Institution Name: Directorate General of Nursing Affairs, MoH

Document Title: Policy& procedure on Pressure Ulcer Prevention and Management

Approval Process

	Name	Title	Institution	Date	Signature
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Content Table:

Acknowledgement

Directorate General of Nursing Affairs would like to thank and appreciate all those who participated in writing and reviewing this policy in particular the following team:

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Acronyms:

MOH	The Ministry of Health
DGNA	Directorate General of Nursing Affairs
NICE	National Institute for Clinical Excellence
RN	Registered nurse
PHC	Primary Health Care
EPUAP	European and US National Pressure Ulcer Advisory panels

Policy& procedure on Pressure Ulcer Prevention and Management

1. Introduction

Pressure ulcers have become a concern for nurses throughout the world, due to its significant impact on patients' health conditions and the treatment process and its burden on the health care system. Pressure ulcer rate is considered a key performance indicator reflecting quality of nursing care. Proper skin assessment and early detection of skin damage and implementation of adequate preventative strategies can prevent tissue damage or reduce the seriousness of the ulceration.

This policy is intended to guide nurses in the management of patients who are at risk of developing pressure ulcers, or/and patients who have already developed pressure ulcers based on evidence. It guides nurses on assessment, documentation and prevention of pressure ulcers. It provides nurses with the standards of care and procedures to follow for patients at risk of or with pressure ulceration. The effective compliance of this policy will reduce the likelihood occurrence of pressure ulcers, and help to prevent the deterioration of patients who acquired pressure ulcers.

2. Scope

This policy applies to all nurses working in healthcare institutions of Ministry of Health (MOH).

3. Purpose

3.1 This document is designed to provide and maintain standards of care on the prevention and management of pressure ulcer across all health care institutions.

3.2 This is to enhance a cultural change among nurses towards implementing preventable measures to prevent and manage pressure ulcers.

4. Definitions

4.1 Pressure ulcer: A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or shear or a combination of both.

4.2 Risk assessment: process of identifying the potential risk of pressure ulcer development.

4.3 Skin Inspection/assessment: a process in which the entire skin of a patient is examined for abnormalities, including looking at and touching the skin from head to toe, with a particular emphasis on bony prominences and skin folds, when prolonged pressure may result in skin breakdown.

4.4 Interventions: the steps taken by the nurse/ or care providers to increase monitoring, reduce pressure, redistribute weight, and / or remove friction and shear to lessen or eliminate the risk of skin breakdown.

4.5 Patients at high risk of pressure ulcer (vulnerable patients): includes those who are bed ridden, seriously ill, neurologically compromised, i.e. individuals with spinal cord injuries, have impaired mobility or who are immobile (including those wearing a prosthesis, body brace or plaster cast), or who suffer from impaired nutrition, obesity, poor posture, or use of equipment such as seating or beds, which do not provide appropriate pressure relief.

4.6 Braden Scale: is a scale made up of six subscales which measure elements of risk that contribute to either higher intensity or duration of pressure, or lower tissue tolerance for pressure. These elements are: sensory perception, moisture, activity, mobility, nutrition and shear/friction. Each item is scored between 1 and 4, with each score accompanied by a description. The lower the score, the greater the risk of developing pressure ulcer.

5. Policy

5.1 Hospital management will make sure that nurses, in collaboration with other health care providers, assess and manage skin integrity for all patients throughout their hospital stay.

5.2 Nursing management will make emphasis on pressure ulcer prevention as one of the key performance indicators.

5.3 All clinical staff to be trained on pressure ulcer prevention and management.

5.4 Multi-disciplinary team involvement is necessary for an optimal pressure ulcer care.

5.5 Patients and families are to be encouraged to participate to the best degree possible in the care and prevention of patients' skin breakdown.

5.6 Monitoring of pressure ulcer incidents is highly encouraged as it is a significant nursing key performance indicator.

5.7 All surgical patients or patients going for long hours procedures are considered at risk for pressure ulcer development.

6. Procedure

6.1 Prevention of Pressure Ulcers/ Skin Inspection:

6.1.1 All patients entering the health care institution will have a skin risk assessment upon admission, upon transfer from unit/ward to another, when a change in patients' condition occurs, and when patients go for any procedure that requires them to not move for more than 2 hours. This is by using Braden skin risk assessment scale.

6.1.2 The Registered Nurse (RN) completing the baseline admission assessment will perform a pressure ulcer risk assessment within 2 hours of admission using the Braden scale.

6.1.3 The RN will develop and implement a plan of care indicating/ reflecting the patient's individual needs for the prevention of pressure ulcers.

6.1.4 Any patient considered at risk of pressure ulcer development Braden scale score < 12, will have a written pressure ulcer prevention plan including, positioning schedule with frequent skin inspections every shift, pressure relieving equipment (e.g. ripple mattress), nutritional requirements, pain management, and continence management. In addition, patients with body mass index (BMI) of above 30 to be considered while developing pressure ulcer prevention plan.

