# Pressure Ulcer Preliminary Assessment to Assist Review Decision Making

**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**

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| **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:** |

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| **Section 2: Pressure Ulcer Details**  |
| Date of first observation of Pressure Ulcer(s):  |  |
| Total number Stage III Pressure Ulcers present: |  | Total number Stage IV Pressure Ulcers present: |  |
| *Tick the specific anatomical site(s) AND state category/stage of each pressure ulcer at each site:* |
| **Sacrum** | [ ]  |  | **Left Buttock** | [ ]  |  | **Left Hip** | [ ]  |  | **Ears** | [ ]  |  | **Other** | [ ]  |
| **Left heel** | [ ]  |  | **Right Buttock** | [ ]  |  | **Right Hip** | [ ]  |  | **Other (state site):** |
| **Right heel**  | [ ]  |  | **Scalp** | [ ]  |  | **Spine** | [ ]  |  |
| Actions Taken by the Service since the Pressure Ulcer was identified and prior to this review: |
| Detail engagement with the Service User since the identification of the Pressure Ulcer and prior to the review:  | **Process** | **Tick if Yes** |
| Open Disclosure?  | [ ]  |
| Date of Open Disclosure |
| Designated Support Person identified for Service User?  | [ ]  |
| Name:  |

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| **Section 3: issues relating to the Service User**  |
| **Did the Service User have any of the following risk factors for pressure ulcer development prior to the initial observation of the pressure ulcer?** | **Yes** | **No** |
| Sensory impairment (neurological disease resulting in reduced sensation and insensitivity to pain | [ ]  | [ ]  |
| Reduced level of consciousness  | [ ]  | [ ]  |
| Deterioration in Service User’s condition whereby the Service User may have been hypotensive, hypothermic, hypoxic, pyrexia, septic etc. | [ ]  | [ ]  |
| Has the Service User had a period of prolonged collapse / injury / immobilisation prior to presentation to hospital which may correlate with presentation of tissue damage? | [ ]  | [ ]  |
| Severe chronic or terminal illness (multi-organ failure, poor perfusion and immobility) | [ ]  | [ ]  |
| Previous history of a pressure ulcer at site of current pressure ulcer ulceration | [ ]  | [ ]  |
| Diagnosed or suspected Peripheral Vascular Disease | [ ]  | [ ]  |
| Sustained pressure from medical related device e.g. from orthopaedic casting, tubing etc. | [ ]  | [ ]  |
| Was the Service User a) fully mobile, b) limited movement dependant on others, c) bed bound d) chair bound? | Enter a, b, c or d |
|  | **Yes** | **No** | **n/a** |
| Has the Service User had a period of prolonged collapse/injury/immobilisation which may correlate with presentation of tissue damage?  |[ ] [ ] [ ]
| Is the Service User unable to maintain position?  |[ ] [ ] [ ]
| Has the Service User declined repositioning? |[ ] [ ] [ ]
| Is the Service User unable to be repositioned satisfactorily due to medical condition e.g. fractures, respiratory disease, spinal precautions, pain etc.? |[ ] [ ]   |
| Was the Service User a) fully continent, b) urinary incontinence only, c) urine and faecal incontinence or d) catheterised and faecal incontinence?  | Enter a, b, c or d |
|  | **Yes** | **No** |
| Does the Service User have Moisture Associated Skin Damage? |[ ] [ ]
| Has the Service User a body weight BMI <20 or BMI > 35? |[ ] [ ]
| **Any Additional Information:** |
| **Based on the above assessment, identify any areas where improvement is required:** |

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| **Section 4: Issues relating to the Environment & Equipment**  |
| **Was all equipment identified as required to prevent pressure ulcer prevention available and in use?** |
| **Equipment** | **Indicated** | **Type** | **Date Ordered** | **Date Available** | **In use at time PU identified?** |
|  | **Yes** | **No** |  |  |  | **Yes** | **No** |
| **Mattress** |[ ] [ ]   |  |  |[ ] [ ]
| **Cushion** |[ ] [ ]   |  |  |[ ] [ ]
| **Heel Protectors** |[ ] [ ]   |  |  |[ ] [ ]
| **Any Additional Information:**  |
| **Based on the above assessment, identify any areas where improvement is required.** |

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| **Section 5: Issues relating to Staffing**  |
| What is the approved staffing and skill mix on the ward/unit? *(applicable to hospitals and residential units only)* | Nurse:  | HCA:  | Student:  |
| If a hospital/residential unit, what is the bed capacity for the ward/unit? |   |
| Have there been any issues in relation to staffing/skill mix in the past week that have impacted on the provision of pressure ulcer prevention interventions required by this Service User?  | **Yes** |[ ]  **No** |[ ]
| **If Yes, please detail:**  |
| **Any Additional Information:**  |
| **Based on the above assessment, identify any areas where improvement is required:** |

