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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.

A root cause analysis as defined in *Core curriculum: Wound management* as, "an important study method to help determine the exact cause of a serious problem (p. 416)." A root cause analysis is usually performed by a team of people who were involved in the event that has occurred (McNichol et al., 2022 p. 416). The goal of the root cause analysis is to look at all angles of the event. Why did it occur? Was there a gap in care that could have led to the problem? Does this provide an example for education or process improvement? By performing a root cause of an event, it could potentially help prevent the same event from occurring in the future. For example, a causative risk area that may be identified in the home care patient with cauda equina surgery was prolonged sitting intervals. This is a patient that stated most of her time was sitting in the recliner. Upon discharge from the hospital to the home setting, was the patient and caregivers educated on frequent weight shifts, use of a gel or foam pressure redistribution cushion, ensuring thighs are parallel to the ground to prevent added pressure to the sacrum (McNichol et al., 2022 p. 408). In the future, plan of care building for a patient with spinal surgery and decrease in lower extremity strength and sensation could include education of performing frequent weight shifts when sitting, suppling a pressure redistribution cushion and proper sitting position.

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.

This patient is experiencing several system failures due to her cauda equina injury. First is the nervous system. There is numbness and loss of full sensation noted to her lower extremities. A patient with cauda equina issues is most likely not going to be able to feel or have full sensation from the lumbar region to the toes. This is going to affect her ability to know that her sacrum is becoming sore, and she should shift her weight. Most of us when sitting for prolonged periods of time can notice our sacrum becoming sore and will begin to shift our weight when sitting in chairs. Additionally, damage to this area of the spine can lead to urinary and bowel incontinence (Wiseman, 2022). This would prohibit the patient from noticing that she is experiencing incontinence, which could lead her to sitting in moisture for an extended period. This leads into urinary system failure. Since there is damage to the nerves in this area of her back, the messages sent to the bladder to indicate fullness and the need to empty is not being communicated to the patient which leads to her urinary incontinence. Prolonged exposure to moisture and pressure leads to failure of the integumentary system. Moisture can weaken the integrity of the skin followed by prolonged pressure leading to breakdown. Finally, the patient is a diabetic. It is unclear if she has good glycemic control per the case study. However, stressing the importance of ensuring she maintains her blood sugars within the appropriate ranges could help reduce the risk of infection to the sacral wound.

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

The first step is understanding is that a change needs to happen, and that we are ready for it to happen (AHRQ, 2014). Developing a pressure injury prevention plan would require a full interdisciplinary team; top to bottom approach. This approach would need to include every person providing care to the patient, as well as include the patient. In the home health care setting people involved would be the patient, caregiver,

home health aides, physical/occupation/speech therapy, and all nurses that would encounter the patient. The team lead would be the wound care nurse. First, implementation of a pressure injury risk assessment tool for all patients admitted to their services would need to be put into place. This tool could be something like the Braden Scale for Predicting pressure Sore Risk (McNichols et al., 2022 p. 398). In addition to using a tool for assessment there needs to be a full understanding of the patient clinical picture, current skin conditions, and ability to access resources needed for pressure injury prevention (AHRQ, 2014). All staff and caregivers within the organization would need to receive training on proper use of the tool. This tool would allow for the development of a set of "bundled" pressure injury prevention interventions, as well as patient specific interventions (AHRQ, 2014). When developing this bundle consideration needs to be taken to ensure interventions are cost effective and manageable for the interdisciplinary team members. Interventions would address anything from mobility, sensory, activity, moisture, nutrition, and friction and sheer (McNichols, et al., 2022 p. 401) This would also include education behind each of these interventions. Once a plan of care is developed for a patient, there would be ongoing monitoring to ensure the interventions are being followed on a consistent basis. Afterall, the only way to ensure pressure injuries do not occur it by proper prevention interventions.

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

Monitoring the effectiveness of the pressure injury prevention plan is key to success. Evaluating each members participation would be necessary, as well as asking for their feedback as to what is working and what may need improvement. There should be regularly scheduled meeting of the interdisciplinary team that could occur monthly. Root cause analysis should be completed to assess for gaps in care, and ways to address these gaps. Patient and caregiver feedback are important as well. Are the interventions manageable and affordable for them? Is the goal realistic? Often plan of cares will need to be adjusted to meet the changing needs of the patient. Additionally, organizations may need to adjust their plan of care based on national requirements and benchmarks.

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

Agency for Healthcare Research and Quality (AHRQ). (2014). *Preventing pressure ulcers in hospitals: A toolkit for improving quality of care.* Content last reviewed October 2014. Rockville, MD: AHRQ. Retrieved June 5, 2022 from https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressureulcer/tool/index.html

McNichol, L. L., Ratliff, C. R., & Yates, S. S. (2022). *Wound, ostomy, and Continence Nurses Society Core Curriculum* (2nd ed.). Wolters Kluwer.

Wiseman, D. (n.d.). *Cauda equina syndrome*. AANS. Retrieved June 5, 2022, from https://www.aans.org/en/Patients/Neurosurgical-Conditions-and-Treatments/Cauda-Equina-Syndrome

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.