Minimizing Risk: Practical Strategies for Accident Prevention in Nursing Homes

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Objectives

Describe	Provide	Discuss	Review
• Describe the regulations and trends related to citations and IJs accidents in nursing homes.	• Provide resources for avoiding accidents, keeping residents safe, and determining root causes to implement solutions, if an accident occurs.	• Discuss just culture and how it can be used to implement a safe culture within your facility.	• Review examples of accidents and how to prepare an internal plan of correction to achieve past noncompliance.

The Regulation- F689

Accidents

The facility must ensure that- the resident environment remains as free of accident hazards as possible; and

Each resident receives adequate supervision and assistance devices to prevent accidents.

Accident- Defined

Refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. This does not include other types of harm, such as adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current professional standards of practice (e.g., drug side effects or reactions).

Avoidable vs Unavoidable Accidents

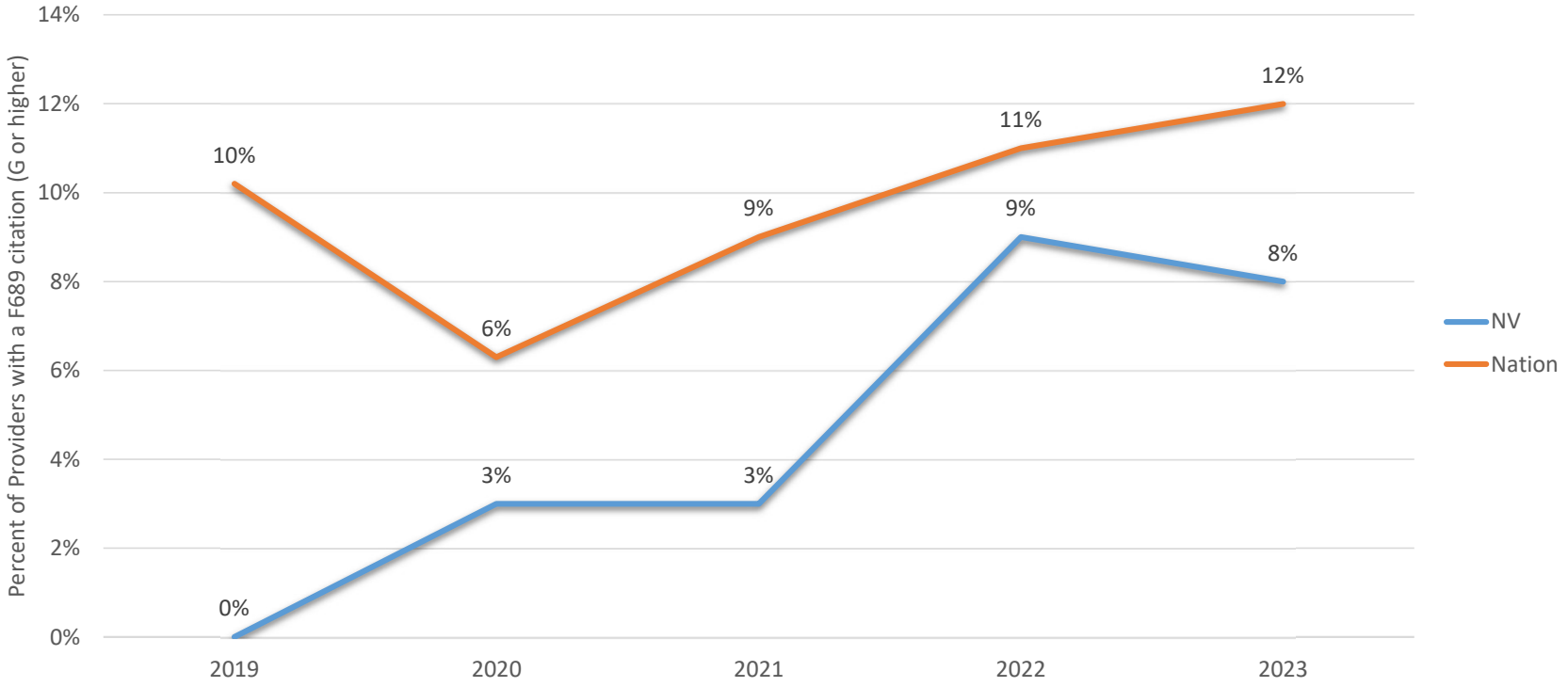
Avoidable- Means that an accident occurred because the facility failed to:

- Identify environmental hazards.
- Evaluate and analyze the hazards.
- Implement interventions.
- Monitor the effectiveness of the interventions and modify the care plan, as necessary.

