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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 necessary tool when performing studies of events that have occurred. “The root cause analysis definition revolves around the process of identifying the source of a problem and looking for a solution in a way that the problem is treated at the root level” (Guevara, 2023, p.1). For this paper, pressure injury prevention failures will be

the focus when discussing RCA of the patient's unstageable pressure injury to the sacrum. There are specific steps to apply the process of RCA. This process includes identifying performance gaps, analyze investigational findings, identify necessary behavioral changes, map root causes, and create a plan. (Han, 2023). Performance gaps include hospitals lack of investigation of the patient's onset of incontinence, lack of relief of pain and numbness, and lack of mobility. The home health nurse lacked identification of patient specific pressure injury risk factors, lacked skin assessments prior to development of this wound, lacked diabetic assessment and management, lacked incontinence management, lacked pain management, and lacked gaining additional information concerning her fever. Physical therapy has the gap of lack of understanding by the patient to reposition every two hours and increasing mobility. After interviewing these professionals and assessing statements, steps are to be taken towards correction and prevention for other patients. Further education is to be provided on assessment, documentation, and education provided by all members of the care team. This patient requires education on pressure injury prevention methods, management of diabetes, continence management, and pain management. Physical therapy should work with the patient to increase the patient's ability to turn and reposition in the chair, as well as gain additional mobility. Behavioral changes include the performing of these actions, as they are crucial elements to the patient's care needs. The next step is mapping root causes, which for this patient, are the failures in performance gaps previously mentioned. If proper assessment and management of patient risk factors were provided, this patient could have avoided this injury. However, to note these causes allows for one to create a comprehensive plan to better care for this patient and avoid future failures.

Guevara, P. (2023, September 4). *A foolproof guide to root cause analysis*. Safety Culture.
<https://safetyculture.com/topics/root-cause-analysis/>

Han, E. (2023, March 7). *Root cause analysis: what it is & how to perform one*. Harvard Business School Online. <https://online.hbs.edu/blog/post/root-cause-analysis>

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.

For this assignment, the case study may be read as the bolded section at the end of this paper for background information. This patient's unstageable pressure injury is due to a multitude of issues; however, there are specific system failures that require attention. These failures are not failures of the system but the lack of identification of patient risk. These risk factors include loss of sensory perception, limited mobility, malnourishment, moisture, friction or shearing, poor hydration, and poor circulation. (Mayo Clinic, 2023). The patient's onset of urinary and fecal incontinence places the patient at risk for skin breakdown to the affected skin. This breakdown can cause place a patient at increased risk for a pressure injury due to the fragility of the skin. With the skin being in a fragile state, added, prolonged pressure can cause an injury easier than if the skin were intact. Mobility is the next identification failure to discuss. This patient reports having lower back pain and numbness in the lower extremities. Due to this, she spends a prolonged amount of time in a reclining chair at home. The lack of mobility and circulation caused by her pain places her at high risk for pressure injuries. The patient also presents with a diagnosis of diabetes which may result in malnourishment and elevated blood sugar, both components of pressure injury risk factors. Her elevated temperature is also a concern. An elevated skin temperature is an independent risk factor for pressure injuries.

(Bridges, Whitney, Burr, & Tolentino, 2018). The deformation of the skin is at high risk when the temperature is raised. These issues needed to be addressed by a multi-disciplinary team to promote mobility, health monitoring, incontinence management, and independence prior to discharge by the hospital, as well as upon admission to home health. The system failed the patient on providing adequate care within these areas.

Bridges, E., Whitney, J. D., Burr, R., & Tolentino, E. (2018). Reducing the risk for pressure injury during combat evacuation. *Critical Care Nurse*, 38(2), 38–45.

