

Norton Scale

Item	Options	Points
Physical condition	Good: Stable, in good general health	4
	Fair: Generally stable, some health problems	3
	Poor: Unwell or unstable	2
	Bad: Critically or severely ill	1
Mental condition	Alert: Oriented and aware	4
	Apathetic: Dull, slow to respond	3
	Confused: Disoriented at times	2
	Stuporous: Barely rousable or unresponsive	1
Activity	Ambulant: Walks on their own	4
	Walks with help: Needs a person or aid	3
	Chair-bound: Sits but does not walk	2
	Bed-bound: Confined to bed	1
Mobility	Full: Moves freely	4
	Slightly limited: Moves with minor limits	3
	Very limited: Moves little without help	2
	Immobile: Cannot change position alone	1
Incontinence	None: Continent	4
	Occasional: Occasional incontinence	3
	Usually urine: Usually incontinent of urine	2
	Doubly: Incontinent of urine and stool	1

Interpretation

5–11	High risk. High risk of pressure injury. Start intensive prevention now, including pressure redistribution, scheduled repositioning and frequent skin checks, and follow your facility protocol.
12–14	At risk. At risk. Start a prevention plan with repositioning, moisture control and nutrition support, and focus on the lowest-scoring items.
15–20	Low risk. Low risk by score. Continue routine skin care and reassess when the patient's condition changes.

Total score: _____ Date: _____ Assessed by: _____

Norton, McLaren & Exton-Smith, 1962. Sources: SCIRE Professional: Norton Pressure Ulcer Risk Scale; Hospital Authority Hong Kong: Norton risk assessment scale; Belgian BEST guideline: De Nortonschaal (cut-offs).

Free calculator and full guide: nursingscales.com/norton-scale/ · Educational material; does not replace clinical judgment or facility protocols.