F689 Free of Accident Hazards/Supervision/Devices

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F-TAG LEADERBOARD

1. F0884 NHSN Reporting
2. F0689 FREE OF ACCIDENTS
3. F0080 INFECTION PREVENTION
4. F0684 QUALITY OF CARE
5. F0812 FOOD STORAGE/PREP/SERVE
6. F0656 DEV/IMP COMP CARE PLANS
7. F0677 ADL CARE
8. F0761LABEL/STORE DRUGS BIOLOGICALS
9. F0686 PRESSURE ULCERS
10. F0609 REPORTING ALLEGED VIOLATIONS

483.25(d) Free of Accidents.

The facility must ensure that –

§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

SOM - Appendix PP (cms.gov)

Objectives

1. Examine the intent of F689.
2. Reflect on the culture of safety in your facility.
3. Recognize the key components of the regulation.
4. Identify hazards and risks.
5. Implement tools and interventions to prevent accidents.
6. Monitor for effectiveness and modify interventions.

Accidents: F689

The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:

- Identifying hazard(s) and risk(s);
- Evaluating and analyzing hazard(s) and risk(s);
- Implementing interventions to reduce hazard(s) and risk(s); and
- Monitoring for effectiveness and modifying interventions when necessary.

Components of the Tag

- Falls
- Smoking/use of electronic cigarettes
- Wandering and elopement
- Safety/Entrapment (e.g., physical restraints, bed rails)
- Environmental hazards (unsafe hot water)
- Resident-resident altercations (also reviewed under abuse)

FALLS CASE

- 2/16 Resident fell in the hallway while ambulating alone (care plan indicates required assistance with ambulation).
- 3/9 Resident fell at the nurse's station while attempting to sit down independently and missed the chair (care plan indicated required assistance with transfers).
  - Care Plan: *Resident sustained a fall on 3/9/22 with no apparent injuries. Interventions: Encourage to be in the dining room during the day.*
- 4/19 Resident had an unwitnessed fall in the doorway of the dining room.
- 5/17 Resident fell ambulating independently in the hallway and found face down with a scratch on his/her face.

[The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities (ahrq.gov)]

Bed Alarm: Be careful! Where's the evidence?

- Device is effective for preventing falls?
- Effect of inhibiting or restricting the resident from free movement out of fear of the alarm going off? (Physical restraint?)
- Alarm used to replace staff supervision?
- While position change alarms are not prohibited from being included as part of a plan, they **should not be the primary or sole intervention to prevent falls.**
- If facility staff choose to implement alarms, they should document their use aimed at assisting the staff to assess patterns and routines of the resident.
- Alarms do not replace necessary supervision.

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Smoking

- Is the resident supervised? (If required.)
- Designated area?
- Uses oxygen?
- Has difficulty holding the cigarette?
- Burned areas on clothing or body?
- Keeps the cigarettes and/or lighter?

Electronic Cigarettes

- Are there potential risks for the smoker?
  - Health effects such as respiratory illness/injury
  - Nicotine overdose by ingestion
  - Explosion or fire caused by the battery
- Do other residents appear bothered by the electronic cigarette use?
  - Secondhand aerosol exposure
- Does your smoking policy include the use of electronic cigarettes?
- Find FDA recommendations at the following link

https://www.fda.gov/tobaccoproducts/labeling/productsingredientscomponents/ucm539362.htm#blue

Wandering/Elopement

- Random or repetitive locomotion.
- Is it goal directed? (Searching for an exit.)
- Is it non-goal directed or aimless?
- Wandering may indicate the resident is frustrated, anxious, bored, hungry or depressed.
- Alarms do not replace supervision.
- If the resident leaves the premises OR A SAFE AREA, without the facility's knowledge or supervision, it would be considered an ELOPEMENT.

