Pressure Ulcer Investigation Tool Instructions

The purpose of this investigation tool is to help identify the root cause for the development of a specific resident's pressure ulcer (PU) and to help identify potential breaks in your system and/or opportunities for improvement. Your findings may include items such as the following.

1. You might find that heels are not floated but being fully supported on pillows and, therefore, at more risk for developing a pressure ulcer.
2. Under the staffing section, you might find that you had all new staff working with the resident prior to the development of the wound, and they might have contributed to its development. You might decide to add a mentoring program or set up a new scheduling program that will have more experienced staff follow behind less experienced staff.
3. You might find that poor lab values, although they are faxed to the physician, are not being addressed.
4. Challenge yourself to identify whether all prevention strategies were in place and whether they were actually working. For example, the specialty bed might be unplugged for long periods of time, or the chair cushion is not a proper fit for the resident or is worn out.
5. Were the risk assessment scores accurate at the time they were recorded? What has changed with the resident that places him or her at more risk?
6. Do the nurses know how to do a risk assessment properly, and are they putting interventions in place right away to address those risks? If not, what is the system fix? Are there issues with orientation or access to proper equipment? Is there a full understanding of what puts the resident at risk?
7. If the resident has been or is now refusing aspects of care and/or prevention strategies, consider involving the physician, the director of nursing, the administrator, family members, the Ombudsman, etc., in helping the resident understand the seriousness of ulcer management and potential negative outcomes.
8. In reviewing the *Changes of Condition* section, you might identify that the 24-hour report system has some failures. Perhaps staff members were not documenting items they thought were small and insignificant, but the items added up over time to a significant change for the resident.

These are examples of possible findings and not intended to include all potential findings.

Remember to keep asking yourself, "Why did this pressure ulcer happen?" Search for the real root cause; and you are looking to find it for both the resident and for the system-wide failure that allowed it to happen. Fixing that cause will reduce the risk of actual injury to another resident.

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Pressure Ulcer Investigation Tool

Resident Name: _____ Room Number: _____

Date Ulcer Identified: _____ Time Ulcer Identified: _____

Date of Last Full Body Skin Assessment: _____ Was Ulcer Found at this Time: ☐ Yes ☐ No

Ulcer is properly diagnosed as a pressure ulcer? ☐ Yes ☐ No

If No, what type of ulcer is it? ☐ Arterial Ulcer ☐ Diabetic Neuropathic Ulcer

☐ Venous Insufficiency Ulcer ☐ Other: _____

Is the new ulcer in a site of a previously healed ulcer of any type? ☐ Yes ☐ No

Location of Ulcer: _____ Stage of PU at Discovery: _____

Is the resident diabetic? ☐ Yes ☐ No

If Yes, have blood sugars been within the resident's usual range? ☐ Yes ☐ No

<u>Prevention strategies that were in place PRIOR to ulcer development:</u>

Mattress: ☐ Overlay on mattress ☐ Conventional ☐ Replacement ☐ Low air loss ☐ Specialty Bed

☐ Other: _____ Is bed functioning/used properly? ☐ Yes ☐ No

Turning and repositioning program: ☐ Yes ☐ No Was it really done? ☐ Yes ☐ No

Heels floated: ☐ Yes ☐ No Chair cushion: ☐ Yes ☐ No Fit/function properly: ☐ Yes ☐ No

Nutritional interventions: ☐ Multi-vitamin ☐ Vitamin C ☐ Zinc ☐ Other: _____

Protein Powder/Liquid: ☐ Daily ☐ Bid ☐ Tid Protein Supplement: ☐ Daily ☐ Bid ☐ Tid

Other: _____

Is nutritional intake what registered dietician (RD) recommends? ☐ Yes ☐ No Last RD Visit: _____

Last three weights:

Date			
Weight			

Laboratory Test History: (H=High L=Low N=Normal)

Date							
Pre Albumin							
Serum Albumin							
Total Protein							

PU Risk Assessment Scores:

Date							
Score							

Were risk assessment scores accurate? ☐ Yes ☐ No

Resident refusing PU Prevention Interventions? ☐ Yes ☐ No Refusing PU Treatment? ☐ Yes ☐ No

Has incontinence (bowl or bladder) or moisture been an unaddressed problem prior to PU? ☐ Yes ☐ No

Has pain been an unaddressed problem prior to PU? ☐ Yes ☐ No

Family notified of PU? ☐ Yes ☐ No Certified Nursing Assistant (CNA) tool/care plan updated? ☐ Yes ☐ No

Physician notified of PU? ☐ Yes ☐ No Care plan updated? ☐ Yes ☐ No

Staff working with resident:	Shift PU Found	1 Shift Prior	2 Shifts Prior	3 Shifts Prior	4 Shifts Prior	5 Shifts Prior	6 Shifts Prior	7 Shifts Prior	8 Shifts Prior
Date									
Nurse									
CNA									
CNA									
CNA									
Other:									

In the same 72-hour period as above, note the changes of condition the resident had PRIOR to the PU being found. Mark "Yes", if present. If not changes of condition have occurred check this box: ☐

	Shift PU Found	1 Shift Prior	2 Shifts Prior	3 Shifts Prior	4 Shifts Prior	5 Shifts Prior	6 Shifts Prior	7 Shifts Prior	8 Shifts Prior
Cognition Level									
Physical Activity Level									
Urinary Incontinence									
Bowel Incontinence									
Mobility: Ability to change and control body position									
Usual Food Intake Pattern									
Usual Water/Liquid Intake Pattern									
Pain									
Started New Medication(s)									
Developed Multi-System Organ Failure									
Became a Hospice Candidate or Recipient									
Started Refusing Care									
Other (e.g., fever, difficulty breathing, shear factor with head of bed up, new devices used) *Note:*									