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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 the method used to identify human or system errors at the root of a problem or adverse occurrence (Black, 2019). Healthcare facilities, practices, and workers use this method to identify problems, understand origins, pinpoint areas for improvement/prevention, and create policy or practice initiatives (Black, 2019). At heart, it is a process meant to prevent repetition of failures and future harms (Black, 2019). Root cause analyses are resource intensive—financially and manpower—investigations of system or human breakdown whether through action or inaction (Black, 2019). A root cause analysis requires a thorough investigation including document review and interviews of everyone involved in the care of the patient (Borchert, 2022). Pressure injuries are common outcomes for patients and nurses are key stakeholders in prevention, especially hospital-acquired pressure injuries. Nurses have the most influence and opportunity to prevent pressure injuries through nursing care plans and practice. Root cause analyses with nurse participation are strong means to identify the cause of pressure injuries and implement evidence-based practice to avoid future pressure injuries. Examples nurse led practices for pressure injury prevention include turning the patient every two hours, offloading bony prominences, and managing temperature and moisture. Possible adverse occurrences could happen at any point in one of these example practices and a root cause analysis can help to catch failures or implement such practices.

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 described in scenario A had multiple risk factors for pressure injuries upon admittance to home care. First, she was a diabetic which puts her at risk for poor healing and infections (Friedrich et al., 2022). Second, she had numbness in her lower extremities likely leading to limited mobility. Immobility is the risk factor most responsible for pressure injuries (Edsberg, 2022). Third, she had urinary and fecal incontinence which can lead to incontinence-associated dermatitis and shear injuries (Edsberg, 2022). Finally, spending most of her day in a recliner can contribute to pressure injuries. This indicates she has reduced mobility (see above), and the angle she sits in the recliner can create downward force putting her at risk for shear injuries (Edsberg, 2022). Having multiple risk factors, this patient needed a thorough assessment to identify these risk factors and a nursing plan to address each one (Edsberg, 2022).

The scenario indicated that she had “no skin conditions noted.” It is unclear if that means that she actually had no skin conditions or if a thorough skin assessment was not performed. A possible system failure would be if a thorough skin assessment was not required or performed upon admission. Every patient should have a complete skin assessment and pressure injury risk assessment performed upon admission to a new healthcare setting (facility, unit, or care type) (Edsberg, 2022).

The scenario does not mention that the home care team identified or implemented any interventions to prevent pressure injuries. Once the assessment was performed on admission and risk factors identified (of which this patient had many), there should have been a care plan

designed to intervene for every risk factor (Edsberg, 2022). This is a fundamental breakdown of procedure or policy if this fundamental practice was not required and performed.

She had fever in week two and a wound with dense eschar was found in week three. The issue was not identified until it had the ability to break through the patient's epidermis, grow in size, and develop dense eschar. This indicates that the patient's skin was not be monitored frequently enough. Additionally, an assessment was not performed to determine the source of the fever. All of this indicates that home care team was not performing routine and thorough assessments. Every patient needs routine and thorough monitoring to catch developments such as this (Edsberg, 2022).

To summarize, system failures that lead to the pressure injury in scenario A included: (1) failure to perform a thorough skin check and risk assessment for pressure injuries upon admission; (2) failure to create and implement an care plan with interventions for each risk factor; (3) failure to frequently monitor and reevaluate the patient's conditions and needs.

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

Based on the issues identified in scenario A, a comprehensive pressure injury prevention plan is needed for the home care team. There are a couple of key requirements that must be addressed in the beginning to ensure success with the plan. First, the plan must be implemented uniformly across the organization. Second, the organization must also have a plan for evaluation of the new prevention plan (see question #4). Third, thorough charting at every step is a fundamental element of this plan.

