HAP PA-HEN
Achieving More Together

Postfall Investigation, Debriefing and Root Cause Analysis
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Speakers

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Objectives

• Review the PSA Postfall Investigation (PFI) Tool and its key components
• Discuss the Data Aggregation Workbook and its purpose as a fall prevention tool
• Provide visual examples of information generated from the Data Aggregation Workbook
• Demonstrate the effectiveness of Debriefing as a means of identifying the root cause(s) of a fall
Postfall Investigation (PFI) Tool

- Design based on:
  - Evidence-based falls prevention guidelines and toolkits (e.g., AHRQ, VHA)
  - Existing PFI tools shared by PA-HEN collaboration members

<table>
<thead>
<tr>
<th>Patient Information</th>
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<tbody>
<tr>
<td>Place Patient Sticker (or complete fields)</td>
</tr>
<tr>
<td>Status: Inpatient/Outpatient</td>
</tr>
<tr>
<td>Age: Gender/Oth/Other</td>
</tr>
<tr>
<td>Chief diagnosis: Other</td>
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**Timeline and Assessments**

**Part A**
- Date of fall:
- Time of fall:
- Unit where fall occurred:
- Staffing ratio: Staffing ratio: No. of RNs/No. of CNAs.
- Count of staff physically present on unit at time of the fall:
- Time elapsed since last rounds or other purposeful interaction of staff with patient (e.g., assessment, rounding, medication) (In hrs): N/A
- Time elapsed since the patient was last assisted with toileting or provided incontinence care (In hrs): N/A
- Was a falls risk assessment completed prior to the fall? (Yes: N): Y
- If YES, how long since last falls risk assessment? < 24 hours: N
- Did the patient score at risk to fall? Y
- If YES, what level of falls risk? Low: Moderate: High: N/A

**Part B**
- Was falls risk communicated between staff or change of shift prior to fall? Y
- Was falls risk communicated during ongoing shift? Y
- Does the patient have cognitive impairment at baseline (prior to the fall)? Y
- Was education about falls risk provided to the patient? Y
- If YES, did the patient verbalize understanding of the falls prevention plan? Y
- Was the patient compliant with the fall prevention plan? Y
- Did the patient have a previous fall during this hospitalization? Y
- Did the patient have a previous fall in the last 12 months? Y
- Does the patient have risk factors for injury? (Select all that apply):
  - A. Age ≥ 65
  - B. Bone fragility—osteoporosis, previous fracture, prolonged steroid use, bone metastases
  - C. Neurologic abnormalities—dementia, Parkinson's disease, other neurologic conditions causing gait pathology
  - S. Surgery—recent limb amputation or major abdominal or thoracic surgery

**Fall Details**
- Was the fall witnessed? Y
- If the fall was assisted by staff, which staff?
- Physical therapist/occupational therapist
- Other staff:
- Type of fall (select one):
  - Accidental (due to environmental hazard or error of judgment, e.g., slip, trip) Y
  - Anticipated physiological (due to physiologic cause that is a known risk factor for falling, e.g., weakness) Y
  - Unanticipated physiological (due to a physiologic cause that cannot be predicted, e.g., seizure, falling) Y
  - Suspected non-accidental (due to attention seeking behavior, non-accidental or physiologic) Y
  - Not determined N
PFI Tool Components

• Patient information
• Timeline and assessments
• Fall details
• Medications
• Fall prevention interventions
• Environmental status
• Attachments
Data Aggregation Workbook

- Excel workbook pre-formatted with pivot charts and tables
- Aids in identifying common risk factors and potential root causes to prevent future falls
Accessing the PFI Data Collection Workbook

- 39 worksheets, including:
  - Instructions
  - Sample charts
  - Fall records data entry worksheet
  - 36 pivot charts
Navigating the Workbook

- Right click the forward arrow in the lower left-hand corner of the Excel window to see a list of all available worksheets.
Fall Records Data Entry

- Enter information about a fall across a single row
- Most questions have a drop-down menu of answer selections
- Click on the green box in the upper left-hand corner when complete
Sample Pivot Charts

- Pivot charts are generated from falls records data
- All charts can be filtered by:
  - Injury level
  - Cognitive impairment
  - Age group
Sample Pivot Charts (cont’d)
Fall Prevention
Debriefing: Getting To The Root Cause

Information Provided by:
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Quality Improvement Manager
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Pittsburgh PA
UPMC St. Margaret

UPMC St. Margaret is a 249 bed community-based hospital located in Western Pennsylvania and is part of the University of Pittsburgh Medical Center (UPMC) health care system.

