Structured Judgement Review Template (Inpatient PU)

(Red text provides examples only, is not exhaustive and should be deleted before submission of review)

Overview of service user and summary of needs

Date of admission, rationale for admission, diagnosis, cognitive state, continence and toilet use, mobility, ability to undertake ADLs and personal care independently, subject to DoLs? Was a mental health capacity assessment carried out? If applicable, was the safeguarding team involved.

Summary of assessments

- *Waterlow*
- *aSSKINg*
- *MUST*
- *GULP*
- *Continence*
- *Moving and handling*
- *Pain*

When were the assessments completed? Is this in line with Trust Guideline? Who were the assessments completed by? Did they have the appropriate level of training to undertake the assessments? Where were the assessments recorded?

Scope and terms of reference

- *To establish the sequence of events that led to the incident.*
- *To establish whether failings occurred in care and/or treatment.*
- *To identify learning opportunities and improvements and to formulate realistic recommendations for practice that will address the root causes of the incident.*
- *To present the key findings in a report that will serve as a record of the incident review*
- *To identify areas of best practice and share accordingly*

Information and evidence gathered

- *Clinical records*
- *Policies and Procedural Guidance*
- *National Guidance*
- *Training records*
- *Supervision records*
- *Staff interviews*
- *Local policies and procedural guidance*

Involvement and support of patient/relatives in the incident review/ How being open and duty of candour principles have been upheld

- *Initial contact made? Flo appointed?*
- *What discussion has been held with the patient/relatives regarding the PU?*
- *Has a DoC letter been sent?*
- *Who will discuss the outcome of the incident review with the patient/relatives?*

PMH

Patient age, social situation as relevant. Full details of past medical history as relevant to the incident EG diabetes, peripheral vascular disease, history of pressure ulcers, extremes of age, dementia, depression, poor nutritional intake, reduced mobility. ***Relevant*** *details of patient's involvement with services including previous admissions.*

Medication

Summary of medications admitted on and any new medications/medication changes prescribed during this hospital admission and rationale for this. Ensure inclusion of PRN and night drugs.

Detection and summary of incident

How the PU was detected and immediate assessment and action/care planning/referral (where appropriate).

Timeline - this should be a summary of the specific key points which led to the incident occurring i.e. omissions in care delivery, delay in treatment plans, deteriorating patient etc.	
Date & Time	**Details**

COMPLETE IN ALL CASES			
QUESTION	**DETAILS/COMMENTS/ACTION (Please identify Yes/No answers)**		
	Yes	**No**	**Detail**
Was a Body Map completed within timeframe set by Policy?			
Was the Pressure Ulcer (PU) risk assessment completed upon admission to A & E or case load? What was the score?			
Is there evidence that the PU risk assessment was reviewed weekly in accordance with Trust Policy?			
Please provide dates & scores of PU risk assessment assessments starting with the most recent:-	N/A	N/A	Date: Score: Date: Score: Date: Score:
Was the Body Map completed weekly in line with Trust Policy?			

	Yes	No	Detail
Was the aSSKINg assessment undertaken daily (or more frequently as required?			
Did the patient have a sensory impairment?			
Is there evidence that the patients' skin was inspected, monitored & documented daily?			
Was there an identified clinical need for a dynamic pressure relieving mattress/cushion? If yes, date ordered. Any equipment issues that were a factor in this incident?			Date:
Was the patient stepped up/down for mattress provision following reassessment?			
Time/hours spent in bed/chair per day			Chair: Bed:
Was the patient concordant with pressure equipment?			
Was the patient able to reposition independently?			
Are there any Safeguarding concerns that should be raised, as per Safeguarding Adults Best Practice Matrix? (provide details and date)			
Was a repositioning plan implemented?			
Was the repositioning plan appropriate to meet the patients;' needs?			
Did the patient receive all repositioning as identified from evidence reviewed?			
Did the patient have three times daily Heel checks undertaken?			
Were Heels 'floated' at all times if appropriate? Were offloading aids used?			
Was there any incontinence/moisture damage to the skin?			Urine □ Faeces □ Sweat □
If yes, please provide details of the skin care plan that was implemented? Was the care plan followed?			
Were barrier products applied to the skin? If yes, how often?			
What continence aids were used?			
Was the patients' MUST score completed within 6 hours of admission to the Trust or during first visit?			
Was the patient identified as being dehydrated?			
Was the patient nutritionally compromised? What was their BMI?			

