PRESSURE ULCERS (PU) SIGNIFICANT ADVERSE EVENT (SAE) REVIEW TEMPLATE

Please read the Adverse Event Review Protocol before initiating this review.

Please use this Significant Adverse Event (SAE) template for **review of all NHS Lothian acquired Grade 4 Pressure Ulcers**: For all grade 4 Pressure Ulcers acquired outwith NHS Lothian care, refer to Pathway for reviewing pressure ulcers in Datix record

1. **Complete Appendix A** to provide relevant information for inclusion in the report.
2. **Include details of hospital/ward or community nursing base**
3. **Reviewer(s) names and designations must all be included in full,** in designated boxes.
4. **Do not include person-identifiable information in the body of the report** – identify persons by patient A/ doctor B.
5. **Save the template securely** on your NHS shared drive **until complete**.
6. **Once completed, update the document control details (within the footer) and attach document to the relevant Datix adverse event as 'Draft'.**

Please complete Appendix A before completing this section

DATIX ID Number:	**Was the pressure ulcer acquired under NHS Care** If so, ward/DN/own home	**Site, Harm Level & Outcome e.g. Hip, Grade 4 - Major**	**Date PU noted:**
Reviewer(s):	**Date Review Started:**	**Date Review Completed:**	**Reported to:** Whoever commissioned the review, Names and Designations
Date referred to Tissue Viability: (if not, reasons)			

When and how did this Pressure Ulcer occur? (What has changed recently)
Background/Timeline to this pressure ulcer episode/deterioration (Relevant timeline leading to the event , include date(s), time(s) and score (risk level) e.g. Waterlow, skin check
Actions Taken as a Consequence of the Assessment(s): (Was there a current care plan and evaluation? What was included e.g. Wound care, equipment, skin check frequency)
Family/Next of Kin Aware (with patient consent): (Date and time, family informed of PU. Were family involved / invited to be involved in the review process? Please ensure that any questions the family have are considered as part of the review.)

Review Outcome (Please indicate the outcome of the review using the codes below)		
1.	Appropriate care - well planned and delivered with no care or service delivery problems identified	
2.	Care or service delivery problems were identified and lessons can be learned though this did not affect the final outcome/ event.	
3.	A different plan and/or delivery of care may have resulted in a different outcome though uncertainty regarding impact on patient outcome/ event.	
4.	A different plan and or delivery of care, on balance of probability, would have been expected to result in a more favourable outcome, i.e. how case was managed had a direct impact on the level of harm	

After review do you consider the PU reported was either: (*Definitions at end of template)	
Avoidable* (some aspect of NHS assessment or care missing) e.g. Outcome 3 or 4: Consider Duty of Candour	**Unavoidable*** (all care given & other contributory factors affected development) e.g. Outcome 1 or 2

Factors which could have contributed to the PU

What factors in Appendix A contributed to the pressure ulcer? This information can then be used to inform and develop the improvement plan.

Factor Type	Factors relevant to the PU
Patient factors	
Social Factors	
Task and Technology factors	
Individual (staff) factors /Team factors	
Work Environment Factors	
Organisational and Management factors	

Please note good practice below:

Lessons to Learn and Improvements to be made

Improvements	Level of Recommendation (Individual, Team, Service Directorate, Organisation)	By Whom	By When	Resource Requirements	Evidence of Completion	Completion Sign-off

Author:	Date:

This SAE cannot be closed on Datix until this report has completed the formal governance approval process. The SAEs will be closed at the end of the process by Quality Improvement Support Team staff.

This sign-off process can be found on the NHS Lothian intranet under: Healthcare > A-Z > Risk Management > *SAE Sign-off process*

SIGNED OFF AT OPERATIONAL LEVEL BY: (IF SIGNIFICANT ADVERSE EVENT):	
Acute: Site/Service Director (or nominated member of CMT) **REAS: Director of Operations** **H&SCP: Joint Director (or nominated member of JMT)**	**Signed:** **Date:**
Acute: Site/Services Nurse/Medical Director **REAS: Associate Medical Director/ Chief Nurse** **H&SCP: Clinical Director/Chief Nurse**	**Signed:** **Date:**
FINAL APPROVAL AT BOARD LEVEL BY:	
NHS Lothian Board Medical Director	**Signed:** **Date:**
NHS Lothian Board Nurse Director	**Signed:** **Date:**