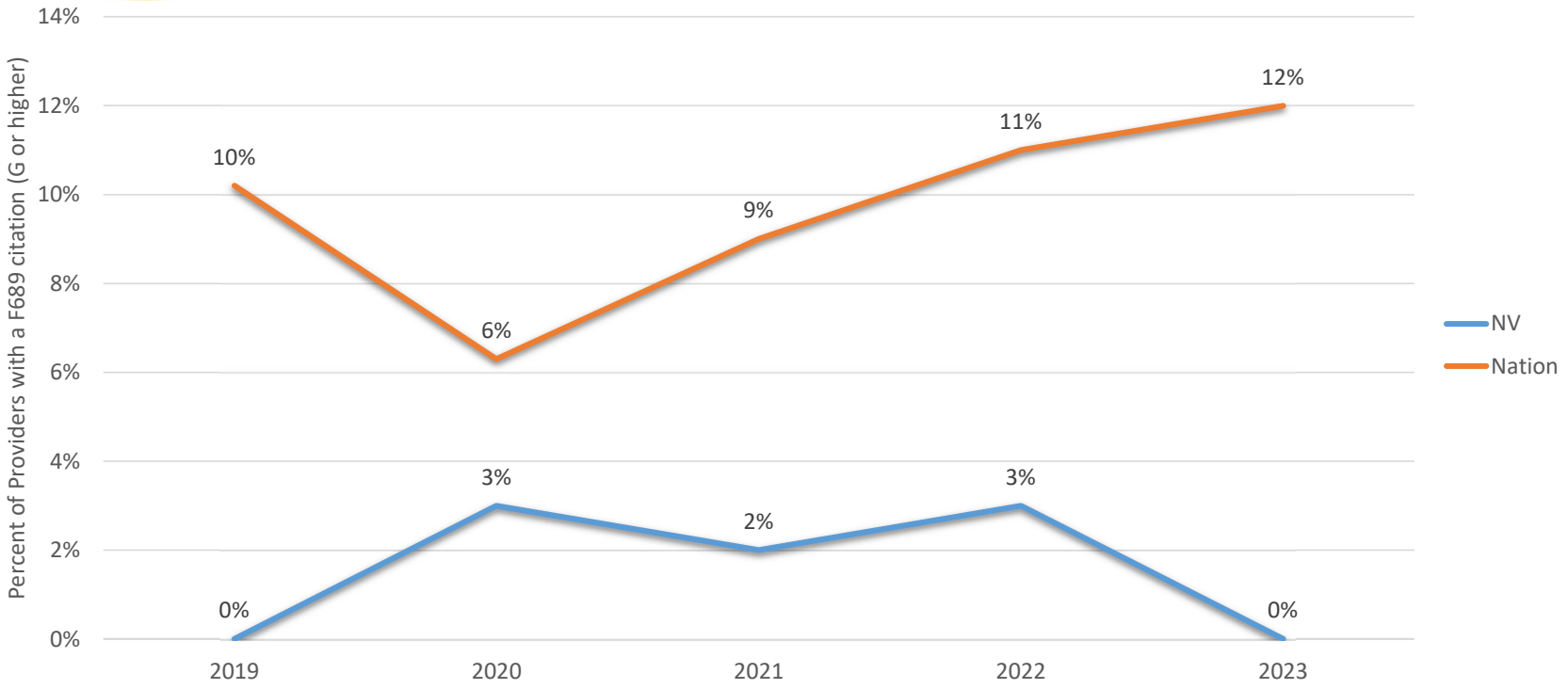
Unavoidable- Means that an accident occurred **despite sufficient and comprehensive facility systems** designed and implemented to identify hazards, evaluate and analyze those hazards, implement interventions, and monitor their effectiveness.

Trends in Accident Citations

F689- Free of Accident Hazards Harm Level Citations



F689- Free of Accident Hazards Jeopardy Level Citations



What's being cited at F689?

What occurred	# of citations given
Van incident	1
Drinking hand sanitizer	1
Lift/transfer injury	1
Multiple falls with injury	1
Fall during incontinent care	1

Types of Accidents

Resident Smoking

- Some facilities do still allow residents to smoke tobacco products on their premises.
- The following things should be considered, if facilities allow smoking.
  - Assessment
  - Supervision
  - Care Plan Interventions
  - Smoking areas
- E-cigarettes- While electronic cigarettes (e-cigs), or vapor pens, are not considered smoking devices, and their heating element does not pose the same dangers of ignition as regular cigarettes, they are not without risk.
  - Ensure staff have the same assessment for safety.
  - Do not allow residents to charge their devices at the bed side, especially with cell phone chargers.

Resident to Resident Altercations

- Certain situations or conditions may increase the potential for such altercations, including, but not limited to:
  - History of aggressive behaviors
  - Behavior that may disrupt or annoy others
- The facility has a responsibility to:
  - Identify residents
  - Put interventions in place
  - If occurs, it must be reported to State Survey Agency

§483.5. The tables below includes examples of resident to resident altercations and whether they are required to be reported.

***NOTE**: This is not an exhaustive list of all reportable types of resident to resident altercations. There may be other incidents that are also reportable.*

Examples of Mental/Verbal Conflict

Required to Report	***Not Required to Report (Unless it rises to the level of what's described in the first column)***
• *Intimidation* • *Bullying- Aggressive behavior in which someone intentionally* and repeatedly causes another resident mental anguish or discomfort** (adapted from the American Psychological Association* [2] • *Communication that is motivated by an actual or perceived characteristic, such as race, color, religion, sex, disability, or sexual orientation that results in mental anguish or social withdrawal*** • *Threats of violence* • *Inappropriate sexual comments that are used in a deliberately* threatening manner* • *Inappropriate sexual comments that offend, humiliate, or demean a resident**;* • *Taking and/or distributing demeaning or humiliating photographs or recordings of residents through social media or multimedia messaging*	• *Non-targeted outbursts* • *Residents with certain conditions (e.g., Huntington's/Tourette's) who exhibit verbalizations* • *Arguments or disagreements, which do not include any behavior or communication identified in the "Required to Report" column*

Environmental Hazards

- The physical plant, devices, and equipment described in this section may not be hazards by themselves but can become hazardous when a vulnerable resident interacts with them.
- Temporary Hazards
- Hazards for certain individuals
  - Scissors
  - Assistive devices
- Improper actions or omissions by staff

Falls

The MDS defines a fall as unintentionally coming to rest on the ground, floor, or other lower level but not because of an overwhelming external force (e.g., resident pushes another resident).

