Reducing Falls in Long-Term Care With Root Cause Analysis Method

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Session Title:
Leadership Poster Session 2

Keywords:
Elderly, Falls and Root Cause Analysis

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Abstract Summary:
This presentation discusses the use of the RCA for falls in one Long-term care facility. The data shows that Falls are a significant problem for many individuals. Even with our current policies in place falls continue to occur. Leadership and collaboration are needed to improve patient outcomes for this population.

Learning Activity:
<table>
<thead>
<tr>
<th>LEARNING OBJECTIVES</th>
<th>EXPANDED CONTENT OUTLINE</th>
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</thead>
<tbody>
<tr>
<td>The learner will be able to utilize the RCA method in order to improve fall rates among the elderly.</td>
<td>An example of the RCA method will get given to learners in order to facilitate the proper use of this tool for individuals that fall.</td>
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<td>The learner will have Improved knowledge that falls require a collaborative, team effort in order to facilitate prevention.</td>
<td>An example of the team approached used will be identified to show the learners how collaboration and team work improved patient fall rates in this population.</td>
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<td>The learner will be able to identify common causes of fall for this population.</td>
<td>A review of the literature will show the most common causes for falls in this population.</td>
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<td>The learner will be able to identify that the current falls risk assessment tools used today are not enough to prevent falls.</td>
<td>Examples of current falls risk assessment tools will be provided to show the learner the comprehensive tools used today are not enough to prevent falls for this population.</td>
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<td>At completion of this presentation the learner will understand how important it is to identify the Root Cause of falls in order to facilitate prevention.</td>
<td>Examples will be given that show how falls were prevented in several patients that were included in this pilot study.</td>
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Abstract Text:

Falls among the elderly are a public health problem that has economic and quality of life burdens not only to the individual patient, but also to society. The Joint Commission identified patient-safety goals to improve patient safety by attempting to eliminate any identifiable risk factors. There are multiple factors that lead to falls in the elderly. All stakeholders need to be aware of these risk factors and implement preventative strategies to assist this vulnerable population in the overall improved quality of care. This economic burden is substantial and increases the likelihood of mortality to the individual (Chen, Zhu, & Zhou, 2014).

Due to the rise in life expectancy in our society and the growing number of elderly, stakeholders need to be motivated to identify proactive plans that will improve falls in this population. Current falls risk assessments and programs utilized today are not enough to prevent reoccurrence of falls in this population. All stakeholders need to be involved in the care of these patients at the onset of care in order to provide adequate preventative modalities that will lead to fewer falls in this population. Providers need to do more than just a fall risks assessments and then treat after the fall. Modifiable programs need to be implemented for falls in the elderly that will improve patient outcomes.

In one pilot study the question was raised Does an evidence-based intervention (falls risk assessment tool) decrease the rates of falls in a long term care facility over a 10 week period compared to fall rates before a given pre-fall intervention? ? The population for this project includes any individual admitted to the long-term care facility that has a history of falls, or that falls during their stay in a long-term care facility. The intervention is to see if an education program that increases the awareness of individuals at high risk for falls in reducing the number of falls in this institution. The comparison will be a chart audit of falls prior to the implementation to discover if the number of falls pre and post implementation. The outcome is to have fewer falls in this population and improve stakeholder’s awareness of risks, as well as the need for effective interventions. The intervention will take place over a 10 week period.

The intervention is to see if an education program that increases the awareness of individuals at high risk for falls is effective. The RCA (Root Cause Analysis) method was taught and utilized during this project initiative change. The comparison of falls pre and post intervention will be completed by a chart audit of falls prior to the implementation and post implementation. The outcome is to have fewer falls in this population and improve stakeholder’s awareness of risks, as well as the need for effective interventions.

The results and data analysis were shown in this study by a bar graph showing before and after values using the RCA method. It was noted that there was a decline in patient falls post implementation of an educational intervention on the use of RCA to prevent falls in this population.

Implications for future research would be to identify if the use of the RCA would result in fewer falls in other populations as well.