Name: _Tammi Watkins_____

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.

Carefully review the above rubric on how points are awarded. Select one (not both) of the case studies listed on page three. Then, using academic writing standards and APA formatting of references and citations, respond to each of the learning objectives listed on page two. Each response should be 150-350 words in length, and should be entered below each objective on this document. Save the completed document as the assignment title with your name and submit to the dropbox.

1. Define root cause analysis & its role in pressure injury prevention.

Root cause analysis (RCA) is defined as the "most fundamental reason leading to a situation where a performance did not meet the expectations" (Black, 2019). It is finding the underlining cause of a problem and not just solving the problem, but looking for the cause. There are 3 layers in RCA the first layer looks at the physical root meaning what is the physical symptom. The second layer is the human roots meaning what act or lack of intervention by humans caused the problem. The third layer is the latent roots meaning the deficiencies or the process issues that were part of the care (Root cause analysis, 2015).

The use of RCA in prevention in pressure injuries (PI) can help in determining human flaws that could be a factor in PI development. It can expose the symptoms that are causing the PI, determining any flaws in the process of care for PI and help to develop critical changes to help in prevention of the PI (Root cause analysis, 2015.)

2. Analyze one (not both) of the case studies from page three of this document, and describe the system failures that led to the pressure injury in that situation.

I will be analyzing case study A for the system failures. Starting with the first layer the physical symptom was the development of the PI. In the physical roots of the RCA it is to confirm and determine where the PI started. We can confirm it is a PI by the appearance and determine that the PI did not start in the hospital based on the NPUAP staging Taxonomy ™ tool (Black, 2019). The taxonomy states nonstaging PI's present within 72 hours of likely onset of the PI (Black, 2019). Another factor of determining the physical roots is where is the PI? The PI is located on the sacral area which usually occurs when a patient is supine in bed with HOB elevated or sitting in a recliner (Pressure injury assessment & management, 2019). In the example the patient has been sitting in recliner at home for 3 weeks. The second layer, the human roots, would be to examine the process of the system. It would be important to determine when a head to toe assessment was completed by the nurse, if it was repeated, if a tool was used to determine if the patient was a high risk for a PI, if any preventative care plans were established, and if the care plans were followed. In the example the patient had a low grade fever a week prior to the PI appearing- what was the nurse's intervention for the fever? It is established the patient is diabetic and it would be important to follow up on the nursing intervention/care plans for the diabetic teaching/care. The patient also is incontinent of bowel and bladder, were there goals of care established for the incontinent patient. It is stated the patient was spending most of her days in a recliner and the RCA process must determine the intervention/planning of both the nursing staff and physical therapy staff. The lack of human actions needs to be determined when examining the problem. For the third layer the process of the home health agency needs to look at the latent causes of the PI. Is there communication breakdown between the physical therapist and the nursing staff? Is there a policy on reassessment of skin on a patient that scores high on a skin tool? Is there a tool used and is the staff educated on the tool; and if a patient scores as high risk what is

the process of addressing the risk? The patient also has a comorbidity that will interfere with the healing of any type of wound. Has the patient's diabetes been monitored and goals of care established?

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

The comprehensive PI prevention plan needs to encompass everyone in the organization; not all home health patients will continue with skilled nursing so the plan needs to include all disciplines providing care.

Here are the following steps I would start in establishing a comprehensive PI prevention plan:

Establish there is an assessment tool for skin, establish that all disciplines know how to complete the tool and make sure all disciplines know how to find the tool if performed by another discipline. Make sure the tool is integrated into the charting of all disciplines and easy to access.

Establish a communication tool for disciplines to use to alert each other of skin changes. In hospice the team interdisciplinary weekly meeting can be one tool.

Establish for patients that score at a certain level on the established tool that they have a thoroughly head to toe assessment performed weekly and the tool is repeated if any change in the patients' health is determined ie the low grade fever. It needs to be determined who will take the lead with the tool if there are multiple disciplines in the patient's home. Also need to determine time frame of when the assessment tool is to be used- ie the first visit of the week.