Wandering/Elopement Case

- Resident was admitted with diagnosis of dementia, one sided weakness s/p stroke, unsteady on feet, aphasic, and lack of coordination.
- Review of the clinical record indicated resident was at risk for wandering as evidenced by the following documentation:
  - Exit seeking/Elopement evaluation/Wandering note completed due to the resident attempting to exit through the stairwell door.
- Assessment: “Resident is self mobile via wheelchair, risk factors include desire to return home, exit seeking behavior, resident attempted to elope through the stairwell, behavioral has occurred for 1-3 days.”
- Also documented, *“Behavior has gotten worse since last assessment.”*
- Summary and plan indicated the resident was NOT at risk for wandering/elopement at the time of the assessment.
- Nursing notes indicated the resident continues to wander out of bed without assistance

Elopement: Special Considerations 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.
- What do your policies say?

Safety/Entrapment

- Does the resident require assistance with transfers?
- Does staff implement care-planned interventions for transfers?
- Is equipment in good condition, maintained and used according to manufacturer's recommendation?
- If bed rails are used:
  - Are they applied safely?
  - Are there areas (large openings/gaps) where the resident could become entrapped or injured (exposed metal, sharp or damaged edges)?

Environmental Hazards

- Clutter
- Handrails (installed properly, free from sharp edges)
- Building and equipment (in good condition?)
- Chemicals and toxins (housekeeping chemicals)
- Electrical safety (cords, extension cords, electric blankets, heating pads?)
- Lighting (insufficient light or glare)
- Assistive devices/equipment hazards
  - Canes, walkers, wheelchairs in good repair?
  - Mechanical lifts, sit to stand devices, transfer or gait belts
- Unsafe hot water

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Environmental Hazards Case

Based on interview, record review, and manufacturer's instruction review, it was determined that the facility failed to follow manufacturer's instruction for Hoyer lift use resulting in an accident.

- Manufacturer’s Instructions: Transferring the Patient-WARNING
  - The legs of the lift must be in the maximum open position and the shifter handle locked in place for the optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under the bed, close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the lift are no longer under the bed, return the legs of the lift to maximum open position and lock the shifter handle immediately.

- Transferring Resident from bed to wheelchair with staff. Staff (1) stated that he/she had the control of the Hoyer lift. Staff (2) also stated that when Resident was raised via the Hoyer lift in between the bed and the wheelchair, the Hoyer lift started to tilt down towards Staff (1) and falling to the floor. Staff (1) stated that the legs of the Hoyer lift were not in an open position and the Hoyer lift was not balanced and tilted over. Staff (2) also stated that Staff (1) was able to assist Resident to the wheelchair and prevented Resident from falling to the floor.

Resident-Resident Altercations

- Did the resident have any altercations (e.g., verbal or physical) with any residents? If so, how did staff respond?

- How does staff supervise/respond to a resident with symptoms such as anger, yelling, exit seeking, rummaging/wandering behaviors, targeting behaviors, inappropriate contact/language, disrobing, pushing, shoving, and striking out?

Resident-Resident Altercations: Interventions

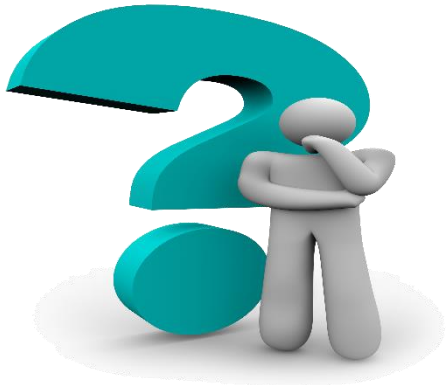
- Evaluating staffing levels to ensure adequate supervision.
- Evaluating staffing assignments to ensure consistent staff who are more familiar with the resident and who thus may be able to identify changes in a resident's condition and behavior.
- Providing safe supervised areas for unrestricted movement.
- Eliminating or reducing underlying causes of distressed behavior such as boredom and pain.
- Monitoring environmental influences such as temperatures, lighting, and noise levels, AND…
- Ongoing staff training, competencies and supervision.

Resident-Resident Altercations Case

- Based on resident interview, staff interview, and record review, the facility failed to provide adequate supervision to prevent accidents for one as evidenced by continued unwanted touching between residents.
- Interviewed Staff (LNA, LPN) not aware of any specific interventions to prevent recurrences of this behavior.
- DON and Administrator unaware of the behavior/incidents.
- Resident affected “felt used and unsafe,” “staff were not doing anything to prevent recurrences and that unwanted touching happened over many days often within minutes of each other.”
- The touching only stopped when the resident requested a room change.

