An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

Pressure Ulcers A Practical Guide for Review

Revision 2, October 2022

This guidance document offers service providers a practical guide to reviewing Pressure Ulcers. It should be read in conjunction with the HSE Incident Management Framework.

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Reader Information

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Use of the Term "Service User" in this document

*Note: The term *Service User* is used in this document to include any persons who use health and social care service within HSE and HSE-funded acute hospitals, mental health and social care inpatient/residential facilities and the community

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[1].

[1] Note : This definition must not be conflated with the definition of "relevant person" in the Assisted Decision-Making (Capacity) Act 2015

Introduction

The HSE Patient Safety Strategy[2] highlighted Pressure Ulcers as one of the Common Causes of Harm and a priority area for patient safety improvement. A pressure ulcer is a ***"localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear"*** (1). These wounds occur frequently among individuals who have difficulty moving, or cannot reposition themselves, such as the frail elderly, individuals undergoing surgery, or individuals with spinal cord injury. However, any Service User, of any age, could develop a pressure ulcer if they are exposed to prolonged, unrelieved pressure and shear forces (2).

Pressure ulcers are common. Within acute and long stay settings in Ireland, the mean pressure ulcer prevalence is estimated at 12.04% (3). This figure reflects the international data where an overall European mean PU prevalence of 13.1% and a European median PU prevalence rate of 10.8% among hospitalised patients (standard deviation (SD): 7%; range: 4.6–27.2%) has been reported (3). Prevalence rates of between 6% and 18.5% have recently been reported in acute care settings (4) and between 3.4–32.4% in long term care settings (5). A more recent study by the OECD indicated that the prevalence of pressure injuries of all stages in long-term care facilities was between 0.9% and 13.1% among OECD countries for which data were available (OECD, 2020 (6))

A study of the global burden of pressure ulcers from 1990 to 2019 (7) identified that the age-standardised rates of prevalence, incidence, and years lived with disability (YLDs) in 2019 are 11.3 (95% UI 10.2 to 12.5), 41.8 (37.8 to 46.2), and 1.7 (1.2 to 2.2) per 100,000 population, and compared with 1990, it has decreased by 10.6% (95% UI 8.7% to 12.3%), 10.2% (8.2 to 11.9%), and 10.4% (8.1 to 12.5%), respectively. In addition, this study highlighted that the global prevalence rate of pressure ulcers increases with age, peaking at the > 95 age group among men and women.

Pressure ulcers pose significant physical and psychological challenges for individuals, impacting negatively on activities of daily living with severe, intractable pain, being one of the most common and difficult aspects of living with a pressure ulcer (8-12). From a financial perspective, pressure ulcers not only impact on the individual, but also on health services and by proxy, society as a whole. Recent data suggest that the cost of pressure ulcers is estimated at between 2 and 4% of total health expenditure (13).

From an Irish perspective, a recent study (14) estimated the financial burden of wounds in general, at 5% (95% CI: 3% to 6%) of total public health expenditure in Ireland for 2017. Given the high prevalence and incidence of pressure ulcers, it is likely that these wounds significantly contribute to this expenditure. Most pressure ulcers can be avoided, providing individuals at risk are correctly identified and appropriate measures are put into place to combat risk. Despite this, the development of pressure ulcers often arises because there has been a failure to implement appropriate prevention strategies. Annually, in the UK, of the 6 most common adverse events, the greatest burden was exerted by pressure ulcers equating to 13,780 healthy life years lost (13). Worryingly, individuals can die as a direct result of

[2] https://www.hse.ie/eng/about/who/nqpsd/patient-safety-strategy-2019-2024.pdf

a pressure ulcer, indeed, global mortality directly attributable to pressure ulcers increased by 32.7% between the years 2000 to 2010 (15)

A proportionate and responsive review of all stages of pressure ulcers when identified can assist in detecting factors that caused and contributed to the development of the pressure ulcer. Such information can then be used to implement improvement initiatives that could prevent subsequent tissue damage to the individual and prevent other Service Users in developing a pressure ulcer. It also gives assurance that appropriate governance structures and processes are in place, as required by the HSE Incident Management Framework.[3]

The HSE Incident Management Framework describes the following six steps in the management of incidents:

- Prevention through supporting a culture where safety is a priority
- Identification and immediate actions required (for Service Users directly affected and to minimise risk of further harm to others)
- Initial reporting and notification
- Assessment and categorisation
- Review and analysis
- Improvement planning and monitoring

Aim

The aim of this document is to give services a practical guide to reviewing pressure ulcers which aligns to the six steps described in the HSE Incident Management Framework (see Figure 1).

Scope

- The scope of this document relates to the review of pressure ulcers identified and reported for Service Users within HSE and HSE-funded acute hospitals, mental health and social care inpatient/residential facilities and the community. This document should be read in conjunction with the HSE Incident Management Framework.
- This guideline is to be applied by staff in HSE and HSE-funded acute hospitals, mental health and social care inpatient/residential facilities and the community.

[3] For the most current version of the Incident Management Framework and templates please access: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/

Note: The Incident Management Framework and associated templates are regularly reviewed and improved. Please always refer to the National QPSD Incicent Management Team website to ensure that the most up to date framework and templates are utilised.

Abbreviations used in this Guide

A full list of abbreviations and definitions is available in the Incident Management Framework which should be read in conjunction with this Concise Review Tool. The following are abbreviations used in this document.

CHO	Community Healthcare Organisation
EPUAP	European Pressure Ulcer Advisory Panel
HIQA	Health Information and Quality Authority
HSCP	Health and Social Care Professional
HSE	Health Service Executive
IMF	Incident Management Framework
LAO	Local Accountable Officer e.g. line manager
MDT	Multidisciplinary Team
NIRF	National Incident Report Form
NIMS	National Incident Management System
NPUAP	National Pressure Ulcer Advisory Panel
NQPSD	National Quality and Patient Safety Directorate
OECD	Organisation for Economic Co-operation and Development
PPPIA	Pan Pacific Pressure Injury Alliance
PUTZ	Pressure Ulcer to Zero
QI	Quality Improvement
QPS	Quality and Patient Safety
QPSD	Quality and Patient Safety Directorate
SAO	Senior Accountable Officer e.g. Head of Service or Hospital Manager
SIMT	Serious Incident Management Team
SRE	Serious Reportable Event
TVN	Tissue Viability Nurse

Pressure Ulcer Staging System

The HSE Wound Management Guideline (2018)[4] describes the following Pressure Ulcer Staging System (see Appendix 1):

Stage I: Intact skin with non – blanchable redness of a localised area usually over a bony prominence. Discolouration of the skin, warmth, oedema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching. The area may be painful, firm, soft, warmer or cooler as compared to adjacent skin.

Stage II: Partial thickness skin loss of dermis presenting as a shallow ulcer with a red pink wound bed, without slough. May present as an intact or open/ ruptured serum filled blister filled with serous or sero-sanguineous fluid. Presents as a shiny or dry shallow ulcer without slough or bruising.

Stage III: Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. The stage may include undermining or tunnelling.

Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. This stage often includes undermining and tunnelling. Exposed bone / muscle is visible or directly palpable.

Suspected deep pressure and shear induced tissue damage, depth unknown

For Service Users with non-blanchable redness and purple/maroon discoloration of intact skin combined with a history of prolonged, unrelieved pressure/shear, this skin change may be an indication of emerging, more severe pressure ulceration i.e. an emerging **Stage III or IV Pressure Ulcer.** Clear recording of the exact nature of the visible skin changes, including recording of the risk that these changes may be an indication of emerging more severe pressure ulceration, should be documented in the Service User's health record. These observations should be recorded in tandem with information pertaining to the Service User's history of prolonged, unrelieved pressure/shear.

