Name/date: Sara Thompson 06/02/2021

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 is a process utilized by the health care system. "The goal of the RCA is twofold. First, the process aims to determine the contributing factors, with a focus on the latent hazards in the system, which contributed to the occurrence of the event. The second is to develop the solutions or proposed changes that, once implemented, will eliminate or reduce the hazard and therefore reduce the chance that a similar event could occur in the future." (Kellogg et al., 2016, pg. 381). For pressure ulcer prevention this is an important process to have in place as it can negatively affect a patient's overall health as well as prevent the hospital from being reimbursed financially for a patient's stay. Patients can get secondary infections related to the open areas and have difficulty healing leading to additional procedures and extensive wound care. *Any source used for this section?*
2. Analyze **one** of the case studies from page two (of this document). Describe the system failures that led to the pressure injury.	When it comes to pressure ulcers, it is not just one singular thing that leads to a pressure injury, it is usually a series of events, or missed opportunities that result in the skin breakdown. In the scenario involving the patient with cauda equina injury the first issue appears to be a failure to identify all risk factors that patient had that could lead to a pressure injury. "As with the general population, many persons with SCI are dealing with multiple medical comorbidities including diabetes, pulmonary disease, cardiac disease and renal failure, and any comorbidities add to the constant demands related to the SCI." (Doughty et al., 2016, pg. 358). *For an edited book, such as the textbook, make sure you cite the chapter authors in scholarly work.* For example, following the surgery the patient

	had decreased sensation, and mobility to her bilateral lower extremities. This made ambulating difficult, and lead to prolonged sitting and lying in the same position with little to now repositioning. She had both bowel and bladder incontinence which itself can lead to skin breakdown but is often worse because she does not have full sensation to that area of her body. Due to her inability to move well, she spends a longer amount of time than recommended in a wet incontinence brief. She also has co-morbidities such as diabetes and has elevated blood sugars. As the team discharging the patient home, we should have looked at the entire picture when making a care plan for discharge. As a facility the changes should have begun post operatively with how we handled pressure ulcer prevention. The first thing that should have been addressed is the treatment plan regarding her blood sugar. Post operatively it is common for there to be an increase in blood glucose following a procedure as they body reacts to the stress of the situation. Regularly this levels out within a few days, but for others this is not the case. It should have been reviewed with the physician about use of short acting insulin until the normal medication regime could be resumed and manage the glucose alone. The next thing that stands out to me is the appropriateness of the referral to home health. Due to the patients decreased ability to ambulate and continued numbness to the lower extremities a more serious conversation should have been had about a referral to short term rehab. The patient would have had access to more services and on a more frequent basis resulting in a safer post-operative healing period and a quicker return to her baseline. If the patient is not agreeable to a referral to inpatient rehab, then we should have looked at linkage to more equipment and services for in home health care. Someone in this scenario should have had a referral to physical, and occupational therapy, as well as skilled nursing and a home health aide. This would have provided the patient with increased access to proper hygiene with the home health aide, more frequent visits so closer monitoring and therapy focused on activities of daily living such as self-care. Social work should have been consulted on this patient prior to discharge or as an additional service with home health to help provide linkage for the patient to

	affordable adaptive equipment such as a lift chair, a purwick system and a pressure relieving mattress. The last factor that could be a major contributor to complications such as pressure ulcers is education for the patient and the family. It is important as a health care team that we make it a point to educate and reinforce the topic reinforce the information on a regular basis. Providing intervention in the hospital and translating it into practical things at home help prevent pressure injuries and as well as build confidence in the patient and their families to provide the care their loved one needs.
3. Based on these findings, develop a comprehensive pressure injury prevention plan for the organization.	The first step in the process needs to begin at the admission with a thorough two nurse skin assessment. This assessment should be documented in detail in the patients chart complete with pictures of any open areas, or areas of question a patient arrives with. This information should be passed to all members of the floor during the shift huddle to ensure assistance with interventions. The next step is to utilize the Braden scale appropriately for each patient. This may require additional education for staff on the importance of accurately scoring a patient. This score should be marked on the patient's white board in their room so that all staff can be aware. If the patient is on a every 2-hour turning schedule than the "odd" or "even" should also be identified in the same location as a reminder to all members of the health care team. For anyone with an open area or area of question there should be a consult placed on admission or with change in condition to the WOCN. From this point interventions, recommendations and topical treatments can be put in place based on the patient's specific needs and WOCN recommendations. For patients with incontinence issues use of toileting schedule, a purwick or male external catheter should be considered to help prevent further skin issues related to moisture. During the stay and prior to discharge both the patient and their caregiver, or family members should be education on pressure ulcer prevention, proper nutrition and incontinence related issues. This information should be provided often and in a variety of forms utilizing teach back. Printable information should be compiled into easy to grab packets for standardization and ease of use to provide continuity of education. "Because the causes of PUs include biological,

	behavioral, and social factors prevention impatient education must address all of these issues." (Doughty et al., 2016, pg. 255).
4. Propose a plan to monitor the results of objective #3.	To monitor for compliance with proper charting of pressure injuries on a patient on admission the hospitals skin team, or the manager for the floor the patient was admitted on should audit the chart of anyone who has a documented pressure injury. "Most rehabilitation programs teach at least once daily visual examination of all bony prominences, especially the sitting surfaces of the sacrum, coccyx, ischial and posterior femurs." (Doughty et al., 2016, pg. 257). For hospital staff this should be done once per shift. The quality department, members of the skin team or the floors management should monitor charting to ensure proper documentation is present. During the morning huddle each nurse should identify their patients who score less than or equal to an 18 so that the floor managers, or charge nurse can follow up on compliance of proposed interventions, and to follow for negative changes in the patient. To check for compliance with turning schedules audits of the chart and a visualization of the patient should be done on an impromptu basis. During rounding management, or the charge nurse should ask specific questions related to toileting, turning, and ambulating with patients labeled high risk to determine if staff is adhering to the plan, or if the patient needs one of these things in between scheduled times. Each patient's folder that is provided on admission should contain all printed education staff provides during the stay. Management or the charge nurse should confirm with patient during daily rounds that this information was provided in a form they understand and see if they have any follow up questions that need to be answered. *Great. Chart audits and physical rounding are important in tandem.*
Quality dep	
References. *See the course syllabus for specific requirements on references for all assignments.* *(3+)*	Doughty, D. B., McNichol, L. L., Maklebust, J. A., & Magnan, M. (2016). In *Wound, Ostomy, and Continence Nurses Society core curriculum* (pp. 333–361). essay, Wolters Kluwer. Doughty, D. B., McNichol, L. L., Rappl, L., & Brienza, D. (2016). In *Wound, Ostomy, and Continence Nurses Society core curriculum* (pp. 253–270). essay, Wolters Kluwer. Kellogg, K. M., Hettinger, Z., Shah, M., Wears, R. L., Sellers, C. R., Squires, M., & Fairbanks, R. J. (2016). Our current approach to root cause analysis: is it contributing to our failure to improve patient safety? *BMJ Quality & Safety*, 381–387.

	https://doi.org/10.1136/bmjqs-2016-005991

When citing an edited text, make sure that the chapter authors are cited from within the book (these chapters count as separate sources). Additionally, try to re-word referenced materials rather than using large direct quotes, as this shows application of material to the content of the paper. Your information looks good here – please update your APA referencing to reflect the 7th edition and assignment requirements to make up for points left on the table from this aspect of the assignment. If you choose to do so, just re-submit a new document to the drop box and of course let me know if there is any further questions. See below rubric for additional guidance.

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	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	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	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

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
	per project.	words per project.	project.	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.