Pressure Injury Root Cause Analysis Tool

Unit: __________ Resident: ____________________________________ Age: _______
Primary Diagnosis: ____________________________________________
Secondary Diagnosis: __________________________________________
Site of Injury: ________________________________________________
Date Injury Identified: ___________ Injury Stage When Identified: ___________
Circle where you think break down first occurred:
Home Hospital Current NH AL Other NH
Braden Assessment on Admit _______ Yes _______ No
If yes, score: ___________ If no, why not: _______________________________
(Risk Assessment within first 24 hrs and then weekly x 4 weeks) Done: ___________
Risk Assessment score consistent with Resident status as documented in medical record?
_______ Yes _______ No

If Resident Found at Risk:
Prevention protocols initiated immediately? _______ Yes _______ No

Trunk Wound:
Age of Pressure redistribution surface resident is currently on: ________________________________
(Note: no egg crate mattress toppers to be used)
Resident on appropriate surface? _______ Yes _______ No Date placed on surface: ___________
Residents in prolonged seating positions: How often is weight shifted and documented?

_______ Yes _______ No

Is Resident able to reposition themselves? _______ Yes _______ No
Turned Q 2-3 hours and documented? _______ Yes _______ No
Skin status charted at least daily? _______ Yes _______ No
Resident is incontinent? _______ Bladder _______ Bowel _______ Both
Catheter in use? _______ Yes _______ No

Nutritional Status:
Resident’s weight: __________________
Nutritional consult: _______ Yes _______ No _______ Not Indicated
Lab Available:  Albumen level: __________________ Date obtained: ___________
Pre-Albumen level: __________________ Date obtained: ___________
Glucose level: __________________ Date obtained: ___________
Resident on: _______ Prednisone _______ Blood thinner
Heel Injury:
Heels elevation consistently maintained? ______ Yes ______ No ______ Partial
Is wound (circle if appropriate) ______ Arterial ______ Venous ______ Diabetic
Support stockings? ______ Yes ______ No
Removed at least bid and skin checked and charted? ______ Yes ______ No ______ N/A
Has the resident been off the unit or out of the facility for greater than 4 hours within the last 3 days? ______ Yes ______ No ______ N/A
If yes, where/how long? _____________________________________________

Barriers Identified:

________________________________
Family

________________________________
Equipment/Supplies

________________________________
Cost

________________________________
Staffing

________________________________
Education

________________________________
Lack of product

________________________________
High acuity of residents within facility

Conclusions
________________________________ All appropriate preventive measures implemented; unavoidable
________________________________ Gaps noted in prevention measures. Specify: _________________
________________________________ Injury most likely began with resident off unit or out of facility
________________________________ Equipment not available

Comments/Recommendations

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________