Using QAPI and PIPs for Accident and Fall Prevention

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Upon completion of this program, attendees will be able to:
1. Understand the falls risk assessment, principles of QAPI, and person-centered care
2. Review case study demonstrating practical application of investigation techniques and current evidence-based interventions
3. Provide tools to develop an effective Falls Prevention Process Improvement Program

This process is a fluid process
- Change
  - New Regulations
  - Updates in Standards of Practice
  - Culture of our buildings
  - Learning is ongoing to meet the individualized quality and safe care for the residents!
  - Continuous process of determining the best possible means of providing quality
QAPI Tools

CMS has provided various tools on the website:
http://cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapitools.html

- Self-Assessment
- Various Guides
- Goal setting
- Resources

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
Because quality assurance is already in place in your nursing home, the added emphasis is on Performance Improvement. They compliment each other and are both key in successful outcomes.

**OLD QA & NEW QAPI**

**AIM, POINT OF VIEW**—
- Old QA: Retrospective — looking backward, PROBLEM TO SOLUTION
- New QAPI: Proactive, Preventative — looking forward

**SCOPE**—
- Old QA: Silo approach, department oriented
- New QAPI: Facility wide, cooperation, support

**METHOD**—
- Old QA: Audits to inspect if standards are met
- New QAPI: Systematic data-driven to identify PI

**FOCUS**—
- Old QA: Mistakes, Finding outliers; solving problems
- New QAPI: Improving processes & systems, Considering balance between quality of life & quality of care outcomes

**EMPLOYEE/LEADERSHIP**—
- Old QA: Quality assurance coordinators & assigned QA team; Very little direct involvement of senior leaders
- New QAPI: Expectation of all staff (Front Line Staff) involved in PI, some as PI leaders, Residents as Performance leaders
• QAPI (Quality Assurance & Performance Improvement)
  – Systematic,
  – Comprehensive,
  – Data-driven,
  – Proactive approach

QAPI Characteristics

A fluid CHANGE process supporting
– New Regulations & updates in Standards of Practice
– Culture of the facility
– Ongoing learning to meet individualized quality & safe care for residents
– Continuously determining the best possible means of providing quality

QAPI is resident-centered yet built on systems thinking.
QAPI involves everyone who works in your facility.
Elements for QAPI in SNFs

- Systemic Analysis and Systemic Action
- Performance Improvement Projects
- Feedback data systems and Monitoring
- Design and Scope
- Governance and Leadership

5 Elements

- You can find the detailed descriptions of the 5 elements on the CMS website:
  
Performance 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.

Work with the Team

Define roles & agree on working ground rules
– Gather improvement ideas from the team
– Pick an idea to test & clearly define it
– Design a good test of the change you want to make from the idea

PIP Key Questions

What do we want to do?
• For whom

• By when

• How can we make it happen
Reviewing Your Data

Sources

• MDS - problem patterns
• Nursing Home Compare
• Recent state surveys
• Resident & family satisfaction
• Caregiver turnover & absence
• Patterns of ER & hospital use

F323: Prevention of Accidents

• 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.
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

Steps for System Overview:
- Resident Risk Identification
- Resident Assessment Risk Factors
- Resident Vulnerabilities
- Realistic Goals
- INVESTIGATION and Root Cause Analysis
- Accident Prevention
- Interventions
  - Creative
  - Individualized
**F323: PREVENTION IS KEY!!**

- Assessment Process
- Assistance/Assistive Devices
- Environment/Resident Environment
  - Rooms
  - Unit Areas
  - Common Use Areas
  - Facility Grounds
  **Alarms, Doors, Cameras, etc.**

**Assessment Process**

- Previous elopement attempts
- Cognitive Status
- Change in Cognition
- Change in Condition (infection, new meds, etc.)
- Behaviors (resistance to care, impulsive, agitation, wandering, etc.)
- Verbalizations of leaving the facility or going home, to work, etc.
- Past life experiences

**Assessment Process-continued**

On an ongoing basis and at least quarterly, the facility staff will want to reassess:
- Any increased behaviors
- Additional attempts to elope
- Decrease in risk for elopement
- Review and revision (if needed) of the care plan
Past & Current H & P's

Read it all, look for:
- History of unsafe wandering, exit seeking behaviors, elopement attempts, etc.
- Differences from current presentation
- Medications
- Safety measures
- Resident & Family Impressions
- Past care giver perspectives

Supervision

- Facility Requirements
- Individualized Resident Supervision Interventions
- Handing over responsibility (breaks, shift changes, etc.)
- Communication
  - Resident specific needs
  - Changes of Condition
  - New Residents
  - Care Plan updates
Falls Risk Assessment

