

Pressure Injury Root Cause Analysis

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Using academic writing standards and APA formatting of references, respond to each of the following learning objectives. Using this document, enter the responses next to the corresponding learning objective. Responses should be 150-350 words in length. Scroll down to see assignment rubric for specific details on how the project will be assessed and how points will be awarded. Save the completed document as the assignment title and submit to the dropbox.

My comments are in green and purple.

Learning Objective	Response
<p>1. Define root cause analysis &amp; its role in pressure injury prevention.</p>	<p>Root cause analysis is defined as a “collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems” (“What is root cause analysis (RCA)?,” 2020, <u>pp. You need to include the page number/paragraph number when exact quotes are used. Applies wherever direct quotes are used in this project.</u>). The root cause is a “factor or problem that caused a nonconformance to policy and should be permanently eliminated through process improvement problems” (“What is root cause analysis (RCA)?,” 2020). When an issue occurs in any type of setting the foundation of the issue has to be uncovered. <u>Yes.</u> One must start from the bottom and begin a thorough investigation of what went wrong and where it began. Pressure injuries are a huge source of failure in many hospitals and acute care facilities <u>(these are the same thing).</u> Pressure injuries alone can and should be prevented. Failure to adhere to policy on pressure injury prevention often leads to negative outcomes. Hospitals have guidelines of how nurses should care for patients to prevent skin breakdown. <u>Usually, but perhaps a root cause for a PI is that there are no policies or the policies are outdated/incorrect!</u> When those policies in place get broken a deep dive must be constructed to find out how the pressure injury occurred. Once the deep dive or root cause analysis is complete, the objective is then to prevent similar injuries from occurring. <u>Okay; changes are made in the system to address the identified issues.</u> <u>An RCA asks five key questions: What happened? When did it happen? Who was involved? How did it happen? Why did it happen?</u></p> <p><u>There are two main types of errors:</u>  <u>-Active-</u>  <u>Currently happening between patient and healthcare provider. An example: Not cleaning a patient who is incontinent as soon as episode occurs</u></p>

	<p><u>-Latent</u>  <u>“Hidden” problem within the system that contributes to the negative effect. An example: No policy to turn a bedbound patient every two hours.</u></p> <p><u>The main focus and reason for root cause analysis is to keep patients safe and free from harm.</u></p> <p><u>Human error happens in healthcare but with the correct policy in place providers can actively avoid future mistakes</u></p> <p><b><u>Three levels of root cause:</u></b></p> <ol style="list-style-type: none"> <li><b><u>1. Failure of Analysis:</u></b> Physical roots (symptoms)</li> <li><b><u>2. “Witch hunting”:</u></b> Human roots (inappropriate human intervention). Most people solve problems at levels 1 &amp; 2</li> <li><b><u>3. Root Cause Analysis:</u></b> Latent roots (deficiencies in the process)</li> </ol>
<p>2. Analyze <b>one</b> of the case studies from page two (of this document). Describe the system failures that led to the pressure injury.</p>	<p>The case study presented below has breaches of policy as well as some factors that were out of one’s control. The first failure that is present is the admitting home care nurse did not do a thorough inspection and documentation of the skin. The nurse reported “no skin conditions noted”. This nurse did not do an efficient assessment or a surgical incision would have been documented. <u>Okay.</u> Home care agencies have admission guidelines that nurses must follow. According to Kajiyama (2018), “nurses make critical care planning decisions about the post transition episode, this is based on skin assessment and medications reconciliation” (Kajiyama &amp; Yoshioka, 2018). <u>Okay.</u> All home care agencies have standard operating procedures or SOP’s that nurses and staff are mandated to follow. Clearly the SOP was breached in this situation. Another major system failure made clear in the case study was the patients’ immobility. The patient was sent home with therapy and nursing services, however the patient remained in her chair consistently. The chair provides constant pressure on her surgical incision. Therapy and nursing both failed to provide her with a chair cushion or something similar to offload her incision. Another failure mainly by nursing is the fact that fecal and urinary incontinence was not properly addressed. <u>Yes, plan was not in place for off-loading or continence care. The majority of factors cluster within the staff skills/knowledge category, the policies category, and the patient risk factors category. Problem areas in addition to those you mention include: hyperglycemia (education and her response to education documented; on-going education based on</u></p>