Appendix A – complete using patient notes/EPR				
Factors which could have contributed to the Pressure Ulcer (PU) Consider factors listed and identify those which contributed to the PU. This information can then be used to inform and develop your improvement plan.				
Patient Factors: Were there any underlying reasons why this patient was more likely to develop a PU?	**Y**	**N**	**NA**	**Comments/additional information**
Reduced mobility				
Sensory / Cognitive impairment				
Pain				
Extremes of age e.g. young babies, older people				
Extremes of size e.g. obese, very thin				
Underlying circulatory problems e.g. PAD, CVA,				
Spinal injury				
Malnutrition etc.				
Previous healed pressure ulcer in same location on body				
Previous surgery to area affecting tissues e.g. flap surgery				
Increased moisture on skin e.g. incontinence, sweat, other body fluids				
Were there any issues identified with patient/carer/family which contradicted the proposed care plan? (e.g. refusing equipment, not agreeing to skin checks or position changes etc.) please specify				
If yes, was it documented that advice and support was given regarding the need to follow proposed care plan?				
Social factors : External factors related to social situation which may have impacted on PU development	**Y**	**N**	**NA**	**Comments/additional info.**
Chaotic lifestyle				
People who inject drugs				
Lack of support				
Interaction with healthcare services etc.				
Was the patient/carer/family involved in the care plan development? please specify				
Was the patient/carer/family involved in the delivery of the patient's goal(s)? please specify				
Task/Technology factors: Were all aspects of assessment, care planning and review in place?	**Y**	**N**	**NA**	**Comments/additional information**
Was Waterlow/PPURA (adults) or Glamorgan (children) risk assessment carried out within 6 hours of admission to an in-patient setting OR first clinician visit in community				
If Waterlow/Glamorgan score was $\geq$10 was a SSKIN Bundle or Care Rounding Tool in place for PU prevention?				
Was the Waterlow/Glamorgan/PPURA reassessed according to patient's condition or on transfer to another area? e.g. changes in patient condition, pre and post- op				
Was a PU prevention care plan in place when risk identified?				
Was PU care plan followed and updated as changes to patient condition were noted?				
Was the pressure ulcer graded according to the Scottish Adaptation of the EPUAP grading tool?				
Were Care Rounding **/SSKIN** bundle element review times appropriate to level of risk/skin damage identified?				

Skin - Was skin assessed as per prescribed time intervals/care plan?				
Was a wound chart completed, accurate and updated?				
Was the wound treatment plan appropriate?				
Surface- Was the patient's mattress suitable for their condition?				
If patient was sitting up, was the chair and/or cushion suitable for the patient?				
Keep Moving - Was repositioning/off-loading carried out as per prescribed time intervals/care plan?				
Incontinence - If patient was incontinent has a review of bladder/bowel function/management taken place? Were appropriate skin protectors used as per formulary?				
Nutrition - If patient required additional nutritional support, did they receive this? e.g. assistance with meal, supplements				
Individual/Team factors:	**Y**	**N**	**NA**	**Comments/additional information**
Was Patient/carer 'Prevent PU' leaflet and/or advice given by staff?				
Staff trained in PU prevention including skin assessment, use of equipment etc.				
Were there any issues around written communication /documentation/ notes?				
Were there any other team factors that may have contributed to the PU?				
Work Environment factors: Equipment working and in place in a timely manner: If no, please explain	**Y**	**N**	**NA**	**Comments/additional information**
Therapeutic mattresses available e.g. foam (pentaflex), static air (repose), alternating pressure (nimbus etc), low air loss (breeze, ambience)				
Cushions e.g. foam (propad), foam + gel/polymer (flotech, dynatech gel), altering pressure (Aura, Talley BASE)				
Hoist plus appropriate slings				
Glide sheets or other transfer aids				
If patient required additional pressure redistribution equipment was this available? (e.g. heel protectors / heel elevators, dermal-type replacement pads/strips)				
If pressure damage is related to a medical device, was there a care plan in place to reduce associated risk?				
Organisation and Management factors: Were the following available if required:	**Y**	**N**	**NA**	**Comments/additional information**
Extra equipment purchased e.g. heel protectors(Repose), heel lift boots, cushions				
Nutritional support e.g. dietetic review, dietary supplements, special diet, etc.				
Specialist input e.g. TVN, Physio, OT, continence team etc.				
Senior management involvement				
Local management structures				
Consider if patient has been boarded and impact on communication etc.				
Were there any other organisational and management factors that may have contributed to the PU?				

Provide details of any other relevant information relating to the development of the PU e.g. co-morbidities, over activity, non-compliance issues etc.	
Completed by (Name & Designation):	**Date:**

Definition of Avoidable/Unavoidable Pressure Ulcer

Avoidable Pressure Ulcer	Unavoidable Pressure Ulcer
The person receiving the care developed a pressure ulcer and <u>the provider of care did not do one of the following</u>; • Evaluate the person clinical condition and pressure ulcer risk factors; • Plan and implement interventions that are consistent with the persons needs and goals and recognised standards of practice; • Monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.	**The person receiving the care developed a pressure ulcer <u>even although the provider of the care did the following;</u>** • Evaluated the person's clinical condition and pressure ulcer risk factors; • Planned and implemented interventions that were consistent with the person's needs and goals; • Recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; • There is documented evidence the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence.

Reference: Tissue Viability Society. Achieving Consensus in Pressure Ulcer Reporting. JTV 2012