Reduction of Falls with Injuries

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Agenda

1. Background
2. Root Cause Analysis
3. Post Fall Huddles
4. Staff

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Background

How did we get here?

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Background

Improving Falls with Major Injury: Our Focus

The Older Adults/MMP Improvement Team is a cross-functional group of QI specialists and subject matter experts who use data-driven strategies to design and scale interventions that improve quality and member experience. One of our key focus areas is reducing Falls with Injury for our members in nursing facilities.

Why It Matters

- Falls among adults aged 65 and older are common, costly, and preventable (CDC.gov).
- Falls are the leading cause of fatal and nonfatal injuries among older adults (CDC.gov).
- Preventing these incidents is essential to improving resident safety and care quality.

Key Actions Taken

- Reviewed quarterly incentive performance reports from facilities participating in incentive program.
- Collaborated with colleagues to identify high-performing sites.
- Met with two nursing facilities to learn about their successful fall prevention strategies.

Common Themes

- Root Cause Analysis (Proactive/Reactive)
- Post-Fall Huddles
- Staff Training & Engagement

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Root Cause Analysis

Why is this happening?

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Root Cause Analysis

QI Tools for Falls Prevention and Analysis

5 Whys is a simple problem-solving technique used to find the real reason a problem happened (or might happen) by asking "Why?" several times until you reach the root cause.

- **Example Problem:** A resident fell in the hallway.
  - Why? Resident was walking unsupervised.
  - Why? No staff were nearby.
  - Why? Staff were attending a meeting.
  - Why? There was no coverage plan during meetings.
  - Why? Staffing schedules don't account for supervision needs during shift changes.

  Root Cause: Inadequate supervision planning during staff transitions.

Five Whys Jefferson Memorial Example:

https://www.youtube.com/watch?v=BEQvq99PZwo

Root Cause Analysis

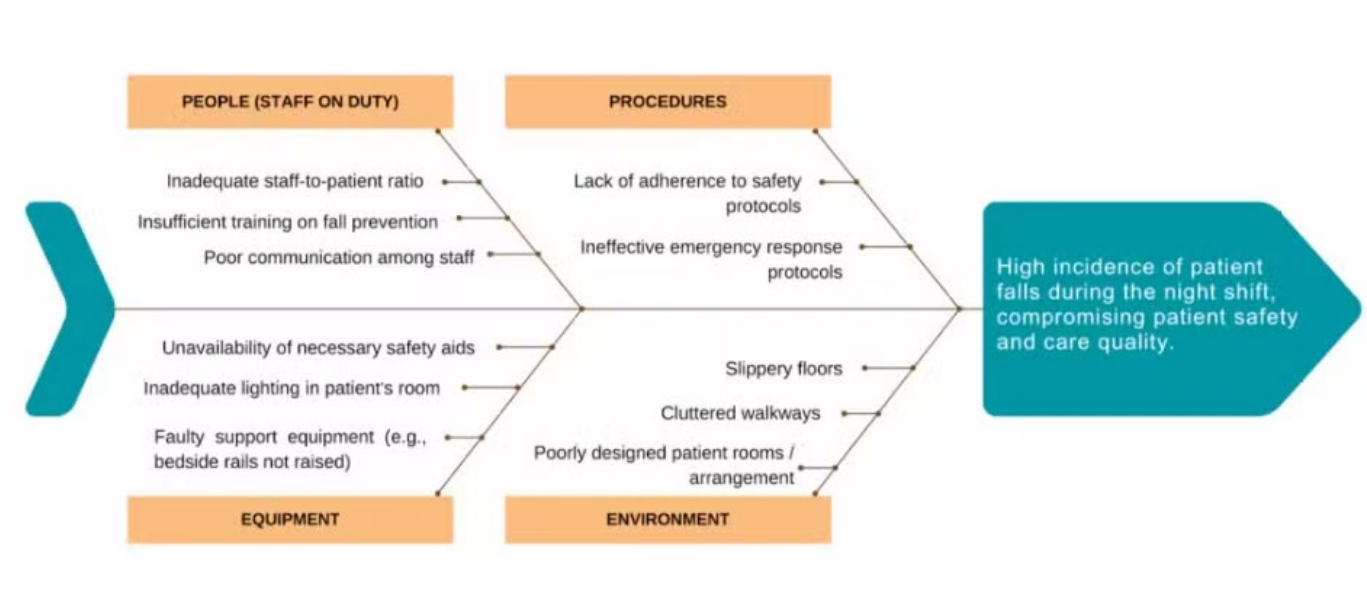
QI Tools for Falls Prevention and Analysis

Fishbone Diagram is a visual tool used to identify and organize possible causes of a problem.