UPMC St. Margaret earned the American Nurses Credentialing Center (ANCC) Magnet® status in 2009. Re-designated in 2014
Objectives

The learner will be able to:

• Describe the criteria for a successful fall prevention program.

• Define members roles on the multidisciplinary team.

• Describe the importance of performing a post fall debriefing and root cause analysis.

• Identify the key elements of debriefing and debriefing techniques.

• Explain the “Just Culture” approach to fall prevention.
Fall Statistics

• More than $19 billion annually is spent on treating the elderly for the adverse effects of falls:
  • $12 billion for hospitalization
  • $4 billion for emergency department visits
  • $3 billion for outpatient care
• Most of these expenses are paid for by the Center for Medicare and Medicaid Services through Medicare.
• It is projected that direct treatment costs from elder falls will escalate to $43.8 billion annually by 2020
  www.cdc.gov
Fall Statistics (cont’d)

- On December 14, 2011, CMS announced the award of $218 million to 26 state, regional, and national hospital system organizations to serve as Hospital Engagement Networks (HEN).
- The Department of Health and Human Services (HHS) sponsored the contract, which is a part of Partnership for Patients.
- This initiative was initiated to keep patients free from harm while in the hospital and reduce costs associated with hospital-acquired falls with injuries.
Best Practices

Evidence-based “key components” to fall prevention:
• Organizational Support And Leadership
• Multidisciplinary Fall Prevention Team
• Risk Assessment
• Multifactorial Interventions
• Communication
• Reassessment
• Data Collection & Quality Improvement
Multidisciplinary Fall Team

- Mentor/Facilitator Role (Clinical Nurse Specialist Or Nurse Manager)
- Patient Safety Manager/Quality Improvement Manager Coordinators
- Leadership Role
- Occupational and Physical Therapists
- Pharmacists
- Facility /Environmental Service Managers
- Clinical Staff
Falls Committee Tasks

• LEAD!
• Review Falls Investigations
• Quality Improvement Data – methodology, patterns and trends
• Track Falls Rate vs. Benchmarks
• Three P’s: Policies, Procedures and Protocols Compliance
• Best Practices
• Sustain Improvement
Team Huddle

A Team Huddle is when the team meets to immediately DEBRIEF after the event to determine the circumstances surrounding the event and to determine the ROOT CAUSE
Debriefing Defined

• “In the educational context, the goal is to facilitate an understanding of what has happened, to find out what the participant learned, and to test that against the instructor’s learning objective.” (Lederman 1992)

• Debriefing is a time to reflect on and discover together what happened and what it all means.
Do Debriefs Work?

• *Teams that debrief effectively outperform others by 25%*
Why Do They Work? What Is The “Science” Behind Them?

• Help teams learn from their experiences and self-correct over time
• The majority of learning takes place on-the-job rather than in formal programs

“In the moment” learning opportunities

• Uncover and correct knowledge gaps, misunderstandings, or misconceptions that left unchecked can lead to significant problems.

Enables them to form “shared mental models”
Debriefing Team

• The Debrief should be facilitated by an objective person
• Every effort should be made to ensure it is not completed by the staff member(s) directly involved
  (concern is for objectivity or biased opinions in defense of judgments, assessments, interventions etc.)

• The debriefing should be done timely to allow for review of the environment” as it is”
Who Debriefs?

High-Risk Environments

- Armed services
- Medical Teams
- Fire-Fighters
- Police
- Airlines

They must use the most effective ways available to build high-performing teams

Lower-Risk Teams

- Management teams
- Project teams (IT, quality, change teams)
- Retail teams (restaurants, banks, hotels)
- Sales teams
- Sports teams
- Student teams
- Production/manufacturing teams
- Customer service teams
- R&D teams (new product teams)
- Consultant teams
Challenges

Don’t
• Any leader can lead the debrief
• Task work discussion
• Leaders often “tell” their teams what they believe the team has done wrong (or right), and fail to involve the team adequately
• Spend too much time discussing issues they do not really need to discuss
• Discussion about what happened in the past, but not establish any agreements about what they intend to do

Do
• Have the right leader/facilitator
• Debriefs should address teamwork issues
• Debriefs should actively involve team members and ensure their participation
• Debriefs should be designed to uncover real team improvement needs as efficiently as possible
• Debriefs should lead to agreements about future actions
Key Components

Non Threatening
Structured
Timely
Determine What Happened

• The first and most important point of debriefing involves identifying and agreeing on “what happened” Do this without assigning blame or implying the cause

• We can all agree the Titanic hit an iceberg and sank
• At this point why the ship is on the bottom of the ocean is irrelevant
Seven Elements Of Debriefing