It is estimated that it could take **3-10 days** from the initial insult causing the damage, to become a **Stage III or IV Pressure Ulcer.**[5]

Stable eschar (dry adherent, intact without erythema or fluctuance) on the heel serves as the body's biological cover and should not be removed. It should be documented as at least Category / Stage III until proven otherwise.

See **Appendix 1** for illustration of the HSE Pressure Ulcer Category/Staging System Recommendations.

[4] HSE National Wound Management Guidelines available at: https://healthservice.hse.ie/about-us/onmsd/quality-nursing-and-midwifery-care/hse-national-wound-guidelines-2018.html

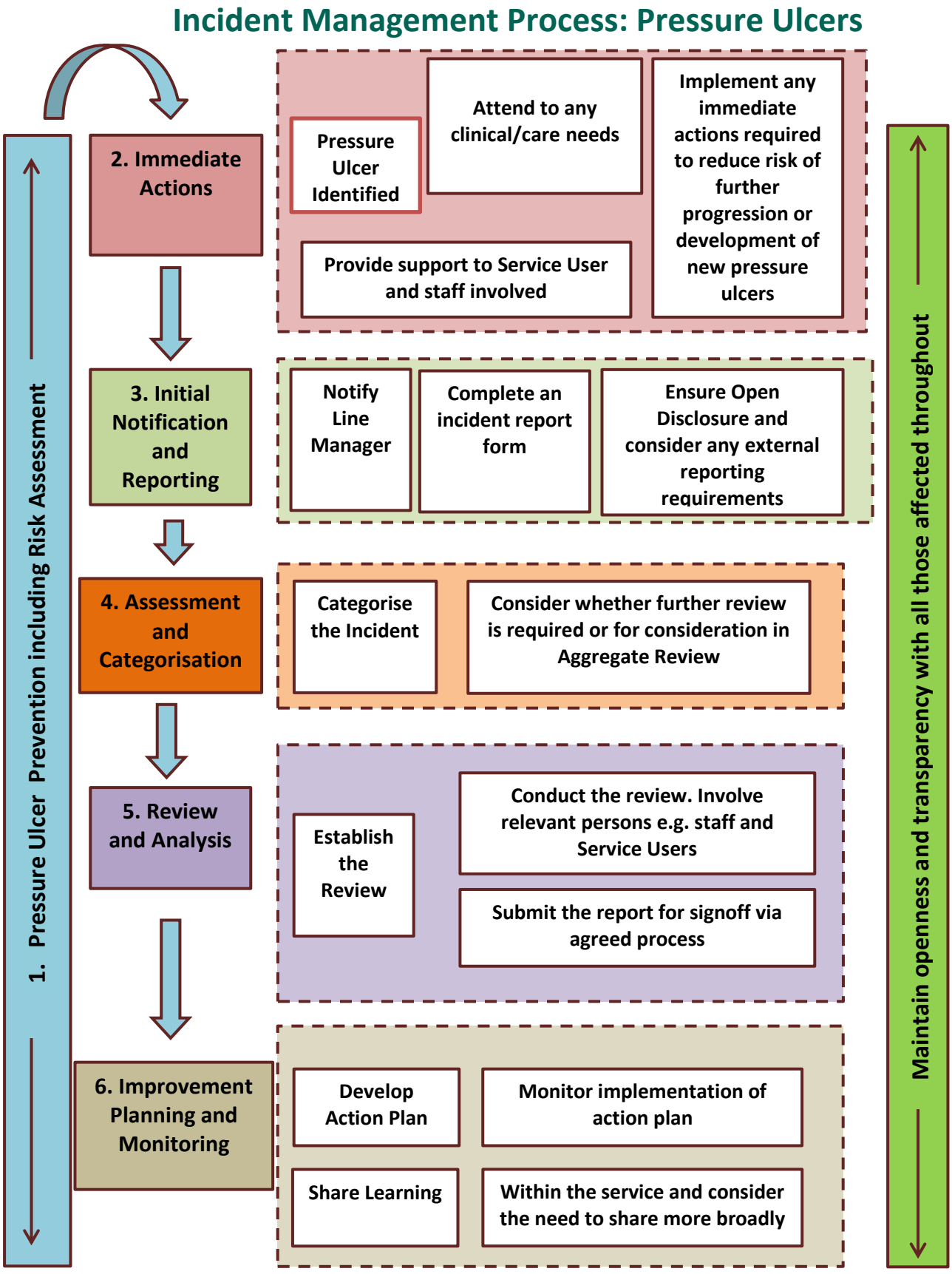


Figure 1: Adapted from HSE Incident Management Framework

Step 1: Pressure Ulcer Prevention – including Pressure Ulcer Risk Assessment

In 2021, 6,529 pressure ulcer incidents reported through the National Incident Management System[5] were acquired by services users while in the care of the HSE. Of these, 4,824 were reported as acquired by Service Users in acute hospitals with 1,676 reported as relating to Service Users in the care of CHOs. A moderate level of harm was reported in 1,799 of these reported incidents with an additional four pressure ulcer incidents classified as resulting in extreme or major harm.

The HSE National Wound Management Guidelines (2018) provide a standardised approach for wound care in the Irish healthcare setting to support safe, quality care for Service Users, who access healthcare across the HSE and HSE funded agencies. For more in-depth guidance on wound care please consult these guidelines[6]. All inpatient, residential and community care services should have local guidelines in place on pressure ulcer prevention and management, centred on the HSE National Wound Management Guidelines.

Pressure ulcer prevention is based on the principle that prevention strategies are planned and based on the individual risk factors that the Service User presents with. Pressure ulcer prevention strategies are informed by risk assessment and clinical judgement. Risk assessment is therefore the first step in the prevention process (17). Evidence suggests that the best practice in Pressure Ulcer prevention is by incorporating a SSKIN[7] bundle into the Service Users care (Appendix 2) (18-21). The SSKIN bundle can be applied across all areas of care and can be instigated where a Service User is deemed at risk of pressure ulcer development as indicated by clinical judgement and/or by use of an assessment tool. Key to the success of implementing the SSKIN bundle is to apply each element to each Service User in the same way, as required, every time. This helps build reliability into prevention processes.

Implementation of the SSKIN bundle in clinical services is a key component of the HSE QPSD *Pressure Ulcer to Zero Collaborative* (PUTZ). PUTZ aims to reduce facility acquired pressure ulcers by 50% during the lifetime of each phase of the collaborative. To achieve this aim the collaborative provides teams with the support and educational resources needed to undertake improvements. It also enables staff to put in place reliable systems so that improvements can be maintained, and become continuous during and after the Collaborative period. *PUTZ and SSKIN resources are available to the public and HSE staff to support pressure ulcer prevention, along with further information through the NQPSD website at:https://www.hse.ie/eng/about/who/nqpsd/patient-safety-programme/pressure-ulcers-to-zero-putz-.html*

Pressure Ulcers to Zero

[5] Data extracted from NIMS on 13/4/22. The National Incident Management System (NIMS) is a dynamic system and is the key platform for HSE and HSE-funded healthcare providers to report incidents on. Additionally, the NIMS system is the source of data in terms of incident management as a quality indicator and is also used to inform the National Service Plan KPIs. More information is available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/nims/national-incident-management-system-nims-.html or NIMS helpdesk at nims@hse.ie.

[6] HSE National Wound Management Guidelines available at: https://healthservice.hse.ie/about-us/onmsd/quality-nursing-and-midwifery-care/hse-national-wound-guidelines-2018.html

[7] The SSKIN bundle focusses on key aspecs of preventative care: Surface, Skin Inpection, Keep Moving, Incontinence and Nutrition

Step 2: Identification and Actions Required

(For Service Users directly affected and to minimise risk of further harm to others)

There are a number of immediate actions that should be completed in the period following the identification of a pressure ulcer to both prevent further damage and the development of new pressure ulcers.

