

Braden Scale

Overview:

The Braden scale can be used to identify those patients at risk for development of pressure ulcerations.

Parameter	Finding	Description	Points
sensory perception (able to respond meaningfully to pressure related discomfort)	no impairment	responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort	4
	slightly limited	responds to verbal commands but cannot always communicate discomfort or need to be turned. Also may have some sensory impairment which limits ability to feel pain or discomfort in 1-2 extremities.	3
	very limited	responds only to painful stimuli and cannot communicate discomfort except by moaning or restlessness. Also may have sensory impairment that limits the ability to feel pain or discomfort over half of the body	2
	completely limited	unresponsive to painful stimuli. Also may have limited ability to feel pain over most of body surface	1
moisture (degree to which skin is exposed to moisture)	rarely moist	skin is usually dry, and linen only requires changing at routine intervals	4
	occasionally moist	Skin is occasionally moist, requiring an extra linen change about once a day	3
	very moist	skin is often but not always moist.	2
	constantly moist	skin is kept moist almost constantly	1
activity (degree of physical activity)	walks frequently	walks outside of room at least twice a day and inside room	4
	walks occasionally	walks occasionally during day but for very short distances, with or without assistance	3
	chairfast	ability to walk severely limited or nonexistent	2
	bedfast	confined to bed	1
mobility (ability to change and control body position)	no limitations	makes major and frequent changes in position without assistance	4
	slightly limited	makes frequent though slight changes in body or extremity position independently	3
	very limited	makes occasional slight changes in body or extremity but unable to make significant changes independently	2
	completely immobile	does not make even slight changes in body or extremity position without assistance	1
nutrition (usual food intake pattern)	excellent	eats most of every meal and never refuses a meal	4
	adequate	eats over half of most meals and may occasionally refuse a meal	3
	probably inadequate	rarely eats a complete meal and has decreased protein intake	2
	very poor	never eats a complete meal and rarely eats more than a third of food offered. Also if NPO or on clear fluid or IVs for more than 5 days	1
shear & friction	no problem apparent	moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move.	3
	potential problem	moves feebly or requires minimum assistance	2
	problem present	requires moderate to maximum assistance in moving; complete lifting without sliding against sheets is impossible.	1

Interpretation: maximum score 23 (best prognosis); minimum score 6 (worst prognosis). A patient is at risk for pressure ulcer if score <= 16.

The breakpoint for determining risk for pressure ulcer may vary with patient population; in an ICU trauma population the breakpoint was found to be 11 rather than 16 (Jiricka, 1995).

References:

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