Purpose of Falls Risk Assessment

- Identification of a baseline in order for individualized precautions and care planning
- To achieve each resident’s highest level of functioning
- To prevent and/or reduce injuries related to falls
- To enhance dignity and self-worth for the resident
- To rehabilitate or restore function

When to do a Fall Risk Assessment

- On Admission
- On Re-Admission
- Quarterly
- With a Change in Condition
Potential Areas to Assess

- History of Falls/Accidents
- Diagnoses
  - Cardiac, Neurological, Elimination concerns, Orthopedic, Perceptual, Cognitive, Psychological, etc.
- Physical Device Use
- Environment
- Medications
- Elopement or Wandering
- Behaviors or Cognitive Impairment
  - Safety Awareness
  - Compliance
- Root Cause Analysis

Other Considerations

- Residents with recent surgery or new admissions
- Psychotropic drug use
- Fall history
- Appropriate clothing and footwear
- Visual deficits
- Impaired mobility/functional status
- Incontinence

- Change of environment
- Cognitive status
- Mood or behavior indicators
- Underlying illness and disease processes
- Sensory status
- Orthostatic hypotension

How Can We Develop a PIP (QAPI) for an Effective Falls Management Program?
Develop a PIP

• Put together a team
• Education
• Organizational Buy In!
• Identify a “Falls Champion”
• Promote an Interdisciplinary Approach
• Identify Team Responsibilities

Review Your System

• Policies and Procedures
• All Staff Education
• Fall Culture
• Resident and Family Education
• Assessment Process
• Incident/Accident Process
• Forms and Documentation
• Follow Up

Post Fall Action

After a Fall:
• Team Huddle
• Post Fall Investigation
• Root Cause Analysis
• Document Objective Findings
• Assess/Reassess
• Evaluate effectiveness of interventions
Required QAPI Components

Early problem identification
- Examination of root causes
- Use of data & feedback from multiple sources
- Understanding how systems of care affect quality outcomes
- Systemic action
- Involvement of all staff in the quality mission

Safety First

Commit to a culture of safety
- What do you look for?
- What do you reward?
- How can you tell when it’s in place?

Resident Considerations

If injured, it can take months to recover, often in a nursing facility, & mobility can be permanently changed.
- By offering effective fall prevention programs, we can reduce falls & help older adults live safer, happier, longer lives.
An Effective Program

**Establish your commitment to Independence and Safety**

- Educate about fall risk factors & prevention strategies for older adults, families, & caregivers
- Environmental assessment & intervention including resident input
- Exercise must be offered as a way to promote independence!

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Resident/Family Alliances

**Establish your commitment to Falls & Injury Prevention**

- Pre-admission considerations
- Admission assessment
- **ALWAYS** include them in assessment findings & education if responsible, or with resident permission

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Use Your Data – MDS

**Run a report of Current Mobility Status for this quarter and last quarter – walk in room, walk in corridor**

- Compare it to report from last quarter
- Have there been changes, declines?
By location, diagnosis, behaviors, and functional status – the more detailed your information is, the more effective your root cause analysis will be.

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

Getting to the reasons for the mobility decline and other risk factors is called Root Cause Analysis

- Interview direct care-giving staff, family, & resident for their perspectives regarding why the decline happened
- Document and analyze interview results

External Factors

- Poor lighting
- Loose rugs
- Poorly fitting shoes
- Beds or toilets without handrails
- Clutter
Internal Risk Factors

- Unsteady gait
- Balance problems
- Weak muscles
- Poor vision/ hearing loss
- Medications
- Dementia (memory loss & confusion)

Safety in Mind

- Are doors easy to open & close for those with mobility issues
- How long are the hallways? Are there benches along the way to destinations
- Is there plenty of closet space & storage available to reduce clutter

Your Response to Alarms

*Remain in place, wait for direction?
*Get up to see what’s wrong?
*See what you can do to help*
* Risk assessment tools by themselves do not prevent patient falls - they predict them...

*National Patient Safety Foundation Professional Learning Series

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**Assessment - Mobility**

**Current Mobility Status**

- Seating
- Standing
- Transfers
- Toileting Needs
- Footwear

*Note resident & family response to immediate safety measures – cooperation is the key to accident prevention!*

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**Seating Challenges**

*Problems with unsafe, uncomfortable seating can lead to restlessness and falls risk*

- People slide into a position of comfort & support. However . . . everyone fatigues out of the ideal sitting posture
- Body type & disability often prevent ideal sitting posture
Anticipate Medication Risks

Do not wait until a fall happens to check for:

• Effects
• Side effects
• Interactions

Plan for Falls Prevention!