Benefits of Proactive Use in Nursing Facilities

- Prevents Problems Before They Occur
  - Helps staff identify potential causes of issues (e.g., medication errors, falls, or low satisfaction) before they happen
- Improves Quality of Care
  - Encourages teams to think through all factors (e.g., staffing, environment, communication, equipment) that could impact resident outcomes.
- Supports Team Collaboration
  - Brings together different roles (nursing, dietary, housekeeping, administration) to share insights and build shared solutions.
- Strengthens Risk Management
  - Helps facilities prepare for audits, inspections, and compliance by proactively addressing weak points.
- Enhances Resident Experience
  - By anticipating and resolving issues early, residents benefit from smoother, safer, and more personalized care.

Fishbone Diagram Example



Using a Fishbone Diagram to Find Root Causes Before a Fall Occurs

1. **Define the Problem:** 50% of patients on the unit have not had a standard fall risk assessment done on admission.
2. **Identify Categories:** List major categories of causes, such as staffing, policy/procedure, environment, equipment.
3. **Brainstorm Causes:** Why does this happen?
4. **Continue Asking "Why":** Generate deeper levels of causes and organize them under related causes or categories.
5. **Address Root Causes:** Once root causes are identified, address each root cause and contributing factor as appropriate.

https://easyrca.com/blog/fishbone-diagram-applications-with-diagram/

A Gemba Walk is when leaders or team members visit the actual place where care is delivered to observe, listen, and learn from frontline staff.

Example: Gemba Walk in a Nursing Facility

Scenario:

A nursing director conducts a Gemba Walk through the long-term care wing of the facility.

Purpose:

To observe daily routines, understand staff challenges, and identify opportunities to improve resident care and workflow.

What Happens:

- The director walks through during morning rounds.
- Observes how medications are administered and how residents are assisted with hygiene.
- Talks with nurses and aides about time pressures and equipment availability.
- Notices delays in documentation due to slow computers.

Outcome:

- Staff suggest a new shift handoff process to improve communication.
- Leadership gains a clearer picture of frontline needs and builds trust with staff.

Key Principles of Gemba

Go to the Source ("Go See")

- Visit the actual place where work happens to see the work firsthand.
- Observe but don’t intervene.

Engage with People

- Talk to the staff doing the work.
- Listen to their insights and challenges.
- Show respect and value the knowledge and experience of frontline workers.

Ask Why

- Be curious.
- Ask questions to understand root causes, not just symptoms.

