**Pressure Ulcer Assessment and Reassessment Guidelines**

**Admission screening assessment** should include the following:
- Comprehensive head to toe skin assessment
- Health history/diagnosis
- Nutrition and hydration
- Mobility, positioning/surface supports
- Incontinence/moisture
- Pain status
- Validated tool such as the Braden Scale or the Norton

Does the person have a pressure ulcer?

- **Yes**
  - **In-depth pressure ulcer assessment** with a validated tool such as the PUSH Tool 3.0 or the BWAT and the following:
    - Location
    - Stage (2007 NPUAP staging system)
    - Size (length, width and depth)
    - Wound Bed: granulation, odor, necrotic tissue, drainage/exudate, slough
    - Presence of undermining, sinus tracts, tunneling
    - Condition of the peri-wound tissue (color, temperature, bogginess, fluctuation, edema)
    - Support surfaces
    - Pain status
  - Implement/update pressure ulcer treatment/intervention

- **No**
  - Identify person-specific risk factors
    - Clear documentation
      - Be specific and detailed
    - **IDT approach**
      - Report Findings
  - Develop, implement and update individualized nursing care plan

If pressure ulcer is present – complete in-depth reassessment.

Reassessment frequency determined by the person’s pressure ulcer risk factors.