DOES IT ALL ADD UP?

- Review the most current comprehensive assessment
- Physician's Orders
- Fall Risk Assessment
- Progress notes related to incidents of smoking, injuries, altercations, elopements, or falls
- Investigative reports
- Care Plan Interventions
- Care Cards for Staff indicating high risk/low risk



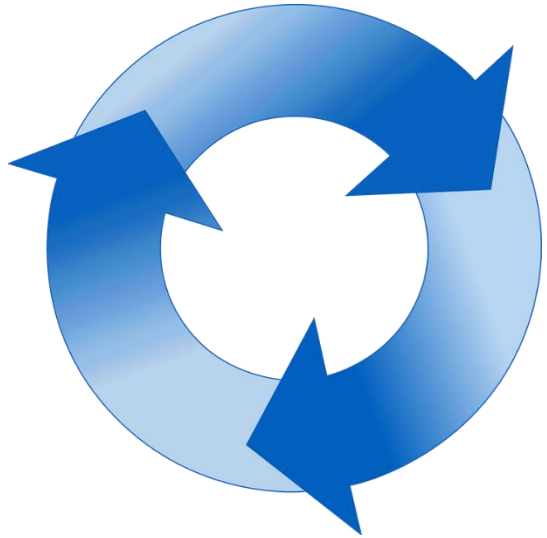
Guidance Overview

An effective way for the facility to avoid accidents is to:

- Develop a culture of safety
- Acknowledge the high-risk nature of its population and setting
- Develop effective communication
- Engage all staff, residents and families in training on safety
- Encourage the use of data to identify potential hazards, risks, and solutions related to specific safety issues that arise;
- Direct resources to address safety concerns
- Demonstrate a commitment to safety at all levels of the organization

Accident Prevention Best Practice Strategies

- Comprehensive assessment (on admission, quarterly annually AND change in condition).
- Use assessment findings to develop individualized care plan with interventions.
- Monitor and manage the resident's response, making care plan revisions as needed.



