Name/date:
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Reviewed by/date: _____

Using academic writing standards and APA formatting of references, respond to each of the following learning objectives. Using this document, enter the responses directly next to the corresponding learning objective on this grid. Responses should be 150-350 words in length. Scroll down to last page of this document 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 with your name and submit to the dropbox.

Learning Objective	Response
1. Define root cause analysis & its role in pressure injury prevention.	Root cause analysis (RCA) is a process for identifying causal factors resulting in variations in performance, including sentinel events (Black, 2019). An RCA in the hospital setting is going to be used to determine the "root cause" of an event or situation at the facility that caused injury or death to a patient. It should be noted that an RCA should be conducted in a systemic approach and not focus on a single individual that was involved in the incident (Finkelman, 2016). An RCA is not used to blame someone for an incident, it is an approach to identify how the incident happened, so we do not have the same thing occur again. When pressure injury occurs, conducting an RCA is a great way to get to find out how and why it occurred. Once we discover the how and why, we can establish structural policies and procedures from the beginning of admission to reduce the chances of it happening again.
2. Analyze **one** of the case studies from page two (of this document). Describe the system failures that led to the pressure injury.	I am selecting the second case study for this project. The patient was admitted to the hospital after being found unconscious. He has uncontrolled diabetes and active symptoms of a heart attack. The assessment indicated he scored a 20. If this was the Braden scale, this would put him at low risk. After reviewing the Braden scale, and given the limited amount of knowledge, I believe we could put this patient at a 16. Sensory perception is 4 for no impairment. Moisture is 4 for rarely moist. The patient is currently bedfast (1). His mobility will be slightly limited putting him at 3. We can place him at a 2 for nutrition given he is NPO for surgery and his nutritional intake will be limited. We can give a 2 for friction and shear given his weakened state. The Braden scale should have been reviewed properly. A study done by Magnan and Maklebust (2008), showed that nurses would misapply the scale and score a 19 just to avoid implementing a

	pressure ulcer prevention plan (Macklebust & Magnan, 2016). Even if the scale still showed a 20, the nurse should be able to make a nursing judgement based on recent events, his uncontrolled diabetes and active symptoms of a heart attack and place him at high risk. Secondly a thorough head to toe assessment should have been conducted on admission. A bruise on his coccyx could have been discovered. This bruise given the recent history could have been a deep tissue injury (DTI). This could have been documented and pressure injury prevention could have been initiated on admission. If the patient regained consciousness, he should have been interviewed along with the neighbor that found him to determine if he had fallen, and how long he was down. The patient was also in the OR for 8 hours putting them at high risk for development. Preventative measures in the perioperative setting should include the padding of bony prominences, use of table pads that provide effective immersion and envelopment and consistent heel elevation (Stechmiller et al., 2016).
3. Based on these findings, develop a comprehensive pressure injury prevention plan for the organization.	A screening on admission needs to occur. Anybody at high risk of PI should be identified. The list should include older adults (65 and older), patients with frail skin, patients with comorbidities such as decreased mobility, decreased perfusion, high BMI, nutritional deficiency, patients with a history of PI, and adults who score an 18 or less on the Braden scale. Head to toe assessment should be done on admission and with change of nursing staff. Special attention should be focused on bony prominences, mucous membranes and anywhere medical devices pose a risk. Consultation to nutritional, physical, and occupational therapy should be ordered if warranted. Patients at high risk with limited mobility shall be placed on a proper mattress with Q-2 repositioning using approved pad and wedges. When appropriate, the head of the bed should not be elevated greater than 30 degrees (Mackey & Watts, 2016). Repositioning in a chair requires hourly repositioning (Macklebust & Magnan, 2016). Prophylactic foam dressings shall be placed on bony prominences of patients undergoing operation greater than 3 hours (Stechmiller et al., 2016).
4. Propose a plan to monitor the results of objective #3.	In order to build a successful pressure injury prevention program, we have to establish an effective monitoring system that provides periodic and ongoing assessment of pressure injury prevalence and incidence (Macklebust & Magnan, 2016). Assessment should take place on admission and with change of caregivers. If a pressure injury is found, it should be documented, staged, and a treatment plan formed by the wound care nurse. Unstageable injuries, deep tissue injuries, and mucous membrane ulcers should be documented as well. PI dressings should be inspected and changed daily or according to the treatment plan implemented by the wound care

	nurse. Nursing staff should document in real time when inspecting the wound, noting a description of the wound and the treatment and dressing used. With accurate and timed documentation, we can then audit the charting. Determining the number and percentage of ulcers that developed prior to and following admission, will provide us with the information needed to determine the effectiveness of our pressure injury prevention program (Macklebust & Magnan, 2016).
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. References should be no more than 5 years old.	Black, J. (2019). Root cause analysis for hospital-acquired pressure injury. *Journal of Wound, Ostomy, and Continence Nurses Society,* 46(4), 298-304 Finkelman, A. (2016). *Leadership and management for nurses core competencies for quality care*. Pearson Education Inc. Mackey, D. & Watts, C. (2016). Therapeutic surfaces for bed and chair. In D. Doughty & L. McNichol (Eds.), *Wound, Ostomy and Continence Nurses Society™ core curriculum: Wound management* (pp. 363-383). Wolters Kluwer. Magnan, M. A., & Maklebust, J. (2008). The effect of web-based Braden Scale training on the reliability and precision of Braden scale pressure ulcer risk assessments. *Journal of Wound, Ostomy, and Continence Nursing,* 35(2), 199-208

	Maklebust, J. & Magnan, M. (2016). Pressure ulcer prevention: Specific measures and agency- wide strategies. In D. Doughty & L. McNichol (Eds.), *Wound, Ostomy and Continence Nurses Society™ core curriculum: Wound management* (pp. 333-361). Wolters Kluwer. Stechmiller, J., Cowan, L. & Oomens, C. (2016). Bottom-up (pressure shear) injuries. In D. Doughty & L. McNichol (Eds.), *Wound, Ostomy and Continence Nurses Society™ core curriculum: Wound management* (pp. 313-332). Wolters Kluwer.

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 wound and how you would set up her plan of care.

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 painful 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 an active alternating pressure powered air mattress. Five days later the bruised area in the coccyx begins to show evidence of an open 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 you would set up his plan of care.

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
Required content objectives	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.
Academic writing standards	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.
APA formatting	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.