

Performance Improvement Project and Falls Fishbone Application



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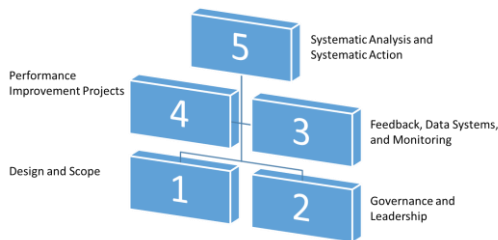
Presentation Goals

- Understand the Quality Assurance & Performance Improvement (QAPI) elements related to Performance Improvement Projects (PIP) and Root Cause Analysis (RCA).
- Identify the steps to developing a PIP charter and the importance of defining data sources, setting goals, and monitoring progress.
- Examine RCA best practices, and apply the “fishbone” diagram to falls.
- Evaluate the next steps after an RCA using Plan-Do-Study-Act (PDSA) cycles.

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Five Elements of QAPI



Quality of Care, Quality of Life, Resident Choice

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PIP Charter Steps

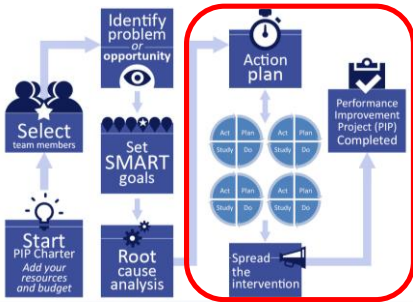


- Review and analyze data, and assess for trends.
- Use MDS 3.0 Certification And Survey Provider Enhanced Reporting (CASPER) reports.
- Set Specific, Measurable, Attainable, Relevant, Time-bound (SMART) goals.

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PIP Charter Steps

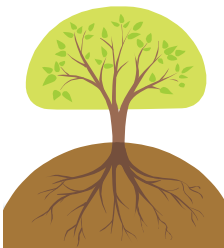


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Root Cause Analysis

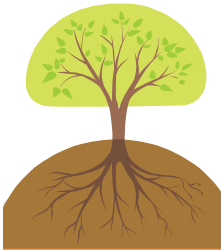
- RCA is a quality improvement method that helps teams get to the root cause of a system issue.



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Root Cause Analysis

- RCA is a quality improvement method that helps teams get to the root cause of a system issue.



Why?

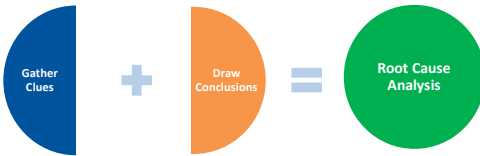
Results of a RCA help to develop systemic actions to prevent future events and to sustain positive outcomes.

How?

Tools such as the fishbone (cause-and-effect) diagram and the five whys technique can be used to conduct a RCA.



Parts of a RCA



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Root Cause Analysis: Gather Clues

- Gather clues, evidence, and data—10 questions
 - Physical environment
 - Resident condition
 - System factors

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Three Types of Causes for Falls

(What are the clues and evidence you would observe?)

Type 1: Extrinsic/External

Examples include: noise, bed height, flooring, footwear, etc.



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Three Types of Causes for Falls (cont.)



Type 2: Intrinsic/Internal

Examples include:
medications, sleep
deprivation, depression,
vision/hearing loss, etc.

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Three Types of Causes for Falls (cont.)



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10 Questions for RCA of Falls: Direct Observation Process

1. Are you okay?
2. What were you trying to do?
3. What was different this time?
4. What was the position of the resident (location, distance, position, etc.)?
5. What was the surrounding area like (noise, visibility, furniture, clutter, toilet contents, etc.)?

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10 Questions (cont.)

6. What was the floor like (wet, urine-soaked, shiny, carpet, etc.)?
7. What was the resident's footwear and apparel?
8. Was the resident using an assistive device?
9. Did the resident wear glasses or hearing aids?
10. Who was in the area when the resident fell?

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RCA: Draw Conclusions

- Investigate and determine causal relationships, fall-scene investigation report, fall huddle, and fall team meeting:
 - Why did this happen?
 - What was different this time?
 - Are there system factors that contributed?



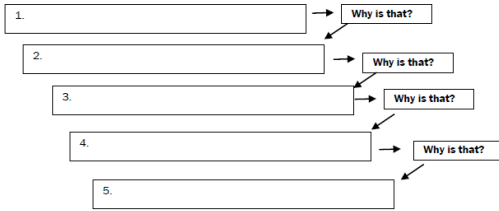
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Five Why's Technique

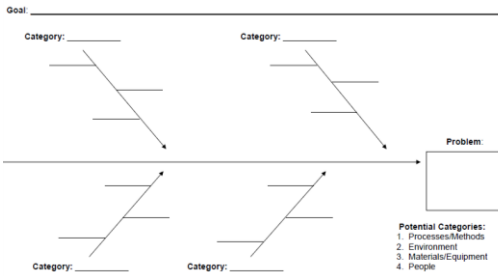
The problem: _____
Why does this occur?



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Cause-and-Effect (Fishbone) Diagram



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Prioritizing Root Causes to Address

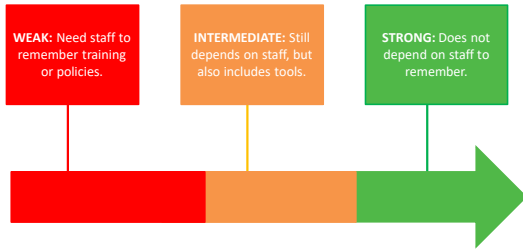
- Which root causes do you have the highest control over?
- Which root causes have the highest impact on the problem?

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Levels of Intervention



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Strong Interventions to Prevent Falls

- RCA of fall incidents
- Hourly rounding—pain, potty, positioning, and personal items within reach (4Ps)
- Fall huddle
- Provide opportunities to balance and move
- Reduce medications

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Strong Interventions to Prevent Falls (cont.)

- Reduce noise
 - Alarm/restraint elimination, staff talking, TVs
- Correct bed heights
- Reduce floor mats
- Contrast environment
- Consistent staffing—know the resident

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PDSA Model for Improvement: Plan

What are you trying to accomplish?
How will you know that a change is making an improvement?
What changes are you going to test?



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PDSA Model for Improvement: Do

What are you trying to accomplish?
How will you know that a change is making an improvement?
What changes are you going to test?



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PDSA Model for Improvement: Study

What are you trying to accomplish?
How will you know that a change is making an improvement?
What changes are you going to test?



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PDSA Model for Improvement: Act

What are you trying to accomplish?
How will you know that a change is making an improvement?
What changes are you going to test?



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PDSA Model for Improvement

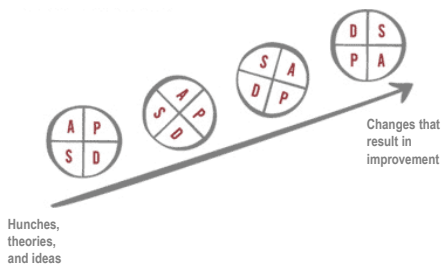
What are you trying to accomplish?
How will you know that a change is making an improvement?
What changes are you going to test?



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PDSA Model for Improvement (cont.)



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Conclusion

- Improved understanding of QAPI with a focus on PIP and RCA
- Learned the steps to develop a PIP charter
- Participated in the application of the RCA Fishbone method to falls
- Learned the steps to perform a PDSA cycle

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- Secrets of the Stars: A Blueprint for a Fall Prevention Program. Sue Guildermann, RN, BA, MA. Empira.

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