Clinical Practice Procedures:
Assessment/Braden Scale risk assessment tool

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Date	November, 2026
Purpose	To ensure a consistent procedural approach to the Braden Scale risk assessment tool.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
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Author	Clinical Quality & Patient Safety Unit, QAS
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Braden Scale risk assessment tool



March, 2026

A pressure injury is an area of localised damage to the skin and underlying tissue that is often caused by friction, pressure or moisture. While pressure injuries are more common in older patients with underlying medical conditions, these injuries can also occur in patients of any age following an extended period of immobility.[1]

As an element of comprehensive care planning, ambulance clinicians play an important role in screening patients to identify existing comorbidities, situational circumstances and social factors that may predispose a patient to potential harm. The Braden Scale score is a validated tool for predicting the development of pressure injuries based on six known risk factors.[2,3] Where clinically indicated, this tool should be performed as part of standard cares unless competing clinical priorities exist.

Indications

- Patients 65 years of age and over
- Aboriginal and Torres Strait Islander people aged 55 years and over
- > 1 hr period of immobility
- Patient on stretcher > 2 hrs

Contraindications

- Competing clinical priorities

Complications

- Nil in this setting

PROCEDURE

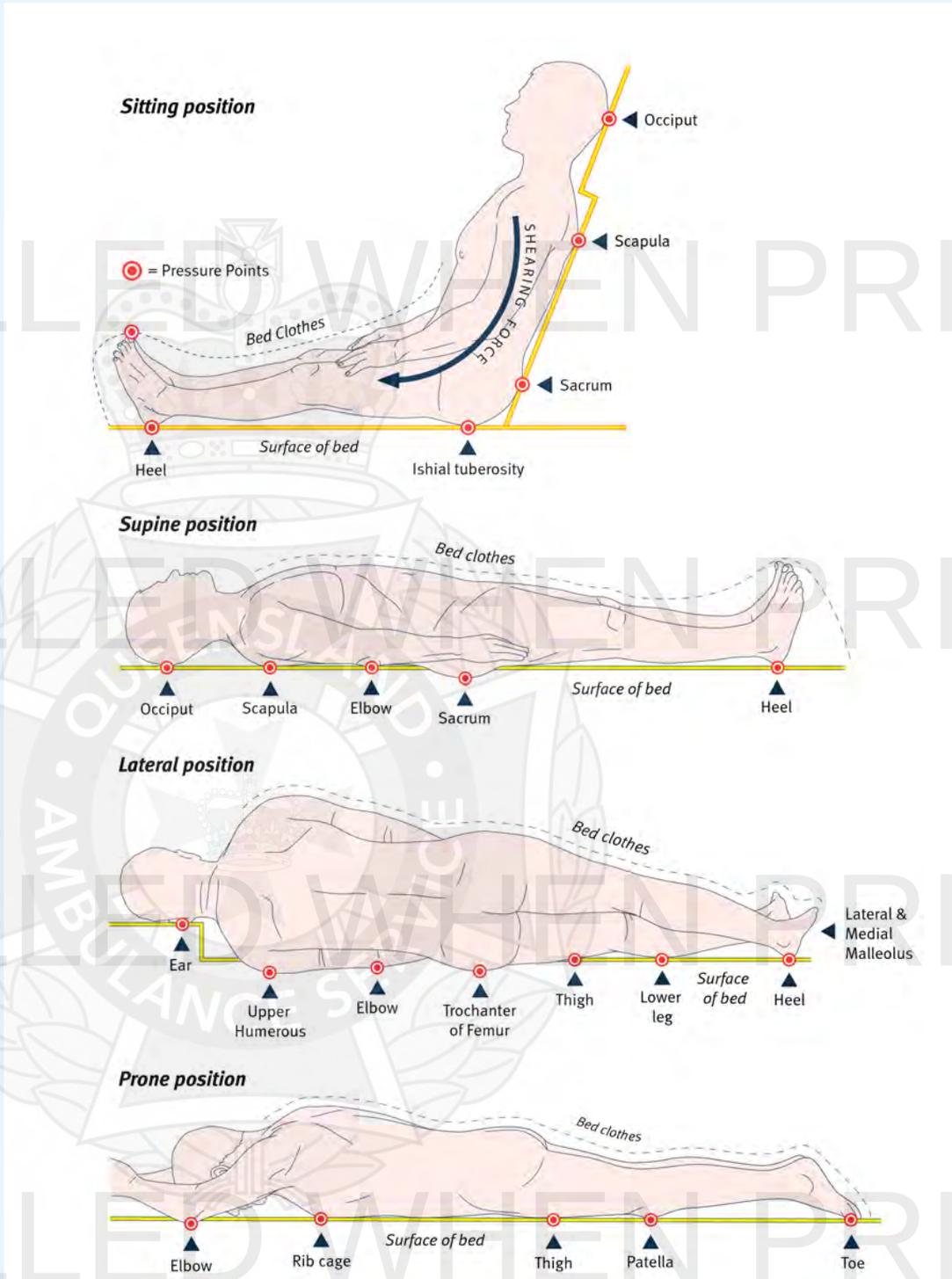
Calculate the Braden Scale score by determine the individual score each of the 6 risk factors. The score for each component is then combine to calculate the overall score.

