



KEY POINT SUMMARY

OBJECTIVES

The objective of this study was to investigate the effectiveness of interventions to prevent falls designed through hazard analysis using root cause analysis.

Applying Root Cause Analysis to Improve Patient Safety: Decreasing Falls in Postpartum Women

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Key Concepts/Context

Patient safety is the foremost issue for medical care; however, it is often overlooked because of cost considerations, decreased level of nursing staffs, increased overtime of nurses, and resident fatigue, all of which can contribute to poorer patient safety outcomes. Postpartum falls are among the most frequent incidents that impair patient safety in obstetric wards. In 2005, the Joint Commission on Accreditation of Health Organization listed “reducing the risk of patient harm resulting from falls” as one of the annual goals on patient safety.

Methods

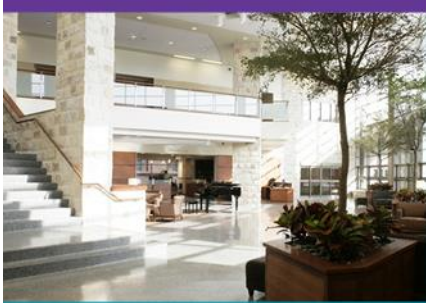
Using a prospective longitudinal study and under preceding root cause analysis with an intervention group and a non-intervention control group in two large hospitals in Taiwan, root factors for postpartum falls were classified into four major categories: environment and facilities, procedure, individual, and communication.

Findings

The major causes of falls were rapidly changing position or standing up, lack of using assistant facilities at the bedside, and holding a baby while walking.

Limitations

Women with complications after pregnancy were excluded from the postpartum fall sample. Women without a companion, relative, or caregiver were also excluded from the study. The study was also conducted in two large hospitals, which may not reflect the same conditions present in small hospitals.



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Design Implications

To decrease the incidence of postpartum falls and improve patient safety, toileting interventions should be made along with environmental assessments. Additionally, use technology and display spaces that incorporate live demonstrations and printed education information.