1. Ensure that a Pressure Ulcer Risk Assessment has been completed
2. Ensure the SSKIN bundle/Pressure Ulcer Prevention Care Plan is appropriate to the Service User's current risk status.
3. Continue vigilance with skin inspection and ensure a wound assessment / management care plan is in place for each area of skin damage.
4. Document findings and actions taken in relation to the on-going management of the pressure ulcer in the Service User's care record.
5. Ensure the Service User is made aware of the pressure damage (Open Disclosure[8]) and is given information in relation to next steps.
    a. This is essential as it significantly contributes to the maintenance of confidence in, and trust between, the Service User and the service providers.
    b. A record of the salient points of the Open Disclosure discussion and details of the apology and/or expression of regret provided to the Service User should be made in the Service User's healthcare record.
6. Continue, with the involvement of the multidisciplinary team (MDT), to evaluate the effectiveness of equipment, repositioning frequency, incontinence management and nutritional interventions.
7. Continue to evaluate the effectiveness of wound management strategies.

[8] The most up to date HSE Open Disclosure Policy and related information may be accessed at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/national-open-disclosure-policy-and-guidelines.html

Step 3: Initial Reporting and Notification

There is a requirement to report the following pressure ulcer incidents via the National Incident Management System (NIMS)[9,10].

a) All newly acquired pressure ulcers, regardless of stage, occurring within a publically funded health service (See **Note 1** below);

b) Existing pressure ulcers which progress/deteriorate to a Stage III or IV Pressure Ulcer;

c) Non-blanchable redness and purple/maroon discoloration of intact skin combined with a history of prolonged, unrelieved pressure/shear (see **Note 2** below).

Note 1: Pressure Ulcer Present on Admission

There is no requirement to report pressure ulcers which are ***present on admission to a facility*** *or* ***present at the time of first contact in the community.*** Rather these should be noted in the healthcare record of the Service User and their care plan should reflect any actions required to prevent further deterioration. **This is because the pressure ulcer should already been reported on NIMS by the service in which the Service User was previously being cared for (see below).**

Remember: When referring a Service User externally to another healthcare facility, or internally to another ward, the referring service/team must document on the Service User's accompanying documentation and healthcare records that the pressure ulcer has been reported at local and national level.

Note 2: Pressure Ulcer Staging and NIMS

In cases where there is suspected deep pressure and shear induced tissue damage, depth unknown, it is estimated that it could take 3-10 days from the initial insult causing the damage, to become a Stage III or IV Pressure Ulcer. In such circumstances when completing Section G of the National Incident Report Form (NIRF) (NIRF 01, Person), in the section Musculoskeletal/Soft Tissue, select **'Other'** and enter **'Non-blanchable redness and purple/maroon discoloration of intact skin'.**

When the Pressure Ulcer is stageable, if the Service User is **still a patient in the department/ service** in which the initial NIRF was completed, then **the original NIRF and the associated incident on NIMS are updated to denote the staging of the pressure ulcer**.

However, if during the period from initial insult to staging of the pressure ulcer, **the Service User is moved** from the department/service, the need for the completion of incident reporting to capture the staging of the pressure ulcer, should form part of the handover of care.

When the pressure ulcer becomes stageable, a further NIRF form should be completed by the receiving department/service denoting the stage of the pressure ulcer. This second NIRF (and any subsequent NIRFs related to this pressure ulcer) should be linked to the original NIRF on NIMS so that it is captured on NIMS that the incidents are related.

[9] Reporting on NIMS via National Incident Report Form (NIRF) or directly on to NIMS (where electronic point of entry is available).

[10] To aid with local data capture and audit of pressure ulcers, local pressure ulcer data collection systems may also be utilised as stipulated and guided by local, service level requirements. However, these systems should not replace the requirement to report pressure ulcer incidents via NIMS.

The staff member who identified the pressure ulcer is responsible for:

- Notifying the line manager within the area where the pressure ulcer occurred/was identified.

- Completing an NIRF as soon as is practicable after the pressure ulcer is identified, but within 24 hours of the identification of the pressure ulcer.
  - All information must be provided in full, as required on the NIRF and must be factual and objective. This is important as it assists in supporting a just and fair culture.
  - It is important in completing a NIRF relating to a facility/community acquired pressure ulcer or progression of an existing pressure ulcer to include detail of the staging that is relevant. This is important as Stage III & IV Pressure Ulcers are designated as Serious Reportable Events. If necessary, consult a health care professional with specialist pressure ulcer knowledge e.g. Clinical Nurse Manager, Medical Staff, Tissue Viability Specialist (TVN) to ensure that the correct Stage of the Pressure Ulcer is applied.

- Local services must clearly identify, and communicate to staff, the route for submission of the NIRF for input onto the NIMS. Stage III or IV Pressure Ulcers, if acquired since admission to the service, are also classified as Serious Reportable Events (SREs) and must be identified on NIMS as SREs and reported externally as set out by the relevant regulatory bodies[11].

- The Mental Health Commission[12] requires any serious reportable event involving a resident to be reported within 48 hours and, as part of the obligation for quarterly statutory notifications in designated centres (NF39), Residential Services are also required to notify pressure ulcers Stage II and higher to the Health Information and Quality Authority (HIQA)[13]. Deaths related to pressure ulcers in any service are reportable to the Coroner.

[11] Refer to the Incident Management Framework Guidance document (Section 6) for external reporting requirements.
[12] Mental Health Commission (2020) requires any serious reportable event involving a resident to be reported within 48 hours, guidance available at https://www.mhcirl.ie/sites/default/files/2021-08/MHC-QSN-Guidance-November-2020.pdf
[13] HIQA, Monitoring Notifications handbook available at https://www.hiqa.ie/sites/default/files/2018-02/Monitoring-Notification-Handbook-DCOP_Guidance.pdf

Step 4: Assessment and Categorisation of the Incident

The purpose of assessing and categorising incidents is to determine the level and approach of review that is required. Categorisation is based on the level of harm sustained as a consequence of the pressure ulcer and is in line with the categorisation of incidents described in the HSE Incident Management Framework.

The level and approach of review must be proportionate to the harm sustained as a result of a pressure ulcer.

Based on the outcome of this assessment, **pressure ulcer incidents** are categorised as follows:

Category 1 Incident Major/Extreme

- Pressure Ulcers of any grade which are
    - associated with septicaemia resulting in death
      Or
    - Resulting in permanent disability such as an amputation.

Category 2 Incident Moderate

- Stage III & IV Pressure Ulcers
    - not associated with septicaemia resulting in death
      Or
    - not resulting in a permanent disability

Note: *Category 1 and Category 2 are also classified as Serious Reportable Events (SREs) if acquired since contact/admission to either the community or acute services.*

