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Quality Improvement

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

A 60-year-old female patient weighing 400 pounds was admitted to the emergency department for myocardial infarction. The patient was brought to the catherization lab, where a stent was placed in order to re-establish blood flow to her heart. During surgery, the patient aspirated her gastric contents, and later developed pneumonia. The patient was admitted to the cardiac intensive care unit where she was ventilated. Upon initial assessment, the patient's skin was intact, dry, warm, free of injury, and the skin color was appropriate to her race. After one week since admission, the patient developed a stage II pressure injury on her sacral area, and pressure injury protocol was initiated. The nurses took pictures of the pressure injury to document progression and wound care was consulted for recommendations regarding management of the wound. Wound care determined that the pressure injury can be managed at a long term care facility, where the patient was discharged to. After a few weeks, the patient was fully recovered and was discharged from the facility. One month after the patient's discharge, she pursued legal action. The nurses and physicians taking care of the patient were subpoenaed.

Medical records indicated a lack of appropriate documentation of interventions taken to prevent the pressure injury. Fox example, charts indicated that the patient was bedridden, intubated, and incontinent. According to the Braden scale risk assessment that the nurses utilized, the patient was considered high risk for developing pressure injuries. With this knowledge, the nurses should have documented their specific efforts in preventing the pressure injury, which they failed to do. There was not enough documentation to prove the nurses turned the patient throughout the day, how often they cleaned the patient, and other interventions that they did to prevent the pressure injury. Sections of the document that were related to skin integrity showed very few comments and input from nurses. Integumentary skin assessments charted by the nurses were inconsistent and incomplete, with very minimal notes. In addition, the pictures that the cardiac nurses took were mislabeled and out of order. The case was settled in court and ruled in favor of the patient.

Although tools such as the Braden scale risk assessment exist to screen patients at risk for pressure injuries, it is not uncommon for nurses to overlook the importance of this piece of documentation. Regardless, it is the nurse's duty to document thoroughly, accurately, and consistently especially for patients at high risk for pressure injuries.

What circumstances led to the occurrence?

In terms of root cause analysis, the root cause of the incident was that the nurses of the facility did not document appropriately**,** although they claimed to have taken preventative measures. Consequently, the outcome is that legal action was taken against the nurses and their lack of proper documentation could not prevent a lawsuit.

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In what way could you measure the frequency of the occurrence? (interviewing nurses, examining charts, patient surveys, observation, etc)

Measuring the frequency of pressure injury occurrence can be achieved by reading through incident reports, reviewing documentation, analyzing patient surveys, interviewing healthcare providers involved in the care of patients with pressure injuries.

What Evidence based ideas do you have for implementing interventions to address the problem?

Documentation of pressure injury progression still stands as an issue in healthcare that many providers struggle with, placing the patient at risk for injury. Some interventions that could aid in this issue include:

- All patients should be screened for the risk of impaired skin integrity using the Braden scale upon admission. Patients with a Braden scale score below 11 are considered high risk and should be monitored closely for development of pressure injuries. In addition, initiation of pressure injury prevention protocol should be carried out.
- All patient should be assessed daily for the risk of developing pressure injuries.
- Once a patient is identified to be at risk for pressure injuries, nurses should provide thorough documentation of all interventions they took to prevent pressure injury development. Thorough documentation plays a key role in protecting nurses from blame and may even save them from being found guilty of negligence in court.
- Two-nurse verification is commonly seen throughout healthcare. For example, when it comes to administering chemotherapeutic agents, insulin, and blood products, two nurses are required to ensure patient safety. This strategy may also prove to be effective in identifying, screening, and assessing patients at risk of pressure injuries. For example, if two nurses evaluate for the risk of pressure injury and are in agreement of their findings, documentation of injury progression will be more accurate.

How will you measure the efficacy of the interventions?

In order to measure the efficacy of the interventions, a study could be conducted comparing how many patients develop pressure injuries before and after the policies, protocols, and interventions are initiated.