Getting to the Root of Falls: Use of a Mini-Root Cause Analysis Tool

Norma D. McNair, PhD (c), RN and Catherine (Cait) Walsh, MSN, RN
Ronald Reagan UCLA Medical Center, Los Angeles, California

Learning Objectives

After reviewing this poster presentation, the learner will:
- Know how to use a post-fall huddle/debriefing form for a mini root cause analysis.
- Develop a unit specific action plan based on the results of the mini-root cause analysis.

Statement of the Problem

- Well established hospital wide fall prevention program
- In July 2008, move to a new hospital
  - Dramatic increase in the number of constant observation aides (sitters) used as the nursing staff adapted to the new hospital environment.
  - Controlling sitter costs, in December 2008, lead to an increase in our fall rate.
  - Implemented hourly rounding with the 5 Ps (position, pain, placement, personal needs and preventing falls) in April 2009, fall rate returned to our baseline of mid 20s to low 30s per month.
- Contributing to this change in fall rates were the differences between the old and new facilities.

- Old facility:
  - Rooms on both sides of hall
  - Semi-private rooms
  - Straight hallways
  - Open doors
  - ICU beds in line of sight of nurses' station

- New facility:
  - Private rooms along one side of the hall.
  - Curved hallway
  - Nursing activities in the "core" behind closed doors.
  - Patients prefer that their doors be closed or privacy curtain in place.
  - ICUs have glass walls with curtains pulled
  - Increased use of constant observation aides (sitters) in the private rooms

Old Hospital Hallway

New Hospital Hallway

Interventions

- Compared fall rates pre and post hospital move.
- NDNQI fall rates at mean compared to other academic and Magnet facilities.

- Reviewed our current practices for falls prevention .
- Posted a query to a listserv seeking ideas from other institutions.
- Answers from the listserv were collated.
- Requested a copy of a post fall huddle form from another institution.

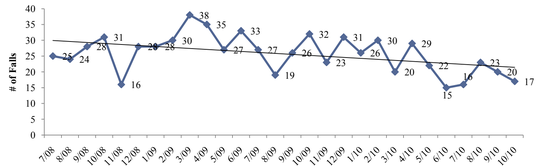
- Reviewed and revised form.
- Instituted form on high fall units, including Hematology/Stem Cell Transplant and Liver Transplant units.
- Form was uploaded to our FoRMs portal for easy access.
- Fall Committee encouraged the use of document for all falls.

- In January 2010, the Hematology/Stem Cell Transplant and Liver Transplant floors (26 beds each) used the tool after each fall
- Hematology unit had 3-4 falls each month
- Liver Transplant unit had 2-3 falls each month
- Results from the form were reviewed with the Unit Director, Clinical Nurse Specialist, Assistant Unit Director and the Accreditation Manager

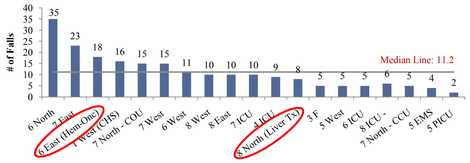
Results

The following graphs show the results of our intervention.

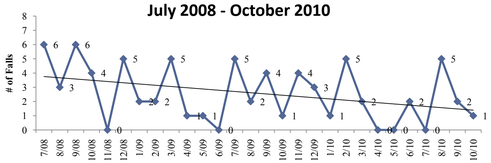
Inpatient Falls by Month
July 2008 - October 2010



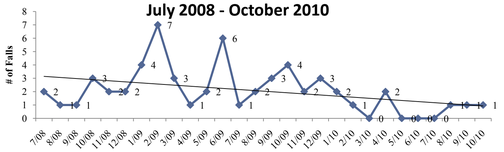
Inpatient Falls on Nursing Units
Jan 2010 - October 2010



6 East - Hem-Onc
Falls
July 2008 - October 2010



8 North - Liver Transplant
Falls
July 2008 - October 2010



Conclusions

- Consistent use of the tool allows immediate assessment of contributors to falls.
- Tool has assisted us in identifying unit specific interventions.
- Education can be provided at the time of the event to assist the nursing staff in falls prevention.
- Expansion of the use of the tool house wide has identified additional areas for improvement including correct sizing of vest restraints and the use of bed alarms in high fall areas.

Acknowledgements

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Contact information

Norma D. McNair, PhD (c), RN
Catherine (Cait) Walsh, MSN, RN

Ronald Reagan UCLA Medical Center
757 Westwood Plaza, Suite B 790A
MC 740430
Los Angeles, CA 90095-7404

E: nmcnair@mednet.ucla.edu
E: cawalsh@mednet.ucla.edu

UCLA Health System