Leading Age Illinois

Momentum

2023 Annual Meeting & Expo

6B Yes, you REALLY CAN prevent Falls! Part 2

Presented By:

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Root Cause
Most Misunderstood Concept!

- Concept applies to any Industry!
- Concept can actually be applied to numerous negative resident outcomes!
- By universal definition: Root Cause is something over which staff can have an effect. It is something within the staff's control to address/solve/resolve.

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Root Cause – What it is Not:
This Slide is Important!!!!!!!!!!!!!

If you can't solve it, it's not the Root Cause.

- Therefore, Root Cause is:
  - NOT a medical diagnosis;
  - NOT the cognitive status;
  - NOT poor safety awareness…

These are risk factors or contributing factors, but are ***NOT*** Root Cause!

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ANOTHER IMPORTANT CONCEPT!!!!!!!

Assist staff to accept the concept that…

- Dementia residents' fall-risky behaviors are not aimless,
- Are in response to internal triggers, unmet needs.
- Are communicating the unmet needs…
- We need to 'break the dementia code!'

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Root Cause

- If we aren't willing to accept the concept that the dementia resident's actions are attempts at communicating unmet needs, then we won't be able to identify the probable Root Cause of their falls.
- Without determination of Root Cause, we aren't addressing the underlying reason for the risky behavior, therefore the most meaningful interventions cannot be developed… the risky behavior won't be extinguished and reoccurrence can't be prevented.

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Root Cause – What it is:

- **Root Cause IS:**
  - The answer to WHY… why did the resident attempt the risky behavior, i.e. self-transfer? Root Cause is NOT a restatement of the circumstances of the fall, i.e. it is NOT 'resident attempted self-transfer'
  - The answer to WHAT… what unmet need was the resident attempting to satisfy that drove the risky behavior?

The resident may not be able to answer these questions for you… that's why we investigate!

Gather the clues during the investigation, decide if it's relevant later!

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Root Cause is based upon…

- Assessment of data and observations collected at the event scene.
- Statements of witnesses.
- Interview of staff present and from other shifts as applicable.
- Knowledge of the resident's typical patterns/behaviors.

'Root Cause' is not a guess…

Similar to a medical diagnosis based upon symptoms, labs, xrays…

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Examples:

- John requires 1 assist with transfer and ambulation, low bed, quarter side rail, has a bed alarm; placed in bed for a nap after lunch; around 3:30pm attempted self-transfer, fell; alarm didn't sound.
- Mary is independent with transfer from w/c to/from bed. Went to bed at 7:30pm, attempted self-transfer at 10pm, fell; w/c lock was broken…

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We Know these Residents…

- Joe is cognitively impaired; keeps standing up during Activities
- Jane asks to go to the bathroom q 10 minutes
- Helen yells out daily "Help me, Help me!"
- Resident who staff believes purposely places self on the floor, 'so it's not a fall.'
  - When the nurse documents 'resident fell out of bed…' Is that what really happened?

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We Know these Scenarios

- All residents go down for a nap after lunch… but do all residents need a nap?
- Residents go to bed after dinner… and some get up 'too early' in the morning.
- Resident is toileted during the night and put back to bed… and then falls r/t attempt at self-transfer 20 minutes later.
- The resident appears cognitively intact… will not ask for help… staff believe they have 'a right to fall'

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Post Fall Care Plan Revisions

- Root Cause identification points team to the most effective intervention to extinguish the risky behavior
- Root Cause may not be a 100% certainty… proceed with the Root Cause that is most supported by the clues and care plan to that.

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Post Fall Care Plan Interventions

- You haven't 'tried everything' if the risky behavior has continued…
- Devices ie alarms, bed height, lipped mattresses, etc., are okay to *buy time* while the team evaluates Root Cause, but these don't extinguish the risky behavior.

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Post Fall Care Plan Interventions

- Actions steps need safety-based interventions!
  - Action Step:
    - Process of gathering information upon which to make a decision, i.e. lab tests, medication review, etc.
    - Process that will take time to have an effect, i.e. referral to PT

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More About Care Planning

- USE the information available prior to the first or next fall:
  - Track the near-misses: when, where, how the resident engages in risky behavior, i.e.attempts self-transfer, sets of the alarm, stands up from the wheelchair…. But they don't actually fall because staff gets to them in time, or we're just lucky!
  - Be open to questioning our own routines, at least on a resident-specific basis, i.e. naps, bedtime, alarms, etc.

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Evaluate Effectiveness

- Is the new intervention extinguishing the risky behavior?
- Does the resident accept the intervention?
- If not to the above, then the intervention needs to be modified BEFORE the next fall occurs!

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