THE BRADEN SCALE PRESSURE ULCER RISK ASSESSMENT

Sensory perception	**1. Completely limited:**	**2. Very limited:**	**3. Slightly limited:**	**4. No impairment:**
Ability to respond meaningfully to pressure-related discomfort	**Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminishing level of consciousness or sedation. OR Limited ability to feel pain over most of body surface.**	**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 ½ the body.**	**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.**	**Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.**
Moisture	**1. Constantly moist:**	**2. Very moist:**	**3. Occasionally moist:**	**4. Rarely moist:**
Degree to which skin is exposed to moisture	**Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.**	**Skin is often, but not always moist. Linen must be changed at least once a shift.**	**Skin is occasionally moist, requiring an extra linen change approximately once a day.**	**Skin is usually dry, linen only requires changing at routine intervals.**
Activity	**1. Bedfast:**	**2. Chair fast:**	**3. Walks occasionally:**	**4. Walks frequently:**
Degree of physical activity	**Confined to bed.**	**Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.**	**Walks occasionally during the day but very short distances with or without assistance. Spends majority of each shift in bed or chair.**	**Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.**
Mobility	**1. Completely immobile:**	**2. Very limited:**	**3. Slightly limited:**	**4. No limitation:**
Ability to change and control body position	**Does not make even slight changes in body or extremity position without assistance.**	**Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.**	**Makes frequent though slight changes in body or extremity position independently.**	**Makes major and frequent changes in position without assistance.**
Nutrition	**1. Very poor:**	**2. Probably Inadequate:**	**3. Adequate:**	**4. Excellent:**
Usual food intake pattern	**Never eats a complete meal. Rarely eats more than ⅓ 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 nothing by mouth and/or maintained on clear liquids or intravenously for more than 5 days.**	**Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement if offered. OR Receives less than optimum amount of liquid diet or tube feeding.**	**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 tube feeding or Total Parenteral Nutritional regimen which probably meets most of nutrition**	**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. Problem**	**2. Potential problem:**	**3. No apparent problem:**	
	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.	**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.**	**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.**	

Salisbury NHS
NHS Foundation Trust

THE BRADEN SCALE

G U I D E L I N E S

The Braden scale is a scale that measures the risk of developing pressure ulcers. The scale consists of six subscales that reflect determinants of pressure (sensory perception, activity and mobility) and factors influencing tissue tolerance (moisture, nutrition and friction and shear). Five of the six subscales are rated from 1 (least favourable) to 4 (most favourable); the friction and shear subscale is rated from 1 to 3. To determine the risk of developing pressure ulcers each subscale has to be rated in reflecting the condition of the patient best.

The sensory perception subscale has two components, one of measuring level of consciousness and the other involving cutaneous sensation. In those instances in which a person exhibits both decreased level of consciousness and diminishing cutaneous sensation, the condition which results in a lower rating should be used. Although most of the other indicators do not clearly consist of several parts, more than one aspect may be included. In these cases the following rule applies:

When in doubt, choose the answer with the lowest score

The sum score of the subscales (with a minimum of 6 and a maximum of 23) determines the risk of developing pressure ulcers.

A *low* total score indicates a *high* risk of developing pressure ulcers; a *high* total score indicates a *low* risk of developing pressure ulcers.

At risk = 15+	**Moderate risk = 13 –14**	**HIgh risk = 10 –12**	**Very high risk = 9 or below**

Liz Crockford – Tissue Viability