

Rebellion against the ‘normal’ to improve safety for patients

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Abstract

Patients who fall in hospital can suffer significant harm. This case study in an NHS hospital using interviews, observation and content analysis looked at how nurse leaders ‘rebelled’ against the norm of accepting patient falls as inevitable. A checklist approach combined with the intentionally checking high risk patients each hour was introduced. Initial results were good but not sustained. Obstacles to improvement included many competing demands, high levels of incremental normalisation supporting the theoretical position of practical drift away from set operational policies with patient safety implications.

Key words: patient falls, intentional rounding, checklist

Introduction

There are a significant number of patients who suffer adverse events in healthcare systems (De Vries et al, 2008). An ‘adverse event’ is defined as ‘any unintended event caused at least partly by healthcare and which resulted in harm’ (Sari et al, 2007). One of the most common causes of harm to patients in hospital are when they fall. A fall is defined as ‘all situations in which a patient suddenly and involuntarily came to rest upon the ground or surface lower than their original station’ (Oliver et al, 1997). In England, patient falls are more routinely reported as incidents than medication errors or adverse drug reactions (NAO, 2005). Historically staff in hospitals regarded patient falls as one of the complications that arise in hospitals and that there was little preventative action that could be taken. Therefore, a relatively high number of patient falls in hospital was regarded as ‘normal’. However, in recent years there has been a change of attitude and approach. This paper reports the outcome of case-based research in an NHS hospital, which has been undertaken to articulate the factors instigating this change of attitude. The study also identifies the specific interventions and actions undertaken by staff at the hospital to prevent patient falls.

Literature

Patient falls in hospital are common. The reported rate ranges from 3 to 14 per 1000 bed days, and are associated with a range of injuries and an increased length of stay in hospital

(Healey et al, 2008, Oliver et al, 2007) In England from September 2005 to August 2006, some 200,000 falls were reported to the National Patient Safety Agency. Analysis of the reported incidents of falls shows that 65% of patients resulted in no harm, 31% in 'low harm', 3.6% in 'moderate harm' and 0.6% in severe harm with 26 reported deaths (Healey et al, 2008). However, it is well recognised that there is serious under reporting of incidents in hospital (Olsen et al, 2007).

A systematic review and meta-analysis of studies to prevent falls and fractures suggested that there 'is reasonable evidence that using a multifaceted intervention for hospital inpatients may have a modest effect on falls but not on fractures' (Oliver et al, 2007). Interventions included risk assessment, medication review, care planning, and education. The literature supports the view that patient falls is a complex issue and that there appears to be no simple solution (NICE, 2004).

Vaughan (1996) shows that normalisation of deviance is key issue for safety. Her study of the Challenger Space Shuttle disaster illustrated that the system within which people work can produce a culture where, through small incremental steps, new situations are seen as 'normal'. This is described as the 'native view'. Outsiders looking at the situation are more likely to see the situation as deviant, not acceptable and therefore potentially dangerous. Waring et al (2007) point to types of behaviour by health care workers that illustrate 'taken for granted assumptions about clinical risk...' Such behaviours 'normalize risk' and as such mean that risk of harm to patients is not addressed. Waring (2005) suggests that medical staff regard error as 'inevitable' which can lead to errors being seen as 'normal'. These errors may not be reported as incidents and therefore do not provide the basis for improvements in safety. Genier-Sennelier et al (2002) suggests that in hospitals, staff can regard patient falls as an inevitable part of the rehabilitation process. Such a view may then influence the reporting of such incidents (Healthcare Commission, 2009).

Merton (1968) provides a framework of how social structures exert pressure on individuals to conform to patterns of cultural goals and institutional norms. 'Rebellion' is one of the five modes of individual adaptation to goals and norms proposed by Merton (1968). The rebellion by key leaders to goals and norms is used as the theoretical explanation of the change of attitude creating a reversal of the normalisation of deviance.

There is a developing science and methodology of improvement in healthcare. It is largely based around the idea of small change which is then tested and refined before being spread to generate larger scale change in practice. The bedrock method is the cycle of plan, do, study, act (PDSA), (Langley et al, 1996).

Research questions

What were the drivers that caused the staff to change their view of 'normal' in relation to patient falls? What and how did the staff change their behaviour and practice to improve the safety of patients?

