1. PURPOSE
   • To provide guidelines to determine the neonatal and pediatric patient’s risk of developing pressure ulcers (PU) following a skin assessment and the use of a risk assessment tool.
   • To ensure proper documentation of skin and risk assessments for all hospitalized neonatal and pediatric patients.
   • To support decision-making and interventions that will (a) reduce the risk(s) associated with developing a pressure ulcer and (b) lead to early identification of hospital and non-hospital acquired pressure ulcers.

2. PROFESSIONALS
   Nurses and licensed practical nurses (LPNs) who have reviewed this protocol while working within the limits of their professional roles and responsibilities at the Montreal Children’s Hospital.

   Patient care attendants working in collaboration with the nurse and LPN.

3. PATIENT POPULATION
   This protocol pertains to all pediatric and neonatal patients hospitalized at the Montreal Children’s Hospital.

4. ELEMENTS OF CLINICAL ACTIVITY
   Professionals are responsible to know the limits and extent of their practice as related to risk assessment and prevention of pressure ulcers.
Procedure:

Skin Assessment

1. The nurse or the LPN working in collaboration with the nurse will ensure that a thorough head-to-toe skin assessment is done on every patient:
   - Within 24 hours of admission or transfer
   - Daily

   Note: Patient Care Attendants: will report any changes noted in the patient’s skin (i.e. redness, broken skin or suspected skin injury) to the nurse/LPN caring for the patient.

2. Skin Assessments should include the verification of all skin surfaces, including:
   - Skin under orthotics, prosthetics, splints, mobility devices (e.g. wheelchairs), and medical equipment (tubes/drains, IV catheters, cervical collars and airway devices required for non-invasive ventilation, tracheostomy, etc.) non-invasive ventilation
   - ALL pressure points
      - Infants and young children:
        - Occipital region
        - Sacral region
        - Ears
        - Calcaneous (heel of the foot)
      - Older children:
        - Sacrum/coccyx
        - Heels
        - Elbows
        - Shoulder blades
        - Lateral malleolus
        - Greater trochanter of the femur
        - Ischial tuberosities

3. Documentation: Skin assessments will be documented in the patient’s chart and in the Plan Therapeutic Infirmier/Therapeutic Nursing Plan.
   - The nurse will document the PU risk in the Plan Therapeutic Infirmier/Therapeutic Nursing Plan (Refer to “Pressure Ulcer Risk Assessment” below)
     - Under ‘Priority Problem or Need’, indicate: “At risk for pressure ulcer (Braden/BradenQ/NSRAS score = ___)”.
   - The nurse or the LPN working in collaboration with the nurse documents a skin assessment, where the words “skin intact” indicate that a thorough skin assessment was carried out, and that:
     - There is no presence of redness over bony prominences (pressure points) or areas of friction and shear.
     - Assessment of surgical wounds or incisions should be documented separately

   Note: When charting by exception, a checkmark for skin assessment indicates that a skin assessment was done and skin is intact.

Pressure Ulcer Risk Assessment:

1. The nurse or the LPN working in collaboration with the nurse assesses and documents the risk of developing a PU by completing the appropriate PU risk assessment tool as described in Table 1 and Appendix 1.
2. The nurse and the LPN working in collaboration with the nurse initiates the most relevant interventions based on patient population (Refer to Appendix 2, 3 & 4).

**Note:** Long-term care patients (Length of stay greater than 21 days with non-acute care requirements) require pressure ulcer risk assessment monthly after initial assessment unless their condition changes.

3. The nurse will document the PU risk in the Plan Therapeutic Infirmier/Therapeutic Nursing Plan (Refer to “Documentation” above).

### Table 1: Pediatric and Neonatal Risk Assessment Tools

<table>
<thead>
<tr>
<th>Risk Assessment Tool</th>
<th>Age Range</th>
<th>Level of Risk</th>
<th>Frequency of Risk Assessment</th>
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<tbody>
<tr>
<td>Neonatal Skin Risk Assessment Scale (NSRAS) NICU only</td>
<td>26 to 40 weeks gestation</td>
<td>At risk: Score greater than or equal to 13</td>
<td>Within 24 hours of admission or transfer. When patient’s condition changes. Every 72 hours for at risk patients.</td>
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<td>Braden Q</td>
<td>Term neonate to 8 years old</td>
<td>At risk: Score less than or equal to 15</td>
<td>Within 24 hours of admission or transfer. When patient’s condition changes. Every 72 hours for at risk patients.</td>
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<td>Braden</td>
<td>Greater than or equal to 8 years old</td>
<td>At risk: Score less than or equal to 14</td>
<td>Within 24 hours of admission or transfer. When change in condition. Every 72 hours for at risk patients.</td>
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<tr>
<td>Braden Q + P Pediatric Operating Room only</td>
<td>For ALL patients in the operating room for a duration greater than 2 hours if no risk assessment tool was previously completed</td>
<td>Not applicable</td>
<td>Not applicable</td>
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**MAIN AUTHOR:**
Nadine Vandal, MCH Wound and Ostomy Nurse Clinician

**CONSULTANTS:**
Stéphanie Lepage, NPDE pediatric surgery
Elissa Remmer, NPDE NICU
Linda Massé, APN PICU
Antonietta Carriero, NPDE pediatric OR
Eren Alexander, Nursing Coordinator
5. APPROVAL PROCESS

Institutional and professional approval

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<thead>
<tr>
<th>Committees</th>
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<td>☑ Clinical Practice Review Committee (CPRC) (if applicable)</td>
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<td>□ Adult Pharmacy and Therapeutics (P&amp;T) (if applicable)</td>
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6. REVIEW DATE

To be updated in maximum of 4 years or sooner if presence of new evidence or need for practice change.

7. REFERENCES


MUHC ALGORITHM


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<td>No 1</td>
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<td>Eren Alexander Nursing Coordinator</td>
<td>2017-10-05</td>
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