Institution Name: Al Masarra Hospital

Document Title: Policy and Procedure of Prevention and Management of Pressure Ulcer

Approval Process

	Name	Title / Designation	Institution	Date	Signature
Written by	Aida Ibrahim Al Balushi	Unit Nurse	Al Masarra Hospital	25.1.23	
Reviewed by	Khadija Al Balushi	Nurse Specialist	Al Masarra Hospital	26.1.23	
Validated by	Kunooz Al Balushi	Document Manager	Al Masarra Hospital	January 2023	
Approved by	Dr. Bader Al Habsi	Executive Director	Al Masarra Hospital	Jan 2023	

Content Table:

Acronyms:

AMRH	Al Masarra Hospital
IRLS	Incident Reporting and Learning System
MOH	Ministry of Health
P&P	Policy and Procedure
RCA	Root Cause Analysis
SBAR	Situation, Background, Assessment, Recommendation
SOP	Standard Operating Procedure
Vers.	Version

Policy and Procedure of Prevention and Management of Pressure Ulcer

1. Introduction

This policy provides a framework for the prevention and treatment of pressure ulcers for inpatients of Al Masarra Hospital (AMRH). This is in light of the national focus on improving patient safety and patient experience, and reducing avoidable harm to clients.

2. Scope

This document covers all clients who are admitted in Al Masarra Hospital (AMRH) and to all employees who work directly with inpatients and who has an impact upon welfare of patients at risk of pressure ulcers.

3. Purpose

3.1 To guide nurses in the prevention and management of pressure ulcers for all client who are at risk of pressure ulcers.

3.2 To maintain skin integrity and prevent the formation of bed sores.

3.3 To promote/facilitate healing process by minimizing the pressure on the affected area.

4. Definitions

4.1 **Braden Assessment:**a scale used to help health professionals, especially the nurse to assess a patient risk of developing a pressure ulcerand categories the pressure based on stages.*(See Appendix 1. Pressure Ulcer Assessment Scale (Braden scale))*

4.2 **Decubitus Ulcer:** The terms "Decubitus ulcer" or "Pressure sore" or "pressure ulcer" are used to describe any area of damage to the skin or underlying tissues caused by direct pressure or shearing forces. The extent of this damage can range from persistent erythematic to necrotic ulceration involving muscle, tendon and bone.

4.3 **Norton Assessment:**a scale used to predict the likelihood a client will develop pressure ulcers. The client is rated from 1 (low risk) to 4 (high risk) using the following five

criteria: physical condition, mental condition, activity, mobility, and incontinence.*(See Appendix 2. Norton Pressure Sore Risk-Assessment Scale Scoring System)*

4.4 **Skin Inspection**: from head to toe evaluation of bony prominences and skin folds/creases when prolonged pressure may result in skin breakdown.

5. Policy

5.1 Al Masarra Hospital iscommitted to providing consistent, evidence based quality care in the prevention, management and treatment of pressure ulcers for all patients. This will incorporate a holistic assessment and demonstrate patient/carer involvement in the care provided.

6. Procedure

6.1 Prevention of Pressure Ulcers

6.1.1 Identifying Clients at Risk

6.1.1 When the client is admitted in inpatient department, the nurse should identify the risk for pressure ulcer development based on the patient's clinical presentation and consideration of the risk factors.

6.1.2 Clients at risk include those who are seriously mentally ill:

6.1.2.1 Catatonic

6.1.2.2 Severely depressed

6.1.2.3 Geriatric clients

6.1.2.3.1 Geriatric or older adults are at high risk for pressure ulcer development because their skin is fragile, they have reduced sensations to pressure, they are commonly in a poor nutritional state, and they have a high prevalence of conditions that cause them to be immobile and edematous.

6.1.2.4 Pregnant clients

6.1.2.5 Neurologically compromised, such as, individuals with spinal cord injuries

6.1.2.6 Have impaired mobility or who are immobile (including those wearing a prosthesis, body brace or plaster cast)

6.1.2.7 Who suffer from impaired nutrition, obesity, poor posture

6.1.2.8 Use of equipment such as seating or beds, which do not provide appropriate pressure relief

6.1.3 The timing of a risk assessment must be based on the needs of the individual patient. However, it must take place within six hours of the start of admission to the episode of care or transfer to a new ward.

