Developed in collaboration with the Wound Care Champions, Wound Care Specialists, Enterostomal Nurses, and South West Regional Wound Care Program (SWRWCP) members from Long Term Care Homes, Hospitals, and South West Community Care Access Centre contracted Community Nursing Agencies in the South West Local Health Integration Network.	

Title	**Procedure: NPUAP PUSH Tool 3.0**

Background	• In 1996 a task force created by the National Pressure Ulcer Advisory Panel (NPUAP) developed the Pressure Ulcer Scale for Healing (PUSH) tool, based on a principal component analysis of existing databases, to measure pressure ulcer healing and to replace the practice of reverse staging of pressure ulcers[1]
	• The tool assesses three components:
	  o Surface area measurement (scored from 0-10)
	  o Exudate amount [scored from 0 (none) to 3 (heavy)]
	  o Tissue type [scored from 0 (closed) to 4 (necrotic tissue)]
	• In order to ensure consistency in applying the tool, definitions for each element scored are supplied at the bottom of the tool
	• Content validity, correlational validity, prospective validity, and sensitivity to change requirements are met by the PUSH Tool[2-3]
	• The tool has since been validated to assess healing of venous and diabetic foot ulcers, in addition to pressure ulcers[4]
	• The use of the tool is meant to trigger the identification of when treatment goals are not being met and when re-evaluation is required
	• The PUSH tool may be used with an ulcer healing record or graph (both developed by the NPUAP) to allow one to quickly note at a glance any progress or deterioration in the wound
	• The tool, along with the reprint agreement, information and registration form, instructions for use, and copyright policy and contract can be found at: http://www.npuap.org/resources/educational-and-clinical-resources/push-tool/
	• Permission has been obtained to include this tool as part of the SWRWCP website

Indications	This procedure is intended to be used by front line registered health care providers, to assist with their assessment and management of individuals admitted with or presenting with a wound.
Procedure	**NOTE: The use of the "NPUAP PUSH Tool 3.0" is but one part of the holistic assessment of an individual admitted with or presenting with a wound.** **Assessment** 1. Review the person's medical records for the most recent PUSH scores/documentation and/or view their PUSH healing record or graph. Note any trends in progression towards closure or deterioration

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	2. Review the person's medical records for current wound care orders
	
	Planning
	1. Expected outcomes:
	    a. Information from the person's chart, the person and/or their substitute decision maker (SDM)/power of attorney for personal care (POA C), and your assessment allows for the completion of the "NPUAP PUSH Tool 3.0"
	    b. Information obtained allows for the determination of whether or not the wound is progressing towards closure or deteriorating
	    c. Registered nursing staff, in collaboration with the individual with the wound and/or their SDM/POA C, and other involved health care disciplines, are able to use the assessment information to initiate/modify and implement an appropriate, person-centered, interdisciplinary plan of care which contains clear directions to staff and others who are providing the person with direct care
	2. Explain the dressing change and wound assessment procedure and purpose to the person and/or their SDM/POA C and obtain verbal or implied consent
	3. Assess the need for pre-procedure pain medication - removal of dressings and/or the dressing change procedure itself can be painful. The person may require pain medication before the dressing change itself (allow enough time to achieve the drug's peak effect BEFORE initiating the dressing change)
	
	Implementation
	1. Provide for privacy and ensure the person is in a comfortable position to facilitate the assessment of the wound
	2. Wash your hands and attend the person with your assessment and dressing supplies
	3. If the person is in bed, raise the bed (if you are so able) to an appropriate ergonomic working position to facilitate ease of assessment. Otherwise position yourself in an appropriate ergonomic position to allow for the wound assessment while preventing self-injury
	4. Ensure adequate lighting
	5. Don clean disposable gloves, and expose the person's wound by removing the existing wound dressing as per the manufacturer's instructions. You may consider the application of gown, goggles, and/or mask pre-procedure if the risk for spray or splash back exists
	6. Dispose of soiled dressings in the appropriate receptacle
	7. Remove your gloves and dispose of them in the appropriate receptacle
	8. Wash your hands. Put on a new pair of clean disposable gloves, and cleanse the wound as per the "South West Regional Wound Care

