

Name: _____ Amanda Walker _____

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.

Pressure Injury Root Cause Analysis

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

Defining root cause analysis and its role in pressure injury prevention requires a breakdown of what root cause analysis is in the healthcare setting. Root cause analysis can be defining a technique to understanding a situation with in depth details of an occurrence and how it could be avoided with the intention to improve patient safety (Martin-Delgado et al., 2020). This type of in depth investigation of certain occurrences plays a role in pressure injury prevention by establishing all the details of pressure injury prevention. Pressure injury prevention in root cause analysis defines a role in creating a cause and effect reasoning as to why a pressure injury is established. Exposure areas of hard surfaces and patients' specific issues such as incontinence, poor perfusion or malnutrition play an important role in why root cause analysis (RCA) is imperative (Black, 2019) Creating a process that investigates the in depth aspects of both reasons and issues that occur in situations help health facilities improve policies or procedures.

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.

Analyzing the case study B there are several issues that play a role in this situation. From the hospital standpoint there is the long surgery lying supine, How did the nurse note a Deep pressure injury? Was the patient walking or still lying in bed? Was the patient scoring a 20 on a skin assessment because it was based on the patient being independent prior to this admission. Secondly the patient's health condition clearly has a vascular issue, a diabetic educator may be necessary with how much nutrition and care goes with diabetes. The mobility of the patient and what necessary dietary restrictions will need to be taken given the CAD and Diabetes. The fall at home was unwitnessed and could have also been a significant issue with everything the patient had following fall. Considering the patient has uncontrolled DM there may be a good chance he is noncompliant with other health issues also. Does he have other risk factors that complicate the DM and CAD such as smoking or drinking.

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

Based on the findings this comprehensive pressure injury prevention plan should include ways to improve the organization and increase patient safety. Given this increased probability that this wound was associated with the surgical intervention the patient had a comprehensive pressure injury prevention would essentially start in the operating room. The OR having its risk assessment tools and guidance on positioning or use of pressure disturbing surfaces can improve this type of pressure injury (Black & Creehan, 2022). This comprehensive pressure injury prevention plan for the organization should focus on ways to help the pressure injuries knowledge and improve patients safety. Creating this plan will help the facility create educational information and improve the nurses expected critical mindframe within the OR setting. Having the understanding of why these DPI occurred and monitoring ways to prevent these injuries is comprehensive and is an approach to help prevent these injuries.

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

A plan of care to monitor the results of the organization wide, comprehensive pressure injury prevention plan could be conducting RCA training for nurses or promoting an organizational wide safety culture for staff to communicate issues (Kwok et al., 2020) Encouraging a safe culture for communication for staff can promote increased succession of implementing new processes. Monitoring the occurrences of DPI after the operating room has increased its awareness of pressure injury prevention, compliance with the necessary equipment and implementations to prevent these injuries can show the organization process of succession. Pressure injuries are an important patient safety issue and are reflected on the nursing quality of care at a facility (Pittman et al., 2022). Developing a group focus on this issue can bring awareness to the importance a pressure injury can be to the patient, nurses and healthcare facility.

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

Martin-Delgado, J., Martínez-García, A., Aranaz, J., Valencia-Martín, J., & Mira, J. (2020, May 15). *How much of root cause analysis translates into improved patient safety: A systematic review*. Karger Publishers. <https://doi.org/10.1159/000508677>

Black, J. (2019). *Root cause analysis for hospital-acquired Pressure Injury*. Journal of wound, ostomy, and continence nursing : official publication of The Wound, Ostomy and Continence Nurses Society. <https://pubmed.ncbi.nlm.nih.gov/31274857/>

Black, J., & Creehan, S. (2022). *Defining practices to avoid hospital-acquired pressure injuries in the operating room*. Journal of wound, ostomy, and continence nursing : official publication of The Wound, Ostomy and Continence Nurses Society. <https://pubmed.ncbi.nlm.nih.gov/35040820/>

Kwok, Y. T. A., Mah, A. P., & Pang, K. M. (2020, June 5). *Our First Review: An evaluation of effectiveness of root cause analysis recommendations in Hong Kong public hospitals - BMC health services research*. BioMed Central. <https://doi.org/10.1186/s12913-020-05356-6>

Pittman, J., Otts, J., Riley, B., & Mulekar, M. (2022). *Pressure injury prevention and management: A gap analysis using key stakeholder engagement*. Journal of wound, ostomy, and continence nursing : official publication of The Wound, Ostomy and Continence Nurses Society. <https://pubmed.ncbi.nlm.nih.gov/36108225/>

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.