The Ongoing Journey of Posttraumatic Growth& Falls PIP

Continuation Phase, Session 14

Today

COVID Update

IHI Curriculum

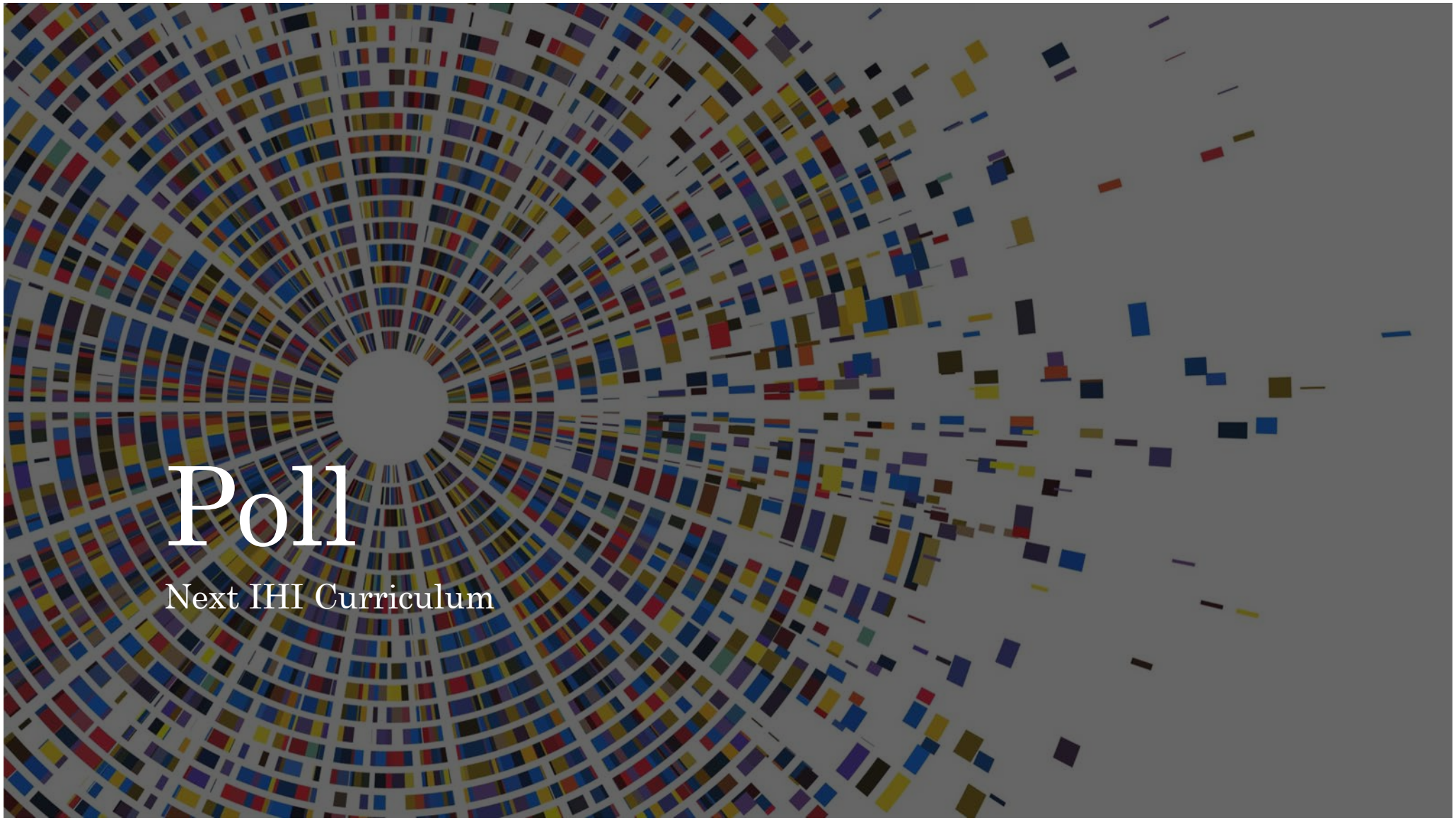
- The Ongoing Journey of Posttraumatic Growth

Falls PIP

Over the Past Week

What did you learn from walk rounds from this past week?

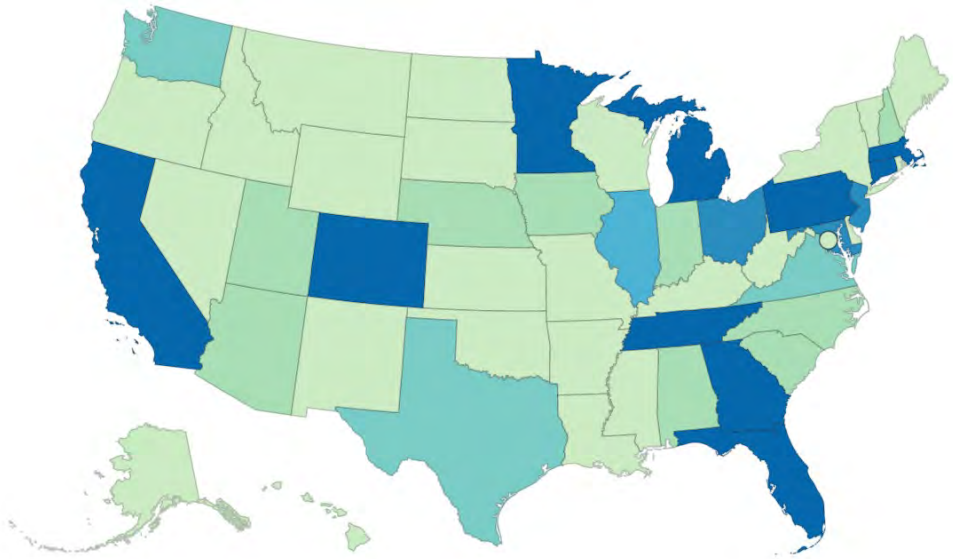
Discuss ideas about implementing QAPI into your work routines