	<p><u>glucose levels; also, continued consultation with MD if glucose continues to be high-was LIP even notified of elevated glucose level?); immobility not only was an issue for her incision, but for PI prevention in general. No steps were delineated being done to address this issue (and there were several things that should have been done); no risk assessment completed on admission; nutritional status; fever; patient’s emotional/psychological status; and staff knowledge and competency. One would also want to look at the agency issues i.e. how they educate/on-board staff and maintain competency; how do you know the appropriate guidelines are in place and followed by staff?; use of risk assessment (was it an error on the staff part or does the agency not mandate a risk assessment on admission?); guidelines for consults including use of home health aides.</u></p>
<p>3. Based on these findings, develop a comprehensive pressure injury prevention plan for the organization.</p>	<p>Pressure injuries on all fronts are avoidable with proper care. I think the vast majority is avoidable, but I question if this means 100% of the time; as people deteriorate in their health, it may not always be possible to prevent a PI in select cases. Discharge care and planning is something that begins from the point of acceptance into a program or admission on a floor. Agreed. The communication between the hospital and home care agency was lacking due to the complexity of this patient’s needs. Could be; what supports this? The hospital may have given all of the appropriate information; the admitting process should have identified areas of weakness that needed to be addressed. The accepting home care should have done many things to combat the immobility and incontinence issues once they were first recognized. Agreed. In order to prevent issues like this from reoccurring, a standard SOP needs to be established and followed closely for admission to home care. The initial assessment of patients must be thorough and complete. Lack of assessment skills only affect patients poorly. Yes. Physical therapist and nurses must be collaborative in care. The therapist and nurses must communicate about the care plan and assessment findings to prevent failures. Okay. All subsequent nurses and therapy staff must assess the patient’s skin and vitals routinely to prevent failure. If trained personnel eyes were laid on the patient several times a week, this injury could have been avoided before it became substantial. I do agree. Also consider the following:</p> <p>Are <u>adequate policies and procedures in place?</u></p> <ul style="list-style-type: none"> <li>-Provide consistency in evaluation and health care practices</li> <li>-Improve the agencies pressure injury prevention program</li> </ul> <p>Create parameters for <u>consult to other</u></p> <ul style="list-style-type: none"> <li>-Consults would include <u>Registered dietitian nutritionist; home health aide to assist with daily care; occupational and physical therapy to help improve mobility.</u></li> </ul>

	<p>-Adequate follow-up for identified issues</p> <p>As you know, education is a key factor in helping patients heal appropriately after discharge.</p> <p>Have handouts/pamphlets available to support pressure injury prevention and, if PI develops, how to heal it so patient is involved in plan of care.</p> <p>Use pamphlets with pictures that delineate common, basic, prevention and treatment practices will help them be in control of their health.</p> <p>Information should be kept simple so all can understand</p> <p>Never assume that staff is always well educated in pressure injury treatment and prevention. One study the nurses and aides' knowledge on pressure injury prevention. Of the 48 staff member tested, 40 of them proved to have insufficient knowledge of basic preventative measures.</p> <p>Agency needs to require continuing PI education for agency staff, which will allow them to stay up-to-date with best practices for PI prevention methods and treatments. -This not only allows staff to have the knowledge to provide better care to their patients, but also to serve as an education resource for patients and caregivers.</p> <p>Reference for any of this information? You need to have at least one reference per paragraph. It goes back to using evidence to base your practice on.</p>
<p>4. Propose a plan to monitor the results of objective #3.</p>	<p>Establishing a collaborative plan between disciplines is critical here. Establishing a single person to oversee the entire care team and become responsible for documentation audit is crucial. Yes, need to do chart audits on a routine and specified basis. Documentation must be completed in a timely fashion by all services present in the home. The documentation audit would be conducted weekly to prevent any failures from occurring. Had this case been reviewed within the first week of admission, the absence of the incision charting would have been caught. This is about more than lack of charting on the incision; there were numerous systems' failures that occurred that allowed this PI to develop. Once caught, it would have given the staff an opportunity to assess and document on the skin conditions at every visit. Along with assigning a case reviewer, a</p>

	<p>member of management should be required to visually inspect all services providing care. This would essentially be a supervisory visit to ensure each patient has everything that they need and the care provided is being monitored appropriately. Okay. This would give management an opportunity to correct any admission assessment fails. Therapy and nursing should communicate daily based on visit findings. Therapy and nursing should forward their visit summary from documentation to one another as well as to the chart reviewer. According to Doughty and McNichol (2016), a collaborative approach to healthcare is the most effective (Doughty &amp; McNichol, 2016). Teamwork serves as the basis for positive outcomes and preventing failures from occurring. Okay. Also consider:</p> <ul style="list-style-type: none"> <li>● Regular PI prevalence surveys (monthly/quarterly as determined by agency)</li> <li>● Annual national surveys: Post dashboards at “home base” sharing home care acquired PI rate</li> <li>● Yearly review of policies/procedures to be sure they are up to date with latest information.</li> </ul>
<p>List at least three current references that support your responses (textbook required as one of the references), and include the citations in the body of the written responses.</p>	<p style="text-align: center;">References:</p> <p>Kajiyama, M., &amp; Yoshioka, S. (2018). Characteristics of and factors related to nurses’ decision-making support for transition to home care settings for end-stage cancer patients. <i>Palliative Care Research</i>, 13(1), 99-108. <a href="https://doi.org/10.2512/jspm.13.99">https://doi.org/10.2512/jspm.13.99</a></p> <p>What is root cause analysis (RCA)? (2020, June). Excellence Through Quality   ASQ. <a href="https://asq.org/quality-resources/root-cause-analysis">https://asq.org/quality-resources/root-cause-analysis</a></p> <p>Wound; Ostomy and Continence Nurses Society®, Doughty, D., &amp; McNichol, L. (2016). <i>Wound, ostomy and continence nurses society® core curriculum: Wound management</i>.</p>

