Free of Accident Hazards: Supervision to Prevent Accidents
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Objectives

• This workshop will integrate falls risk assessment, principles of QAPI, and person-centered care.
• A case study example will demonstrate practical application of investigation techniques and findings as well as current evidence-based interventions.
• The goal of this session is to give you the tools to develop an effective Falls Prevention Process Improvement Program.

F323

• Intent is that the facility provides an environment that is free from hazards over which the facility has control and
• Provides appropriate supervision to each resident to prevent avoidable accidents.
F323

This includes systems and processes to:

• Identify hazard(s) and risk(s);
• Evaluate and analyze hazard(s) and risk(s);
• Implement interventions to reduce hazard(s) and risk(s); and
• Monitor for effectiveness and modify approaches as indicated.

• Residents receive supervision and assistive devices to prevent avoidable accidents

Examples of Survey Deficiencies

• Failure to provide prevention services
  — Root Cause Analysis
  — Individualized interventions
  — Supervision
• Failure to prevent resident elopement
• Safe water temperatures
• Safe resident smoking
• Side Rail Safety
• Resident altercations

Examples of Survey Citations

• Failure to follow manufacture's guidelines for mechanical lifts
• Chemicals left unattended
• Failure to evaluate fall prevention devices
• Residents with falls without investigation and plan to prevent injury
• Staff not trained on use of resident devices or equipment
• After several falls - no emergency services
A Culture of Safety?

Accident Definition

• An unexpected or unintentional incident that may result in injury or illness
• Does not include side effects or reactions related to an adverse effect from a drug or treatment

Definition: Unavoidable Accident

Accident occurred when:
• Environmental hazards had been identified
• Resident risks were identified
• Hazards & risks were assessed
• Interventions were implemented to decrease hazards and risk
• Effectiveness of interventions were being monitored and modified as needed
Definition: **Avoidable Accident**

Accident occurred related to *failure* to:

- Identify environmental hazard
- Identify individual resident risk factors
- Evaluate/analyze hazards & risks
- Implement interventions to reduce an accident
- Monitor and modify interventions as needed

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Definition: **Adequate Supervision**

- An *intervention* to decrease the risk of an accident.
- *Adequate* supervision must be based on individual resident’s needs and identified hazards in the resident’s environment.

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**Steps for System Overview:**

- Resident Risk Identification
- Resident Assessment Risk Factors
- Resident Vulnerabilities
- Realistic Goals
- INVESTIGATION and Root Cause Analysis
- Fall Prevention
- Interventions
  - Creative
  - Individualized
Steps for System Overview:

- Assistive Devices
- Hazards and/or Positioning Devices
- Unsafe Wandering &/or Elopement
- Resident Smoking
- Chemicals
- Oxygen Use

Environmental Rounds

- Hazards
  - Electrical cords
  - Beds by heat registers
  - Carpet condition
  - Handrails secure
  - Sharp edges on furniture
  - Chemicals secured
  - Sharps secured
  - Equipment working properly

Operational

- Updated Policies and Procedures for Accident Prevention
- Staff Education (examples)
  - Policies and Procedures
  - Culture of Safety, Prevention, Quality
  - Assessment Process
  - Hazard Identification
  - Equipment Use
  - Consistent Implementation of Care Plan Interventions
  - Safe Lifting and Transfers
  - Investigation and Root Cause Analysis
  - Communication
QAPI
Quality Assurance and Performance Improvement

QAPI
QA – Quality Assurance (F520 QA&A, Quality assessment & assurance)
- Identifies and corrects quality issues
- Retrospective
- Focus on outliers or individuals
- Efforts end once achieved
- DON, Physician and 3 staff members
- Meet quarterly

Performance Improvement
PI - Performance Improvement
- Proactive approach
- Efforts are on-going
- Focus on system changes
- Plan involves input from staff representing all roles and disciplines within the organization
- Meet at more frequent intervals
QAPI (Quality Assurance & Performance Improvement)
- Systematic,
- Comprehensive,
- Data-driven,
- Proactive approach

System Changes

Elements for QAPI in SNFs
- Systemic Analysis and Systemic Action
- Performance Improvement Projects
- Feedback data systems and Monitoring
- Design and Scope
- Governance and Leadership

What is Your Commitment?
It must include:
- Blameless problem-solving
- Involvement of those most affected by the issue
- Willingness & means to coach & mentor after training
- Person-centered care
QAPI is resident-centered yet built on systems thinking.