6.1.4 It must be recognized that in some situations e.g. geriatric care risk assessment should be carried out immediately so as not to delay appropriate prevention measures being put in place.

6.2 Reassessment and Skin Inspection

6.2.1 Nurses should reassess clients' skin every time that there is a change in the patient's condition that increases or decreases the patient's risk of developing pressure ulcers.

6.2.2 It is expected that nurses discovering changes in the clients' skin or overall condition that affect their risk of skin breakdown will make an immediate assessment of changes required to that clients' care and implement any indicated changes as soon as is practicably possible in order to prevent any further deterioration.

6.2.3 It is expected that on initial inspection, all dressings will be removed and all areas will be assessed.

6.2.4 Where areas cannot be accessed, the reason for this lack of access must be clearly documented so that it is evident which areas were not assessed.

6.2.5 A patient who has capacity may decline skin inspection. This refusal must be clearly documented.

6.2.6 Clients who do not have capacity may require their skin to be inspected as part of their overall risk assessment and this must be discussed with the consultant in the

assessment in the patient's best interest, and consent to be obtained before this is undertaken.

6.2.7 A patient with pressure ulcers, the nurse must undertake a formal risk assessment (**Norton assessment**) and develop nursing care plan for pressure ulcer prevention and management. *(See Appendix 2. Norton Pressure Sore Risk-Assessment Scale Scoring System)*

6.2.8 The nurse should notify the physician of pertinent abnormal observations and document interventions used to prevent/manage pressure ulcer.

6.3 Management of Pressure Ulcers

6.3.1 A pressure ulcer can develop when pressure on an area of skin increases, temporarily cutting off circulation to the affected area and leading to tissue death. Besides pressure and shearing force, factors that contribute to pressure ulcer development include:

6.3.1.1 moisture

6.3.2.2 friction

6.3.3.3 immobility

6.3.4.4 sensory loss

6.3.5.5 certain underlying medical conditions

6.3.2 Areas over bony prominences are at particular risk for developing pressure ulcers, because the skin in these areas is less vascular. Such areas include:

6.3.2.1 occiput

6.3.2.2 acromion process

6.3.2.3 scapula

6.3.2.4 vertebrae

6.3.2.5 sacrum

6.3.2.6 coccyx

6.3.2.7 ischial tuberosities

6.3.2.8 condyles

6.3.2.9 malleolus

6.3.2.10 calcaneus

6.3.3 If the client developed pressure ulcer, the following nursing intervention to be carried out:

6.3.3.1 Assess the area to provide appropriate data baseline information on which to base care and treatment. Use formal risk assessment for pressure ulcer staging. *(Appendix 1. Pressure Ulcer Assessment Scale (Braden scale))*

6.3.3.2 Explain the procedure to the client to promote health education.

6.3.3.3 Wash and dry hands to prevent cross contamination. *(Refer to Policy and Procedure of Hand Hygiene- AMRH/IC/P&P/006/Vers.01)*

6.3.3.4 Ensure privacy to avoid unnecessary embarrassment during the procedure.

6.3.3.5 Do not rub any broken skin to prevent maceration and degeneration of subcutaneous tissues especially in the elderly which may contribute to infection.

6.3.3.6 Wash the areas at risk if the client is incontinent or sweating profusely, use mild soaped liquid detergent.

6.3.3.7 Ensure soap/detergent is rinsed and the area is dry, use moisture cream if the area is very dry.

6.3.3.8 Assess patient physical activity level, **If the patient is mobile and able to reposition themselves:**

6.3.3.8.1 Educate patient to change position 2-4 hours when in bed and at least hourly when seated to encourage active participation of the client in his own care.

6.3.3.8.2 Educate the patient to pull or push up regularly to examine the vulnerable areas, and record risk assessment every 48 hours.

