

Post-Fall Root Cause Analysis Guidance

Aside from assessing patients at risk of falling and implementing multidisciplinary interventions aimed at identified risk factors, the best way a hospital or nursing home can help prevent falls is by conducting a post-fall root cause analysis (RCA) (i.e., a process intended to uncover the cause(s) of falling. It goes beyond analysis of internal and external fall factors; it includes the clinical process and system or organizational factors that may have contributed to falling as well). In essence, the purpose of RCA is to discover what caused a fall and to prevent any future falls. The following provides a step-by-step approach to conducting RCA.

Step 1: Fall Assessment

Collect details of the fall/include:

- Circumstances of the fall(s)
 - Symptoms (prior to/after fall)
 - Previous falls (patterns?)
 - Location (of fall)
 - Activity (at time of fall)
 - Time (hour of day)
- Fall risk factors (new/additional)
- Presence of environmental hazards.

Step 2: Root Cause Analysis (Resident)

Based on assessment information determine:

- What happened?
- Why did it happen?

Ask "Why?" questions until all logical causes can be identified.

Possible contributing causes (s) of fall include:

- Patient-related or internal factors.
- Patient-related mobility or activity being undertaken at time of fall.
- Environmental/equipment or external factors.

Step 3: Root Cause Analysis (Staff/Organization)

Corresponding processes and systems or organizational factors are identified that can be related to falling. In this step, the focus is on the clinical process and organization, not the patient.

Ask "Why?" questions until all logical causes can be identified.

Clinical Process Factors

- Risk assessments not complete/inaccurate
- Risk not communicated
- Underreporting falls
- No care plan/follow-up

Organizational Factors

- Lack of policies/procedures
- Communication problems
- Staff related (lack of education; lack of staff)
- Lack of resources (equipment/restraint alternatives)

Step 4: Chart Audits

To determine clinical process factors, conducting chart audits can be helpful.

Purpose:

- Helps to separate what you think is happening from what is really happening

Objectives:

- Evaluate staff adherence with fall prevention program
- Recommend further actions for improvement.

Step 5: Organizing and Planning

- Once all the possible why questions are answered, then the possible root causes, processes, and systems are evaluated to determine if it contributed to the fall.

- Those factors that contributed to the falls are analyzed to determine how they can be improved. After this is complete, a plan for improvement is implemented and evaluated to verify that any changes put in place have produced the desired outcomes.

Achieving Success

- Involve all stakeholders (e.g., staff nurses, leadership/management staff, pharmacists, physicians and other individuals directly related to the occurrence).
- Create a "blame free" culture (i.e., staff are not afraid to discuss safety issues and where leadership will support and implement any necessary changes).
- Devote adequate time to conduct a root cause analysis.

Source: Dr. Rein Tideiksaar www.nurseassist.com