Case Study – Unstageable Pressure Ulcer

Previous medical history
Coronary artery disease, atrial fibrillation, and a previous hip replacement surgery one year ago.

Event description
83 year old female was admitted on 10/1/2008 from a nursing home to the Surgery Admission Unit (SAU) for a two vessel CAB. The surgery was successful with no complications. Post surgery, the patient was admitted to the ICU. For the next several days she was hypotensive, which worsened when she was repositioned. On 10/7/2008, she was transferred to the Telemetry Unit. On 10/8/2008, the nurse caring for the patient noted an open wound on the patient’s sacrum. The wound was the size of an eraser with purple coloring around it. The WOC nurse was consulted and described it as an unstageable pressure ulcer.

RCA discussion
The SAU is responsible for completing a full assessment on admission, and the ICU process is not to repeat that assessment. The SAU did not communicate any issues related to skin integrity when the patient was transferred to ICU.

When the patient was transferred from the ICU to the Telemetry Unit, the usual report was documented, which included the patient’s latest vitals, medications, any order changes, and current activity status. Similar information was exchanged at shift-to-shift report. Nurses indicated that in general, skin is not a consistent focus area in hand-off communication at shift change or report. The hand off communication focuses on the issues that occurred during their shift rather than providing a comprehensive overview. There is no standardized hand-off communication process that prompts staff for all the key patient elements of care such as skin, fall risk, etc.

The staff is qualified to care for the patient. Regular, yearly education on skin assessment and inspection is provided for the staff. The unit was very busy, but staffing was believed to be adequate.

The ICU has a rotation bed to assist with turning a patient; however another patient was in that bed. Although the patient in the rotation bed did not need it for rotation, the unit was full and they couldn’t switch beds.

ICU nurses stated the patient’s unstable condition made it difficult to regularly turn the patient as the blood pressure would drop significantly. As a result, skin assessments were documented inconsistently. Staff knew the policy related to assessments, stating that the policy indicated “document skin inspection every shift.” However, when asked what documentation was required for situations where the patient could not be turned to do skin assessments, staff were unsure. It was unclear exactly when the skin began to break down. At one entry, a nurse noted a reddened area on the sacrum, but for several shifts after that the nurses noted no skin problems.
The electronic health record has screens for documenting skin assessment and inspection, and there is the capability to type in comments in that section. Nurses report it is difficult to see what was previously documented. One must go through several steps in order to view what was previously documented, and the system does not provide prompts to assist staff in finding the necessary screens. Electronic documentation is new in the ICU in the past two months and staff is still becoming accustomed to documenting and reviewing data electronically.

The dietician was called in to assess the patient while in the ICU. She made several recommendations, which were carried out as the patient’s nutritional status was low.

The patient’s daughter is an ICU nurse at another local hospital and visited the patient daily. She assisted with caring for the patient and never mentioned a wound developing. She was very concerned about the patient’s pain status and would stop staff from moving her if the patient moaned or cried out in pain.

**RCA Exercise**

- Review the case study information
- Using the information provided, identify root cause statements for this event
- Refer to the RCA Resources in the Resource Guide including:
  - Root Cause Categories

- For any human factors or deviation from expected process, provide the preceding cause(s) as part of the root cause finding.

**Identify the possible RCA Statements for this event:**
CAP Exercise

- Review root cause findings
- Develop corrective actions and measurement strategy
- Refer to the Corrective Action Plan intervention categories under Tab 4 in the Resource Guide as you develop your interventions
- Determine whether the corrective action proposed is a stronger action, an intermediate/moderate action or a weaker action.
- Determine the process and outcome measures for the action plan.

Develop the Corrective Action Plan for this event: