Investigating with a Different Lens
The condensed version

Incident or Adverse Event; Unusual Occurrence; Problem becomes known

Implied:

- Immediate resident safety
- Preliminary preventive steps in place
- Initial / 1st why answered/addressed
- Regulatory/abuse reporting complete
- Point person for investigation identified
- Initial perspectives gathered

1. Gather & Document Initial Information (within 24 hours, consider severity) **Day 1**

- Include interviews, diagram/drawing of the scene of the incident, clinical record/course, maintenance/other ancillary services records)
- What was the initial report?
- Who has information from before, during & after the event?
- How does each of them describe the event (who, what, when, where, how, why)
- What factors does each of them think contributed to the event?

2. **Fill in the Gaps** (within 72 hours) **Days 2-4**

- What other information & interviews do you need to get (re-interviewing some staff may be necessary)
- Outline sequence of events (ex: flowchart, page 7 of PSIC guide)
- List contributing factors
- Determine who can help with the analysis of the event
- Determine who will attend the RCA meeting

3. Analysis

- Identify the contributing factors that were the primary reason the event occurred
- Choose the high priority contributing factors (those that are likely to recur and/or impact others)
- Identify the root cause by completing the 5-whys for the high priority contributing factors

4. Action Plan Development

- Use the “action plan worksheet” (last page of appendix)
- Determine action plan goals & approaches (short-term versus long-term)
- Write action plans with SMARTS (specific, measurable, attainable, realistic, timely, supported)
- Implement action plan, monitor, re-evaluate (PDSA)

5. Evaluation of Results

- How are other residents impacted?
- What are the other implications?
- How will you track & trend?
- What is the global impact (facility-wide)?
- Did you identify & solve an organizational/system

Resident Event Scenario
Case Example Exercise
Directions: Use the guide to RCA in LTC to investigate the resident event scenario assigned to you. Write your investigation findings below. Choose a table spokesperson to report your findings.

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1. Gather & Document Initial Info

- Include interviews (consider what you would ask a C.N.A./caregiver, Nurse and/or resident and how they would answer based on the information in the case), diagram drawing of the scene (based on case example)
- Who has information from before, during or after the event
- Ask each person to describe the contributing factors they think played a role in the event and why.

2. Fill in the Gaps

- Draw the sequence of events
- List contributing factors (see Handout 5)
- List people you will include in the RCA meeting

Resident Event Scenario
Case Example Exercise

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3. Analysis

- Identify the contributing factors that were the primary reason the event occurred
- Identify the root cause using the 5-whys methodology

4. Action Plan Development

- Write action plans to address your root causes using the SMARTS (specific, measurable, attainable, realistic, timely, supported) method.

5. Evaluation of Results

- How will this impact other residents?
- How will you track and trend?

Resident Event Scenario One

Resident Data:

Resident is an 83 year old woman living within a Secure Alzheimer's Enhanced Dementia Unit for the last three months. She has had a long history of elopement prior to admission. She is ambulatory, non-combative and pleasantly confused. She wanders daily throughout the unit without direction or purpose. She sleeps only 4-5 hours per day and is found napping on various surfaces or on the floor throughout the day. She has very supportive family who visit daily and has evening meals with her. She has a Wander Guard type of alarm device attached to her.

The resident has the following diagnosis and Medications:

Alzheimer's disease:
- Aricept 10 mg PO each day

Atrial Fibrillation:
- Lanoxin 0.125 mg PO each morning, hold for pulse below 60 bpm

Congestive Heart Failure:
- Lasix 20 mg PO each day
- Potassium Chloride 20 meq PO each day as supplement/replacement

Dementia with Agitated Features:
- Risperdal 0.5 mg PO every HS

Anxiety:
- Ativan 0.5 mg PO every 4-6 hours as needed

Constipation:
- Colace 50 mg PO twice daily
- Milk of Magnesia 30 cc PO everyday as needed

Mild Pain:
- Tylenol 325 mg 2 tablets PO every 4 hours as needed

*see next page for event.