Poll
Next IHI Curriculum

COVID – 19 Update


Viruses like to
masquerade

COVID-19 Variant: preparing for the fall



Territories AS GU MH FM MP PW PR VI

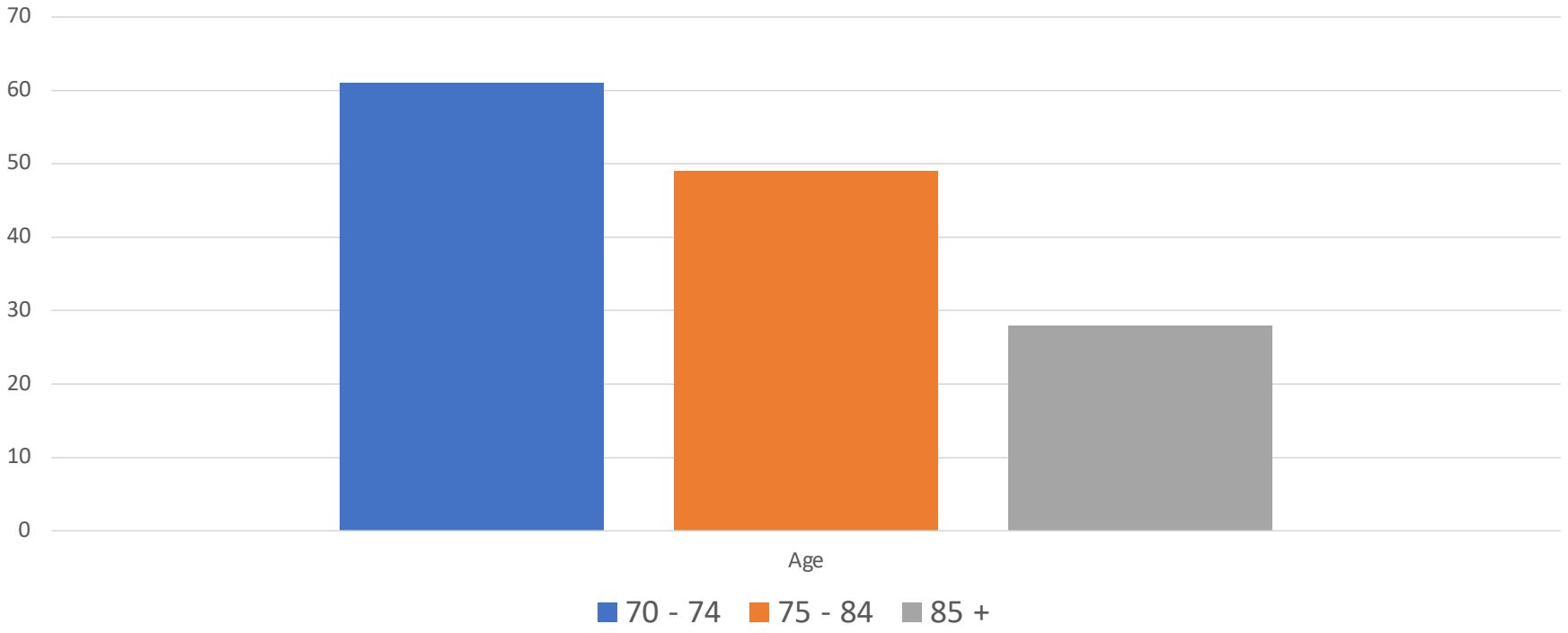
Number of Cases

0 to 0
1 to 150
151 to 300
301 to 450
451 to 600
601 to 750
751+

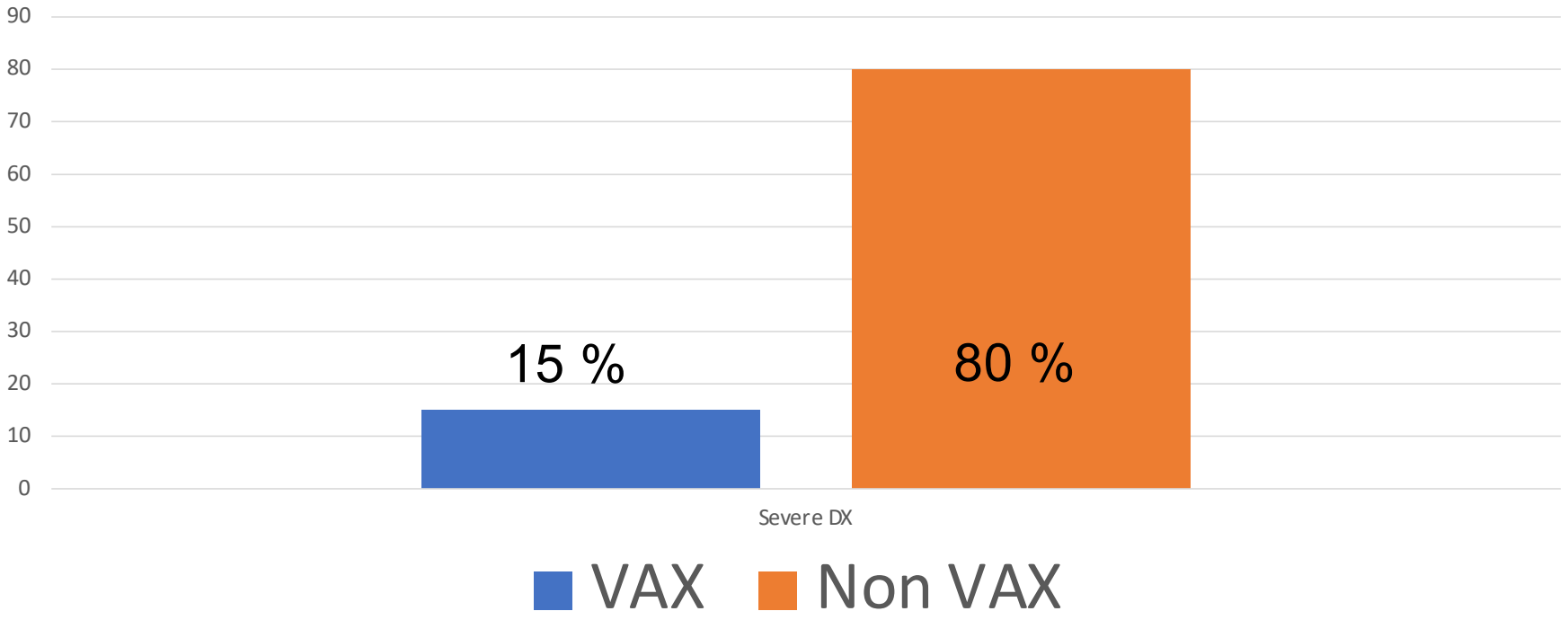
Filters

Variant B.1.1.7

Vaccine efficacy against variant declines with age



NH Vaccination reduces but does not eliminate severe COVID-19 variant disease



Clinical Infectious Diseases, 2021;, ciab446, https://doi.org/10.1093/cid/ciab446