6.3.3.8.3 Document the care in the nursing note in the Al Shifa 3+ system.

6.3.3.9 **If the patient is immobile and unable to reposition themselves**:

6.3.3.9.1 Turn the client at least two (2) hourly, and record the position in nursing note in the Al Shifa 3+ system.

6.3.3.9.2 Initiate a mobility programme. Refer to the physiotherapist as appropriate.

6.3.3.9.3 Use pressure reliever bed matters as appropriate.

6.3.3.9.4 If there is a wound, perform dressing.

6.3.3.9.5 Maintain and review nutritional status when appropriate.

7. Responsibilities

7.1 Assigned Staff Nurse Shall:

7.1.1 Ensurethat the Norton risk assessment is completed and documented in the patient notes upon admission.

7.1.2 Ensure that the results of the assessments are communicated to other persons who have a need to know the outcome and any action that needs to be taken using SBAR communication tool.

7.1.3 Keep up to date with latest guidance on the management of clients at risk of pressure ulcers or with actual skin breakdown.

7.1.4 Report pressure ulcers or moisture lesions using event registration system in Al Shifa 3+ system.

7.1.5 Identify any gaps in their knowledge and seek the appropriate training, education and support to address these deficits.

7.2 Ward/ Shift in-charge Nurse Shall:

7.2.1 Ensure staff are competent to carry out the risk assessments and manage skin integrity.

7.2.2 Ensure the policy is maintained in practice through the monitoring and auditing of the key recommendations of the policy.

7.2.3 Ensure monitoring and audit is completed.

7.2.4 Ensure pressure ulcers and moisture lesions are appropriately reported using the Incident Reporting and Learning System (IRLS).

7.2.5 Undertake and participate in Root Cause Analysis (RCA) investigations when clients develop pressure ulcers.

7.3 **HOD of Nursing Affairs Shall:**

7.3.1 Ensure staffs are advised of the policy and any of its revision and new development.

7.3.2 Ensure the policy is implemented and monitored.

7.4 **SHO of caring psychiatry unit/First on-call psychiatry/First on-call Physician Shall:**

7.4.1 Be approachable and answerable to the calls and respond properly on time.

7.5 **Quality Management and Patient Safety Department Shall:**

7.5.1 Ensure the key recommendations of the policy are followed.

7.5.2 Overseeserious incidents requiring investigations.

8. Document History and Version Control Table

Document History and Version Control			
Version	**Description of Amendment**	**Author**	**Review Date**
02	Initial Release	Aida Ibrahim Al Balushi	January 2021

Written by	**Reviewed by**	**Approved by**
Aida Ibrahim Al Balushi	Khadija Al Balushi	Dr. Mohammed Al Balushi

9. Related Documents

9.1 Appendix 1. Pressure Ulcer Assessment Scale (Braden scale).

9.2 Appendix 2. Norton Pressure Sore Risk-Assessment Scale Scoring System.

9.3 Appendix 3. Flowchart of Prevention and Management of Pressure Ulcer.

9.4 Appendix 4. Audit Tool.

9.5 Appendix 5. Document Request Form.

9.6 Appendix 6. Document Validation Checklist.

10. Reference

Title of book/journal/articles/website	Author	Year of Publication	Page
General Nursing Procedure Manual	MOH	1999	Section 31 P.P (2-2)
Pressure Ulcer Prevention	MOH Nursing Protocol Adapted for use by DGNA from Lippincott	2015	1-19
• Pressure Ulcer Prevention, Long-term Care • Pressure Ulcer Management, Long-term Care	MOH Nursing Protocol Adapted for use by DGNA from Lippincott	2015	1-16 1-16
Pressure Ulcer Prevention And Management Policy	Isle of Wight NHS	2015	1-28
Skin Safety Protocol; Risk Assessment and Prevention of Pressure Ulcers	Institute for Clinical System Improvement Guidelines	2007	1-3
Prevention and Management of Pressure Ulcers	Wound Ostomy Continence Nurses Society Clinical Practice Guideline	2007	1-3