	1	2	3	4
Sensory perception *Ability to respond meaningfully to pressure-related discomfort*	Completely limited	Very limited	Slightly limited	No impairment
Moisture *Degree to which the skin is exposed to moisture*	Constantly moist	Very moist	Occassionally moist	Rarely moist
Activity *Degree of physical activity*	Bed bound	Chair bound	Walks occassionally	Walks frequently
Mobility *Ability to change and control body position*	Completely immobile	Very limited	Slightly limited	No limitation
Nutrition *Usual food intake pattern*	Very poor	Probably inadequate	Adequate	Excellent
Friction and shear *Patient movements which may cause pressure injuries*	Problem	Potential problem	No apparent problem	N/A

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Additional information

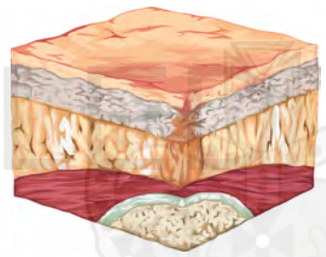
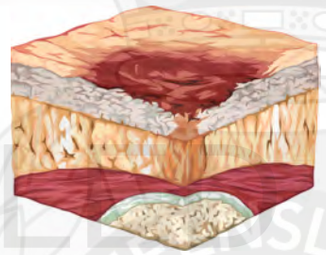
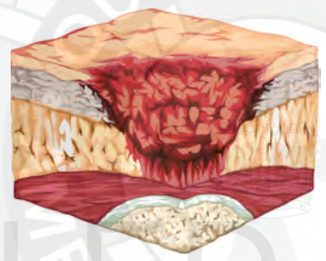
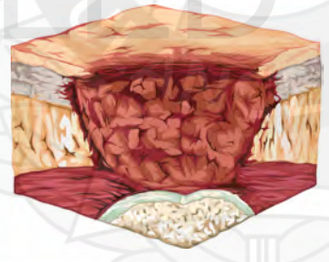
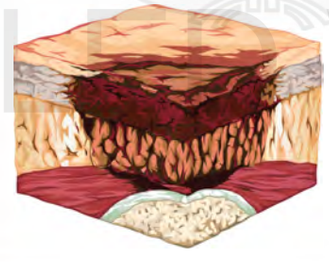
- The total score is used to predict the risk of pressure injury development as follows:
  - Score > 15 = at risk
  - Score 13–14 = moderate risk
  - Score 10–12 = high risk
  - Score < 9 = very high risk
- The calculated Braden Scale score should be documented with the eARF and provided to the receiving facility.
- Preventative measures ambulance clinicians an perform to reduce pressure injury development include:
  - Ensuring the patients skin is clear and remains dry when positioned on a stretcher
  - Ensuring linen is free of bumps, large folds or creases
  - Consider utilising support surfaces such as pillows or similar to manage pressure load shear and friction
  - Consider regularly repositioning patients that are unable to do this themselves due to injuries and/or comorbidities
- The most common sites pressure injuries are those with bony protrusions that are frequently in contact with surfaces, however, they can occur anywhere on the body.
- Common sites of pressure injuries in the sitting, supine, lateral and prone position are displayed in the opposite diagrams.



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Additional information

- **Pressure injury severity:** For patient's with existing pressure injuries, the following staging system can be used to document injuries accurately.

Stage 1 (superficial)	• Skin intact but may be inflamed/red non-blanchable • Painful and warm to touch • Spongy or firm texture ***N.B.*** *Superficial pressure injuries can rapidly deteriorate into severe, life-threatening deep tissue ulcers in patients who are not managed properly.*	
Stage 2	• Skin broken, red and painful • Blistering, with/without ooze • No visible loose, dead tissue • Tissue may be pale, red, swollen and warm	
Stage 3	• Skin ulcerated, extending to fat layer • May or may not be painful • White to black in colour, may be dead tissue • May have a foul smelling drainage	
Stage 4	• Full thickness ulcer extending to muscle, tendon or bone • White to black in colour • May be painful if bone is infected • Slough or eschar (dead tissue visible) • Foul smelling drainage possible	
Stage 5	***Non-gradable*** *– Dark skin/tissues that may be intact and conceal deep underlying tissue damage. Most common over the heel area.*	

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