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| **Bolton Nursing Homes - Pressure Ulcer Root Cause Analysis (RCA)**  **Data Gathering Tool**  **(For patients who acquire category 3/ 4 pressure ulcer complete within 5 working days)** | |
| **Stage 1: What were the critical problems** | |
| Patient Initials: | Patients age: |
| RCA Completed by:  Date : | Designation: |
| Date Incident Reported: | Incident Number: CCG purposes only |
| Past Medical History: | Current Medical History: |
| Date and time admitted to Nursing Home: | Were there any transfers/moves after admission?  Give details: |
| Date pressure ulcer was identified: | Category of Pressure Ulcer: |
| Site of pressure ulcer/s please state category and site of each pressure ulcer? | Where did pressure ulcer develop? |
| Was patient identified as at risk of pressure ulcers on admission to the Nursing Home:  Yes / No Waterlow score: | Was the six hour skin inspection completed: Yes/No  Date & Time:  Completed on any transfers: Yes/No  Date &Time |
| List all dates and scores of completed Waterlow: | Is the patient incontinent: Yes / No  If yes - Urine / faeces / both  If yes – date continence assessment completed:    How is the continence managed?  Does the patient have a urinary catheter? |
| List all pressure relieving equipment that has been used and the relevant dates:  (E.g. Mattress and/or cushion etc). | Is the patient independently mobile / mobile with assistance / chair bound / bed bound? |
| Is the patient meeting their nutritional needs?  Yes /No  What is their nutritional score? | Approximate height:  Approximate weight:  Referred to dietician: yes / no / NA |
| Reposition chart commenced:  Yes / No Date: | Is this completed appropriately?  Yes / No |
| Date care plan commenced: | Is this completed appropriately?  Yes / No |
| Have the patient / family / NOK been made aware of the pressure ulcer?  Yes / No Date:  If NO please state why: | Who has the pressure ulcer been reported to within the Nursing Home? |
| Any Vulnerable Adult Concerns: | Describe: |
| **Stage 2: Record - Complete a timeline from the patient’s records review** | |
| What actually happened: (timeline of events include dates & frequency of skin inspections) | What should have happened: |
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| **Stage 3: Root cause – WHY did the pressure ulcer develop** | |
| Why: | Rationale: |
| **Stage 4: Outcome.** | |
| Pressure ulcer is deemed:  Avoidable or Unavoidable | Rationale for decision: |
| **Stage 4: Recommendations.** |  |
| **Actions to be taken:** | **By who and by when:** |
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