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Reviewed by/date: _061221_____

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 utilized by health care organizations to identify and analyze contributing factors related to incidents events. Through the use of data collection, the revision of medical record information, interviews, and research, the organization can gather causative factors, applying corrective actions and finding preventive measurements to avoid future incidents from happening (Kusserow, 2021) According to Joyce M. Black, there are three levels used in the investigation of a root cause analysis related to pressure injury. The first RCA level is divided into two sections. The first section investigates when the pressure injury starts. Timing is very important concerning the time the pressure injury was first seen and when it developed. The second section indicates the location of the pressure injury. The anatomic location of the pressure injury will determine possible events leading to the incidence. The second RCA level investigates the care process utilized by organizations such as the head-to-toe assessment performed by the nurse during admission, the risk factors leading to the pressure injury, the prevention measurement taking by the team, and the care plan provided during the hospital stay. The third RCA level identifies the prevention system created by the organization such as policies, resources, and education (Black, 2019). The main role of a root cause analysis in the prevention of pressure injuries is to investigate, identify, and determine contributing factors that resulted in the harming of a patient or concluded as an undesirable outcome. It is taking preventative measurements through monitoring and auditing to avoid the reoccurrence of the event (Kusserow, 2021).

2. Analyze **one** of the case studies from page two (of this document). Describe the system failures that led to the pressure injury.	Due to the way events occurred from the moment the patient was found unconscious in his backyard until the time the nurse found the open wound; it is hard to know exactly when the skin started deteriorating. Some of the factors contributing to the pressure injury include the lack of conducting continuous skin assessment/inspection such as head-to-toe assessment after admission. There is no evidence supporting that skin assessment/inspection documentation was done every shift or proof of Braden scale score done after admission. Immobility was another contributing factor because of the length of time the patient stayed in a supine position during the 8 hours of surgery. Precautions should have been initiated to identify risks for developing pressure injuries and protect areas for example buttocks, head, shoulder blades, elbows, and heels before and during surgery. The use of proper equipment such low air loss bed should have been utilized earlier to protect and prevent the risk of pressure injuries. Other areas leading to system failure could have been a lack of mobility such as repositioning and pressure distribution every two hours after surgery as per protocol. Inconsistent follow-up by the WOC nurse. Pressure injuries should be followed once or twice weekly and no evidence that a consult for nutrition was established for the patient. Also, there is no evidence of additional preventions being suggested by the WOC nurse only the use of a powered air mattress Taking into consideration the patient medical history and new illnesses such as diabetes and cardiovascular issues can potentially affect tissue perfusion and delayed wound healing.
3. Based on these findings, develop a comprehensive pressure injury prevention plan for the organization.	Pressure injury prevention plan initiates the first-day patient is admitted to the hospital until the date patient is discharged. The main goal for this plan is to identify risk factors for potential pressure injuries during the patient hospital stay. • Complete Initial skin inspection between 24 to 48 hours upon patient's admission • Additional skin inspection/assessment documentation must be completed on transfers, at every shift, and upon discharge. • Braden scale score performs on admission, upon transfers, on each shift, and if changes in patient's condition. • Notify and initiate wound consult for the Inpatient Wound Team if compromised skin is suspected or detected.

	• Notify the WOC nurse of any sudden changes in skin condition, deterioration, or emergent. • Initiate consultation for Nutrition if Braden score is below 18 and if pressure injuries are identified. • Place head of the Bed (HOB) no more than 30 degrees unless for medical reasons. • Reposition the patient every two hours to relieve any surface pressure. • Document time and location when repositioning was performed. • Identify areas at risk of pressure injury and utilize preventative padding dressing when the patient is having surgery for a prolonged period time. • Maintain skin intact and clean. • Apply cream barriers for protection on patients experiencing fecal and urinary incontinence. • Utilize waffle boots, waffle cushion or specialty bed to offload area at risk for pressure injuries • Elevation of legs for edema management through the use of pillows and when sitting on the recliner. • Utilize sling pad, sheets, or proper equipment to reposition patient. • Apply ear protection pad when the patient uses nasal canula tubing. • Use of a powered air mattress for the patients with a Braden score less than 18, or any patient with compromised skin. • Complete a specialty bed request for patient over 400 pounds. • Utilize bed extension when needed to avoid pressure injuries.
4. Propose a plan to monitor the results of objective #3.	Implementation plan for monitoring pressure injuries includes: • Perform ongoing monitoring and auditing by the charge nurse each shift ensuring pressure injuries prevention plan is in place. • Review for the completion of skin inspection/assessment notes and Braden scale score at every shift. • Complete patient rounding to monitor if patient's needs have been met and to address any patient's concern. • Monitor if repositioning and pressure injury precautions are performed and documented promptly. • During patient's rounding, observe if waffle boots, star cushions, specialty beds or

	air mattress are been utilized on patients with a Braden scale score of less than 18 or patients with compromised skin issues. • Anticipate and determine possible risks for patients undergoing surgery for long periods and communicate with the staff to use the proper guidelines to avoid possible pressure injuries. • In the presence of a pressure injury or skin-related issue review documentation to obtain information if the proper interprofessional team was consulted such as Inpatient wound registered nurse, nutrition nurse, surgeons, and social workers.
References. *See the course syllabus for specific requirements on references for all assignments.*	References Black, Joyce M. (2019). Root cause analysis for hospital-acquired pressure injury. *Journal of Wound, Ostomy and Continence Nursing*, 46(4), 298-304. http://dx.doi.org/10.1097/WON.0000000000000546 Kusserow, R. P. (2021). Compliance root cause analysis: A problem-solving process for addressing identified noncompliance. *Aspen Publishers, Inc*. 61-64.

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.