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 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.

Case study

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.

Learning Objective	Response
1. Define root cause analysis & its role in pressure injury prevention.	A Root cause, defined in its simplest form, is the origin of a problem. In other words, it is the primary causative factor that has led to an outcome that did not meet organizational standards (Black, 2019). So now that we know what a root cause is let us define a root cause analysis. A root cause analysis is a problem-solving process whereby the intention is to identify the cause of a problem, gain understanding and produce prevention measures (Black, 2019). An effective root cause analysis can identify issues and promote necessary changes with the organization (Black, 2019). It does this by critically analyzing patient care provided and identifying the gaps in care (Maklebust & Magnan, 2016). This process should begin within 72 hours of the adverse event. (Black, 2019) Root cause analysis teams are comprised of 4 to 6 persons within the organization hierarchy (Black, 2019). These individuals should be familiar with the disease process and protocols in place (Black, 2019). This process can help in pressure injury prevention by identifying failures with the system and creating new protocols and necessary staff education.

2. Analyze **one** of the case studies from page two (of this document). Describe the system failures that led to the pressure injury.	Black (2019), in her article, presents a 3-level root cause analysis process. Level 1 assesses the problem, level 2 identifies the staff level of care, and level 3 identifies the system policies and procedures that are in place (Black, 2019). I will be using that process to analyze the case presented above. Level 1: Based on this wound's location, it can be confirmed that it is indeed a pressure injury. This injury most likely resulted due to the patient spending excessive time in the recliner chair. Based on the wound's assessment, this is an unstageable pressure injury (Maklebust & Magnan, 2016). Based on the NPUAP staging taxonomy, this pressure injury occurred within 72 hours or earlier (Black, 2019). Several other factors contributed to patient wound development. Moist conditions were provided by the patient's incontinence and fever (which can cause diaphoresis), and shear forces generated by the patient elevated >30 degrees in a recliner are known factors to cause skin breakdown. Patient's lower extremity numbness decreased patient mobility abilities to reposition herself and greatly affected the patient's sensation of pain, which would have promoted skin breakdown. Patients spinal cord injury and history of diabetes are known conditions that increase the patient risk for pressure injury development Level 2: The case study states that upon admission to home health three weeks prior patient had no evidence of skin damage on assessment. The case study doesn't note that patient was supplied with appropriate support surfaces or incontinence pads and supplies. It also doesn't state if daily skin assessments were being performed or if the patient was being repositioned while in the recliner chair or in bed. Therefore, it can be assumed that the patient was not or that appropriate care was limited. Probable lack of preventative measures contributed to the development of the pressure injury, such as daily skin assessments, frequent patient repositioning, use of skin moisture barriers, use of incontinence pads, timely skincare, and use of supportive surfaces. Level 3: The home health agencies' policies and procedures on pressure injury prevention need to be evaluated. It should then be identified what policies and procedures were ignored. This should prompt re-education and the creation of new policies as required.
3. Based on these findings, develop a comprehensive pressure injury prevention plan for the organization.	A prevention plan should consist of 3 basic categories: comprehensive skin assessment, the use of a skin risk assessment tool, and the development of care plans and intervention (Agency for Healthcare Research and Quality, 2017). 1. Comprehensive skin assessment: A head-to-toe skin assessment should be completed on

	the initial and all subsequent visits. Skin assessments are a vital component for pressure injury prevention and must be completed (Maklebust & Magnan, 2016). Staff will be educated on how to perform a proper skin assessment. Skin assessments should include the inspection and palpation of the skin, with particular attention being given to areas over bony prominences (Agency for Healthcare Research, 2017). This aids in the identification of the patient's risk factors for skin breakdown and observation of any current skin breakdown (Maklebust & Magnan, 2016). All obstructing materials should be removed during skin inspection (Maklebust & Magnan, 2016). After the assessment, staff should document all findings. A body diagram will be provided to staff for accurate recordings of skin injury placement. Please note that all suspected pressure injuries should be referred to the WOC nurse. Staff should also be providing routine skincare to maintain healthy skin (Maklebust & Magnan, 2016). This includes regular cleansing using disposable cleansing wipes, moisturizing and peri-care as needed per patient (Maklebust & Magnan, 2016). 2. Pressure injury risk assessment tool: The utilization of standardized risk assessment tools aids in clinical decision making, allows for preventative intervention selection, and guides care planning (Agency for healthcare research and quality, 2017). Staff will be trained to use the Braden Scale tool. The Braden scale assesses and scores six risk factors that contribute to pressure injury: Sensory perception, moisture, activity, mobility, nutrition, and friction shear (Maklebust & Magnan, 2016). Prevention measures should not be implemented only on the basis of the total risk score but on the individual risk factor score (Maklebust & Magnan, 2016). Risk assessment should be completed daily, and changes made to interventions as needed 3. Care planning and intervention: Based on the patient's risk assessment, an action plan is developed (Agency for Healthcare Research, 2017). Please note that plans should be individualized for each patient (Agency for Healthcare Research, 2017. Each risk factor with the assessment tool will be provided an intervention for each score. Based on the patient scare per risk factor, the accompanying intervention should be initiated. Interventions will be updated based on new evidence-based guidelines (Maklebust & Magnan, 2016). Staff will be provided with and/or be able to order, for same-day delivery, the resources needed for intervention implementation. The patient and family members should also be educated on the risk factors and the interventions for prevention (Agency for Healthcare Research, 2017). Be sure to assess understanding and ability to carry out interventions correctly. As patients are within the home, family involvement is necessary

	to pressure injury prevention.
4. Propose a plan to monitor the results of objective #3.	A team will be put in place to monitor the results of the implemented prevention program. This team should involve individuals who are knowledgeable of care practices, such as nurses, nurse assistants, and wound care specialists (Maklebust & Magnan, 2016). An effective prevention plan will lower the incidences of pressure injuries within the organization. Therefore, assessing for a decrease in pressure injury prevalence and incidences will be a part of the monitoring plans. A monthly report of acquired pressure injuries will be formulated and compared to previous rates. Prevalence and incidence rates should also be compared against other systems providing a similar level of care. There will be a decrease in the frequency of these reports from monthly to quarterly to yearly, as goals are met. A hindrance to the prevention plan will be the staff's willingness to participate. At weekly team meetings, assess ease and reluctance to implement prevention interventions. This would provide the wound nurse with information on how practices are being used. Changes should be made as needed, and interventions be made to increase or sustain staff motivation should also be implemented.
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.	Agency for Healthcare Research and Quality. (2017, October). *Module 3: Best practices in pressure injury prevention* [PowerPoint slides]. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressureinjury/workshop/guide3.html Black, J. M. (2019). Root cause analysis for hospital-acquired pressure injury. *Journal of Wound Ostomy Continence Nursing 46*(4), 298-304. https://doi.org/10.1097/WON.0000000000000546 Maklebust, J., & Magnan, M. A. (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.