*Please note - all information contained is fictional, used for example purposes only.

83 year old female was admitted from nursing home to the Surgery Admission Unit (SAU) for a 2 vessel CAB. Patient history includes Coronary Artery Disease, Atrial Fibrillation and a previous hip replacement surgery 1 year ago. Recent symptoms include shortness of breath with activity, increased lethargy and decreased appetite. The surgery was successful with no complications. Post surgery, the patient was admitted to the ICU in stable condition. During the night, she developed atrial fibrillation which was difficult to manage despite multiple pressors. For the next several days she was hypotensive and would drop her blood pressure every time she was moved. She also developed pulmonary insufficiency making it difficult to extubate. By Post Operative Day (POD) 5, she became more stable and was able to be extubated. On POD 6 she was transferred to Telemetry. She seemed to be slowly improving. On POD 8 the physical therapist was assisting her with walking when her gown slipped open and he noted an open wound on her sacrum. After he returned her to her room, he stopped at the nurses station to let them know about the wound. There were no nurses available so he left the message with the unit coordinator. The unit coordinator made a note of this and placed a post-it on the medical record. The next day, the nurse caring for her saw the note and went to check the wound. The wound was noted to be very small, about the size of an eraser with purple coloring around it. The WOC nurse was consulted and described it as unstageable. The patient continued to improve and was transferred to TCU for further care.

While gathering information for the RCA, it was noted that her admission assessment was done electronically in the SAU computer system. That system (SIS) does not interface with the inpatient electronic medical record. The ICU Clinical Director was asked how they review the admission information they receive from surgery. She explained SAU is responsible to complete a full assessment on admission and their process is not to repeat that assessment. They expect the full assessment is complete unless SAU indicates they were unable to complete a section. She informed us that sometimes SAU will print out a copy of the admission assessment, but not always. When they have printed it out, the assessment seemed complete. The SAU did not indicate there was any incomplete section on this patient.

During the RCA:
ICU nurses stated the patient's unstable condition made it difficult to regularly turn the patient as the blood pressure would drop significantly. The ICU has a rotation bed to assist with turning a patient, however another patient was in that bed. That patient in the rotation bed did not need it for rotation, however the unit was full and they couldn't switch beds. Besides, the rotation bed was new and the staff were unfamiliar with how to use it so it wasn't used at this point. Skin assessments were documented, however not consistently as the patient was unstable. It was unclear exactly when the skin began to break down as documentation was inconsistent. At one entry, a nurse noted a reddened area on the sacrum and for several shifts after that the nurses noted no skin problems. The electronic medical record has fields for documenting skin assessment and inspection and there is the capability to type in comments for that section. It is difficult for the nurse to see what was previously documented in the electronic medical record. The nurse is required to go through several steps in order to review what was previously documented. Electronic documentation is new in the ICU in the past 2 months and staff

are still becoming accustomed to documenting 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. The unit was very busy, but staffing was felt to be adequate. The staff were felt to be qualified to care for the patient. Regular, yearly education on skin assessment and inspection is provided for the staff. When the patient was transferred to Telemetry, the usual report was given which included the patient's latest vitals, medications, any order changes and current activity status.