1. Debriefer Is Guide Or Facilitator
2. Participants
3. Experience
4. Impact
5. Recollection
6. Reporting
7. Time Frame

(Lederman 1992)
Reason’s Swiss cheese model

Levels of defence

Latent conditions:
- poor design
- procedures
- management decisions

Patient Safety Incident

Active Errors
Fall Analysis: Age

Patient Age

- 20-29: 0%
- 30-39: 4%
- 40-49: 6%
- 50-59: 14%
- 60-69: 20%
- 70-79: 23%
- 80-89: 27%
- 90-99: 6%
- > 100: 0%
Fall Analysis: Sex

Sex Distribution

- Male: 50%
- Female: 50%
Fall Analysis: Assistance

Assisted

83.2% no
16.8% yes
0.0% utd*
Fall Analysis: Cognitive Impairment

Cognitively Impaired

- Yes: 41.5%
- No: 58.5%
- UTD*: 0.0%
Fall Analysis: Day of the Week

Day of Week Distribution

<table>
<thead>
<tr>
<th>Day</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Mon</td>
<td>7.7%</td>
</tr>
<tr>
<td>Tues</td>
<td>14.2%</td>
</tr>
<tr>
<td>Wed</td>
<td>13.7%</td>
</tr>
<tr>
<td>Thurs</td>
<td>15.8%</td>
</tr>
<tr>
<td>Fri</td>
<td>14.2%</td>
</tr>
<tr>
<td>Sat</td>
<td>14.8%</td>
</tr>
<tr>
<td>Sun</td>
<td>19.7%</td>
</tr>
</tbody>
</table>
Fall Analysis: Day of the Week (cont’d)

Day of Week Distribution

- Mon: 20%
- Tues: 14%
- Wed: 15%
- Thurs: 16%
- Fri: 14%
- Sat: 14%
- Sun: 7%
Fall Analysis: Shift

Shift Distribution (with Rehab)

- Day: 39%
- Evening: 26%
- Night: 35%
Root Cause Analysis

- Employee depart unsupervised in BR: 12%
- Employee depart alarm not engaged: 29%
- Incorrect fall risk assessment: 8%
- Medication induced: 1%
- Equipment: 3%
- Environment: 0%
- Transferring Technique: 5%
- Medical: 4%
- Patient Non Compliance: 22%
- Activity Intolerance: 13%
- Communication: 1%
- Suspected Intentional: 1%
- Staffing: 1%
- Extended call light response time: 0%
Root Cause Analysis (cont’d)
Identify Barriers When Noncompliance Occurs
Evaluate and Standardize Equipment

Least sensitive
Alarms when patient is out of the bed

More sensitive
Alarms when patient is moving towards the perimeter of the bed

Most sensitive
Alarms when the patient is moving in the bed

IMPORTANT:
- Alarm defaults to the LEAST sensitive setting.
- You must change to zone 2 every time the alarm is re-engaged
A “Just Culture” Approach

• Design Good Systems
• Communicate Expectations
• Personal Accountability: What Am I Responsible For?
• Share-Transparent Environment
• Learn
• Prevent Future Events
Just Culture

• Defined set of values, beliefs, and norms about what is important and how to behave
• Ensuring behavioral choices and decisions are appropriate related to occurrences of human error or near misses
• Open reporting and participation in prevention and improvement is encouraged
• Recognition that errors are often system failures (not personal failures)
• Understanding the root of the problem allows for learning, process improvement, and changes to design strategies and systems to promote prevention
Accountability

✓ A “Just Culture” is a culture of Accountability

✓ Individuals will be held responsible for their actions within the context of the system in which the error occurred

✓ Accountability may involve system improvement, review of process, policy, structure

✓ Accountability of leaders: may involve individual consoling, coaching, education, counseling, or corrective action
Education

Avoid widespread one time education
Consider possibilities for cultural transformation
education

• Onboarding
• Consistency
• Event Occurrences
• Regular Updates
• Story Telling
References


Upcoming Events

• Regional Networking Meetings
  • **WEST** 3/18/16 8A-12N - Healthcare Council of Western Pennsylvania (Warrendale, PA)
  • **EAST** 4/1/16 8A-12N - ECRI Institute (Plymouth Meeting, PA)

• Educational Webinar 4/26/16
  • “Patient-Centered Fall Prevention Care Planning”

• Coaching Call 5/24/16
Important Deadlines

• Monthly outcome and process measure data
  • Due by the 15th of every month

• Quarterly Point Prevalence Audits
  • Deadline 3/31/16

• OVERDUE ITEMS:
  • Falls Self-Assessment Tool (SAT)
  • Falls SAT Action Plan
  • December 2015 and January 2016 data
Questions
Thank you!
ACHIEVING more TOGETHER

Pennsylvania Hospital Engagement Network