Name/date: ___Rena Witcher

Reviewed by/date: _____qq

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.

Mistakes happen in every organization, including health care facilities. Patients trust medical professionals with their health, leaving little tolerance for error. However, errors will occur even under the best circumstances usually due to unintended failures. Root cause analysis (RCA) is an effective investigative tool used in many health care settings for the identification and prevention of errors that led to patient harm (Black, 2019).

The Joint Commission has classified in house acquired pressure injuries as sentinel events. A sentinel event is any unexpected and preventable occurrence that led to patient harm or even death (Finkleman, 2019). The goal of RCA is to gain an understanding as to why the pressure injury occurred. Although these findings will eventually lead to a solution, the purpose of the RCA is to understand the problem first. Investigative teams should be comprised of multi disciplinary ***multi-disciplinary*** members, all of which do not have a connection to staff involved in order to maintain objectivity (Black, 2019)

The first level of RCA is to identify the problem. The suspected injury must be confirmed as having etiology of pressure. This step is usually completed by a wound specialist having expertise in characteristics of pressure injuries, such as a

WOC nurse. Information should be gathered that includes when the injury was identified, who was involved in care and where ***the*** injury occured. ***occurred*** This information will provide clues that can assist in leading the investigation (Black, 2019).

Level two examines the processes to the care delivered. Investigators must dig into why the event occured. ***occurred*** In the case of pressure injuries, there is usually not a single incident that led to the cause but a series of events. One technique to identify the basic pieces of the problem is called “the 5 whys”. The collective members of the team ask and answer the question “why did this happen” a series of 5 times and record the findings. This will uncover the root cause to the problem which can then lead to problem solving.

Incidences of pressure injuries acquired in a facility is an indicator of performance and can be costly for facilities. The third level of RCA is to complete investigations of all pressure injury occurrences and compare findings. There are often systemic interventions that can be addressed with changes in policies and education to reduce incidents (Black, 2019). ***As you suggest here, RCA focuses on a systems approach rather than looking at an individual or small group of individuals. The focus is finding a system failure as opposed to pointing blame at an individual or individuals.***

2. Analyze **one** of the case studies from page two (of this document). Describe the system failures that led to the pressure injury.

In the case of the women ***woman*** admitted to home care after a cauda equina injury, a root cause analysis identifies a systemic failure leading to the pressure injury event. The wound care specialist would first need to confirm the injury etiology as pressure. Then the investigation into the root cause would consist of asking a series question referring to why the pressure injury occurred.

Using “the 5 whys” technique, the following results were discovered. The injury occurred due to the patient having no preventative interventions in place. The patient was unaware that she was at risk for a pressure injury. This was due to the absence of education regarding pressure injury prevention for the patient during hospital stay, upon discharge from the hospital and admission to home health care. The opportunity to provide this education was lost due to care providers

not identifying her to be at risk. This patient's risk evaluation should have identified factors of decreased mobility, impaired sensation and incontinence of bowel and bladder as high risk for pressure injury development. Her risk is also further aggravated by a comorbid condition of diabetes, increasing her probability for infection and injury. ***Also, the diabetes was not being managed effectively as evidenced by her hyperglycemia.*** This education did not occur due to failure to refer residents to wound care specialists. It is possible that the referral was not placed because her pressure injury risk assessment was scored too high. ***Other important factors are the patient's fecal and urinary incontinence, nutritional status, fever and whether or not the patient's temperatures were being taken by the home care staff, her mental and emotional status, the skills and knowledge of the staff, and whether pertinent agency policies were in place.***

This RCA leads the team investigating to determine the root cause of the incident as failure of identifying pressure injury risk by hospital as well as home health care providers. The policy and procedure of assessing risk of pressure injury, frequency of assessment, and assessment tools used will need to be reviewed. The procedure for referral to wound care specialists should also be included in the policy review.