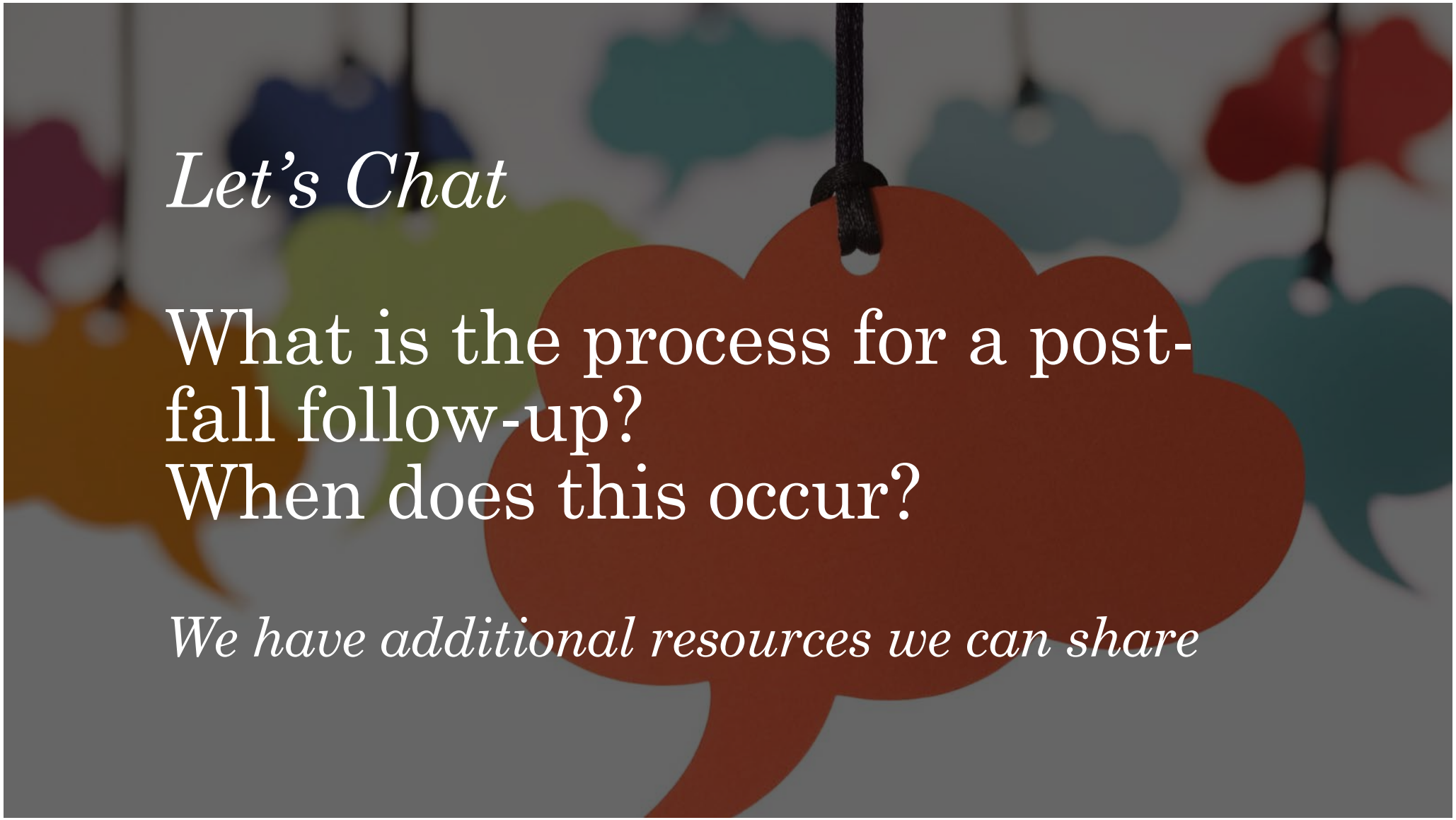

We are not out of the woods yet !

