

# Nursing Home Huddle – April 29, 2021: Falls

## Webinar Transcript

Mitzi Vince: Good afternoon and welcome to this afternoon's webinar Huddle. Today's Huddle will focus on falls. We will get started in just a few minutes, but first a few quick housekeeping items. All participants enter today's webinar in "listen only" mode. If you have a question or comment during today's call, we ask that you please type it into either the chat or the Q&A box to the right of your screen. If you're unable to locate your chat box, hover over the bottom of your screen and click on the word "chat" with the speech bubbles in the right bottom corner of your screen. I'll now turn things over to Patty Austin, project specialist with Quality Insights. Patty?

Patty Austin: Hi, everybody. Thanks, Mitzi. Welcome to the second session of our Revisit, Renew, and Revitalize series, Quality Measures: Falls. As Mitzi said, I am Patty Austin here with you today, along with Penny Imes and Kristin Carson. We're quality improvement specialists with Quality Insights. Just a quick reminder that today's webinar will be followed by a series of coaching calls that's designed to explore this topic in greater detail. We'll look at some of the tools that we talk about today, we'll consider some potential fall interventions, and we'll also look at ways to incorporate fall safety into daily practice. Additionally, we'll consider what roadblocks you might be experiencing, and we hope to highlight some of the successes that you're finding as well.

30 minutes moves very quickly, and today's WebEx is going to be pretty fast-paced and information packed. The coaching calls are designed to slow things down a little bit and really consider the concepts that we're going to cover today. This recording will be available to you for review in the next few days in case you wish to take another look or maybe share it with some team members. So let's get started.

Today's objective will be to touch on the QAPI process and how it fits into the fall management program. If you're in need of additional help with these techniques, please see the recording on our website from the QAPI session that we held about a month ago now, or contact your quality improvement specialists. We're always happy to help. We're also going to look at the Fall QM so that we can gain an understanding of what makes the measure trigger on your CASPER reports, and then we'll talk about some ways to operationalize fall management into daily life.

So just a quick poll. How confident are you in your ability to apply the QAPI process to fall management? I'll give you a little bit to answer that, and we're going to use the results of this poll as we move forward to see how in depth we need to go in each session related to the QAPI techniques.

Patty Austin:

A few words on QAPI as we begin today. At its most basic level, the QAPI process uses data to identify problems and to measure success of applied intervention. It relies on root cause analysis to determine the actual cause of the problem, and then it helps to decide where to initiate Plan-Do-Study-Act cycles to correct that problem. It ensures that you monitor the processes that you put into place, and that those changes are able to be sustained over time. A ton of resources are available to assist you with those concepts and they're available on our website. Please reach out to us if you have any questions related to accessing those tools or to the questions related to the techniques that they refer to.

So the question now becomes where do we start to navigate the process of looking at our fall program? We know that to manage and maintain any process, we use data to identify our strengths and weaknesses and to measure our success. When we're looking at falls, most likely the primary data point we're considering is the quality measure percent of residents experiencing one or more falls with major injury. We tend to focus on that data point because it's produced for us and therefore it's pretty easy to obtain, and because it affects our publicly available star rating.

To manage the measure, we have to first understand how it works. One of the first things you might want to take note of is that it is a long stay measure, meaning that only residents who have been in your facility for 101 or more cumulative days will count toward the measure. Also, due to the selection logic used in the look-back scan, residents who sustain a fall with major injury are going to trigger that measure for up to a year following the event. The description of the event is very specific in that falls with major injury are defined as bone fractures, joint dislocation, closed head injuries with altered consciousness, or subdural hematomas. Those are the only falls included in the numerator. There aren't really any exclusions for this measure, other than not coding that section on the MDS, because the data is pulled directly from Section J of the MDS onto your QM report. Of course, falls for short stay residents are every bit as concerning, and the same concepts that we're going to talk about today are used to manage falls for the short stay residents as well.

Chances are good that falls are already part of your routine and facility monitoring, but sometimes the change in the rate will cause us to initiate a more focused review, often with a performance improvement project. Understanding how the measure is constructed leads us to the first step in gathering the data that we're going to need to move forward, and that's making sure that all the falls that have triggered on your report are accurately triggered. We need to ensure that the coding for all the falls shown on the report has been done correctly, and that they reflect true falls with injury.

Patty Austin:

For example, we might find that lacerations that required sutures are being counted as a fall with major injury. Then we could initiate a root cause analysis, or maybe we'll find that a typo on an MDS led to someone who didn't have a fall being counted. We might then decide to do a modification to the MDS to remove that flag from our report. This ensures that you're moving forward with a clear baseline. Once you know that the QM data is accurate, then you can begin to look at the subset of remaining incidents to refine your PIP.