Establish a plan for patients to help decrease their mechanical load. For patients that have limited mobility they shall have options for support surfaces (Support surfaces, 2020). Teach the patient with limited mobility the importance of redistributing their weight and actions they can take to reduce the mechanical load.

Establish a plan for patients that are incontinent and provide teaching for the staff to provide patients/caregivers on importance of keeping the skin dry, provide guidelines to staff on usage of pressure dressings, lotions, skin barrier ointment, and engaging certified home health aides in assisting with bathing to provide another set of eyes involved in the patients care (cite article).

For patients with comorbidities that hinder or may exacerbate wound healing provide teaching on the comorbidity. Have pre-teaching sheets for the staff to copy and provide patients/caregivers on the comorbidity. Also teach the patient/caregiver on how to assess their skin, and the importance of maintaining blood sugars within normal range. If a patient has a comorbidity that can be monitored such as diabetes by blood sugars; develop a tool to keep track of the patient's blood sugars on a regular basis.

Establish yearly staff education on PI's and preventative measures.

4. Propose a plan of care to monitor the results of the organization wide, comprehensive pressure injury prevention plan.

It would be important to establish a committee that will focus on PI's for the organization. This committee must be provided established time to work on the plans and have full support of upper management of the team members attending. It is important to stress the importance of the plan and establishing a set time frame when the results will be reviewed. It is important to have the team an active team and not one that only meets sporadically, the time commitment needs to be established and supported.

The plan of care to monitor the results of the PI plan would be as follows:

Nursing diagnosis:

Readiness plan for high risk patients for pressure injuries

Goals of Outcome:

High risk patients for PIs will maintain good skin integrity and be provided patient-centered plans of care.

Intervention:

Use established tool for skin assessment and determine HR patients for PIs.

Perform weekly skin assessments for patients that are HR for PI

If a patient develops a PI, the findings will be sent to the committee overseeing PIs in the organization

Staff will chose patient-centered plans of care goals that have been established by the agency for PIs

The committee will follow the established implemented procedures for PIs that occur after admission

Evaluation:

Staff is able to evaluate and use effectively skin tool assessment and pre-determine patients HR for PIs

Staff is knowledgeable in the established plans of care goals for PIs

Staff is able to determine proper teaching material for the patient/caregiver

Staff is able to determine if support surfaces are appropriate for the patient and prevention of PI

PIs acquired after admission to home based health services decrease

Over 80% of the staff has attended PI educational events

5. List the references used & cited in this assignment.
    a. *See the course syllabus for specific requirements on references for all assignments.*

Black, J. (2019). Root cause analysis for hospital-acquired pressure injury. *Journal Wound Ostomy Continence Nurse*, *46*(4), 298–304. https://doi.org/https://nursing.ceconnection.com/ovidfiles/00152192-201907000-00007.pdf

Pressure injury assessment & management (2019, September 23). [PowerPoint slides]. R. B. Turnbull, Jr. MD School of WOC Nursing Education. https://www.youtube.com/watch?v=mhPliiZkkkY

Root cause analysis (2015). [PowerPoint slides]. J Black, National Pressure Ulcer Advisory Panel. file:///C:/Users/Tammi/Downloads/2a.RootCauseAnalysisJBlack.pdf

Soban, L., Kim, L., Yuan, A., & Miltner, R. (2017). Organizational strategies to implement hospital pressure ulcer prevention programs: findings from a national survey. *Journal of Nursing Management*, *25*(6), 457–467. https://doi.org/10.1111/jonm.12416

Support surfaces (2020, Augusts 23). [PowerPoint slides]. R. B. Turnbull, Jr. MD School of WOC Nursing Education. https://www.youtube.com/watch?v=UwhKpguDZgk

Select just one (not both) to respond to the learning objectives listed on page two.

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.