AMERICA'S ESSENTIAL HOSPITALS

A featured project from the Essential Hospitals Engagement Network (EHEN)

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

John H. Stroger Jr. Hospital of Cook County

A Multidisciplinary Approach to Preventing and Reducing Falls

Problem Identified

Evidence-based interventions to prevent falls had been implemented in some units, however, the interventions were applied in an inconsistent manner. In addition, almost 20 percent of patient falls occurred in non-acute care areas where limited interventions were in place to prevent and reduce falls. In response, a multidisciplinary workgroup was created to implement fall prevention initiatives in a consistent manner hospital-wide.

Interventions

Stroger formed a multidisciplinary workgroup that was charged with the coordination and implementation of programs for reducing and preventing falls. The workgroup identified four interventions and prioritized them for implementation. They include: (1) purposeful rounding, (2) post-fall huddles, (3) re-evaluation of patient/family education, and (4) collaboration with the pharmacy department to review medications in high-risk patients. Compliance with the new interventions is tracked as a performance measure using a falls dashboard.

Outcomes

Stroger reduced its all-fall rate by 40 percent, successfully meeting the hospital's fall reduction goal. Since the first quarter of 2013, the all-fall rate and the fall with injury rate have decreased by 52.9 percent and 84.6 percent, respectively. In the future, Stroger plans to consistently implement evidence-based interventions to reduce falls hospital-wide, by expanding to the maternal-child unit, procedural areas, and the emergency room.

Falls EHEN Collaborative Workgroup

	TARGET	SOURCE	Q1 2014	Q2 2014	Q3 2014	Q4 2014
John H. Stroger, Jr. Hospital						
All Medical/Surgical Units and ICUs/CCUs						
All Fall Rate	7.1	Internal	8.93	4.28		
Falls with Injury Rate	0.8	Internal	0.79	0.37		
Medical/Surgical						
Total Falls	0	Internal	162	68		
Falls with Injury	0	Internal	12	6		
ICU						
Total Falls	0	Internal	29	24		
Falls with Injury	0	Internal	5	2		
Maternal-Child (OB, L&D, Peds, Nursery)						
Total Falls	0	Internal	2	11		
Falls with Injury	0	Internal	0	0		
Other: Including ER, Procedural (Infusion Center, Radiology/Imaging)						
Total Falls	0	Internal	14	9		
Falls with Injury	0	Internal	0	2		
FALL RISK ASSESSMENT						
Total Falls	0	Internal	207	112		
Fall Risk Assessment upon Admission	100% Compliance	Internal			Begin tracking in Oct 2014	
Risk Assessment every 24 hours	100% Compliance	Internal				
Fall Precautions in Place	100% Compliance	Internal				

Leadership and Patient Engagement

The executive director of nursing serves as the executive sponsor for the multidisciplinary workgroup. The hospital's chief quality officer is a member of the workgroup, and nursing representation consists primarily of nurse managers and directors. Patient/family education and engagement is currently being re-evaluated by the workgroup.

Lessons Learned

The hospital recognized the need to better align its fall prevention policy with existing practices and procedures on medical/surgical units. The project demonstrated that improved coordination with the pharmacy department and other members of the multidisciplinary team would generate improved outcomes. Hospital staff also recognized that purposeful rounding and post-fall huddles were either inconsistently practiced or not implemented at all for many units across the hospital. The workgroup learned that consistent and hospital-wide adherence to the interventions would lead to continued reductions in falls and falls with injury at the hospital.

Strategies for Successful Replication

Strategies for successfully implementing a falls reduction program include the following:

- Track and measure compliance of the evidence-based interventions through a falls dashboard.
- Present the dashboard quarterly to the Nursing Quality Assurance Committee and the hospital's Patient Safety Council to engage leadership.