Factors that can result in falls:

- Environmental hazards, such as wet floors, poor lighting, incorrect bed height and/or width, or improperly fitted or maintained wheelchairs;
- Unsafe or absent footwear and loose or improperly worn clothing;
- Underlying chronic medical conditions, such as arthritis, heart failure, anemia and neurological disorders;
- Acute change in condition such as fever, infection, delirium;
- Medication side effects; Orthostatic hypotension; • Lower extremity weakness;
- Balance disorders;
- Poor grip strength;
- Functional impairments (difficulty rising from a chair, getting on or off toilet, etc.);
- Gait disorders;
- Cognitive impairment;
- Visual deficits;
- Pain; and
- Incontinence.

Wandering/Elopement

Wandering is defined as a **repetitive locomotion**.

It may be goal-directed, or not.

Moving about the facility aimlessly may be the result of the resident being frustrated, anxious, bored, hungry, depressed, or all the above.

Wandering may become unsafe when a resident becomes overly tired or enters an area that is physically hazardous.

Residents also wander into other residents' rooms which may become a hazard, if the resident doesn't want anyone to enter their space.

Elopement

- A situation in which a resident leaves the **premises or a safe area without the facility's knowledge and supervision**, if necessary, would be considered an elopement. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle.
- If a resident's risk assessment shows the resident is at risk for wandering, there should be interventions established to ensure the resident is appropriately always supervised.
- Furthermore, a facility's disaster and emergency preparedness plan should include a plan to locate a missing resident.

Safety for Residents with Substance Use Disorder (SUD)

- Residents with a history of substance use disorder may be at increased risk for leaving the facility without notification and/or for illegal or prescription drug overdose if the resident continues using substances while residing in the nursing home.
- Residents with a history of substance use disorder should be assessed for these risks and care plan interventions should be implemented to ensure the safety of all residents.
- The facility should advise residents of the risks of leaving the facility to seek out substances and/or early, unplanned discharge, and provide appropriate referrals and discharge instructions whenever possible.
- A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement **unless the facility is unaware of the resident's departure and/or whereabouts.**

Water Temperature

Table 1. Time and Temperature Relationship to Serious Burns

Water Temperature		Time Required for a 3rd Degree Burn to Occur
155°F	68°C	1 sec
148°F	64°C	2 sec
140°F	60°C	5 sec
133°F	56°C	15 sec
127°F	52°C	1 min
124°F	51°C	3 min
120°F	48°C	5 min
100°F	37°C	Safe Temperatures for Bathing (see Note)

NOTE: Burns can occur even at water temperatures below those identified in the table, depending on an individual's condition and the length of exposure.

Assistive Devices/Equipment Hazards

Assistive devices for mobility

- Resident Condition
- Personal fit and device condition
- Staff practices

Assistive devices for transfer

Restraints

- Side rails

Accident Prevention/Mitigation- A Systems Approach

Identification of Hazards and Risks

Risk refers to an external factor, facility characteristic or characteristic of an individual resident that influences the likelihood of an accident.

Risk management requires a systems approach that evaluates and analyzes hazards and risks.

A key element of a systemic approach is the consistent application of a process to address identified hazards and/or risks.

An effective system not only proactively identifies environmental hazards and the resident's risk for an avoidable accident, but also evaluates the resident's need for supervision.

All staff are to be involved in observing and identifying potential hazards in the environment.

Interventions

- Implementation refers to using specific interventions to try to reduce a resident's risks from hazards in the environment.
- Implementation requires:
  - Communicating the interventions to relevant staff.
  - Assigning responsibility.
  - Providing training as needed.
  - Documenting interventions.
  - Ensuring that the interventions are put into action and are working for the resident.
- Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with professional standards, including evidence-based practice.

Monitoring and Modification

- Monitoring and modification processes include:
  - Ensuring that interventions are implemented correctly and consistently;
  - Evaluating the effectiveness of interventions;
  - Modifying or replacing interventions as needed; and
  - Evaluating the effectiveness of new interventions.

Root Cause Analysis

There is danger in starting with a solution without thoroughly exploring the problem. Multiple factors may have contributed, and/or the problem may be a symptom of a larger issue. What seems like a simple issue may involve a number of departments.

What is Root Cau

Helpful hint- be sure to start with a problem and not the solution. It is tempting to assume we know what will fix the problem before we've thoroughly examined it. Assumptions are often wrong and may hinder complete analysis of the underlying causes.

- A systematic process for identifyi
  variations in performance.
- It is designed to get to the underlying ca
  - This leads to identification of **effective** interventions that can be implemented to make improvements.
- RCA focuses on systems and processes.
- RCA takes practice and can be a valuable tool for performance improvement.