11. Appendices

11.1 Appendix 1. Pressure Ulcer Assessment Scale (Braden scale)

Pressure ulcer staging reflects the depth and extent of tissue involvement. The classification system developed by the National Pressure Ulcer Advisory Panel is the most widely used system and categorizes pressure ulcers into four stages and two additional categories—suspected deep tissue injury and unstageable pressure ulcers.	
Stage I	Stage I ulcers are characterized by intact skin with non-blanchable redness of a localized area, usually over a bony prominence. The area may be warmer or cooler than adjacent tissue or painful and firm or soft. Darkly pigmented skin may not have visible blanching, but its color and temperature may differ from the surrounding area.
Stage II	A stage II pressure ulcer is characterized by partial-thickness loss of the dermis, presenting as a shallow, open ulcer with a red-pink wound bed without slough. It may also present as an intact or open serum-filled blister. This stage shouldn't describe skin tears, tape burns, excoriation, perineal dermatitis, or maceration.
Stage III	A stage III pressure ulcer is characterized by full-thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, and muscle aren't exposed. Slough may be present but doesn't obscure the depth of tissue loss. Undermining and tunneling may be present. The depth of a stage III ulcer varies by anatomic location.
Stage IV	A stage IV pressure ulcer involves full-thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Undermining and tunneling are also common. The depth of a stage IV ulcer varies by anatomic location.
Suspected deep tissue injury	Deep tissue injury is characterized by a purple or maroon localized area of intact skin or blood-filled blister caused by damage of underlying soft tissue from pressure or shear. It may be preceded by tissue that's painful, firm, mushy, boggy, or warm or cool compared to adjacent tissue. The depth of the suspected deep tissue injury is unknown. It may be difficult to detect in individuals with dark skin tones. It may initially appear as a thin blister over a dark wound bed.
An unstageable	An unstageable ulcer is characterized by full-thickness tissue loss in which the base of the ulcer in the wound bed is covered by slough, eschar, or both. Until you can remove enough slough or eschar to expose the base of the wound, you can't determine the true depth and, therefore, stage.

11.2 **Appendix 2. Norton Pressure Sore Risk-Assessment Scale Scoring System**

The Norton Pressure Sore Risk-Assessment Scale Scoring System

The **Norton Scoring system**, shown below, and created in England in 1962, has been the first pressure sore risk evaluation scale to be created, back in 1962, and for this it is now criticized in the wake of the results of modern research. Its ease of use, however, makes it still widely used today.

To evaluate the Norton Rating for a certain patient look at the tables below and add up the values beside each parameter which apply to the patient. The total sum is the Norton Rating (NR) for that patient and may vary from 20 (minimum risk) to 5 (maximum risk).