Just a reminder that all quality improvement asks us to consider three questions. First, what are we trying to accomplish? Second, how will we know that our changes actually lead to improvement? And finally, what can we change that will result in the improvement that we're looking for? Keeping these basic ideas in the forefront guides the formation of a performance improvement project.

Hypothetically, let's assume that we know our quality measure report is reflecting an increase in falls and we wanted to get a performance improvement project. As we formulate our goals for the project, we may begin with the simple idea of reducing falls with injury to a percentage below the state average. That's a perfectly acceptable goal. However, the length of time of fall with injury stays on your QM report makes it less than ideal as a short-term goal.

So we're then compelled to consider what data we think we have that will produce the information we need to identify areas for improvement, and then to measure the success of our interventions more quickly. To do that, we need to understand the information we have, right? We'll need to find the data that will allow us to see it in a way that's going to determine what specific population we need to concentrate on. We can then create a focus status set to measure success with. That doesn't mean that we abandon the goal of reducing the measure to below state averages. It just means that our journey to achieving that goal will require us to take smaller measured steps to get there, each with its own goal.

What message is the data that you have trying to tell you? Some of the common areas you might consider listening to in addition to that QM data are survey deficiencies, fall assessments, incident reports, maybe critical element pathways, but most importantly, staff input. What do those who are not directly involved with hands-on care think might be causing the increase in falls? Often those that work in ancillary departments like housekeeping and dietary, or how about activities, have a different perspective that can lead to some unexpected results. Once you've decided to find the information you think is going to help inform the project, begin the process of grouping it in a way that will help you to clarify the picture. As your picture becomes more clear, you'll be able to prioritize what you would like to work on first.

Patty Austin:

So let's try to put things into perspective. We're going to use a generic scenario to walk us through this process in a little more detail. In our fictional case, we know that fall QMs are on the rise. Additionally, we know that we've had two deficiencies in the past year that relate to falls. Our data analysis has also shown that we have a trend of falls on isolation units, and another trend of falls involving residents diagnosed with dementia. Looking at our data, we decide to prioritize falls on the isolation unit as well as falls on dementia as a factor.

Let's take a look at one of those prioritized areas in more detail. We'll focus the next few slides on decreasing falls on our isolation unit, but the same process would be used if you chose to focus on residents with dementia. To begin, we have to first define what we hope to accomplish... Excuse me... And what we'll use to measure our success with. This is our first step in achieving the long-term goal of our fall QM falling below that state average.

Remember the SMART technique is going to help you to write a good goal. In this case, we decide that we're going to be specific by stating that falls will decrease on the isolation unit during second shift. We chose that after analyzing our data and trending that most falls occur on that unit during that time. We decide we will measure our progress by knowing that falls have decreased by a certain percentage.

Again, we're working with a subset of falls, not falls throughout the facility. To create a percentage of that subset, we will count the number of falls on the isolation unit during second shift, and that will become our numerator. The total number of falls would then be the denominator. When we divide the numerator by the denominator and multiply it by 100, we arrive at a percent of all falls that occurred during second shift on the isolation unit.

Don't forget to consider your timeframe when you're doing those kinds of measure developments. If in the past three months you have say 21 falls and 7 of them were on second shift on the ISO unit, that calculation, 7 divided by 21 times 100, means that 33% of all your falls on the past three months happened on the ISO unit during second shift. We now have a baseline to create a goal around. We can talk more about creating those kinds of measures on our coaching call.

We also know that building the right team will help lead to success. In this case, some of the positions we might consider could be the restorative nurse, the infection control nurse, a nurse from the ISO unit. We would also benefit from having a nursing assistant who works on that unit during second shift, maybe even an isolation activity aide or housekeeper. Each is going to bring a unique perspective to the table. It can also be helpful to include someone who has experience in an area that has low fall rates. That can help to highlight the differences in processes that might go unnoticed otherwise.

Patty Austin:

Now that we have a team of people with a defined goal, we can begin to determine what we think the root cause of the problem might be. Remember that one root cause analysis most likely is not going to provide you with enough information to predict the actual cause with any certainty.

In our example, when we ask our first why question... Why are falls increasing on the isolation unit more than any other unit... We arrive at the same conclusion from multiple sources. Staff who are participating in the root cause analysis tell us that residents are unobserved for longer periods of time on the unit. Our fall team members also note during direct observation that most residents on the isolation unit are only being observed by staff entering their room once every two hours, as compared to once every 45 minutes on average on the other unit. During our next why question, we ask why are residents left alone for longer periods of time on this unit? The reply we get is that staff just doesn't have the time to round more often on that unit.

