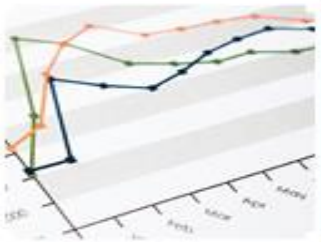
Oklahoma Dementia Care Network

Quality in Medication



OFMQ
ADVANCING QUALITY » IMPROVING LIVES

- Polypharmacy is taking multiple medications for multiple conditions usually defined as 5 or more medications daily. This term is being transformed into a new term Excessive Polypharmacy which is defined as 10 or more different medications.
  - Polypharmacy in 65 and over is on average 41%
  - Excessive Polypharmacy is on average 15%

Medication
Risks verses Rewards

88% more likely to experience adverse drug events

30% higher medical costs

49% risk of developing dementia

- Risk of Falls increase by 2.3 times

Path to PIP

Identify	Goals	Interventions	Successes
• Team • Focus • Quality Measure Performance on MDS reports • Residents • Residents Triggering Multiple QMs	• Medication Process • Medication Reductions • Fall Prevention • Quality Measure Improvement • Milestones • Timeframe • Staff Cohesiveness	• Review Residents • Individual Care Plans • Timeline Evaluation • New medication Protocols • Root Cause Analysis • Tapering Plans • De-Prescribing	• Review for success • Celebrate success • Keep the Process a success

All Encompassing Focus

- Cause and Effect
- Why?
- What has changed
- Family Engagement
- Counseling
- Education
- Story Boards

Sustainable Change

Post-Fall Huddle Checklist and Root Cause Analysis

Post-Fall Huddle Documentation

Directions: Items 1 - 3 should be completed by the huddle facilitator. Item 4 - by the fall risk reduction team

1. **Date of Huddle** _____ **Time of Huddle** _____ **Huddle Facilitator Initials** _____

2. **Who was included in the huddle? CHECK All THAT APPLY**

☐ Patient	☐ Primary Nurse	☐ COTA	☐ Physical Therapist
☐ Family/Caregiver	☐ CNA	☐ Pharmacist	☐ Physical Therapy Assistant
☐ Charge Nurse	☐ Occupational Therapist	☐ Pharmacy Tech	☐ Quality Improvement Coordinator

☐ Other. _____

3. **Please identify the proximal cause(s) of the fall by checking ALL appropriate boxes below and describe actions taken to prevent a reoccurrence for this resident.**

FALL CAUSE	FALL TYPE	ACTIONS TAKEN TO PREVENT. REOCCURENCE FOR THIS PATIENT
☐ Environmental (E11trinsic, Risk factors Examples- liquid on floor; ·Trip over tubing, equipment, or furniture. Equipment malfunction	PREVENTABILITY Accidental Possibly could have been prevented Anticipated Physiological Possibly could have been prevented Unanticipated Physiological Unpreventable	
☐ Known Patient-Related (Intrinsic) Risk Factors Examples: Confusion /Agitation, Lower extremity weakness, Impaired gait, Poor balance/postural control, Posture hypotension, centrally acting meditation		
☐ Unknown, Unpredictable Sudden Condition Examples: Heart Attack, Seizure, Drop attack		

☐ Unsure – Please describe fall cause and your assessment of preventability: _____

4. If preventable, determine error type and describe actions taken to decrease risk of recurrence at the system level.

ERROR TYPE	ACTIONS TAKEN TO DECREASE RISK OF REOCCURRENCE AT THE SYSTEM LEVEL
☐ Task An individual did NOT ensure planned interventions were in place as intended (ie: Purposeful Rounds)	
☐ Judgement An individual made a decision about an uncertain process (ie. patient at high risk for falls left alone while toileting in the absence of a policy not to do so)	
☐ Care Coordination Communication among multiple staff members was Incomplete, inconsistent, or misunderstood (ie: fall risk status not communicated lo all parties)	
☐ System Communication and multiple elements (tasks. knowledge, equipment) combine to make the system unreliable (ie: unreliable process for monitoring orthostatic BP across the system)	

Medical Record Number_____ **Date of Fall**_____ **Time of Fall**_____

Post Fall Huddle Facilitation Guide

PURPOSE: To lead front line staff and the patient/family in a conversation to determine why a patient fell and what can be done to prevent future falls.

Directions: Complete as soon as possible after ALL (assisted and unassisted) patient falls once patient care is provided but prior to leaving the shift.