Category 3 Incident Minor/Negligible

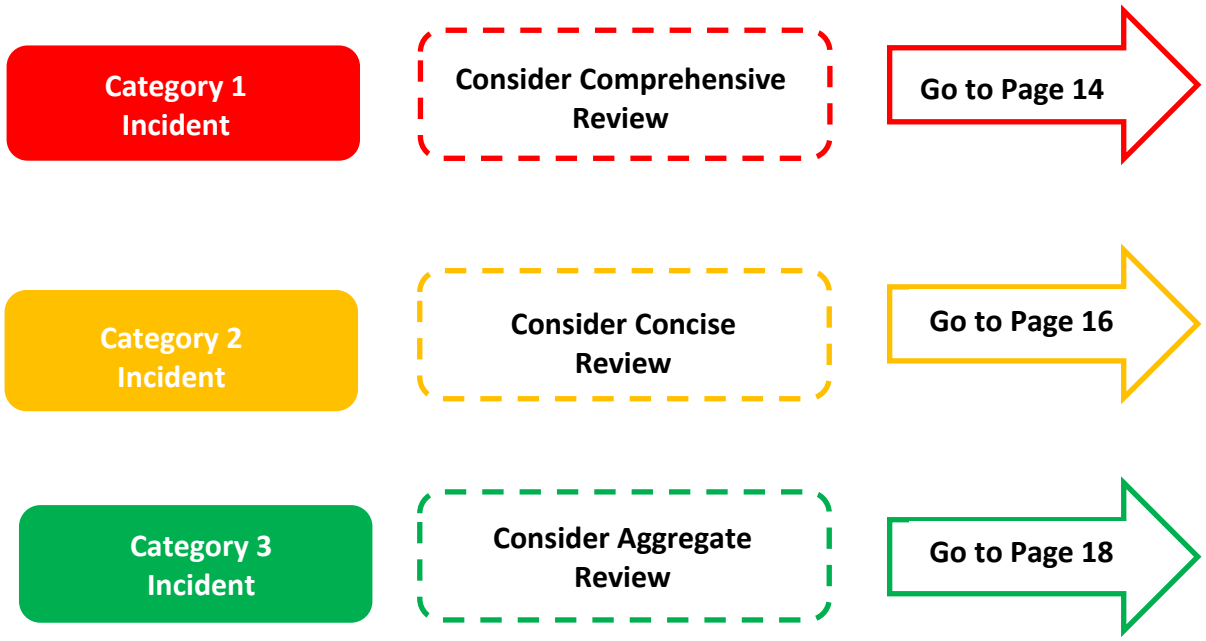
- Stage I & II Pressure Ulcers

Note: *However, it is important that services continue to monitor and assess these pressure ulcers to identify any deterioration.*

Decision making in relation to the review of Pressure Ulcer Incidents

Based on the categorisation of **the incident,** a graduated and proportional level of review (i.e. Comprehensive, Concise and Aggregate) should be considered in line with the HSE Incident Management Framework.

The incident category applied to the pressure ulcer will point you to the appropriate review process to follow.



Category 1 Incidents (Major/Extreme Harm)

Decision Making for Category 1 Pressure Ulcer Incidents

In line with the HSE Incident Management Framework, **Category 1** incidents, when identified, must be notified to the Senior Accountable Officer (SAO) within 24 hours. The arrangement for notification must be clearly defined within each organisation. The SAO is required to convene a meeting[14] of the Serious Incident Management Team (SIMT) within 5 working days to make a decision in relation to review. Category 1 pressure ulcer incidents are SREs and therefore must also be categorised as an SRE on NIMS.

Preparing for Decision Making by the SIMT

In order to assist decision making at the SIMT, the Quality and Patient Safety (QPS) Advisor arranges for collection of data relating to the pressure ulcer required by the *Preliminary Assessment to Assist Review Decision Making form* (Part A) (Appendix 3). The data required to complete this form should be accessed from relevant sources e.g.

- The line manager in whose area of responsibility the pressure ulcer occurred
- Clinically relevant persons e.g. Tissue Viability Lead[15], Health and Social Care Professional (HSCP) etc.
- National Incident Report Form
- Service User's healthcare record
- Engagement with:
    - staff who were either on duty or involved in the Service User's care prior the incident
    - the Service User

Decision Making by the SIMT

Using the data collected in Part A, the SIMT should determine if there was evidence of the following:

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.*

Based on this determination, a decision is taken in relation to the conduct of a review. A Comprehensive Review approach to review is generally accepted as most appropriate for Category 1 incidents. However, a Concise approach to review may be considered for some Category 1 incidents (Refer to the Incident Management Framework for further guidance on the level of review to be adopted).

[14] In line with the IMF, the SIMT meets on a scheduled basis to monitor and gain assurance in relation to the ongoing management of all Category 1 incidents within the service. The SIMT must also convene on an unscheduled basis within 5 working days of a Category 1 incident.

[15] This may be a local clinical manager such as Clinical Nurse Manager 2, Assistant Diretcor of Nursing, Person-in-Charge or a person with specialist knowledge in tissue viability

Where a decision **to review** using a Comprehensive or Concise approach is taken, this is noted in Part B of the *Preliminary Assessment to Assist Review Decision Making form* along with other required information and the SAO moves to establish the review. The SAO is now the Commissioner of the Review. The decision to review along with detail of the approach being undertaken must be recorded on the NIMS review screens[16].

Where a decision **not to review** using a Comprehensive or Concise approach is taken, the completed *Preliminary Assessment to Assist Review Decision Making form* (Part A and Part B) must be submitted to the relevant Quality and Safety Committee (or equivalent) for review and ratification of the decision. The decision not to review, when ratified by the Quality and Safety Committee (or equivalent), must be recorded on the NIMS review screens.

[16] More information on recording on the NIMS review screens is available on the NQPSD Incident Management Team webpage at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/nims/national-incident-management-system-nims-.html or NIMS helpdesk at nims@hse.ie.

Category 2 Incidents (Moderate Harm)

Decision making for review of Category 2 Pressure Ulcer Incidents

Category 2 pressure ulcer incidents are classified as SREs and must be reported as an SRE on NIMS. Unlike Category 1 incidents, there is not a requirement to notify the SAO within 24 hours[17] nor is there a requirement to convene a SIMT to make decisions about review. Decisions relating to review are taken by the QPS Advisor (or equivalent) in consultation with Local Accountable Officer (LAO) as soon as possible after the identification of a Category 2 pressure ulcer.

Preparing for decision making

In order to assist decision making, the service where the incident occurred is responsible for the collection of data relating to the pressure ulcer as required by the Preliminary Assessment to Assist Review Decision Making form (Part A) (Appendix 3). The data required to complete this form should be accessed from relevant sources e.g.

- The line manager in whose area of responsibility the pressure ulcer occurred
- Clinically relevant persons[18] e.g. Tissue Viability Lead, Health and Social Care Professional etc.
- National Incident Report Form
- Service User's healthcare record
- Engagement with
    - staff who were either on duty or involved in the Service User's care prior the incident
    - the Service User

The *Preliminary Assessment to Assist Review Decision Making* form should be returned to the relevant QPS Advisor or equivalent and having reviewed the data in Part A, an assessment is made by the QPS Advisor (or equivalent) in conjunction with the LAO, as to whether there is evidence of the following:

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.*

Decision making

Where it is agreed that there was evidence of a failure to adequately or consistently apply one or more of the interventions required to avoid the development of a pressure ulcer a concise approach to review is generally considered appropriate.

Where a decision **to review** using a concise approach is taken, it is noted in Part B of the form along with other required information and the LAO proceeds to commission and establish the review.

[17] It is however recommended that as Grade III and IV Pressure Ulcers are designated as SREs, that the SAO receive a monthly report in relation to the number of these reported in the previous month.
[18] This may be a local clinical manager such as CNM2, ADON, Person-in-Charge or a person with specialist knowledge in tissue viability

If, in exceptional circumstances, it is considered that a comprehensive approach is indicated this must be referred by the LAO to the SAO who is responsible for commissioning comprehensive reviews. The decision to review along with detail of the process to be undertaken must be recorded on the NIMS review screens[19].

Where a decision is taken **not to review** using either a Comprehensive or Concise approach, the completed *Preliminary Assessment to Assist Review Decision Making* form (Part A and Part B) must be submitted to the relevant Quality and Safety Committee (or equivalent) for review and ratification of the decision. The decision not to review, when ratified by the Quality and Safety Committee (or equivalent), must be recorded on the NIMS review screens.

[19] More information on recording on the NIMS review screens is available on the NQPSD Incident Management Team webpage at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/nims/national-incident-management-system-nims-.html or NIMS helpdesk at nims@hse.ie.