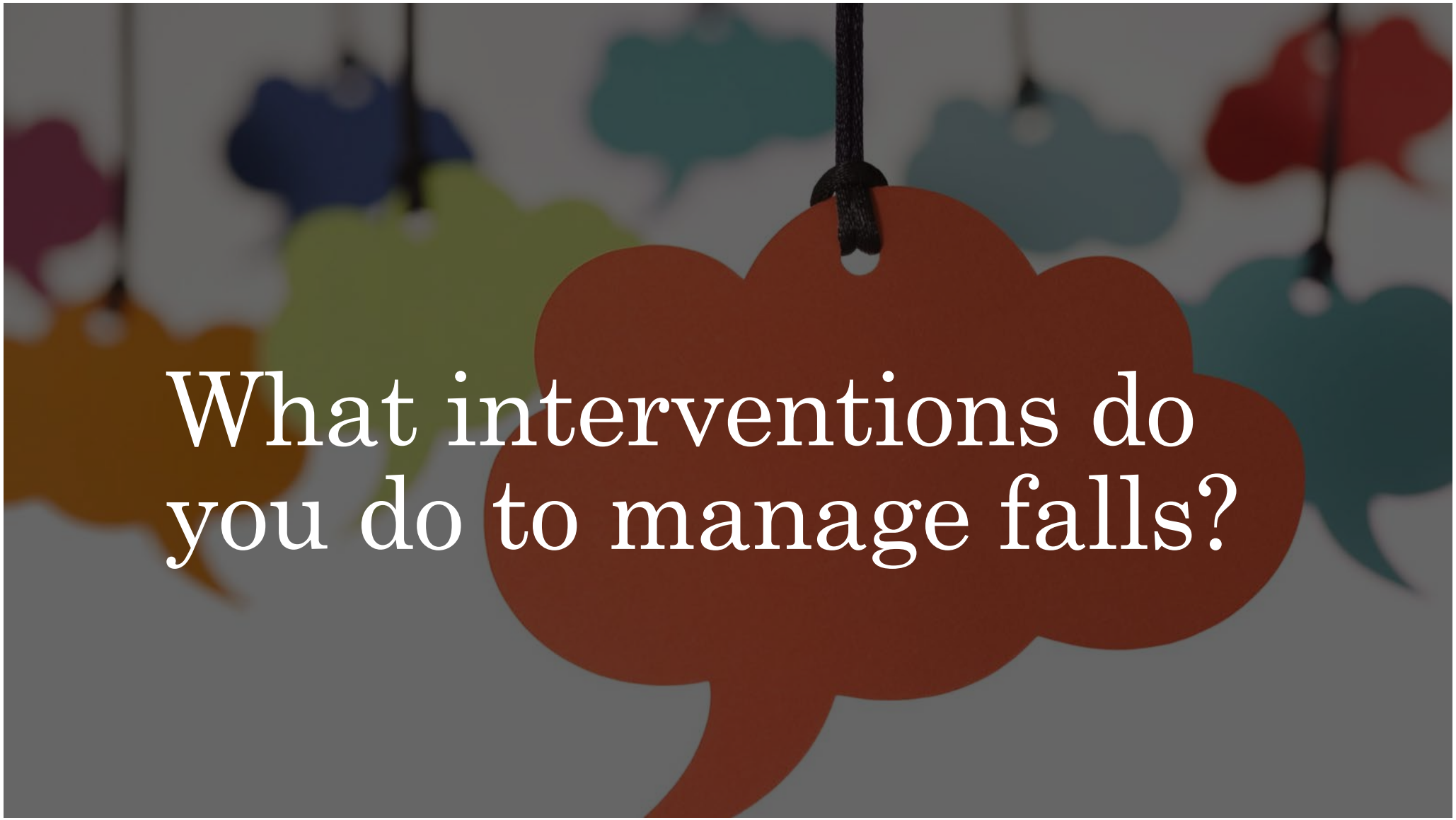
Video


Paige Hector
Emotional and Organization Support
Week 5 - The Ongoing Journey of Posttraumatic Growth
AHRQ ECHO National Nursing Home COVID-19 Action Network
HEALTH SCIENCES
ECHO
AHRQ
Agency for Healthcare Research and Quality
Institute for Healthcare Improvement

Older Adults & Falls

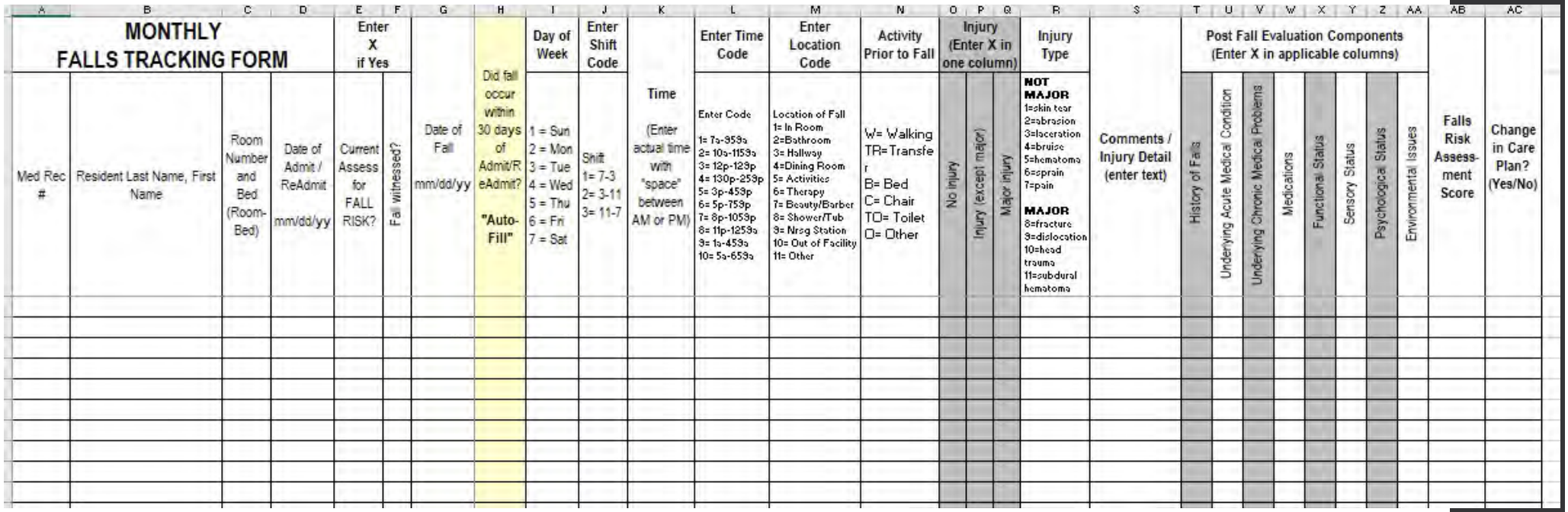
Heading into our next PIP


Let's Chat
What is the process for a post-fall follow-up?
When does this occur?
We have additional resources we can share


What interventions do you do to manage falls?

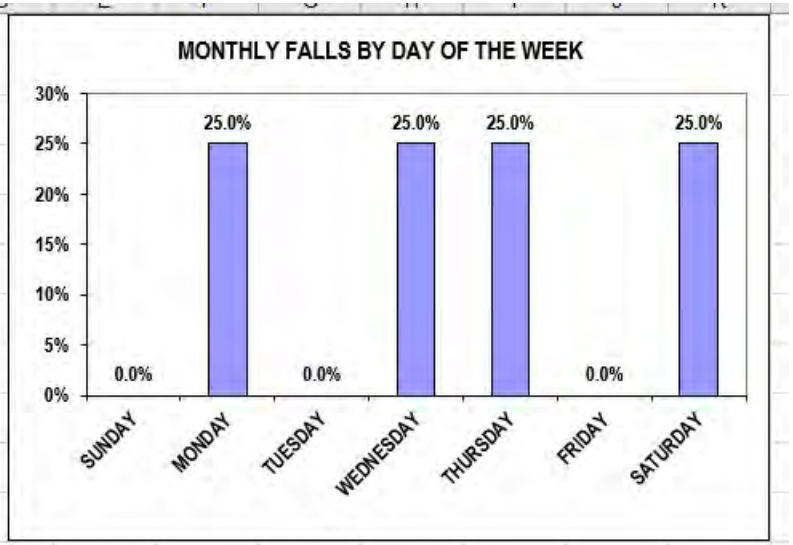

How do you communicate with staff about post falls follow-up?

