Cleveland Clinic

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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 (RCA) is a systematic approach to taking a deeper dive into an incident to answer what, why, and how the incident may have occurred and to discover any system failures or human errors that may have caused or led to a negative outcome.

Additionally, the RCA implements measures to prevent an incident from happening again. RCAs are most successful when performed using a multidisciplinary approach to identify system failures, and input from various teams is instrumental in getting to the origin of the problem. An important component to remember is that the RCA's purpose is intended to serve as a guideline and not punitive but as a learning opportunity to improve the process to promote safe patient care.

RCA's role in pressure injury prevention is to assist with identifying practice gaps and knowledge deficits and to implement organizational standards of care guidelines to prevent pressure injuries (Driesen et al., 2022, p. 342). In the setting of hospital-acquired pressure injuries, reviewing current standards or practice, patient-based risk factors include malnutrition, immobility, co-comorbidities, and disease processes, and reviewing current durable medical equipment utilized for pressure prevention.

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 failures identified in the scenario are as follows. An inaccurate Braden score of 20 documented on admission prevented the patient from being identified as a high risk for skin breakdown, which delayed preventative measures from being in place. With an accurate Braden score, preventive measures to preserve skin integrity, like placing the patient on a specialty bed sooner, could have decreased the patient's risk of developing a pressure injury; thus, delaying the intervention increases the likelihood of developing a pressure injury. Next, there is a failure to collaborate with the multidisciplinary team to address uncontrolled diabetes and poor nutrition. The patient presents with a poor nutrition status: blood glucose of 220 mg/dl and an A1c of 13.2. These co-morbidities place the patient at a higher risk of developing pressure injuries. During surgery, the patient remained supine for 8 hours, and there was no documentation of preventative measures to protect against tissue damage; tabletop pads could have protected the patient's skin during surgery. Lastly, there was a delay in skin assessment after the patient returned from surgery, along with a failure to reposition the patient routinely. Several missed opportunities left the patient vulnerable to developing a deep tissue pressure injury.

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

The goal is to develop a comprehensive plan by increasing awareness and creating pressure injury prevention guidelines. A thorough assessment will be conducted within 2 hours of admission to the unit, requiring a two-nurse skin check and a co-sign with ongoing nursing assessment each shift. Inspection will be required for all patients returning from any procedures, especially surgical procedures. The evaluation must occur with the primary nurse receiving the patient back to the unit, and the procedural nurse will conduct a thorough skin assessment, noting and documenting any change in the patient’s condition that deviates from baseline. The Braden assessment must be conducted on admission, each shift, and when a patient returns to the unit after a procedure. It should include the following components: sensory, activity, mobility, nutrition, friction, and shearing. If the patient's Braden score is <18, prevention measures must be ordered and in place. Prevention measures include specialty mattresses, chair cushions, repositioning schedules, offloading, and moisture management if identified. The primary team must be notified to place the appropriate consultations if any deficits are identified (Tayyin & Ramaiah, 2021). The nurse must also complete the Patients Need Screen (PNS) for any additional deficit or risk factors. Examples of needs include dietary, mobility, and wound care management.

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

The proposed plan of care to monitor the results of the organization-wide, comprehensive pressure injury prevention plan includes the following: There will be an institutional-wide initiative to perform weekly chart audits on patients admitted to the unit, focusing on Skin and Braden assessment. The chart audits' criteria are to focus on the following components: a two-nurse skin with co-sign must be documented, the Braden score must reflect the patient's presenting hospital problems, and daily care/repositioning must be verified every two hours with alternating positions. Hourly rounding will occur daily by the leadership team to ensure prevention measures are in place for patients with a high risk for skin breakdown. Any deficits with documentation will be addressed in real-time with the staff to identify any knowledge gaps with the required documentation (Fulbrook et al., 2019, p. 106). If any educational gaps are noted, the leadership team will collaborate with the Education department to develop additional training for staff to comply with their assessment and documentation. In addition, each unit will conduct weekly skin assessments on all patients with a monthly Pressure Injury Prevention (PIP) plan. The PIP study is a more in-depth study that reviews all components related to skin prevention, documentation, nutrition, repositioning, moisture, and skin integrity. Any deficits are referred to the WOC nursing team for validation before the PIP is emailed to the Quality department for tracking and trending.

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

Reference

Driesen, B. E. J. M., Baartmans, M., Merten, H., Otten, R., Walker, C., Nanayakkara, P. W. B., & Wagner, C. (2022). *Root Cause Analysis Using the Prevention and Recovery Information System for Monitoring and Analysis Method in Healthcare Facilities*: A systematic literature review. *Journal of patient safety*, *18*(4), 342–350. https://doi.org/10.1097/PTS.0000000000000925

Tayyin, N.A., Ramaiah, P. (2121). *Nurses' Challenges in Wound Care Management* – A Qualitative Study, J Clin of Diagn Res. 15(3), LC17-LC20. https://doi.org/10.7860/JCDR/2021/47039/14626

Fulbrook, P., Lawrence, P., & Miles, S. (2019). Australian Nurses' Knowledge of Pressure Injury Prevention and Management: A cross-sectional survey. *Journal of Wound, Ostomy, and Continence Nursing*, *46*(2), 106–112. https://doi.org/10.1097/WON.0000000000000508

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.