Method

A case study approach was used as being the most appropriate to gather the contextual detail needed (Yin, 2003) and where there is complexity in the subject matter (Stuart et al,

2002). A criticism of case studies is that of being context specific and therefore transferability of findings to other situations can be problematic. However, when ‘they are used to contextualize key points of an explanation, and the explanation, and not the cases, carries the argument, case studies can be very powerful (Nightingale et al, 2003).

A mixed method approach using the simultaneous collection of qualitative and quantitative data was used (Creswell, 2003; Bergman, 2008). The underlying philosophy is that to obtain a better understanding of the phenomenon a range of epistemological perspective were used. Multiple sources of data collection were utilized. This assists in achieving triangulation in data collection, the interpretation and subsequent theory development.

An 760 bed NHS hospital was chosen as the case study where an improvement methodology was being used and significant change was beginning to occur in the level of falls prevention. The case studied was five medical wards where a new approach to falls was being implemented set within the context of the wider hospital. Those wards specialised in care of the elderly (48 beds), stroke (30 beds) and neurology (24 beds).

The hospital reported 1631 in-patient ward falls in 2008. The five wards had 568 (34%) of that total. On admission patients were assessed for the risk of falling. A scoring system of over 30 indicates that the patient is at very high risk of falling. The hospital Falls Management Policy in place at the beginning of 2008, required that certain actions must be taken by staff for any patient with a risk assessment score greater than 13.

Twenty seven staff (doctors, nurses and managers) were interviewed as part of a wider study using an interview protocol and then six further semi structured interviews were conducted with nurses working within the five wards focusing on the issue of patient falls. Meetings about patient falls were observed, papers and reports analysed and data on falls plotted using statistical process control charts (Wheeler, 2003). The interviews were transcribed and then coded using NVivo 8 to develop themes which were triangulated with the observational data and content analysis of meeting papers and reports.

Findings

The analysis showed that during the first part of 2008 there were different histories within the wards of staff attitudes to patient falls. The histories were related to the leadership of the ward areas. On two of the wards (A & B) the attitude was described as falls “just being one of those things that happens in hospital”. Risk assessments often were not done and when they were, little if any action was then taken. There had been a gap in the senior nursing leadership on those wards and for other nurses the situation was described as rather “chaotic”. The other three wards (C – E) had more stable senior nursing leadership at ward level. The attitude to falls was that they were “not what you want to happen but an inevitable part of getting patients mobile”. Risk assessments were undertaken and actions put in place especially when mobilising patients. There was little if any awareness of the national initiatives to reduce harm from patient falls (DoH, 2001; NICE, 2004).

At the end of 2007 and within the first few months of 2008 on wards A&B there were two falls incidents where both patients subsequently died. Root cause analysis (RCA) of the incidents were carried out. In one case a confused patient climbed over the bed rails (raised

in this case inappropriately to help prevent the patient getting out of bed) on two occasions the same night and had fallen. That patient subsequently died from a head injury sustained from the second fall. The other incident concerned a confused patient who had fallen some twenty times over a number of weeks on the ward without any significant action being taken. That patient sustained a fractured hip and subsequently died. Both RCAs showed systemic failure within the wards. The hospital Falls Management Policy did not appear to be well known by staff and therefore poorly implemented and supervised. This situation was set within the context of the hospital achieving the highest rating for its services from the Healthcare Commission and with a Hospital Standardised Mortality Rate (HSMR) below the expected rate.

Following the RCAs the Lead Nurse with overall responsibility for all the medical wards in the hospital felt ‘ashamed that these patients had died’ and then led the ‘rebellion’ against regarding patient falls as a ‘normal’ part of a hospital stay. Her primary lever was to engage with the emotions of staff by presenting the patient stories. Most staff were not fully aware of the potential level of harm that can result from a patient fall. Staff were also shocked and some visibly upset that these incidents could have occurred. There were also many competing demands on staff time and preventing falls was regarded as just one among a number of priorities.

QUALITY: Patient Safety–Falls

For patients with a falls risk score of >30, please enter either ‘A’ = achieved or ‘V’ = variance in columns.
Record reason for variance and action taken overleaf.

