

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

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## Fall Prevention Program

- Assessment of all patients on admission, each shift and after a fall
- Identification of high risk patients
  - Yellow fall risk arm band
  - Falls sign at head of bed
  - Yellow falling star sign on door frame
- Hourly rounds
- Bed exit alarms

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## UCLA Westwood CHS vs. RRH (The Environment)

CHS (Center for Health Science)

### Floors:

- Semi-private rooms
- Rooms on both sides of the hallway
- Straight hallways
- Doors were not closed unless indicated

### ICUs:

- Curtains around beds instead of walls
- Beds around nursing station in line of sight

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### UCLA Westwood CHS vs. RRH (The Environment)

RRH (Ronald Reagan Hospital)

Floors:

- Private rooms
- Fewer floor beds
- Rooms on only one side of hallway
- Curved hallway
- Doors closed or curtain drawn if the door is kept open
- Nursing activities in "core" of unit

ICUs:

- Glass walls with curtains drawn
- More ICU beds

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### Typical Medical-Surgical Unit

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## Event Reporting System

Falls:

- CHS occurred mainly at night
- RRH occurred equally between night and day
- Occurred around bathroom activities at both CHS and RRH
- Did not involve the same staff individual/s at CHS and RRH

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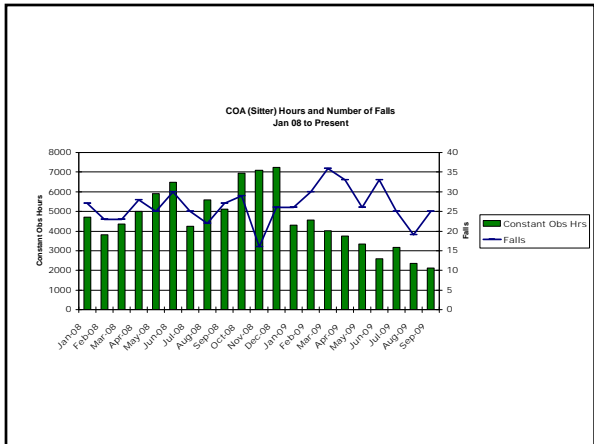
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## RRH

- September 2009: Fall Rate over the previous months is about the same that of CHS
- NDNQI reports show UCLA RRH at the mean when compared to other academic and Magnet Hospitals

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## Improving Our Fall Rates

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## What to Do?

- Reviewed all of our current practices for falls prevention
  - What could be added?
- Posted a query to a listserv for help from other institutions
- Collated the answers from the listserv
- Requested a copy of the Post Fall Huddle form from another institution

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### What to Do?

- Revised the Post Fall Huddle/Mini Root Cause Analysis form for use at RRUCLA
- Instituted the form on our high falls areas
- Uploaded form for easy access (forms portal)
- Discussed at our Fall Committee Meetings

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### Post Fall Huddle/Mini Root Cause Analysis Tool

- **Three sections**
  - Fall event details
  - Post fall huddle – root cause analysis
  - Post fall checklist

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### Post Fall Huddle/Mini Root Cause Analysis Tool

- **Fall event details**
  - Date, time, location, room
  - Fall precautions in place
  - Last time of rounds and what was assessed
  - Location of fall
  - Witnessed or unwitnessed fall
  - Assisted fall: equipment in use
  - Number of side rails
  - Medications
  - Preventative measures

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## Post Fall Huddle/Mini Root Cause Analysis Tool

- Post fall Huddle – mini root cause analysis
  - Team members: Lead nurse, primary nurse, care partner, other
  - Contributing factors
    - Activity and mobility
    - Cognitive and functional
    - Environmental and equipment
    - Interventions
    - Reason for fall as reported by patient/family and huddle members
    - Corrective and preventive measures to prevent another fall

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## Post Fall Huddle/Mini Root Cause Analysis Tool

- Post Fall Checklist
  - MD notification
  - Unit management notification
  - Update care plan
  - Documentation of fall
  - Patient becomes automatic high fall risk
  - Event report
  - Shift handoff
  - Notification of family

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## Unit Takes Initiative to Use Tool

- Adult Hematology/Stem Cell Transplant Unit
- 26 Beds
- High Fall Rate (Average 3 to 4/month)
- Patient diagnosis contributed to falls

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### Unit Takes Initiative to Use Tool

- Used post fall huddle tool to evaluate every fall
- Accreditation Manager:
  - Reviewed every huddle form
  - Met with Unit Director and CNS to discuss findings
- Findings:
  - Falls mainly happened at night
  - Same Night Lead Nurse for most of the falls

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### Unit Takes Initiative to Use Tool

- Action Plans specific to the Unit created
- Falls decreased
- Fall Rate now 1 to 2/month

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### Where do we go from Here?

- Expand the use of the tool to all of the units in the hospital, not just high fall units
  - Assessment of falls at the time of the event, not hours or days later
  - Allows all involved to participate in the huddle and be part of the solution

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## Contact Information

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