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	Program's Dressing Selection and Cleansing Enabler – HEALABLE" or "South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE", as indicated. Gently pat the wound dry with gauze (if required) 9. Assess the wound using the "NPUAP PUSH Tool 3.0": a. Using a disposable, paper centimeter ruler, measure the longest length (head to toe) and widest width (side to side) as per PUSH Tool instructions. Multiply the length and width to determine the surface area in cm^2. Select the corresponding sub score and note it in the tool's sub score column. **NOTE: for linear wounds, i.e. approximated surgical incisions, the aforementioned method for measuring length/width will not work, unless the incision line is situated head to toe or side to side. Instead, measure the wound end to end for length and at the widest point for width. Note on the form how you measured (all subsequent measurements should be conducted in the same fashion)** b. Estimate the amount of exudate after removal of the dressing and wound cleansing. Select the corresponding sub score and note it in the sub score column c. Identify the type of tissue. **NOTE: if there is any necrotic issue it is scored as a 4. If there is any slough, it is scored as a 3, even if most of the wound consists of granulation tissue** d. Sum the sub scores of the three elements of the tool to derive a total PUSH score. Note that score in the 'Total Score' box e. Transfer the total score to a healing record or healing graph 10. Apply a new dressing as per the person's medical order or as per the "South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – HEALABLE" or "South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE", using clean technique unless otherwise indicated (i.e. unless the wound is considered acute) 11. Assist the person to a comfortable position, if required 12. Lower the person's bed to an appropriate height (if applicable), and ensure the person's safety, i.e. apply side rails, personal alarms, restraints, etc. as per the person's care plan/medical orders 13. Clean reusable equipment/surfaces touched during the procedure with warm soapy water or detergent wipes and dry thoroughly to prevent cross infection, returning reusable equipment to the appropriate places. Dispose of any personal protective equipment and soiled dressing supply materials in the appropriate receptacle 14. Remove and dispose of your gloves in the appropriate receptacle, and wash your hands 15. Discuss your findings and the implications of those findings with the person and/or their SDM/POA C 16. Share the results of your assessment with the interdisciplinary members of the person's wound care team

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	17. Complete documentation as required, i.e.: a. Document initial and on-going “NPUAP PUSH Tool 3.0” total scores on the designated form according to your organization’s policy b. Store completed tools in the person’s medical chart for future reference c. Complete/update an appropriate, person-centered, interdisciplinary care plan, as per your organizations policy, based on the person’s score and your overall assessment **Evaluation** 1. Unexpected Outcomes: a. If you had deemed the wound to be ‘healable’ using the “Determining Healability Tool”, exudate amounts and surface area should not be increasing and the tissue type should not be deteriorating. The total PUSH score should be getting smaller if the wound is improving as anticipated b. If you had deemed the wound to be ‘maintenance’ or ‘non-healable/palliative’, exudate amounts and surface area should be stable/minimally fluctuating and the tissue type should not be significantly deteriorating (unless the person is acutely palliative). The total PUSH score should be stable/minimally fluctuating as anticipated c. The current dressing does not meet the needs of the wound or the person d. The “NPUAP PUSH Tool 3.0” is not completed according to this procedure 2. Re-assess the person’s comfort/pain post dressing change and wound assessment 3. Registered nursing staff, in collaboration with other involved health care disciplines and the person with the wound and/or their SDM/POA C are able to use the assessment information to develop/modify and implement an appropriate, person-centered, interdisciplinary plan of care 4. Re-assess the wound using the “NPUAP PUSH Tool 3.0” at a minimum of weekly
References	1. Thomas DR, Rodeheaver GT, Bartolucci AA, et al. Pressure ulcer scale for healing: Derivation and validation of the PUSH tool. Adv Wound Care. 1997;10(5):96-101. 2. Stotts NA, Bartolucci A. Testing the pressure ulcer scale for healing (PUSH) and variations of PUSH. Paper presented at: Symposium for Advanced Wound Care and Medical Research Forum on Wound Repair, Miami Beach, FL, 1998. 3. Stotts NA, Thomas DR, Franz R, et al. Development and validation of the pressure ulcer scale for healing (PUSH). J Gerontol Series A. 2001;56(12):M795-799.

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	4. Hon J, Lagden K, McLaren AM, et al. A prospective multicenter study to validate use of the PUSH in patients with diabetic, venous, and pressure ulcers. Ostomy Wound Management. 2010;56(2):26-36.
Related Tools (NOTE: these tools and their instructions can be found on the SWRWCP's website: swrwoundcareprogram.ca)	• NPUAP PUSH Tool 3.0 • South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – HEALABLE • South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE • Determining Healability Tool

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