Rosewood on Broadway, Fargo, ND

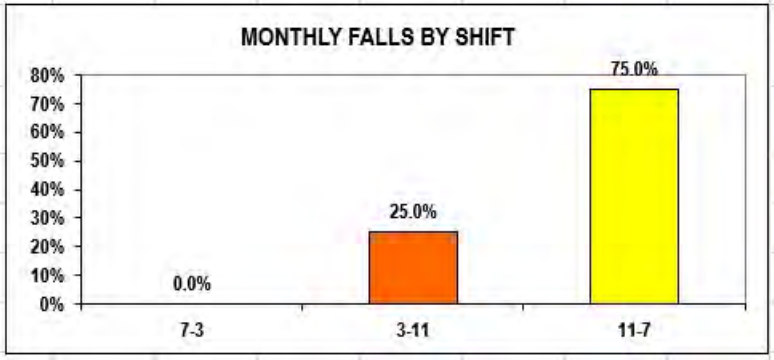


MONTHLY FALLS TRACKING FORM				Enter X if Yes										Injury (Enter X in one column)					Post Fall Evaluation Components (Enter X in applicable columns)										
Med Rec #	Resident Last Name, First Name	Room Number and Bed (Room-Bed)	Date of Admit / ReAdmit mm/dd/yy	Current Assess for FALL RISK?	Fall witnessed?	Date of Fall mm/dd/yy	Did fall occur within 30 days of Admit/ReAdmit? "Auto-Fill"	Day of Week 1 = Sun 2 = Mon 3 = Tue 4 = Wed 5 = Thu 6 = Fri 7 = Sat	Enter Shift Code Shift 1= 7-3 2= 3-11 3= 11-7	Time (Enter actual time with "space" between AM or PM)	Enter Time Code Enter Code 1= 7a-359a 2= 10a-1159a 3= 12p-129p 4= 130p-259p 5= 3p-459p 6= 5p-759p 7= 8p-1059p 8= 11p-1259a 9= 1a-459a 10= 5a-659a	Enter Location Code Location of Fall 1= In Room 2=Bathroom 3= Hallway 4=Dining Room 5= Activities 6= Therapy 7= Beauty/Barber 8= Shower/Tub 9= Nrsg Station 10= Out of Facility 11= Other	Activity Prior to Fall W= Walking TR=Transfer B= Bed C= Chair TO= Toilet O= Other	No injury	Injury (except major)	Major injury	Injury Type **NOT MAJOR** 1=skin tear 2=abrasion 3=laceration 4=bruise 5=hematoma 6=sprain 7=pain **MAJOR** 8=fracture 9=dislocation 10=head trauma 11=subdural hematoma	Comments / Injury Detail (enter text)	History of Falls	Underlying Acute Medical Condition	Underlying Chronic Medical Problems	Medications	Functional Status	Sensory Status	Psychological Status	Environmental Issues	Falls Risk Assess-ment Score	Change in Care Plan? (Yes/No)

MONTHLY FALLS BY DAY OF THE WEEK		
Day of Week	# by Day	% by Day
SUNDAY	0	0.0%
MONDAY	1	25.0%
TUESDAY	0	0.0%
WEDNESDAY	1	25.0%
THURSDAY	1	25.0%
FRIDAY	0	0.0%
SATURDAY	1	25.0%
TOTAL-->	4	100.0%



MONTHLY FALLS BY SHIFT		
SHIFT	# of Falls by Shift	% of Falls by Shift
7-3	0	0.0%
3-11	1	25.0%
11-7	3	75.0%
TOTALS-->	4	100.0%



Root Cause Analysis

Five Whys Tool for Root Cause Analysis

QAPI

Overview: Root cause analysis is a structured team process that assists in identifying underlying factors or causes of an event, such as an adverse event or near –miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain corrections.

The Five Whys is a simple problem-solving technique that helps to get to the root of a problem quickly. The Five Whys strategy involves looking at any problem and drilling down by asking: "Why?" or "What caused this problem?" While you want clear and concise answers, you want to avoid answers that are too simple and overlook important details. Typically, the answer to the first "why" should prompt another "why" and the answer to the second "why" will prompt another and so on; hence the name Five Whys. This technique can help you to quickly determine the root cause of a problem. It's simple, and easy to learn and apply.

Directions: The team conducting this root cause analysis does the following:

- Develops the problem statement. (See Step 1 of Guidance for RCA for additional information on problem statements.) Be clear and specific.
- The team facilitator asks why the problem happened and records the team response. To determine if the response is the root cause of the problem, the facilitator asks the team to consider "If the most recent response were corrected, is it likely the problem would recur?" If the answer is yes, it is likely this is a contributing factor, not a root cause.

Problem statement	One sentence description of event or problem
Why? ⇨	
Why? ⇨	
Why? ⇨	
Why? ⇨	
Why? ⇨	
Root Cause(s)	1. 2. 3. To validate root causes, ask the following: If you removed this root cause, would this event or problem have been prevented?

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FiveWhys.pdf

Fall Huddle

Fall Huddle:

Who: Nurse, primary RA, person finding resident (also NSM, CM, Therapy, Quality when available)

What: Review the circumstances of the fall

- What was resident doing at time of fall? Before fall?
- Were there any changes in resident behavior or function prior to the fall?
- Was the resident on any new meds? When was last PRN given?
- When was resident last toileted? Last repositioned? Last eaten?
- What was staffing like at the time? Where were staff when the resident fell?
- What activities were available? Does resident participate?
- Review the careplan – what interventions are in place already? Were they used?
- What interventions could be added to prevent another fall?

