# Learning from Falls following RCA

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This document presents data arising from focus groups held at Hospital A and facilitated by Dr Nicola Burgess and Professor Graeme Currie of Warwick Business School. The focus groups convened to discuss how we can improve the transfer of learning from the RCA process across the ward and across the organization as a whole in order to prevent in-patient falls. Findings from the focus groups are presented very simply in a table format with 'challenges' related to learning from RCA expressed on the left hand side and 'prescriptions for change' on the right. Themes, challenges and prescriptions for change are emergent from the focus group data, the views of the authors are not expressed; i.e. this a 'you told us' document and should be used as a platform for further discussion concerning the viability of the prescriptions for change that are suggested and how they might be implemented.

All data has been anonymised. The authors would like to thank all those who attended the focus groups for their valuable input and we hope that the findings will form a sound basis for service improvement and falls prevention.

## Focus Group data

| Theme | Problem or Challenge | Potential prescriptions for change and examples of best practice |
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| Brokering learning from RCA following presentation to IPFC across ward often does not take place | Limited gathering of all staff due to lack of time for ward meetings and brief handovers makes distributing learning across wards challenging | Look for opportunities to convey learning to all staff in a formal manner following an RCA. Failure to do so can result in knowledge brokering via the 'gossip chain' and subsequent 'chinese whispers' (i.e. knowledge is increasingly inaccurate as it is mobilised from one member of staff to another); learning from RCAs should be brokered to Doctors as well as Nurses and NRNs.<br><br>**1.** Board rounds were identified as an option for disseminating learning across to both doctors and nurses. Board rounds are currently being trialed with variable success, with some wards reporting that Doctors are not attending. However, this is potentially an opportunity to broker knowledge re. learning from RCA and more generally knowledge regarding falls prevention from nurses to doctors for a joint prevention focus between nurses and doctors on a daily basis. Relatedly, F1 doctors should be encouraged to attend board rounds alongside more senior doctors (Focus group 1).<br><br>1.A3/A4 learning: refers to one sheet of A3/A4 paper or a PowerPoint slide split into 4 sections with a heading at the top: 'We caused an injury/We made a drug error' followed by 'this is what we did really well. Again this solution (anonymised) encourages a team approach to falls prevention and does not restrict learning to nurses. The A4 document essentially translates the RCA into a summary document. The document might also be made publicly available for viewing by doctors, physios, patients themselves and patient families (Focus group 4)<br><br>2.Time out days are repeatedly mentioned in focus groups and in our wider evaluation across the Trust as opportunities to reflect upon RCAs and learning from RCAs, particularly using case examples; whilst valuable they take place infrequently and therefore preclude learning from RCAs in 'real time' to influence practice immediately<br><br>3. "A 'message of the day' from the ward manager is a quick activation trigger to highlight new learning or continually reinforce learning from RCAs to enhance a team approach to falls prevention (Focus group 3)<br><br>4."Snazzy" learning points on the notice board as an activation trigger similar to above (Focus group 2) |

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| | RCA is typically undertaken by the ward manager and presented at IPFC by the ward manager with limited involvement from others. RNs are often not exposed to committee and rely upon ward manager to broker learning and implement actions | Typically it is the ward manager who conducts and presents RCAs at committees however, most ward managers who participated in the focus groups have begun to encourage band sixes to get more involved. The following prescriptions for change were put forward:<br><br>- "The person who reported the fall should be the person that actually fills in the RCA because they were there", [with support from ward manager] (Focus group 3)<br>- Mini RCAs for falls without fracture (Focus group 3): "going through their paperwork...and if you're going to do every fall it may just trigger in them "Actually I don't want to do this again, I'm going to make sure it's alright next time"". Focus group 4 gave an example of conducting a mini RCA in the case of a fall without fracture<br>- The role of falls champion needs to be clearly defined...and they need time enough time to do the role effectively (Focus group 3); a Falls champion needs to be proactive and involved in RCAs, incorporating learning from RCA into training. A good falls champion needs to be someone who is proactive, genuinely interested/engaged in falls prevention on a daily basis (Focus group 2).<br>- Falls champions should be involved with Falls RCAs, attending IPFC regularly and brokering learning back from the IPFC across the ward. Time should be allocated to this activity |
| Actions not implemented following RCA | Too many RCAs; the process is seen as a mechanistic, time consuming, box ticking exercise. Once the RCA has been presented at committee it is filed away and invariably actions are not implemented. Ward managers do not have time to implement action plans: "For everything in the world I'm just going to present that at my meeting and that's out of the way, I can get on with the rest of it" (Ward Manager) | Many ward managers admitted to not implementing actions, often due to service line pressures (including RCAs for other patient safety issues such as infection and pressure sores) and a lack of resources: 'We haven't got time to actually do any actions because we're too busy writing action plans" (Focus group 3). Implementing actions should take priority, numbers of RCAs should reduce in volume following the implementation of appropriate actions based upon the root cause of the fall. All focus groups suggested trend analysis to be useful.<br><br>1. "Is it night time? is it going to the toilet? If so what specifically is the issue that causes patients to fall (eg. lack of staff, toilet roll in wrong place) and what can be done to prevent it? (Focus group 3)<br><br>2. The RCA should be quicker (Focus group 3) |