	Yes	No	Detail
Did the patient require a diet/fluid chart?			
If yes, have all charts been completed to provide adequate details of the patient's dietary/fluid intake?			
Was the patient referred to the Dietician?			
Has there been a rapid deterioration in the patient's medical condition?			
Was the patient concordant with advice?			
Is there documentary evidence that the patient has been given advice on consequences of refusing care/advice?			
Have we involved the family/carers to help with understanding of the information?			
Is there evidence of re-assessment and evaluation of care plans?			
Were correct referrals made and MDT staff involved in the care plan?			
Were specialist care plans followed?			
Was the patient information leaflet provided? If not, why not?			
Does the patient have Mental Capacity?			
Was a DOL's required/in place?			
Have any Safeguarding issues been identified?			***Safeguarding trigger question examples:*** • *Were all appropriate assessments and prevention measures in place?* • *Were there previous concerns identified but not addressed by the organisation?* • *Were there insufficient prevention measures in place such as training, supervision and auditing?* • *Has there been numerous PU's affecting more than one patient from the same care setting requiring specialist TVN attention?*

Care and service delivery problems identified/Contributory factors

Identify all the care and service delivery problems involved in the incident – these are the elements that went wrong in the provision of care to the patient/event – use the contributory factors framework. It is essential that each CDP/SDP has an accompanying contributory factor.

- ***Care and Service Delivery Problem 1***
  A waterlow assessment was not undertaken on admission
- ***Contributory Factor***
  There was no induction on PU prevention and management new staff
- ***Care and Service Delivery Problem 2***
  Positional changes were not undertaken as recommended from assessment
- ***Contributory Factor***
  There was inadequate information communicated during the shift handover

- ***Care and Service Delivery Factor 3***
  Pressure relieving equipment was not installed in a timely fashion

- ***Contributory Factor***
  There was an ineffective interface for communicating with other providers EG Equipment Supplier

Root causes

The most fundamental underlying contributory factor within the incident that can be addressed. There should be a clear link, by analysis, between the root cause and the effect on the patient. A root cause is not a failure to do something but the understanding behind why something was not done. Could the incident be predicted or prevented?

- *Several of the staff on the ward were not familiar with the assessments*
- *There were insufficient staff to provide adequate supervision.*
- *Staff were unable to access specialist tissue viability advice and equipment*

Even if there is no root cause please outline this: E.g. the review was unable to identify specific and distinctive root causes, but have detailed associated factors that may have influenced the outcome.

Recommendations - These must be reflected in the Action Plan

What are your recommendations to prevent this happening again

Lessons Learned

What are the key areas of learning, for example:

- *Training on PU assessment and aSSKINg should be included in nursing local induction*
- *Ward manager to ensure all staff are up to date with mandatory PU training*
- *Service level agreement/contract with Equipment Provider to be formalised*

Arrangements for shared learning

- *How will this incident be shared with those involved?*
- *How will this incident be shared with others working in a similar area?*
- *Who is this information to be shared with?*

Areas of good practice

Omissions in care?

Summary of conclusion of decision

RECOMMENDATIONS AND ACTIONS – key recommendations for long term quality improvements		
Key recommendation/action 1	**Action Lead:**	
	Target Date:	
	Outcome Measure:	
	Completed date:	
Key recommendation/action 2	**Action Lead:**	
	Target Date:	
	Outcome Measure:	
	Completed date:	
Key recommendation/action 3	**Action Lead:**	
	Target Date:	
	Outcome Measure:	
	Completed date:	
Key recommendation/action 4	**Action Lead:**	
	Target Date:	
	Outcome Measure:	
	Completed date:	
Key recommendation/action 5	**Action Lead:**	
	Target Date:	
	Outcome Measure:	
	Completed date:	