Intentional Rounding as a Strategy to Decrease Patient Falls

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### Introduction
- Falls are the leading cause of injuries and hospitalizations in the United States.
- Falls are directly related to the quality of nursing care in the hospital setting.
- Falls result in longer lengths of stay, effectively increasing patient morbidity and mortality in the acute care setting.

### Purpose
Decrease the need for call light use by hourly rounding, thereby impacting patient fall rate.

### Methods
- In 2015, a committee was formed to include Nursing staff, Nursing Management, and the Unit-Based Council.
- Baseline data was collected and reviewed for fiscal year quarter four 2015 (FY Q4 ‘15).
- The team identified obstacles including: staff buy-in; availability of staffing; clearly defining the role of the hourly rounding staff; consistency of staff rounding; and patient perception of too many interruptions.
- A revised workflow was developed and implemented. Including but not limited to: taking a Certified Nursing Assistant out of patient assignment to serve solely as rounding staff; rounding on every patient at least once an hour; rounding conversations with patients targeting the areas of pain, bathroom help, position change, personal items not in reach, and equipment check.

### Results

#### Baseline data for Quarter 4 of 2015
- Patient falls rate at 5.6%
- Patient calls at 42,000

#### Post-implementation data for Quarter 1 of 2016
- Patient falls rate decreased to 1.46%
- Patient calls decreased to 37,000

#### Post-implementation data for Quarter 2 of 2016
- Patient falls rate decreased further to 0.46%
- Patient calls decreased further to 33,000

### Conclusions
- Positive impact on fall rate and the number of patient calls requesting assistance.
- Staff perception of CNA assigned as a rounder was positive.
- CNA completing hourly rounding additionally was able (depending on census and acuity) to assist with ambulating patients.
- The project was negatively impacted when there was a higher number of patients requiring 1:1 sitters.

### Recommendations
- Further staff education is needed on the Morse Falls Scale.
- There are opportunities for the Unit Secretary to check the Morse Falls Scale fall prevention measures that are being utilized.
- Evaluate for a strategy that includes acuity.