Event:
On March 30th, 2012 at 2030 in the evening, about an hour after the resident's family left for the evening after dinner, the resident was found sitting on the ground in the front parking lot of facility A. The resident was confused and disoriented. She could only mumble unintelligible responses to the staff that found her. The resident was given Ativan 0.5 mg PO at 1915 due to increased anxiety as the resident was calling out for her mother and pushing out and slapping at staff who were attempting to assist her with ambulation. The staff saw her sitting on the ground when looking out the window of another resident's room. She was dressed in her sleeping gown. She had no shoes or socks on. She had her favorite stuffed bear with her that she was clutching as she rocked back and forth. There was a skin tear noted on her left shin that measured 4 cm in length and 0.5 cm in width and was actively bleeding. The staff was not able to determine if she lowered herself to the ground or fell and hit her head. There were no signs of head trauma or injury. The resident's neurological assessment matched her normal baseline. There was nothing near the resident that she could have caught her calf on and there was no blood noted on the exit door way. The residents Wander Guard type of alarm was missing and the staff later located it in her bedside table drawer wrapped in a tissue. It had previously been on her left ankle. The strap to the alarm had been cut. The resident's vital sign's at the time she was found was B/P 162/88, Pulse 104, Respirations 20 and Temperature 98.2 sitting. Her standing B/P was 140/86, Pulse 102, Respirations 20 and Temperature 98.2. The resident did not exhibit any pain on palpation other than to her skin tear area. Her upper and lower extremities all moved within her normal range of motion and there were no signs of evidence of any potential hip fracture. The resident was gotten up by a licensed nurse and two CNA's and returned to the facility via wheelchair. The resident had increased anxiety on entering the facility by calling out "NO, NO, NO, I want to go home, I want to go home" and grabbing at the door frames to the facility, the unit and her room. The staff notified the resident's physician and responsible party of the event and the injury to her left leg and obtained a treatment for the skin tear to the left leg.
An incident and accident report was completed for the unusual occurance and the resident was put on alert charting alert status per the facility policy for a fall with injury and the event was noted on the 24 hour facility report process for the fall with injury.

Please follow the Root Cause Analysis tool in determining the steps to success in investigating this event.

Resident Event Scenario Two

Resident Data:

Resident is an 81 year old male resident who has resided in the facility for 17 days. He has been admitted from an Acute Care Hospital secondary to a ground level fall that resulted in a right hip fracture with an ORIF repair completed. He was admitted to a Skilled Nursing/Rehabilitation Facility for Physical Therapy and Occupational Therapy for Gait training, and ADL needs. He is Weight Bearing as tolerated. He tends to be impulsive and does not follow hip precautions or call for assist. He lived alone at home and has a daughter that lives close by and visits daily at home and now in the facility. He is fiercely independent. His fall at home occurred while he was working in his yard doing some weeding and his dog ran through his legs, catching him off balance and resulted in the fall. He has poor vision and is hard of hearing. He has a cane at home but refuses to use it per his daughter. He is not good at taking his medications as prescribed and often forgets them.

The resident has the following diagnosis and Medications:

Mild Age Related Dementia

Hypertension:
Cardizem 30 mg PO every day

Coronary Artery Disease/Clot prevention:
Plavix 75 mg PO every day

Gerd:
Protonix 20 mg PO every day

Congestive Heart Failure Chronic with Acute flare up
Lasix 80 mg PO every day:

Surgical and Joint Pain
Vicodin 500/5 mg PO every 4-6 hours as needed for pain

Surgical and Joint Pain
Tylenol 325 mg 1-2 tabs PO every 4-6 hours as needed for pain

Urinary Tract Infection:
Ciprofloxin 250 mg PO QID times 10 days (6 more days left)

Constipation:
Colace 50 mg PO BID

*see next page for event.

Event:

At 1600 the resident was found sitting on the floor in his bathroom next to the toilet with his back resting against the wall that faces the toilet. The resident's right leg is externally rotated and the resident is yelling out in pain and discomfort at any movement of his body. He is complaining of dizziness and chest discomfort. The only complaint of pain prior to event per the resident on interview was that his legs had been cramping and he became dizzy. He is pale and diaphoretic. He states that he had to go to the bathroom so just got up and walked in there on his own. He did not put his call light on in his room or pull the call light in the bathroom. His call light is still attached to his bedding on his bed and is functional when tested. The cord to the call light in the bathroom is present but now out of reach. There is a walker that is folded outside the bathroom door and leaning against the wall. The resident's vital signs while sitting are B/P 100/60 Pulse 82 and irregular, Respirations 22, Temperature 100.2. The resident's usual B/P is 140/78 and temperature has been 99.2 earlier in the day. His baseline respirations are usually at 16 per minute. There is urine on the floor at the resident's feet. The resident's oxygen saturation is 88 and oxygen at 2 liters per minute has been started to raise his oxygen saturation rate. 911 has been called secondary to the external rotation and chest pain. Resident is a full CPR. The resident's physician has been notified as well as the resident's responsible party with the resident's permission.

Please flow the Root Cause Analysis tool in determining the steps to success in investigating this event.