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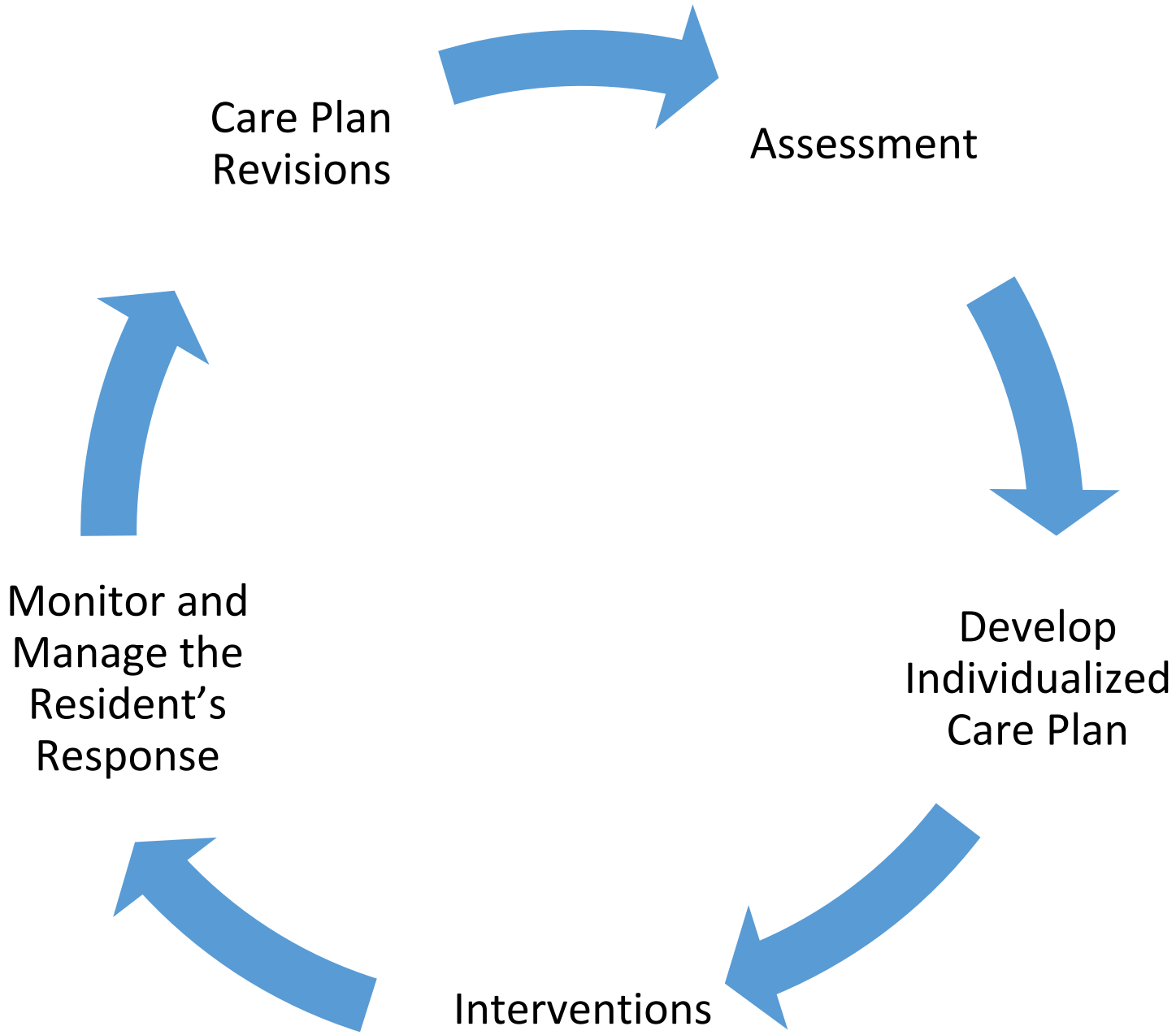
Assessment
Develop Individualized Care Plan
Interventions
Monitor and Manage the Resident's Response
Care Plan Revisions

Interventions: What can I do?

- Respond to the resident's requests timely.
- Low bed, providing a fall mat.
- Monitoring resident positioning to prevent sliding/falling.
- Providing proper footwear to prevent slipping.
- Resident use of assistive devices.
- PT/OT/restorative care.
- Resident room free from accident hazards (adequate lighting, clutter, trip hazards, providing assistive devices.
- Bed alarms for position change.
- Resident's mobility status.

