

PRESSURE ULCER ASSESSMENT & MANAGEMENT GUIDE

New admission/readmission - The first step in a pressure ulcer risk assessment is to identify individual risk factors for the development of pressure ulcer(s) and/or the presence of pressure ulcer(s) within first six hours. The pressure ulcer risk assessment should be repeated weekly for the first four weeks, then monthly for the first quarter, and then quarterly thereafter or whenever the person's condition changes.

Pressure ulcer risk assessment & management

Key elements of a pressure ulcer risk assessment include:

- **Comprehensive head to toe skin assessment:** Assessment should include identification of any of the following:
 - Erythema
 - Dry skin
 - Edema, Overhydrated ,or moist skin, especially over bony prominences
 - Muscle wasting with loose skin folds, especially over the buttocks
 - Adequate peripheral tissue perfusion
- **Health history/diagnosis:**
 - Acute and chronic conditions
 - A review of medications
- **Nutrition and hydration:** Adequate calories, protein, fluids, vitamins and minerals are required by the body for maintaining tissue integrity and preventing tissue breakdown. Reliable indicators of dehydration are elevated serum sodium, serum osmolality, and BUN/creatinine ratio. The most common clinical assessments of dehydration include the presence of dry oral mucous membranes, tongue furrows, decreased saliva, sunken eyes, decreased urine output, upper-body weakness and a rapid pulse.
- **Mobility, positioning/surface supports:** Multi-disciplinary team effort.
 - Pressure-reducing and/or pressure-relieving devices
 - Wedges and pillows

- Written schedule - time frames are dependent on individual needs. Identify key pressure point areas, as well as any compromised areas for care givers.
- Positioning -“The Rule of 30 degrees”
- Maintaining the head of the bed at the lowest possible degree of elevation
- Open and clear communication with physician

- **Incontinence/moisture:** Minimize skin exposure to moisture due to incontinence, perspiration or wound drainage. Reversible or treatable conditions, such as urinary tract infection, fecal/urinary incontinence, or fecal impaction can increase the potential for prolonged exposure to moisture.
- **Pain status:** Assess for pain in an individual who is at risk for development of a pressure ulcer and/or pain related to the pressure ulcer or its treatment.
- Use a validated pressure ulcer assessment tool such as: The Braden Scale for Predicting Pressure Sore Risk

In-depth assessment for individuals with pressure ulcers

Individuals with a pressure ulcer should have a comprehensive assessment including the following key elements:

- Location
- Staging using the 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 (ie: color, temperature, bogginess, fluctuation, edema)
- Support surfaces
- Pain status

Use a validated tool to monitor the healing of a pressure ulcer

- The Pressure Ulcer Scale for Healing (PUSH) Tool
- Bates-Jensen Wound Assessment Tool (BWAT)