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| Doctors lack of involvement in falls prevention | Nurses describe lack of involvement,<br>Doctors describe lack of awareness | All focus groups describe difficulty obtaining in obtaining consultant involvement with RCAs, one nurse states that she has been waiting 2 months so far for a consultant to complete a section of an RCA form. There is some consensus of feeling amongst nurses that patient falls and the subsequent paperwork and learning is seen as a nursing issue and not a medical or surgical issue (all focus groups). The suggestion is that Doctors will deal with medical/surgical consequences of fall but do not seek to find a cause: “they don’t see themselves as having a role in terms of service improvement and preventing falls” (Focus group 1), the mentality of both doctors and nurses on the ward is “we’ll deal with our issues, you’ll deal with yours” (Focus group 2), as opposed to an MDT approach.<br><br>By contrast, the Doctors who attended our focus groups were very concerned that learning from RCAs and learning about fall prevention is shared between nurses and doctors: “All I knew is she fell...it’s happened. But there is no mechanism for following up on things that happened and passing on information...if we were to identify something - eg. not enough staff, we can put our weight behind changing that. If we don’t know about it we can’t” (Doctor). The following solutions were suggested by doctors who attended the focus groups:<br>· Present serious incidents of patient falls at Mortality & Morbidity Meetings (Focus groups 2, 3 and 4) for example “this is what happened, this is what the RCA has provided and this is what we’re doing about it” (Focus group 2)<br>· Ensure nurses are aware of when M&M meetings are so they can plan in advance for a representative to attend<br>· Present analysis of falls data bi-annually at M&M: “if we got together twice yearly together with our mortality things and we looked at patterns and there is a pattern, then we can do something about it” (Focus group 4)<br>· Doctors should be familiar with the falls tool kit, in support of this one doctor who did look at the tool kit following the death of a patient from a fall states: “it really does open your eyes” (Focus group 2)<br>· Action and learning from RCAs needs to come back to medics as well as nurses (Focus group 2)<br>Other potential solutions to raising doctor awareness of patient falls (not specifically proposed by doctors):<br>1. Doctors should be able to access incident data on Datex (Focus group 1)<br>2. A monthly MDT meeting with nurse involvement (not just nurse specialists) to incorporate issues on wards (Focus group 1)<br>3. Use yellow arm bands to highlight patient at risk of falls - this visual management tool is considered very successful by respondents in Focus group 3 due to ease of use<br>4. All staff (NRNs, RNs, doctors, physios) should be checking that patients with high falls risks are wearing slippers/glasses as needed (Focus group 3)<br>5. Allocating doctors to look after specific bays in collaboration with nurses: “forming part of our invisible eyes as it were as well as the nursing team”; incorporating doctors in nursing handover (Focus group 3) |

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| Falls risk awareness | Risk assessments are paper based, and considered inappropriate by some specialties. Often a high majority of patients are identified as 'at risk' therefore patients at risk of falls are normalised, often there risk status is not communicated to the rest of the team and documented intervention is inconsistent.: "just a piece of paper in the nursing notes... people weren't in that mindset of making that link between risk and intervention" (Falls champion, Focus group 2) | All focus groups talk about training and learning about falls awareness as crucial to embedding falls prevention across professions, particularly for student and newly qualified doctors and nurses, induction is reportedly more in-depth than it used to be and pushes patient safety issues such as falls, infection and pressure ulcers - this is reportedly having an impact. The following mechanisms for improving awareness amongst new members of staff were recorded:<br><br>1. Invest more in newly qualified nurses, one ward manager in Focus Group 3 states that she gives them six weeks supernumerary period: "I think that investment, even though we kind of paid for it with staffing time...really has an impact"<br>2. Monthly meetings with clinical educator to talk through notes of patient and RCA with the whole ward team (Focus group 3)<br>3. What training are student nurses receiving related to falls? Can the level of training outside of the organization prior be influenced?<br>4. Falls champion to include examples of patient falls in training, "nothing like an example of a patient maybe they've had an interaction with" (Focus group 4)<br>5. Beyond training: Staff need to understand the trend of falls on the ward, perhaps ask them "why do you think our patients are falling? What can we do?" (Focus group 4)<br>6. Mobility assessment needs to be recorded and kept up to date. It is not currently recorded on dashboard or picked up by assessment tools (Focus group 4)<br>7. When patients are transferred from one place of care to another it is beneficial for the receiving ward to be aware if the patient is at risk of falls. Morris ward (Focus group 2) now engage with daily communication with the transferring ward to identify patients who are at risk.<br>8. Focus group 2 also communicate daily with physios and OTs as they will hold key information about a transferring patients mobility issues<br>9. Doctors need to know if their patients are high risk of falls (Focus group 2), because they can then help the patient if they try and go to the toilet without their slippers for example. The wearing of yellow bands by patients who are very high risk presents one solution that provides a quick visual clue<br>10. Morris ward describe a recent innovation known as the mobility club or 11 o'clock club where an MDT meeting is held and patients who need two people to mobilise will be the responsibility of the physios and everybody else will be risk stratified as to who is going to walk with them (Focus group 2) |

