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

SUPERIOR HEALTH
Quality Alliance

Falls: Keeping Residents Safe

Jenna Heim, RN, DNS-CT

May 10, 2023

Objectives

- Identify how to use root cause analysis (RCA) to drive new intervention identification immediately post fall.
- Identify strategies for reducing alarms in skilled nursing facilities (SNF).
- Identify fall interventions that are alternatives to alarms.

Statistics from The Centers for Disease Control and Prevention (CDC)

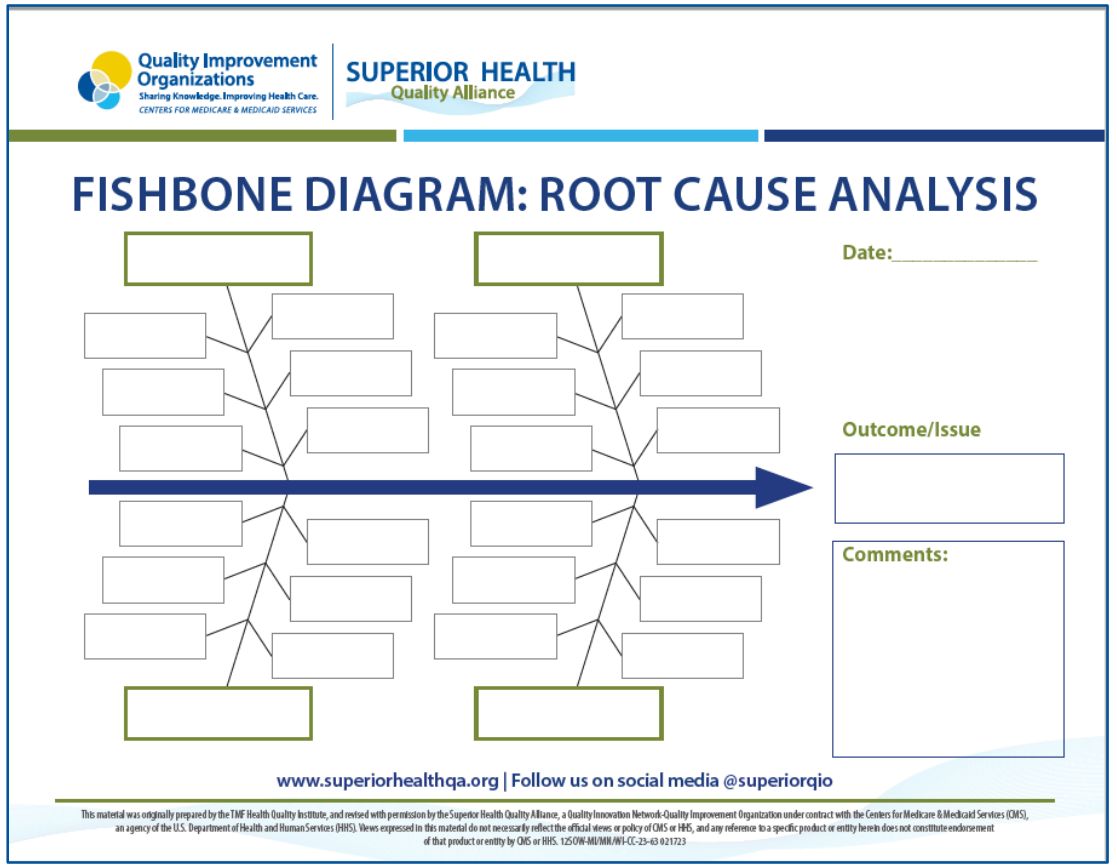
- About 36 million falls are reported among older adults each year, resulting in more than 32,000 deaths.
- Each year, about 3 million older adults are treated in the emergency department (ED) for a fall related injury.
- One out of every five falls causes an injury.
- Each year at least 300,000 older people are hospitalized for hip fractures, and 95% of hip fractures are caused by falling.

Root Cause Analysis

Different Types of RCA

Fishbone (Cause-and-Effect) Diagram

- Under each category answer the question, “Why?” for the identified problem.
- Once completed discuss the various causes to get to the root of the problem.

