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# Clarity PSO Learning Series

Topic: Falls and the Question "Why?"

Patient falls is an age-old topic of safety. It is one that often frustrates clinicians, data analysts, administrators, researchers, families and patients alike. Why? For one, it is a complicated issue and requires a number of interventions. We also pour time, effort, and diligence into preventing falls, but complete falls prevention constantly eludes us. There is not a single solution that will prevent falls in every aspect of healthcare delivery.

While there will never be one answer to this issue, we have to continue to look for ways to improve and minimize patient harm. For this PSO Learning Series Report, Clarity PSO focuses on patient falls and the importance of looking beyond the basic facts.

## What We Learned

The following are some high-level concepts that we learned about falls and fall prevention from the PSO event reporting database and a literature review:

- We may not be able to prevent *every* fall, but this does not mean we shouldn't reach for a goal of zero falls or at the very least, a goal of zero injurious falls.
- Evidence indicates that falls prevention is better achieved when several interventions are used together (Willy & Osterberg, 2014).
- A fall risk screening tool should be used followed by a thorough multifactorial fall risk assessment.
    - These tools must have high reliability and validity in capturing the patients likely to fall within the unit (Flarity, Pate, & Finch, 2013). Not all patients are equal in their risks for falling.
    - These tools must be tailored to the unit's patient population in order to accurately recognize those at risk (Flarity, Pate, & Finch, 2013).
    - The multifactorial fall risk assessment needs to lead to personalized interventions to address the patient's specific identified risks.
- It is crucial that a patient and his/her family is incorporated into the falls prevention program.

While these are only a few learnings, each of them is an important concept for organizations to know and to learn to ***do well***. Authors Betty Willy and Christine Osterberg (2014) published an article entitled, *Strategies for Reducing Falls in Long-Term Care Facilities*, that takes the high-level concepts outlined above to the next level. The target audience is long-term care facilities, but Willy and Osterberg shift the perspective on falls to a much broader audience.

The article outlines two case studies: one of a man diagnosed with Parkinson's disease and one of a woman with severe dementia. Both patients are identified as being at risk for falling and both do fall. The eye-opening information comes from the interdisciplinary teams' root cause analyses (RCAs) after the incidents.

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In each situation, the nurse, physical therapist, dietician, social worker, nursing assistant, physician and a family member gathered around the RCA table. The first question the group asked was: why did the patient fall? Instead of stopping after receiving the direct answer, which might have been "because he was trying to go to the bathroom," the group asked a follow-up why and then another why and then another. From asking a stream of whys, the team discovered underlying factors that not only increased both patients' risk for falling, but also revealed methods for personalized falls prevention measures as well as improved quality of care.

## Discussion & Resources

***In your organization, how many times is why asked after a patient falls?***

Of course, interdisciplinary RCAs for every fall may not be feasible with time constraints, staffing barriers, and organizational finances, ***but can we challenge ourselves***—as providers—to approach falls with this type of mindset? **To prevent a fall by comprehensively understanding our patient through the eyes of each discipline and by applying personalized support to those identified areas in need?** For example, within the article, the patient with Parkinson's disease fell while attempting to get out of his wheelchair, but upon investigation, it was found that he had a mouth sore. The mouth sore caused a decline in the patient's eating and resulted in a 10% weight loss over the course of a month. The weight loss perpetuated him developing weakness, stiffness and emotional upset. It was all of these factors that eventually led to his fall (Willy & Osterberg, 2014).

We must challenge ourselves to look deeper, to ask another why and to strive to seamlessly fit the pieces of a patient's story together. We are understandably frustrated by falls as they are undeniably challenging from multiple fronts. Their surface is deceiving; they appear simple and related to noncompliance, but they are abundantly complex with a myriad of influencing factors. Maybe the truth is we can't prevent every single fall, but ***to that patient and family, it is worth it to try***. Even though we will find trouble and setbacks, in the end, we will have a safer care environment and less patient injuries.

The following are a few questions to ask as you review your falls protocols and work to incorporate more whys into your discussions:

- What protocols, if any, do you have in place at your organization to ensure that a comprehensive perspective about the patient is achieved?
- How are clinicians educated, trained and supported to look comprehensively at falls prevention?
- What are the barriers preventing this comprehensive perspective? A lack of EMR interface? An EMR layout that doesn't allow you to easily piece together a patient's story? Lack of time? Lack of communication methods with varying disciplines?
- Does your fall risk score lead to a multifactorial fall risk assessment?
- Does that multifactorial fall risk assessment lead to the application of not only bundled falls prevention measures, but also personalized prevention measures?
- To what extent is the interdisciplinary team involved in falls prevention? In falls RCAs?
- How encompassing and impactful are your falls RCAs? Do they lead to practice changes?
- What do frontline staff think about falls RCAs?
- With the tools your organization has in place, ***how well does your organization perform/use those tools?***

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We encourage you to read Betty Willy's and Christine Osterberg's (2014) article, *Strategies for Reducing Falls in Long-Term Care Facilities*. It is an eye-opening read that challenges us to look at falls a little differently.

There are a variety of other resources available through organizations and societies that promote falls prevention and patient safety improvements, such as:

- AHRQ: TeamSTEPPS
- The National Patient Safety Foundation: RCA2: Improving Root Cause Analyses and Actions to Prevent Harm
- VA National Center for Patient Safety: Falls Toolkit
- The Joint Commission: Preventing Falls and Fall-Related Injuries in Health Care Facilities
- AHRQ's publication on preventing falls in hospitals: A Toolkit for Improving Quality of Care

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References

Flarity, K., Pate, T., & Finch, H. (2013). Development and Implementation of the Memorial Emergency Department Fall Risk Assessment Tool. *Advanced Emergency Nursing Journal, 35*(1), 57-66.

Willy, B. & Osterberg, C. M. (2014). Strategies for reducing falls in long-term care. *Annals of Long-Term Care: Clinical Care and Aging, 22*(1). Retrieved from http://www.managedhealthcareconnect.com/article/strategies-for-reducing-falls-long-term-care