PRESSURE ULCER INCIDENT REVIEW REPORT

CONFIDENTIAL

Date of Incident	
NIMS Reference Number	
Acute Hospital/Community Service	
Review Commissioner	
Lead Reviewer	
Date Report Completed	

INTRODUCTION
Click here to enter text.

DETAILS OF SERVICE USER AND PRESSURE ULCER			
Background Click here to enter text.			
Date of Admission/ First Contact		Date of first observation of Pressure Ulcer/s :	
Reason for Admission/Referral			
Total number Stage III Pressure Ulcers present		Total number Stage IV Pressure Ulcers present	
Tick the specific anatomical site(s) AND state category/stage of each pressure ulcer at each site			
Sacrum	Left Buttock	Left Hip	Ears
Left heel	Right Buttock	Right Hip	Other (state site)
Right heel	Scalp	Spine	
Actions Taken by the Service since the Pressure Ulcer was identified and prior to this review. Enter text here			
Involvement of the Service User/Family since the identification of the pressure ulcer: Enter text here		Open Disclosure ❑ Key Liaison Service user Select	

ISSUES RELATING TO THE SERVICE USER		
Did the service user have any of the following risk factors for pressure ulcer development prior to the initial observation of the pressure ulcer?		
Sensory impairment (neurological disease resulting in reduced sensation and insensitivity to pain	**Yes** ❑	**No** ❑
Reduced level of consciousness	**Yes** ❑	**No** ❑
Deterioration in service users condition whereby the service user may have been hypotensive, hypothermic, hypoxic, pyrexia, septic etc.	**Yes** ❑	**No** ❑
Has the service user had a period of prolonged collapse / injury / immobilisation prior to presentation to hospital which may correlate with presentation of tissue damage?	**Yes** ❑	**No** ❑
Severe chronic or terminal illness (multi-organ failure, poor perfusion and immobility)	**Yes** ❑	**No** ❑
Previous history of a pressure ulcer at site of current pressure ulcer ulceration	**Yes** ❑	**No** ❑
Diagnosed or suspected Peripheral Vascular Disease	**Yes** ❑	**No** ❑
Sustained pressure from medical related device e.g. from orthopaedic casting, tubing etc	**Yes** ❑	**No** ❑

Was the service user a) fully mobile, b) limited movement dependant on others, c) bed bound d) chair bound?			Enter a, b, c or d
Has the service user had a period of prolonged collapse/injury/immobilisation which may correlate with presentation of tissue damage?	**Yes ❑**		**No ❑**
Is the service user unable to maintain position?	**Yes ❑**	**No ❑**	**N/A ❑**
Has the service user declined repositioning?	**Yes ❑**	**No ❑**	**N/A ❑**
Is the service user unable to be repositioned satisfactorily due to medical condition e.g. fractures, respiratory disease, spinal precautions, pain etc.?	**Yes ❑**		**No ❑**
Was the service user a) fully continent, b) urinary incontinence only, c) urine and faecal incontinence or d) catheterised and faecal incontinence?			Enter a, b, c or d
Does the service user have Moisture Associated Skin Damage?	**Yes ❑**		**No ❑**
Has the service user a body weight BMI <20 or BMI > 35?	**Yes ❑**		**No ❑**
Based on the above assessment, identify any areas where improvement is required.			

ISSUES RELATING TO THE ENVIRONMENT & EQUIPMENT

Was all equipment identified as required to prevent pressure ulcer prevention available and in use?

Equipment	Indicated		Type	Date Ordered	Date Available	In use at time PU identified?	
Mattress	**Yes ❑**	**No ❑**				**Yes ❑**	**No ❑**
Cushion	**Yes ❑**	**No ❑**				**Yes ❑**	**No ❑**
Heel Protectors	**Yes ❑**	**No ❑**				**Yes ❑**	**No ❑**

Based on the above assessment, identify any areas where improvement is required.

ISSUES RELATING TO STAFFING

What is the approved staffing and skill mix on the ward/unit? *(applicable to hospitals and residential units only)*	Nurse: Enter No.	HCA: Enter No.	Student: Enter No.
If a hospital/residential unit, what is the bed capacity for the ward/unit?			Select
Have there been any issues in relation to staffing/skill mix in the past week that have impacted on the provision of pressure ulcer prevention interventions required by this service user?		**Yes ❑**	**No ❑**
Based on the above assessment, identify any areas where improvement is required.			

