**Pressure Injury Root Cause Analysis**

Cleveland Clinic

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**Points criteria:**

| Criteria | Under performance<br><3 points per criteria | Basic<br>3 – 3.9 points per criteria | Proficient<br>4.0 – 4.4 points per criteria | Distinguished<br>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 is defined as a systematic process that was created by industry, was adapted to healthcare, and was used to analyze the factors that lead to an adverse event, such as pressure injuries in the hospital (Hibbert et al, 2018). Every healthcare system has their own version of root cause analysis that maps an event chronologically tracking the time, sequence of events that are relevant, interviewing parties involved, analyzing data sources, developing cause and effect diagrams, and recommendations (Hibbert et al, 2018). Root cause analysis is a helpful tool that collects data for health care institutions and allows them to reflect on the events that transpired before pressure injury development. Using root cause analysis can help to analyze and determine factors that contributed to a patient developing pressures injuries (PI) while in a medical facility. Knowing what led to this development of PI can help the effort in preventing PI formation in the future. PI are an adverse event that is preventable, healthcare providers and staff need to learn and adapt to systems that will help to prevention the formation of PI.

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.

The scenario analyzed is scenario B. The patient has multiple comorbidities that can delay healing. The patient was found unconscious and may have had a pressure injury from lying on the ground. The patient is a diabetic that has uncontrolled blood glucose levels and was diagnosed with coronary artery disease which led to decreased prefusion across his body. The patient also had prolonged bypass surgery which would decrease his prefusion during and after surgery putting him at great risk for developing a pressure injury. The surgeons and surgical nurses in the operating room may have not taking this risk factor in to account when doing surgery and did not apply the proper prophylactic dressings over boney prominences leading to the deep tissue pressure injury after surgery. The assessment done to assess this patient's risk for skin breakdown may have been flawed as well, because it had scored this patient as a low risk. The patient had risk factors that were new that may not have been considered when calculating the risk score.

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

The hospital should evaluate the risk assessment tool that they are currently using and choose one that is going to provide the best evaluation to determine the patient's risk for skin breakdown. It is important to interpret the patient as a whole in addition to utilizing assessment tools, assessment tools alone are not all encompassing (R.B. Turnbull, Jr. MD School of WOC Nursing Education, 2022). The hospital should enact a standardized policy for placing preventative dressings on all pressure points on patients who will be in prolonged surgeries, as well as immobilized patients. The hospital can create policies on the proper positioning of the patient to help decrease pressure on the bony

prominence points on the body. The hospital can also have a policy of skin assessment upon admission to determine if there were any injuries that were present when admitted to the hospital. This can help to start the wound care process and care before the injuries become worse. The units and department should receive standardized education on these new policies and changes.

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

The hospital can create a quality improvement committee that will be able to monitor the effectiveness of the new policies in place. The hospital can monitor randomly selected patients and record their skin care outcomes over multiple months to a year. The effectiveness of interventions will take time to reflect. The hospital can utilize the unit-based skin care nurses and the WOC nurses to provide skin assessments on the high-risk patients and evaluate for development of pressure injuries on all the patients on the units. The hospital can use programs to collect data on which patients have developed pressure injuries while in the facility that may need to be evaluated further to determine what factors led to their wound formation after the new policies and procedures are in place. The quality improvement team can help to evaluate these patients and determine where the system failed and what may need further improvement. For the future.

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

Hibbert, P.D., Thomas, M. J. W., Deakin, A., Runciman, W.B., Braithwaite, J., Lomax, S., Prescott, J., Gorrie, G., Szczygielski, A., Surwald, T. & Fraser,

C. Are root cause analyses recommendations effective and sustainable? An observational study. *International Journal for Quality in Health*

*Care*. 30 (2). https://doi.org/10.1093/intqhc/mzx181

R.B. Turnbull, Jr. MD School of WOC Nursing Education. (2022, February 16). [Lecture notes on pressure injury assessment & management].

**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.