

1 Problem

What When	Problem(s)	Patient fall
	Date	March, 2013
	Time	Early morning
Where	Different, unusual, unique	Patient given sleeping pill; raises risk of falls
	Facility, site	Medical Center
	Task being performed	Helping patient sleep
Impact to the Goals	Patient Safety	Three broken ribs
	Patient Services	Lack of additional care after sleeping pill
	Schedule/ Operations	Additional two weeks in hospital
	Labor/ Time	Months of physical therapy
	Frequency	Fall rates unknown

HOW BEST TO PREVENT PATIENT FALLS?

Cause Map

Though there is consensus that improvement must be made in the area of injury due to patient falls, how to reduce patient injury due to falls has raised questions about effective solutions to this problem.

According to the Agency for Healthcare Research and Quality, accidental falls contribute to patient complications in 2% of hospital stays.

Cause Mapping is a Root Cause Analysis method that captures basic cause-and-effect relationships supported with evidence.

CAUSE MAPPING

Problem Solving • Incident Investigation • Root Cause Analysis

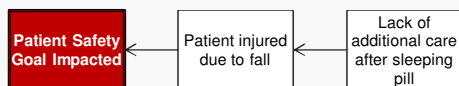
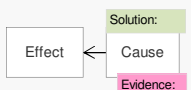
- Step 1 **Problem** - What's the Problem?
- Step 2 **Analysis** - Why did it happen?
- Step 3 **Solutions** - What will be done?

2 Analysis

Basic Level Cause Map - Start with simple Why questions.

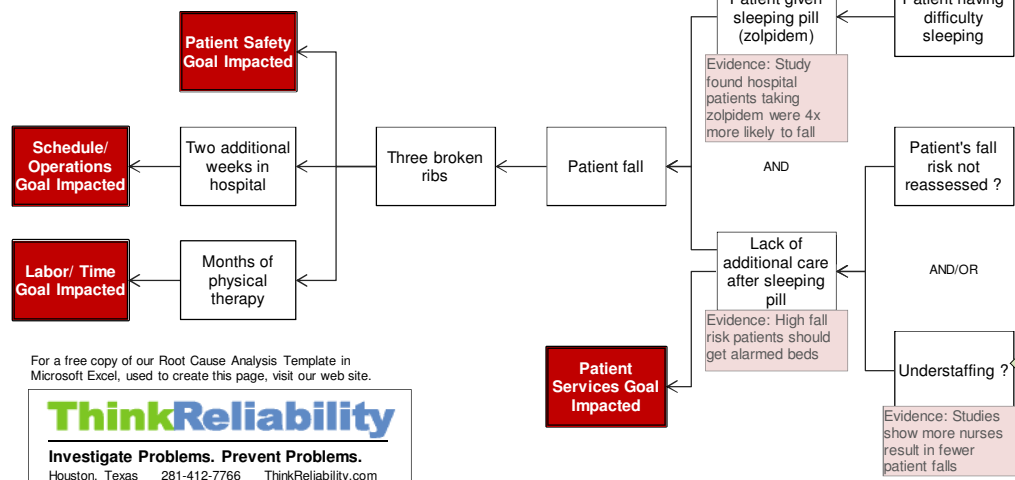
Basic Cause-and-Effect

A patient was badly injured after he fell while being medicated with a sleeping pill found to significantly raise the risk of falls.



3 Solutions

More Detailed Cause Map - Add detail as information becomes available.



Some hospitals have begun phasing out zolpidem as a sleeping pill because it makes patients more likely to fall. For hospitals that continue to use the pill, patients who receive it should have their fall risk upgraded due to the higher potential of falls related to use of these pills.

Studies show that more nurses result in fewer patients falling. Nurses in Washington have supported legislation requiring higher staffing levels. But hospital management is concerned about the cost of this requirement, although the hospital did add 29 more nurses at the hospital where this fall occurred.

Additionally, that hospital's Chief Nursing Officer says "What we have found is it has much less to do with staffing ratios than with having good solid reliable processes in place and following those every single time."

Many of these processes involve bed alarms - which some studies have shown to be ineffective at preventing falls. Additionally, as a nurse states, "You still need a person to be close enough nearby to be able to respond to the alarm."

For a free copy of our Root Cause Analysis Template in Microsoft Excel, used to create this page, visit our web site.

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