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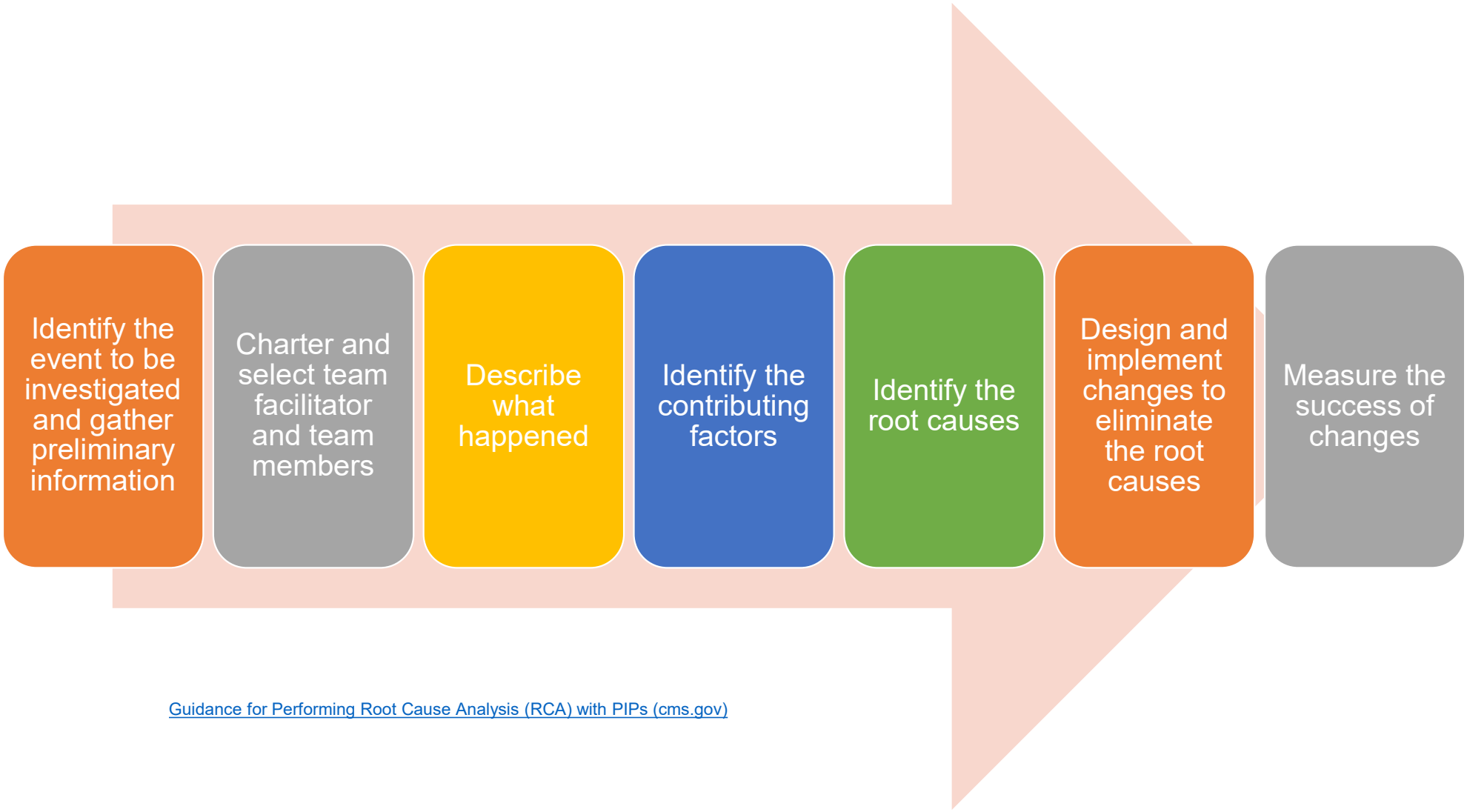

Guidance for Performing Root Cause Analysis (RCA) with PIPs (cms.gov)

RCA Informs All (High Performing Organizations)

- Data to track your performance
- Teams to pilot test new ideas and approaches
- Leadership to empower and provide resources
- Learn from others

Root Cause Analysis: **Start with Mindset**

"To address this mistake we need to utilise our thorough system of root cause analysis. I will begin, if I may, by pointing out that it's not my fault"

Root Cause Example

- Last night around 10:30pm staff noticed that they could not find resident, Tony.
- The facility staff initiated their lost resident procedure, and notified those parties appropriately, and did a grid search for the resident.
- At 12 midnight, the facility received a phone call, from the Emergency Department, Tony had been found about two miles away, and he was injured.
- Of note, he had a broken hip, lacerations to his forehead, and abrasions to his left elbow.
- On admission, about three months prior, Tony was a 7/10 on his BIMs and triggered at high risk for wandering on his risk assessment.

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Root Cause Example Continued

- One week prior to the elopement- nursing notes reveal that Tony was confused and ambulating in the hallway, entering other residents' rooms, pushing exit doors, pressing the exit door buttons, and fiddling with the fire alarms.
- A few days later- Tony needed redirection at the nurse's station/entrance as he was attempting to leave the unit 2 times.
- There were not interventions initiated after the risk assessment was completed, or after either of the instances of wandering requiring redirection.
- Tony has never been given a wander guard.