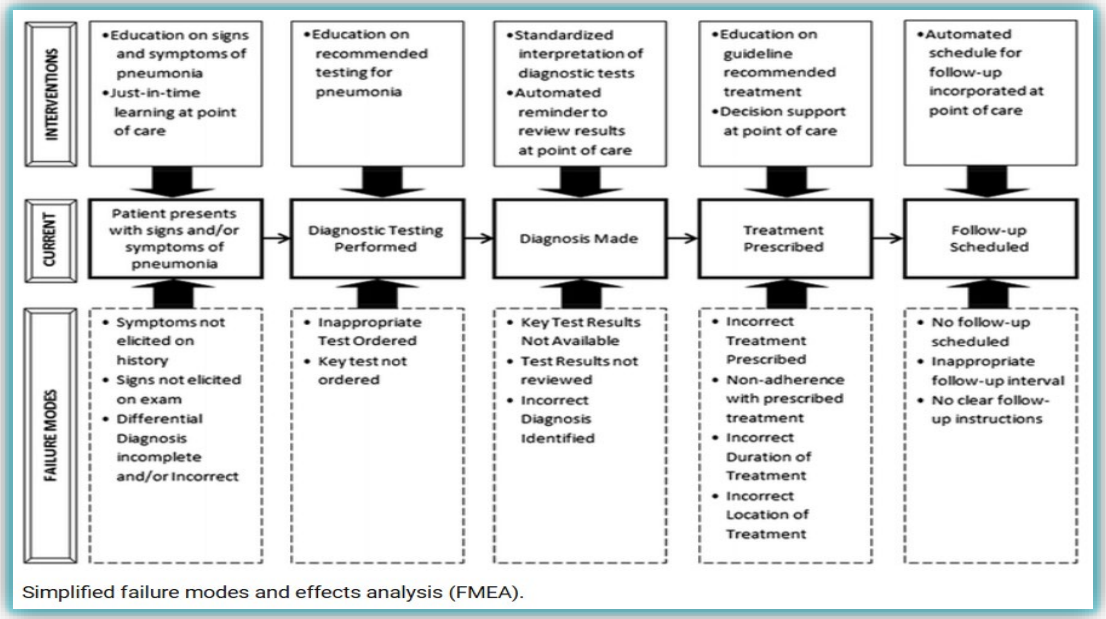
Focus on Process, Not People

- Look at how the work is done, not who is doing it. The goal is improvement, not evaluation.
- Watch and learn without making suggestions or changes.
- Take notes and follow up.
- Share findings and involve the team in solutions.

Simplified FMEA (sFMEA): A systematic and proactive approach to identifying the causes and risks of process failures, aimed at developing effective and targeted interventions.

sFMEA Implementation

1. Define the process: Choose a process with potential safety risks.
2. Assemble a Team: Include stakeholders from all relevant areas.
3. Map the Process: Team works together to create a high-level process map.
4. Identify Potential Failure Modes: What could go wrong at each step?
5. Develop Mitigation Actions: Generate potential interventions to mitigate failure modes.