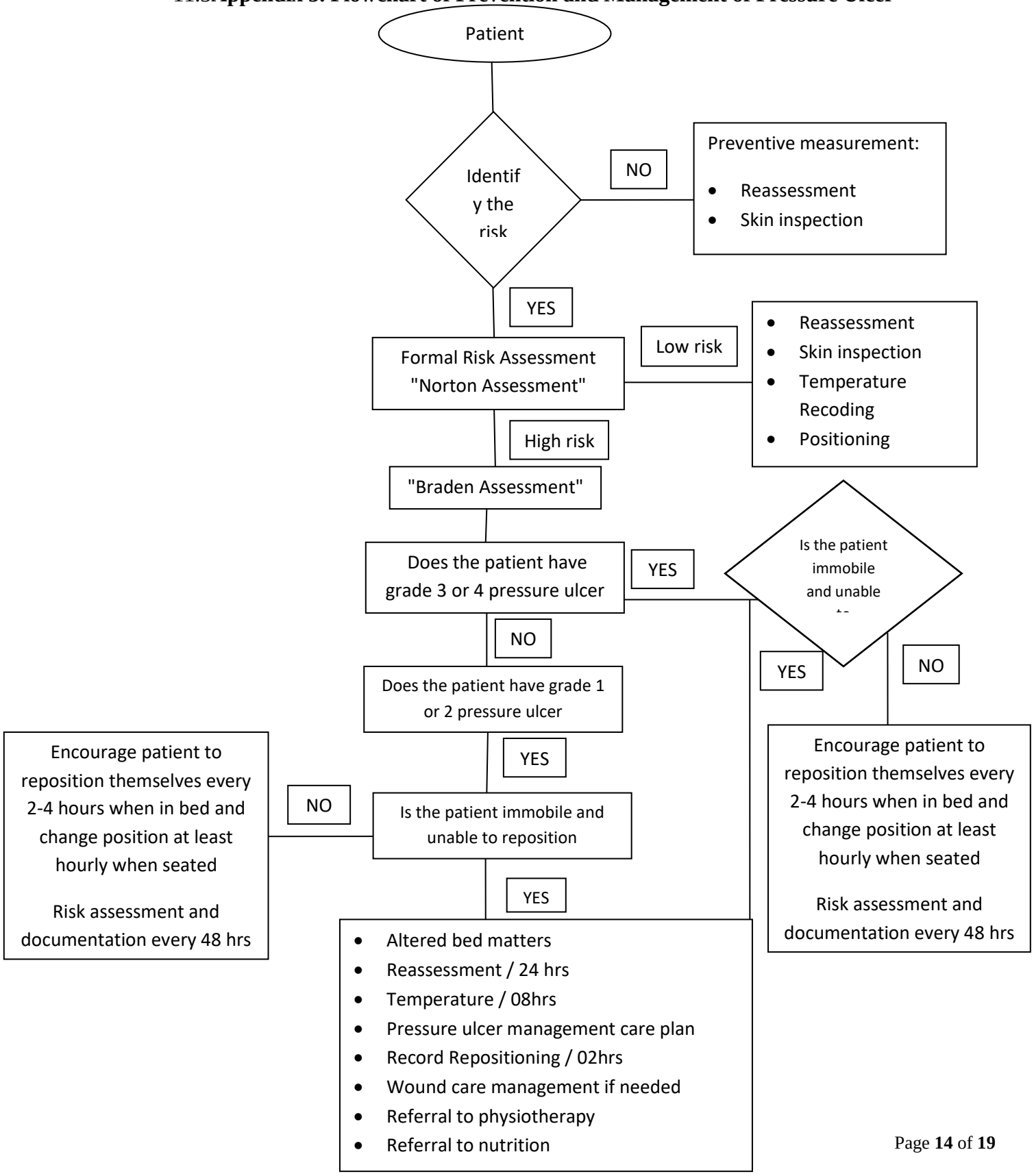
(Indicatively, a Norton Rating below 9 means Very High Risk, 10 to 13 means High Risk, 14 to 17 medium risk and above 18 means low risk)

Physical Condition	Good	4
	Fair	3
	Poor	2
	Very Bad	1
Mental Condition	Alert	4
	Apathetic	3
	Confused	2
	Stuporous	1
Activity	Ambulant	4
	Walks with help	3
	Chairbound	2
	Bedfast	1
Mobility	Full	4
	Slightly Impaired	3
	Very Limited	2
	Immobile	1
Incontinence	None	4
	Occasional	3
	Usually Urinary	2
	Urinary and Fecal	1

Generally, the risk factor is coded this way:

Greater than 18	Low Risk
Between 18 and 14	Medium risk
Between 14 and 10	High Risk
Lesser than 10	Very High Risk

11.3Appendix 3. Flowchart of Prevention and Management of Pressure Ulcer



11.4 Appendix 4. Audit Tool

Department: _____ **Date: _____**

S.N.	Audit Process	Standard / Criteria	Yes	Partial	No	N/A	Comment
1	Interview Document Review	Did the nurse identify the client for pressure ulcer development based on the patient's clinical presentation and consideration of the risk factors?					
2	Document Review	Is the risk assessment carried out within six hours of the start of admission to the episode of care or transfer to a new ward?					
3	Document Review	Does the nurse use formal risk assessment and develop a clear nursing care plan for pressure ulcer prevention and management when the patient was discovered with pressure ulcers?					
4	Interview Document Review	Are the results of the assessments communicated to other persons who have a need to know the outcome and any action that needs to be taken using SBAR communication tool?					
5	Observation Interview	Is hand hygiene proceduredone before and after assessment and management of pressure ulcer to prevent cross contamination?					