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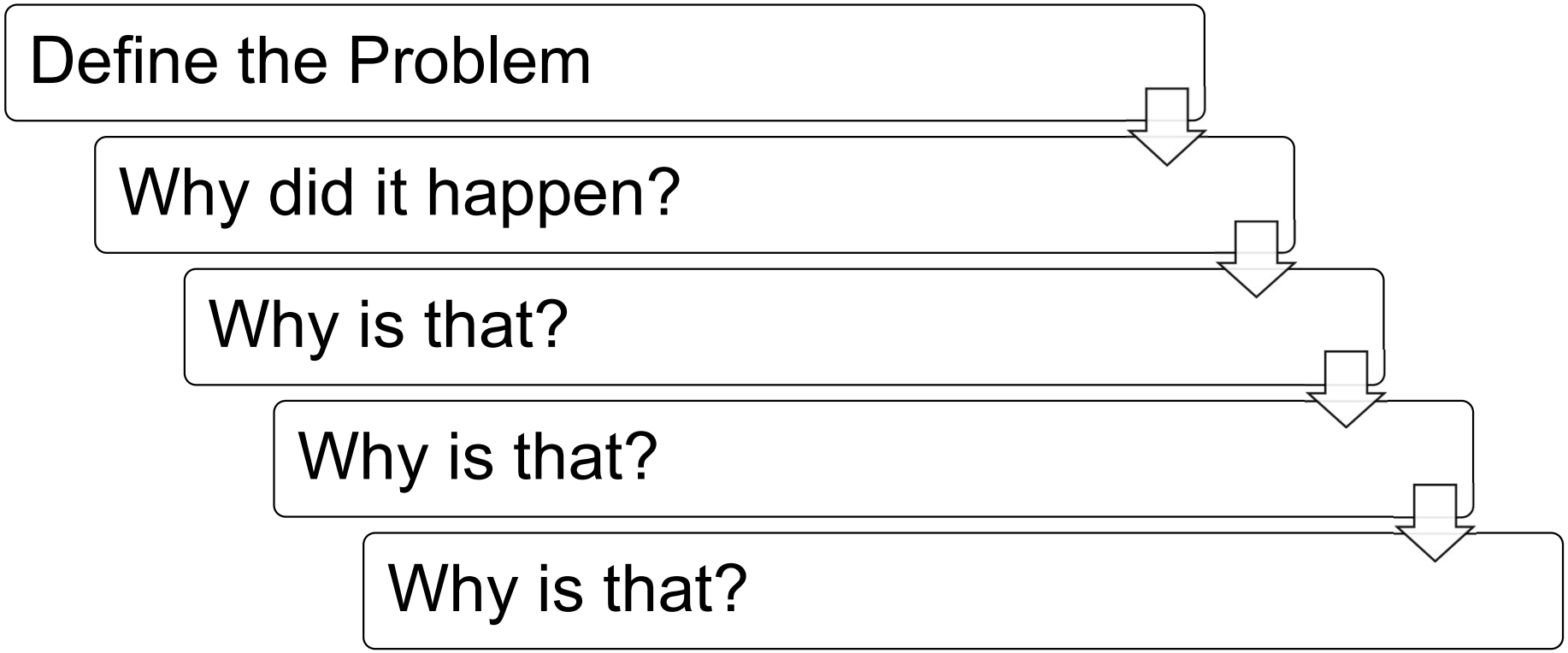
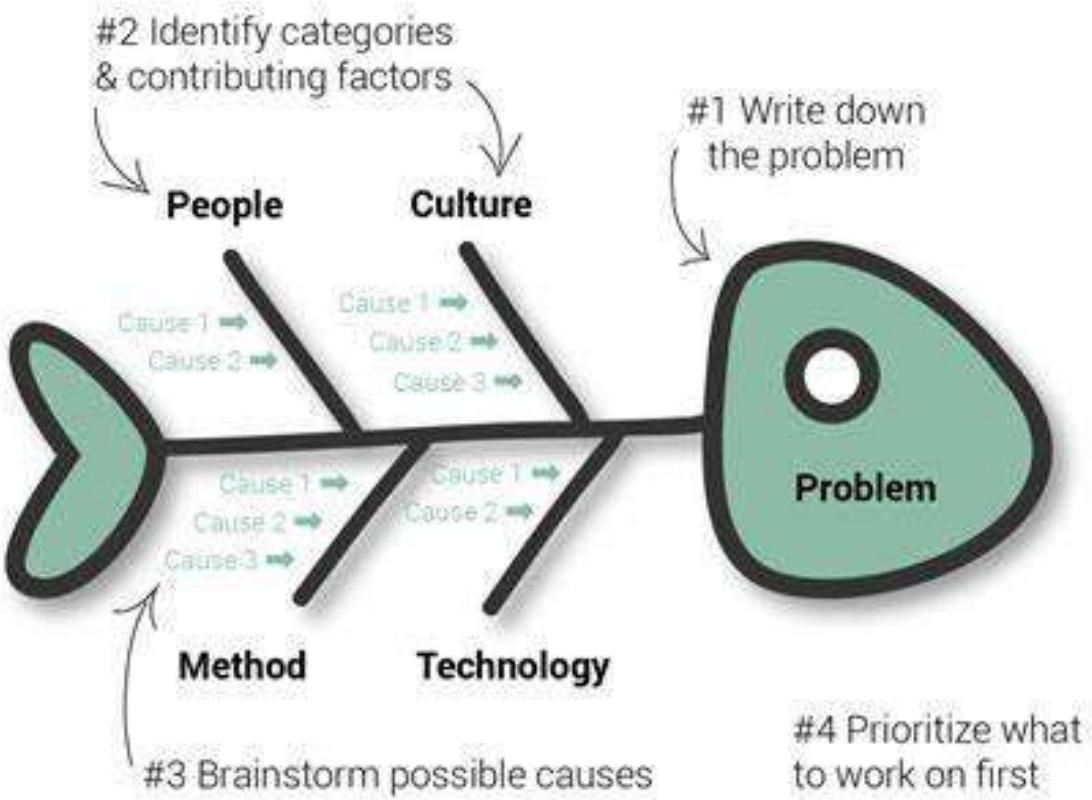
5 Whys


Define the Problem
Why did it happen?
Why is that?
Why is that?
Why is that?

