



HEALTH HOLDING

HAFER ALBATIN HEALTH
CLUSTER
MATERNITY AND
CHILDREN HOSPITAL

Department:	Pediatric Intensive Care Unit (PICU)		
Document:	Multidisciplinary Policy and Procedure		
Title:	Care and Prevention of Pressure Sores		
Applies To:	All Pediatric Intensive Care Unit Staff		
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1. PURPOSE:

- 1.1 To reduce the breakdown of tissues and maintain skin integrity.
- 1.2 To outline the nursing management for all patients developing skin or tissue breakdown.

2. DEFINITIONS:

- 2.1 **Pressure Ulcers** – a pressure ulcer or a pressure injury is an area of the skin that has been damaged as a result of constant pressure, poor blood flow or chafing and rubbing of the skin.

3. POLICY:

- 3.1 All patients are assessed for pressure ulcers on admission using a standard risk assessment tool (Braden Scale – Skin Risk Assessment)
- 3.2 Risk for skin breakdown is higher for the following pediatric children:
 - 3.2.1 Those with Spina Bifida.
 - 3.2.2 A Spinal Cord Injury.
 - 3.2.3 Neurological Impairment.
 - 3.2.4 Obesity.
 - 3.2.5 Impaired Vision.
 - 3.2.6 Patients who are in cast or traction.
 - 3.2.7 Patients with infection and edema.
 - 3.2.8 Anemic and with inadequate hydration.
 - 3.2.9 Patients who are unable, unwilling or restricted from changing their position.
- 3.3 Development of pressure sores includes 3 major factor:
 - 3.3.1 Pressure – any external pressure will cause capillary obstruction leading to insufficient blood supply to the tissues resulting to tissue destruction.
 - 3.3.2 Shearing – this may occur when the patient slips down the bed or is dragged up the bed.
 - 3.3.3 Friction – this component of shearing which causes stripping of the stratum corneum, leading to superficial ulceration.
- 3.4 Assessment of skin over regions of pressure ulcer prone areas (bony prominences)
 - 3.4.1 Back of the head.
 - 3.4.2 The base of the spine.
 - 3.4.3 Ear.
 - 3.4.4 Bridge of the nose, heel and elbow.
 - 3.4.5 Buttocks.
- 3.5 All patients are reassessed for pressure ulcers on every shift.

4. PROCEDURE:

4.1 Skin Care:

- 4.1.1 Use lukewarm water for bathing and showering.
- 4.1.2 If using soap or liquid cleanser, try to use a product that is perfume free and alcohol free.

- 4.1.3 A barrier cream (available at pharmacy) on inflamed or bony areas may be helpful for the child.
- 4.2 Positioning:
 - 4.2.1 Encourage the patient to change their position at least every 2 hours if sitting for long period.
 - 4.2.2 If patient is spending extended periods of time in bed, changed position every 2 hours to every 4 hours. Do not drag their skin when moving. Make sure bed sheets are tightly tucked in and not crumpled. Small creases or folds in sheets can damage the skin.
 - 4.2.3 Encourage patient to be active where appropriate.
- 4.3 Nutrition:
 - 4.3.1 Good nutrition is important for healthy skin and wound healing.
 - 4.3.2 A balance diet helps the child maintain an appropriate weight.
 - 4.3.2 Encourage patient to drink adequate fluids.
- 4.4 Documentation:
 - 4.4.1 Record assessment findings.
 - 4.4.2 An evaluation of the effectiveness of care.
 - 4.4.3 Stability/ instability of overall skin condition.
 - 4.4.4 Improvement or deterioration of risk factors.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

- 6.1 Nurses

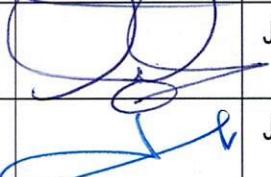
7. APPENDICES:

- 7.1 Braden Scale Monitoring Tool

8. REFERENCES:

- 8.1 Ministry of Health Policies and Procedures, 2013.

9. APPROVALS:

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Appendices 7.1 Braden Risk Assessment Scale

Braden Risk Assessment Scale						
Sensory/ Mental	Moisture	Activity	Mobility	Nutrition	Friction/ Shear	
1. Totally limited	1. Constantly moist	1. Bedfast	1. 100% immobile	1. Very poor	1. Frequent sliding	
2. Very limited	2. Very moist	2. Chairfast	2. Very limited	2. < ½ daily portion	2. Feeble corrections	
3. Slightly limited	3. Occasionally moist	3. Walks w/ assistance	3. Slightly limited	3. Most of portion	3. Independent corrections	
4. No impairment	4. Dry	4. Walks w/out assistance	4. Full mobility	4. Eats everything		
Total Braden Score _____						
15-18 Mild Risk 12-14 Moderate Risk <12 High Risk 15-18 is considered Mild Risk for those > 75 years						

Braden BI, Bergstrom N. Clinical Utility of the Braden Scale for Predicting Pressure Sore Risk. *Decubitus*, August 1989, 2: 44-51.