EVALUATION OF RISK FACTORS FOR PRESSURE ULCERS ACCORDING TO

For each of the 6 criteria below, tick the box corresponding to the situation of the person at risk

Criterion	Level	Description	Score	SCORES
SENSORY PERCEPTION Ability to respond meaningfully to pressure related to discomfort	Completely limited	Unresponsive to painful stimuli, due to diminished level of consciousness or sedation Limited ability to feel pain over most of body	1	
	Very limited	Responds only to painful stimuli. Cannot communicate his/her discomfort except through complaints or agitation. Or has a sensory impairment which limits the ability to feel pain or discomfort on half of the body	2	
	Slightly limited	Responds to verbal commands, but cannot always communicate his/her discomfort or his/her need to be turned. Or has some sensory impairment which limits ability to feel pain or discomfort in1 or 2 extremities.	3	
	No impairment	Responds to verbal commands. Has no sensory deficit that limits his/her ability to feel and express his/her pain and discomfort	4	
MOISTURE Degree of moisture to which the skin is exposed	Constantly moist	Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is observed every time patient is turned or moved.	1	
	Very moist	Skin is often but not always moist. Linen must be changed at least once a shift.	2	
	Occasionally moist	Skin is occasionally moist, requiring an extra linen change approximately once a day.	3	
	Rarely moist	Skin is usually dry, linen only requires changing at routine intervals.	4	
ACTIVITY Degree of physical activity	Bedfast	Confined in bed.	1	
	Confined to chair	Ability to walk severely limited or non-existent. Cannot support his/her own weight and/or needs help transferring to chair or wheelchair.	2	
	Occasionally walks	Walks occasionally during the day, but for very short distances with or without assistance. Spends most of the time bed or in chair.	3	
	Frequently walks	Walks outside his/her room at least twice a day and in his/her room at least once every 2 hours during the day.	4	
MOBILITY Ability to change and control body position	Completely immobile	Does not make even slight changes in body or extremity position without assistance.	1	
	Very limited	Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	2	
	Slightly limited	Makes frequent though slight changes in body or extremity position independently.	3	
	No limitation	Makes major and frequent changes in position without assistance.	4	
NUTRITION Usual food intake pattern	Very poor	Never eats a complete meal. Rarely eats more than ½ 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 fasting and/or is hydrated orally or intravenously for more than five days.	1	
	Probably inadequate	Rarely eats a complete meal and usually eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. May occasionally take a dietary supplement. Or receives less than optimum amount of liquid diet or tube feeding.	2	
	Adequate	Eats more than half his/her meals. Eats 4 protein rations per day (meat, dairy products). Occasionally refuses a meal, but usually takes a dietary supplement when offered. Or is fed through tube or parenteral nutrition, adapted to most of his/her nutritional needs.	3	
	Excellent	Eats most of every meals. Never refuses a meal. Usually east at least 4 rations of meat or dairy products a day. Occasionally eats between meals. Does not require dietary supplements	4	
FRICTION AND SHEAR	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.	1	
	Potential problem	Moves with difficulty or requires minimum assistance to do so. During transfer, 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.	2	
	No apparent problem	Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed and chair.	3	

Add the scores of each criterion to obtain the total score

TOTAL SCORE

Source: Braden scale for predicting pressure ulcer risk. Copyright Barbara Braden and Nancy Bergstrom, 1988.
Translated from English to French.

Room number:

Patient name:

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RESULTS ANALYSIS

BRADEN score [1]	Risk level	Indications [2]
23 - 18	No risk to low risk	Patient bedridden for a few days, moving alone and without problem.
17 - 13	Low to medium risk	Patient bedridden from 10 to 15 hours moving alone with difficulty, without significant neurological disorder, without arterial disease, general condition good to medium.
12 - 8	Medium to high risk	Patient up during the day, bedridden for more than 15 hours.
< 8	High risk	Patient not up during the day, in poor general condition and/or with an arterial disease, and/or a recent severe neurological disorder.

Assessment must be associated with clinical judgment.
The scale is quantified at the entrance of the person in the nursing home, institution or hospital and must be revised every once an event, relating to the evolution of the pathology or the general state of the person, leads to changes in prevention.

Sources:
[1] Risk level established according to the recommendations of the learned society PERSE. www.escarre.fr
[2] Categories and descriptions according to the National Authority on Health

BRADEN SCALE

"The Braden Scale is a validated pressure ulcer risk assessment method that considers factors such as sensory perception, moisture, activity, mobility, nutrition, friction and shear, which are responsible for the occurrence of a pressure ulcer."