QAPI involves everyone who works in your facility.

Realizing Goals

QAPI aims to help nursing home residents realize their own goals for care and how they live their lives, including these areas:

- health and safety
- quality of life
- exercise of choice
- effective transitions

Making Data Meaningful

- Without a baseline or point of comparison, it is hard to judge your own performance.
- QAPI uses performance indicators to monitor care processes and outcomes.
- It reviews findings against benchmarks, or targets the facility has established for performance.
- Objective data (Numbers) will give you concrete information on improvement, decline or maintenance of goals!
Benchmarking

Identifying a standard against which facility processes can be measured -

Benchmarking is the process of comparing your results to best practices & the performances of your peers.

PIP

Process Improvement Projects examine performance & make improvements

• In any area needing attention

  Or

• Found to be a high priority based on the needs of the residents.

ACCIDENT PREVENTION is an EXCELLENT PIP!

PIP Key Questions

• What do we want to do?

• For whom?

• By when?

• How can we make it happen?
Analysis

Break down a problem into small, detailed parts to better understand the big picture.

Create a chart of all of the possible causal factors ('Root Cause Analysis), to see where the trouble may have begun.

Involving All Staff in QAPI

• Direct care staff have valuable & unique input vital to success

• All levels of staff must be involved in planning & improving systems & processes

• Identify barriers & speed bumps

Accident Prevention

PIP
You will need to put together a team!
- All departments
- All levels
- Ask for Volunteers

QAPI Principles - Staff Driven
- Include staff members at all levels, all departments, in program development, implementation & support.
- Leaders facilitate, provide resources, and coach
- ALWAYS include your care giving staff in decision making

Use Your Data – MDS
Teach the team how to interpret data!
1. Run a report of Current Mobility Status for this quarter and last quarter – walk in room, walk in corridor
2. Compare it to report from last quarter
3. Have there been changes, declines?
What to Look For - Trending

Look for trends in conjunction with - wing, diagnosis, falls, behaviors - the more granular, the more effective your root cause analysis will be.

- Location - room, hallway, bathroom
- Devices in use, call lights, alarms, etc.

Team Functions

- Policies
- Procedures
- Risk Assessment forms
- Care Plans
- Implementation compliance
- Follow Up

Risk Assessment Tools

Risk assessment tools by themselves do not prevent patient falls - they predict them...

*National Patient Safety Foundation Professional Learning Series
When to Assess?

- On admission*
- Upon transfer from one unit to another*
- With any status change*
- Following a fall*
- At regular intervals*

*How soon?

Assessment Recommendations

History & Root Causes Documentation

Current Status

- Footwear
- Seating
- Standing
- Transfers
- Toileting status
- Ability to understand safety needs

Past & Current H & P’s

Read it all, look for:

- Differences from current presentation
- Medications
- Safety measures
- Resident & Family impressions
- Past care giver perspectives
Pain

Untreated, pain leads to:

- Restlessness
- Irritability
- Depression
- Reduced mobility
- Atrophy

What’s Your Response to Alarms?

Remain in place, wait for direction?

Get up to see what’s wrong?

See what you can do to help?
Safety Rounds

- Everyone’s responsibility
- What do you see?
- Are you really LOOKING for unsafe conditions?
- Who will be responsible to correct?
- How are we making changes to the culture of the facility?

Anticipate Medication Risks

Do not wait until a fall happens to check for:

- Effects
- Side effects
- Interactions

Plan for Falls Prevention!

Function

Where could the problem start?

- How effective is your restorative program?
- Do residents lose function through reduced mobility?
- Could you review ambulation status to find out?
Effective Investigation

Root Cause Analysis:
• Reviews what ACTUALLY happened versus what we may think has happened!

Root Cause Analysis:
• Does your staff understand how to immediately begin a RCA investigation with resultant pertinent interventions?
Resident Fall at 3am:

- C.N.A. reported to the nurse, “He didn’t use his call light”
- New intervention on the Care Plan, “Remind resident to use call light for assistance during the night.”

**Does this happen??

More often than you think!

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Steps to Root Cause Analysis

1. Immediate Investigation
2. Include information from anyone that could possibly have knowledge
3. Step back and look at the whole picture
4. Where is the concern?
   1. Resident Need?
   2. Staff Error?
   3. Resident Noncompliance?
   4. Medical Condition?
   5. Equipment Failure?
   6. Environmental Concerns?
   7. Other?