Fishbone Diagram



Case Studies

Case Study #1

- Barb was admitted to the facility recently. Her admitting diagnosis was cerebral infarction and dysphagia following a cerebral infarction.
- She had an order for honey thickened liquids, and was noted to be at risk for choking, needed assistance with feeding, and pureed meals.
- Barb had a BIMs of 2 out of 15, which indicated that she was severely impaired.
- LPN, Katherine, found the resident in her wheelchair appearing asleep. Katherine noted that she was unresponsive and called a CODE BLUE.
- Katherine noted that the resident had pieces of a pimento cheese sandwich in her mouth. The sandwich was removed, and CPR was initiated.
- 911 was called and the EMTs called time of death.

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What's next?

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Resident Impacted

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Then what?

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Others impacted

The facility immediately implemented education on not leaving snack carts unattended, placing all snacks in the nourishment room, and monitoring all residents during mealtimes, snack times, and activities including food/drink items.

Similar residents were assessed and were confirmed to not be at risk for wandering and retrieving food items. No other residents were affected by the deficient practice.

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Then what?

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Systemic Change and Ongoing Monitoring

Nursing and dietary staff will continue to check placement of snacks to be safely secured and all meals and activities involving meals to be monitored by staff.

There was a QAPI meeting held. The facility continues to review residents at risk for choking accident hazards and revise the Correct Action Plan as needed.

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Case Study #2

- Minnie had diagnoses of depression, hypertension, DM, CKD stage 3, and dementia.
- Her BIMs was most recently recorded as a 3 out of 15, indicating severe cognitive impairment.
- She was noted to require extensive assistance with activities of daily living.
- Last week, an aide, Diane, entered Minnie's room and observed her entangled in quarter length side rails on the right side of her bed. Diane notified the nurse.
- The nurse entered the room and noted Minnie unresponsive and entangled inside the side rail. She immediately called EMS.
- EMS arrived, but they were unable to revive Minnie.

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Case Study #3

- Regina admitted with a diagnosis of a history of a CVA and major depressive disorder.
- On admission, her BIMs was a 4 out of 15.
- She was admitted to the geri-psych unit for a period, prior to admission.
- Last week, Regina exited the front of the facility.
- During a medication pass, on second shift, the LPN noted that Regina was not present in the facility.
- The nurse called a Code Gray (the facility's alert system) and the police were called.
- After review of the camera, the facility discovered that Regina walked out of the front door alone at 4:30pm. The receptionist assisted the resident out of the facility without verifying her identity.

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Elopement #3- Continued

- When the police located Regina (the next day), down the street sitting on the sidewalk, she was found to be hypertensive and required hospitalization.

Tips for Achieving Past Noncompliance

Tips for Achieving PNC

- ❑When an adverse event occurs, including an elopement, pull together all appropriate staff to have an Ad Hoc QA meeting.
- ❑At this meeting, discuss what occurred, what you believe to be the Root Cause (this may be initial until you can complete a thorough investigation).
- ❑Make sure to have all staff sign in at the meeting.
- ❑Start a folder, or binder, for all documentation to support what you have completed.
- ❑Complete any reports to the SSA, as appropriate.
- ❑Begin to fill in your internal Plan of Correction.

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Additional Tips for Achieving PNC

- ❑Do an initial audit- for elopement this will normally be a count of all residents in the building to ensure everyone is present in the facility.
- ❑Establish what the ongoing monitor will be, based on the RCA.
- ❑Identify who will complete the ongoing monitor.
- ❑Complete staff education with all appropriate staff and contract staff.
- ❑Update any care plans, as appropriate, and ensure interventions are appropriate and communicated to all staff.
- ❑Review interventions routinely to ensure they are still appropriate.
- ❑Maintain your folder or binder in a safe place so it is accessible when surveyors enter the facility.

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Ad Hoc QAPI Meeting Notes

Internal Plan of Correction

Facility team has identified a potential Adverse Event and has implemented the following Plan of Correction to ensure continuing high standards of Quality of Care and compliance with state and federal regulations.	
Date and Time of the Event:	February 2, 2023, at 2:00pm
Description (brief of Event):	Sometime between 1:30 and 2:00pm, a resident (Sam) exited the building. At the time, he was wearing a long sleeve shirt, long pants, and gripper socks (no shoes). The resident has a BIMs of 10 and scored at High Elopement Risk on his recent Risk Assessment. During the interview, staff reported the exit doors did not alarm and they were not aware Sam had exited the building until a staff member observed him sitting on a bench outside. Although he wore a wander guard bracelet, he had successfully exited through a push-activated emergency exit door that did not alarm. Staff immediately escorted Sam back inside with no injury noted. Of note, it was 46 degrees outside when this incident occurred.
Residents Impacted:	Resident, Sam
Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	
Sam was immediately brought back into the facility when the staff saw him sitting on a bench outside. He was checked for an injury related to his exit and being in the elements outside. Sam did not incur any noted injuries. His responsible party and MD were called and notified of the incident by the DON. An Ad Hoc QA Meeting was held that day to determine if any other interventions were necessary.	
Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	
The facility reviewed any residents at moderate or high risk for wandering and ensured interventions are in place for those residents. Each wander guard was checked to ensure it works properly, for these residents identified. All facility staff (including contract staff) were re-educated on door alarms and elopement. The facility ordered a lock box for the door	