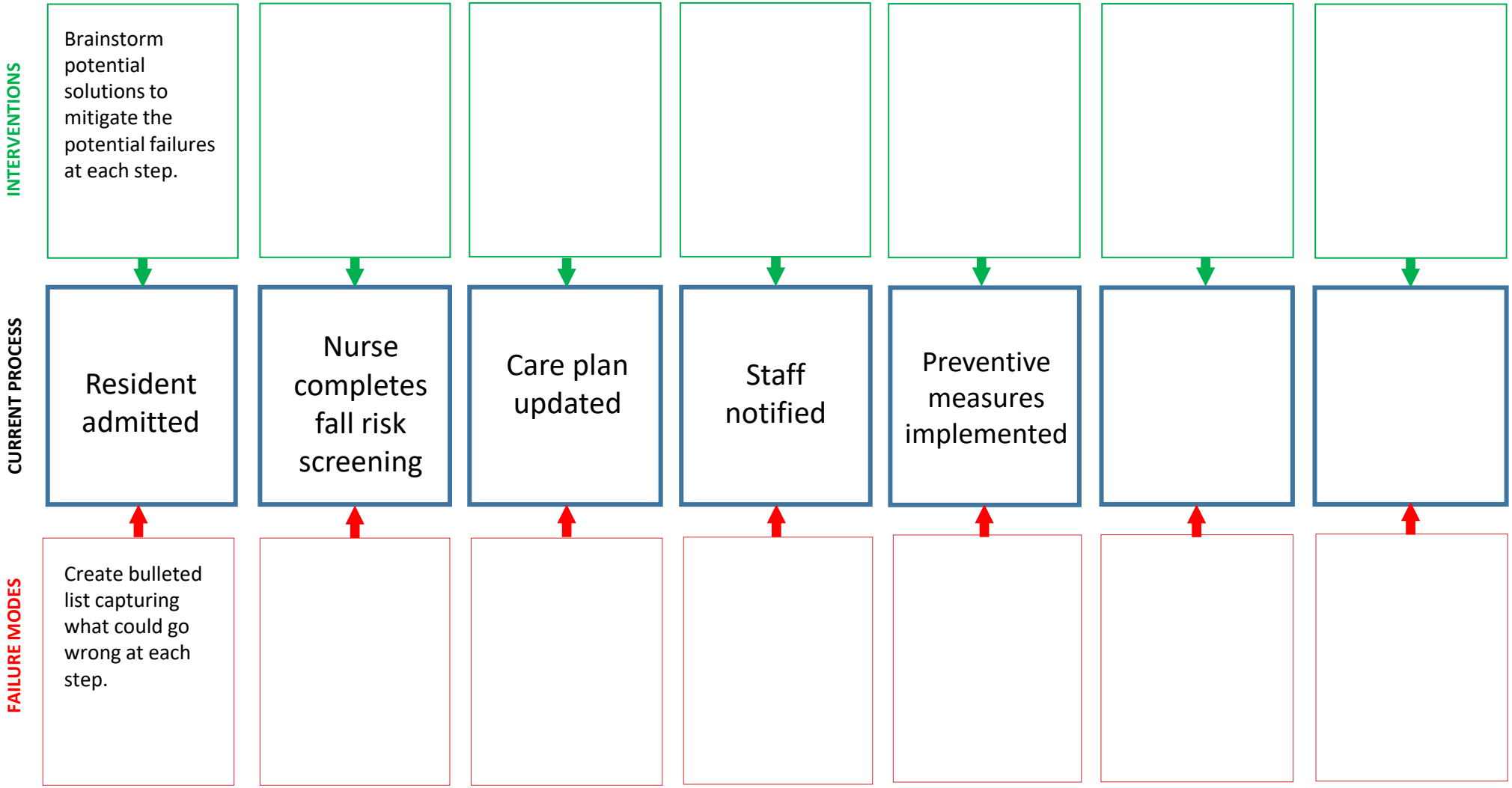


Simplified failure modes and effects analysis (FMEA).

Kurowski E, Schondelmeyer A, Brown C, Dandoy C, Hanke S, Tubbs-Cooley H. A practical guide to conducting quality improvement in the health care setting. *Curr Treat Options Pediatr.* 2015;1(4):309-322. doi:10.1007/s40746-015-0027-3

sFMEA (Simplified Failure Mode and Effects Analysis)

- Proactively identifies potential failure points in a process and mitigating interventions



Example: Mapping the fall risk assessment process from admission to daily care

Post Fall Huddles

Why did this happen and how we can prevent it?

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Post Fall Huddles
Best Practice

The Post Fall Huddle is a meeting with all staff that were working during the time of the fall and is a time to complete the root cause analysis.

The Root cause analysis should be individualized.

Ask questions such as: What lead to the fall? What was the environment like? Is there information from the resident's past that might be useful to keep in mind? (Example: Are they are retired postal worker? Retired from a "helping profession"?)

After the fall

- In person with all staff that was working
- Immediately following or the next day
- Complete root cause analysis
- Identify interventions and communicate to every shift and caregiver

Other ideas

- Rescue meetings weekly about residents that have had at least 2 falls within last month
- PT/OT/ST screen for a decline or a need for equipment
- Evaluate FIM score and cognitive status
- Update MDS: are all diagnoses documented such as Osteoporosis?

Staff

An organization's best resource

Staff

Training

How is staff trained at your organization both upon hire and ongoing?

Onboarding/Orientation

- Anticipation of resident's needs
- Importance of a fall prevention environment (call light in reach, no tripping hazards, water glass full and within reach, mobility devices within reach)
- Shadowing
- What is a root cause analysis?

Ongoing Training

- Behavioral management training
- Scenario based training
- Monthly unit meetings
- Competency trainings/skills checkoffs

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Staff

Engagement

Care giving is hard work. It is vital to have a good team of care givers to reduce falls with injuries. An engaged work force will stay longer and work harder.

Best Practices

- Peer interviews
- Recognition programs
- Foster a culture that values all voices
- Teamwork culture
- Live the values of the organization

Thank you

for your time and engagement!

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