Name/date: Sharon McCoy, Cauda Equina Injury Case Study

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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.

Learning Objective	Response
1. Define root cause analysis & its role in pressure injury prevention.	Root cause analysis is a multi- team disciplinary team approach to discover the causes of close calls and adverse events to identify interventions to prevent them from happening again. This approach looks past human error, it concentrates on prevention not punishment. RCA approach is part of an effort to build a culture of safety and not a culture of blame. The goal of this approach is to determine what happened and why it happened. This approach uses 5 "why" questions to determine the root cause (Fogle & Kandler,2017). This approach concentrates on the "how" and "why" not "who". By understanding the root cause of an event, we can improve patient safety by preventing future harm by coming up with a plan to prevent the close call or adverse event from happening again. The goal of RCA is to determine what happened, why did it happen and how to prevent it from happening again. RCA role would be especially important tool to use determining "why" and "how "a pressure injury would develop on a patient by looking at an individuals intrinsic factors and extrinsic factors to develop a plan to prevent a pressure injury. This will allow interventions to be put in place to prevent skin breakdown before it happens.
2. Analyze **one** of the case studies from page two (of this document). Describe the system failures that led to the pressure injury.	A big system failure here would be the poor transition of care and there is substantial amount of research that suggested that patients transitioning from acute settings to home setting care are often not prepared to manage their own conditions (Krapfl & Peirce, 2016). Home health nurse and therapy should have assessed her and her home and would have discovered that the patient was discharged home and she still did not have feeling to her lower extremities and was still incontinent of urine and bowel and needed more education about self-care and evaluated for assistance devices for mobility. Without feeling she was unable to know when she urinated or had a bowel movement. This would increase her chances of skin breakdown and increase the chances

	of infection to the area of the incision. The incision is in an area where the patient cannot easily visualize or do her own dressing changes. Patient also had decreased mobility to her lower extremities and spent most of her time in her recliner this would increase her chances of developing a pressure ulcer. Pressure is the biggest cause of skin breakdown because it decreases blood flow to the skin. It often occurs over boney areas. She was also known to be a diabetic and her blood sugars were controlled in the hospital setting. If her blood sugars were not being monitored and her eating habits changed along with her decreased activity her blood sugars could have been high which could have contributed to an increase chance that her incision would not heal properly and developing a pressure injury. I feel if she had a comprehensive plan of care at discharge with proper education this pressure injury could have been avoided.
3. Based on these findings, develop a comprehensive pressure injury prevention plan for the organization.	A pressure prevention plan is necessary to protect the patient from harm from developing an avoidable pressure injury. The best prevention of developing an inhouse pressure injury is following a prevention plan. The first step in developing an effective pressure ulcer prevention plan is setting up a program to monitor ulcer incidence on an ongoing basis. The most crucial data that needs tracked to monitor the effectiveness of the pressure ulcer prevention program is the tracking of "in house pressure injuries". In house pressure injuries are developed on patients under the care of the facility with the pressure prevention program in place. This tracking usually is done quarterly. When creating a comprehensive preventative care plan, I would start by putting a plan in for routine skin care maintenance and routine skin assessments. A pressure preventive plan should also include preventative measures for limited mobility to reduce pressure load and duration of pressure. I would implement the use special pressure relieving support surfaces, routine repositioning, foam positioning wedges, elevation of heels, breezy sheets and use of preventative foam dressings to high-risk areas of friction or shearing. These interventions are beneficial to prevent pressure load and duration of pressure. I would include measures on protecting the skin from over exposure to moisture. Interventions like using wicking or absorbing incontinent products or using moisture barrier creams will help with protection from excess moisture. The use of urinary catheters, condom catheters, or fecal incontinent pouches are also options if needed. These interventions assist with protecting the skin from excessive moisture. Nutrition would be another important area to add to the prevention plan. Oral supplementation, offering favorite foods to increase calories and encouraging patients to keep hydrated. The organization needs to utilize an at-risk assessment tool to identify patients that are at risk for developing a pressure injury. The risk assessment needs to be done on admission and periodically to see if more interventions or adjustments to the current prevention plan are necessary to avoid

	pressure injury development. The prevention plan for the patient will be determined by resources available and assessment of the patient. Patients health condition, comorbidities, risk assessment score and current skin condition are all determining factors in developing a prevention plan. The whole team should be involved in the prevention plan. The team should involve the patient, therapy, dietary, the primary physician, bedside nurse, wound rounding nurse and the care technicians (Maklebust & Magnan, 2016). A comprehensive prevention plan includes strategies and practices to reduce or eliminate risk of developing a pressure injury such as scheduling turning and body repositioning, determining appropriate bed positioning, skin care, padding for bony prominences. The plan should include periodical assessments to alert wound nurse of change in skin conditions that alert impending skin breakdown. Other interventions for contractures, support surfaces, nutrition and mobility are also beneficial (Kirman, 2020).
4. Propose a plan to monitor the results of objective #3.	I would propose a more specific tracking program that tracks inhouse pressure injuries and alerts the care team right away so interventions if needed can be developed to prevent pressure related injuries. A more effective tracking system would be if the bedside nurse noted a potential pressure injury, she would document this new potential pressure injury in the medical record. The tracking system automatically alerts the wound nurse to assess the patient. If the wound nurse determines it be pressure related, she will hold a care team meeting and use the root cause analysis to determine if the preventive measures in the prevention plan can be improved. This will give more specific information in real time so adjustments can be made right away to the plan to improve effectiveness. If the organization has not had an inhouse pressure injury for the team to review for a long period of time. It would be a good sign that your prevention plan is working and is effective. Tracking of pressure injuries that developed in house will determine if the prevention plan is working or not. Tracking of patients who are admitted with pressure injuries will determine how big the pressure injury problem is. Wound nurse should keep track of the degree in which best practices for pressure ulcer prevention is being utilized throughout the facility. This will help to understand the severity of pressure injury problem and the utilizing of preventive care. Example it is important to know which patients are require alternating air mattress, roho cushions or to know those requiring a turning schedule. Tracking will help determine the effectiveness of the preventions that are in place (Makebust & Magnan,2016).
List at least three current references that support your responses (textbook required	Flogle, A., Kandler, Edward (2017 January) One Good Idea: Five Whys And A Why Not, *Quality*

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.	*Progress*, https://asq.org/quality-progress/articles/one-good-idea-five-whys-and-a-why-not?id=7310c6d1a8c64e109cc372cd82. Krapfle, L & Pirce, B. (2016) General Principles of Wound Management Goal setting and Systemic Support, *Wound, Ostomy and Continence Nurses Society ™ Core Curriculum Wound Management*, (pp.72-76) Wolters Kluwer. Maklebust,J., Magnan, M,. (2016) Pressure Ulcer Prevention Specific Measures and Agency-Wide Strategies, Wound, Ostomy and Continence Nurses Society™ Core Curriculum Wound Management, (pp 334-354) Wolters Kluwer. Kirman, C., (2020, March 26) What are the elements of a comprehensive care plan for effective prevention or pressure injuries (pressure ulcers)?, *Medscape* https://medscape.com/answers/190115-82579/what-are-the-elements-of-a-comprehensive-care-plan-for-effective-prevention-of-pressure-injuries

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.