The first step in the pressure injury prevention plan would requires every patient should have a full body skin check upon admission to identify any skin conditions or injuries (Borchert, 2022). Second, they should also have a thorough risk assessment for pressure injuries performed at the time of admission (Borchert, 2022). This would include a complete health history and health assessment to check for conditions at higher risk of pressure injuries. For example, the risk factors for pressure injury identified in scenario A (question #2 above) were diabetes, immobility, incontinence, and positioning. Additionally, the use of risk assessment tools, such as a Braden Scale, can and should be used to complete the risk assessment (Borchert, 2022). Once the risk factors are identified, a care plan with interventions should be identified for every risk factor (Borchert, 2022). Using the example in scenario A, the home care team should have aimed to help the patient with (1) glycemic control, (2) frequent shifting of position, (3) managing moisture from incontinence and performing skin care, and (4) options for other sitting/lying surfaces or offloading with wedges. With a strong, structured care plan, the home care team should be united and consistent in implementation. Each of the interventions should be performed consistently by every team member performing care for the patient, and actions should be charted every shift that care is given. One of the most important policies that should be enacted in this prevention plan and monitoring and reevaluating (Borchert, 2022). The assessments should occur frequently and changes in condition should impact the care plan. Examples of ways to implement this are policies that require completion of a skin assessment on a routine basis and a Braden assessment every shift that care is given. Additionally, it should be policy (and part of the prevention plan) that a sudden change in condition should automatically trigger an

assessment to determine the cause and treatment. For example, an assessment should have been performed when the patient in scenario A spiked a fever. In addition to these successive steps, the plan should include frequent and clear communication (Borchert, 2022). Every team member caring for the patient should be aware of the plan and developments/changes. Communication can occur through charting, but should also happen at hand-offs. There should also be clear and immediate communication with supervisors of sudden changes in condition. Communication across the team is fundamental to the process.

As described, this plan is a basic outline. This should be seen as the fundamental base of the prevention plan. However, there is no doubt that steps should be adjusted as needed. Different patient populations and departments might need to make minor adjustments to fit their needs (Borchert, 2022).

This pressure injury plan can best be summarized as: Assess, Plan, Implement, Monitor, Re-Assess, Communicate

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

Once the pressure injury prevention plan is developed the organization needs a plan to monitor implementation. First, the organization should create an oversight committee to perform quality checks on a routine basis (Borchert, 2022). It would be best if the same committee was involved in the creation of the pressure injury prevention plan to encourage uniformity between planning, implementation, and evaluation (Borchert, 2022). They should also have the authority necessary for an effective implementation and evaluation (Borchert, 2022). Once the committee is created and the plan rolled out, they must include organization-wide education with check-offs for every team member (Borchert, 2022). The education requirements should be part of the compliance requirements for employment. In addition to a committee, each unit or group should have an assigned pressure injury resource person (Borchert, 2022). They would be responsible for checking the compliance requirements of their team members and performing routine audits of pressure injury prevention action items for their team. In addition to the routine audits among the unit or team, there should be organization-wide annual or bi-annual audit. This would entail a team performing audits across all units or groups within the organization. The organization-wide audits should include chart review and on-site checks. This means the team would collect data for prevalence and incidence rates to know statistics on pressure injuries among patients cared for by the organization (Borchert, 2022). They would also audit charting to check at each point of required implementation—assessments, plans, implementation, and monitoring. In addition to checking for initial assessments, they could look for required Braden assessments for each patient. On-site visits could involve checking for required equipment, talking to healthcare workers about practice, performing skin assessments of the patients, and talking to patients about their care experiences. In order to effectively monitor the results of the organization-wide plan, the organizations must make a plan from the beginning to evaluate their efforts. The evaluation plan has to occur on every level of the organization and must be performed routinely.

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

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

Borchert, K. (2022). Pressure injury prevention: Implementing and maintaining a successful plan and program. In L.L. McNichol, C.R. Ratliff & S.S. Yates (Eds.), *Core curriculum: Wound management* (2nd ed., p.p. 396-424). Wolters Kluwer.

Edsberg, L. (2022). Pressure and Shear Injuries. In L.L. McNichol, C.R. Ratliff & S.S. Yates (Eds.), *Core curriculum: Wound management* (2nd ed., p.p. 373-395). Wolters Kluwer.

Friedrich, E., Posthauer, M.E., & Dorner, B. (2022). Nutritional strategies for wound management. In L.L. McNichol, C.R. Ratliff & S.S. Yates (Eds.), *Core curriculum: Wound management* (2nd ed., p.p. 116-135). Wolters Kluwer.

**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.