3. Based on these findings, develop a comprehensive pressure injury prevention plan for the organization.

Based on the above findings, the policy and procedure for identifying pressure injury risk needs to be reviewed. A committee of members should be designated from multiple disciplines including nursing, therapy, dietary, safety, staff development and medicine. After reviewing the existing policy, changes to procedures should be considered. ***And a plan for regularly reviewing policies and procedures to make sure they reflect current knowledge and best practice should be adopted.***

The Braden scale is the predominant tool used to assess pressure injury risk. However, the reliability of this tool depends on the accuracy of the individual using it. In clinical settings, nurses may be arbitrarily assigning scores of "19" to avoid developing pressure ulcer prevention plans. Other errors include coping ***copying*** previous scores, not taking into account changes in condition and scoring incorrectly (McNichol, 2021). Therefore, education to nurses needs to be provided regarding accurate scoring of the Braden scale. The strategy of "when in doubt, score low" should be emphasized to

avoid underestimating risk (McNichol, 2021). ***Education also needs to be provided about the prevention and care of pressure injuries and re education should occur on a regular basis.***

Braden scale assessment needs to be completed every shift to detect changes in condition and input from multiple nurses at different times. A score of 17 or under should warrant a referral to the wound care team for screening. ***However in the home care setting, the patient may only be seen 2-3 times per week making this not possible.***

The home health care nurse will need to receive the above training to ensure accuracy in Braden scales assessments. In the home health setting the assessment should be conducted weekly and with any change of condition such as fever, decline in mobility or function, pain or new onset of incontinence. Any score of 17 or below warrants referral for wound care followup.

Additionally, a warm handoff between the nurse, or WOC nurse if applicable, to the home health nurse consisting of standardized orders for interventions and treatments is best practice to ensure accurate information is relayed on transition to home. This will improve outcomes and decrease pressure injuries (Novy, 2020).

Also, a plan and procedure for consulting other needed disciplines should be developed.

A sub-committee should research other assessment tools of pressure ulcer prediction that might better meet the needs of the facility. The Jackson/Cubbin Pressure Injury Risk Scales was shown in one study conducted in trauma-surgical ICU units to be more useful than the Braden scale (Higgins & Casey et. al., 2020).

4. Propose a plan to monitor the results of objective #3.

The key to successfully implementing any change is consistent follow-up. The WOC nurse should conduct random audits of Braden scores in hospital and during home health care to check accuracy of results and provide reeducation if needed. A interactive Braden Scale check off should be incorporated into the annual skills fair and reeducation provided as needed. Reinforcement of the need for assessments to be completed accurately and "when in doubt, score low" to ensure any patient at risk receives proper preventative interventions and education. ***Data about pressure injury occurrences should also be collected regularly.***

Follow up calls should be initiated with discharged patients the next day, two weeks and then monthly for three months to track post discharge occurrence of pressure injury. These results should be included in quality assurance reports ***and*** data analysis. The committee that conducted the review of the pressure injury risk identification policy should then meet quarterly to review these findings and consider additional changes needed to the policy. If incidents are continuing, perhaps a more comprehensive assessment tool may be needed.

> ***The following should also be included: Annual national surveys-Post dashboards on units sharing hospital acquired PI rates, chart audits-Assess adequacy of documentation of assessment parameters, interventions, and effect or outcomes, observe staff perform care on a regular basis, yearly review of policies/procedures to align them with best evidence.***

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.

References ***The word references should be centered at the top of the reference list.***

Black, J. M. (2019). Root cause analysis for hospital-acquired pressure injury. *Journal of Wound Ostomy & Continence Nursing*, *46*(4), 298-304. ***Remember that the second and subsequent lines of every reference should have a hanging indent.***

Finkelman, A. W. (2019). Leadership and management for nurses: Core competencies for quality care. In *Leadership and management for nurses: Core competencies for quality care* (pp. 435-436). Hoboken: Pearson.

Higgins, J., Casey, S., Taylor, E., Wilson, R., & Halcomb, P. (2020). Comparing the Braden and Jackson/Cubbin Pressure Injury Risk Scales in Trauma-Surgery ICU Patients. *Critical Care Nurse, 40*(6), 52-61. doi:10.4037/ccn2020874.

McNichol, L. L. (2021). Wound, Ostomy and Continence Nurses Society Core Curriculum: Wound Management. In *WOUND, OSTOMY AND CONTINENCE NURSES SOCIETY CORE CURRICULUM: Wound management* (pp. 340-343). NEW YORK: WOLTERS KLUWER MEDICAL. ***None of the reference should be in all caps. In APA seventh edition the city of publication is not included in the reference.***

Novy, T. K. & Woith, W. M. (2020). Standardized Hospital Discharge Communication for Patients With *with* Pressure Injury. Journal of Wound, Ostomy and Continence Nursing, 47(3), 236–241. Doi: 10.1097/WON.0000000000000644.

- 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.

- 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.