Decision Making for Category 3 Pressure Ulcer Incidents

Category 3 Incidents (Minor/Negligible Harm)

In the main **Category 3** pressure ulcer incidents should be collated and analysed on an aggregate basis. See Point 1 in Step 5, Review and Analysis, for details of this.

Whilst there is not a requirement to review these incidents individually, if it is considered that an individual **Category 3** incident presents an opportunity for learning, a concise review should be considered.

Step 5: Review and Analysis

The purpose of a review is to find out what happened, why it happened and what learning can be gained in order to minimise the risk of pressure ulcers occurring in the future. The review and analysis of pressure ulcers should be considered a key tool for quality improvement. There is a need not just to understand **what happened** in relation to the pressure ulcer but also to understand **why it happened** i.e. the cause and the factors that contributed to the pressure ulcer.

Review of Individual Pressure Ulcer Incidents

In line with the HSE Incident Management Framework, there are two levels of review that relate to the conduct of review of individual cases. These are as follows:

- ***Comprehensive Review***: Comprehensive Reviews use the Review Team Approach. Guidance on the methodology for this approach can be found in the HSE Incident Management Framework.

- ***Concise Review***: Concise Reviews use the Pressure Ulcer Concise Review Tool (Appendix 3). This tool is specific to pressure ulcer incidents and was co-designed by Tissue Viability Specialists and QPS Advisors experienced in the conduct of systems based reviews. The tool commences with the conduct of a Preliminary Assessment of the pressure ulcer to enable decision making in relation to the requirement for a review. Where a decision is taken to conduct a review, guidance on the conduct of the concise review and the Review Report template is also provided (Appendices 4 and 5).

NIMS: To assist with aggregate analysis of Pressure Ulcer Reviews the Reporting Screens on NIMS must be completed in full for Comprehensive and Concise Reviews. A copy of the report must also be uploaded onto NIMS.

In relation to undertaking an ***Aggregate Review*** two types of aggregate reviews can be carried out:

1. **An 'all pressure ulcer' aggregate review:** The NIRF 01 (NIRF Person) contains data relating to pressure ulcers in the Clinical Care Section. Services should seek to pull an 'all pressure ulcers' report from NIMS on a periodic basis for review at their appropriate MDT meeting/ Quality and Safety Committee (or equivalent)[20].

2. **Concise Reports Aggregate Review:** Due to the structured nature of the Concise Review process, consideration should also be given to the conduct of aggregate analysis of Concise Reviews completed within a service/service area. The outcome of such an analysis can contribute to a greater understanding of the issues underlying pressure ulcers within the Service User population. This can be done at service level, regional level, care group level and/or national level. For this reason, it is important that completed Concise Reports are uploaded to NIMS, and the Reporting Screens on NIMS are completed in full. Guidance on the methodology

[20] More information on generating reports from NIMS is available on the NQPSD Incident Management Team webpage at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/nims/national-incident-management-system-nims-.html or NIMS helpdesk at nims@hse.ie

for for aggregate analysis can be found in the HSE Incident Management Framework. Key learning points from any Comprehensive Review conducted can also be incorporated into this aggregate analysis.

Whatever approach to review is taken a report will be developed which will set out details of the case, identify the Statement of Findings and the Factors which contributed to the development of the pressure ulcer and set out recommendations for areas where improvement has been identified as being required[21] (Appendix 5).

Recommendations must be linked to the Factors that contributed to the pressure ulcer and must be:

- Framed in a manner that conform with CLEAR[22] principles
- Capable of supporting any changes in practice required
- Where possible aimed at changing systems in a manner that supports people to behave in a safe and consistent manner rather than relying on people to behave in a specific manner.
- Discussed with the Review Commissioner to ensure that they are both implementable and consistent with the policy framework within which the service operates.

When the draft report is available it will be provided to relevant staff and the Service User to confirm factual accuracy and provide comment within a specified timeframe in line with the Incident Management Framework. This should be carried out in a supportive manner. It is one of the final tasks prior to completion of the incident management cycle and it is important that appropriate consideration is given to how this is done.

In line with the Incident Management Framework, following acceptance of the report by the Commissioner, the Service User Designated Support Person should contact the service user to inform them that the report is finalised and offer them a meeting to discuss this. The service user should be offered an opportunity to receive a copy of the report in advance of the meeting and so have had a chance to review it. Staff should also be advised of the outcome of the review in a manner that is supportive and can be provided with a copy of the report.

Following the finalisation of the report, an action plan is developed to ensure that recommendations made in the report are implemented. A copy of the report is also submitted to the relevant QPS Advisor (or equivalent) for inclusion in aggregate analysis to inform learning and to enable the completion of the review screens on NIMS. The final report and action plan is also submitted to the relevant Quality and Safety Committee (or equivalent) for their information and consideration as part of the service's overall quality improvement plans.

Refer to the HSE Incident Management Framework for details on the governance and approval process for review reports.

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[21] See Appendix 5 for report template and also link to template available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/incident-management.html

[22] CLEAR is an acronym used to describe the key elements/features that a recommendation should have to support successful implementation i.e. Case for Change, Learning Orientated, Evidence, Assign, Review. Reference Section 14, HSE Incident Management Framework

Step 6: Improvement Planning and Monitoring

It is the responsibility of the person commissioning the review to ensure that an action plan to implement any recommendations is developed. It is recommended that rather than monitor action plans for individual reviews, that action plans developed are interfaced with relevant service improvement plan and that the implementation of this plan be monitored.

To facilitate monitoring, actions developed must be assigned to named individuals with a due date for completion. Where there is evidence that actions are behind schedule appropriate corrective action must be taken to address this. Improvement plans must therefore be owned by the service and reviewed and updated regularly. If an action is identified which is outside the control of the service a formal system of escalation should be applied so that the action can be referred to the appropriate level/location for implementation.

An action plan could focus on the introduction of, or audit of the use of the SSKIN Bundle to confirm that suitable measures for pressure ulcer prevention are in place and are being used appropriately. Improvement planning should consider how reliable SSKIN bundle processes can be implemented into the daily routine to support pressure ulcer prevention. For example if an issue with nutrition is identified through audit of the SSKIN Bundle it is recommended that collaboration with the Dietetics Department (where available) and Practice Development should be initiated. The purpose of this should be to embed understanding and continuous correct use of the local nutritional screening tool– e.g. MUST[23] screening tool.

Effective measurement systems should be established to monitor for safe care and positive outcomes. Daily recording of newly acquired or newly transferred pressure ulcers can be recorded on a safety cross and publically displayed. This visual information promotes awareness and ownership for multidisciplinary staff and facilitates a reliable reporting mechanism from a governance perspective. For further information on the Safety Cross and for further guidance and support on other quality improvement and pressure ulcer prevention measures visit the PUTZ website at *https://www.hse.ie/eng/about/who/nqpsd/patient-safety-programme/pressure-ulcers-to-zero-putz-.html*

To guide and support the improvement process, application of the HSE's *Framework for Improving Quality*[24] can assist in influencing and guiding the planning and delivery of care in services to help improve Service User experience and outcomes. The framework describes six drivers of quality that need to be considered in every improvement effort to ensure successful, continuous and sustainable improvements in the quality of care even in the busiest environments.