When: Meet to review fall as soon as possible but within 1 hour of fall

Where: Review at the scene where the fall occurred to give you clues about what could have happened and how to prevent further incidences

- Where did fall occur?
- Was equipment positioned where it should be? Where was the w/c or walker?
- What does the area look like where fall occurred? Is there clutter? Tripping hazards?

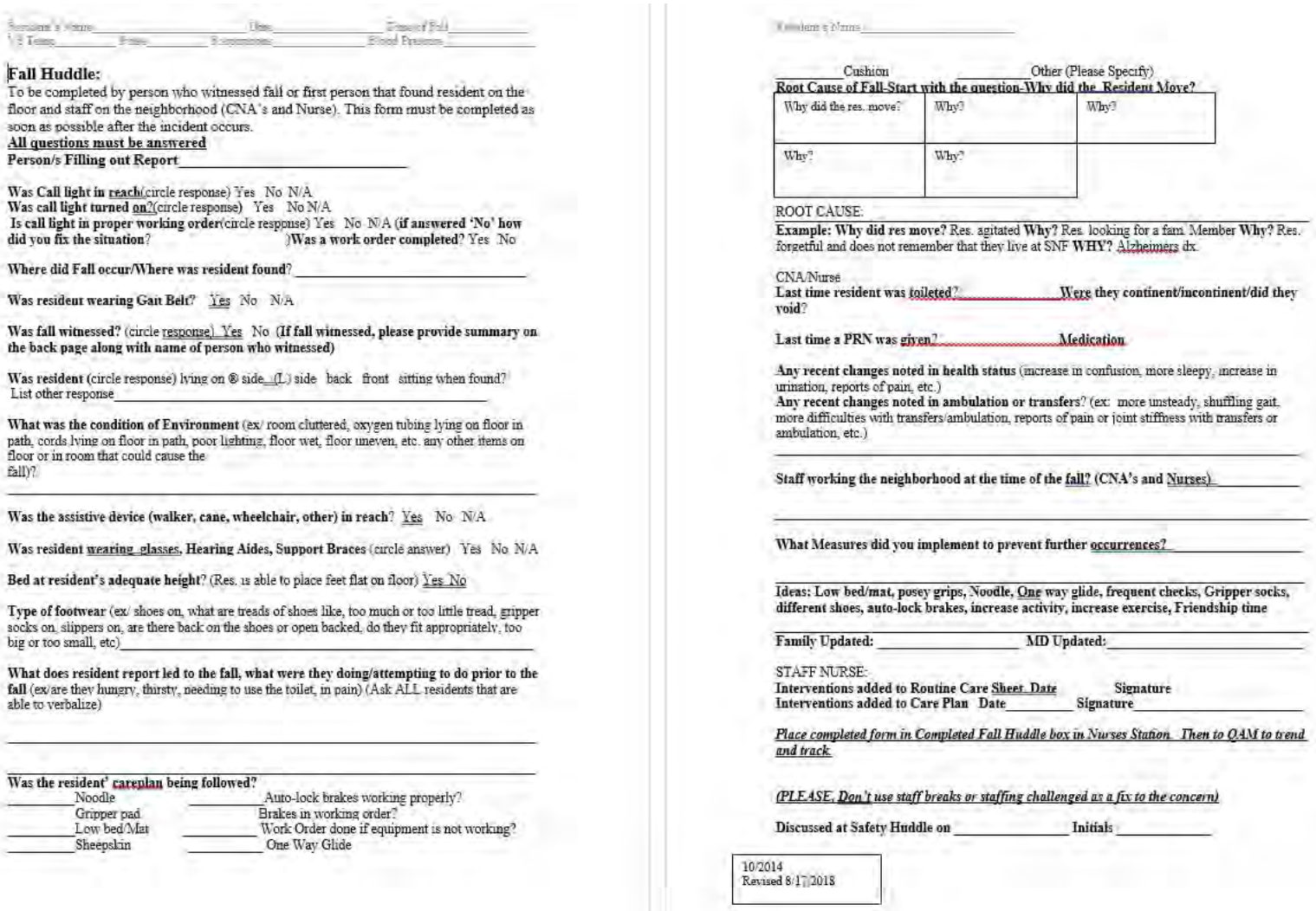
Conclusion : Why did the fall occur?

Document findings in the Risk Management report and include any additional information that will be helpful in the Risk Management report. Remember to also document the fall in the progress notes.

- Discussed with Team
  - Team members include:

Additional Follow-Up

Ave Maria



Resident's Name:_____ Date:_____ Time of Fall:_____
V/S Temp:_____ Pulse:_____ R:_____ Blood Pressure:_____

Fall Huddle:

To be completed by person who witnessed fall or first person that found resident on the floor and staff on the neighborhood (CNA's and Nurse). This form must be completed as soon as possible after the incident occurs.

All questions must be answered

Person/s Filling out Report_____

Was Call light in reach(circle response) Yes No N/A
Was call light turned on?(circle response) Yes No N/A
Is call light in proper working order(circle response) Yes No N/A **(if answered 'No' how did you fix the situation**? **)Was a work order completed**? Yes No

Where did Fall occur/Where was resident found? _____

Was resident wearing Gait Belt? Yes No N/A

Was fall witnessed? (circle response) Yes No **(If fall witnessed, please provide summary on the back page along with name of person who witnessed)**

Was resident (circle response) lying on ® side (L) side back front sitting when found?
List other response_____

What was the condition of Environment (ex/ room cluttered, oxygen tubing lying on floor in path, cords lying on floor in path, poor lighting, floor wet, floor uneven, etc. any other items on floor or in room that could cause the fall)?

_____

Was the assistive device (walker, cane, wheelchair, other) in reach? Yes No N/A

Was resident wearing glasses, Hearing Aides, Support Braces (circle answer) Yes No N/A

Bed at resident's adequate height? (Res. is able to place feet flat on floor) Yes No

Type of footwear (ex/ shoes on, what are treads of shoes like, too much or too little tread, gripper socks on, slippers on, are there back on the shoes or open backed, do they fit appropriately, too big or too small, etc)_____

What does resident report led to the fall, what were they doing/attempting to do prior to the fall (ex/are they hungry, thirsty, needing to use the toilet, in pain) (Ask ALL residents that are able to verbalize)

_____

_____

Was the resident' careplan being followed?