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| **Section 6: Issues relating to Task & Team**  |
| 1. **Task Factors**
 | **Yes** | **No** |
| Is there documented evidence that skin was inspected within 6 hours **of presentation** to Emergency Department, admission to the ward or on **first** community visit?  |[ ] [ ]
| Was a pressure ulcer risk assessment carried out within 6 hours **of presentation** to the Emergency Department, admission to the ward or on **first** community home visit? |[ ] [ ]
| What risk assessment scoring system was used e.g. Waterlow, Braden/Other? | Enter Name |
| What was the pressure ulcer risk assessment score on admission?  | Enter Score |
|  | **Yes** | **No** |
| Was there evidence of on-going pressure ulcer risk assessment prior to the development of the pressure ulcer? |[ ] [ ]
| What was the pressure ulcer risk assessment score on the date the pressure ulcer was identified? | Enter Score |
|  | **Yes** | **No** |
| Was there evidence that a pressure ulcer prevention plan was in place (e.g. SSKIN bundle or specific pressure ulcer care plan?  |[ ] [ ]
| Is there evidence that the pressure ulcer prevention plan in place (e.g. SSKIN bundle or specific pressure ulcer care plan**)** was completed in full as appropriate to the date the Service User was assessed as ‘at risk’? |[ ] [ ]
| Was the frequency of skin inspection stated on the care plan? |[ ] [ ]
| Was a wound assessment chart documenting the pressure ulcer assessment and management plan completed?  |[ ] [ ]
| What date was the first identification of skin damage documented in the nursing notes?  |  |
|  | **Yes** | **No** | **N/A** |
| Has the Service User been > 2 hours in Theatre up to 6 days prior to identification of the pressure ulcer?  |[ ] [ ]   |
| Was there evidence of on-going pressure ulcer risk assessment prior to the development of the pressure ulcer? |[ ] [ ]   |
| If the Service User was dependant, was there evidence of a written repositioning schedule when the Service User was sitting/in bed? |[ ] [ ] [ ]
| Was the frequency of repositioning appropriate to the risk identified? |[ ] [ ]   |
| If the Service User was incontinent, had the Service User an Elimination Care Plan in place?  |[ ] [ ]   |
| If the Service User was incontinent Is there evidence that a skin cleanser and skin barrier protector were used as part of the skin care regimen? |[ ] [ ]   |
| Did the Service User have a nutritional risk assessment? |[ ] [ ]   |
| Date nutritional risk assessment carried out: |  |
|  | **Yes** | **No** | **N/A** |
| If indicated from the nutritional risk assessment has the Service User been offered nutritional support (such as fortified diet advice or supplements)? |[ ] [ ] [ ]
| Was Service User/carer information in relation to pressure ulcer prevention provided? |[ ] [ ]   |
| **Any Additional Information:**  |
| **Based on the above assessment, identify any areas where improvement is required:** |
| 1. **Team Factors**
 | **Yes** | **No** | **N/A** |
| If available, was the TVN involved in the pressure ulcer management plan?  |[ ] [ ] [ ]
| Is there evidence that the medical team / GP were aware of the Service User’s elevated risk status for pressure damage/developing skin damage? |[ ] [ ] [ ]
| If the Service User had reduced mobility were they referred to physiotherapy for additional advice or mobility rehabilitation? |[ ] [ ] [ ]
| If the Service User had nutritional or feeding needs identified were they referred to the Dietician/ Speech & Language Therapist for additional advice / support? |[ ] [ ] [ ]
| If the Service User was identified as requiring specialist advice for seating/equipment were they referred to the Occupational Therapist?  |[ ] [ ] [ ]
| Was there evidence that the Service User’s family/carers were involved in the care plan and agreed with it? ***(Note: as appropriate and with appropriate Service User’s consent)*** |[ ] [ ]   |
| **Any Additional Information:**  |
| **Based on the above assessment, identify any areas where improvement is required:** |

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

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

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

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| **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**

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| **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[[1]](#footnote-1): |
| 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** |

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|  **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: |
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| *\* 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.***  |

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| **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. |

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| **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. |

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| **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[[2]](#footnote-2) |[ ]
| 4. Team external to the CHO/HG/NAS Directorate/ Regional Health Area |[ ]

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| **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*
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| **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* |

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| **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 |  |

1. 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. [↑](#footnote-ref-1)
2. Once these are established. See https://healthservice.hse.ie/staff/news/latest-updates-on-regional-health-areas-in-the-hse/ [↑](#footnote-ref-2)