<https://doi.org/10.4037/ccn2018223>

Mayo Clinic. (2023, May 13). *Bedsore (pressure ulcers)*. <https://www.mayoclinic.org/diseases-conditions/bed-sores/symptoms-causes/syc-20355893>

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

As pressure injury prevention is primary treatment for these wounds, it needs to be prioritized within the patient's care. The first requirement for this patient would be to gain an evaluation and treatment plan with a continence certified nurse. These nurse specialists have training to perform screening patient, performing physical assessments, implementing the first line of treatment, and make referrals to the certified continence advance practice nurse, as well as referrals to tertiary care. (Berke, et al., 2019). Managing the patient's incontinence assists with creating a dry, healthy area to protect the skin and assists in healing the active pressure injury. The next area that needs to be addressed is the patient's lack of mobility. The wound care nurse may need to speak with the primary care provider about having a physical therapist assess the patient for possibility of care needed. This will allow the patient to gain care for her lack of

mobility and work towards relieving the pressure on the buttocks and surrounding areas. In the meantime, the patient needs to be educated on the need to turn in the chair frequently. It is suggested to shift positions in a chair every 10 to 15 minutes; however, if this is not possible, have someone assist in repositioning at least once an hour. (Johns Hopkins Medicine, n.d.). Items such as seat cushions, low air loss mattress beds, preventative foam dressing, zinc barrier cream to areas effected by incontinence, and offloading booties should be ordered and placed on the patient. Education is required for the use of these products, such as what action each item performs and how to use them. Safety tips should be included, such as not to ambulate in offloading booties due to risk of slipping or falling, or to avoid using foam dressings to areas effected by incontinence due to risk for skin breakdown from bodily output becoming lodge underneath dressing and pressed against skin. Finally, a comprehensive patient assessment, as well as assessment of the wound, should be performed and documented at each home visit. With the use of these items, the patient will be assisted with the protecting herself from further breakdown.

Berke, C., Conley, M., Netsch, D., Franklin, L., Goodman, E., Shephard, C. & Thompson, D.

(2019). Role of the wound, ostomy and continence nurse in continence care. *Journal of Wound, Ostomy and Continence Nursing*, 46 (3), 221-225. doi:

10.1097/WON.0000000000000529

Johns Hopkins Medicine. (n.d.). *Pressure Ulcers*. www.hopkinsmedicine.org/health/conditions-and-diseases/pressure-ulcers

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

After implementing a plan of care for the management and treatment of patient risk factors and root cause of her present pressure injury, there needs to be a plan on monitoring the patient's progress and treatment. The main form of monitoring of these prevention methods comes in the form of documentation of interventions and education provided during the home care visit. The most effective form of this documentation is produced by using the SOAP notes model. This model includes the usage of subjective data, objective data, assessment information, and planning information to provide a framework for one's documentation. (Sindhu, 2020). Subjective information to include in the nurse's documentation is the patient's statements regarding self-offloading frequency and satisfaction of care and progress. Objective data that is appropriate to document for this case includes the proper usage of items provided as prevention measures: foam dressings, seat cushions, zinc paste, etc. Assessment data would include the results of the patient's skin assessment. This will also include wound care nurse's follow up assessment of the present pressure injury. This monitoring will ensure that the patient's present wound is healing, as well as allowing for the opportunity to provide additional education on prevention of future injuries. If assessment details show improvement of the present wound, as well as a clear skin assessment, then this is a sign that prevention methods are being used appropriately. The final piece of the SOAP documentation model is planning. The nurse should always include the patient care plan in his/her notes, as well as any adjustments to the plan. These steps allow for a comprehensive overlook of prevention and management interventions in place for the patient. With the usage of this documentation model, there will be proper monitoring of the plan of care.

Sindhu, Kunal. (2020, March 10). *What are soap notes?* www.wolterskluwer.com/en/expert-insights/what-are-soap-notes

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

- a. *See the course syllabus for specific requirements on references for all assignments.*

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Business School Online. <https://online.hbs.edu/blog/post/root-cause-analysis>

Johns Hopkins Medicine. (n.d.). *Pressure ulcers*. www.hopkinsmedicine.org/health/conditions-and-diseases/pressure-ulcers.

Mayo Clinic. (2023, May 13). *Bedsore (pressure ulcer)*. <https://www.mayoclinic.org/diseases-conditions/bed-sores/symptoms-causes/syc-20355893>

Sindhu, Kunal. (2020, March 10). *What are soap notes?* www.wolterskluwer.com/en/expert-insights/what-are-soap-notes.

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.