**Appendix 4 Hospital Acquired Pressure Ulcer 72hr aSSKINg Patient Safety Review**

 **All sections must be completed**

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| DATIX incident number: |  |
| Date of DATIX: |  |
| STEIS Reference Number (if STEIS reportable): |
| Hospital number: |  |
| NHS number: |  |
| Patient’s Consultant: |  |
| Date and Time of incident: |  |
| Location (ward) of the PU incident: |  |
| Date patient admitted to the ward/department where the pressure damage originated: |  |
| When did the pressure damage develop(Days into the hospital admission): | 1-7 days |  |
| 8-14 days |  |
| 15-21 days |  |
| >21 days |  |
| Location of Pressure Ulcer(s) and Category: |  |
| Diagnosis/underlying co-morbidities/patient factors relevant to the PU Incident: |  |
| Is there reason to doubt the person’s capacity to consent to every element of care? | YES/NO |
| Has an MCA been completed? | YES/NO/NA |
| Name and job role of person completing the aSSKINg Review/Chronology: | Name: |  |
| Job Role:- |  |
| Date aSSKINg PSR completed:  |  |
| Duty of Candour compliance (for moderate and above harm).Patients and/or their relatives or carers must be informed that an incident has been reported, and that a preliminary review/chronology of events is being completed to establish the facts which will clarify if more in-depth review is required.  | 1. Who has been informed?
 |  |
| 1. Who informed them?
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| 1. How was the contact made? (Phone, letter, email, face to face).
 |  |
| 1. On what date and time were they informed?
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| **Please answer each of the following questions, which will assist in determining if the pressure ulcer was avoidable or unavoidable, (delete Yes/No, as appropriate). The answers must reflect the situation** WHEN the pressure Ulcer was FIRST IDENTIFIED and not AFTERWARDS **(following implementation of pressure ulcer prevention strategies)** |
| **Assessment** | **Has the Braden Risk assessment been completed ASAP/within 6 hours of admission to hospital and updated daily thereafter, as per policy (change in condition, after procedure on transfers)?**  | **YES / NO** |
| **COMMENTS: RISK/S IDENTIFIED, DATE OF FIRST AND LAST BRADEN RISK ASSESSMENT/S AND SCORE:** |
| **Support** | **Is all pressure ulcer prevention equipment appropriate to patient need and was it provided when risk first identified?** | **YES / NO** |
| **Was Heel-Risk identified (diabetics, vascular and neuropathy identified)? Were heels offloaded with pillow or appropriate boots/devices/gel pads?** | **YES / NO** |
| **Have all support surfaces (bed/mattress/cushions/boots) been checked and confirmed in good working order?**  | **YES / NO** |
| **COMMENTS AND LIST WHAT EQUIPMENT IS IN PLACE:** |
| **Skin checks** | **Have all other vulnerable/at-risk areas been checked daily? This includes checking under, around and after removal of devices.** | **YES / NO** |
| **Has the body map been completed daily?** | **YES / NO** |
| **Have the heels been checked daily?** | **YES / NO** |
| **COMMENTS AND LIST FREQUENCY OF SKIN INSPECTION:** |
| **Keep moving** | **Is a repositioning schedule (SSKIN Bundle) in place? And, Is repositioning provided as per the schedule?** | **YES / NO** |
| **Have discussions taken place with patient/carers/relatives with regard to the need for regular movement/repositioning?** | **YES / NO** |
| **COMMENTS:** |
| **Incontinence** | **Does the patient have any issues with incontinence? Have all appropriate strategies (MASD Pathway) been implemented to manage moisture (all types)?** | **YES / NO** |
| **COMMENT:** |
| **Nutrition** | **Has a MUST score been completed within 24hrs and updated regularly?**  | **YES / NO** |
| **Is there evidence of patient nutritional and fluid intake charting/recording?** | **YES / NO** |
| **Have discussions taken place with patient/carers/relatives with regards to the importance of meeting nutritional and hydration needs?** | **YES / NO** |
| **COMMENTS AND DATE OF LAST MUST SCORE UPDATE AND SCORE:** |
| **Giving Information** | **Have all the elements above been fully discussed, as appropriate, with patients, relatives and carers?**  | **YES / NO** |
| **Has the patient, relatives, carers been given written information regarding pressure ulcer prevention (The Trust Pressure Ulcer Prevention Leaflet), from the time of admission?** | **YES / NO** |
| **Was understanding and retention of information checked? Mental capacity assessed?** | **YES / NO** |
| **Have patient compliance issues been identified and recorded? Is there a plan for non-compliance?** | **YES / NO** |
| **COMMENTS:** |
|  | **If any answers in RED from the above list have been selected, the pressure ulcer may be as the result of lapse(s) in care and may require reporting onto STEIS which would require a full chronology and full investigation being completed.** |
| **Additional questions that are required to be answered.** |
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| **Tissue Viability Referral** | **Has the patient been referred to the Tissue Viability Team?****Date of referral:**  | **YES / NO** |
| **PLEASE NOTE *ALL* CATEGORY 3, 4, DTI, Unstageable PRESSURE DAMAGE REQUIRES A REFERRAL TO THE TISSUE VIABILITY SERVICE** |
| **Safeguarding** | **Have all elements of pressure ulcer prevention, with regards to local safeguarding adult guidance?** | **YES / NO** |
| **Has a safeguarding concern been raised to the appropriate local authority safeguarding adults’ team?** | **YES / NO****N/A** |
| **IF YES, DATE OF REFERRAL MUST BE COMPLETED: -**  |  |
| **Please indicate if this is deemed to be a new OR deteriorating pressure ulcer and whether a lapse(s) in care are indicated.** |
| **“New” or “Deteriorating” pressure ulcer** |  | **Lapses in care indicated.** | **YES / NO** |
| **Please detail your rationale below:** |

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| **Current treatment plan for this patient and their pressure ulcer/s** |
| **Daily Braden risk assessment** **Daily Body map/head-to-toe skin inspection****Wound care-plan/chart in place****SSKIN Bundle (*specify planned frequency*)****Specific repositioning plan/techniques (*specify what they are*)****Physiotherapy referral/plan (*specify*)****Occupational therapy referral/plan (*specify*)****Air mattress in-situ (*specify which type*)****Air cushion in-situ (*specify which type)*****Heel devices in-situ (*specify which type*)****Incontinence/Moisture management plan (*specify* *what the plan is*)****Nutrition plan (*specify*)****Dietitian referral****Patient compliance issues (*specify what the plan is to manage this/these*)****Pressure ulcer/s is included in the ward handover/handover sheet****Discharge planning/Transfer of care information includes the pressure ulcer** |

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| **STEIS reportable** | **YES / NO** | **Name of Lead who approved STEIS reporting**  |  |
| **Date reported onto STEIS** |  | **Signature** |  |
| **Comments/rationale for why incident is STEIS reportable.** |

**Immediate ward actions taken to ensure staff/patient safety**

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| **Immediate action required** | **Closure date**  | **Date closed**  | **Actioned by whom** |
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**Signature**

**Tissue Viability Nurse Specialist : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PSR Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**Divisional Matron: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Final Sign-off Date (divisional matrons’ meetings): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Please scan and uploaded to Datix report once signed off)**

**11. Version Information**

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| --- | --- | --- | --- |
| **Version No.** | **Updated By** | **Updated On** | **Description of Changes** |
| 1.0 | Zoë Evans Lead Tissue Viability Clinical Nurse Specialist | 04/09/2023 | New Policy |
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