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Pressure ulcer-related harm: beyond root cause analysis

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The causes and contributory factors that result in pressure ulcer (PU) formation are typically identified by the use of a root cause analysis (RCA)1. RCA is founded on the high reliability theory (HRT) or the idea that health-care organisations can learn how to improve the quality and safety of care from other safety-critical industries and previous adverse events.2 HRT focuses on identifying the factors and processes that enable an organisation to consistently meet safety standards. The effectiveness of the RCA as an HRT-based quality improvement tool (QIT) for reducing PU-related harm can however be limited by the perception that it is a way of apportioning blame. Clinicians may be reluctant to disclose the root cause(s) of an adverse event because of a sense of shame; a fear of reprisals; a belief that the causes cannot be effectively addressed by their organisation;1 or concerns about the legal, financial and professional consequences of full disclosure.

Normal accident theory (NAT) focuses on the characteristics of organisations that contribute to adverse events or 'accidents'.3 NAT also assumes that there is a limit to the lessons that can be learned by one organisation from other high-hazard industries and prior incidents, as the intra-organisational rewards needed to foster incident reporting and learning without blame are often absent.2,3 Unlike HRT, NAT acknowledges that adverse safety events often have a high social cost and can give rise to blame and reprisals that undermine meaningful learning. There is a more measured view of the use of HRT-based approaches like the RCA in NAT, as they are subject to the ambiguity and politics and that can arise when an adverse event occurs resulting in key contributory factors or causes being overlooked or ignored.2

PUs can arise through the complex interplay of different patient-related factors, errors by clinicians, contextual factors and organisational shortcomings.4,5 PUs can have a delayed onset of up to 72 hours,6 making it challenging to accurately identify the root cause(s). Given the challenges of using the RCA and other HRT-based QIT, it may be more prudent to frame efforts to reduce PU-related harm through a more comprehensive approach that incorporates other QIT based on the NAT. This would entail using a combination of HRT and NAT-based QIT such as the RCA and trigger tools to allow blame-free reporting and learning from adverse PU-related events. A more comprehensive approach to reducing PU-related harm is needed as success in maintaining skin integrity is contingent on the extent to which learning occurs when adverse events are fully disclosed without fear or favour.

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