Let's look at the responses to the first two why questions. This example highlights one of the reasons that people can initially become discouraged with the 5 Why technique and not see its value. The responses seemed very similar. Residents are alone longer, and we don't have time to round more often. If we stop here, the intervention might look something like: educate staff to round on each resident every 45 minutes. While that intervention might very well prevent falls in the short term, we don't yet understand why the time difference exists. Without knowing more, we can't intervene to create a sustainable intervention.

Often root cause analysis, when completed with multiple people, will generate several viable paths to take. In our example, we received three separate paths that we could choose to follow. The first path is that the use of PPE requires additional time to put on and to take off. The second path is that because everyone has to stay in their rooms at all times, more people require help at all times. And the third is that the lack of visitors means that only nursing staff can address even the most simple requests.

Following each of these paths may lead to the same cause or to different causes. When multiple causes are determined, you might have to prioritize which to correct first. Keep in mind that multiple system changes happening at one time can make it very difficult to determine the individual impacts any of them have. Therefore, it's harder to decide what works and should be implemented versus what is change for change's sake and isn't really going to have an impact. When changes don't have an impact, they're seldom sustainable. Each time we create a system change and boldly state, "This is how we're going to do things now," and then we allow them to slowly slip back to the old way, we make it more difficult to sustain any change moving forward.

Patty Austin:

For our purposes today, we're going to follow the path related to PPE use. When we ask why PPE makes it more difficult to round on our residents, the response we get is that it takes time to retrieve that PPE because we keep it in a centralized location, and then even more time is required to dispose of it in the soiled utility room. Once again, we might be tempted to stop here and feel that we've come to the root of the problem. If we make PPE more accessible, then we'll have corrected the problem. And again, that might be true, and it is indeed actionable. Without asking for further information, we can't be sure we're not missing a piece of the puzzle.

When we ask our final why question, why are supplies kept in central supply and disposed of in soiled utility, the response is that no one considered how supply availability and disposal would affect work flow, or more accurately put, no one asked us what we thought. So our root cause in this pathway is that new process planning didn't consider the end user of the process leading to PPE being inappropriately placed and requiring more time away from residents. Our next steps will consider both the process of implementing new procedures as well as the placement of PPE.

So what's next? It's time to determine what interventions we think we can trial to correct our root cause analysis finding. Let's look at the two pieces of this individually. One will impact our fall rates and should have direct impact on our goal of reducing falls on the isolation unit. The other isn't going to impact our goal, but it's just as important in moving our quality improvement efforts forward.

First let's talk about the idea that when a new process was created for the isolation unit, consideration wasn't given to the end user when designing the workflow. If we did an RCA on that concept, we might determine that we lacked a formalized method of assessing change on workflow. We decided that using process mapping would help us to identify that moving forward. When we have our ideal process mapped out formally and then create changes within that process, observing the process in action can help identify areas that are leading to unintended changes like longer, more complicated workflow. Comparing the real to the ideal and maintaining current process maps ensures that the end user is considered in all processes. Part of our first PDSA might be to create a process change tool that defines the concept of including process mapping and employee input into those process changes.

Patty Austin:

Now let's consider the issue that directly relates to our problem of decreasing falls: the placement and disposal of our PPE. We need to do a root cause analysis that is focused on that very specific issue. Our root cause quickly identifies that PPE should be kept and disposed of in the resident rooms. But we remember the original lesson learned and realize that we need to look at the process maps related to how stocking and removal of isolation waste is currently happening, and how changing the location will impact those involved with that side of the process. If we don't consider this, we risk creating a solution that works to reduce falls while causing a problem unrelated to falls. If our solution for one thing causes a problem for another, it will be much less likely to be sustained.

Working in conjunction with housekeeping, we decided that our first PDSA cycle will be the trial, stocking PPE in rooms twice a day, and waste removal every shift. As we study the results of our PDSA, don't forget to solicit feedback, not only from the staff using the PPE, but the housekeeping staff involved in the change of stocking and the removal of waste process. This will help to identify issues and increase the odds of creating a sustainable intervention. We'll monitor the time spent in rooms, along with fall rates. This will allow us to compare data after the change with information we collected prior to the change.

