Name: ___Kelly Fleming_____

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 a systematic process which identifies causative factors in discrepancies in performance which have a negative outcome. A root cause is the significant event that results in a situation not having the expected outcome. “RCA is a method of problem solving with the goal of identifying the true roots of a problem in order to understand it and prevent it from occurring again” (Black, 2020, p298). Hospital acquired pressure injuries should be a never event and when they happen in a facility or health system RCA’s can help the risk managers determine how the event happened and what steps need to be taken to prevent further pressure injuries or negative events from happening again. In 3-level RCA process, the first step is to explore the symptoms of the problem. The 2nd level identifies the human roots or the actions/ inactions of the staff, and the 3rd level is to identify the laten roots which include the system of care and processes within the system. RCA reviews should begin within 72 hours of the occurrence and usually consist of 4 to 6 persons from all levels within the organization to participate. By completing a RCA on pressure injuries, you can identify issues that exist in the system and implement changes in policies or procedures to reduce the risk of subsequent pressure injury development and aim to reduce negative outcomes for other patients.

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.

   System level aspects of pressure injury development are commonly used as an indictor of performance of healthcare facilities. The RCA identifies the major causes or system failures that lead to the pressure injury (PI). This includes looking at when did the PI begin and where is the location of the PI. It is also important to review the process of care, what is the condition of the skin at the time of admission, the patients PI risk, preventive care plans for PI, and the care provided. (Black, 2020, p 301). In case study B, the patient was found down in his backyard and brought to the hospital by EMS. The patient is found to have poor blood glucose control and based on test results CAD requiring triple bypass surgery. On day 3 of admission, he undergoes an 8-hour surgery and then 18 hours after surgery he is found to have a DTPI to his coccyx. The WOC nurse confirms the pressure injury and implements a plan of care. DTPI are often not visible for 48 to 72 hours after the injury occurred (*Pressure injury assessment & management*, 2022). Depending on the timing of events preceding admission, the patient’s skin may be intact and not show signs of purple discolored tissue until several days later. In this scenario they talk about doing a Braden scale on admission but do not state if the patient skin was assessed on admission or if any skin assessment or another Braden score was preformed again until the breakdown is found 3-4 days after admission. Also, the patient was ordered a pressure redistribution mattress after the PI was found, but does not state if any other preventive care plan was in place prior. There are several risk factors that are not clearly addressed prior to the finding of the PI, it does not state if the patient able to turn and reposition independently or required help, there is no mention of a protective foam dressing placed on his sacrum during surgery, also does not state if his blood glucose levels where managed, or if this patient had any issues with tissue prefusion prior to surgery.

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

   A comprehensive pressure injury prevention plan should be based on knowledge and assessment data related to the patient's clinical condition, current skin condition, pressure risk/ specific risk factors, and resources available at the facility (Borchehert, 2022, p 413). Creating a plan takes a coordinated effort by people within in the organization who have specialized knowledge and skill to develop a unified program at the institutional level, across all departments and among multiple disciplines. A pressure injury prevention plan that should be developed for this organization should include policies on head-to-toe skin assessment on admission and subsequent skin assessment at least every shift, as well as a facility chosen risk assessment tool to be completed every shift. This should include looking at areas that are high risk for breakdown, boney prominences like the sacrum/ coccyx and heels, and any areas under medical devices/ tubes. Prevention in specialty service areas like the OR also need to be addressed, and make sure that preventative dressings, positioning equipment and transfer devices are being used. Pressure injury prevention education needs to implemented which provides skill training for all staff members on how to effectively execute policies and procedures relative to pressure injury prevention. Staff need to be educated on how to assess skin and stage pressure injuries, importance of turning and repositioning for patients at high risk for breakdown, how to order specialty equipment to help optimize pressure redistribution, moisture management or implementation of toileting/ incontinence care, as well as diet and nutrition management. The plan needs to address the policy on how to consult other team members to help facilitate care of patients with multiple risk factors; such as consulting WOC nursing, physical therapy, and/ or nutritionist to name a few.

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

   An important part of the pressure injury prevention plan is to ensure that the facility has a process for reporting a hospital acquired pressure injury. (Borchehert, 2022, p 415). An effective monitoring system is needed to provide an assessment of pressure injury prevalence and incident rates within the organization. This helps to determine if the polices and procedures in place are being followed and if they are effective. The organization needs to develop a way to submit an initial incident/ error in care report that would be submitted into a reporting data base within the organization. This report would then be reviewed a risk assessment team to determine if the event is a reportable event. Many facilities partake in a quarterly audit through the National Database of Nursing Quality Indicators ® (NDNQI), this tool helps to report the prevalence of HAPI rates within the facility on a given day. By looking at the HAPI rates of pressure injury development between each quarter the facility would be able to identify the units at risk who require further education on pressure injury prevention and implementation of prevention plans.

5. List the references used & cited in this assignment.

Black, J. (2019). Root cause analysis for hospital-acquired pressure injury. *Journal of Wound, Ostomy and continence Nursing*, 46 (4), 298-304. doi.10.1097/WON.0000000000000546.

Borchehert, K. (2022). Pressure injury prevention: implementing and maintaining a successful plan and program. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.) *Wound Ostomy and Continence Nurses Society™ core curriculum: Wound management*. (2nd., pp.396–424). Wolters Kluwer.

(2022, February 17). 2022 *Pressure injury assessment & management* [PowerPoint slides]. R. B. Turnbull, Jr. MD School of WOC Nursing Education. https://www.youtube.com/watch?v=Gh5YwtSXuoQ

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.