THIS PATIENT REQUIRES OBSERVATION EVERY MINUTES

DATE:	TIME					
1.CONTINENCE Do you need to go to the toilet?						
2.PAIN Do you have any pain?						
3.ORIENTATION – fully alert=FA; mildly confused/disorientated=MC; severe confusion/disorientation=SC; asleep=A						
4.POSITION / COMFORT Are you comfortable?						
5.DRINK / MOUTHCARE Would you like a drink?						
6.CALL BELL WITHIN REACH If you need me, press this button						
7.BED RAILS DOWN						
8.BED TO FLOOR						
9.IS THERE ANYTHING ELSE I CAN DO? Because I’ve got the time						
INITIALS						

Figure 1 Intentional Rounding (IR) checklist

As well as engaging with the emotions of staff to shock them out of normalising falls in hospital, the Lead Nurse with a colleague developed a tool for staff to use to improve their care of patients at high risk of falling. The tool combined two patient safety techniques; a 'checklist' approach (Frank, 2006) and 'intentional rounding' (Owensboro Medical Health System, 2008). The checklist was a simple list of questions and actions (Figure 1) for staff to undertake with any patient who had been assessed as having a high risk of fallings (score >30). The 'intentional rounding' (IR) is the requirement to go round the ward and speak to those high risk patients every hour using the checklist. A simple checklist form was devised for staff to use which then became part of the medical record for that patient. Using the PDSA methodology IR was tested by one nurse on one patient on one ward on one shift. Amendments to the checklist form were made before the tool was then disseminated to other nurses and then the whole ward team. A training pack was developed which helped the tool to be implemented in other ward areas within a short period of time.

In wards where a number of patients were assessed to be high risk then they were cohorted in a six bedded bay and a nurse allocated to that area all the time. This made the process of IR much quicker and focused staff resource towards the higher risk patients. The use of bed rails was also questioned and staff were reminded of the need to carefully risk assess and document their use. The checking of the bed rail status was then incorporated into the intentional rounding checklist. For many patients bed rails can increase the risk of harm from falling so should be used selectively.

There was some opposition to the introduction of IR. The concern was whether staff had the time to dedicate to IR given the many other priorities on a busy ward. The principle of PDSA was again employed and nurses realised that in some ways it helped them in prioritising and managing their workload. PDSA was also used to introduce IR to Care Assistants who provide much of the practical hands on care for patients. Registered nurses could then delegate IR to them and focus their attention on those tasks requiring their skills, such as dispensing medications.

The Lead Nurse set up weekly then monthly meeting to review progress with wards that implemented IR. As more wards took on the tool they were invited to the meeting. The reliability of the tool being used was tested informally by senior nurses visiting the wards and looking at the medical records of high risk patients.

Initial results from the first two wards to use IR (Wards A&B) were encouraging. The staff attitude towards patient falls changed, the number of falls reduced (Table 1) and there was a determination to learn from those incidents that did occur. The hospital incident form was supplemented by asking for further information as nurses suspected from studying the results, that patients with risk scores of between 20-30 and who had some form of cognitive impairment, could also benefit from IR.

The IR tool was spread rapidly from wards A&B to C-E and then within two months to a further four wards. Using the PDSA methodology what became evident during this rapid spread was that the training of staff was diluted and results were not sustained. Even on the initial wards (A&B) it was found that a patient had been assessed on seven occasions with a score greater than 30 but had not been put on IR because the nurses believed she was bed

bound and therefore unlikely to fall. However, that patient did fall although was not injured. There was also a case of one patient who despite being on IR, fell a number of times and caused a ‘blip’ in the ward A results.

