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RCA Analysis of Inpatient With Moderate Injury Fall Events

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Purpose

It is a common topic for a patient to fall or cause injury during hospitalization. We hope to confirm the proximate cause of moderate injury caused by inpatients, review the operation process and make systematic improvements to prevent mistakes, reduce the incidence of falls for inpatients.

Preliminary results suggest the Incident Decision Tree is an effective tool to guide decision making around patient safety incidents in health care organizations. The tree is sufficiently robust and adaptable to be used in a range of local settings and across a range of different professional groups.

Methods

Our project want to use Root Cause analysis (RCA), the case of falling moderate injury in January-March 2018, by the Incident Decision Tree (IDT) to determine the system factor, and drawing a simple flow chart, and then according to the time sequence the list looks for the proximate cause, and the fishbone diagram determines the correct execution procedures and differences, and develop an action plan.

Results

According to the analysis, the cases of moderate injury cases were 4 at surgical wards, 3 at medical wards and 1 at intensive care unit. It is confirmed by the incident decision tree (IDT) that all 8 cases are system factors for RCA improvement, and the key processes and errors are confirmed according to each event. Then the fishbone diagram is used to determine the correct execution procedure and the difference problem points and develop an action plan.

Conclusions

Through team discussion and literature verification, we propose improvement measures: Revision of "Standards for Fall Prevention" SOP, increase of accessibility resources to increase the awareness of hospitalized patients on the severity of falls, and use of information system to mark the risk of extreme falls. In addition to the group's conditions, it can strengthen the preventive assessment of patients with multi-drugs, and implement the effectiveness of patients' prevention of falls through inter-departmental multiple anti-fall interventions, and even mobilize the entire hospital, all staff, and the whole family to participate in patient safety work. We will regularly monitor and review changes in inpatient fall indicators to provide patients with safer medical care.

Title:

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Keywords:

RCA, fall and moderate injury

References:

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Taiwan Patient Safety Net (<http://www.patientsafety.mohw.gov.tw/>)

Abstract Summary:

We hope to confirm the proximate cause of moderate injury caused by inpatients, review the operation process and make systematic improvements to prevent mistakes, reduce the incidence of falls for inpatients.

Content Outline:

I. Introduction

It is a common topic for a patient to fall or cause injury during hospitalization. Preliminary results suggest the Incident Decision Tree is an effective tool to guide decision making around patient safety incidents in health care organizations.

We hope to confirm the proximate cause of moderate injury caused by inpatients, review the operation process and make systematic improvements to prevent mistakes, reduce the incidence of falls for inpatients.

II. Body

Main Point #1 **Methods**

1. Use Root Cause analysis (RCA) to investigate the case of falling moderate injury in January-March 2018.
2. By the Incident Decision Tree (IDT) to determine the system factor, and drawing a simple flow chart, and then according to the time sequence the list looks for the proximate cause.
3. Use the Fish bone diagram determines the correct execution procedures and differences, and develop an action plan.

Main Point #2 **Results**

1. According to the analysis, the cases of moderate injury cases were 4 at surgical wards, 3 at medical wards and 1 at intensive care unit.
2. It is confirmed by the incident decision tree (IDT) that all 8 cases are system factors for RCA improvement and the key processes and errors are confirmed according to each event.
3. Revision of "Standards for Fall Prevention " SOP Precautions for patients and their families who use the bed detector Precautions for patients and their families who use the bed detector

III. Conclusion

We propose improvement measures: Revision of "Standards for Fall Prevention" SOP, increase of accessibility resources to increase the awareness of hospitalized patients on the severity of falls, and use of information system to mark the risk of extreme falls.

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Author Summary: I graduated from the Institute of Health Services Management, China Medical University 2003. For the past seven years, I have been in the Mennonite Christian Hospital, where I have been am a Section Manager of Medical Quality Control Department. I like this job and I am proud of this hospital. In the past, now and in the future, I have tried my best to do my job.