6	Observation Document Review	Is privacy ensured to avoid unnecessary embarrassment during the procedure?					
7	Observation Interview Document Review	**If the patient is mobile and able to reposition himself/herself:** 1. Is education provided to patient to change position 2-4 hours when in bed and at least hourly when seated to encourage active participation of the client in his own care? 2. Is education provided to the patient to pull or push up regularly to examine the vulnerable areas, and record risk assessment every 48 hours? 3. Is the documentation of the care done in nursing notes?					
8	Observation Interview Document Review	**If the patient is immobile and unable to reposition himself/herself:** **1.** Is the client turned at least two hourly, and the position is recorded in the nursing notes? **2.** Is a mobility programme initiated?(Refer to physiotherapist as appropriate.) **3.** Is a pressure reliever bed matters used appropriately? **4.** Is wound dressing performed if there is a wound?					

9	Interview	Are pressure ulcers or moisture lesions reported using event registration system in Al Shifa 3+ system?					

Audit Process:

1. Observation
2. Interview
3. Document Review

11.5 Appendix 5. Document Request Form

Document Request Form

Section A: Completed by Document Requester

1. Requester Details

Name	Aida Ibrahim Al Balushi	Date of Request	January 2023
Institute	Al Masarra Hospital	Mobile	—
Department	Nursing Department	Email	—

The Purpose of Request

☐ Develop New Document	☑ Modification of Document	☐ Cancelling of Document

1. Document Information

Document Title	Policy and Procedure of Prevention and Management of Pressure Ulcer
Document Code	AMRH/NSG/P&P/004/Vers.02

Section B: Completed by Document Controller

☑ Approved	☐ Cancelled	☐ Forward To:……..