[23] MUST: Malnutrition Universal Screening Tool
[24] Available at https://www.hse.ie/eng/about/who/nqpsd/

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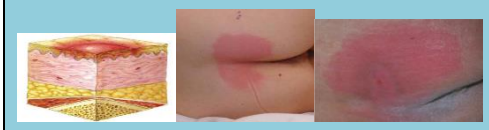
- HSE Incident Management Framework and Guidance, 2020: For the most current version of the Incident Management Framework please access: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/
- HSE Wound Management Guidelines (2018) available at: https://healthservice.hse.ie/about-us/onmsd/quality-nursing-and-midwifery-care/hse-national-wound-guidelines-2018.html
- National HSE Open Disclosure Guidelines, available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/national-open-disclosure-policy-and-guidelines.html
- HSE Patient Safety Strategy (2019-2024) https://www.hse.ie/eng/about/who/nqpsd/patient-safety-strategy-2019-2024.pdf

Appendix 1. HSE Pressure Ulcer Category/Staging System Recommendation[25]

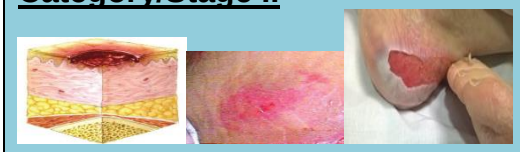
Definition: ***"A pressure ulcer is a localised injury to the skin and / or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance has yet to be elucidated"***

Category / Stage I



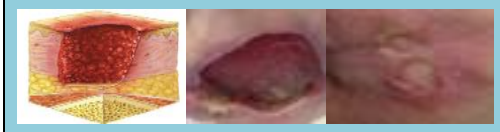
Category/ Stage I: Intact skin with non – blanchable redness of a localised area usually over a bony prominence. Discolouration of the skin, warmth, oedema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching. The area may be painful, firm, soft, warmer or cooler as compared to adjacent skin. (EPUAP 2009)

Category/Stage II



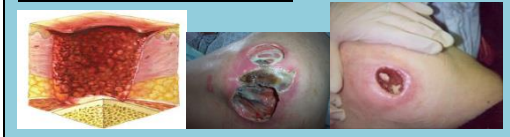
Category / Stage II: Partial thickness skin loss of dermis presenting as a shallow ulcer with a red pink wound bed, without slough. May present as an intact or open/ ruptured serum filled blister filled with serous or sero-sanginous fluid. Presents as a shiny or dry shallow ulcer without slough or bruising. (EPUAP 2009).

Category/Stage III



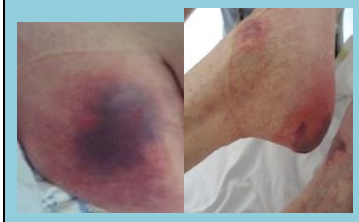
Category / Stage III: Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. The stage may include undermining or tunnelling (EPUAP 2009).

Category/Stage IV

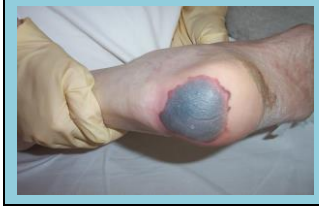


Category / Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. This stage often includes undermining and tunnelling. Exposed bone / muscle is visible or directly palpable (EPUAP 2009).

Suspected deep pressure and shear induced tissue damage, depth unknown



In individuals with non-blanchable redness and purple/maroon discoloration of intact skin combined with a history of prolonged, unrelieved pressure/shear, this skin change may be an indication of emerging, more severe pressure ulceration i.e. an emerging **Category/Stage III or IV Pressure Ulcer**. Clear recording of the exact nature of the visible skin changes, including recording of the risk that these changes may be an indication of emerging more severe pressure ulceration, should be documented in the patients' health record. These observations should be recorded in tandem with information pertaining to the patient history of prolonged, unrelieved pressure/shear.
It is estimated that it could take **3-10 days** from the initial insult causing the damage, to become a **Category/Stage III or IV Pressure Ulcer** (Black et al, 2015).



Stable eschar (dry adherent, intact without erythema or fluctuance) on the heel serves as the body's biological cover and should not be removed. It should be documented as at least Category / Stage III until proven otherwise.

[25] **Reference:** HSE National Wound Management Guidelines available at: https://healthservice.hse.ie/about-us/onmsd/quality-nursing-and-midwifery-care/hse-national-wound-guidelines-2018.html

Appendix 2 SSKIN Bundle

Ref: PUTZ Collaborative at https://www.hse.ie/eng/about/who/nqpsd/patient-safety-programme/pressure-ulcers-to-zero-putz-.html

Pressure Ulcers to Zero

Frequency of care delivery (circle as appropriate)	1 hrly	2hrly	3hrly	4hrly								
Date												
Time (24 Hour Clock)												
SURFACE	Indicate each day if Foam Matress or Pressure Relieving Mattress											
Mattress appropriate & functioning correctly												
Appropriate seating												
Heel protectors												
SKIN INSPECTION	Inspect skin at boney prominence every 2-4 hours. Existing Pressure Ulceration **Y/N CIRCLE** Stage* & site of existing ulceration recorded in wound assesment chart **Y/N CIRCLE**											
Pressure areas checked												
New Redness State Site:												
KEEP MOVING	Frequency of repositioning is determined by skin inspection if red at least 2 hourly											
BED R side												
BED L side												
BED Back												
CHAIR												
Standing/Mobilising												
INCONTINENCE	Incontinence Related Skin Care regime Implemented Y/N											
Dry and Clean												
Peri-anal skin healthy												
NUTRITION	Fluid Balance Chart/Food Chart in progress Y/N (Circle and continue) Otherwise record below.											
Meal/Snack taken												
Drink taken												
Supplements taken												
Signature												
Grade: SN = Staff Nurse												
HCA= Health care Attendant												
OT= Occupational Therapist												
D= Dietician												
P= Physiotherapist												
S= Student												
SALT												
KEY: Care Delivered: √ = YES X = NO (if NO Document & Explain in Nursing notes)												

RED SKIN - RELIEVE PRESSURE - REVERSE DAMAGE

Patient Pressure Ulcer Prevention Information booklet given ☐

Category/Stage: Please refer to the interantion NPUAP/EPUAP Pressure Ulcer Classification system

Appendix 3 Pressure Ulcer Preliminary Assessment to Assist Review Decision Making[26]

Part A, Case report: To be completed in advance of the SIMT/Review Decision Making Meeting.

To be completed in the event of a Stage III/ IV facility/community acquired Pressure Ulcer or any other stage of Pressure Ulcer that results in a Category 1 Incident

Section 1: Details of Service User *(affix service user label to a copy of this form for retention in healthcare record)*			
NIMS Reference No:		**Date entered on NIMS:**	
Date notified to SAO/LAO:		**Date of SIMT/ QPS meeting:**	
Medical History (brief summary)			
Location of service:			
Ward/Unit/Care Setting:			
Date of Admission/First Contact:		**MRN: (if applicable)**	
Treating Consultant /GP			
Reason for admission/First Contact:			
Any other relevant details:			

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:	

[26] link to template available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/incident-management.html

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:			

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.							

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: 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**			
If Yes, please detail:						
Any Additional Information:						
Based on the above assessment, identify any areas where improvement is required:						

SECTION 6: ISSUES RELATING TO TASK & TEAM			
A. 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?	Enter date		
	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:	Enter date		
	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:			

B. 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:			

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:		

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:		

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:		

Preliminary Assessment Form completed by:
Date:

(Note Sections 2 – 9 of this Preliminary Assessment Form may be used as Part 1 of the Review Report if a decision is made to undertake a Concise Review of the Pressure Ulcer)

Part B – Record of Decision (to be completed at the SIMT/Review Decision Making Meeting.

The decision to commission a CONCISE REVIEW or a COMPREHENSIVE REVIEW should be considered in the event of **CATEGORY 1** or **CATEGORY 2** harm pressure ulcer incidents. Part A of this form seeks to identify whether or not the key elements required for pressure ulcer prevention were in place. Part A should therefore be considered in making the decision to conduct a review or to decide if a review is not required.

