Title: PREVENTING FALLS WITH MAJOR INJURY (Fiscal Year 17-18)

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I. **Background:** Falls with major injury can impact residents morbidity and mortality, as well as significantly decrease functional status and quality of life. In response to an increase in falls with major injury at Laguna Honda (LH) during Fiscal Year (FY) 15-16, LH implemented an A3 LEAN process on Falls With Major Injury, integrating timely Root Cause Analysis (RCA) reviews post fall with major injury in FY 16-17. The use of a RCA approach was believed to be helpful in the LH resident population in an effort to "drill down" to the root contributing factor(s) as identified by front-line staff (e.g., the GEMBA) and develop individualized interventions. Although the intervention was successful in reducing the percentage of falls with major injury, several areas were identified that could benefit from further performance improvement strategies, as well as reducing greater numbers of falls with major injury and tightening the project goal for FY17-18.

II. Current Conditions:

A. Processes & Interventions: During the first phase of the Falls With Major Injury Project (FY 16-17), LH consistently met the quarterly CASPER Report goal for Falls With Major Injury, remaining < 2.0%, through implementation and continuation of the following processes and interventions;

- Weekly falls data monitoring and resident rounds to assist in identifying fall prevention interventions, including Geriatric Clinical Nurse Specialist (GCNS) Clinical Review,
- Root Cause Analysis (RCA) reviews completed after each Fall With Major Injury by the GCNS, Quality Management staff, neighborhood Nursing Leadership, and front-line staff (GEMBA) within **5** business days of the fall event,
- Implementation of 'Bright Spots' (bi-annually) acknowledgements to neighborhoods who have not experienced a resident Fall With Major Injury over the prior 6 months,
- Sharing best practices on a quarterly basis at the Nursing Quality Improvement Committee meeting
- Reinitiating the Falls Improvement Team (FIT).

B. Outcomes Data (CASPER REPORT Falls With Major Injury):

C. Performance Data (RCA w/in 5 days)

23 out of 26 completed within 5 days of falls with major injury event = 88%

FY 16-17 Baseline: 1.5% (CMS)	Q1: FY 17-18: 1.6% (CMS)	Q2: FY 17-18: 1.9% (CMS)	Q3: FY 17-18: 2.5% (CMS)	Q4: FY 17-18: 3.1% (CMS)	Remain below the national CASPER %
FY 17-18 Target: < 1.2%	FY 17-18 Target: < 1.2%	FY 17-18 Target: < 1.2%	FY 17-18 Target: < 1.2%	FY 17-18 Target: < 1.2%	

III. Problem Statement: Although LH's publicly reported CASPER CMS Quality Measure for Falls with Major Injury remained below (better than) the national average and the California average, we believe that falls with major injury can be reduced even further through addressing the performance improvement areas identified by front-line staff and the project team through the RCA approach in FY 16-17. It is an area that can be impacted by continuous quality improvement. Evidence-based strategies for falls prevention are changing, leading to new opportunities for staff engagement, and can be integrated in the new approach to falls prevention for this project period (FY 17-18).

IV. Project Goals & Targets: Through the interventions implemented in FY 16-17, and through additional interventions identified through the RCA processes, LH will;

- Achieve a CMS CASPER Report 'Falls With Major Injury' goal percentage of **< 1.2%** for FY 17-18,
- Achieve **100% compliance** with the Standard Work Processes for Post Fall With Major Injury RCA reviews, as compliance being defined as completion within 5 business days of the fall with major injury.

V. Analysis

- Through the RCA review of falls, the following factors were identified as likely contributing factors to the residents' falls with major injury.

STAFF COMMUNICATION

- Inconsistent hand-off at change of shift
- Shift report not standardized
- Post-Fall Communication x 72 hours is not consistent and varies on locale
- Resident Care Plans lack individualization to address the actual root cause of the fall
- Inconsistent communication/attention to provide float staff with up-to-date information regarding their assigned residents

EDUCATION/TRAINING

- EZ Lift training needed
- Improper use of alarms
- Slippery grab bars (see it-say it-fix it)
- Toileting; scheduled and prompted, never alone training
- Low vision recognition and intervention
- Other: Staff fatigue, fall risk

RCA PROCESS/ACCOUNTABILITY

- Prioritization of a post-falls review and scheduling of RCA by Nursing Leadership
- Monitoring continuous quality improvement and accountability (e.g., implementation of the action plan and status updates)
- Streamlining the RCA process for Nursing Leadership
- More active participation in RCA process (would benefit from mentoring the process)

VI. Recommendations / Proposed Countermeasures

Focus: Communication
- Standardized shift report; all falls are reported out for 4 weeks post fall
- Identify and create a Visual Management Process
- Inclusion of float staff in shift report

Focus: Staff Education & Training
- Safe Equipment Use (e.g., EZ lift, grab bars)
- Alarms and Low-Bed Appropriateness
- Alarms Monitoring
- RCA Training (ND, NM, CNS)
- Fall Risk-Stratification Tool Implementation (Will be part of the collaboration with ZSFG with EPIC build and implementation)

Focus: RCA Process Accountability
- Streamlined Standard Work-Flow to complete RCA process within 5 business days by neighborhood nursing leadership
- "See one, do one, teach one" implementation strategy to train neighborhood leadership in RCA process

VII. Plan

PLAN	DO	CHECK	ACT	STATUS
COMMUNICATION: Create standard work process for falls	By 6/30/2018; • Standard work process for falls completed by KM. On-hold (needs modification due to other instructions/process set in place set).	Completed initial workflow but will revise in FY 18-19 to include role of NM and RCA being completed by the end of the shift in which the fall occurred.		
COMMUNICATION: Standardize method of providing shift report to float staff.	By 9/30/2018; • Develop standardized process for report on neighborhoods for float staff to obtain needed care information • Meet with Charge RN Council to discuss (KM met with CN Council and received feedback)	Identified the need and met with Donna re standardization. CNs interested in process for change. Continue in FY 18-19.		
COMMUNICATION: Identify/Create a pilot visual management on two neighborhoods to communicate status in falls within the neighborhood.	By Identify and create tool in June 2018. Pilot on South 3 and North 3 currently in collaboration with LLD project (Elizabeth S., Herbert, Jacky, Camille)	Complete in identifying tool and choosing 2 pilot units (S3 and N3). Continues with process; positive feedback from pilot neighborhoods.		
RCA PROCESS ACCOUNTABILITY: RCA completion within 5 business days	By 6/30/2018; On-going • Continuous tracking of data by GCNS re completion • GCNS mentor nursing leadership with RCA process	Process was completed and is being revised. Training to take place in August 2018.		

VII. Follow-Up (will include new CMS data and completion of RCA within 5 days post fall): Revise performance measure/data point to Falls with Major Injury per 1,000 patient days and add and additional performance measure/data point of Falls per 1,000 patient days. Align improvement efforts with LLD initiative sessions. Integrate reporting on real case post fall with major injury scenarios into monthly NQIC.