Comment and Recommendation: Proceed with the document

Name	Kunooz Al Balushi	Date	January 2018
Signature	Kunooz	Stamp	

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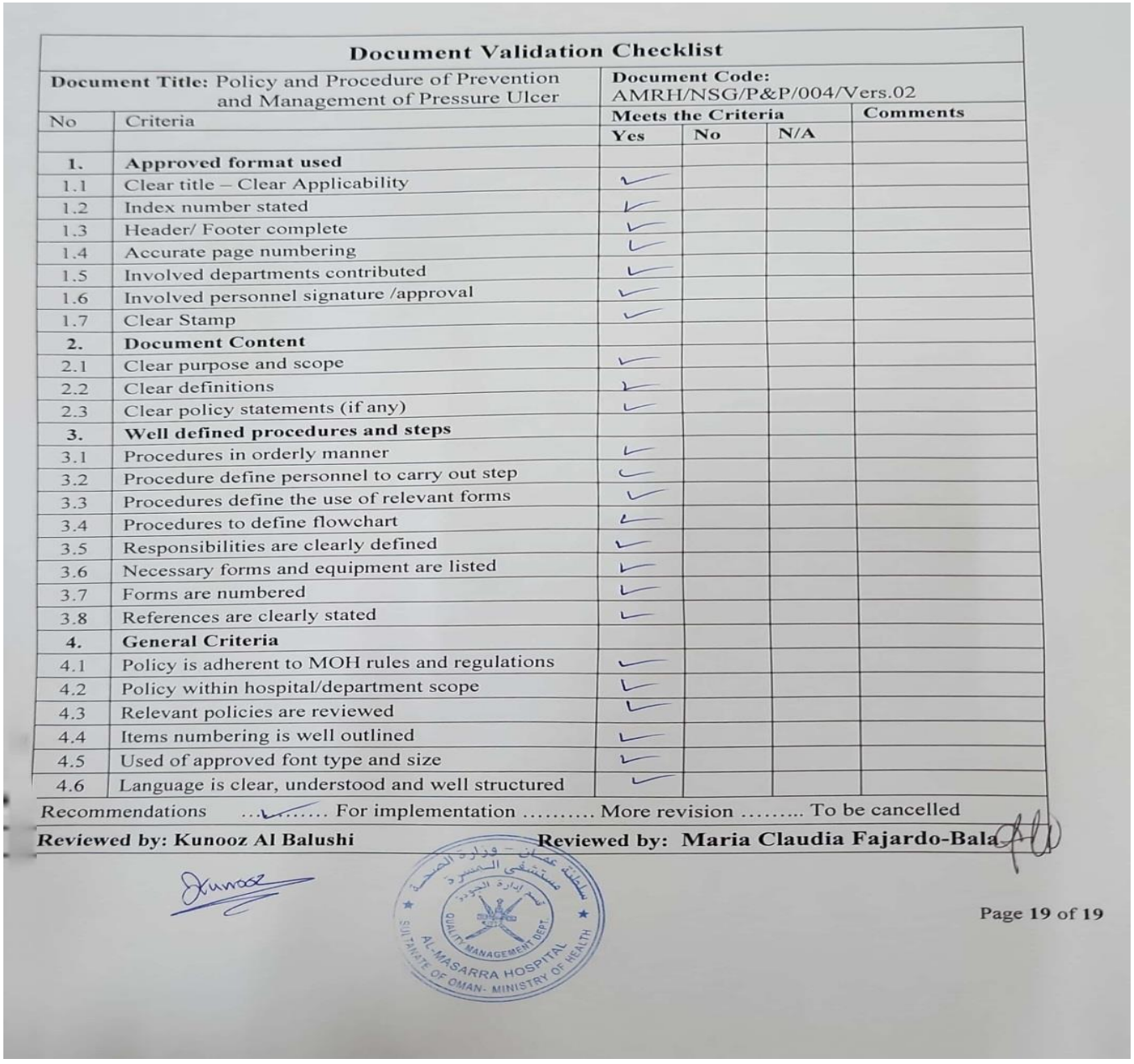
11.6 Appendix 6. Document Validation Checklist



Document Validation Checklist

Document Title: Policy and Procedure of Prevention and Management of Pressure Ulcer		**Document Code:** AMRH/NSG/P&P/004/Vers.02			
No	Criteria	**Meets the Criteria**			**Comments**
		Yes	**No**	**N/A**	
1.	**Approved format used**				
1.1	Clear title – Clear Applicability	✓			
1.2	Index number stated	✓			
1.3	Header/ Footer complete	✓			
1.4	Accurate page numbering	✓			
1.5	Involved departments contributed	✓			
1.6	Involved personnel signature /approval	✓			
1.7	Clear Stamp	✓			
2.	**Document Content**				
2.1	Clear purpose and scope	✓			
2.2	Clear definitions	✓			
2.3	Clear policy statements (if any)	✓			
3.	**Well defined procedures and steps**				
3.1	Procedures in orderly manner	✓			
3.2	Procedure define personnel to carry out step	✓			
3.3	Procedures define the use of relevant forms	✓			
3.4	Procedures to define flowchart	✓			
3.5	Responsibilities are clearly defined	✓			
3.6	Necessary forms and equipment are listed	✓			
3.7	Forms are numbered	✓			
3.8	References are clearly stated	✓			
4.	**General Criteria**				
4.1	Policy is adherent to MOH rules and regulations	✓			
4.2	Policy within hospital/department scope	✓			
4.3	Relevant policies are reviewed	✓			
4.4	Items numbering is well outlined	✓			
4.5	Used of approved font type and size	✓			
4.6	Language is clear, understood and well structured	✓			

Recommendations ..✓..... For implementation ..... More revision ..... To be cancelled

***Reviewed by:* Kunooz Al Balushi** **Reviewed by: Maria Claudia Fajardo-Bala**

AL-MASARRA HOSPITAL QUALITY MANAGEMENT DEPT. SULTANATE OF OMAN- MINISTRY OF HEALTH

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