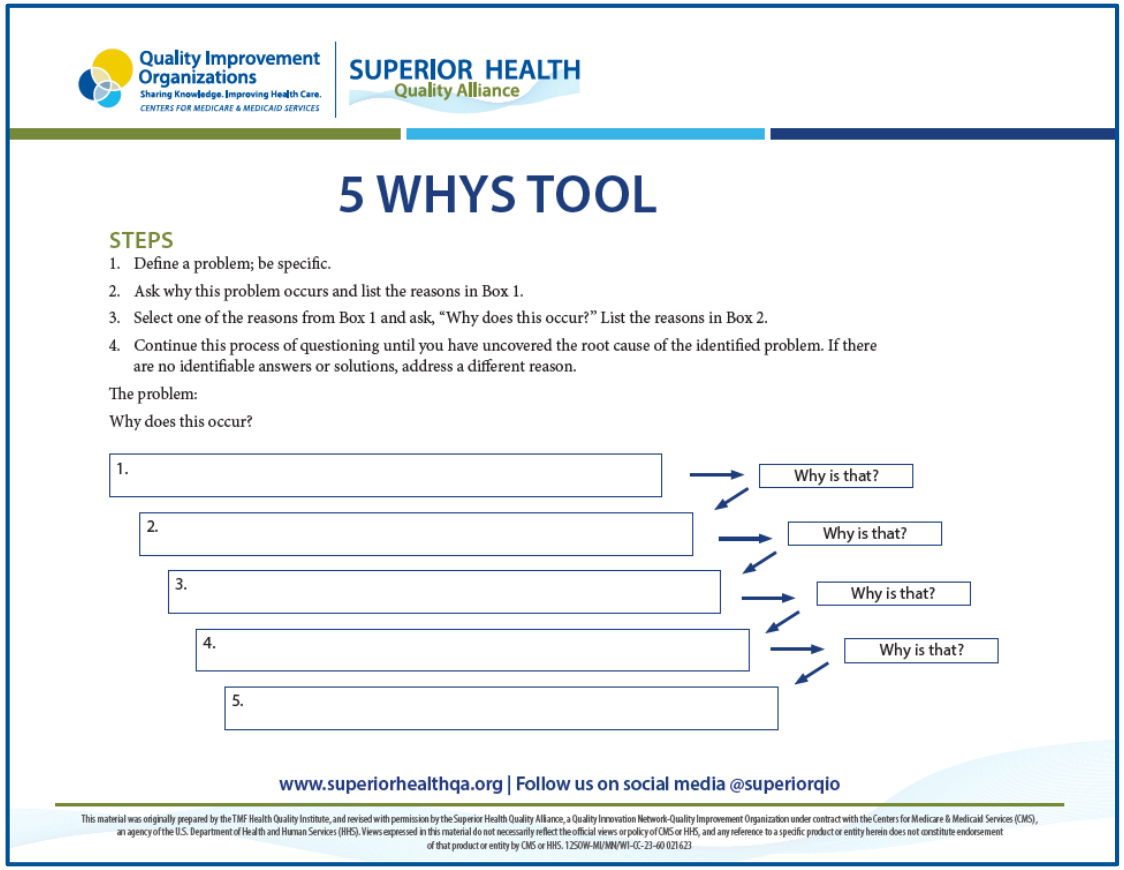


Download the Fishbone Diagram.

Different Types of RCA

Five Whys

- Begin by identifying a specific problem, and ask why it is occurring. Continue to ask, “Why?” to identify causes until the underlying cause is determined.



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

SUPERIOR HEALTH Quality Alliance

5 WHYS TOOL

STEPS

1. Define a problem; be specific.
2. Ask why this problem occurs and list the reasons in Box 1.
3. Select one of the reasons from Box 1 and ask, “Why does this occur?” List the reasons in Box 2.
4. Continue this process of questioning until you have uncovered the root cause of the identified problem. If there are no identifiable answers or solutions, address a different reason.

The problem:

Why does this occur?

1. → Why is that?
2. → Why is that?
3. → Why is that?
4. → Why is that?
5.

www.superiorhealthqa.org | Follow us on social media @superiorqio

Download the 5 Whys Tool.

Root Cause Analysis Post Fall

- Environment
  - Trip hazards?
  - Assistive device within reach?
  - Wet floor?
  - Noise level?
  - Lighting?
- Bathroom
  - Last time toileted?
  - Contents of toilet?
  - Wet incontinence brief?

Root Cause Analysis Post Fall

- Timing
  - Evening/sundown?
  - Shift change?
  - Weekend?
- Other factors
  - Lack of sleep?
  - Confusion?
  - Recent med changes?
  - What were they trying to do when the fall occurred?

Fall “Pick-Me-Up”

- RCA used to determine new intervention.
- Part of fall incident report.
- Completed immediately post fall with all staff in area.
  - Not just nursing staff – include housekeepers, maintenance staff, etc.
  - **All** staff educated on fall culture upon new hire orientation.
- Reviewed with interdisciplinary team (IDT) the following morning.