ISSUES RELATING TO TASK & TEAM			
TASK			
Is there documented evidence that skin was inspected within 6 hours **of presentation** to Emergency Department, admission to the ward or on **first** community visit?	**Yes** ❑	**No** ❑	
Was a pressure ulcer risk assessment carried out within 6 hours **of presentation** to the Emergency Department, admission to the ward or on **first** community home visit?	**Yes** ❑	**No** ❑	
What risk assessment scoring system was used e.g. Waterlow, Braden/Other?	Enter name		
What was the pressure ulcer risk assessment score on admission?	Enter Score		
Was there evidence of on-going pressure ulcer risk assessment prior to the development of the pressure ulcer?			
What was the pressure ulcer risk assessment score on the date the pressure ulcer was identified?	Enter Score		
Was there evidence that a pressure ulcer prevention plan was in place (e.g. SSKIN bundle or specific pressure ulcer care plan?	**Yes** ❑	**No** ❑	
Is there evidence that the pressure ulcer prevention plan in place (e.g. SSKIN bundle or specific pressure ulcer care plan**)** was completed in full as appropriate to the date the service user was assessed as 'at risk'.	**Yes** ❑	**No** ❑	
Was the frequency of skin inspection stated on the care plan?	**Yes** ❑	**No** ❑	
Was a wound assessment chart documenting the pressure ulcer assessment and management plan completed?	**Yes** ❑	**No** ❑	
What date was the first identification of skin damage documented in the nursing notes?	Enter date		
Has the service user been > 2 hours in Theatre up to 6 days prior to identification of the pressure ulcer?	**Yes** ❑	**No** ❑	
Was there evidence of on-going pressure ulcer risk assessment prior to the development of the pressure ulcer?	**Yes** ❑	**No** ❑	
If the service user was dependant, was there evidence of a written repositioning schedule when the service user was sitting/in bed?	**Yes** ❑	**No** ❑	**N/A** ❑
Was the frequency of repositioning appropriate to the risk identified?	**Yes** ❑	**No** ❑	
If the service user was incontinent. had the service user an elimination care plan in place?	**Yes** ❑	**No** ❑	
If the service user was incontinent Is there evidence that a skin cleanser and skin barrier protector were used as part of the skin care regimen?	**Yes** ❑	**No** ❑	
Did the service user have a nutritional risk assessment?	**Yes** ❑	**No** ❑	
Date nutritional risk assessment carried out.	Enter date		
If indicated from the nutritional risk assessment has the service user been offered nutritional support (such as fortified diet advice or supplements)?	**Yes** ❑	**No** ❑	**N/A** ❑

Was service user/carer information in relation to pressure ulcer prevention provided?	Yes ❑		No ❑
TEAM			
If available, was the TVN involved in the pressure ulcer management plan?	Yes ❑	No ❑	N/A ❑
Is there evidence that the medical team / GP were aware of the service user's elevated risk status for pressure damage/developing skin damage?	Yes ❑	No ❑	N/A ❑
If the service user had reduced mobility were they referred to physiotherapy for additional advice or mobility rehabilitation?	Yes ❑	No ❑	N/A ❑
If the service user had nutritional or feeding needs identified were they referred to the Dietician/ Speech & Language Therapist for additional advice / support?	Yes ❑	No ❑	N/A ❑
If the service user was identified as requiring specialist advice for seating/equipment were they referred to the Occupational Therapist?	Yes ❑	No ❑	N/A ❑
Was there evidence that the service user's family/carers were involved in the care plan and agreed with it?	Yes ❑		No ❑
Based on the above assessment, identify any areas where improvement is required.			
ISSUES RELATING TO POLICIES AND PROCEDURES			
Does the service have local a pressure ulcer prevention policy or equivalent in place?	Yes ❑		No ❑
If yes, is this accessible to all relevant staff?	Yes ❑		No ❑
Is this policy in line with current National Wound Care Guidelines?	Yes ❑		No ❑
Based on the above assessment, identify any areas where improvement is required.			
ISSUES RELATING TO STAFF TRAINING AND EDUCATION			
Is there evidence that all staff providing care in the ward/unit/home been trained in the pressure ulcer prevention polices of the service?	Yes ❑		No ❑
Based on the above assessment, identify any areas where improvement is required.			
ISSUES RELATING TO COMMUNICATION			
Is there documented evidence that the service user's pressure ulcer risk was communicated to the service user and their family?	Yes ❑		No ❑
Is there documented evidence that the service user's pressure ulcer risk was communicated to relevant staff?	Yes ❑		No ❑
Based on the above assessment, identify any areas where improvement is required.			

KEY CAUSAL FACTOR

This key causal factor best explains why this pressure ulcer occurred.
Failure to adequately or consistently apply one or more of the interventions required to avoid the development of a pressure ulcer i.e. a failure to ○ evaluate the service user's clinical condition and pressure ulcer risk factors and/or; ○ plan and implement interventions that are consistent with the service users' needs and goals, and recognised standards of practice and/or; ○ Monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. ***Note:*** *amend the KCF as appropriate to the case being reviewed e.g. if it was that there was good evidence that the service user's clinical condition and pressure ulcer risk factors were evaluated but the planning, implementation and monitoring of interventions were in deficit then you could delete the first bullet point.*

CONTRIBUTORY FACTORS
The contributory factors that relate to the key causal factor identified are as follows.

INCIDENTAL FINDINGS
These are areas identified as requiring improvement but did not cause or contribute to the incident.

NOTABLE PRACTICE
The following are points in the incident or review process where care and/or practice had an important positive impact and may provide valuable learning opportunities

OTHER ISSUES OF NOTE

REVIEW OUTCOME

RECOMMENDATIONS	
1	
2	
3	
4	

SIGN OFF	
Was the service user and/or family advised of the plan for review before beginning the review?	❑
Was the service user and/or family provided with on-going communication and support throughout the review?	❑
Were staff who participated in the process provided with the draft report and requested to provide feedback on factual accuracy and their comments?	❑
Were the service user and/or family given a draft report for review and offered a meeting to discuss?	❑
Comments:	
Name SAO/LAO:	
Date report accepted:	

ARRANGEMENTS FOR SHARED LEARNING	
Learning has been shared in the following manner	
1	
2	
3	
4	