6.1.5 Patients going for procedures lasting >2 hours, including surgeries, are to be considered at risk for pressure ulcer development, therefore, pressure ulcer prevention precautions to be implemented. This includes procedures related to cardiovascular conditions, trauma management, transplants, bariatric procedures, and dialysis.

6.1.6 For ambulatory patients with normal Barden assessment score, scale is to be updated once a week. For patients with low skin assessment score, scale is to be updated twice a week or whenever dressing is changed (if pressure ulcer develops).

6.1.7 Preventative Interventions for all patients include, but are not limited to:

6.1.7.1 Promoting activity and mobilization.

6.1.7.2 Quick measures to maintain and improve tissue tolerance to pressure for bed ridden patients, e.g ripple mattress and reducing heel and sacral pressure, friction and shear forces as per available resources.

6.1.7.3 Repositioning schedule, documented in Al shifa record system and updated daily.

6.1.7.4 Daily skin assessment documented in Al shifa record system.

6.1.7.5 Proper nutritional assessment and recommendation by a dietician for patients who are at risk of developing pressure ulcers.

6.2 Care and interventions (Skin Breakdown)

6.2.1 If any patient develops a pressure ulcer, a comprehensive wound assessment will be completed and documented in the wound chart in Al shifa system, using **EPUAP** system level of grading as 1, 2, 3 or 4, location, size, and description of the tissue involved (see appendix 1).

6.2.2 Inform medical officer and Nurse in-charge and wound nurse of identified pressure ulcer and stage.

6.2.3 Electronic incident reports of hospital acquired pressure ulcer is to be completed.

6.2.4 Clear individualized wound care plan to be carried out in every identified pressure ulcer case, as per wound management protocol, and as per wound nurse advice if available.

6.2.5 If a patient needs long term pressure ulcer care, he/she to be referred to wound nurse, discharge planner and ensure community nurse is informed for follow up.

6.2.6 Patient's family education on the care process to be done from the moment of wound identification.

6.2.7 The pressure ulcer stages will be monitored and re-evaluated on every dressing change, and the current stage and condition of the pressure ulcer will be recorded in the pressure ulcer chart, nursing kardex, and in the clinical handover notes.

6.2.8 Braden skin risk assessment scale to be updated twice a week or whenever dressing is changed.

6.2.9 Collaborate with the dietitian to perform nutritional assessment and recommend intervention based on the outcomes.

7 Responsibilities

7.1 Hospital Director

7.1.1 Oversee dissemination and implementation of the policy

7.1.2 Provide adequate resources to ensure proper implementation of the policy.

7.2 Director/Head of Nursing Services

7.2.1 Facilitate communication related to policy implementation and evaluation with all involved in provision of patient care.

7.2.2 Ensure that the policy is disseminated to all staff.

7.2.3 Ensure resources are available to ensure proper compliance.

7.2.4 Create a mechanism to ensure that the policy is implemented effectively by all staff within HC Institution/Governorates.

7.2.5 Assign teams and internal taskforce for training on and monitoring the compliance to the policy and reporting the incidences with action plans.

7.3 **Nursing supervisor and Nursing In-Charges**

7.3.1 Disseminate the policy to all staff and provide guidance.

7.3.2 Assist in the implementation of the policy.

7.3.3 Monitor and evaluate policy implementation focusing on patient-centered care and safe and effective practice.

7.3.4 Ensure that nurses carry out the policy effectively and that required resources are available.

7.3.5 Ensure all nursing staff have received training in relation to this policy and procedure to maintain professional competence in pressure ulcer prevention and management.

7.3.6 Nominate a Link nurse for overall monitoring of compliance and provide support to enable them to fulfil the role.

7.3.7 Ensure all pressure ulcers are reported and investigated as per hospital policy.

7.3.8 Conduct monthly audit and monitoring on the policy implementation and compliance, and submit a report to top management (Appendix 3).

7.3.9 Review all pressure ulcer incidents, conduct root cause analysis and develop action plans accordingly.

7.3.10 Share information and lessons learned on pressure ulcer incidences across clinical areas to prevent similar occurrence in the future.

