braden scale to identify patients at risk for pressure ulcer?

The Braden scale has been widely studied to determine whether it predicts pressure ulcer risk. Early studies established its value. Although rigorously conducted, these studies were done when pressure ulcer prevention was not a standard part of nursing care. As pressure ulcer prevention has become routine in hospital care, study results have changed. Today when a prevalence study is conducted, it measures the number of people who have pressure ulcers with some pressure ulcer prevention having been undertaken. Thus, the ability of the Braden scale to accurately predict who will develop pressure ulcers cannot be assessed as purely as before. Nevertheless, the available research indicates that it does a good job of predicting ulcer development and can be relied upon in clinical settings. (For more information on interpreting psychometric aspects of tools, see “Define Your Terms,” October.)

• **Reliability.** The Braden scale has high \( r = 0.99 \) interrater reliability among RNs on medical–surgical and critical care step-down units.

• **Validity.** The Braden scale has demonstrated strong predictive validity, meaning that it effectively predicts the development of pressure ulcers. For example, in one study that used a cutoff score of 16 in 60 critical care patients, researchers found that the scale’s positive predictive validity (correctly predicting that a pressure ulcer would occur) was 61% and its negative predictive validity (correctly predicting that a pressure ulcer would not occur) was 86%.

  - **Sensitivity.** In a systematic review of 33 studies, researchers concluded that the Braden scale’s sensitivity—its ability to identify those at risk for pressure ulcers—has been extensively validated and is reasonably good (57.1%).

  - **Specificity.** The same review found that the Braden scale has reasonably good specificity (67.5%), indicating that nurses can be fairly confident that the scale will accurately determine that someone with a high score is not at risk for developing a pressure ulcer.

For a more complete discussion of the studies on the psychometric properties of the Braden scale, go to http://links.lww.com/A182.

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REFERENCES