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| IPFC RCA presentation process | Some respondents expressed fear of presentation | Whilst the anticipation of presenting an RCA at IPFC has caused some staff anxiety, the majority feel the experience is useful, particularly in terms of a 'learning fora'. This is positive and work needs to be done to extend the reach of such learning back to the ward (see solutions under theme 1: *Brokering learning from RCA following presentation to IPFC across ward often does not take place*)<br><br>1. Representatives from the wards should attend IPFC on a regular basis from a learning perspective and not just when they are involved themselves<br><br>2. Representatives should stay for whole IPFC rather than leaving after their RCA presentation<br><br>"I presented [an RCA to IPFC]... I think i was so focused on nurses, nurses, nurses that it took you [committee Chair] to say "Hang on, where was the doctor in all this? and I was like "Oh crikey, yes!"...it took that meeting to think actually yes why are we just focussing on what we've done, its quite a learning thing...if there wasn't that accountability you could become complacent..." (Focus group 3)<br><br>"if you get a chance to stay and listen to others you learn from those as well" (Focus group 3)<br><br>"The main thing that's changed [since presenting the RCA at IPFC] on our ward is training. We've got the two falls champions that are really hot on training now...attending the RCA, it was just things I hadn't thought of before" (Focus group 2)<br><br>"We've started cohorting for our very high risk patients now" (Focus group 2) |

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| Lack of nursing resources | Staffing must be sufficient to support the patient cohort. Changing patient demographics not reflected in staffing; overspend on agency and bank staff can deter ‘specialling’ of patients in need of one-to-one | Prescriptions for change:<br>1. Best practice example: “The other day we had two ladies that were both a high falls risk, they’re in the next bed together so all we did was simply put two chairs together, sat one person with them and we had a conversation” (Focus group 4?)<br><br>2. Focus groups 1, 2 and 4 all report that they are recruiting for new nurses having been understaffed for some time. Regular analysis of patient cohorts (eg. biannually or annually) to identify increasing co-morbidities of patients that might require additional resources. |
| Competing Trust Priorities | Priorities such as infection control and pressure ulcers and falls compete priority: “infection control think they’re top dog, falls think they’re top dog, tissue viability think they’re top dog and it’s really difficult to say who is and who takes priority and what do you need us to do...[the champions] are fighting with that person constantly” (ward manager). Linked to this, nurses are often faced with implementing new initiatives that often fizzle out once support has gone, eg. productive ward, care around the clock, patient safety thermometer etc | A number of patient safety priorities compete for attention and some are seen to be more important than others and may lead to a focus on one particular issue at the expense of another. Similarly, nurses suffer from change fatigue. Potential solutions:<br><br>1. Change needs constant champions, therefore champions should be self selected due to their interest in patient safety<br>2. For a new initiative to succeed, staff need to see the benefit of it<br>3. If staff do not see the benefit, the ward manager needs to be able to either reject it or modify it. Focus group 3 consisted of three ward managers, each described a different approach to dealing with a new initiative that was not perceived to add value: 1) accept it; 2) challenge via a process of shared governance through Union Practice Council (UPC); 3) subvert it: “my ward, my way”.<br>4. Morris ward has one ‘patient safety champion’ as opposed to several champions for separate priorities...this could possibly be a model for other wards to follow |

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| | The dashboard is a time consuming activity that is not considered to add value: “It [the dashboard] takes such a long time to do the business, to talk to everybody thats been telling you off for having a red dashboard and al the meetings you have to go to to do that...it’s not looking at the right things”. | No prescriptions |
| | Patient outliers present an additional challenge to nurses as their needs may differ from other patients | When reviewing outliers Doctors should adopt a balance of risk beyond a mechanical process of: “do they look like they will peg it [sic]” to consider patient safety issues such as falls that might be exacerbated by outlying the patient. |
| | At night, ward is controlled by Duty Nurse Manager who’s priority is patient flow, moving patients | Ward manager negotiated a compromise: patients not to be moved between hours of midnight and 6 am (Focus group 3) |
| Organizational governance structure | A lack of clarity regarding the organizational governance structure and knowledge of how to broker patient safety concerns upward to the board | Ward managers and ward matrons should make sure staff understand the governance structure and how it works. Ward staff (including doctors) need to know their role and part in the governance structure and how to use it, eg. “there’s a problem, who do I contact” (Focus group 2) |