**PRESSURE ULCER INCIDENT REVIEW REPORT**

**CONFIDENTIAL**

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

**Note: Part 1, Sections 2-9 are identical to the Preliminary Assessment Form and therefore, these sections from the PAF may be inserted in to this template and updated if further information has come to light since the SIMT meeting.**

**To complete the Concise Review of the Pressure Ulcer, Part 2 of this template must be completed to identify the Findings, Contributory Factors, Recommendations and Shared Learning.**

**Review Report Part 1**

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| Introduction |
| Click here to enter text. |

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| **Section 1: Details of Service User** |
| Background  Click here to enter text. |
| Reason for Admission/Referral: |
| Date and details of Admission/ First Contact: |

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| **Section 2: Pressure Ulcer Details** | | | | | | | | | | | | | | | | |
| Date of first observation of Pressure Ulcer(s): | | | | | | |  | | | | | | | | | |
| 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** |  |  | **Other** | |  |
| **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: | | | | | | | | | | | | | | | | |
| Detail engagement with the Service User since the identification of the Pressure Ulcer and prior to the review: | | | | | | | | | | **Process** | | | | | **Tick if Yes** | |
| Open Disclosure? | | | | |  | |
| Date of Open Disclosure | | | | | | |
| Designated Support Person identified for Service User? | | | | |  | |
| Name: | | | | | | |

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| **Section 3: 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?** | **Yes** | | **No** | |
| Sensory impairment (neurological disease resulting in reduced sensation and insensitivity to pain |  | |  | |
| Reduced level of consciousness |  | |  | |
| Deterioration in Service User’s condition whereby the Service User may have been hypotensive, hypothermic, hypoxic, pyrexia, septic etc. |  | |  | |
| 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? |  | |  | |
| Severe chronic or terminal illness (multi-organ failure, poor perfusion and immobility) |  | |  | |
| Previous history of a pressure ulcer at site of current pressure ulcer ulceration |  | |  | |
| Diagnosed or suspected Peripheral Vascular Disease |  | |  | |
| Sustained pressure from medical related device e.g. from orthopaedic casting, tubing etc. |  | |  | |
| 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 | | | |
|  | **Yes** | **No** | | **n/a** |
| Has the Service User had a period of prolonged collapse/injury/immobilisation which may correlate with presentation of tissue damage? |  |  | |  |
| Is the Service User unable to maintain position? |  |  | |  |
| Has the Service User declined repositioning? |  |  | |  |
| Is the Service User unable to be repositioned satisfactorily due to medical condition e.g. fractures, respiratory disease, spinal precautions, pain etc.? |  |  | |  |
| 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 | | | |
|  | **Yes** | | **No** | |
| Does the Service User have Moisture Associated Skin Damage? |  | |  | |
| Has the Service User a body weight BMI <20 or BMI > 35? |  | |  | |
| **Any Additional Information:** | | | | |
| **Based on the above assessment, identify any areas where improvement is required:** | | | | |

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| **Section 4: 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?** | |
|  | **Yes** | **No** |  |  |  | **Yes** | **No** |
| **Mattress** |  |  |  |  |  |  |  |
| **Cushion** |  |  |  |  |  |  |  |
| **Heel Protectors** |  |  |  |  |  |  |  |
| **Any Additional Information:** | | | | | | | |
| **Based on the above assessment, identify any areas where improvement is required.** | | | | | | | |

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| **Section 5: Issues relating to Staffing** | | | | | | | | |
| What is the approved staffing and skill mix on the ward/unit? *(applicable to hospitals and residential units only)* | Nurse: | HCA: | | | Student: | | | |
| If a hospital/residential unit, what is the bed capacity for the ward/unit? | | |  | | | | | |
| 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** |  |
| **If Yes, please detail:** | | | | | | | | |
| **Any Additional Information:** | | | | | | | | |
| **Based on the above assessment, identify any areas where improvement is required:** | | | | | | | | |

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| **Section 6: Issues relating to Task & Team** | | | | | | | |
| 1. **Task Factors** | | | | **Yes** | | **No** | |
| 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? | | | |  | |  | |
| 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? | | | |  | |  | |
| 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 | | | | | | |
|  | | | | **Yes** | | **No** | |
| 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 | | | | | | |
|  | | | | **Yes** | | **No** | |
| Was there evidence that a pressure ulcer prevention plan was in place (e.g. SSKIN bundle or specific pressure ulcer care plan? | | | |  | |  | |
| 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’? | | | |  | |  | |
| Was the frequency of skin inspection stated on the care plan? | | | |  | |  | |
| Was a wound assessment chart documenting the pressure ulcer assessment and management plan completed? | | | |  | |  | |
| What date was the first identification of skin damage documented in the nursing notes? |  | | | | | | |
|  | | | **Yes** | | **No** | | **N/A** |
| Has the Service User been > 2 hours in Theatre up to 6 days prior to identification of the pressure ulcer? | | |  | |  | |  |
| Was there evidence of on-going pressure ulcer risk assessment prior to the development of the pressure ulcer? | | |  | |  | |  |
| If the Service User was dependant, was there evidence of a written repositioning schedule when the Service User was sitting/in bed? | | |  | |  | |  |
| Was the frequency of repositioning appropriate to the risk identified? | | |  | |  | |  |
| If the Service User was incontinent, had the Service User an Elimination Care Plan in place? | | |  | |  | |  |
| 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? | | |  | |  | |  |
| Did the Service User have a nutritional risk assessment? | | |  | |  | |  |
| Date nutritional risk assessment carried out: | |  | | | | | |
|  | | | **Yes** | | **No** | | **N/A** |
| If indicated from the nutritional risk assessment has the Service User been offered nutritional support (such as fortified diet advice or supplements)? | | |  | |  | |  |
| Was Service User/carer information in relation to pressure ulcer prevention provided? | | |  | |  | |  |
| **Any Additional Information:** | | | | | | | |
| **Based on the above assessment, identify any areas where improvement is required:** | | | | | | | |

