Oklahoma Foundation for Medical Quality
Pressure Ulcer Root Cause Analysis

Floor/Unit______________________________ Resident/Patient Age____________________________
Primary Diagnosis______________________ Secondary Diagnosis____________________
Site of Ulcer____
MDS Coding Identified as____
Date Ulcer first identified________________ Ulcer Stage when identified_____________

Circle Below Where You Think Break-Down First Occurred:
Home Hospital Skilled Facility Current Facility Other

Risk Assessment Done on Admission? (Circle) Yes No
If yes, score_______________________ Tool Used______________________________

Frequency of Risk Assessment____
(LTC best practices for risk assessment: Once in first 24 hours, then weekly 4 times a week)

Yes, consistently__________ Sometimes___________ No______________

Risk Assessment Score Consistent with Resident/ Patient Status as Document in Medical Record?
Yes___________ No______________

If Patient Found at Risk:
Prevention protocol initiated immediately? Yes__________ No____________

Trunk Wound:
Age of Pressure Redistribution Surface Resident/Patient is Currently On: ______________

Does your facility use foam (eggcrates) on top of mattress? Yes______ No______

Resident/ Patient on Appropriate Surface? Yes___ No____ Date Placed on Current Surface: ______________

Residents/Patients in Prolonged Seating Positions: How often is weight shifted and documented?
____

Is Resident/Patient Able to Reposition Themselves? Yes______ No_______

Turned and repositioned every 2-3 hours and documented? Yes______ No_______

Does staff routinely check for "bottoming out"? Yes______ No_______

Skin Status Documented at Least Daily? Yes____ No______ Partial_____ Is Resident/Patient Incontinent________

Barrier Cream in Use and Documented? __________________ Does resident/patient wear disposable briefs?________

Catheter in use? Yes_____ No_______

Nutritional Status:
Resident/Patient Weight____________________

Nutritional Consult? Yes_______ No_________ Not Indicated___________

Additional Lab Available: Alb level_______________ Date Obtained______________
Pre-Alb level__________ Date Obtained______________
Glucose Level__________ Date Obtained______________

Resident/Patient Taking Any of the Following: (Circle) Prednisone Blood Thinners

Heel Ulcer
Heel elevation consistently maintained? Yes________ No_________ Partial_________

Is wound arterial, venous or diabetic? Yes________ No_________
If yes, circle all appropriate above.

Support stockings/ SCDs removed at least bid and skin status documented? Yes______ No_______ N/A________

Has resident/patient been off unit/out of facility greater than 4 hours within the last 3 days? Yes_____ No______
If yes, when, where and how long?____

Barriers Identified
Family____
Equipment/Supplies____
Cost____
Staffing____
Education____
Lack of product/equipment company representative support?____
High acuity of residents/patients within facility____

Conclusions
___________________ All appropriate preventative measures implemented, ulcer unavoidable
___________________ Gaps noted in prevention measures
Specify____
___________________ Ulcer mostly likely began with resident/patient off unit or out of facility
___________________ Equipment not available

Comments/Recommendations in policy/procedure of care:

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