These Conditions = Risk

Look at Medical Conditions for Risk:

• Hypertension
• Angina
• Parkinson’s Disease
• Urine Output
• Constipation
• Heart Rate & Rhythm
• Pain

Psychotherapeutic Effects

• Involuntary movements
• Low blood pressure with position changes
• Heart rhythm changes
• Cause drowsiness, imbalance, incoordination, slowed reactions, dizziness, confusion.
• Poor impulse control
• Hyperglycemia
Anticoagulants

Excessive decrease in ability to form blood clots can cause bleeding, leading to anemia, weakness & dizziness.

Watch for bruising easily, unusual bleeding around gums, blood in urine, or rectal bleeding.

Effective Investigation

To get the most out of critical times around an event

Staff on the scene must be coached in skills of observation and 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.

Assemble Key Players

Assigned nurse/care assistants/Others on duty
- Supervisor
- Dining Services Staff
- Housekeeping/Maintenance
- Administrator/Clinical Managers

More eyes & ears = more thorough perspectives

Observations + Questions

Placement of the person’s body at the time of the fall
- What was the person trying to do?
- Was it unusual or typical – has it happened before?
If they don’t, or didn’t wait – WHY?
what makes them unsafe to do it independently?
weakness, stiffness, dizziness...?

Compensation VS Restriction

If they are known not to call for help, what are you doing to make it safer for them?

Strengthen, loosen up, address causes of dizziness

Use of Devices

• Watch them in action to assess correct use
• Therapies evaluation to identify modifications
• Do not let the device be a potential cause for falls
**Critical Investigation Elements**

*Make immediate modifications based on causes*

- Communicate interventions & rationales to everyone to reinforce safety as soon as possible

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**Leadership**

*Leadership supports staff participation in all stages of problem solving, providing time & materials.*

- Assure that full support is observable & positively viewed by your staff - Talk it up & follow up with actions
- Integrate the process with other efforts & find ways to make the most of times the team gets together
- Interview & ask how you can better help them participate

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**Facility-wide Participation**

*Residents, Family & Staff provide feedback regarding problem identification, intervention development, & goal setting.*

- Get signatures on postings, meeting minutes & plans indicating participation
- Include QAPI in admission process (packet), staff explain and discuss with residents and families
- Include QAPI in orientation & other in-services, give opportunities for all to participate
Coach & Mentor

On-going coaching & mentoring should accompany training to assure success.

• Lead by example, train department heads & supervisors to actively incorporate new information & changes into daily routine
• Be a cheerleader & maintain positive support (expect the same from the team)
• Be patient & consistent, ask how you can help

Small Sample Testing

Test processes & changes on a small sample to work out the barriers & unforeseen issues before full roll out.

• Take suggestions supported by data (QM’s, QI’s, etc.)
• Solicit enthusiastic staff, ask for volunteers (one unit, one hallway, etc.)
• Use PDSA cycle to test, work out the bugs (retest till a smooth process is found, keep measuring results)

Record Keeping

Monitor progress, maintain electronic records of projects.

• Showcase successes
• Stay organized, current & connected to the data
• Be able to pull out & review, revisit
Establish QAPI as THE process for monitoring quality.

- Include QAPI discussions at every meeting, add agenda items to all routine meetings
- Be sure staff are fluent in answering questions about QAPI and any PIPs in the facility
- *Remember, surveyors may be using the same process to review regulatory compliance*

Implement QAPI to develop an effective way of planning, working, & problem-solving together

- Not only about meeting the minimum standards, but about *continually aiming higher*
- Not just about compliance, *about inventing better ways of providing care & service*

**HOW CAN YOU DEMONSTRATE THIS MISSION?**

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>Hazards Observation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are chemicals accessible to residents?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are staff promptly responding to alarms?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Is the environment safe for residents?</td>
<td></td>
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</tr>
</tbody>
</table>

Record review:
- Resident is assessed for unsafe wandering and/or elopement
- Risk of falls is assessed and care plan is individualized

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

Critical to Success

Teaches staff members the mission of QAPI

We can’t do it without them!

Case Study
QAPI Action Plan (Tool Example)

Resources

QAPI News Brief Volume1, 2013:

- http://www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

References and Helpful Websites

- https://www.nhqualitycampaign.org/goalDetail.aspx?g=mob
**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.visn8.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
Willy BA; Wheelchair Seating for Elders; Online pamphlet prepared under contract for Mountain Pacific Quality Health – Wyoming 2010.

Illustrations by Chris Willy; Web publication by Mountain Pacific Quality – Wyoming’s 9th Scope of Work CMS; Wheelchair Seating for Elders by BA Willy.

Resources

• Newsletter & CEUs – Initiatives in Safe Patient Care
• www.cdc.gov/injury/STEADI
• http://www.npsf.org/wp-content/uploads/2013/03/PLS_1302_FallPrevention_LAG_MF.pdf
• http://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html

Questions
Thank You!  

Thank you!