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Examples:

- Let’s go back to the resident who fell out of bed at 3am.
  - Why did the resident fall?
  - What was the resident doing?
  - Where did the resident fall?
  - When did the resident fall?
  - Who observed or has direct knowledge of the resident fall?
  - How did the resident fall?
KEY POINT

• How can we put sensible, realistic interventions into place, if we don’t dig deep enough for the information!
• **The interventions should match the need!**

Documentation Necessary

We need to substantiate that we have thoroughly investigated with Root Cause Analysis by: (Immediate investigation following resident stabilization)

• Assessing the situation
  – Environment
  – Devices and/or equipment
  – Etc.
• Interviewing
  – The resident
  – All Staff with possible knowledge
  – Roommate
  – Visitors/family

Investigation:

• Resident Activity
• Underlying changes of condition?
• Contributing Factors (i.e. medications, eyeglasses not on, etc.)
• Staff involved
• Presence of hazards?
DOCUMENTATION

Giving yourself CREDIT for Investigation

Remember: If you didn’t chart it.....

Documentation

• Assessment Process
• Environmental Assessment
• Interviews
  — Resident
  — All staff with possible knowledge
  — Families/visitors
  — Roommate
• Identification of Hazards
• Change in Condition
• Contributing Factors

What NOT to document

• Impressions
• Assumptions
• It is wise not to document in the nurse’s notes that you completed an Incident Report (Check your facility Policy and Procedures)
• Staff concerns (they do not belong in the resident record)
• Other resident’s names
Care Plan Updates:
• Need to be based on the root cause analysis—identification of the \textit{reason} for the fall/accident
• Include revised interventions to prevent further avoidable accidents
• Identified potential hazards and risks
• Individualized to each resident to address the current need for prevention
• Communicated to all staff caring for the resident!

Plan of Care
• RAI Process
• Updates based on changes, assessment and root cause analysis investigation
• Documented
• Communicated
  – 24 hour report
  – Nurse to Nurse
  – Nurse to C.N.A.
  – Nurse to IDT
• Consistently Implemented

Care Plan Interventions
You can keep a list at the nursing station of a variety of ideas to help with the thought process after assessment!
– Individualized toileting Plan
– Assistive devices in reach
– Adequate Footwear
– Low Bed
– Environmental adaptions
– Individualized Monitoring schedules
– Resident centered activities
– Floor Mats
– Room Arrangements
– Lighting
– Music
– Medication change
IMPORTANT POINT

TIMELY Care Plan Updates are Essential!

Implementation of Interventions

- The process includes communication of the new interventions to all relevant caregivers
  - 24 hour report
  - Verbal report
  - C.N.A. Care Card/Care Plan/Care Record
  - Nurse Manager Rounds
  - DON Rounds
  - Fall Team Meeting

- Assigning Responsibility
- Providing training and resources if necessary
- Consistent Implementation of Interventions
- Documentation

Teach Staff

IMMEDIATE Investigation and CP Updates!

To get the most out of critical times around an event
Staff on the scene must be coached in:
- skills of observation
- critical thinking
Don’t Wait!

Delaying the investigation until morning or Monday, or whenever the DON or Risk Manager gets around to it will not improve your outcomes or statistics.

Analyze the Trends!

• As the Leader—get involved! Be part of the falls team/committee to review accidents/incidents each week to determine:
  – Time of day/shift
  – Location
  – Resident Activity at time of accident
  – Personnel working
  – Environmental Conditions

Audit

Audit your system for success:
• F323 Rounds by the IDT
• Hazard Identification
• Fall Audits
• Incident/Accident Reports
* Use these audits to correct the system through your QA process for success!
AUDIT-Example

<table>
<thead>
<tr>
<th>Area of Review</th>
<th>YES</th>
<th>NO</th>
<th>Recommended Action</th>
<th>Staff Responsible/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are chemicals accessible to residents?</td>
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<tr>
<td>Are staff promptly responding to alarms?</td>
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<tr>
<td>Is the environment safe for residents?</td>
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<tr>
<td>Record review:</td>
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<tr>
<td>Resident is assessed for unsafe wandering and/or elopement</td>
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<tr>
<td>Risk of falls is assessed and care plan is individualized</td>
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</tbody>
</table>