Consideration therefore should be given to whether the case report indicates that one or more of the following issues might pertain:

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.*

In cases where all key elements were in place and the pressure ulcer occurred despite this, it may indicate the pressure ulcer was not preventable and that a review is not required.

RECORD OF DECISION TO CONDUCT A REVIEW

Incident Details		
NIMS Ref No:		
Date of Incident:		
Date Notified to SAO/LAO:		
Date entered on NIMS:		
Date of SIMT /Relevant Meeting:		
Case Officer/ QPS Manager:		
Section A. Decision to Conduct a Review under the Incident Management Framework		
Please indicate the decision in relation to the level of review to be conducted[27]:		
Comprehensive Review		**If a Comprehensive Review is selected please proceed to Section C of this form**
Concise Review		**If a Concise Review is selected please proceed to Section C of this form**
No Review *		**If No Review is selected please proceed to Section B of this form**

[27] Document on NIMS the decision to review the incident and as the incident review progresses, update all fields on the NIMS Review Screen to capture and track the management of the incident.

Section B. No Review
If the decision is **NOT** to commission a Comprehensive Review or Concise Review, please set out below the reason or rationale for this decision and the evidence upon which it was based:
** Decisions not to review must be:* • *Communicated to persons affected i.e. Service User and staff.* • *Submitted for review and ratification by the Quality & Safety Committee, along with Part A* • *Complete NIMS Review Screens and this should include the reason and rationale for no further review.* *These incidents should be included in an Aggregate Review process.*
Sign Off: (as applicable to the level of review chosen) **Name of SAO/LAO:** **Signature of SAO/LAO:** **Date:**
Ratification by QPS Committee (or equivalent) Having reviewed the Preliminary Assessment and discussed the incident the QPS Committee agrees/disagrees (circle as appropriate) with the recommendation that No Review is required. **Name of Chair:** **Signature of Chair:** **Date:** ***In cases where the QPS Committee feels that a review is required the case is referred back to the SAO (Category 1 incidents) or LAO (Category 2 incidents) for commissioning.***

Section C.
Comprehensive Review
If the decision is to commission a Comprehensive Review, this will be by way of a **Review Team Approach** and the Systems Analysis review Report Template as detailed in the HSE Incident Management Framework is utilised.
The Final Report of the Comprehensive Review must be accepted by the SAO within 125 days of identification of the incident.

Concise Review
If the decision is to commission a Concise Review, please complete the Pressure Ulcer Review Report Template
The Final Report of the Concise Review must be accepted by the SAO/Local Accountable Officer (as appropriate to incident categorisation) within 125 days of identification of the incident.

Level of Independence attaching to the Review	Please Tick
1. Team internal to the ward/department/ NAS Operational Region	
2. Team internal to the service/hospital/NAS Operational Area	
3. Team external to the service/hospital but internal to the CHO/HG/NAS Corporate Area/ Regional Health Area[28]	
4. Team external to the CHO/HG/NAS Directorate/ Regional Health Area	

Terms of Reference

Please include at a minimum detail of the purpose and scope of the review and that it will adhere to the principles of natural justice and fair procedures e.g.

- *That the purpose of the review is to identify what happened, why it happened and to identify recommendations to reduce the risk of recurrence.*
- *The scope of the review i.e. from X time e.g. admission to Y time e.g. time pressure ulcer identified or from the point where the skin was last intact to the point that the pressure ulcer was identified.*
- *That the process will adhere to the principles of natural justice and fair procedures*

Composition of the Review Team

Whilst it is not necessary to identify by name members of the Review Team at this stage the composition by title/profession should be listed here

Contacts in relation to the review process.

Commissioner of the Review	
Name	
Title	
Email	
Telephone	
Service User Designated Support Person	
Name	
Title	
Email	
Telephone	
Staff Liaison	
Name	
Title	
Email	
Telephone	

[28] Once these are established. See https://healthservice.hse.ie/staff/news/latest-updates-on-regional-health-areas-in-the-hse/

Appendix 4. Conducting a Concise Review Guidance

Responsibility to Review

The primary responsibility for commissioning a review is as follows;

1. Category 1 incidents - the Senior Accountable Officer
2. Category 2 incidents – the Local Accountable Officer i.e. the manager of the service in which the pressure ulcer occurred.

QPS or Tissue Viability staff (or equivalent) may be consulted with in relation to advice on the review process

Terms of Reference

The terms of reference should have been set out in the *Preliminary Assessment to Assist Review Decision Making Form – Part B – Record of Decision.*

Who Should Be Involved?

The review should seek the involvement of relevant staff i.e. those on duty at the time the pressure ulcer was identified, the line manager in the relevant area and the Service User.

The Service User should be contacted to advise them of the plan for review and to ask them if there are any specific issues that they would like to see addressed by the review. This engagement also provides an opportunity to clarify the purpose of the review, the likely timeframe for completion and how they will be advised of the outcome.

In relation to staff whilst there is no requirement to conduct formal interviews it is important to engage with staff to understand their involvement and gain their perspective. This can be done on a one to one basis or by way of a multidisciplinary meeting.

If engaging on a multidisciplinary basis it is important to facilitate this in a way which focuses on learning. To ensure that the process is open and participative the following ground rules should be set at the outset: everyone's perspective is valued (regardless of their grade/profession); it is not about blame or finger pointing; and the focus is on understanding why the pressure ulcer occurred and what can be learned in order to prevent any further deterioration of the pressure ulcer identified and to prevent any further pressure ulcers occurring to this Service User or other Service Users.

The Report

The template for the report is set out below and this should be used in **all** circumstances and completed in **full**. This is important so that services can conduct an aggregate analysis of their concise reports to identify further learning.

Much of the template reflects information gathered in the completion of the *Preliminary Assessment to Assist Review Decision Making Form Part A* earlier in the process. The blank template is 6 pages long and it is anticipated that a concise report when complete should not exceed 10 pages.

The review report is divided into the following 14 sections. *It is recommended that you print off this table when drafting the report as it will serve as a guide to completion.*

Section	Detail to be included
1. Introduction	This section should include information about the services commitment to quality and how the learning from this review will inform safety improvement. It should also contain detail of the approach to review used, the information considered, and the source of this information e.g. healthcare record, discussion with key staff etc. Detail of the disclosure of the pressure ulcer and the apology provided to the Service User should be included here.
2. Details of Service User and Pressure Ulcer	Concise details of the Service User's background i.e. when and why they were admitted and brief detail of their medical and social history. Description of the pressure ulcer i.e. its location, category/stage should be included and detail of immediate actions taken following its identification. The section on involvement of the Service User relates to the period following identification of the pressure ulcer.
3. Issues relating to the Service User	Service User related issues are listed in this section. Management of Service User risk factors are a key to pressure ulcer prevention and particular emphasis should be given to this section. Having answered the questions, consider any areas identified where improvement is required and list these. This will assist you when it comes identifying contributory factors and incidental findings and to making recommendations.
4. Issues relating to Environment & Equipment	Environment & equipment related issues are listed in this section. The identification and timely supply of equipment identified as required is key to prevent pressure ulcers. High risk Service Users can develop pressure ulcers quickly if the correct equipment is not available and utilised appropriately. Having answered the questions, consider any areas identified where improvement is required and list these. This will assist you when it comes identifying contributory factors and incidental findings and to making recommendations.
5. Issues relating to Staffing	Staffing related issues are listed in this section. Having answered the questions, consider any areas identified where improvement is required and list these. This will assist you when it comes identifying contributory factors and incidental findings and to making recommendations.
6. Issues relating to Task and Team	Task and team related issues are listed in this section. The prevention of pressure ulcers is optimal when staff work as a team to ensure that all tasks required are undertaken in a consistent and complete manner. Having answered the questions, consider any areas identified where improvement is required and list these. This will assist you when it comes