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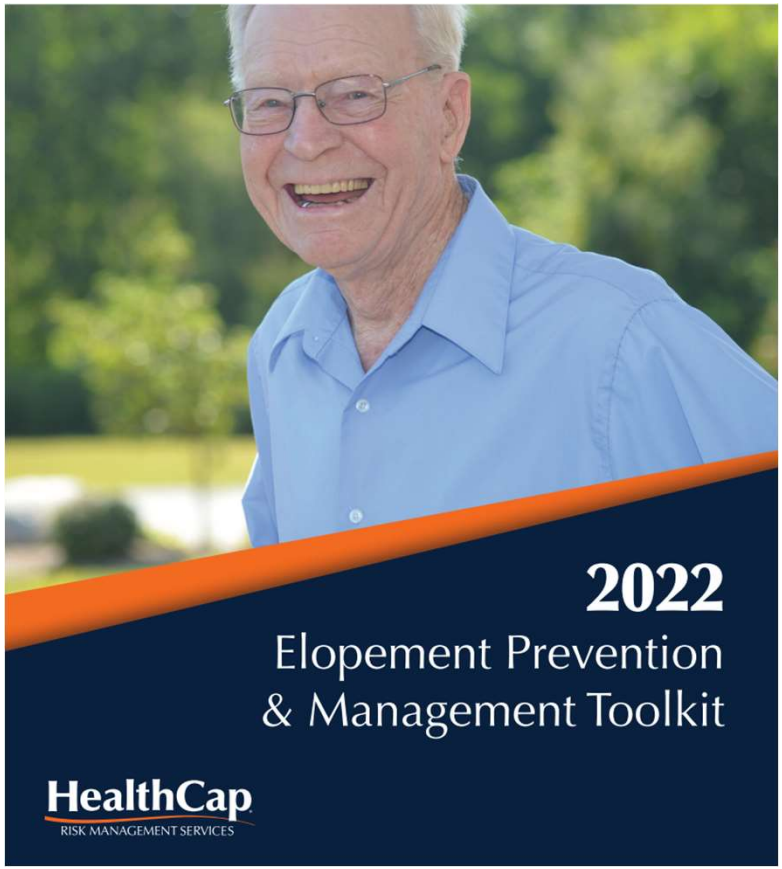
Resources for Preventing Accidents

Falls Prevention Guide

- 6 modules review fall prevention, specific to the long-term care population.
- Modules include topics on:
  - Regulatory Requirements
  - Creating a Culture of Safety
  - Falls Education
  - Maintaining Function
  - Post-falls Management
  - Falls QAPI
- Additional Resources for:
  - Restorative care
  - Best practices for transfers
  - HealthCap Falls Toolkit


2022
Elopement Prevention
& Management Toolkit
HealthCap
RISK MANAGEMENT SERVICES

Accidents- How to Stay Ahead of F689 and Keep Your Residents Safe

The Accidents Webinar will review regulations related to supervision to avoid accidents. It also pulls together various resources available on ahcancalED, as well as external resources. The Webinar provides resources for development of policies to remain compliant with accident regulations. Finally, real-life case studies will be reviewed with explanations for what facilities should do if similar events occur.

There is also a facility registration so it can be reviewed multiple times with your staff.

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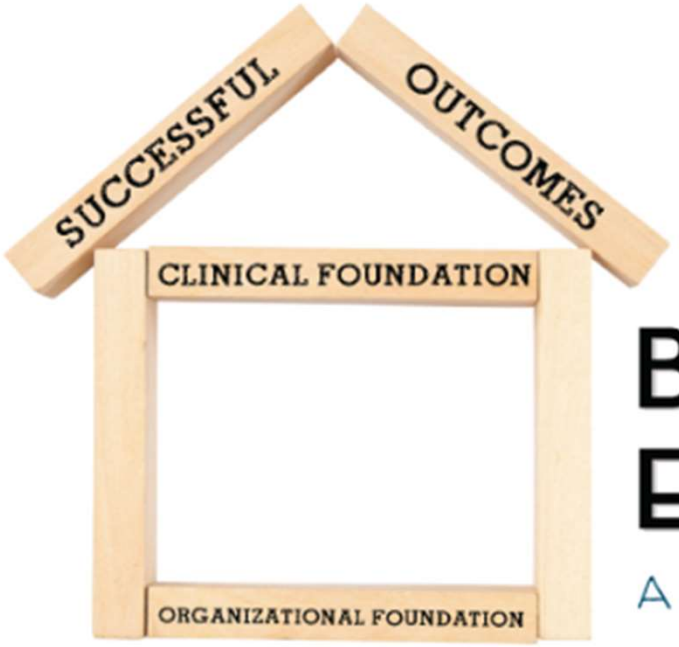

Building Prevention into Every Day Practice:

A Framework for Successful Clinical Outcomes

Additional AHCA Resources

- Action Brief: Trauma-Informed Care
- Behavioral Health and Trauma Informed Care Webinar Series
- Nursing Centers Action Plan Response for Adverse Events
- Opioid Use: What Do We Do and How?
- Pressure Injury Prevention and Wound Management in LTC
- Screening and Prevention: Tools for Reducing Older Adult Falls
- Survey Tip- F689 and Past Noncompliance

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QSEP | DRIVING HEALTHCARE QUALITY

Quality in Focus: QSEP Training on Long Term Care Accidents

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Center of Excellence for Behavioral Health In Nursing Facilities (COE-NF)

The COE-NF focuses on increasing the knowledge, competency and confidence of nursing facility staff to care for residents with behavioral health conditions.

