Pressure Injury Root Cause Analysis

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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.**

   Root cause analysis is a tool used to identify the incidence and prevalence of a topic to determine whether proper interventions are in place or if additional education is needed (Borchert, 2022). In most hospitals, the occurrence of pressure injuries is closely monitored because these injuries are deemed "preventable" and the center for Medicaid services do not reimburse associated costs, making the hospital responsible to absorb the financial burden. Pressure injuries can often be avoided with proper education and implementation of preventative measures carried out by the entire hospital. Frequent analysis of whether pressure injuries are occurring and if the proper steps were taken to avoid these injuries is one way to hold caregivers accountable for delivering appropriate care, as well as documenting its occurrence. Root cause analysis allows for evaluation of current intervention practices and whether they need to be reconstructed or revised for better outcomes.

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 patient in scenario B was initially found down in his backyard, no amount of time is noted for how long he was down nor are any other conditions of this event noted. For example, was this patient down for several hours before he was found? Did he land in any type of water or loose control over his bowel/bladder? Did he land on his backside? Was anything under him causing additional pressure? This information would bring awareness to a possible preexisting wound caused by the fall. The patient did not have surgery until his third day at the hospital, was his skin thoroughly assessed upon admission? Was there any slight discoloration noted on any area of his body? If so, was this documented? Was this patient educated and encouraged to reposition often? Was this documented? The skin breakdown risk assessment placed him at low risk for breakdown, was this tool used accurately? If any of these previously listed interventions were missed, these areas could be improved upon with additional education. However, the condition of his skin is not noted until after surgery, so the attention will be redirected towards how the system failed him and lead to a deep tissue pressure injury. The patient was having surgery for coronary artery disease, this alerts hospital staff that the patient has circulatory issues. The patient's HbA1c was also noted to be 13.2%, which indicates poorly controlled blood sugars. Both pieces of information predispose this patient for pressure injury occurrence. This patient is then left in the same supine position for an eight-hour long surgery. This prolonged exposure of pressure to the coccyx likely compressed the surrounding blood vessels causing tissue death to the area (R.B. Turnbull, Jr. MD School of WOC Nursing Education, 2022). Additionally, following surgery the patient's skin should have been reassessed once

transferred to postoperative unit. Failure to assess for early signs of pressure injuries leads to failure of early identification and interventions to stop further damage from occurring.

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

Initial skin assessments must be completed upon admission, if the patient is in critical condition and being rushed to surgery then following surgery this must be completed and documented. Failure to complete this assessment results in the facility not having a baseline of the condition of the patient's skin, therefore no comparison is available for how the patient arrived versus how they currently present. The objectives for the pressure injury prevention plan will be aimed towards surgery and interventions to reduce the risk of pressure injuries from occurring during long surgical procedures. These interventions will include preoperative and postoperative position changes, protecting bony areas of the body with foam dressings, ensuring no medical devices are underneath the patient, reposition patient during surgery if possible, offloading heels, and incorporating pressure redistribution surfaces when possible (Borchert, 2022). All these options allow for a shift in direct pressure on the patient and reduce the likelihood of a new injury occurring. The more surface area created when positioning the patient for surgery, the more the pressure is distributed.

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

Due to the maintenance of sterility and the limited mobility during surgery, precise interventions that directly target the redistribution of pressure is fundamental. Standardizing support surfaces in the operating room that accommodate the patient's size and utilizing offloading devices will maximize the surface area, decreasing the amount of pressure on one area. Monitoring the effectiveness of the proposed pressure injury prevention plan will include implementing the previously mentioned interventions to reduce the incidence of pressure injury occurrence during surgery. A thorough two-person assessment is needed upon initial assessment. If a patient is unstable, this must be documented and completed as soon as the patient stabilizes. Any concerns with findings should be immediately reported to a WOC nurse at the facility for further evaluation. Additional education will be provided throughout the hospital with emphasis on preventative measures in the operating room. Pressure injury prevention is necessary for all departments in the hospital, therefor it is everyone's responsibility to be aware of pressure injury prevention interventions. This will help create a hospital-wide culture that aims

to provide the best care while preventing pressure injuries (Borchert, 2022). Incidence and prevalence will be monitored quarterly to determine the efficacy of the proposed plan.

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

Borchert, K. (2022). Pressure injury prevention: implementing and maintaining a successful plan and program. In L. L. McNichol, C. R. Ratliffe, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound Management* (2nd ed., pp. 396-419). Wolters Kluwer.

R.B. Turnbull, Jr. MD School of WOC Nursing Education. (2022). *Pressure injury assessment & management*. [PowerPoint slides]. Vimeo@CCF.

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.