Alarm Reduction

Alarm Reduction: Getting Started

Considerations:

- Resident/family buy in
- Staff buy in
- Budget/resources
- Care plans
- Staff education
- Project name/activities
- Timeline

Alarm Reduction: Staff Reaction

Staff reaction counterintuitive.

- Usual staff reaction when an alarm goes off is to tell the resident to, “Sit down.”

Think about when you set a timer on the oven to be reminded to check on the cookies.

- Able to temporarily forget about them and move on to another task until you hear the timer go off

Alarms cause reactionary rather than anticipatory nursing.

- “Sit down” vs. “What do you need?”

Alarm Reduction: Ineffective in Reducing Falls

- Alarms have been proven to not be an effective fall reduction intervention.
- Alternatively, noise has been shown to be a common cause or contributor of falls.
    - Counterintuitive to everything we have ever learned or have been taught since childhood regarding alarms: “drop, roll, get out!”

F-Tags Associated with Alarms

- Bed and chair alarms are addressed in at least four updated F-Tags.
  - F584: Safe Environment
  - F604: Respect and Dignity
  - F689: Accidents
  - F725: Sufficient Staff
- The Requirements of Participation (RoP) states that for some residents, a position change alarm may act as a restraint.

Accidents - Critical Element Pathway

Does the resident have a position change alarm in place:

- What evidence is there that this device has been effective in preventing falls?
- Is there evidence this device has had the effect of inhibiting or restricting the resident from free movement out of fear of the alarm going off?
- Is there evidence that the alarm is used to replace staff supervision?

Alarm Reduction Case Study

Alarm Reduction Case Study
The Before: Fall Risk Process

- Fall risk identified upon admission based on fall assessment tool.
- Falling leaf on outside of resident door frame.
- “Standard” interventions.
- After fall happens **maybe** look at specific interventions related to cause of fall.

Alarm Reduction Case Study
The Before: Fall Interventions

- Bed alarm
- Wheelchair alarm
- Door alarm
- Low bed
- Fall mat
- Room close to nurses' station
- Increased visibility – keep resident in common areas
- Frequent checks

Alarm Reduction Case Study
Hurdles and Challenges to Alarm Reduction

- “The family wants us to use them.”
- “It prevents a resident from falling.”
- “It gets me to them faster if they’re on the floor.”
- “The resident has dementia and…”

- **“We don’t know what else to do.”**

Alarm Reduction Case Study
The After: Post Fall Process

- Post fall huddle with all staff available.
- Completion of “Pick-Me-Up” form with every fall.
- RCA to determine new intervention related to specific fall.

Alarm Reduction Case Study
The After: Updated Interventions

- New intervention options
  - Anti-skid mat to chair/wheelchair
  - Anti-slip strips to floor
  - Motion detected light strips under bed

- Eliminate entirely
  - All alarms
  - Low beds
  - Fall mats
  - 15 minute checks

Alarm Reduction Case Study
The After: Fall Injury Risk Identifiers

- All residents = **high fall risk** based on need for SNF placement.
- Fall injury risks determined instead.
- Identifiers placed on **inside** of resident door frame and **explained** to the resident so they are aware of their own fall injury risks and how to prevent.
  - A: Age – over age 85
  - B: Bone – osteoporosis
  - C: Coagulant
  - S: Surgery – recent surgery

Post Implementation Monitoring

- Quality Measures, The Centers for Medicare & Medicaid Services (CMS) Fall rate and interventions.
- Was there an improvement in fall rate?
- Was there a reduction in fall related injuries?
- Correlation between falls and noise levels in the facility and time of day.

Questions?

Jenna Heim, RN, DNS-CT, Quality Improvement Advisor

jheim@metastar.com

Resources

- INTERACT® Tools Library, Pathway Health
- Patient Safety Essentials Toolkit, Institute for Healthcare Improvement (IHI)
- Older Adult Fall Prevention, CDC
- Keep on Your Feet - Preventing Older Adult Falls, CDC
- State Operations Manual - Appendix PP, Guidance to Surveyors for Long-term Care Facilities, CMS
- Accidents Critical Element Pathway, CMS

Continue the Conversation in

Superior Health Connect

Connect is a shared learning environment for Superior Health participants to come together to foster and promote an all-teach-all-learn climate that provides the framework to improve and sustain mutual health care quality improvement initiatives locally, regionally, and nationally.

https://bit.ly/3BhfHc1

Scan to join Connect.

Questions?

Jenna Heim, RN, DNS-CT

jheim@metastar.com

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

SUPERIOR HEALTH
Quality Alliance

This material was prepared by the Superior Health Quality Alliance, a Quality Innovation Network-Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS.
12SOW-MI/MN/WI-NH-23-48 050423