- Provides mental health and substance use trainings, 1:1 customized technical assistance and resources at no cost
- Services are available to all CMS certified nursing facilities throughout United States
- Established by the Substance Abuse and Mental Health Services Administration (SAMHSA) in collaboration with the Centers for Medicare and Medicaid Services

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

For assistance, submit a request at nursinghomebehavioralhealth.org

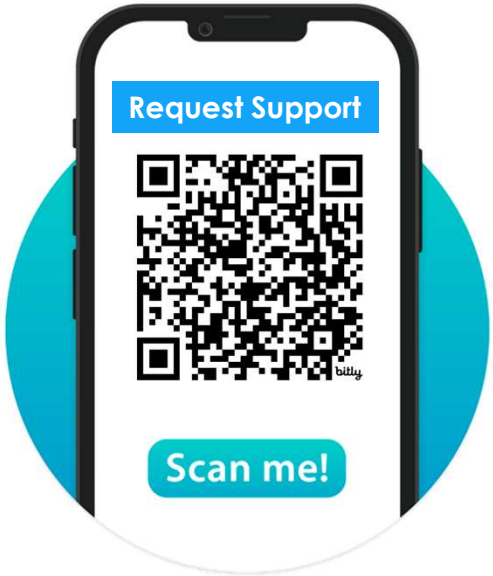
Contact us:
National Call Center: **1-844-314-1433**

Email: coeinfo@allianthealth.org

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

COE-NF Services & Support

- **Technical Assistance**
  - 1:1 support from COE-NF Behavioral Specialist
  - Program design
  - Care planning
  - Provider search
  - Implementation strategies
- **Training**
  - Live Virtual (Webinars)
  - Cohort Learning Series
  - On Demand Videos
- **Resources**
  - Online Resource Hub: Toolkits, flyers, tip sheets



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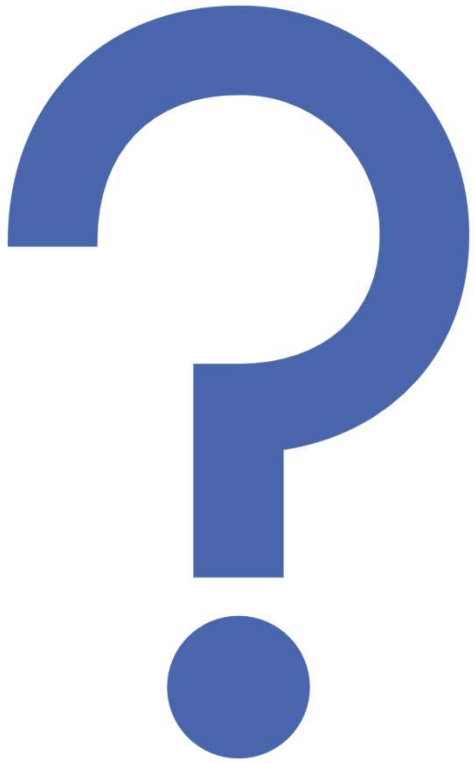
Questions?



Contact Information

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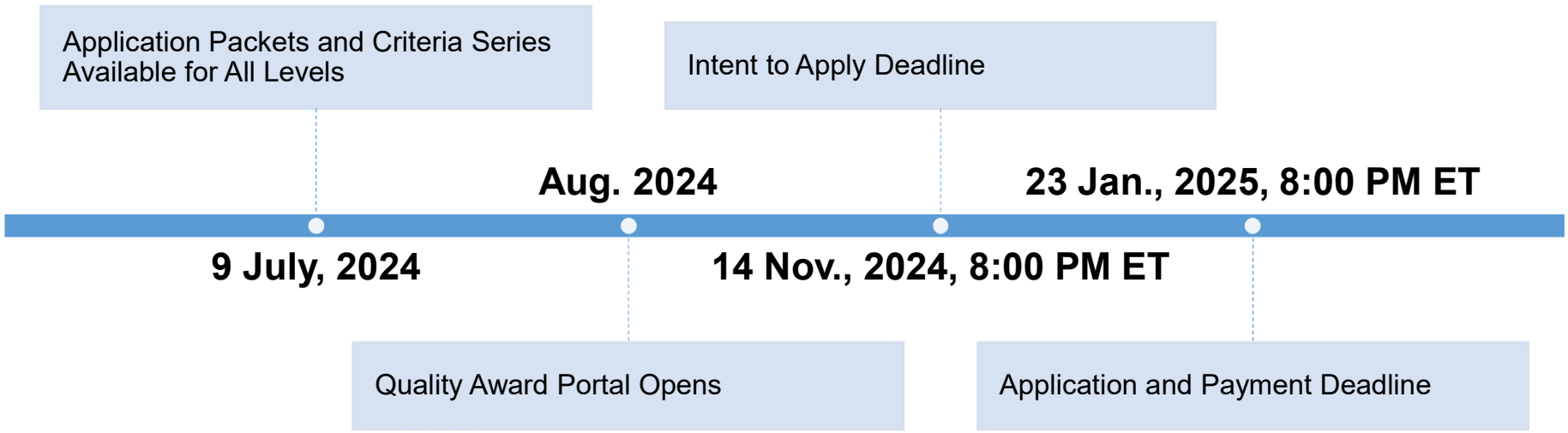
AHCA/NCAL Quality Awards Program

Looking Ahead – 2025 Program Cycle



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Multi-Facility Support Plan Resource

- Provides one-on-one, dedicated support for organizations submitting 15 or more applications during the award cycle.
- Service includes:
  - Orientation Call
  - Dedicated application portal and bulk payment assistance
  - Ongoing Quality Award team access throughout the award cycle
- **Sign up staring July 9, 2024**
- **Deadline**: October 11, 2024

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We Are Here to Help!

- Urvi Patel: upatel@ahca.org
- Kendyl Kelly: kkelly@ahca.org
- Quality Award Inbox: qualityaward@ahca.org

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DELIVERING SOLUTIONS *for*
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