Producing Evidence to Make Healthcare Safer: Implementation and Evaluation of Multi-Team Systems to Decrease Fall Risk in Critical Access Hospitals

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Background/Purpose

Context: The 1,333 Critical Access Hospitals (CAHs), which are licensed for 25 beds or less and serve rural areas of the U.S., are exempt from non-payment for hospital-acquired conditions. Yet, they care for a high proportion of older adults who are at greatest risk for injury from falls.

Fall rates are labeled a nursing-sensitive outcome. However, falls are multifactorial in etiology, and evidence indicates that interprofessional teams are most likely to sustain successful fall risk reduction programs.

Local Problem: In 2011, we found that the risk of falls and fall-related injury was significantly greater in Nebraska’s Critical Access Hospitals (CAHs) than in its’ larger hospitals that receive payment under the prospective payment system (PPS).

However, after adjusting for volume, hospitals in which teams learned from data and integrated evidence from multiple disciplines had significantly lower fall rates than hospitals in which teams did not perform these coordinating activities.

Purpose: The purpose of Collaboration and Proactive Teamwork (CAPTURE) was to use a multi-team system (MTS) to implement and coordinate fall risk reduction in 17 small rural hospitals in Nebraska. An MTS is made up of two or more interdependent component teams that work together to achieve a common goal. A second purpose was to produce a toolkit that complemented the existing AHRQ Preventing Falls in Hospitals Toolkit.

Methods

2011-2012 Conduct Gap Analysis

2012 Assess Organizational Context

Focus Group/Interview Topics
- Awareness of Gaps
- Accountability for Outcomes
- Ability – Knowledge to Bridge Gaps
- Action – 3 Things to Improve

2012-2014 Standards Event Reporting & Post-Fall Huddle

2012-2014 Implement Evidence-Based Practices

Conclusions: Consistent with MTS theory, interprofessional teams that coordinate activities of component teams may be an effective structure to make healthcare safer. Post-fall huddles are a coordinating mechanism that facilitates a shared mental model of the fall risk reduction interventions and goals for component team members. AHRQ’s most recent annual update on HACs reported limited progress in decreasing injury from falls. More widespread adoption of an MTS fall risk reduction strategy may accelerate national progress in reducing injury from falls.