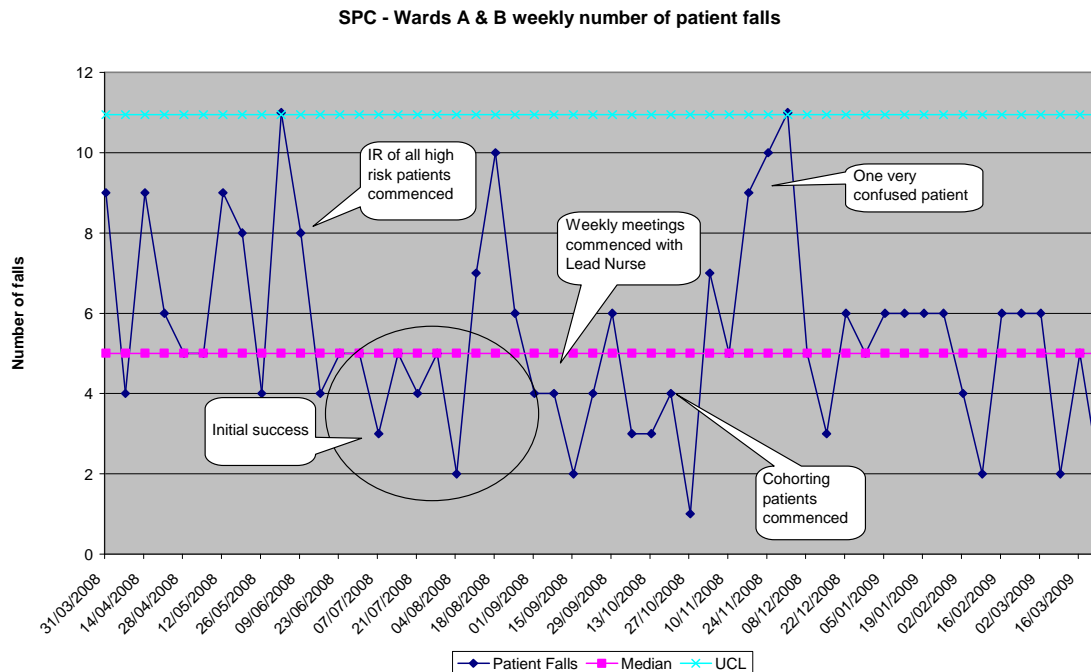


Table 1 Statistical process control chart - number of patient falls on wards A & B

Discussion

The ‘rebellion’ signifies the rejection of the ‘normal’ cultural goals; the rejection of the institutional means of acceptance and mechanical reporting of falls combined with minimal preventative action. Staff who engaged in the ‘rebellion’ put in place new goals (any fall is unacceptable) and institutional practice (staff using a checklist approach every hour to speak to patients at high risk of falling). It is accepted that to achieve no falls for patients in hospital is not a feasible goal. However, the unquestioning acceptance (normalisation) of the likelihood of falls in hospital results in a failure to implement systematic methods to reduce the risk for certain patients. The adoption of the changes required considerable leadership, education, training and persistent communication. However, even with the level of leadership given, the initial improvements were not sustained to the level desired. Using the PDSA methodology lessons were drawn as to why the initial improvement was not sustained as the new practice was spread. A number of changes to the training and auditing of results have since been put in place.

The findings support the theory of practical drift from a designed way of working (Snook, 2000) as set out in the ‘Falls Management Policy’. Staff drifted from the ‘Policy’ due to the competing priorities and finding practical ways to achieve their workload. In doing so they traded effectiveness for thoroughness (Hollnagel, 2004) and normalised their position as acceptable (Vaughan, 1996; Weick and Sutcliffe 2003). The danger of using a root case analysis approach to investigate those patient falls that result in significant harm, is that

such a method often fails to look at the broader systemic issues such as practical drift and trade offs which are endemic amongst staff due to the competing pressures (Dekker, 2006). Senior managers can be left with the impression that the problem is isolated to particular wards rather than being a system wide issue that relates to more than one safety policy area.

Whilst PDSA is a powerful tool to achieve change, the cultural norms that have been established incrementally over many years, it takes a sustained effort by leaders to install rebellion. Regular meetings with staff were necessary plus constant feedback and learning when falls did occur. Those staff in this study who had been directly involved or felt responsible for a patient falling with a serious subsequent injury engaged with the change process at a much deeper level supporting the theory that 'emotions can act as drivers or motivators, of subjects' engagement with discourses' (Garrety et al, 2003).

Conclusions

Improving patient safety in the midst of many competing demands requires considerable effort. Despite national initiatives and a revised Falls Management Policy staff in the case study hospital which was externally assessed as 'excellent', largely accepted the cultural norm that patient falls were part of being a patient in hospital. Theory relating to change in clinical practice to improve safety must take account of the strong cultural bias for staff to accept what is regarded as 'normal' and not challenge the status quo. Ways to encourage 'rebellion' include engaging with staff about the emotional stories of individual patients who suffer harm through a lack of proactive action.

Whilst there are limitations to this single case study there are aspects that have relevance to the wider practitioner interest in improving patient safety through cultural and practice-based change. From a theoretical perspective it seeks to build on the literature by developing the understanding of the drivers that reversed the normalisation of deviance and how safety was improved for patients in hospital.

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