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 process by which a team of health care professionals systematically reviews a case that involves an adverse patient care outcome to determine the causes of the adverse outcome, and identify strategies to treat and prevent similar situations in the future (Black, 2019). Root cause analysis (RCA) can specifically be applied to pressure injuries as an RCA allows healthcare facilities and clinicians to evaluate cases that involve pressure injuries, determine the etiology and circumstances leading to the pressure injuries, and mitigate and correct the factors that lead to the pressures injuries. In this way, the RCA works to prevent future injuries. By looking at the case systematically through an RCA, clinicians can identify system and process issues, as well as individual causes. Evaluating patterns of pressure injuries, or utilizing common cause analysis, may allow for further assessment and prevention at a broader and systemic level. This may aid in enacting system wide policies to address pressure injury treatment and 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.

I chose to analyze case scenario A. Briefly, this scenario describes a patient who is two weeks post-hospital stay after a cauda equina injury that required surgical repair. She was discharged to home with homecare and has subsequently developed a pressure injury. In review of the case, she now has an unstageable sacral wound that measures 2.5 cm x 3 cm with thick, dense eschar, and a fever. The information given in the case also notes that she spends most of her day in the recliner. Therefore, it is likely the wound's

etiology is secondary to excessive sitting in the recliner as evidenced by the location of the wound on the sacrum (Black, 2019). This patient developed a pressure injury likely in part due to several system failures.

First, this patient was at high risk for pressure injury prior to surgery, after surgery, and on discharge. A risk assessment should have been completed at all stages, and certainly on admission to homecare. The case does not state if a risk assessment was completed or documented. Elevated risk factors attributable to this patient include lower extremity numbness indicating decreased sensation, immobility, poorly controlled diabetes, pain postoperatively and post injury, and fecal and urinary incontinence. There is no indication or documentation of measures put in place to prevent pressure injury despite elevated risk. A skin assessment on admission was apparently completed, but then appears that no reassessment occurred. Additionally, the case study does not specifically state skin over the sacrum was evaluated or that it was intact. The patient is noted to have decreased sensation with numbness in her lower extremities; this may lead to decreased pain sensation, and therefore impairs alerting the patient to the need to move. On the other hand, if her post op pain is not well controlled, this may lead to decreased mobility, further increasing risk of pressure injury. The patient and her caregivers at home should have been educated on the need to change positions on a regular basis to prevent injury. The patient's mobility should have been assessed prior to discharge home. She was ordered to have physical therapy via home health and presumably they were working with her on mobility. Rehab therapists should also be reinforcing the need for regular repositioning. Incontinence issues place the patient at high risk for tissue injury and infection (European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, & Pan Pacific Pressure Injury Alliance, 2019). Preventative measures could have been put in place to mitigate injury secondary to incontinence, including highly absorbent incontinence products, use of preventative foam dressing,

and/or barrier ointments. Additionally, it is reported that the patient developed a fever at 2 weeks. Was the patient assessed for why she had a fever? Was skin assessment completed again at that time?

Numerous factors played a role in this patient developing a pressure injury. She slipped through cracks in the system, as she apparently did not have a risk assessment completed, a thorough skin assessment completed, or a prevention plan put in place. Additionally, the requisite re-assessment of skin and risk did not occur at each homecare visit. A combination of these, and her elevated risk factors resulted in an otherwise avoidable pressure injury.

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

A comprehensive pressure injury plan for an organization will take a dedicated multidisciplinary team of people that will include administration, provider, nursing staff, PT/OT, and nutrition. This team will work together to first complete a needs assessment, and determine where further education and protocols are needed. The team will then develop a protocol and policy that will be applied to every patient in the organization. All staff involved will be educated on the importance of the plan, how to carry out the plan, and to whom they should go to with questions. The plan for pressure injury prevention will include risk identification. Each patient on admission to home health organization will be assessed for risk of a PI. This will include a validated risk assessment tool. The same risk assessment tool will be used throughout the organization in order to increase reliability and validity. The tool should not be the only thing used to determine risk however (Ayello et al., 2020). Skin assessment, patient history and comorbidities will also be considered. Any risk factors a patient has will be identified and addressed. A holistic look at risk factors will include assessment of activity and mobility, skin status,

perfusion, circulation, and oxygenation, patient's nutrition status, skin moisture and temperature, age of patient, and any possible sensory issues. The goal will be to maintain skin integrity, off load pressure off areas of common pressure injury, and evaluate patients holistically to ensure their total condition is considered in prevention and treatment strategies. Finally, and perhaps most importantly, the patient and their family and caregivers will be educated on the importance of prevention and as well as necessary strategies. This will include education on the importance of post-incontinence hygiene, and barrier cream application. All pressure injury prevention plans of care will be unique and individualized to each patient. The plan will include skin assessment and documentation of skin condition will occur on admission, and continue at every homecare visit (Ayello et al., 2020). Consideration will also be given to ordering preventative dressings of soft-silicone foam dressings to be placed on at risk bony prominences like patients' heels and sacrum (European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, & Pan Pacific Pressure Injury Alliance, 2019). The individualized plans will also include assessing the need for offloading pressure areas, and implementing measures to do so. This may include orders for DME of supports surface such as seat cushions, heel cups, and mattress surfaces (Ayello et al., 2020).

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

Results of the prevention plan will be measured quantitatively by obtaining a baseline assessment of the total number of patients under care of the organization, the total number of patients with a pressure injury risk and skin assessment completed and documented on admission, and an assessment of the baseline staff knowledge on pressure injury prevention and treatment. Furthermore, a baseline assessment of the number of the patients who develop pressure injuries will also occur. This will be a part of

the initial needs assessment described in the plan. To assess outcomes, the dedicated team will review the number of patients admitted to the organization, as well as the number of patients who have an initial pressure injury risk assessment completed and documented, at regular intervals after the plan is put in place. Further assessment will be completed by determining the number of patients that develop a pressure injury in that time frame. A quality indicator to monitor and assess results will be that patients who are identified to have elevated risk do have appropriate prevention plans of care documented, and implemented (European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, & Pan Pacific Pressure Injury Alliance, 2019). By comparing the total number of patients in the organization, to the total number who have a risk assessment completed, the team will be able to monitor if their prevention plan is being utilized as expected. Furthermore, evaluating the number of pressure injuries that develop will assess for the outcome of the plan, which will hopefully show a reduced number of pressure injuries.

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

References

Ayello, E. A., Baranoski, S., Cuddigan, J. E., Gefen, A., Berlowitz, D. R., Smart, H., & Harris Jicman, W. S. (2020). Pressure injuries. In S. Baranoski & E. A. Ayello (Eds.), Wound care essentials: Practice principles (5th ed., pp. 369- 406). Wolters Kluwer

Black, J. M. (2019). Root cause analysis or hospital-acquired pressure injury. Journal of Wound Ostomy Continence Nursing, 46(4), 298-304. doi:10.1097/WON.0000000000000546

European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, & Pan Pacific Pressure Injury Alliance. (2019). Prevention and treatment of pressure ulcers/injuries: Quick reference guide 2019.

https://static1.squarespace.com/static/6479484083027f25a6246fcb/t/647dc6c178b260694b5c9365/1685964483662/Quick_Reference_Guide-10Mar2019.pdf

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.**