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:

	Name	Title	Signature	Date
Prepared by:	Ms. Asma AlShammary	Head Nurse of PICU		January 06, 2022
Prepared by:	Dr. Eman Abdelhakim Amer	Pediatric Specialist		January 13, 2022
Reviewed by:	Mr. Sabah Turayhib Al Harbi	Director of Nursing		January 13, 2022
Reviewed by:	Dr. Ali Alfayez	PICU Head of the Department		January 13, 2022
Reviewed by:	Mr. Abdulelah Ayed Al Mutairi	QM&PS Director		January 13, 2022
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		January 13, 2022
Approved by:	Mr. Fahad Hazam Al Shammari	Hospital Director		January 20, 2022

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. < ⅓ 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 _____

15-16 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.