CRiSP
COMPREHENSIVE RESIDENT SAFETY AND PREVENTION
A Nevada Department of Health and Human Services and HealthInsight Nevada collaborative

Falls Investigation Guide

Protocol Components
(per facility policy)

Immediately Ensure Resident is Safe; Assess and Treat for Injury
- Put any preventive steps into place

Fall Occurs

Make Required Notifications

Nurse or CBC Health Services
- 911 (if applicable)
- Physician (use SBAR)
- Admin and DNS (or leadership team)
- Resident's responsible party

Administrator or DNS
- Notify Adult Protective Services if abuse/neglect suspected

SBAR
The SBAR is a technique that promotes quality and patient safety by bridging gaps in communications, including hand-offs, patient transfers, critical conversations and telephone calls
- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendation

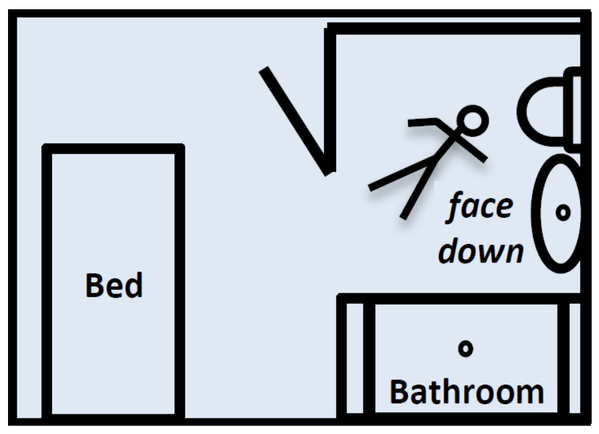
Investigation Components
(Root Cause Analysis)

Begin Investigation

Document Event
- Update care communication tools
  → Alert charting
  → 24-hour report
- Temporary care/service plan
- New physician order (note and implement)
- Begin incident report (or other facility document)

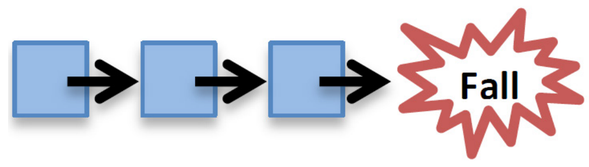
No. 1: Gather and Document Info

- Interview staff and others closely involved (last to see the resident, first responder, witness, resident, visitors, etc.)
- What do they think happened (sequence of events) and why (contributing factors)
- Use open-ended questions (e.g., "Tell me about...")
- Make a diagram of the scene at time of discovery, attach it to the investigation (show position of furniture, door and doorways, equipment and other relevant features)
  → Draw a stick figure to indicate where the resident fell/was found (label as face-up or face-down)



No. 2: Fill in the Gaps

Review Findings
- Identify gaps and gather any missing information (review record, falls history, interviews, plan of care, etc.)
- Outline the sequence of events leading up to the fall
- List possible contributing factors



No. 3: Analyze

Identify Contributing Factors
- Possible contributing factors to consider:
  → Environment- and equipment-related
  → Medication-related
  → Communication-related
  → Were identified fall prevention/risk interventions in place?
  → Was the care/service plan appropriate, updated and followed?
- Use the 5 Whys to uncover root causes

See Environment and Equipment Guide

See Medication Guide

See Communications Guide

See Resident Guide

Document Analysis Findings

5 Whys
- A question-asking method used to uncover the underlying cause of an event
- Uncovering the root cause(s) leads to action plans that are more likely to prevent the event from happening again

No. 4: Action Plan Development

- Include interdisciplinary team in process
- Ask, "What can we do to keep similar events from happening again?" (system-level, not just resident)
- Address identified root causes
- Develop an action plan with **SMARTS**

SMARTS
A technique that helps with setting clear and reachable goals
- **S**pecific
- **M**easurable
- **A**ttainable
- **R**ealistic
- **T**imely
- **S**upported

Considerations for Action Plan
- Include resident and/or responsible party
  → Review risk/benefits
  → Ask for alternative ideas to prevent recurrence
  → Review proposed changes to care/service plan
- Consider:
  → Resident's needs, goals and preferences
  → Effectiveness of previous plans
  → Managed risk agreement
  → Supervision plan
- Review:
  → Regulations and best practices
  → Policies and procedures
  → Care/service plan

No. 5: Evaluation of Effectiveness

Test the Plan (PDSA)
- Plan: Formulate action steps
- Do: Implement steps on trial basis
- Study: Monitor effectiveness for set time period
- Act: Review effectiveness, revise or adopt plan

Document Action Plan and Results
- Update care communication tools
  → Care/service plan (or document reasons for no change)

Implement the Plan and Monitor for Effectiveness
- Track and trend data over time
- Share results with safety and quality teams

Developed by the Oregon Patient Safety Commission's Nursing Home Expert Panel, V. 1.0