	<p>Philadelphia, PA: Wolters-Kluwer. <a href="#">This is not the correct way to reference a chapter in our textbook. See the handout in the APA section for the correct way to do this.</a></p>
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- a. A patient is admitted to home care after a cauda equina injury. The injury occurred 2 weeks ago at her home and she was then admitted to the hospital for severe lower back pain and numbness in the lower extremities. During the hospitalization, she developed urinary and fecal incontinence. Surgery was performed to repair the injury and after an unremarkable recovery, she is referred to home health care for physical therapy and skilled nursing care. The surgical site is well approximated without drainage. She has a comorbid condition of diabetes, continues to have numbness in the lower extremities along with urinary and fecal incontinence, and spends most of her day in a recliner chair. On admission to home care she has no skin conditions noted and her blood sugar is 165 mg/dL. After 2 weeks she develops a fever of 100.8 F. After 3 weeks of home care a 2.5cm length x 3.0cm width area of thick, dense eschar is noted over her sacral area, and she is referred to the WOC nurse for evaluation. Explain what risk factors led to the sacral injury and how this should be addressed in the plan of care (see learning objective #2).
  
- b. A 58 year old patient with a history of uncontrolled diabetes is admitted to the ED. He was discovered unconscious in his back yard by neighbors who called 911. He was transported to the ED of Acme Hospital where he regained consciousness. His blood glucose was 220 mg/dL, and his HbA1c is 13.2%. He is also experiencing mild chest pain, nausea, and tingling in his left arm. He is admitted to the hospital to rule out MI and to gain control of his blood glucose level. On admission, his risk assessment for skin breakdown indicated a 20 or very low risk. After several tests to determine the cause of his chest pain, he is diagnosed with coronary artery disease and is in need of bypass surgery to open three coronary arteries. He goes to surgery on day three of his admission and is in the OR for 8 hours in a supine position. 18 hours after surgery, his nurse notices he has a ~~pink~~ <sup>60</sup> deep purple bruised area in the coccyx region and contacts the WOC nurse to evaluate the lesion. At this point the patient is placed ~~on~~ <sup>on</sup> an active alternating pressure powered air mattress. Five days later the bruised area in the coccyx begins to show evidence of an open ~~at~~ <sup>on</sup> wound, with measurements of 4.0 length x 1.0 cm width, and deep in the

natal cleft there is dense slough with mild serous drainage. The surrounding skin is indurated with redness and evidence of a resolving bruise Explain what risk factors led to the sacral injury and how this should be addressed in the plan of care (see learning objective #2).

**Points criteria:**

Criteria	Under performance <3 points per criteria	Basic 3 – 3.9 points per criteria	Proficient 4.0 – 4.4 points per criteria	Distinguished 4.5 – 5 points per criteria
<b>Required content objectives</b>	Content objectives are missing or sparsely covered.	Content objectives are not consistently addressed. Demonstrates minimal understanding of content.	Content objectives consistently addressed. Demonstrates understanding of content.	Content objectives consistently addressed. Demonstrates mastery of content.
<b>Academic writing standards</b>	Writing lacks scholarly tone & focus. Sparse content. Multiple grammatical, spelling, & factual errors. Reliance on bullet points rather than effective writing in speaker notes. 4 or more direct quotes per project.	Writing is unclear and/or disorganized. Inconsistent scholarly tone. Inadequate depth of content. Grammatical and spelling errors. No more than 3 direct quote of less than 40 words per project.	Writing demonstrates general exploration of content. Responses are clearly written using scholarly tone. Few grammatical and/or spelling errors. No more than 2 direct quote of less than 40 words per project.	Writing demonstrates comprehensive exploration of content. Responses are clearly written using scholarly tone. Rare grammatical and/or spelling errors. No more than 1 direct quote of less than 40 words per project.

Criteria	Under performance <3 points per criteria	Basic 3 - 3.9 points per criteria	Proficient 4.0 - 4.4 points per criteria	Distinguished 4.5 - 5 points per criteria
<b>APA formatting</b>	References and citations have multiple errors or are missing.	References and citations have errors.	References and citations have few errors.	References and citations have rare errors.