Short RCA for Reviewing Hospital-acquired Stage III/IV Pressure Ulcers

Hospital Name: **Event #**

Note: All hospital-acquired Stage III/IV pressure ulcers or deep tissue injury (DTI) must be reported in accordance with the requirements of 10.07.06. This form may be used in lieu of a root cause analysis.

Please provide the following:

1. Patient date of birth:
2. Patient sex:
3. Patient admit date:
4. Patient admitting diagnosis:
5. Patient secondary diagnoses:
6. Functional status changes during hospitalization?
7. Was family notified?
8. Does physician documentation reflect awareness of skin condition?

9. Functional and cognitive contributory or causal factors:

	Present on Admission	Y	N	Root Cause	Contr. Factor
a.	Compromised level of consciousness				
b.	Inability to eat or enteral feedings				
c.	Restricted mobility				
d.	Incontinence- bowel, bladder				
e.	Peripheral vascular disease				
f.	Impaired sensory perception				
g.	Diabetes mellitus				
h.	Obesity or cachexia				
i.	Sepsis or multi-system organ failure				
j.	Hypoperfusion state				
k.	Chronic end-stage disease such as liver, heart, lung, or kidney.				
l.	Immunosuppressive diseases				
m.	Hip fracture and/or spinal cord injury				
n.	Dehydration and/or malnutrtion				

10. Did communication breakdown contribute to the development and/or worsening of the pressure ulcer to DTI or Stage III/IV?

		Y	N	Root Cause	Contr. Factor
a.	Staff to staff				
	1. Nutritional consult requested prior to progression to Stage III/IV				
	2. Wound nurse consult requested on identification of Stage III				
	3. PT/OT consult regarding mobility				
b.	Staff to/from patient				
c.	Staff to/from family/other				
d.	Evidence of MD involvement with assessment/treatment plan?				

Thanks to Suzanne Butterbaugh RN at Sinai Hospital for the prototype of this document.

11. Medical Treatment and Medications

	During hospitalization	Y	N	Root Cause	Contr. Factor
a.	Antidepressant medication				
b.	Sleeping medication				
c.	Pain medication				
d.	Immunosuppressive medication				
e.	Steroids				
f.	Radiation*				
g.	Chemotherapy*				
h.	Renal dialysis*				
i.	Multivitamin / Mineral supplements (if deficiency confirmed or suspected)				
j.	Bedrest ordered Total days Total hours				
k.	Operative procedure >/= to 4 hours.				
l.	Nuclear Medicine/MRI imaging obtained				
m.	Restraints				
n.	Other (describe):				

*** - Also includes treatments prior to admission**

12. Interventions:

	Interventions	Y	N	Root Cause	Contr. Factor
a.	Identified as high risk for hospital-acquired pressure ulcer on admission?				
b.	Preventive measures implemented with high risk score?				
c.	Did care plan address these issues?				
d.	Complete skin inspection documented daily (minimally).				
e.	Intake and output monitored.				
f.	Nutritional needs met?				
g.	Evidence of turning every two hours (minimally) while in bed.				
h.	Patient turned minimally 40° to reduce pressure on sacrum				
i.	Evidence ROM exercises twice per day and mobilization as tolerated?				
j.	Urinary and/or fecal incontinence evaluated and managed prior to skin breakdown.				
k.	Head of bed elevated no higher than 30° unless medically required.				
l.	Other				

13. What happened? Include date of identification presence/progression of hospital-acquired pressure ulcer, findings of skin assessments, and interventions implemented prior to progression/development of DTI or Stage III/IV pressure ulcer during hospitalization. Please also briefly discuss any failures of interventions and treatment once pressure ulcer was identified. What is patient's prognosis?

Contributing Factor(s) Discussion

Root Cause(s) Discussion

14. Patient-specific care plan changes after DTI/Stage III/IV pressure ulcer identified

15. Organizational Corrective Actions/Monitoring/Responsible Party

Immediate Actions

After Case Review Actions

16. Compliance Monitoring