_____ Noodle
_____ Gripper pad
_____ Low bed/Mat
_____ Sheepskin
_____ Auto-lock brakes working properly?
_____ Brakes in working order?
_____ Work Order done if equipment is not working?
_____ One Way Glide

Resident's Name:_____

_____ Cushion _____ Other (Please Specify)

Root Cause of Fall-Start with the question-Why did the Resident Move?

Why did the res. move?	Why?	Why?
Why?	Why?	

ROOT CAUSE:_____

Example: Why did res move? Res. agitated **Why?** Res. looking for a fam. Member **Why?** Res. forgetful and does not remember that they live at SNF **WHY?** Alzheimers dx.

CNA/Nurse
Last time resident was toileted?_____ **Were they continent/incontinent/did they void?**

Last time a PRN was given?_____ **Medication**

Any recent changes noted in health status (increase in confusion, more sleepy, increase in urination, reports of pain, etc.)
Any recent changes noted in ambulation or transfers? (ex: more unsteady, shuffling gait, more difficulties with transfers/ambulation, reports of pain or joint stiffness with transfers or ambulation, etc.)

_____

Staff working the neighborhood at the time of the fall? (CNA's and Nurses)_____

_____

What Measures did you implement to prevent further occurrences?_____

_____

Ideas: Low bed/mat, posey grips, Noodle, One way glide, frequent checks, Gripper socks, different shoes, auto-lock brakes, increase activity, increase exercise, Friendship time

_____

Family Updated: _____ **MD Updated:**_____

STAFF NURSE:
Interventions added to Routine Care Sheet Date **Signature**
Interventions added to Care Plan Date_____ **Signature**_____

Place completed form in Completed Fall Huddle box in Nurses Station. Then to QAM to trend and track.

(PLEASE, Don't use staff breaks or staffing challenged as a fix to the concern)

Discussed at Safety Huddle on _____ **Initials** _____

10/2014
Revised 8/17/2018

Purposeful Post-Fall Huddle

RESIDENT

Resident: _____ □ Male □ Female Age____
Date of Fall: _____ Time of Fall _____ Day of week _____

HUDDLE INFORMATION

Date of Huddle: _____ Time of Huddle _____
Location of Huddle: □ Nurse's Station □ Location of Fall □ Resident Room □ Other _____
Huddle Leader/Facilitator: _____ Number of attendees: _____

□ Charge nurse _____ □ Social Services_____ □ Resident _____
□ RN _____ □ PT _____ □ Family Member_____
□ LPN _____ □ OT _____ □ Visitor_____
□ Med Aide _____ □ Housekeeping _____ □ Other (Name/Title)
□ CNA _____ □ Dietary _____ _____
□ Administrator _____ □ Maintenance_____ _____
□ DON _____ □ Activities_____ _____

FALL INFORMATION

Location of Fall: □ Resident Room □ Resident Bathroom □ Hallway □ Dining Room □ Bathing Room
□ Outside on campus □ Outside off campus □ Other _____

Type of Fall: □ Witnessed (observed to fall)
□ Unwitnessed (found on floor/ground)
□ Intercepted (would have fallen if not caught self or by another person)

Injury from Fall: □ No injury
□ Injury, except major (skin tears, abrasions, lacerations, superficial bruises, hematomas, sprains, or any related injury causing the resident to complain of pain
□ Major Injury (bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma)

Outside Medical Treatment immediately after fall? □ None □ Sent to Emergency Room □ Sent to Physician Clinic

RESIDENT

What were you trying to do? _____
Was something different this time?_____
Assistive Device being used? □ None □ Walker □ Cane □ Crutches □ Wheelchair □ Other _____
Footwear? □ Barefoot □ Shoes □ Gripper Socks □ Socks without grippers □ Slippers □ Other_____
Clothing? □ Fit well □ Loose □ Tight □ Other_____
Wears glasses? □ Yes □ No Wearing glasses when fell? □ Yes □ No
Wears hearing aides? □ Yes □ No Wearing hearing aides when fell? □ Yes □ No

STAFF

Approximate time of last contact or visual of resident before fall - _____Who? _____
What was the resident doing? _____
Who was in the area at the time of the fall?_____
Anything about the resident different today than normal?_____

ENVIRONMENT

Floor: □ Carpet □ Tile □ Rug □ Uneven □ Steps □ Shiny □ Wet: suspected liquid _____
□ Other: _____
Area where fall occurred: □ Light □ Dark □ Noisy □ Busy □ Cluttered □ Other_____
What items were near fallen resident? □ Bed □ Wheelchair □ Walker □ Chair/Recliner □ Toilet/Commode
□ Other:_____
Equipment Used at time of fall: □ Total Lift □ Sit-to-Stand Lift □ Bath Chair □ Other: _____
Other Environment Factors: _____

DRAW THE SCENE

Draw the scene of the fall. Be descriptive. Include the resident's position, equipment, assistive devices,

FALL ROOT CAUSE ANALYSIS

Use the 5 Whys to identify the root cause of the fall – Ask why until reach the cause of the fall. Verify this result is the root cause by asking if this reason was removed, would the fall have occurred?

Problem Statement: _____
(One sentence description of event)

WHY? _____

WHY? _____

WHY? _____

WHY? _____

WHY? _____

ROOT CAUSE(S)

1.
2.
3.

To validate Root Causes – Ask the following:
If you removed this Root Cause, would this event have been prevented?