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| 1. **Team Factors** | **Yes** | **No** | **N/A** |
| If available, was the TVN involved in the pressure ulcer management plan? |  |  |  |
| Is there evidence that the medical team / GP were aware of the Service User’s elevated risk status for pressure damage/developing skin damage? |  |  |  |
| If the Service User had reduced mobility were they referred to physiotherapy for additional advice or mobility rehabilitation? |  |  |  |
| If the Service User had nutritional or feeding needs identified were they referred to the Dietician/ Speech & Language Therapist for additional advice / support? |  |  |  |
| If the Service User was identified as requiring specialist advice for seating/equipment were they referred to the Occupational Therapist? |  |  |  |
| Was there evidence that the Service User’s family/carers were involved in the care plan and agreed with it? ***(Note: as appropriate and with appropriate Service User’s consent)*** |  |  |  |
| **Any Additional Information:** | | | |
| **Based on the above assessment, identify any areas where improvement is required:** | | | |

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| **Section 7: Issues relating to Policies and procedures** | | |
|  | **Yes** | **No** |
| Does the service have local a pressure ulcer prevention policy or equivalent in place? |  |  |
| If yes, is this accessible to all relevant staff? |  |  |
| Is this policy in line with current National Wound Care Guidelines? |  |  |
| **Any Additional Information:** | | |
| **Based on the above assessment, identify any areas where improvement is required:** | | |

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| **Section 8: Issues relating to Staff Training and Education** | | |
|  | **Yes** | **No** |
| Is there evidence that all staff providing care in the ward/unit/home been trained in the pressure ulcer prevention polices of the service? |  |  |
| **Any Additional Information:** | | |
| **Based on the above assessment, identify any areas where improvement is required:** | | |

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| **Section 9: Issues relating to Communication** | | |
|  | **Yes** | **No** |
| Is there documented evidence that the Service User’s pressure ulcer risk was communicated to the Service User? |  |  |
| Is there documented evidence that the Service User’s pressure ulcer risk was communicated to relevant staff? |  |  |
| **Any Additional Information:** | | |
| **Based on the above assessment, identify any areas where improvement is required:** | | |

**Review Report Part 2**

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| **Section 10: Statement of Findings** |
| **This Statement of Finding best explains why this pressure ulcer occurred.** |
| Failure to adequately or consistently apply one or more of the following interventions increased the likelihood that the service user would develop a pressure ulcer:   * evaluate the Service User’s clinical condition and pressure ulcer risk factors and/or * plan and implement interventions that are consistent with the Service User’s 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 Statement of Finding 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.* |

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| **Section 11: Contributory Factors** |
| **The Contributory Factors that relate to the Statement of Findings (SOF) identified are as follows.** |
| Enter Contributory Factors that relate to SOF |
| Enter Contributory Factors that relate to SOF |
| Enter Contributory Factors that relate to SOF |
| Enter Contributory Factors that relate to SOF |
| Add additional rows as required |

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| **Section 12: Incidental Findings** |
| **These are areas identified as requiring improvement but did not cause or contribute to the incident.** |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Add additional rows as required |

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| **Section 13: 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** |
| Click here to enter text. |
| Click here to enter text. |
| Add additional rows as required |

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| **Section 14: Other issues of Note** |
| Click here to enter text. |

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| **Section 15: Review Outcome** |
| See guidance for detail of possible outcomes |

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| **Section 16: Recommendations** | |
| **Recommendations for improvement must be linked to the Statement of Findings and Contributory Factors** | |
| 1 | Click here to enter text. |
| 2 | Click here to enter text. |
| 3 | Click here to enter text. |
| 4 | Click here to enter text. |
|  | Add additional rows as required |

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| **Section 17: Arrangements for Shared Learning** | |
| **Learning has been shared in the following manner** | |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
|  | Add additional rows as required |

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| **Section 18: Sign Off** | | |
|  | **Yes** | **No** |
| Were the Service User[[1]](#footnote-1) and relevant Staff advised of the plan for review before beginning the review? |  |  |
| Were the Service User and relevant staff 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? |  |  |
| Was the Service User given a draft report for review and offered a meeting to discuss? |  |  |
| Comments: | | |
| Name SAO/LAO: | | |
| Date report accepted: | | |

1. Note: The term Service User is used in this document to include any persons who use health and social care service within HSE or HSE funded services and who have developed a pressure ulcer. The term Service User also includes their appropriate Relevant Person who has been legally assigned, or who has been nominated in writing to the health services provider, as a person to whom clinical information in relation to the patient may be disclosed.

   Relevant Persons is defined in the Civil Liability (Amendment) Act 2017 as:

   “Relevant person”, in relation to a patient, means a person— (a) who is— (i) a parent, guardian, son or daughter, (ii) a spouse, or (iii) a civil partner of the patient, (b) who is cohabiting with the patient or (c) whom the patient has nominated in writing to the health services provider as a person to whom clinical information in relation to the patient may be disclosed. [↑](#footnote-ref-1)