Because falls aren't predictable in nature and PDSA cycles are intended to be run for short periods of time, one of the most important things for us to recognize is that while we may feel our intervention is successful and plan to adopt it, it's going to require continued monitoring to ensure it's actually effective. That's just the nature of something as unpredictable as falls. We're not able to determine the schedule for falls, so if we run the PDSA for two weeks, and during those two weeks we see that staff is indeed able to round more frequently, housekeeping's not negatively impacted, and we move to adopt the intervention, it may be on the 15th day that we have three falls on second shift on the isolation unit.

This doesn't mean that the intervention wasn't successful and should be abandoned. While it may not have been successful in reducing fall rates, it was successful in correcting what was felt to be the root cause of the problem: staff availability to round, and therefore it is useful. This is when we return to the other identified causes and move them through the same cycle. This is the same process that we would use to tackle an increase in falls related to residents with dementia. In the interest of time, we're not going to go into that in detail today, but in upcoming coaching calls, we'll highlight that aspect of fall management as a team.

Patty Austin:

So let's take a minute and look at some of the other ways that fall management may have been impacted by changes within our facility related to the ongoing pandemic. Probably the most significant thing is that any change in routine is difficult, and we know this leads to falls even in the best circumstances. Consider that falls are more prevalent statistically after a hospital transfer, after admission, or even after a room change. Sometimes something as seemingly innocuous as a roommate change can lead to an unexpected fall.

For over a year we've been living in a state of constant change. It can be difficult to make sure that the processes we choose keep up with those that we can't control. For example, the added time that's required for staff to put on PPE is more than just inconvenient for staff. For a resident who experiences urinary urgency, the few more minutes staff require to respond to toileting needs may lead to unassisted attempts to self-toilet. We might need to look at adjusting toileting schedules for some residents. The time to use PPE correctly can also lead staff to being less likely to go into resident rooms to check on residents. That means that each trip into the room really needs to count. Anticipating needs rather than responding to needs is more important than ever. Our residents may not recognize the person behind the mask as we provide care. That could lead to them being less willing to request help.

Decreasing mobility is inherent to having less interaction with others, and that can lead to a decrease in the ability to complete tasks that were once part of the residents' daily routine. It can also lead to increased pain. We know that pain can lead to restlessness and falls. Also worthy of consideration is the fact that social isolation can lead to increased depression and confusion, both contributors to the risk of falling. When we consider the current climate for those residents residing on our isolation units, it's very clear that they're at greater risk for falls.

Falls have been, and most likely always will be, a primary concern for those in our setting. Please join us next week for the first in our series of coaching calls related to this subject. Feedback provided during the QAPI coaching calls is indicated that many of you are experiencing varying levels of burnout, leading to feelings of frustration as you try to accomplish things like create new interventions for things like falls.

During our first call, we'll focus on using root cause analysis to create individualized interventions, and creating a grab and go list of potential interventions to select in certain situations. Be on the lookout for the coaching call invite, the link to this recording, and some one page handouts that will help you highlight the importance of fall safety within your facility. Please come to the coaching call prepared to share some successful fall interventions you might have, and to discuss some of the barriers you're facing on your own team. That is all the new information I have for you today. I'm going to turn it over to Penny to see if we have any questions in the chat.

Penny Imes:

I don't see any questions. If anyone does have any questions, the chat bubble is in your lower right hand side of your screen, so you can type something in there, or into Question and Answer if you have any questions. And if no questions over the next minute, Patty, thank you very much. I think that was very informative, a good start. As Patty said, we are definitely... Next Thursday at 2:00 PM, we're going to have a coaching call. We will be sending out the link. It's through GoToMeeting. We'll be sending out the link to join that. We'll also be sending out some resources to all of you. The coaching calls are an hour long because that allows us a little bit more time to go into the tools. This today was an overview just to get you and your team started thinking about where you want to move ahead with falls, if that's an area of concern.

So next week on the coaching call, we'll dive a little bit more deeper into some of the tools and resources we have available. And we've been able to open the lines up and have conversation to hear from those who are part of those calls. And honestly, please come to the call. Send some team member, brings some team members with you. The feedback and the interaction that we have with you is priceless. Hearing from each other has been very helpful to those who have attended the coaching calls, and it just gives us an idea of where you need to go next. So I still don't see any questions or chat. Mitzi, did you receive any?

Mitzi Vince:

I have not received any.

Penny Imes:

Okay. Well, I do know in the polling question, it did show that most of you felt fairly confident in understanding QAPI related to falls, but I think the next step would be join the coaching call. We'll introduce some resources that might be helpful for you. We can talk about those areas that might be... Maybe it's your team using root cause analysis, or how to monitor and sustain. We can discuss whatever your needs are on the coaching call. So thank you all very much for attending, and hopefully we'll talk to you next week.

Mitzi Vince:

Thanks, everyone.