	identifying contributory factors and incidental findings and to making recommendations.
7. Issues relating to Policies and Procedures	Policy and Procedure related issues are listed in this section. Pressure ulcer prevention must be underpinned by robust policy which is based on best practice, available, workable and in routine use. Having answered the questions, consider any areas identified where improvement is required and list these. This will assist you when it comes to identifying contributory factors and incidental findings and to making recommendations.
8. Issues relating to Staff Training and Education	Staff training and education related issues are listed in this section. Though a service may have the relevant policies and procedures in place, staff training and education is essential if these are to underpin practice. Having answered the questions, consider any areas identified where improvement is required and list these. This will assist you when it comes identifying contributory factors and incidental findings and to making recommendations.
9. Issues relating to Communication	Communication related issues are listed in this section. Communication is vital and it is essential that all those caring for the Service User are aware of their risk of developing a pressure ulcer. Communication can be achieved at handovers of care, through signage and other means. Having answered the questions, consider any areas identified where improvement is required and list these. This will assist you when it comes identifying contributory factors and incidental findings and to making recommendations.
10. Statement of Findings	Statements which describe the relationships between the contributing factors and the incident and/or outcome. In relation to pressure ulcers, the Statement of Findings relates to that outlined below. 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. Depending on the information gathered so far in the review, amend the above Statement of Findings as appropriate to the case 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. If a Service User has many risk factors **and** all preventative measures were in place it may be that there was no Statement of Findings i.e. that the pressure ulcer was not preventable. That does not mean that learning cannot take place and improvements made to the care of other Service Users.
11. Contributory Factors	These should link to the Statement of Findings. As part of the completion of the sections relating to issues (3 – 9 above) you will have identified issues relating to the prevention of pressure ulcers. These may have either been contributory or incidental to the development of the pressure ulcer. ***Contributory factors are defined as a circumstance, action of influence which it is thought to have played a part in the origin or development of the pressure ulcer or to increase the risk of development of the pressure ulcer.*** List these here starting with the issue e.g. Task – That the Service User, though having had a nutritional risk assessment, was not provided with the nutritional supports required.
12. Incidental Findings	These are areas identified in the course of the review, as requiring improvement but did not cause or contribute to the incident.
13. Notable Practice	The inclusion of notable practice is important in providing balance to the report as they highlight positive aspects of the service. Points such as how the service responded to the Service User and managed the pressure ulcer at the time of identification can be included here. Consider also including detail of any immediate actions put in place within the service to prevent a similar event occurring to other Service Users.
14. Other Issues of Note	These should include detail of the response to any queries raised by the family/carers at the outset of the review that are not dealt with in the above report.
15. Review Outcome	Pick one of the following outcomes and enter it in section 11 of the report. **Appropriate care and/or service (Good/Notable Practice)** • Well planned and delivered, unpreventable outcome and no Statement of Findings identified. **Indirect system of care/service issues** • No Statement of Findings identified but Incidental Findings were identified i.e. improvement lessons can be learned but these were unlikely to have affected the outcome. **Minor system of care/service issues** • A different plan and/or delivery of care may have resulted in a different outcome. For example, systemic factors were identified although there was uncertainty regarding the degree to which these impacted on the outcome. **Major system of care/service issues** • A different plan and/or delivery of care would, on the balance of probability, have been expected to result in a more favourable outcome. For example, systemic factors were considered to have an adverse and causal influence on the outcome.

16. Recommendations	Recommendations must be linked to the Statement of Findings and Contributory Factors as they aim to reduce the risk of pressure ulcers occurring to this or other Service Users. This is linked to the purpose set out in the Introduction i.e. improving safety and preventing harm to others.
17. Arrangements for Shared Learning	Consider how you will share the learning from this review to; • Staff within the ward where the pressure ulcer occurred • Staff within the hospital/residential unit where the pressure ulcer developed • Within the CHO/HG e.g. through the relevant Quality and Safety Committee (or equivalent) and have it included in an aggregate review of pressure ulcer incidents.
18. Sign off	Prior to completion of this section the draft report should be considered in the context of the Governance Approval Process for Final Draft Reports (please refer to Section 16 of the HSE Incident Management Framework). It is the responsibility of the Commissioner of the report to ensure that the above consideration is carried out. The draft report is then submitted to the Commissioner. Based on a satisfactory review of the report and its acceptance by the Commissioner, the report is then considered final. Completed reports must be uploaded onto NIMS. Review screens on NIMS must be completed at this stage as the availability of this summary information is important to assist with aggregate analysis.

Appendix 5. Pressure Ulcer Review Report Template

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

PRESSURE ULCER INCIDENT REVIEW REPORT[29]

CONFIDENTIAL

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.

[29] link to template available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/incident-management.html

Review Report Part 1

INTRODUCTION
Click here to enter text.

SECTION 1: DETAILS OF SERVICE USER
Background Click here to enter text.
Reason for Admission/Referral:
Date and details of Admission/ First Contact:

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:									

	Process	**Tick if Yes**
Detail engagement with the Service User since the identification of the Pressure Ulcer and prior to the review:	Open Disclosure?	
	Date of Open Disclosure	
	Designated Support Person identified for Service User?	
	Name:	

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:			

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.

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: 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**				
If Yes, please detail:							
Any Additional Information:							
Based on the above assessment, identify any areas where improvement is required:							

SECTION 6: ISSUES RELATING TO TASK & TEAM			
A. 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?	Enter date		
	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:	Enter date		
	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:			
B. 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:			

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:		

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:		

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

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.*

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

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

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

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

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

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

SECTION 17: ARRANGEMENTS FOR SHARED LEARNING	
Learning has been shared in the following manner	
1	
2	
3	
4	
	Add additional rows as required

SECTION 18: SIGN OFF		
	Yes	**No**
Were the Service User[30] 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:		

[30] 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.

Appendix 6. Membership of the Pressure Ulcer Review Guide Development Group (2018)

- Cornelia Stuart, Assistant National Director, Quality Risk and Safety, Quality Assurance and Verification Division (Chair)
- Deirdre Carey, Risk & Incident Officer, Acute Hospitals Division
- Fiona Concannon, Clinical Nurse Specialist Tissue Viability and Wound Management, CHO 9
- Geraldine Craig, Clinical Nurse Specialist Tissue Viability, Our Lady of Lourdes Hospital, Drogheda
- Catherine Hogan, Quality Improvement Division
- Pat McCluskey, Advanced Nurse Practitioner Wound Care and Tissue Viability, Cork University Hospital
- Margaret McGarry, Risk Manager, Quality Risk and Safety, Quality Assurance and Verification Division
- Professor Zena Moore, Professor and Head of the School of Nursing and Midwifery, Royal College of Surgeons in Ireland
- Annette Ridley, Risk Advisor, University of Limerick Hospitals Group

Appendix 7. Membership of the Pressure Ulcer Review Guide Review Group (2022)

- Dr. Samantha Hughes, Incident Management Team, QPSD
- Professor Zena Moore, Professor and Head of the School of Nursing and Midwifery, Royal College of Surgeons in Ireland
- Fiona Concannon, Clinical Nurse Specialist Tissue Viability and Wound Management, CHO 9
- Maureen Nolan, Director of Nursing, ONMSD
- Gillian O'Brien, Registered Advanced Nurse Practitioner Tissue Viability, Naas Hospital
- Helen Meagher, Registered Advanced Nurse Practitioner Tissue Viability, UL Hospitals Group, University Hospital Limerick

Thank you also to all those who participated in the consultation process, including the National Quality and Patient Safety Teams in HSE Acute Operations and HSE Community Healthcare. Thank you also to the QPSD Team and the QPSD Incident Management Team members who contributed to reviewing this document.