Background: Given the current fears regarding healthcare reimbursement (Cosgrove et al., 2013) as based partly on quality outcomes and patient satisfaction data, hospital administrators have been challenged to find better ways to improve patient outcomes and ensure appropriate utilization of resources (CMS, 2013). One facility, in a large healthcare organization, made the decision that each clinical nurse specialist/nurse clinician would be charged with championing quality issues that affect the entire site. Inpatient fall numbers were a challenge as the inpatient units were working independently without sharing data, successes, and struggles.

Purpose: To: 1.) Break down existing barriers to collaboration within the site, 2.) Share successes and struggles between units, 3.) Decrease house-wide fall numbers

Framework: The Johns Hopkins Nursing Evidence-Based Practice Conceptual Model as depicted in Melnyk and Fineout-Overholt (2011).

Population: All inpatient medical/surgical, general surgical, orthopedic surgical, cardiac, and rehabilitation patients on non-ICU patient care units located in a large, urban, quaternary care hospital in the Midwest.

Method: The inpatient, non-ICU, falls champion made a decision, after consulting unit CNSs, to hold quarterly team meetings with the leadership dyads and their respective falls champions to break down barriers to collaboration and strengthen communication of identified best practices and struggles within the site. The meetings were held in an open discussion format with each unit identifying barriers and successes. Hospital-wide themes were identified and taken, by the falls champion, to appropriate internal partners for rationale/resolution. The meetings were scheduled for mid-month following dissemination of unit-based nurse sensitive indicator reports to ensure adequate time was available for review and analysis of unit-based data.

Results: There was a 19% overall reduction in falls between 2011 and 2012. 2013 YTD has continued this downward trend with an 8% overall reduction in total falls.

Conclusions/ Implications: The quarterly sessions as well as the sharing of data between all inpatient non-ICU units appears to have had a positive effect on overall fall rates within the inpatient units. Implications for the site are to continue this process and consider expanding into other problematic quality forums such as pressure ulcer prevention with the champion of that group implementing quarterly team meetings during the third quarter of 2013 to facilitate transfer of current best practice information and to identify internal barriers.