Te Tāhū Hauora
Health Quality & Safety Commission

Event of harm review report: Pressure Injury (PI)

This report provides an account of the review undertaken into

The report outlines the analysis, findings and opportunities for improvement. The review is undertaken according to the organisation's review of harm principles, reflecting the Healing, Learning and Improving from Harm national policy https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/national-adverse-events-reporting-policy.

REPORTABLE EVENT NUMBER: [*insert number*]	
Patient name:	Patient location:
NHI Number:	Date and time pressure injury found:
Date of birth Age: Gender:	Site and grade:
Ethnicity:	Date of admission:

REVIEW TEAM	
Role:	**Designation:**
Role:	**Designation:**
Role:	**Designation:** Team member
Meet people who were affected by the PI to seek to understand their experience	**Consumer** **Whānau** **Health care workers**
Date review completed:	

REPORT CONFIRMED AND AUTHORISED BY:			
Signature 1:		**Signature 2:**	
Name:		**Name:**	
Role:		**Role:**	
Date:		**Date:**	

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EXECUTIVE SUMMARY

REVIEW

a. Background- describe the event

b. Influencing Factors (Tick if relevant for this consumer/reside)

Patient factors – that increased likelihood of developing a pressure injury		**Comments**
History of previous pressure injury	☐	
Predisposing medications / polypharmacy	☐	
Comorbidities / clinical conditions	☐	
Personal needs were unmet (toileting, hygiene, hydration)	☐	
Family involved in providing care	☐	
Cognitive impairment / confusion / delirium	☐	
Consumer/resident refused to use preventative tools or aids	☐	
Other factors?	☐	
Task factors – were tasks completed as per policy?		
Risk assessment had been completed	☐	
Risk assessment current	☐	
Care plan current	☐	
Care plan addresses risks	☐	
Care plan implemented	☐	
Staff factors – issues related to staff training/numbers and competency		**Be mindful that 'human error' is not a 'cause' of the fall rather a symptom of a system problem. Seek to**

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		understand how decisions made sense at the time for staff.
Staffing number/mix not at planned level	☐	
Training given (e.g. completion of pressure injury prevention training)	☐	
Risk perception	☐	
Ability to adapt to changing work conditions and prioritisation	☐	
Organisation of care factors – Care Bundle SKINS		
S. Appropriate pressure relieving equipment provided	☐	
K. Consumer or resident sat out of bed for less than 2 hours at any one time (at risk consumers/residents only)	☐	
K. Mobility or position change documented in clinical record	☐	
I. Skin was clean and dry (continence and hygiene issues were addressed)	☐	
N. Nutritional assessment, including consumer/resident weight, undertaken	☐	
N. Measures taken to optimize nutrition and hydration (at risk consumer/residents only). supplementation prescribed AND administered	☐	
S. For consumers/residents transferred from another ward or facility, skin inspection and PI assessment completed on transfer/admission	☐	
S. Skin inspected frequently around pressure points and medical devices, and findings documented	☐	
S. Pressure injury reassessed formally at least daily	☐	
Communication		
Information regarding pressure injury prevention plan transferred at handover	☐	
Visual cues reinforcing risk used (daily planner)	☐	
Consumer/resident/whānau given P.I. prevention information leaflet	☐	
Teamwork factors		
Multidisciplinary team referrals made	☐	
Model of care supported teamwork	☐	

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Organisational influences		
Pressure injury prevention policy utilised	☐	
Equipment resourced	☐	
Managers support/wound care CNS	☐	
Outcomes are measured	☐	
The Systems Engineering Initiative for Patient Safety Human Factors tool (which informed this template) may provide further support to enable a system review https://www.hqsc.govt.nz/resources/resource-library/systems-engineering-initiative-for-patient-safety-human-factors-tool/		

c. Key Findings (determine underlying systems or process issues involved in the event of harm)	
1.	
2.	
3.	

d. Additional Findings (identified as a quality issue)	
4.	
5.	
6.	

Opportunities	
a. Opportunities to improve	
Finding	**Quality improvement action**

b. Organisational learning and sharing

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Event of harm Action Plan					
RE number:		**Service:**	**Report date:**		
Key finding	**Recommendation**	**Actions required & progress**	**Person/role responsible**	**By when**	**Date completed**
1.					
2.					
3.					

Authorising Signature (1): Date:

Authorising Signature (2): Date: