



Background

- Falls occur more commonly among patients in acute care settings
- 5 % of falls result in fracture and an additional 2 % result in serious injury requiring medical attention
- Risk factors for falls: age, history of falls, cognitive impairment, dizziness, impaired mobility, etc.
- In a study, a staff-led quality improvement intervention to reduce falls on a neuroscience ward was done. In this intervention, intentional rounding was evaluated. A 50% decrease in falls was demonstrated on wards that implemented intentional hourly rounding

Practice Change

- In this pilot study a total of ten patients (seven rooms) were selected to have hourly rounding conducted each night for two weeks
- A paper was near each patient bed for the nurse to initial during hourly rounding

Methods

- Introduced the concept of hourly rounding in conjunction with bed alarms on nights to reduce fall rates in huddles and at a Shared Governance meeting
- After the study was complete a questionnaire was answered by nurses to gauge how they felt the unit was doing with screening patient fall risk on admission

Measures and Results

Hourly Rounding Tool

Patient Positioning

Is Bed Alarm On?

Call Bell/Personal Items Within Reach

IV Sites Assessed

Elimination Needs Addressed

Actual or Suspected Pain addressed

Psychosocial and Safety Needs Addressed

Level of Consciousness

Results

- In the two weeks prior to our pilot study implementation (June 9th-June 25th) there were a total of six falls on Grant 4 Cardiac
- In the two weeks during our pilot study implementation (June 25th-July 9th) there were a total of two falls by the same patient on Grant 4 Cardiac
- *See group member to view how nursing staff filled out hourly rounding papers*

Lessons Learned

- Our results from the implementation of hourly rounding on nights in conjunction with bed alarms were inconclusive as nurses were not open to the idea of changing the current routine of rounding every two hours on nights to every hour
- Nurses were also not happy with having to fill out the normal “Caregiver Rounding” in the chart and sign the papers for hourly rounding in the rooms

Questionnaire

- Do you think high quality hourly rounding will help to improve fall rates on Grant 4 Cardiac?
- Do you think a visual reminder at bedside will help to remind staff to turn on the bed alarm?
- Do you think we could improve on screening patients during admission? (Recent falls, medications, orthostatic hypotension, etc.)
- What do you think is the number one reason patients fall on this unit?
- *See group member to view staff answers*

Conclusion

- Nurses are not currently on board with implementing hourly rounding on the night shift
- Nurses were found to be signing off the papers in chunks at a time, which defeats the purpose of hourly rounding
- Nurses report that patient confusion and staff to patient ratios are the biggest cause of falls on Grant 4 Cardiac
- Nurses think that a visual reminder at bedside, such as falling star signs, would help to decrease fall rates

References

Berry, S., & Kiel, D. (2016, September 26). Falls: Prevention in nursing care facilities and the hospital setting. Retrieved from <https://www.uptodate.com/contents/falls-prevention-in-nursing-care-facilities-and-the-hospital-setting>

Morgan, L., Flynn, L., Robertson, E., New, S., Forde-Johnston, C., & McCulloch, P. (2016). Intentional Rounding: a staff-led quality improvement intervention in the prevention of patient falls. *Journal of Clinical Nursing*, 26(1-2), 115-124. doi:10.1111/jocn.13401