

Braden Scale

Item	Options	Points
Sensory perception	Completely limited: No response to painful stimuli, or cannot feel pain over most of the body	1
	Very limited: Responds only to pain, or sensory loss over half the body	2
	Slightly limited: Responds to voice but cannot always express discomfort, or loss in 1-2 limbs	3
	No impairment: Responds to voice and has no sensory deficit	4
Moisture	Constantly moist: Skin is wet almost every time the patient is moved	1
	Very moist: Skin is often wet; linen changed at least once a shift	2
	Occasionally moist: Needs an extra linen change about once a day	3
	Rarely moist: Skin is usually dry; routine linen changes only	4
Activity	Bedfast: Confined to bed	1
	Chairfast: Walking severely limited or absent; needs help into a chair	2
	Walks occasionally: Short distances, with or without help; mostly in bed or chair	3
	Walks frequently: Walks outside the room at least twice a day and inside often	4
Mobility	Completely immobile: Makes no position change without help	1
	Very limited: Makes occasional slight changes but not frequent or significant ones alone	2
	Slightly limited: Makes frequent slight changes on their own	3
	No limitation: Makes major and frequent changes without help	4
Nutrition	Very poor: Rarely eats more than a third of meals; little protein or fluid; or NPO/clear liquids for more than 5 days	1
	Probably inadequate: Usually eats about half of meals, or gets less than optimal tube feeding	2
	Adequate: Eats more than half of most meals, or tube feeding/TPN likely meets needs	3
	Excellent: Eats most of every meal, never refuses, good protein intake	4
Friction and shear	Problem: Needs moderate to maximum help to move; often slides down; spasticity or agitation	1
	Potential problem: Moves weakly or needs minimal help; skin likely slides somewhat	2
	No apparent problem: Moves independently and keeps good position in bed and chair	3

Interpretation

6–9	Severe risk. Very high risk of pressure injury. Start a full prevention plan now, including a pressure redistribution surface, scheduled repositioning and skin checks every shift.
10–12	High risk. High risk. Reposition on a set schedule, use pressure redistribution support, manage moisture and nutrition, and involve the wound care team per protocol.
13–14	Moderate risk. Moderate risk. Use a turning schedule, protect heels and bony prominences, and address the lowest-scoring subscales.
15–18	Mild risk. At risk. Start basic prevention: frequent turning, early mobility, moisture control and heel protection. Treat as higher risk if other risk factors are present.
19–23	No risk. No significant risk by score. Continue routine skin care and reassess on schedule or when the patient's condition changes.

Total score: _____ Date: _____ Assessed by: _____

Bergstrom, Braden, Laguzza & Holman, 1987. Sources: AHRQ Preventing Pressure Ulcers Toolkit: Braden Scale; Indiana Department of Health: Braden Scale form; Nursing Fundamentals (Open RN): 10.5 Braden Scale; Official Braden Scale site (licensing).
Free calculator and full guide: nursingscales.com/braden-scale/ · Educational material; does not replace clinical judgment or facility protocols.