7.4 **Clinical Nurses**

7.4.1 Be familiar and adhere to the pressure ulcer prevention policy.

7.4.2 Ensure that all pressure ulcers are assessed, graded and documented within patient's file.

7.4.3 Ensure that any skin changes/ damages are reported to the in-charges and treating team, and are well documented.

7.4.4 Ensure to attend training on pressure ulcer identification, staging, prevention and management.

7.4.5 Ensure that any skin damages/ changes noted are reported to the nursing team.

7.4.6 Ensure that patients are assessed and appropriate plan of care is developed and implemented.

7.5 **Wound care nurse**

7.5.1 Provide guidance and support for nurses in relation to pressure ulcer assessment and wound care.

7.5.2 Participate in pressure ulcer prevention and management training sessions.

7.5.3 Follow up referred cases and communicate the wound care plan with assigned nurse.

8. Document History and Version Control

Document History and Version Control			
Version	**Description of Amendment**	**Author**	**Review Date**
01	Initial Release	Pressure Ulcer Prevention Taskforce	January/ 2022
02			
03			
04			
05			

Written by	**Reviewed by**	**Approved by**
Pressure Ulcer Prevention Taskforce	Dr. Amal Al Shidi DGNA Team	Dr. Majid Rashid Al Maqbali

9. References:

Title of book/ journal/ articles/ Website	Author	Year of publication	Page
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Caregiving, Definition(s) https://workfamily.sas.upenn.edu/glossary/c/caregiving-definitions	Work and Family researchers Network (WFRN)	no date	
Evaluation of three commonly used pressure ulcer risk assessment scales. British Journal of Nursing, 20, pp. 27– 28.)	Claire O'Tuathail and Rebecca Taqi	2011	
Pressure ulcers: prevention and management of pressure ulcers.	National Institute for Clinical Excellence (NICE)	2014	
Pressure Ulcer Treatment Quick Reference Guide http://www.epuap.org/guidelines/Final_Quick_Treatment.pd	National Pressure Ulcer Advisory Panel / European Pressure Ulcer Advisory Panel	2010	
Pressure Ulcer Prevention and Managing Skin Integrity https://www.mnhospitals.org/Portals/0/Documents/ptsafety/skin/pu-prevention-policy.pdf)	Minnesota Hospital Association Health East Hospitals		
Pressure ulcer stages/categories http://www.npuap.org/wp-content/uploads/2012/01/NPUAP-Pressure-Ulcer-Stages-Categories.pdf	National Pressure Ulcer Advisory Panel (NPUAP)	2007	

Appendix 1: Pressure Ulcer Grading Scale

Pressure Ulcer Grading Pressure ulcers are graded using the EPUAP (**European Pressure Ulcer Advisory panel)** grading scale.
Grade 1
Non blanchable erythema of intact skin. Discoloration of the skin, warmth, oedema induration or hardness may also be used as indicators, particularly on individuals with darker skin.
Grade 2
Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.
Grade 3
Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through to fascia.
Grade 4
Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.
□ If hard necrotic eschar is covering the pressure ulcer then this is unstageable until the eschar is removed. Therefore treat as grade 4 until grading can be carried out.
□ If the lesion is deep purple discoloration and the skin is intact then this is usually a sign of deep tissue injury. It is unstageable but are treated as a grade 4.
□ Reverse grading are not undertaken as the pressure ulcer heals.
□ Topical management of all pressure ulcers should be managed by following the wound care formulary.

Appendix 2: Braden Scale – For Predicting Pressure Risk

Date:					Score
Sensory Perception - Ability to respond meaningfully to pressure related discomfort	**1.Completely Limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	**2.Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	**3.Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4.No Impairment** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort	
Moisture - Degree to which skin is exposed to moisture	**1.Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient/ client is moved or turned.	**2.Very Moist** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3.Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4.Rarely moist** Skin is usually dry. Linen only requires changing at routine intervals.	
Activity - Degree of physical activity	**1.Bedfast** Confined to bed	**2.Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4.Walks Frequently** Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	
Mobility - Ability to change and control body position	**12. 1.Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2.Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3.Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4.No Limitations** Makes major and frequent changes in position without assistance.	

Nutrition - Usual food intake pattern	**1.Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV's for more than 5 days	**2.Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	**3.Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4.Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	
Friction and Shear	**1.Problem** Requires moderate to maximum assistance in moving.	**2.Potential Problem** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.	**13. 3.No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		
Patient with a total score of 16 or less are considered at risk: **Total Score** **15-16 = low risk, 13-14 = moderate risk, 12 or less = high risk.**					

Appendix 3: Pressure Ulcer -Prevention Compliance Assessment Tool

Hospital: _____ **Ward:** _____ **Date:** _____

Patient No.	Assessment form available in patient file	All element in the assessment form are filled	Assessment conducted within 2 hours of admission	Pressure Ulcer risk score documented in nursing notes	If patient at risk, skin inspection is conducted every shift	If patient at risk preventive care plan is documented	Appropriate preventive measures are available	Pressure Ulcer risk score is communicated in clinical handover	If patient with PU requires long term care, is communicated with discharge team and PHC		Total		Compliance Rate %
											Yes	No	
1st											0	0	0%
2nd											0	0	0%
3rd											0	0	0%
4th											0	0	0%
5th											0	0	0%
6th											0	0	0%
7th											0	0	0%
8th											0	0	0%
9th											0	0	0%
10th											0	0	0%
Total=Yes	0	0	0	0	0	0	0	0	0		0	0	
Total=No	0	0	0	0	0	0	0	0	0				