Participants: Designated post-fall huddle facilitator for the shift, healthcare professionals who directly care for the patient, a member of your fall **risk reduction** team as available (i.e. PT. OT, pharmacy, quality improvement), the patient and **family** members as appropriate.

Remember: Patients fall because their center of mass is outside their base of support.

During the huddle look for specific answers and continue asking "why" until the root cause is identified.

ESTABLISH FACTS:

1-1. Did we know this resident was at risk? YES NO

1-2. Has this resident fallen previously during this stay? YES NO

1-3. Is this resident at high risk of injury from a fall? (ABCS)

__Age 85+ __Brittle Bones __Coagulation _Post-Hospital Patient

NOTES

2. Establish what resident and staff were doing and why.

ASK: What was the resident doing when he/she fell? (Be specific. Ie: transferring sit to stand from the bedside chair without walker). Ask why multiple times.

ASK: What were staff caring for this resident doing when the resident fell? Ask why multiple times.

NOTES

3. Determine underlying root causes of the fall.

ASK: What was different this time as compared to other times the resident was engaged in the same activity for the same reason? Ask why multiple times.

NOTES

4. Make changes to decrease the risk that this resident Will fall or be injured again.

ASK: How could we have prevented this fall?

- ☐ Need to consult with physical/occupational therapy about mobility/positioning/seating
- ☐ Need to consult with pharmacy about meditations

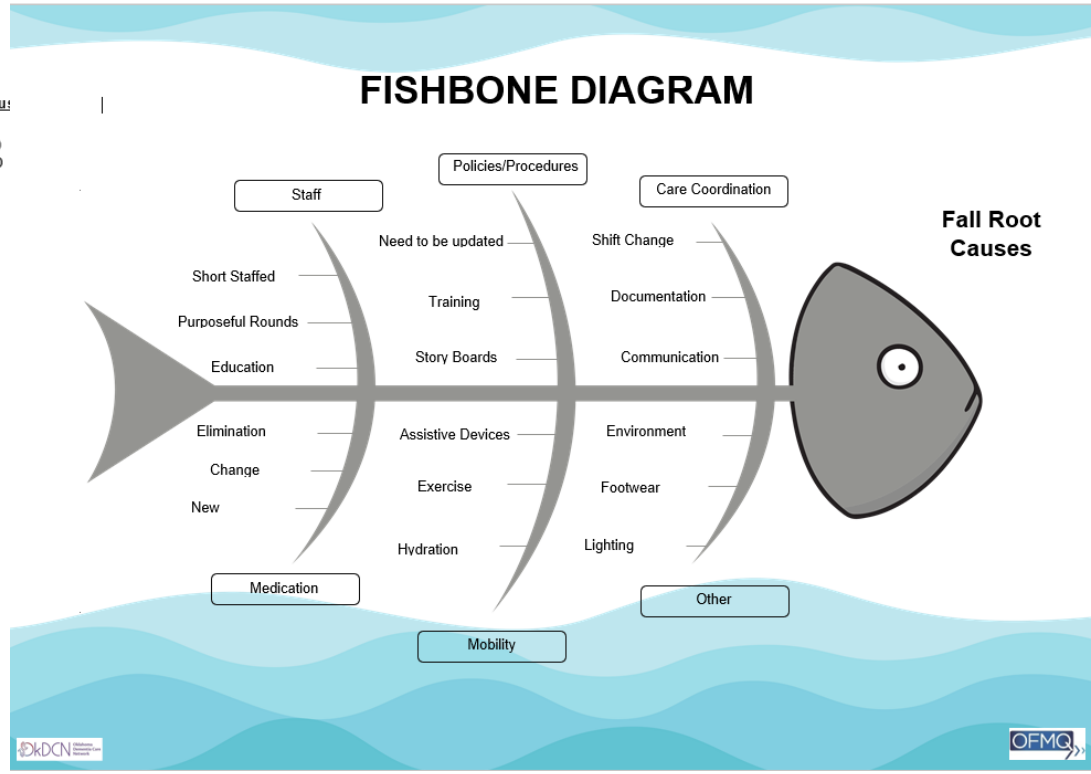
ASK: What changes will we make in this resident 's plan of care to decrease the risk of future falls?

NOTES

ASK: What resident or system problems need to be communicated to other departments, units, or disciplines?

NOTES

Thank you for contributing to Resident safety and quality of care.



Share your successes or challenges with medications and falls.

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Project ECHO