Following a Fall/Accident:
- The incident/accident was investigated (root cause analysis)
- Interventions were put into place based on investigation and are individualized
- The Plan of Care was promptly updated
- Hazards and risks were identified
- Staff consistently implement new care plan interventions

CASE STUDY

On the Scene Investigation:
- Alarmed chair
- Alarmed

MAY 4-5, 2015
BE THE VOICE
INALA HOPE ElderHelp

MARY
- Chair of drawers
- Curtains
- Call light
- Bed
- Sid rail alarmed

57
Fishbone – Root Cause Analysis Tool

QAPI Action Plan (Tool Example)

Resources

QAPI News Brief Volume 1, 2013:

- [http://www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx](http://www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx)
References and Helpful Websites

- https://www.nhqualitycampaign.org/goalDetail.aspx?g=mob

Resources

Advancing Excellence in America’s Nursing Homes:
https://www.nhqualitycampaign.org/

Stratis Health:
http://www.stratishealth.org/providers/QAPI.html

**The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." [See Deming WE. The New Economics for Industry, Government, and Education. Cambridge, MA: The MIT Press; 2000.]**

Resources

- http://www.stopfalls.org/service_providers/sp_bm.shtml
- Veteran’s Administration projects
- http://www.vissn.va.gov/patientsafetycenter/fallsTeam/
- Institute for Person Centered Care
- http://ubipcc.com/
Vibrant Living Concepts


Sue Ann Guildermann, RN, BA, MA. Effective Fall Prevention Strategies Without Physical Restraints or Personal Alarms Empira, 4/24/2012 Webinar for Stratis Health

Resources

- Newsletter & CEUs – Initiatives in Safe Patient Care
- www.cdc.gov/injury/STEADI

Questions
Thank You!
Susan LaGrange, RN, BSN, NHA
Director of Education
Pathway Health
Mary fell. She was lying on her side, her head near the basket with the blue bunny in it that she likes to keep on the floor. She couldn’t explain, but you know she loves to go into her chest of drawers taking items out to arrange on her bed. She seems to ignore the chair next to her bed. She gets around in her wheelchair, propelling with her hands on the wheels, her feet on the footrests. In use are bed & chair alarms. You investigate immediately-

LIST EVERYTHING YOU CAN THINK OF THROUGH OBSERVATION OF FALLS RISKS IN THE ENVIRONMENT:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What immediate actions can you take, add to the care plan and communicate to staff, resident & family?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

USE THE INFORMATION ON THE FOLLOWING PAGE TO COMPLETE THE FALLS FISHBONE ANALYSIS
IDENTIFY RISKS

<table>
<thead>
<tr>
<th>Medical Diagnoses</th>
<th>Medications</th>
<th>Interventions to modify medication risks?</th>
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<tbody>
<tr>
<td>Anemia</td>
<td>Iron supplement</td>
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<tr>
<td>CHF</td>
<td>Lasix</td>
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<td>Dementia</td>
<td>Exelon patch</td>
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<tr>
<td>Osteoarthritis</td>
<td>Ibuprofen</td>
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<tr>
<td>Diabetes</td>
<td>Metformin</td>
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<tr>
<td>Atrial fibrillation</td>
<td>Coumadin</td>
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Could this fall have been prevented in your facility? Why, or why not?

What are the components of your current investigation process?

Who participates?

What do they do?

When do they do it?

What is done with the investigation information?

You get the call while you are in this meeting—what are 5 instructions/questions will you give the team?

1. __________________________________________________________________________
2. __________________________________________________________________________
3. __________________________________________________________________________
4. __________________________________________________________________________
5. __________________________________________________________________________
QAPI ACTION PLAN

<table>
<thead>
<tr>
<th>Location: Facility Name</th>
<th>Unit or population:</th>
<th>Date:</th>
<th>Team Members</th>
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</table>

**Concern**
Falls exceed corporate standard of 3.1%

**Root Cause Analysis:**

**Goals**

<table>
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<tr>
<th>Action Items (corresponding to Root Cause Analysis)</th>
<th>Responsible Team Member(s)</th>
<th>Start Date</th>
<th>Estimated Completion Date</th>
<th>Actual Completion Date</th>
<th>Comments</th>
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<td>Goals &amp; Objectives</td>
<td>Action Items</td>
<td>Team Members</td>
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