ACTION PLAN

What can be done to avoid future falls (intervention)? _____
_____
Care plan Updated? □ Yes □ No
Signature of PPFH Leader/Facilitator: _____ Time Huddle Completed: _____
Fall Committee Review & Action: _____
Fall Committee Signature: _____ Date:_____
QAPI Committee Review & Action: _____
QAPI Committee Signature: _____ Date:_____

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains Quality Innovation Network

This material was prepared by Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Dept. of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 12SOW-GPQIN-86/0621

FSI -- Fall Scene Investigation Report

Facility Name:

Resident Name: _____ Med. Rec. # _____ Room # _____

Date of Fall _____ Time of Fall: _____ AM / PM Admit Date: _____

Staff / Witness present at / or finding resident after fall: _____

FALL DESCRIPTION DETAILS:

1. Factors observed at time of fall:
   - ☐ Resident lost their balance
   - ☐ Resident slipped (give details):
   - ☐ Lost strength/appeared to get weak
   - ☐ Wheelchair / bed brakes unlocked
   - ☐ Bed height not appropriate
   - ☐ Equipment malfunction (specify):
   - ☐ Environmental noise
   - ☐ Environmental factors (circle or write in): clutter, furniture, item out of reach, lighting, wet floor, other (specify)

2. Draw a picture of area and position in which resident was found. (e.g. face down, on back / R or L side, position of arms and legs, furniture /equipment /devices nearby)

*If fall within 5 feet of transfer surface do orthostatic BP

3. Fall Summary:
   - ☐ Found on the floor (unwitnessed)
   - ☐ Fall to the floor (witnessed)
   - ☐ Intercepted fall (resident lowered to floor)
   - ☐ Self-reported fall

4. Fall Location
   - ☐ Resident room
   - ☐ Activity Room
   - ☐ Hallway
   - ☐ Dining room/day room
   - ☐ Bathroom [CHECK TOILET CONTENTS]
     - ☐ Toilet contains urine /feces
   - ☐ Shower/tub room
   - ☐ Outside building on premises / off premises
   - ☐ Other (specify) :

5. What was resident doing during or just prior to fall?
   - ☐ Ambulating
   - ☐ Attempting self-transfer
   - ☐ Transfer assisted by staff
   - ☐ Reaching for something
   - ☐ Slide out / fall from wheelchair
   - ☐ Rolling/sliding out of bed
   - ☐ Sitting on shower/toilet chair
   - ☐ Other (specify):

6. What type of assistance was resident receiving at time of fall?
   - ☐ Assisted per care plan:
   - ☐ Alone and unattended
   - ☐ Assisted with more help than care plan describes

FSI -- Fall Scene Investigation Report

Facility Name:

Resident Name: _____ Med. Rec. # _____ Room # _____

7. What did the resident say they were trying to do just before they fell?

CONTRIBUTING FACTORS TO HELP IDENTIFY ROOT CAUSE OF FALL:

8. Describe resident's mental status prior to fall:

   How does this compare to the resident's usual mental status?

9. Describe resident's psychological status prior to fall:

   How does this compare to the resident's usual psychological status?

10. Footwear at time of fall:
    - ☐ Shoes
    - ☐ Bare feet
    - ☐ Gripper Socks
    - ☐ Slippers
    - ☐ Socks
    - ☐ Off load boots
    - ☐ Amputee

11. Gait Assist devices at time of fall:
    - ☐ None
    - ☐ Has device and was in use
    - ☐ Has device but was not in use

12. Did vision or hearing contribute to fall?
    - ☐ Yes
    - ☐ No

    Explain:

13. Alarm being used at the time of the fall?
    - ☐ Yes
    - ☐ No

    If yes, was it working correctly?

14. Time last toileted or Catheter emptied:
    _____ AM /PM

    Continence at above time:
    - ☐ Wet ☐ Soiled
    - ☐ Dry

15. Did fall occur?
    - ☐ Next to transfer surface (assess postural hypotension)
    - ☐ 10 ' from transfer surface (assess balance)
    - ☐ > 15 ' from transfer surface (strength /endurance)

16. Medications given in last 8 hours prior to fall (check all that apply):
    - ☐ Anti-anxiety
    - ☐ Anticoagulant
    - ☐ Antidepressant
    - ☐ Antipsychotic
    - ☐ Cardiovascular
    - ☐ Diuretic
    - ☐ Laxative
    - ☐ Narcotic
    - ☐ Seizure
    - ☐ New meds/changed dose within last 30 days

FSI -- Fall Scene Investigation Report

Facility Name:

Resident Name: _____ Med. Rec. # _____ Room # _____

17. Vital Signs:
- ☐ Were temperature, pulse, respirations and/or O2 Sat out of normal range for this resident?
  - ☐ Yes
  - ☐ No
- ☐ Did orthostatic BPs suggest the BP change contributed to the fall? Lying _____ Sitting _____ Standing _____
  - ☐ Yes
  - ☐ No

18. (Blood Sugar check is required for diabetic resident) Was resident's Blood Sugar significant?
- ☐ Not applicable
- ☐ Blood sugar within normal range for resident
- ☐ Blood sugar out of normal range (describe):

19. Does recent Hgb show evidence of Anemia?
- ☐ Yes
- ☐ No

Re-Creation of Last 3 Hours Before Fall

Below, the primary Nursing Assistant who observed and /or assisted the resident during the three hours prior to the fall will write a description to re-create the life of the resident before the fall:

PRINT NAME:

Re-enactment of fall (to be done if Root Cause is NOT determined):

Fall Huddle *(What was different THIS time?)*

ROOT CAUSE OF THIS FALL:

Review of Contributing factors (Check all that apply):

- ☐ Alarm
- ☐ Amount of assistance in effect
- ☐ Assistive/protective device
- ☐ Environmental factors/items out of reach
- ☐ Environmental Noise
- ☐ Footwear
- ☐ Medication
- ☐ Medical status/Physical condition/Diagnoses
- ☐ Mood or mental status
- ☐ Toileting status
- ☐ Vision or hearing
- ☐ Vital signs abnormal or significant
- ☐ Last 3 hours "re-creation" issue/s

FSI -- Fall Scene Investigation Report

Facility Name:

Resident Name: _____ Med. Rec. # _____ Room # _____

What appears to be the root cause of the fall?

Describe initial interventions to prevent future falls:

☐ Care Plan Updated ☐ Nurse Aide Assignment updated

NURSE COMPLETING FORM:

Printed Name: _____

Signature:

Date and Time:

Falls Team Meeting Notes:

Summary of meeting:

Conclusion:

Additional Care Plan / Nurse Aide Assignment Updates:

Signatures with Date and Time:

If you would like additional technical assistance, please let us know.

You can work with our mentors one-on-one.

Homework

This week

- **Please Send in RCAs**
  - We have a few but would like more

Submit Homework via Dropbox

- Now on our website (direct link to dropbox with instructions)
- https://www.dakotageriatrics.org/project-echo-can/phase-2-continuing-education
- Please note we might share your work with the group (if you don't want to share, please let us know)