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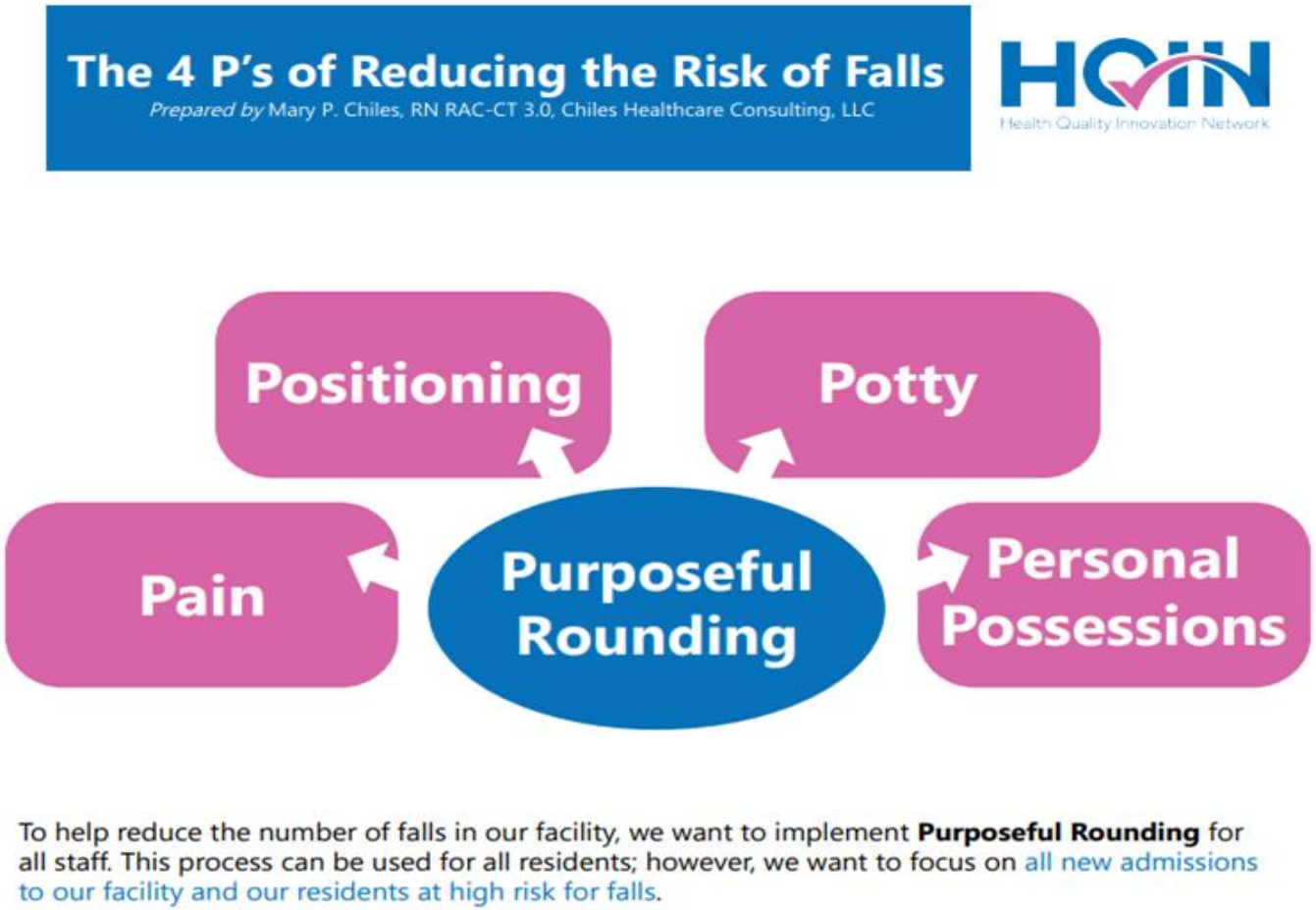
Purposeful Rounding



Be Proactive
Not Reactive

The 4 Ps of Reducing the Risk of Falls (hqin.org)

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Huddles

WHO?

The TEAM

WHAT?

1) Safety and quality concerns and successes in the past day
   - Patients/Residents
   - Staff
   - Physicians
2) Safety and quality issues for patients/residents on today's schedule
3) Review of tracked issues
4) Inputs on other safety and quality issues
5) Announcements and information to share

Huddles

WHEN?

- ✓Shift-Shift
- ✓New Admission(s)
- ✓After an event
- ✓Need to change the plan

HOW LONG?

- ✓10-15 minutes or less

WHY?

- ✓To improve staff communication, engagement and most of all, ***improve resident safety***

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Tools and Resources

- IPRO QIN-QIO Resource Library
- https://qi.ipro.org/upcoming-events/
- Microsoft Word - Huddles_Tip_Sheet.doc (pioneernetwork.net)
- Purposeful and timely nursing rounds: a best practice implementation project - PubMed (nih.gov)
- The 4 Ps of Reducing the Risk of Falls (hqin.org)

References

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- Falling Leaf Program: Implementing a Fall Prevention Program - buildingtherapyleaders.com
- The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities (ahrq.gov)
- Microsoft Word - Huddles_Tip_Sheet.doc (pioneernetwork.net)
- Purposeful and timely nursing rounds: a best practice implementation project - PubMed (nih.gov)
- The 4 Ps of Reducing the Risk of Falls (hqin.org)

What's Next?

Open Discussion/Questions

Contact us
We're Here to Help!

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