

OSF St. Joseph Medical Center: Fall Prevention



Bloomington, Illinois
Submitted by the JCR HEN with hospital permission

FALL RATE not at "ZERO" PREVENTABLE falls

A sentinel event in 2010 triggered OSF St. Joseph Medical Center to look more closely at their fall prevention efforts and develop a standardized process.

The first step was to survey the staff and determine barriers to implementing the fall prevention strategies and to gain input and suggestions on how to improve the process. A team was formed that included managers and frontline staff. The team reviewed literature and current research to determine "best practice" for fall prevention.

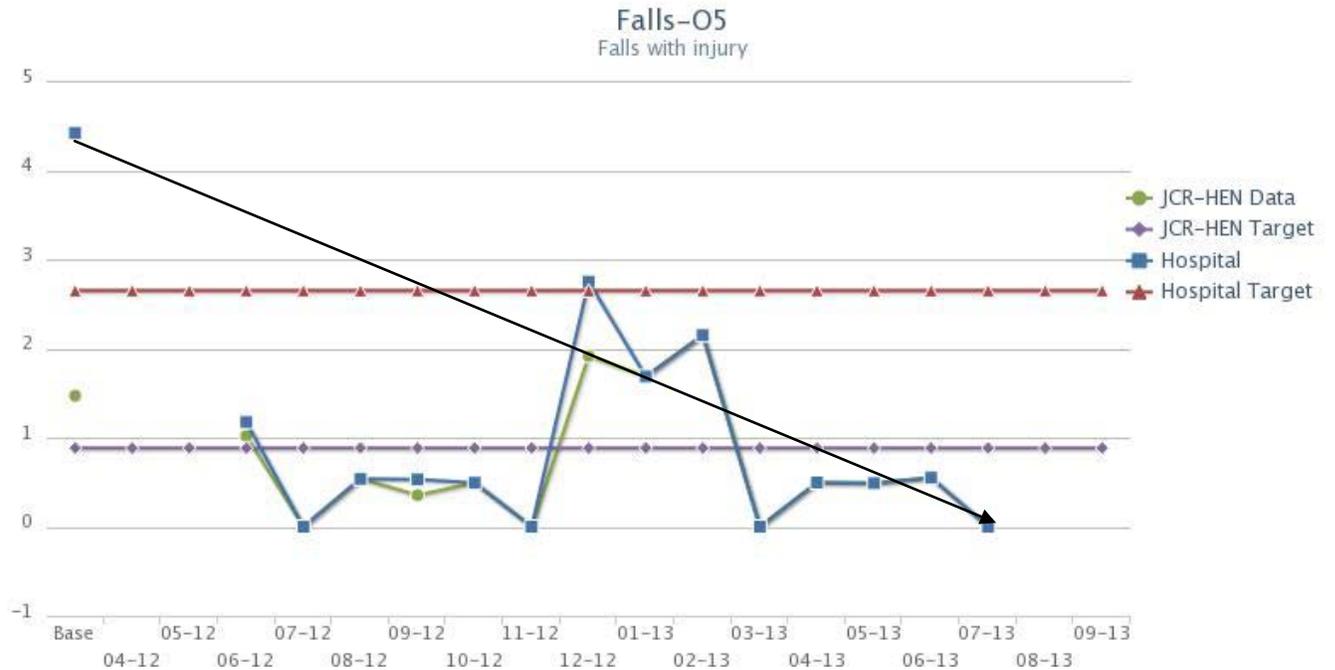
A Fall Prevention Fair was held to allow staff to trial and vote on products they wanted to use as well as using that time to introduce new processes such as the Fall Prevention Cart. This is a self contained cart that is placed on each nursing unit and contains signs, alarms and everything that is needed for the fall prevention program. Education was developed for ancillary staff, volunteers and nursing staff. In order to promote accountability, a Partnering for Fall Prevention document was developed to be used with patients and their families. Patients, families and staff are asked to initial and date the document. An ancillary department checklist was also developed to remind ancillary staff working with fall risk patients to be sure the call light is within reach, inform unit staff that the patient has been returned to the room, assure top side rails are up, the bed height is in lowest position and the bed alarm is on. 100% of the OSF St. Joseph Medical Center staff completed "no pass zone" training for answering call lights.

As with any new process, there are barriers to change. It is hard to change how you have "always" practiced. It is difficult to remember when returning the patient to the unit to inform the nurse; and to be sure the bed alarm is on. The

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implementation of the “no passing zone rules” has helped to hardwire the processes and change the culture of the entire organization.

Baseline Falls with Injury rate was 4.42 in 2011—in July 2013 the rate is 0.00.



Respectfully Submitted By: Cindy Archer

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